7 March 2026

Via email: NDISRegulation@health.gov.au.

Catholic Health Australia Submission: Getting It Right – A New Definition for NDIS Providers

Thank you for the opportunity to provide Catholic Health Australia (CHA)'s views on priority actions to consider as part of the consultation on a new definition for NDIS providers. CHA appreciates the work of the Department of Health, Disability and Ageing (the Department), in exploring policy options to strengthen and modernise the NDIS provider registration framework as informed by findings of the 2023 NDIS Review and the NDIS Provider and Worker Registration Taskforce.

Our submission presents strategic recommendations to support the design and implementation of a risk-proportionate provider registration and regulatory framework. In particular, we outline key considerations for developing a fit-for-purpose definition of an NDIS provider; the importance of embedding mechanisms that enable integration with wider care and support system reforms from the outset; and the essential preconditions – drawn from recent reform experiences – that should guide the successful implementation of these changes.

We emphasise the critical role of government leadership in driving system-wide reform through targeted investment in foundational system architecture and infrastructure, aligned funding settings, and genuine co-design with the sector. Strong, coordinated leadership anchored in a shared vision is essential to building a resilient and equitable care system. Our proposed approach aims to support a cohesive, whole-of-system response that enhances efficiency and, most importantly, enables more time to be directed to delivering high-quality care.

CHA welcomes the opportunity to contribute to ongoing discussions and assist in the implementation of reforms that will build a more resilient, sustainable, and equitable healthcare system for all Australians. If you wish to discuss anything further, please contact Dr Katharine Bassett, Director of Health Policy on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

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Catholic Health Australia – Getting It Right – A New Definition for NDIS Providers Submission

March 2026
Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government, not-for-profit group of health, community, and aged care providers. Our members operate 80 hospitals in each Australian state and the ACT, providing around 30 per cent of private hospital care and 5 per cent of public hospital care, in addition to extensive community and residential aged care.

Background

The National Disability Insurance Scheme (NDIS) has undergone significant change in recent years. In 2023, the Australian Government commissioned an Independent Review of the scheme (henceforth 'the Review'), examining its sustainability, effectiveness, and the experiences and outcomes of NDIS participants. The Review identified structural concerns with the existing provider regulatory framework and made recommendations to strengthen oversight while reducing unnecessary burden on lower-risk providers.

Following the Independent Review, a dedicated Taskforce was established to translate the Review's findings into actionable policy. Among its recommendations, the Taskforce proposed amendments to the definition of an "NDIS provider" that would create a more proportionate, risk-based approach to regulation which distinguished between provider types based on the nature and risk profile of the supports they deliver.

This consultation seeks to: establish a level playing field for providers of similar services, with more responsive and cost-effective regulation for lower and medium risk supports; leverage registration to help the NDIS Quality and Safeguards Commission (the Commission) and the National Disability Insurance Agency (NDIA) incentivise quality while combating fraud, abuse, neglect and exploitation; and improve the integrity, sustainability and productivity of the Scheme.

CHA and its members understand the consultation to cover four key areas:

- the scope of supports included in the definition;
- how an amended definition can uphold participant rights, including choice and control;
- the benefits of amendment, including improved market monitoring; and
- potential unintended consequences, such as service disruption or unnecessary regulatory burden.

Overall comments

Australia's disability sector is undergoing significant structural change. An ageing population is placing growing pressure on care systems, while decades of deinstitutionalisation have rightly shifted care expectations toward more community-based, and person-centred support. Rates of disability diagnosis are increasing, best practice continues to evolve, and the boundaries between disability, aged care, and mental health support are becoming increasingly complex to navigate.

These pressures reflect a broader shift in how disability policy is framed, from service provision to increasing participation. The NDIS was born from a recognition that people with disability deserve not just care, but genuine participation in community life. CHA members – whose work is grounded in Catholic teachings of dignity, equity and the value of the human person – welcome these reforms as a valuable opportunity to strengthen the NDIS founding vision, ensuring that the principles of autonomy, fairness, and inclusion operate at the centre of the system, rather than being subordinated to medical concerns of diagnosis and clinical management alone. CHA therefore strongly supports the direction of these reforms, and encourages the Government to use this moment as an opportunity to build a system that improves efficiency whilst upholding equitable outcomes.

The case for refining the NDIS provider definition is well known. A 2023 review of the NDIS found that out of the 170,000 providers in the market, only 16,000 (less than 10%) were

registered and visible to the regulator.[1] Moreover, out of the 154,000 unregistered NDIS providers, fewer than 6,500 had a single worker who had been screened.[2] These figures have only grown since, with ANAO's 2025 performance audit indicating that the total number of unregistered providers is now over 250,000.[3] Contained within this are various examples of improper practice, including evidence of individuals who have been banned from working with disabled people moving into the unregistered market to circumvent screening requirements.[4]

In its current design, the NDIS system places disproportionate burden on registered providers – including all CHA members operating in this space – whilst allowing potentially problematic operators to exist outside regulatory scope. The Review identified this issue and sought to address it by making all providers visible via a four-tier risk-proportionate regulatory framework. This new model offered light-touch regulation for the lowest risk providers, alongside cross-system mechanisms to avoid unnecessary auditing for providers already accredited in health or aged care, a more effective regulator, and a five-year transitional period.[5]

This consultation departs from the model outlined in the Review, proposing instead a framework with three registration tiers, a fourth 'not an NDIS provider' tier, no cross-system recognition mechanisms, and mandatory registration for Supported Independent Living (SIL) and platform providers by 1 July 2026. All of this despite ongoing issues with the NDIA Participant and Claims Enhancement (PACE) system, which has yet to fully migrate participant plans, and currently has no completion date in place.[6] The current issues with existing infrastructure have the potential to derail any reforms, and must be addressed as a priority.

With that being said, CHA recognises that these reforms have been designed to strengthen the NDIS Commission's regulatory capacity, and improve the system for providers, participants, and all other stakeholders involved in the NDIS. It is from this perspective that CHA welcomes the opportunity to contribute to this consultation on *Getting it right: a new definition of a NDIS provider*, and urges the Government to seize this key moment of reform.

Key observations and issues related to the NDIS definition articulated in our submission include:

- That **the definition must be fit-for-purpose**, not only for the current service landscape, but for an evolving care economy that increasingly encompasses digital platforms, remote support delivery, and AI-assisted tools. This means disaggregating broad support categories that currently mask materially different risk profiles, accounting for mode of delivery and the legal relationships between providers, workers and participants, and embedding a built-in review mechanism so the support type list does not become outdated as service models change.
- That the operational design of the definition must anticipate **integration with broader care economy reforms from the outset**. CHA recommends that each support type be boundary-tested before going live, that cross-system accreditation be recognised to avoid duplicating compliance obligations already met under equivalent

[1] Bonyhady, B., & Paul, L. (2023). *Working together to deliver the NDIS: Independent Review into the National Disability Insurance Scheme - Final Report.* Commonwealth of Australia, p. 214
[2] Bonyhady & Paul (2023), p. 214
[3] Australian National Audit Office. (2025). *Regulatory Oversight of NDIS Providers: NDIS Quality and Safeguards Commission. Performance Audit*
[4] Bonyhady & Paul (2023), pp. 213-215
[5] Bonyhady & Paul (2023), Recommendation 17 and supporting text, pp. 210–230. The Review recommended advanced registration, general registration, basic registration, and enrolment as four distinct tiers, with a five-year transition period.
[6] National Disability Insurance Agency. (2025). Evidence to the Australian National Audit Office.

