Catholic Health Australia – New Aged Care Act Rule consultation – Release 1 – Service list

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Catholic Health Australia
www.cha.org.au

CHA is Australia's largest non-government grouping of health, community, and aged care services, accounting for approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of care provision in the home.

Our members also 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, which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Submission on the new Aged Care Act Rule consultation – Release 1 – Service list

Executive Summary

Catholic aged care providers are committed to working with the Australian Government to ensure the sustainable provision of aged care and support services for older Australians and that those services meet community expectations of safety and quality of care.

CHA appreciates the opportunity to provide input into the consultation to inform the Rules for the Service List. Our members aim to ensure a high-quality and safe aged care system, irrespective of an older Australian's wealth or geography. The Support at Home program will be transformational for the aged care system in enabling older Australians to age in place and CHA strongly supports it. However, CHA has concerns about the significant risk of unintended consequences in the implementation of the Support at Home program, including consequences arising from the cap on care management. There are significant risks to the program stemming from its very short implementation timeframe. These risks include:

- the sector's ability to prepare systems, its workforce and its (current and future) clients for the changes;
- unintended consequences including from the cap on care management and prices;
- how the community will respond to changes in what they will have to pay; and
- how the sector can viably operate a service with many fixed overheads, including the cost of transition.

We are concerned that potential changes in provider or consumer behaviour resulting from this program have not been modelled; and that the implementation timeframe of 1 July 2025 is insufficient for providers to meet logistical challenges, including workforce training, software development, and client communication. Accordingly, CHA recommends delaying the commencement of Support at Home to 1 July 2026. Further, Independent Health and Aged Care Pricing Authority (IHACPA) prices for service lists should operate as benchmarks rather than caps. Alternatively introduce Support at Home as planned on 1 July 2025 while maintaining existing funding for providers for 12 months. This would be achieved through a shadow pricing approach to ascertain the potential impact of the new pricing approach for consumers and providers, similar to that used by IHACPA for public hospitals.

Other recommendations are made to address implementation risks and unintended consequences of Support at Home for care recipients, such as:

- ensuring billing arrangements are clear and workable;
- building in the ability to be responsive to urgent changes in care needs;
- the ability to cater to irregular supports and to care recipients moving to a new provider; and

- ensuring enough flexibility to respond in a consumer-choice, client-centred system.

Specific recommendations made include the need for appropriate liaison with states and territories about scope, definitions of care management and nursing services, and differentiating between similar service types.

It is also crucial that there is clear, comprehensive communication from the Department to both providers and older Australians (regarding the program, including co-contributions and why they are set at the levels proposed) and Services Australia (regarding billing arrangements).

Affordability of co-contributions to Support at Home for consumers and the adequacy of hardship arrangements are important. While CHA understands that this is a separate issue, it is important to highlight in the context of the reforms. The Inspector-General for Aged Care should monitor Support at Home for any unintended consequences for vulnerable and marginalised people to ensure access is equitable and hardship provisions are adequate as part of its remit.

In terms of residential aged care, some of the current requirements under Residential everyday living and Residential clinical care are unduly homogenised and do not reflect the diversity of care recipient needs and wants and/ or the capacity of current residential aged care homes to provide these services.

Practical recommendations addressing these issues are below.

Recommendations

CHA makes the following recommendations for the Service List, including the draft Support at Home and Residential aged care Rules and The *Support at Home program handbook* Version 1.0 (the Support at Home Handbook):

1. Support at Home

Recommendation 1:

- Delay the start of Support at Home by 12 months to July 1, 2026; and
- Use Independent Health and Aged Care Pricing Authority (IHACPA) prices for service lists as benchmarks rather than caps.

Recommendation 2:

If the Government does not pursue recommendation 1, instead:

- implement Support at Home on 1 July 2025;
- have IHACPA shadow price the new pricing approach; and
- providers continue to be funded under the existing pricing approach until 1 July 2026.

Recommendation 3:

The Inspector-General for Aged Care should monitor the implementation of the Support at Home program and report on outcomes by December 2026 for any unintended consequences for vulnerable and marginalised people to ensure access is equitable and hardship provisions are adequate, and any issues are addressed as quickly as possible.

Recommendation 4:

If a 10% care management cap is retained, IHACPA will need to factor in significantly higher per unit prices than most providers currently charge. This is necessary to enable the expenditure providers have for care management and administration costs to be recouped so that it is viable for them to participate in Support at Home.

Recommendation 5:

Under the restorative care pathway,

- provide that the care partner 'be supervised' or 'in partnership with', a care partner with clinical qualifications rather than having clinical qualification, to reflect current practise; and
- clarify that ‘restorative care management’ is not included under the 10% care management cap, if this cap proceeds.

