



## Questions & Answers

### Improved Payment Arrangements (IPA)

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\* Question numbers are accurate at the relevant version of the document



## Definitions

### 1. What is the price?

The **price** is the amount that providers report to Services Australia in their claim. Providers will report the price per care recipient, each month. Please note, Services Australia refers to the price as the **invoice amount**.

The definition of price is the cost of care and services provided to the care recipient in the claim period, **minus** any [Basic Daily Fee](#) and any additional service charges (if collected).

Providers must claim from Services Australia:

- the cost of care and services delivered
  - minus any Basic Daily Fee if charged
  - minus any [additional care and services fees](#) if charged.
- GST is not included in the price.

Providers must **not** deduct the **income tested care fee** payable from the price claimed. Services Australia will **automatically deduct** the income tested care fee payable from the payment made to providers, for care recipients who are assessed as needing to pay it.

This reflects the intent of the new arrangements to ensure that care recipient fees are spent on their care each month and are **not** accruing with the provider.

### 2. What is the shortfall amount?

If you have **opted-in**: The **shortfall amount** is the price (*minus the Commonwealth portion of any unspent funds which are being returned, for providers that opt-in*), minus any income tested care fee the care recipient is assessed to pay.

If you **have not opted-in**: The **shortfall amount** is the price, minus any income tested care fee the care recipient is assessed to pay.

### 3. What is the maximum contribution amount?

The **maximum contribution amount** is the full [Government subsidy entitlement](#) and anything available in the care recipient's home care account.

### 4. What is a home care account?

On 1 September 2021, Services Australia created a home care account for each care recipient, with a balance of \$0. The home care account cannot go into deficit.

When a provider lodges their monthly claim the Government subsidy will be used to cover the price.

If the Government subsidy is:

- more than the price, the difference will accrue in the home care account for future use.
- less than the price, Services Australia will draw down on the home care account balance to cover the difference.

If there are no available funds in the home care account, the provider will need to first draw down on any unspent funds they may be holding on behalf of the care recipient, if the provider has no unspent funds they will need to absorb the outstanding cost.

Care recipients will retain their full Government subsidy regardless of whether their provider chooses to opt-in.



## Claiming and Home Care Packages fees

### 5. What is included in the provider claim to Services Australia?

Providers only need to claim a total dollar amount for each care recipient in their monthly claim (this is referred to as the **price** or **invoice amount** – definition above). GST is not included in the claim.

Providers do not need to include an itemised list of fees, care and services delivered to the care recipient during the relevant month to Services Australia. However, this information must be provided to the care recipient as part of their detailed monthly statement.

### 6. How do providers know what their care recipient's home care account balance is?

Providers view the home care account balance at the end of the month when the monthly payment statement is updated and issued to providers.

The Aged Care Provider Portal displays the current home care account balance along with all transactions. This is updated when a claim is processed and for transferred care recipients when the quarantine period ends. This will show when the home care account balance is transferred from the previous provider.

### 7. What happens if the care and services provided in a month exceed the care recipient's available package budget, do providers still claim the full amount from Services Australia?

Providers should claim the full cost of services delivered in the month. Providers will be paid the lesser of: The **shortfall amount** or the **maximum contribution amount** (definitions above).

The outstanding amount can be covered by any unspent funds held by the provider for the care recipient or else the costs must be covered by the provider. The outstanding amount cannot be added to a claim in a future month, except in the case of errors.

See advice in Q8 about planning for payment of large purchases.

Alternatively, the provider and care recipient can agree to postpone the purchase until the care recipient has accrued sufficient funds in their home care account or agree to cover the cost through additional fees (see [additional care and services](#)).

### 8. How can providers make large purchases for their care recipients?

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 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.

Providers must not split the cost over multiple claim months except where as part of an agreed leasing or lease to buy arrangement agreed with the care recipient.

There are certain circumstances where a HCP care recipient can access Commonwealth Home Support Programme (CHSP) services over and above the services provided through the home care package budget. See the [Commonwealth Home Support Programme Manual](#) for more information. This may be subject to the available capacity of CHSP providers and their available funding, given CHS clients will be the priority. Consumer contributions may apply.



**9. Are there changes to package management or care management fees as part of Improved Payment Arrangements?**

IPA has not changed the ability for providers to charge package management and care management fees. As per existing arrangements, fees must be included in the Home Care Agreement and providers must discuss and agree these fees with the care recipient before they start services.

The **price** reported to Services Australia should incorporate the services delivered to care recipients. Package management fees and care management fees are considered services and can be included as part of the **price**.

Under the 2019 [Pricing Transparency and Comparability](#) changes, providers are required to complete the [Price Schedule](#) for My Aged Care, which includes completing a dollar value per package level for care management and package management fees. It is a matter for providers to determine their own prices. IPA has not changed providers' requirements under Pricing Transparency and Comparability.