Commonwealth frameworks such as aged care and the National Safety and Quality Health Service (NSQHS) standards,[7] and that the Commission's capacity and system readiness be independently verified before mandatory registration is introduced.

- That the **lessons of recent reform implementation must be actively applied**. The registration model should grandfather existing registered providers without reapplication, be preceded by an impact assessment in thin markets to model the risk of provider exit, and be subject to a statutory review within three years of commencement.

Contents

[7] Catholic Health Australia. (2025). NSQHS Public Consultation 1. Accessed at: https://cha.org.au/catholic-health-australia-submission-on-the-nsqhs-public-consultation-1/

Our list of recommendations

Recommendation 1: The definition of an NDIS provider should:

a) Distinguish between digital platforms that only facilitate connections with those that are interconnected with aspects of service delivery;
b) Explicitly state that each support type is applicable irrespective of the mode of delivery (i.e., in-person, telehealth, or platform).
c) Enable compliance and enforcement responses under the new framework to be explicitly calibrated to the corresponding registration tier and risk profile, ensuring that regulatory action remains proportionate and supports continuous improvement rather than punitive disengagement from the market.

Recommendation 2: Broad categories such as 'capacity building support' can encompass support types with materially different risk profiles. These categories should therefore be disaggregated into distinct categories, rather than treated as a single line item.

Recommendation 3: The language of the definition of an NDIS provider and support types should be refined through co-design to reflect the lived experience of participants and carers, and operational knowledge and expertise of providers across the sector to ensure the proposed changes are fit-for-purpose.

Recommendation 4: That all support types are boundary-tested against relevant use cases or worked examples prior to implementation.

Recommendation 5: Provider registration obligations should be aligned with the risk profile of each support type to ensure a balanced, risk-proportionate approach is taken to maintaining provider visibility within the regulatory framework.

Recommendation 6: All components of the proposed regulatory framework, including the NDIS provider definition, registration tiers, regulatory obligations, and funding structures, are aligned from the outset and co-designed with sector partnership.

Recommendation 7: That the NDIS Rules, or other subordinate legislation, that establish the support types list includes a mandatory review cycle of no more than five years to ensure the list remains fit-for-purpose and aligned with emerging models of care and new service delivery modalities.

Recommendation 8: That the registration tiers and associated compliance obligations be subject to periodic recalibration alongside the mandatory review of the support types list, to ensure that tier allocation remains proportionate to evolving risk profiles and service delivery models.

Recommendation 9: Use of any technology to promote accountability within the system must be subject to the following safeguards as a condition of implementation:

a) Disability inclusion principles must be used as a guiding framework to ensure disability-inclusive values are embedded from the outset, not as an afterthought;
b) Data governance mechanisms are robust and build on lessons learnt from recent reforms, such as in aged care.

Recommendation 10: That the definition include a functional test enabling the NDIS Commission to assess the substance of what an entity delivers. This test should reference existing quality standards in other healthcare sectors, such as the Aged Care Quality Standards and the NSQHS Standards.

Recommendation 11: That the definition account for the mode of service delivery alongside support type, with registration obligations calibrated to reflect the distribution of risk and accountability between provider, worker, and participant under each arrangement

Recommendation 12: Where agency staff are deployed to deliver supports under a registered provider's registration tier, the agency itself should be required to hold registration as an NDIS provider and be subject to relevant registration requirements aligned with their risk profile.

Recommendation 13: Registration requirements should be contingent on the risk profile of the support delivered, as opposed to whether the participant self-manages their plan.

Recommendation 14: That the registration framework incorporate a cross-system recognition mechanism enabling providers already registered and assessed under equivalent Commonwealth regulatory frameworks, such as the Aged Care Act 2024 or the NSQHS Standards, to have those assessment outcomes recognised in lieu of duplicative NDIS compliance requirements.

Recommendation 15: That the NDIA certify that PACE is technically capable of administering new registration categories without significant disruption to existing provider payment cycles. Mandatory registration must not commence until defined operational benchmarks are met and system readiness has been independently verified.

Recommendation 16: That the NDIS Commission confirm that DART is sufficiently operational to support expanded registration functions under the new model. Mandatory registration must not commence until defined operational benchmarks are met and system readiness has been independently verified.

Recommendation 17: Implementation of the new provider definition and registration framework be subject to independent monitoring during the first 24 months, with public reporting on system performance, payment timeliness, market impacts, and participant outcomes.

Recommendation 18: That the registration model be subject to a statutory review within three years of commencement, assessing whether proportionality has been achieved in practice, whether thin markets have been affected, and whether the Commission has the capacity to administer the model.

Recommendation 19: Implementation of the new provider definition and registration tiers occur through a staged approach, commencing with higher-risk support types and progressing to lower-risk tiers only after evaluation of system performance, provider readiness, and participant impact.

Recommendation 20: That a regulatory impact assessment be completed and its findings publicly released prior to the commencement of the new definition of an NDIS provider, modelling the risk of provider exits in thin markets, including regional, rural, and remote areas.

Recommendation 21: To mitigate potential transition disruption, participants receiving services from providers impacted by changes to the definition of an NDIS provider should be grandfathered so that their current terms continue until their next scheduled plan reassessment.

Recommendation 22: Establish a time-limited transition fund to support the sector in adopting the new registration model, with dedicated streams for workforce inclusivity, smaller and regionally-based providers, and administrative alignment at the aged care-disability interface.

Recommendation 23: That commencement of the new definition of an NDIS provider and associated mandatory registration requirements (including for SIL and platform providers) be deferred from 1 July 2026 until such time as the preconditions in Recommendations 14 to 17 have been demonstrably met, and in any event not earlier than 1 July 2027. Where those preconditions cannot realistically be achieved three months prior to the proposed commencement date, the Government should formally defer implementation and publicly communicate a revised, staged timeline developed in partnership with the sector.

Submission

Section 1: Defining roles and responsibilities in a clear framework for a complex system

Digital platforms and technology-enabled supports

Table 2 does not explicitly identify or address those digital platforms that act as intermediaries for matching participants with providers, despite this being the business model of Mable, Hireup, and several other services in Australia. Moreover, it fails to sufficiently capture services that are provided via telehealth support delivery modalities, or by AI-assisted tools that may be used in care planning and decision-making.

Rather, the list in Table 2 uses broad phrases such as “provision of”, or “services to”, language that assumes a traditional model of delivering services in-person. Digitally- and technology-enabled supports may be inferred in these types, but this is not explicit, and inference is not a sound basis for a registration framework.

In an environment where digital transformation is increasingly synonymous with emerging models of care delivery, this gap is significant. The use of digital tools and platforms in the care of NDIS participants - who are, by definition, vulnerable – introduces distinct risks around data privacy, algorithmic accountability, and the adequacy of duty of care obligations on intermediary platforms. Without explicit recognition of these delivery modes within the registration framework, providers operating through them risk falling outside the oversight the Act intends to establish.

To resolve these issues, CHA recommends two actions. First, the definition of an NDIS provider should distinguish between platforms that only facilitate connections (so-called ‘marketplace models’) and those that exercise substantive control over service delivery, quality, and/or worker conduct. Where a platform recruits, screens, and matches providers and participants, alongside processing payments, providing insurance, and monitoring and upholding quality, it is functionally operating as a provider, even if it does not describe itself as such. In these cases, registration obligations should apply accordingly.

