Australian Government
Department of Health and Aged Care

Responses to questions from the Home Care Packages (HCP) program assurance reviews

Unspent funds and pricing transparency on My Aged Care

March 2024

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HCP program assurance reviews

Unspent funds (Commonwealth portion) review

Q. Why did you only choose 44 providers?[1]

A. All reviews are risk based. The 44 providers were chosen using a risk-based approach if they satisfied either of 2 criteria:

- providers held an average unspent funds amount of $15,000 or higher per care recipient
- providers reported a $0 balance of the Commonwealth unspent funds for a high proportion of exited care recipients.

Q. Was there a certain type or size of provider that didn't have financial capacity to return funds[2]?

A. No there wasn't. As stated in the review report published on our website, all 44 providers gave the required assurance that they could return Commonwealth unspent funds if required.

Most providers selected to take part in Review 2 - Unspent Funds were corporations. The Department of Health and Aged Care (the department) did not publish the size or type of the companies that did not have financial capacity to return unspent funds due to commercial-in-confidence considerations.

Pricing transparency on My Aged Care review

Q. Why can't my hyperlink on My Aged Care just go on my home page?[3]

A. To meet the legislative requirements of the *Quality of Care Principles 2014* and the responsibilities under section 19C(1) and (4) of the *User Rights Principles 2014* providers are required to have a full price list available on My Aged Care as either a document, such as a PDF or Word document, or as a hyperlink that opens directly to the provider's pricing information. It's important that the hyperlink opens directly to the pricing information as it's often difficult for people to navigate and find pricing information on the website.

Q. Would you please clarify the status of observations as opposed to issues in individual pricing reports.[4]

A. Findings were set out in three sections.

1. Findings where providers were not meeting program requirements in relation to pricing transparency. These required actions from providers as mentioned in their reports.

[1] Response provided during webinar and refined/paraphrased in this document. Verbatim response can be read in the webinar transcript.
[2] ibid.
[3] ibid.
[4] Ibid., page 3

2. Incidental findings, which were findings where providers were not meeting program requirements, other than those relating to pricing transparency. These required actions from providers as mentioned in their reports.
3. Observations, which in principle were made to support the provider's continuous improvement, even where they are meeting program requirements. It was up to the provider to consider any action, as appropriate, and there is no follow up from the department for these.

For each review, the definitions of terms are articulated in the reports to ensure clarity for providers. Observations, for the purposes of the individual pricing reports, were made to assist providers to improve their pricing information on My Aged Care and their websites, for example, suggestions regarding better practice and making things more transparent for consumers, or aligning more closely to the HCP program's intent.

Q. Please provide more details about the incidental finding of the HCP Program Assurance Review 3 – Pricing transparency on My Aged Care - "prices subject to change without demonstrating adequate consultation and/or consent".

A. Review 3 noted that some providers indicated that their prices may be subject to change without seeking consent from care recipients.

Providers must notify care recipients of any changes to their pricing, and provide adequate consultation to enable them to give their informed consent as per 23(3) of the *User Rights Principles 2014.* This should be documented in the home care agreement before providers start charging the new rates. All prices and price increases must be reasonable and justifiable.

Providers are also required to support care recipients to understand their home care agreements, including any changes made regarding fees and charges as per 22(3) of the *User Rights Principles 2014.*

For more information on home care agreements, including reviewing and updating a home care agreement with a care recipient, see home care agreements for home care packages.

Q. I would like to understand why you state charging $0 for care management means that care management is not being delivered? Surely you can deliver care management and choose not to charge for it?

A. Entering '0' or '$0' is not aligned with the HCP program's intent. To meet legislative requirements, including complying with the Aged Care Quality Standards, care management should be delivered by all providers and therefore should have an associated cost per fortnight entered.

Q. In regard to "staff travel" in the 3rd review, the review team noted some charging model descriptions were unclear as to when and how much a care recipient would be charged. Would you explain how travel costs should be charged and price published?

A. Providers are required to enter a price per kilometre (if any) that they charge care recipients for travel to a care recipient for the purpose of providing care or services as per section 19B(1)(b) of the User Rights Principles 2014.

Providers are required to enter $0 when they do not charge for travel in this way. A staff travel description may be entered.

Providers have the flexibility to explain their business model within the free text fields. This could be to explain how this cost is calculated, for example whether it calculates per kilometre from their office, or if they charge for this cost in a different way.

When determining whether to charge for staff travel, providers are reminded that all costs must be reasonable and clearly identified for care recipients.

