Catholic Health Australia –

Submission to the Inquiry into the Transition of the Commonwealth Home Support Program to the Support at Home Program

January 2026

Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged advocating for an equitable, compassionate, best practice and secure health system that is person-centred and community focused in its delivery of care.

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Overall comments

CHA supported the introduction of the Aged Care Act 2024 and recognises its importance in driving long-term reform of the aged care system. CHA remains committed to working with Government to ensure the Act underpins a safe, high-quality and equitable system that supports older Australians to age in place, regardless of income or location.

The transition of the Commonwealth Home Support Programme (CHSP) to the Support at Home program is the largest and most complex reform yet undertaken in home and community-based aged care. With more than 830,000 older Australians and over 1,200 providers involved, even modest disruption would have material impacts on access to care, particularly in thin markets and for vulnerable cohorts.

Lessons from the Home Care Packages (HCP) program to Support at Home program transition demonstrate that there are significant risks to major reforms in the aged care sector. Fortunately, they also provide a road map for managing these risks by ensuring adequate time, funding, workforce capacity and system readiness is provided to prevent service disruption, provider exit and harm to older people. The CHSP transition must include stronger safeguards than have been applied to date.

This submission addresses the Inquiry’s Terms of Reference by examining sector preparedness, access to timely and appropriate care, service viability, workforce and administrative pressures, and the continuity of care for vulnerable cohorts.

CHA’s recommendations are focused on ensuring that the CHSP transition improves outcomes for older Australians without destabilising the services they rely on - through mixed funding, targeted transition and thin-market support, and administrative and assessment systems that function at scale.

Terms of Reference Map

Inquiry Term of Reference	Relevant section	Summary of Catholic provider position
The preparedness of the aged care sector for the transition from CHSP to Support at Home	2.1, 2.2, 5.1	Current timelines, funding, workforce capacity and administrative systems are not adequate for a transition of this scale, and without stronger safeguards, the CHSP transition risks service disruption and provider withdrawal.
Impacts of the transition on access to timely, appropriate care	1.1, 2.1, 6.1	Without explicit continuity, navigation and assessment safeguards, older people will face extended waits, fragmented care and loss of access to preventative, restorative and community-based supports during the transition.
Workforce capacity and administrative burden	2.3, 5.2, 5.3	Workforce pressures are being compounded by duplicative ICT, client needs and service screening, training and reporting requirements, diverting staff from care and increasing the cost to service, ultimately increasing the risk of service failure and viability during transition.
Service viability, particularly in thin or regional markets	3.1, 4.1, 4.2	Rigid package-based / individual funding and disproportionate compliance settings risk accelerating provider exit in thin markets unless mixed funding and market-stabilisation measures are retained.
Arrangements to ensure continuity of care for vulnerable cohorts	1.2, 2.3, 6.2	CHSP clients with complex, deteriorating or end-of-life needs require explicit interim and continuity arrangements to prevent gaps in care as they move into the Support at Home program.
Any other related matters	3.2, 5.1	Data, digital system readiness and evidence-based funding design and claims systems are critical enablers of a safe, efficient and sustainable CHSP transition and must be treated as core reform infrastructure.

Key Recommendations

To retain health promotion, early intervention, and community-based approaches of CHSP, the Committee should recommend that:

1. **Core CHSP principles** including early intervention, prevention, relationship-based and community-based care be explicitly identified and retained within the design of Support at Home, and embedded in program guidelines, outcomes and performance frameworks.
2. CHSP's low-cost, entry-level, preventative core be maintained through an **annual funding cap per client** and **clear exclusion rules** to ensure the stream is not used as a substitute for ongoing, high-intensity care.
3. **Dedicated funding** be established within the Support at Home program for navigation and preventative functions, including welfare checks and support to navigate assessments, co-contributions and hardship processes.
4. **CHSP Specialised Support Services funding** be maintained.

To learn from the Support at Home transition and ensure provider readiness, the Committee should recommend that:

5. The Department of Health, Disability and Ageing clearly communicate all transition guidance, rules and expected impacts by a hard deadline of **1 December 2026**, providing at least six months for provider planning and readiness, with a Regulatory Impact Statement by mid-2026. A commitment from the Department to produce no further material program or transition changes from this date is needed, outside responding to sector input.
6. **A per-client transition grant of $400–$500 per client** be introduced for providers transitioning clients from CHSP to Support at Home, to reflect administrative, workforce and ICT transition costs and protect provider viability.
7. The introduction of Support at Home price caps be deferred by 12 months to **reduce delivery and market stability risks** during early implementation and allow providers to focus on CHSP.
8. Up to **15 per cent** of Support at Home packages be **allocated for care management** to support continuity and coordination during transition.

To support service sustainability and innovation through flexible funding, the Committee should recommend that:

9. **Targeted grant funding be retained** alongside Support at Home packages for community / centre-based respite, transport, dementia and other specialised support services that cannot be sustainably delivered through individualised funding alone. Many of these services do not 'fit' within the current service types under the Support at Home program.
10. Consistent provider-reported data on service delivery, financials and client outcomes be used to inform funding decisions, forecast demand and guide strategic investment in preventative and community-based services, applying a **one-collection, multiple-use principle** across reporting requirements.
11. Prior to finalising funding settings for the CHSP transition, Government incorporate a **targeted evidence-testing phase** - distinct from broad stakeholder consultation - to test proposed funding models against service-level evidence from providers delivering community-based and preventative services.

To establish market safeguards to support viability of small providers, the Committee should recommend that:

12. For the CHSP transition period, compliance and reporting requirements for allied health and small providers be reviewed and streamlined to ensure they are proportionate, risk-based, and do not create unnecessary barriers to participation.
13. A **dedicated, time-limited market sustainability grant** be established to support small and specialist providers operating in thin markets during the CHSP transition, to prevent irreversible service loss and protect access for older people.

