Silverchain submission

Senate Community Affairs References Committee Inquiry into the Support at Home program

30 July 2026

silverchain

Acknowledgement of Country

Silverchain respectfully acknowledges the Traditional Custodians of the lands on which we work and live. We acknowledge Elders both past and present, whose ongoing effort to protect and promote Aboriginal and Torres Strait Islander cultures will leave a lasting legacy for future leaders and reconciliation within Australia. Our Innovate Reconciliation Action Plan artwork was created by artist, Charmaine Mumbulla from Mumbulla Creative. The artwork is crafted from many individual pieces and is layered to tell the Silverchain story, including our increased commitment and efforts towards healing, reconciliation, and social justice.

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Contacts

For more information, please contact:

Bronwyn Perry
Executive Director, Strategic Communications
Bronwyn.Perry@silverchain.org

Dr Ronelle Hutchinson
Head of Policy & Advocacy
ronelle.hutchinson@silverchain.org.au

Executive Summary

Support at Home program has immense promise but is falling short of its aspiration and community need.

Process and access barriers across assessment, reassessment, approval, funding and claiming are delaying or preventing older people from receiving the services and funding they need.

We recommend targeted process improvements to make Support at Home faster, simpler and more flexible, particularly for vulnerable people with complex needs, those approaching end of life, people requiring assistive technology and home modifications, and communities in remote or underserved areas.

Without timely access to appropriate care at home, older people are more likely to deteriorate, enter residential aged care earlier, and experience more frequent and potentially avoidable hospital admissions.

As the third largest provider of in-home aged care in Australia, Silverchain welcomes the Senate Committee's inquiry into the Support at Home program. Currently, we provide services to more than 8,300 Support at Home participants and more than 33,500 people through the Commonwealth Home Support Program (CHSP) across all states and territories of Australia except the Northern Territory, and within all Modified Monash Model regions.

This submission draws on our direct experience delivering Support at Home since its commencement in November 2025, our continuing role as a major CHSP provider, and our experience delivering Home Care Packages before the transition. It sets out practical implementation issues that are affecting older people's access to care, provider sustainability and the ability of the program to deliver on its central promise: helping older Australians live safely, independently and with dignity at home.

When access to Support at Home breaks down, older people's ability to live safely and independently at home is put at risk. Access is being undermined by a My Aged Care assessment system that is not working effectively, restrictive Support Plans that require repeated reassessment, interim funding that does not meet assessed need, and short-term pathways affected by delay and red tape. While the Restorative Care and the End-of-Life pathways show real promise, they require refinement so older people can access time-critical support when it matters. Across the program, excessive compliance, complex claiming and interim budget processes are adding avoidable administrative burden and unfunded work, with limited evidence of benefit for older people and, in some cases, delaying access to the care they need.

Support at Home risks becoming a reform about process, not people. The program has become weighed down by complexity that is not proportionate to the risks it is meant to address. This is most evident in the Assistive Technology and Home Modification scheme, Associated Provider requirements, care management settings, financial hardship processes and pricing rules. These settings are confusing for older people, placing avoidable pressure on care partners and providers, and weakening the relationship-based model of care that is essential to providing support at home safely.

Co-contributions, hardship settings and pricing rules are changing consumer behaviour in ways that may undermine care outcomes. Older people are already making difficult choices about whether they can afford services they have been assessed as needing, including personal care, domestic assistance, assistive technology and end-of-life supports. Package utilisation appears to be falling at the same time as providers are carrying new billing, debt and communication burdens. Government must monitor utilisation, bad debt and service avoidance closely, strengthen hardship assistance, remove end-of-life co-contributions, and provide clear public education so older people understand the value of services that keep them safe and well at home.

Support at Home will only succeed if Government treats implementation as a continuing responsibility, not a one-off launch event. The program is a once-in-a-generation reform that will take years to embed. Too many of the responsibilities for explaining the changes to older people, families, referrers and the health sector have been shifted to providers without dedicated funding or acknowledgement. Government must treat Support at Home as an ongoing change program, fund the communication, education and transition support required, retain and strengthen CHSP as a distinct low-complexity program, and avoid layering further disruption onto the system until it is stable and working for older people.

Our recommendations

We have made recommendations based on our evidence and experiences outlined in this submission and our estimation of the impact on the Federal Budget.

Silverchain recommendation	Expected Federal Budget impact	Detailed in submission
MAC assessment, Support Plans and access to care		
The Government should abandon the false economy of interim packages (minimum support offer/MSO) as they do not meet the assessed needs of older people, require duplicative care and budget planning by Care Partners, are frustrating for consumers and leave gaps in the care and support available that leads to deterioration.	Negative	pp. 15–17
Remove requirements for individual services to be 'approved' on Support Plans and instead allow for categories to be 'approved' – allowing older people to access any service from approved categories (clinical, independence and everyday living) in the Support List within their classification budget without the need for a reassessment. The Support at Home budget is the existing limitation to the number of services people can access.	Neutral (and reduced administrative complexity should enable the assessment system to see more people)	pp. 8–10
Any review of the integrated assessment tool (IAT) and assessment process should investigate the need for all classifications of Level 5 and above to receive approval for clinical services given the complexity of clients receiving these classifications, and the ability of Support at Home to maintain their help and prevent avoidable hospitalisations.	Neutral (a predicted increase in clinical services delivered, but a likely reduction in downstream care costs)	pp. 8–10
The Support at Home Service List should be urgently reviewed and missing services added to ensure older people are able to access the support they need within the parameters of their Support at Home classification budget.	Neutral	pp. 10–11
Develop an expedited reassessment process for changes to Support Plans that do not relate to classification changes.	Neutral	pp. 8–10
Establish Key Performance Indicators including time-based indicators for the MAC Assessment system (for both initial assessment and reassessments). Monitor and regularly publicly report on the performance of the Assessment system against the KPIs (including for the short-term pathways).	Neutral	pp. 8–10
Assistive Technology and Home Modifications		
Older people who are deemed not eligible for AT-HM because of state-based health or disability programs should be able to purchase these items through a Support at Home AT-HM budget.	Neutral	pp. 11–12; 31
Support Plans for AT-HM should have allied health services auto-approved to enable access to the prescriptions required for many of the AT items.	Neutral	pp. 27–28
The AT-HM prioritisation criteria and waiting times should be reported publicly and regularly.	Neutral	pp. 11–12; 27–28

Silverchain recommendation	Expected Federal Budget impact	Detailed in submission
To ensure continuity of care and services, Government should reconsider the need for annual reassessment of AT-HM.	Positive (through reduced assessment demand)	pp. 29–31
The claiming requirements for AT-HM need to be urgently changed to allow clinical services to be provided and paid for separately from a claim for a prescription or quote.	Neutral	pp. 28–29
The claiming codes for AT-HM need to be simplified significantly.	Neutral	p. 29
Claiming for AT-HM costs legitimately incurred for clients in the first quarter of Support at Home should be reopened to allow providers to claim for costs incurred in good faith during the program transition.	Neutral	p. 29
End-of-Life and Restorative Care Pathways		
Co-contributions for End-Of-Life Pathway services should be removed to reduce disincentives to participate in the program. Further education regarding the pathway should be developed and distributed to consumers and referrers.	Negative (through marginal reduction in co-contributions)	pp. 13–14; 32
Access to the End-of-Life Pathway should be provided in less than a week from application to approval.	Neutral	p. 13
Restorative Care packages should be released immediately in the same way that access to End-of-Life Pathway is expedited.	Neutral	p. 12
A suite of services should be auto-approved for the End-of-Life Pathway (detailed in appendix B) to reduce unnecessary administration and time waiting for reassessment for people in this pathway.	Neutral	pp. 13–14; 32
Promised changes to legislation to allow for an additional 12-16 weeks of end-of-life care should be expedited.	Neutral	p. 13
KPIs for time to approval for people in the End-of-Life Pathway should be established.	Neutral	p. 13
Government should be required to report the number of Restorative Care packages that will be released each quarter and year, and where those packages will be released if by state.	Neutral	p. 12
Care management, provider settings and pricing		
The cohort of older people eligible for additional care management funding should be broadened to include others with high complexity and risk profiles. A mechanism should be established to allow providers to request additional care management funding for clients with high complexity or risk profiles beyond those identified during the MAC assessment process.	Negative (through marginal increase in care management pool)	p. 14
Pro-rata allocation of care management funds for the quarter should be assigned to the new provider when an older person chooses to change provider.	Neutral	p. 14

Silverchain recommendation	Expected Federal Budget impact	Detailed in submission
Pooled funding of care management beyond more than one service delivery branch should be possible for larger providers with multiple service delivery branches.	Neutral	p. 14
Government should reduce duplicative worker screening requirements by expediting the introduction of an industry-wide aged care worker clearance system, or, in the interim, allowing providers to rely on statutory declarations from Associated Providers confirming relevant staff hold current checks.	Neutral	pp. 14–15
The My Aged Care portal functionality should be updated to allow providers to list common prices for services they deliver without listing a fixed price. This would reduce confusion for consumers and enable providers to accurately reflect their pricing structures in accordance with the Support at Home rules.	Neutral	p. 17
Government should abandon the proposed introduction of price caps for Support at Home given the likely unintended consequences on the market's ability to care for older people with complex needs.	Neutral	pp. 18–19
Co-contributions, hardship and consumer behaviour		
Financial hardship should be assessed as part of the Support at Home access and income testing process, rather than requiring a separate, duplicative application. An ability for older people to apply for financial hardship at any time if their means change needs to be retained in the system.	Positive (marginal reduction in operating costs of Services Australia)	p. 19
The financial hardship threshold for pensioners and part-pensioners should be decreased.	Negative	p. 19
Government should exclude First Nations redress and reparation payments from income and asset testing for Support at Home and hardship applications on grounds of equity and fairness.	Negative (marginal due to small cohort of people it impacts)	p. 19
There should be clearer Government guidelines on co-contribution waivers for CHSP to align with Support at Home.	Neutral	pp. 19–21
Government investment is required in an ongoing consumer education and communication campaign about Support at Home and how making the most of the services available keeps people well at home.	Neutral (outlay on campaign costs, balanced with reduced downstream acute care demand)	pp. 17–18; 20
Ongoing community education by Government is needed for older people to explain the roll-over process for budgets at the end of each quarter and the importance of using their budgets on services designed to keep them independent at home.	Neutral	pp. 17–18; 20
A mechanism should be built into the provider portal to allow visibility to providers if a person has made a financial hardship assistance application.	Neutral	p. 19

