

National Disability Insurance Scheme

Annual Pricing Review 2021-22

Report on Consultations



Delivered by the
National Disability
Insurance Agency

Copyright

© 2022

Copyright of the information contained in this document is owned and protected by the National Disability Insurance Scheme Launch Transition Agency (National Disability Insurance Agency).

Use of National Disability Insurance Agency copyright material

The material in this report, with the exception of logos, trademarks, third party material and other content as specified, is licensed under Creative Commons CC NC licence, version [4.0](#). With the exception of logos, trademarks, third party material and other content as specified, you may reproduce the material in this document, provided you acknowledge the National Disability Insurance Agency as the owner of all intellectual property rights in the reproduced material by using '© National Disability Insurance Scheme Launch Transition Agency 2021' and do not use the material for commercial purposes.

Reproduction of any Creative Commons material in this document is subject to the CC NC licence conditions available on the Creative Commons site, as is the full legal code for this material.

Table of Contents

Executive Summary	5
1 Introduction	14
1.1 Terms of Reference of the Review	14
1.2 Consultation Paper	15
1.3 Working Groups	16
1.4 Participant Reference Group.....	17
2 Core Pricing Arrangements	19
2.1 Pricing Strategy	19
2.2 Key Parameters of the Cost Model	21
2.3 Fair Work Commission’s 4 yearly review of the SCHADS Award 2010	34
2.4 Claiming Rules.....	37
2.5 Considerations by participants	42
2.6 Planning and other Issues.....	43
3 Group Based Core Supports	45
3.1 Value of Group Based Programs	45
3.2 Pros and Cons of the New and Transitional Pricing Arrangements	45
3.3 Costs of delivering group-based supports	50
3.4 Programs of Support.....	51
3.5 Capital and other costs	53
3.6 Options for change.....	54
4 Temporary Transformation Payment	58
4.1 Support for the TTP	58
4.2 Barriers to accessing and claiming the TTP	60
4.3 Future of the TTP	63
5 Quality and Safeguarding Costs	68
5.1 Provider registration and ongoing compliance audits	68
5.2 Practice standards	71
5.3 Incident and restrictive practice reporting.....	72
5.4 Training and Professional Development.....	77
5.5 Supervision.....	79

5.6	Other issues.....	81
6	Therapy Supports	83
6.1	Pricing Arrangements	83
6.2	Compliance and administration	87
6.3	Comparisons to other schemes.....	89
6.4	Planning Issues	91
6.5	Major Therapy Provider Submission	93
7	Nursing Supports.....	96
7.1	Price limits	96
7.2	Pricing Arrangements	98
7.3	Provider Travel	99
7.4	Planning Issues	99
8	Plan Management Supports	101
8.1	Disability Intermediaries Australia Submission and Survey	101
8.2	Role and Value of Plan Managers.....	104
8.3	Pricing Arrangements	104
8.4	Indexation	112
8.5	Other Issues	113
9	Support Coordination	117
9.1	Disability Intermediaries Australia Submission and Survey	117
9.2	Role and Value of Support Coordinators.....	121
9.3	Pricing Arrangements	123
9.4	Other Issues	127
10	Location Specific Issues	130
10.1	Workforce Attraction, Training and Retention.....	130
10.2	Operating costs.....	134
10.3	Other Issues	138
	Appendix A – List of Submissions	141
	Appendix B – Working Group Members.....	146

Executive Summary

This document summarises the evidence that was provided to the National Disability Insurance Agency (NDIA) through the extensive consultations with participants, providers and other stakeholders that were undertaken as part of the 2021-22 Annual Pricing Review:

- The publication of a Consultation Paper and the careful analysis of submissions received in response to the Consultation Paper.
- The establishment of 14 working groups of providers and other stakeholders, and ad hoc meetings with providers and other stakeholders.
- Consultation with the NDIA's Participant Reference Group.

A total of 254 submissions were received. Some 249 individuals from 136 organisations participated in the working groups.

Consultations were also held with other insurers and funding schemes; state and territory governments and relevant Australian Government agencies. The outcomes of those consultations are presented in the final report of the 2021-22 Annual Pricing Review.

The views expressed in this document are not necessarily those of the NDIA. They informed the analysis and the recommendations that are presented in the *Report of the 2021-22 Annual Pricing Review*, which is published separately.

Core pricing arrangements

A total of 90 submissions on this topic were received in response to the Consultation Paper. A working group of providers and other stakeholders was also established. The working group had 36 members from 28 organisations and met, by video-conference, on three occasions: 2 December 2021, 3 February 2022 and 28 February 2022.

On the overall pricing strategy, a number of providers expressed concern that by defining the efficient provider as one that is in the top quartile for all cost domains the current strategy sets too high a bar, and that only a small minority of organisations could be expected to make a profit under current parameters. Providers were also concerned that the NDIS Disability Support Worker Cost Model makes no allowance for payroll tax, which disadvantages for-profit providers.

Providers were particularly concerned about the impact on their costs of the changes to the SCHADS Award that were due to be implemented on 1 July 2022 following the Fair Work Commission's 4 yearly Review of the SCHADS Award. Particular concerns were raised with respect to the new two-hour minimum engagement period of casual staff and the new broken shift allowance provisions.

Providers appeared to be largely comfortable with the NDIA's COVID-19 responses, although there were a number of specific concerns. However, some providers argued that overheads needed to be increased to address COVID costs such as PPE and vaccinations. They suggested the NDIA should act quickly to ensure these providers are able to receive this additional funding sooner than later.

Some providers argued that the shortage of workers due to COVID-19 had reduced supervision ratios, thus making it harder to cover supervisor costs. Providers also argued that COVID-19 had increased their workers' compensation premiums as protracted periods of lockdown have resulted in higher levels of psychological injury, along with increased incidents at work including those caused from having to wear PPE. Providers also argued that the various COVID-19 border restrictions had exacerbated existing workforce shortages by impeding the free flow of labour.

The key issues raised in consultations on the current claiming rules were with respect to High Intensity Supports, Provider Travel and Short Notice Cancellations.

With respect to High Intensity Supports, stakeholders reported that the pricing arrangements for high intensity supports are confusing and difficult to administer, mainly because: the definition of high intensity used in the Pricing Arrangements and Price Limits does not align with the use of the term by the NDIS Commission; and the criteria that determine if a provider should bill for the support at Level 1, Level 2 or Level 3 are difficult to understand and explain to participants, and complex to audit.

With respect to Provider travel, stakeholders argued that it was often difficult for them to recover costs and to convince participants to allow them to do so from plan funding. They also argued that the current arrangements were often difficult to apply especially when travel costs needed to be apportioned between participants. Stakeholders also argued that the current inability to bill for return travel for disability support workers was not in line with the Award. A number of submissions also argued against the current maximum provider travel time limits, suggesting that these limits are insufficient, inflexible and create unintended consequences. For example, providers need to absorb travel costs where a worker needs a minimum of an hour to travel between locations, but the provider may only be able to claim for thirty minutes.

With respect to Short notice cancellations, stakeholders argued that the current arrangements for short notice cancellations did not align with shift cancellation conditions in the SCHADS Award and would be further out of line with the Award after 1 July 2022.

Members of the Participant Reference Group suggested that the development of a Plain English or an 'easy read' version of the Pricing Arrangements and Price Limits, and noted that this could be particularly useful for participants with intellectual disability.

The analysis and recommendations relating to the consultation on these topics can be found in Chapters 2 (Pricing Strategy), 3 (Disability Support Worker Cost Model), and 4 (General Pricing Arrangements) of the *Report of the 2021-22 Annual Pricing Review*.

Group-based Core Supports

A total of 41 submissions about the pricing arrangements for group-based core supports were received in response to the Consultation Paper. A working group of providers and other stakeholders was also established. The working group had 26 members from 20 organisations and met, by video-conference, on two occasions: 2 December 2021 and 3 February 2022.

A number of submissions argued that group programs are cost effective and provide value for money for both the NDIS and participants through spreading the cost of staffing and infrastructure across multiple individuals while also providing the required level of care and supporting participants' goals.

Stakeholders suggested that the new (post 2020) pricing arrangements enabled providers to charge more accurately for non-face-to-face time, which was considered particularly valuable for complex clients; however, they introduced new challenges for participants and their families alongside increased administrative complexity and costs for both providers and participants. A number of providers recommended that the price limits for group supports should revert to the arrangement that was in place prior to 1 July 2020, while others wanted to retain the new arrangements as they were transitioning services.

Stakeholders suggested that irrespective of the pricing arrangements, group programs require additional resources to deliver and incur greater costs to manage appropriately. Stakeholders also argued that capital and infrastructure costs associated with running group-based core supports were significantly higher than allowed for in the NDIS pricing arrangements.

Stakeholders welcomed the addition of programs of support to the pricing arrangements, and acknowledged that they have been useful to secure financial viability of group activities and helped manage cancellation risk — although there were suggestions around lengthening the length of time allowed for the programs of support.

The analysis and recommendations relating to the consultation on the Temporary Transformation Payment topics can be found in Chapter 5 (Group-based supports) of the *Report of the 2021-22 Annual Pricing Review*.

Temporary Transformation Payment (TTP)

A number of submissions reported that the TTP arrangements have supported the costs associated with the reinvestment required to transform and streamline operations.

Many submissions also argued that transformation costs were ongoing – not 'temporary'. They claim substantial investment in new software and core operating systems and other associated costs is necessary to address constant changes by the NDIA to rules and processes.

Many of the submissions detailed how providers can experience barriers to accessing and claiming the TTP, which they argued might also explain why a large proportion of eligible providers are not claiming TTP. Providers were concerned about the cost and administrative burden of applying for and claiming TTP.

Several submissions reported that the TTP can prove to be a disincentive for participants and providers, as the higher TTP price limit reduces the number of hours available in a participant's plan. This meant that TTP providers were less competitive in some markets. Some providers reported difficulties in explaining the additional cost of TTP to participants.

Some members of the Working Group considered that there might be some value in maintaining the TTP arrangements as a separate loading to the base price limit, as this would allow the NDIA to reward/incentivise investments in desired areas by modifying the eligibility criteria for the TTP.

The analysis and recommendations relating to the consultation on the Temporary Transformation Payment topics can be found in section 3 of Chapter 2 (Pricing Strategy) of the *Report of the 2021-22 Annual Pricing Review*.

Quality and Safeguarding Compliance Costs

Many submissions argued that the NDIS Quality and Safeguarding Commission (the Commission) requirements were complex and had substantially increased administrative cost and burden. They also suggested that the DSW Cost Model does not recognise the full costs associated with implementing the NDIS's quality and safeguarding requirements.

Members of the Working Group also reported significant increases in quality compliance costs in recent years. Members reported having had to set up specialised quality assurance teams to carry out the additional compliance requirements of the Commission. Members noted that Commission compliance costs were in addition to those of existing State-based bodies and professional associations.

Members of the working group considered that the NDIS DSW Cost Model did not fully capture all the costs associated with quality and safeguarding.

The analysis and recommendations relating to the consultation on Quality and Safeguarding Compliance Costs can be found in section 5 of Chapter 3 (Disability Support Worker Cost Model) of the *Report of the 2021-22 Annual Pricing Review*.

Therapy supports

A total of 122 submissions were received about the pricing arrangements for therapy supports in response to the Consultation Paper. A working group of providers and other stakeholders was also established. The working group had 61 members (from 41 organisations) and met, by video-conference, on three occasions: 3 December 2021, 4 February 2022 and 1 March 2022.

A number of submissions, and working group members, argued that the current price limits for therapy supports were too low. The principal reason advanced for an increase to the price limits was the need to pay higher wages because of a shortage of existing and future therapists. Providers also argued that there were high compliance costs associated with the NDIS Quality and Safeguards Commission and related audits, which were in many cases unnecessary given the profession-specific regulation of the Australian Health Practitioner Regulation Agency.

Consultations indicated that there was strong demand for therapy outside the NDIS, and by other public and publicly funded schemes; however, comparisons to other therapy arrangements were not straightforward and needed to be made with care, even recognising that therapists charged NDIS participants more than other patients for what sometimes appeared to be the same service.

The submissions to this topic included a major joint submission from providers that together account for about 20% of all NDIS expenditure on therapy supports. Among other things, the joint submission made the following recommendations to the NDIA:

- Reintroduce price indexation for therapy supports, with an immediate increase recommended to make up for the lack of indexation in previous years, and look to removing price limits in more mature markets in the medium term if not sooner.
- Broaden the definition of billable time to reflect the true productivity of therapy support providers, and work with the providers who made the joint submission to better understand the cost of services, and to develop a mature costing model to help identify the true cost of therapy supports.
- Provide more certainty for the future, as providers need to make decisions around services and infrastructure based on forecasts for the next 5-10 years, and give adequate notice of future changes — for example, the 2022-23 pricing framework would ideally be provided by February 2022 to align with budget and planning cycles.

The analysis and recommendations relating to the consultation on Therapy Supports can be found in Chapter 6 (Therapy Supports) of the *Report of the 2021-22 Annual Pricing Review*.

Nursing supports

A total of seven (7) submissions were received about the pricing arrangements for nursing supports in response to the Consultation Paper. A working group of providers and other stakeholders was also established. The working group had 15 members (from 13 organisations) and met, by video-conference, on two occasions: 3 December 2021 and 4 February 2022. A detailed report of the consultations is provided in Chapter 7 of the *2021-22 Annual Pricing Review Report on Consultations*.

The principal claim in submissions and by members of the working group was that the current price limits for nursing supports do not allow providers to pay nurses wages that are competitive with the public system, noting that nurses employed in the public system were often entitled to additional benefits including COVID-19 incentives, long service leave portability, six weeks of annual leave, and study support. Stakeholders argued that the above issue was becoming more and more acute under COVID-19 with providers needing to pay for personal protective equipment for their employees and offer them COVID-19 leave in order to retain them.

Stakeholders were also concerned that some of the pricing arrangements for nursing supports were aligned with SCAHDS ward, and should instead be aligned with the Nurses Award — particularly the definition of shift timings.

The analysis and recommendations relating to the consultation on Nursing Supports can be found in Chapter 7 (Nursing Supports) of the *Report of the 2021-22 Annual Pricing Review*.

Plan management supports

A total of 69 submissions about the pricing arrangements for plan management were received in response to the Consultation Paper. Disability Intermediaries Australia made a submission that included summary results of a survey of plan management providers on the costs of their services and a proposed cost model for plan managers. A working group of providers and other stakeholders was also established. The working group had 22 members from 20 organisations and met, by video-conference, on two occasions: 6 December 2021 and 7 February 2022.

The DIA submission argued for significant increases in the price limits that apply to plan management supports and for the annual indexation of those price limits. These calls were echoed in a number of other submissions to the Review. A number of submissions argued that Plan Managers undertake additional work beyond processing invoices that is not adequately factored into the current monthly fee, including providing a de facto support coordination role, educating and fielding enquiries from participants about the use of funds in their plans.

A number of submissions were concerned with the “one size fits all” nature of the price limit for the monthly fee. They stated that the current flat monthly fee was insufficient to cover the increased workload and transactions associated with larger participant plans.

Many submissions were concerned that the NDIS did not increase the price limits for plan management supports in-line with other disability supports as part of the 1 July 2021 price limit increases. They proposed that the price limits of plan management supports should always be increased in line with an index such as the Consumer Price Index.

A number of submissions acknowledged the potential efficiency benefits of the NDIA implementing the new Claims at Point of Support (CPOS) system. However, this raised concerns about the potential impact of the CPOS system and how it will affect the costs and role of Plan Managers and participants. Members of the Working Group felt that a major difficulty facing Plan Managers was that the roles of Support Coordinators and Plan Managers were blurred and poorly defined. This lack of role clarity inhibited participants from clearly understanding the differences in services between Plan Managers and Support Coordinators and the associated fees.

The analysis and recommendations relating to the consultation on Plan Management Supports can be found in Chapter 8 (Plan Management Supports) of the *Report of the 2021-22 Annual Pricing Review*.

Support coordination

A total of 88 submissions about the pricing arrangements for support coordination were received in response to the Consultation Paper. Disability Intermediaries Australia made a submission that included summary results of a survey of support coordination providers on the costs of their services and a proposed cost model for support coordinators. A working group of providers and other stakeholders was also established. The working group had 27 members from 16 organisations and met, by video-conference, on two occasions: 6 December 2021 and 7 February 2022.

A key theme through consultations was the need for a tighter definition of the role of Support Coordinators. Stakeholders identified the benefits of support coordination with greater efficiency, capacity building, and relationships and networks for participants. There was also a range of varied activities undertaken and expectations of support coordinators and stakeholders generally supported the need to establish quality and professional standards of practice to support registration and audit structures.

The DIA submission contained a detailed proposal for support coordination pricing. Other submissions noted that price limits for support coordination were not increased in-line with other disability support price limits implemented on 1 July 2021, despite increasing cost pressures. Submissions proposed price limits for support coordination to be indexed in line

with the Consumer Price Index as well as changes to superannuation, SCHADS Industry Award, and fair work increases.

Several submissions raised concerns about unregistered providers compromising the quality of supports being delivered through the NDIS by creating confusion amongst participants and skewing the market away from registered staff. Providers considered capacity building to be a crucial element to support coordination, but not adequately recognised in the current pricing arrangements. Support Coordinators were also suggested to undertake unfunded work following the death of a participant. There was a number of submissions that stated that Plan Managers, Support Coordinators, and disability support providers should be independent and that the provision of both types of services creates an opportunity for conflict of interest.

The analysis and recommendations relating to the consultation on Support Coordination can be found in Chapter 9 (Support Coordination) of the *Report of the 2021-22 Annual Pricing Review*.

Location Specific Issues

A total of 34 submissions were received on the pricing arrangements for supports delivered in regional, remote and very remote Australia in response to the Consultation Paper. A working group of providers and other stakeholders was also established. The working group had 24 members from 19 organisations. It met twice by video-conference, on 7 December 2021 and 8 February 2022. A detailed report of the consultations is provided in Chapter 10 of the *2021-22 Annual Pricing Review Report on Consultations*.

A number of stakeholders argued that the NDIS Disability Support Worker Cost Model does not sufficiently take into account of the higher costs associated with attracting and maintaining a workforce outside metropolitan areas. Submissions stated that while workforce shortages were a significant issue affecting providers nationally, these issues are more pronounced in regional and remote areas.

Working group members also argued that NDIS providers had to compete harder for staff in some parts of the country. Members flagged that providers needed to compete with local health providers who could often offer more attractive salary packages and were better able to compensate for travel and other expenses.

Submissions also stated that participants in parts of the country were disadvantaged as a result of 'thin markets, where allied health professionals and other specialists are dispersed and provide inconsistent supports'. This led to less choice of providers and difficulties with accessibility.

Regarding allied health professionals, submissions reported these costs were increasing, exacerbated by providers' inability to fully recoup travel costs. This further discouraged specialists and allied health providers locating to regional, remote areas and very remote areas.

Several submissions stated that the current arrangements provide insufficient funding to cover the additional cost of providing fly-in-fly out services in remote and very remote communities where flights, accommodation, translators and infrastructure are required.

Submissions stated that as a consequence of insufficient funding for travel and the time limit in plans, providers typically lose money delivering supports to participants in remote locations, due to the extra time spent attracting staff that are willing to travel, or subsidising travel/transport for the employee.

A number of submissions and members of working groups requested that Geraldton in Western Australia be reclassified as an “Isolated town” by the NDIS (effectively treating it as remote / MMM6).

A total of 16 submissions about the pricing arrangements for supports delivered in Queensland, South Australia or Western Australia were received in response to the Consultation Paper. Three working groups of providers and other stakeholders were also established. Each working group met twice by video-conference, on 7 December 2021 and 8 February 2022.

- The Queensland working group comprised 9 members from 8 organisations.
- The South Australia working group comprised 9 members from 8 organisations.
- The Western Australia working group comprised 17 members from 12 organisations.

With respect to Western Australia, working group members argued that the population is more transient, which results in higher costs for the organisation. A study conducted by the University of Western Australia of nine disability service providers operating in Western Australia indicated that this high turnover of staff resulted in recruitment costs increasing by 12% in 2019-20 and 28% in 2020-21. In total, direct labour costs increased by 9% in 2019-20 and a further 16% in 2020-21.

Working group members argued that competition for staff in Western Australia continues to increase, driven by the expanding mining sector. One large provider (Rocky Bay) stated that its current vacancy rate was 15%. Equally however, working group members recognised that Western Australia’s hard border and strict reopening strategy meant that there were a limited number of workforce candidates overall.

Some Western Australian providers advocated that the Cost Model should allow temporary price increases in any year where economic data warrants such.

With respect to Queensland, submissions noted that delivering training and supervision to workers in regional areas of Queensland can be logistically difficult and a costly exercise. Further, attempts to deliver training and supervision virtually or remotely to staff in regional Queensland are not effective in supporting staff and meeting their needs. For example, one working group member stated that in Mt. Isa there are no available people who want to work in disability.

Members of the South Australia working group said that WorkCover and compensation levies were more expensive in South Australia than other states. They further argued that Workcover rates of 2% and 3.9% were not appropriately reflected in the DSW Cost Model, which was set at 1.7%.

Members of the South Australian and Western Australian working groups argued that their State had the highest costs of compliance and reporting. Similarly, members of the South Australia and Queensland also argued that their State had the highest number of public holidays.

Members of all three working groups agreed on the need for greater education and awareness of participants about travel costs, and noted the current hesitancy by participants to pay for provider travel. Participants had not had to pay for provider travel under the previous block funding arrangements, and did not understand why providers were now charging for travel.

The analysis and recommendations relating to the consultation on location specific issues can be found in Chapters 10 (Regional, Remote and Very Remote Areas) and 11 (Queensland, South Australia and Western Australia) of the *Report of the 2021-22 Annual Pricing Review*. Some of the location specific issues are able to be addressed by recommendations to general price limits and arrangements, which are discussed in Chapters 2 (Pricing Strategy), 3 (Disability Support Worker Cost Model) and 4 (General Pricing Arrangements) of the *Report of the 2021-22 Annual Pricing Review*.

1 Introduction

This document summarises the evidence that was provided to the NDIA through the extensive consultations with participants, providers and other stakeholders that were undertaken as part of the 2021-22 Annual Pricing Review.

The views expressed in the document are not necessarily those of the NDIA.

The NDIA's response to the issues raised in the consultations is published separately in the *Report of the 2021-22 Annual Pricing Review*.

1.1 Terms of Reference of the Review

The Terms of Reference of the 2021-22 Annual Pricing Review were established by the NDIA Board. They required the NDIA to examine, through engagement with participants, providers and community and government stakeholders and targeted research, whether the NDIS's existing price control framework (pricing arrangements and price limits) continues to be appropriate or should be modified.

In particular, the NDIA was required to:

- Examine options to simplify, where possible, the NDIS price control framework to better support participants to exercise choice and control, and to reduce, as far as possible, the regulatory burden that the pricing arrangements impose on participants and providers.
- Review the pricing arrangements and price limits for core supports, by:
 - Examining the ongoing appropriateness of the methodology and parameters used in the *NDIS Cost Model for Disability Support Worker*, including through analysis of the most recent financial benchmarking data, paying particular regard to the outcomes of the Fair Work Commission's 4 yearly review of modern awards – *Social, Community, Home Care and Disability Services Award 2010 (AM 2018/26)*¹;
 - Identifying any unintended consequences of the new pricing arrangements for group-based community participation supports that were introduced on 1 July 2020, including the extent to which the arrangements impact on overhead costs and administrative complexity for providers and participants; and
 - Examining the extent to which the Temporary Transformation Payment arrangements have achieved their purpose and continue to provide value for money.
- Review the pricing arrangements for therapy and nursing supports, including whether the NDIS pricing arrangements are appropriately aligned with those in comparable Australian Government and state schemes, and with the private market for therapy supports, by

¹ The decision by the Fair Work Commission can be found [here](#).

- Examining the nature of the markets for therapy and nursing services, including the extent to which the markets are made up of distinct segments, including in thin and undersupplied markets and in regional and remote areas;
- Undertaking detailed benchmarking on therapy and nursing supports, including therapy assistants, against both relevant comparable Australian Government and state government schemes and the private mainstream markets; and
- Examining the extent of competition in the market for therapy services.
- Review the pricing arrangements for support coordination and plan management to encourage innovation, improve quality of service and ensure value for money.
- Review the pricing arrangements that apply to supports delivered in regional, remote and very remote areas to ensure continued access to appropriate supports for participants living in those areas.
- Examine, in line with Recommendation 2 of the 2019 WA Market Review, whether the current economic conditions in states where economic trends are often counter cyclical to the trends in other states and territories (and, in particular, in Western Australia, Queensland and South Australia) are such as to require temporary adjustments to price controls in those states in order to proactively manage any potential impacts on the supply of disability goods and services.¹

In framing its recommendations, the NDIA was required to be cognisant of the objects and principles set out in the *National Disability Insurance Scheme Act 2013*, including that the NDIS should:

- Support the independence and social and economic participation of people with disability;
- Enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports;
- Facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability;
- Promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community;
- Adopt an insurance based approach, informed by actuarial analysis, to the provision and funding of supports for people with disability; and
- Be financially sustainable.

1.2 Consultation Paper

A Consultation Paper was released on 14 October 2021 to assist stakeholders to prepare a submission to the Annual Pricing Review. Submissions were required to be lodged by Sunday, 28 November 2021, but a number of submissions were accepted after that date. In total, 254 submissions were received. They are listed in Appendix A.

¹ NDIA. (2019). *NDIS Western Australia Market Review*. Download [here](#).

Most submissions were from provider organisations (143) and individual therapists or support workers/providers (77). A small number of submissions (4) were received from participants, their representatives and participant representative organisations. The NDIA is engaging with participants on options to simplify the pricing arrangements and to empower participants as consumers through the Participant Reference Group and other channels. Submissions were also received from provider peak bodies (10), professional peak bodies (13), state and territory governments (4), and unions (3). Submissions addressed a wide variety of topics. The most responded to topics were Therapy (122), Core Pricing Arrangements (90), Support Coordination (88), and Plan Management (69).

The NDIA is grateful to all the individuals and organisations who took time to make a submission and has carefully considered all submissions.

1.3 Working Groups

Twelve (12) stakeholder working groups were also established.

- Working Group 1 (Core Pricing Arrangements) was established to assist the NDIA to examine the design and key parameters use by the NDIS Disability Support Worker Cost Model to set price limits in the NDIS; with a particular concern for the implications for the cost model and price limits of the outcomes of the Fair Work Commission's 4 yearly review of modern awards—Social, Community, Home Care and Disability Services Award 2010 (AM2018/26). This Working Group was also tasked with reviewing the general pricing arrangements (including the rules governing billing for non-face-to-face supports, travel and cancellations).
- Working Group 2 (Quality and Safeguard Costs) was established to assist the NDIA to examine the costs of registering with the NDIS Quality and Safeguards Commission and the costs associated with ensuring quality and safety of supports for people with disability are appropriately accounted for in the pricing arrangements for core and capacity building supports.
- Working Group 3 (Group Pricing Arrangements for Core Supports) was established to assist the NDIA to identify any unintended consequences of the new pricing arrangements for group-based community participation supports that were introduced on 1 July 2020, including the extent to which the arrangements impact on overhead costs and administrative complexity for providers and participants.
- Working Group 4 (Temporary Transformation Payment) was established to assist the NDIA to examine the extent to which the Temporary Transformation Payment arrangements have achieved their purpose and continue to provide value for money.
- Working Group 5 (Therapy Supports) was established to assist the NDIA to examine the extent of competition in the market for therapy supports and options to improve the effectiveness and efficiency of those supports.
- Working Group 6 (Nursing Supports) was established to assist the NDIA to examine the extent of competition in the market for nursing supports and options to improve the effectiveness and efficiency of those supports.

- Working Group 7 (Plan Management) was established to assist the NDIA to examine the costs of delivering plan management supports and the appropriate pricing arrangements for those supports.
- Working Group 8 (Support Coordination) was established to assist the NDIA to examine the costs of delivering support coordination and the appropriate pricing arrangements for those supports.
- Working Group 9 (Regional and Remote Supports) was established to assist the NDIA to examine the costs of delivering supports in regional and remote areas, and arrangements to ensure access to supports for participants living in those areas.
- Working Group 10 (Queensland) was established to assist the NDIA to examine the costs of delivering supports in Queensland relative to other states and territories.
- Working Group 11 (South Australia) was established to assist the NDIA to examine the costs of delivering supports in South Australia relative to other states and territories.
- Working Group 12 (Western Australia) was established to assist the NDIA to examine the costs of delivering supports in Western Australia relative to other states and territories.

Some 249 individuals from 136 organisations participated in the working groups (see Appendix B). The working groups each met by videoconference on several occasions between November 2021 and March 2022 (see Exhibit 1).

EXHIBIT 1: MEETINGS OF THE WORKING GROUPS

Working Group	First Meeting	Second Meeting	Third Meeting
Core Pricing Arrangements	30 Nov 2021	2 Feb 2022	28 Feb 2022
Quality and Safeguarding Costs	30 Nov 2021	2 Feb 2022	1 March 2022
Group Supports	2 Dec 2021	3 Feb 2022	
Temporary Transformation Payment	2 Dec 2021	3 Feb 2022	
Therapy Supports	3 Dec 2021	4 Feb 2022	1 March 2022
Nursing Supports	3 Dec 2021	4 Feb 2022	
Plan Management	6 Dec 2021	7 Feb 2022	
Support Coordination	6 Dec 2021	7 Feb 2022	
Regional and Remote Supports	7 Dec 2021	8 Feb 2022	
Queensland	7 Dec 2021	8 Feb 2022	
South Australia	7 Dec 2021	8 Feb 2022	
Western Australia	7 Dec 2021	8 Feb 2022	

The NDIA is grateful to all the individuals and organisations who brought their considerable experience and expertise to the Working Groups.

1.4 Participant Reference Group

The NDIA convenes a Participant Reference Group that meets on the second Wednesday of each month, and that is consulted on a range of issues relevant to the NDIA, the NDIS and participants. It is comprised of 20 members with good representation across gender, age, location, support needs and types of plan management (including members who manage plans on behalf of their children). Membership is not disclosed.

The Participant Reference Group was consulted on the *Pricing Arrangements and Price Limits* by videoconference at the 13 April 2022 meeting. 11 members attended the meeting and participated in the discussion. Their comments are included in the summary, without attribution to individual members.

The NDIA is grateful to all of the members of the Participant Reference Group who attended the meeting and contributed their valuable insights to the Annual Pricing Review.

2 Core Pricing Arrangements

This chapter reports on the consultations that were held with participants, providers and other stakeholders on the ongoing appropriateness of the methodology and parameters used in the *NDIS Cost Model for Disability Support Worker*, paying particular regard to the outcomes of the Fair Work Commission's 4 yearly review of modern awards – *Social, Community, Home Care and Disability Services Award 2010* (AM 2018/26). It also reports on the consultations that were held on the NDIS's general pricing arrangements.

A total of 90 submissions on these topics were received in response to the Consultation Paper. Details of the submissions are provided in Appendix A. A working group of providers and other stakeholders was also established. The working group had 36 members from 28 organisations and met, by video-conference, on three occasions: 2 December 2021, 3 February 2022 and 28 February 2022. Details of the members of the working group are provided in Appendix B.

The key topics raised in the consultations were:

- Pricing Strategy;
- Key Parameters of the Cost Model;
- Fair Work Commission's 4 yearly review of the SCHADS Award 2010; and
- Claiming Rules.

The analysis and recommendations relating to the consultation on these topics can be found in Chapters 2 (Pricing Strategy), 3 (Disability Support Worker Cost Model), and 4 (General Pricing Arrangements) of the *Report of the 2021-22 Annual Pricing Review*.

2.1 Pricing Strategy

A number of submissions indicated that the principal assumption of the current pricing arrangements – the use of the 25th percentile of provider performance – was inappropriate. These submissions argued that it was unreasonable to assume that the providers can achieve this efficiency level across all aspects for different client complexities and support types. The submission from Tulgeen, for example, argued that the 25th percentile approach should be reconsidered as the current approach is “*not an environment which gives any degree of comfort to participants that the services they receive can be maintained*”.¹

The submission from Empowered Futures similarly stated that:

*A model in which prices are set at the 25th percentile is blatantly not a needs-based model. The pricing is set on an assumption of the lowest price of support delivery with a stagnant view of support needs.*²

¹ Tulgeen, Submission S029, p. 4.

² Empowered Futures, Submission S065, p. 2.

A number of submissions suggested moving from the 25th percentile to an alternate benchmark, such as the median or average. The submission from Avivo recommended that the NDIA:

Do not apply '25th percentile' assumptions across all provider types. Use the model to set price caps that are viable for larger organisations supporting agency-managed customers and permanent employment.¹

The submission from Empowered Futures argued that if price limits were to continue to exist in the NDIS then they should be set according to the median or average rather than the 25th percentile of performance.² The submission from genU similarly argued that:

... the NDIA [should use] the mean or median for parameters analysed in the Benchmarking Survey to inform the Cost Model, as this is achievable by half of the providers participating in the Benchmarking Survey.³

Members of the working group also expressed concerns about the logic and impact of the pricing strategy assumption that price limits should be set at efficient prices. They argued that it was unclear how quality is taken into account in determining efficient prices. Members argued that some providers operating at lower cost levels may be doing so because they are cutting corners or reducing quality. They argued that the pricing strategy needs to address this issue in its definition of efficiency.

Some members of the working group also argued that there may not be a single efficient price for the sector because the needs of participants may be best served by a mixed model of large and smaller individualised and local providers. The price limits set by the pricing strategy should not necessarily preclude certain modes of service delivery – especially where those are known to have benefits for participant outcomes.

Members of the working group were also concerned that there were flaws in the current method of implementing the pricing strategy that price limits should be set at efficient prices. They argued that the assumption in the pricing strategy that there was no correlation between a number of the key drivers of provider efficiency means that a provider is only considered to be efficient if they operate at the 25th percentile in each of the efficiency domains. They suggested that a better approach would be to measure the efficiency of providers overall and to set the efficient price at the 25th percentile of total costs achieved rather than at the total costs of some theoretic provider who was operating at the 25th percentile of every driver of efficiency.

Members of the working group also agreed that if the annual financial benchmarking survey was to remain the basis for the parameters, then the survey should be more granular and be comprehensive (survey everyone). Providers should agree on the definitions used in the survey so that it was comparing apples-to-apples.

The submission by the Australian Services Union (ASU) argued that the NDIS price limits should reflect the true cost of disability support work (including appropriate classifications for the work performed, the intensity of support, adequate time allocated for tasks,

¹ Avivo, Submission S112, p. 3.

² Empowered Futures, Submission S065, p. 2.

³ genU, Submission S219, p. 5.

administration, supervision, training etc.).¹ The ASU submission also argued that the NDIS pricing assumptions should be aligned with minimum Award entitlements and the National Employment Standards including:

- Annual leave for shift workers of 25 days;
- Annual leave loading for shift workers of 17.5% of pay;
- Compassionate leave of 2 days; and
- Community service leave / jury duty of 10 days of paid leave.

The ASU submission also argued that allowance should be included in the NDS DSW Cost Model for 10 days paid Family and Domestic Violence Leave and for provide portable entitlements to paid annual leave, personal leave and long service leave. It also argued that the pricing arrangements should encourage permanent employment, including full-time employment; and should support training and professional development of workers.

The submission from the United Workers Union was also concerned that the NDIS's current pricing arrangements were having adverse impacts on the working conditions and effective take home pay of disability support workers.

By setting these pay rates and on costs at Award and legally required minimums not only does the cost model institutionalise low pay, but it also entrenches these conditions as the ceiling rather than the minimum as they are intended. ... Leave and leave loading are conditions of work that could be improved to attract and retain workers. Based on the current cost model and resultant price employers are constrained in being able to offer conditions above minimum.

An issue of importance to disability support workers that is not factored into the cost model at all is that of costs incurred while doing their job. This ranges from the need to have up to date smart phones or other related technology even to consideration of the type of car they have for those workers who are required to transport participants in their own car, this also extends to car related insurance and cleaning costs. Other costs may be related to paying for items on behalf of participants. ... While some of these costs may seem small, they add up and can be a significant burden for workers on low rates of pay and part time hours. Reimbursement of costs associated with work should be factored into a pricing model.²

2.2 Key Parameters of the Cost Model

Rates of Pay for Disability Support Workers

A number of submissions argued that the base pay rate assumptions in the NDIS DSW Cost Model should be higher. The submission from Tulgeen, for example, stated that the assumed SCHADS Classification for Level A DSWs should be increased:

... difference between SCHADS 2.3 (\$30.94) and SCHADS 2.4 (\$31.77) is \$0.83 or 2.6%, so given the theoretical margin assumption of 2%, every hour of support provided by a SCHADS 2.4 worker at the standard rate theoretically results in a negative margin for the provider. This is not

¹ Australian Services Union, Submission S122, p. 4.

² United Workers Union, Submission S123, pp. 7-10.

sustainable. ... This price point issue could be addressed by rating DSW Level A as a mix of SCHADS 2.3 and 2.4 award rates (50:50 would be ideal, 70:30 may be adequate).¹

Ability Options similarly argued that:

The Disability Support Worker Cost Model does not align with Ability Options actual workforce costings. The DSWC model is benchmarked against Grade 2 Year 3 of the Social Community Homecare and Disability Services Award at an equivalent benchmarked figure of \$30.94 per hour. Paradoxically, the average Ability Options hourly rate relating to service delivery (DSW actual spend) is more aligned to Grade 2 Year 4 of the Social Community Homecare and Disability Services Award, or an actual average cost of \$31.74 per hour.²

Members of the working group also pointed out that any assumption below the SCHADS 2.4 level was problematic because pay levels tended to increase annually for workers who remained with an employer until they reached the 2.4 level. Given the need to retain workers within the NDIS, both to address workforce shortages and because more experienced staff often provided higher quality support, the price limits should be based on the assumption of a mature and experienced workforce rather than of one rapidly turning over.

Members of the working group also raised a concern that the benchmarking results might be artificially low because they were included certain providers whose workforce falls under the home care stream of the SCHADS awards. Members noted that home care award rates (ranging from \$831.30 - \$1,093.70 per week) were lower than Social and Community Services award rates (ranging from \$840.10 - \$1,499.50 per week), and that many providers do not have the flexibility to pay at the home care rates.

Members also reported that some providers are locked into existing Enterprise Bargaining Agreements (EBA) and that it is always difficult to renegotiate a rate that is lower than the current rate in an EBA noting that EBAs continued in force past their notional expiry date. They also reported recent trends of providers terminating their enterprise agreements.

In any case, some members argued, notwithstanding the difference in minimum wages in the two sectors covered by the SCHADS Award, the reality was that workers were demanding that home care shifts be paid at disability sector rates and otherwise would not accept those shifts. This difference may also be moot shortly when the Fair Work Commission finalises the current Work Value Case for aged care workers.

Days Worked Versus Days Paid

Submissions also raised concerns about salary related costs including shift loadings and the costs of annual leave, personal leave and long service leave. Specifically, providers delivering SIL services reported that there is inadequate consideration given in the cost model to the costs of shift workers for SIL support.

Providers reported that the allowance of 20 days of annual leave in the Cost Model is too low for shift workers, who are entitled to have 25 days paid annual leave as per SCHADS Awards. The submission from Crosslinks Disability Support Services reported that most of it

¹ Tulgeen, Submission S029, p. 3.

² Ability Options, Submission S218, p. 29.

workforce providing SIL support is represented by shift workers, who represent 60% of Crosslinks workforce.¹

The submission from Supporting Independent Living Co-Operative reported that it calculated that the additional week of annual leave increased fully loaded cost by about 2%.² The submission from Community Living Options also reported that the Cost Model's:

... long service leave assumptions have been made based on the NSW rate for employees working 10 years is 2 months (8.67 weeks) paid leave, however in South Australia this is 13 weeks. This is a variance of approximately \$0.26 per hour of support provided.³

The submission from Beacon Support raised a number of similar issues:

Lack of allowance for increased annual leave if worker works more than 10 weekends in a year, they are entitled to an additional week of annual leave. ... Lack of allowance in price increase at 1.7.21 to allow for industry specific long service leave payments. ... There is insufficient allowance for and flexibility in responding to changes that occur in the sector, e.g., portable long service leave was introduced in January it is now October and our costs have increased by circa \$60,000 per annum with no response from the NDIS pricing system.⁴

Salary on-costs

Employee allowances

A number of submissions reported that the provision for allowances in the NDIS DSW Cost Model is insufficient. For example, the submission from Kyeema stated that:

Whilst 1% is allowed in the cost modelling, the SCHADS Award allows 1.45% which is mostly the First Aid allowance for employees.⁵

The submission from Rocky Bay stated that:

... while the Cost Model assumes an employee allowance of 1%, in accordance with SCHADS Award a weekly first aid allowance of 1.67% of the standard rate per week is paid to a full-time employee.⁶

The submission from Mercy Connect stated that:

Damaged clothing costs need to be factored into the Cost Model, with Mercy Connect estimating it can cost approximately \$14k per year, at current staffing levels i.e. approximately 270 staff.⁷

The submission from Crosslinks Disability Support Services stated that:

Employee allowances at 1.0% of base salary are insufficient to cover even one allowance which all employees must receive – the first aid allowance. The first aid allowance is a weekly allowance

¹ Crosslinks Disability Support Services, Submission S217, p. 13.

² Supporting Independent Living Co-Operative, Submission S142, p. 3.

³ Community Living Options, Submission S101, p. 2.

⁴ Beacon Support, Submission S022, p. 4.

⁵ Kyeema, Submission S226 (email).

⁶ Rocky Bay, Submission S141, p. 7.