To minimise administrative complexity, the Committee should recommend that:

14. A **centralised administrative system or platform** for associated providers - including a worker passport - be developed to support the new aged care worker screening system and ensure workforce mobility and continuity of services during the CHSP transition.
15. Training requirements be aligned to the specific responsibilities and risk profile of each role and be proportionate to the duration of engagement in an aged care setting, while maintaining appropriate safeguards for consumers.

To maximise assessment accuracy, the Committee should recommend that:

16. Government clearly and proactively communicate how prioritisation, interim budgets and waitlist management will operate for CHSP clients during transition, so providers can apply these mechanisms in practice to prevent delays to care - prior to 1 December 2026.
17. The Committee should recommend that a **short, structured assessment tool** be developed and integrated within the Single Assessment System for referrals flagged as requiring **low-level support**, applying clearly defined criteria for low-level needs. Safeguards should be incorporated to define clear indicators for conducting a full assessment to ensure supports are accurately aligned with ongoing care needs.
18. Providers have access to a **central portal**, integrated with the Single Assessment System, to update service volume and cadence directly - reducing duplication, avoiding repeated client conversations, and ensuring a single, accurate source of care information across My Aged Care, providers and the assessment system.

Section 1: Retaining health promotion, early intervention, and community-based supports to protect access and continuity of care under Support at Home

1.1 Maintaining the best features of CHSP

The transition of the Commonwealth Home Support Program (CHSP) to the Support at Home program marks an important step in providing unified aged care and enabling participant choice from a wide range of services. To ensure the transition achieves its objectives, key features of CHSP that have proven effective need to be preserved, particularly those focused on early intervention, preventative care, relationship-centred care, and community-based support.

CHSP currently offers light-touch services, often provided at an early stage before care needs become more complex and comprehensive. Catholic providers recognise the value of health promotion and preventative models of care, particularly in an aged care sector already under pressure, with potential to reduce demand for residential aged care and improve quality of life for older Australians.

These issues go directly to the Inquiry's consideration of whether the transition to Support at Home will preserve access to low-intensity, preventive and community-based supports for older people.

Equally important are CHSP's relationship-centred and community-based supports. Under the current model for example, providers are supported to offer welfare checks by registered aged care staff and programs that facilitate social connection, such as choirs and day centres. These programs strengthen community wellbeing, reduce social isolation, and enable the provision of care in alignment with older Australians' varied values. Evidence further suggests that such approaches contribute to improved health outcomes, for example lowering dementia risk through sustained social engagement.[1]

Considering the breadth of care levels that Support at Home must accommodate following the transition of CHSP, there is a risk of unintentionally shifting the system away from early intervention, prevention, and relationship-centred care towards higher-cost, crisis driven care. In addition, changes to funding models and co-contribution rates increase the risk of vulnerable clients declining essential supports due to cost. This may result in reduced access to preventative care and programs fostering social connectedness, both of which are critical for maintaining wellbeing and reducing long-term demand on the aged care system.

[1] Wang, S., Molassiotis, A., Guo, C., Leung, I. S. H., & Leung, A. Y. M. (2023). Association between social integration and risk of dementia: A systematic review and meta-analysis of longitudinal studies. *Journal of the American Geriatrics Society*, *71*(2), 632-645.https://doi.org/10.1111/jgs.18094

Case Study

Under CHSP, grant funding enabled providers to deliver affordable community-based services that foster social connection. For example, one not-for-profit provider offered an in-demand community choir for around 50 participants at a cost of only $12 per participant per two-hour session. Under current Support at Home rules, participant costs would increase to more than three times the CHSP rate. This price increase has already deterred participation and risks making such programs unaffordable for many older Australians. Without grant funding, essential community-based initiatives that reduce isolation and support wellbeing are likely to disappear.

Preserving CHSP principles will be critical to achieving the objectives of Support at Home, enabling older Australians to live well at home for as long as possible and delivering person-centred care. There are needs to explicitly carry over CHSP principles into Support at Home. This includes embedding preventive and social wellbeing outcome measures within Support at Home, as well as implementing funding models, such as those outlined in Section 3, that support early intervention and community-based approaches.

Recommendation 1: The Committee should recommend that the Government explicitly identify and retain core CHSP principles - including early intervention, prevention, relationship-based and community-based care - within the design of Support at Home, and embed these principles in program guidelines, outcomes and performance frameworks.

Recommendation 2: The Committee should recommend that the entry-level, low-cost features of CHSP be maintained through an annual funding cap per client and clear exclusion rules to ensure the stream is not used as a substitute for ongoing, high-intensity care.

1.2 Funding navigation and preventative care services

Effective navigation and preventative supports are essential to ensuring older people can access the right care at the right time. While CHSP includes a navigation function in principle, it is inconsistently utilised and insufficiently funded in practice.

The system has become more complex under Support at Home, particularly with new co-contribution arrangements, interim budgets, and multiple service pathways. Older Australians increasingly require support to navigate My Aged Care, hardship applications, and service choices. Without funded navigation support, older people will either be left to manage complex systems alone or experience delayed, fragmented or inappropriate care.

These navigation and preventative functions are central to ensuring older people can access care safely and continuously during the transition to Support at Home, particularly for those with emerging or complex needs.

Similarly, preventative care activities such as welfare checks, informal clinical risk monitoring, and short “snapshot” reviews are currently embedded within CHSP but are unlikely to be funded under transactional package models. The loss of these functions would increase the risk of undetected deterioration, avoidable hospitalisation and premature entry into residential care, particularly for people living alone or with emerging cognitive decline.