Excluded items review

Q. When will the review of exclusions be completed and results published?

A. The review into excluded items is expected to be completed, and results published, around mid-2024.

Q. What are the components of the excluded items review?

A. Previous assurance reviews and stakeholder feedback have identified a lack of understanding about what the HCP program subsidy can be used for. This impacts the ability of care recipients to make informed choices about their care, affects value for money for the program and could mean funds are misused. This review seeks to answer 2 critical questions.

4. Is the program subsidy being used for care and services that are exclusions and how widespread is this practice?
5. Why such practices are occurring?

Q. Have the providers already been selected for the current review?[5]

A. Yes. The review into excluded items is currently underway. We are at the fieldwork stage and all providers have been selected and are aware of this.

Provider reports

Q. Will providers who participated receive individual reports and feedback from their report?[6]

A. All providers are informed of the outcomes of a review, and all will receive advice or feedback in writing at the conclusion of the review. For example, if no issues relating to program requirements are identified, a provider may only receive a letter noting this finding and thanking

[5] ibid., page 3
[6] ibid., page 3

the provider for participating in the review. When issues with program requirements are identified, providers receive individual reports.

Procedural fairness is a very important part of the review process. Even though review officers engage with providers throughout a review, providers are offered an opportunity to review and challenge review findings in their draft reports and then their report is finalised. Entry and exit interviews are also offered, usually on a voluntary basis.

Compliance

Q. If we need to ask any questions if we don't understand compliance, where can we find the support or who to contact?

A. For program assurance review reports related questions, including any follow up queries regarding actions outlined in your individual report, please contact the team at HCPProgramAssuranceCompliance@health.gov.au.

If your compliance question relates to regulatory findings made by the Aged Care Quality and Safety Commission (the national regulator for aged care), please contact info@agedcarequality.gov.au, or call 1800 951 822.

Volunteering for next review

Q. Are providers able to volunteer for the next review?[7]

A. Yes, providers can volunteer to participate in assurance reviews. For example, 5 providers volunteered to participate in the first review into indirect and care management charges.

If you would like to volunteer to participate, please contact the program assurance mailbox: hcpassurancereviews@health.gov.au.

General

Q. What is the difference between what you do and what the Aged Care Quality and Safety Commission does?[8]

A. The government is committed to enhanced accountability and transparency of home care. The department, not the Aged Care Quality and Safety Commission (the Commission), is responsible for good program governance. Ensuring that public funds are used for the purposes provided is critical to support responsible use of taxpayer funds, and to ensure that the maximum number of older people can benefit from home care packages. That is why the department is undertaking HCP program assurance reviews.

The Commission is responsible for protecting and enhancing the safety, health, wellbeing and quality of life of people receiving aged care. It is the national end-to-end regulator of aged care

[7] ibid., page 3
[8] ibid., page 3

services, and the primary point of contact for consumers and providers in relation to quality and safety.

Where appropriate, HCP program assurance review information is shared with the Commission. Where the Commission identifies non-compliance, it will respond in a way that is proportionate to the issues identified which, depending on the extent of non-compliance, may involve enforcement action.

Q. The reviews sound beneficial from a care recipient perspective. Are you likely to do them again?[9]

A. Yes. The department is doing program assurance reviews to support enhanced transparency and accountability of home care and ensure value for money for care recipients. Where required, the department will repeat a review, for example, based on findings from the previous review, due to updated risks or where new intelligence becomes available.

The department has an assurance plan that details which program assurance reviews and activities may be undertaken. The 2023-25 assurance plan is available on our website. This is informed by, among other things, findings from previous reviews, provider posture, relevant intelligence, and a detailed assurance planning process.

HCP Program Assurance Community of Practice

Q. Is there a list of organisations represented on the HCP Program Assurance Community of Practice?

A. No, there is no list of organisations represented on the HCP Program Assurance Community of Practice. Registration is open to staff from approved HCP providers, and from peak bodies of providers and consumers. There is a simple sign-up process on the HCP Program Assurance Community of Practice webpage.

How to report suspected fraud

Q. What is being done to follow up with the providers who have purposefully flaunted the rules for quite some time? Is there any meaningful penalty, or are they being rewarded for their behaviour?[10]

A. Provider's must use HCP program funds for approved purposes and the department expects providers to follow program rules and requirements.

This is one reason why the department has been undertaking program assurance reviews since October 2021. The reviews are risk-based, and as part of planning for a review the department considers findings from previous reviews, public concerns, program risks, relevant intelligence and other such aspects.

[9] ibid., page 3
[10] ibid., page 3

In terms of consequences for providers, please note that all providers that are corporations are *legally required to participate in reviews*. If a provider does not provide information, fails to answer questions, or fails to give reasonable assistance, *providers may be fined* as per powers under the *Aged Care Act 1997* (30 penalty units). In addition, *the department may also publish on its website the names of any providers* that do not satisfactorily participate in a review.