Under legislation, providers prices must be reasonable, and they must be able to justify how the amount they are charging for management is considered reasonable, in the event of a review.

Any increases in prices, including administration and package management costs, must be reflected in providers pricing schedule on My Aged Care. Providers must include a copy of their pricing schedule in their care recipient's Home Care Agreement. There must be mutual agreement by both the care recipient and the provider for any pricing changes. Providers should include usual business costs (such as office rent, insurances, and marketing, etc.) in their prices for care and services. This ensures care recipients can see the all-inclusive cost of delivering the service.

Further information on fees can be found in the [Understanding fees for home care fact sheet](#).

**10. Do providers need to include the supplements in the price when reporting a claim to Services Australia?**

No, providers do not need to report supplements as part of the **price** to Services Australia in their claim. Supplements will automatically be applied by Services Australia if the home care recipient is eligible. It will be included as part of the calculation completed by Services Australia of the subsidy available to the care recipient.

**11. What happens if I don't report the Commonwealth portion of unspent funds by the 31 December deadline?**

The deadline for reporting was **31 December 2021**. Providers will be unable to finalise their December claim (and all subsequent claims) until they have reported the Commonwealth portion of unspent funds held for each care recipient in care prior to 1 September 2021 to Services Australia for at least one claim period (September – November 2021).

**12. What if a provider made an error in reporting the Commonwealth portion of unspent funds they hold to Services Australia?**

If a provider identifies an error with the unspent funds amount they have reported, and they have **not** opted-in, they will be able to update this amount after it has been reported.

However, if a provider chooses to opt-in for a care recipient, the amount they enter when opting in **cannot** be changed after it is reported. We encourage all providers to check these amounts before submitting them.



## Opting-in to return Commonwealth unspent funds

### 13. How do providers opt-in to draw down on the Commonwealth portion of unspent funds?

Providers can opt-in to return the Commonwealth portion of any unspent funds they hold for care recipients until **28 February 2022** (see table below).

Opting-in can be done in the Services Australia Aged Care Provider Portal via the 'Bulk reported Commonwealth Unspent amounts screen' or against individual care recipient profiles or via the paper claim form.

Opt-in to return unspent funds key dates

Action	2021 (calendar dates)			2022 (calendar dates)		
	Oct	Nov	Dec	Jan	Feb	Mar - ongoing
Opt-in to return unspent funds	Optional					No longer available

### 14. What is the benefit of opting-in to return provider held Commonwealth unspent funds?

The benefit of opting-in to return provider held Commonwealth unspent funds is a reduction in administrative burden for providers. Once a provider reports their unspent funds balance and opts-in, Services Australia will keep track of the Commonwealth portion of provider-held unspent funds. The provider will not need to report on the Commonwealth portion of provider-held unspent funds after this.

Opting-in also benefits care recipients. In an opt-in scenario, the provider does not need to use the care recipient portion of unspent funds they hold first, unless they deliver services in excess of what is otherwise available to the care recipient.

There are currently \$1.4 billion of Commonwealth unspent funds held by Home Care Package Program providers and this is growing rapidly. Moving unspent funds back to the Government will enable providers to transfer the financial and prudential risks of holding these funds to the Government. Providers will no longer be responsible for the liability of managing substantial sums of unspent funds.

### 15. Once opted-in, how long will providers have to draw down on unspent funds?

Once a provider has opted-in to draw down the Commonwealth portion of a care recipient's unspent funds, there is no specified time limit on returning the full amount.

The time period for return will depend on the amount of unspent funds a provider holds and the care recipient's monthly entitlements. Providers will continue to draw down the Commonwealth portion of unspent funds until they hold zero for that care recipient.

Regardless of whether a provider has opted in or not, unspent funds will need to be examined in the transition to a new support at home program.

### 16. Can a provider choose to opt-in for some care recipients but not all?

Yes, a provider can opt-in for one or more care recipients (or none). However, once a provider has opted-in to return the Commonwealth portion of unspent funds for a particular care recipient, this cannot be changed.

There is no requirement for providers to tell their care recipients if they have opted them in or not. However, if the care recipient asks, the provider must inform them of the decision.



## 17. What happens for new providers and new care recipients after 1 September 2021?

**New providers** delivering Home Care Packages will claim payment from Services Australia in arrears, for care and services delivered to a care recipient in that month.

Any applicable income tested care fees, Basic Daily Fees and any additional services fees will be collected by the service provider as per usual.

Services Australia will **automatically** deduct the income tested care fee from the payment made to providers, for care recipients who are assessed as needing to pay it.

From 1 September 2021, all new care recipients assessed and found eligible to have to pay an income tested care fee must do so. Please see [income tested care fees](#) for more information.

