Delivered by the National Disability Insurance Agency

Pricing Reference Group

Minutes of the Meeting of 14 March 2019

Members present

- Antonia [redacted]
- Jim [redacted] PSM, Independent Member
- David Cullen
- Michael [redacted]
- Graeme [redacted] AM, Independent Member
- Sarah [redacted]
- Louise [redacted] (proxy for Vicki [redacted]
- Anthony [redacted]
- Victor [redacted]

Secretariat

- David Cullen

Item 1.2 – Update of Terms of Reference

1. The Pricing Reference Group (PRG) **NOTED** the update to the Terms of Reference and PRG membership.

Item 1.3 – Conflicts of interest

2. The PRG **NOTED** that Graeme [redacted] was:

   (a) a member of the Board of Life Without Barriers;

   (b) a member of the Board of the Summer Foundation

   (c) a member of the Board of Joblife Employment; and

   (d) [redacted]

Item 1.4 – Minutes of meeting of 14 December 2018

3. The PRG **AGREED** to the minutes of the previous meeting.

Item 2.1 – Pricing Strategy

4. The PRG **AGREED** to the National Disability Insurance Scheme (NDIS) Pricing Strategy.

Item 2.2 – 2018-19 Annual Review of Costs, Efficiency and Price Controls

5. The PRG **DISCUSSED:**

   (a) how new information has arisen since the Independent Pricing Review (IPR) that required re-examination of the price controls and arrangements in the NDIS and the adequacy of the current price limits in a market that is not transitioning as fast as anticipated;

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(b) options to create a more efficient market for participants and providers, and to establish the most accurate prices that will create a sustainable marketplace for transaction; and

(c) the sector's efficiency and a cost model based on assumptions as received in the most recent benchmarking survey results conducted by AbleInsight.

6. The PRG **AGREED TO RECOMMEND TO THE NDIA BOARD** that the price limits for attendant care and community participation should be set in line with the efficient cost model under revised assumptions based on the benchmarking survey results.

7. The PRG **AGREED TO RECOMMEND TO THE NDIA BOARD** that the current Temporary Support for Overheads (2.5 per cent) should be replaced with a Temporary Transformation Payment:

(a) set at 7.5 per cent of the efficient price in the first year;

(b) that reduced by 1.5 percentage points a year thereafter; and

(c) that is only payable to providers who agree to the following conditions:

- publication of prices (for NDIS and non-NDIS clients if they differ) on their own websites;
- participation the Provider Finder arrangements; and
- participation in a financial benchmarking survey/service approved by the NDIA, with de-identified data to be provided to the NDIA to assist with future price setting.

8. The PRG **AGREED TO RECOMMEND TO THE NDIA BOARD** that the price limits for attendant care and community participation in Western Price Guide should be set in line with the Eastern Price Guide, noting that the WA Market Review is still to report and may provide additional information about prices in WA.

9. The PRG **AGREED TO RECOMMEND TO THE NDIA BOARD** that new price limits for attendant care and community participation should take effect from 1 July 2019 and should be indexed in the usual way by an 80/20 weighted average of:

(a) a wages component index estimated as the percentage increase in wages due to the Fair Work Commission Minimum Wage Case in June 2019 and the Equal Remuneration Order due to take effect on 1 December 2019; and

(b) a non-wages component index estimated as the percentage increase in the CPI in the 12 months to March 2019.

10. The PRG **AGREED TO RECOMMEND TO THE NDIA BOARD** that existing and new plans should be adjusted to reflect the changes in the price limits for attendant care and community participation with effect from 1 July 2019 as part of the annual indexation of plans.

Item 2.3 –Results of the Review of Therapy Pricing Arrangements

11. The PRG **AGREED TO RECOMMEND TO THE NDIA BOARD** the recommendations of the Review of NDIS Therapy Pricing.

12. The PRG **AGREED TO RECOMMEND TO THE NDIA BOARD** that the new price limits for therapy services should take effect from 1 July 2019 and should be set equal to the price limits recommended by the Review of NDIS Therapy Pricing, which are expressed in 2018-19 prices, indexed in the usual way by an 80/20 weighted average of:

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(a) a wages component indexed by the increase in Average Weekly Earnings; and

(b) a non-wages component index estimated as the percentage increase in the CPI in the 12 months to March 2019.

13. The PRG **AGREED TO RECOMMEND TO THE NDIA BOARD** that existing and new plans should be adjusted to reflect the changes in the price limits for therapy services with effect from 1 July 2019 as part of the annual indexation of plans.

Item 3.1 – Western Australia Market Review (Update)

14. The PRG **NOTED** the update on the WA Market Review.

Item 4.1 – Inclusion of 'assistance with personal care' support item for Short Term Accommodation (STA) providers

15. The PRG **AGREED** to the recommendations for the inclusion of new support items for STA providers, subject to further work to address how these items will be monitored and audited by the NDIA.

Item 4.2 – Technical updates to Assistive Technology (AT) support items

16. The PRG **AGREED** to the four recommendations set out in this paper to address technical changes to be made for several AT support items.

Item 4.3 – Pricing Issues associated with the transition of funding for Australian Disability Enterprises (ADEs) to the NDIS

17. The PRG **AGREED**, in principle, on the pricing arrangements for ADEs supports to be in line with the current pricing arrangements for group-based community and centre activities. This is pending finalisation of the policy by the Agency.

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Matter for decision

Pricing Startegy

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 For the Pricing Reference Group (PRG) to endorse the Pricing Strategy for the National Disability Insurance Scheme as set out in this paper.

2. Recommendations

2.1 That PRG **ENDORSE** the Pricing Strategy for the National Disability Insurance Scheme at Attachment A.

3. Discussion

3.1 The supply of disability goods and services in Australia is undergoing significant reform with the phased creation, commencing from 1 July 2013, of the National Disability Insurance Scheme (NDIS). The National Disability Insurance Agency (NDIA) has responsibility for administering the NDIS, including (together with the NDIS Quality and Safeguards Commission) regulating the markets for disability goods and services.

3.2 Where possible, the NDIA utilises market mechanisms to deliver the level of supply required to meet participant demand and deliver the correct mix of goods/services, produced at market clearing (efficient) prices. Prices play an important role in coordinating this, within overall budget constraints. However, in the underdeveloped or non-existent markets, reliance on a deregulated market mechanism may not meet participant demands; may not deliver adequate supply; may not deliver the correct mix of disability supports and may not produce efficient prices. To address these issues, the NDIA has a role, as market steward, to create an efficient and sustainable marketplace through a diverse and competitive range of suppliers who are able to meet the structural changes created by a consumer driven market.

3.3 As part of its market stewardship role, the NDIA limits the prices that registered providers can charge for some supports. During transition, price controls are in place to ensure that participants receive value for money in the supports that they receive. In the short to medium term, price controls are required for some disability supports because the markets for disability goods and services is not yet fully developed. The longer-term goal of the NDIA is to remove regulatory mechanisms from the markets for disability supports. Currently, the NDIA varies its approach to the regulation of prices, depending on market conditions, between:

(a) No regulation (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.

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(b) The imposition of price caps: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care.

(c) Quotable supports: in which participants are expected to obtain quotations from suppliers to provide to the NDIA which will verify that the prices are fair and reasonable. This approach is typically used in the case of highly specialised, differentiated supports that may not have a high level of competition ¬– for example, assistive technology. They are also used in cases, such as Supported Independent Living (SIL), where a bundle of supports or quasi-outcome is being purchased. In these situations, providers have greater flexibility to adjust how they achieve the required outcomes in response to the input costs that they face.

3.4 The purpose of the attached document is to set out the NDIS Pricing Strategy – that is, the critical role that pricing will play in the NDIS in empowering people supported by the NDIS to exercise choice and control; maintaining and expanding the supply of high quality disability supports; driving efficiency and innovation in the market for those supports; and supporting the transition of the NDIS over the longer term to a more deregulated outcomes-based approach. The NDIS Pricing Strategy set out in this document is primarily concerned with those types of core supports on which the NDIA currently imposes price caps, including:

(a) Attendant Care Services (Assistance with Self-Care Activities);

(b) Short Term Accommodation; and

(c) Assistance to access community, social and recreational activities, including community and centre group based supports.

3.5 The NDIS Pricing Strategy is a critical component in transitioning the NDIS markets to cope with significant demand growth, reaching the longer-term goal of price deregulation and improving efficiency and quality of care. It recognises that during the transition to deregulation, there is a requirement to maintain current supply in the short term and significantly increase the supply of disability supports in the medium to long term, to meet the needs of increased numbers of people entering the scheme and increased levels of support. This transition and the required growth in supply will take a significant time and may need to increase to encourage providers to expand existing operations and new suppliers to enter the markets. Depending on the relative ease with which supply can be increased (referred to as price elasticity of supply), longer term prices may also increase.

3.6 The NDIS Pricing Strategy is best understood in terms of four different concepts of pricing:

(a) Efficient price levels – Price levels that represent the long run minimum cost of production. Sufficient production at efficient price level is only expected to be achievable in the long run in mature markets, with strong competition between providers.

(b) Sustainable price levels – Price levels that represent, at a given time, the price at which the average current firm is viable (even if inefficient). In the short term, prices at or above sustainable levels are required to ensure that current supply levels remain stable and providers with costs somewhat above the most efficient level remain viable.

(c) Transitional price levels – Price levels that represent, at a given time, the price necessary to attract new providers to enter the market or reduce exits from the market. Transitional

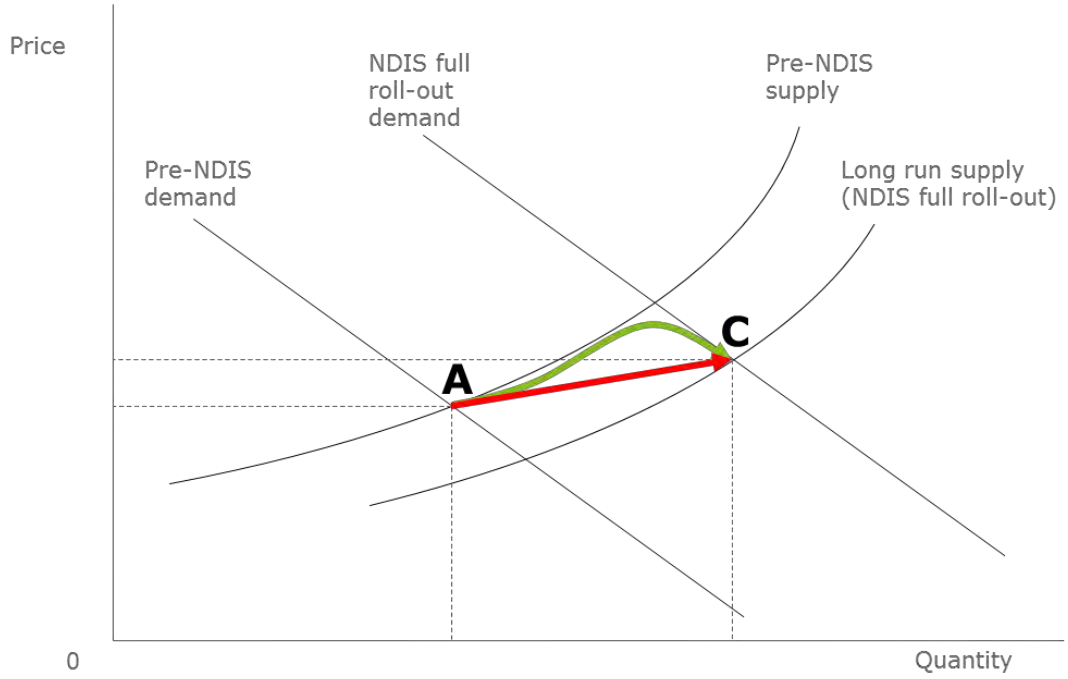
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price levels represent the price required to attract economic resources from other parts of the economy to expand provider supply. Transitional price levels are above sustainable price levels, but should only be adopted where, as is the case in the NDIS transition period, a significant expansion of supply is required.

(d) Price caps – Upper limits on prices, used to prevent potential abuse of market power.

3.7 Figure 1 below shows the market clearing equilibrium price and quantity of disability supports prior to the NDIS (at point A) and the long run market clearing equilibrium price and quantity of disability supports including the NDIS demand (at point C). It also illustrates the paths that sustainable price levels (red arrow) and transitional price levels (green arrow) will take in real terms over the transition to the long run market clearing equilibrium price, recognising the entrenched inefficiency of the current providers (for example, through existing Enterprise Bargaining Agreements) and the need to significantly expand and not unnecessarily disrupt the supply of services to people with disabilities.

Figure 1: Transition from equilibrium prior to the NDIS to the long run NDIS equilibrium



3.8 To date, NDIS price levels, both in terms of the level of funds included in participant's plans and price caps, have been predominantly set with longer run efficient price levels in mind.

3.9 The pricing strategy proposed in this document better reflects the current situation of inefficient supply and growing demand. It represents an approach to pricing aimed at maintaining and increasing market supply, assisting in the transition of the NDIS to full roll out and helping markets grow to a more mature state in the future, while being cognisant of the need for financial sustainability. Figure 2 below summarised the stages through which price regulation in the NDIS needs to move as the economic forces outlines above play out.

3.10 Price controls need to take into account efficiency and the need to expand supply. Markets for disability supports are continuing to develop, with both increases in market supply and improvements in production efficiency required. While improvements to production efficiency

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imply reductions to costs in the long run, expansion of market supply necessitates higher short to medium term prices. In order to maintain and expand production volumes of disability supports, higher short-term prices are thus needed. This will serve as an incentive to redirect the allocation of resources to the NDIS from other sectors in the economy. Without price growth, supply side shortages will likely exist.

3.11 In the longer term, efficient price levels are the best representation of the reasonable cost of the provision of a support and will, eventually, be the price levels best suited for the development of plans, which are concerned with efficient, effective and appropriate supports. However, in the short to medium term, sustainable price levels are the best representation of the reasonable cost of the provision of a support. In the long run, sustainable price levels tend towards efficient price levels. In the short to medium term, however, as the market matures and expands, price caps need to be sufficient to both maintain current supply and attract new supply. That is, price caps for the NDIS need, in the short to medium-term at least, to be set with regard to transitional price levels, rather than sustainable and efficient price levels.

3.12 In brief, prices in the NDIS need to follow two paths under the NDIS Pricing Strategy:

(a) Funding levels in plans should be set as currently, at sustainable price levels, and increased annually in line with movements in the unit input costs of providers (the red arrow in Figure 7). This means that the purchasing power of participants would be maintained in real terms. In the longer run, as transitional and sustainable price levels converge participants will be able to purchase greater quantities of support for their fixed budgets, reaping the benefit of the improved efficiency of the sector.