All providers with issues identified by the review team receive individual reports that identify, among other things, actions the provider must respond to. Providers who do not respond appropriately are followed up by the department's program assurance review team. So far, providers have generally cooperated and undertaken the required actions.

Where appropriate, the department does share review information with the Aged Care Quality and Safety Commission (the Commission). The Commission is the national regulator for aged care. Where the Commission identifies non-compliance, it will respond in a way that is proportionate to the issues identified which, depending on the extent of non-compliance, may involve enforcement action.

Any program assurance related concerns can be emailed to the department at: hcpassurancereviews@health.gov.au.

Anyone wishing to share information about a provider, or another aged care provider can provide such information, including anonymously, through the department's fraud reporting channels:

Telephone: 1800 829 403 (this hotline is open 9am to 5pm Australian Eastern Standard Time (AEST), Monday to Friday)

Email: agedcarefraud@health.gov.au

Website: Report suspected fraud form.

Q. How can we report third party service providers who do not provide the care recipient with the services they require?

A. The approved provider is responsible for ensuring the provision of quality and safe services. Approved providers can be reported to the Aged Care Quality and Safety Commission on 1800 951 822. Any intelligence for program assurance review purposes can be provided to the department either through the fraud line (where appropriate – see response to the previous question above) or to the email address: hcpassurancereviews@health.gov.au

HCP provider registration

Q. I would love to become a provider but not sure where to start.

A. Please refer to the the provider approval process webpage.

HCP assessments

Q. Where can we report care recipients that need their HCP level changed to a lower level?

A. Some care recipients may accumulate a surplus of funds in their home care package. These care recipients should request their provider review their care plan to ensure more efficient and appropriate use of HCP funds. The provider should also be regularly reviewing care plans and individualised budgets to ensure the assessed care and services needs of the care recipient are being met.

If a care recipient accumulates surplus funds, known as unspent funds, they will be returned to the government when they leave the program.

Eligibility for a HCP

Q. Who can get a Home Care package with Aged Care ID?

A. The program is intended to support people over 65 years of age with complex ageing related care needs to stay at home.

Exceptions to the age cut offs include:

- younger people, or people with disabilities not otherwise supported by other programs, or individuals on a low income
- people who are homeless, or at risk of being homeless, aged 50 years or older (45 years or older for First Nations people).

An Aged Care Assessment Team (ACAT) assessment will determine if a person is eligible for the program and what level HCP they are approved for. Individuals will need to contact My Aged Care to apply for an assessment on 1800 200 422.

HCP program waiting times

Q. What are the waiting times for a HCP?

A. Access to a HCP is a two-step process: firstly assessment, and secondly allocation of a package from the National Priority System.

The National Priority System allows for a nationally consistent and equitable process for assigning HCPs based on people's individual needs and circumstances, regardless of where they live. A person's wait time is dependent only on their date of approval and priority for service.

Information about the National Priority System is available in the Home Care Packages Program Data Report which comes out quarterly and is available via the aged care data reports and publications webpage.

Wait times are also published on the My Aged Care website.

Q. Why are the waiting times for a HCP so long?

A. The department is monitoring a significant increase in the number of HCP assessments and approvals in recent times which has led to an increase in wait times. In addition, both the number of HCPs and HCP take-up rates are at an all-time high.

Publishing of pricing information

Q. With the publication of all providers spending to be released in February 2024 to increase transparency, what will be the implications for providers that are not publishing their pricing in 2024?

A. Under the *Aged Care Act 1997*, providers must comply with their legislative obligations relating to pricing, including ensuring that prices do not exceed the sum of the maximum daily amount charged for HCP as required under Part 3, Division 3B of the *User Rights Principles 2014*. The requirement to publish pricing aims to increase consumer transparency and make more funds available to meet the assessed needs of care recipients.

Providers who are found to be charging above the maximum daily amounts for HCP will be required to refund to the care recipient the difference as required under Part 3 of the *Fees and Payments Principles 2014*.

Providers may also be referred to the Aged Care Quality and Safety Commission for further analysis and investigation.

HCP program unspent funds

Q. Do you recognise that unspent funds are often "saved up" by package recipients for eventualities and uncertainties? Many pensioners are reluctant to delve into their allocated budget. Notwithstanding this, they certainly merit those funds and discretion in how they "spend" same.

A. Yes, the department is aware that recipients save up unspent funds to facilitate large purchases of equipment or home modifications in line with inclusions permitted in the program.

As per existing arrangements, any large purchases must be:

- related to the care recipient's care needs
- agreed within the care recipient's care plan
- within the available budget for the package level, with any charges mutually agreed with the care recipient through the home care agreement before purchase.