Silverchain recommendation	Expected Federal Budget impact	Detailed in submission
KPIs should be established for the efficient and timely reconciliation of payments when a financial hardship assistance application has been approved to allow for the refund of any co-contributions already made to a provider.	Neutral	p. 19
Government should monitor and publicly report on utilisation of Support at Home packages for each quarter to improve visibility of consumer behaviour in relation to co-contributions.	Neutral	p. 18
Analysis should be undertaken on the impact of contribution rates on the utilisation of different services in Support at Home to determine if the structure of the program is influencing consumer behaviour.	Neutral	p. 18
System design, CHSP and market stability		
CHSP should be retained as a block-funded, low-complexity program, strengthened and clearly defined so it does not become a default safety net for gaps, delays or failures in Support at Home or the MAC assessment system.	Net positive, or neutral (additional investment in CHSP is required but would be offset by fewer hospitalisations and reduced demand for other acute care)	pp. 20–22
Research should be undertaken to demonstrate consumer preferences for a move to a multi-provider model of Support at Home before it is introduced.	Neutral	pp. 18–19
A set of readiness benchmarks should be developed with providers and consumers to reflect the point at which Support at Home and the provider market is sufficiently stable as to be able to accommodate additional disrupters including the introduction of a multi-provider model.	Neutral	pp. 18–19
Thin markets, cultural safety and workforce		
Alternative policy/pricing mechanisms should be considered for supporting the provision of Support at Home for geographically remote older people.	Unclear (depending on the mechanism chosen)	p. 22
A cultural safety audit should be undertaken of the entire Government-managed part of the aged care system, from initial contact with MAC through assessment and funding/package/place release.	Neutral	pp. 22–23
Cultural safety principles should be developed to inform providers' practice and linked to the Aged Care Quality Standards.	Neutral	pp. 22–23
A national aged care workforce strategy should be developed and implemented.	Unclear (depending on strategy)	p. 23
A report on the impacts and effectiveness of the thin market grants should be prepared and released publicly.	Neutral	p. 22

Silverchain recommendation	Expected Federal Budget impact	Detailed in submission
In reporting of the Aged Care Workforce Survey 2026, a focus should be made on the home care sector workforce and historical trends reported.	Neutral	p. 23

We welcome any questions the Senate Committee may have, and the opportunity to provide additional evidence the Committee requires.

About Silverchain

For 130 years Silverchain has provided high-quality, in-home health and aged care services to multiple generations of Australians. As a not-for-profit organisation, we employ more than 5,900 people, including nurses, doctors, allied health, care experts, and a dedicated research and innovation division.

Our ambition is to create a better home-care system for all Australians.

Our team provides a range of health and aged care and services to more than 140,000 people across Australia each year. We specialise in home and community-based care because we believe that people should have, and prefer to have, their care in or close to their homes. Our services comprise personal care, domestic support, social support and wellbeing services, complex and acute nursing, hospital in the home, community palliative care, independence services, reablement allied health to improve mobility and independence, the provision of equipment and home modifications, digitally enabled care and remote monitoring, and chronic and complex disease management. We provide services in metropolitan, regional and remote locations and across all aspects of aged care, including the range of services funded under Support at Home, the Commonwealth Home Support Program and the Transition Care Program.

We are accredited according to both the national health care and aged care standards. We are recognised as a rural and remote aged care provider through the Department of Health, Disability and Ageing specialist verification framework and are in receipt of Support at Home thin market grants.

At present, we provide services to more than 8,300 Support at Home participants and more than 33,500 people through the Commonwealth Home Support Program.

The ability for older Australians to access services to live safely and with dignity at home

The ability of Support at Home to support older people to live safely and with dignity in their homes for longer has been compromised by a rushed and inadequately planned roll out reflected in key aspects of the current implementation of the program. The Committee has already accepted that Support at Home is not yet stable through the findings of the Committee's inquiry into the transition of the Commonwealth Home Support Program (CHSP) into Support at Home. These concerns continue eight months into the program. The following issues undermine the success of the program and have been raised with the Department of Health, Disability and Ageing (the Department) through our role on the Department's Support at Home Sector Reference Group and include:

- The My Aged Care Assessment system is not fit for purpose, adds undue complexity without comparable benefits, wastes provider and participant time and delays access to the care and services that support people to live safely and with dignity in their homes.
- The Support at Home service list requires refinement.
- The Assistive Technology and Home modification (AT-HM) scheme is not working as intended and undermines the intent of the Support at Home program. Significant changes to how it operates are required to see the expected benefits of the overall program and this short-term scheme.
- The Restorative Care Pathway has the potential to support older people to live safely and with dignity at home but needs to be scaled considerably to respond to demand and prevent avoidable hospitalisations and preventable deterioration in older people's function.
- The End-of-Life Pathway has benefits for older people who wish to pass away in their own homes but continues to require refinement.
- The way care management has been conceptualised and funded for the program reflects an unrealistic understanding of what is needed to support older people to live safely and with dignity in their own homes.
- In the absence of a national aged care worker screening system, current requirements place excessive and duplicative compliance obligations on Registered Providers, particularly when working with large networks of Associated Providers. This creates significant administrative burden without clear proportional benefit to older people's safety or quality of care.

- The introduction of interim packages has created a false economy in which older people can access their Support at Home package 'earlier', but without it meeting their assessed needs. The Government has not made a case for why interim packages (or minimum service offers) are required; the Government should meet the clearly recorded demand for Support at Home packages and work towards the commitment of a three-month waiting list by the end of the 2027 financial year. Releasing 60% of a person's package to them when they have been assessed as needing 100% of that budget and services delays access to care, leads to deterioration, causes consumer frustration, and layers even more complexity and unfunded work into care planning in the context of restrictive care management caps (as budgets and care plans must be done twice in a short period – once when the MSO is released, and again when the full package becomes available).

The My Aged Care assessment system is not fit for purpose

The My Aged Care (MAC) assessment system adds undue complexity without comparable benefits, wastes participant and provider time, and delays access to the care and services that support people to live safely and with dignity in their homes.

No home care system can succeed if older people are left waiting for the assessment decisions that unlock their care. The MAC assessment system is central to whether older people can access the right supports at the right time to stay healthy, safe and independent at home. At present, assessment delays, inconsistent approvals and repeated reassessments are creating barriers to timely care and weakening the intended outcomes of Support at Home.

- The MAC assessment process is a point-in-time assessment and does not adequately account for the way a person's support needs will change over time as they age in place. Long waits for funding mean that by the time services can commence (sometimes 12 months after the assessment), a person's circumstances may have changed, and a reassessment may be required to ensure the right level and type of support is in place. This can place older people in an avoidable cycle of repeated assessments, delaying access to the care and services that help them remain safe, well and independent at home. We support the Government's recent decisions to establish a new IAT escalation process and amendment process, however until we see the implementation detail, we remain cautious as to whether this will resolve the issues.
- Assessment outcomes are unexpected and do not consistently have the necessary approvals in place. Silverchain has many examples across ongoing and short-term pathways where people have not been approved for nursing or allied health services. We also had an End-of-Life Pathway client whose Support Plan came through without approval for nursing services, so they needed to spend a few weeks in the reassessment cycle getting this rectified before we could begin providing the services they need. Two weeks of waiting within an expected 12 weeks' life expectancy is an inefficient use of the system, but more importantly, is a cruel waste of nearly a fifth of someone's remaining life expectancy. The quality of their remaining days is ruined by a broken bureaucratic process to access the care that they have already been deemed eligible for.
- Older people should not have to wait for another assessment simply because their care needs shift. Under Support at Home, individual services must be specifically approved before they can be delivered, creating unnecessary demand on the assessment system, delaying access to care and reducing the flexibility older people and providers need to respond quickly as circumstances change. This is a significant departure from the former Home Care Package system, in which older people could access any service on the inclusion list within their allocated budget, and providers could use clinical and professional judgement to adjust supports as needs changed. It is not clear that the benefits of granular service approvals outweigh the administrative burden, delays and loss of flexibility they create for older people, providers and Government. We recognise there needs to be some parameters on the use of clinical services from a Support at Home budget given they are fully funded by the Government, but we believe that there could be sensible guidance/requirements put in place to ensure that clinical services were not over-utilised (in the same way that there are requirements/limits put on administrative claiming for the AT-HM scheme or similar).
- Since the commencement of Support at Home, we have requested hundreds of Plan Reviews for clients. While a number of these will have been for reassessment for a higher classification when the

person's needs have actually changed, most of them are to correct Support Plans that lack approval for specific services needed for the client[1].

We provide the following case examples to illustrate the inadequacy of the current assessment system to support appropriate access to care for older people.

Case 1: Approved in theory, unsupported in practice

Our client was previously on a Level 2 Home Care Package and was grandfathered to Support at Home HCP classification 2. She was receiving weekly domestic assistance and fortnightly social support. She sustained a major fall with fractured ribs, hip and pelvis, complicated by arthritis, frozen shoulder and chronic pain. A Support Plan Review was submitted, requesting specifically an increase of classification level for existing services plus allied health and personal care.

She was approved for a Support at Home Level 4 with approvals only for personal care and social support. Allied health approvals were missing. She was approved for the Restorative Care Program but no funding for this was received.

Another Support Plan Review was then submitted. In this case, allied health services that were deemed necessary were not approved on the revised Support Plan. This is a client who would have benefited greatly from the Restorative Care program, and while she was approved for it, the associated allied health services were not approved in the ongoing Support at Home Level 4 Support Plan. Had allied health been approved, we would have started these interventions (even if not at the same level of intensity as in the Restorative Care pathway) to minimise further deterioration.

Case 2: Assessment outcomes failed to reflect complexity

Our client had a recent hospital admission for reduced mobility and abnormal fluid in the abdomen. He is currently residing in a men's health hostel after release from a custodial sentence. He is not able to remain at the hostel due to ongoing physical and functional decline. He is essentially homeless or at high risk of homelessness.

This man has a complex medical history including Schizophrenia with medication non-compliance, congestive heart failure, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, diabetic neuropathy, hypertension, elevated cholesterol and cholelithiasis. He has a guardian and an administration order in place and the public trustee manages his finances.

This client has only been approved for a budget of classification 3 with limited services, despite him also being MAC approved for:

- Residential Permanent
- Residential Respite Care
- Transition Care

His Support at Home classification 3 included these specific services: domestic assistance, gardening, meals, social supports, respite, personal care, continence management, assistance to maintain personal affairs and transport.