Recommendation 3: Establish dedicated funding within Support at Home for navigation and preventative functions, including welfare checks and support to navigate assessments, co-contributions and hardship processes.

1.3 Extend CHSP Specialised Support Services

Specialised Support Services (SSS) are of critical importance for clients under CHSP. Of particular concern is the continuation of the Dementia Advisory Service, a well-established program which has offered expert support to people living with dementia and their families for the past 15 years. This program supports the provision of information needed to understand and manage a dementia diagnosis, assists people with dementia and their families to access services, provides navigation support, and enables people with dementia to remain living at home. Dementia Advisory Services are critical in meeting the intent of the National Dementia Action Plan 2024-2034 to deliver accessible, integrated, and person-centred services.[2]

Catholic providers welcome the Department's intent to work closely with providers on realigning Specialised Support Services (SSS), including the Dementia Advisory Service, to the Support at Home service list. We support the extension of CHSP SSS funding to support workforce retention and minimise the risk of service disruptions for people living with dementia. Funding should be maintained for CHSP SSS through to 1 July 2027. After this date, funding for these important services must be maintained, though providers recognise this may be via a different mechanism after reforms are complete.

Recommendation 4: The Committee should recommend that the Department commit to maintaining CHSP SSS funding.

[2] Department of Health, Disability and Ageing. (2024). *National Dementia Action Plan: 2024-2034.* Australian Government. https://www.health.gov.au/sites/default/files/2025-08/national-dementia-action-plan-2024-2034.pdf

Section 2: Lessons from the Support at Home Transition: Ensuring Provider Readiness

The recent transition from Home Care Packages (HCP) to Support at Home provides important lessons for the upcoming CHSP transition. Challenges affecting provider readiness can be mitigated through the provision of clear and timely information as well as adequate funding. It is essential that the Government recognises additional pressures the sector will face during the CHSP transition and implements measures to ensure a smooth transition.

In contrast with the transition from HCP to Support at Home, the CHSP transition involves a client cohort more than three times larger, all of whom do not access funded care management, delivered through a far more diverse provider base, including many small and specialist services. No single provider carries responsibility for the overarching client support requirements, unlike with HCP. Even modest levels of disruption or provider exit during this transition would have material impacts on access, particularly in thin markets and regional areas. Put simply, CHSP providers can be more vulnerable than HCP providers financially – if this transition is not carefully managed the consequences for care provision may be severe.

These issues go directly to the Inquiry's consideration of sector preparedness, service continuity and the risk of provider exit during the CHSP to Support at Home transition.

2.1 Clear communication and timely information

Access to clear information is essential for providers to plan and prepare for significant aged care reform. The lead up to the introduction of the Aged Care Act 2024 highlighted challenges associated with frequent timeline changes and sporadic communication of new information. Providers require timely and consistent information to plan workforce arrangements and training, adapt service models, and invest in systems needed to align with reforms. Where guidance is delayed or frequently revised, providers may defer preparation or implement changes that are later misaligned with finalised rules. This increases the risk of disruption to services for older Australians.

CHA recommends the Government commit to providing clear and timely information to providers at least six months in advance of the CHSP transition, minimising the number of revisions made following this date. The recommendations in this section together demonstrate that certainty, resourcing and care coordination are the minimum standards for a safe CHSP transition.

Recommendation 5: The Committee should recommend that the Department of Health, Disability and Ageing clearly communicate all transition guidance, rules and expected impacts with a hard deadline of 1 December 2026, allowing providers at least six months to plan and prepare for the transition. To give effect to this recommendation, the Government should release a Regulatory Impact Statement by mid-2026 and provide a clear commitment that all Rules and Guidance relating to the transition will be finalised and published by 1 December 2026.

2.2 Adequate funding via transition grants

Aged care reform requires significant resources and places high costs on providers. The recent transition from HCP to Support at Home highlighted the risks of inadequate funding,

with providers bearing the costs of upgrading IT systems, arranging service agreements, managing workforce training, and educating clients on new rules. The $10,000 transition payment offered to support IT upgrades covered a fraction of costs – this had particular impact on medium to large scale providers where IT system changes cost in excess of $400k.

Without adequate funding, the upcoming CHSP transition poses comparable risks. Both small and large providers will face similar challenges, compounded in regional, rural, and remote communities where travel costs add further pressure. Government funding for the transition that reflects the scale and complexity of this reform will ensure provider readiness and minimise the risk of service disruptions and reduced access for older Australians during the transition period.

Government should provide transition grants of $400–$500 per client. This reflects the unavoidable workload associated with transferring CHSP clients into Support at Home, including an estimated 3-5 hours of additional administrative effort per client (based on provider experience per date), alongside IT system changes, workforce training and supervision, and new service agreement and consent processes. This level of funding is modest relative to the scale of the reform and is intended to prevent service disruption, provider withdrawal and resulting service gaps during transition.

Recommendation 6: The Committee should recommend the introduction of a per-client transition grant for providers transitioning clients from CHSP to Support at Home, with a one-off payment of $400–$500 per client to reflect administrative, workforce, and ICT transition costs and to protect provider viability.

2.3 Deferring price caps for Support at Home

The scheduled introduction of Support at Home price caps within months, before prices have been finalised or tested in operation, creates material delivery and viability risks during early implementation. With limited time for IHACPA to assess pricing in practice and risks to consumer access not yet fully articulated or mitigated, premature caps risk constraining service availability, particularly in thin markets and higher-complexity services. A 12-month deferral would allow prices to be assessed in operation, consumer protections to be strengthened, and the reform to transition in a stable and sustainable way.