⁷ Mercy Connect, Submission S106, p. 6.

paid at 1.67% of the standard rate per week for full-time employees and pro rata for part-time and casual employees. ...

Laundering only accounts for one element, which is \$1.49 per week or \$0.32 per shift.¹

WorkCover rate

Many submissions indicated that providers are paying higher workers compensation premiums than what is assumed in the DSW Cost Model:

- Community Living Options stated that “providers in the sector pay a rate of 2.3%”.²
- Empowered Futures stated that their “current workers compensation premium sits at 1.9% and as an organisation they are not funded adequately for the shortfall”.³
- Kyeema stated that their “Workcover is currently 1.907%”.⁴
- Mind Australia Ltd stated that their “workers compensation premium is 3.1%”.⁵

The submission from Minimbah Challenge Inc. stated that their:

*Workers’ compensation premium has more than doubled since 2017. For a small provider, a doubling of insurance premiums, without any capacity to engage in further unfunded additional training is an unacceptable position to be placed in when pricing is fixed.*⁶

Submissions provided a number of reasons for why workers compensation premiums were relatively high in the disability sector. For example, the submission from Crosslinks Disability Support Services stated that disability support services have a high worker injury rate due to risks associated with manual handling, infection control and behaviours of concerns.⁷ The submission from the Council of Regional Services stated that the risk of lost time injuries appears to be more significant and prevalent in NDIS supports.⁸

Submissions also reported that COVID-19 has also had a significant impact on Workcover. The submission from Interaction Disability Services reported that:

*The assumption that the Worker’s Compensation premium for the sector is 1.7% I would suggest is incorrect. The impact of COVID-19 and the ongoing and protracted periods of lockdown have resulted in higher levels of psychological injury within the general community. This is exacerbated within the sector as our participants have had fewer external stimuli [and] have become increasingly frustrated The increase in incidents at work, combined with the impact of having to wear PPE continually for months at a time have also increased the psychological injuries for staff. These are very debilitating and take long periods of time for recovery. As such, the cost of Worker’s Compensation premiums is escalating and this has not been recognised within the cost model.*⁹

¹ Crosslinks Disability Support Services, Submission S217, pp. 16-9.

² Community Living Options, Submission S101, p. 2.

³ Empowered Future, Submission S065, p. 5.

⁴ Kyeema, Submission S226 (email)

⁵ Mind Australia Limited, Submission S105, p. 8.

⁶ Minimbah Challenge Inc. Submission S143, p. 3.

⁷ Crosslinks Disability Support Services, Submission S217, p. 14.

⁸ Council of Regional Disability Services, S072, p. 9.

⁹ Interaction Disability Services, Submission S047, pp. 3-4.

The submission from Greenacres Disability Services reported that the rate of 1.7% didn't reflect the realities of serious risk related to COVID-19 in disability supports. It suggested that the NDIA should use the average premium for the sector reviewed annually as the basis for calculating worker compensation rather than 25th percentile. They suggested that as a result the workers compensation premium assumption in the NDIS DSW Cost Model should be adjusted upwards to 2.6%.¹ Life Without Barriers similarly suggested that the real allowance in Supported Independent Living services should be in the vicinity of 2.6%.²

The submission from Tulgeen suggested that the workers compensation calculation in the NDIS DSW Cost Model also need to be amended as providers are also required to include allowances and superannuation in the wages on which they pay workers compensation.³

Members of the working group agreed that their organisations were finding it impossible to bring down their workers compensation premium rates to the 25th percentile, despite ongoing efforts at improving efficiency. They argued that some large employers can't get below 3.2% given workers are at participant's homes. One member, who was part of an organisation that offers aged care and disability services, noted that they could not get their rate below 3.2%, despite having large improvements in claims experience and performing better than the sector in their state and nationally. They also suggested that the Cost Model should recognise that the rate varied according to the types of services offered by the provider, noting that there are greater risks in working in participant homes rather than in centres.

One member of the working group stated that the cost model should consider that some providers may be self-insured. As a self-insured organisation, they have more leeway with their premiums and claims management, which has enabled them to outperform the rest of the sector which is insured externally. Despite these efficiencies, they have been unable to bring their premiums to 1.7% and are currently around 2.3-2.4%.

Another member of the working group stated that their rates are around 4%, partly due to a large claim that has lasted a long time, but also because they ran an Australian Disability Enterprise, which includes work that does not fall into the disability services category (e.g. manufacturing, warehousing) that further drives up the premium.

One member of the working group reported that their organisation did have a premium at the 25th percentile level, but that this was due to the dilution across their other services (therapy, Supported Independent Living, support work). Another member hypothesised that providers at the 25th percentile are either smaller providers that are not experience rated, or have greater diversity in the nature of their work such that the higher workers compensation rates for disability services are being subsidised by lower rates from other parts of their business.

Members of the working group also discussed whether it may be more suitable to remove in explicit salary on cost assumption in the NDIS DSW Cost Model for workers compensation premiums, and instead include it implicitly into a higher overheads figure. They considered that this would allow providers flexibility in either paying higher workers compensation rates, or investing in better risk management practices and having lower workers compensation

¹ Greenacres Disability Services, Submission S048, p. 5.

² Life Without Barriers, Submission S227, p. 5.

³ Tulgeen, Submission S029, p. 2.

rates. A member noted that their organisation had brought down their rates from 7% to 2% but that that had increased their overheads (due to stricter recruitment, higher turnover due to fewer employees passing probation).

Another member of the working group suggested that this issue could also be overcome by relying on the gazetted rates rather than the actual rates providers were reporting – although gazetted rates can be quite different across states as benefit entitlements may vary.

Supervision costs

Classification (SCHADS Award)

A number of submissions argued that the current assumption in the NDIS DSW Cost Model that supervisors could be employed at SCHADS Awards level 3 and 4 was unrealistic. The submission from Mind Australia Limited, for example, noted that:

Mind employs SCHADS 5-6 workers to provide supervision to our staff, depending on roles being undertaken. We have found that the requisite knowledge of NDIS systems, understanding of psychosocial theory and leadership capabilities to properly support staff is not found in applicants when we recruit below this level.¹

The submission from genU stated that:

... the base salary of [Front Line Supervisors] is costed at SCHADS Level 4.2 to account for a realistic supervisor mix that supports the quality safeguards and a quality service and is achievable for half of the providers in the Benchmarking Survey.²

The submission from Greenacres Disability Services stated that:

To attract good Coordinators (supervisors) you need to pay above level 3 of the SCHADS Award. Our preferred position is Level 5 but at the very least the cost model should calculate the rate at level 4.3 for supervisors overseeing general support work. ... Supervisors should be calculated at Level 4.3 of SCHADS Award.³

Greenacres further noted that attracting good leaders is very important at a supervisory level and this can only be achieved at supervisory rates being at or above level 4.

The submission from Interaction Services stated that:

In order to provide adequate supervision with highly experienced, knowledgeable and qualified staff, the SCHADS Award levels might need to be re-visited. This is directly linked to the requirement to provide good governance and as noted previously, this comes at a cost.⁴

Providers also argued that a very high level of skills and experience was required to supervise and support staff while catering to different participants with diverse goals and support needs, as well as implementing the NDIS Commission practice requirements. The submission from Empowered Futures stated that:

¹ Mind Australia Limited, Submission S105, p. 10.

² genU, Submission S219, p. 7.

³ Greenacres Disability Services, Submission S048, p. 4.

⁴ Interaction Services, Submission S047, p. 3.

... we have found that we need to employ supervisors at level 5 of the Award. Due to the removal of complex level 3 support funding for SIL supports we find ourselves limited to 'DSW B' assumptions in the current NDIS Disability Support Worker Cost Model. These assume that supervisors are employed at an Award level 4.2. We could not attract and retain suitably qualified staff at this pay point. Hence as an organisation we are not funded adequately for the shortfall.¹

Several members of the working group agreed that while the assumed base rates of pay for disability support workers were adequate, the base rates of pay for Front Line Supervisors were not high enough. They noted that their organisations pay supervisors a rate that is much higher than the grade 3 rates assumed by the NDIS DSW Cost Model.

Span of Control

A number of submissions indicated that the assumed supervision ratio (ratio of workers per supervisor of 15 to 1) is not realistic or appropriate especially when considering the impact of the part time and casual workforce because the ratio of 1:15 FTE can translate into a supervisor being responsible for about 30 employees in terms of headcount. Submission reported that the actual ratio of supervisors to workers achieved ranges between 1:6 and 1:13. At the lower end of the spectrum, the submission from Greenacres Disability Services reported that their average ratio pre COVID-19 shut down was 1 to 6 FTE.²

For Supported Independent Living supports, the submissions from Life Without Barriers and the Council of Regional Disability Services argued that the current span of control assumption is not reflective of safe and efficient services.³

A number of submissions suggested adjusting the supervision ratio. For example, the submission from genU suggested that a span of control of 1:11 (headcount) be used in the Cost Model, as this would be achievable for half of the providers in the Financial Benchmarking Survey and would deliver efficiencies for the NDIA.⁴

The submission from Autism Spectrum similarly recommended a change to a 1:10 ratio and stated that:

The current span of control of 1:15 is untenable and there is no evidence this ratio supports service viability, quality and practice. A significant adjustment to the span of control needs to be made so services are viable.⁵

The submission from Community Living Options called for a review of the ratio assumption and stated that:

Currently CLO are providing a span of control on average of 7.5-8 FTE per supervisor. This is a variance of \$3.00 per hour of support provided. The Financial benchmarking survey shows the median span of control at 5.3 FTE indicating the assumptions in the DSWCM need to be reviewed.⁶

¹ Empowered Futures, Submission S065, p. 5.

² See: Greenacres Disability Services (S048), Mercy Connect (S106), Mind Australia Limited (S105), Rocky Bay (S141), and We are Vivid (S060).

³ See: Life Without Barriers (S227) and Council of Regional Disability Services (S072).

⁴ genU, Submission S219, p. 7.

⁵ Autism Spectrum Australia (Aspect), Submission S066, p. 2.

⁶ Community Living Options, Submission S101, p. 2.

The submission from Greenacres Disability Services argued for a 1:8 ratio:

... to enable the supervisors to have personal interaction with DSWs and both observe and guide good practice, in our view, the span of control needs to be reduced to 1 to 8 equivalent fulltime employees as a minimum.¹

The submission from Rocky Bay suggested that supervision cost:

... should be reflective of organisational size and nature rather than a one size fits all approach.²

The submission from the United Workers Union reported on the employee experience of the supervision ratio:

The cost model has an assumed supervisory ratio of 15:1. In our members experience this ratio does not provide adequate supervision. The 2020 survey of workers found that lack of supervision was a significant issue and particularly compounded health and safety concerns. Overall, only 36% of respondents agreed or strongly agreed with the statement 'I get the time I need with my supervisor', and 42% disagreed. (Source: Cortis, N. van Toorn, G. Working in new disability markets: A survey of Australia's disability workforce. University of NSW April 2020.)³

Members of the working group had similar concerns. They argued that the 1 to 15 supervision ratio may not be enough to do job properly, which leads to poor outcomes (as higher levels of management were needed to reach better participant outcomes). They were also concerned that front line supervisor roles vary significantly across organisations and aspects of supervision may sit in multiple roles. As a result, the data from the benchmarking survey may not give a true picture of span of control achievable in the sector

Members of the working group considered that it was hard / impossible for small organisations operating in regional areas with a dispersed workforce to meet the supervision ratio. The organisation may not have 15 employees, or the employees may be dispersed across a number of different sites requiring a great deal of travel by the supervisor, with less time for supervision.

Members of the working group generally agreed that supervision should be based on headcount rather than full time equivalent (FTE), since supervision levels would not be significantly lower for part-time and casual workers. However, a member noted that this creates a discrepancy with the model which is an FTE model.

Members of the working group argued that the current assumption should be reduced because of a number of factors. First, the current high turnover means higher involvement for front line supervisors in on-boarding and training, which would further require the ratio to be lower. Second, a lower ratio would mean the supervisor was spread out across fewer workers to mentor and oversee, which will lead to a better outcomes.

Members of the working group also suggested there may be a high degree of variation in the span of control between providers. They suggested that the NDIA should analyse the span of control by the different service delivery models (e.g. Supported Independent Living, Community participation, Assistance with Daily Living may have different ratios). They also

¹ Greenacres Disability Services, Submission S048, p. 4.

² Rocky Bay, Submission S141, p. 6.

³ United Workers Union, Submission S123, p. 7.

noted that span of control is also affected by the mix and complexity of the participants who are being supported.

Permanent v Casual Workers

A number of submissions expressed concern with the assumption in the NDIS DSW Cost Model that 70% of the workers are permanently employed. The submission from Empowered Futures reported that even though their preference is for most of their workforce to be permanent, the nature of the job with 24/7 shifts requires a strong casual workforce to cover unplanned leave, etc. They stated that:

We currently have 64% of our disability support workers employed on a permanent basis. The current NDIS Disability Support Worker Cost Model uses an assumption of 70%, hence as an organisation we are not funded adequately for the shortfall.¹

The submission from Kyeema reported that around 70% of their staff are casuals who work in other jobs.² The submission from Illawarra Disability Alliance also reported that the current assumption of 70:30 for permanent to casual workforce is challenging. They suggested a ratio of 50:50 would be more accurate.³

The submission from the United Workers Union submitted that the current assumption in the Cost Model is incorrect:

The National Disability Services (NDS) 2020 workforce census suggests that 62% of the entire disability workforce is permanent. ... The NDIA financial Benchmarking survey, based on responses to it found on average 43.8% of disability support workers are permanent.⁴

Utilisation rates

A number of submissions reported that the current utilisation assumptions in the NDIS DSW Cost Model don't account for time required to undertake a range of tasks necessary to provide quality supports. These include: paid training, training for complex supports, staff meetings, peer support, note taking/updating, handover, other administration, reporting and regulatory compliance, debriefing, and buddy shifts among others.

The submission from the Queensland Alliance for Mental Health stated that:

Staff recruited from the disability sector and those with generic disability qualifications (e.g., Certificate III Individual Support) require training to understand the very specific needs of people receiving psychosocial supports. It is also not uncommon to recruit staff to work in the NDIS with no formal qualifications, particularly in rural and remote regions where there is a lack of qualified applicants. The significant cost of this training is currently absorbed by service providers, but this is not a sustainable model going forward.⁵

The submission from Carers ACT stated that:

¹ Empowered Futures, Submission S065, p. 5.

² Kyeema, Submission S226 (email).

³ Illawarra Disability Alliance, Submission S104, p. 4.

⁴ United Workers Union, Submission S123, p. 8.

⁵ Queensland Alliance for Mental Health, Submission S099, p. 5.

The utilisation rate of 92%, does not even allow for a monthly staff meeting of 1 hour, essential for communication. Nor does the model allow for regular performance discussion and review, only allowing .54% for "other" activities. (0.54% of 220 days = 1.18 days or 9 hours per year). Where in the pricing model is there time permitted for the worker to report concerns about the client's wellbeing or other work-related issues.¹

The submission from Interaction Services stated that one of the reasons for inadequate utilisation rates is:

... the increased quantum of practice standards produces an increase in training, which in turn reduces availability.²

The submissions from the Council of Regional Disability Services and Rocky Bay reported that their utilisation rates are lower than the model assumptions, with Rocky Bay's utilisation rates ranging from 71% to 75%.³ The Council of Regional Disability Services also stated that their utilisation is generally impacted by the part-time nature of support work.⁴

Several members of the working group stated that the utilisation rate in their organisation was lower than the currently assumed rate of 92%. One member stated that 92% is unrealistic for their workers, given the nature of their shift work, change-overs between clients, and miscellaneous client hours they are unable to bill (e.g. chatting with their client's family after dropping them off, picking up cars, parking). They stated that the median result of 85% was the maximum that their organisation could achieve without sacrificing the quality of their services and employee retention.

A member of the working group provided examples of additional non-billable hours, including team meetings (debriefs, planning, talking with supervisor), timesheet, client note taking, incident reporting, unbilled travel time. Another member noted that certain activities (e.g. team meetings, training) are not proportionally reduced for part-time and casual workers, who would thus have a lower utilisation all else equal.

Members of the working group discussed the viability of removing the Front Line Supervisor utilisation parameter from the model and allowing for these supervision costs through other areas of the model. They noted that this area of the survey is open to the most subjective responses and different interpretations (e.g. who counts as a supervisor, especially in multi-layered organisations). Members also discussed whether, for simplicity, the supervision costs could be included as part of the overhead loading. One member noted that while they believed this was a good idea, they had concern that it may be absorbed into the overheads in a manner that makes it difficult to argue for an increase in that parameter. Another member noted an additional downside, whereby including this cost in the overhead would mean removing the span of control from the model, which currently provides valuable information on the support model of an organisation.

¹ Carers ACT, Submission S147, p. 1.

² Interaction Disability Services, Submission S047, p. 5.

³ Rocky Bay, Submission S141, p. 6.

⁴ Council of Regional Disability Services, Submission S072, p. 9.

Overheads

A number of submissions indicated that the assumption of 12% for overheads in the NDIS DSW Cost Model is insufficient and that they are currently experiencing annual overheads between 15% and 22%. Submissions also consistently argued overheads are increasing due to increased management, financial, administrative and compliance costs, such as:

- Increased governance required for regulatory compliance with the NDIS Commission for Restrictive Practices.
- Dealing with reportable incidents and emergency management strategies.
- Quality supervision required under the NDIS Practice Standards framework to ensure well governed and quality service.
- Associated costs resulting in the creation of new administrative, financial and IT processes.
- Cost pressures of operational and regional management, rostering, the cost of property and the high cost of compliance.¹

A confidential submission indicated that current corporate costs, combined with the rollout and administrative challenges of the NDIS, have led to additional staff costs and FTE. To support the statement, the submission further noted that they are:

... currently recruiting a dedicated participant funding team to manage the complexity of billing for NDIS participants at a cost of approximately \$600k per annum as well as acquiring project teams to facilitate the changes and support the business to transform to meet the changing requirements.

The submission from Mercy Connect noted that providers that support High Intensity participants have additional overhead costs, as they are required to have staff that can lodge and review incidents with the NDIS Commission.²

The submissions from Greenacres Disability Services and Illawarra Disability Alliance suggested that the provision for overheads in the DSW Cost Model should be increased from 12% to 25% to capture overhead costs accurately and fairly.³ An increase in the provision for overheads in the cost model was also supported by the submission from genU, which suggested that the NDIA:

... increases the overheads provision to the 25th percentile or 26% from the current 12%. This would assist registered providers with the cost of complying with the requirements of the Commission.⁴

Members of the working group discussed separating the overhead allowance into corporate overheads, which relate to running a standard business (including Work Health and Safety, Human Relations, etc.) and fixed operating overheads that are specific to managing a disability workforce (including quality and safeguarding costs). They suggested that 10% is a

¹ See: Autism Spectrum Australia (S066), Bedford (S145), Carers ACT (S147), Community Living Options (S101), Crosslinks Disability Support Services (S217), Illawarra Disability Alliance (S104), Minimbah Challenge Inc. (S143), We are Vivid (S060), and Wellways Australia (S222).

² Mercy Connect, Submission S106, p. 5.

³ See: Greenacres Disability Services (S048) and Illawarra Disability Alliance (S104).

⁴ genU, Submission S219, p. 12.

commonly known rate across sectors for corporate overheads. To calculate fixed operational overheads, they suggested using the Financial Benchmarking Survey's 25th percentile for the overall overhead rate (18%) less the corporate overhead (10%) plus a loading for span of control (if that is brought directly into the overheads). One member noted that this approach will provide a more elegant and transparent view of the overhead costs and help build a stronger argument to illustrate how the service-heavy disability sector will have higher overheads than other organisations.

Margin

Many submissions indicated that the margin assumption of 2% in the NDIS DSW Cost Model is insufficient. For example, the submission from genU argued that with this level of margin providers were unable to reinvest into services and supports for clients to provide better experience.¹ The Illawarra Disability Alliance similarly argued that this level of margin doesn't allow investment in strategic planning and organisational strengthening initiatives.² The submission from Tulgeen stated that the 2% margin allowance in the cost model is:

.. inadequate to ensure providers have a sustainable business (and thereby able to provide some certainty of ongoing support to participants), and is certainly insufficient to provide for future investment in facilities and equipment to improve the experience enjoyed by participants.³

The submission from Council of Regional Disability Services also argued for a higher margin.

The NDIS DSW model assumes a support margin based on 2% of delivery cost. This compares to a reported support margin in the comparable aged care market of 8% of revenue. If NDIS prices were adjusted to include a margin of 8% of revenue (rather than 2% of cost), the DSWA core price generated is \$67.42 per hour in non-SIL core and \$70.42 in SIL based core.⁴

The submission from Community Living Options similarly stated that the:

...cost margin assumed by the DSWCM is 2% based on delivery of service cost. Comparing this to the aged care market of 8% of revenue. If the NDIA considered changing the 2% margin to be based on 3% of revenue this would enable providers greater financial sustainability.⁵

Other Issues

Allowance for overtime in the model

Several submissions argued that the NDIS DSW Cost Model does not appropriately recognise the costs and prevalence of overtime in the sector. For example, the submission from Crosslinks Disability Support Services stated that:

¹ Ibid., p. 11.

² Illawarra Disability Alliance, Submission S104, p. 4.

³ Tulgeen, Submission S029, p. 4.

⁴ Council of Regional Disability Services, Submission S072, p. 8.

⁵ Community Living Options, Submission S101, p. 2.

There are no overtime assumptions built into the Disability Worker Cost Model. When factoring in the supply shortages of Disability Support Workers and the inability to cancel SIL supports, overtime or agency use is unavoidable.¹

The submission from Life Without Barriers similarly argued that:

There are insufficient allowances to manage a 24/7 workforce, including necessary usage of casual, overtime and agency arrangements.²

Members of the working group agreed that the NDIS DSW Cost Model should recognise that the payment of overtime can be the efficient solution and is often the only solution – for example, if a worker does not turn up at shift handover in a Supported Independent Living dwelling then it is necessary to pay the overnight worker overtime to continue to provide necessary support while a replacement worker is found. Members considered that the cost model should be adjusted to provide for a share of care to be delivered through overtime in its assumptions.

Payroll tax

Several submissions were concerned that there is no allowance for payroll tax in NDIS DSW Cost Model. They suggested that payroll tax was a significant business cost for many providers that accounted for in the cost model. The submission from the Council of Regional Disability Services stated that the model assumes 0% payroll tax, which is likely to be a barrier to for-profits who pay more than \$700,000 in wages. The submission from Beacon Support stated that:

Payroll tax is not based on profit, but based on number of staff. We currently have approximately 185 staff for 85 clients and have to significant payroll tax. Last year's payroll tax bill was \$438,999.26. We are a medium size business only. With a 2% profit margin as allowed by NDIA price controls, this eats significantly into the profit margin, making many non-government organisations or non-charities unviable.³

The submission from Hireup was also concerned that the cost model as many medium-sized business are subject to paying payroll taxes which reduces their profit margins.

The Cost Model does not provide for payroll tax as most jurisdictions exempt not-for-profit and smaller organisations from payroll tax.⁴ In a \$24 billion program that is the NDIS, there are now a vast array of providers and organisations offering services, and many of them will be subject to payroll tax, as Hireup is. In some jurisdictions payroll tax is an added cost of almost 7% to the wages of workers, yet it is missing from the Cost Model⁴

The Hireup submission also stated that any move to include an allowance for payroll tax in the Cost Model should be aware that there is an increasing number of support workers who are working as unregistered, ABN-contracted sole traders (using online platforms) who may not be subject to payroll tax as well. They further noted that if payroll tax is included in the

¹ Crosslinks Disability Support Services, Submission S217, p. 16.

² Life Without Barriers, Submission S227, p. 2.

³ Beacon Support, Submission S022, p. 10

⁴ Hireup, Submission S107, p. 8.

Cost Model, providers who employ their support workers would be able to cover the full cost of hiring workers and control the number of workers who may not be subject to payroll tax.

2.3 Fair Work Commission's 4 yearly review of the SCHADS Award 2010

Members of the working group discussed the potential impact of the SCHADS changes on their costs. Several members noted that providers will face difficulty in changing their business practices to minimise the impact of the SCHADS changes (e.g. there will be a higher cost for broken shifts, but providers might not be able to reduce instances of these occurring due to having already agreed on rosters of care). Members considered that significant adjustments to the NDIS DSW Cost Model were needed given the extent of the changes to the underlying employment conditions.

Broken Shifts

A number of submissions argued that the new broken shift allowance provisions that will commence on 1 July 2022 would significantly increase costs for providers. The submission from Mercy Connect estimated that the new arrangements would add an additional cost of approximately \$65k per annum to current shift rates.¹

The submission from the Disability Trust stated that:

Broken Shift Allowances must be included in the price structure. Given the breadth of the Disability Trust services, up to 15% of all DSW shifts are broken shifts.²

Some providers also indicated that the broken shift proposal will increase their administration costs, which are not captured in the cost model. This also extended to the need for travel between shifts and impact on the travel allowance provided. The submission from Rocky Bay stated that:

The FWC is proposing to cap workers to three broken shifts per day, with additional allowances payable for each subsequent shift. The changes in this broken shift allowance will increase the cost of administration to providers, however the NDIS funding model doesn't capture the administrative burden required by these changes proposed by SCHADS.³

The submission from Hireup stated that:

New broken shift allowance — broken shifts with one unpaid break will attract an allowance of 1.7% of the standard rate, equal to \$17.53 currently; and broken shifts with two unpaid breaks will attract an allowance of 2.25% of the standard rate, equal to \$25.78 currently. (Further, it will no longer be permitted for employees to work more than three broken shifts each day, even if they would choose to.)

Hireup is particularly impacted by this change due to our model providing choice and control to both clients and support workers, instead of a centralised, inflexible roster system. For example, if a worker is working with multiple clients in a day, to simply reduce the number of broken shifts would impinge significantly on the choice and control of both parties.⁴

¹ Mercy Connect, Submission S106, p. 6.

² The Disability Trust, Submission S159, p. 3.

³ Rocky Bay, Submission S141, p. 8.

⁴ Hireup, Submission S107, p. 10.

A number of submissions suggested that an allowance should be included in the NDIS DSW Cost Model for broken shifts, travel between shifts, and the administrative burden of broken shifts. The submission from genU suggested that a 9% allowance for broken shifts should be included in the new cost model:

The cost of paying the allowance for broken shifts has been calculated for worker rosters over a four-week period and extrapolated over 12 months. genU has calculated that the allowance for paying broken shifts would need to be 9%, based on an averaging of the number of breaks.¹

Two-hour minimum engagement for part-time and casual employees

A number of submissions were also concerned that the proposed changes to the SCHADS Award wherein a minimum of two hours engagement is paid for part-time as well as casual employees would significantly impact on their costs and on their ability to allow participants choice and control. The problem was that this award provision was not well aligned with the needs of participants, who often will only request half an hour or one hour of service. The new award condition would therefore have a negative impact on providers' financial performance as they would have to pay for the extra hour to the employee even if they could not find billable work elsewhere for them to do.

The submission from Hireup stated that more than one-third of their clients have booked a shift of less than two hours in the past 12 months. It stated that:

Significantly, these shorter shifts are frequently utilised on the platform, with approximately 23% of all Hireup bookings in any given week representing shifts of less than two hours in length.²

The submission from Beacon Support indicated that spacing between shifts also causes problems for employees, where an employee ends up working less hours in a day due to gap between shifts. They stated that:

Having to have a 10-hour gap between a 2-hour shift in the morning and a 2-hour shift in the evening. Why would a worker accept a 2-hour shift and then not be able to work until a 2-hour shift in the evening – this makes it more difficult to fill 2 hour shifts when they could get a full 8–10-hour day – they are limited to only working sometimes 4 hours per day because of split shift rates not being taken into consideration in the pricing, when there is not a 10-hour gap between shifts.³

The submission from genU argued that the 2-hour minimum shift requirement should be included in the cost model as an addition to the base salary of a DSW. They argued that the DSW base rate would need to increase by 5.9% to account for this provision.

genU is currently paying a 2-hour minimum engagement to direct support workers. Over the last 6 months, genU has paid an additional 5.9% of ordinary time towards additional hours, where it has not been possible to provide a minimum 2-hour engagement. Some of the reasons for this are:

- *Participants do not always agree to a 2-hour shift, as they may not require this amount of time to complete the scheduled activity and funding is needed for other necessary supports. For example, daily showering.*
- *Shifts may be rostered to follow one another to provide a 2-hour minimum, but this may not occur in practice. For example, one of the participants in a rostered engagement may cancel*

¹ genU, Submission S219, p. 13.

² Hireup, Submission S107, p. 11.

³ Beacon Support, Submission S022, p. 4.

their shift, or staff may call in sick, and the replacement staff roster may not accommodate a 2-hour engagement on short notice.

- It is not always practical to provide work in other service types to ensure 2-hour minimum shifts and, where this does happen, workers have a reduced capacity to provide support in high-volume timeslots (morning, lunch time and evening), as the additional hours can result in overtime.
- Support worker shortages can make it difficult to always roster efficiently and meet participants' reasonable needs. For example, having a shower, or getting out of bed at a reasonable time.¹

Remote response work / Recall to work overtime away from the workplace

The submission from the Disability Trust stated that:

Recall to work/Remote Work for [Supported Independent Living] pricing is essential for high needs participants, or alternatively inclusion in plan budgets via irregular funding for these specific recall instances.²

The submission from Crosslinks Disability Support Services argued that this change in award conditions would need to be reflected in the NDIS DSW Cost Model.

There is a decision out for Support Workers to have a remote response, which means they will be entitled to claim a 30-minute allowance if contacted between 6:00am and 10:00pm, and 1 hour if between 6:00am and 8:00pm. It is yet to be determined and would need to be another allowance cost built into the cost model and at the very least the 1% allowance needs to increase.³

Client cancellations

A number of submissions pointed out that there was a misalignment between the NDIS cancellation policy and the SCHADS cancellation requirements, and that this causes challenges for providers. Under the NDIS requirements, a participant who cancels an appointment more than 48 hours prior to the appointment cannot be billed for the cancellation even if the provider has not been able to find alternative billable work for the support worker. By contrast, under the new award conditions, according to submission from Rocky Bay:

If the shift is cancelled, the employee will be paid the amount they would have received had the shift not been cancelled or provide the employee with the makeup time. The customer is not required to pay for the service (in line with NDIS model, cancellations with 48 hours' notice do not require the customer to pay), however SCHADS requires that Rocky Bay would then need to find an equivalent shift for the worker or pay the worker for the shift.⁴

Members of the working group argued that the claiming rules in the NDIS for short notice cancellations should be amended to align with the new award conditions.

¹ genU, Submission S219, p. 13.

² The Disability Trust, Submission S159, p. 9.

³ Crosslinks Disability Support Services, Submission S217, p. 18.

⁴ Rocky Bay, Submission S141, p. 8.

Overtime for part-time and casual workers

The submission from At Home Care Pty Ltd indicated that clients often request their care team members to work overtime, however, there is a gap between the NDIS rates and SCHADS rate for compensating overtime for workers. It stated that:

The SCHADS award applies the following multipliers - 1.5 to Saturday rates, 2.0 to Sunday rates and 1.125 to Evening rates whereas the NDIS rates only apply the following multipliers - Saturday 1.4, Sunday 1.8 and 1.1 to Evening rates. As the need for complex care increases, the margins decrease. This is exacerbated by increased supervision needs and overtime to ensure there are no gaps in service where required.¹

The submissions from Avivo and Hireup reported that real costs of overtime penalty rates paid in line with SCHADS (which account for over 2% of the direct wages), are not included in the current model. The submission from Avivo suggested that the Financial Benchmarking Survey should be expanded to:

Secure detailed benchmarking submissions to support reasonable estimations of the costs of all aspects of the SCHADS award, including overtime, allowances, on-call, cancelled shift payments.²

2.4 Claiming Rules

Activity Based Transport

A number of submission indicated that the current claiming rules for activity based transport placed a considerable administrative burden on providers. The submission from Rocky Bay stated that:

In relation to claiming for Activity Based Transport, the current price guide uses a unit of measure of Each and a unit rate equal to \$1, rather than a unit of measure being kilometre and the unit rate being that charged per km. This means that the underlying data captured in the CMS system of kilometres cannot be used in its native state. This results in a further conversion calculation to multiply the kilometres by the unit rate to derive a value that is then used as the quantity to claim. This unnecessarily adds administrative complexity.

Perth is one of the longest metropolitan cities in terms of suburban sprawl, therefore it is important to develop an appropriate transportation and travel pricing, particularly for the provision of disability services as transportation is a key factor in providing this service.³

Provider Travel

Members of the working group were particularly concerned about the claiming rules that mean they are often not able to claim for return travel for core providers. Members also commented on the difficulty for providers to attribute travel costs on the administrative side and in particular, the need to apportion travel costs between participants. They also raised issues with the current travel limits and stated that if a worker needs a minimum of an hour to travel between locations, they should not only be covered for fifteen minutes only

¹ At Home Care Pty Ltd, Submission S054, p. 2.

² Avivo, Submission S112, p. 4.

³ Rocky Bay, Submission S141, p. 9.

A number of submissions also argued against the maximum provider travel time limits. For example, the submission from the Australian Podiatry Association suggested that these limits are insufficient, inflexible and create unintended consequences.

The submission from HelpingMinds suggested that:

... the 30 minutes travel time limit is not always possible, even in a metropolitan environment, due to traffic conditions. ... Any travel exceeding the 30 minutes is another cost that falls to the provider to cover which is not sustainable given the margins.¹

The submission from Queensland Alliance for Mental Health (QAMH) suggested that:

Providers operating in remote and very remote areas of Queensland face such financial disadvantage that there is no incentive such as travel, training, and other incentives required to attract appropriately trained staff.²

A number of submissions also suggested that the current claiming rules in relation to transport/ travel are complex resulting in administrative burden for providers. The submission from the Queensland Alliance for Mental Health stated that the:

Transport line items are reported by QAMH's members to be particularly complex and the source of most confusion. The requirement to claim separately for the non-labour costs associated with travel adds an extra layer of administrative burden and needs to be reviewed.³

The submission from the Queensland Alliance for Mental Health also suggested that:

... consideration should be given to setting price limits which accurately reflect the challenges associated with delivering services in rural and remote areas.⁴

Carers ACT stated that:

Travel/transport should be 2 items only reflecting the different rates depending on vehicle type. Participants do not differentiate between provider travel and activity based transport. They simply want to understand how much travel/transport cost they have been charged. We have been asked multiple times to simplify our billing, but the NDIS price guide makes that impossible.⁵

The submission from Down Syndrome Australia argued that the provider travel costs for Allied Health Professionals should be reduced to a more reasonable hourly rate or are factored into NDIS Plan Builds by NDIS planners to allow for adequate therapy provision.⁶

Short Notice Cancellations

The submission from We are Vivid argued that the current short notice cancellation provisions in the pricing arrangements do not support smart rostering and causes

¹ Helping Minds, Submission S085, p. 4.

² Queensland Alliance for Mental Health, Submission S099, p. 7.

³ Ibid., p. 4.

⁴ Ibid., p. 7.

⁵ Carers ACT, Submission S147, p. 2.

⁶ Down Syndrome Australia, Submission S128, p. 6.

inconsistent charging for the remaining participants as they end up paying for costs of staff not being able to be redeployed.¹

The submission from Empowered Futures reported that the ability to claim short notice cancellation is necessary as there can be participants with high and complex medical needs with unplanned hospital admissions that require funding to be drawn upon.²

The submission by Wellways Australia stated that:

While in theory we understand the need to have stringent late cancellations policies, in reality this isn't always viable when working with people with complex mental health diagnosis for multiple reasons. ... There are potentially significant flow on effects. For example, a failure by relevant staff to follow up the reasoning behind multiple cancellations by a participant, we know can often lead to people falling through the cracks and missing out on the support they need. Issues like this are caused by a lack of resources and appropriate training of staff to be considerate of the participants needs.³

A number of submissions were concerned that the current short notice cancellation arrangements can be unfair to participants as well as result in higher costs for the providers due to covering cost of staff who are rostered to work but can't be reallocated. The submission from Tulgeen stated that:

... it is unfair on other participants in a group if a non-claimable cancellation occurs, and the remaining participants in the group are required to pay the cost at a higher ratio than usual in order to cover the costs of the worker now shared between less participants.⁴

The submission from Autism Spectrum Australia stated that:

Short notice cancellation should not be applied to 1:1 participants. We recommend 2 weeks exit notice - the same as other participants attending Programs of Support.⁵

The submission from Gippsland Disability Advocacy stated that even though participants need to pay 100% of the fee if they fail to cancel before 48 hours of the appointment, the providers can cancel a participant's service without any notice, leaving participant unable to find alternatives. They suggested a need for more equality in the decision making.⁶

Non-face-to-face supports

A number of submissions were concerned that NDIS planners do not allocate non-face-to-face support in the funding plans of participants and if providers charge for such activities then, participants may be required to use funds allocated for other supports.⁷

The submission from Exercise and Sports Science Australia suggests that non-face-to-face support provided to participants generally include review of behavioural support plans (which

¹ We Are Vivid, Submission S060, p. 4.

² Empowered Futures, Submission S065, p. 8.

³ Wellways Australia, Submission S222, p. 11.

⁴ Tulgeen Submission, Submission S029, p. 6.

⁵ Autism Spectrum Australia (Aspect), Submission S066, p. 5.

⁶ Gippsland Disability Advocacy, Submission S130, p. 4.

⁷ See: Empowered Futures (S065), Beacon Support (S022), and Exercise and Sports Science Australia (S070).

can be up to 30 pages long) and supporting participants to understand NDIS and their individual plans. This additional non-face-to-face work is neither covered in the current model nor is required to be carried out in other schemes.¹

Submission by Queensland Advocacy Incorporated

Queensland Advocacy Incorporated has been assisting a participant who has complex support needs. The participant has been informed by their service provider that additional funding is required due to the complex nature of the participant's support needs and the additional hours for staff handover and meetings that are required. The NDIA has declined to provide additional funding, stating that this should already be provided for in the participant's current funding. However, the service provider has stated that the additional staff handovers and meeting hours are beyond what is ordinarily expected from support workers due to the participant's unique support needs.²

The submissions from genU, Lizard Centre and Empowered Futures all suggested that the NDIA needed to provide more guidance to providers and participants on the type of supports that can be claimed as non-face-to-face activities.³

Time and Day of Week

Members of the working group were concerned that the claiming rules did not always line up with the SCHADS Awards. Which has the potential to create anomalies and may potentially cause employers to underpay their workforce. For example, the SCHADS award indicates that when a shift finishes after 8pm, the evening rate must be paid to the worker, regardless of the length of the shift; that this can accumulate to a large amount of money. The pricing arrangements, however, are not concerned with the worker's shift but with the time that the worker delivers supports to each participant.

The submission from Bedford similarly argued that there are inconsistencies between the SCHADS award for payment arrangements to staff as compared to what can be claimed for from the NDIS which disadvantage the provide.

For example, a DSW may work an eight-hour shift on a Wednesday, 2pm to 10pm, providing Access Community Social and Rec Activities. From 2pm to 6pm they support three Participants (John, Joe and Mary) to attend a cooking class, and from 6pm to 10pm, they support another Participant (Patricia) to attend an evening computer class. Under clause 29.3(a) of SCHADS, the DSW is working an Afternoon Shift (being any shift which finishes after 8.00 pm and at or before 12 midnight Monday to Friday) therefore a loading of 12.5% of their ordinary rate of pay must be paid for the whole of such a shift. Under the NDIS Pricing Arrangements and Pricing Limits, "the important consideration is when the support is provided to the participant, not the shift of the worker used to deliver that support." For the above shift, Bedford can claim the Weekday Evening Support rate from Patricia (as it crosses over between a Weekday Daytime Support and a Weekday Evening Support, but is delivered by the same worker, therefore the higher of the relevant price limits applies to the entire support. However, for John, Joe and Mary, Bedford can only claim the Weekday Daytime Support, but must pay the worker the Afternoon Shift rate.⁴

The submission from Bedford proposed adjusting the claiming rules so that there is an:

¹ Exercise and Sports Science Australia, Submission S070, p. 7.

² Queensland Advocacy Incorporated, Submission S110, p. 3.

³ See: Empowered Futures (S065), genU (S219), and Lizard Centre (S056).

⁴ Bedford, Submission S145, p. 7.

... ability to claim a Weekday Evening Support where the support worker delivering the support is reasonably rostered to work an Afternoon Shift.¹

Night-Time Sleepover supports

Members of the working group discussed the claiming rules for sleepover supports and whether it was appropriate for a provider to bill for the expected number of active hours that a worker works for in sleepover shifts instead of the current arrangement. Some members were concerned that this approach would not cover the breadth of sleepover issues that providers deal with. Providers could trust the budgeted amount would be reasonable, but practically every provider would get the budget for the same amount and some would need it more than others. Members of the working group considered that the current arrangement is appropriate as providers are able to plan for up to two hours of active support within the sleepover shift; that it would be hard for providers to predict whether funding is enough as it would be hard to predict the number of active hours. They also reported that the transaction costs and the development of the system to track the number of active hours on a participant level would be problematic; that the current arrangement works as it is a known rate among the participant cohort and allows provider management at a participant level; and the current arrangement makes the difference between sleepover and night shifts clear.