Given that mandatory registration for digital platform providers commences on 1 July 2026, this issue must be resolved as soon as possible, by ensuring that the definition clearly describes what activity types those platforms are registering for. Here Australia should learn from England, where the Care Quality Commission (CQC) has never satisfactorily resolved this issue, leading to a growing number of introductory agencies and matching platforms operating entirely outside of CQC’s oversight frameworks, with no inspections, quality assurance, or recourse to action when something goes wrong.[8]

Second, the definition should make it explicit that each support type listed in Table 2 should apply irrespective of how it is delivered, whether that be in-person, via telehealth, a platform, or with AI/algorithmic assistance. To address this, the Department should consider adopting France’s *services à la personne* framework which is a model that captures supports regardless of delivery mode, instead distinguishing between modes of employment

[8] Care Quality Commission. (2023). *Scope of Registration.* CQC guidance on the boundaries of regulated activities.

relationship.[9] Without this or an equivalent approach, the NDIS definition may be limited to in-person delivery, and lack the flexibility to adapt to new modalities.

Importantly, in a risk-proportionate framework for registration, there should be equivalent proportionate enforcement. For instance, where registration tiers are risk-based, enforcement responses should also be risk-calibrated. Without appropriate and proportionate enforcement approaches in place, low tier providers may risk heavy sanctions – which is inconsistent with the intent of the model proposed in this consultation paper.

Recommendation 1: The definition of an NDIS provider should:

a) Distinguish between digital platforms that only facilitate connections with those that are interconnected with aspects of service delivery;
b) Explicitly state that each support type is applicable irrespective of the mode of delivery (i.e., in-person, telehealth, or platform).
c) Enable compliance and enforcement responses under the new framework to be explicitly calibrated to the corresponding registration tier and risk profile, ensuring that regulatory action remains proportionate and supports continuous improvement rather than punitive disengagement from the market.

Disaggregating broad support categories

Several categories in Table 2 are too broad and risk folding supports with different risk profiles into a single line item. For example, 'intermediary services to support a person to manage their NDIS plan, support services, or financial management' could cover anything from simple administrative plan management to complex service brokerage cases. Despite both nominally falling under this category, these examples clearly represent different activities with variable risk profiles and should not sit in the same registration tier.

Likewise, 'capacity building support' is overly encompassing, as it could capture anything from intensive allied health interventions to life-coaching delivered by a peer worker. In both cases, the current formulation risks either over-regulating low-risk functions, or under-regulating high-risk ones, by applying a lowest common denominator type standard. These ambiguous categories should therefore be disaggregated into specific activities with different registration tiers according to their actual risk profile.

Recommendation 2: Broad categories such as 'capacity building support' can encompass support types with materially different risk profiles. These categories should therefore be disaggregated into distinct categories, rather than treated as a single line item

Determining where these boundaries should be drawn is not a task that should be undertaken in isolation. The lived experience of participants and carers, and the operational knowledge of providers across the sector, are essential inputs into any disaggregation exercise to ensure that proposed changes are fit-for-purpose.

In practice, this could involve developing structured case studies to anchor focus group discussions with relevant stakeholder groups, testing whether proposed categorisations resonate with real community experiences. Any such process should reflect a genuine commitment to inclusive co-design, prioritising collaboration with a diverse range of

[9] Code du travail (France), Articles L7231-1 to L7233-9, as amended. See also: Direction générale des entreprises (2025), *Circulaire relative aux activités de services à la personne,* 3 January 2025, pp. 12–18.

community stakeholders and adopting approaches that seek to empower participants and carers as agents in this reform, rather than treating them solely as recipients of it.

Recommendation 3: The language of the definition of an NDIS provider and support types should be refined through co-design to reflect the lived experience of participants and carers, and operational knowledge and expertise of providers across the sector to ensure the proposed changes are fit-for-purpose.

Each support type must be boundary-tested before commencement

Several categories in Table 2 are drafted broadly enough to create boundary disputes upon implementation. A boundary dispute arises when it is unclear whether a particular activity falls inside or outside of a given support type. In cases where the boundary is uncertain, providers cannot determine what they are registering for, while participants cannot know whether their support is covered, and it becomes unclear who bears legal responsibility if something goes wrong. This can lead to situations where providers, participants, and regulators are all operating under different assumptions about who is responsible for the safety of the person receiving the support.

This has been the case in England, where the design of CQC's regulated activities list has led to persistent boundary disputes, for example in cases such as helping someone to dress ('regulated personal care') which is considered meaningfully different from helping them to tidy their bedroom ('unregulated domestic support').[10] Recent changes to the CQC's 'scope of registration' guidance have finally sought to address these boundary issues, but this has come years after the regulated activities list came into effect.

In addressing this, CHA recommends that each support type be boundary-tested against existing worked examples before the list goes into effect. These tests should set out what falls inside each category, what falls outside, and where the boundary sits. This should offer enough specificity to reassure providers that they can register for particular activities, whilst providing participants with clarity on coverage.

Recommendation 4: That all support types are boundary-tested against relevant use cases or worked examples prior to implementation.

CHA does not see the need for broad exclusions from Table 2, but rather calls for targeted refinements based on whether the registration tier accurately reflects the risk profile. Excluding supports entirely from the definition would increase the opaqueness of certain providers, as it would undermine visibility through the payment system.

In adopting a risk-proportionate approach to regulation, the broad inclusion of supports and services in Table 2 provides a regulatory lever to manage and mitigate risks of technical non-compliance. A clearly defined and comprehensive set of supports and services in Table 2 is essential to establishing clarity in the roles and responsibilities of sector actors, and to build a systematic framework that is deemed trustworthy by participants, carers, and providers.

One solution would be to link tier registration obligations to the risk profile of the support type, so that every provider remains visible in the system, whilst ensuring that the regulatory

[10] Care Quality Commission. (2015–2024). *Scope of Registration* guidance (various eds.). CQC's guidance distinguishes between "personal care" (a regulated activity) and domestic support (not regulated), but the boundary between the two has been a persistent source of dispute between providers and inspectors.

burden is proportionate to the level of risk that their activity carries. For example, a provider delivering specialist disability accommodation with restrictions in place should face a high registration tier, with corresponding audit, inspection, and workforce requirements, whilst a provider delivering community access support should face a low registration tier, with a correspondingly lighter touch approach.

Recommendation 5: Provider registration obligations should be aligned with the risk profile of each support type to ensure a balanced, risk-proportionate approach is taken to maintaining provider visibility within the regulatory framework

Section 2: The critical role of systems architecture in delivering intended outcomes

Pricing arrangements that support a tiered registration model

Equally important is the need for appropriate funding mechanisms to recognise and account for the varying levels of risk and administrative burden that registered providers would assume across tiers. Meeting the requirements of a high registration tier, for instance, carries differential cost implications –including more rigorous audit obligations and comprehensive workforce training requirements – relative to those faced by providers operating under a lower registration tier. Building on the findings of the 2023 NDIS Review,[11] which concluded that pricing arrangements to administer the scheme were not fit-for-purpose, there is a clear opportunity to develop a comprehensive pricing approach and data strategy that better aligns with the introduction of a new NDIS provider definition and its corresponding registration and regulatory model.