Recommendation 6:

- Exclude from any description or definition of care management: nursing assessment, treatment or monitoring, so that care management services do not include these activities that are undertaken by nurses as part of their scope of practise.
- Broaden nursing service definitions in the draft Rules to make sure that nursing items are clearly covered, for example case conferencing, client health literacy, risk assessment and planning, and managing any restrictive practices with a behaviour support plan.

Recommendation 7:

Through forums such as the Health Chief Executives Forum, make state and territory governments aware of the expectations relating to what services are within their scope, including managing waiting lists, noting that Support at Home is designed to have a higher clinical scope.

Recommendation 8:

Ensure definitions are clear to meet the needs of care recipients; reflect current scope of service; and administrative efficiency; including:

- The definition of allied health assistant in the draft Rules requires the allied health assistant to be appropriately skilled without being specific regarding the type of Certificate IV to reflect other appropriate qualifications such as a Certificate IV in fitness.
- Nursing care: The draft Rules to stipulate that clinical nursing care can be delivered 1:1 and in a group setting (for example diabetes education), consistent with allied health, as this is equally appropriate for this profession.
- Definition of nursing assistant: If a definition of nursing assistant is included in the Rules, include someone with a Certificate III in Aged Care.
- Inclusion of pastoral care practitioners and spiritual care: Include Pastoral Care and spiritual care within the service list, for example in social support and community engagement services, reflecting the value of this profession and their inclusion in the Aged Care Quality Standards and strengthened Quality Standards.
- Include Advance Care Planning, palliative care and end of life care for home support providers for consistency with residential aged care services.
- Include care after death reflecting the activities undertaken such as complex liaison and psychosocial support to families; engaging a medical professional to certify the death; offering grief and bereavement support; providing after-death care of the person’s body; and undertaking other administrative arrangements.
- Differentiate between similar service types in definitions so it is clear what service type should be used in a given situation, for example:
    - Independence: therapeutic services for independent living;
    - Clinical: allied health and other therapeutic services; and

    - Provide clear descriptors for the Clinical/ Nursing care/ Education and the Clinical/ Nursing care/ Specialist service linkages.
- Medication assistance: The guidelines should be clarified such that if medication assistance is undertaken by a Personal Care Worker with suitable training and experience, or an Enrolled Nurse, rather than by a Registered Nurse, this would be acceptable under Independence: Personal Care, to reflect current practise.
- Home modifications and home maintenance and repairs: Ensure that the AT-HM and home modifications and repairs lists provide clarity as to coverage, for example if fixing a lock or other home modification is eligible, that the service per hour is inclusive of the tradesperson's travel time. Also clarify in the Support at Home Handbook that a further co-contribution would need to be paid if the care recipient was engaging the tradesperson directly and the available service cap is too low.
- Therapeutic services for independent living: Under Therapeutic services for independent living, it would be useful to publish a report or other evidence for which services are included here versus which are listed under Health and Specialised Support.

Recommendation 9:

Include provision for urgent changes in service eligibility in the Support at Home Handbook in order to provide consumer-directed care. For example, urgent access to cottage respite to allow providers to respond appropriately in an agile, timely way if a given service had not been identified on an individual's care plan and their needs increase suddenly, as well as provision for irregular services such as domestic assistance.

Recommendation 10:

If not undertaken already, develop the Support at Home program in consultation with existing clients to ensure it is workable and understood from the perspective of older Australians who will be most immediately impacted by it.

Recommendation 11:

Include mechanisms in the Support at Home Handbook around service pricing, such as how a care recipient's funding allocation is transferred to a new provider.

Recommendation 12:

Further clarify the scope of grandfathering arrangements. Clarification is needed in instances such as:

- whether home maintenance and repairs managed by a provider will be grandfathered; and
- how the service cap operates in practice, for example where a tradesperson charges more than the price cap.

Recommendation 13:

- The Department and Services Australia to articulate a timeline for when the new Support at Home IT and administrative infrastructure will be available for providers, including portals, forms and invoices; consult with the sector on these; then make them available no later than February 2025; and
- This should include clear, simple billing arrangements to minimise administrative burden on providers.

Recommendation 14:

The Inspector-General of Aged Care is to review the implementation of Support at Home from a provider viability perspective commencing in February 2026 and make early recommendations to Government as to how providers will be protected if funding doesn't reflect costs due to cost increases after prices have been set.

Recommendation 15:

The Department should provide comprehensive education to age care recipients and older people in plain English, and other languages, about the Support at Home program, including that co-contribution fees are set at what the Government has determined is a fair rate.