(b) Price caps should be set in accordance with the movements in transitional price levels (the green arrow in Figure 7), to recognise the costs providers are facing in adjusting to the new arrangements, the time required to unwind established agreements, and to encourage growth in supply while driving efficiency. This should be done through an explicit and decreasing loading on sustainable price levels —¬ the Transition Support Payment (TSP) of about 10 per cent —¬ with a clear statement to the market of the expected glide path over five to eight years to efficient price levels through the phased reduction of the TSP. Detailed ongoing monitoring of markets should also be conducted to determine whether short-term price increases have been sufficient to expand supply, attract new entrants and increase competitive pressure. In the longer term, it is expected that competition between providers will result in a reduction of prices towards the long run efficient price. As market prices reduce towards long run efficient prices, the price caps imposed are expected to no longer be binding, in which case their removal can be considered.

3.13 At the same time, the collection and dissemination of more market and consumer information is essential to effective pricing and future outcomes based pricing. This should ideally include market information such as:

(a) quantity and prices of disability supports provided (for example, hours of care) by NDIS disability support group, and location (these data could be obtained by linking the details of suppliers to each payment made from NDIS support budgets);

(b) market entrants and exits;

(c) profitability and other financial metrics from financial statements of providers; and

(d) supply conditions such as the total expenditure of participants on supports by location.

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3.14 Gathered supply data can be used to assist the NDIA determine pricing caps in the short term and enable better informed decision making when considering deregulation of markets in the medium to long term. As transitional pricing is above long run competitive equilibrium prices, it may also be reasonable to oblige providers to participate in data collection, as a form of 'dividend'. To gain access to transitional prices, providers would need to participate in data collection in good faith (i.e. provide accurate responses).

3.15 Providers also need to be given the tools to achieve long run efficiencies, by being able to properly understand the performance of their own organisation and to accurately compare their performance to that of their peers. This requires good accounting and governance standards and practices and the ability to compare performance across providers. The NDIA and the NDIS Q&SC can assist providers to do this by requiring providers to adopt better accounting and governance standards and practices over time as part of the provider registration process. The NDIA can also support the establishment of independent performance and financial benchmarking services and provider's participation in those services, especially where providers are operating in thinner markets. The NDIA can also incentivise participation in such performance and financial benchmarking services, and the development of better accounting and governance standards practices, by making access to the transitional price level loading (Transitional Support Payment), or at least a part of that loading, contingent on such activities.

3.16 Going forward, consumer and outcomes data should be collected and published on a regular basis to enable consumers to get a detailed view of provider performance and enable future moves towards outcomes based pricing. Information collected could include:

(a) satisfaction with individual supports received;

(b) outcomes (for example, employment gained and engagement with the community);

(c) ease of market access (measuring any potential supply shortages);

(d) level of participant empowerment; and

(e) plan utilisation and any reasons plan budgets were not fully expended (especially where these indicate undersupply).

3.17 Collecting such additional consumer data can be used to both measure the performance of disability support providers in the longer-term transition to outcomes based pricing, and can help identify any areas in which undersupply is occurring in the short term.Since the PRG's inception, there has been an update to membership and proxies on what is currently stated in the TOR.

4. Implementation and communication

4.1 The Pricing Strategy will be published on the NDIS website wias part of the Annual Review of Costs, Efficiency and Price Controls.

Attachment(s):

A PRG – 2090304-2.1A – *NDIS Pricing Strategy*

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National Disability Insurance Scheme

Pricing Strategy

Version release date: 1 April 2019

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Terms that we use

NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDIS Q&SC	National Disability Insurance Scheme Quality and Safeguards Commission

Further information

Further information on pricing in the National Disability Insurance Scheme can be found at the NDIS website

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Contents

Executive Summary **5**

1 Introduction **11**

2 Current arrangements **13**

2.1 Participants 14

2.2 Plans 15

2.3 Plan management 15

2.4 Pricing 16

2.4.1 Terms of Business 16

2.4.2 Support Catalogue 16

2.4.3 Price Guide 16

2.4.4 Special NDIS Pricing Arrangements 17

3 Market stewardship **18**

3.1 Price controls 19

3.2 Other market interventions 20

3.3 Economic and regulatory context 21

3.4 Domestic and international lessons 24

3.4.1 Lessons from the Australian aged care sector 24

3.4.2 Lessons from international schemes 25

4 NDIS Pricing Strategy **28**

4.1 The Evolution of the NDIS Pricing Strategy 30

4.2 Proposed Strategy – 'Glide path' to the new equilibrium 31

4.2.1 Balance efficiency and growth 33

4.2.2 Assist providers, and the market, to become more efficient 33

4.2.3 Address information asymmetries to empower consumers 34

4.2.4 Measuring success 36

References **37**

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

Table of Figures

Figure 1: Transition from equilibrium prior to the NDIS to the long run NDIS equilibrium 7

Figure 2: Transition strategy 7

Figure 3: Employment growth in the disability support sector due to the NDIS 21

Figure 4: Historical and projected increases in selected economic sectors, 1995 to 2023 ... 22

Figure 5: Transition from pre-NDIS equilibrium to the NDIS long run equilibrium 22

Figure 6: Average price impact of the NDIS on disability services 23

Figure 7: Average quantity impact of the NDIS on disability services 23

Figure 8: Phases of NDIS and pricing 30

Figure 9: Transition from equilibrium prior to the NDIS to the long run NDIS equilibrium 32

Figure 10: Transition strategy 32

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Executive Summary

The supply of disability goods and services in Australia is undergoing significant reform with the phased creation, commencing from 1 July 2013, of the National Disability Insurance Scheme (NDIS). The National Disability Insurance Agency (NDIA) has responsibility for administering the NDIS, including (together with the NDIS Quality and Safeguards Commission) regulating the markets for disability goods and services.

As of 31 December 2018, some 244,653 people with disabilities, including children in the Early Childhood Early Intervention (ECEI) program were being supported by the NDIS. This number is estimated to increase to about 475,000 by 2020. The growth in the market for supports is also expected to be substantial in the early years of the NDIS. Overall funding for the disability support sector is expected to effectively double during the roll out to full scheme to about $22 billion (or just over 1 per cent of GDP) in 2019-20.

Where possible, the NDIA utilises market mechanisms to deliver the level of supply required to meet participant demand and deliver the correct mix of goods/services, produced at market clearing (efficient) prices. Prices play an important role in coordinating this, within overall budget constraints. However, in the underdeveloped or non-existent markets, reliance on a deregulated market mechanism may not meet participant demands; may not deliver adequate supply; may not deliver the correct mix of disability supports and may not produce efficient prices. To address these issues, the NDIA has a role, as market steward, to create an efficient and sustainable marketplace through a diverse and competitive range of suppliers who are able to meet the structural changes created by a consumer driven market.

As part of its market stewardship role, the NDIA limits the prices that registered providers can charge for some supports. During transition, price controls are in place to ensure that participants receive value for money in the supports that they receive. In the short to medium term, price controls are required for some disability supports because the markets for disability goods and services is not yet fully developed. The longer-term goal of the NDIA is to remove regulatory mechanisms from the markets for disability supports. Currently, the NDIA varies its approach to the regulation of prices, depending on market conditions, between:

- **No regulation** (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- **The imposition of price caps**: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care.
- **Quotable supports**: in which participants are expected to obtain quotations from suppliers to provide to the NDIA which will verify that the prices are fair and reasonable. This approach is typically used in the case of highly specialised, differentiated supports that may not have a high level of competition – for example, assistive technology. They are also used in cases, such as Supported Independent Living (SIL), where a bundle of supports or quasi-outcome is being purchased. In these situations, providers have greater flexibility to adjust how they achieve the required outcomes in response to the input costs that they face.

The purpose of this document is to set out the NDIS Pricing Strategy – that is, the critical role that pricing will play in the NDIS in empowering people supported by the NDIS to exercise

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choice and control; maintaining and expanding the supply of high quality disability supports; driving efficiency and innovation in the market for those supports; and supporting the transition of the NDIS over the longer term to a more deregulated outcomes-based approach. The NDIS Pricing Strategy set out in this document is primarily concerned with those types of core supports on which the NDIA currently imposes price caps, including:

a) Attendant Care Services (Assistance with Self-Care Activities);

b) Short Term Accommodation; and

c) Assistance to access community, social and recreational activities, including community and centre group based supports.

The NDIS Pricing Strategy is a critical component in transitioning the NDIS markets to cope with significant demand growth, reaching the longer-term goal of price deregulation and improving efficiency and quality of care. It recognises that during the transition to deregulation, there is a requirement to maintain current supply in the short term and significantly increase the supply of disability supports in the medium to long term, to meet the needs of increased numbers of people entering the scheme and increased levels of support. This transition and the required growth in supply will take a significant time and may need to increase to encourage providers to expand existing operations and new suppliers to enter the markets. Depending on the relative ease with which supply can be increased (referred to as price elasticity of supply), longer term prices may also increase.

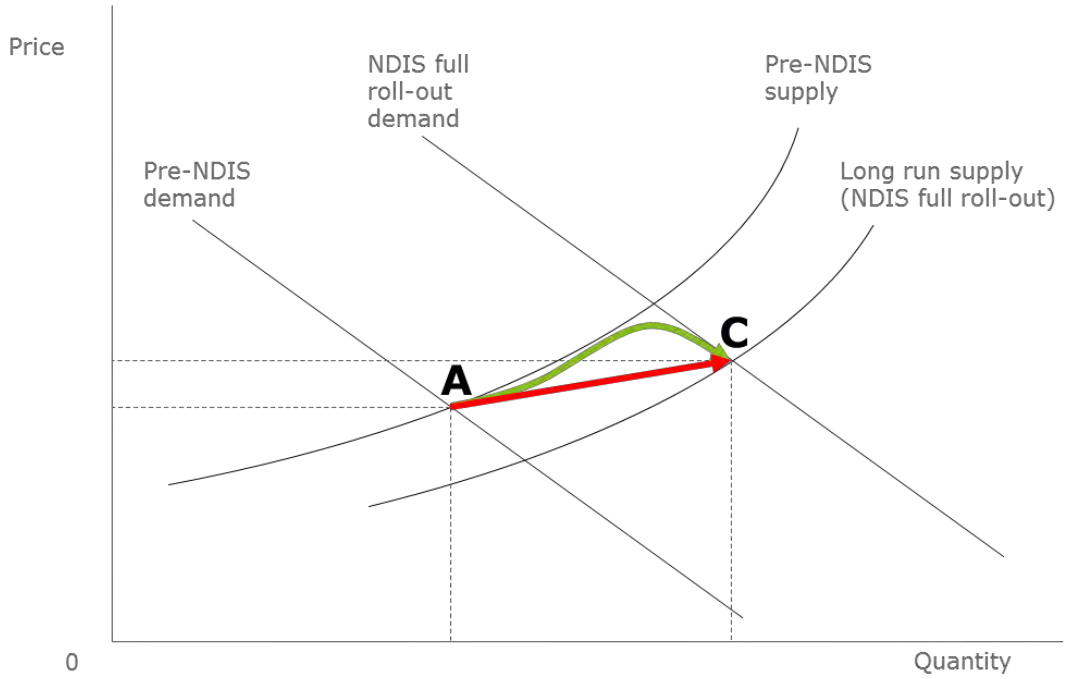
The NDIS Pricing Strategy is best understood in terms of four different concepts of pricing:

- **Efficient price levels** – Price levels that represent the long run minimum cost of production. Sufficient production at efficient price level is only expected to be achievable in the long run in mature markets, with strong competition between providers.
- **Sustainable price levels** – Price levels that represent, at a given time, the price at which the average current firm is viable (even if inefficient). In the short term, prices at or above sustainable levels are required to ensure that current supply levels remain stable and providers with costs somewhat above the most efficient level remain viable.
- **Transitional price levels** – Price levels that represent, at a given time, the price necessary to attract new providers to enter the market or reduce exits from the market. Transitional price levels represent the price required to attract economic resources from other parts of the economy to expand provider supply. Transitional price levels are above sustainable price levels, but should only be adopted where, as is the case in the NDIS transition period, a significant expansion of supply is required.
- **Price caps** – Upper limits on prices, used to prevent potential abuse of market power.

Figure 1 below shows the market clearing equilibrium price and quantity of disability supports prior to the NDIS (at point A) and the long run market clearing equilibrium price and quantity of disability supports including the NDIS demand (at point C). It also illustrates the paths that sustainable price levels (red arrow) and transitional price levels (green arrow) will take in real terms over the transition to the long run market clearing equilibrium price, recognising the entrenched inefficiency of the current providers (for example, through existing Enterprise Bargaining Agreements) and the need to significantly expand and not unnecessarily disrupt the supply of services to people with disabilities.

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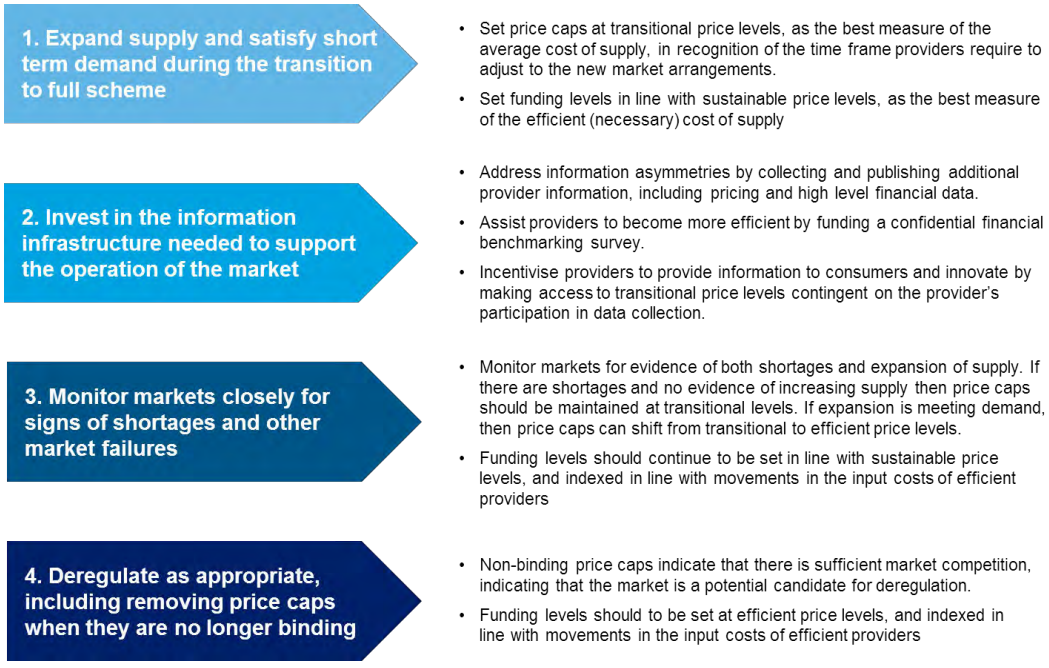
Figure 1: Transition from equilibrium prior to the NDIS to the long run NDIS equilibrium



To date, NDIS price levels, both in terms of the level of funds included in participant's plans and price caps, have been predominantly set with longer run efficient price levels in mind.