The assessment states the man is independent with his cooking, shopping and cleaning, however it is noted he cannot lift or carry items. He was also approved for AT and HM (despite not having a home to make modifications to).

In this case, the services approved (and sheer number of them) don't seem to match the classification he has been provided. This classification is very low given his complex medical and social situation. We expected that someone approved through the assessment system for residential care would have been approved for a Support at Home classification 8, rather than classification 3.

[1] As of 24 July 2026. It is our understanding that it is not the IAT algorithm itself that prescribes the approved services for an individual and request that the Senators inquire into how services are selected for a person's Support Plan. This information is not publicly available to providers or older people.

Case 3: Multimorbidity recognised, but clinical care missing.

Our client was approved for Support at Home classification 5 with services only approved for personal care (medication support) and domestic assistance for shopping support. This person lives with dementia and Type 2 Diabetes (including peripheral neuropathy) and had approval for CHSP services previously including domestic assistance, personal care, welfare checks and continence management.

The MAC support plan states client has "*Dementia, Delirium, Osteoarthritis, Type 2 Diabetes Mellitus, Hypertension, Hypercholesterolaemia, Hypothyroidism, Heart disease, Gastro-Oesophageal Reflux and Asthma. She experiences ongoing pain and pins and needle sensations in her hands due to Arthritis, numbness in her feet, reduced walking tolerance, shortness of breath and light-headedness*".

In December 2025, a high priority CHSP personal care referral was received for medication support as the client was forgetting medication (client is independent with personal care such as showering and dressing) but the client declined the referral to CHSP as she was waiting for her Support at Home classification.

It is clear now that she requires support with personal care for medication management, as well as support with cleaning, physiotherapy, podiatry, nursing and continence aids. Family members have reported that they have seen a further decline in her functional abilities over the past few months.

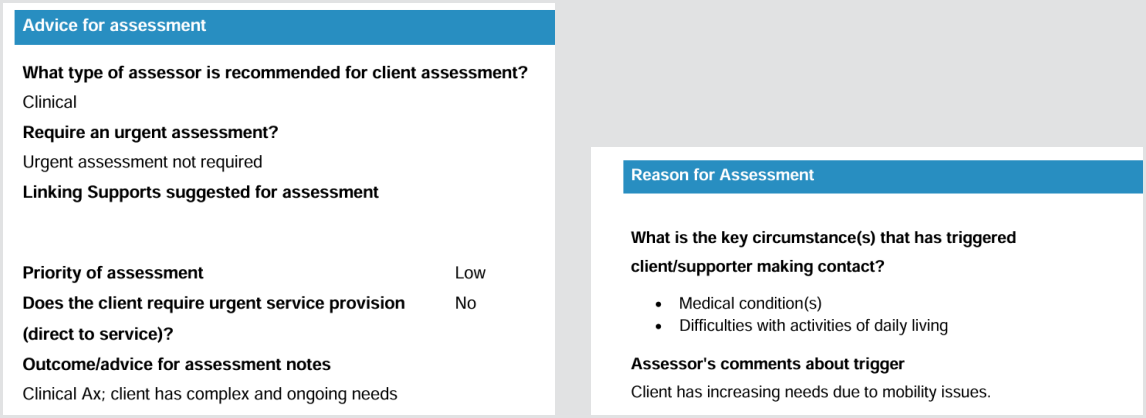
We have made a Support Plan Review request for the additional services which we hope will begin to restore some of her function and reduce any further decline. In this case, the Support at Home classification 5 and type and number of services approved doesn't seem to make sense in the context that the MAC Assessor was aware of her multimorbidity. We would expect many more approved services including clinical services for someone at a level 5 and with this medical history.

Case 4: A Support Plan that overlooked clinical risks.

A client we support through CHSP has been assessed for Support at Home. She has significant medical history, including neuropathic pain, a brain aneurysm, left macular degeneration; Dyslipidaemia, dizziness, Hypothyroidism; Osteoarthritis, Ulcerative Colitis, cognitive impairment and Cervical Spondylosis. She sees her GP, and multiple specialists, and is listed to have 11 medications.

Our clinical team has assessed this person as a high falls risk and she currently uses multiple mobility aids. In the MAC assessment, it is acknowledged that she has complex and ongoing clinical needs. We have provided screen shots below of the deidentified information that is provided in this person's MAC assessment. We were disappointed to see that the MAC Assessment had not approved any clinical services and only provided a classification 3 Support at Home package.

Figure 1: Screenshots from MAC Assessment report for client.



As the time this submission was prepared, the Support at Home Service List requires review and refinement to ensure it includes all the services that would benefit older people to remain independent and living at home, or greater flexibility within the service list inclusions to ensure genuine need is addressed. We remain concerned that there is no ability to claim for:

- services relating to social support for housing alternatives for people living in dwellings characterised by hoarding and squalor;
- the development of advanced care plans for people receiving care in their homes;
- the development of Dementia and cognition management plans for people receiving care in their homes;
- The inclusion of allied health services (namely orthotists, prosthetists and orthoptists to support prescription of AT-HM).

There are many assumptions made in the service list about access to services and supports through adjunct care systems (including the health care system) and these assumptions are used to justify the exclusion of these services from purchase through Support at Home. In many cases, whilet the programs may exist, some clients are not eligible for the program, or the program does not provide the type of care/services sufficient to meet their needs.

For example, blood glucose monitoring is presumed to be accessed through the National Diabetes Scheme, however this scheme does not cover a nurse attending to support an older person to check their blood glucose level every day. Similarly, continuous positive airway pressure (CPAP) machines are assumed to be covered under state and territory funded health programs, however we find that many clients are not eligible for these programs and subsequently cannot access the equipment either through Support at Home or their state health program. The creation of webster packs or other dose administration aids are an important support in managing medication error in older people but the funding for the creation of these by community pharmacy under the 8th Community Pharmacy Agreement is restricted for each pharmacy to the first 90 clients each week. This means that older people who are not ‘first in’ are unable to access this service at no cost – leaving a gap in an important support for medication management in older people that Support at Home will not currently fund. This disproportionately affects older people living in rural areas, where a higher share of the population is older and may rely on pharmacy-prepared dose administration aids to manage their medicines safely.

The Assistive Technology and Home modification (AT-HM) scheme

The AT-HM scheme is not working as planned and undermines the intent of the Support at Home program. Equipment and home modifications are not extras in aged care: they are essential supports that keep older people independent, safe and well at home as they age. The Support at Home Assistive Technology and Home Modification (AT-HM) scheme requires significant review and refinement. We have been advocating through multiple forums to address issues with the implementation of this part of the program. There are multiple issues that prevent older people accessing the very equipment and assistance in their homes that can keep them living independently and importantly, prevent their entry to residential aged care or hospital. There are many issues with the scheme which have been detailed in Appendix A.

Significant changes to how the scheme operates are required, in order to see the expected benefits of the overall program and this short-term scheme. Improvements are needed in relation to:

- Client access and funding:
  - Delay in AT-HM approval for equipment. This can take months for some clients even if the need is urgent.
  - Approved funding is not sufficient to cover the required AT-HM.
  - Ongoing Support at Home participants who have additional AT-HM pathways assigned are missing out on accessing their AT-HM funding.
  - Processes relating to AT-HM only clients in a single provider model are not transparent.
  - Co-contributions are a significant barrier to an effective AT-HM scheme.
  - Lifetime funding limits are too low to meet some people’s needs.
  - The interaction between CHSP and Support at Home AT-HM is problematic.
- Assessment, prioritisation and tiering issues:

  - The IAT assessment teams do not seem to understand in sufficient detail what AT or HM a person needs, or the costs associated with the items.
  - The delay in allocation of AT-HM funding after approval can take months for some clients even if the need is urgent.
- Support Plan review and pathway problems:
  - Requesting a Support Plan Review (SPR) for AT and/or HM funding requires a quote that cannot be completed without AT-HM funding in place. It is a circular requirement.
  - End-of-Life and Restorative Care pathway clients who have the relevant AT-HM funding are not having relevant allied health service approvals auto assigned and therefore cannot have prescriptions undertaken for AT-HM.
- Claiming and coding:
  - The claiming codes that must be used for each AT-HM (in order for a provider to claim) are too complex.
  - The claiming process for the transition phase was closed off prematurely, leaving providers out of pocket for AT-HM that were ordered and provided in good faith. Silverchain is owed $250,000 in AT-HM claims for services provided in good faith but could not be claimed before the claiming process was closed off.
  - High Tier AT and HM require a prescription be attached for every clinical claim regardless of the amount the item costs.
  - The need to reapply for funding for ongoing subscriptions (such as for falls alarms[2]) annually is inefficient.
- Scope inclusions and gaps:
  - Repairs and maintenance of home modifications - stair lifts and bidets (most common ones) are not included.
  - The lack of care management for AT-HM only clients is problematic given the significant work that is often needed to liaise with other external health providers involved in the person's care[3].
  - There are items missing from the AT-HM List that clients need and are not able to procure through state-based health or disability schemes.
  - The lack of specificity in the AT-HM List for some items is problematic and causes significant issues in determining if the AT-HM being ordered meets the exact requirements under the AT-HM guidance.

The Restorative Care pathway

It is unacceptable that older Australians assessed as needing short-term restorative care are waiting five months for services[4] designed to restore function, prevent decline and keep them out of hospital.

Silverchain was a Short-Term Restorative Care (STRC) provider prior to the commencement of Support at Home. However, we have not seen a significant influx of clients through the Restorative Care Pathway. As the third largest home-based aged care provider in Australia, we would have expected to see a significant uplift in the number of clients in this program given its critical role in preventing readmissions/admissions to hospital.