2. Residential aged care

Some of the current requirements are unduly homogenised and do not reflect the diversity of care recipient needs and wants and/ or the capacity of current residential aged care homes to provide these services. Recommendations to address these issues are outlined below:

Recommendation 16:

- To reflect what services are practicable and are currently provided and the preferences of residents, amend the descriptors so that:
    - telephones and internet are to be accessible on site;
    - armchairs are to be provided in rooms where possible or required; and
    - a shower chair is provided in showers should an aged care recipient want one.
- IHACPA would need to ensure pricing is adequate in relation to the requirement for residential aged care to offer ironing services given that in many services this is not practicable or current practise.
- Reflecting the residential aged care setting, refer to a window within which cooked meals would be available, or 'as appropriate to a residential aged care setting' rather than 'flexibility in mealtimes if requested by the individual. Remove "and supper" as being duplicative.

Recommendation 17:

- Refer to 'help to put on' rather than 'fitting' to avoid association with professional fitting services.
- Remove reference to provision of wheeled walkers and wheelchairs as care recipients tend to bring their own.
- Replace 'regular' with 'periodic' in relation to outings into the community, unless these may be funded through an additional wellbeing fee.

1. Support at Home

1. Significant risk of unintended consequences in the Support at Home funding model

This section reiterates CHA's support for the Support at Home reform. It highlights:

- key requirements to prevent significant unintended consequences during implementation; and
- the necessity of understanding pricing impacts through shadow pricing before full implementation.

CHA is very supportive of the new Support at Home program and the broader reform agenda of Government. We strongly support the passage of the Aged Care Bill (the Act) as an urgent priority in 2024. The new Support at Home program and new Act are essential to address the recommendations of the Royal Commission and lay the foundation for a better quality and more sustainable aged care system that older Australians deserve.

While the intent of the reform is commendable, CHA has concerns about the significant risk of unintended consequences in the Support at Home program, including consequences arising from the cap on care management. We are concerned that the implementation timeframe of 1 July 2025 is insufficient for providers to meet logistical challenges, including workforce training, software development, and client communication.

The Government has not provided modelling on potential changes in provider or consumer behaviour resulting from this program. It is reasonable to expect that changes in consumer co-contributions and restrictive price caps for providers will influence what services older Australians choose and what is available. Providers will face increased clinical risks as Support at Home packages are designed to support high-acuity older Australians aging in place. However, it remains unclear if providers will have the funding flexibility to deliver these services effectively at scale or to meet their particular needs These include variations in prices when faced with workforce shortages, needing to employ more agency staff, or the need to deliver specialist services such as complex dementia management or wound management.

The cost of implementing these reforms, particularly for smaller providers and those in regional, rural and remote areas, is likely to be substantial. The home care market is diverse, and not all providers have the infrastructure or resources to adapt to the proposed changes. Smaller providers, often the sole providers of critical care support in less accessible areas, will need additional time to implement the new program. Even larger providers will face significant operational and funding changes.

Ensuring a sustainable transition for older Australians

Providers will receive the final list of services and prices in February 2025, leaving little time to adapt and advocate for change if prices are inadequate. Implementing a new pricing regime based on this timeline presents logistical challenges, including workforce training, change management, software development, and client communication.

CHA believes that risks can be effectively managed by modifying some elements of the implementation of the Support at Home program, including the schedule.

Adjusting implementation would help mitigate the risks associated with expanding capacity and introducing extensive price controls while simultaneously raising consumer contributions.

CHA is particularly concerned about how price caps may interact with consumer behaviour in response to increased co-contributions. The Government has not released modelling on the behavioural economics likely to drive these changes. In a system where prices are controlled based on a list of services, competition among providers may focus primarily on reducing costs, limiting high-quality service offerings.

CHA hopes that prices released by IHACPA in February 2025 will support high-quality service provision and genuine competition. However, the uncertainty surrounding price caps could deter investment in the sector. Potential negative outcomes of capping prices represent a significant risk to the successful implementation of Support at Home, including:

- hindering specialised providers focused on high end services from entering the market;
- providers cherry-picking clients based on profitability, further impacting less profitable providers; and
- older Australians making service choices influenced by their experience with the co-contribution regime to minimise out-of-pocket costs.

CHA has made recommendations to limit these risks.

Recommendation 1:

- Delay the start of Support at Home by 12 months to 1 July 2026; and
- Use IHACPA prices for service lists as benchmarks rather than caps in 2025-26.

In this scenario, Support at Home would be delayed by 12 months to 1 July 2026. Even if it was not delayed, as a transition measure, from 1 July 2025 to 1 July 2026, providers would charge what they consider to be reasonable for the services on the Service List, using IHACPA prices as benchmarks rather than caps.

Shadow Pricing as an alternative approach

CHA strongly endorses the transition to Support at Home to sustainably meet the needs of older Australians. If the Government does not view a delay as feasible, CHA suggests adopting a shadow pricing[1] approach from 1 July 2025 to 1 July 2026, to assess the impact of the proposed changes.

Shadow pricing has been effectively used by IHACPA for over a decade to model changes in hospital funding. While shadow pricing in healthcare typically spans two years, CHA believes a 12-month period could suffice for Support at Home (noting further analysis and exploration is required).