The pricing strategy proposed in this document better reflects the current situation of inefficient supply and growing demand. It represents an approach to pricing aimed at maintaining and increasing market supply, assisting in the transition of the NDIS to full roll out and helping markets grow to a more mature state in the future, while being cognisant of the need for financial sustainability. Figure 2 below summarised the stages through which price regulation in the NDIS needs to move as the economic forces outlines above play out.

Figure 2: Transition strategy



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Price controls need to take into account efficiency and the need to expand supply. Markets for disability supports are continuing to develop, with both increases in market supply and improvements in production efficiency required. While improvements to production efficiency imply reductions to costs in the long run, expansion of market supply necessitates higher short to medium term prices. In order to maintain and expand production volumes of disability supports, higher short-term prices are thus needed. This will serve as an incentive to redirect the allocation of resources to the NDIS from other sectors in the economy. Without price growth, supply side shortages will likely exist.

In the longer term, efficient price levels are the best representation of the reasonable cost of the provision of a support and will, eventually, be the price levels best suited for the development of plans, which are concerned with efficient, effective and appropriate supports. However, in the short to medium term, sustainable price levels are the best representation of the reasonable cost of the provision of a support. In the long run, sustainable price levels tend towards efficient price levels. In the short to medium term, however, as the market matures and expands, price caps need to be sufficient to both maintain current supply and attract new supply. That is, price caps for the NDIS need, in the short to medium-term at least, to be set with regard to transitional price levels, rather than sustainable and efficient price levels.

In brief, prices in the NDIS need to follow two paths under the NDIS Pricing Strategy:

- **Funding levels** in plans should be set as currently, at sustainable price levels, and increased annually in line with movements in the unit input costs of providers (the red arrow in Figure 7). This means that the purchasing power of participants would be maintained in real terms. In the longer run, as transitional and sustainable price levels converge participants will be able to purchase greater quantities of support for their fixed budgets, reaping the benefit of the improved efficiency of the sector.
- **Price caps** should be set in accordance with the movements in transitional price levels (the green arrow in Figure 7), to recognise the costs providers are facing in adjusting to the new arrangements, the time required to unwind established agreements, and to encourage growth in supply while driving efficiency. This should be done through an explicit and decreasing loading on sustainable price levels – the Transition Support Payment (TSP) of about 10 per cent – with a clear statement to the market of the expected glide path over five to eight years to efficient price levels through the phased reduction of the TSP. Detailed ongoing monitoring of markets should also be conducted to determine whether short-term price increases have been sufficient to expand supply, attract new entrants and increase competitive pressure. In the longer term, it is expected that competition between providers will result in a reduction of prices towards the long run efficient price. As market prices reduce towards long run efficient prices, the price caps imposed are expected to no longer be binding, in which case their removal can be considered.

At the same time, the collection and dissemination of more market and consumer information is essential to effective pricing and future outcomes based pricing. This should ideally include market information such as:

a) quantity and prices of disability supports provided (for example, hours of care) by NDIS disability support group, and location (these data could be obtained by linking the details of suppliers to each payment made from NDIS support budgets);

b) market entrants and exits;

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c) profitability and other financial metrics from financial statements of providers; and

d) supply conditions such as the total expenditure of participants on supports by location.

Gathered supply data can be used to assist the NDIA determine pricing caps in the short term and enable better informed decision making when considering deregulation of markets in the medium to long term. As transitional pricing is above long run competitive equilibrium prices, it may also be reasonable to oblige providers to participate in data collection, as a form of 'dividend'. To gain access to transitional prices, providers would need to participate in data collection in good faith (i.e. provide accurate responses).

Providers also need to be given the tools to achieve long run efficiencies, by being able to properly understand the performance of their own organisation and to accurately compare their performance to that of their peers. This requires good accounting and governance standards and practices and the ability to compare performance across providers. The NDIA and the NDIS Q&SC can assist providers to do this by requiring providers to adopt better accounting and governance standards and practices over time as part of the provider registration process. The NDIA can also support the establishment of independent performance and financial benchmarking services and provider's participation in those services, especially where providers are operating in thinner markets. The NDIA can also incentivise participation in such performance and financial benchmarking services, and the development of better accounting and governance standards practices, by making access to the transitional price level loading (Transitional Support Payment), or at least a part of that loading, contingent on such activities.

Going forward, consumer and outcomes data should be collected and published on a regular basis to enable consumers to get a detailed view of provider performance and enable future moves towards outcomes based pricing. Information collected could include:

a) satisfaction with individual supports received;

b) outcomes (for example, employment gained and engagement with the community);

c) ease of market access (measuring any potential supply shortages);

d) level of participant empowerment; and

e) plan utilisation and any reasons plan budgets were not fully expended (especially where these indicate undersupply).

Collecting such additional consumer data can be used to both measure the performance of disability support providers in the longer-term transition to outcomes based pricing, and can help identify any areas in which undersupply is occurring in the short term.

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DISCLOSURE LOG

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1 Introduction

The supply of disability goods and services in Australia is undergoing significant reform with the phased creation, commencing on 1 July 2013, of the National Disability Insurance Scheme (NDIS). The NDIS operated on a trial basis in some regions between 1 July 2013 and 30 June 2016 and is transitioning to full Scheme from 1 July 2016 to 30 June 2019 (30 June 2020 in Western Australia). The National Disability Insurance Agency (NDIA) has responsibility for administering the NDIS, including (together with the NDIS Quality and Safeguards Commission) regulating the markets for disability goods and services.

As of 31 December 2018, some 244,653 people with disabilities, including children in the Early Childhood Early Intervention (ECEI) program were being supported by the NDIS. This number is estimated to increase to about 475,000 by 2020. The growth in the market for supports is also expected to be substantial in the early years of the NDIS. Expenditure on disability goods and services across the Australian economy is expected to effectively double during through the transition to full scheme to about $22 billion (or just over 1 per cent of GDP) in 2019-20.

One of the principal objects of the NDIS is that people with disabilities have choice and control over how, and with which providers, they spend their available budgets. The role of prices in the NDIS is therefore very significant. Prices, or more precisely participants' choices in response to the prices they face in the market, reflect the preferences and relative values that different NDIS participants place on different types of supports. The aggregation of these individual responses in turn signals to suppliers the quantity and mix of supports to supply. Prices also affect the purchasing power of participants. Higher prices reduce the supports participants can purchase within a given care budget. Prices also affect the total costs of the NDIS and therefore its financial sustainability, and the allocation of resources to the NDIS (and therefore possible production), relative to other sectors. Pricing can also affect providers' choices, including by providing incentives: for entering the market; for upskilling and right-skilling; for innovation in models of care; and for improvement in service quality and outcomes.

As the markets for disability goods and services develop and operate more effectively, it is expected that the NDIA will play a less interventionist role. However, deregulation will necessarily occur at different points in time for different markets and may not be feasible in some cases. Currently, the NDIA varies its approach to the regulation of prices between:

- **No regulation** (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- **The imposition of price caps**: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care.
- **Quotable supports**: in which participants are expected to obtain quotations from suppliers to provide to the NDIA which will verify that the prices are fair and reasonable. This approach is typically used in the case of highly specialised, differentiated supports that may not have a high level of competition – for example, assistive technology. They are also used in cases, such as supported independent living, where a bundle of supports or quasi-outcome is being purchased. In these situations, providers have greater flexibility to adjust how they achieve the required outcomes in response to the input costs that they face.

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The purpose of this document is to set out the NDIS Pricing Strategy – that is, the critical role that pricing will play in the NDIS in empowering people supported by the NDIS to exercise choice and control; maintaining and expanding the supply of high quality disability supports; driving efficiency and innovation in the market for those supports; and supporting the transition of the NDIS over the longer term to a more deregulated outcomes-based approach.

The NDIS Pricing Strategy set out in this document is primarily concerned with those types of core supports on which the NDIA currently imposes price caps, including:

a) Attendant Care Services (Assistance with Self-Care Activities);

b) Short Term Accommodation; and

c) Assistance to access community, social and recreational activities, including community and centre group based supports.

The NDIA also imposes price caps on Capacity Building supports, including therapy. To an extent, these price caps have a different purpose and operate differently from those for core supports because the NDIS only represents a part of the market for therapy services. The pricing strategy for therapy services is being reviewed in the Review of Therapy Pricing.

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2 Current arrangements

The establishment of the NDIS will fundamentally transform the ways in which Australians with qualifying disabilities purchase, and are funded to purchase, the goods and services that they need to mitigate or alleviate the activity limitations and participation restrictions that arise as a result of their qualifying impairments. The historical system of (mainly) budget-capped, program-based, primarily State/Territory government funded, managed and (often) delivered schemes will be replaced by a national no-fault insurance based approach jointly funded by the Australian Federal government and the governments of the eight States and Territories from general taxation.

The objects and principles of the NDIS are set out in the *National Disability Insurance Scheme Act 2013,* including that the design of the NDIS should:

a) support the independence and social and economic participation of people with disability (Section 3(1)(c) of the Act);

b) enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports (Section 3(1)(e) of the Act);

c) promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community (Section 3(1)(g) of the Act);

d) adopt an insurance based approach, informed by actuarial analysis, to the provision and funding of supports for people with disability (Section 3(2)(b) of the Act); and

e) have regard to the need to ensure the financial sustainability of the NDIS (Section 3(3)(b) of the Act).

The NDIS provides funding to eligible individuals (***participants***) so that they can purchase, in the open market, those disability related goods and services (***supports***) that they need. It is administered by an independent government agency, the National Disability Insurance Agency (NDIA), which has responsibility for determining whether or not an individual is eligible for assistance, and the level of that assistance – the participant's personalised budget (***plan***) based on an assessment of their support needs.

The NDIA, together with the NDIS Quality and Safeguards Commission (NDIS Q&SC)[1], also has a role in regulating the markets for disability goods and services and the providers that operate in those markets.

[1] The NDIS Q&SC commenced operations on 1 July 2018. It has been established to improve the quality and safety of NDIS supports and will regulate the NDIS market, promote safety and quality services, and identify areas for improvement.

The Commission has had responsibility for New South Wales and South Australia since 1 July 2018. It will assume responsibility for Victoria, Queensland, Tasmania, the Australian Capital Territory and the Northern Territory from 1 July 2019 and for Western Australia from 1 July 2020.

The principal market regulatory function of the Commission is with respect to determining the suitability of providers to operate in the markets for disability goods and services.

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2.1 Participants

When the Scheme is fully rolled out, a person will be eligible for assistance if they meet either the disability eligibility criteria or the early intervention eligibility criteria.[2]

- In order to meet the ***disability eligibility criteria***, a person needs to meet three basic requirements: specificity, permanence and substantiality. Their disability must be attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition. The impairment or impairments must be, or be likely to be, permanent and the person must be likely to require support under the Scheme for their lifetime. This includes impairments that are chronic or episodic in nature, where the person's support needs are likely to continue for the person's lifetime. The impairment(s) must also result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more core activities (communication; social interaction; learning; mobility; self-care; and self-management). They must also affect the person's capacity for social and economic participation.
- In order to meet the ***early intervention eligibility criteria***, a person needs to meet three basic requirements: specificity, permanence and a capacity to benefit from early intervention. As with the disability eligibility criteria, the person's disability must be attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition. The impairment or impairments must also be, or be likely to be, permanent. However, unlike in the case of the disability eligibility criteria it does not have to be the case that the person must be likely to require support under the Scheme for their lifetime. A person who is a child can also meet the early intervention eligibility criteria if they have developmental delay and a capacity to benefit from early intervention. The capacity to benefit from early intervention criteria is met if the provision of early intervention supports is likely to reduce the person's future needs for supports in relation to disability. This could be because the early intervention mitigates or alleviates the impact of the person's impairment upon their functional capacity to undertake core activities; or prevents the deterioration of, or improves, their functional capacity to undertake core activities; or strengthens the sustainability of informal supports available to the person.

[2] Participants must also meet the following two conditions:

- The ***age eligibility criteria*****:** A person must be aged under 65, at the time they first apply for assistance from the Scheme. A person who is receiving assistance from the Scheme with their reasonable and necessary supports can continue to receive those supports after they turn 65. However, they become ineligible to receive supports if they enter a residential aged care service on a permanent basis or start being provided with home care (funded under the Aged Care Act 1997) on a permanent basis.
- The ***residence eligibility criteria*****:** A person must be resident in Australia and either an Australian citizen or the holder of Permanent Visa or a protected holder of Special Category Visa. Once eligibility is determined a person can continue to receive supports while temporarily absent from Australia.

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2.2 Plans

Funding for a support is included in a participant's plan if and only if the support is both reasonable and necessary.

- A support meets the ***reasonableness criteria*** if it is efficient, effective, and appropriate. The support must represent value for money in that the costs of the support are reasonable, relative to both the benefits achieved and the cost of alternative support.[3] It must also be, or be likely to be, effective and beneficial for the participant, having regard to current good practice. Finally, the Agency must consider whether it is not reasonable to expect families and carers to provide the support, and whether the support would be more appropriately provided by other mainstream services.
- A support meets the ***necessity criteria*** if it would assist the participant to pursue their goals, objectives and aspirations, including by facilitating their social and economic participation, by mitigating or alleviating the activity limitations and participation restrictions associated with the participant's qualifying impairment. Put simply, a support would not pass the necessity test if it either was not in line with the participant's goals, or if it was addressing an issue not related to the participant's qualifying impairment(s). Supports, even when related to a qualifying impairment are also only necessary in so far as they are concerned with restoring the participants to capacity to live an ordinary life.

2.3 Plan management

If the NDIA agrees that the participant has the requisite capacity, then the participant can ***self-manage*** their budget, in which case they pay providers directly for the services that they receive and are reimbursed by the NDIA from their personalised budget. Participants who are not self-managing can choose to appoint (and use some of the funds in their personalised budget to pay for) a ***plan manager***. In this case, the plan manager pays the providers who deliver services to the participants (with the participant retaining choice of service provider) and is reimbursed by the NDIA from the participant's budget. All other participants have their budgets managed by the NDIA (***Agency-managed***). In this case, the participant's providers are paid directly by the NDIA from the participant's budget, while the participant still chooses their providers and the supports that they purchase. Where a provider is paid directly by the NDIA – that is, where the funding is Agency-managed – the provider is required to be registered with the NDIA or with the NDIS Q&SC, meet specified quality and safeguarding standards, and agree to standard terms and conditions of business – including price caps. These restrictions do not apply to providers who are paid directly by self-managing participants or by plan-managers on behalf of participants.