To our knowledge, Government has not reported the number of Restorative Care packages that have been or will be released since 1 November 2025. According to the first mandatory Support at Home wait-times report, the median commencement time for the Restorative Care Pathway was approximately five months[5]. For a pathway intended to deliver early, time-limited intervention, this delay is more than an administrative

[2] It is our experience that once an older person is assessed as needing a falls alarm for daily use – it is unlikely that they will restore function to a point that they will no longer need this falls alarm (unless they are in a restorative care program). The annual review of AT-HM for the purposes of paying for an annual falls alarm subscription is unlikely to result in a different outcome of need for AT-HM.
[3] This care management is not the administration involved in ordering and delivering AT-HM which has a separate funding allowance under the AT-HM guidelines.
[4] Australian Government Department of Health, Disability and Ageing 2026, *Aged Care Act 2024 – Wait Times Report: Residential care and Support at Home: First report, 1 November 2025 – 31 March 2026*, Australian Government Department of Health, Disability and Ageing, Canberra, published 12 May 2026.
[5] The report also notes that waiting-time measures reflect the full access pathway, not simply the period between allocation and service commencement, highlighting broader system pressures affecting timely access to care.

problem; it undermines the purpose of the program. Every month spent waiting increases the risk that an older person will lose function, become less independent and require more intensive health or aged care services.

The End-of-Life Pathway

The End-of-Life Pathway has incredible potential to deliver benefits for the community and the care system, but it continues to require refinement. We are proud to have supported more than 100 people to die in their own homes through this pathway, to date. We believe this could have been a much larger number of people if some of the implementation issues associated with the pathway had been resolved.

We welcomed the improvements made by Government with the proposed extension of time for this pathway with the opportunity for an additional 12-16 weeks of funding if a person were to live beyond their first block of support. However, clarification is needed urgently as to when this change will be implemented to support older people, their families and the health sector who predominantly refers to this program. Our understanding is that it requires legislative change and that no interim arrangements are in place for older people needing the program between now and when this change is enacted. We have had at least one older person decline the pathway because he was uncertain whether he would be supported through to his final days. This example illustrates the real harm caused by unclear implementation timelines: older people nearing the end of life should not be forced to delay care or make decisions about when to seek support because they are trying to navigate an unnecessary bureaucratic process.

The ability for this pathway to support older people effectively is undermined by implementation problems and design features.

This includes inconsistencies in the services approved through Support Plan Reviews (as detailed previously) and the need for regular Support Plan Reviews to have necessary services approved under this pathway. The services needed in the final three months of life being supported to live at home are predictable and outlined in Appendix B. We understand these needs, based on our provision of the program to date and our expertise in community-based palliative care across Australia.

According to the *Aged Care Act 2024* Wait Times Report, the median waiting time for the End-of-Life Pathway is 15 days, while the average waiting time is 35 days. These figures reflect the elapsed time from application through My Aged Care to the commencement of care for individuals who began services between 1 November 2025 and 31 March 2026. Even in the most generous of perspectives, waiting 18% or 42% (respectively) of someone's remaining life for urgent end of life services and support is a tragic failure in the system that is designed to keep older people out of hospital if that is their preference, and dying in the comfort and familiarity at home, with dignity.

A system-changing pathway cannot succeed if the doctors and health professionals expected to refer older people into it do not know it exists or how it works. Promotion by the Government of the End-of-Life Pathway and communication with the health sector, particularly General Practitioners (GPs) as key referrers, has been inadequate. This creates a direct access barrier for older people who may be eligible for support to die at home but are not referred early enough, or at all. To help fill this gap, Silverchain has taken the initiative to deliver its own education sessions for GPs and their teams through our Silver Learnings program. This program is designed to explain the pathway, identify eligible patients and support timely referrals so care can be expedited. Greater effort is needed by the Department to promote the pathway and GP eligibility to refer patients to the service.

No one should have to choose between dying at home and leaving their family with a bill. Government communication to older people and their families about co-contributions under the End-of-Life Pathway has been inadequate, creating confusion and distress at a time when people need clarity, certainty and support. We have seen older people decline the pathway once they understand the out-of-pocket costs that may apply to everyday living services, independence supports and assistive technology, including essential items such as hospital beds. This is not restricted to co-contributions towards the cost of personal care (which in time will be resolved when it moves to the clinical category of services). Co-contributions create a significant access barrier and risk undermining the purpose of the pathway, which is to support people to remain at home, receive appropriate care and die with dignity in the place of their choosing. Co-contributions for the End-of-Life Pathway should be removed, given the time limited nature of the program and the aim to prevent unnecessary hospitalisations and allow people to die in the place of their choice, with dignity.

Care Management

Part of Silverchain's commitment to our clients is Care Management provided by highly experienced professionals, many of whom hold clinical qualifications. Our model of care deliberately varies care partner caseloads according to client complexity and risk, recognising that older people with higher clinical, functional or psychosocial needs require more intensive coordination, monitoring and support. Our experience is that a key factor associated with their complexity is the social environment in which the older person lives: their support from family, spouses and other loved ones who help to care for the older person. People with larger and more stable social networks require less care management and conversely, those with limited or unstable social networks often require significantly more care management to support them to remain living independently, well and safely in their homes.

This approach stands in contrast to the blanket Support at Home policy approach, which limits care management funding to 10% of a person's budget in most circumstances, regardless of the level of complexity or risk involved[6]. Even with varying our approach based on client need, we find that we are exceeding the case management allocation. At present we are absorbing the additional hours of care management cost and are hopeful that this is a time limited artifact of the significant time needed to educate and orientate older people to the new Support at Home system, rather than reflecting an ongoing need embedded in the system design.

The pooling of case management funds goes only some way towards levelling out the varying case management needs of clients, but we are concerned that it is inadequate to fund the levels of complexity we are witnessing across our client cohort. In essence, this penalises providers who accept older people with higher risk and complexity profiles.

Care management is where safe home care starts, yet the current funding design fails to recognise the real work required when an older person first enters care or changes providers. For every client, care management is front-loaded: onboarding, assessment, care planning and service coordination all occur early in the relationship with the provider. This work can generally be accommodated when a new client enters at the start of their Support at Home journey as their 10% care management allocation is included in the pooled funding for that period. However, the model breaks down when an older person changes providers. In these circumstances, the previous provider retains the care management allocation for that quarter, while the new provider receives no pro-rata allocation to support the intensive onboarding and care planning work required. The cost of ensuring a safe and well-managed transition must be absorbed (written off) by the new provider.

A care management system should follow the needs of older people, not the boundaries of a provider's local structure. Under the current model, pooled care management funding is restricted to the service delivery branch level, limiting how providers can use these funds across their broader client cohort. For larger organisations such as Silverchain, this reduces our ability to balance variation in client complexity across regions and services, and risks creating a structural disincentive to accept older people with higher clinical complexity, psychosocial needs or care coordination requirements.

Associated Providers

Older people should see better care from aged care reform, not a paperwork boom. The changes introduced by the *Aged Care Act 2024* to the way Registered Providers work with Associated Providers have created significant governance, administrative and contractual burden. While Silverchain supports strong accountability for quality and safety, the current implementation requirements have driven a proliferation of new and more complex legal agreements, compliance processes for worker screening and insurance checks, and sector-wide administrative costs, with limited evidence to date that these changes are improving the experience or outcomes of older people receiving care. Given the size and scale of our services across all Modified Monash Model regions, we currently have more than 1,000 Associated Providers who we contract with, and this is after a concerted effort to reduce the number of entities. The administration and governance associated with managing contracts and compliance at this scale is burdensome with limited benefits to the older person.

[6] We acknowledge that some older people may be allocated an additional number of hours of care management each quarter if they have certain characteristics such as are veterans, have a history of homelessness, are Aboriginal and/or Torres Strait Islander etc – but consider the number of additional hours inadequate to meet their needs.

Despite the release of additional guidance materials designed to clarify the definition of an Associated Provider, there is still some uncertainty/confusion in relation to particular arrangements. Two such examples are:

- There remains uncertainty about whether some AT-HM wraparound activities make a supplier an Associated Provider. For example, a supplier staff member may fit shoes that have already been prescribed, or set up equipment purchased through AT-HM tier funding, without being involved in assessment, prescription or ongoing care. The current guidance does not clearly state whether supplier staff should be treated as Associated Providers in these circumstances.
- For instances when Silverchain arranges a taxi or rideshare services and the fee is allocated to a Silverchain account. In these cases, we are not providing vouchers to our clients (the guidance clearly states that in this situation the provider would be a supplier and not an AP). However, in this case when we have an account with the transport provider, it is unclear if the transport provider should be considered an Associated Provider.

Many of our Associated Providers are private practice allied health organisations that support the provision of AT-HM to our clients[7]. These, and many other small businesses, are now required to comply with lengthy contracts designed to ensure Registered Providers meet their obligations under the Act. While stronger oversight of poor-quality providers is important, the current framework casts too wide a net.

The current worker screening requirements for Associated Providers create a disproportionate administrative burden for Registered Providers, particularly where services are delivered through large networks of subcontracted or partner organisations. In practice, Registered Providers may be required to obtain and maintain evidence of worker screening checks for every employee of an Associated Provider, even when only a small number of those employees are likely to deliver services to aged care clients. For example, if we are using a cleaning provider, we are required to have records of police checks for every individual cleaner the agency has on contract – even those that may not ever provide services to Silverchain clients. This is difficult to operationalise because Registered Providers often do not know in advance which individual workers will attend a client's home and so the prudent approach appears to be requiring a compliance check on all of them.

This creates duplicated compliance activity across the sector, with each Registered Provider separately seeking assurance about the same workforce. The result is a significant investment of Registered Provider and Associated Provider time in documentation, tracking and contract management, rather than in activities that directly improve quality, safety or access for older people. For large Registered Providers working with hundreds or thousands of Associated Providers, the cumulative administrative cost is substantial and risks discouraging smaller allied health, trades and community-based businesses from participating in aged care service delivery.

Silverchain supports robust worker screening and strong safeguards for older people receiving services in their homes. The Australian Government has indicated it intends to introduce a national aged care worker screening model aligned with the NDIS Worker Screening Check framework. Current worker screening requirements commenced under the Aged Care Act 2024 on 1 November 2025, with Departmental guidance foreshadowing a future nationally consistent screening system with ongoing monitoring and cross-sector recognition, but the sector has not been informed of a timeframe for its implementation. In the interim, the current approach should be better targeted and more proportionate to the risks it is intended to manage. Registered Providers should be able to rely on clear, auditable assurances from Associated Providers that relevant workers hold current checks, rather than duplicating the collection and monitoring of individual records across multiple Registered Providers.

Over the longer term, an industry-wide aged care worker clearance or licensing system would provide a more efficient and reliable safeguard. A centralised system that verifies, records and maintains worker screening status would reduce duplication, improve consistency and allow providers to focus compliance effort on service quality, supervision and client outcomes rather than repeated administrative checking.