Price caps are a significant structural change to the funding and delivery of in-home aged care services. If set incorrectly or introduced prematurely, they risk undermining provider viability, constraining service availability, and reducing choice for older people - particularly in thin markets and for higher-complexity services.

CHA has previously raised concerns about the premature introduction of price caps - particularly delivery and viability risks - concerns which have since been reflected in Government decisions to defer their commencement. These risks have not yet been substantially mitigated or addressed, particularly given the delay of the commencement of the Aged Care Act 2024 to 1 November 2025. To impose price caps and their resulting uncertainty, risk to viability and consumer choice on 1 July 2026 will meaningfully reduce providers capacity to respond to implement the significant reforms required to roll CHSP into SaH by 1 July 2027.

CHA recognises and supports the Government's objective of protecting older people from unreasonable pricing. Consumer protections should be more clearly articulated alongside this deferral of price caps, so that consumers can be assured that prices they are charged are reasonable. These explicit consumer protections might include:

- clear authority for the Aged Care Quality and Safety Commission to require reimbursement or remediation where a client is overcharged;
- a transparent set of actions the Department will take where pricing is deemed unreasonable or not based in actual costs; and
- further publicity around the publicly available pricing providers are required to submit to the Department to encourage consumer choice.

Strengthening these protections would provide meaningful safeguards for older people while avoiding the unintended consequences of prematurely imposed price caps.

Recommendation 7: That the Committee recommend the deferral of the introduction of Support at Home price caps by 12 months to reduce delivery and market stability risks during early implementation and maintain consumer access.

2.4 Recognition of strain on the care management workforce

Care managers play a critical role in delivering person-centred care under the aged care reforms. The care management workforce has been and remains a key part of the transition to Support at Home, ensuring continuity of care. However, care management is not funded under CHSP, and the care management workforce is shrinking due to the reduction in the care management cap from 20 per cent to 10 per cent under Support at Home. As a result, there is significantly less to no capacity to coordinate care for people transitioning from CHSP, despite this being the largest and most complex cohort yet to move into the new system. CHSP supports a wide range of services and many clients access CHSP supports through multiple providers. Without adequate care management funding, change management and communication from multiple providers will result in mixed messaging and poorer client experiences.

An insufficient care management workforce risks fragmented care, delayed service commencement, and increased complaints and hospital presentations during transition. With more than 830,000 people expected to transition from CHSP,[3] the remaining care management workforce will face considerable strain, making this transition far more challenging than the previous HCP reform. CHA continues to advocate for an increased cap on care management under Support at Home, an urgent measure given the heightened pressure associated with the CHSP transition.

Recommendation 8: The Committee should recommend that Government allocate up to 15 per cent of Support at Home packages for care management.

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[3] Department of Health, Disability and Ageing. (2025, July 11). *Financial Report on the Australian Aged Care Sector 2023-24*. Australian Government Department of Health, Disability and Ageing. Retrieved from: https://www.health.gov.au/resources/publications/financial-report-on-the-australian-aged-care-sector-2023-24?language=en

Section 3: Supporting Service Sustainability and Innovation through Flexible Funding

The transition of CHSP to Support at Home presents both risks and opportunities for service sustainability. CHSP currently supports a wide range of community-based, preventative, and low-intensity services through a grant-based funding model that allows providers to respond flexibly to local demand. This flexibility is particularly important given the diversity of services delivered under CHSP and the varied needs of clients, many of whom rely on early intervention and social supports to maintain independence.

Moving prematurely or rigidly to individualised package-based funding risks undermining service sustainability, particularly for services that do not lend themselves to per-client pricing or economies of scale. Without targeted safeguards, this transition could result in the loss of proven service models that support wellbeing, reduce crisis presentations, and help delay entry into higher-cost care. For this reason, a mixed funding model combining individualised packages with targeted grants should be understood not as a transitional compromise, but as a deliberate design feature to preserve service diversity, support early intervention, and maintain market resilience. Without this, the transition risks reducing access to low-intensity and community-based care, particularly in thin markets and for people with emerging needs.

3.1 Maintaining community-based, respite, and social support services

Catholic aged care providers utilise grant funding for services that are inherently community-based or shared in nature. These include respite cottages, day centres, social support groups, transport services, and health and wellness programs that address social isolation and cognitive and physical decline.

Under the current CHSP model, grant funding enables providers to cross-subsidise services and reallocate resources to meet fluctuating demand. A clear example is funding transport to medical appointments in rural areas when transport-specific funding is insufficient. Under a rigid package-based model, this flexibility could be lost, rendering many services financially unviable. For example, Catholic Healthcare delivers a *Mind and Move* program across NSW, which is well suited to grant funding. It is not clear how similar care models can be delivered with unit pricing.

Providers also identified several best-practice models that would struggle to survive without grant funding, including:

- assistance with care and housing programs,
- hoarding and squalor interventions, and
- dementia advisory and outreach services.

These services are critical to keeping people safely at home and preventing avoidable deterioration, but are not suited to transactional, per-client pricing. They often support clients with complex needs who may not yet qualify for higher-level packages but would deteriorate rapidly without early intervention. Maintaining a mixed funding model - either within Support at Home or with elements of CHSP remaining external - is critical to preserving service diversity, supporting early intervention, and avoiding unintended market exits during the transition. Making grants administratively easy to access (while ensuring appropriate eligibility) will be key to the continued availability of these services. Where CHSP is retained outside Support at Home it should be as a low-cost, preventative program. This should

include a strict cap on annual expenditure per person and clear safeguards to ensure individuals requiring more extensive care move into Support at Home.

Recommendation 9: The Committee should recommend the retention of targeted grant funding alongside Support at Home packages for community-based, respite, transport, dementia, and social support services that cannot be sustainably delivered through individualised funding alone.