All **new care recipients** who enter into the Home Care Package Program will have a **home care account** created for them. This account will accrue any unspent subsidy for future use as required. Their provider will not hold any Commonwealth unspent funds for them.

## Order of spending funds

## 18. Is there an obligation to use unspent funds before the Government subsidy when claiming?

There are a number of different sources of unspent funds available to care recipients. These include the:

- Provider-held Commonwealth portion of unspent funds
- Provider-held care recipient portion of unspent funds
- Services Australia-held home care account balance

The order a provider will draw on different sources of unspent funds will depend on whether they have opted-in to return the unspent Commonwealth funds they hold.

### Opt-In:

If a provider **opts-in** to return unspent funds for a care recipient, they will begin to draw down on the provider-held Commonwealth portion of unspent funds before receiving any further subsidies from Services Australia. During this time, any excess Government subsidies will accrue in the care recipient's home care account, so the care recipient retains their full subsidy entitlement.

In an opt-in scenario, the provider does not need to use the care recipient portion of unspent funds they hold, unless they deliver services **in excess** of what is otherwise available to the care recipient.

### Not opt-in:

If a provider **does not opt-in** to return unspent funds for a care recipient, Services Australia will pay the provider from the Government subsidy available to the care recipient and their home care account balance.

If the care and services delivered are **in excess** of the Government subsidy and the care recipient's available home care balance, the provider will need to draw on the unspent funds they hold. As they have not opted-in, they must **first** draw down on the care recipient portion of unspent funds before drawing on the Commonwealth portion. This ensures care recipient fees are being spent on the care recipient's care and services, not accruing with the provider as unspent funds.

The provider must report the Commonwealth portion of provider-held funds each month when they are finalising their claims and include the total provider-held unspent funds in the care recipient's monthly statement (see question 42 for more information on the monthly statement).



## Income tested care fees

### 19. How are income tested care fees collected?

Improved Payment Arrangements has not changed the way the income tested care fee is calculated or collected. Full pensioners do not pay the income tested care fee.

If a care recipient has been assessed as needing to pay the income tested care fee, this is deducted from the Government subsidy paid to the provider by Services Australia. If a care recipient's assessed income tested care fee is equal to or more than the price reported to Services Australia, no Government subsidy entitlement will be paid to the provider.

If the provider does not collect the income tested care fee from care recipients, the provider could be out of pocket for package expenses and will be liable to pay these expenses out of retained earnings. For advice on what to do if a care recipient refuses to pay see question [27](#).

Any unspent government subsidy accrues in the care recipient's home care account for future care and services.

It is the responsibility of the provider to put in place the business processes to collect and manage income tested care fees from care recipients who have been assessed as needing to pay the fee. Providers must collect the income tested care fee regardless of whether the care recipient is using the full amount of their package.

Providers must continue to support care recipients to understand fees and their means assessment. This may also require providing information about how to request to Services Australia review of the assessment decision, or how to apply for financial hardship supports through Services Australia.

As per existing arrangements, fees must be outlined in the Home Care Agreement and providers must discuss and agree these fees with the care recipient before they start services.

### 20. What happens if a provider had not been collecting the income tested care fee prior to 1 September 2021?

In the majority of cases, providers will need to commence collecting income tested care fees from care recipients who are assessed as needing to pay. See question [20](#) for implications if a provider does not collect the income tested care fee.

The only exception to this is where a provider had made a business decision prior to 1 September 2021 that they would not collect the income tested care fees from care recipients where a care recipient was not using the full amount of their package.

Providers are permitted to continue to not collect the income tested care fee where:

- they can demonstrate that they had not collected fees from that care recipient on an ongoing basis (not just ad-hoc) for some months prior to 1 September 2021; AND
- they hold unspent funds and have not opted-in for this care recipient so have access to unspent funds.

In all other circumstances, including where the provider is not holding any unspent funds for the care recipient, the provider **must** collect the income tested care fee. For advice on what to do if a care recipient refuses to pay see question [27](#).

The Department and Services Australia do not have oversight of the income tested care fee arrangements. It is the provider's responsibility to ensure they keep track of these arrangements as part of their business processes. Providers should document the arrangement to not collect income tested care fees and the use of unspent funds with agreement between themselves and the care recipient. This evidence could be used to support review or assurance activities.





Providers must advise departing care recipients, who are transferring providers, that they will be required to start paying their full assessed income tested care fee with their new provider. Previous income tested care fee arrangements do not carry over to new providers.

Providers cannot charge care recipients the income tested care fees that they have not collected in the past.

Care recipients may not need to be referred to Services Australia for an assessment, see [Income and means assessments | My Aged Care](#) for more information.