This work is already underway. The Independent Health and Aged Care Pricing Authority (IHACPA) has been tasked by the Australian Government with identifying opportunities to reform NDIS pricing,[12] including reviewing existing pricing approaches, developing a pricing data strategy, and identifying options for pricing reform. Following extensive consultation with participants, providers, and stakeholders, IHACPA published a snapshot of what it heard in September 2025, finding that the current NDIS pricing model is generating significant unintended consequences for participants, providers, and the disability sector more broadly. CHA welcomes this work and considers it a critical foundation upon which a more equitable, risk-proportionate pricing framework can be built — one that explicitly recognises the differential costs associated with operating across registration tiers.

CHA and its members therefore recommend that all components – including the provider definition, registration tiers, regulatory obligations, and funding structures – are aligned from the outset, implemented as intended, and subject to ongoing evaluation to ensure long-term sustainability

Recommendation 6: All components of the proposed regulatory framework, including the NDIS provider definition, registration tiers, regulatory obligations, and funding structures, are aligned from the outset and co-designed with sector partnership.

[11] Bonyhady & Paul (2023). p 172.
[12] IHACPA. (2025). *NDIS Pricing Reform Opportunities.* Accessed at: https://www.ihacpa.gov.au/news/ndis-pricing-reform-opportunities-what-weve-heard

The support type list should be subject to regular review

Commonwealth legislative instruments – such as the instruments containing the NDIS rules –are usually subject to automatic sunsetting under the Legislation Act 2003, meaning they should be reviewed and substantially refined at least every ten years. Currently, however, all instruments made under the NDIS Amendment (*Getting the NDIS Back on Track, No.1*) Act 2024 – including the NDIS rules used to establish the support type list – are exempt from the sunset clause.[13]

This means that there is no legislative mechanism in place to ensure that the support type list is reviewed at any point after it first takes effect. In a sector where technological innovations such as digital platforms, remote supports, and AI-assisted decision-making tools are already reshaping how care is delivered – and creating new regulatory gaps in the process as previously discussed – this poses a significant risk, namely that the support type list will become outdated and fail to effectively regulate new and emerging support types.

England offers an instructive example of the unintended consequences arising from a lack of regular review. The CQC's regulated activities list went largely unchanged for nearly fifteen years, until a belated revision finally took place in 2024.[14] This meant that the CQC could not incorporate new platforms and technologies into its regulatory orbit, undermining oversight and leaving vulnerable people in settings beyond their reach.[15] England finally addressed this in 2025 through an amendment to its regulated activities regulations that now mandates a five-year review cycle.[16] By contrast, France's equivalent activity lists in the *services à la personne* framework are subject to regular review via a 'ministerial circular', with the most recent one taking place in January 2025, which replaced the 2019 list in its entirety.[17]

To mitigate the risk of the support list being misaligned with emerging support types and models of service provision, CHA recommends that the NDIS Rules establishing the support type list include a mandatory review cycle of no more than five years, following the approach now used in England and France. In the absence of the Legislation Act's sunset clause safeguards, this is the only way to ensure that the support type list remains fit for purpose.

Recommendation 7: That the NDIS Rules, or other subordinate legislation, that establish the support types list includes a mandatory review cycle of no more than five years to ensure the list remains fit-for-purpose and aligned with emerging models of care and new service delivery modalities.

[13] Department of Health, Disability and Ageing. (2025). *Changes to the NDIS Act.* The Department confirms that the Getting the NDIS Back on Track No. 1 Act 2024 includes "[e]xempting all instruments made under the NDIS Amendment (*Getting the NDIS Back on Track - No. 1*) Act 2024, including NDIS rules, from ending after 10 years." See: https://www.health.gov.au/topics/disability-and-carers/reforms-and-reviews/ndis-act-changes

[14] *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* (UK), SI 2014/2936. The list of regulated activities was substantially unchanged from its original form in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 until revisions commenced in 2024-25.

[15] One example was the care/housing split in supported living, which CQC described as "a significant regulatory gap" that ultimately required a separate Act of Parliament to be addressed. See: Care Quality Commission, Written evidence to the House of Commons Levelling Up, Housing and Communities Committee: Inquiry into Exempt Accommodation (EAC0085), 2022; *Supported Housing (Regulatory Oversight) Act 2023* (UK).

[16] Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2025 (UK). The amending regulations removed the previous open-ended duration of the regulated activities list and substituted a five-year review cycle, with the first review due no later than 2030.

[17] Direction générale des entreprises (France). (2025). *Circulaire relative aux activités de services à la personne,* 3 January 2025. This 48-page circular replaced the previous 2019 version and updated definitions, activity types, and operational requirements.

Mechanism for tier calibration

As outlined previously, each registration tier must be explicitly calibrated to the compliance and regulatory requirements of the registration framework. It follows that a mechanism is needed to review whether that calibration remains fit-for-purpose and proportionate over time — particularly given the emergence of new models of care and service delivery driven by evolving technologies and shifting market dynamics. These developments can materially alter the risk profile of certain supports, meaning that without a formal recalibration mechanism, tier settings risk becoming either unnecessarily burdensome or insufficiently protective of people with disability.

Recommendation 8: That the registration tiers and associated compliance obligations be subject to periodic recalibration alongside the mandatory review of the support types list, to ensure that tier allocation remains proportionate to evolving risk profiles and service delivery models.

Covering the lightest-touch providers

The NDIS Review proposed four tiers of provider registration: advanced, general, basic, and enrolment. The latter category was specifically designed for the lightest-touch providers, involving a simple online process for low-risk support types where the Review Panel judged that Australian Consumer Law (ACL) would be sufficient.[18] Examples of this included purchasing continence products from a pharmacy, or buying a laptop from a retailer, and other transactions where the provider is often a standard business with no ongoing clinical or care relationship with the participant. Under this framework, enrolled providers would thus still sit inside the regulatory orbit, being visible to the NDIS Commission and NDIA, although the obligations and expectations of them would be minimal.

Following this, the NDIS Provider and Worker Registration Taskforce (henceforth 'the Taskforce'), established in February 2024 to advise on the design and implementation of the new regulatory model, departed from this approach. Rather than requiring all providers to register or enrol, the Taskforce proposed four registration categories (advanced, general, self-directed, and basic) with a fifth (Purchase Visibility) which it described as "not a category".[19] The logic being that under this model, providers of goods and services below the registration line would – by definition – not be NDIS providers, and therefore not be required to register at all. Instead, they would become visible to regulators through an enhanced payment system.

The model proposed in the consultation paper follows the approach of the Taskforce, rather than the 2023 Review. It presents three registration tiers (advanced, general, and basic) above the dotted line, with Purchase Visibility categorised as 'not an NDIS provider', and therefore outside the formal registration requirements. This follows the logic of the Taskforce, which concluded that not all providers should be required to register.

CHA supports the principle that the lowest-risk providers should face the lightest touch regulations, and should not be subject to unnecessary red tape. There is, however, a substantive difference between what the Review proposed – namely to ensure that all providers were kept within the regulatory orbit – and what is now described. The decision to remove the lowest tier from the regulatory framework represents a significant architectural

[18] Bonyhady & Paul (2023), Recommendation 17, Action 7.3. The Review recommended enrolment as the lightest-touch tier, involving "a simple online process" for supports where "Australian Consumer Law protections are sufficient".
[19] NDIS Provider and Worker Registration Taskforce. (2024). *Final Advice,* 2 August 2024, pp. 38–39. See https://www.dss.gov.au/disability-and-carers-standards-and-quality-assurance/ndis-provider-and-worker-registration-taskforce

choice, and the consultation paper does not explain why it has been made, or what assessments have been undertaken, including the potential trade-offs and broader impact on the sector.