3.2 Smarter use of data to support sustainability and outcomes

The CHSP transition presents an opportunity to strengthen the use of data to inform policy, funding, and service design. Existing data sources, such as the Data Exchange (DEX),[4] already capture valuable information on service delivery and utilisation but are underused in system planning.

A stronger focus on outcomes rather than activity alone would support more effective investment decisions and enable Government to identify which preventative and community-based services deliver the greatest value. This is particularly important in the context of early intervention, where benefits may not be immediately visible in utilisation data.

As data requirements evolve under Support at Home, it is critical that data collection is designed around a one-collection, multiple-use principle. Data collected for service delivery, funding acquittal, quality assurance, and regulatory oversight should be captured once and reused across government systems wherever possible. Without this principle, there is a significant risk of duplicative reporting, increased administrative burden, and reduced time available for care delivery - particularly given the scale of CHSP and the diversity of providers involved.

Aligning data collections across My Aged Care, DEX, funding systems, and regulatory reporting would improve data quality, reduce provider burden, and support more timely and accurate system insights. This approach would also enable Government to leverage existing provider-reported data to monitor outcomes, forecast demand, and guide strategic investment, rather than introducing new or parallel reporting requirements.

As funding settings for the CHSP transition are developed, it will be important that proposed models are informed by real-world service delivery evidence from providers delivering community-based and preventative services. Catholic providers can provide detailed service-level examples of programs that are likely to cease without targeted funding, including cost structures and participation impacts. This evidence highlights the risk of unintended service loss if funding settings are finalised without testing against provider experience.

[4] The Data Exchange (DEX) is an Australian Government program performance reporting system used for a range of Commonwealth-funded community services, including CHSP.

Recommendation 10: The Committee should recommend that Government use consistent provider-reported data on service delivery, financials, and client outcomes to inform funding decisions, forecast demand, and guide strategic investment in preventative and community-based aged care services, applying a one-collection, multiple-use principle across all data and reporting requirements.

Recommendation 11: The Committee should recommend that, prior to finalising funding settings for the transition of CHSP to Support at Home, Government incorporate a targeted evidence-testing phase into the policy development pathway, distinct from broad stakeholder consultation, to test proposed funding models against service-level evidence from providers delivering community-based and preventative services before policy settings are locked in.

Section 4: Establishing Market Safeguards to Support Viability of Small Providers

The success of the CHSP transition to Support at Home depends on maintaining a diverse provider market capable of meeting varied and localised needs. Small, specialist, and community-based providers play a critical role in delivering allied health, meals, transport, respite, specialised support and culturally appropriate services - particularly in thin markets. In many communities, the loss of even a single small provider would mean older people can no longer access essential services at all.

Disproportionate compliance settings risk driving otherwise viable providers out of the market, reducing service availability for older people. This risk is heightened during periods of reform, when providers must absorb additional costs associated with system changes, reporting, and workforce compliance.

4.1 Proportionate compliance settings to protect service access in thin markets

Increasing regulatory and compliance requirements disproportionately impact small providers and allied health organisations, many of which operate on thin margins. For these providers, duplicative screening, reporting, and contractual obligations across multiple registered providers create barriers to continued participation in aged care.

In some cases, specialist providers such as Meals on Wheels or niche allied health services may withdraw entirely if compliance costs outweigh revenue. This would reduce service availability, particularly in regional areas, and undermine continuity of care for older people.

CHA cautions against reform settings that inadvertently favour larger, more consolidated providers at the expense of local service ecosystems. Preserving multi-provider models and subcontracting arrangements is essential to maintaining access, choice, and market resilience.

The development of market safeguards should include structured examination of evidence from small and specialist providers operating in thin markets. Given the scale of the CHSP transition, testing proposed compliance and funding settings against provider experience is a critical step in preventing avoidable market exits and ensuring continuity of services for older Australians.

Recommendation 12: The Committee should recommend that, for the CHSP transition period, compliance and reporting requirements for allied health and small providers be reviewed and streamlined to ensure they are proportionate, risk-based, and do not create unnecessary barriers to participation.

4.2 Protect service diversity and prevent unintended market exits during transition

The transition of CHSP to Support at Home could unintentionally accelerate provider exit, particularly among small, specialist, and community-based organisations operating in thin markets. While integrated or consolidated service models may deliver efficiencies in some contexts, excessive consolidation risks reducing service diversity, limiting consumer choice, and eliminating specialist services that support specific cohorts or local needs.

The scale of the CHSP transition (more than 830,000 older Australians) means that even modest levels of provider withdrawal could have significant system-wide impacts. This risk is most acute in regional, rural, and remote areas, where the loss of a single provider can materially reduce access to essential services such as allied health, transport, meals, respite, or culturally appropriate care.

Many small providers operate on thin margins and have limited capacity to absorb the combined pressures of reform-related costs, changes to funding models, and increased compliance requirements. Without targeted safeguards, otherwise viable providers may choose to exit the aged care system during or shortly after the transition, increasing pressure on remaining services and reducing access for older people.

To mitigate these risks, transition settings must be proportionate to provider size and capacity and recognise the unique role of small and specialist providers in maintaining service continuity and market resilience. Targeted, time-limited supports are critical to stabilising the market during the transition period and preventing irreversible service loss.

Recommendation 13: The Committee should recommend the Government establish a dedicated, time-limited market sustainability grant to support small and specialist providers operating in thin markets during the transition of CHSP to Support at Home to prevent irreversible service loss and protect access for older people. This grant should:

- apply for at least the **first two years following transition**,
- be targeted to providers at demonstrated risk of exit due to transition-related costs or funding changes,
- support continuity of essential services (such as allied health, transport, respite, meals, and culturally specific programs), and
- operate alongside proportionate compliance and transition settings to prevent unnecessary provider withdrawal and protect access to care.