## **21. Will income tested care fee contributions always be used in full?**

There are a limited number of circumstances where an income tested care fee may be accrued by the provider. For example:

- If a care recipient is on leave from their Home Care Package but is still paying an income tested care fee to their provider.
- If a provider opts-in to return the Commonwealth portion of unspent funds held for a care recipient, the provider may accrue unspent income tested care fees while drawing down on these unspent funds.

## **22. What if a care recipient has not had a means test when they start home care?**

A care recipient may begin to receive services prior to their means test being finalised. Services Australia assume no income tested care fee is payable and will pay the full monthly claim entitlement until the care recipient is assigned a 'means not disclosed status'.

If a care recipient is assigned a 'means not disclosed status' Services Australia assume the full income tested care fee is payable. This may result in a provider being paid less than the care recipient is entitled to.

Once a means test outcome is finalised, Services Australia will apply the correct income tested subsidy reduction backdated to the date the care recipient first entered the Home Care Packages Program. This means that:

- If a care recipient's means test outcome has resulted in an overpayment to the provider, Services Australia will deduct the overpayment from the next payment to the provider.
- If a care recipient paid income tested care fees in excess of what they were required to pay, the provider must repay these to the care recipient.

To manage risk for new care recipients, providers can apply the maximum income tested fee, the second daily cap in the [Schedule of Fees and Charges](#), for any care recipients where they have not received their initial means testing advice.

This should not impact pensioners as their means tests are automatically matched by Services Australia through Government data and full pensioners do not pay the income tested care fee.

Providers should manage their cash-flow accordingly to cover any future liabilities arising from a late submitted means test.

## **23. How are means testing adjustments being managed?**

As per existing arrangements, if a care recipient is paying an income tested care fee and receives a delayed income assessment which determines they should have been paying a lower contribution than the maximum income tested care fee, or no fee, the provider must refund the difference to the care recipient once the care recipient fees are set. Services Australia will continue to pay all refunds to the provider as per existing arrangements and not to the home care account.

If a care recipient receives a delayed income assessment which determines they should have been paying a higher income tested care fee, this is backdated to their date of entry. This means the





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income tested subsidy reduction is also backdated. An adjustment will be applied in the next claim, and the subsidy paid for that care recipient in the next claim would be reduced by the backdated adjustment amount.

If the adjustment amount was greater than the care recipient's payment determination for the current claim month, this would result in a negative payment amount for the care recipient for the month. This negative amount would be factored into the overall service payment. The provider may then claim the underpaid income tested care fee from the care recipient.

If an income tested care fee is refunded to a provider due to a quarterly review but the care recipient has already left care and their balance has been settled the following applies:

- If the care recipient has exited care to move to another provider, the refunded income tested care fee must be transferred from the previous provider to the new provider
- If the care recipient has exited care, due to entry into residential care or has passed away, then the income tested care fee must be refunded to the care recipient/or their estate

If a care recipient does not agree with the outcome of their means test, they can request Services Australia to review this decision. If a care recipient is unable to pay their fees due to financial hardship, they can apply for financial hardship help from the Government.

#### **24. Is there a report from Services Australia which details each care recipient's subsidy and fees?**

The home care payment statement available within the Aged Care Provider Portal shows supplements and subsidies amounts paid for each care recipient.

It also shows the home care account balance for each care recipient (where unspent Government subsidy and supplements accrue from 1 September 2021 onwards).

#### **25. Do providers need to remove the income tested care fee when reporting the 'price' to Services Australia in their claim?**

No, providers do **not** need to remove the income tested care fee payable when reporting the **price** to Services Australia.

Services Australia will automatically deduct the income tested care fee when making subsidy payments to providers.

If the price reported is equal to or less than a care recipient's assessed income tested care fee, no subsidy will be paid to the provider for that care recipient.

#### **26. What if a care recipient refuses to pay their income tested care fee?**

All providers must provide security of tenure to all care recipients, however refusal to pay agreed fees without a valid reason is grounds for a provider to cease care.

A provider may cease to provide home care to a care recipient if:

- the care recipient has not paid to the provider any home care fees as agreed to in the home care agreement for a reason within the care recipient's control,
- has not negotiated an alternative arrangement with the provider for payment of the home care fees.

As a provider you have a responsibility to support your care recipient if they are experiencing financial hardship. You should advise them to apply for financial hardship assistance via Services Australia. Discuss with your care recipient an appropriate timeframe for them to pay their agreed fees.

You can refer your care recipient to Older Persons advocacy Network (OPAN). They can access free, confidential and independent aged care advocacy through OPAN on 1800 700 600 or visit [www.opan.org.au](http://www.opan.org.au)



## Basic Daily Fees

### 27. What if there are no Basic Daily Fees collected from the care recipient?

If the provider has **not** collected a Basic Daily Fee, they should **not** deduct this from the price they report to Service Australia.