IHACPA uses shadow pricing in public hospitals to ensure accurate data collection and reporting, which helps mitigate undesirable consequences during funding model transitions. A similar approach in the aged care sector could provide valuable insights as it shifts from the existing funding model to Support at Home. Shadow pricing would involve maintaining the current pricing model for actual provider funding while collecting data to understand the potential impact of the new pricing approach.

IHACPA should develop and implement a 12-month shadow pricing framework for Support at Home.

Below is an indicative timeline for the shadow pricing period:

Date	Activity
February 2025	IHACPA releases service list prices as planned.
1 July 2025	Support at Home commences as planned.
1 July 2025 – 1 July 2026	Providers funded at FY 2025 prices; submit data for shadow pricing. IHACPA provides ongoing advice on new pricing implications.
February 2026	IHACPA advises the Government on pricing arrangements post-shadow pricing.
1 July 2026	Providers transition to the new Support at Home pricing approach, informed by shadow pricing insights.

[1] IHACPA ordinarily uses a 'shadow pricing' period prior to implementing a new funding mechanism. This shadow pricing period is intended to ensure robust data collection and reporting and to accurately model the financial and counting impacts of changes. Shadow pricing involves continuing to price and fund services using the existing system while concurrently pricing the same services using the new funding model. These two prices are then compared to understand the impact of moving to the new system.

Throughout this period, IHACPA and the Department would gather crucial data to understand:

- changes in consumer or provider behaviour due to adjustments in co-contributions; and
- the impact of care management and service price caps on provider viability.

Importantly, consumer contributions would proceed as currently scheduled, simultaneously with the shadow pricing approach.

The Government may consider introducing controls during this period to ensure any provider price increases under the existing pricing approach are appropriate. CHA is available to collaborate on developing suitable limits.

Potential outcomes of a 12-month transition period with shadow pricing include IHACPA altering service price caps or recommending they instead act as a benchmark.

These outcomes would significantly reduce the risk of unintended negative impacts on service delivery for older Australians resulting from this reform.

Affordability of co-contributions to Support at Home for consumers and the availability and effectiveness of hardship provisions are important. This is particularly important given the high cost of living and can be exacerbated if an older person is renting and experiencing financial stress. While CHA understands that these are separate issues, it is important to highlight in the context of the reforms. The Inspector-General for Aged Care should monitor the affordability of Support at Home for aged care recipients and of hardship provisions as part of its remit.

Recommendation 2:

If the Government does not pursue recommendation 1 (delay Support at Home for 12 months and use IHACPA prices for service lists as benchmarks rather than caps in 2025-26), instead:

- Implement Support at Home on 1 July 2025;
- have the Independent Health and Aged Care Pricing Authority (IHACPA) shadow price the new pricing approach; and
- providers continue to be funded under the existing pricing approach until 1 July 2026.

Recommendation 3:

The Inspector-General for Aged Care should monitor the implementation of the Support at Home program and report on outcomes by December 2026 for any unintended consequences for vulnerable and marginalised people to ensure access is equitable and hardship provisions are adequate, and any issues are addressed as quickly as possible.

2. Care management and administration

Recommendations 1 or 2 above would also have the benefit of understanding and mitigating the impact of the proposed cap on care management under Support at Home. CHA does not believe that a cap on care management is consistent with providing high quality care. In addition, the cap proposed is low and will not deliver the care management required to meet care recipients' needs unless significantly higher per unit prices are provided than most providers currently charge.

Effective care management is crucial for maintaining wellbeing[2] and delivering services to high-acuity older Australians. The Department notes that care management ensures "that aged care services contribute to the overall wellbeing of an older Australian."[3] Client risk, dignity of choice, advanced care directives and guardianship arrangements are required aspects of care articulated in the new Standards, that are managed in an integrated way through care management. Care management is also an important aspect of behavioural management approaches in providers being able to comply with the Standards.

The planned reduction of the care management cap is significant, as care management can be charged at 20% of packages and commonly sits at 16-17% of packages at time of writing. Nationally, providers spend on average 36% of revenue for care management and package management combined.[4] The Support at Home Handbook does not provide an administrative component (i.e. package management). Given the need for care management and package management to cover expenses for these important aspects of providing care, CHA considers that this 10% care management cap is insufficient to cover the costs of delivering the Support at Home program unless there are significantly higher per unit prices than most providers currently charge.

A sudden and significant reduction of care management caps from 20% to 10% could lead to unintended consequences, including:

- a reduced focus on care management, which is essential for maintaining wellbeing;
- a decrease in service availability due to inadequate compensation for lost care management revenue;
- providers potentially avoiding higher-acuity patients to protect their service mix; and
- experienced care managers leaving the sector.

[2] 5 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3508812/

[3] https://www.youtube.com/watch?v=xu7CpmPug0A&t=1611s.