The submission from Beacon Support was concerned about the inclusion of two hours of active supports during a sleepover shift and its impact on the health and safety of the support worker. It stated that:

if a support worker is awake for 2 hours out of 8, they only get 6 hours of sleep, assuming they are able to go back to sleep straight away. These can be a regular occurrence and fatigue of staff is a serious factor and could put the support worker and client at significant risk of harm, which could be catastrophic. This was a serious concern from a recent work health and safety audit at Beacon Support by Worksafe Qld, and needs to be addressed.²

The submission from Hireup advocated for greater participant choice and control with regards to the starting time of their chosen sleepover support. It stated that:

... the claiming rules state that a night-time sleepover support 'commences before midnight on a day and finishes after midnight on that day' — however, from a similar perspective as the paragraph above, our clients rightly point out that they should be able to be supported with a sleepover service that begins at the time of their choosing.³

The submission from Wellways Australia stated that:

Based on SCHADS Award requirements, it is expected that all active hours connected to sleepover shifts are paid at a night rate, however in reality there are charges that are paid at an afternoon rate or day rate if active hours are completed in the morning.⁴

¹ Ibid.

² Beacon Support, Submission S022, p. 9

³ Hireup, Submission S107, p. 15.

⁴ Wellways Australia, Submission S222, p. 8.

Programs of Support

A number of submissions suggested that the 12 week timeline for programs of support is restrictive and causes administrative burden. The submission from the Lizard Centre, for example, suggested increasing the timeframe for Programs of Support as many participants require much more intensive programs to support their wellbeing and enable them to participate fully in their environment. It argued that this would reduce the administrative cost associated with claiming and re-commencing the program after 12 weeks.¹

Crosslinks, which provides Supported Independent Living as a Program of Support, reported that it has to analyse every participant's SIL schedule every 10 weeks to complete the costing breakdown, meet all the decision makers, have the arrangements finalised and the program of support signed off within the 12 weeks. The submission stated that this had at least quadrupled the administrative and planning time for SIL services that has not added value to participant's direct service, goal achievement or improved value for their money.²

The submission from Kurrajong stated that more clarification on the claiming rules for Programs of Support was needed.³

2.5 Considerations by participants

Members of the Participant Reference Group demonstrated a wide range of familiarity and comfort with the *Pricing Arrangements and Price Limits*. Some members said they learned how to navigate the document, and that once they got used to it they could quickly find the information that they needed in it. Some had heard about it but found it difficult to use. One member noted that it was confusing when providers referred to specific item numbers that did not mean anything to them, and left them uncertain about what they were paying for.

Other members of the Participant Reference Group said their Plan Managers or Support Coordinators introduced them to the *Pricing Arrangements and Price Limits*, and relied on them to help navigate and interpret the document. This had mixed outcomes as members further noted that the advice from their Plan Managers or Support Coordinators appeared sometimes to contradict what was in the *Pricing Arrangements and Price Limits*.

In general, members of the Participant Reference Group indicated that the *Pricing Arrangements and Price Limits* were immensely useful to check prices quoted by providers and to check what was able to be claimed from their plans. However, it was generally felt that the document as currently drafted was very long and not user-friendly. Even members who were comfortable with the document noted that this had only come after making a big investment in learning what it contained and how to use it.

Several members of the Participant Reference Group suggested an 'easy read' version of the *Pricing Arrangements and Price Limits*, and noted this could be particularly useful for participants with intellectual disability. Some members of the Participant Reference Group also felt it would be useful if providers made their pricing information more generally

¹ Lizard Centre, Submission S056, p. 2.

² Crosslinks Disability Support Services, Submission S217, p. 7.

³ Kurrajong, Submission S094, p. 30.

available, including the prices they usually charge clients or patients who do not have NDIS plan funding.

2.6 Planning and other Issues

A number of issues were raised submissions about current planning processes. Members of the working group also indicated that participant plans (and funding for core vs capacity building) needed to be funded at level to provide appropriate support, and that funding is a “constant struggle” for providers. The following areas were particularly identified:

- A lack of funding for provider travel time in participant plans.
- A lack of funding by planners for claiming for more than one worker at a time, which may not align to the provider’s assessment for an individual’s needs.
- A lack of funding for high intensity supports.

Members of the working group emphasised the importance for quality and safety of providers being able to claim for more than one worker, especially where supports included manual lifting, and for appropriate handovers.

- A member stated that from a WorkSafe perspective, providers are required to provide enough support where necessary, regardless of the level of funding given.
- Another member reported that handovers are another example: e.g. an injunction was raised against a provider as a staff member was not given a handover time and was not made aware of a situation and could not act accordingly. However, originally 25 hours a day (with the extra hour allowed for handover time) were allowed as part of the funding model, but this was reduced to 24 hours in the plan

Members of the working group suggested that planners seem to consistently reject therapist recommendations which are built on managed risks, leading to people being funded at a lower level.

A member of the working group raised that the issue of not receiving payments for more than one worker has increased, due to Plan Managers and Support Coordinators encouraging participants that they should not be charged for the extra staff, despite this sometimes appearing in the service agreement.

A number of submissions were also concerned that the rules governing when a provider can claim for more than one support worker to effectively address clients with complex needs are not clear.¹ For example, the submission by HelpingMinds stated that:

The current arrangements for Shadow Shifts do not take into consideration the complexities of individuals who have a psychosocial disability or acknowledge a person-centred approach where participants have choice. Many participants with a psychosocial disability prefer to have a warm introduction to a new worker which can often exceed a one-hour support. Unfortunately, staff turnover can be common in this workforce, especially when supporting participants with complex needs, and participants may be introduced to several Support Workers throughout a year. The limit

¹ See: At Home Care Pty Ltd (S054), Australian Podiatry Association (S205), Autism Queensland (S144), Empowered Futures (S065), Gippsland Disability Advocacy (S130), HelpingMinds (S085), Marathon Health (S108), Minimbah Challenge Inc. (S143), The Disability Trust (S159), Tulgeen (S029), and We are Vivid (S060).

on the number of shadow shifts that a provider can claim of 6 hours a year is insufficient to meet the needs of the participants with psychosocial disabilities.

Occasions also arise through supporting individuals with complex psychosocial needs where issues of safety and risk are heightened due to periods of escalated mental health symptoms. To ensure Support Worker and participant safety, a two-person support would be the most appropriate and responsible course of action. The pricing arrangements do not include this in the list of examples of what constitutes a Shadow shift.¹

The submission from the Disability Trust suggests that:

... shadow shifts should be increased beyond 6 hours per year depending on the participant's complexity and support needs.²

The submission from At Home Pty Ltd similarly stated that:

... 6 hours per annum in funded buddy shifts is insufficient. It recommended that for high/complex needs clients this should be increased significantly to circa 24 hours based on multiple carers and levels.³

The submission from the Australian Podiatry Association noted that case conferences between podiatrists and other therapists in consultation with family/carer and/or support worker are more efficient than billing for multiple phone calls and emails. The submission suggests that the system should allow for supports to be claimed in single step process for 2:1 support provision.⁴

A member also raised a case where their Plan Manager had run out of funds for the provider, and a participant increased supports without making the provider aware, leading to a significant budget blow out. As the provider was not first in with the invoice, the loss was left with the provider. Even if the provider asked for an early plan review, that it would not cover the cost that the provider had already incurred.

¹ HelpingMinds, Submission S085, p. 4

² The Disability Trust, Submission S159, p. 4.

³ At Home Pty Ltd, Submission S054, p. 2.

⁴ Australian Podiatry Association, Submission S205, p. 6.

3 Group Based Core Supports

A total of 41 submissions about the pricing arrangements for group-based core supports were received in response to the Consultation Paper. Details of the submissions are provided in Appendix A. A working group of providers and other stakeholders was also established. The working group had 26 members from 20 organisations and met, by video-conference, on two occasions: 2 December 2021 and 3 February 2022. Details of the members of the working group are provided in Appendix B.

The key topics raised in the consultations were:

- Value of Group Based Programs;
- Pros and Cons of the New and Transitional Pricing Arrangements;
- Cost of delivering Group Based Core Supports;
- Programs of Support;
- Capital Costs; and
- Options for Change.

The analysis and recommendations relating to the consultation on the Temporary Transformation Payment topics can be found in Chapter 5 (Group-based supports) of the *Report of the 2021-22 Annual Pricing Review*.

3.1 Value of Group Based Programs

A number of submissions argued that group programs are cost effective and provide value for money for both the NDIS and participants through spreading the cost of staffing and infrastructure across multiple individuals while also providing the required level of care and supporting participants' goals. The submission from Novita, for example, stated that group programs meet a real need in the market, and provide the following benefits to participants, their families and their communities:

- Opportunities to form social connections with others.
- A sense of belonging and community.
- An opportunity to establish a daily routine out in the community.
- Access to new experiences.
- Opportunities to maintain and learn more skills.¹

3.2 Pros and Cons of the New and Transitional Pricing Arrangements

Members of the working group agreed that the group-based pricing arrangements that were put in place in 2020 had a number of theoretic benefits. They acknowledged that the new

¹ Novita, Submission S154-2 (Group Supports), p. 2.

pricing arrangements enabled providers to charge more accurately for non-face-to-face time, which is considered particularly valuable for complex clients, and to look more in depth at each type of group activity, and to determine the level of non-face-to-face support that is required to run the activity. Members of the working group also acknowledged that programs of support had the potential to drive better outcomes for people and to improve the quality of the support delivered, including through the inclusion of goal reporting as part of a program of support. They also acknowledged that the introduction of programs of support had encouraged some providers to review their supports and consider how they might develop some of these into capacity building programs. Some members of the working group also thought that the separation of the capital and labour in the pricing arrangements had allowed providers to demonstrate to participants that they needed to use a component of their income for maintaining their capital assets.

Members of the working group also acknowledged that the new pricing arrangements for group-based core supports were designed to resolve the challenge associated with the per person allowance for non-face-to-face activities. However, they suggested that in trying to solve this problem, the new pricing arrangements had created other challenges.

Some submissions also acknowledged that the pricing arrangements for group supports that were introduced on 1 July 2020 provided a more accurate link between costs and individual participants than the previous arrangements. The submission from the AEIOU Foundation, for example, stated that the introduction of the current arrangements had “resulted in a much more granular understanding of the true ‘cost to serve’ each of our clients”.¹

However, a number of submissions suggested that some important activities that providers had funded from the previous built-in allowance for non-face to face activities were difficult to claim for under the new pricing arrangements. This included program development and the purchase of the necessary equipment or specialist facilitation to enable participants to develop skills and interests in group programs (for example, washing, ironing, barista skills, etc.). The submission from Carers ACT stated that:

*With that work now needing to be attributed to individuals, providers have little capacity in the pricing to invest time and resources into program development.*²

Submissions also stated that the new (2020) pricing arrangements had introduced new challenges for participants and their families. Specifically:

- Uncertainty for participants and families, as providers are unable to provide a clear and ongoing expectation of cost for each participant due to the need to proportion rates.³
- Difficulty for participants and their families to track and budget their plans, which could lead to over-servicing in some cases, and under-servicing in others.⁴

¹ AEIOU Foundation, Submission S207, p. 3.

² Carers ACT, Submission S147, p. 4.

³ See: Job Centre Australia Limited (S102), Merri Health (S061), and Tulgeen (S029).

⁴ See: Job Centre Australia Limited (S102) and Merri Health (S061).

- Lack of choice and control if certain group programs are no longer viable under new pricing arrangements.¹

Members of the working group also reported that the costs associated with implementing the new pricing structure had very high, including:

- Developing a framework to implement the new pricing structure.
- Developing specific tools to allow site managers to apply the three different pricing points.
- Training and up-skilling service delivery staff and support workers.

Members also reported that the ongoing increased administrative burden and complexity, was on par with or outweighed the income received from the non-face-to-face component of the pricing arrangements. The increased administrative burden included:

- Having to use multiple line items in planning, developing schedules of supports, invoicing and operational calculations.
- Having to undertake new activities such as goal reporting.
- Having to spend time justifying supports to Plan Managers and Support Coordinators and disputing when invoices are not paid. Members complained that a lack of understanding of the new pricing arrangements among Plan Managers and Support Coordinators was leading to invoices being rejected and to increased debt.
- An increased risk of error in claiming and invoicing associated with using multiple line items. This in turn, creates additional administrative burden to resolve.

Members of the working group were concerned that the administrative burden associated with the new pricing arrangements was taking time that otherwise could be dedicated to providing a better service for participants. They asked for simplicity in pricing.

Several submissions from providers suggested that if the new pricing arrangements for group supports were made mandatory, this would result in the reduction in group programs available to the participants, which would in turn would place greater pressure on the rest of the NDIS and increase the risk of social isolation and disconnection among participants. The submission from Rocky Bay, for example, stated that:

... the new pricing arrangements make it difficult for service providers to profitably offer group programs due to their additional administrative complexity. This could be detrimental to participants' choice and control due to the importance of group supports for social well-being.²

Many submissions also raised concerns that moving to the new (2020) pricing arrangements for group-based supports would have a negative impact on their sustainability. Some reported they had modelled moving to the new pricing arrangements, with the modelling projecting significant deficits. A confidential submission suggested that the risks of moving to new arrangements were even higher currently due to high levels of uncertainty and disruption due to COVID restrictions and the impact on the workforce associated with

¹ See: Down Syndrome Australia (S128), Job Centre Australia Limited (S102), and Novita (S154-2 (Group Supports), p. 15).

² Rocky Bay, Submission S141, p. 11.

mandated vaccinations. Another confidential submission suggested that their net loss was projected to increase from 1.5% to 8.2% as a result of moving to the new arrangements, driven by an 11.7% reduction in revenue from the NDIS.

The submission from Life Without Barriers acknowledged that the impact on revenue can be addressed by utilising the new items for non-face-to-face supports and capital costs, however, that this would be a “time consuming and complex” process. It stated that:

COVID19 and the subsequent suspension of business-as-usual operations delayed assessment and implementation of the new group pricing arrangements. Alliance20 members' cost analyses to assess the impact of these changes indicates an estimated 11% reduction of revenue... The potential adverse revenue impact of moving from the 'old' pricing inclusive cost per hour (direct service provision, centre capital cost and non-face-to-face) to an exclusive cost per hour of direct service provision where centre capital cost and non-face-to-face need to be claimed separately. This 'headline' loss of income can only be addressed by time consuming and complex administration and claiming processes.¹

Some members of the working group also associated the new pricing arrangements with a decrease in revenue, as they found that the costs of their group-based core supports could not be recouped by the ability to charge non-face-to-face time. One member used an analogy to explain the increased complexity under the new pricing arrangements. They compared the arrangements to a hypothetical situation where the NDIS ran a bus service, and required the charges for that service be split between fuel, driver cost, assets, and overheads. It was suggested that the provider of the bus service would also be required to adjust their price depending on how many people got on the bus. It was suggested that this would not be practical in a transport market, and hence questioned why the NDIA thought it was practical in the market for group-based core supports.

Increased Overhead Costs and Administrative Complexity

A large number of submissions suggested that the introduction of the new arrangements had increased administrative complexity and costs for both providers and participants. In particular, they suggested that the requirement to claim separately for non-face-to-face supports and capital costs associated with a group program, placed an administrative burden on providers.²

Members of the working group and submissions reported that under the new pricing arrangements for group supports providers are now required to undertake additional activities such as:

- Identifying and calculating the non-face-to-face time for each participant.
- Explaining reducing participant to staff ratios when participants do not attend, non-face-to-face supports and capital allowances to participants and families, and resolving disputes when this is challenged.

¹ Life Without Barriers, Submission S227, p. 4.

² See: Ability Options (S218), Australian Community Industry Alliance (S025), Autism Spectrum Australia (S066), Bedford (S145), Carers ACT (S147), Crosslinks Disability Support Services (S217), Down Syndrome Australia (S128), Illawarra Disability Alliance (S104), Jobs Are Us (S129), Job Centre Australia Limited (S102), Kurrajong (S094), Life Without Barriers (S227), Mind Australia Limited (S105), and Novita (S154-2 (Group Supports)).

- Gathering sufficient evidence to record varying participant to staff ratios throughout a day of service, including charges for non-face-to-face supports.
- Determining whether a capital allowance is applicable or not, based on the ownership of the premises.
- Manually entering prices per participant under different staffing ratios within systems that are not designed to accommodate the new model.
- Manually checking the claim is correct across the multiple line items.
- Manually adjusting invoices to include the separate line items for direct service provision, non-face-to-face supports and capital.

The submission from Crosslinks Disability Support Services stated that:

With the proposed changes to splitting hourly rates, Crosslinks would need to charge non-face-to-face hours to cover this extra planning and preparation time. This becomes another administrative task to identify who you worked to plan for, how much time was spent on which participant. When you have one coordinator arranging these events for two to four people it is difficult to identify the non-face-to face charges.¹

The submission from Carers ACT, for example, reported that:

The implementation of the new pricing model will create a significant administration burden... Applying the new model, we now must calculate the number of workers x the hourly rate and divide it by the number of participants to establish the amount to charge. Without an item code for each ratio of staffing, we have no way to set up our system and will need to manually enter the description and rate on every invoice we raise or claim we make. This will mean our invoice processing will take many more hours²

The submission from Kurrajong similarly reported that:

The time to calculate separate non-face to face charges, centre capital costs and then supports has to increase the admin [sic] time by providers as it has tripled the products to be chosen and calculated and then in turn explained to the participants when signing service agreements.³

The submission from Community Living Australia indicated that:

The group service pricing structure components of direct and non-face-to-face support worker elements does not provide any benefit to providers (in our opinion) as the services do not operate in succinct groups of times or tasks. Support workers will perform elements of direct and non-face-to-face tasks throughout their day.⁴

Providers also suggested that this increased complexity increased the risk of claiming errors.

The submission from Rocky Bay indicated that:

The administration and potential errors from the need to calculate the fraction of an hour to charge the customer based on the ratios and any rework needed when ratios change.⁵

¹ Crosslinks Disability Support Services, Submission S217, p. 12.

² Carers ACT, Submission S147, p. 3.

³ Kurrajong, Submission S094, p. 34.

⁴ Community Living Australia, Submission S228, p. 8.

⁵ Rocky Bay, Submission S141, p. 10.

Some submissions reported that they had estimated the impact of moving to the new pricing arrangements for group supports, and concluded that this model would not cover their operating costs. A confidential submission suggested that they expected that the total corporate and program costs for running group-based programs to increase from a combined total of 18.4% to 25.5% of revenue as a result of moving from the pre-2020 pricing arrangements to the post-2020 pricing arrangements (see Exhibit 2).

EXHIBIT 2: PROVIDER ESTIMATE OF THE IMPACT OF MOVING TO THE 2020 GROUP-BASED PRICING ARRANGEMENTS

Item	Current Program Overhead	Current Corporate Overhead	Projected Program Overhead	Projected Corporate Overhead
Senior Management Costs	1.80%	1.80%	2.70%	1.80%
NDIS Quality and Accreditation	0.33%	0.99%	0.50%	0.99%
NDIS Compliance and Incident Reporting	0.34%	0.34%	0.52%	0.46%
NDIS Funding Recovery	0.68%	0.68%	1.13%	1.12%
NDIS Plan Administration	0.86%	0.42%	1.72%	0.85%
Participant and Stakeholder Liaison	0.56%	0.56%	1.69%	0.84%
Human Resources	1.34%	1.34%	1.34%	1.34%
Marketing	0.35%	1.06%	0.53%	1.06%
Finance	0.84%	2.53%	0.84%	3.80%
Other	0.78%	0.78%	1.57%	0.78%
Total	7.90%	10.52%	12.53%	13.05%
Combined Total		18.41%		25.57%

Job Centre Australia reported it had undertaken a pilot program to understand the impact of the new pricing arrangements in 2020, from which they concluded that they would not only lose income from the change, but would incur additional overhead and administration costs in both transition and ongoing administration of the revised pricing arrangements. The provider did not transition to the new pricing arrangements.¹

3.3 Costs of delivering group-based supports

A number of submissions suggested that irrespective of the pricing arrangements, group programs require additional resources to deliver and incur greater costs due to, for example:

- Time required to plan and organise group activities that can cater to each individual's needs, abilities and goals.
- Planning and active management is required to manage the interrelationships between participants during group programs.
- Activity specific risk assessments.
- Program specific mandatory training and professional development.
- Assistive technology and building modifications are required to facilitate group programs (in particular, to facilitate the delivery of personal care for participants).

¹ Job Centre Australia, Submission S102, p. 4.

- High costs of running centres and facilities, particularly where specialised equipment is required to deliver the program or activity.
- Limitations on group sizes and participant numbers due to COVID requirements.
- Liaison with participants, families, Support Coordinators and Plan Managers to explain and justify charges for group programs.¹

Members of the working group also argued strongly that the overheads associated with running a group-based program are not the same as those associated with running a non-group-based program, and that the 12% overhead allowed for in the Disability Support Worker cost model is insufficient for group based supports.

In addition to these costs, and as discussed above, submissions suggested that the new pricing arrangements for group supports will further increase service delivery costs, due to factors such as the ongoing need to explain the arrangements to participants and families; process invoices with increased granularity and complexity; ensure compliance with NDIS pricing rules; and resolve disputes and claiming errors.²

3.4 Programs of Support

A number of submissions considered that Programs of Support were a welcome addition to the pricing arrangements, and acknowledged that programs of support have been useful to secure financial viability of group activities and to manage cancellation risk.³

However, many providers suggested the 12 week timespan for Programs of Support is restrictive and causes administrative burden. They cited the additional administration required to renew and update a Program of Support every 12 weeks, as well as when participant ratios change due to client cancellations or changes to staffing (which has been particularly challenging due to isolation requirements associated with the COVID-19 pandemic), suggesting this was impractical.⁴

An example of the impact of client cancellations within a Program of Support on the costs of providers was given in the submission by Autism Spectrum Australia as follows:

The cancellations rules for claiming program of supports is based on a sound rationale. However, the complexity of reducing ratios when participants do not attend, is very challenging to explain to participants and their carers, as the costs are constantly changing, and this makes it hard to budget over the 48 weeks [of the year]. In terms of our CRM, this has required significant modification, with increased overhead costs. This additional technology cost is not accounted for in the overhead margin.⁵

¹ See: Novita (S154-2 (Group Supports)), Carers ACT (S147), Job Centre Australia (S102).

² See: Down Syndrome Australia (S128), Rocky Bay (S141), Job Centre Australia (S102), Life Without Barriers (S227), Carers ACT (S147), Flourish Australia (S121), Novita (S154-2 (Group Supports)), and Vision 2020 Australia (S234).

³ See: Community Living Australia (S228, p. 7) Novita (S154-2 (Group Supports), p. 16) and Vision 2020 (S234, p. 6).

⁴ See: Autism Spectrum Australia (S066), Bedford (S145), Crosslinks Disability Support Services (S217), Lizard Centre (S056), Novita (S154-2 (Group Supports)), Rocky Bay (S141), The Disability Trust (S159), Vision 2020 (S234), and We are Vivid (S060).

⁵ Autism Spectrum Australia (Aspect), Submission S066, p. 5.

A number of providers also reported that Programs of Support were administratively costly to implement, and that the NDIA has provided insufficient information regarding how Programs of Support can be implemented and operate practically.¹ The submission from Kurrajong reported that:

Programs of Support require more clarification in the NDIS Pricing Arrangements and Price Limits. Providers require clarity for the claiming rules, when the NDIA introduced the Employment Strategy, Providers were informed that all supports could be added together so one weekly claim could be made the same as SIL. It did not clarify that this could not be done for other Programs of Support. Providers are now being questioned around claiming Programs of Support, which is unfair when the guidance is not clear and providers are trying to comply with all claiming rules.²

The submission from Tulgeen similarly reported that:

There is insufficient information or guidance currently available on how the programs can be implemented in practice. For example, it is stated that a participant can withdraw with 2 weeks [sic] notice, but no guidance on how such withdrawal affects the pricing for the remaining participants in a group.³

Some submissions highlighted challenges for operating a Program of Support in Supported Independent Living (SIL). Specifically, the submission from Crosslinks Disability Support Services suggested that under a Program of Support, they are required to analyse participants' SIL schedules every 10 weeks, which "quadrupled the administrative and planning time for SIL services".

SIL rosters and participants arrangements [sic] change frequently, however these changes are usually minor and the cost impact is usually not material. However, program of support arrangements must be regularly tweaked to ensure transparency and accuracy in claiming as the current process stands. This results in conducting a breakdown of everyone's SIL schedules every 10 weeks to complete the costing breakdown, meet with all decision makers, have the arrangements finalised and the program of support signed off within the 12 weeks. This has at a minimum quadrupled the administrative and planning time for SIL services that in no way has added value to participant's direct service, goal achievement or improved value for their money.⁴

Other submissions suggested that Programs of Support can place funding management pressure on participants. For example, the submission from Minimbah Challenge Inc. the issues was particularly acute for participants:

... where their primary residence is a group home requiring funding support for any periods of absence, but still billable through a Program of Support, impacting participant funds availability.⁵

A number of submissions suggested that the allowable timespan for Programs of Support should be extended beyond 12 weeks. Specifically, the submission from Novita suggested that extending the period over which Programs of Support could operate would

¹ Council of Regional Disability Services, Submission S072, p. 11.

² Kurrajong, Submission S094, p. 30.

³ Tulgeen, Submission S029, p. 5.

⁴ Crosslinks Disability Support Services, Submission S217, p. 6.

⁵ Minimbah Challenge Inc., Submission S143, p. 5.

... cater for individuals who wish to secure an annual program of supports at a fixed rate and reduce administrative overheads on all parties.¹

The submission from Autism Spectrum Australia also suggested that if a participant agrees to a program of support at a set ratio, then this ratio should be charged for the duration of the service, regardless of who attends weekly.² Additionally, some submissions suggested further clarity and guidance was required relating to the claiming rules associated with Programs of Support.³

The submission from Beacon Support suggested that:

... programs of supports should be automatically built into SIL supports, whereby a provider is able to charge for a support regardless of whether the participant is there or not, even if for a maximum period of time.⁴

Members of the working group held mixed views on programs of support. Some members indicated that the new arrangements increased administrative burden and complexity, which was compounded where there is also a program of support or service agreement that is required to be reviewed regularly every 12 weeks. These members considered that, while programs of support work well for targeted capacity building needs, administrative burden is unnecessarily increased when needs and goals don't change. Members suggested that the reference to a "typical pattern of supports" for programs of support in employment services was a simpler and sensible approach, and questioned why this language had not been used for programs of support in group-based core supports.

Some members of the working group also suggested that their consultations with participants and families identified concerns about how complex it was to explain and navigate the new pricing arrangements. This issue was compounded where there were multiple parties who would need to be involved to sign off on new agreements, including carers, guardians, the Public Trustee, etc. Members who have not implemented programs of support reported that this is often due to push back from families, as well as the administrative burden associated with implementation and ensuring they remain up-to-date. Members also suggested that Plan Managers and Support Coordinators don't understand programs of support.

Members of the working group suggested that the processes associated with the programs of support could be simplified, to decouple the front end calculations and back end invoicing, and avoid the requirement to repeat administrative activities. A monthly or quarterly invoice was suggested.

3.5 Capital and other costs

Members of the working group reported that the actual capital or infrastructure costs associated with running group-based core supports were significantly higher than is currently allowed for in the pricing arrangements. In particular, they suggested that the current

¹ Novita, Submission S154-2 (Group Supports), p. 16.

² Autism Spectrum Australia (Aspect), Submission S066, p. 5.

³ See: Kurrajong (S094), The Disability Trust (S159), and Tulgeen (S029, p.5).

⁴ Beacon Supports, Submission S022, p. 8

allowance for capital costs does not compensate for the shifts within the property market that economy has experienced in recent years. One provider estimated infrastructure costs of between 12-15% of total revenue.

Members felt that while the previous arrangements allowed providers to cover infrastructure costs the new pricing arrangements do not.

3.6 Options for change

To reduce the complexity associated with the pricing arrangements for group supports, a number of providers recommended that the price limits for group supports should revert to the arrangement which was in place prior to 1 July 2020, with these price limits used by providers and participants that desire a packaged hourly fee that covers all costs of service delivery.¹ The submission from Crosslinks Disability Support Services suggested that:

... the current group rates, which are slightly higher than the current 1:1 rates, remain in place as this covers those transactional costs in a simpler way and reduces the need to charge non-face-to-face time which enhances transactional costs.²

The submission from the Illawarra Disability Alliance proposed the introduction of group-based hourly rates, including a 10% loading for each additional participant in the group ratios 1:2, 1:3 and 1:4 which would allow a standard amount to be allocated within the hourly rate to minimise additional transactions and record keeping requirements, reducing overheads for providers, and ensuring the sustainability of group activity delivery.³

The submission from Kurrajong suggested that:

... allowing for fewer line items to be used across multiple categories and then going back to set ratio line items will reduce the amount of confusion for both Participants and Providers would simplify everything.⁴

The submission from Bedford suggested that:

Non-Face-to-Face supports require clearer guidance/communication on how these support costs can be claimed. Since the split of non-face-to-face supports into a separate support line item has meant that providers are constantly having to justify the claiming of these supports. Clearer case studies for usage would be beneficial to providers and could be used as set examples to Participants.⁵

Conversely, other submissions, including the submission from genU, suggested that given the cost of transition they had already incurred, and satisfaction among participants, the new (2020) pricing arrangements for group supports should be retained.⁶

¹ See: Down Syndrome (S128), Flourish Australia (S121), Novita (S154-2 (Group Supports)), and Vision Australia (S109).

² Crosslinks Disability Support Services, Submission S217, p. 12.

³ Illawarra Disability Alliance, Submission S104, p. 5.

⁴ Kurrajong, Submission S094, p. 35.

⁵ Bedford, Submission S145, p. 7.

⁶ genU, Submission S219, p. 15.

The submission from Novita suggested that if the transitional arrangements for group-based supports were not continued then expanding the timespan for Programs of Support to beyond 12 weeks could be a mechanism to:

... cater for individuals who wish to secure an annual program of supports at a fixed rate and reduce administrative overheads on all parties.¹

Submissions also reported that the move to the 2020 group-based pricing arrangements had required providers to incur costs in redesigning or modifying their claiming, invoicing and/or customer relationship management systems to accommodate the additional complexity.² This had often required the involvement of external software developers. The submission from Vision Australia estimated a cost of \$27,600 associated with the systems development needed to implement the new (2020) pricing arrangements. This was broken down across scoping of requirements and solution design, building and testing the solution, and preliminary change management. They stated that:

...the systems development costs required to introduce this change have been substantial and have involved both internal and external effort from Vision Australia and the software developers of our invoicing platform... It should be noted that the above data does not account for the opportunity cost of doing other important work that was planned.³

Submissions were concerned that further development costs might be required if the NDIA was to again significantly alter the group-based pricing arrangements. They also reported that providers had been provided insufficient support and notice to transition.⁴

The submission from Novita suggested that the new arrangements were:

... announced without notice and consultation and caused significant upset in the disability sector and undermined future confidence.⁵

Submissions also highlighted a lack of education and training associated with the transition to the new pricing arrangements. The submission from Job Centre Australia Limited stated:

... since the development of new pricing arrangements for group-based community participation supports, introduced on 1 July 2020, there has been no training supplied by the NDIA to Providers, Participants, Co-ordinators of Support or Plan Managers.⁶

Additionally, submissions suggested that the information that is provided by the NDIA often lacks the level of detail required to adequately plan for implementation, with most information about changes being at too high a level and lacking the required detail for implementation.

The submission from Bedford reported:

Confusion from participants and lack of consultation and communication from the NDIS has resulted in some participants rejecting the costing framework (i.e. non-face-to-face supports

¹ Novita, Submission S154 (Group Supports), p. 16.

² See: Autism Spectrum Australia (S066), Carers ACT (S147), Job Centre Australia Limited (S102), Novita (S154-2 (Group Supports)), and Vision Australia (S109).

³ Vision Australia, Submission S109, p. 6.

⁴ See: genU (S219), Kurrajong (S094), Novita (S154-2 (Group Supports)).

⁵ Novita, Submission S154-2 (Group Supports), p. 4.

⁶ Job Centre Australia Limited, Submission S102, p. 5.

identified as a separate item). Bedford liaised closely with the NDIS on these changes when proposed and highlighted the critical importance of this being communicated by the NDIS so participants understood this was an NDIS decision, not a provider decision. That this was not done has created issues and an additional administrative burden for providers.¹

The submission from genU similarly reported:

Poor / non-existent communication from the NDIA to participants, informing them of the change. This was left to providers to communicate the reasons for the change. This again, was an additional cost absorbed by providers. genU spent many months providing forums, workshops and individual communication for participants and their families so changes could be understood.

The guidance provided by the NDIS to providers was vague and the time taken to transition to the new model was longer than anticipated. Fortunately, the NDIS recognised this and shifted the date of transition out to 2022.²

The submission from Novita suggested that to provide certainty for participants, providers and future investment, the NDIA should commit to a long-term pricing framework. They stated that:

... commitment to a long-term road map for group based pricing and supports would give participants and providers clarity about the long term environment and if pricing is adequate, the confidence to invest will significantly increase.³

Members of the working group also called for more certainty in the pricing arrangements.

We require a pricing framework that allows them sign longer term leases (i.e., 7 to 10 years) with some certainty. Providers seek a long-term roadmap indicating what the pricing landscape will look like over the next few years, to provide a degree of certainty to invest without the risk that the pricing arrangements will change again.

Members of the working group also requested that there should continue to be multiple options for how group-based programs are charged, and that providers should be able to choose which approach to adopt. Under the current price guide, once providers have transitioned to the new pricing arrangements for group-based core supports, they are not able to move back. It was argued that for providers to have a choice in which approach they adopt, this provision would need to be removed. Members felt that some providers would prefer to continue operating group-based core supports under the previous arrangements, while many of those who had invested capital to transition to the new arrangements would not want to move back.

They also expressed a desire for the NDIA to acknowledge daily support providers, group support providers and other support workers as experts in their field, and for increased trust in the sector.

Members of the working group also identified a number of challenges associated with interactions with Plan Managers and Support Coordinators. Members expressed concern that they no longer have visibility of what is in a participant's plan, and this has led to debts where providers are not informed that funding has been exhausted. Members also indicated that there is a perception that Plan Managers and Support Coordinators are "policing" the

¹ Bedford, Submission S145, p. 9.

² genU, Submission S219, p. 15.

³ Novita, Submission S154-2 (Group Supports), p. 16.

NDIS, and often insist on detailed itemised accounts and justifications which increase administrative burden for providers. It was acknowledged that Plan Managers need to consider what is reasonable and necessary, including scheme sustainability and value for money. However, some providers are concerned with what they describe as “systemic underfunding” – that is, where the expertise of support workers is unduly challenged and the supports they recommend are denied.

It was suggested that there is a tendency for Plan Managers to shift participants from complex to standard funding arrangements, or to non-centre based funding arrangements, when this is not what that participant either chooses or requires.

Members of the working group argued this was evidence of a need for increased education/guidance for planners, participants and Plan Managers. Members suggested that education in the space of non-face-to-face supports was lacking – both among Plan Managers and Support Coordinators, as well as participants and carers. Some members suggested a guide from the NDIA covering what non-face-to-face supports can be charged for would be beneficial.

4 Temporary Transformation Payment

A total of 35 submissions about the Temporary Transformation Payment were received in response to the Consultation Paper. Details of the Submissions are in Appendix A. A working group of providers and other stakeholders was also established to examine the extent to which the TTP arrangements have achieved their purpose and continue to provide value for money. The working group had 18 members from 17 organisations and met, by video-conference, on two occasions: 2 December 2021 and 3 February 2022. Details of the members of the working group are provided in Appendix B.

The key themes that arose in the consultations were:

- Support for the TTP;
- Barriers to accessing and claiming the TTP; and
- Future of the TTP.

The analysis and recommendations relating to the consultation on the Temporary Transformation Payment topics can be found in section 3 of Chapter 2 (Pricing Strategy) of the *Report of the 2021-22 Annual Pricing Review*.

4.1 Support for the TTP

A number of submissions reported that the TTP arrangements have supported the costs associated with the reinvestment required to transform and streamline operations. The submission from Life Without Barriers stated that the TTP supports providers to implement transformative initiatives to their operations and noted that Alliance20 members are utilising the TTP funds to continue with projects including: claiming to align with NDIA requirements; the development of systems to track non face-to-face supports for claiming; and the review of business processes to align with the efficient price model.¹

The submission from We Are Vivid stated that:

The TTP has allowed some additional funds to implement systems and processes to streamline operations/increase efficiencies.²

The submission from Minimbah Challenge Inc. similarly stated that:

The additional revenue generated through the TTP has enabled Minimbah to financially cope with the changes that we are continually undertaking with the majority of expenditure of redeveloped CRM and quality solutions to be undertaken in 2022-23, particularly with the changeover to [non-face-to-face] data capture, recording and billing.³

A number of submissions also argued that transformation costs were ongoing. The submission from Beacon Support indicated that substantial investment in new software and

¹ Alliance20, Submission S238, pp. 5-6.

² We Are Vivid, Submission S060, p. 5.

³ Minimbah Challenge Inc., Submission S143, p. 1.

core operating systems is necessary and ongoing to ensure the long-term viability of their business, particularly to address constant changes by the NDIA to rules and processes.¹

The submission from the Disability Trust was also concerned about the implications for their system costs of changes to Agency rules and process.

There is recognition that our overhead structures must reduce in order to compete, however beyond the TTP up-lift there has not been adequate stability in the NDIA's operating and pricing guidelines to design processes and build and configure systems. It is difficult to just transact in the first place and we continually find ourselves reacting to shifts in NDIA processes.²

The submission from Avivo also indicated that they believed transformation costs were ongoing, not temporary or related to a limited transformation period, and that those that are reduced over time tended to be offset with higher costs in other areas (e.g., quality and safeguarding, technology license and cloud storage costs, cyber security, recruitment, and retention, etc.).

...to meet quality and safeguarding requirements, Avivo has established a Practice Support team which includes Positive Behaviour Support Specialists who are supervised by an external Clinical Psychologist. We have invested in training colleagues to provide this service, as well as in developing our guidelines and materials around positive behaviour support and restrictive practices. Any revenue we may ultimately claim in this area will be immaterial compared to the cost. We also now incur the \$145 per person cost of worker screening (on top of national police clearance, still required by aged care and mental health funders) and pay employees to complete the NDIS orientation module.³

The submission from Crosslinks Disability Support Services raised similar issues.

... the NDIA has changed the rules and processes providers are subject to throughout this period in such significant ways and with very little notice. For example, program of support, SIL hourly claiming and rate cuts, separation and rules around provider travel and participant transport, group rate changes and cancellation changes.

This requires significant IT system changes and resources to manage these ongoing rule changes. Crosslinks does not believe the loading has yet achieved its purpose and believes without it our Organisation's sustainability would be further jeopardised.⁴

The submission from Sylvanvale similarly argued that:

...the billing complexity created by NDIA pricing arrangement to itemise Group activity funding into support, capital allowance and non-f2f has significantly increase[d] the Provider's admin effort and costs to transact. TTP will continue to help Providers to meet NDIA report and billing requirement.⁵

Other submissions reported that providers had already committed to investments to improve performance over the next two years on the basis of the continuation of the TTP as originally announced. The submission from ONCALL suggested that there shouldn't be an early

¹ Beacon Support, Submission S022, p. 11.

² The Disability Trust, Submission S159, p. 5.

³ Avivo, Submission S112, pp. 16-17.

⁴ Crosslinks Disability Support Services, Submission S217, pp. 19-20.

⁵ Sylvanvale, Submission S092, p. 5 (Attachment LF21-01317).

withdrawal of TTP pricing as this would be detrimental to those providers that continue to actively improve systems and practices to ensure positive outcomes for participants.¹

The submission from genU reported that the payments from the TTP, to be received in 2022-23 and 2023-24, will help them in investing about \$2.0 million in a new rostering and payroll system, which will increase efficiency in rostering and complying with the complexity around Enterprise Bargaining Agreement conditions.²

Not all providers supported the continuation of the TTP. For example, the submission from Paragon Support Limited, a SIL provider, stated in their submission that the NDIS should:

*Get rid of TTP immediately. It is an immoral price gouge from the participants plan by the companies that still claim it.*³

4.2 Barriers to accessing and claiming the TTP

A number of submissions detailed how providers can experience barriers to accessing and claiming the TTP, which they argued might also explain why a large proportion of eligible providers are not claiming TTP. Providers were concerned about the cost and administrative burden of applying for and claiming TTP. The submission from Mind Australia Ltd, for example, stated that:

*... TTP do[es] not provide value for money. The costs and administrative burdens of accessing TTP tend to outweigh the benefits of maintaining eligibility.*⁴

Other providers felt that providers and participants often found the TTP arrangements to be confusing. The submission from Queensland Alliance for Mental Health stated that:

*One member stated that "no one understands it, it's too confusing, and it would take too much administrative time to untangle when we're struggling as it is".*⁵

The submission from Gippsland Disability Advocacy was concerned that:

*Anecdotal evidence from some families have advised that they may be charged by TTP, but it is not clear what (if any) value for money occurs as a result which directly affects the outcomes, goals and aspirations of a participant.*⁶

The submission from Jobs Are Us stated that with less than 20 participants receiving supports through the TTP it is difficult for their organisation to cover the associated development costs, the survey responses, financials, and accounting fees. However, the submission from Jobs Are Us recommended the continuation of the TTP, and suggested it would be feasible and profitable if they had a few additional participants receiving supports through this arrangement.⁷

¹ Oncall Accommodation Services, Submission S124, p. 2.

² genU, Submission S219, p. 17.

³ Paragon Support Limited, Submission S208, pp. 3-4.

⁴ Mind Australia, Submission S105, p. 12.

⁵ Queensland Alliance for Mental Health, Submission S099, p. 6.

⁶ Gippsland Advocacy Service, Submission S130, pp. 5-6.

⁷ Jobs Are Us, Submission S129 (email).