Providers can access unspent funds to pay for large purchases. Where the cost exceeds available funds for the care recipient, providers and their care recipients can:

- postpone the purchase until there are sufficient funds to cover the costs

- enter leasing arrangements where appropriate
- pay for a piece of equipment in instalments through a lease-to-buy arrangement
- access additional support (up to $1500) through the Commonwealth Home Support Programme (CHSP) in certain circumstances. This may be subject to the available capacity of CHSP providers and their available funding, given CHSP care recipients will be the priority. Care recipient contributions may apply.

The HCP program is governed by the applicable legislation. Home care providers are responsible for understanding and complying with all legislation that is relevant to delivering home care.

Q. How long can unspent funds be held for?

A. Any accrued unspent funds will stay with the care recipient until the person exits the program. Unspent funds are returned to the Commonwealth unless the care recipient returns to the program within 70 days.

Q. I have worked as a case manager with clients who have huge amounts of accumulated funds and refuse services. Why is this not managed better as there are many people on waiting list that need the support to remain in the community?

A. Some care recipients may accumulate a surplus of funds in their home care package. These care recipients should request their provider review their care plan to ensure more efficient and appropriate use of HCP funds. The provider should also be regularly reviewing care plans and individualised budgets to ensure the assessed care and services needs of the care recipient are being met.

Any unspent funds which have accrued will stay with the care recipient until they exit the program.

When a care recipient departs the program, the Commonwealth portion of unspent funds will be returned to the government. The only portion of funds that would be returned to a care recipient's estate upon death is the funds they have contributed toward their package that have not been spent on care and services (e.g. income tested care fee).

Q. Does the Government plan to cap the proportion or amount of unspent funds that can be accumulated?

A. Any accrued unspent funds will stay with the care recipient until they exit the program. Unspent funds are returned to the Commonwealth unless the care recipient returns to the program within 70 days.

Q. Is there any update on using unspent funds for new technology?

A. When making decisions on inclusions and exclusions, providers are expected to work with their care recipients in consultation with the 'Inclusions/Exclusions Framework' at Part 9 of the the Home Care Packages Program Operational Manual (version 1.4).

Q. We have been trying to return unspent funds that were sent to us by another provider. We have not been able to do this. Would you please confirm the best process.

A. Consideration needs to be given to the type of unspent funds. Are the unspent funds the provider-held Commonwealth portion (pre-September 2021) which the previous provider should have returned to Services Australia; or are they the provider-held care recipient portion, which should be used first before putting through a subsidy claim?

Details on processes for providers are outlined in the the Home Care Packages Program Operational Manual (version 1.4).

Information on return of unspent funds is at section 13 of the the Home Care Packages Program Operational Manual (version 1.4).

Q. To what extent are unspent funds related to a lack of available services?

A. The department does not track the underlying reasons for unspent funds. The program was designed to facilitate accumulating funds for large purchases or respite entries.

Self-managing a HCP

Q. How does your Branch plan to deal with different approaches to managing HCPs? Recipients who self-manage a HCP have different needs and aspirations (emphasis on independence and autonomy) compared to fully-managed HCPs and residential care. More "control and oversight" will see more complaints.

A. Providers should tailor care and services to suit the individualised needs of the care recipient.

Home care packages are delivered under a Consumer Directed Care (CDC) approach. CDC is a service delivery model where care recipients have more of a say in their own care. Care recipients are placed in the centre of the health and wellbeing process.

Care management is a service providers must deliver to all care recipients even if an individual chooses to self-manage. Self-management means a care recipient is more actively involved in their care planning. This will look different for everyone. A provider may decrease their care management charges depending on how involved a care recipient is in their care planning. This must be negotiated between care recipient and provider.

The provider is still responsible for meeting the requirements of the program even if an individual chooses to self-manage.

The onus is on the provider to meet the accountability principles of the program and the assessed care needs and preferences of the individual.

Inclusions and exclusions of the HCP program

Q. Why do service providers use care recipients' unspent funds to pay for excluded items.

A. When resolving complaints in relation to a person's care and services, if it is found that a service provider has used HCP funds for payment of an excluded item, the Aged Care Quality and Safety Commission can issue Directions in order for the provider to comply with their responsibilities under the *Aged Care Act 1997* and principles. This could include, at a minimum, repayment of any amounts that have been unlawfully charged against the budget.

Q. This government is putting so many restrictions on how care recipients are able to spend HCP funds, even though they have sufficient funds available, and the things needed fall within the idea of packages being available to keep people in their homes. Some of these things are recommended by a GP, but people still cannot get them. Why not?

A. The HCP program is governed by the applicable legislation. Home care providers are responsible for understanding and complying with all legislation that is relevant to delivering home care.

