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Workshop 2: Approach to Business Cost Out FAQs

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Frequently Asked Questions

The following table provides suggested guidance to answer questions asked during the Approaches to Business Cost Out workshops on 9 October 2025. The answers aim to provide general guidance to assist aged care providers prepare for the SaH reforms.

Question	Answer
Setting prices	
Any news on the standard pricing that needs to go on MAC? Very confused about what that is.	**Short answer:** Providers are required to publish the *most common price*. For services where pricing often varies, you can publish a representative example based on the more frequent service arrangements. **Detailed answer:** Under the new Support at Home program, providers are required to publish the *most common price* for each support service on the My Aged Care website, even if the service is typically delivered via quotes or includes a call-out fee. Providers will need to review (but not necessarily update if prices have not changed) prices every two months to align with specific reporting periods. An example of a reporting is July to August. If a provider's price within a reporting period is different to that on My Aged Care, the price must be updated within 30 days. There can be no changes to pricing without a new service agreement with the participant, and agreement must be recorded and acknowledged. How frequently a provider changes their prices depends on the organisation's business strategy. We suggest also referring to the Australian Consumer and Competition Commission for an overview of consumer rights - Home care services | ACCC Prices must be published for the services providers are delivering (or have delivered) in the last 12 months. Providers will need to review prices every two months to align with specific reporting periods. *Relevant government guidance: Support at Home – Guidance for providers on service agreements | Australian Government Department of Health, Disability and Ageing; Publishing prices for Home Care Packages | Australian Government Department of Health, Disability and Ageing*; Support at Home transition activities | Australian Government Department of Health, Disability and Ageing
Third-party providers	
Did we get some clarification regarding the 10% surcharge on 3rd person providers for our Managed Clients from the last meeting please	**Short answer:** The 10% self-management overhead cap only applies when a participant has directly sourced a third-party worker and is self-managing the service. It is capped at 10% of the actual cost of the third-party service. This needs to be included in the final price. If the participant is not self-managed, but nominates a third-party worker themselves, the overhead cap does not apply.

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Question	Answer
	Detailed answer: The self-management overhead cap may apply under the following conditions: ▪ Where a participant has directly sourced a third-party worker; and ▪ The participant is self-managing the service. Providers are able to charge an overhead to cover their costs of supporting use of the third-party worker for activities such as: ▪ oversight to ensure a third-party worker meets worker obligations under the Act (e.g., carrying out worker screening, training the worker in the provider's complaints and incident management procedures) ▪ claiming for subsidy and paying the third party. The cap is 10% of the actual cost of the third-party service. The overhead is not claimed separately by the provider. Therefore, considerations such as the self-management overhead cap and GST must be included in the final service price for the third-party worker. **The overhead cap does not apply if the provider has elected to engage a third-party to deliver services outside of self-management, and the participant is not contributing to coordinating the third-party.** **If the participant is not self-managed, but nominates a third-party worker themselves, the overhead cap does not apply.** *Relevant government guidance: *Support at Home program manual - version 4.1*
Utilisation and labour costs	
Can you give an example of how you can achieve anywhere near Front Line utilisation of >85% in home care considering I am presuming you are factoring in travel time, paid training, sick days. Its not possible.	**Short answer:** A potential benchmark utilisation rate for Direct Care Workers is generally expected to be above 85%. However, many factors may impact this benchmark. **Detailed answer:** The benchmark utilisation rate for Direct Care Workers under the Support at Home model is generally expected to be above 85%, taking into account time spent on training, travel, and other non-client-facing activities. However, this benchmark can be lower in rural and remote areas, where extended travel times and logistical challenges significantly impact the proportion of time spent delivering direct care. In these contexts, lower utilisation rates are recognised as a practical reality and should be factored into your workforce planning and pricing models. Further information can be found in Workshop 2: Approaches to Business Cost Out
For the utilisation target of greater than 85% is this based solely on direct support workers or would you include management and back of house wages in this calculation?	
What is most cost-effective, having staff, permanent or casual staffs	**Short answer:** Permanent full time, part-time, casual and agency staff all serve different benefits and operational roles. In general, a workforce with a high proportion of casual employees is expected to cost more however this depends on employee entitlements, location, type of services, client acuity, and many other factors.