Providers also reported that, because plans had not been increased for the TTP, they choose not to claim TTP to ensure that participants were able to receive sufficient supports. The submission from Beacon Support reported that:

... providers often do not charge TTP, because it will disadvantage the participant if they have a very tight funding budget. This then disadvantages the provider, if they are not able to claim the payment, but yet participating in all the requirements for TTP, such as benchmarking surveys which have a cost associated with it.¹

The submission from Carers NSW similarly reported that:

...as prices were increased without an indexing of Participant plans, many providers have not been claiming the TTP against services provided due to fear of the impact of this on participant plans which have not been increased to reflect increase pricing caps.²

Several submissions reported that the TTP can prove to be a disincentive for participants and providers, as the higher TTP price limit reduces the number of hours available in a participant's plan. This meant that TTP providers were less competitive in some markets. The submission from Merri Health reported some difficulties in explaining the additional cost of TTP to participants.³ The submission from Mercy Connect reported that:

... participants have been forced to either choose the non-TTP provider, or receive less support as the TTP providers were more expensive.⁴

Several providers recommended that participants should not be disadvantaged by choosing a TTP provider. The submission from genU stated that:

... the funding for the TTP [should] be available in participants' plans to ensure they are not disadvantaged by choosing a provider that is eligible to claim the TTP.⁵

The submission from Action on Disability within Ethnic Communities (ADEC) similarly recommended that:

TTP support should not come at the participant's expense, rather should come directly from the NDIA. The NDIA should encourage participants to choose newer providers to promote growth.⁶

The submission from Beacon Support reported that:

...when TTP was first introduced all plans were indexed to include TTP pricing but was quickly removed after that first indexation period and participants are now left with reduced funding or lack of choice and control. While the NDIS states that they will keep an eye on funds if funds run out due to TTP being charged, this is usually not the case.

¹ Beacon Support, Submission S022, p. 10.

² Carers NSW, Submission S087, p. 5.

³ Merri Health, Submission S061, p. 4.

⁴ Mercy Connect, Submission S106, p. 11.

⁵ genU, Submission S219, p. 17.

⁶ Action on Disability within Ethnic Communities, Submission S055, p. 5.

Providers were also concerned that participants were often advised by Support Coordinators and other intermediaries, as well NDIA staff on occasion, that they should not allow the provider to charge the TTP. The submission from Wellways Australia stated that they:

... had incidents where some Support Coordinators have attempted to put pressure on Wellways staff to provide quotes with TTP removed in order to increase the value of the participant's plan.¹

The submission from the Disability Trust similarly stated that:

Large providers are also subject to Support Coordinators steering clients away from TTP-providers to address an 'underfunded' plan. Rather than addressing the issues with the plan, we have witnessed behaviours to move to non-TTP providers even though the client may be happy with their existing arrangements.²

The submission from At Home Care Pty Ltd similarly argued that:

Although the NDIS allows the claiming of TTP rates they do not adjust the Individual Client Service Bookings to have enough funds to enable the provider to claim for TTP. ... Clients are often advised to find non TTP [sic] providers.³

Several providers of supported independent living supports also reported that difficulties can arise because the TTP is not applicable to their services. The submission from Rocky Bay stated that:

TTP rates only apply within Community setting not SIL. This inconsistency makes it more difficult to negotiate with customers who may be provided services across both areas.⁴

The submission from Paragon Support Limited similarly reported that:

TTP favoured few external providers who were able to claim while other providers, like SIL just had to accept what the NDIS deemed an (un)acceptable level of funding. It is a totally unfair funding stream.... NDIS does support our participants with extra funding if the service providers we use claim TTP. It just means the participant does less, which places more burden on the SIL providers to cover the hours that funded TTP.⁵

Members of the working group argued that the Review needed to carefully consider the meaning of the reported statistic that fewer than half (by dollar value) of all eligible supports were billed at rates inclusive of TTP. Providers warned that this may not reflect that services were being delivered sustainably but might more appropriately reflect the market power that Support Coordinators and planners held in the current arrangements.

The working group also considered that the current underutilisation of the TTP support items was, in part at least, an artefact of the planning arrangements which builds plans on the assumption that prices were governed by the TTP-exclusive price limits. It was also argued that Plan Managers overstep their role to influence participants by advising the participant not to accept the TTP price limit because it was not in line with how the plan had been made. Providers with long standing and trusting relationships with participants also claim that a duty

¹ Wellways Australia, Submission S222, p. 13.

² The Disability Trust, Submission S159, p. 5.

³ At Home Care Pty Ltd, Submission S054, p. 4.

⁴ Rocky Bay, Submission S141, p. 4.

⁵ Paragon Support Limited, Submission S208, p. 4.

of care might mean that they reduce their price for a participant to below their break-even point rather than reduce the number of hours of support funded by a plan – particularly where those supports maybe considered necessary, such as personal care, by increasing their prices to the level allowed by the TTP arrangements. The majority of the working group did not consider that they could continue to absorb costs in this way.

4.3 Future of the TTP

A number of submissions argued that the TTP arrangements have achieved their purpose and have been successful in promoting competition by increasing capacity for providers in an ever-changing market. The increased provider capacity and efficiency is expected to generate positive outcomes for participants through increased availability of supports and greater price competition. These submissions also argued that there was an ongoing need for the TTP to support further development. The submission from Hireup stated that:

Now that pandemic restrictions are reducing, many participants are finding new providers and services, so it is challenging to predict new client loads and the TTP can assist businesses to prepare. The TTP will be an important support for providers as participants continue to fully adopt their services under the NDIS.¹

The submission from One Door Mental Health similarly stated that:

Temporary Transformation Payments have helped ODMH to develop capacity in the ever-changing market; noting that the rate of payment reduces significantly until it is phased out on 1 July 2024. ... TTP will help providers to recover from the impact of COVID; which will benefit participants by ensuring that specialist and responsive supports continue. ... At a minimum, continue the existing schedule for rollout of TTP.²

The submission from genU argued that:

The money spent on this transformation will positively impact participants and assist genU to continue to deliver efficient supports into the future.³

Many submissions supported the continuation of the TTP loading as it generates additional revenue that enables service providers to deliver quality services, cope with significant financial and administration costs from the increased number of transactions and maintain systems and processes to align with NDIS policies. The submission from National Disability Services argued strongly that:

... the NDIA should honour its commitment to only reduce the TTP at the 1.5% per annum rate. Many providers are relying on this payment to fund the upgrade to their systems and processes. To remove it quickly would harm the relationship between providers and the NDIA.⁴

The submission from Autism Spectrum Australia stated that the TTP:

¹ Hireup, Submission S107, p. 16.

² One Door Mental Health, Submission S097, p. 10.

³ genU, Submission S219, p. 17.

⁴ National Disability Services, Submission S152, p. 13.

... supports organisations to provide high quality services, particularly when delivering Programs of Support and the necessary infrastructure. Given how challenging it is to provide services in this area due to the inadequate funding, any additional funding supports service delivery.¹

The submission from Vision Australia similarly argued that:

The TTP has been instrumental in rendering the provision of these services more sustainable, particularly for providers who work in thin markets with low incidence cohorts.²

The submission from Tulgeen suggested that removing the TTP loading:

... would have a drastic impact on most registered regional-based providers, leading to significant reduction in service quality and choice by participants.³

Providers felt that there would be value in maintaining the TTP as recognition of the different services delivered by registered and unregistered providers. The submission from Jobs Are Us argued that:

Currently for TTP item groups this is the only financial incentive between being a registered NDIS provider and a non-registered provider. We pay thousands of dollars on audits to maintain the standards needed to receive registration and having a similar provider compete that does not have to go through the registration is difficult. We recommend the continuation of TTP.⁴

The submission from Tulgeen similarly argued that registered providers provide participants with a higher quality of support and greater choice of control than unregistered providers, and by removing the TTP rates the unregistered providers (generally individuals) would gain an undue competitive cost advantage. Therefore, to improve cost efficiency for registered providers the submission recommended that:

As an incentive and encouragement for registration, a permanent additional 5% price limit margin should be introduced for registered providers, in place of the current TTP loading.⁵

The submission from Action on Disability within Ethnic Communities also recommended that that TTP should continue for providers who meet the criteria post 2024.⁶

The submission from Merri Health suggested that the TTP should be continued and that the eligibility requirements for the TTP should be increased. They reported that there are currently no outcome or quality benchmarks for organisations to achieve to receive the TTP payment, and that this is a missed opportunity to enhance the quality of providers in the market. The submission suggested that the TTP could be replaced by incentives for outcome-based supports, with services attracting a higher rate for supports where positive outcomes are achieved. It argued that:

¹ Autism Spectrum Australia (Aspect), Submission S066, p. 6.

² Vision Australia, Submission S109, p. 7.

³ Tulgeen, Submission S029, p. 7.

⁴ Jobs Are Us, Submission S129 (email).

⁵ Tulgeen, Submission S029, p. 7.

⁶ Action on Disability within Ethnic Communities, Submission S055, p. 5.

This would then allow providers to compete on quality of service, rather than purely on volume. Such a model could involve a set price limit and then additional funding based on outcome measures, thus encouraging innovation and the delivery of high-quality supports.¹

Members of the working group considered that the principal purpose of the TTP was to assist providers meet the costs of transforming their systems in order to be able to transition into the NDIS. In this regard, members of the working group advised that the additional costs associated with being a registered provider in the NDIS were not temporary and were not diminishing over time. Rather, they were permanent and, in some cases, increasing. In particular, while some of the costs that were associated with the transition to the NDIS might have been expected to be temporary – for example, investment in new accounting or staff management systems – continued investment has been and is still necessary as the NDIS is still not in a steady state as far as its administrative and regulatory arrangements are concerned. One working group member remarked that they were trying to automate as much of their claiming administration as they could, but that substantial new investment was still required whenever the requirements of the NDIA or the Commission changed.

Members of the working group also advised that new costs were also arising. For example, the costs associated with liaising with the NDIA; reporting incidents, accidents and safeguarding issues to the Commission and the costs of audits for accreditation; investigating rejected claims and resolving issues, including credit control (bad debt) costs for self-managed and plan managed participants; advocating for and supporting participants in their plan reviews; software, licensing and cybersecurity, etc.

Concerns were also raised that any reduction in the TTP below its current level would mean that it did not adequately compensate for the costs of the ongoing changes that the NDIA and the Commission, as well as other regulators, were making that were increasing the administration requirements of working within the NDIS.

Some members of the working group were also concerned that constant changes to the regulatory arrangements for the sector (in particular, the apparently ever increasing transactionalisation of planning, pricing and quality regulation) was inhibiting their ability to remain dynamic. For example, where it maybe normative to charge an inclusive price in other sectors, providers are required to transactionalise labour and non-labour costs associated with travel and transport and then override the actual time and distance travelled, limiting the charge to outbound travel only at the same time as implementing a cap and converting the quantum of agreed non labour charges to units of \$1.

Some members of the working group suggested that the NDIS Disability Support Worker Cost Model does not reflect the true costs of operation, and that it is unlikely that the TTP enables the true costs of delivering services as a registered provider to be covered. More than one member of the working group indicated that they considered that even the TTP-inclusive rates were already not sufficient to cover the costs of operation. Specifically, it was argued that some core business elements such as quality and safeguarding are not reflected in the model. As a result, it was suggested that many providers are using the TTP as a stop gap measure, to partially offset the cost impost associated with community participation and that if TTP is removed before the cost model is correct, some providers would not survive

¹ Merri Health, Submission S061, p. 4.

(particularly in regional areas or those providers servicing high intensity participants). The “middle band” of providers (by size) were considered to be most at risk of not being able to survive without the TTP, as they could not achieve economies of scale over which they could distribute their adjustment and investment costs.

The TTP arrangements were acknowledged to provide support to enable providers to invest in and establish systems as part of their transition to the NDIS environment. Additionally, some members of the working group indicated that the TTP arrangements assisted their organisations to implement the ongoing changes to the NDIA’s rules and ways of operating. The working group considered that the TTP arrangements were one of the few initiatives under the NDIS through which the government invested in the sector to support efficiency, innovation and the implementation of reform. It was suggested that currently, there is little innovation occurring in the sector, primarily because any direct surplus that is generated is used to cover underfunded plans and being absorbed in overheads, pricing which does not reflect the true costs of operation and adapting to changes in the NDIS. Some providers argued in the current transactional environment, innovation can only be achieved with the support of TTP or another form of dedicated funding.

Members of the working group also argued that that depth and diversity in the provider landscape was important to the strength and viability of the sector. However, this diversity led to differences in cost structures, for example, between providers who offer a variety of services and those who specialise. The working group suggested that boutique and smaller providers could “cherry pick” the services that worked for their cost structure, and that larger providers could more easily absorb costs. However, as noted above, the working group suggested that due to the transactional nature of the NDIS, economies of scale were not achievable as providers get larger.

The working group considered that there is an ongoing need to balance the need for efficiency with the need to maintain quality. It was suggested that a lack of quality can increase costs both in the NDIS and in adjacent areas. It was also suggested that some supports need local, innovative and responsive providers and that there was a danger that a one price fits all approach would drive the sector towards aggregation at the cost of diversity.

Some members of the working group considered that, because transition and transformation costs were likely to be ongoing, it would be more efficient to scrap the TTP and to recognise these costs of operation in cost model for core supports. This would also have the advantage of both funding and incentivising innovation as well as reducing transactional complexity in claiming and negotiation. Some members of the working group considered that there might be some value in maintaining the TTP arrangements as a separate loading to the base price limit, as this would allow the NDIA to reward/incentivise investments in desired areas by modifying the eligibility criteria for the TTP.

The working group considered that, while the NDIA continues to make regular and substantial changes to its rules and ways of operating, the TTP arrangements should either:

- Remain in place and at its current level to assist providers make the associated required investments and to meet the associated costs; or
- Be replaced by a higher set of base prices that recognised the ongoing nature of the costs to providers of addressing changes in the operating procedures of the NDIA and NDIS Commission.

On balance the working group favoured the second option as it also addressed other issues that providers faced with the TTP, including barriers to charging rates inclusive of TTP from, for example, push back from Plan Managers and Support Coordinators for quoting rates inclusive of TTP; and was better aligned with the planning arrangements.

5 Quality and Safeguarding Costs

A total of 48 submissions about the costs of ensuring the quality and safety of supports for people with disability were received in response to the Consultation Paper. Details of the submissions are in Appendix A. A working group of providers and other stakeholders was also established. The working group had 46 members from 31 organisations and met three times, by video-conference: 30 November 2021; 2 February 2022; and 1 March 2022. Details of the members of the working group are provided in Appendix B.

The key topics raised in the consultations were:

- Provider registration and ongoing compliance audits;
- Practice Standards;
- Incident and restrictive practice reporting;
- Training, professional development; and
- Supervision.

The analysis and recommendations relating to the consultation on Quality and Safeguarding Compliance Costs can be found in section 5 of Chapter 3 (Disability Support Worker Cost Model) of the *Report of the 2021-22 Annual Pricing Review*.

5.1 Provider registration and ongoing compliance audits

Many submissions reported that the Commission's provider registration process is administratively burdensome and costly, sometimes requiring third party support.¹ Paragon Support Limited suggested that the Commission should employ staff to conduct the audits, to avoid the need for providers to engage "overpriced auditors". They also suggested that:

If anything the auditors need to be supportive of new companies rather [sic] expect to have the perfect documentation supplied by a third party with their name on the cover.²

Several providers also expressed concern that the auditing requirements to maintain accreditation are extensive, both financially and in terms of time and resource requirements.³

The Australian Community Support Organisation highlighted the lack of funding mechanism to support auditing requirements, suggesting:

There is no current pricing arrangement to account for the additional NDIS audit costs for registered organisations to remain accountable and ensuring a high level of service provision.⁴

¹ See: Allied Health Professions Australia (S111), Australian Physiotherapy Association (S098), Avivo (S112), NeuroRehab Allied Health Network (S068), and Paragon Support Limited (S208).

² Paragon Support Limited, Submission S208, p. 7.

³ See: Allied Health Professions Australia (S111), Australian Community Support Organisation (S082), Avivo (S112), Beacon Support (S022), Council of Regional Disability Services (S072), Exercise & Sports Science Australia (S070), genU (S219), NeuroRehab Allied Health Network (S068), and Paragon Support Limited (S208).

⁴ Australian Community Support Organisation, Submission S082, p. 4.

A number of submissions provided case studies of the direct and indirect costs of ongoing compliance audits. For example, Ability First Australia reported that:

The full cost of participating in the three-year NDIS audit cycle for our member organisations is, on average, \$1.2M with the highest cost reported being just under \$4M. This equates to an average of 1.3% of corporate overheads with a high of 4.7%. The cost doesn't just lie in the audit itself, there are significant expenses in staff salaries, internal auditing, IT costs, paying staff to attend audit interviews, policy and procedure development and the ongoing monitoring and compliance work of the quality team.¹

The submission from Council of Regional Disability Services (Western Australia) noted that the higher price limit is required to cover:

...the higher NDIS quality and safeguarding compliance cost, higher staff labour costs including salary and for staff housing, the lack of an application of a geographic lens to planning or the higher costs associated with provision of staff safety and security which are impacted by the significantly higher crime rates in regional and remote communities.²

They reported that:

Examples of costs incurred by some large organisations to prepare for and support the audit process range from \$700,000 to \$1M. The transition to the NDIS Quality and Safeguarding [sic] Commission in WA has resulted in sector concerns about the increasing costs of additional administration and regulation and the loss of capability and expertise within State Government.³

The submission from Council of Regional Disability Services also quoted from research at the University of Western Australia that showed:

Increases in compliance and quality control requirements including the requirement to hire additional personnel and undertake additional control processes... total costs increased by 2.61% in 2019-2020 and 5.65% in 2020-21.⁴

The submission from NeuroRehab Allied Health Network reported that:

Direct costs for external auditors' [sic] amount to ~\$10,000 per annum. Indirect costs are significantly higher than this. We are currently undergoing a mid-way review audit and the process has taken at minimum 200 hours of our senior management time to prepare, review and update policies ensuring they are current with practice standards. In addition to this our Psychology Clinical Manager and Team Leader have each needed to spend around 20 hours of time reviewing policy and updating team members with appropriate BSP knowledge. This is both costly from a wage perspective but even more costly from a lost revenue aspect.⁵

The submission from Avivo reported that:

In recent months, Avivo have been receiving audit files requiring significant review down to source documents before responding, relating to several hundred claims. Each time, the deadline for response is 2 weeks. This detracts resources from their usual responsibilities for those two weeks.⁶

¹ Ability First Australia, Submission S229, p. 14.

² Council of Regional Disability Services, Submission S072, p. 3.

³ Ibid., p. 5.

⁴ Ibid., p. 8.

⁵ NeuroRehab Allied Health Network, Submission S068, p. 4.

⁶ Avivo, Submission S112, p. 14.

Providers also made a number of suggestions as to how the current quality and safeguarding arrangements could be improved to reduce unnecessary compliance activity whilst still ensuring that services were safe and of the highest quality. In particular, Ability First Australia suggested that:

Prior to the implementation of any major changes to compliance requirements, the NDIS Commission should undertake a cost analysis and share this with the NDIA with a requirement that the NDIA provides appropriate financial support to providers to support implementation. ...

The NDIA should work with providers that navigate its systems prior to rolling out any new changes, particularly when they are seeking to reduce complexity.¹

Members of the working group were also concerned with the costs of quality audits, describing them as “extensive”, both financially and in terms of time. They reported that the audit requirements seemed to be better suited for larger providers rather than smaller providers / allied health professionals. A particular issue is the costs of travel (including accommodation and meals) for auditors to rural and remote locations. One member of the working group stated that in their experience audits are performed by two auditors, and rural and remote practitioners and providers are unable to undertake a certification audit because they cannot cover the travel costs of two auditors. They also noted that it was not always easy to “match up” with another provider in the same area to get audited together because of the timing of audits.

Members of the working group also noted that individual allied health professionals are already well regulated by their own bodies (which have codes of conduct, ethics, standards). Some members thought this was essentially duplication. The Review notes, however, that the Commission registers providers rather than individual practitioners, unless the practitioner is a sole trader.

Several members of the working group shared that their compliance costs were high and increasing. One member reported that their organisation had five full time investigators (paid at \$100k a year minimum each) and but were still struggling to keep up as they have 24 hours to respond to reportable incidents. Another member added that there were the additional costs associated with paying overtime, in particular where responses need to be addressed within 24 hours.

A member of the working group reported that their quality and safeguarding costs had gone from 0.3% to 1.4% of revenue. In the past year, they reported a 30% increase in revenue, but a 500% increase in Commission costs. Another reported that they had incurred additional costs in the policy team, training team, supervision model that they used for management, incident management, and investigation management. Additionally they have invested millions in a client management system that was the “engine room of incident management for clients”.

In the discussion in the Participant Reference Group, some members raised the value of provider registration and quality standards. They noted that providers of supports typically tended to charge at the price limit so it was not possible to distinguish support offerings on the basis of price — instead, members noted that they looked for providers who were

¹ Ability First Australia, Submission S229, p. 28.

registered as there was no other way to discern the quality of the offering. Several members of the Participant Reference Group recognised that providers who have higher qualifications or who have put in the years of training are entitled to higher financial payment than providers who are less qualified, but added that this was difficult for them to assess, particularly when both types of provider were able to charge the same price.

5.2 Practice standards

While providers welcomed robust practice standards, many suggested that the number of NDIA's practice standards is excessive. For example, Ability First Australia reported that:

Under the NDIS Commission a service provider registered to deliver most core supports will be required to be certified to a minimum of 24 standards and 124 quality indicators (irrespective of size). ... If you add higher risk registration groups such as behaviour support, high intensity daily personal activities, early childhood supports, specialist support coordination and specialist disability accommodation, you could be required meet up to 62 standards and 297 quality indicators. ... To put this in perspective, the National Standards for Disability Services has just six standards and 40 quality indicators.¹

Submissions reported that each amendment to the standards requires investment to implement, which adds to the growing cost of being a registered provider. genU, for example, reported that the implementation of a new practice standard can require the establishment of a team of people to: understand and translate the procedures; develop supporting policies, training and materials; deliver in house training; support providers, participants and their families; and optimise systems and develop a mechanism to monitor the business' ongoing adherence.

The submission from Avivo similarly reported that they had established a Practice Support team, including Positive Behaviour Support specialists supervised by an external Clinical Psychologist to ensure adherence to standards and the delivery of safe, quality supports. This team develops policies, training and materials to support their workers, participants and their families.²

With respect to the most recent Practice Standards, genU stated that:

... the NDIS (Quality Indicators) guidelines have just been amended to include three new practice standards. [sic] Mealtime management, Severe [sic] dysphagia management and Emergency [sic] and disaster management. The new practice Standards and Quality Indicators were released a week before the Mealtime management practice standard commenced. The new standards require extensive investment in specific training.³

Ability First Australia reported that they had undertaken an initial estimate of the impact, training and costs required to comply with the new Mealtime Management standard.

Training costs are estimated at between \$175,000 to \$2.7M depending on the number of participants and staff affected. For one member, this impacts approximately 300 participants. The

¹ Ability First Australia, Submission S229, p. 14.

² Avivo, Submission S112, p. 13.

³ genU, Submission S219, p. 11.

training and organisation to become compliant with this and in such a short period of time, has not been costed by the Commission nor factored into any pricing adjustments by the NDIA.¹

A number of other providers also suggested that the new practice standards have increased their operating costs to meet quality and safeguarding requirements.² Paragon Support stated that:

With the new meal management and disaster planning, companies will need to spend hundreds of unpaid work hours in developing plans and organising OT [Occupational Therapists] to perform assessments. None of this is funded.³

Another provider made a confidential submission along the same lines:

There is no allowance for the cost of implementing and embedding new quality and safeguarding measures. With new additions to the practice standards launched in November, providers continue to stretch themselves to react to yet another new way of working.

Members of the working group echoed the concerns that practice standards and other regulatory arrangements were often released and imposed without sufficient attention to the costs and timing of their implementation. In particular, members agreed that the introduction of the new meal management practice standard had taken no account of the shortage of professionals available to undertake the necessary assessments, especially in some regions, and that many participants did not have funding in their plans to pay for the assessments.

5.3 Incident and restrictive practice reporting

The Cerebral Palsy Alliance provided a detailed view of how much has changed in terms of reporting and compliance activities in New South Wales since the Commission commenced. This includes the extension of reporting requirements from incidents to incidents and allegations of incidents and from people with disability who lived in supported group accommodation to all participants, along with an expansion in the types of incident that are reportable.

In NSW - the old reporting requirements were for events below – and were managed by our operational team.

There were four categories of ‘reportable incidents’ involving people with disability who lived in supported group accommodation a) Employee to client incidents, b) Client to client incidents, c) An incident involving a contravention of an apprehended violence order made for the protection of a person with disability, or d) An incident involving an unexplained serious injury to a person with disability.

We now have the national legislation – which is a requirement for all NDIS participants and has an expanded scope, as per below – we now have a dedicated team of 6 people supporting this function.

For an incident to be reportable, a certain act or event needs to have happened (or be alleged to have happened) in connection with the provision of supports or services. This includes:

- *the death of a person with disability*

¹ Ability First Australia, Submission S229, p. 16.

² See: Avivo (S112), Dietitians Australia (S239), genU (S219) and Paragon Support Limited (S208).

³ Paragon Support Limited, Submission S208, p. 7.

- *serious injury of a person with disability*
- *abuse or neglect of a person with disability*
- *unlawful sexual or physical contact with, or assault of, a person with disability*
- *sexual misconduct, committed against, or in the presence of, a person with disability, including grooming of the person with disability for sexual activity*
- *use of a restrictive practice in relation to a person with disability where the use is not in accordance with an authorisation (however described) of a state or territory in relation to the person, or if it is used according to that authorisation but not in accordance with a behaviour support plan for the person with disability*

Not questioning the intent of the legislation – just highlighting that the change in scope is where a lot of the compliance costs come from.

Training staff

We have also moved from no regulation around how we on board, train and supervise our staff (as this has been largely employer discretion) to now regulated requirements for some training and also who can deliver this training – we have incurred new costs bringing on extra nurses to deliver this type of training.¹

Providers reported that incident reporting involves the following responsibilities that are essential to meet the Commission's requirements for registered providers: triage of all incident reports to ensure compliance with providers' policies and mandatory requirements; responding to and reporting of incidents; follow up of incident reports, including implementation of practice improvements, identification of trends, and development of strategies to address these trends; incident investigations, incident reviews when required; and staff and manager education. In addition to the above, registered providers who develop behaviour support plans or use restrictive practices are required to provide monthly reports to the Commission. Submissions also reported that the management of behaviour support plans and restrictive practice involves following responsibilities: approval of behaviour support plans in line with requirements; development and implementation of strategies to reduce restrictive practice; monitoring review of plans; monthly reporting of restrictive practice; and implementation for strategies to enhance awareness and drive best practice.²

Sylvanvale provided the following case study to highlight Quality and Safeguarding work required that is not currently captured in the pricing arrangements. They reported that they have more than 25 similar case studies running at any one time.

Fred is an adult living in a SIL Service. Fred has complex behaviours of concern and requires a Behaviour Support Plan (BSP) that includes several regulated restrictive practices including routine chemical restraint and the use of PRN medication. Fred's Comprehensive Behaviour Support Plan was first written by a Sylvanvale Specialist Behaviour Support Practitioner. In order to write the Comprehensive Behaviour Support Plan the registered Behaviour Support Practitioner attended the SIL location on two occasions for observations, met with the Site Manager, read and interpreted the data that had been consolidated by another team and considered other allied health reports on file. The Comprehensive Behaviour Support Plan was approved at the next monthly Sylvanvale Restrictive Practice Authorisation (RPA) Panel (Chaired by Senior Manager Practice and Compliance – since the Senior Manager Clinical Services reviewed the BSP, an independent Psychologist, Regional and Site Managers attend together with the Behaviour Support Practitioner/ Senior Manager Clinical Services and customer with a Support Worker).*

¹ Cerebral Palsy Alliance, Submission S248 (email).

² See, for example: genU, Submission S219, p. 12.

Prior to the panel being convened and in order to submit to RPA Panel the following tasks must be completed:

- The Site Manager compiles an RPA Submission Pack (takes Site Manager 3-4 hours and a Regional Manager to review would take another hour).
- The pack is checked by the Senior Manager Clinical Services as if incorrect then will source and correct information that will go to Department of Communities and Justice - DCJ Portal (2 hours per pack).
- Entered by Sylvanvale Admin (one participant with 10 Restrictive Practices will take approx. [sic] 2 hours including Outcomes) into the Department of Communities and Justice -DCJ Portal for Authorisation by RPA Panel Members.
- The Authorisation that is produced also needs to be downloaded from the DCJ Portal for the Sylvanvale Customer File as well as uploaded to the NDIS Q&S Commission Portal (another hour).

Subsequent to the panel process the Behaviour Support Practitioner needs to:

- Upload the BSP, Functional Behaviour Assessment, identifies each individual Restrictive Practice and Authorisation into the NDIS Q&S Commission Portal.
- The Authorised Reporting Officer, Senior Manager Clinical Services has to report every single use of the Restrictive Practice at each Sylvanvale Outlet Location (e.g. SIL and Community Participation) each month (10 Restrictive Practices take approx. [sic] 20-30 minutes).
- Reports need to be run by Admin each month to gather the data required to report any use of PRN Restrictive Practices (5 minutes per customer to pull data).

Note – While the Behaviour Support Practitioner can claim billable hours paid from the Customers [sic] NDIS Plan for their time regarding the tasks, other admin is a cost of doing business.

Six months later, a month before the SIL provider planned to support the re-engaging of the Sylvanvale Specialist Behaviour Support Practitioner via Fred's Support Coordinator who wrote the plan left Sylvanvale. Fred's Support Coordinator located a new external Specialist Behaviour Support Practitioner after two months. However, this provider then withdrew the service and the search continued until an appropriate provider was engaged several months later. This Specialist Behaviour Support Practitioner took a month to complete an assessment and develop a new BSP – however, the plan was overly complex and incomplete, which meant that the practices could not be authorised before the old plan expired. The practitioner was requested to update the plan but was slow to respond and difficult to contact.

During this time each regulated restrictive practice use which had been part of the previously approved BSP was:

- Required to be reported monthly on an expired BSP by the Authorised Reporting Officer (10 Restrictive Practices will take approx. [sic] 20-30 minutes).
- Also required to be reported as a Reportable Incident – Unauthorised Use of Restrictive Practices (URP) within 5 days of the BSP expiring. (Initial Set Up of Reporting for 10 Restrictive Practices would take 1 hour)
- The BSP contained 10 different Restrictive Practices (chemical restrictions must each be reported separately 30 mins [sic] to 1 hour for 10 Restrictive Practices but also depends on how many PRN instances) which were reported weekly until the Practitioner updated the BSP and it was approved at Sylvanvale RPA Panel. For the period that the BSP had expired, there were a total of 14 weeks and 140 separate reports (at least 14 hours) of URP to the NDIS Q&S Commission.

Note – All of the associated pre panel tasks as outlined above had to be repeated prior to the Plan coming back to panel.¹

The Submission by Crosslinks Disability Support Services also argued that the costs incurred due to time spent managing reportable incidents, restrictive practices, and communication with the Commission, is not accounted for in the NDIS DSW Cost Model.

Crosslinks Quality and Safeguarding Lead spends approximately 15 hours of management time on managing the restrictive practice register, organising, and leading restrictive practice panel meetings and assisting managers when liaising with therapists and the NDIS. Crosslinks pays an external consultant \$200 per hour to sit on the restrictive practice panel as per State requirements. A total of seven managers spend approx. [sic] 15-20 hours per month managing, reducing and or eliminating restrictive practices within services and the General Manager spends approximately 4 hours per month managing issues relevant to restrictive practices. This does not include the daily and monthly reporting requirements which change by the day and month, therefore are difficult to quantify.²

The submission by HelpingMinds similarly suggested there is significant requirement for reviewing incident reporting when providing psychosocial supports and that this is not factored into the DSW Cost Model.

The level of complexity and risks associated with providing psychosocial supports to this cohort of participants requires robust and comprehensive internal support structures to be able to provide this level of service delivery. The level of managerial experience and resources required to oversee quality and safeguarding, and the extensive level of incident reporting, are costs all covered by the provider, which is not factored into the pricing arrangements.³

Rocky Bay reported that the average time spent per investigation was 30 minutes, but that a significant number of investigation required more than five hours work.

Rocky Bay Community reported around 407 accidents and incidents in the 6-month period to June 2021, compared to 391 for the full year 2020, with an average of 30 minutes per investigation. However around 10% required well above that investigation time ranging from 5 hours to over 30 hours due to the challenging behaviours of customers or complexity in family peripherals where there may be many factors affecting delivery of a safe home environment.⁴

Cara Inc. provided several examples of costs flowing from the reporting requirements.

... the trend towards real-time reporting from the NDIS Commission, without development of the NDIS Commission's ICT platform to allow import/export of data via ETL's or API's [sic], limits all providers to manually enter data that already exists in provider Incident Management systems. We have estimated the cost, purely of duplication of data entry, to be around \$100K per annum.

Another example of additional costs has occurred again this week, where the NDIS Commission has directed Cara to complete a Reportable Incident for a customer receiving long term palliative support who, after admission to hospital, passed away with COVID after 7 days. To our understanding, the death is not connected in any way to the provision of supports, and yet Cara is

¹ Sylvanvale, Supplementary Submission S250a (email).

² Crosslinks Disability Support Services, Submission S217, p. 18.

³ HelpingMinds, Submission S085, p. 2.

⁴ Rocky Bay, Submission S141, p. 3.

now required to complete a 24 hour notification and 5 day notification, with a range of details required to be obtained from the hospital and acute sector in order to complete the notification.¹

Several submissions suggested that the Commission's incident and restrictive practice requirements should be acknowledged and allowed for within the DSW Cost Model.²

Paragon Support Limited suggested that a separate line item should be added to the pricing arrangements to allow providers to claim for reporting restrictive practices. It also suggested that the reporting methods should be reviewed, to reduce the complexity and time taken to adhere to the requirements.³

Members of the working group agreed that the level of content required for reporting and compliance requirements are higher than previously. They were also concerned that the data entry costs for reporting incidents to Commission were higher than necessary because of the limited technological solutions offer by the Commission. This was particularly problematic because the Commission had an expectation of real-time reporting that providers could not efficiently meet because of the Commission's manual entry technology and a lack of funding for investment in new technology by providers.

Members of the working group also raised a concern that some reportable incidents were reportable to state-based bodies (coroner, police) as well as to the Commission. They considered that governments should streamline the information transfer between their agencies so as to relieve providers of this unnecessary duplication. Members also thought that there would be considerable value in the Commission creating a single incident reporting system that would be interoperable with the managements systems use by most major providers to allow easier import and export of data. One member suggested that the Commission should itself create an investigation and reporting system that providers could purchase.

Members of the working group were also concerned that the Commission appeared to "one size fits all" approach to the investigation of incidents and alleged incidents, A member reported on one of their current investigations, which was based on an alleged incident reported by a third party. The provider stated that this incident would have been previously resolved through one phone call to the participant to investigate the allegation but has now resulted in 30 hours in investigation for the provider as no one from the Commission called the participant to validate the allegation. Members of the working group were also concerned that the Commission had "set a low bar for possible compliance issues", with providers having to provide significant amounts of material (at considerable cost) in response to each compliance monitoring letters, no matter the issue.

Members of the working group accepted that all incidents and allegations should be investigated, especially given the vulnerability of some participants. However, they did not consider that this precluded the adoption of a triage and tiered approach.

¹ Cara Inc., Submission S249 (email).

² See: Australian Community Support Organisation (S082), Community Living Options (S101), and Sylvanvale (S092).

³ Paragon Support Limited, Submission S208, p. 7.

5.4 Training and Professional Development

Many submissions reported that the Cost Model provides inadequate funding for staff training and professional development to meet the expectations and requirements of the NDIS Code of Practice and NDIS Practice Standards, work health and safety requirements, and provider policies designed to maximise the quality of support.¹

In general, submissions agreed with the Australian Services Union that training was “*necessary to fulfil quality and safety requirements*”.² They also agreed with the point made by the Illawarra Disability Alliance submission that training:

*... needs to be prioritised through a combined commitment between the NDIA, the Quality and Safeguards Commission, disability service providers and employees...*³

However, submissions reported several challenges in the ability of providers to deliver adequate training and professional development. For example, the Queensland Alliance for Mental Health stated that it is not uncommon to recruit staff in the disability sector with generic disability qualifications (for example, Certificate III Individual Support), or no formal qualifications (particularly in rural and remote regions where there is a lack of qualified applicants) and that these staff often require considerable training to understand the specific needs of people receiving psychosocial supports, with this cost absorbed by providers.⁴

Qualified practitioners also require substantial training to meet the quality and safeguarding requirements of the NDIS. For example, NeuroRehab Allied Health Network reported that:

*In order to meet the NDIS PBS [Positive Behaviour Support] Capability Framework requirements of a ‘core’ behaviour support practitioner, we have calculated that it requires our registered psychologists between 50- 70 additional hours of training, including our internal induction and participation in external workshops. Aside from the costs of attendance at external workshops, there is a substantial amount of lost earnings for the outlay of time taken for practitioners to attend these courses. This is in addition to the standard professional development requirements that psychologists are required to complete as part of their professional development obligations.*⁵

The submission from Vision Australia similarly reported that:

*Training and development costs for new service providers are high, as they seldom possess a vision specific skillset at commencement of their employment. Once a therapist role has been filled, it takes three months, on average, for the provider to develop specialist blindness and low vision skills. The cost of training and development is over \$25,000 per role, given that the provider is relatively unproductive during this time.*⁶

¹ See: Australian Physiotherapy Association (S098), Australian Services Union (S122, S243), Avivo (S112), Crosslinks Disability Support Services (S217), Dietitians Australia (S239), Empowered Futures (S065), Exercise & Sports Science Australia (S070), genU (S219), Greenacres Disability Services (S048), Illawarra Disability Alliance (S104), Mercy Connect (S106), NeuroRehab Allied Health Network (S068), One Door Mental Health (S097), Queensland Alliance for Mental Health (S099), Rocky Bay (S141), and Wellways Australia (S222).

² Australian Services Union, Submission S122, p. 6.

³ Illawarra Disability Alliance, Submission S104, p. 3.

⁴ Queensland Alliance for Mental Health, Submission S099, p. 5.

⁵ NeuroRehab Allied Health Network, Submission S068, p. 4.

⁶ Vision Australia, Submission S109, p. 8.

The submission from Rocky Bay also reported that they struggled to meet the current utilisation rate outlined in the Cost Model due to the need to schedule enough hours for training on quality and safeguards alongside other essential activities (team meetings, incident reporting and supervision).¹

The submission from Ability First Australia also argued that the utilisation rates in the Cost Model do not allow sufficient time for non-billable tasks such as administration, handover, team meetings and training.

This is consistent with our modelling where these activities (with the exception of training) presumably fall within the 'other utilisation' category. The DSW model accounts for just 0.54% for standard and 0.25% for high intensity in this category. This is clearly unattainable, as highlighted in the breakdown below which details Ability First's modelling for SIL services of 'other utilisation'.²

	Standard	High Intensity
Shift Handover	2.2%	2.7%
Client Reports	2.3%	3.2%
Family/Stakeholder Engagement	1.5%	2.1%
NDIS Coordinator Contact	0.7%	0.9%
Liaising with Other Supports	1.0%	1.2%
Total	7.7%	10.1%

The submission from Carers ACT stated that:

... the utilisation rate of 92%, does not even allow for a monthly staff meeting of 1 hour, essential for communication. Nor does the model allow for regular performance discussion and review, only allowing .54% for "other" activities. (0.54% of 220 days = 1.18 days or 9 hours per year). Where in the pricing model is there time permitted for the worker to report concerns about the client's wellbeing or other work-related issues. [sic]³

The submission from Empowered Futures and Mercy Connect both suggested that there was no allowance within the DSW Cost Model for the additional training requirements for staff who deliver complex supports, including high intensity support to participants with behaviours of concern.⁴

The submission from Empowered Futures also reported that providers can be required to deliver specific training to allow their staff to support the individual requirements of a participant with particularly complex needs, which is not provided to staff for any other participant, and that these costs are not recognised in the Cost Model or by planners.

... we currently have a Participant with an Administrative Appeals Tribunal (AAT) case where the NDIA is refusing to pay for MAYBO training facilitation or staff time to complete the training which the NDIS Quality and Safeguards Commission have stated they require on an annual basis. This training is specific to the participant's BSP [behaviour support plan] and RP [restrictive practices] practices [sic]. We do not ordinarily provide this training to staff for any other participant.⁵

¹ Rocky Bay, Submission S141, p. 3.

² Ability First Australia, Submission S229, pp. 12-13.

³ Carers ACT, Submission S147, p. 1.

⁴ Empowered Futures, Submission S065, p. 5 and Mercy Connect, Submission S106, p. 5.

⁵ Empowered Futures, Submission S065, pp. 5-6.

Sylvanvale also suggested that the impact of staff turnover further undermines the adequacy of training allowances within the DSW Cost Model:

... 7.89% training is not reflecting the staff turnover impact. 7.89% is approx. [sic] 2 weeks' worth of training which is standard for complex support workers. This should be uplifted by staff turnover of 12% as industry average.¹

Finally, while providers acknowledged that even if the time to attend training was covered in the utilisation assumptions in the DSW Cost Model, other costs of training (materials, travel and paying the trainer) were not adequately covered by the overheads allowance. Several providers and peak bodies suggested that the NDIA should allow for the additional time and costs involved in providing training and professional development within the Cost Model, and that training should be fully funded to ensure the workforce is well qualified.²

Greenacres Disability Services further suggested that:

Separating the funding of training from the funding of participant support will ensure that organisations provide adequate industry standard quality training to their workforce.³

Greenacres Disability Services and the Illawarra Disability Alliance suggested that there was a need for an independent industry training body to define mandatory training requirements to ensure the disability workforce is sufficiently qualified to deliver services in accordance with the NDIS Codes of Practice and Practice Standards.⁴ The Australian Services Union suggested that governments should establish a Portable Training Entitlement System for the Disability Support Services Sector as outlined by the Australia Institute.⁵

5.5 Supervision

Submissions acknowledged the need for, and benefit of, supervision. Mind Australia stated:

Supervision allows staff to discuss concerns and issues with a more experienced practitioner, in order to maintain their wellbeing, improve their practice and, ultimately, provide higher quality service to participants.⁶

However, many submissions stated that the workload for supervisors and managers has increased because of the need to assist (and ensure) workers adhere to quality and safeguarding requirements, including practice standards and reporting requirements.⁷

¹ Sylvanvale, Submission S092, p. 3.