Interim Funding (Minimum Service Offer)

The introduction of interim funding has created a false economy in which older people can access their Support at Home package 'earlier', but without it meeting their assessed needs. The Government has not

[7] See section on AT-HM which indicates that the AT-HM Scheme is significantly problematic, complex and administratively burdensome to implement.

made a case for why interim packages (or minimum service offers) are required; the Government should meet the clearly recorded demand for Support at Home packages and work towards the commitment of a three-month waiting list by the end of the 2027 financial year.

Releasing 60% of a person's package to them when they have been assessed as needing 100% of that budget and services delays access to care, leads to deterioration, causes consumer frustration, and layers even more complexity and unfunded work into care planning in the context of restrictive care management caps (as budgets and care plans must be done twice in a short period – once when the MSO is released, and again when the full package becomes available).

Interim funding is simply an accounting trick; it is a poor substitute for timely access to the full Support at Home budget someone has already been assessed as needing, and leaves older people with only partial access to the services required to keep them safe, well and independent at home.

Rather than embedding interim budgets as a permanent feature of the program, the Government should focus on fixing the underlying allocation delays and ensuring older people receive their full approved budget as quickly as possible.

Interim budgets appear to be an unusual and problematic feature in a needs-based care program. While some government schemes use temporary or advance payments to manage transition or cashflow, it is difficult to identify comparable care programs in which a person is assessed as needing a particular level of support but is then systematically funded for only part of that support. This risks making under-service an accepted design feature rather than a temporary shortcoming that needs to be fixed.

The current implementation of interim funding requires providers to complete care planning twice: first when the interim budget is allocated, and again when the full budget becomes available. The second round of care planning must be funded from the same 10% care management allocation that is already pooled and capped. This is not sustainable and places additional unfunded pressure on providers at the very point when older people need timely, coordinated support. This adds to the unsustainable load providers must carry as part of the false economy of the interim packages system.

A key flaw in interim funding is that they reduce the amount of funding available without reducing the person's assessed level of need. MAC assessments at higher classification levels continue to produce Support Plans that identify all the services and supports a person requires, regardless of whether those services can actually be delivered within an interim funding offer. This places providers in the untenable position of explaining why an older person cannot access all of the services the Government has assessed them as needing.

We are also seeing older people allocated interim funding at classification levels that are clearly below their assessed and observable needs. While this may be intended to provide faster access to some support, it risks creating a false economy. Older people receive less care than they need, providers must explain the gap between assessed need and available funding, and the system is then pushed back into another cycle of reassessment when the person's needs inevitably exceed the interim classification. Worse still is the likely outcome that the older person's health and wellbeing declines, leading to an avoidable hospital admission and deterioration.

If interim funding is to be an ongoing and problematic part of Support at Home, the bare minimum required includes:

- The Government should detail whether interim funding will be a permanent feature of Support at Home, and if not, for how long interim funding will be used.
- The allocation of interim funding and timeframes for these to convert to standard Support at Home budgets should be reported publicly. Silverchain's experience is an average of 8-10 weeks for our clients on minimum service offers, which underscores the falsehood of the additional funding becoming 'available'; it is currently a measurable and consistent time span which would indicate it is deliberately phased.
- Additional care management hours should be allocated for every minimum support offer to acknowledge the additional care planning needed when care planning is required to be done twice against two different budgets.
- The ability to apply for 'top up' funding for people on interim budgets should be available for the last month in the quarter in instances when the interim budget is insufficient to meet the needs of the person (which would defeat the purpose of interim funding, but again underscores the falsehood of this aspect of the system).

The impact of the co-contributions on the financial security and wellbeing of older Australians

Older people should not need a policy interpreter to understand how to use the aged care services they have been assessed as needing. Insufficient Government communication and education before and during the Support at Home rollout has left many older people, their families and related sectors confused about how the program works. Providers have had to step in, at their own cost, to explain the changes to people transitioning from Home Care Packages, and the same confusion is now being experienced by people newly entering Support at Home. The key questions have shifted from whether people will be "no worse off" to why they have not received the full budget they expected, why only some services are approved on their Support Plan, and why they cannot use their assessed budget flexibly for the supports they need. Explaining that choice is restricted to services specifically approved by MAC is particularly difficult and reinforces the need for clearer, consistent communication from government.

The Government now has a critical opportunity to improve understanding of Support at Home before any further reforms are layered into the system.

Older people should not have to choose between a shower, a clean home, a safe garden and filling their prescriptions. Silverchain recognises that people who can afford to contribute to the cost of their aged care should do so. The hardship application process is difficult to navigate, and the threshold for assistance appears too restrictive for older people with very limited financial flexibility. We are hearing accounts of older people weighing up whether they can afford cleaning, gardening or essential medicines. These are not choices that should be placed on financially insecure older Australians. Silverchain's philanthropic program, Silver Hand, has received a 90% increase in requests for support from clients struggling with the cost of living in FY26. This fund supports urgent, last resort financial relief for clients and is funded by philanthropic donors.

The shift of personal care to the clinical care category of the service list from 1 October 2026 is a welcomed example of the Government making refinements to Support at Home, however, a significant number of additional changes are needed. Silverchain is covering our clients' personal care co-contributions in the months leading up to the 1 October change, as qualitative and quantitative data shows our clients were declining personal care services due to the co-contribution requirement.

Case 1: Declining essential support because of cost

We have a new Support at Home client who has a history of hoarding and squalor. The level of cleaning required to allow for a clean, safe work environment for Silverchain employees to attend his home is significant and will come at a significant co-contribution cost. The client is unwilling (or unable) to afford the co-contribution and has declined this service, meaning that his home environment is not safe for Silverchain employees to attend and provide care.

In this scenario, there are risks to the older person in declining care and risks to Silverchain in terms of duty of care to this older person whom we know needs care and services, but he is unwilling to pay the co-contributions for this care. Under Support at Home, we are unable to assess financial hardship on behalf of the Government.

Sector data indicates that package utilisation has fallen in the early months of Support at Home, despite expectations that utilisation would increase under quarterly budgets with limited rollover. Stewart Brown noted that "other factors currently seem to be at play", suggesting the need for close monitoring of whether co-contributions, service pricing, confusion about budgets or restricted service approvals are causing older people to use less of the care they have been assessed as needing. This is problematic as prices were set with an assumption of package utilisation rates that would allow fixed costs to be covered and a fall in utilisation places upward pressure on prices.

An early hypothesis supports that co-contributions are driving consumer behaviour; consumers are avoiding certain services due to the co-contributions required. This means that older people are not receiving the care, support and services they have been deemed eligible for, and as needing, to stay at home safely and independently. In addition, from a provider perspective, under-utilisation of this scale compromises financial viability.

The extent of bad debt arising from co-contributions across the sector remains unknown. However, the introduction of co-contributions has shifted additional financial and administrative risk onto providers, who must now absorb the costs of billing, debt management and follow-up, while also carrying the risk of unpaid contributions. This creates a further unfunded burden for providers and adds pressure to an already financially constrained home care sector.

A co-contribution system that pushes providers into discounting is not delivering transparency or fairness for older people. Across the sector, there is emerging evidence of unintended market behaviour, with some providers promoting waivers, discounts, incentives or bundled arrangements that effectively reduce out-of-pocket costs for older people to encourage them to switch or choose that provider. While these arrangements may technically preserve the required co-contribution, they risk creating an uneven and confusing market in which older people compare offers that are not transparent, consistent or easy to understand. This undermines the intent of co-contributions and risks shifting consumer choice away from quality, safety and continuity of care towards short-term price incentives.

Trends and impacts of pricing mechanisms on consumers

Older people cannot make informed choices about their care if pricing rules keep shifting beneath them. Silverchain welcomed the deferral of price caps for Support at Home. The recent release of the Independent Health and Aged Care Pricing Authority (IHACPA) Support at Home Pricing Advice 2026–27 may also operate as a proxy ‘price cap’ in the minds of consumers and the broader community, even when it does not reflect the real cost of delivering safe, high-quality care in different locations and circumstances under the Support at Home program.

The introduction of capped pricing would have significant ramifications to the operation of the aged care system. It will lead to the unintended consequence of older people with complex health or care needs not being able to access the care they require and deserve. The introduction of capped pricing - while on face value a noble initiative seeking to cap costs for older people - will cause significant upheaval within the home care sector, and lead to the likely exclusion of those with complex needs or comorbidities. This will then drive increased hospital admissions, as older people’s health will not be actively managed and improved through the Support at Home program.

Setting capped prices is an unnecessarily blunt policy tool, which will mean any provider currently delivering care and services above a ‘capped price’ would have to reorganise their business to meet the capped price. This will mean mass redundancies across the aged care sector at a time when the sector can ill-afford to lose dedicated and experienced staff. Setting the capped price at the median or mean of the cost of services, for example, under the Home Care Package system (based on the only evidence IHACPA has to date) will lead to ‘cherry picking’ of clients by some aged care providers. The outcome will be that some providers will screen clients so that they selectively choose not to provide care to older people with complexity, given the difficulty of accommodating complex needs within a price cap.

This is a perverse outcome for the aspirations of the Government’s aged care reforms. It will drive increased hospitalisations of older people over time, and degrade the quality of care that can be provided under the Support at Home program. This is the opposite of the intent of the aged care reforms.

Variation in prices across the Support at Home market should not automatically be interpreted as poor value or excessive charging. In many cases, price differences reflect the real cost of delivering services safely, including workforce availability, travel, geography, quality systems and the complexity of a person’s care needs. Consumers need clear, accurate and contextual information so they can understand what they are paying for and make choices based on quality, safety, continuity and value, rather than price alone.

Financial viability of providers is also a consumer issue. Ongoing reform, system changes and communication requirements all create costs that providers must absorb or recover. If pricing settings do not reflect the real cost of care, older people may face reduced service availability, less continuity of care, thinner provider choice in some markets and a greater risk that high-quality providers are unable to sustainably deliver the services consumers rely on to remain safe and independent at home.

Older people are not just looking at the prices of services where there is a co-contribution in their decision making. Informed choice depends not only on transparent prices, but on older people understanding the value of the services they are choosing. At present, there is not a clear community understanding of the role of services such as allied health and care management. Without that context, these services can appear expensive or discretionary, even though they are often critical to maintaining independence, preventing deterioration, coordinating care and supporting older people to remain safely at home.