[4] From StewartBrown - Aged Care Financial Performance Survey Report March 2024.pdf Expenses: Care management costs are 10.1% of revenue and Administration and support costs are 26.1% of revenue (page 16).

Though not necessarily seen or appreciated by clients for the value it provides, a lack of adequate care management tends to relate to a lot of concerns raised with the regulator.[5]

A parallel can be drawn to the reform pathway for residential care funding, which defers the most significant redesign (removal of RADs) for future review. Reducing the care management cap from 20% to 10% and imposing price controls on service lists are pricing approach mechanisms proposed for Support at Home that are similar in their scale. Potential outcomes of the 12-month transition period with shadow pricing outlined in Recommendation 2 include:

- implementing the reduction in care management with better sector preparedness; and
- IHACPA recommending adjustments to the care management cap for Government consideration.

Recommendation 4 outlines the necessary impact on unit prices if the Government does not pursue recommendation 2.

Recommendation 4:

If a 10% care management cap is retained, IHACPA will need to factor in significantly higher per unit prices than most providers currently charge. This is necessary to enable the expenditure providers have for care management and administration costs to be recouped so that it is viable for them to participate in Support at Home.

Other care management issues

The requirement in the Support at Home Handbook stipulates that care partners delivering Care Management for the restorative care pathway must have clinical qualifications. This is different to current requirements in the Short-Term Restorative Care program and represents a significant consideration for workforce and funding. It would be preferable to provide that the care partner 'be supervised' or 'in partnership with', a care partner with clinical qualifications, to reflect current practise. It needs to be clarified whether ‘restorative care management’ should be included under the 10% Care Management cap. CHA suggests that it is not to avoid even less services being able to be apportioned to the main care management category.

In addition, it is important not to include in any definition of care management nursing assessment, treatment or monitoring. If too much is expected under the service type of Care Management, providers will not be able to afford to deliver the service and it would further erode the funding available to deliver care management given that this is capped. There are already significant costs involved in coordinating services for clients without any 'nursing' component of care management being considered as in scope.

[5] The third most frequent issue raised with the regulator via home care complaints is "consistent client care and coordination" at 502 complaints or 6.9% of all complaints Complaints Report Apr22-Mar23 (agedcarequality.gov.au) page 20.

Accordingly, nursing service inclusions would benefit from some broadening of the current definitions in the draft Rules to make sure that these aspects are clearly covered in nursing items, for example case conferencing, client health literacy, risk assessment and planning, and managing any restrictive practices with a behaviour support plan.

Recommendation 5:

Under the restorative care pathway:

- provide that the care partner 'be supervised' or 'in partnership with', a care partner with clinical qualifications rather than having clinical qualification, to reflect current practise;
- clarify that 'restorative care management' is not included under the 10% care management cap; and
- Outline how providers would be protected if funding doesn't reflect costs due to cost increases after prices have been set. Management cap, if this cap proceeds.

Recommendation 6:

- Exclude from any description or definition of Care Management: nursing assessment, treatment or monitoring, so that Care Management services do not include these activities that are undertaken by nurses as part of their scope of practise.
- Broaden nursing service definitions in the draft Rules to make sure that nursing items are clearly covered, for example case conferencing, client health literacy, risk assessment and planning, and managing any restrictive practices with a behaviour support plan.

3. Scope

The Home Care Packages Program Assurance Review No. 4 – Excluded items – Public summary report (health.gov.au) highlights the importance of clarity for aged care recipients and providers as to what is in and out of scope for Home Care Package services. Clarity is equally important for the new Support at Home program.

So that care recipients don't miss out on services due to being caught in state/territory funding demarcations, state and territory governments need to be made aware of the expectations relating to what services are within their scope, noting that Support at Home is designed to have a higher clinical scope. Discussions of waiting lists will be important in this context.

Recommendation 7:

Through forums such as the Health Chief Executives Forum, make state and territory governments aware of the expectations relating to what services are within their scope, including managing waiting lists, noting that Support at Home is designed to have a higher clinical scope.

Other considerations in relation to scope of service/ profession are outlined below.

Recommendation 8:

1) The definition of allied health assistant in the draft Rules requires a Certificate IV in allied health assistance. It would be beneficial if the allied health assistant is appropriately skilled without being specific regarding the type of Certificate IV.

Case Study

ONE OF CHA'S MEMBER ORGANISATIONS USES STAFF WITH A CERTIFICATE IV IN FITNESS, RATHER THAN IN ALLIED HEALTH ASSISTANCE, TO DELIVER EXERCISE PROGRAMS UNDER AN ALLIED HEALTH SERVICE TYPE.

2) Nursing care

The draft Rules stipulate that allied health can be delivered 1:1 and in a group setting, but they don't have the same detail in relation to clinical nursing care. Clinical nursing care should also be able to be delivered in a small group session, for example diabetes education. Group education, such as for diabetes, is an effective approach[6] and would also allow much lower fees to be charged.