[3] The value for money test is concerned with effectiveness, direct cost comparison and investment effects. A support must substantially improve the life stage outcomes for, and be of long term benefit to, the participant. There must also be no comparable supports that would achieve the same outcome at a substantially lower cost. The cost comparison must also take into account any likely reduction in the cost of the funding of supports for the participant in the long term that may arise from the provision of a support, including whether the support will increase the participant's independence and reduce the participant's need for other kinds of supports.

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2.4 Pricing

Price controls are part of a broader set of pricing arrangements, which includes definitions of the services subject to price controls, and payment rules. The legislative framework for the NDIS is set out in:

a) the National Disability Insurance Scheme Act 2013;

b) the NDIS Rules made under the NDIS Act;

c) the Terms of Business for Registered Providers;

d) the NDIS Support Catalogue; and

e) the NDIS Price Guide.

2.4.1 Terms of Business

All registered providers are required to adhere to the Terms of Business. This means that in their dealings with participants who are not self-managing:

a) providers must adhere to the NDIS Price Guide or any other Agency pricing arrangements and guidelines as in force from time to time;

b) providers must declare relevant prices to participants before delivering a service. This includes declaring any notice periods or cancellation terms. Participants are not bound to engage the services of the Registered Provider after their prices have been declared;

c) prices must not exceed the price caps prescribed in the NDIS Pricing Guide; and

d) providers cannot charge cancellation fees, except when specifically provided for in the NDIS Price Guide.

In addition, the terms of Business require all Registered Providers, regardless of whether funding for the support is managed by the participant, or managed by a Registered Provider, or managed by the Agency to not add any other charge to the cost of the supports they provide, including credit card surcharges, or any additional fees including any 'gap' fees, late payment fees or cancellation fees.

2.4.2 Support Catalogue

The Support Catalogue sets out clear definitions of all of the supports that providers can supply to participants through the NDIS.

2.4.3 Price Guide

The NDIS Price Guide is a summary of NDIS price limits and associated arrangements (price controls) as set by the NDIA.[4] It is designed to assist participants and disability support

[4] Currently, different price caps apply in the 'eastern states' – New South Wales, Victoria, Queensland and Tasmania – to those that apply in the 'western states' – South Australia, Western Australia, the Australian Capital Territory and the Northern Territory. The Independent Pricing Review recommended (recommendation 5) that 'the NDIA should converge the two Price Guides and move toward a single national price guide by 2021'.

Different price caps also apply in remote and very remote areas, where the western price caps are inflated by 20 per cent and 25 per cent respectively.

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providers, both current and prospective, to understand the way that price controls for supports and services work in the NDIS.

The NDIA sets price controls for certain NDIS supports to ensure NDIS participants obtain reasonable value from their support packages. The price limits in the Guide are the maximum prices that Registered Providers can charge NDIS participants for specific supports. There is no requirement for providers to charge at the maximum price for a given support or service. Participants and providers are free to negotiate lower prices.

Price controls must be sustainable, which means that efficient providers must be able to recover the cost of delivering high quality disability supports. The NDIA takes into account market risks, when setting price controls to protect against supply gaps and ensure participants receive critical supports. This is important especially in markets that are immature or where there is limited choice for participants. Over time, the need for price controls will reduce, as disability support markets develop and competitive tension increasingly keeps support prices at reasonable levels.

Not all NDIS support items have price limits, and the NDIS Price Guide is not a comprehensive list of all supports that are available to NDIS participants. Instead, the Guide lists the specific supports that have maximum prices, and also sets out other rules and support definitions that are part of NDIA's market intervention approach.

Where price limits apply, prices charged to participants must not exceed the price limit prescribed for that support in this Guide. No other charges are to be added to the cost of the support, including credit card surcharges, or any additional fees including any 'gap' fees, late payment fees or cancellation fees unless otherwise stated in this Guide.

When claiming, it is the responsibility of the provider to ensure that the claim accurately reflects the supports delivered, including the frequency and volume of supports. Falsifying claims for any aspect of supports delivered, is a serious compliance issue and may result in action against the provider. Providers are also required to keep accurate records of claims, which are subject to audit at any time.

2.4.4 Special NDIS Pricing Arrangements

In certain circumstances, providers may be entitled to charge for expenses incurred in the provision of supports. These may include certain transport and travel costs, set up costs and costs associated with cancellations.

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3 Market stewardship

Where possible, the NDIA utilises market mechanisms to deliver the level of supply required to meet participant demand and deliver the correct mix of goods/services, produced at market clearing (efficient) prices (NDIA, 2016). Prices play an important role in coordinating this, within overall budget constraints. However, in the presence of underdeveloped or non-existent markets (due to factors such as imperfect and asymmetric information or reduced competition), relying on a deregulated market mechanism may not meet participant demands; may not deliver the correct mix of disability supports and may not produce efficient prices.

The operation of markets, which serve to match suppliers of services with consumers, are also affected by geography (including jurisdiction and remoteness) and the types of services offered (for example, support for activities of daily living, therapy, employment supports). Many of the markets in which the NDIS operates are also closely related to other sectors, such as aged care, may employ the same people as other sectors (for example aged care workers may also work in the disability support sector) or draw from the same labour market or education stream. As a result, markets may be subject to influences outside of the NDIS.

To address these issues, the NDIA has a market stewardship role during the transition to a competitive and open markets for disability goods and services. As market steward, the NDIA aims to create an efficient and sustainable marketplace through a diverse and competitive range of suppliers who are able to meet the structural changes created by a consumer driven market. It also aims to ensure that participants have choice and control over their supports and providers, and to give providers the freedom to attract participants with innovative and high quality products and services. The sheer level of expansion of supply that will be required over the next few years also necessitates a close attention to market development – noting that the transition from block funding to a market approach requires careful management; and that some of the markets created may require some form of economic regulation, even after the transition is complete. The NDIA's approach recognises that the operation of the markets for disability goods and services is not yet mature and that consumers are adapting to the new market and learning to exercise choice, and to express their individual needs. The matching of providers offering services, and participants wanting supports, is also still evolving.

Other stakeholders will also have vital roles to play. The expansion of disability support supply within the NDIS and progression towards deregulation of markets will require that barriers to entering or growing in the markets for disability goods and services are addressed which, in turn, will require the enabling of facilitating factors, such as:

a) appropriate employment, education and immigration pathways to ensure adequate levels of positions and training for disability support workers, and recruitment and retention of appropriate staff in the sector; and

b) appropriate support infrastructure for the sector, such as digital platforms for their industry interfaces and networks.

Various Commonwealth and state/territory government departments and agencies will need to play a key role in enabling these facilitating factors. Expansion of supply and progress towards deregulation will also require close coordination with stakeholders in the disability support sector, such as the providers themselves as well as representative bodies.

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3.1 Price controls

One of the NDIA's market stewardship functions is regulating entry to, and continued participation in, the Scheme by providers of disability supports (with some of this function being taken on by the NDIS Q&SC over time). Providers need to agree and adhere to the operational terms, system rules and standards. Operational guidelines, safeguards, and other rules help protect market viability and the long term interests of both participants and providers. The NDIS has an established Terms of Business that are binding on a Registered Provider of supports to participants in the NDIS and that ensure providers agree to uphold the objectives of the NDIS and work with participants to achieve individual outcomes.

The NDIA also limits the prices that registered providers can charge for some supports. During transition, price controls are in place to ensure that participants receive value for money in the supports and services that they receive. In the short to medium term price controls are required for some disability supports because the markets for disability goods and services is not yet fully developed. Some participants do not have sufficient information, or experience, to make effective choices – participants need information on the quality and price of service to make effective choices about the best provider for them. This means providers have less incentive to improve their services if this information is not available as participants won't use their power as consumers to ask for these improvements. Participants may also have insufficient incentives to look for alternative providers – certain aspects of the NDIS may mean that participants do not receive the full benefits of switching to lower cost providers and therefore may not actively seek out alternative providers. For example, a participant has less incentive to save money on a given support item if the remaining budget cannot be spent on other products or services.

In a developing markets there can also be a lack of choice of providers coupled with barriers to entry – for example, markets for highly specialised supports may have a small number of providers and high entry costs that act as barriers to new entrants. Participants can also face high costs to switching providers – switching costs are those associated with changing provider or supports, including both financial and social costs. For example, many supports provided under the NDIS are highly personal in nature and so a strong relationship is established with the provider over time. This creates resistance to switching providers and may limit competition.

These market immaturities may lead to higher prices and/or lower quality services for participants. Price limits can help to ensure that prices do not rise too far above the competitive level for providers that have substantial market power, whilst allowing competition to occur between those providers that do not. Price limits are not needed when there is enough competition between providers to encourage efficiency. In this case, prices are set in accordance with costs and providers will meet consumers' demand for quality and variety. Therefore, the role of price controls should diminish as the NDIS develops and markets for supports become more competitive.

The longer-term goal of the NDIA is to remove regulatory mechanisms from markets for disability supports. As markets develop and operate more effectively, the NDIA will play a less interventionist role and deregulate markets. However, deregulation will necessarily occur at different points in time and may not be feasible in some cases. Different approaches to market

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regulation may also be required depending on geography, level of competition, cost factors (labour and overhead) and the type of services provided.

- **Geography** – Remote regions, relative to metropolitan regions tend to have both higher input costs (due to transport costs, thin labour markets etc.) and reduced competition. Therefore, different geographies may require different approaches to regulation.
- **Level of competition** – Some markets may have inherently low competition, due to the small size of the market or the complexity in offering supports. For example, in Australia there are few suppliers of guide dogs due to both the complexity of training and the relatively small market size. The ideal level of regulation will be dependent on the level of competition. Generally, those markets with greater competition will require less regulation.
- **Cost factors** (labour and overhead) – Highly specialised or costly labour, capital intensive supports or supports with high levels of overhead may represent significant barriers to market entry. In the case of highly specialised or costly labour and markets with significant barriers to entry, regulation may be required in the long term to avoid monopolistic pricing.
- **Type of service provided** – Some supports may inherently have low levels of competition such as those which represent natural monopolies. The type of support offered may dictate the strategy for market regulation. Other markets may be inherently competitive such as the market for transport services.

3.2 Other market interventions

As well as price controls, the NDIA can also improve the operation of the market by:

- **Providing market data, including on outcomes** – To improve the level of information available in markets and therefore encourage market competition, the NDIA is able to collect and publish market information such as prices of particular providers, average prices and market share. This may assist consumers in determining which supplier of supports they choose, and therefore encourage market competition. It is also possible for the NDIA, or an independent body funded by the NDIA, to collect and publish aggregate data on the performance of providers, with data either collected from providers themselves or from participants. Examples of provider performance include satisfaction rates of participants or the change in employment rates for employment support providers. Publishing some measure of performance publically may assist consumers in choosing their most valued provider and encouraging competition. Further, it may assist producers in lowering costs by benchmarking their organisation's cost against sector averages.
- **Supporting providers to benchmark their performance** – It is possible for the NDIA, or an independent body funded by the NDIA, to collect and publish data on the financial performance of providers, to assist providers to benchmark their performance against their peer providers and identify opportunities to improve efficiency and effectiveness.
- **Educating and empowering participants** – NDIS participants play a key role in assisting market transition to deregulation and facilitating increased supply. To ensure that providers are incentivised to compete and provide the best possible level of service at a given price, consumers need to be empowered to understand the value they receive and negotiate prices and better services from their providers. This will require education for participants or their representatives, an area where the NDIA can play an important role.

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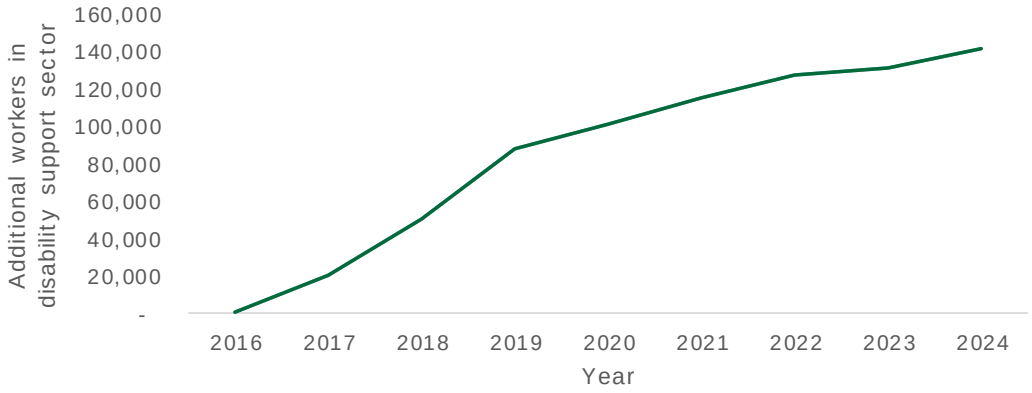
3.3 Economic and regulatory context

The NDIS Pricing Strategy has to be aware of and sensitive to its economic and regulatory environment. There are many factors that may influence prices, which are outside of the control of the NDIA. For example, the pricing strategy of the NDIS is unable to influence changes to labour costs resulting from the industrial bargaining system, including changes to Enterprise Bargaining Agreements (EBAs) or worker conditions in different jurisdictions. As almost half of the workforce is under EBAs, these factors may have significant impacts on NDIS pricing. In addition, input prices may change significantly due to macroeconomic conditions outside of the NDIS. Labour costs in particular may change significantly based on labour demand in other sectors. Immigration and skills policies may also influence the supply of workers in the sector and their relative wages. Finally, the broader regulatory environment may also influence prices. For example changes in compulsory superannuation contributions or minimum standards of care (for example, minimum required qualifications) may influence prices.

This section discusses the high-level dynamics of the transition of the markets for disability goods and services from the pre-NDIS equilibrium to the new long run equilibrium in which the NDIS is fully rolled out. The rollout of the NDIS represents a significant shift of resources in the Australian economy. When fully rolled out, the scheme is expected to provide overall funding for the disability support sector of $22 billion per annum, with a net increase of approximately $11 billion in funding above annual expenditure in the sector prior to the NDIS. Given this doubling of expenditure, the NDIS has tangible impacts on Australia's overall macro economy.

Analysis by the Productivity Commission (2011, 2017) suggests that one in five new jobs over the near term will need to be in disability care. The Productivity Commission also found that current growth in employment is far too low, risking significant shortages. Raising prices for disability supports would enable resources (labour and capital) to be attracted from other sectors of the Australian economy, going some way to increase supply and reduce risks of shortages. Figure 3 below shows estimates by Dixon and Cullen (2018) of the labour growth required to reach market-clearing equilibrium in the markets for disability goods and services.