Section 5: Minimising Administrative Complexity

CHSP operates within a highly diverse provider landscape, encompassing organisations of varying size, maturity, and service scope. In 2023-24, CHSP expenditure totalled approximately $3.0 billion, delivered through 1,264 providers to support over 830,000 older Australians[5] - a client base more than triple the size of Support at Home. These providers range from large multi-service organisations to small, community-based entities, delivering an extensive mix of services including domestic assistance, transport, allied health, and respite care.

These volumes far exceed those currently managed under Support at Home, meaning any design weaknesses in current administrative systems will be magnified many times over for CHSP providers. At this scale, even small failures in administrative and digital systems will have system-wide consequences for access, funding flows and continuity of care during the CHSP transition.

This heterogeneity, combined with high client volumes, significantly amplifies administrative complexity when compliance, assessment, and reporting requirements are overly prescriptive or fragmented. Providers must navigate multiple systems and platforms - such as the Data Exchange (DEX)[6] and Government Provider Management System (GPMS)[7] - with limited interoperability and functionality. These technical constraints have already contributed to unsustainable administrative burdens under Support at Home and are expected to escalate for CHSP providers managing far greater client numbers.

While some issues may be addressed through the upcoming Aged Care Data and Reporting Roadmap,[8] Catholic providers remain concerned about the governance, assurance, and accountability mechanisms underpinning digital transformation, which have yet to be clearly articulated to the sector. Without streamlined processes and transparent governance, risks include data handling errors, delays in service delivery, and non-compliance arising from technical limitations rather than provider intent. Addressing these challenges is critical to ensure administrative systems enable, rather than hinder, care delivery.

There is an urgent need for a coordinated and well-governed transition strategy that looks specifically at key components, such as ICT, reporting, and compliance requirements, to support the integration of CHSP into Support at Home. Without this, there is a significant risk that critical systems will not be ready to manage the large-scale migration of CHSP clients - whose numbers far exceed those currently in Support at Home. Any system underperformance or failure could trigger costly manual workarounds, disrupt service delivery, and compromise care quality. These failures would directly impact provider operations, delay funding flows, and ultimately undermine care outcomes for older people.

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[5] Department of Health, Disability and Ageing. (2025, July 11). *Financial Report on the Australian Aged Care Sector 2023-24*. Australian Government Department of Health, Disability and Ageing. Retrieved from: https://www.health.gov.au/resources/publications/financial-report-on-the-australian-aged-care-sector-2023-24?language=en

[6] Australian Government. (2025, September 18). *Commonwealth Home Support Program (CHSP) – specific DEX Protocols and Program Specific Guidance | Data Exchange*. Retrieved from: https://dex.dss.gov.au/document/1836

[7] Australian Government Department of Health, Disability and Ageing. (2025, December 19). *About the Government Provider Management System*. Retrieved from: https://www.health.gov.au/our-work/government-provider-management-system-gpms/about?language=en

[8] Australian Government Department of Health, Disability and Ageing. (2025, July 21). *Aged Care Data and Reporting Review: Phase 1 Consultation Paper*. Retrieved from: https://www.health.gov.au/resources/publications/aged-care-data-and-reporting-review-phase-1-consultation-paper?language=en

5.1 Centralised administrative system for third party providers

The complexity of the CHSP provider landscape is further compounded by the significant number of third-party (associated) providers that must be formally listed and administratively managed on platforms such as the GPMS. Under Section 11(4)(a) of the Aged Care Act 2024, an aged care worker of a registered provider includes any individual employed or otherwise engaged - including volunteers - to deliver funded aged care services. This definition extends to workers of associated providers and volunteers.

Under the Aged Care Rules 2025, these workers are required to complete multiple, similar forms for each registered provider they work with. For many, this means duplicating compliance processes across several organisations, creating an onerous administrative burden. This approach risks deterring workforce participation and accelerating workforce attrition at a time when providers are already struggling to recruit and retain staff.

Given the scale and diversity of CHSP, and the imperative to maintain workforce capacity, it is critical that administrative processes for associated providers and their workers are streamlined. Failure to address these inefficiencies will exacerbate provider workload, increase compliance costs, and further strain an already fragile workforce.

Within the context of the CHSP transition to Support at Home, CHA advocates for a nationally coordinated approach to administrative requirements - such as worker screening, compliance, and reporting - that moves toward a model that is proportionate, efficient and capable of supporting continuous improvement.[9] Harmonising these requirements across aged care programs would better align worker screening objectives with broader policy goals, support workforce development, and enhance outcomes across the care and support economy - particularly given the diversity and complexity of the CHSP landscape.

To achieve this, CHA proposes the design and implementation of a centralised administrative platform or "worker passport." This solution would enable workers to maintain a single, portable compliance profile that can be recognised across multiple providers, reducing duplication, improving efficiency, and lowering barriers to workforce participation - critical in the context of ongoing workforce shortages.

Recommendation 14: The Committee should recommend the development and implementation of a centralised administrative system or platform for associated providers. This could also include a 'worker passport' to support the new aged care worker screening system to ensure workforce mobility and continuity of services during the CHSP transition.