This uncertainty is likely to increase if Support at Home moves to a multi-provider model. While greater choice may benefit consumers, it can also make the system harder to navigate if pricing, co-contributions and service responsibilities are not clear. Older people may be left trying to compare multiple providers, different service prices and different out-of-pocket costs, without a simple way to understand the total impact on their care, budget and continuity of support. No further reforms should be layered onto Support at Home until the system is refined and stabilised.

The adequacy of financial hardship assistance for older Australians facing financial difficulty

We provide the following evidence from our experience providing Support at Home to inform the Committee's deliberations on the adequacy of the financial hardship assistance process for older Australians:

- The Services Australia financial hardship application process places an unreasonable administrative burden on older people at the very point they are seeking access to care. Currently, aged care providers are offering significant educative support to clients to help them through this process and for most clients, this requires support from a care partner. Financial hardship assistance should be assessed as part of the Support at Home access and income testing process, rather than requiring a separate, duplicative application. While this is a pragmatic change that would assess ability to pay (and subsequent reductions/waivers) at the same time as the MAC assessment, there should be the ability for older people to seek financial hardship assessment at any point if their financial circumstances change.
- The current hardship threshold appears to be too high for pensioners and part-pensioners, leaving some older people reluctant to use services they have been assessed as needing because of the co-contribution burden. This is reflected as an underutilisation of quarterly budgets despite the limited ability to 'roll over' funds to the next quarter.
- Transferring responsibility for assessment and allocation of fee reductions and waivers from providers to Services Australia creates a disincentive for CHSP clients to accept lower-level Support at Home packages. Under CHSP, providers have some discretion to reduce or waive fees when clients are experiencing financial hardship. Under Support at Home, that flexibility is removed as Services Australia is the only entity that is able to assess financial hardship applications, meaning some older people may face substantially higher co-payments for a Support at Home package that offers little additional value to CHSP and with no certainty that Services Australia will approve a financial hardship application. Clearer government guidelines on co-contribution waivers for CHSP to align with Support at Home is needed. At the same time, the threshold for financial hardship assistance assessed by Services Australia should be lowered.
- First Nations redress and reparation payments should be excluded from income and asset testing for Support at Home and hardship applications on grounds of equity and fairness. People should not be financially penalised for receiving payments intended to acknowledge past harms.
- Providers have limited visibility of whether a client has applied for hardship assistance unless the client tells them. This creates uncertainty for both clients and providers, including the risk that clients defer needed services because they fear receiving a large bill if their application is unsuccessful.
- The Services Australia reconciliation process needs to be improved so that any co-contributions paid to a provider while a hardship application is being assessed can be refunded promptly and transparently when hardship is approved. There is currently a significant delay in this process, and it is particularly problematic if the hardship application is approved close to the end of the quarter, requiring significant time for the provider to resolve quarterly statements and refund any overpayments in co-contributions for the quarter.

The impact on older Australians transitioning from Home Care Packages

The transition from Home Care Packages to Support at Home has had limited adverse impacts for most older people, largely because the grandfathering arrangements provided an important level of protection. However, the transition also relied heavily on providers to explain the new program, reassure clients and support them to understand their changed funding arrangements, without dedicated funding for this work. As a result, the quality and consistency of information received by older people depended significantly on the capacity and approach of their provider, rather than being underpinned by a nationally consistent

government communication and education strategy. Silverchain advocated for such a strategy prior to the implementation of Support at Home.

A key point of confusion for consumers was individual interpretation of the Government's promise of being 'no worse off', given the structure of Support at Home service pricing changed substantially and service prices were no longer the same as under the Home Care Package program. This meant some consumers could 'afford' fewer services in their transitioned budget. Ongoing work is needed for older people to understand the "use it or lose it" rules of Support at Home budgets, as many transitioned clients still retain a desire to keep or retain some funds (above the allowed amount) for a "rainy day".

The interaction between CHSP and Support at Home

Silverchain strongly supports CHSP continuing beyond 30 June 2027 as a distinct, strengthened, block-funded and low-complexity aged care program. CHSP should not be folded into Support at Home unless and until there is clear evidence that Support at Home is stable, affordable, operationally mature and capable of absorbing the scale, community infrastructure and lower-level preventative supports currently provided through CHSP. Reform should be judged by a simple test: will it improve access, affordability, safety, continuity and outcomes for older people? If that test is not clearly met, CHSP should remain separate, strengthened and properly funded.

CHSP works because it is simple, local, preventative and trusted. It supports older people early, often before their needs escalate to higher-cost aged care, hospital or residential care. It also funds services that cannot be sustained through a purely individualised, transactional funding model, including local transport routes, group-based social connection, volunteer-supported services, specialist outreach and community infrastructure. These are not peripheral features of the aged care system; they are the foundations that help older people remain independent, connected and safe at home.

To retain CHSP as a strong and effective entry-level tier of aged care, Government should strengthen the program in the following ways:

- Clearer service definitions and program boundaries, so CHSP remains focused on entry-level support, prevention, reablement, social connection, respite and time-limited clinical or restorative support;
- Sustainable block funding that grows with demand and reflects the real cost of maintaining existing community infrastructure, local coordination, volunteer capability, transport routes and group-based supports;
- Automatic thin-market funding arrangements, including direct subsidies when required, to protect access in rural, regional, outer metropolitan, low-density and specialist service markets;
- Capacity to operate as a properly funded thin-market pathway when no Support at Home provider or service is available, including for First Nations, culturally and linguistically diverse or other specialist service needs;
- Transparent reporting on demand, wait times, unmet need and service availability to support stronger local planning and public accountability;
- Explicit protections for services that rely on community infrastructure, volunteers, group delivery, local transport routes or existing capacity;
- Stronger integration with primary care and local health systems, particularly for reablement, through dedicated funding for care coordination and liaison;
- Clear pathways between CHSP, Support at Home and other aged care supports, with reassessment and transition triggered by ongoing clinical need, increased complexity, reduced reablement potential or the need for dedicated care partnering;
- Clearer Government guidance on fees, co-contribution waivers and consumer communication, so older people understand what CHSP can and cannot provide and are not discouraged from moving to Support at Home when their needs require it.

CHSP should not become a holding program for people waiting for Support at Home, nor should it be used indefinitely to compensate for gaps elsewhere in the system. A sustainable home care system requires both a strong CHSP and timely access to Support at Home, with disincentives to moving between the programs removed once a person's needs clearly meet the threshold for higher-level support.

The central transition risk is less about people moving from HCP to Support at Home, and more about CHSP clients who see little benefit in accepting a low-level Support at Home classifications. We have observed

many clients who are unwilling to move to Support at Home for a variety of reasons including co-contributions and a perception that they will be 'worse off' under Support at Home compared to CHSP[8]. Many CHSP clients currently receive fee reduction and waivers that were at the discretion of their provider. However, under Support at Home, this is no longer possible, so they are needing to pay regular co-contributions as assessed by Services Australia. Since October 2025, a very significant number of our CHSP clients who have received a Support at Home classification have decided to stay on CHSP – including some people who have been deemed eligible for the End-of-Life Pathway. This speaks to the perception by consumers that CHSP is a 'better' program than Support at Home.

Clarity is needed as to whether people receiving CHSP must move to Support at Home if offered a classification or if this is 'optional'. The Government's current policy is that accepting a Support at Home package is optional and consumers can remain on CHSP indefinitely. This is problematic for many reasons with our primary concerns being:

- The provider holds increased risk if attempting to provide care and services to an older person through CHSP when that person's needs have been assessed as needing a higher level of care and support[9]. The risk is that the older person's health, wellbeing and ability to remain living at home is compromised by not receiving the right type, level or intensity of care.
- Ongoing and intensive clinical care cannot be provided through CHSP which is critical to prevent unnecessary use of primary and tertiary health care services, entry to hospital or premature entry to residential aged care. In the past six months, we have seen hundreds of CHSP clients awaiting Support at Home/Home Care Packages or awaiting reassessment to enter residential aged care permanently.
- People with higher needs require care coordination that is a core component of Support at Home but can only be provided in very limited capacity and circumstances under CHSP. Again, the risk lies with the provider in this situation.
- The use of CHSP by people with higher level needs that are more appropriate for Support at Home will result in less CHSP services for the community overall. As CHSP is a block funded program there will be reduced access for others if this continues. The principle of CHSP is that it is an entry level program with high volumes of clients who require low volumes of supports/services.

Other implementation issues

Thin markets including those affected by geographic remoteness and population size

Older people in rural and remote communities should not lose access to home care because the funding model pretends it costs the same to deliver services everywhere. Silverchain has received thin market grants through both rounds offered to date. While these grants are intended to support providers to maintain services in regional, rural and remote areas, the poorly developed funding model does not encourage providers to expand services into underserved communities.

A key weakness of the thin market grants is that each funding round (including the current round) only allows providers to claim a subsidy for new clients who have not received thin market funding support under previous rounds. This wrongly assumes that the higher costs of delivering care in rural, regional and remote communities are incurred only when a provider first starts supporting a client. It also assumes an equal additional cost per client regardless of the volume of services that are provided to that client. In reality, these additional costs - including travel, workforce availability and local market constraints - apply every time care is delivered.

Limiting subsidies to new clients and providing a flat rate of subsidy per person fails to reflect the ongoing cost of providing services in thin markets. The IHACPA studies need to demonstrate the evidence relating to the costs of rural, remote and regional service provision under Support at Home and the thin market grants need to be structured and resourced adequately to support service provision at those cost points.

Under Support at Home, the requirement to deliver services at a single rate does not adequately recognise the higher costs of operating in regional, rural and remote areas, including workforce availability, travel distances and local market conditions. Thin market grants are currently the only mechanism available to offset these cost differences. Without updating the thin market grant structure, providers will continue to

[8] Particularly for clients who have been allocated a lower classification level for Support at Home.
[9] This risk is compounded by the lack of visibility over if the person is receiving CHSP services from multiple providers and if any of these are 'over servicing' these clients.

withdraw services from regional and remote communities. A more sophisticated pricing framework is needed to encourage providers back to these areas.

The impact on First Nations communities, and culturally and linguistically diverse communities

We support the ability of First Nations older people to choose the provider that best meets their needs, including their cultural needs. This may or may not be an Aboriginal or Torres Strait Islander specific organisation. Regardless of their choice, the care they receive that is subsidised by the Australian Government should be high quality and culturally safe. Silverchain has about 1500 clients who identify as Aboriginal and/or Torres Strait Islander.