Both the Review and the Taskforce based this approach on the existence of a functioning payment visibility architecture that could account for transactions involving providers outside the formal registration framework, ensuring that participant safety and scheme integrity could still be maintained without the lever of registration. CHA's concern is that the consultation paper does not sufficiently address how this architecture will be designed, resourced, and evaluated. If the payment visibility mechanisms underpinning the lowest tier are not fit-for-purpose, then the model risks failing on its own terms.

Payment visibility mechanisms, in principle, offer a proportionate and less burdensome alternative to registration for the lowest tier of providers. However, their effectiveness cannot be assumed, because it is contingent upon the quality of the systems architecture underlying them, and the safeguards built into their design from the outset. A payment visibility mechanism that is experienced by participants as surveillance, or that is implemented without their genuine understanding and consent, will undermine the very trust that the new provider definition framework is intended to build.

CHA therefore calls for the payment visibility framework supporting the lowest tier to be co-designed with participants, providers, and the sector - with disability inclusion principles embedded as a compulsory design principle. This should be piloted transparently before full implementation, and subject to ongoing independent evaluation. The question is not whether such a system can work but rather whether it will be given the architectural investment and genuine co-design it requires to work as intended.

In practice, this means explicitly defining what data will be collected and how it will be used, what triggers will prompt review or intervention, how consumers can contribute to or challenge decisions made – including a right to explanation for any participant where an automated flag has been generated against their account – and how outcomes will be evaluated over time. This reinforces our earlier recommendation that a comprehensive pricing approach and data strategy – one that is aligned with the new provider definition and its corresponding registration tiers – is developed in partnership with the sector. A payment visibility framework that is not underpinned by a coherent data strategy risks being fragmented and reactive rather than systematic and preventative, undermining the very accountability it is designed to deliver.

CHA recommends that any technology used to promote accountability within the system to be subject to the following safeguards as conditions of implementation:

a) **Disability inclusion principles as a guiding framework**. Any payment visibility mechanism must be designed and operated in accordance with disability inclusion principles – recognising the rights of NDIS participants to autonomy, dignity, and self-determination. Monitoring mechanisms must not be designed or applied in ways that are infantilising, stigmatising, or that treat participants as subjects of surveillance rather than rights-holders exercising choice and control. The design of these systems should embed disability-inclusive values from the outset, not as an afterthought.
b) **Robust data governance,** modelled on lessons from aged care reform. The aged care sector offers instructive lessons on what is required to implement data systems responsibly in a care context. The development of the Aged Care Data and Digital

Strategy 2024–2029 and the Integrated Assessment Tool (IAT) involved extensive consultation with over 400 stakeholders - including providers, consumers, researchers, and peak bodies - before the data architecture was finalised.[20] The IAT design process also grappled directly with questions of data sovereignty, limits on data sharing, and the right of individuals to understand how their information is being used — lessons that are directly transferable to the NDIS context.

Recommendation 9: Use of any technology to promote accountability within the system must be subject to the following safeguards as a condition of implementation:

c) Disability inclusion principles must be used as a guiding framework to ensure disability-inclusive values are embedded from the outset, not as an afterthought;
d) Data governance mechanisms are robust and build on lessons learnt from recent reforms, such as in aged care.

The need for a functional test

Any activity-based definition creates a structural incentive, namely that if a provider can redesign its structure so that no single entity performs the activity that triggers registration, it falls outside regulatory oversight whilst delivering the same service to the same person.

An example of this can be found in the current NDIS regime, which funds housing (Specialist Disability Accommodation, or SDA) separately from daily living support (Supported Independent Living, or SIL). Despite this structural separation, providers routinely deliver both through the same or related entities, an arrangement that some have described as 'third line forcing',[21] where a single organisation acts as both landlord and support provider.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (henceforth: the Royal Commission) found that the separation of housing and support in group homes had been only superficial, and that NDIS funding policies of disaggregation had not realised their anticipated benefits. Recommendation 7.41 called for a specific review of mechanisms to transition away from allowing the same provider to deliver both SIL and SDA, with interim arrangements to strengthen oversight and monitor conflicts of interest.[22]

The Australian Government committed $49.7 million to explore legal separation of SIL and SDA, and the NDIS Commission conducted broad consultation with over 800 stakeholders between August and October 2024.[23] As of February 2026, however, the separation has not been implemented.

This experience demonstrates why the definition must include a functional test, a provision that would enable the NDIS Commission to assess what an entity does, not merely how it describes itself. Such a test is not novel in the Australian context, as the Fair Work Act

[20] Department of Health, Disability and Ageing. (2024). Aged Care Data and Digital Strategy 2024 – 2029. Accessed at: https://www.health.gov.au/resources/collections/aged-care-data-and-digital-strategy-2024-2029?language=en
[21] Winkler, D. (2023). 'The disability royal commission recommendations could fix some of the worst living conditions – but that's just the start,' *The Conversation,* 29 September 2023. See also Bigby, C. (2024). 'A flawed model or weak implementation? A critical review of the approach to group homes taken by the Disability Royal Commission,' *Research and Practice in Intellectual and Developmental Disabilities,* 11, 9–28.
[22] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2023). *Final Report,* 29 September 2023, See in particular: Volume 7, Recommendation 7.41.
[23] Department of Health, Disability and Ageing. (2025). *Disability Royal Commission Progress Report 2025,* Recommendation 7.41 update.

already takes a functional approach to determining employment relationships,[24] whilst the Aged Care Act 2024 introduced the concept of an 'associated provider' under which the registered provider remains responsible for contraventions by entities delivering care on its behalf, even where those entities are not themselves registered.[25] Without an equivalent provision in the NDIS definition, the SIL/SDA pattern will repeat across every new support type that is introduced.

Recommendation 10: That the definition include a functional test enabling the NDIS Commission to assess the substance of what an entity delivers. This test should reference existing quality standards in other healthcare sectors, such as the Aged Care Quality Standards and the NSQHS Standards.

Who employs the worker matters

Alongside the type of support being delivered, there is another potential risk factor that should be considered: the legal relationship between the provider, participant, and the worker. Currently, however, the definition does not take this relationship into broader consideration.

In France, the *services à la personne* framework assigns registration requirements according to both the activity type and the mode of delivery (*mode d'exercice*), the latter referring to the employment relationship through which the support type is delivered. The framework adopts three levels to map this relationship, namely *mode prestataire*, where the provider employs the worker and invoices the client directly; *mode mandataire*, where the provider recruits and administers but the client is the legal employer; and *emploi direct*, where the client engages the worker with no intermediary at all. Each mode triggers a different level of authorisation, reflecting the different distribution of risk and accountability that each arrangement entails.

CHA and its members consider this a critical distinction for maintain the integrity of a risk-proportionate framework. A provider that employs workers, supervises practice, and directed how care is delivered assumes clear accountability for workforce conduct, training, and quality assurance. This creates a materially different risk profile from a platform that facilitates connections between participants and workers, without exercising control over how supports are delivered. Both arrangements differ again from a participant directly employing their own worker, where accountability rests primarily with the individual.