[6] Microsoft Word - Pt Education Guideline 21 August 2009 SG1.doc (diabetesaustralia.com.au).

3) A definition of nursing assistant is not in the rules but if/when a definition is added, it would be beneficial that this includes someone with a Certificate III in Aged Care.

Case study

A CHA MEMBER ORGANISATION EMPLOYS THEIR HOME CARE ASSISTANTS UNDER A CERTIFICATE III IN AGED CARE. THESE NURSING ASSISTANTS OFFER IN-HOME MEDICATION SUPPORT AFTER BEING INTERNALLY CREDENTIALLED.

4) Inclusion of pastoral care practitioners and spiritual care

Pastoral care and spiritual care must be included within the service list, for example in Social Support and Community Engagement Services, to reflect current practise and the importance of this service.

There is a strong body of evidence that engagement with spirituality in health and aged care increases resilience, reduces depression and anxiety, and improves quality of life.[7] The Aged Care Quality Standards and strengthened Quality Standards have embedded requirements of providers to deliver holistic comprehensive care, in which the provider should consider the older person's physical, mental and emotional, social and spiritual wellbeing.[8]

As an example, Pastoral Care Practitioners are part of the clinical team in all Calvary Health, Aged and Community Care Services. They are a credentialed and accountable workforce that is provided by skilled and competent practitioners working within a clearly designated and defined scope of practice in accordance with the Standards of Practice requirements for membership of Spiritual Care Australia. They assess a person's spiritual and emotional needs and resources to guide effective spiritual care and improve clinical outcomes. The content of the pastoral interaction and any ongoing care interventions are shaped by the identity and lived experience of the person being cared for, with respect to the person's needs and wishes.[6]

5) Advance Care Planning, palliative care and end of life care

While the draft service list for residential aged care includes "Advance Care Planning, palliative care and end of life care," there is no such listing for home support providers. These components of care should be included in the home support service list for consistency.

6) Care after death

Neither care, nor its costs, end as soon as a person dies. For example, services may provide complex liaison and psychosocial support to families, engage a medical professional to certify the death, undertake other administrative arrangements, offer

[7] https://meaningfulageing.org.au/wp-content/uploads/2017/06/Meaningful-Ageing-Summary-of-Evidence-key-points- 24.5.17.pdf.

[8] Aged Care Quality Standards and Glossary - Final Draft - Nov 2023 (health.gov.au) - page 31.

grief and bereavement support, and provide after-death care of the person's body. Aged care services, older people and families should be assured that this work will be recognised and included in the Service list.

7) It is unclear how the definitions of some categories should be differentiated. For instance, the difference between the below two service types (key similarities are italicised):

- Independence: therapeutic services for independent living
  (*Assistance* (e.g., treatment, education, advice) provided by university qualified or accredited health professionals using evidence-based techniques *to manage social, mental and physical wellbeing in support of the older person remaining safe and independent at home*.); and

- Clinical: allied health and other therapeutic services
  Assistance for an older person to *regain or maintain physical, functional and cognitive abilities which support them to remain safe and independent at home*.

As an example, if an occupational therapist is assessing a care recipient for a wheely walker or a wheelchair, it is not clear which category they should be using.

The Clinical/ Nursing care/ Education and the Clinical/ Nursing care/ Specialist service linkages also need to be clearly defined to differentiate these two similar service types.

8) Medication assistance
The guidelines need to be clear that if medication assistance is undertaken by a Personal Care Worker with suitable training and experience, or an Enrolled Nurse, rather than by a Registered Nurse, this would be acceptable under Independence: Personal Care.

9) Home modifications and home maintenance and repairs
The AT-HTM and home modifications and repairs lists need to provide clarity as to coverage. For example, if fixing a lock or other home modification is eligible, the time used to calculate the service cost (which is per hour) should be inclusive of the tradesperson's travel time. It should also be clarified in the Support at Home Handbook that a co-contribution would need to be paid if the care recipient was engaging the tradesperson directly and the available service cap is too low.

10) Therapeutic services for independent living

Under Therapeutic services for independent living, it would be useful to publish a report or other evidence for which services are included here versus which are listed under Health and Specialised Support.

11) AT-HM Scheme and home maintenance and repairs

If the job needs to be negotiated with the tradesperson directly, a co-contribution would need to be paid if the available service cap is too low.

Home maintenance and repairs are contingent on tradespeople. Jobs include travel, consistent with the usual billing practise of tradespeople. Both of these issues should be clarified in the Handbook.

4. Additional flexibility and oversight are needed

The Support at Home model will feature eight standard packages, an increase from the four standard packages currently available under home care. Grandfathering arrangements will result in different fee structures for participants of the same generation – potentially the same household - causing confusion. To achieve the goals of this transformative reform, it is crucial to mitigate unintended consequences and ensure the program operates flexibly.