The HCP program supports older people with ageing related care needs to live independently. A HCP delivers co-ordinated packages of care and services to meet the care recipient's assessed ageing related care needs. Care and services delivered must align with the individual home care budget and the scope of the program. It is not a general income support program.

General income is defined as those expenses that all citizens must pay for themselves throughout their life, regardless of age. If a care recipient would have paid for items and services themselves prior to entering the program, then it would be a clear exclusion.

Please see question 4 of the Home Care Packages Program Inclusions and Exclusions – FAQs for Providers – version 1.

A range of health professionals can prescribe or recommend services, supports and items to be included as part of a HCP, noting that not all services require a prescription.

This may include:

- an assessor (Aged Care Assessment Team (ACAT) or Regional Assessment Service (RAS)) at an initial assessment for the HCP program or re–assessment
- a treating medical practitioner, such as a general practitioner (GP) or specialist
- a registered nurse (RN)
- a registered allied health professional, such as an occupational therapist, physiotherapist, exercise physiologist, speech pathologist, podiatrist, etc.

The health professional must have experience and training within their relevant field. Allied health professionals must be registered with the Australian Health Practitioner Regulation Agency (Ahpra) or self–regulated by another national professional association.

A prescription for services, supports and items must be within the scope of the health professional's area of practice. For example, a dietitian can advise on nutrition, hydration, meal preparation and diet. Examples are in the table below.

HCP type of service, support or item	**Prescriber/assessor**
Personal services	ACAT, RN, occupational therapist, physiotherapist
Activities of daily living	ACAT, speech pathologist, GP, RN or other health professionals operating within their scope of practice
Nutrition, hydration, meal preparation and diet	ACAT, dietitian, speech pathologist, GP or RN or other health professionals operating within their scope of practice
Management of skin integrity	ACAT, RN, GP or other health professionals operating within their scope of practice
Continence management	ACAT, RN, GP other health professionals operating within their scope of practice
Mobility and dexterity	ACAT, RN, GP, physiotherapist, occupational therapist, chiropractor other health professionals operating within their scope of practice
Support services	ACAT, RN other health professionals operating within their scope of practice
Care management	ACAT, RN other health professionals operating within their scope of practice
Clinical care	ACAT, RN other health professionals operating within their scope of practice

Not every item would need a prescription, for example, a jar opener.

Care managers are encouraged, where possible, to work with care recipients' existing supports through the primary care and other health systems when conducting care planning.

It is important to note while the department encourages care recipients to follow the advice of treating professionals, the HCP program is not obliged to fund all recommendations from treating professionals as they may not be within scope of the program.

Recommendations may be funded under the HCP, provided they meet the other requirements of the 'Inclusions/Exclusions Framework' in the the Home Care Packages Program Operational Manual (version 1.4). We recommend care recipients discuss with the provider whether it meets the requirements of the framework, how purchases such as this would impact the package budget, and their capacity to deliver other care and services.

Q. Is there a set amount where letters of approval are not required in order to purchase an item under a HCP?

A. Please see question 6 of the Home Care Packages Program Inclusions and Exclusions – FAQs for Providers – version 1.

There is no set amount for purchasing goods, equipment and assistive technology (GEAT) without a health professional's assessment.

To determine whether a GEAT item should be included in a care recipient's package, providers must consider the following factors:

- the assessed care needs of the individual
- the package budget
- scope and intent of the program
- how they will plan for these purchases.

GEAT may be provided to a care recipient where consideration has been given to the inclusions/exclusions framework in the Home Care Packages Program Operational Manual (version 1.4), and it meets the following criteria:

- the need for the item can be identified in the care recipient's care plan, program scope, assessed needs
- the item can be provided within the care recipient's package budget
- the GEAT provided is specific to frailty, for example, functional/postural decline, not standard household items. There are exceptions for some standard household items, such as a recliner or electric adjustable bed, if a relevant health professional determines that items meet the care recipient's current and prospective age-related care needs.

Q. Can a client who does not speak English buy an iPhone to interact with his daughter who lives in Hong Kong? He is deaf in his left ear and has low hearing in his right, even though he wears hearing aids.

A. Please see question 10 of the Home Care Packages Program Inclusions and Exclusions – FAQs for Providers – version 1.

- Laptops, phones, and similar electronics are typically excluded under the HCP program.
- Telephone and internet costs (except for setting up the connection) are excluded.
- There are exceptions for the purchase of IT equipment, including tablets, laptops and internet subscriptions, to help older people communicate with their providers, family, carers and social groups under the following circumstances:
    - homelessness

- medication management (page 68 of the Home Care Packages Program Operational Manual (version 1.4))
- social inclusion purposes consistent with the Commonwealth Home Support Programme, noting support is capped at $500 per care recipient per year (or up to $1,000 in exceptional circumstances).