² See: Crosslinks Disability Support Services (S217), Empowered Futures (S065), Exercise & Sports Science Australia (S070), Greenacres Disability Services (S048), Illawarra Disability Alliance (S104), and Mercy Connect (S106).

³ Greenacres Disability Services, Submission S048, p. 5.

⁴ Greenacres Disability Services, Submission S048, p. 5; Illawarra Disability Alliance, Submission S104, p. 3.

⁵ Australian Services Union, Submission S122, p. 4. See: The Australia Institute. (2018). *A Portable Training Entitlement System for the Disability Support Services Sector*. Download [here](#).

⁶ Mind Australia Limited, Submission S105, p. 9.

⁷ See: Autism Spectrum Australia (S066), Beacon Support (S022), Carers ACT (S147), Crosslinks Disability Support Services (S217), Dietitians Australia (S239), genU (S219), Hireup (S107), Kyeema (S226), Mind Australia Limited (S105), NeuroRehab Allied Health Network (S068), and Wellways Australia (S222).

Many submissions also reported that the current supervision ratios and utilisation assumptions do not support allow for sufficient education, professional development and upskilling of new staff, nor the required practices to meet the quality and safeguarding standards of the Commission.¹

Additionally, many providers suggested that they are paying supervisors at a level higher than assumed in the DSW Cost Model due to the need to attract and retain qualified, experienced, and skilled staff to supervise disability support workers and implement the Commission's practice requirements.²

Mind Australia suggested it was unrealistic to expect Social, Community, Home Care and Disability Services Level 3-4 staff to provide appropriate supervision, indicating that:

Mind employs SCHADS 5-6 workers to provide supervision to our staff... We have found that the requisite knowledge of NDIS systems, understanding of psychosocial theory and leadership capabilities to properly support staff is not found in applicants when we recruit below this level.³

The submission from NeuroRehab Allied Health Network reported a particular supervision cost issue that arose from the Positive Behaviour Support Capability Framework, namely that registered behaviour support practitioners must receive regular supervision from someone rated above their own proficiency level (or at the same proficiency level if the clinician is ranked at the top tier of 'specialist').

Within our service, we have just one clinician available over the next 6 months who we anticipate obtaining an endorsement above the 'Core' level of practitioner and able to supervise our 11 behaviour support practitioners. This supervisor will be unable to adequately cover all supervision needs due to the volume of work. As a result, the service will be required to fund external supervision (costs typically in excess of \$200 per hour, per supervisee). The supervisors are required not only for discussion of clinical cases, but also for detailed review and co-signing of behaviour support plans containing regulated restrictive practices.⁴

The submission from Kyeema argued that supervision is "severely under-funded", and suggested supervision time is being donated by providers.

As we are a smaller organisation with fewer than 200 participants we lack the economies of scale that would mean we can spend less on overheads and subsidise the Supervision layer to a great extent. ... Our Supervision staff, mostly called Team Leaders in our organisation cost us 12% of revenue. We are paid less than 6% of revenue for this (7% of built-up cost).

... Right now Kyeema is donating \$25,000 - \$27,000 per month to the NDIS in uncharged Supervision time. That lost \$300 K per annum would solve our financial problems.⁵

¹ See: Australian Community Support Organisation (S082), Autism Spectrum Australia (S066), Beacon Support (S022), Crosslinks Disability Support Services (S217), genU (S219), and Mercy Connect (S106).

² See: Crosslinks Disability Support Services (S217), Empowered Futures (S065), genU (S219), Greenacres Disability Services (S048), and Mind Australia Limited (S105).

³ Mind Australia Limited, Submission S105, p. 10.

⁴ NeuroRehab Allied Health Network, Submission S068, p. 4.

⁵ Kyeema, Submission S226 (email).

A number of submissions suggested that the allowance for supervision costs should be set at a higher rate to attract and retain qualified and experienced staff at the supervisory level.¹

For example, Greenacres Disability Services suggested that supervisors should be calculated at Level 4.3 of SCHADS Award.²

Many submissions also suggested that the supervision ratios and utilisation assumptions should be reviewed to provide fewer workers per supervisor and more time built in for non-face-to-face activities, which would allow for sufficient education, professional development and upskilling of staff.³

For example, Greenacres Disability Services suggests a span of control of 1 to 8 FTE and genU suggested that a span of control of 11:1 (headcount) should be used in the model.⁴

5.6 Other issues

Some submissions drew comparisons with what they considered to be the lower compliance requirements of unregistered providers, suggesting the cost differential places unregistered providers at an advantage.⁵ The submission from Allied Health Professions Australia (AHPA) indicated that this was particularly true for sole practitioners. AHPA suggested that the NDIA and the Commission should consider simplifying the provider registration and auditing processes, with the aim of reducing the costs and complexity of registration, regulation, and pricing arrangements.⁶

The submission from NeuroRehab Allied Health Network reported that:

Undertaking NDIS certification provides NDIS participants with a higher level of quality and safety however it is effectively financially penalising providers that do undertake this process.⁷

It was also suggested by some providers that the penalty placed on registered providers, in terms of the costs associated with registration and ongoing compliance, disincentivises provider registration and increases the risk that inadequate care is provided to participants. Greenacres Disability Services described this as “*incentivising growth in Unregistered Providers at the cost of quality and safety*” and suggested that, to avoid these disincentives and their negative consequences, unregistered providers should not receive the same level of funding as registered providers.⁸

The Australian Community Support Organisation warned that:

Unregistered organisations receive the same funding (or can negotiate a higher rate in some instances) and remain unaccountable with no regulatory or statutory oversight. This model is

¹ See: Greenacres Disability Services (S048), Illawarra Disability Alliance (S104), and Wellways Australia (S222).

² Greenacres Disability Services, Submission S048, p. 4.

³ See: Greenacres Disability Services (S048), Mind Australia Limited (S105), and Wellways Australia (S222).

⁴ Greenacres Disability Services, Submission S048, p. 4; genU, Submission S219, p. 7.

⁵ See: Australian Community Support Organisation (S082), Beacon Support (S022), genU (S219), Greenacres Disability Services (S048), Hireup (S107), Interaction Services (S047), and We are Vivid (S060).

⁶ Allied Health Professions Australia, Submission S111, p. 4.

⁷ NeuroRehab Allied Health Network, Submission S068, p. 4.

⁸ Greenacres Disability Services, Submission S048, p. 9.

lacking fairness and is likely to create a two tiered system where there is a disincentive for providers to be registered. It also means that there continues to be situations where unregistered providers are not monitored leaving participants in vulnerable or even dangerous situations where inadequate care is being provided.¹

Some members of the working group were also concerned with the lack of differentiation in the NDIS Pricing Arrangements between registered and unregistered providers. One member wondered why any provider would choose to register with the Commission (other than those delivering supports where registration was compulsory) given that registered and unregistered providers are subject to the same price limit. Some members reported that they were aware of allied health professionals who had decided not to re-register under the Commission due to the requirement for auditing.

Members of the working group agreed that in a well-functioning market it was advantageous to have a reputation for high quality, and that registration could help in this regard. However, they were not convinced that the NDIS market was currently operating at that level of sophistication.

Members of the working group were also concerned that the “unfair” competition between registered and unregistered providers was having other impacts on the sector. They argued, for example, that registered providers faced difficulties in matching the pay rates offered by unregistered providers, who could afford to pay their staff higher rates from their savings on quality assurance costs. Members of the working group considered this to be particularly problematic as registered providers were often dealing with participants who had very complex support needs.

Working Group members also identified a number of issues, including Continuity of Support and Duty of Care, where the requirements of the Commission were not well aligned with the NDIA’s planning processes or with the pricing arrangements. Members reported that the Commission appeared to expect that if support is untenable then the provider should continue to provide it until another provider is in place – even if the participant’s plan does not include sufficient funding to safely provide the support that the participant needs. For example, if the NDIA has funded a participant at 1:1 but workplace safety requirements require the presence of two workers then the provider is expected to absorb the cost of the second worker, apparently indefinitely. Providers said this was particularly problematic if a planner found the additional supports required by the Commission to not be reasonable and necessary as part of a change of circumstances review.

¹ Australian Community Support Organisation, Submission S082, p. 4.

6 Therapy Supports

The Review received a total of 122 submissions about pricing arrangements for Therapy Supports. Details of the submissions are at Appendix A. A working group of providers and other stakeholders was also established. The working group had 61 members from 41 organisations. The working group met by video-conference on three occasions: 3 December 2021, 4 February 2022, and 1 March 2022. Details of the members of the working group are provided in Appendix B.

The key topics raised in the consultations were:

- Pricing Arrangements;
- Training and Registration;
- Comparisons to Other Schemes; and
- Planning Issues.

A submission, coordinated by Ability First Australia was also received on behalf of: Ability WA, Benevolent Society, Cerebral Palsy Alliance, CPL, Cootharinga North Queensland, Montrose, Northcott, Novita, Rocky Bay, Scope, St Giles, Senses WA, Therapy Focus, Xavier and Yooralla. This group of providers is estimated to have accounted for 20% of the NDIS Therapy support market in 2020-21 financial year. That submission included a detailed cost model for therapy supports and is reported in Section 8.5 below.

The analysis and recommendations relating to the consultation on Therapy Supports can be found in Chapter 6 (Therapy Supports) of the *Report of the 2021-22 Annual Pricing Review*.

6.1 Pricing Arrangements

A number of submissions, and working group members, argued that the current price limits for therapy supports were too low. The principal reason advanced for an increase in the price limits was the need to pay higher wages because of a shortage of therapists. For example, Jibber Jabber Allied Health reported that:

The wages of qualified people in this field has risen substantially in recent years. The median wage is \$90,000 and an entry average is a staggering \$78,810. This increase has been driven largely by shortages in hiring people with qualifications.¹

The submission from NeuroRehab Allied Health Network similarly reported that the base salaries for Allied Health Professionals have increased on an average of \$5k per annum for junior team members and \$7-\$10k per annum for senior members as a result of labour shortages.²

¹ Jibber Jabber Allied Health, Submission S006 (email) (citing figures from seek.com.au)

² NeuroRehab Allied Health Network, Submission S131, p. 1

Novita was particularly concerned with their inability to compete with Government service providers for therapists:

The South Australian Government... is a major competitor for allied health therapy staff, and is a primary determiner of therapy salaries... The Government pays higher salaries than NDIS providers are able to pay under the price cap.¹

Working group members also argued that therapy demand was higher than supply in selected markets — in particular, providers reported that there are thin markets for speech pathologists and psychology, even in metropolitan areas.

Providers were also concerned that costs were also increasing because of increases in awards and superannuation rates, while price limits have not been increased in two years.²

For example, Therapy Pro argued that:

The current base rate of \$193.99 was calculated more than two and a half years ago. Since then, there has been movement of 12.7% on the cost inputs, primarily on therapist salaries and on-costs, that were not offset by pricing increments, which in turn is putting pressure on industry-wide business sustainability.³

Submissions and working group members also argued that the current price limits were too low because there was no allowance in the current price limits for the additional costs associated with COVID-19 despite the continuing impacts of the pandemic — for example, parents requesting therapy providers and their office to take RAT tests daily, or higher rates of cancellation as parents and participants isolate or try to minimise contact.

Members of the working group noted that the price limits for psychology were lower than the Society's recommended rates and argued that in their experience they were also lower than general market rates particularly for those psychologists holding an endorsement with AHPRA. The price limits were considered to be particularly low for clinical psychologists, neuropsychologists, counselling psychologists and forensic psychologists. It was argued this likely decreased access to these more specialised services. It was also argued that exercise physiologists should not have a lower price limit than other therapists, as their services were equally valuable and that the costs of employing an exercise physiologist were the same as other therapists, if not more, when considering the cost of equipment, that exercise physiologists required an equivalent level of training and overheads as the services of other therapists and because they were already disadvantaged by being subject to GST.⁴

IoT's submission suggested that the price limits for therapy supports should be increased to \$210 per hour to provide incentive for allied health practices to continue to recruit experienced and clinically skilled practitioners at salaries that are competitive with government providers. The submission noted that NSW Health would pay a total package salary of close to \$120,000 for a physiotherapist with around five (5) years of post-graduate experience. IoT suggested that if the hourly price limit is not increased then over time they

¹ Novita, Submission S154 (Therapy Supports), p. 8

² See: Jibber Jabber Allied Health (S006), National Disability Services (S152), NeuroRehab Allied Health Network (S131), Novita (S154), PC Ability (S090), and Therapy Pro (S156).

³ Therapy Pro, Submission S156, p. 3

⁴ Exercise and Sport Science Australia, Submission S070, p. 14.

will lose skilled allied health practitioners to the public health system who can provide higher salaries and working conditions.¹

In the context of personal training and comparing NDIS price limits to other schemes, a submission from Extra Mile PT stated that, even after acknowledging exercise physiologists should attract higher price limits for requiring university degree qualifications and professional registration, the rate for personal trainers (\$58.10) is around three times lower than that of exercise physiologists (\$166.99). The submission stated that at these rates, personal trainers find it unviable to offer services through the NDIS, discouraging providers from participating.²

The need to attract and retain skilled therapists was raised a number of times, with several discussions about the pipeline of future therapists. Working group members noted that university graduates do not immediately have the skills necessary to work with NDIS participants. Around 12 to 18 months on-the-job training was needed before a graduate can work effectively in the NDIS. Working group members argued that providers could only achieve relatively low utilisation rates because of the need to train junior staff, meet a high compliance burden, and absorb underfunding in participant plans. Members reported that utilisation rates for NDIS therapists rarely exceeded 50% to 55%. A working group member suggested that a review of the pricing for provisional psychologists (registered with AHPRA) may assist with some workforce issues.

In a comparison to the private market for therapy, one working group member noted that training and upskilling NDIS therapy practitioners cannot be leveraged in the same way that a private practitioner can. They argued that private providers could spread the cost of training across a larger base of clients who each see the private therapist less frequently. As a related point, it was noted that price limits needed to account for the cost of supervision by experienced staff.

The submission from Living My way similarly argued that:

It is essential that new graduate and early years therapists are provided with adequate training and support by more experienced therapist [sic]. However, the current pricing limits make this more difficult to provide and most definitely is not provided with all organisations.³

Working group members also argued that there was a high turnover in junior therapists who did not remain NDIS practitioners, arguing that not only did this limit the pipeline of future therapists, but it increased search, recruitment and training costs for existing providers. Members argued that without an increase in the price limits for therapy supports, even established NDIS therapy providers would exit to private practice, leading to participants losing access to therapists familiar with their conditions.

Consultations consistently indicated a preference for a 'per hour' pricing approach, rather than a 'per consultation' approach as in some other schemes. Reasons given included:

¹ IoT, Submission S125, p. 7

² Extra Mile PT, Submission S155 (email).

³ Living My Way, Submission S120, p. 11

- The amount of time a service takes to provide may be highly variable depending on the client and their needs. Tasks can take varying amounts of time to complete depending on the home, the client and the overall situation.¹
- The therapist can match service delivery to the participant's energy, availability, and clinical need(s); for example one client may need 30 minute consults for 6 weeks, whereas another may require one session of 3 hours.²

The Australian Podiatry Association argued that:

*A paediatric client may require a 60-minute consultation for therapy assessment and intervention compared to a 30-minute consultation for personal care/hygiene for a client with an intellectual disability. A per-consultation billing minimises the inherent variation in participant presentations and diminishes opportunity for quality care.*³

Pricing Arrangements for Group Based Therapy

A number of submissions also called for a reform in the group based pricing arrangements. For example, the Australia Music Therapy Association argued that:

*Current group pricing limit innovative service design and delivery. Discounts for group programs per participant do not recognise the additional administrative work for groups. Group services should be recognised for the additional value they provide and the workload they involve and costed appropriately.*⁴

Dietitians Australia, Speech Pathology Australia and the Mental Illness Fellowship of Australia Inc. all similarly argued that the pricing for group services should be increased and higher than individual supports as the current price limit does not account for the increased complexity and time associated with running group sessions.⁵

Weekend Pricing

To enable greater participant choice and control and to grow the market, the Australian Physiotherapy Association suggested introducing evening and weekend pricing for therapy supports. They proposed that evening and weekend pricing would drive a new market and offer more choices to participants, potentially increasing the workforce allowing allied health professionals who cannot access childcare to work half day on weekend that they otherwise wouldn't have been able to work during the week. This may bring more skilled therapists from health sector into disability. The submission by Australian Physiotherapy Association stated that:

... physiotherapists should be entitled to work at reasonable and appropriate times, or be appropriately rewarded for working outside these times, as other sections of the Australian workforce are. Increasing remuneration for services outside of award hours could provide an incentive for part-time or casual physiotherapists, or those juggling work and family commitments,

¹ See: Ability Options (S218), Kurrajong (S094) and PC Ability (S090).

² Lime Therapy, Submission S157 (email).

³ Australian Podiatry Association, Submission S205, p. 4.

⁴ Australia Music Therapy Association, Submission S211, p. 3.

⁵ See: Dietitians Australia (S239), The Mental Illness Fellowship of Australia Inc (S153), and Speech Pathology Australia (S242).

to provide services to NDIS participants. This could provide new opportunities for providers as well as expanding the NDIS market and facilitating more supply of services for participants.¹

Greater Certainty

Consultations also emphasised the need for certainty in future price limits. Working group members noted that stability in price limits is necessary for practitioners to continue to perform work in the disability space and to continue to train and support new university graduates without changing existing business models.

The submission from Allied Health Professionals Association called on the NDIA to provide greater certainty going forward by committing to:

- Increase the price limits for all allied health services so that they are consistent.
- Ensure the pricing arrangements and price limits are GST exclusive for all therapy support providers.
- Increase therapy support prices in line with inflation each financial year.
- Increase allied health price limits to consider after hours loading.
- Remove the current pricing cap on the provision of group supports, allowing these to be provided at a cost determined by the provider to enable them to be financially viable.²

6.2 Compliance and administration

Working group members reported high compliance costs associated with the NDIS Quality and Safeguards Commission and related audits. They argued that for a small or individual practitioner, there was little value-add to becoming a registered provider especially given that AHPRA-regulated professions are accountable externally and non-AHPRA-regulated professions are accountable to professional bodies that have strict codes of conduct.

Lime Therapy suggested in their submission that the current pricing model does not factor in the costs associated with complying with reporting requirements of the NDIS under the NDIS Quality and Safety Commission.

[T]he significant time burden associated with NDIS reporting, AT application, review, without the associated requirement to 'sign off' on recommendation prior to payment. Under other schemes, the therapist will apply for funding [and when] funding is approved, the therapist is asked to review.³

The submission from NeuroRehab Allied Health Network also suggested that schemes such as the Victoria Transport Accident Commission do not require the same level of reporting or accreditation to standards that the NDIS Commission requires.⁴

Submissions also noted that the providers who are registered with the NDIS are required to undergo routine audit, adhere to the changes made to NDIS practice standards, and

¹ Australian Physiotherapy Association, Submission S098, p. 8

² Allied Health Professions Australia, Submission S111, p. 3.

³ Lime Therapy, Submission S157 (email).

⁴ NeuroRehab Allied Health Network, Submission S131, p. 2.

complete mandatory training modules, all of which give rise to costs that are also not factored into the current pricing structure.¹

The Australian Association of Psychologists Inc.'s submission stated that the costs associated with working in the NDIS, such as audit costs, can be between \$1,000 and \$15,000 per year. This does not account for the additional costs incurred in time and energy to produce the required policies and procedures.²

The submission from NeuroRehab Allied Health Network reported high levels of compliance cost.

For the larger NDIS registered organisation the compliance costs to maintain registration through certification auditing are very high and requires a significant direct cost (~\$10,000pa in auditor fees) and indirect cost (our recent mid-way audit preparation took Senior management and Senior Clinicians at minimum 250 hours labour costs and a reduction in revenue from reduced clinician time available to see participants). With only 14% of our 3000+ participants utilising agency managed funding this massive outlay of time and funds has no significant benefit.³

To address these issues, the submission from Allied Health Professionals Australia called on the NDIA to work with:

- The Regulatory Alignment Taskforce and the NDIS Quality and Safety Commission to simplify current provider registration and auditing processes.
- Allied health peak bodies to investigate the current therapy market when considering benchmarking and acknowledge the potential impacts of thin markets.
- Allied health peak bodies to publish clear and communication-accessible information on pricing, and to ensure this information is consistently provided to participants.⁴

Submissions also indicated that the current price limits also did not provide sufficient allowance for administration costs and overheads. Merri Health stated that the current hourly rate does not adequately account for overhead costs for organisations. They stated the expected overhead rates in NDIS DSW cost model are 15% or lower, which in their experience, is incongruent with the broader community health and allied health sector where overhead costs range between 20-25%.⁵

The submission from Vision Australia similarly argued that their

... average direct cost of service delivery over the last 12 months is \$190.23, however, overheads increase the overall cost of service delivery significantly. We are currently investing in a number of projects to improve efficiencies and reduce overhead costs, however, even with overheads set modestly at 20%, our total cost of service will still be over \$210 per hour, and well above the current NDIS price ceiling.⁶

¹ See: Australian Association of Psychologists Inc. (S213), Chorus Music Therapy Clinic Pty Ltd (S089), Dieticians' Australia (S239), Lime Therapy (S157), and Tropics Occupational Therapists (S026).

² Australian Association of Psychologists Inc., Submission S213, p. 6

³ NeuroRehab Allied Health Network, Submission S131, p. 1

⁴ Allied Health Professionals Australia, Submission S111, p. 3.

⁵ Merri Health, Submission S061, p. 5

⁶ Vision Australia, Submission S109, p. 8

The submission from First Voice suggested that the administrative costs of delivery under the NDIS scheme, including the need for new systems and new processes across organisations has hampered their ability to compete with other sectors for workforce.¹

The submission from NeuroRehab Allied Health Network suggested that various overheads such as rent, equipment, training and vehicle provision are required to be incurred in order to provide quality service to NDIS clients but, with price limits being now frozen for two subsequent financial years, it has resulted in reduced margins.²

The submission from Lime Therapy similarly argued that:

NDIS set the expectation that administration costs would be at between 9 - 11% whereas all organisations have been reporting that it is more like the 17 - 18%. This hasn't changed given the additional worker orientation modules to be completed, mandatory reporting, particularly under COVID19 conditions (NDIS registered providers must report to both the NDIA Commission and Department of Health).³

The submission from Kurrajong also suggested that continual changes by the NDIA to the NDIS, along with confusing pricing arrangements and ambiguous guidelines, have increased administration workload.⁴

Members of the working group also raised a concern that the current arrangements do not differentiate enough by providers, particularly where non face-to-face time differs between professions. Dieticians, for example, spend a larger portion of non-face-to-face time performing activities such as dietary analysis and meal plan analysis, compared to physiotherapists who perform more hands-on therapy. Providers argued that the current pricing arrangements do not account for these differences. For remote participants, non-face-to-face time was reported to be critical in resolving complex issues that cannot all be resolved face-to-face, and to prepare individualised resources for these participants.

6.3 Comparisons to other schemes

Consultations indicated that there was strong demand for therapy outside the NDIS, and by other public and publicly funded schemes; however, comparisons to other therapy arrangements were not straightforward and needed to be made with care.

Providers argued that some other schemes only allowed a 20 minute appointment, which was an insufficient length of time to provide quality therapy, especially for complex needs participants. Providers argued that the complexity of NDIS participants means they require longer consultations and a higher level of skill. They also argued that the complexity of NDIS participants also increased the costs of training new graduates, and limited opportunities for providers to take advantage of scale in service delivery.

They also argued that some schemes, such as the Medicare Benefits Scheme, provide a rebate rather than fully funding the support, so providers typically charge rates above the specified price in the schedule and recover the 'gap'.

¹ First Voice, Submission S088, p. 4

² NeuroRehab Allied Health Network, Submission S131, p. 1.

³ Lime Therapy, Submission S157 (email).

⁴ Kurrajong, Submission S094, p. 44

It was also argued that the administration load on NDIS participants is more significant compared to private patients and other schemes. The transaction costs associated with being an NDIS provider were also argued to be higher than in other schemes; and providers in other schemes were not required to undergo quality reviews and had more limited auditing processes. It was also argued that NDIS therapy support providers had to deal with more intermediaries such as Plan Managers and Support Coordinators.

Providers also pointed out that comparisons were inappropriate in the case of thin markets or where NDIS participants made up the majority of the market, such as therapy for children or for amputees. Moreover, they argued, just because prices or limits set by other schemes were lower did not mean they were appropriate or sustainable — a working group member gave an example where Department of Veterans' Affairs rates for orthotists and prosthetists, which are lower than NDIS price limits, has resulted in orthotists and prosthetists leaving the DVA scheme;

The Australian Physiotherapy Association submission presented several reasons why it was inappropriate to compare NDIS price limits to the prices paid in other schemes. They suggested there are differences in training and experience required from the workforce operating in the different schemes, with one member reporting that they "*utilise more junior and thus less experienced staff in some schemes of which remuneration for service provision is less*". Additionally, some schemes with lower fees allow for gap payments. Finally, the fact that physiotherapists operate in lower priced schemes does not imply these providers think those fees are fair and reasonable.¹

In the context of exercise physiology and comparing NDIS price limits to other schemes, ESSA disagreed with the analysis reported by the NDIA in the Consultation paper that claimed that the price limit under the NDIS is 17% higher than the average price limit of comparable insurance schemes as the other comparable schemes offer GST exclusive fees, whereas the NDIS price limits are GST inclusive.² When considering GST, it was suggested that NDIS price limits are 5% lower than the comparable schemes. ESSA argued their data showed that 72% of exercise physiologists that work in the NDIS are GST registered (including unregistered providers).

Further, ESSA noted that exercise physiologists are better remunerated under the aged care system, as they can set their own prices for service provision. An analysis of recent Home Care Package data by Stewart Brown in 2020 indicated that, on average, exercise physiologists charged \$186.85 per hour in the aged care sector.

First Voice's submission stated that expectations of NDIS participants are different from clients accessing services through Medicare, and noted that Medicare services tended to be more discrete and time limited.³ Submissions also stated that NDIS participants require significantly more inter-professional and multi-disciplinary liaison, carer contact, resource preparation, risk management, therapy accommodations/modifications, assessment, report

¹ Australian Physiotherapy Association, Submission S098, p. 5

² Exercise and Sports Science Australia, Submission S070, p. 14.

³ First Voice, Submission S088, p. 3

preparation, as well as assistance with advocacy.¹ The Australian Community Support Organisation's submission further noted instances when therapists have to deal with highly complex and dual diagnostic participants where supports from specialised practitioners such as a forensic psychologist are required. These specialisations do not attract any additional funding support under the NDIS, although they do in other government funded programs.²

Some members of the Participant Reference Group indicated that providers generally did not negotiate on price but charged at the limit, and that they risked going without the support entirely if they tried to negotiate. They further indicated that this was particularly true of providers of therapy supports. Several members provided examples where a therapy support provider charged them more as an NDIS participant than if they had been paying out of pocket. One member indicated that they had asked the provider why the price for an NDIS participant was higher than for someone without NDIS plan funding but had not been given an explanation.

6.4 Planning Issues

Through the consultations, it was argued that some of the issues currently experienced by providers could be due to insufficient hours for therapy being included in a participant's plan, rather than to a price limit that was too low. Working group members argued that planners do not always understand the value of allied health and are often making decisions without clinical training. They suggested that this results in an under-allocation of therapy hours in participants' plans. A working group member provided an example of assistive technology being underfunded compared to the actual amount of time required to complete trials and reports. It was noted some therapists will perform services and bill less than the full amount of time required, particularly if trials and reports are already underway. Providers noted that such pressures can have a negative impact on quality and intensity of service provision if left unaddressed.

This was argued by some working group members to be particularly true for psychology and clinical psychology. A working group member suggested that the Medicare Benefits Scheme and other health systems, including private health insurance, provide for the treatment of mild to moderate conditions, often with a goal of symptom reduction or remission of diagnoses. In comparison, services provided under the NDIS are more likely to be aimed at rehabilitation and supporting participants to maximise quality of life while living with lifelong conditions. Psychologists have advised that a lack of understanding by planners of the role of psychology often resulted in psychology being underfunded in participant plans.

Providers noted there was a lack of information and clarity around how long some services, such as quality reports, may take and that participants were often unwilling to sign off on the time spent on these reports.

Providers also noted insufficient funding also impacts the amount of non-face-to-face time that can be billed.

¹ See: Australian Association of Psychologists Inc. (S213), Can:Do Group (S091), Dieticians' Australia (S239), and Roslyn Thorpe Occupational Therapist (S212).

² Australian Community Support Organisation, Submission S062, p. 7

Working group members also suggested that more training and guidance for Plan Managers (particularly in relation to what can and cannot be charged for) would save administration time spent having therapists explain the different supports charged.

Members also discussed how therapy supports were categorised. They noted that in some instances, certain therapy sessions may not relate strictly to building capacity but are still important for the person to maintain their standard of living and not lose capacity — for example, wound care. However, other members noted that if these items remain in Core, it may lead to plans being funded with the expectation that therapy items will be funded through the Core budget.

Consultations also spoke to insufficient funding for travel. In the discussion, working group members noted that some forms of therapy such as early childhood or exposure were more effective in participants' homes or in particular locations that required the provider to travel. Working group members noted that planning travel arrangements between multiple participants for a rural/remote clinic was difficult, especially if participants drop out and travel fees need to be renegotiated across the remaining participants. Working group members noted that therapists providing services to thin markets needed to travel further, but that even therapists in metropolitan areas were unable to fully pass on or recover travel costs and that a lot of travel was unbilled.

These arguments were also supported in submissions received. For example, First Voice said that the restriction to charge only 30 minutes of travel time is challenging for any service, but particularly specialist services where the number of providers are limited and providers may be travelling long distances to service the metropolitan areas.¹ The Australian Music Therapy Association stated that members can end up travelling up to one hour return for an appointment in a metropolitan area, whilst the NDIS Price Guide states the maximum amount of travel that can be claimed in MMM1-3 areas is 30 minutes.²

Down Syndrome Australia noted that:

...a therapy budget of \$9,311.52 (48 hours @ \$193.99) is designed to service a participant with one therapy session per week allowing for holidays. With provider travel being able to be allocated to 30 minutes per session the participant is reduced to 32 hours of service over the 12-month plan period. This reduction in face-to-face service provision impacts the outcomes for participants.³

The submission from Vision Australia noted that its:

... members have found that travel arrangements for one-on-one therapy supports have frequently proven insufficient for providers. According to the Modified Monash Model, providers can claim up to 30 minutes of travel time for participants in metro areas, but there are many clients for whom travel will take significantly longer than this, even within capital cities. One provider calculated that for every NDIS service delivered, the average non-billable travel time was 7 minutes, at a cost of \$9.50 that is funded by Vision Australia.⁴

¹ First Voice, Submission S088, p. 3

² Australian Music Therapy Association, Submission S211, p. 4

³ Down Syndrome Australia, Submission S128, p. 5

⁴ Vision 2020, Submission S234, p. 9

6.5 Major Therapy Provider Submission

A major joint submission on the pricing arrangements for therapy supports was received from Ability First Australia, Ability WA, Benevolent Society, Cerebral Palsy Alliance, Cootharinga North Queensland, CPL, Montrose, Northcott, Novita, Rocky Bay, Scope, St Giles, Senses WA, Therapy Focus, Xavier and Yooralla.¹

These providers together account for about 20% of all NDIS expenditure on therapy supports. Their joint submission identified the following shared characteristics for these organisations:

- They operate at scale, often with a State-wide, and in some cases a National, footprint.
- They recruit, train and employ large workforces of allied health professionals. In fact, around 250 new staff (new graduates or workers new to the sector) are employed and trained by the group each year.
- They have robust clinical governance systems at all levels of the organisation – from service level to the Board.
- They operate with significant physical and IT infrastructures that are important at a market level.
- They support staff to develop skills to a high standard, and in a number of specialisations required to support people with disability.
- They have a particular service focus, and therefore deep expertise, in working with people with multiple and complex disabilities.

As part of their submission these providers engaged Deloitte Access Economics to construct a cost model for therapy providers based on a detailed analysis of the financial performance of the various providers. The submission stated that:

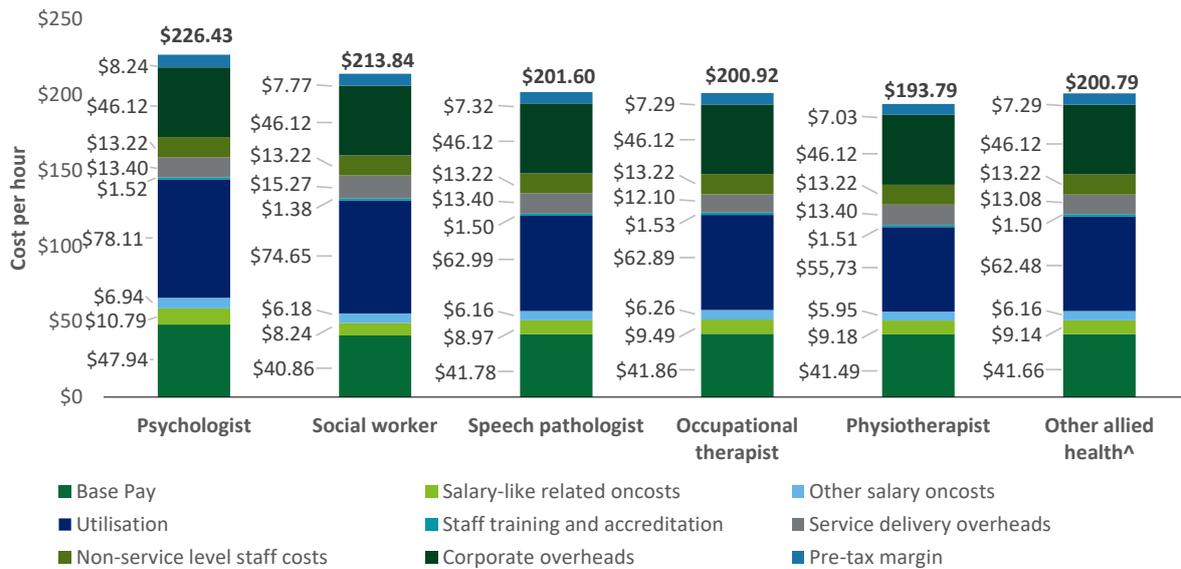
The Cost Model shows that the actual cost of service delivery in 2021 for the organisations surveyed was \$226.43 per hour for psychology staff and \$200.79 per hour of the other allied health disciplines [Occupational Therapy, Physiotherapy, Speech Pathology, Social Work, Psychology]. When disaggregated by regionality, the result for metropolitan regions was \$224.38 per hour for psychology staff and \$197.04 for other allied health staff.

This analysis demonstrates that the majority of providers surveyed operate at, or slightly below, break-even against the current NDIS prices caps.

More detail of the cost modelling undertaken by Deloitte Access Economics for the major therapy providers is shown in the following chart (Exhibit E.1 in the Deloitte report to the major therapy providers).

¹ Major Therapy Providers, Joint Submission S241.

EXHIBIT 3: DELOITTE ACCESS ECONOMICS ESTIMATE COST PER HOUR OF ALLIED HEALTH SERVICES UNDER THE NDIS



[^] Other allied health is the weighted average of social worker, speech pathologist, occupational therapist and physiotherapist.

The joint submission from the major therapy providers also addressed the issue of the appropriate benchmark for NDIS prices. The submissions argued that comparisons with other schemes are flawed as they assume:

... the cost structures of therapy supports in these other jurisdictions are strongly aligned to those of therapy supports provided under the NDIS. Accident recovery schemes, for instance, are largely rehabilitative in focus, whereas NDIS therapy supports are significantly focused on long term habilitation, as well as strategies to maximise participation, choice and control for people with often complex and/or specialised needs. This difference is fundamentally a difference between a medical model and a social model of therapeutic support.

Working in a social model of support can be challenging and complex work, often requiring approaches and service models that do not fit within more traditional rehab models such as those used in other insurance schemes.

The joint submission made the following recommendations to the NDIA:

- Don't reduce the current price cap. Based on the findings in the Deloitte report, and noting that the NDIA is not proposing to move away from price capping in the short term, this group of providers recommends that the current pricing be at least maintained at current levels, using the current blended single pricing cap.
- Reintroduce price indexation for therapy supports, with an immediate increase recommended to make up for the lack of indexation in previous years.
- Broaden the definition of billable time to reflect the true productivity of therapy support providers.
- Work towards the removal of price capping in more mature markets in the medium term if not sooner. We propose that this begin with piloting the removal of price-capping applied to therapy supports in selected markets (e.g. capital metropolitans).
- Reconsider the NDIA's approach to benchmarking price with other jurisdictions, including which jurisdictions it considers appropriate to benchmark with. Further, it recommends that the NDIA undertake research into the underlying cost structures of

services delivered under each jurisdiction before confirming the pricing arrangements in other jurisdictions are appropriate to benchmark with.

- Work with this group to better understand the cost of services. This group of providers invites that Agency to work with it to develop a mature costing model to help identify the true cost of therapy supports. This will help ensure that the NDIA is able to understand and price for the cost of quality services and provide a meaningful basis for benchmarking with the private providers and other potentially comparable funding regimes.
- Provide certainty for the future. The NDIA should commit to a long-term pricing framework. Providers need to make decisions around services and infrastructure based on forecasts for the next 5-10 years. Commitment to a long-term road map for therapy pricing and supports will give participants and providers clarity about the future environment, and if pricing is adequate, the confidence to invest. This should include a commitment to annual indexation of pricing.
- Provide adequate notice of future changes. The NDIA must provide ample notice to therapy support providers about what pricing changes will come into effect from 1 July 2022. Providers need to make significant investment in systems, staff training and communication to customers every time a change is made to the pricing framework. This can take months to prepare. Notice regarding changes to the 2022-2023 pricing framework would ideally be provided by February 2022 to align with budget and business planning cycles of service providers.

7 Nursing Supports

A total of seven (7) submissions about the pricing arrangements for nursing supports were received in response. Details of the submissions are at Appendix A. A working group of providers and other stakeholders was also established. The working group had 15 members (from 13 organisations) and met, by video-conference, on two occasions: 3 December 2021 and 4 February 2022. Details of the members of the working group are provided in Appendix B.

The key topics raised in the consultations were:

- Price limits
- Pricing Arrangements
- Provider Travel, and
- Planning Issues.

The analysis and recommendations relating to the consultation on Nursing Supports can be found in Chapter 7 (Nursing Supports) of the *Report of the 2021-22 Annual Pricing Review*.

7.1 Price limits

Members of the working group argued that the current price limits for nursing supports do not allow providers to pay nurses wages that are competitive with the public system, noting that nurses employed in the public system were often entitled to additional benefits including COVID incentives, long service leave portability, six weeks of annual leave, and study support. They emphasised that this issue was becoming more and more acute under COVID with providers needing to pay for personal protective equipment for their employees and offer them COVID leave in order to retain them. Members of the working group reported that the supply of nurses was also under pressure, with nurses less able than previously to work across sectors or across multiple sites. They also reported that vaccine mandates have further reduced the supply of nurses. Western Australian members of the working group argued that they also faced additional difficulties in competing with the resources sector.

Members of the working group also argued that the NDIS's price limits were not high enough to attract appropriately skilled, disability trained nurses, noting that less skilled nurses often do not feel comfortable working in the disability sector. They also argued that the current price limits were not high enough to cover: additional expenses such as offices and infrastructure (including infrastructure associated with nursing assessments), finance, administration, the extensive ongoing refresher training required for nurses, which are more significant than allied health professionals, and the costs of registering with the NDIS Commission. They indicated that, as a result, providers were choosing to not be registered with the NDIS Commission and choosing to only provide services to self-managed clients.

Members of the working group also argued that the current price limits do not account for the costs associated with nurses needing to have a minimum amount of consumables stock on hand. One member shared that for an initial wound assessment, for example, the nurse

needs to be able to treat the wound on the first visit. This is prior to participants being able to use their plan budgets to purchase the necessary consumables for ongoing support and treatment of the wound, leaving nurses potentially out-of-pocket for the consumables required for the initial wound assessment.

Members of the working group were particularly concerned that the price limits for nursing had remained the same over the last two years whilst the cost to deliver services has increased. Different members of the working group suggested different level of increase in the price limits, ranging from a 3.5% increase to match the increases requested by unions, to pay parity between Clinical Nurse Consultants and allied health professionals. They stated that experienced clinical nurse consultants and allied health professionals who work in the disability sector are typically paid similar salaries. Provider submissions also suggested that the price limits for nursing supports should be aligned with those for allied health providers for similar services being provided.

The Continence Foundation of Australia reported that for the last two years, Nurse Continence Specialists (NCSs) have generally only been able to claim through the Delivery of Health Supports by a Clinical Nurse Consultant – Weekday Daytime support item with an associated price limit of \$146.72 per hour, whereas some allied health professionals have been able to claim \$193.99 for what the Foundation argued were equivalent services. The Foundation suggested that the lack of parity between NCSs and allied health professionals does not align with the qualifications and experience that NCSs have in performing specific tasks, and results in an undersupply of practitioners.