The focus to date on the cultural safety of aged care has been firmly focused on the regulation and performance of aged care providers, however we see gaps in cultural safety in the entire government-controlled aged care ecosystem that need to be addressed. While there are some First Nations-specific assessment agencies, there is no culturally specific financial hardship application process or entry point into MAC. We welcomed the recent appointment of the Interim First Nations Aged Care Commissioner and legislation to make the Commission a permanent part of the aged care system and we ask the Committee to refer to the Commission's identification of any other cultural safety gaps that need to be addressed.

Impact on workforce

A reform intended to improve care for older people should not be forcing experienced aged care workers out of the sector. The workforce impact of Support at Home has been significant and should not be underestimated. A more planned, staged and better supported rollout would have reduced much of this pressure. Instead, the rapid implementation of major reform, combined with continuing uncertainty, administrative complexity and frequent changes in guidance, has placed avoidable strain on the people responsible for making the new system work for older people.

Incredible burden has been placed on the role of the care partner. These are experienced employees who are skilled in supporting people with complex needs, but the additional layers of administrative burden, system uncertainty and program complexity have made their work increasingly difficult. They want to focus on achieving good outcomes for clients, yet too much of their time is now spent interpreting changing rules, managing system constraints, understanding complex claiming requirements and explaining program issues that sit outside their control. This is especially due to a lack of any Government education and communication campaign to the broader community, to help support people's understanding of the new system and how it works.

Care partners are operating in an environment of continual change, with limited visibility of when implementation issues will stabilise or when administrative complexity will reduce. For some employees the cumulative effect is not simply frustration with one provider or one role; it is a decision to leave aged care altogether. Losing experienced employees from the sector is one of the most serious unintended consequences of the reform.

The impact is also financial and operational. In addition to the cost of workforce turnover, providers are absorbing the ongoing cost of educating employees, updating processes and quality assuring implementation changes each time the Department clarifies guidance or makes further piece-meal adjustments to the program. This burden falls most heavily on high-quality providers that invest in training, governance and safe implementation - the very providers the system needs to retain.

Conclusion

The test for Support at Home is simple: does it help older people get the right care, at the right time, at home where they want to be? At present, many parts of the program are failing that test.

Assessment delays, restrictive Support Plans, interim budgets, AT-HM barriers, underfunded care management, pressure on the workforce, and consumer uncertainty are not isolated implementation issues. Together, they create a system that is harder for older people to navigate, harder for providers to deliver, and less able to achieve the reform's central promise of safe, timely and dignified care at home.

Silverchain supports the intent of the aged care reforms and the ambition to help more older Australians live safely, independently and with dignity at home. We commend the collective courage of parliamentarians who have delivered these reforms and are seeking to continue to improve the legislation and the system. Our concern is that the current implementation of Support at Home is making that ambition harder to achieve than it needs to be.

Silverchain urges the Committee to recommend practical changes that put people back at the centre of Support at Home: faster and more accountable assessment pathways; simpler approvals and claiming; fairer co-contribution and hardship settings; timely access to Restorative Care, End-Of-Life support and assistive technology; sustainable care management and workforce settings; and a strengthened, clearly defined CHSP that continues to provide simple, local and preventative support.

Support at Home has enormous potential to become the home care system older Australians were promised. Every day, hundreds of thousands of Australians are receiving high quality aged care at home, from providers who are invested in their wellbeing and care teams who do their best for each and every older person.

The opportunity now is to ensure the Support at Home program can reach its potential by treating implementation as an ongoing responsibility, not a set-and-forget outcome.

If Support at Home is to fulfil its promise, it must work better for the people it was created to serve. Older people deserve a system that makes care easier to access, not harder to navigate.

That is the standard older Australians were promised, and the standard the system must now meet.

Appendix A Assistive Technology and Home Modification scheme issues

The Assistive Technology and Home Modification (AT-HM) scheme is not working as intended and undermines the intent of the Support at Home program. Significant changes to how it operates are required to see the expected benefits of the overall program and this short-term scheme. Improvements are needed in relation to:

- Client access and funding
- Assessment, prioritisation and tiering issues
- Support Plan Review and pathway problems
- Claiming and coding
- Scope inclusions and gaps

Client access and funding delays

Delay in AT-HM approval for equipment. This can take months for some clients even if the need is urgent.

We are seeing a delay from when the clinician completes the assessment, identifying a need for AT-HM for Support at Home clients who do not have an AT-HM approval and the subsequent approval. The client is waiting for (sometimes urgent) equipment until the funding is approved. We have been advised by the Department that the AT- HM scheme has its own prioritisation framework which is not transparent to the sector. It is unclear how the waiting times relate to the prioritisation framework.

Approved funding is not sufficient to cover the required AT-HM.

We are seeing examples of AT-HM funding not being sufficient to cover the quoted amount for AT-HM.

> **Case example: When medium-tier approval does not meet high-tier need**
>
> A request was submitted to MAC for review with relevant documentation prepared and attached on the MAC portal for HM funding (including a quote value of above $4,000), however HM funding approval was for HM medium tier ($2,000) which was insufficient to cover HM cost. This resulted in an extension of wait time for HM high tier for the older person due to follow up, another assessment and the person being in a queue for HM high tier funding to be received. This caused a delay in the older person accessing the HM they needed to stay safely at home.

Ongoing Support at Home participants who have additional AT-HM pathways assigned are missing out on accessing their AT-HM funding due to a lack of visibility in the system.

When an existing Support at Home person has AT-HM added into their package mix, no one at the provider side is notified that the participant has been allocated AT-HM. The take-up date is not visible on the MAC home page. We have had circumstances when the take up date has been missed due to this lack of visibility and we have then needed to put in a Support Plan Review to request the funding be allocated again. This is inefficient and a poor outcome for the client as their access to AT-HM is delayed.

Processes relating to AT-HM only clients in a single provider model are not transparent.

There are many clients who were provided with AT-HM standalone funding at the commencement of Support at Home and were not assigned with an ongoing classification 1-8. They have started AT-HM servicing through a different provider and now those clients have an ongoing package, they would like to receive services from Silverchain. In the MAC portal their AT-HM only package has been accepted by another provider, and we cannot accept their Support at Home package under the Single Provider Model. In theory, it requires us to support the client to 'switch' their AT-HM package to our service to then be able to accept them for their ongoing package. This process causes client confusion.

The MAC team have informed us that this is something that they too weren't prepared for and cannot provide appropriate advice on how to manage these clients. If we accept the Support at Home ongoing package in

these instances, we cannot claim in the payment portal as the client has been enrolled initially with the AT-HM only provider.

A solution to this would be to have the visibility in the MAC referral process if they have enrolments in other Support at Home short term programs before completing the final acceptance of referral codes in the MAC portal.

Co-contributions are a significant barrier to an effective AT-HM scheme.

We have had a significant number of clients refuse to purchase recommended AT-HM once it is clear what their co-contribution will be. The out-of-pocket co-contribution can sometimes not be estimated until the work has been done up to the point of a prescription and quote are finalised (particularly for home modifications). AT-HM is a critical support to keep people living independently at home – yet some do not wish to spend their savings on equipment or home modifications. This then leaves the older person exposed to identified risks to their health and safety and exposes the provider to managing a client who has demonstrated their right of refusal of care/supports – and who then becomes a high-risk client for the provider (who remains accountable for their care).

Lifetime funding limits are too low to meet some people's needs and are not well understood by older people.

Funding for high tier home modifications is subject to a $15,000 lifetime cap. There is an inherent assumption that people as they age in place will reach a point when they will not need additional or different AT-HM beyond that costing $15,000. The nature of supporting someone at home as they age means that they will, in time, lose their functional abilities and require more supports to stay at home, out of hospital and out of a residential aged care facility – therefore saving the Australian community significant cost. The lifetime cap on home modifications is counterproductive to the goal of ageing in place that Support at Home is designed to achieve.

Older people are confused about the lifetime cap and assume that any contribution they make is deducted from the capped amount.

The interaction between CHSP and Support at Home AT-HM is problematic.

Clarity is needed if the Government has ceased the Home Modifications stream within CHSP and if this will continue until CHSP transitions into Support at Home (if it will at all). We have seen a significant gap in access to critical supports currently at the intersection of the CHSP and Support at Home programs.

Assessment, prioritisation and tiering issues

The IAT assessment teams do not seem to understand in sufficient detail what AT or HM a specific person needs, or the costs associated with the items.

This is problematic because the tier provided by an assessor is not always congruent with what the client needs:

- The mid-tier AT-HM is insufficient for most needs as $2,000 doesn't cover the cost of most AT and only a few rails and a couple of ramps for HM. It is not sufficient when the allied health prescription assessment needs to be claimed against the AT-HM code instead of Support at Home ongoing codes.
- The high-tier AT-HM is usually what is needed and the requirements are complex. AT-HM funding is normally used by multiple disciplines at the same time and is depleted quickly.
- While the Department has advised that assessments for AT-HM may be funded through ongoing Support at Home funding when they form part of a broader clinical assessment, this does not resolve a key funding gap. We have experienced many clients who have been assigned an AT-HM tier and an ongoing Support at Home Support Plan without being approved for allied health services (e.g. occupational therapy or physiotherapy). As a result, the assessments needed to identify and prescribe appropriate AT-HM cannot be funded through either the AT-HM budget nor the ongoing Support at Home funding stream.

The delay in allocation of AT-HM funding after approval can take months for some clients even if the need is urgent.

There is an AT and HM prioritisation system separate from the Support at Home prioritisation system that governs when AT-HM funding will be allocated even after approval is granted. Our understanding is that there are three prioritisation systems in place for funding: Support at Home ongoing; AT; and HM. We have cases of clients whom we believe should be an urgent/high priority but have been deemed 'medium', including a client showering outside in winter while he awaits his funding to be allocated for a hob removal in his bathroom.

We estimate that it takes approximately eight weeks from request to receive a Support Plan Review and then an additional eight weeks for AT-HM funding to come through. Within 16 weeks, a person's needs for AT-HM may change considerably and during this time they are exposed to a range of risks (the key one being falls) that could be prevented through the use of appropriate AT-HM.

There is no visibility over the waiting times for AT-HM funding to be allocated based on the prioritisation system.

Support Plan Review and pathway design issues

Requesting a Support Plan Review (SPR) for AT and/or HM funding requires a quote that cannot be completed without AT-HM funding in place. It is a circular requirement.