### 28. Is the Basic Daily Fee treated the same as the income tested care fee?

The Basic Daily Fee and income tested care fee are treated differently.

The Basic Daily Fee is a non-mandatory fee which a provider can charge a care recipient. If a provider collects a Basic Daily Fee, it is added to the amount of Government subsidy to increase the funds available to the care recipient in their Home Care Package budget. If a care recipient pays a Basic Daily Fee, the provider will reduce this from the **price** they report to Services Australia.

A care recipient should contribute an income tested care fee if they have been assessed as needing to pay it. The income tested care fee reduces the amount of Government subsidy a care recipient receives, as the care recipient is contributing that portion to their package.

If a care recipient is assessed as needing to pay an income tested care fee, their subsidy payment will be automatically reduced by the fee amount as per existing arrangements.

If the provider decides to not collect the income tested care fee payable, in part or in full, the subsidy payment will still be reduced by the full income tested care fee amount by Services Australia. Please refer to [question 21](#) for further details.

## Exit fees

### 29. Can providers continue to charge exit fees?

Exit amounts may only be deducted if the care recipient leaves a provider's care (to change providers or to exit the HCP program altogether) and:

- the provider has published the exit amount on the My Aged Care website
- the care recipient has agreed to an exit amount in their Home Care Agreement
- the care recipient still has unspent funds held by the provider when they exit care.

If the criteria above are not met, the provider will not be able to charge an exit fee for that care recipient.

The department notes that the level of unspent funds held by providers is likely to reduce as a result of IPA. and that this may impact on the ability to charge exit fees into the future.

An exit amount is **not** considered a type of care or service and cannot be charged as part of the **price** reported to Services Australia.

If a provider holds no unspent funds on behalf of the care recipient when they exit care, the provider will have to absorb any potential cost related to exiting the care recipient.

### 30. Do providers need to calculate the percentage proportions of unspent funds they hold when a care recipient exits care?

Providers are no longer required to recalculate the percentage breakdown of Commonwealth and care recipient portions of unspent funds when a care recipient exits care.

The provider must be tracking the care recipient portion and (if they have not opted-in) tracking the Commonwealth portion separately.

If the provider has opted-in, Services Australia will track the Commonwealth portion on their behalf.



## Additional care and services

### 31. What happens if a care recipient needs or wishes to purchase care and services and this exceeds the available package budget, can they top it up?

Improved Payment Arrangements will not change the ability of providers to charge fees to cover additional care and services over and above those the care recipient could otherwise afford under their package.

If a care recipient needs or wishes to purchase care and services over and above the budget of their available package budget, they need to consider:

- reviewing their care plan to identify alternatives and priorities or
- purchasing additional care and services from their own funds to increase the value of their package.

As per existing arrangements, fee changes must be included in the Home Care Agreement and providers must discuss and agree on these fees with the care recipient before they start services.

Any agreed additional care and service fees **must** be subtracted from the **price** reported to Services Australia.

An Aged Care Assessment Team (ACAT) assessment may also be required if the care recipient's care needs have increased significantly. Some care recipients may already have suitable approvals. If they do need a new ACAT assessment, the provider can assist to arrange this, with the care recipient's permission.

## Business practices

### 32. Were there changes to leave arrangements?

No, there will be no change to leave arrangements.

### 33. How do providers manage paying for brokerage and contracted services?

Providers should receive and accept a quote for these services and can claim these in the month the service was delivered.

If at a later point, the provider receives an invoice for a higher or lower amount, they will be able to correct this by adjusting the price in a future month's claim. A price for a previous month cannot be updated once claimed.

### 34. Can providers claim GST costs?

There were no changes to the way that GST can be paid or collected from a Home Care Package as part of Improved Payment Arrangements.

GST should not be claimed as part of the price submitted to Services Australia. Providers should deal with GST that is incurred from sub-contracting arrangements and the purchase of goods through the Australian Taxation Office (ATO).

More information about subcontracted services, along with GST and home care, is available at the [ATO website](#) by using the search term 'Government funded Home Care'. The ATO also provides an example of the supply of subcontracted services to a care recipient.

### 35. Can providers pass any potential increase in administrative costs on to care recipients?

Any increases in prices, including administration and package management costs, must be reflected in providers pricing schedule on My Aged Care. Providers must include a copy of their pricing schedule in their care recipient's Home Care Agreement.



There must be mutual agreement by both the care recipient and the provider for any pricing changes.

Providers should include usual business costs (such as office rent, insurances, and marketing, etc.) in their prices for care and services. This ensures care recipients can see the all-inclusive cost of delivering the service. The amount providers include must be reasonable.