An NCS uses a whole-systems assessment process in the same way as an Occupational Therapist assesses functional capacity and needs. Comprehensive continence assessments and management plan reports conducted by NCSs are necessary and provide multiple health, economic and quality of life benefits.¹

The Continence Foundation of Australia provided a detailed estimate of their hourly costs, based on the costs that they incurred in delivering NDIS services between July and December 2021 (see Exhibit 4).²

EXHIBIT 4: CONTINENCE FOUNDATION OF AUSTRALIA ESTIMATE OF FULLY LOADED HOURLY COST OF NURSING

Cost centre (for four hour continence assessment)	Cost
Staffing Costs	
Nurse Continence Specialists	\$254.00
Administration	\$33.00
Finance	\$19.18
Management	\$137.00
Payroll and On costs (no unbillable hours included)	\$15.74
Training and Development (Staff Training, CPE and Case Conferencing)	\$63.52
Clinical Costs (PPE, Specialised Continence Equipment, Promotion)	\$56.04
Infrastructure Costs, includes Office & utilities, Computer Hardware, Software & Clinical Software	\$192.23

¹ Continence Foundation of Australia, Submission S100, p. 5.

² Continence Foundation of Australia, Supplementary Submission S100a, p.1.

Cost centre (for four hour continence assessment)	Cost
Total cost for a four hour Continence Assessment	\$770.71
Total cost per hour	\$192.68

The Continence Foundation of Australia recommended that:

The fee for service for an expert nurse including a Continence Nurse Specialist working at the level of a Clinical Nurse Consultant, providing a continence assessment, should be the same as the fee for service for an allied health professional (episodic therapy rate).¹

The submission from the Royal District Nursing Service of South Australia stated that the NDIS's price limits are significantly lower than both their Fee for Service rates and the rates they currently have with various funders including SA Health, the Commonwealth Home Support Program and the DVA Community Nursing Program.²

7.2 Pricing Arrangements

In general, members of the working group supported the current structure of the support catalogue for nursing supports. Although there are a high number of nursing items (62) compared to allied health, the current structure is necessary to recognise different nursing levels and loadings for night time and weekends so that the pricing structure is more comparable to the public health sector.

Members of the working group also supported the duplication of the nursing supports in core as this ensured that participants would have funds to purchase nursing supports if they needed them without waiting for a plan review. Members of the working group did consider, however, that greater clarity should be given as to when supports could be considered to be disability related health supports.

Members of the working group were also concerned that the pricing arrangements were not always well aligned with the Nurses Award. For example, the cost model did not recognise that supports were sometimes delivered by staff who were working overtime. Also, the definitions of Evening and Night shifts, which were based on the SCHADS Award, did not align with the shift definitions in the Nursing Award.³ Members also considered that the pricing arrangements did not recognise the costs imposed on providers by award conditions such as broken shift allowances and the minimum engagement requirement, which required them to pay a nurse for at least two hours each time they were employed. Another member suggested that it was important to consider changes in market conditions. Nurses who work in private businesses or are self-employed are in a different financial situation than nurses employed in the usual Nursing Award environments.

One member of the working group suggested that there might be value in having an additional support item, with a higher price limit, that would make it financially viable to offer the required rates to attract nurses to fill last-minute requests, such as a sick call by another nurse, especially when the provision of the nursing was vital to the participant.

¹ Continence Foundation of Australia, Submission S100, p. 6.

² Royal District Nursing Service of South Australia, Submission S148, p. 1

³ See also: At Home Care, Submission S247 (email).

7.3 Provider Travel

A number of submission were concerned with the billing rules for travel, and in particular the limits on the amount of travel time that can be claimed from plans. The submission from At Home Care Pty Ltd suggested that travel costs have not been sufficiently considered in the NDIS's pricing arrangements.¹ The Continance Foundation of Australia stated that:

... the amount of travel that can be claimed to facilitate specialist continence is limited to one hour for a round trip this must also be increased through in-kind contributions as existing fee structures will not nearly compensate services for some regional and almost all remote area travel.²

The Continance Foundation argued that this is especially pertinent to be able to build a connection with and deliver culturally safe continence services to Aboriginal and Torres Strait Islander communities. They stated that having direct in-person access is crucial as it enables facilitating necessary therapeutic supports such as the examination of pre-existing problems through face-to-face assessments which can greatly assist with improved quality of life.³

Members of the working group agreed that the current time limits on travel were inadequate and argued that this was also the case in metropolitan areas. The also argued that the limits were unnecessary because participants would not choose to use the funds in the plan to pay for travel if it was not necessary.

7.4 Planning Issues

A number of submissions reported cases where insufficient funding was included in plans to meet clinical need. The submission from At Home Care stated that:

... the NDIS only fund one hour for a catheter change which doesn't take into consideration travel time to/from the client's home. ... Travel time is not supported for certain clients - clients are knocked back and do not have choice if there is only 1 provider in their local area.⁴

Members of the working group argued that planners sometimes do not build enough hours into plans. They provided examples where they considered that planners had not included:

- Sufficient funding for the defined task – for example, providers reported instances where planners only allowed for four hours in the plan continence assessments when providers considered that these generally require around six hours.
- Funding for nurses to provide training or additional support to support workers.
- Funding for services that drive better long term outcomes – for example, a planner refused to provide to provide appropriate wrap-around supports required to ensure high quality diabetes management.
- Funding for handovers that are clinically necessary. For 24 hour supports, providers argued that participants should receive 25.5 hours of funding to also cover handovers.

¹ At Home Care Pty Ltd, Submission S054, p. 5.

² Continance Foundation of Australia, Submission S100, p. 6

³ Continance Foundation of Australia, Submission S100, p. 6

⁴ At Home Care Pty Ltd, Submission S054, p. 5.

- Funding to cover the necessary amount of travel. This means the participant cannot receive the clinically necessary amount of treatment as they need to spend some of the treatment funds in their plans on travel or receive no supports at all.

Members of the working group were also concerned that planners may not understand the skills and scope of practice of the different levels of nurses and so may not provide sufficient funding to allow participants to engage a nurse with the necessary qualifications. They were also concerned that there were inconsistencies in planning decisions and suggested that there was a need for better education for planners regarding the funding of appropriate nursing support to assist participants with their disability related health needs.

The submission from the Continence Foundation of Australia stated that greater access to both specialist comprehensive continence health assessments and capacity building supports are necessary to deliver improved outcomes for NDIS participants. In its submission, the CFA suggests the NDIA should actively recognise:

... the need for continence services that can deliver contemporary, evidence-based and effective continence assessments rather than lower quality alternatives and ensure the stewardship of the market to provide equitable access to these services.¹

The submission by Continence Foundation of Australia also reported that:

Following a major policy change to include some disability-related continence supports in the NDIS in 2019, it is estimated 40-60,000 participants required reassessment in light of the change ... it is highly unlikely that even one-tenth of the affected participants had appropriate access to NCSs for comprehensive continence assessments.²

The submission from the Royal District Nursing Service of South Australia argued that current planning arrangements can restrict participant choice and control and increase scheme costs overall. They stated that where a participant's nursing funding ceases, nurses are generally replaced by support workers for supports like medication administration. The submission argued that support worker providers generally have a minimum visit time of 1.5 hours, whereas the Royal District Nursing Service's virtual nursing service is able to charge a lower rate, at increments of 15 minutes.³

¹ Continence Foundation of Australia, Submission S100, p. 5.

² Continence Foundation of Australia, Submission S100, p. 5.

³ Royal District Nursing Service of South Australia, Submission S148, p. 2.

8 Plan Management Supports

A total of 69 submissions were received about the pricing arrangements for plan management. Details of the submissions are at Appendix A. A working group of providers and other stakeholders was also established. The working group had 22 members from 20 organisations and met, by video-conference, on two occasions: 6 December 2021 and 7 February 2022. Details of the members of the working group are provided in Appendix B.

The key topics raised in the consultations were:

- Disability Intermediaries Australia Submission and Survey;
- Role and Value of Plan Managers;
- Pricing Arrangements; and
- Indexation.

The Review's analysis and recommendations of the pricing arrangements for Plan Management Supports can be found in Chapter 8 (Plan Management Supports) of the *Report of the 2021-22 Annual Pricing Review*.

8.1 Disability Intermediaries Australia Submission and Survey

The submission from Disability Intermediaries Australia (DIA), the industry group for providers of Intermediary supports (plan management and support coordination) included summary results of a survey that DIA undertook of Plan Management and support coordination providers. DIA reported that it collected data from 803 unique submissions (430 Plan Management Submissions and 373 support coordination). DIA provided a de-identified version of the data set to the NDIA. The DIA Submission included letters of endorsement from 43 providers of support coordination and plan management.¹

¹ Disabilities Intermediaries Australia, Submission S161.

The DIA submission stated that, in most cases, information was collected directly from providers and unless specifically requested or instructed otherwise, publicly available information or the 'most standard' information available was utilised. DIA collected data from 803 unique submissions (430 Plan Management Submissions and 373 Support Coordination). Raw data was used in the analysis of survey results. Results were not averaged or altered in any way.

The DIA Submission was endorsed by: My Plan Manager, Leisure Networks Association Inc., Plan Partners, The Growing Space, Leap In! Australia, Ablelink Pty Ltd, Peak Plan Management, Ethical Coordination of Supports, myintegra, Valued Lives, Connect Plan Management, The Carers Place Pty Ltd, Ideal Plan Management, Empowrd, Claire Coordination of Supports, myCSN Disability Pty Ltd, Your Plan Manager, PMCSS, All Disability Plan Management, Amelia Edmonds (Sole Trader – Support Coordinator), Canny Plan Management, Roy Co., Balanced Account Bookkeeping, Knapp Connections, iAssist Plan Management, Jigsaw Plan Management Pty Ltd, Slater Coordinator, JRA Plan Management, JD Coordination & Support Services, Pathways to Care Pty Ltd, Rise and Shine Plan Management, Shoalhaven Plan Management, Total Plan Management, P. Fernandez Support Coordinator, NDSP Plan Managers, Gregg Fitzgerald Support Coordination, 1 Call Plan Management, Raj Howe (Sole Trader – Support Coordinator), #1 Answer Plan Management, Lori Crowther (Sole Trader – Support Coordinator), Effie Schroeder (Sole Trader – Support Coordinator), Monica Mckee Support Coordination, Burke Support Coordination.

The DIA submission argued that registered Plan Managers represented value for money for participants and the NDIS.

In 2020-21 RPMPs managed approximately \$12.43bn of committed Scheme funds.

For the same period RPMPs billed the NDIS \$337m for their services or just 2.7% of funds under management or 4% of funds claimed.

To compare and contrast adjacent sectors, DIA's research indicates that in 2020-21:

- *Financial Services sector operated at around 14.6%;*
- *Administration and Support Services sector at around 8.7%;*
- *Health Care and Social Assistance sector (private) at around 18.0%;*
- *Administration and Insurance sector (public) at around 8.1%; and*
- *Professional Services sector operated at around 20.4%.¹*

The DIA submission reported that 54% of the 430 Plan Managers who responded to its indicated that they has made a profit in 2020-21 with a further 15% indicating that they had broken even in 2020-21. Some 86% of responses to the survey by “large” Plan Managers reported a surplus in 2020-21 compared to 52% for “medium” Plan Managers and 56% of “small” Plan Managers. At the same time, only 14% of responses to the survey by “large” Plan Managers reported a loss in 2020-21 compared to 32% for “medium” Plan Managers and 27% of “small” Plan Managers. The survey found no statistical differences between for-profit, profit-for-purpose and not-for-profit Plan Managers.²

With respect to the size of the profits being made by Plan Managers, the DIA submission reported that the survey found an average EBITDA (as a percentage of total costs) across respondents of 24%, with 46% of Plan Managers achieving a 2020-21 EBITDA above 10%. The DIA submission also reported that “large” Plan Managers achieved higher returns, on average, than smaller Plan Managers. The average EBITDA (as a percentage of total costs) for “large” Plan Managers was 30%, compared to 25% for “medium” Plan Managers and 21% for “small” Plan Managers. Almost two-thirds (64%) of “large” Plan Managers achieved an EBITDA of more than 10% in 2020-21, compared to 46% for “medium” Plan Managers and 38% for “small” Plan Managers. The survey again found no statistical differences between for-profit, profit-for-purpose and not-for-profit Plan Managers.³

With respect to industrial conditions, the DIA survey found that only 29% of respondents to the DIA survey reported employing their participant facing staff under the SCHADS Award, noting that this share had increased by 12 percentage points in the last 18 months. Some 35% of respondents reported employing their supervisory staff under the SCHADS Award, up by 14 percentage points in the last 18 months.⁴

With respect to allowances, the DIA survey reported that:

¹ Disabilities Intermediaries Australia, Submission S161, p. 42

² Ibid, pp. 19-20.

³ Ibid, pp. 27-29.

⁴ Ibid, pp. 20-21.

... 35% of the organisations paid allowances or fringe benefits whilst 59% answered they did not. 6% of the survey's respondents did not provide an answer.¹

With respect to utilisation, the DIA survey found that

... the majority of Participant Facing workers have a [sic] utilisation rate (the percentage of overall time undertaking billable work) between 75% and 85% ...²

With respect to overheads, the DIA survey found an average reported overhead (as a share of direct costs) of 79% (with a median of (67%).³

Disability Intermediaries Australia's Proposed Cost Model

DIA's submission included a cost model for the fully-loaded hourly costs that Plan Managers incur when employing participant facing staff (see Exhibit 5). The structure of the DIA Cost Model was based on that of the NDIS Disability Support Worker Cost Model that is used by the NDIA to set the price limits for many core supports. DIA reports that its Cost Model assumptions were based on the results of its survey, other information collected directly from providers and publicly available information. It further reports that the 'most standard' information available was utilised.⁴

EXHIBIT 5: DISABILITY INTERMEDIARIES AUSTRALIA COST MODEL FOR PLAN MANAGEMENT

	DIA Cost Model per hour worked	Cumulative Price per hour worked	Rationale for DIA price
Base Pay	\$34.90		SCHADS 3.4 pay point / 38 hour week
Leave Entitlements			No shift loadings
- Annual leave	\$3.17		20 days per year
- Personal leave	\$1.59		10 days per year
- Public holidays	\$1.59	\$41.25	10 days per year
Employee costs			
- Superannuation	\$4.12		Added at the statutory minimum
- Workers' comp	\$0.82		Workers Compensation premiums were found to be 2% of wages and salaries
- Allowances	Nil	\$46.19	
Supervision	\$5.94	\$52.14	SCHADS 4.4 pay point / 38 hour week 1:9 ratio of supervisors to staff
Utilisation	\$8.34	\$60.48	84% of time delivering NDIS supports – rest of time in on breaks, training, and other activities.
Overheads	\$10.89	\$71.36	18% of direct costs: Rent 3%, IT 9%, Audit and compliance 1%, Marketing 4%, Other 1%.
Margin	\$3.57	\$74.93	5% share of other costs

¹ Ibid, p. 25.

² Ibid, p. 29.

³ Ibid, p. 27.

⁴ Ibid, pp. 33-39.

Fully loaded cost models attribute to the hours worked by participant facing staff the costs of management, supervision and overheads, as well as on-costs and the costs of those hours spent by participant facing staff in other non-billable activities such as training.

8.2 Role and Value of Plan Managers

Members of the working group emphasised the point made in a number of submissions that the Plan Manager role involves much more than processing of invoices. They stated that it also encompasses education, guidance, capacity building and customer service; and that by educating participants and families on budget issues Plan Managers help ensure that a plan is working efficiently and effectively thereby supporting Scheme sustainability. This includes educating providers on how to use the NDIS Support Catalogue, what to charge and how to present a compliant invoice as well as addressing provider errors within invoices. Members of the working group also argued that Plan Managers play a key role in Scheme integrity by working with the NDIA to prevent fraud and ensure financial rigour of billing and payments.

Members of the working group reported the scope of the Plan Manager role was varied – often being determined by the needs of the participant. One member defined their role as being the “financial intermediary” of the participant. That is, the person who advises a participant on their finances by helping them understand financial decisions and the flow-on consequences of spending their allocated funds. They contrasted this to the role Support Coordinators, who are “service intermediaries”.

Members of the working group also noted that Plan Managers are often the first point of call, or only support available to participants to guide them during times of change and uncertainty as participants often found it took too long, or was too complex, to seek information and assistance from the NDIA. Members stated that Plan Managers were often the “only ones who will pick up the phone” and “picked up the slack in a lot of ways” to assist participants in times of crisis or changing circumstances.

Members of the Participant Reference Group noted that their Plan Manager had introduced them to the *Pricing Arrangements and Price Limits*. One member noted that they relied on their Plan Manager to explain the *Pricing Arrangements and Price Limits* to them. Another said that they did not negotiate prices with providers as they trusted their plan manager to do this for them but noted that this opened up the risk of exploitation by the Plan Manager.

8.3 Pricing Arrangements

Monthly Fee - Amount

The DIA submission argued for significant increases in the price limits that apply to plan management supports and for the annual indexation of those price limits. These calls were echoed in a number of other submissions to the Review by Plan Managers.¹

By contrast, Gippsland Disability Advocacy stated that the current level of funding for Plan Managers was fair and reasonable.² Spinal Cord Injuries of Australia proposed that the NDIA should commission a market review of Plan Management fees.³

¹ See: Avivo (S112), Connect Plan Management (S127), Disabilities Intermediaries Australia (S161), First2Care (S093), Living Right (S221), Merri Health (S061), Spinal Cord Injuries of Australia (S235), and Tulgeen (S029).

² Gippsland Disability Advocacy, Submission S130, p. 8.

³ Spinal Cord Injuries of Australia, Submission S235, p. 3 and p. 6.

DIA proposed that the price limit on the Monthly Fee should be increased from its current level of \$104.45 to \$110.90. This was based on the results of the DIA Cost Model and an assumption that, on average, a Plan Manager would commit 1.48 hours of participant facing time to a participant each month, noting that:

*The Cost Model has set this assumption at the historical ratio of 1.48. DIA recognise that this rate is an average and does not indicate the hours of service for each individual participant. ... By setting a monthly price for this service there is an expectation that Plan Managers will engage some participants for less than 1.48 hours and others for more than 1.48 hours.*¹

First2Care emphasised what they considered to be the inadequacy of the current price limit for the monthly fee by arguing that the \$104.45 monthly fee can be broken down to \$24.10 a week over a four-week period, which they said translates to approximately an hour's wages of a Level 1-2 SCHADs 2010 Award employee. They reported that:

*...It takes more than one hour per week per participant, and it takes the work of employees who are qualified beyond level 2 of the Award to deliver high quality plan management... The monthly rate of \$104.45 for Plan Managers is dismal compensation for the services we provide, especially in comparison to other types of providers. For example, \$104.45 represents a 29 minute appointment with an allied health worker or a 32 minute appointment with a psychologist.*²

A number of submissions argued that Plan Managers undertake additional work beyond processing invoices that is not adequately factored into the current monthly fee, including:

- Providing a de facto support coordination role where a participant does not have support coordination in their plan and participants do not know who their Local Area Coordinator is or have a good rapport with them.³
- Educating and fielding enquiries from participants about the use of funds in their plans, particularly if the participant does not have a Support Coordinator or doesn't understand the information provided by the NDIA:

*Most participants do not download and consume the NDIS Price Guides, so without this information being presented in a digestible format, it is the Plan Manager who must convey changes in plain-English for participants.*⁴

Living My Way stated that there were unfunded costs in seeking information from the NDIA on the interpretation of pricing arrangements and in communicating this to participants.

*When a participant sends an invoice that is not clearly within NDIS Pricing arrangements, it takes time to liaise with participants and service providers and attempts to contact NDIS for consistent answers. This is not factored into the Monthly Processing Fee.*⁵

The Disability Trust pointed out that their costs were higher than they needed to be (and higher than they were currently funded for) because of the increased costs associated with processing invoices from providers (in PDF or paper-based versions), and then keying in

¹ Disability Intermediaries Australia, Submission S161, p. 40.

² First2Care, Submission S093, p. 2.

³ Action on Disability within Ethnic Communities, Submission S055, p. 8; Tulgeen, Submission S029, p. 9.

⁴ The Disability Trust, Submission S159, p. 9.

⁵ Living My Way, Submission S120, p. 16.

these invoices into their internal systems for payment and reimbursement. They suggested that NDIS registered providers who already claim to the NDIA portal should have the option of submitting “plan managed” claims to the portal, which would enable Plan Managers to approve these claims in the portal.¹

A number of submissions also highlighted costs that they incur as a result of mistakes made by planners. For example, Action on Disability within Ethnic Communities stated that

*NDIS plans are frequently approved with pricing which is not in line with the updated NDIS prices. ADEC has received plans which have stated Plan Management fees which were 2 years old. Currently, approximately one-third of ADEC Plan Management clients are not billed at the current rate as the participants' plans are outlined with an older rate.... providers must cover the gap and charge the participant at a lower rate. The amount of administration a provider must go through to rectify this issue is not proportionate, it is unfair to reject a request for service from a participant simply because the NDIA made an administrative error on the participant's plan.*²

Submissions stated that ensuring funding is allocated correctly and in-line with NDIS price limits is necessary for providers to be adequately compensated for service provision. Not doing so may result in thinning of margins and may disincentivise providers from remaining in the provider space.³

Several submissions identified information technology as a particular area of increasing cost for Plan Managers. The DIA submission reported that technology was the second largest overhead cost for Plan Managers, and accounted for 16.8% of total overheads, following administrative overheads at 40.7%. DIA argued that the pricing arrangements need to give greater consideration for technology overheads if Plan Managers and the NDIA were to benefit from the streamlining and efficiency gains that were available from technology.⁴

The submission from Action on Disability within Ethnic Communities similarly stated that a quality IT system is required for a Plan Manager to be “*high functioning and effective*” but that acquiring such technology is a substantial cost, especially for small-to-medium Plan Managers.

*A low end Plan Management software can cost \$15,000, and a high-end software could cost \$35,000+. This is a large upfront cost for new providers. Without this, a provider may find it difficult to grow, process its workload and monitor a high number of plans. Plan management is different from other NDIS services where a complex IT system is required for a high functioning program. This need must be factored into plan management rates.*⁵

In this regard, Connect Plan Management reported that the cost of IT had increased above inflation, in part due to disruptions to:

*...global supply chains, shortages of semiconductors and the absence of skilled worker immigration into Australia during the COVID-19 pandemic.*⁶

¹ The Disability Trust, Submission S159, p. 9.

² Action on Disability within Ethnic Communities, Submission S055, p. 12.

³ See: Action on Disability within Ethnic Communities (S055) and Living My Way (S120).

⁴ Disability Intermediaries Australia, Submission S161, p. 28.

⁵ Action on Disability within Ethnic Communities, Submission S055, p. 11.

⁶ Connect Plan Management, Submission S127, p. 2.

Members of the working group also felt that the current price limit for the monthly fee was inadequate and identified a number of areas in which Plan Managers were facing cost pressures that were unaccounted for in the current pricing arrangements, including where they were called on to do work to address inefficiencies elsewhere in the NDIS.

One member of the working group stated that there were a lot of participants within the NDIS that see Plan Managers “*as all that they’ve got*”. They noted that only 54% of their Participants have support coordination. Another member stated that Plan Managers were now “*doing the role of a Local Area Coordinator*” and that plans are not adequately funded to support this task. They argued that funding should be redirected to Plan Managers to support this responsibility. They further stated that the NDIA should hold Local Areas Coordinators accountable for this gap in their role and it should be the expectation that Local Areas Coordinators would continue to sustain a relationship with participants throughout the tenure of their plan and not wait until the renewal of a plan to re-engage with a participant. Members stressed that Plan Managers faced a rising number of overspends from doing unfunded work. One member stated that their team had grown “*three times over the rate of growth*” in order to be able to effectively support participants. A solution proposed by one member was to incorporate a few extra hours within a plan to accommodate working with Local Areas Coordinators.

Members of the working group also reported that they often have to spend unfunded time resolving what they considered to be “*Agency errors or capacity issues*”. Members stated that Plan Managers sometimes needed to diagnose service bookings made by the NDIA and communicate the issues to the NDIA for it to be resolved. Members expressed the view that they are often the only ones “*driving absent capacity issues*”.

A major concern for members of the working group was the implication for them and their costs of what they perceived to be increasing expectations by the NDIA with respect to checking invoice evidence, preventing fraud, and compliance when participants spend beyond their allocated funds. One Member summarised this by saying that:

.. there is a disparity between what is funded [within the NDIS] and how this is used flexibly versus who is liable for this.

Members raised the challenges associated with liabilities around making a claim if Plan Managers were to be ultimately held liable for overspent funds within plans. One member noted that 8.9% of their clients spend beyond the means of their plans. Another member pointed to the open-ended liability around the service agreements that participants are able to sign (without any involvement by the Plan Manager) for an infinite amount of time for an infinite amount of money. Members noted that it was unfair for Plan Managers to take on this responsibility, noting that, for example, tax accountants are not responsible for paying the debt of their clients. Members queried why Plan Managers should be any different in this regard. Members emphasised that Plan Managers do not have the control to oversee all of a participant’s decision-making processes.

In summary, members of the working group reported that Plan Managers are unsure of the NDIA’s expectations with respect to checking invoice evidence and preventing fraud. They called for a clear statement to be issued by the NDIA detailing the liabilities that Plan Managers could face to help mitigate this confusion.

Members of the working group also emphasised that they were particularly disadvantaged in carrying out the role that some areas of the NDIA now seemed to expect of them as the current arrangements do not provide Plan Managers with visibility of a participant's plan. As a result, Plan Managers cannot have sufficient clarity on funding limitations, budgets and allocation of agency-managed and plan-managed supports. They argued that this causes numerous administrative and payment problems and weakens relationships with providers and participants when funding is suddenly exhausted, and providers are not paid for services delivered in good faith and in accordance with a service agreement with the participant.

Members of the working group were united in their desire to be given full visibility of participants' plans in order to perform their role within their remit. They argued that the document that Plan Managers are currently provided does not always provide sufficient information as to why funds have been included in a plan. Plan Managers are expected to ensure that funds are spent in alignment with the intent of a participant's plan, but they cannot do this as they are not given access to the reasons why a planner has included funds in a plan and so cannot know what the intent of a participant's plan is. One member advised there are instances where the plan is more detailed with additional contexts and figures being recorded. This document is available at the NDIA's back-end portal. Members stressed that the lack of correlation between the information that a Plan Manager has access to and that the NDIA's compliance team can access was deeply problematic.

A sub-issue that arose within this discussion was the challenges that providers faced in liaising with Agency. Members pointed to five main challenges:

- **Invoicing:** Members stated that the NDIA's payments teams refuse to receive direct communication from the provider of a plan-managed support, so that the Plan Manager has to step in and make those claims in lieu of the provider. Specifically, the Plan Manager has to claim the invoice for the service and also disperse the funds. Members also raised the hesitancy of participants to approach the NDIA, which leads to an increase in the calls fielded by their workforce. One Member noted that 40% of their team is not touching invoices and instead spending time responding to participant queries that should, in the Member's view, be being handled by the NDIA.
- **Manual Claims:** Members stated the difficulties with processing manual claims with the NDIA's payments team and the additional administrative burden that comes with completing a manual claim by having to detail every item that needs to be claimed.
- **Timeliness of Communication:** Members also raised the lack of timeliness of communication of the NDIA noting that it often takes months for invoices to stop being paid after reports of fraud. As a result of this lack of timeliness Plan Managers reported that they often have to step in to recuperate the lost funds for the participant in lieu of the NDIA.
- **Change of Circumstances:** Members noted the difficulties that arise when providers behave as if changes of circumstances have been approved and bill for services without conducting appropriate checks as to whether the increased level of service has been approved. Members felt that clearer guidance should be given to providers that they needed to operate as if any chance of circumstance request has the possibility to be refused to mitigate this issue. Members pointed out that these issues were exacerbated by the fact that neither providers nor Plan Managers were informed by the

NDIA when plans were altered as a result of change of circumstances or for any other reason.

- **Out of scope work, including after a participant's death:** Members reported that Plan Managers often perform work that is out of scope of the current pricing arrangement, but they believe is expected, suggested, or recommended by the NDIA. For example, when a participant dies, Plan Managers are expected to tie up loose ends and resolve unpaid invoices for services such as lawn mowing, gardening or no-show fees that have been incurred before providers were notified of the participant's death even though they are not permitted to charge the monthly fee after the participant has died.

Members of the working group stressed that all of these issues both directly increased the costs of being a Plan Manager and increased risk for Plan Managers, which in turn raises costs. They were some of the main reasons why the current price limits were inadequate.

Another cost pressure on Plan Managers was identified in the submission from Spinal Cord of Australia, namely the difficulty providers faced in attracting and retaining a suitable workforce that holds the professional qualifications required by the NDIS for Plan Management.¹

The challenge of sourcing appropriately qualified labour was further supported by Connect Plan Management who stated that there:

... has been widespread commentary in the media regarding the difficulty employers generally, and specifically in certain sectors, have found and continue to find it difficult to attract and retain staff. This is confirmed anecdotally from our own experience and conversations with other NDIS providers.²

The submissions from Disability Intermediaries Australia and Connect Plan Management Services also raised a concern that the costs of payroll tax were not addressed by the current pricing arrangements for Plan Managers (and other supports). Both submissions recognised that payroll tax liabilities do not accumulate for every Plan Manager (due to size, and to charity and NFP status) but argued that they are pertinent for almost all larger providers of plan management services. The submissions proposed that the NDIA should undertake further analysis of this issue.³

Monthly Fee - Structure

A number of submissions were concerned with the "one size fits all" nature of the price limit for the monthly fee. They stated that the current flat monthly fee was insufficient to cover the increased workload and transactions associated with larger participant plans, particularly where a participant receives a large number of supports from different providers. Many

¹ Spinal Cord Injuries of Australia, Submission S235, p. 6.

² Connect Plan Management, Submission S127, p. 1.

³ Connect Plan Management, Submission S127, p. 1; Disability Intermediaries Australia, Submission S161, p. 113.

submissions proposed that monthly fee should be restructured to more accurately reflect the level of work undertaken for large and complex plans.¹

Avivo reported that:

At present, providers receive the same monthly fee for a participant with annual funding of \$5k (perhaps a bi-monthly invoice) as we do for a participant with funding of over \$100,000 across capacity building, daily, social and employment – with multiple weekly payments to a variety of providers.²

In addition, submissions stated that a plan that only receives allied health supports has far fewer invoices than a client receiving daily supports with consumables and assistive technology, amongst other supports.³ However, as Action on Disability within Ethnic Communities stated:

... a participant who only has the Consumables section of their NDIS plan pays the same annual rate for plan management as a participant who may have their entire plan managed by a Plan Manager.⁴

Dennluc8 Pty Ltd reported that “the ratio of invoices and line items per participant vary up to 95%” resulting in significant differences in effort between smaller and larger participant plans, whilst receiving the same monthly fee.⁵

Living Right argued that the current price limit for the monthly fee does not recognise the need to provide additional support to participants with complex needs, or to disadvantaged and/or Culturally and Linguistically Diverse participants.⁶ Their submission stated that the current monthly fee was insufficient when supporting participants who are from culturally and linguistically diverse or disadvantaged backgrounds who have higher support needs:

...participants or plan nominees from these backgrounds generally do not have a reasonable level of numeracy and literacy skills to understand their plan statements and to negotiate provider supports and agreements within budget. In addition due to the transience of the Northern Territory population and changes in Local Area Coordinators, participants inevitably seek further support from us.

...many of our participants do not have access to emails and do not feel empowered enough to ring the NDIA directly for supports which further intensifies the way we are required to communicate with them and support our participants. Often, we are requested by participants to negotiate service agreements, oversee the plan budget management and act as an intermediary for provider enquiries, especially in relation to unregistered providers who do not understand the NDIA guidelines or price limits. We are also required to provide regular phone updates on their plan spending and funding balances. For these reasons, we believe that the monthly fee is

¹ See: Action on Disability within Ethnic Communities (S055), Disabilities Intermediaries Australia (S161), First2Care (S093), Living My Way (S120), Merri Health (S061), and Tulgeen (S029).

² Avivo, Submission S112, p. 18.

³ See: The Disability Trust (S159), and Action on Disability within Ethnic Communities (S055).

⁴ Action on Disability within Ethnic Communities, Submission S055, p. 11.

⁵ Dennluc8 Pty Ltd, Submission S008.

⁶ Living Right provides plan management services in the Northern Territory. They report that their clientele comprises approximately 30% Indigenous with the majority living in remote or very remote communities and another 20-30% are from migrant backgrounds. See: Living Right, Submission S221.

inadequate as plan management supports go over and beyond the standard processing of payment claims and issuing regular financial reports to participants.¹

A number of submissions proposed that the NDIA should consider replacing the existing flat monthly fee price limit with a price limit that was either proportionate to the total value of a participant's plan to reflect the additional workload from processing a larger number of invoices or took into account the complexity of a participant's plan, as a complex plan requires more effort by Plan Managers, with a higher number of supports and providers.²

Members of the Working Group, while acknowledging that the workload of a Plan Manager varied significantly by participant did not, on balance, support a differential fee structure. They considered that this was an issue for the Plan Manager to manage within their overall budget and that any differential fee structure would need to be very complex and therefore open to abuse or disagreement.

Establishment Fee

A number of submissions stated that the current establishment fee is insufficient to on-board new participants.³ Disabilities Intermediaries Australia proposed that the price limit on the Establishment Fee should be increased from its current level of \$232.35 to \$299.40. This was based on the results of the DIA Cost Model and an assumption that, on average, a Plan Manager would commit four hours of participant facing time to on-boarding a participant.⁴

Submissions also argued that the current arrangement were poorly designed as the establishment fee is only funded once per participant plan. They pointed out that this results in only one Plan Manager being able to charge the establishment fee, even if a participant changes Plan Managers during the plan period. Connect Plan Management reported that the establishment fee is vital for recouping the setup costs of on-boarding a new participant, with little or no difference in the cost to on-board a new participant versus a participant moving Plan Managers. They argued that the current arrangement therefore create a disincentive for Plan Managers to on-board participants who switch Plan Managers, which in turn limits participant choice and control.⁵

Spinal Cord Injuries of Australia proposed that the rules around set-up costs should allow greater flexibility for participants to move between providers and ensure that providers are appropriately compensated for their work.⁶ Disabilities Intermediaries Australia proposed that this issue should be addressed by amortising the establishment fee be over a 12-month period and incorporating the subsequent monthly amount into the monthly plan management price limit.⁷ This was supported by some members of the Working Group as it would allow

¹ Living Right, Submission S221.

² See: Action on Disability within Ethnic Communities (S055), Avivo (S112), Disabilities Intermediaries Australia (S161), and First2Care (S093).

³ See: Connect Plan Management (S127), Disabilities Intermediaries Australia (S161), and Spinal Cord Injuries of Australia (S235).

⁴ Disabilities Intermediaries Australia, Submission S161, p. 41.

⁵ Connect Plan Management, Submission S127, p. 2.

⁶ Spinal Cord Injuries of Australia, Submission S235, p. 3.

⁷ Disabilities Intermediaries Australia, Submission S161, p. 42 and p.100.

Plan Managers that take on a new client mid-plan to recoup some of the plan management establishment costs.

Capacity Building & Training

With respect to the “Capacity Building and Training in Plan and Financial Management by a Plan Manager” support item, Spinal Cord Injuries of Australia stated that the major difficulty was that participants:

... rarely have access to the “CB Training in Plan management” supports ... in the price guide.¹

Members of the working group agreed that plan management funding was very rarely included in plans above the set-up and monthly fee costs. They considered this to be unfortunate, as greater use of this support item would allow Plan Managers to vary their support offering depending on participant needs so that the standard monthly fee would cover the standard service and additional capacity building supports could be billed separately. One option might be to allow a one-way fungibility between the core and plan management budgets, so that participants could choose to spend some of their core funding on capacity building their plan management skills if they so desired.

The DIA submission also proposed that the NDIA should consider increasing the hourly price limit for the support item for Capacity Building and Training in Plan and Financial Management delivered by either a Plan Manager or Support Coordinator to \$68.33 per hour and linking that amount to the support coordination Level 1 price limit for any future pricing changes.²

8.4 Indexation

Many submissions were concerned that the NDIS did not increase the price limits for plan management supports in-line with other disability supports as part of the 1 July 2021 price limit increases. They proposed that the price limits of plan management supports should always be increased in line with an index such as the Consumer Price Index to ensure that plan management costs continued to be met by Scheme’s pricing arrangements. A number of submissions reported that the lack of indexation was problematic with the costs of consumables, IT, labour, and other inputs rising.³

First2Care was concerned that Plan Managers were unintentionally disadvantaged by the increasing number of plans that had a duration of more than one year as the Plan Manager was essentially locked into a fixed monthly fee for the duration of the plan.

Plan managers are also locked to this \$104.45 monthly rate for the duration of the plan, whether the plan lasts for one year or five years. When inflationary pressures cause CPI increases, Plan Managers are almost always excluded from the resulting changes as they are locked into the set monthly account that was relevant at the time of the plan start date...⁴

¹ Spinal Cord Injuries of Australia, Submission S235, p. 7.

² Disabilities Intermediaries Australia, Submission S161, p. 72.

³ See: Disabilities Intermediaries Australia (S161), First2Care (S093), With Care Plan Managers (S001), Living My Way (S120), and Spinal Cord Injuries of Australia (S235).

⁴ First2Care, Submission S093, p. 2.

Members of the Working Group agreed that any pricing outcome needs to reflect an increased allowance for wages growth and the difficulty of attracting and retaining staff at the appropriate price and skills. Members added that macroeconomic drivers – employment, unemployment, and wages growth – should be factored into the indexation algorithm.

Members of the Working Group also raised a number of issues with how price limits were currently indexed within plans. They stated that plans that are rolled over do not have the price limits for stated supports increased to the new limits applicable for the new time period. They identified plans that still had 2017-18 price limits apply to plan management supports. Members of the Working Group were also concerned about the implications for their cash flows of the trend towards multi-year plans. Again, because the plan management support item was stated in plans, providers would be forced to operate on a fixed and increasingly out of date price limit for the length of the plan.

8.5 Other Issues

Shared Management

The submission from Avivo stated that while the charts in the Consultation Paper showed that plan management is growing as a support within the disability sector, they also showed a steady decline in shared management and a stagnation in self-management. The submission further stated that within the NDIS funding management policy, there is an inability for participants to opt-in to formally “Share Manage”, and a lack of guidance on how participants can work towards self-management. They also reported that planners often reject requests for funding for the fees of a Shared Management Advisor or payroll services, because they are not clearly provided for in the NDIS Support Catalogue.

This highlights the opportunity for an option to Share Manage to support participants in a way that works for them while ensuring a safety net is present.

Under the current NDIS management policy, there is no formal option to Share Manage, and the options for participants to work towards self-management are not obvious. No support appears to be offered to help them to navigate engaging and managing staff. There appears to be an assumption that to self-manage a plan is to bear full responsibility for all the tasks involved in engaging supports, which is unrealistic and not comparable to other schemes globally. Participants may choose to engage their own supports but choose not to take on tasks such as payroll due to their capacity to do so, their risk appetite, or their personal preferences.¹

Avivo proposed that the NDIA should consider broadening the services available under plan management to incorporate shared management advisory and payroll services as options to support participants to self-manage.

Claims Point of Support System

A number of submissions acknowledged the potential efficiency benefits of the NDIA implementing the new Claims at Point of Support (CPOS) system. However, they also raised

¹ Avivo, Submission S112, p. 19.

concerns about the potential impact of the CPOS system and how it will affect the costs and role of Plan Managers and participants.¹

Other submissions were concerned that the introduction of the CPOS system might have unintended consequences for Scheme sustainability and integrity. The submission from First2Care argued that Plan Managers provide oversight into the claims made, and ensure claims align with service agreements and that the introduction of an instantaneous CPOS system might:

... lead to overspending, underutilisation of budgets, and purchasing supports that do not align with participants' plans, stated items and goals.²

First2Care proposes careful consideration of how CPOS will impact Plan Manager's visibility of participant budgets, and their consequent role in active fraud prevention and alignment of spending with participant goals.

The submission from Avivo was similarly concerned that the CPOS might replace some or all the current responsibilities of Plan Managers, such as replacing their role in handling payments, and therefore potentially restricting their capacity for real-time budget monitoring.³

The submission from Connect Plan Management was concerned that CPOS has the potential to escalate technology costs for Plan Managers.⁴

The submission from Avivo proposed that the NDIA should offer CPOS as an option for participants, rather than a replacement for plan management. They urged the NDIA to recognise that Plan Managers provide services beyond the processing of invoices, such as supporting participants to work towards or maintain self-management. They stated that there are several situations where a participant may value another option beyond the CPOS system, including participants:

- Engaging their own employees – wages, tax, super can't be paid using CPOS;
- Making payments to contractors who don't have CPOS facilities;
- Making payments to providers who did not provide a "Statement by Supplier"; and
- Engaging unregistered providers if the payments are linked to registration status.⁵

Members of the Working Group were also concerned about the costs that Plan Managers would face in adapting to CPOS. They reiterated the challenges faced by smaller organisations who lack the digital infrastructure to provide participants with the full array of services needed and have difficulty subsidising back-office costs, whereas larger organisations have invested heavily in technology to drive efficiencies and provide the value add to the NDIA such as financial and fraud checks. One member of the Working Group was concerned that CPOS may potentially heighten the challenges for the sector in terms of information flows between participants, providers, and the NDIA, particularly for smaller

¹ See: Avivo (S112), Connect Plan Management (S127), First2Care (S093), and Support Care Management Services (S005).