Treating these models as regulatory equivalents risks obscuring where responsibility genuinely lies and may unintentionally create competitive distortions between providers who invest in structured workforce governance and those who operate through more fragmented arrangements. Incorporating mode of delivery into the definition would better align regulatory settings with actual accountability structures and ensure a level playing field across different service models.

Currently, Table 2 does not reflect these differences, applying the same registration tier regardless of who employs the worker or who bears the associated accountability. CHA recommends that the definition account for mode of delivery alongside support type, with registration obligations calibrated accordingly.

Recommendation 11: That the definition account for the mode of service delivery alongside support type, with registration obligations calibrated to reflect the distribution of risk and accountability between provider, worker, and participant under each arrangement.

[24] *Fair Work Act 2009* (Cth), s. 15AA, inserted by the *Fair Work Legislation Amendment (Closing Loopholes No. 2) Act 2024* (Cth), commenced 26 August 2024
[25] *Aged Care Act 2024* (Cth), s. 12 (responsible persons duty) and the definition of "associated provider" at Chapter 3

Incorporating mode of delivery into the registration framework requires careful consideration of workforce implications. Where a registration tier carries specific workforce training requirements, the cost and administrative burden on registered providers can be significant, particularly where those providers rely on agency or contracted staff to meet demand. Agency staff change frequently, are often rostered at short notice, and may be deployed across multiple providers and settings. Expecting a host provider to brief a contracted worker on incident management protocols or registration-specific requirements during a last-minute shift is neither realistic nor conducive to quality care.

CHA's position is that where agency staff are deployed to deliver supports under a registered provider's registration tier, the agency itself should be required to hold registration as an NDIS provider. The responsibility for ensuring that agency workers are appropriately informed and trained should rest with the agency prior to shift commencement, not with the host provider at the point of care, and not with the participant. This distributes accountability in a way that reflects the actual employment relationship and is consistent with the risk-proportionate principles underpinning the new model. Registration requirements must be rigorous enough to ensure quality, but designed in a way that does not exacerbate the workforce pressures that already place significant strain on the sector.

Recommendation 12: Where agency staff are deployed to deliver supports under a registered provider's registration tier, the agency itself should be required to hold registration as an NDIS provider and be subject to relevant registration requirements aligned with their risk profile.

Plan management type and regulatory protection

Another factor for consideration is the way(s) in which a participant's plan is managed. Under current arrangements, self-managed participants can purchase supports from unregistered providers, whilst agency-managed and plan-managed participants cannot. The registration requirements that apply to a provider therefore vary according to how a participant manages their plan, rather than the risk profile of the support being delivered.

The risk associated with a support does not change based on the plan management type. A self-managed participant receiving behaviour support or personal care from an unregistered provider is exposed to the same risks as an agency-managed participant receiving similar support from a registered provider.

Plan management also correlates with participant capacity. Participants who self-manage are more likely to have higher cognitive capacity, stronger informal supports, and a greater ability to assess providers and pursue complaints where necessary. Agency-managed participants are more likely to have complex needs and fewer personal resources. Linking regulatory protection to plan management therefore produces inconsistent safeguards depending on who is receiving the support.[26]

The consultation paper indicates that self-managed participants may continue to access unregistered providers under the proposed framework.[27] In CHA's view, registration should attach to the support type and its assessed risk tier, regardless of plan management. Where a support warrants registration for one participant, it should warrant registration for all.

[26] National Disability Insurance Agency. (2024–25). *NDIS Quarterly Report to disability ministers.* NDIA data consistently shows that self-managed participants are more likely to have psychosocial or physical disability, whilst agency-managed participants are overrepresented among those with intellectual disability and complex support needs.
[27] Department of Health, Disability and Ageing. (2025). *Getting it right: a new definition of an NDIS provider - Consultation paper.*

Participant choice can be maintained without creating differential regulatory standards based solely on administrative category.

Recommendation 13: Registration requirements should be contingent on the risk profile of the support delivered, as opposed to whether the participant self-manages their plan.

Cross-system supports across the NDIS-aged care interface

CHA members deliver supports across the NDIS-aged care interface, including in-home support for older participants and respite care. The new Aged Care Act, which came into effect on 1 November 2025, introduced its own registration framework with strengthened provider obligations.[28] Providers operating across both systems –including CHA members – will face dual regulatory regimes unless the NDIS definition and accompanying rules explicitly address how cross-system providers are captured.

This is not a marginal issue for CHA members and providers more broadly. Over 42 percent of all aged care providers are also registered with the NDIS.[29] Of these, most tend to be larger organisations delivering a greater proportion of services across these systems. CHA members operating in this space are already registered under the new Aged Care Act, accredited against the National Safety and Quality Health Service Standards, and subject to workforce screening requirements that overlap substantially with those required under the NDIS.

Providers delivering both Commonwealth Home Support Program and Home Care Package services, for example, already use the same staff but must maintain separate compliance records for police checks and NDIS Worker Screening Checks, a duplication that will intensify with the introduction of the new national screening check for the aged care sector that will be expected from mid-2026.[30] As work to develop a new national screening check is already underway,[31] where the introduction of a new NDIS provider definition has follow-on impacts for the care workforce, specific controls should be in place to mitigate unintended consequences, such as the duplication of effort or resources.

The 2023 NDIS Review acknowledged this point, stating that proportionality could be achieved through “recognising compliance in other regulatory systems”.[32] Unfortunately, the consultation paper does not currently deliver on this element of the 2023 Review. CHA views this as a significant omission, with direct cost consequences for providers who are already compliant with equivalent or higher standards under other Commonwealth legislation. Requiring these providers to demonstrate compliance twice is inconsistent with the risk-proportionate principles that the consultation paper itself endorses.

Recommendation 14: That the registration framework incorporate a cross-system recognition mechanism enabling providers already registered and assessed under equivalent Commonwealth regulatory frameworks, such as the Aged Care Act 2024 or the NSQHS Standards, to have those assessment outcomes recognised in lieu of duplicative NDIS compliance requirements.

[28] *Aged Care Act 2024* (Cth).
[29] CHA Submission to the Productivity Commission Interim Report on Pillar 4: Delivering Quality Care Efficiently, September 2025
[30] Under the Aged Care Act (s. 154-1140), providers must record screening checks in the Government Provider Management System, with a new national screening check expected from mid-2026.
[31] Department of Health, Disability and Ageing. (2025). *Screening requirements for the aged care workforce*. Accessed at: https://www.health.gov.au/topics/aged-care-workforce/screening-requirements?language=en
[32] Bonyhady & Paul (2023), p. 218. The Review stated that proportionality could be introduced through "simplifying Practice Standards, recognising compliance in other regulatory systems, using risk-based auditing and targeting scope of audits to most relevant and important issues."

System readiness

CHA members have reported negative experiences of the NDIA's PACE system, giving rise to serious concerns about whether the infrastructure that will administer the new registration model is ready for the transition. These concerns are replicated across the sector, with only three percent of providers surveyed in the National Disability Service's *2025 State of the Disability Sector* agreeing that NDIS systems and processes are working well.[33] The new registration categories, including mandatory SIL and platform registration from 1 July 2026, will be processed through PACE, even though migration to the new system has not yet been completed.

In February 2025, the NDIA removed the expected completion date from its website and subsequently confirmed to the ANAO that no revised timeline had been set.[34] Providers – including CHA members – have documented persistent payment delays, as well as technical barriers in the My NDIS Provider Portal, and failures in the My Provider endorsement process.[35] These failures are most acute for participants with profound intellectual disability, who cannot independently navigate digital endorsement processes, and for whom claims have been rejected because the required provider relationship could not be recorded in the system.