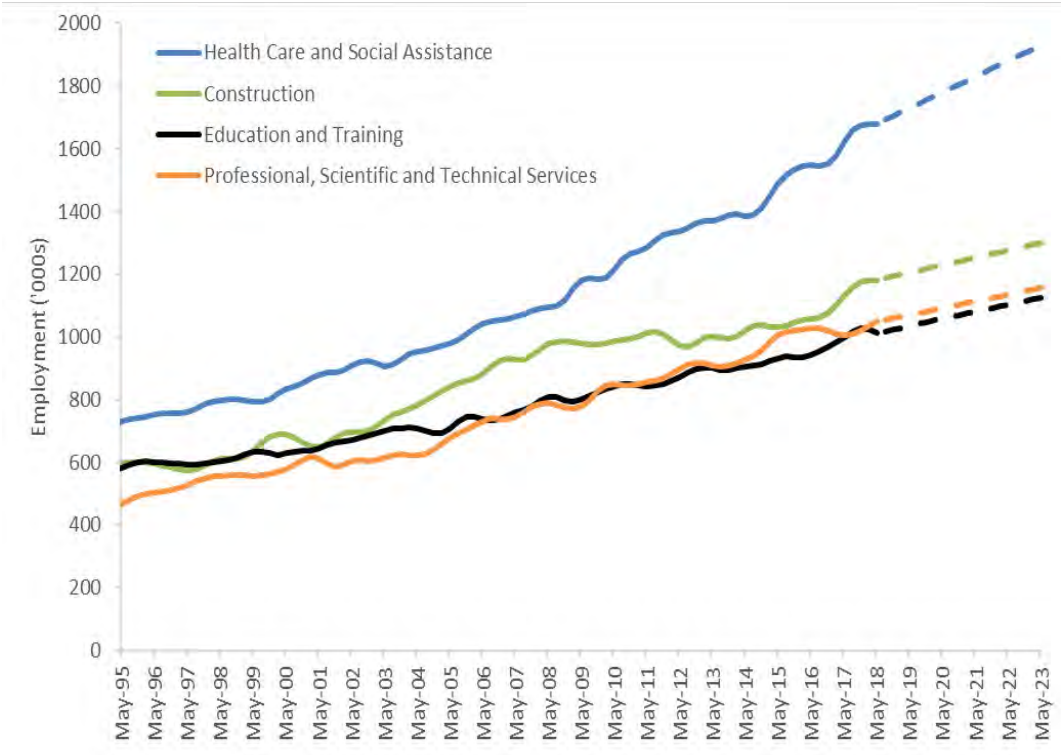
Figure 3: Employment growth in the disability support sector due to the NDIS



Moreover, this growth is occurring at the same time as substantial growth in the entire Health and Social Assistance Sector, and after a period of considerable growth in those sectors (see Figure 4) (Australian Department of Jobs and Small Business, 2018).

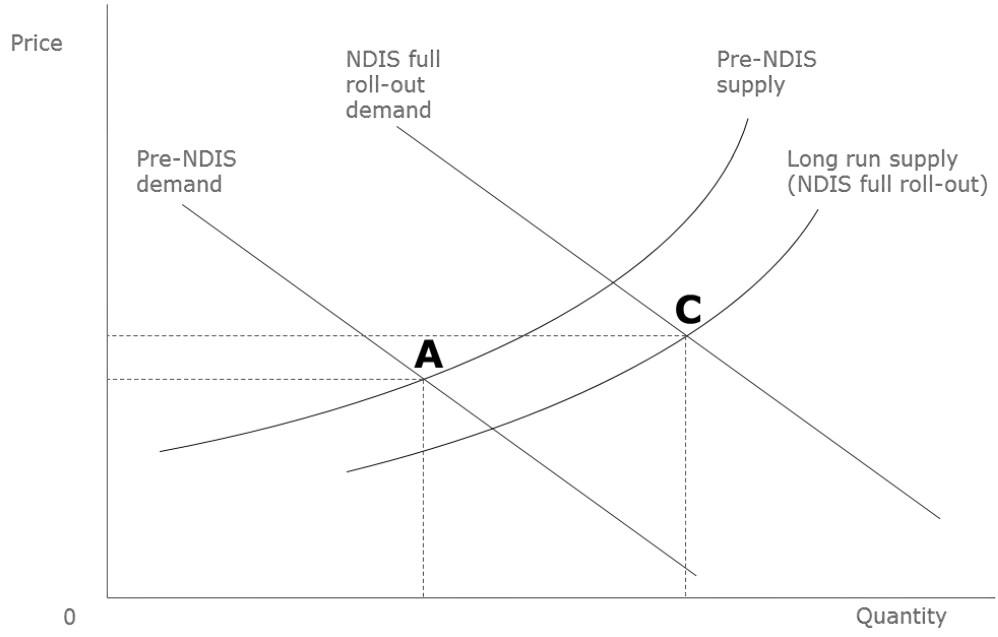
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Figure 4: Historical and projected increases in selected economic sectors, 1995 to 2023



Macroeconomic modelling by Dixon and Cullen (2018) of the impact of the NDIS on the Australian economy shows that the scale and speed of growing demand for disability goods and services has significant impacts on market clearing equilibrium prices and wages in the sector. Figure 5 below shows the market clearing equilibrium price and quantity prior to the NDIS (at point A) and the long run market clearing equilibrium price and quantity with the increased demand from the NDIS (at point C).

Figure 5: Transition from pre-NDIS equilibrium to the NDIS long run equilibrium



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The macroeconomic model underpinning this analysis (a national computable general equilibrium model developed by Victoria University) assumes competitive market clearing prices. However, currently many markets within the disability support sector where the NDIS operates are not competitive and are subject to price regulation. As such, point C, together with price and quantity time series shown in Figure 6 and Figure 7 respectively, does not represent a 'forecast' of what is actually happening in the sector. Rather, this analysis shows the likely effects on market clearing prices and quantities of disability supports in competitive markets. Given this, Figure 6 and Figure 7 can be used to guide NDIS pricing policy as markets make the transition from pre-NDIS prices and quantities to long run prices and quantities with the NDIS fully rolled out (moving from point A to point C in Figure 5).

Prices and quantities shown in Figure 6 and Figure 7 represents the estimated set of market equilibrium prices and quantities, which minimise production cost and maximise consumer utility at every point of the transition, given competitive markets. Ideally, the NDIS regulated prices would match this transition path, in which prices rise from pre-NDIS levels to attract additional supply (peaking at approximately 14 per cent higher real prices – Point B in the Figures – and then start to reduce towards long run competitive equilibrium prices (approximately 6 per cent above real pre-NDIS levels) – Point C in the Figures.

Figure 6: Average price impact of the NDIS on disability services

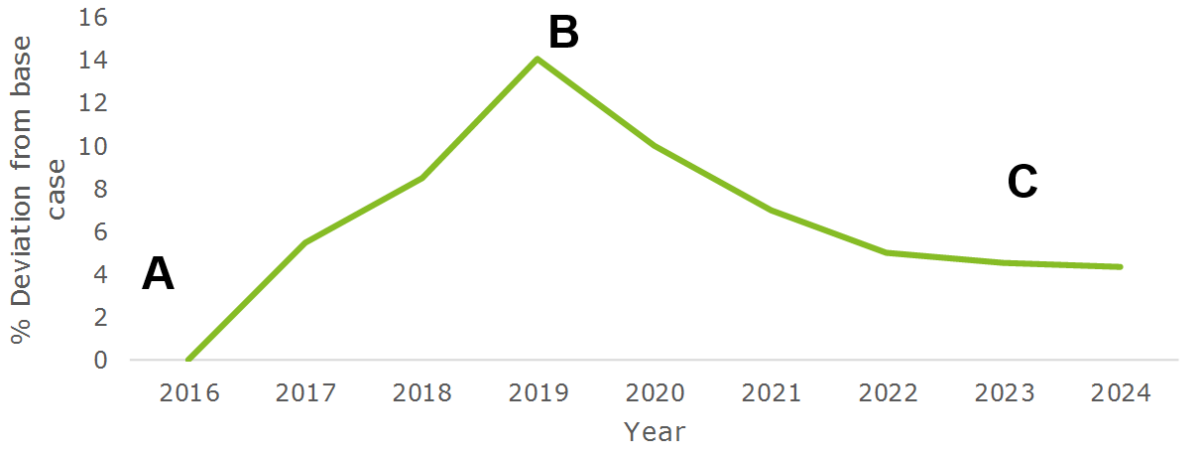
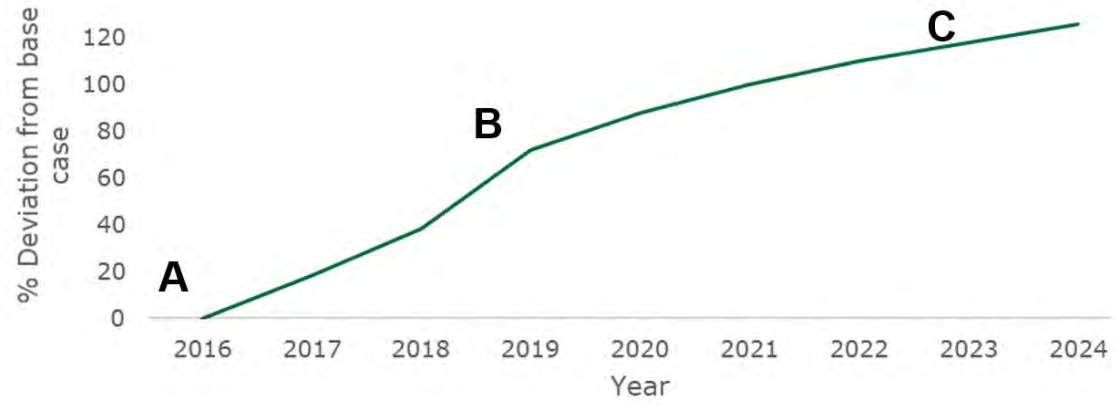


Figure 7: Average quantity impact of the NDIS on disability services



Increases in the level of competition through measures such as reductions to information asymmetries will likely assist in the reduction of longer term prices towards Point C. While

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information collection and dissemination are costly, reductions to information asymmetries will assist in driving efficiency and move the sector as a whole towards the long run efficient price.

Over the course of the introduction of the NDIS, equilibrium prices of disability services peak in 2019 with the increase in prices reflecting the fact that significant resources need to be redirected from other parts of the economy to meet the needs of the sector. However, in the longer term, prices decline and stabilise at a price that is still higher than previous levels, as new firms enter the sector and additional workers are trained and employed.

Key points relating to the NDIS pricing strategy made by Dixon and Cullen (2018) are that the relatively fast implementation of the NDIS results in significant price pressures; and the doubling of expenditure of disability supports does not double the volume of service delivery due to shorter term supply side constraints. Critically, higher prices are needed to both maintain current supply volumes and enable greater volumes of disability support, as this provides an incentive to redirect the allocation of resources to the NDIS from other sectors in the economy. Without price growth, supply side shortages will likely exist.

Overall, macroeconomic modelling shows that market-clearing efficient prices for disability services rise significantly in the short term and reach a long run equilibrium of approximately 5 per cent higher than pre-NDIS levels in real terms (and peaking at about 15 per cent higher than pre-NDIS levels in real terms – point B in the Figures). It is not clear at which point markets for disability supports are currently operating or whether they are at equilibrium or whether demand is fully satisfied (i.e. no shortages exist). However, there has been some past price increases from pre-NDIS levels and limited expansion in supply. Further, there has been some evidence of potential under-supply in the markets for disability goods and services (low plan budget utilisation, even for participants who have bene in the NDIS for some time). The increased demand for labour in 'competitor sectors' noted above further exacerbates the need for increased prices to support the increased wages to attract the required labour supply. The implication of this analysis is that to avoid shortages in the short and longer term, NDIS prices would need to rise significantly in the short term.

3.4 Domestic and international lessons

This section seeks to draw lessons for the NDIS Pricing Strategy from similar systems in Australia (the reform of the Australian aged care system) and internationally (the social care schemes that operate in Germany, Sweden and the United Kingdom).

3.4.1 Lessons from the Australian aged care sector

In 2012, the Australian Government undertook major reforms of the aged care sector, with the aim of providing older Australians with more choice, more control and easier access to services. Key elements of the reform included (Productivity Commission, 2015):

a) greater choice and control for consumers;

b) new and more equitable ways of meeting the costs of aged care;

c) the sector working more closely with the wider health system;

d) a single identifiable entry point for consumers, called MyAgedCare; and

e) access to aged care based on need and not ability to pay.

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The policy change implemented a market mechanism to allow consumers to choose aged care and support based on their own needs and preferences. Consumers were empowered to choose the setting in which care is provided (be it in a person's home, in the community or in a residential setting) and the types of care and support received. Under this policy, the Australian Government ceased regulating the number or distribution of services, allowing the market to respond to consumer demand. However, in situations where the market does not respond to consumer demand or cannot respond, the Australian Government acts as a safety net to ensure services are available and accessible.

Under this model, consumers are primarily responsible for their accommodation and everyday living costs, as they have been throughout their lives. Providers determine how much they expect consumers to pay for their accommodation/everyday living, and care/support costs. The Australian Government then sets and publishes reasonable prices it will pay on behalf of consumers who cannot afford to fully meet their own costs. The underlying principle of this market mechanism is that consumers will drive quality and innovation by exercising choice as to which providers they choose.

Similar to the NDIS, a market mechanism underlies the Australian Government approach to aged care policy. However, in order to improve market efficiency, price transparency and the level of consumer information, the MyAgedCare website publishes a full list of providers, their prices, features, services offered and other market information. The website also provides cost comparison tools and financial calculators to empower consumers to make informed choices, in addition to regulatory compliance reviews. This website serves to improve market efficiency and encourage competition between providers (Australian Department of Health, 2016).

In addition to publishing market information, the Australian Government also sets and publishes reasonable price guides for accommodation and everyday living costs. Price guidance varies based on factors such as the geographical location of the consumer. This serves to limit prices providers are able to charge and sets a base price in particular regions.

3.4.2 Lessons from international schemes

A number of countries have implemented schemes comparable to the NDIS, where the disabled or elderly are provided budgets to spend on a chosen allocation of goods or services. Most often, these schemes are focussed around provision of attendant care, where the needs of individuals are the most variable, and where the argument for self-directed care is the strongest. Among some of the most prominent examples of these schemes are in Germany, Sweden and the United Kingdom.