² First2Care, Submission S093, p. 3.

³ Avivo, Submission S112, p. 4 and p. 20.

⁴ Connect Plan Management, Submission S127, p. 2.

⁵ Avivo, Submission S112, p. 20.

organisations who do not have the ability to invest. They stated the importance of addressing this challenge when the NDIA rolls out CPOS and the need to acknowledge organisations may be operating on different technology platforms.

Another Member raised the inherent costs incurred by providers whenever the NDIA changes systems. They noted that some providers are rolling out the previous API system despite it being formally launched in two years ago. It was also noted that the sector's investment in technology was static.

Role Clarity and Independence

Members of the Working Group felt that a major difficulty facing Plan Managers was that the roles of Support Coordinators and Plan Managers were blurred and poorly defined. They considered that this lack of role clarity inhibited participants from clearly understanding the differences in services between Plan Managers and Support Coordinators and the associated fees. This concern was also raised in a number of submissions. For example, the submission from Action on Disability within Ethnic Communities stated that the:

...Plan Management Principle verges onto support coordination and is a time consuming duty. A duty which the current pricing arrangement does not factor in. Greater clarity is required for classifying the role of a Plan Manager and if it is to include greater participant interaction, the rate must reflect this.¹

Members of the Working Group also considered that greater clarity on role definitions will allow participants to better understand the services a Plan Manager provides and may allow participants to increasingly leverage a Plan Manager's Capacity Building and Training in Plan and Financial Management services. This would allow participants to increasingly understand how and where their money is used and might encourage participants to have more control over their plans and payments.

A number of submissions also recognised that conflicts of interest could arise when Plan Managers, Support Coordinators, and disability support providers were not independent of each other.² They were concerned that participants may be subject to 'client capture', whereby a single provider signs a participant with their complete funding signed to the one provider. This allows a single provider to fully exhaust the budget of a participant with one organisation, maximising their individual revenue at a potential detriment to the participant.

The submission from CPS (Choice Plan Services) stated that supporting and enforcing the independence of Plan Managers, Support Coordinators, and disability support providers is vital to ensure participants are not being taken advantage of and locked into plans that do not provide them with appropriate supports.

I know from talking to Participants that they often feel that they are not able to engage with other services, or new services that might become available, as they have signed 100% of their funding to one service provider. Sometimes these participants (young children) are put onto waiting lists for months for services such as speech therapy (there is currently a 4-6 month wait for speech therapy

¹ Action on Disability within Ethnic Communities, Submission S055, p. 10.

² See: Action on Disability within Ethnic Communities (S055), CPS Choice Plan Services (S013), and Merri Health (S061).

in the Southwest), and during this wait time, they feel that they cannot source another provider as they have already signed a service agreement.¹

Some of the disability support providers on the Working Group identified examples of biases among Plan Managers, including: Plan Managers refusing to accept invoices from particular providers; Plan Managers have a relationship with support workers (for example, spousal relationships) and this resulting in preferential treatment; and the situation where a Plan Manager is also a participant's SIL provider, and hence by rejecting invoices from other providers, there is more money draw down on for the SIL services.

One member of the Working Group suggested that reporting the bad practices of Plan Managers and Support Coordinators to the NDIA or the Commission had not led to satisfactory outcomes. They said that when they have reported Plan Managers to the NDIA, they have been told that the NDIA does not get involved in Plan Manager disputes. They also said that some providers have experienced consequences for reporting Plan Managers and Support Coordinators to the NDIA or Commission. This includes, for example, losing participants. It was suggested that the Commission does not have sufficient processes in its legislation to de-register Plan Managers and Support Coordinators acting outside of the spirit of the NDIS.

¹ CPS Choice Plan Services, Submission S013 (email).

9 Support Coordination

The Review received a total of 88 submissions about the pricing arrangements for support coordination. Details of the submissions are at Appendix A. A working group of providers and other stakeholders was also established. The working group had 27 members from 16 organisations and met, by video-conference, on two occasions: 6 December 2021 and 7 February 2022. Details of the members of the working group are provided in Appendix B.

The key topics raised in the consultations were:

- Disability Intermediaries Australia Submission and Survey;
- Role and Value of Support Coordinators;
- Pricing Arrangements; and
- Other Issues.

The Review's analysis and recommendations relating to the pricing arrangements for Support Coordination can be found in Chapter 9 (Support Coordination) of the *Report of the 2021-22 Annual Pricing Review*.

9.1 Disability Intermediaries Australia Submission and Survey

The submission from Disability Intermediaries Australia (DIA), the industry group for providers of Intermediary supports (plan management and support coordination) included summary results of a survey that DIA undertook of Plan Management and support coordination providers. Further information on the survey can be found in the Chapter on Plan Management at page 101.

The DIA submission argued that:

- Intermediary Service Providers deliver extremely cost-effective services providing exceptional value for money to the NDIS Participants and the NDIS;*
- The Intermediaries sector continues to experience gaps in policy and operational scheme direction driven by inconsistent and variable advice from the NDIA about the role, scope and function of Plan Management and support coordination;*
- Current pricing arrangements and limits are driving providers to focus on efficient service delivery. Intermediary Service Providers are seeking greater pricing focus on workforce capability and capacity to ensure they are able to meet the increasing demands on attracting, developing and retaining a workforce that is focused on delivering quality and safe services for the participants that they work with, whilst driving continuous improvement; and*
- The NDIS is a constantly evolving scheme, resulting in substantial impact on the operating environment of providers in the sector. This constant change and evolution continues to put pressure on providers to be agile and responsive, however the current price limits force a focus on service delivery efficiency over agility and responsiveness.¹*

¹ Disabilities Intermediaries Australia, Submission S161, p. 10

The DIA submission reported that 41% of the 373 Support Coordinators who responded to its survey indicated that they made a profit in 2020-21 with a further 20% indicating that they had broken even in 2020-21. Some 39% of responses to the survey by “large” Support Coordinators reported a surplus in 2020-21 compared to 42% for “medium” Support Coordinators and 45% of “small” Support Coordinators. Around one-fifth of responses to the survey by “large” and “medium” Support Coordinators reported a loss in 2020-21 compared to 17% for “small” Support Coordinators. The survey found that financial results were similar between for-profit, profit-for-purpose and not-for-profit Support Coordinators.¹

With respect to the size of the profits being made by Support Coordinators, the DIA submission reported that the survey found an average EBITDA (as a percentage of total costs) across respondents of 3%, with a median of 1% for 2020-21. The DIA submission also reported 6% EBITDA as a share of total costs for “small” operators compared to 3% for both “medium” and “large” operators. The survey found no differences between for-profit and not-for-profit Support Coordinators.²

The DIA survey found that 89% of respondents to the DIA survey reported employing their participant-facing staff under the SCHADS Award, and that this had increased by two (2) percentage points in the last 18 months. The same proportion reported employing their supervisory staff under the SCHADS Award, also up by two (2) percentage points in the last 18 months. The DIA submission further noted that:

- 88% of respondents reported paying a base rate of salary between \$35-\$39 per hour for Level 1 Support Connection;
- 65% of respondents reported paying a base rate of salary between \$40-\$44 per hour for Level 2 Coordination of Supports; and
- 52% of respondents reported paying a base rate of salary between \$65-\$69 per hour for Level 3 Specialist support coordination.³

With respect to allowances, the DIA survey reported that “60% of the organisations paid allowances or fringe benefits whilst 40% answered they did not”.⁴

With respect to utilisation, the DIA survey reported:

- three-fifths of Level 1 coordinators reported utilisation between 71% and 75%;
- three-fifths of Level 2 coordinators reported utilisation between 71% and 75%; and
- just over one half of Level 3 coordinators reported utilisation between 71% and 75%.⁵

With respect to overheads, the DIA survey found average reported overheads (as a share of direct costs) of 27% (with a median of 26%).⁶

¹ Ibid, p. 47-8.

² Ibid, pp. 58-9.

³ Ibid, pp. 49-50.

⁴ Ibid, p. 55.

⁵ Ibid, pp. 59-61.

⁶ Ibid, p. 57.

Disability Intermediaries Australia's Proposed Cost Model

Exhibit 6 summarises the findings comparing the NDIA's current price limits for support coordination with those put forward by DIA based on their survey results. As with the NDIA's DSW Cost Model, the DIA's cost model for Support Coordinators builds from a base pay rate adding incremental hourly costs that are incurred in the delivery of the support coordination supports. DIA's proposal for each support coordination level is shown in Exhibitions 7 to 9.

EXHIBIT 6: COMPARISON OF NDIA AND DIA PRICE LIMITS FOR SUPPORT COORDINATION

Level	NDIA current price limit per hour			DIA proposed price limit per hour		
	National	Remote	Very Remote	National	Remote	Very Remote
Level 1	\$61.76	\$86.46	\$92.64	\$68.33	\$95.66	\$102.49
Level 2	\$100.14	\$140.19	\$150.21	\$110.04	\$154.02	\$165.06
Level 3	\$190.54	\$266.75	\$285.80	\$199.67	\$279.54	\$299.51

EXHIBIT 7: DISABILITY INTERMEDIARIES AUSTRALIA COST MODEL FOR SUPPORT COORDINATION LEVEL 1

Parameter/Cost	DIA Cost Model	Cumulative Price	Rationale for DIA price
Base Pay	\$33.48		SCHADS 3.2 per hour
Leave Entitlements		\$39.57	No shift loadings
- Annual leave	\$3.04		152hrs
- Personal leave	\$1.52		76hrs
- Public holidays	\$1.52		76hrs
Employee costs		\$45.27	Over half of respondents pay allowances with vehicle (\$1,289) and miscellaneous (\$300) representing the cost to employers.
- Superannuation	\$3.96		
- Workers' comp	\$0.79		
- Allowances	\$0.95		
Supervision	\$3.36	\$48.63	Assume supervision ratio of 1:15
Utilisation	\$5.35	\$53.98	Participant facing SCs spend 89% of their time delivering NDIS supports – rest of time in on breaks, training, and other activities
Overheads	\$10.80	\$64.77	Overheads are 20% of direct costs (i.e., the above costs)
Staff Retention and Turnover		\$65.07	Survey found that the Median cost for the replacement of Support Coordinators was \$4,692 per annum.
Staff Retention	\$0.30		
Staff Turnover	\$0.95		
Margin	\$3.25		5% share of other costs
Total		\$68.33	

EXHIBIT 8: DISABILITY INTERMEDIARIES AUSTRALIA COST MODEL FOR SUPPORT COORDINATION LEVEL 2

Parameter/Cost	DIA Cost Model	Cumulative Price	Rationale for DIA price
Base Pay	\$40.39		SCHADS 4.4 per hour
Leave Entitlements		\$47.73	No shift loadings
- Annual leave	\$3.67		152hrs
- Personal leave	\$1.84		76hrs
- Public holidays	\$1.84		76hrs

Parameter/Cost	DIA Cost Model	Cumulative Price	Rationale for DIA price
Employee costs		\$54.41	
- Superannuation	\$4.77		
- Workers' comp	\$0.95		
- Allowances	\$0.95		It was found that well over a half of respondents pay allowances with vehicle (\$1,289) and miscellaneous (\$300) representing the cost to employers.
Supervision	\$12.86	\$67.27	The 'span of control' for Level 2: Coordination of Supports workers is set at a ratio of one Supervisor overseeing five and half (5.5) FTE Level 2: Coordination of Supports workers.
Utilisation	\$16.82	\$84.09	Participant facing SCs spends 75% of their time delivering NDIS supports – rest of time in on breaks, training, and other activities
Overheads	\$16.82	\$100.91	Overheads are 20% of direct costs (i.e., the above costs)
Staff Retention and Turnover		\$104.80	Survey found that the Median cost for the replacement of Support Coordinators was \$4,692 per annum.
Staff Retention Cost	\$1.20		
Staff Turnover Cost	\$2.69		
Margin	\$5.25		5% share of other costs
Total		\$110.04	

EXHIBIT 9: DISABILITY INTERMEDIARIES AUSTRALIA COST MODEL FOR SUPPORT COORDINATION LEVEL 3

Parameter/Cost	DIA Cost Model	Cumulative Price	Rationale for DIA price
Base Pay	\$65		SCHADS 8.3 per hour
Leave Entitlements		\$76.82	No shift loadings
- Annual leave	\$5.91		152hrs
- Personal leave	\$2.95		76hrs
- Public holidays	\$2.95		76hrs
Employee costs		\$86.99	
- Superannuation	\$7.68		
- Workers' comp	\$1.54		
- Allowances	\$0.95		It was found that well over a half of respondents pay allowances with vehicle (\$1,289) and miscellaneous (\$300) representing the cost to employers.
Supervision	\$33.35	\$120.33	The 'span of control' for Level 3: Specialist Coordination workers is set at a ratio of one Supervisor overseeing three FTE Level 3: Specialist Coordination workers. This assumption is lower than Level 2 reflecting the more complex nature of the support being provided.
Utilisation	\$34.90	\$155.23	Participant facing SCs spends 71% of their time delivering NDIS supports – rest of time in on breaks, training, and other activities
Overheads	\$31.05	\$186.28	Overheads are 20% of direct costs (i.e., the above costs)
Staff Retention and Turnover		\$190.17	The survey found that the Median cost for the replacement of Support Coordinators was \$4,692 per annum.
Staff Retention Cost	\$1.20		
Staff Turnover Cost	\$2.69		
Margin	\$9.51		5% share of other costs
Total		\$199.67	

9.2 Role and Value of Support Coordinators

A key theme through consultations was the need for a tighter definition of the role of Support Coordinators. Stakeholders identified the following benefits of support coordination:

- **Efficiency:** support coordination, when delivered effectively, creates efficiencies, and can save money for the NDIS and participants.
- **Capacity building:** support coordination, when delivered effectively, can build participant capacity and, in some cases is not required long-term.
- **Relationships and networks:** support coordination, when delivered effectively, builds effective relationships and networks within communities and assists participants to navigate the NDIS and get the most out of their plans.

Stakeholders noted that the definition of support coordination supports was unclear, and difficult to clearly distinguish from Plan Management supports. Several submissions state the roles of Support Coordinators and Plan Managers are blurred and poorly defined.¹ One provider drew a comparison between Plan Management and support coordination stating:

Plan Management Principle verges onto support coordination and is a time consuming duty. A duty which the current pricing arrangement does not factor in. Greater clarity is required for classifying the role of a Plan Manager and if it is to include greater participant interaction, the rate must reflect this.²

Consultations revealed that the scope, activities undertaken and expectations of Support Coordinators varied between metropolitan, regional and rural areas. Stakeholders generally supported the need to establish quality and professional standards of practice to support registration and audit structures.

Stakeholders also spoke of the need to clearly define the different levels of support coordination from one another. One Member stated a distinction was “*absolutely necessary at the moment because some of the Participants are specialised.*” One Member also stated that within their organisation, they have a specialist skill set for managing “*complex case meetings with clinical mental health services.*” This Member further noted such supports were not within the remit of their Level 2 support coordination service.

The Working Group discussed that Specialist support coordination is more than just “*coordinating a large number of supports, or even just supporting a Participant with a particular need.*” Rather, it involved effectively supporting people with homelessness, drug dependencies, poor social networks, mental health issues and other social determinants of health issues that place such Participants at risk of poor outcomes. Specialist Support Coordinators fill a huge need in pulling together siloed parts of multiple service systems that overlap into disability supports. Further, Support Coordinators may spend a significant amount of time educating providers on things such as how to use the support catalogue and what supports can be provided to the participant.

Stakeholders noted that the lack of clear expectations and scope for support coordination made it difficult to ensure participants’ plans contained an appropriate number of hours for

¹ See: Action on Disability Within Ethnic Communities (S055) and genU (S219).

² Action on Disability Within Ethnic Communities, Submission S055, p. 10.

this support. Members noted that it was commonplace for plans to comprise 10 hours for support coordination over two-three years, but that this was almost entirely utilised in the initial meetings undertaking administrative tasks. This left few or no hours remaining for Support Coordinators to provide tangible supports past the initial meetings.

Another member noted for a person who has received 12 hours across two years that it is incredibly difficult to set and meet a Participant's expectations. This member stated it is not appropriate for the NDIA to put Support Coordinators in the position of claiming someone is outside of their allocated hours without being able to do anything more to aid them as it could run the risk of a Participant choosing a less qualified or appropriate Support Coordinator.

Some submissions noted that support coordination Level 2 funding does not provide participants with sufficient hours to be effectively supported, particularly for new entrants to the NDIS and when supporting participants through a crisis situation.¹ The Australian Community Industry Alliance stated:

[T]here remains a sense in the participant and provider feedback received by ACIA that there is an inconsistent allocation of support coordination with no clear guidelines to allocation and assignment of such requirements.²

Working Group members and submissions noted the need for flexibility in the delivery of support coordination supports, including:

Needing to absorb hidden administration costs when a plan changes, a participant dies or circumstances change — working group members expressed concern that they were often required to 'solve the problem' and gave examples of times they received correspondence from the NDIA recommending they undertake activities that they will not be reimbursed for. A member of the working group expressed the issue as follows:

A Change of Circumstances is submitted to request additional support coordination funding to the NDIA, however there are major delays in response, so service providers are forced to provide a pro bono service which impacts on the financial viability of their service.

In the case of crisis situations — Support Coordinators manage these situations by providing intensive support to stabilise the impact of a crisis for a participant and are often forced to use up the minimal hours allocated. Merri Health stated that:

The majority of support coordination clients have very complex needs, most often without adequate hours built into their plans to support them. This would often leave clients without hours in their plan to adequately access supports and put staff in the position of having to request plan reviews and / or extensions, all of which is unfunded time.³

Supporting greater trust and a closer relationship between participants and Support Coordinators, arguing that support coordination is a relationship-based support, which means that pricing in a transactional manner can lead to detrimental outcomes. Wellways stated that:

¹ See: Autism Queensland (S144) and Australian Community Industry Alliance (S025).

² Australian Community Industry Alliance, Submission S025, p. 7.

³ Merri Health, Submission S061, p. 6.

From our experience, with psychosocial participants, there is a lot of confusion around the services that Support Coordinators can provide. The limited flexibility in their role can be sometimes difficult for the participant to understand and detrimental to the relationship. It can lead to animosity and a lack of trust between the Support Coordinator and the participant.¹

Working group members noted that many Support Coordinator businesses operate as small community-based organisations. The back-office costs that such organisations experience isn't scalable and there is an importance in understanding local markets and having strong networks and relationships with community organisations and service providers.

9.3 Pricing Arrangements

The DIA submission contained a detailed proposal for support coordination pricing. Other submissions noted that prices limits for support coordination were not increased in-line with other disability support price limits implemented on 1 July 2021, despite increasing cost pressures (labour, hiring costs, technology costs, etc.).² Submissions proposed price limits for support coordination to be indexed in line with the Consumer Price Index (CPI) as well as changes to superannuation, SCHADS, and fair work increases.³

Submissions outlined the challenges with attracting and retaining staff as a result of the inability to compete with salary packages of other sectors.⁴ Rocky Bay noted that:

...the current price limit does not allow providers to be competitive to attract and recruit staff who are able to effectively undertake this role.⁵

The submission from the Council of Regional Disability Services stated that providers often need to pay a higher salary to attract the necessary higher-qualified staff members, which leads to higher overhead costs due to:

...providers struggling to recruit and retain enough employees to service demand on an average of SCHADS 2.3 base salary.⁶

The submission provided a case study on the challenges of attracting appropriately qualified staff in the current pricing structure:

...The pricing regime for support coordination does not recognise the complexity of the work and the need for highly qualified and experienced staff. Many organisations are paying much higher salary levels (SHADS Level 4-6) acknowledging that participants are still looking for Support Coordinators to be case managers and take on a lot of direct accountabilities for their wellbeing rather than just coordinating services. These roles require more supervision and training than is recognised, but the higher costs to deliver this is not reflected in current NDIS prices.⁷

¹ Wellways, Submission S222, p. 7.

² See: Living My Way (S120), Mind Australia Limited (S105), Tulgeen (S029), and We are Vivid (S060).

³ Living My Way, Submission S120, p. 10.

⁴ See: Council of Regional Disability Services (S072), Mercy Connect (S106), Mind Australia Limited and Rocky Bay (S141).

⁵ Rocky Bay, Submission S141, p. 15.

⁶ Council of Regional Disability Services, Submission S.072, p. 9.

⁷ Ibid., p. 12.

Members stated Level 3 Support Coordinators should be paid under the same award as specialist behaviour intervention or therapeutic supports and be employed under Health awards not the SCHADS Award. This proposal was built on the notion that Level 3 Support Coordinators were generally a group of clinicians with a higher skillset and qualifications.

One member noted it was important to acknowledge that Participants requiring Level 3 support coordination also expected their Support Coordinator to not only be able to manage crises but also to mitigate the reoccurrence of such crises in the future. Members also proposed Specialist Support Coordinators be registered with the Australian Health Practitioner Regulation Agency and the Australian Association of Social Workers.

One member raised the comparability between the role of a Recovery Coach and a Support Coordinator. They noted that further clarification was needed around the funding for psychosocial recovery coach versus support coordination and proposed the price limit for Recovery Coaches needed to increase in line with support coordination to recognise the emerging specialisation.

Submissions state the current price limits for support coordination are insufficient to cover the costs of operations.¹ Further to the detailed submission from DIA, the other submissions raised issues that fall into the following three broad areas:

- Non-billable hours;
- Allowance for travel; and
- Workforce attraction and retention.

Non-billable hours

Consultations overall revealed participants did not get sufficient hours in their plans for support coordination. Providers indicated that they often provided continuity of supports to meet duty of care standards of a participant even once a participant's allocated funding has been utilised but this comes at the cost of their financial viability.²

Autism Queensland stated that one of the largest non-billable costs is attending planning meetings with their client and the NDIA.

Partners/NDIS staff conducting planning meetings to actively ask participants about needs they may have that they have not raised themselves, so that the Plan is appropriately reflective of the participant's needs, reducing the likelihood of a review being lodged, which is a costly, stressful, and time-wasting exercise.³

They stated that whilst this is good practice and is valued by participants, their families, and carers, it is an additional cost that is absorbed by the business without payment.

Living My Way reported that:

¹ See: Disability Intermediaries Australia (S161), genU (S219), Interaction Services (S047), Spinal Cord Injuries Australia (S235), and We are Vivid (S060).

² See: Australian Community Industry Alliance (S025), Autism Queensland (S144), Community Assist (103), Living My Way (S120), One Door Mental Health (S097), and Paragon Support Limited (S208).

³ Community Assist, Submission S103, p. 6.

...our small team provided 295 hours of non-billable supports including providing hours of services (despite) inadequate funding, (needing to) travel, providing two Support Coordinators when complex needs or risk environment, team case reviews, training, supervision from Senior Support Coordinators, intake and introduction prior to service agreement signed. This equals lost revenue that could not be claimed according to current pricing arrangements.¹

Members also noted that Support Coordinator's time spent resolving agency errors or wading through NDIA red tape increases operating costs. For example, members expressed how time is wasted and costs accrued every time they wait on hold to resolve an issue with the NDIA. One member reported that:

Often the first time a Support Coordinator finds out that a participant's NDIS plan has been reviewed, is when either the Support Coordinator or another service provider is unable to make a claim against the service booking, as it has expired from the participant's NDIS plan being reviewed.

Consultations revealed that the lack of hours for support coordination was particularly felt in relation to three areas:

- New entrants — Support Coordinators provide additional support to participants to help them navigate the NDIS, gather resources, and make informed decisions. The Australian Community Industry Alliance stated that:

What isn't adequately covered in the pricing of such is the role of advocacy and support for dignity of risk / risk management activities [sic]. It is an area of considerable need, and currently, the hours and provisions allocated within the current scheme are not adequately supporting these additional responsibilities. Additionally, we consider that there is an additional element of support coordination required for all new entrants into NDIS that should be prioritised for the first year of the plan as this is often a very stressful period for the participant to navigate the NDIS landscape, appropriately gather resources and support planning decisions.²

- Participants with complex needs — Autism Queensland provided the following case study of a participant that recently joined their organisation with high and complex needs and who they state has insufficient hours in their plan to meet their support needs:

[The participant receives] 72 hours of support coordination time for a 12-month period (6 hours per month) and has a history of incarceration, homelessness, drug use, suicide attempts, self-harm and mental health issues...

[The participant] ...is his own decision-maker and attended his planning meeting by himself. There is no reference in his NDIS plan to any of these matters. It is not known if any of these issues were disclosed by the participant to the NDIS Partner, either voluntarily or in response to questions, but the lack of reference and lack of appropriate goals indicates that they were not...

...[H]e did not engage with support coordination until 7 months after his plan commenced due to many crises and an overall lack of understanding of the process...

...In the less than 2 months that we have been providing support coordination to him, there have been 5 serious incidents including:

- *3 contacts by the participant to the Support Coordinator stating suicidal ideation*
- *1 contact by the participant's support worker to report a suicide attempt*

¹ Living My Way, Submission S120, p. 10.

² Australian Community Industry Alliance, Submission S025, p. 7.

- 1 contact by the participant to the Support Coordinator reporting assault and theft by his house mate
- 1 contact by the participant to the Support Coordinator saying that he wished to have the DVO against his house mate removed...

...20 of his support coordination hours have been used up already by the responses to these incidents required from his Support Coordinator...none of these hours have gone towards the tasks that the funding was intended and stated in his plan for...a number of hours that cannot be billed have also already been accrued.¹

- Crisis supports — when a crisis requires an urgent and ongoing support coordination response, prioritising the remaining hours until plan review becomes challenging to manage. Merri Health’s submission indicates the ethics of the provider often mean non-billable time is invested in managing their crisis and changed circumstance. This is a transactional cost many providers cannot afford and has led to Merri Health making the decision to stop providing support coordination in September 2021.²

Allowance for travel

Working group members agreed travel and getting travel arrangements right “is critical”. Members stated one of the most important aspects of the Support Coordinator role is to support a Participant to overcome complex barriers which cannot be done effectively without being in the community where the Participant is (i.e., remotely). Members noted there was no budget in Participants’ plans to cover for Support Coordinator travel to see Participant in order to fulfil this duty.

Gippsland Disability Advocacy stated that there is no rationale to support higher rates for travel for support coordination Level 3 and that travel for Level 3 should be charged at the same rate as support coordination Level 1 and Level 2.³

Members also raised the need for support coordination to be localised and delivered by Support Coordinators who understood the market within which services were being delivered in. This would enable the appropriate understanding of the complexity and intensity of different supports allowing Support Coordinators to effectively cater to Participants’ needs at the suitable Level.

Workforce attraction and retention

Several submissions stated the need for price increases to cover the costs of attracting, developing, and retaining a workforce that is focused on delivering quality and safe services for participants and driving continuous improvement.⁴ A number of submissions outlined the

¹ Autism Queensland, Submission S144, p. 9.

² Merri Health, Submission S061, p. 6.

³ Gippsland Disability Advocacy, Submission S130, p. 7

⁴ See: Action on Disability Within Ethnic Communities (S055), Council of Regional Disability Services (S072), Community Assist (S103) and We are Vivid (S060).

challenges with attracting and retaining staff as a result of the inability to compete with salary packages of other sectors.¹ The submission from Rocky Bay stated that:

...the current price limit does not allow providers to be competitive to attract and recruit staff who are able to effectively undertake this role.²

Another provider noted they often need to pay a higher salary (SCHADS Level 4 to Level 6) to attract the necessary higher-qualified staff, leading to higher overhead costs due to:

...providers struggling to recruit and retain enough employees to service demand on an average of SCHADS 2.3 base salary.³

Working group members were split on whether there should be a minimum standard of qualification for Support Coordinators. One Member stated some of their best Support Coordinators “aren’t the ones with clinical qualifications.” Rather, this Member noted “they’re people who had experience as supervisors; home site supervisors. They don’t have a university degree.” This member further urged the Group to be careful with mandating a minimum qualification for Support Coordinators.

9.4 Other Issues

Registered versus Unregistered Providers

Several submissions raised concerns about unregistered providers compromising the quality of supports being delivered through the NDIS by creating confusion amongst participants and skewing the market away from registered and qualified staff.⁴ One submission stated that unregistered providers are the catalyst for staff shortages and “skewing the market towards unregulated and inexperienced Support Coordinators.”⁵ Another submission stated that unregistered providers are also responsible for confusion amongst participants.

Having moved to these providers, many participants are now looking to seek out previous or other more qualified organisations to undertake their [continuity of support].⁶

Capacity Building

Providers considered capacity building to be a crucial element to support coordination, but not adequately recognised in the current pricing arrangements. The Australian Community Industry Alliance stated that:

¹ See: Council of Regional Disability Services (S072), Mercy Connect (S106), Mind Australia Limited (S105) and Rocky Bay (S141).

² Rocky Bay, Submission S141, p. 15.

³ Council of Regional Disability Services, Submission S072, p. 9.

⁴ See: Australian Community Support Organisation (S082), genU (S219), Merriwa (S223), and National Disability Services (S152).

⁵ genU, Submission S219, p. 18.

⁶ Merriwa, Submission S223 (email).

[T]here is far from adequate time allocations in order to facilitate the actual needs of this area of the support coordination process.¹

The Council of Regional Disability Services also argued there was a lack of recognition for capacity building. They stated that regional disability organisations have flagged experiences where *“their most at risk customers, have no support coordination funded in plans leaving these participants without the opportunity to build their own capacity”*.²

Participant Deaths

As with plan management supports, consultations revealed that Support Coordinators also undertake unfunded work following the death of a participant, including the administrative work associated with returning equipment, and completing forms.

Incorporation of support coordination under Core or Capacity Building Budgets

Working group members proposed the price arrangements need to be more flexible to ensure participants do not run out of budget for support coordination. They said that providers must currently undertake a manual process to seek Agency approval to move funds from another part of the plan to cover support coordination costs which is time consuming and adds costs to doing business. One Member stated that in some instances, when budgets are exhausted, participants are forced to choose other supports rather than support coordination. To mitigate this occurring, they proposed moving support coordination to sit under Core Supports or Capacity Building as a stated support. This member proposed, once funds are down (which they note happens regularly), Support Coordinators would then have more flexibility to continue providing supports. This proposal was supported by DIA and many members as it resembled a historical approach to pricing arrangements for support coordination.

Conflict of interest

A number of submissions stated that Plan Managers, Support Coordinators, and disability support providers should be independent and that the provision of both types of services creates an opportunity for conflict of interest. The concern was that participants may be subject to ‘client capture’, whereby a single provider signs a participant with their complete funding signed to the one provider. This allows a single provider to fully exhaust the budget of a participant with one organisation, maximising their individual revenue at a potential detriment to the participant.³

Working group members also discussed the conflict of interest that can be created when Support Coordinators provide other supports and have an effective monopoly over the funds in a participant’s plans. They discussed the importance of accountability and the need to safeguard support coordination services and hold Support Coordinators to account for the services they deliver. They agreed that Support Coordinators are a safeguard for a

¹ Australian Community Industry Alliance, Submission S025, p. 7.

² Council of Regional Disability Services, Submission S072, p. 12.

³ See: Action on Disability Within Ethnic Communities (S055), CPS Choice Plan Services (S013) and Merri Health (S061).

participant, as they ensure participants receive the service they have agreed to receive, including identifying and taking action when service providers have a conflict of interest. Even though the NDIS make clear statements around conflict of interest, there does not appear to be clear correlation to how the NDIS Quality and Safeguard Commission manage or even investigate complaints around conflict of interest. One member of the working group put it as follows:

[We talk] with Support Coordinators daily who are disillusioned with the number of conflicts of interest by service providers, that are reported to the Commission via a complaint and the participant is not advised how they have been managed or of the outcomes from any investigations.

10 Location Specific Issues

The Review received a total of:

- 16 submissions about the pricing arrangements for supports delivered in Queensland, South Australia and Western Australia, and
- 34 submissions about the pricing arrangements for supports delivered in Regional, Remote and Very Remote Australia.

Details of the submissions are at Appendix A.

Four stakeholder working groups were established.

- The working group on Queensland supports had 9 members from 8 organisations.
- The working group on South Australia supports had 9 members from 8 organisations.
- The working group on Western Australia supports had 17 members from 12 organisations.
- The working group on Regional, Remote and Very Remote supports comprised 24 members from 19 organisations.

Details of the members of the working group are provided in Appendix B. Each working group met twice by video-conference, on 7 December 2021 and 8 February 2022.

Three shared themes developed across the consultations with the above groups, covering the implications of geographic dispersion on:

- Workforce attraction, training and retention;
- Operating costs; and
- Other issues.

The Review's analysis and recommendations relating to the pricing arrangements for location specific issues can be found in Chapters 10 (Regional, Remote and Very Remote Areas) and 11 (Queensland, South Australia and Western Australia) of the *Report of the 2021-22 Annual Pricing Review*. Some of the location specific issues were addressed by recommendations about general price limits and arrangements, which are discussed in Chapters 2 (Pricing Strategy), 3 (Disability Support Worker Cost Model) and 4 (General Pricing Arrangements) of the *Report of the 2021-22 Annual Pricing Review*.

10.1 Workforce Attraction, Training and Retention

A number of stakeholders argued that the current DSW Cost Model does not sufficiently take into account of the higher costs associated with attracting and maintaining a workforce in parts of Australia, particularly outside metropolitan areas. Working group members provided numerous examples of workforce shortages. Submissions stated that workforce shortages were a significant issue affecting providers nationally, however they are more pronounced in regional and remote areas. For example, Jibber Jabber Allied Health stated that:

While a Melbourne or Sydney based office can advertise on Seek and gain potentially 2 candidates of either role, a regional or rural office has little to no success on job posting boards. They require the services of a recruiter. They often need to offer higher salaries to entice candidates and sometimes need to include relocation costs. The added pressure on these businesses results in the cost of delivery services increasing. This is a difficult number to quantify, but recruitment costs are often from \$6,000 to \$12,000 per candidate hired.¹

The submission from the National Aboriginal Community Controlled Health Organisation (NACCHO) stated that:

For Aboriginal and Torres Strait Islander workers to make up a modest proportionate component (say 3.3%) of the forecast increase, an additional 8,233 Aboriginal and Torres Strait Islander workers are required by 2025. But we know that Aboriginal and Torres Strait Islander people make up a far greater proportion of the people who need care, so this number is an underestimate. Our established network of 143 [Aboriginal Community Controlled Health Organisations] with their 550 clinics are a well-established national resource. But our existing services are already experiencing severe workforce shortages.²

One working group member noted the complexity of having to train a new workforce who are not familiar with working in the NDIA space within a community context.

For that very reason, to be able to deliver core supports in a place-based situation, the costs of attracting staff are higher because of training...the cost of supervision to be able to support people [to] appropriately learn is a little bit different. You are working with a low base of workforce and they need a lot of support to make it work.

HelpingMinds' submission stated that the costs of sustaining a regional or remote workforce are compounded by having to:

... provide the essential training, development and equipment needed by the workforce. This often involves high travel and logistics costs for workers to attend appropriate training and for management to support the workforce on-site and develop the local resources to sustain the service.³

In the Western Australia working group, one member proposed the NDIA reflect the additional cost of training in regional and remote locations within Western Australia in the price limits. They argued that the population is more transient, which results in higher costs for the organisation.

A submission quoted a study conducted by the University of Western Australia of nine disability service providers operating in Western Australia ("the Gilchrist and Parks Study") which indicated that labour and recruitment costs have increased over two years (2019-20 to 2020-21) adjusting for service growth.⁴ The Gilchrist and Parks Study found that:

- **Labour costs:** per client labour costs increased by 9% in 2019-20 and a further 16% in 2020-21. NDIS-specific clerical staffing costs have increased by 21% and 33% respectively.

¹ Jibber Jabber Allied Health, Submission S006 (email).

² National Aboriginal Community Controlled Health Organisation, Submission S150, p. 6.

³ HelpingMinds, Submission S085, p. 6.

⁴ Gilchrist DJ and Parks B. (2021). *NDIS Price review: Western Australian Costs Assessment – Cost Increases*. Non-for-profits. University of Western Australia, Perth, Australia.

- **Agency staff costs:** the number of agency staff employed as a percentage of total workforce has increased from 33% in 2019-20 and 40% in 2020-21. As a result, the proportion of agency costs to direct labour costs rose from 3.8% to 5.6% over the period.
- **Recruitment costs:** the high turnover of staff has resulted in increased recruitment costs. These costs increased by 12% in 2019-20 and 28% in 2020-21.

Another study by the University of Western Australia that was quoted in a submission reported that employee expenses for social services not-for-profit organisations (includes providers delivering NDIS and non-NDIS supports and excludes aged care and health services) are higher in Western Australia than the rest of Australia and that these employee costs are increasing over time. The same study found that Western Australia has the least disparity between wages in the capital city versus the regions, resulting in rural and remote areas earning comparable wages to those in Perth, likely the result of increased competition for labour in a tight labour market.¹

In relation to Queensland, submissions noted that delivering training and supervision to workers in regional areas of Queensland can be logistically difficult and a costly exercise. Wellways stated that the current price limits do not adequately take into account the cost to recruit, induct and train staff in regional and remote areas. Attempts to deliver training and supervision virtually or remotely to staff in regional Queensland are not effective in supporting staff and meeting their needs.²

Submissions also stated that participants in parts of the country were disadvantaged as a result of '*thin markets, where allied health professionals and other specialists are dispersed and provide inconsistent supports*'. This led to less choice of providers and difficulties with accessibility.³

Costs for specialists were also reported to be increasing, exacerbated by providers' inability to fully recoup travel costs, which further discouraged specialists and allied health providers locating to regional, remote areas and very remote areas. Several submissions stated that the current pricing arrangements provide insufficient funding to cover the additional cost of providing fly-in-fly out services in remote and very remote communities where flights, accommodation, translators and infrastructure are required.⁴

Working group members also argued that NDIS providers had to compete harder for staff in some parts of the country. Members of the Regional, Remote and Very Remote Supports working group flagged that providers needed to compete with local health providers who could often offer more attractive salary packages and were better able to compensate for travel and other expenses. Members of the Queensland and the Western Australia working

¹ Gilchrist DJ. (2021) *Green Paper 6: Cost Differentials, Cost Pressures & Labour Competition Impacting Disability Service Provision in Western Australia: A Report of Not-for-profits*. University of Western Australia, Perth, Australia.

² Wellways, Submission S222, p. 17.

³ Ibid., p. 15.

⁴ See: Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's (S096), Australian Prosthetic Association (S064), and the National Aboriginal Community Controlled Health Organisation (S150).

groups noted the need for providers to compete with both the mining and agriculture sectors not just for staff, but also for accommodation for staff that was becoming more expensive.

The submission from Rocky Bay stated that:

Competition for staff in WA continues to increase driven by the expanding mining sector despite the highest participation rate and lowest unemployment rate of all jurisdictions. This is demonstrated by Rocky Bay's current vacancy rate of 15%.¹

The submission from Avivo stated that they:

... received less than half the number of applicants (387 applicants for the 12 months to September 2021) for support worker positions compared to the previous 12 months (812 applicants in the 12 months to September 2020).²

Members of the Western Australia working group gave the following examples:

- A worker being offered \$40,000 to work for fewer hours in mining.
- The State Government Health Service paying for return flights from regional areas and providing an air conditioning allowance — it was also reported that the State Department of Health was offering to pay off student debt loans.

Working group members also acknowledged that Western Australia's hard border and strict reopening strategy meant that there were a limited number of workforce candidates overall.

Members of the Queensland working group gave examples of thin markets that increased overhead costs for providers and lowered average utilisation of workers, in part due to new workers are always being brought up to speed. One member noted as *"unemployment drives down more than 4%, it is difficult to get workers. Whilst there's the regional rates, the second thing is having people available and trained."* Another member gave an example from Mt Isa where there are no available people who want to work in disability.

Members of the Queensland working group also noted the added complexity brought about by COVID-19 stating the minimum number of hours for training has increased resulting in providers needing to plan for extra staff. One member also noted within their organisation, they were encouraged to not stretch staff between too many households to lower the risk of exposing participants and support workers to COVID-19.

Members of the Regional, Remote and Very Remote Supports working group noted that these workforce issues did not sit entirely within the NDIA's remit, and one member stated that this issue needs "other government departments being brought into this".

The discussion with the Participant Working Group suggested that difficulties in finding providers were not limited to remote or regional areas. Some members of the Participant Reference Group gave examples of difficulty finding providers even in metropolitan areas. Examples given included long wait list times for therapy supports, as well as participants who were unable to find support workers to clean the house or mow the lawn.

¹ Rocky Bay, Submission S141, p. 16.

² Avivo, Submission S112, p. 23.

10.2 Operating costs

Related to the workforce attraction and retention issues, members of all four working groups considered that the Disability Support Worker Cost Model does not adequately recognise the additional costs associated with supervision in parts of the country. Members noted that the supervision ratio assumption in the Cost Model did not reflect that some supervisors need to spend time travelling between a widely distributed workforces.

Consultations also revealed pressures related to provider travel and other costs.

Travel

Members of the Regional, Remote and Very Remote Supports working group argued that it was necessary and beneficial to visit participants in their homes where they reside and feel most at ease, but that providers are often unable to recoup costs for travel from participant plans. Members suggested a greater travel allocation is needed in plans as in many cases a provider may travel all day to deliver supports to just one participant. Members recognised that this was not sustainable.

One member argued the MMM geographical classification did not always equate to where the participants who need to receive services are actually located. They gave the example of a provider delivering specialist therapy supports in Port Lincoln in South Australia because there are no other providers remaining in the area. To do so, this provider needs to drive several hours to the airport in Adelaide and fly to Port Lincoln but is only able to support 2 or 3 participants each trip due to the availability of flights. Under the current travel rules, this is not financial viable for the provider as they are only able to claim 20% of the costs incurred.