The NDIS Commission faces a parallel challenge with its $160 million Data and Regulatory Transformation (DART) program. Announced in the 2024 Budget as a replacement for the Commission's current operating system (which was considered no longer fit for purpose), DART is still in development, with no confirmed completion date. If DART is not fully operational by 1 July 2026, when mandatory SIL and platform registration commences, then providers and participants will have to navigate a new model where both the funder's and the regulator's systems are undergoing major changes, at the very moment when the regulatory framework that they administer is being overhauled.

Commencement of a new regulatory architecture without fully operational funder and regulator systems would create avoidable instability across the care economy. Regulatory reform cannot be divorced from the systems that administer it, and where system readiness has not been independently verified within an appropriate lead time, deferral is not an act of resistance but a responsible safeguard to prevent disruption to participants, providers, and workforce stability.

To ensure system readiness, CHA calls for the NDIA to certify that PACE will be able to administer new registration categories without disrupting existing provider payment cycles before 1 July 2026. CHA also calls for the Commission to confirm that DART will be sufficiently operational to support expanded registration functions at least three months before mandatory registration commences. Without these confirmations in place before commencement, then the reform risks compounding the very disruption it is designed to prevent.

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[33] National Disability Services, *State of the Disability Sector Report 2025*, p. 7. Survey conducted by the Centre for Disability Research and Policy, University of Sydney. Usable responses were received from 290 organisations.
[34] Australian National Audit Office. (2025). *NDIA Management of Claimant Compliance with NDIS Claim Requirements.* Auditor-General Report No. 48, 2024–25.
[35] National Disability Services (NDS). (2024). 'PACE refinements on the way to reduce issues for providers.' NDS reported that providers using PACE described "long delays for payment, technical barriers in using the My NDIS Provider Portal, and the difficulty in getting effective troubleshooting support," with the NDIA acknowledging these as "known system issues for which they have scheduled system improvements."

Recommendation 15: That the NDIA certify that PACE is technically capable of administering new registration categories without significant disruption to existing provider payment cycles. Mandatory registration must not commence until defined operational benchmarks are met and system readiness has been independently verified.

Recommendation 16: That the NDIS Commission confirm that DART is sufficiently operational to support expanded registration functions under the new model. Mandatory registration must not commence until defined operational benchmarks are met and system readiness has been independently verified.

Assessing system readiness requires sustained monitoring and evaluation throughout implementation to ensure that reforms are being delivered as intended and are genuinely contributing to their stated outcomes. As illustrated by the concerns raised in the preceding section regarding PACE, DART, and broader system readiness, iterative monitoring mechanisms would provide an important safeguard against implementation failures compounding over time.

In practice, this should include structures that enable real-time tracking of key reform activities during at least the first 12-24 months of implementation. Such structures would serve multiple purposes: providing early visibility of implementation gaps before they entrench; strengthening accountability across the various parties responsible for delivering reform functions; and giving the sector confidence that implementation is being actively assessed and adjusted in response to on-the-ground experience, rather than left to self-correct.

Recommendation 17: Implementation of the new provider definition and registration framework be subject to independent monitoring during the first 24 months, with public reporting on system performance, payment timeliness, market impacts, and participant outcomes.

Statutory review

CHA recommends that the registration model be subject to statutory review within three years of commencement. The review should seek to assess whether proportionality has been achieved in practice across the three tiers, alongside establishing whether the basic tier is genuinely lighter than the tiers above it, thin markets have been affected by registration requirements, and if the Commission has the capacity to administer the model it has been given.

A three-year window is long enough for the model to generate meaningful data on provider behaviour, market composition, and regulatory burden, whilst being short enough to allow course correction before structural problems become difficult to reverse. Gaps between regulatory intent and regulatory reality can persist for years without a formal obligation to examine them. Australia can therefore build that obligation in from the start, and CHA strongly encourages the Government to do so.

Recommendation 18: That the registration model be subject to a statutory review within three years of commencement, assessing whether proportionality has been achieved in practice, whether thin markets have been affected, and whether the Commission has the capacity to administer the model.

Section 3: Safeguarding the transition by minimising unintended consequences for participants and providers

Given the significance of these reforms, it is critical that they are communicated clearly to the sector, supported by appropriate transitional arrangements, and underpinned by meaningful opportunities for stakeholder involvement in both design and implementation. This will help minimise unintended consequences and ensure that providers, workers, and participants are adequately prepared for change. Subsequent sections in our submission provide further detail on the key risks that must be actively managed throughout this transition.

It is the understanding of CHA and its members that the transition to new regulatory settings is intended to be done in a staged and considered way, as outlined in the insights report.[36] To support this, clear timeframes and expectations for providers —and for the broader sector — should be communicated well in advance of the transition period. Early clarity will enable all relevant parties to engage with these changes in a meaningful and informed way.

A practical way to achieve this is through a staged implementation pathway rather than progressing multiple reform activities concurrently. Staging the rollout would reduce disruption to participants, enable close monitoring of potential impacts on thin markets, and ensure that comprehensive system readiness checks are completed before progressing to subsequent phases.

Recommendation 19: Implementation of the new provider definition and registration tiers occur through a staged approach, commencing with higher-risk support types and progressing to lower-risk tiers only after evaluation of system performance, provider readiness, and participant impact.

Thin market disruption

CHA members operate across regional, rural, remote, and very remote (RRRvR) areas, serving in communities where provider options are already limited. If the registration threshold for low-risk supports is set too high, then struggling providers – for example, not-for-profits delivering allied health and respite care – may exit the NDIS market. This would directly affect participant access in the very communities that can least afford such disruption, an example of the inverse care law.

The National Rural Health Alliance and Services for Australian Rural and Remote Allied Health have raised urgent concerns about 2025-26 NDIS pricing changes, which halve allied health travel allowances, reduce remote loadings, and cut hourly price limits for several therapy disciplines.[37] Providers report that services to small rural communities are becoming financially unviable, with many of these being small and medium sized businesses delivering essential services and employing local people.

The new definition should not compound these pressures by imposing compliance costs that further erode the business case for RRRvR delivery. CHA recommends that a regulatory impact assessment is carried out prior to the commencement of the new definition to model provider exit risks in thin markets.

[36] NDIS Quality and Safeguards Commission. (2025). Mandatory Registration of Platform Providers. Accessed at: https://www.ndiscommission.gov.au/about-us/ndis-commission-reform-hub/mandatory-registration#paragraph-id-107371
[37] National Rural Health Alliance & Services for Australian Rural and Remote Allied Health. (2025). Statements on 2025–26 NDIS pricing arrangements, June 2025.

Recommendation 20: That a regulatory impact assessment be completed and its findings publicly released prior to the commencement of the new definition of an NDIS provider, modelling the risk of provider exits in thin markets, including regional, rural, and remote areas.

Transition must not disrupt existing participants

Participants currently receiving supports from registered providers should not experience disruption as the system transitions to the new registration model. Any transition should be anchored in the principle that existing registration continues until a scheduled review takes place, rather than requiring providers to be re-accredited before they can continue delivering care they are already delivering. This process, commonly referred to as 'grandfathering', has recent precedent in regulatory transitions across Australia and international systems.