### **Not opting-in to return Commonwealth unspent funds**

#### **36. What happens with unspent funds post March 2022 if a provider does not opt-in?**

If a provider does not opt-in, they will continue to hold these funds on behalf of the care recipient. They can continue to be used to pay for care and services.

If a care recipient transfers to a new service (including a new service under the same approved provider) the Commonwealth portion of unspent funds will be moved into their home care account to fund care and services delivered by their new provider. Providers should not adjust the unspent funds amount for a departed care recipient where the invoice amount is higher than the maximum contribution amount for that month. Refer to [question 43](#) for further details.

This will also occur if a provider has opted-in but has not finished drawing down on the unspent funds before the care recipient moves services.

The care recipient portion will need to be transferred to the new service by the ceasing provider.

For more information on transferring services see [question 40](#) for information regarding the 70-day (calendar days) quarantine period.

Regardless of opt-in status, when a care recipient exits home care, the Commonwealth portion of unspent funds will be returned to the Government and reinvested into the Home Care Packages Program.

#### **37. If a provider does not opt-in, do they need to report the Commonwealth portion of the unspent funds balance for each care recipient?**

Reporting of unspent funds became mandatory from 31 December 2021 for all care recipients in care prior to 1 September 2021. Providers will not be able to finalise their December 2021 claim (and all subsequent claims) until they have reported unspent funds balance to Services Australia for these care recipients at least once.

Providers who do not opt-in are responsible for ongoing tracking of unspent funds balances and must report the unspent funds for each care recipient each month.

#### **38. Does the Commonwealth portion of unspent funds held by the provider include pre-July 2015 unspent funds?**

No, providers will not need to transfer or return unspent home care subsidy and home care fees which were paid before 1 July 2015, as they were not held at the individual care recipient level.

From 1 July 2015, all Home Care Packages must be delivered on a 'consumer directed care' basis. This includes the requirement for providers to supply care recipients with monthly invoices accounting for any unspent amounts associated with their individual package.



## Transfers between providers (including services under the same provider)

### 39. What happens to unspent funds when a care recipient transfers or exits a Home Care package?

#### If the care recipient is transferring to a new service

Portion	Where to return?	Timeframe to return
Care recipient portion of unspent funds	The losing provider must transfer the care recipient portion to the gaining provider	Up to 70 calendar days after the departure from the losing provider
Commonwealth portion of unspent funds	If the care recipient is opted in, the Services Australia payment system will reconcile the outstanding amount through the claim period and return it to the Commonwealth.	Up to 70 calendar days from the date of departure
	If the care recipient is not opted in, the provider must create a 'Commonwealth unspent amount on departure' event in order to return the amount, and the Services Australia payment system reconciles the funds into the care recipient's home care account.  If the provider is not holding any Commonwealth unspent funds, they must report a \$0 amount to Services Australia.  Providers should not adjust the <b>unspent funds amount for a departed care recipient</b> in the departure month where the invoice amount is higher than the maximum contribution amount for that month. Refer to <a href="#">question 43</a> for further details.	

#### If the care recipient is exiting the HCP program

Portion	Where to return?	Timeframe to return
Care recipient portion of unspent funds	The provider must return the care recipient portion to the care recipient	70 calendar days from the date of departure
	If the care recipient has passed away, the provider must return the care recipient portion to the care recipient's estate	14 calendar days after the provider is shown the care recipient's probate of the will or letters of administration of the estate
Commonwealth portion of unspent funds	If the care recipient is opted in, the Services Australia payment system will reconcile the outstanding amount through the claim period and return it to the Commonwealth.	Up to 70 calendar days from the date of departure
	If the care recipient is not opted in, the provider must create a 'Commonwealth unspent amount on departure' event in order to return the amount, and the Services Australia payment system reconciles the funds into the care recipient's home care account.  If the provider is not holding any Commonwealth unspent funds, they must report a \$0 amount to Services Australia.	

For further information and worked examples of calculating unspent funds please refer to the [Unspent Funds Fact Sheet](#) available on the Improved Payment Arrangements webpage.



#### **40. What is the 70-day quarantine period?**

When a care recipient departs care or transfers to a new service (even under the same approved provider), providers have up to 70 days (calendar days) from a care recipient's departure date to adjust their claims (see questions [45](#) and [46](#) for more information on adjusting previous claims).

Any adjustments need to be submitted with the monthly claim. This means in some situations a provider may have less than 70 days' time to claim due to a departure occurring in the middle of a claim month.

After this period, providers will not have access to the care recipient's home care account.

Providers should be claiming for the cost of care and services provided to the care recipient in the claim period via the existing monthly claim cycle. This ensures providers will have minimal adjustments to make once the care recipient departs care.

If a care recipient is transferring to a new service, the new service provider will have access to the transferred balance of the home care account on day 71.