CHA's members have identified the need to provide for:

- urgent changes in service eligibility;
- irregular service provision to address consumer-directed care and the way people may use services in practise;
- provision for care recipients moving to a new provider;
- flexibility and clear timeframes for providers to operate smoothly to meet their clients' needs; and
- flexibility in billing arrangements for providers.

Flexibility for care recipients

It is unclear how providers would bill for services in practise, given the way that homecare operates on the ground. For example:

- if taking a client to a medical appointment, collecting a prescription from a pharmacist and taking the client shopping, would these episodes have to be split across independent living categories and everyday living categories?
- A personal care worker employed for two hours in the morning may undertake a range of tasks such as personal care, medicine prompts, meals, and domestic assistance. How would this be billed in practice given they are in different service categories in different service lines?

Provision for urgent changes in service eligibility will also need to be made in order to provide consumer-directed care. The Support at Home Handbook provides that participants can only use their budget for services that they have been assessed as requiring and as documented in their notice of decision and accompanying support plan. It is positive that participants can move $1,000, or 10% of their budget between quarters to meet unplanned needs, however further flexibility may be needed. Needs can change quickly, for example cottage respite can be urgent. There is a need to

clarify how the set funding list will allow providers to respond appropriately in an agile and timely way, if a given service had not been identified on an individual's care plan and their needs unpredictably and quickly increase.

It is positive and beneficial for the workability of the Support at Home program that consultation has occurred with aged care providers. CHA also suggests that the program needs to be established in a way that works for consumers and to cover the diversity of how they live at home, for example if they require irregular services such as domestic assistance. If not undertaken already, the program needs to be developed in consultation with existing clients.

In addition, there needs to be mechanisms around service pricing, such as how a care recipient's funding allocation is transferred to a new provider and an agreement on the consideration of the care coordination cap if someone wants to move aged care providers.

While there are grandfathering arrangements relating to the funding amount that existing home care package recipients will receive, it is not clear whether the arrangements they had will remain the same. Examples of unclear grandfathering arrangements include:

- In relation to home maintenance and repairs, if a provider currently manages this, would it be grandfathered (as clients might expect)? and
- How does the service cap operate in practice – for example if a tradesperson charges more than the price cap, how would this work?

Recommendation 9:

Include in the Support at Home Handbook provision for urgent changes in service eligibility in order to provide consumer-directed care.

Recommendation 10:

If not undertaken already, develop the Support at Home program in consultation with existing clients to ensure it is workable from a user perspective.

Recommendation 11:

Include mechanisms in the Support at Home Handbook around service pricing, such as how a care recipient's funding allocation is transferred to a new provider.

Recommendation 12:

Further clarify the scope of grandfathering arrangements in the Support at Home Handbook. Clarification is needed in instances such as:

Flexibility and clear timeframes for providers

Flexibility is important not just for individual clients, but also across a provider's service. If Support at Home proceeds on 1 July 2025, so that the sector can prepare their systems, the Department and Services Australia need to:

- articulate a timeline for when the new Support at Home IT and administrative infrastructure will be available for providers, including portals, updated forms and invoices;
- consult with the sector on these; then
- make them available no later than February 2025.

Recommendation 13:

- The Department and Services Australia to articulate a timeline for when the new Support at Home IT and administrative infrastructure will be available for providers, including portals, forms and invoices; consult with the sector on these; then make them available no later than February 2025; and
- This should include clear, simple billing arrangements to minimise administrative burden on provides.

Invoicing arrangements have the potential to have a huge administrative burden, and software to drive such billing hasn't been developed yet. As part of systems preparations, a practical approach may need to be developed for invoicing, as will clear, simple invoicing arrangements.

CHA understands that there is a margin being built into the service list. The prices need to be set correctly so that services operate smoothly and flexibility can be built into the service for clients. The approach for identifying prices should be transparent.

The Department and IHACPA should be cognisant of the significant risk of making these changes to the funding model without testing. Prices will need to be set very liberally to mitigate these risks.

In practice, the existing model allowed care management and package management to act as a flexible fund for providers to respond to fluctuations in clients' needs and acuity across their case mix. This will be substantially reduced in the new system.

Oversight by the Inspector-General of Aged Care

Given the significance of the Support at Home pricing changes to the sector and the risks to aged care recipients and the sector if prices are not set correctly, CHA recommends that the Inspector-General of Aged Care should review the implementation of Support at Home from a provider viability perspective commencing in December 2025, and make early recommendations to Government as to how providers will be protected if funding doesn't reflect costs due to cost increases after prices have been set.

Recommendation 14:

The Inspector-General of Aged Care is to review the implementation of Support at Home from a provider viability perspective commencing in February 2026 and make early recommendations to Government as to how providers will be protected if funding doesn't reflect costs due to cost increases after prices have been set.