The *Quality of Care Principles 2014* lists the care and services that cannot be paid for through a HCP. This includes the use of package funds as a source of general income.

General income includes those expenses that all citizens must pay for themselves throughout their life at every age.

When making decisions on inclusions and exclusions, providers are expected to work with their care recipients in consultation with the 'Inclusions'.

If, prior to entering the program, the care recipient would have paid for a phone (smart phone or otherwise) themselves, and can afford to do so, then it is a clear exclusion.

Q. How do you deal with care recipients who pressure case managers to purchase excluded items?

A. To meet legislative obligations, providers may need to have challenging conversations with care recipients and their carers about whether a type of care, service or item can be included in a HCP. It is the responsibility of providers to be clear with care recipients about the scope and intent of the program.

Providers must comply with their legislative obligations, and this cannot be impacted by care recipient pressure.

Care and services delivered must align with the individual home care budget and the scope of the program. It is not a general income support program.

When resolving complaints in relation to a person's care and services, if it is found that a service provider has used HCP funds for payment of an excluded item, the Aged Care Quality and Safety Commission can issue Directions for the provider to comply with their responsibilities under the *Aged Care Act 1997* and principles. This could include, at a minimum, repayment of any amounts that have been unlawfully charged against the budget.

A framework of considerations is included in section 9.5 of the Home Care Packages Program Operational Manual (version 1.4) to support these discussions.

It is also important that providers document and retain records of the reasons why a service or item is included or excluded.

Providers will also need to help care recipients understand what care, services, and purchases they can afford within their package budget.

Q. Will there be review of the HCP inclusion and exclusion list soon since there is still a lot of grey area that needs to be rectified.

A. The department is regularly reviewing communication products and welcomes feedback. Please write to the department at agedcareenquiries@health.gov.au and provide specific examples of suggested grey area clarifications.

Q. Who do we contact to see if a service is covered by a home care package if we are unsure?

A. Please see page 9 of the Home Care Packages Program Operational Manual (version 1.4)

Alternatively, you may wish to read the Home Care Packages Program Inclusions and Exclusions – FAQs for Providers – version 1.

To answer any questions you have, the My Aged Care contact centre is open Monday to Friday 8am-8pm and Saturday 10am-2pm. You can call the My Aged Care provider and assessor helpline on 1800 836 799.

The department's state and territory offices will be able to assist you with HCP program management enquiries that cannot be answered by My Aged Care.

WA	WAPlaces@health.gov.au
NSW/ACT	NSWPlaces@health.gov.au
VIC	vic.office@health.gov.au
QLD	engagement.QLD@health.gov.au
SA	SAPlaces@health.gov.au
TAS	TAS.Office@health.gov.au
NT	NTPlaces@health.gov.au

The following peak bodies may be a further source of information and support for delivering aged care services generally:

- Aged & Community Care Providers Association (ACCPA) www.accpa.asn.au 1300 222 721
- COTA Australia www.cota.org.au (02) 6154 9740
- Federation of Ethnic Communities Councils of Australia (FECCA) www.fecca.org.au (02) 6282 5755
- National Aboriginal Communities Controlled Health Organisation (NACCHO) Affiliates www.naccho.org.au (02) 6246 9300
- National Seniors www.nationalseniors.com.au 1300 765 050
- Older Persons' Advocacy Network (OPAN) www.opan.com.au 1800 700 600
- Australian Association of Gerontology www.aag.asn.au (03) 8506 0525

Q. We find inconsistency between advice given by My Aged Care to clients and the guidelines around acceptable use of funds. Will there be some work around this?

A. The department is regularly reviewing My Aged Care contact centre scripting, and welcomes feedback. Please write to the department at agedcareenquiries@health.gov.au and provide specific examples of inconsistencies.

Q. To ensure timely services/care for a client, can a documented phone call with agreeance on price and frequency of a service take place prior to the budget being signed to allow the client to access services immediately?

A. Agreement with the care recipient to meet their care needs, goals and preferences, and the prices to be charged, does not have to be in writing. However, all conversations with care recipients must be documented within the home care agreement. Updates to home care agreements can be made after consent has been given.

Allied health charges

Q. For allied health what does it mean to be able to charge face-to-face and non-face-to-face contact. What work can be charged and what cannot?

A. Section 9.8 of the Home Care Packages Program Operational Manual (version 1.4) provides guidance on which allied health services can and cannot be funded through a HCP.

Third party services charges

Q. For equipment purchased on behalf of clients, are providers bound to charge exactly the same price as quoted by the equipment supplier or can they agree a different price?

A. From 1 January 2023, providers must not charge a separate amount for third-party services, even if they made a business decision to engage a third-party or the care recipient chose a third-party to provide those services.