- **Germany** - The German system of 'Pflegegeld', similar to the NDIS, has also assisted people with severe disabilities since 2008. As of 2013, there were around 2,000 participants in total, most with physical disabilities (ENIL, 2013a).
- **Sweden** - The Swedish Personal Assistance scheme was created in 1993 for those between the age of 0 and 65. As of 2015, around 20,000 people participated in this scheme (ENIL, 2013b; Westberg, 2010).
- **United Kingdom** - In the United Kingdom, the Community Care (Direct Payments) Act of 1996 created a scheme similar to the NDIS for working-age and elderly people living with disabilities. The rate of uptake with older people, however, is relatively low. As of 2013, around 100,000 people participated in the scheme (Ungerson, 2003).

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These schemes all have commonalities:

a) participants receive an amount of money to spend on a combination of services and/or goods of their choosing;

b) budget allocations are usually benchmarked as a gross sum or hourly rate by the level of care required;

c) co-payments are implemented as a part of the schemes (although the size varies);

d) choice of those employed as carers is relatively open (in some cases, carers may not be at arm's length); and

e) schemes face issues of labour shortages and/or affordability for service users.

In general, there is a complex balancing of various scheme features and market interventions in an attempt to provide systems where services are accessible, sustainable and efficient.

Price controls

In the pricing of disability services, the countries discussed aim to achieve similar outcomes through a number of difference policy approaches, including:

a) encouraging greater supply and competition

b) removing barriers to market entry

c) through co-payments, incentivising consumers to seek out services which provide good value.

In addition to policies aimed at the performance of markets outlined above, these countries also have pricing policy settings tailored to their specific needs. Sweden sets a flat hourly rate for care based on industry minimum wages, regardless of the level of care requirements (instead varying the number of hours based on need). Germany addresses undersupply issues by giving suppliers access to a variety of grants and incentives to participate in the industry, essentially subsidising suppliers. Finally, the United Kingdom addresses the undersupply of services to rural areas by compensating suppliers for increased costs with flexible funding.

Supply issues

Regional variability in supply is an issue faced by the UK scheme. In many remote areas, the price of attendant care is relatively high. To address this issue, the UK system varies support based on the recipient's disability and the location of the user or the local labour market. A 2007 study found local authorities most often changed the hourly direct payment rate, increasing the amount so the recipient was not required to cut down on care hours because of increased prices. The UK experiences issues of low supply of personal care workers, however it is not as urgent as in other countries, suggesting perhaps this method helps to alleviate supply issues (Davey et all, 2007).

The German scheme addresses labour supply issues by setting a relatively high legal minimum wage for personal care workers, encouraging workers to enter the sector. This has greater power given there are very few industry-specific minimum wages in the country (Pflege.de, 2019). The German scheme also takes further steps to encourage participation of suppliers in the Pflegengeld scheme. Government grants are available to cover project-related

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expenses incurred by providers in transitioning to the scheme. As of 2006, this had been paid out in approximately 250 cases (Deutscher Bundestag, 2006). The German government also provides publically funded vocational and retraining programs for personal care workers as of 2012 (Eurofound, 2013). An additional method employed by the German government to increase supply of care workers was a publicity campaign to improve the public image of the profession. This was in response to a social perception of care work as being undignified, leading to a lack of desire in young Germans to seek employment in the field (Eurofound, 2013). These strategies give the German government an ability to increase supply without intervening in markets directly.

Affordability

There are a diverse range of policy responses to affordability issues in disability schemes internationally. In Sweden, barriers to work in disability care such as licensing, minimum qualification and registration have been removed to reduce costs and therefore market prices of care. However, this has also led to a shortage of skilled workers and issues in quality control (Eurofound, 2013).

Sweden and Germany have also allowed employment of informal carers such as partners, relatives or friends. This is an important factor in the affordability of care support from a government standpoint, as it leads to cheaper care and also more widespread incidence of paid informal care. In Germany and Sweden, however, informal care is also more highly regulated than similar systems in Europe. In Germany, participants can use a proportion of their total care budget for paid informal care, in addition to formal care. However, informal carers can only receive half of the hourly formal care rate. Additionally, as of 2011, if a family member changes their employment to part-time to provide home care for a disabled relative, they are entitled to 75 per cent of their salary for up to two years (Eurofound, 2013). In some cases, income from informal care may also be tax exempt (Pflege.de, 2019).

Co-payments are also an important feature of the schemes in Germany and the United Kingdom. The German scheme has a 25 per cent co-payment on care received, although in cases of financial difficulties this can be waived (Eurofound, 2013). In the UK, direct payments tend to be less than the market value of the care, requiring top-up co-payments (Davey et all, 2007). Requiring co-payments may reduce overall government costs and encourage participants to seek out lower cost providers and create increased competition.

Conclusions

Overall, there are a number of difficulties faced by countries in market stewardship of disability goods and services. Examination of international schemes similar to the NDIS show that no scheme can completely alleviate these issues. However, a variety of policies designed to incentivise the supply of an effective workforce can create an accessible and high-quality system. To increase supply, policies such as higher minimum wages, business subsidies and publically-funded training schemes may help to alleviate supply side constraints. Internationally co-payments appear to have assisted in reducing prices and in driving stronger competition in the market. Although these policies may not be appropriate in an Australian context, they do provide insight into other potential options for market stewardship and the development of a pricing strategy for the markets for disability goods and services.

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4 NDIS Pricing Strategy

The NDIS Pricing Strategy set out in this document is a critical component in transitioning the NDIS markets to cope with significant demand growth, reaching the longer-term goal of price deregulation and improving efficiency and quality of care. It recognises that during the transition to deregulation, there is a requirement to maintain current supply in the short term and significantly increase the supply of disability supports in the medium to long term, to meet the needs of increased numbers of people entering the scheme and increased levels of support. This transition and the required growth in supply will take a significant time and may need to increase to encourage providers to expand existing operations and new suppliers to enter the markets. Depending on the relative ease with which supply can be increased (referred to as price elasticity of supply), longer term prices may also increase.

Over the longer term, the introduction of the Scheme should reduce barriers to entry to the disability service sector. Supply will no longer be limited to those organisations funded and procured directly by government, or to services which governments deliver directly. Moreover, smaller and more innovative providers should be able to enter the market through direct engagement with the consumers of disability goods and services. At the same time providers should be able to achieve greater economies of scale by operating as a single entity across Australia. The nature of the market for disability goods and services should also fundamentally change, with the current arrangements, which primarily consist of long term, large scale volume-based transactions between a monopsony purchaser and a small number of providers, replaced by a myriad of smaller episodic transactions between almost half a million consumers and a larger number of providers. In sum, there should be a stronger market, as there are a significantly larger number of purchasers, accessing a wider range of providers.

In the immediate term, however, the picture is a little different. Large or monopoly providers of services in the historical arrangements (sometimes government operated services) were the first movers into the new market. They often transferred in with an established and loyal client base, where the budget constraints of the previous arrangements tended to induce a sense of gratitude amongst those people with disabilities who did manage to secure funding and services. At the same time, these providers were not well prepared for the new arrangements. They were often accustomed to block, or even deficit or cost plus, funding and had inefficient workforce and management practices. They were unaccustomed to innovating and often had no history of tailoring services to clients. Conversely, new and more innovative providers face difficulties in attracting a sufficient client base to establish competing businesses.

In this situation of constrained supply, the significant increase in available funding meant that there was a considerable risk of rent seeking from existing providers. A set of price caps were established. These price caps have, however, operated to an extent to stifle innovation within the market. This is because the nature of price caps requires that the products to which those caps apply be well defined. Thus the Agency has produced a catalogue of all of the services on which participants can spend their personalised budget. This in turn requires participants to make their purchasing decisions at a micro level (and at the level of inputs rather than desired outcomes). That is, participants purchase from their providers a mix of strictly defined unit services (for example, a number of hours of assistance with activities of daily living – all price capped separately) rather than a bundle of services or an outcome.

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This unbundling of services also has implications for the regulation of quality. It is important to note that a distinctive feature of social services delivery is that it often involves a bundle of related services. Successfully assisting such clients can require a range of services that can be either mutually reinforcing or in conflict. Conversely, providing some services without other services risks undermining the effectiveness of the services provided. The delivery of social services can therefore require multiple interventions by one or more providers. This raises questions about how best to bundle provision by different providers, and the range of services to be offered by any one provider. Where participants purchase services from a number of different providers it can be difficult to ascertain which provider should be held to account when the outcome sought by the participant are not being achieved. A different approach has been adopted in Australia in the regulatory arrangements for long term care services for older people. Here a single head-provider is funded for and held responsible for the quality of the bundle of services and the outcomes achieved. They may subcontract the delivery of these services but regulators and consumers are each more able to hold a provider responsible for the failure to deliver outcomes.

On the demand side, more people will be eligible to receive assistance with the costs of the disability goods and services that they need and the total demand for these goods and services will increase. The demand side implications of the introduction of the Scheme will not, however, be limited to an increase in aggregate demand. Consumers will also have greater control over the funds that are expended to purchase disability goods and services, which will increase the efficiency of the expenditure, by better matching expenditure to the goods and services most valued by consumers. Because a wider range of supports will be available to participants, they will be more likely to be able to access the supports that will be most useful to them, rather than being restricted in their choice to the supports determined by traditional programs. Moreover, person-centred plans should more efficiently allocate resources as they should be better aligned with the participant's utility valuation.

In general, subsidiarity does lead to improved efficiency, and individualised budgets are the ultimate form of localisation. However, the competitive nature of the market also depends on the extent to which consumers can make informed choices. At a minimum, prior to choosing a provider, potential consumers must be able to compare many providers at low cost and observe the price and quality of care. On the positive side, unlike acute medical care, the demand for disability care is often not time sensitive. Potential consumers may have weeks or months in which to search, as they transition (for example) from informal care arrangements. Moreover, disability services are not technical and can be evaluated more easily by consumers than, say, surgical skills. Conversely, consumers of disability services can be unclear about the variety and quality of services on offer, or unclear as to which services might best meet their needs. They may also be unclear about their needs. These features are shared to varying degrees with other service markets (e.g., legal advice). In such markets, consumers face search and switching costs, and might only learn about service quality after using the service, by which time it might be too late (or costly) to change providers. Transaction costs of switching can also be high – especially if not met by the insurer.

Information asymmetries can seriously undermine the impact of subsidiarity. To exercise informed choice, individuals require accessible, accurate information. Information needs to be personalised to suit individual needs. The ability to exercise choice also depends on the availability of at least two positive alternatives.

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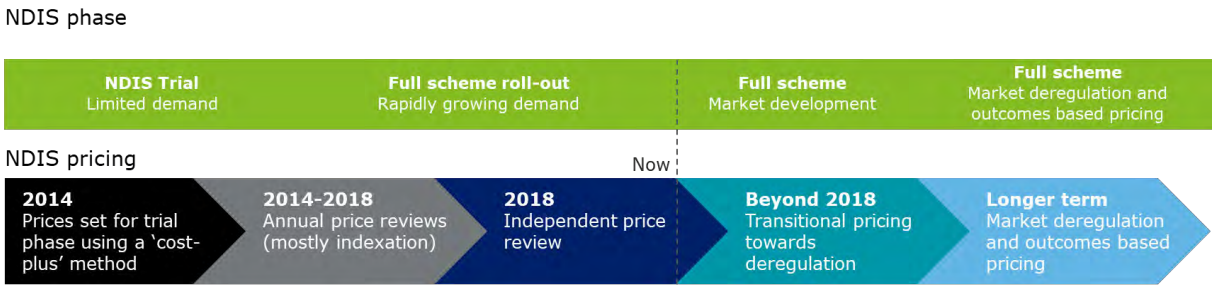
4.1 The Evolution of the NDIS Pricing Strategy

The NDIS Pricing Strategy has evolved and will continue to do so as the NDIS advances towards full roll-out and further matures (see Figure 8 below). Before the introduction of the NDIS, most State and Territory governments block-funded, in the main, disability support providers to deliver services to a set number of people. Under this approach, consumers typically did not have a significant level of input into the supports allocated to them but, rather, a 'one size fits all' approach was used and no market prices were present.

In the trial phase of the NDIS (which had limited participant numbers) markets were regulated using unit price caps. These caps were in most cases determined using 'cost-plus' inputs based pricing based on block funding allocations made to providers prior to the NDIS. However, some markets, which were already well developed such as transport, were not price regulated. Although price regulation was imposed on the majority of market, this was intended as a temporary albeit necessary measure to ensure the scheme functions appropriately in the presence of non-existent markets, under developed markets or market failures.

As the NDIS transitioned towards full rollout, annual price reviews were conducted, whereby the unit price caps introduced were indexed annually based on updates to the costing methodology and consultations. As the number of participants in the NDIS grew, the supply requirements rapidly increased. Pricing needed to respond to this need and some questions were raised about how unit prices were constructed, leading in turn to the NDIA Board commissioning the Independent Pricing Review in 2017.

Figure 8: Phases of NDIS and pricing



The Independent Pricing Review investigated the appropriateness of current price levels and the approach to pricing. The key findings of the report were:

- while there is no general evidence of supply shortages, there is a risk of undersupply in the future, as demand grows rapidly;
- while some providers are profitable at current prices, many are unsustainable at those prices, given future expected market conditions; and
- NDIS prices are broadly in line with similar schemes, although the aged care system typically has higher prices.

Overall, the Independent Pricing Review recommended that the NDIA should:

- collect information to allow monitoring of market supply and institutional capacity;
- implement a Temporary Support for Overheads to encourage supply growth and implement several price loadings to better reflect supplier costs;

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- conduct a trial of outcomes based pricing and move to this approach in the longer term;
- aim for deregulation of markets in the long term; and
- better prepare for deregulation, including through investment in infrastructure such as an online e-market.

As outlined in Figure 8 above and highlighted by the Independent Pricing Review, the NDIS has the challenge of boosting the supply of disability services provided by the market, while maintaining consumer value. In order to do this, the Independent Pricing Review recommended that the NDIA continue on its path to deregulation and in the longer term, move to outcomes based pricing. However, as noted in the Independent Pricing Review, the NDIA does not currently have a clear path to deregulation and ultimately outcomes based pricing.

4.2 Proposed Strategy – 'Glide path' to the new equilibrium

The NDIS Pricing Strategy is best understood in terms of four different concepts of pricing:

- **Efficient price levels** – Price levels that represent the long run minimum cost of production. Sufficient production at efficient price level is only expected to be achievable in the long run in mature markets, with strong competition between providers.
- **Sustainable price levels** – Price levels that represent, at a given time, the price at which the average current firm is viable (even if inefficient). In the short term, prices at or above sustainable levels are required to ensure that current supply levels remain stable and providers with costs somewhat above the most efficient level remain viable.
- **Transitional price levels** – Price levels that represent, at a given time, the price necessary to attract new providers to enter the market or reduce exits from the market. Transitional price levels represent the price required to attract economic resources from other parts of the economy to expand provider supply. Transitional price levels are above sustainable price levels, but should only be adopted where, as is the case in the NDIS transition period, a significant expansion of supply is required.
- **Price caps** – Upper limits on prices, used to prevent potential abuse of market power.