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Question	Answer
	Some potential industry benchmarks to consider*: • **Permanent full time:** 17.7% • **Permanent part time:** 35.9% • **Casual / fixed term contract :30.3%** • **Indirectly employed staff (including agency, sub-contractors and independent contractors):** 12.72% **Detailed answer:** Permanent full time, part-time, casual and agency staff all serve different benefits and operational roles. This includes: • Permanent full-time or part-time staff: Suitable for workloads that are generally predictable and stable. Supports continuity of care for participants. • Casual staff: Suitable for situations where demand is variable. Can be used as surge resources as well. • Agency: suitable to provide short-term coverage as they are generally at a premium Several factors may impact this including state location (rural and remote areas), employee entitlements, type of services provided, if workforce are specialised or required for high acuity, and if organisations would like to pay above award rates. Further information can be found in Workshop 2: Approaches to Business Cost Out *Source: Aged care data snapshot—2025 - AIHW Gen
In terms of labour costs as % of revenue, are you using total labour costs or are you considering only the variable/direct labour costs?	**Short answer:** For this benchmark, labour costs only include costs associated with direct care workers. Indirect labour costs should be included in corporate costs. ▪ Labour costs % of revenue: 65%- 75% (Direct labour costs) ▪ Agency costs % of labour costs: <10% ▪ Corporate costs % of revenue: 5%-15% (including indirect labour costs) **Detailed answer:** Further information can be found in Workshop 2: Approaches to Business Cost Out
Other	
Re: allied health professionals - Do we need to roster them in our system?	**Short answer:** While the Support at Home Manual does not state any regulatory requirements to have third-party allied health professionals in system, please note that there are strengthened governance requirements under the Aged Care and Quality Act.

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Question	Answer
	Detailed answer: Within the Support at Home Manual, there are no regulatory requirements to have third-party allied health professionals in system. However, it is suggested that there is a single source of truth for all individuals providing direct care, especially under the strengthened governance requirements under the Act. These requirements include: ▪ Providers must ensure associated providers are properly registered, competent and capable of delivering safe, high-quality care. This includes conducting worker screening of the associated provider's employees. ▪ Notify the Commission about any new associated providers at registration and renewal or registration. ▪ Ensure there is a clear and current framework in place to manage subcontractor compliance, quality and risk so the Governing Body can monitor and maintain accountability. ▪ Provide ongoing monitoring and oversight while the contract is in place
RE: SAH agreement if client can't sign it, no POA in place for next of kin. How can we register client? As per SAH template supporters can't sing it. Any advice in this situation.	**Short answer:** If you are unable to have the client or their next of kin sign the agreement you should keep a record of your attempts to obtain the signature. This can include keeping a copy of the agreement you provided and making detailed notes of any discussions or efforts to arrange the signing, along with the dates these occurred. **Detailed answer:** In the event that a participant cannot sign the service agreement, providers should keep detailed records of the participant's agreement to the service agreement. Proof may include: • a copy of the service agreement document that the provider offered to the participant. • a file note of the discussion with the participant about the basis of the service agreement (including the date the discussion took place). Providers should confirm who has authorisation to enter into the service agreement on behalf of an older person based on the law in their state or territory. In some circumstances, commonwealth, state or territory arrangements may be in place for an individual to enter into a service agreement on an older person's behalf (as an active, appointed decision-maker). *Relevant government guidance: *Support at Home program manual - version 4.1*(section 7.2.2)
In relation to the slide stating care workers not being paid travel time between clients. All care workers are paid for travel time between clients, so I'm confused about that comment?? What does that mean?	**Short answer:** Providers cannot bill participants for travel time and costs using the hourly price set. Generally, costs associated with a worker travelling to a participant's home to provide services must be included in the price for that service. **Detailed answer:** Provider/worker travel costs associated with services (for example, travel by a worker to travel to a participant's home or to meet a participant at a clinic/activity) must be included in the price for that service. You can set prices for services delivered in different locations (i.e. different areas within the same city) to reflect differences in travel times by the worker.

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Question	Answer
	However, travel time is part of the list of excluded activities that cannot be claimed by the provider separately. This includes (but is not limited to) staff travel to/from a scheduled service. *Relevant government guidance:* *Support at Home program manual - version 4.1* (section 8.4). *Support at Home service list FAQs*; *Support at Home Pricing FAQ*
Probably not related to this discussion, but how are we reducing FTE for indirect staff considering IR/Fairwork rules about terminations?	Please seek independent legal advice regarding obligations under the Fair Work Act.
Just wondering if EY has gathered data on sector benchmarks that we can access? See screen shot below	The Aged Care Quality and Safety Commission has released a Sector Performance Report - Quarter 4 | April – June 2025 which provides an overview of the data used to assess performance of the aged care sector. The Department releases Quarterly Financial Snapshots which outline the performance of the aged care sector across residential aged care and home care supports.