Electronic claiming is generally approved one business day after submitting the claim. A longer lead time applies for providers submitting paper-based claims, as these have a 10-day (business days) turnaround. When finalising claims, the Department encourages providers to factor in these timeframes when accounting for the 70-day (calendar days) quarantine.

Providers may wish to discuss with care recipients any large purchases they wish to make before the transfer, to ensure that funds are available and not quarantined.

#### **41. How do I claim for costs for care recipients outside of the 70-day period?**

- Where a provider did not finalise a claim that included a departed care recipient with an outstanding invoice amount within the 70-day period their claim may be unable to be submitted. Services Australia has implemented a system change to rectify this issue but if you still cannot submit a claim, please call Services Australia's aged care claims and payments enquiry line on 1800 195 206 (from 8.30am to 5pm AEDT, Monday to Friday) to have this resolved promptly.
- If a provider finalises a claim with a departed care recipient after the 70-day period, they will not be paid that amount as part of their monthly claim. Invoice amounts submitted outside the 70-day period will be considered on a case-by-case basis. Providers can call Services Australia or email the claim details [aged.care.liaison@servicesaustralia.gov.au](mailto:aged.care.liaison@servicesaustralia.gov.au) for consideration.

We understand that in some cases delays are difficult to avoid, particularly with the current impact of the COVID-19 pandemic. However, we expect that providers are adjusting business processes to ensure departures are processed within 70 days. Providers may need to manage their suppliers to ensure they meet the providers deadlines, and to ensure their payments are not held up.

#### **42. If a care recipient moves to a new provider and their funds are in the 70-day quarantine period, does the new provider have to pay for the care recipient's services out of their own pocket?**

The new provider will receive Government subsidy for the care recipient, which should cover the care and services needed during the 70-day (calendar days) quarantine period.

To ensure the old provider can finalise their accounts, the new provider will be unable to access the home care account balance until they are out of the 70-day (calendar days) quarantine.

The new service provider and care recipient may wish to discuss minimising large purchases until the quarantine period has ended.



**43. How is the Commonwealth and care recipient portion of unspent funds handled when care recipients exit or transfer service providers?**

IPA does not change how the **care recipient portion** of unspent funds is treated when they exit or transfer.

- If a care recipient exits the Home Care Packages Program, the provider will transfer the care recipient portion back to the care recipient or the care recipient's estate.
- If a care recipient transfers to a new service provider, the old provider will need to transfer the care recipient portion to the new service.

The Commonwealth portion of unspent funds will be transferred into the care recipient's home care account to fund care and services delivered by their new provider. This will also occur if a provider has opted-in but has not finished drawing down on the unspent funds before the care recipient moves services.

Providers should not adjust the **unspent funds amount for a departed care recipient** in the departure month where the invoice amount is higher than the maximum contribution amount for that month. This leads to errors in unspent funds calculations and the amount transferred to the receiving provider. Services Australia's systems will **automatically** reconcile the last invoice amount with the reported unspent funds amount for departed care recipients. If you have adjusted the unspent funds amount for a departed care recipient, please contact Services Australia for resolution.

If the care recipient is exiting the program, the Commonwealth portion of unspent funds will be re-invested into the Home Care Packages Program.

**44. What if my care recipient departed my service prior to 1 September, but didn't enter the new service until October, meaning the unspent funds were transferred to the new provider but they can't access them due to system functionality?**

The Services Australia system does not allow unspent funds to be reported or returned for care recipients who entered a service after 1 September. In this scenario, Services Australia would process a negative manual adjustment for the new provider to recover the funds, and a manual adjustment will be made to the home care account to apply the amount owing.

Providers should contact Services Australia's aged care payments team by email at [aged.care.liaison@servicesaustralia.gov.au](mailto:aged.care.liaison@servicesaustralia.gov.au) to review and process.

**45. What happens if a care recipient departs a service but returns within the 70-day quarantine period?**

The care recipient's home care account will remain available for 70 days after departure, regardless of the departure reason. If the care recipient returns to home care within the 70 days, the home care account balance will be made available to them again.

If the care recipient returns to the same provider, the unspent funds balance will be made available to them immediately.

If the care recipient returns to a different provider, the 70-day quarantine provision will apply.

If provider-held unspent funds have been returned to Services Australia following departure, these will be available in the home care account.

However, if a care recipient returns to home care more than 70 days after their original departure, their home care account balance will no longer be available.





**46. After the 70-day quarantine on a transfer, what if a provider receives an invoice which is higher than expected, can it be adjusted?**

No, this amount cannot be changed after the 70-day (calendar days) quarantine. The provider should have already agreed the invoice charge with the contractor/service.

**47. How do we manage automatic departure entries where a client has entered residential care?**

If a care recipient enters permanent residential care, Services Australia will not automatically depart the care recipient. However, My Aged Care will withdraw the home care package. The provider must submit a "Commonwealth Unspent Amount on Departure" event within 70 days of the departure.