A Support Plan Review requires the Care Partner to attach both a copy of the prescription and a copy of the quote/invoice for the AT-HM. They are compulsory attachments for Services Australia despite the guidance material saying a quote 'may be needed' (indicating it may be optional).

For a Support at Home client (without unspent funds), the only assessment completed is the allied health professional's initial assessment which outlines the issues and the recommendations, however no trials of equipment or meetings with builders can be completed yet as we have to wait for the AT-HM funding to be approved. Therefore, there is no quote/s to attach. This is a Catch 22 for providers as we can't request a Support Plan Review for AT-HM until we have progressed to the commissioning stage of the AT-HM (which we cannot do until we have AT-HM funding).

Case example: No funding without a quote, no quote without funding

An occupational therapy (OT) referral was received because the person needed support for community access. The OT completed a holistic initial assessment from ongoing Support at Home funding and identified the following issues and recommendations:

- Reduced endurance due to COPD for accessing community - would benefit from a scooter or power wheelchair.
- Difficulty with shower hob transfer and has had two falls in the bathroom – would benefit from level access shower requiring a home modification to the bathroom.
- Difficulty with toilet transfer – would benefit from rail to toilet.
- Difficulty with activities of daily living – would benefit from a variety of small aids.

As the person does not have any unspent funds or AT-HM funding, the OT is unable to continue with any further trials or plans. The client has consented to all the above recommendations. Until AT-HM funding is approved and received, we are unable to progress because we will not be paid for the work entailed in progressing to get a quote for the home modifications, but without progressing, we are unable to get AT-HM funding approved.

The Care Partner submits a Support Plan Review for AT-HM funding – however there are no quotes to attach as the OT has not been able to do any trials or meet with the builder to create a scope of works for quoting as funding for the work to meet with the builder etc must come from AT-HM funding.

End-Of-Life and Restorative Care Pathway clients who should have the relevant AT-HM funding are not having relevant allied health service approvals assigned.

We have experienced significant time delay to get the AT funding during short-term pathways. Clients requiring these services almost always need to have an AT tier and this should be assigned together with approval for allied health services. Without approval for allied health services in their Support Plans, we are restricted from developing prescriptions for much of the equipment on the AT-HM List.

Claiming and coding

Claiming codes for "prescription" and "clinical services" have been combined into a single claiming code. The code is now "clinical services and prescription" which means that clinical services can only be claimed if they lead directly and imminently to a prescription.

In reality this means that a provider cannot claim for any clinical service that does not result in a prescription that can be attached to the claim. This means that all of the work undertaken by a clinician up until the point of a prescription is not funded. It is becoming clear that a key issue is a mismatch between the Department's intent and how Services Australia has designed the claiming system.

The merged claiming code creates a problem, as clinicians often provide services that do not immediately result in a prescription, and these services cannot be claimed for on their own. These activities occur every day and include in-home and showroom assessments, equipment trials, preparing documentation, and sourcing and reviewing quotes. All of this work must be claimed under the single "prescription and clinical services" code, even when no prescription is issued at that time. You cannot claim without attaching a prescription.

In practice, prescriptions are often finalised weeks later, once the client has made a decision or the supplier has provided a formal quote. However, until a prescription is completed and attached, none of the earlier clinical work can be claimed under the current system. In the context of co-contributions, we find that on some occasions, we do all the work leading up to a prescription and then the client declines the AT-HM due to their out-of-pocket cost, leading us to a situation where we cannot claim any of the allied health clinician's time up until that point.

The codes for billing for clinical services need to be separated from prescription. Not every clinical service results in a prescription that can be added to the claim. This is confusing for clients who wish to see the costs associated with wrap around services and the item itself separated on their budgets and statements.

The codes that must be used for each AT-HM (in order for us to claim) are too complex.

This issue has been raised regularly since the release of the AT-HM List. Making the decision on which code corresponds to the AT-HM can be difficult and this impacts on the time care partners spend on ordering. It takes away from Care Partner time that otherwise could be spent working directly with clients and is inefficient in the context of capped care management hours.

The claiming process for the transition phase was closed off prematurely leaving providers out of pocket for AT-HM ordered and provided in good faith.

Providers have up to 60 days post the close of the quarter to submit claims that can be paid through a client's Support at Home or AT-HM budget. When the system is working effectively, this amount of time may prove to be sufficient, however the ability to put in claims in the first quarter of Support at Home was ceased after only 60 days – despite the fact that the system overall was not working effectively.

During this time, providers have been following up on AT-HM that had been ordered or were currently in the works for clients (e.g. home modifications or individually designed and tailored motorised scooters) when the invoices from the suppliers were not received in that first 60 days despite the best efforts of the provider in follow up.

Providers now have no recourse to submit these legitimate claims through Services Australia for payment.

For Silverchain, this amounts to $250,000 in AT-HM costs for products and services that were provided in good faith to clients during this transition time. The payment for individualised and tailored AT already ordered is also problematic when a client dies prior to the delivery of the AT – the provider is required to still pay for the equipment that is then not able to be claimed for after the date of death.

High tier AT and HM requiring prescription be attached for every clinical claim regardless of amount.

It appears that the Government has assumed that high-tier will be mainly used for one or two expensive ATs. This is not the case, and clients usually need multiple items which are more than $2,000 so a high tier prescription is required for claiming each item even though they are not over the $15,000 amount.

A change this year to Services Australia claiming means that all clinician claims against the high tier AT-HM funding require a prescription to be attached. Previously only the AT-HM with prescription (according to the AT-HM List) required the prescription to be attached (we believe Services Australia removed the service code for the non-prescription claim, so all claims now require the prescription service code).

This includes trials or visits with the builder which occur prior to a prescription and the indirect time spent on progress notes for these visits; these are all low type costs. This also includes non-prescribed AT such as non-slip bathmats and small aids that are purchased using this funding tier; there is no prescription for these.

The need to reapply for funding for ongoing subscription annually is inefficient.

This is an inefficient use of funding. It is very unlikely that an older person will cease the need for a falls alarm within a 12-month period and likely will require its use for the remainder of time they live at home – to help them live at home independently and safely.

This requirement means that every 12 months, a care partner has to manage this by taking the time to reapply for a Support Plan Review (and provide all the current details request at present) and wait for the next 12 months AT-HM to be assigned. We are unable to ascertain yet if this process will result in 'gaps' in coverage for clients as we have not reached the first year of Support at Home operations.

This is complicated further by the lack of visibility in MAC of when a client's AT-HM will cease, meaning our ability to actually monitor when their AT-HM is ending for a client is problematic.

Improvements to the assessment system are needed to be able to assess and approve a new 12 months of AT-HM in a timely manner.

A cost neutral solution to this should be to allow the funding of ongoing subscriptions for AT to be funded through the ongoing classifications. This approach would reduce demand from the assessment system and expediting access to supports for older people.

As the care economy evolves to include more and more virtual-based supports and services that require subscriptions, we believe this issue will become increasingly problematic for Support at Home if it is not resolved.

Scope, exclusions and maintenance gaps

Repairs and maintenance of HM - stair lifts and bidets (most common ones) are not included.

Stair lifts, platform lifts, lifts, and bidets are all included in HM and not AT.

Repairs and maintenance of home modifications under Support at Home are excluded, including the annual maintenance of these items. Only repairs and maintenance for AT are funded.

The lifetime cap of $15,000 means that only one stair lift can ever be installed under HM. If it is not maintained and breaks, the client has no recourse to purchase another one.

For bidets, it is likely that clients will opt to buy a replacement, increasing the cost to the Government as this could have been repaired for lower cost.

The simplest solution is that maintenance for HM be claimable within the person's AT-HM budget. This is a cost neutral solution.

The lack of care management for AT-HM only clients is problematic.

Older people provided within only AT-HM and not an ongoing classification are not eligible for care management. This is particularly problematic in the AT-HM service space due to the significant work usually involved in obtaining a prescription and then quote for relevant AT-HM. The work involved then goes unfunded for these clients.

There is an assumption in the AT-HM Guide that all people with AT-HM will also have ongoing classifications and the associated planning processes in place (a service agreement and care plan) which are usually

funded through the care management funding pool. These planning processes are not, and cannot be funded through AT-HM.

There are items missing from the AT-HM List that clients need.

An exclusion list similar to what was available under Home Care Packages would support accurate claiming.

There are significant assumptions made about the ability of programs in other sectors (e.g. health) to fund items. Whilst there may be programs funded through state governments (e.g. access to CPAP), not all clients will be eligible for these programs; it is unclear if people ineligible for these programs are able to fund their items through AT-HM.

The lack of specificity in the AT-HM List for some items is problematic.

There is a range of issues that require clarification in the List:

- Multiple quotes: there remains an "urban myth" that three quotes are needed for HM and high-cost AT-HM. This is not clearly addressed in the AT-HM list as to how many quotes are required.
- Single vs. multiple provider: some delegate letters reportedly imply a second provider can be used for AT-HM. This needs clarification.
- Pricing: the guideline uses ambiguous language ("plus", "including") about whether wraparound, prescription and administration costs sit inside or outside the final agreed price.

Appendix B Services that are likely to be needed in the End-of-Life Pathway

Silverchain created the first at-home community palliative care service in 1982, and we have continued to deliver world-class palliative care in patients' homes for more than 40 years.

This experience gives us a unique perspective on the End-of-Life Pathway, which is a welcome initiative to support more Australians at home at their end of life, if that is their preference.

We recognise that the End-of-Life program isn't supposed to be a full community palliative care service, but we would expect to see at least the following on a MAC Support Plan for any person approved for the End-Of-Life Pathway:

Service Type	Services	Notes
Nursing Care	Registered nurse Enrolled nurse Nursing assistant* Nursing care consumables Oxygen Supplement	*Not all organisations would use nursing assistants for this type of client.
Allied health and other therapeutic services	Aboriginal and Torres Strait Islander health practitioner* Aboriginal and Torres Strait Islander health worker* Allied health therapy assistant Counsellor or psychotherapist Occupational therapist Physiotherapy Social worker Speech pathologist**	*For First Nations people **May require urgently if develops swallowing problems
Care management	Home support care management	
Personal care	Assistance with self-care and activities of daily living Assistance with the self-administration of medication	We have experience with clients declining the pathway due to co-contributions in the 'Independence' and 'Everyday Living' categories, and other financial pressures at end of life. This undermines the intent of the pathway.
Respite	Respite care	
Assistive technology and home modifications	Assistive technology	
Domestic assistance	General house cleaning	

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