To date, NDIS price levels, both in terms of the level of funds included in participant's plans and price caps, have been predominantly set with longer run efficient price levels in mind.

The pricing strategy proposed in this document better reflects the current situation of inefficient supply and growing demand. It represents an approach to pricing aimed at maintaining and increasing market supply, assisting in the transition of the NDIS to full roll out and helping markets grow to a more mature state in the future, while being cognisant of the need for financial sustainability.

Figure 9 below shows the market clearing equilibrium price and quantity of disability supports prior to the NDIS (at point A) and the long run market clearing equilibrium price and quantity of disability supports including the NDIS demand (at point C). It also illustrates the paths that sustainable price levels (red arrow) and transitional price levels (green arrow) will take in real terms over the transition to the long run market clearing equilibrium price, recognising the entrenched inefficiency of the current providers (for example, through existing Enterprise Bargaining Agreements) and the need to significantly expand and not unnecessarily disrupt the supply of services to people with disabilities.

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Figure 9: Transition from equilibrium prior to the NDIS to the long run NDIS equilibrium

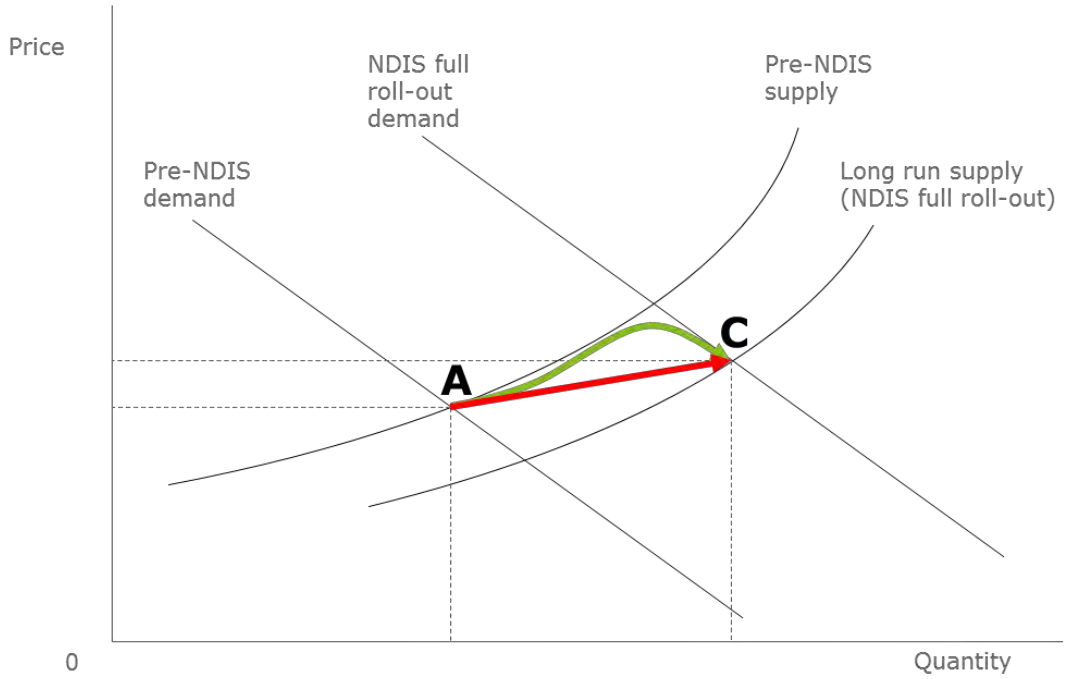


Figure 10 below summarises the stages through which price regulation in the NDIS needs to move as the economic forces outlined above play out. In the first phase, price controls need to balance the drive for greater efficiency with the need to expand supply. Providers need to be given time to adjust their operations and supply needs to expand significantly, requiring additional investment and roll out costs. In the second phase, the Agency, as market steward, needs to invest in the infrastructure needed address information asymmetries and to assist providers gain access to the information that they need in order to improve their operations. In the third and fourth phase, the Agency needs to monitor the development of the markets closely and identify opportunities for deregulation as they arise.

Figure 10: Transition strategy

1. Expand supply and satisfy short term demand during the transition to full scheme

- Set price caps at transitional price levels, as the best measure of the average cost of supply, in recognition of the time frame providers require to adjust to the new market arrangements.
- Set funding levels in line with sustainable price levels, as the best measure of the efficient (necessary) cost of supply

2. Invest in the information infrastructure needed to support the operation of the market

- Address information asymmetries by collecting and publishing additional provider information, including pricing and high level financial data.
- Assist providers to become more efficient by funding a confidential financial benchmarking survey.
- Incentivise providers to provide information to consumers and innovate by making access to transitional price levels contingent on the provider's participation in data collection.

3. Monitor markets closely for signs of shortages and other market failures

- Monitor markets for evidence of both shortages and expansion of supply. If there are shortages and no evidence of increasing supply then price caps should be maintained at transitional levels. If expansion is meeting demand, then price caps can shift from transitional to efficient price levels.
- Funding levels should continue to be set in line with sustainable price levels, and indexed in line with movements in the input costs of efficient providers

4. Deregulate as appropriate, including removing price caps when they are no longer binding

- Non-binding price caps indicate that there is sufficient market competition, indicating that the market is a potential candidate for deregulation.
- Funding levels should to be set at efficient price levels, and indexed in line with movements in the input costs of efficient providers

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4.2.1 Balance efficiency and growth

Price controls need to take into account efficiency and the need to expand supply. Markets for disability supports are continuing to develop, with both increases in market supply and improvements in production efficiency required. While improvements to production efficiency imply reductions to costs in the long run, expansion of market supply necessitates higher short to medium term prices. In order to maintain and expand production volumes of disability supports, higher short-term prices are thus needed. This will serve as an incentive to redirect the allocation of resources to the NDIS from other sectors in the economy. Without price growth, supply side shortages will likely exist.

In the longer term, efficient price levels are the best representation of the reasonable cost of the provision of a support and will, eventually, be the price levels best suited for the development of plans, which are concerned with efficient, effective and appropriate supports. However, in the short to medium term, sustainable price levels are the best representation of the reasonable cost of the provision of a support. In the long run, sustainable price levels tend towards efficient price levels. In the short to medium term, however, as the market matures and expands, price caps need to be sufficient to both maintain current supply and attract new supply. That is, price caps for the NDIS need, in the short to medium-term at least, to be set with regard to transitional price levels, rather than sustainable and efficient price levels.

In brief, prices in the NDIS need to follow two paths under the NDIS Pricing Strategy:

- **Funding levels** in plans should be set as currently, at sustainable price levels, and increased annually in line with movements in the unit input costs of providers (the red arrow in Figure 7). This means that the purchasing power of participants would be maintained in real terms. In the longer run, as transitional and sustainable price levels converge participants will be able to purchase greater quantities of support for their fixed budgets, reaping the benefit of the improved efficiency of the sector.
- **Price caps** should be set in accordance with the movements in transitional price levels (the green arrow in Figure 7), to recognise the costs providers are facing in adjusting to the new arrangements, the time required to unwind established agreements, and to encourage growth in supply while driving efficiency. This should be done through an explicit and decreasing loading on sustainable price levels – the Transition Support Payment (TSP) of about 10 per cent – with a clear statement to the market of the expected glide path over five to eight years to efficient price levels through the phased reduction of the TSP. Detailed ongoing monitoring of markets should also be conducted to determine whether short-term price increases have been sufficient to expand supply, attract new entrants and increase competitive pressure. In the longer term, it is expected that competition between providers will result in a reduction of prices towards the long run efficient price. As market prices reduce towards long run efficient prices, the price caps imposed are expected to no longer be binding, in which case their removal can be considered.

4.2.2 Assist providers, and the market, to become more efficient

The NDIS is able to collect supply data from both observing market interactions and collecting data directly from suppliers. Supply data is able to assist the NDIA to monitor costs, supply conditions, prices, profitability and indicators of market competition, such as number of organisations entering and exiting markets. Currently, the NDIA collects basic profitability

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information from market participants through a provider survey. However, given that participation in the survey is optional and responses are not verified, there is potential for this survey to present an inaccurate view of the supply conditions.

To effectively monitor market conditions in the NDIS, compulsory data collections from NDIS suppliers could be considered. Under such a system, NDIS-registered providers could be incentivised to provide their audited financial statements or to participate in a provider data collection process. Providers would be incentivised to participate in this collection process if access to transitional pricing was made contingent upon providing accurate financial information and good faith participation in the data collection. The collection of supply data is likely to be highly valuable in decision making as to the appropriateness of price caps and the market readiness for deregulation.

The collection and dissemination of more market and consumer information is essential to effective pricing and future outcomes based pricing. This should ideally include market information such as:

a) quantity and prices of disability supports provided (for example, hours of care) by NDIS disability support group, and location (these data could be obtained by linking the details of suppliers to each payment made from NDIS support budgets);

b) market entrants and exits;

c) profitability and other financial metrics from financial statements of providers; and

d) supply conditions such as the total expenditure of participants on supports by location.

Gathered supply data can be used to assist the NDIA determine pricing caps in the short term and enable better informed decision making when considering deregulation of markets in the medium to long term. As transitional pricing is above long run competitive equilibrium prices, it may also be reasonable to oblige providers to participate in data collection, as a form of 'dividend'. To gain access to transitional prices, providers would need to participate in data collection in good faith (i.e. provide accurate responses).

Providers also need to be given the tools to achieve long run efficiencies, by being able to properly understand the performance of their own organisation and to accurately compare their performance to that of their peers. This requires good accounting and governance standards and practices and the ability to compare performance across providers. The NDIA and the NDIS Q&SC can assist providers to do this by requiring providers to adopt better accounting and governance standards and practices over time as part of the provider registration process. The NDIA can also support the establishment of independent performance and financial benchmarking services and provider's participation in those services, especially where providers are operating in thinner markets. The NDIA can also incentivise participation in such performance and financial benchmarking services, and the development of better accounting and governance standards practices, by making access to the transitional price level loading (Transitional Support Payment), or at least a part of that loading, contingent on such activities.

4.2.3 Address information asymmetries to empower consumers

In addition to supplier data, the NDIS would ideally collect data from consumers (Scheme participants) in order to monitor short to medium term outcomes, including participant

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satisfaction rates of with their providers, the degree to which participants feel they are empowered to choose their own care, and plan utilisation rates (underutilisation may indicate supply shortage). Currently, participant data collection is limited to a brief annual survey collecting information about overall satisfaction. Additionally, one-off surveys have been used in the evaluation of the NDIS.

Going forward, consumer and outcomes data should be collected and published on a regular basis to enable consumers to get a detailed view of provider performance and enable future moves towards outcomes based pricing. Information collected could include:

a) satisfaction with individual supports received;

b) outcomes (for example, employment gained and engagement with the community);

c) ease of market access (measuring any potential supply shortages);

d) level of participant empowerment; and

e) plan utilisation and any reasons plan budgets were not fully expended (especially where these indicate undersupply).

Collecting such additional consumer data can be used to both measure the performance of disability support providers in the longer-term transition to outcomes based pricing, and can help identify any areas in which undersupply is occurring in the short term.

A key recommendation of the Independent Pricing Review were strategies to decrease the level of information asymmetries between suppliers of disability supports and NDIS participants. Specifically, the Independent Pricing Review recommended the introduction of a more mature e-market, enabling participants to compare prices across providers and transact with their preferred provider. This would serve to decrease the current level of information asymmetries in the markets for disability goods and services. Currently, there is no requirement that prices of goods and services charged by NDIS-approved providers be publically available. Participants in the NDIS may have no mechanism to easily compare the prices and services offered by multiple providers, other than requesting quotes or making contact with each provider, which may impose significant transaction costs on the participant.

A key piece of infrastructure used in reducing information asymmetries in the NDIS and enabling the pricing strategy is an e-market. The greatest value of an e-market would be in providing an online tool in which all providers are obliged to participate (potentially as a condition of their registration with the NDIS or as a condition of access to transitional price limits). Such an online tool could also provide information related to areas serviced, level of service offered, participant ratings and observed outcomes data (for example, proportion of people gaining employment in the case of employment services) in addition to pricing information.

Although the creation of an e-market is likely to require a considerable investment and ongoing maintenance, it is well placed to reduce information asymmetries between participants and providers, assist in the transition to outcomes based pricing (by requiring outcome measures to be collected and reported), increase market competition and empower participants to exercise choice in determining their care. This would likely result in greater price competition by better informing consumers and allowing multiple providers of supports to be compared easily. Publishing reasonable prices for deregulated markets may also assist consumers in making informed choices between providers and in setting a ‘base’ price for providers.

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An example of a successful model utilised by the Australian government in similar sectors is 'MyAgedCare'. This online tool enables users to determine: the types of aged care services available in their area; their eligibility for services; the contact details, locations and service offerings of providers in their area; the costs associated with care; and the quality of care of different providers. A similar model could be applied to the NDIS to assist in reducing information asymmetries. While collecting and disseminating information may be costly, this is likely to play a role in improving the efficiency of the disability support sector, moving markets closer towards their long run efficient prices.

4.2.4 Measuring success

In designing the glide path of the new NDIS Pricing Strategy, it is important to understand the criteria that indicate market maturity and precipitate progress towards market deregulation and expanded supply, in order to determine when the pricing strategy objectives have ultimately been reached. The following criteria are indicative of a well-functioning supports market, which has adequate supply, strong competition between providers and does not require market intervention through measures such as price caps.

- **Demand is satisfied** – Provider organisations enable adequate supply to fully satisfy participant demand. An indicator of this is high levels of participant budget utilisation (as participants are able to purchase all supports they demand within their budget) and high participant satisfaction rates.
- **Price caps are not binding** – When markets are well-functioning with adequate supply and strong competition, the price caps imposed by the NDIA (which are set at transitional prices, above the efficient long run minimum cost of production) will not be binding. Rather, prices will be close to or at long run efficient equilibrium prices.
- **Competition between providers results in efficient equilibrium prices** – Market prices are close to or at long run efficient equilibrium prices and there is evidence of strong competitive pressures between support providers.

Outcomes based pricing is about ensuring that prices are reflective of the value and outcomes received by participants as a result of the support, rather than the costs of providing the support. In order to move towards outcomes based pricing, a prerequisite is detailed information on the outcomes of participants resulting from their support. For example, potential outcomes of providing a disability service are wellbeing measures, education outcomes (for children and youth) and workforce participation (for adults). In order to implement outcomes based pricing, information on the improvement towards these outcome measures is required.