5.2 Recognition of the administrative burdens associated with training of workers

The diversity and complexity of the CHSP provider landscape - combined with the significant number of associated providers - makes it challenging for registered providers to hold sole responsibility for training and qualification requirements. Under the Aged Care Rules 2025, obligations such as Section 165-20(1)(e)(vi) require registered providers to deliver training on topics including "the roles and functions of independent aged care advocates in the system." While well-intentioned, applying such requirements uniformly to all aged care

[9] Catholic Health Australia. (2025, October 16). *Catholic Health Australia – Submission on a national approach to care and support worker screening*. Catholic Health Australia. https://cha.org.au/catholic-health-australia-submission-on-a-national-approach-to-care-and-support-worker-screening-2/

workers - regardless of their role - creates inefficiencies and unnecessary cost. For workers performing limited or non-clinical tasks, this level of training is often not proportionate to the risk profile of many roles, yet providers remain accountable for compliance. This approach risks diverting resources from frontline care and exacerbating administrative burden.

CHA has raised similar concerns in its feedback to the Aged Care Quality and Safety Commission's Regulatory Strategy 2025–26,[10] particularly regarding the principle that providers must "engage with, educate and learn from their workers." While commendable in intent, this obligation lacks clarity on what it entails in practice. Many Catholic providers already maintain robust workforce engagement mechanisms - both formal and informal - yet it remains uncertain whether these existing frameworks meet the Commission's expectations under the new regulatory model. This ambiguity is especially concerning in the context of broader reforms introduced by the new Aged Care Act, including worker registration and the Commission's expanded oversight role.

As CHSP transitions to Support at Home, clarity on these roles and responsibilities is critical. Without clear guidance, providers risk duplicating effort, misinterpreting obligations, and diverting resources away from care delivery - further compounding administrative burden in an already complex and diverse service environment.

Regulatory expectations must be fair, equitable, and transparent, with obligations tailored and proportionate to the diversity of roles within aged care. Harmonising training and engagement requirements across programs, and aligning them with adaptive regulatory approaches, would embed a culture of continuous improvement rather than compliance for compliance's sake.

Recommendation 15: The Committee should recommend that as part of the proposed centralised administrative system or platform, training requirements should be clearly aligned with the specific responsibilities of each role and proportionate to the duration of engagement in an aged care setting. This ensures that training obligations are relevant, targeted, and practical - avoiding unnecessary duplication and administrative burden compliance and quality standards while maintaining appropriate safeguards for consumers.

[10] Catholic Health Australia. (2025, September 10). *Catholic Health Australia –Submission on the Draft Regulatory Strategy 2025-26*. Catholic Health Australia. https://cha.org.au/catholic-health-australia-submission-on-the-draft-regulatory-strategy-2025-26/

Section 6: Maximising Assessment Accuracy

The Single Assessment System represents a major shift in aged care assessments, combining the Integrated Assessment Tool (IAT), a unified assessment workforce, and new First Nations assessment organisations. While these reforms aim to streamline access, CHA remains concerned about the system's readiness to support timely and accurate assessments for older people, along with its current capacity and resourcing.

A streamlined, accessible, and equitable assessment process is essential to ensure older people receive the right support at the right time.[11] However, systemic challenges persist. Providers continue to report delays in assessments - particularly in regional, rural, and remote areas - where assessors face significant travel barriers and alternative assessment options remain limited. In practice, these delays often result in older people remaining on existing care arrangements even as their needs escalate. Providers are expected to maintain continuity of care without updated assessments, placing significant financial and administrative pressure on services to deliver high-quality care under constrained conditions.

For a cohort of this size, any delays or inaccuracies in assessment will directly translate into lost care, unmet need, and avoidable deterioration for older people.

In the context of the large-scale transition of CHSP clients to Support at Home, these challenges – including IAT design and workforce capacity - must be urgently addressed. Failure to resolve these issues risks leaving significant numbers of older Australians without timely access to appropriate care, undermining the objectives of aged care reform, and increasing strain on providers.

6.1 Reduce unnecessary complexity in assessment service codes

It is the experience of Catholic providers that the Single Assessment System introduces delays and rigid service codes, creating significant administrative bottlenecks that ultimately delay care.

Providers have highlighted that these rigid coding requirements under the IAT are forcing unnecessary reassessments whenever a client's needs change. Under the new system, highly itemised service codes mean that even minor adjustments in care - such as moving from one type of allied health support to another - trigger a formal reassessment. Previously, broader program codes allowed providers to manage related services flexibly, ensuring timely care without administrative delays. This shift has introduced delays, reduced clinical responsiveness, and created barriers to timely, appropriate care.

[11] Catholic Health Australia. (2025, November 16). *Catholic Health Australia – Submission to the Inquiry into Aged Care Service Delivery*. Catholic Health Australia. https://cha.org.au/catholic-health-australia-submission-to-the-inquiry-into-aged-care-service-delivery/

Case study

Previously, providers could use a single allied health and therapy code to cover multiple services, such as group exercise sessions and physiotherapy, allowing flexibility to adjust care as client needs evolved. Under the Integrated Assessment Tool (IAT), this flexibility has been removed. Providers must now obtain a specific referral code for each service type - for example, one for a group exercise program and another for physiotherapy.

In practice, this means that a client who begins with group exercise and later requires physiotherapy must return to My Aged Care for a new referral code, rather than having the adjustment managed directly by the provider. This process creates unnecessary inefficiencies, prolongs wait times for care, and significantly increases administrative workload for providers - diverting resources away from frontline service delivery.

The complexity of coding consumables used in routine care - and managing third-party suppliers who access these consumables - adds significant cost and resource strain to providers. Due to the intricate clinical details involved in interpreting and applying these codes, clinical staff expertise is now required to review invoices line by line to ensure each item is correctly attributed to the appropriate instance of care delivery. Clinical staff are being diverted from direct care to perform administrative coding, increasing costs and reducing care capacity.