Providers should ensure they check the care recipients home care account closure date so that they can include any outstanding amounts. If the care recipient has been in respite and has then entered residential care, the provider may not have anything outstanding to claim for them.

## Reconciliation

**48. If an invoice is received months after the service was delivered, can it be backdated, or would it need to be included in the current month's claim?**

Providers should claim the price of care and services in the month where the service was delivered (when the cost was incurred – even if the provider hasn't paid for the service yet, e.g. through a subcontracting payment).

Providers will be unable to adjust the **price** submitted to Services Australia once claimed for that month. Where a provider needs to make an adjustment to a claimed amount (a positive or negative adjustment) or to claim a late payment, they will need to add this to a claim in a subsequent month.

**49. If a provider has made an error in their claim, will there be an opportunity to make an adjustment after it has been submitted?**

If a provider makes an error in their monthly claim to a care recipient event, they will be able to request a variation to the claim through Services Australia.

If the error was in the **price**, this will need to be corrected by adjusting the amount in the next month's claim.

The ability to make retrospective adjustments due to an administrative error by a Government Department or a change in the care recipient's financial circumstances, remains unchanged and do not have a limit within aged care legislation.

**50. What will happen if there are arrears adjustments made by Services Australia and providers have expended the amounts in prior months?**

If providers have claimed the full invoice amount (price) in the prior month, providers will receive a subsidy adjustment for that month when the subsidy adjustment occurs. Any residual amount will be added to the home care account.

However, we would not encourage providers to provide services in anticipation of additional funds being received later unless it is certain an adjustment is pending.

The home care account will be updated as soon as the claim is approved and processed.

## Monthly Statements and reporting to care recipients

**51. What must be included on the care recipient monthly statement?**

Section 21B of the User Rights Principles 2014 includes the requirements of the care recipient monthly statement.



Providers must give each care recipient their own statement for every month they are in care, so they have transparency of the services delivered through their package that month.

The statement must include:

- The amount of home care subsidy for the care recipient for the month.
- The amount of home care fees (if any) paid or payable by the care recipient for the month, and any unpaid home care fees relating to previous months.
- An itemised list of:
  - the care and services provided to the care recipient during the month (including any travel, subcontracting arrangements and package management) for which the care recipient was charged.
  - the price that the provider charged the care recipient for each of these services for the month and the total of these prices.
- The care recipient's unspent home care amount (provider-held unspent funds) in respect of the previous month and the current month.
- If, during the month, the provider received the care recipient portion of unspent funds from another provider—the amount that was received.

The statement should align with the provider claim for care and services delivered during the month (the payment period). That is, both the claim and the statement should include care and services even if the payment for these services has not been finalised, for example as it was delivered by a sub-contractor and the invoice has not been received. Any adjustments can be reflected in subsequent months (in both the claim and statement).

Statements do not need to break down the unspent funds balance into the provider-held care recipient portion, Commonwealth portions, or the home care account balance until providers are ready to include this information.

However, if provider's systems are ready to report on each unspent fund amount, this is supported by the department and the provider can commence immediately.

The Department will review this early in 2022, to determine the date at which this reporting requirement becomes mandatory. Advance notice will be provided to the sector.

A non-mandatory better practice statement has been developed and is available to for use on the IPA webpage.

Services Australia will expand the payment statement issued to providers to report the balance of Government subsidy held within each care recipient's home care account and any provider-held amounts returned.

## **52. Do providers need to report the home care account balance to care recipients?**

Providers must maintain oversight of their care recipients' home care account balance.

Providers do not need to report on home care account balances in care recipient monthly statements, until providers' systems are ready. The Department will review this early in 2022, to determine the date at which this reporting requirement becomes mandatory. Advance notice will be provided to the sector.

If a care recipient requests the balance of their home care account, a provider must disclose the balance of their home care account. Home care account balances are available through the Aged Care Provider Portal and the payment statement Services Australia issues to providers.



## **System Issues**

### **53. What to do if providers are having ongoing issues in integrating with Services Australia systems?**

If providers are having ongoing issues with the claiming process or questions about integrating their systems with Services Australia's systems, please contact Services Australia's aged care claims and payments enquiry line on 1800 195 206 (from 8.30am to 5pm AEDT, Monday to Friday).

For queries that are not time-sensitive, Services Australia's aged care payments team can also be contacted by email at [aged.care.liaison@servicesaustralia.gov.au](mailto:aged.care.liaison@servicesaustralia.gov.au).

### **54. Does Services Australia have a list of software providers who interact with the portal?**

Services Australia publishes a list of software developers who have passed integration testing. This list is on the [Services Australia website](#).