Providers must indicate in their HCP pricing schedule whether they charge an additional amount for any services they sub-contract from another service provider.

The provider must agree an all-inclusive price with the care recipient before the services start, or before purchasing any goods.

Staff travel charges

Q. Can you advise if any guidance has been or will be provided on charges for transport to visit a client? I note in your first review there was inconsistencies between providers. It can include both the costs of staff time or wage costs as well as mileage costs of the vehicle.

A. Staff travel means travel by a staff member to a care recipient and providers must ensure all charges are reasonable, justifiable and easy to understand.

Staff travel is a common service charge covering reasonable staff costs for travel to and from care recipients' homes. This may include travel from a provider's office or a staff member's home to deliver care and services, such as nursing, garden maintenance, and care management.

Providers must:

- consider whether it is reasonable to charge for staff travel separately from service prices, taking into consideration:
    - their location – as a guide, the median charge for staff travel is $1.10/km (January 2023)
    - their business model – whether staff travel is already covered in common service charges
    - staff scheduling logistics.
- publish reasonable staff travel prices on My Aged Care as a per kilometre charge and provide details of when and how these charges will be applied, for example, to and from travel, for distances >10km, or charged for the total distance travelled etc
- include any details of travel costs (per km) in care recipient home care agreements, monthly statements and pricing schedules
- aim to provide care recipients with predictable, consistent and reasonable charges for staff travel
- ensure charges are not duplicated, for example charged as part of an inclusive third-party price and then charged again separately for staff travel
- be able to demonstrate the costing model and justify pricing if requested.

While staff travel charges may also include a contribution toward the costs of staff travel time, wage costs or vehicle costs, the charge does not necessarily offset all charges associated with staff travel, as some of this (if not all) will be covered in the general service charge.

The department expects providers to price their care and services so that they cover the costs of delivering them. Providers may occasionally have to absorb costs such as staff parking and bridge tolls as part of general business costs.

Providers must enter the price per kilometre (if any) they charge for travel to a care recipient for the purpose of providing care or services as per section 19B(1)(b) of the *User Rights Principles 2014*. Providers must enter $0 where they do not charge for staff travel in this way.

Providers are encouraged to explain their business model within the free text field on My Aged Care, such as how the cost is calculated. For example, whether it is calculated per kilometre from the provider's office, or if they charge for this cost in a different way.

End of life care

Q. Where and when can we discuss waiting times and urgency of packages especially for end of life.

A. People who have chronic or terminal health conditions may be supported by state and territory health palliative care specific services and housing systems, as well as the aged care

system, to provide basic daily living support and care. This can include assistance with daily chores, personal care, providing meals, transport assistance, respite care, home modifications and social support.

A person may require specialist palliative care if they have complex palliative care needs. Specialist palliative care service provision is delivered through the state and territory health systems, although in some cases a person's palliative care needs can be met by their general practitioner. All Australians are eligible to access the primary care health system through hospitals, general practitioners and allied health practitioners. All Australians, regardless of age, can and should access these services as needed.

Palliative care

Q. I work in palliative care and home care packages are not responsive enough or address the complex needs dying patients often face. Some providers who take palliative patients on don't even have nursing supports they can provide. Having providers who specialise in just providing services for palliative patients with complex medical needs is imperative.

A. When a care recipient has complex or complicated symptoms which cannot be managed by aged care workers using a palliative approach, a referral to a specialist palliative care service is appropriate.

While the Australian Government provides a national leadership, education and policy role in palliative care, it provides funding to state and territory governments for the delivery of specialist care services in their jurisdictions. This arrangement enables each state and territory government to make decisions about the provision and delivery of specialist palliative care services in their health systems, to meet the needs of their community. This forms part of their responsibilities through hospital and community service provision. Information on specialist palliative care service providers can be found on the find a palliative care service provider page.

Social, Community, Home Care and Disability Services (SCHADS) Award

Q. My concern is the implementation by providers of the 2-hour minimum service under the Social, Community, Home Care and Disability Services (SCHADS) award. Many HCP recipients require one-hour service daily am and pm; therefore, the package hours will fail to meet their other care needs. What can be done to address this situation?

A. The changes to the SCHADS Award which were introduced from 1 July 2022 resulted in casual and part-time home care employees being paid for a minimum two-hour shift. This is a good outcome for aged care workers who want job security.

However, providers are required to consider how they schedule their workers accordingly to not impact care recipients. For example, providers can schedule more than one care recipient within the two-hour minimum, rather than imposing a two-hour minimum on a care recipient.

The provider cannot charge a package for time when services are not being delivered, nor can they set unreasonable minimum service periods.