A recent and relevant example is the implementation of Australia's Aged Care Act 2024, which commenced on 1 November 2025. [38] Here, those participants who had received an approved Home Care Package on or before 12 September 2024 were formally classified as 'grandfathered participants' and automatically transitioned into the new Support at Home program.[39]

Under a 'no worse off' principle, these participants retained their existing funding level, chosen provider, any unspent funds, and care arrangements, with no requirement for reassessment unless their needs had changed. CHA was actively involved in advocating for a sustainable transition for older Australians through this process - including calling for a delay to the implementation of price caps for Support at Home - and draws directly on those lessons in making the following recommendations for the NDIS context.

Effective grandfathering requires deliberate investment in sector education and consumer support. Where grandfathering arrangements result in two parallel systems operating simultaneously, the risk of participant confusion is significant. Clear, timely, and accessible communication – tailored to participants, carers, and providers – is essential to ensure that people can navigate the transition without detriment to their care arrangements.

The Government's current Inquiry into the Support at Home Program presents a timely opportunity to draw on emerging findings from that transition to inform the design of any grandfathering mechanism within the NDIS context. CHA recommends that this cross-sector learning be explicitly incorporated into the NDIS transition design process, and that grandfathering arrangements be subject to the same co-design principles CHA has recommended throughout this submission.

CHA calls for the NDIS to adopt the same approach during the transition to a new definition. If changes to the provider definition mean that a participant's current provider must register for the first time, or is reclassified into a different tier, then the participant's existing NDIS plan and support arrangements should continue on their current terms until their next scheduled plan reassessment. CHA recognises that whilst the NDIS Review recommended a five-year transition period, the mandatory SIL and platform registration from 1 July 2026 is taking place faster than the timeframes envisaged by the Review Panel and therefore, may have reduced timeframes for a grandfathering scheme to the same scale of aged care participants during the implementation of the Aged Care Act.

[38] Beyond Australia, international approaches, such as England's cohort-based grandfathering in their Special Education Needs and Disabilities reform offer similar examples of how this can be operationalised in practice. See Department for Education (UK). (2026). *SEND Reform: Putting Children and Young People First* (White Paper), 23 February 2026.
[39] *Aged Care (Consequential and Transitional Provisions) Act 2024* (Cth).

Recommendation 21: To mitigate potential transition disruption, participants receiving services from providers impacted by changes to the definition of an NDIS provider should be grandfathered so that their current terms continue until their next scheduled plan reassessment.

Transition funding to implement a new provider definition and regulatory model

Alongside grandfathering arrangements, CHA recommends the establishment of a time-limited transition fund to support the sector in adopting the new registration model. The disability services sector is not homogenous. For example, providers vary significantly in size, resourcing capability, geographic context, and workforce composition. A transition fund would enable targeted support to be directed where it is most needed, rather than assuming a uniform capacity to absorb reform. CHA has identified three priority areas where a transition fund would have the most material impact.

First, workforce inclusivity. The care workforce spans a wide range of cultural backgrounds, languages, and professional experience, and for many workers, English is an additional language. A dedicated portion of transition funding should be directed toward the development of accessible, multilingual resources to support workers and providers in understanding and meeting the new registration requirements.

Providers led by and employing people from culturally and linguistically diverse communities hold deep knowledge of the populations they serve and the barriers their workforces face. Transition funding should therefore include mechanisms for government to work in partnership with these providers in co-designing resources, rather than producing materials and disseminating them to the sector. A system designed with providers, rather than for them, is more likely to be understood, adopted, and sustained.

Second, support for smaller and regionally-based providers. Not all providers have the infrastructure or financial capacity to absorb the costs of regulatory transition at the same pace. This is particularly acute for smaller providers in regional, rural, and remote areas, who may be the sole source of support for participants in their communities. For these providers, the risk is not administrative burden but rather concerns around viability.

If the costs of transitioning to the new model are not adequately cushioned, the likely outcome is market exit, reducing the supply of supports in areas that are already underserved. The loss of even a single provider in a thin market can have immediate consequences for participants who have no alternative. A transition fund should include a dedicated stream for these providers, with flexible timeframes that recognise the pace of transition must be calibrated to the capacity of the provider, not the convenience of the reform timetable.

Third, reducing administrative burden at the aged care-disability interface. Many CHA members and their staff operate across both systems. Where registration requirements overlap, duplicative obligations divert resources away from direct care. This is particularly pertinent given ongoing work to align care worker regulation across sectors — provider registration must be designed in step with, not in isolation from that parallel reform. Transition funding should support targeted administrative alignment at this interface, to minimise duplication and ensure that providers navigating both systems are not disadvantaged.

Recommendation 22: Establish a time-limited transition fund to support the sector in adopting the new registration model, with dedicated streams for workforce inclusivity, smaller and regionally-based providers, and administrative alignment at the aged care-disability interface.

CHA acknowledges that there are documented cases of provider misconduct that warrant regulatory response. However, the broader sector has operated for several years under a compliance environment of suspicion. This has eroded sector morale, created a culture of defensiveness, and in some cases driven capable providers out of the market entirely.

If the new registration model is to succeed in its risk-proportionate intent, it must be accompanied by transition support designed from a presumption of good faith, recognising that where capability gaps exist, they are more likely the product of inadequate support and systemic complexity than of intent to cause harm. Rebuilding trust between government, regulators, and providers is not a secondary objective but should rather be a prerequisite for enabling the collaborative implementation that these reforms require.

Transition timeframes

As of February 2026, the regulatory reform roadmap envisages key system readiness milestones as the next steps for the implementation of mandatory registration and the commencement of the new registration framework on 1 July 2026.[40] It is the understanding of CHA and its members that this consultation forms an integral part of the current state activity – to design new registration requirements and transition arrangements. In practice, this means that critical activities – including certification of PACE and DART, the completion and publication of a regulatory impact assessment, and the design of appropriate transition supports – should be finalised at least three months prior to the estimated date of commencement. Given the limited time remaining, and the scale of the changes proposed, CHA is concerned that these milestones cannot be met without compromising the quality of design, consultation, and implementation.

Proceeding to a 1 July 2026 commencement in the absence of robust system readiness would risk replicating the challenges experienced in other recent reforms, where compressed timeframes led to avoidable payment disruption, workforce strain, and confusion for participants and providers. In the context of thin markets, particularly in regional, rural, and remote communities, the consequences of a poorly sequenced transition could be severe and, in some cases, irreversible.

CHA therefore considers it preferable to adjust the implementation timetable, rather than proceed to an arbitrary date that no longer reflects operational reality. A short, clearly communicated deferral, tied to objective readiness criteria, would provide the NDIA, the NDIS Commission, and providers with the time required to complete co-design, finalise ICT and data systems, and meaningfully prepare the workforce and participants for change.

Recommendation 23: That commencement of the new definition of an NDIS provider and associated mandatory registration requirements (including for SIL and platform providers) be deferred from 1 July 2026 until such time as the preconditions in Recommendations 14 to 17 have been demonstrably met, and in any event not earlier than 1 July 2027. Where those preconditions cannot realistically be achieved three months prior to the proposed commencement date, the Government should formally defer implementation and publicly communicate a revised, staged timeline developed in partnership with the sector.

[40] NDIS. (2026). Regulatory Reform Roadmap. Accessed at: https://www.ndiscommission.gov.au/about-us/ndis-commission-reform-hub/about-reform-program#paragraph-id-10016