The Australian Orthotic Prosthetic Association stated that:

From a direct-cost perspective, it is more expensive to provide these services because of the provider travel required to conduct mobile clinics – including travel time, travel cost, accommodation, meals etc.¹

Several submissions also stated that as a consequence of insufficient funding for travel in plans and the time limits on claiming for travel, providers typically lose money delivering supports to participants in remote locations, due to the extra time spent attracting staff that are willing to travel, or subsidising travel/transport for the employee.²

The Queensland Alliance for Mental Health stated that:

... the pricing arrangements do not reflect real world operating costs of delivering services in remote and very remote areas, including things such as travel, training, and other incentives required to attract appropriately trained staff.³

The submission from the Australian Physiotherapy Association gave an example of a physiotherapist based in Burnie, noting that the physiotherapist and the provider couldn't reach an agreement, resulting in participants on King Island going without service:

¹ Australian Orthotic Prosthetic Association, Submission S112, p. 8.

² See: Australian Physiotherapy Association (S098), Avivo (S112), Carers NSW (S087), Council of Regional Disability Services (S072), Mind Australia Limited (S105), and The Disability Trust (S159).

³ Queensland Alliance for Mental Health, Submission S099, p. 7.

The physiotherapist used to travel to King Island for fortnightly day trips to provide onsite physiotherapy services to a local business. ... The physiotherapist was contacted by a disability provider to deliver services on King Island. The physiotherapist was interested however that would have meant incurring the cost of spending the night on the island (there were only two flights a day). The provider explained that he could only pay for the delivery of the physiotherapy services but not for the travel and accommodation costs.¹

Members of all four working groups agreed on the need for greater education and awareness of participants about travel costs, and noted the current hesitancy by participants to pay for provider travel. Members thought there could be better guidance on who has responsibility for what costs – for example, was it the participant to whom, or from whom, the provider was travelling. A further complication was that participants or their families had not had to pay for provider travel under the previous block funding arrangements, and did not understand why providers were now charging for travel.

Several submissions proposed an increase in the travel loadings for regional areas of Australia.² They recognised that the travel time limit is higher and that travel loadings are 40% higher in remote areas and 50% higher in very remote areas, but argued that the lack of regional loadings creates significant barriers for participants being able to access supports and exercise choice and control in selecting their preferred provider. They also argued that the current pricing arrangements do not enable providers to adequately upskill workers or attract workers to regional areas due to the significant travel costs.

The submission from ONCALL stated that:

Using Bendigo as an example, the travel for this trip is 2 hours and 5 minutes each way [to and from Melbourne], which means that providers have to bear the cost for over 3hours each instance. This does not represent value for money.³

The submission from Vision Australia stated that:

Vision Australia provides services to a client in Nanango, in regional Queensland. We have only one client with an NDIS package in this location. It is a 5-hour round trip for therapists to travel to appointments with this client from our nearest office in Maroochydore, however, because of the way in which Nanango is classified under the MMM model, we are only able to bill for 60 minutes of that travel time. There are no other providers in the area so the client is at considerable risk of not receiving services. We have trialled a range of options – from seeking to deliver multiple services per visit, to dual service provision with multiple providers – there is no combination of approaching break even with our costs. The costs of providing services considerably outweigh the expenses we incur in delivering them.⁴

The submission from National Disability Services stated that:

Therapists (as well as other providers) increasingly absorb the travel costs beyond the 30 minutes in MMM1-3 areas and 60 minutes in MMM4-5 areas. Participants and families balk at the cost.

¹ Australian Physiotherapy Association, Submission S098, p. 6.

² See: National Disability Services (S152), Oncall Accommodation Services (S124), Rocky Bay (S141), Vision Australia (S109), and Wellways (S222).

³ Oncall Accommodation Services, Submission S124, p. 2.

⁴ Vision Australia, Submission S109, p. 10.

They are also reluctant to pay for the non-face-to-face supports they receive; again these are often absorbed by providers.¹

Several submissions stated that remote loadings do not cover all elements of service provision such as excessive travel time, limited facilities for specific therapies, capital costs for equipment and the cost of developing and supporting a workforce while the NDIS participant base is expanding.²

The National Aboriginal Community Controlled Health Organisation stated that in remote and very remote Aboriginal and Torres Strait Islander communities, price arrangements need to include sufficient funding allocation for travel and subsistence funding (e.g., Medical Outreach Indigenous Chronic Disease Program type funding). They stated that *“there are a lot of lessons that can be learnt from the health sector on the provision of specialist and allied health services to remote communities that are directly transferable to NDIS.”*³

Submissions also stated that the current travel policy was administratively burdensome. Because funding for provider travel is accessed through a participant’s individual plan, these administrative steps must be completed prior to service provision, and for every participant. The Australian Orthotic and Prosthetic Association’s submission stated that to provide services requiring provider travel, orthotic/prosthetic providers are required to:

- Ensure each participant has provider travel in their plan (if a participant does not have provider travel in their plan, the participant must instigate a plan review which can take a long time and disturbs current service bookings)
- Obtain consent from each participant to invoice provider travel
- Negotiate provider travel hourly rates with each participant, and
- Negotiate how provider travel will be apportioned between participants (when a provider travels to provide services to multiple participants, for example at a monthly clinic attended by ten participants).

The submission argued that the current NDIA provider travel policy means it is difficult for providers to establish efficient and sustainable provider travel. It further argued that absorbing these costs is unsustainable and has resulted in some providers: reducing the number of outreach clinics; or refusing to operate any outreach clinic and relying on state-based support to operate clinics.⁴

Other costs

The submission from Vision Australia stated that the separation of centre capital costs from service delivery prices (recently introduced) is causing needless complexity and extensive administrative burden for service providers.⁵ It further detailed that the implementation of

¹ National Disability Services, Submission S152, p. 14.

² See: Avivo (S112), Dieticians’ Australia (S239), National Aboriginal Community Controlled Health Organisation (S150), and Rocky Bay (S141).

³ National Aboriginal Community Controlled Health Organisation, Submission S150, p. 3.

⁴ Australian Orthotic Prosthetic Association, Submission S064, p. 8

⁵ Vision Australia, Submission S109, p. 5.

these arrangements has required significant investment in client management and billing systems, for gains to the provider that are minimal.

In its submission, the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, suggested a lack of clarity in current NDIA guidance leads to its organisation not being able to understand how many costs can be recouped.

When working remotely, vehicles for both provider and participant transport must be 4-wheel drive, and have these high lease, maintenance, and fuel consumption costs, as well as requiring specific driver training. Maintenance costs for one 4-wheel drive vehicle amount to around \$9,000 per year, exclusive of least costs (an additional \$21,000 pa). The cost of fuel in remote locations is up to a dollar per litre higher than in the more populous areas of Australia. For the safety of workers and participants, when traveling on remote roads where there is no phone reception, each vehicle needs to carry a satellite phone and an EPIRB, both of which entail ongoing costs as well as usage costs. Many of these costs are incurred as overheads that is, they occur regardless of whether staff are able to travel out to the Lands or visit clients.¹

Members of the South Australia working group noted the additional costs providers incurred to manage COVID-19 and said that these were not adequately reflected in the cost model. One member stated COVID-19 has meant a reliance on Agency staff and paying staff for overtime which is not factored into the current pricing arrangements. They stated their organisation paid \$30,000 of overtime and \$20,000 in PPE. Another member noted their organisation had spent "\$54,000 in the last three months on PPE including \$23,000 on RATS" and had "only received \$264 in compensation from the NDIA."

Members of the South Australia working group said that WorkCover and compensation levies were more expensive in South Australia than other states. They further argued that Workcover rates of 2% and 3.9% were not appropriately reflected in the DSW Cost Model, which was set at 1.7%. They felt should be addressed by either bringing the state's arrangements into alignment with other jurisdictions (a state government matter) or by the NDIA allowing higher price limits for South Australian providers. Members of the Queensland working group discussed that the DSW Cost Model needs to account for increased work cover costs as a result of the increase in the number of staff calling in sick and claiming work cover based on adverse vaccine affects — something that cannot be avoided because vaccinations are mandatory for staff members.

South Australia working group members also stated that abiding by the Quality and Safeguard Standards is more expensive in South Australia than other states, due to the South Australian government not paying for Authorising Coordinators unlike other state governments that did. Submissions on Western Australia argued that the costs of compliance and reporting are higher in Western Australia than other states.

The Queensland and South Australia working groups discussed that the state had more public holidays than were reflected in the pricing arrangements. The example given was that SIL services are only funded for 12 public holidays when there are in fact 16 public holidays in Queensland, and half day public holidays for Christmas Eve and New Years' Eve in South Australia. While providers can use the public holiday support items for supports delivered on

¹ Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, Submission 096, p. 3.

each public holiday, there was not sufficient funds in the plan to allow this to happen. This meant that providers needed to absorb the cost, which adds to their overheads.

10.3 Other Issues

Remote and very remote

Council of Regional Disability Services submission stated the costing model does not recognise costs that arise when a provider becomes the de facto provider of last resort in remote and very remote communities. They stated that some providers are filling the gap left by State and Federal Governments who exited from delivering disability services during the transition to the NDIS. As a de facto provider of last resort, Council of Regional Disability Services stated that there is a need and responsibility to continue to provide supports in these communities, even if it is not financial beneficial to do so.¹

Life Without Barriers stated that a new model is required to address the complexities of delivery supports in remote and very remote communities and achieve better outcomes. They stated that:

...tinkering with the current pricing structure will not deliver for people with disability in remote communities. This is consistent with the NDIA's stated co-design approach...and is fully supported by Alliance20.²

Aboriginal and Torres Strait Islander

The submission from the National Aboriginal Community Controlled Health Organisation (NACCHO) stated that *"there is significant unmet need for services for Aboriginal and Torres Strait Islander participants."*³ The submission also pointed to an absence of culturally appropriate supports as a reason for this unmet demand. The submission for the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council similarly stated that the NDIS:

... takes little or no account of people's lifestyles and their background. Plans are written in English, in language that is incomprehensible to Anangu, whose culture is oral and based in traditional Aboriginal languages. Goals do not reflect people's desire for access to basic needs, and often focus on services that are unavailable in remote communities. There is excessive, incomprehensible paperwork for clients to sign.⁴

The NACCHO submission stated that:

[D]espite the clear need and challenges facing Aboriginal and Torres Strait Islander peoples in Australia, and the undisputed potential for the ACCHO [Aboriginal Community Controlled Health Organisation] sector to redress these inequalities, it is notable that the NDIS Annual Price Review 2020-21 consultation paper does not once mention or acknowledge [us].

¹ Council of Regional Disability Services, Submission S072, p. 10.

² Life Without Barriers, Submission S227, p. 8.

³ National Aboriginal Community Controlled Health Organisation, Submission S150, p. 5.

⁴ Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, Submission S096, p. 2.

[E]vidence supports the notion that Aboriginal and Torres Strait Islander peoples will only access those services where they feel culturally safe and prefer to use Aboriginal Community Controlled Organisations (ACCO) when available.¹

The NACCHO submission also called for reform to the funding of supports in remote and very remote Aboriginal and Torres Strait Islander Communities. It stated that:

[I]n 2019, the COAG Disability Reform Council agreed to use a more flexible approach to address market challenges in the NDIS and recognised a 'one size fits all' approach to deliver NDIS is not suitable to address market gaps faced by geographic location, particular cohorts, and certain disability types²

It also proposed that the NDIA include additional incentives similar to the Practice Incentives Program and Service Incentive Payments and the bulk billing incentives which are provided in Aboriginal and Torres Strait Islander Health:

[A] long-term stable funding agreement (with the Commonwealth and State governments) should be in place to ensure that our sector can transform itself to be able to thrive in this market.³

Western Australia

Submissions specific to Western Australia proposed that the NDIA consider pricing arrangements and price limits that are specifically designed for Western Australia and that respond to local economic cycles, the challenges of building the local workforce and address the prevalence of thin markets.⁴ The submission from Crosslinks Disability Support Services, for example, proposed that the NDIA consider offering a higher hourly rate to enable Western Australian providers to compete with the mining sector by offering comparable salaries and conditions.⁵

The submission from Avivo proposed that the NDIA adopt a more comprehensive and flexible cost model that reflects local market experience and evidence-based best practice including for regional and remote parts of a State.

Allow for different cost models and price caps in different states if the benchmarking data supports this overall. Alternatively, allow state by state loadings onto price caps in a year where the economic data supports it.⁶

One member of the Western Australia working group proposed that the NDIA introduce a regional loading of at least 10% for towns classified as regional. They also indicated that some reclassifications of isolated towns would also be welcome.

... the MMM model and the classification of regional and remote is not really helping with no loading on regional and the challenge to be classified as remote (sic). We still have some towns

¹ National Aboriginal Community Controlled Health Organisation, Submission S150, p. 4.

² Ibid., p. 8.

³ Ibid., p. 8.

⁴ See: Avivo (S112), Council of Regional Disability Services (S072), Crosslinks Disability Support Services (S217), Western Australia Department of Communities (S231), and Mind Australia (S105).

⁵ Crosslinks Disability Support Services, Submission S217, p. 22.

⁶ Avivo, Submission S112, p. 4.

classified as regional but every sense of the word in terms of the challenges unique to remote towns, they are remote.

Another member of the Western Australia argued that Geraldton be reclassified as remote “as a major priority” as without the classification, the organisation was struggling to make funding allocations work. The member explained the biggest issue facing the organisation was having to staff a workforce from Perth. Despite there being a demand for services in Geraldton, the organisation was unable to “*make it work from a P&L perspective because prices are not reflective of the realities of working in Geraldton.*” Another member agreed that “*Geraldton and Carnarvon were the most challenging areas to deliver services*” and deserved reclassification.

The submission from Avivo argued that the Southern Cross and Dongara should also be classified as Isolated Towns.

Dongara is 45 minutes’ drive away from Geraldton and has a population of approximately 1,380. It is very challenging to recruit support workers in the town, and if they are unavailable for a planned support, it either needs to be cancelled or we incur the costs of sending a support worker from Geraldton to cover the support if it is essential.

Southern Cross is classified as Remote. 60km to the east is classified as Very Remote. It has a population of under 700. The nearest major town is Merredin, which is 114km away. This is the closest town in which Avivo has a small team of employees, and it is from here that we need to undertake the challenging task of building a workforce in Southern Cross to meet the needs of the few customers who require services.¹

¹ Avivo, Submission S112, p. 22.

Appendix A – List of Submissions

Reference	Type of Respondent	Respondent
S001	Provider	With Care Plan Managers
S002	Individual Support Worker/Therapist	Continence Specialist Services
S003	Provider	Sunflower Services
S004	Provider	First Service Inc.
S005	Individual Support Worker/Therapist	Support Care Management Services
S006	Individual Support Worker/Therapist	Jibber Jabber Allied Health
S007	Individual Support Worker/Therapist	I Support Disability Services
S008	Individual Support Worker/Therapist	Forman's Business Services
S009	Individual Support Worker/Therapist	Sole Trader
S010	Individual Support Worker/Therapist	Not provided
S011	Individual Support Worker/Therapist	BE Physiology
S012	Individual Support Worker/Therapist	BE Physiology
S013	Individual Support Worker/Therapist	CPS Choice Plan Services
S014	Individual Support Worker/Therapist	Made To Measure Services
S015	Individual Support Worker/Therapist	Meaningful Movement
S016	Individual Support Worker/Therapist	HWO
S017	Individual Support Worker/Therapist	HWO
S018	Individual Support Worker/Therapist	HWO
S019	Individual Support Worker/Therapist	HWO
S020	Individual Support Worker/Therapist	HWO
S021	Professional Peak Body	Osteopathy Australia
S022	Provider	Beacon Support
S023	Individual Support Worker/Therapist	Forman's Business Services
S024	Individual Support Worker/Therapist	Hall and Prior
S025	Provider Peak Body	Australian Community Industry Alliance
S026	Individual Support Worker/Therapist	Tropics Occupational Therapy
S027	Government	WA Department of Justice
S028	Provider	Ocean Physio
S029	Provider	Tulgeen
S030	Individual Support Worker/Therapist	Active Ability
S031	Individual Support Worker/Therapist	Active Ability
S032	Individual Support Worker/Therapist	Active Ability
S033	Individual Support Worker/Therapist	Move and Empower
S034	Individual Support Worker/Therapist	Active Ability
S035	Individual Support Worker/Therapist	Active Ability
S036	Individual Support Worker/Therapist	Active Ability
S037	Individual Support Worker/Therapist	Active Ability
S038	Individual Support Worker/Therapist	Sole Trader
S039	Individual Support Worker/Therapist	Sole Trader
S040	Individual Support Worker/Therapist	Help at Hand Support
S041	Individual Support Worker/Therapist	Active Ability
S042	Individual Support Worker/Therapist	Active Ability
S043	Individual Support Worker/Therapist	Active Ability
S044	Individual Support Worker/Therapist	Active Ability
S045	Individual Support Worker/Therapist	Total Rehab Solutions
S046	Individual Support Worker/Therapist	Sole Trader
S047	Provider	Interaction Disability Services
S048	Provider	Greenacres
S049	Individual Support Worker/Therapist	Hunter Rehabilitation and Health

Reference	Type of Respondent	Respondent
S050	Individual Support Worker/Therapist	Active Ability
S051	Individual Support Worker/Therapist	The Active Studio
S052	Individual Support Worker/Therapist	Lane Cove Physio
S053	Provider Peak Body	Specialist Disability Accommodation Alliance
S054	Provider	At Home Care
S055	Provider	Action on Disability within Ethnic Communities
S056	Provider	Lizard Centre
S057	Individual Support Worker/Therapist	NeuroRehab Allied Health Network
S058	Individual Support Worker/Therapist	NeuroRehab Allied Health Network
S059	Individual Support Worker/Therapist	NeuroRehab Allied Health Network
S060	Provider	We are Vivid
S061	Provider	NDIS Services
S062	Individual Support Worker/Therapist	Thomas Nicholas (sole trader)
S063	Individual Support Worker/Therapist	NeuroRehab Allied Health Network
S064	Professional Peak Body	The Australian Orthotic Prosthetic Association
S065	Provider	Empowered Futures
S066	Provider	Autism Spectrum Australia (Aspect)
S067	Provider	Community Support Inc.
S068	Provider	NeuroRehab Allied Health Network
S069	Provider	MED-EL
S070	Professional Peak Body	Exercise & Sports Science Australia
S071	Participant Representative	NDIS Participant's Father
S072	Provider Peak Body	Council of Regional Disability Services
S073	Individual Support Worker/Therapist	RE Physiology
S074	Individual Support Worker/Therapist	The EP Clinic
S075	Individual Support Worker/Therapist	Active Ability
S076	Individual Support Worker/Therapist	Flex Out
S077	Individual Support Worker/Therapist	Clinical Health Rehabilitation
S078	Individual Support Worker/Therapist	Ability Action Australia
S079	Individual Support Worker/Therapist	Active Ability
S080	Individual Support Worker/Therapist	The Active Studio
S081	Individual Support Worker/Therapist	All Abilities Allied Health
S082	Provider	Australian Community Support Organisation
S083	Provider	Abacus Learning Centre
S084	Provider	NeuroRehab Allied Health Network
S085	Provider	Helping Minds
S086	Professional Peak Body	Occupational Therapy Australia
S087	Provider	Carers NSW
S088	Provider	First Voice
S089	Individual Support Worker/Therapist	Chorus Music Therapy Clinic
S090	Provider	PC Ability
S091	Provider	Can Do Group
S092	Provider	Sylvanvale
S093	Provider	First2Care
S094	Provider	Kurrajong
S095	Provider	Plumtree
S096	Provider	Ngaanyatjarra Pitjantjatjara Women's Council
S097	Provider	One Door Mental Health
S098	Professional Peak Body	Australian Physiotherapy Association
S099	Provider	Queensland Alliance for Mental Health
S100	Provider	Continence Foundation of Australia
S100a	Provider	Continence Foundation of Australia
S101	Provider	Community Living Options
S102	Provider	Job Centre Australia

Appendix A – List of Submissions

Reference	Type of Respondent	Respondent
S103	Provider	Community Assist
S104	Provider	Illawarra Disability Alliance
S105	Provider	Mind Australia
S106	Provider	Mercy Connect
S107	Provider	Hireup
S108	Provider	Marathon Health
S109	Provider	Vision Australia
S110	Participant Representative Organisation	Queensland Advocacy Incorporated
S111	Professional Peak Body	Allied Health Professions Australia
S111a	Professional Peak Body	Allied Health Professions Australia
S112	Provider	Avivo
S113	Individual Support Worker/Therapist	Active Ability
S114	Individual Support Worker/Therapist	Move 2 Thrive
S115	Individual Support Worker/Therapist	Optimum Health Services
S116	Individual Support Worker/Therapist	Optimum Health Solutions
S117	Individual Support Worker/Therapist	Better Exercise Physiology
S118	Individual Support Worker/Therapist	Optimum Health Solutions
S119	Individual Support Worker/Therapist	Uplift Exercise Physiology
S120	Provider	Living My Way
S121	Provider	Flourish Australia
S122	Union	Australian Services Union
S123	Union	United Workers Union
S124	Provider	Oncall Accommodation Services
S125	Provider	IOTAH
S126	Provider	Activ
S127	Provider	Connect Plan Management
S128	Provider	Down Syndrome Australia
S129	Provider	Jobs Are Us
S130	Participant Representative Organisation	Gippsland Disability Advocacy
S131	Provider	NeuroRehab Allied Health Network
S132	Individual Support Worker/Therapist	Life in Action
S133	Individual Support Worker/Therapist	Hunter Rehabilitation and Health
S134	Individual Support Worker/Therapist	Effect Exercise Physiology
S135	Individual Support Worker/Therapist	Active Ability
S136	Individual Support Worker/Therapist	o2 active
S137	Individual Support Worker/Therapist	KG Exercise Physiology
S138	Individual Support Worker/Therapist	Active Ability
S139	Provider	North East Exercise Solutions
S140	Individual Support Worker/Therapist	UniquePhysio
S141	Provider	Rocky Bay
S142	Provider	Supporting Independent Living Co-Operative
S143	Provider	Minimbah
S144	Provider	Autism Queensland
S145	Provider	Bedford
S146	Individual Support Worker/Therapist	Darling Downs Therapy Services
S147	Provider	Carers ACT
S148	Provider	RDNS SA
S149	Participant Representative	NDIS Participant Carer
S150	Provider	National Aboriginal Community Controlled Health Organisation
S151	Provider	Galway Trading
S152	Provider Peak Body	National Disability Services
S153	Provider	Mental Illness Fellowship of Australia
S154	Provider	Novita
S155	Individual Support Worker/Therapist	Extra Mile PT

Reference	Type of Respondent	Respondent
S156	Provider	Therapy Pro
S157	Provider	Lime Therapy
S158	Provider	Hunter Valley Children's Therapy
S159	Provider	The Disability Trust
S160	Provider	Mia's Health
S161	Provider Peak Body	Disability Intermediaries Australia
S162	Provider	Knapp Connections
S163	Provider	iAssist Plan Management
S164	Provider	Jigsaw Plan Management Pty Ltd
S165	Provider	My Plan Manager
S166	Provider	Slater Coordinator
S167	Provider	Leisure Networks Association Inc.
S168	Provider	JRA Plan Management
S169	Provider	Plan Partners
S170	Provider	JD Coordination & Support Services
S171	Provider	The Growing Space
S172	Provider	Pathways to Care Pty Ltd
S173	Provider	Leap In! Australia
S174	Provider	EMMJ Disability Services Trading As Rise and Shine Plan Management
S175	Provider	Ablelink Pty Ltd
S176	Provider	Shoalhaven Plan Management
S177	Provider	Peak Plan Management
S178	Provider	Total Plan Management
S179	Provider	Ethical Coordination of Supports
S180	Provider	P. Fernandez Support Coordination
S181	Provider	My Integra
S182	Provider	NDSP Plan Managers
S183	Provider	Valued Lives
S184	Provider	Gregg Fitzgerald Support Coordination
S185	Provider	Connect Plan Management Pty Ltd
S186	Provider	1 Call Plan Management
S187	Provider	The Carers Place Pty Ltd
S188	Provider	Sole Trader
S189	Provider	IDEAL Plan Management
S190	Provider	#1 Answer Plan Management
S191	Provider	Empowrd
S192	Provider	Sole Trader
S193	Provider	Claire Coordination of Supports
S194	Provider	Sole Trader
S195	Provider	myCSN Disability Pty Ltd
S196	Provider	Monica Mckee Support Coordination
S197	Provider	Your Plan Manager
S198	Provider	Burke Support Coordination
S199	Provider	PMCSS Specialist Support Coordination
S200	Provider	All Disability Plan Management
S201	Provider	Amelia Edmonds Support Coordination
S202	Provider	Canny Plan Management
S203	Provider	Roy Co.
S204	Provider	Balanced Account Bookkeeping
S205	Professional Peak Body	Australian Podiatry Association
S206	Provider	Nganana Inc.
S207	Provider	AEIOU Foundation
S208	Provider	Paragon Support Limited
S209	Provider	Veritable

Appendix A – List of Submissions

Reference	Type of Respondent	Respondent
S210	Provider	Multicultural Services Centre of Western Australia
S211	Professional Peak Body	Australian Music Therapy Association
S212	Individual Support Worker/Therapist	Sole Trader
S213	Professional Peak Body	Australian Association of Psychologists Inc.
S214	Individual Support Worker/Therapist	Integrated Children's OT
S215	Individual Support Worker/Therapist	NeuroRehab Allied Health Network
S216	Provider	Mpower You
S217	Provider	Crosslinks Disability Support Services
S218	Provider	Ability Options
S219	Provider	Gen U
S220	Individual Support Worker/Therapist	Not provided
S221	Provider	Living Right
S222	Provider	Wellways Australia
S223	Provider	MerriWA
S224	Provider	Made to Measure Bookkeeping Pty Ltd
S225	Provider	Bespoke Lifestyles & Made to Measure Services
S226	Provider	Kyeema Support Services
S227	Provider	Life Without Barriers
S228	Provider	Community Living Australia
S229	Provider Peak Body	Ability First Australia
S230	Professional Peak Body	Australian Psychological Society
S231	Government	Western Australian Department of Communities
S232	Provider	MJD Foundation
S233	Provider	New Horizons
S234	Provider Peak Body	Vision 2020 Australia
S235	Provider Peak Body	Spinal Cord Injuries Australia
S236	Provider	Leisure Networks
S237	Provider	Xavier
S238	Provider Peak Body	Alliance20
S239	Professional Peak Body	Dietitians Australia
S240	Government	Queensland Government
S241	Provider Peak Body	Ability First Australia
S242	Professional Peak Body	Speech Pathology Australia
S243	Union	Australian Services Union
S244	Provider	Minda
S245	Government	Heads of Workplace Safety Authorities Australia & NZ (Confidential)
S246	Provider	Minda
S247	Provider	At Home Care
S248	Provider	Cerebral Palsy Alliance
S249	Provider	Cara
S250	Provider	Sylvanvale
S250a	Provider	Sylvanvale
S251	Provider	KB NeuroPhysiotherapy

Appendix B – Working Group Members

Working Group 1 – Core Pricing Arrangements

Organisation represented	Attendee to at least one session
Ability First Australia	Andrew Rowley
Ability First Australia	Michael Bink
Achieve Australia	Lorraine Salloum
Autism Spectrum Australia (Aspect)	Nikki Lui
Avivo	Lynsey McDonnell
Bedford	Rachael Griffiths
Cerebral Palsy Alliance	Shaun Curry
Cerebral Palsy Alliance	Tim Pines
Challenge Community Services	Dino Santos
Challenge Community Services	Tania Mills
Civic Disability Services Ltd	Ethan Chishty
Civic Disability Services Ltd	Kimberley Rathmanner
Community Living Options	Lauren Cronin
Community Living Options	Tiff Hodge
CPL - Choice Passion Life	Murray Sandon
Fighting Chance	Laura O'Reilly
Golden City Support Services	Shelley Moore
Greenacres	Chris Christodoulou
HireUp	Liam Caulfield
Life Without Barriers	Steve Sloan
Macarthur Disability Services	Brenda Odewahn
Mambourin	Alma Zulovic
Mind Australia	Anath Dissanayake
Minda	Antony Sellentin
Minda	Nathan Thompson
National Disability Services	Kerrie Langford
National Disability Services	Philippa Angley
Northcott	Pat Buick
Oak Possability	John Rowland
Oak Possability	Jon Anning
Rocky Bay	Adam Maxwell
Stride	Emma Thomas
Sylvanvale	Oliver Parker
The Disability Trust	Suze Mandicos
The Housing Connection	Nicola Hayhoe
Unisson	Rayni Gauci

Working Group 2 – Quality and Safeguard Costs

Organisation represented	Attendee to at least one session
Ability First Australia	Andrew Rowley
Ability First Australia	Jennifer Luff
Ability First Australia	Michael Bink
Achieve Australia	Ranita Chatterjee
Achieve Australia	Tina McManus
ACT Government	Michelle Waterford
Allied Health Professions Australia	Erin West
Australian Physiotherapy Association	Carole Sarasa
Australian Physiotherapy Association	Carolyn OMahoney

Organisation represented	Attendee to at least one session
Australian Physiotherapy Association	Dan Miles
Autism Association of Western Australia	Nicola Abernethy
Avivo	Dannielle Wenn
Avivo	Denver Forsdike
Avivo	Janine Croker
Avivo	Lisa Davies
Bedford	Taryn Alderdice
Better Rehabilitation	David Pettersson
Cara	Todd Williams
Carpentaria Disability Services	Annie Rily
Cerebral Palsy Alliance	Elise Taylor
Choice Passion Life	Amelia Rowell
Choice Passion Life	Robert Irvin
Civic Disability Services Ltd	Carrie Voysey
Endeavour Foundation	Eric Teed
Endeavour Foundation	Jaime Zischke
Endeavour Foundation	Jennifer Knight
HireUp	Liam Caulfield
Life Without Barriers	Greg Reynolds
Macarthur Disability Services	Brenda Odewahn
Minda	Amy Ambagtsheer
NDIS Commission	Samantha Taylor
National Disability Services	Carmen Pratts-Hincks
National Disability Services	Kerrie Langford
National Disability Services	Philippa Angley
Northcott	Aleta Carpenter
Novita	Andrea Collett
Novita	Tara Richards
Nulsen Group	Gordon Trewern
Oak Possability	John Rowland
Oak Possability	Jon Anning
Occupational Therapy Australia	Madison Silver
Occupational Therapy Australia	Michael Barrett
Occupational Therapy Australia	Samantha Hunter
Scope (Aust) Ltd	Ian Morgan
Scope (Aust) Ltd	Richard Drew
Stride	Emma Thomas
Sylvanvale	Leanne Fretten
Sylvanvale	Tammy Sargeant
Therapy Focus	Danelle Milward
VIC Department of Families, Fairness and Housing	Christopher Brophy
VIC Department of Families, Fairness and Housing	Heidi Tarjani
VIC Department of Families, Fairness and Housing	Shaun Nicholson
WA Department of Communities	Susan Quin

Working Group 3 - Group Pricing Arrangements for Core Supports

Organisation represented	Attendee to at least one session
Ability First Australia	Andrew Rowley
Ability First Australia	Michael Bink
Allevia	Philip Petrie
Autism Spectrum Australia (Aspect)	Ben James
Bedford	Stefanie Veitch
Centacare	Kaylene Moore

Organisation represented	Attendee to at least one session
Central Bayside CHS	Amrita Ahluwalia
Cerebral Palsy Alliance	Anne-Marie Bell
Cerebral Palsy Alliance	Paul Henderson
Cerebral Palsy Alliance	Shaun Curry
Disability Services Australia	Heath Dickens
Flourish Australia	James Herbertson
Greenacres	Chris Christodoulou
HireUp	Peter Willis
Life Without Barriers	Steve Sloan
National Disability Services	Graeme West
National Disability Services	Philippa Angley
Nexus Inc.	Mark Jessop
Northcott	John Preston
Novita	Greg Ward
Novita	Jeremy Brown
Rocky Bay	Adam Maxwell
Stride	Emma Thomas
Sunnyfield	Belinda Gannon
Sunnyfield	Matt Parrott
The Disability Trust	Suze Mandicos

Working Group 4 – Temporary Transformation Payment

Organisation represented	Attendee to at least one session
Ability First Australia	Jennifer Luff
Autism Spectrum Australia (Aspect)	Nghi Hua
Avivo	Lynsey McDonnell
Bedford	Tahlia Gradara
CareChoice	Michelle Eriksen
Centacare	Derek Millar
Community Living Australia	Mark Kulinski
Dared Disability	Andrew Daly
Ermha	Michael Bowers
Flourish Australia	Megan Hancock
HireUp	Liam Caulfield
Life Without Barriers	Nelson Contador
National Disability Services	Henry Newton
National Disability Services	Karen Stace
Nextt	Simon Wright
Northcott	John Preston
Rocky Bay	Adam Maxwell
Sunnyfield	Peter Dixon

Working Group 5 – Therapy supports

Organisation represented	Attendee to at least one session
Ability First Australia	Andrew Rowley
Ability First Australia	Michael Bink
Allied Health Professions Australia	Dr Chris Atmore
AMTA	Helen Cameron
Autism Spectrum Australia (Aspect)	Maryanne Pease
Autism Spectrum Australia (Aspect)	Rachel Kerlake
Autism Spectrum Australia (Aspect)	Rebecca Keane
Audiology Australia	Feiya Zhang

Organisation represented	Attendee to at least one session
Australian Association of Social Workers	Sharon Paetzold
Australian Association of Social Workers	Sophie Staughton
Australian Clinical Psychology Association	Caroline Hunt
Australian Clinical Psychology Association	Dr Paul Gertler
Australian Clinical Psychology Association	Monique Shipp
Australian Orthoptic Board	Sue Silveira
Australian Physiotherapy Association	Carole Sarasa
Australian Physiotherapy Association	Dan Miles
Australian Physiotherapy Association	Julienne Locke
Australian Physiotherapy Association	Simon Tatz
Australian Psychological Society	Tamara Cavenett
Autism Association Of Western Australia	Nicola Abernethy
Autism Queensland	Valerie Preston
Better Rehabilitation	David Pettersson
Carpentaria Disability Services	Fiona Tipping
Cerebral Palsy Alliance	Alison O'Toole
Cerebral Palsy Alliance	Jo Ford
Cerebral Palsy Alliance	Paul Henderson
Dietitians Australia	Aimee McLeod
Dietitians Australia	Carmel Curlewis
Dietitians Australia	Jodie Sheraton
Early Start Australia	Karen Brown
Endeavour Foundation	Jenny Madden
Exercise & Sports Science Australia (ESSA)	Carla Vasoli
Firstchance	Darleen Taylor
Macarthur Disability Services	Brenda Odewahn
Melbourne City Mission	Ben Spooner
Melbourne City Mission	Sally Moore
Montrose Therapy & Respite Services	Kerrie Mahon
National Disability Services	Philippa Angley
NeuroRehab Allied Health Network	Steve Woollard
NextSense	Andrew Steen
NextSense	Sharon Nann
NextSense	Shy Bastianpillai
Noah's Ark	Roxanne Higgins
Northcott	Danielle Coogan
Novita	Jeremy Brown
Occupational Therapy Australia	Sarah Jones
Physio Inq	David Shearer
Rocky Bay	Adam Maxwell
Rocky Bay	Mia Huntley
Scope (Aust) Ltd	Andrew Hanson
Scope (Aust) Ltd	Richard Drew
Speech Pathology Australia	Erin West
Spinal Cord Injuries Australia	Sam Mitchell
St Giles	Andrew Billing
Stride	Emma Thomas
The Australian Orthotic Prosthetic Association	Dr Emily Ridgewell
The Australian Orthotic Prosthetic Association	Natasha Korbut
Therapy Pro	Phil Laidlaw
Vision Australia	Caitlin McMorrow
Vision Australia	Chris Edwards
Yooralla	Cassie Kenyon

Working Group 6 – Nursing supports

Organisation represented	Attendee to at least one session
Achieve Australia	Tina McManus
At Home Care	Christian Lenzarini
Australian Primary Health Care Nurses Association (APNA)	Jayne Lehmann
Blue Care	Jo Martinaglia
Blue Care	Sue Macgregor
Canberra Health Services	Barbara Bolton
CareChoice	Michelle Eriksen
Civic Disability Services Ltd	Rebecca VanLierop
Continence Foundation of Australia	Janie Thompson
Eskleigh Foundation	Sharlene Knight
Home Care Nurses Australia	Busi Faulkner
Intensive Care at Home	Patrik Hutzel
NNA Direct Support Service	Ellen Banks
NNA Direct Support Service	Joanne Kernot
Yooralla	Kristy McMurray

Working Group 7 – Plan Management

Organisation represented	Attendee to at least one session
AiIM Choices	Sandy Powell
All Disability Plan Management	Jo Hollis
Avivo	Emer Hickey
Avivo	Gareth Rees
Budget Net	Michael Coyne
Connect Plan Management	Anthony Oostenbroek
Disability Intermediaries Australia	Jess Harper
Disability Intermediaries Australia	Nicolas Phipps
Ermha	Jackie Ashmore
First2Care	Peter Whitey
Leisure Networks Association	Paul Davies
Manage it	Colin Andison
Maple Plan	Christopher Holt
Moira	Fahmy Singh
National Disability Services	Jim Vanopoulos
NDSP Plan Managers	Graham Oades
Nexia Canberra	Billy Kang
Parent to Parent Association Qld	Kevin Reilly
Plan Partners	Sean Dempsey
Scorpion Business Services	Karen Frost
Tweed Coast Plan Management	Jude McColm
Your Plan Manager	Tanya Walford

Working Group 8 – Support Coordination

Organisation represented	Attendee to at least one session
Avivo	Emer Hickey
Avivo	Gareth Rees
Disability Intermediaries Australia	Jess Harper
Disability Intermediaries Australia	Nicolas Phipps
Each	Kerry Boyd
Each	Lisa Gort
Facilitatrix	Caitriona Byrne
Facilitatrix	Caroline Marshall

Organisation represented	Attendee to at least one session
genU	Brandon Howard
genU	Schree Barry
Golden City Support Services	Shelley Moore
Life Without Barriers	Nelson Contador
Life Without Barriers	Nicole Harrop
Macarthur Disability Services	Brenda Odewahn
Melbourne City Mission	Ben Spooner
Melbourne City Mission	Julia Henning
Mercy Community	Kimberley Dillon
Mind Australia	Elena Slodecki
Mind Australia	Nicola Ballenden
National Disability Services	Karen Stace
Stride	Emma Thomas
Stride	Juliet Middleton
Support Coordination Academy	Mary Ingerton
Wellways Australia	Laura Collister
Wellways Australia	Michael Ashenden
Wellways Australia	Nikki Wynne
Your Plan Manager	Tanya Walford

Working Group 9 – Regional and Remote

Organisation represented	Attendee to at least one session
Avivo	Christine Gibson
Avivo	Nichole Kostal
Council of Regional Disability Organisations	Kathy Hough
Department of Communities Tasmania	Ingrid Ganley
Department of Communities Tasmania	Wendy Yardy
Department of Seniors and Disability Services and Aboriginal and Torres Strait Islander Partnerships	Elizabeth Rowe
Department of Seniors and Disability Services and Aboriginal and Torres Strait Islander Partnerships	Melissa Fallon
East Kimberly Job Pathway	Laura Little
HireUp	Liam Caulfield
Hireup	Larissa Silva
Ingham Disability Support Services	Liz Sutton
Life Without Barriers	Scott Ferguson
Midway Community Care	Heath Flanagan
MJD Foundation	Nadia Lindop
National Disability Services	Ian Montague
Novita	Cathryn Blight
NSW Disability Secretariat	Amanda Viner
NSW Disability Secretariat	Brian Woods
Occupational Therapy Australia	Michael Barrett
Office of Disability	Michelle McColm
Speech Pathology Australia	Erin West
St Giles	Andrew Billing
Through Life Physio	Helen Lowe
WA Department of Communities	Suzanne Velarde

Working Group 10 – Queensland

Organisation represented	Attendee to at least one session
121 Care	Kym Chomley
CPL - Choice Passion Life	Murray Sandon
Department of Employment, Small Business, and Training	Tim Maloney
Endeavour Foundation	Eric Teed
Endeavour Foundation	Jennifer Knight
Ingham Disability Support Services	Liz Sutton
National Disability Services	Ian Montague
Xavier	Richard Littler
Yumba Bimbi Support Services	Rachel Freeman

Working Group 11 – South Australia

Organisation represented	Attendee to at least one session
Bedford	Rebecca Greenfield
Benevolent Society	Josie Kitch
Cocoon SDA Homes	Donna Maidment
HCO	Sue Horsnell
HireUp	Eliza Wallace
Lutheran Disability Services Inc	John Van Ruth
National Disability Services	Janine Lenigas
Novita	Cathryn Blight
Novita	Greg Ward

Working Group 12 – Western Australia

Organisation represented	Attendee to at least one session
Avivo	Lyn-Lee The
Avivo	Lynsey McDonnell
Cocoon SDA Homes	Donna Maidment
East Kimberly Job Pathway	Laura Little
Far North Community Services	Kathy Hough
HireUp	Eliza Wallace
Midway Community Care	Heath Flanagan
National Disability Services	Coralie Flatters
National Disability Services	Jim Vanopoulos
Nulsen Group	Gordon Trewern
SensesWA	Sarah Love
St Jude's Health Care Services	Binu Joseph
St Jude's Health Care Services	Danyel Zalsman
WA Department of Communities	Marion Hailes-MacDonald
WA Department of Communities	Suzanne Velarde
Western Australian Association for Mental Health (WAAHM)	Tabetha McCallum
Western Australian Association for Mental Health (WAAHM)	Nicole Fitch