Under the *User Rights Principles 2014*, the *Aged Care Act 1997* and Australian Consumer Law, a home care agreement is an agreement between the home care provider and care recipient. A provider cannot change a care recipient's service delivery arrangements without consent to the changes, and being reflected in the home care agreement, individualised budget and care plan. If a provider wishes to increase their service charges, these changes must be reasonable and justifiable, and they must also be agreed and documented in the care recipient's home care agreement.

If you feel a provider is not complying with their responsibilities, you can escalate those concerns to the Aged Care Quality and Safety Commission. The Aged Care Quality and Safety Commission provides a free service for people to raise concerns about the quality of care or services delivered to people who receive Commonwealth-funded residential or home care services. There are strict confidentiality and anonymity provisions within aged care legislation that ensure people who request confidentiality are protected from having their identity disclosed. The Aged Care Quality and Safety Commission can be contacted on 1800 951 822 or by visiting the website at www.agedcarequality.gov.au.

Alternatively, if individuals need assistance with their aged care services, the Australia-wide Older Persons Advocacy Network (OPAN) provides advocacy services. OPAN can be contacted on 1800 700 600 between 8am and 8pm from Monday to Friday, and between 10am and 4pm on Saturday. Details about OPAN can also be found at www.opan.org.au.

Q. Is there a way you can find out whether providers are accurately interpreting the SCHADS award, ie some providers are charging 2 hours for every service? Others are charging the actual time spent on a service?

A. Please see response above.

National Aged Care Advisory Council

Q. Will the government consider setting up a group of older people to advise them on their opinions relating to the planned changes to Australian aged care services?

A. The National Aged Care Advisory Council was established as part of governance arrangements arising from the aged care reforms. The National Aged Care Advisory Council provides advice to government on key matters relating to the aged care sector and meets every 6 weeks. For more information, please visit the department's website committees and groups page.

The Aged Care Council of Elders was established as an advisory body to the aged care reforms. The Aged Care Council of Elders provides a direct voice to government from older people. The council talk to older people about changes being made to aged care and listen to their experiences. The council uses this information to give independent advice to government about the aged care system and ageing well. They consider views from older people across

Australia when providing advice to government. For more information, please visit the department's website committees and groups page.

Support at Home questions

Questions were received during the webinar about the future Support at Home program, which were outside the scope of program assurance of the HCP program. These included questions about how the department will treat unspent funds in the future, and whether unspent funds that have been accumulated will be protected.

The Support at Home team has presented webinars on the proposed new program which can be found on the department's webinars for the aged care sector.

Q. How can I find out more about the Support at Home program?

The new Support at Home program will replace the HCP program and Short-Term Restorative Care Programme (STRC) from 1 July 2025. The Commonwealth Home Support Programme will transition to the new program no earlier than 1 July 2027. Support at Home will improve access to services, equipment and home modifications to help older people to remain healthy, active and socially connected to their community. The department will continue to work with HCP and STRC providers to ensure they are prepared to transition to Support at Home well ahead of 1 July 2025. Visit the department's webpage for more information about the Support at Home program.

Masks in home care

Q. What is the consensus on mask wearing in home care?

A. COVID-19 continues to pose risks for some people in Australia, especially older people and aged care residents. We need to remain mindful of the symptoms of COVID-19 and other respiratory viruses and stay home if unwell to minimise transmission to others. Continued vigilance by maintaining COVID safe behaviours, such as mask wearing, is recommended.

The Chief Medical Officer recently advised that for people at higher risk of severe illness, mask wearing is encouraged, especially if a worker or visitor to the home is experiencing unwell symptoms. Wearing face masks is a very important part of infection prevention and control measures and has shown to reduce the risk of transmission for respiratory viruses.

The department encourages all aged care workers who provide close personal care to older people to wear masks. Wearing a mask when working or visiting settings with people at higher risk of serious disease, particularly in times of high respiratory viral activity, is important to reduce the risk to others.

All aged care providers are required to deliver safe and quality services in line with the Aged Care Quality Standards. Aged care services and providers should be regularly assessing the risk of infectious diseases, including COVID-19, and adapting their planning and preparedness to respond. Each service and provider should take all possible steps to address any risks identified through their risk assessments.

The National Statement of Expectations on COVID-19 Management in Aged Care Settings provides nationally consistent principles and best practice guidance to the aged care sector on their responsibilities for preparing for and responding to COVID-19 outbreaks, including the appropriateness of mask wearing in aged care settings, including for in-home care.

Aged care providers can also adopt their own policies, and work health and safety arrangements. Under state and territory workplace safety legislation, all aged care providers are responsible for providing a safe working environment for staff.

You can read more about COVID-19 advice for in-home aged care providers and Managing COVID-19 in aged care on the department's website.