One alternative approach could be to provide clinical training to administrative staff so they can manage this coding process. While feasible in theory, this solution imposes substantial cost and resource burdens - both to deliver the training and to ensure administrative staff can apply it effectively in practice. These inefficiencies highlight the urgent need for streamlined coding systems and centralised compliance processes that reduce duplication and free up clinical staff to focus on care rather than administrative tasks.

6.2 Ensuring that the assessment system meets care needs

Catholic providers report that the Single Assessment System has delivered mixed outcomes, particularly regarding the accuracy of assigned care levels and corresponding funding against actual client needs. Two key issues underpin these concerns: (1) administrative barriers that delay access to care, and (2) misconceptions that CHSP clients only require low levels of care.

Delays to care

Administrative bottlenecks within the Single Assessment System are creating significant risks for timely support. For example, one provider reported delays of up to eight months for an individual to access restorative care - a timeframe that could severely compromise health outcomes and independence. In the CHSP context, where early intervention and prevention are critical, accurate and timely assessment is essential to allow sufficient lead time for designing and implementing supports before needs escalate.

To mitigate these risks, there must be clinically-supported mechanisms to allow interim or preventive services to be delivered where algorithmic or administrative processes delay access to care - and ensuring that providers are adequately funded to implement them. While the prioritisation mechanism outlined in the Rules provides some precedent for this, guidance on how these provisions apply in practice has not been clearly communicated to

the sector. Clear direction, supported by embedded and resourced workarounds within the Single Assessment System, is essential to enable providers to deliver preventative supports while older people wait for formal assessment outcomes.

Given the scale of CHSP clients transitioning to Support at Home, such measures - alongside transition supports outlined in Section 2 of this submission - are essential to ensure older Australians do not fall through gaps in the system.

In addition, a simplified assessment process is needed for clients with low-level needs. With high demand on the Single Assessment System, a streamlined assessment process would improve the availability of comprehensive assessments for clients with more complex needs. Additionally, this approach would relieve pressure on assessment waitlists and reduce delays for older Australians waiting for care. Low-level needs should be clearly defined and may include clients requiring services such as transport to essential services, shopping assistance, or meal support.

Recommendation 16: The Committee should recommend that Government clearly and proactively communicate how prioritisation, interim budgets and waitlist management will operate for CHSP clients during transition, so providers can apply these mechanisms in practice to prevent delays to care. As with all transition information, this should be finalised no later than 1 December 2026.

Recommendation 17: The Committee should recommend that a short, structured assessment tool be developed and integrated within the Single Assessment System for referrals flagged as requiring low-level support, applying clearly defined criteria for low-level needs. Safeguards should be incorporated to define clear indicators for conducting a full assessment to ensure supports are accurately aligned with ongoing care needs.

Accuracy and misconceptions about care needs

Some providers have reported needing to manually sense-check client care needs through My Aged Care or engage in repeated conversations with clients to validate information provided by the IAT. This reliance on client self-reporting can lead to incomplete or inaccurate assessments, particularly in a multi-provider environment. Providers should have access to a central portal to update service volume and cadence directly, reducing duplication and avoiding multiple conversations that frustrate older people and diminish their experience of care.

The system must also address misconceptions about CHSP clients requiring only low-level care. In reality, many CHSP clients have complex needs equivalent to a Support at Home Level 4 package. In line with CHA's broader policy positions, aged care must move toward a demand-driven model rather than a rationed system, ensuring that package supply and funding levels reflect actual care needs.[12]

[12] Catholic Health Australia. (2025, November 16). *Catholic Health Australia – Submission to the Inquiry into Aged Care Service Delivery*. Catholic Health Australia. https://cha.org.au/catholic-health-australia-submission-to-the-inquiry-into-aged-care-service-delivery/

Recommendation 18: The Committee should recommend that providers should have access to a central portal to update service volume and cadence directly, reducing duplication and avoiding multiple conversations that frustrate older people and diminish their experience of care. This portal should be integrated with the Single Assessment System platform to ensure older people have a seamless experience with accessing care through providing information about their care needs and preferences, to ensure a single, accurate source of care information across My Aged Care, providers and the assessment system.

Monitoring through the transition

As CHSP transitions to Support at Home, close monitoring of assessed care levels and service utilisation is essential to prevent older people from falling through the gaps. Providers have reported instances where individuals choose to remain on CHSP rather than transition to Support at Home - not only due to affordability concerns (outlined in Section 3) but also because of uncertainty about whether the system can meet their evolving care needs. This underscores the need for an assessment framework that is responsive, accurate, and capable of adjusting funding as needs change over time.

Currently, there is limited data on how different CHSP service types are used in practice, particularly in relation to assessed need versus actual uptake. The transition process presents a critical opportunity to capture and analyse this information - such as identifying clients assessed for specific services but not accessing them - to better predict and model demand and supply for a range of preventative supports (refer to Section 1). Leveraging this data will enable the sector to plan and respond proactively, ensuring adequate package volumes and service diversity to meet real-world needs (refer to Section 3).

Without this visibility, the system risks continuing to ration care based on outdated assumptions rather than actual need.

Closing remarks

The transition of the Commonwealth Home Support Program to Support at Home will shape the future of home-based aged care for hundreds of thousands of older Australians. If this transition is rushed, under-resourced or poorly governed, the result will be reduced access, loss of trusted local services, and increased pressure on hospitals and residential aged care.

This Inquiry provides a critical opportunity to ensure that does not occur. By embedding mixed funding through targeted grants, providing transition and thin-market safeguards, strengthening assessment and care management capacity, and ensuring administrative systems function at scale, Government can deliver a transition that improves outcomes without destabilising the sector.

Catholic providers stand ready to work with the Parliament and Government to implement these reforms in a way that protects older Australians, supports providers, and delivers a more responsive and sustainable aged care system.