5. Clear, comprehensive communication from the Department and Services Australia is crucial

The Support at Home program is complex, and arrangements can be particularly complicated for some older people, such as situations where there are different costs and eligibility for recipients living in the same household over time due to when they accessed supports. Some older people may then avoid using the service or complain to the provider due to its complexity. These issues may be exacerbated if there are language barriers. This highlights the need for education and communication to older people about the program in plain English and other languages. Information from the Department should also highlight that fees are set at what the Government has determined is fair to pay.

Services Australia also needs to make invoices as simple and clear as possible, so they are not ambiguous.

Recommendation 15:

The Department to provide comprehensive education to age care recipients and older people in plain English, and translated, about the Support at Home program, including that co-contribution fees are set at what is fair to pay.

2. Residential aged care

Some of the current requirements are unduly homogenised and do not reflect the diversity of care recipient needs and wants and/ or the capacity of current residential aged care homes to provide these services. These requirements are outlined below, with recommendations to address them:

1. Clause 58: Residential everyday living

Telephone and internet services: This should be changed to indicate that a telephone and internet should be accessible on site, rather than needing to be provided in each room. Some providers don't have the broadband/ fibre infrastructure to enable phones to be provided in every care recipient's room, so care recipients access phones via reception or with mobile phones.

Recliner chair: This should be rephrased to refer to an armchair 'where possible or required', that meet the resident's seating needs. An estimated approximately half of rooms in residential aged care are not big enough currently to fit all of the required furniture as well as a recliner chair. In addition, aged care recipients who weigh less than approximately 45kg are not heavy enough to be able to make it recline. A recliner also costs around $3,000 more than an armchair, unnecessarily adding costs to providers.

Shower chair: This should say 'should an aged care recipient want one.' Not all aged care recipients will want or need one, and some may find it confronting to have one placed in their shower if they don't need it and don't think of themselves as disabled.

Personal laundry: Aged care homes do not tend to offer ironing services. One provider estimates that less than 5% of providers would offer this service as standard. The contract with the laundry provider would need to be renegotiated to provide ironing, and for a service of 150 aged care recipients, it is estimated that this would require 1.5 fulltime equivalent staff to perform this function. It is also not practical to offer ironing services as there is often no space for an ironing board, and ironing does not fit in with the rhythm of the day, with washing typically occurring in the mornings and drying and folding occurring in the afternoons (i.e. the staff would not be able to just fit it in to any less busy times).

Accordingly, IHACPA would need to ensure pricing is adequate in relation to the requirement for residential aged care to offer ironing services given in many services this is not practicable or current practise.

Meals and refreshment: The current descriptor presents challenges regarding the stated flexibility that can practicably be provided. The descriptor should refer to a window within which cooked meals would be available, or 'as appropriate to a residential aged care setting' rather than 'flexibility in meal times if requested by the individual.' This recognises that aged care homes are not staffed or set up like restaurants; food safety requirements; and the need to keep hot food hot. Reference to 'and supper' should be removed as this is typically a buffet that is always available.

Recommendation 16:

- To reflect what services are practicable and are currently provided and the preferences of residents, amend the descriptors so that telephones and internet are to be accessible on site; armchairs are to be provided in rooms where possible or required; and a shower chair is provided in showers should an aged care recipient want one.
- IHACPA would need to ensure pricing is adequate in relation to the requirement for residential aged care to offer ironing services given that in many services this is not practicable or current practise.
- Reflecting the residential aged care setting, refer to a window within which cooked meals would be available, or 'as appropriate to a residential aged care setting' rather than 'flexibility in meal times if requested by the individual. Remove "and supper" as being duplicative.

2. Clause 59: Residential non-clinical care

In 3(b) and 5(c), refer to 'helping to put on' rather than 'fitting' hearing aids and artificial limbs and other personal mobility aids. 'Fitting' has a specific meaning that is tied to being professionally fitted.

In relation to mobility and movement aids in 5d), 'provision. . . of wheeled walkers and wheelchairs', aged care recipients tend to bring their own if they require one and not everyone requires them. Accordingly, references to provision of these items should be removed.

In 7., Recreational and social activities, 'regular outings into the community' are included. Historically, bus trips for some providers have been part of their Additional Wellbeing Fee. The term 'regular' causes some concern and is ambiguous. Given that lifestyle is not included in AN-ACC funding for Care Minutes, it is unclear where the funding would come from for this.

Recommendation 17:

- Refer to 'help to put on' rather than 'fitting' to avoid association with professional fitting services.
- remove reference to provision of wheeled walkers and wheelchairs as care recipients tend to bring their own.
- replace 'regular' with 'periodic' in relation to outings into the community, unless these may be funded through an additional wellbeing fee.