Collection and reporting of participant outcomes, or interim variables that reliably predict these outcomes in the longer term, is likely to also assist participants make informed choices regarding providers of support and could potentially also be reported on in the online e-market.

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NDIA Board Meeting of 28 March 2019

Agenda Item: #

Agenda Item: Attendant Care and Participation Price Limits

Paper Type: For Decision

ELT Sponsor: Antonia s47F - personal privacy, s22 Head, Markets, Provider and Sector Development

Draft resolution: That the Board AGREE to set the price limits for attendant care and community participation in line with a new efficient cost model and to introduce a Conditional Adjustment Payment of 7.5% (phasing out over five years) to maintain and encourage the expansion of supply and allow time for providers to develop efficiencies in their operations.

1. Purpose

1.1. To seek the Board's agreement to new arrangements for setting price limits for attendant care and community participation in line with a new efficient cost model and to introduce a Conditional Adjustment Payment of 7.5% (phasing out over five years) to maintain and encourage the expansion of supply and allow time for providers to develop efficiencies in their operations.

2. Recommendations

2.1. That the Board AGREE to set the price limits for attendant care and community participation in line with the efficient cost model outlined in this paper, noting that the headline effect of this increase is:

- a 7.6 per cent increase in real terms in the base price for Level 1 weekday attendant care in the East Price Guide;
- a 10.2 per cent increase in real terms in the base price for Level 2 weekday attendant care in the East Price Guide;
- a 10.8 per cent increase in real terms in the base price for Level 3 weekday attendant care in the East Price Guide.

2.2. That the Board AGREE to replace the current Temporary Support for Overheads (2.5 per cent) with a Conditional Adjustment Payment:

- set at 7.5 per cent of the efficient price in the first year;
- that reduced by 1.5 percentage points a year thereafter; and
- that is only payable to providers who agree to the following conditions:
  - publication of prices (for NDIS and non-NDIS clients if they differ) on their own websites;
  - participation the Provider Finder arrangements; and
  - participation in a financial benchmarking survey/service approved by the NDIA, with deidentified data to be provided to the NDIA to assist with future price setting.

2.3. That the Board AGREE to set the price limits for attendant care and community participation in Western Price Guide line with the Eastern Price Guide (as per

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recommendation 2.1 above), noting that the WA Market Review is still to report and may provide additional information about prices in WA.

2.4. That the Board NOTE that further work is required to set the price limits for non-weekday attendant care and community participation, to ensure that all relevant award conditions are recognised in the efficient cost model, and that the increases in all rates will not be precisely that same as in recommendation 2.3 above, but will have the same effect. This additional work will be done over the next couple of months for implementation from 1 July 2019.

2.5. That the Board AGREE that new price limits for attendant care and community participation should take effect from 1 July 2019 and should be set equal to the price limits agreed in recommendations 2.1 to 2.4 above, which are expressed in 2018-19 prices, indexed in the usual way by an 80/20 weighted average of:

- a wages component index estimated as the percentage increase in wages due to the Fair Work Commission Minimum Wage Case in June 2019 and the Equal Remuneration Order due to take effect on 1 December 2019; and
- a non-wages component index estimated as the percentage increase in the CPI in the 12 months to March 2019.

2.6. That the Board AGREE that existing and new plans should be adjusted to reflect the changes in the price limits for attendant care and community participation with effect from 1 July 2019 as part of the annual indexation of plans.

2.7. That the Board NOTE that the Scheme Actuary has estimated that the effect of adopting recommendations 2.1 to 2.6 above is to raise expenditure in the Scheme by 5.0 per cent – equating to $789 million in 2019-20.

2.8. That the Board NOTE that the Annual Review of Price Controls will re-examine, in consultation with the sector, the price control arrangements for group based care and review the implementation of the IPR pricing rules for travel and cancellations, with any new arrangements to be implemented from 1 July 2019.

3. Discussion

3.1. As part of its market stewardship role, the NDIA limits the prices that registered providers can charge for some supports. During transition, price controls are in place to ensure that participants receive value for money in the supports that they receive. In the short to medium term, price controls are required for some disability supports because the markets for disability goods and services is not yet fully developed. The longer-term goal of the NDIA is to remove regulatory mechanisms from the markets for disability supports. Currently, the NDIA varies its approach to the regulation of prices, depending on market conditions, between:

- No regulation (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- The imposition of price caps: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care.

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- Quotable supports: in which participants are expected to obtain quotations from suppliers to provide to the NDIA which will verify that the prices are fair and reasonable. This approach is typically used in the case of highly specialised, differentiated supports that may not have a high level of competition ¬– for example, assistive technology. They are also used in cases, such as supported independent living, where a bundle of supports or quasi-outcome is being purchased. In these situations, providers have greater flexibility to adjust how they achieve the required outcomes in response to the input costs that they face.

3.2. The NDIS Pricing Strategy is a critical component in transitioning the NDIS markets to cope with significant demand growth, reaching the longer-term goal of price deregulation and improving efficiency and quality of care. It recognises that during the transition to deregulation, there is a requirement to maintain current supply in the short term and significantly increase the supply of disability supports in the medium to long term, to meet the needs of increased numbers of people entering the scheme and increased levels of support. This transition and the required growth in supply will take a significant time and may need to increase to encourage providers to expand existing operations and new suppliers to enter the markets. Depending on the relative ease with which supply can be increased (referred to as price elasticity of supply), longer term prices may also increase.

3.3. The NDIS Pricing Strategy is best understood in terms of four different concepts of pricing:

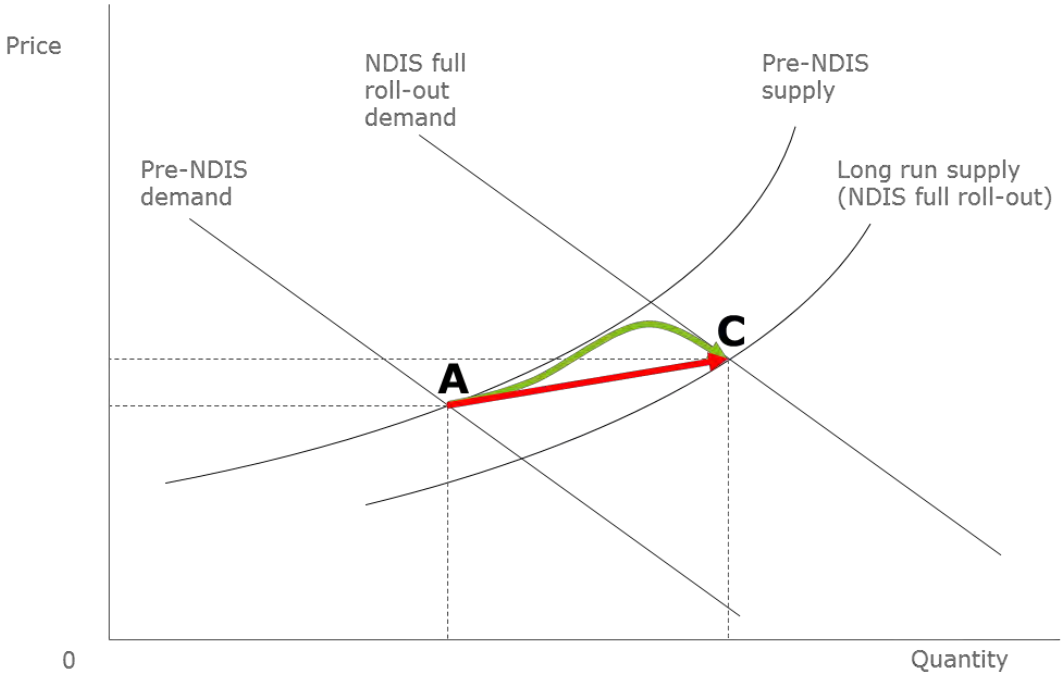
- Efficient price levels – Price levels that represent the long run minimum cost of production. Sufficient production at efficient price level is only expected to be achievable in the long run in mature markets, with strong competition between providers.
- Sustainable price levels – Price levels that represent, at a given time, the price at which the average current firm is viable (even if inefficient). In the short term, prices at or above sustainable levels are required to ensure that current supply levels remain stable and providers with costs somewhat above the most efficient level remain viable.
- Transitional price levels – Price levels that represent, at a given time, the price necessary to attract new providers to enter the market or reduce exits from the market. Transitional price levels represent the price required to attract economic resources from other parts of the economy to expand provider supply. Transitional price levels are above sustainable price levels, but should only be adopted where, as is the case in the NDIS transition period, a significant expansion of supply is required.
- Price caps – Upper limits on prices, used to prevent potential abuse of market power.

3.4. Figure 1 below shows the market clearing equilibrium price and quantity of disability supports prior to the NDIS (at point A) and the long run market clearing equilibrium price and quantity of disability supports including the NDIS demand (at point C). It also illustrates the paths that sustainable price levels (red arrow) and transitional price levels (green arrow) will take in real terms over the transition to the long run market clearing equilibrium price, recognising the entrenched inefficiency of the current providers (for example, through existing Enterprise Bargaining Agreements) and the need to

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significantly expand and not unnecessarily disrupt the supply of services to people with disabilities.

Figure 1: Transition from equilibrium prior to the NDIS to the long run NDIS equilibrium



3.5. To date, NDIS price levels, both in terms of the level of funds included in participant's plans and price caps, have been predominantly set with longer run efficient price levels in mind.

3.6. It is recommended that the NDIS move to a pricing strategy that better reflects the current situation of inefficient supply and growing demand. The new strategy represents an approach to pricing aimed at maintaining and increasing market supply, assisting in the transition of the NDIS to full roll out and helping markets grow to a more mature state in the future, while being cognisant of the need for financial sustainability.

3.7. Price controls need to take into account efficiency and the need to expand supply. Markets for disability supports are continuing to develop, with both increases in market supply and improvements in production efficiency required. While improvements to production efficiency imply reductions to costs in the long run, expansion of market supply necessitates higher short to medium term prices. In order to maintain and expand production volumes of disability supports, higher short-term prices are thus needed. This will serve as an incentive to redirect the allocation of resources to the NDIS from other sectors in the economy. Without price growth, supply side shortages will likely exist.

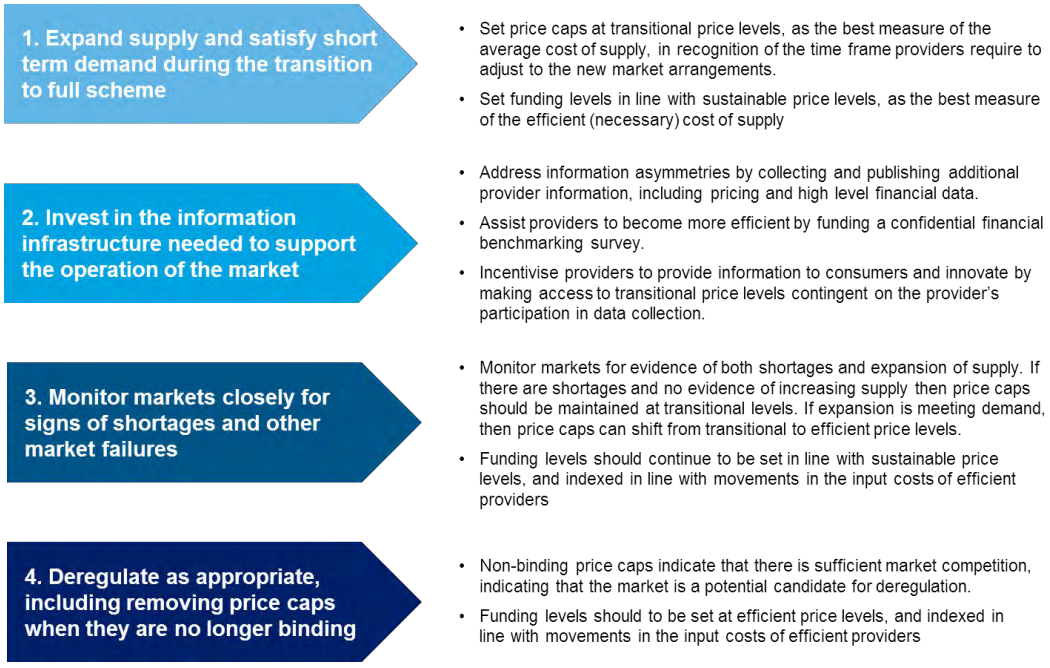
3.8. In the longer term, efficient price levels are the best representation of the reasonable cost of the provision of a support and will, eventually, be the price levels best suited for the development of plans, which are concerned with efficient, effective and appropriate supports. However, in the short to medium term, sustainable price levels are the best representation of the reasonable cost of the provision of a support. In the long run, sustainable price levels tend towards efficient price levels. In the short to medium term, however, as the market matures and expands, price caps need to be sufficient to both maintain current supply and attract new supply. That is, price caps for the NDIS need, in

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the short to medium-term at least, to be set with regard to transitional price levels, rather than sustainable and efficient price levels.

3.9. Figure 2 below summarised the stages through which price regulation in the NDIS needs to move as the economic forces outlines above play out.

Figure 2: Transition strategy



3.10. In brief, prices in the NDIS need to follow two paths under the NDIS Pricing Strategy:

- Funding levels in plans should be set as currently, at sustainable price levels, and increased annually in line with movements in the unit input costs of providers (the red arrow in Figure 1). This means that the purchasing power of participants would be maintained in real terms. In the longer run, as transitional and sustainable price levels converge participants will be able to purchase greater quantities of support for their fixed budgets, reaping the benefit of the improved efficiency of the sector.
- Price caps should be set in accordance with the movements in transitional price levels (the green arrow in Figure 1), to recognise the costs providers are facing in adjusting to the new arrangements, the time required to unwind established agreements, and to encourage growth in supply while driving efficiency. This should be done through an explicit and decreasing loading on sustainable price levels –¬ the Transition Support Payment (TSP) of about 10 per cent –¬ with a clear statement to the market of the expected glide path over five to eight years to efficient price levels through the phased reduction of the TSP. Detailed ongoing monitoring of markets should also be conducted to determine whether short-term price increases have been sufficient to expand supply, attract new entrants and increase competitive pressure. In the longer term, it is expected that competition between providers will result in a reduction of prices towards the long run efficient price. As market prices reduce towards long run efficient prices, the price caps imposed are expected to no longer be binding, in which case their removal can be considered.

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3.11. At the same time, the collection and dissemination of more market and consumer information is essential to effective pricing and future outcomes based pricing. This should ideally include market information such as:

- quantity and prices of disability supports provided (for example, hours of care) by NDIS disability support group, and location (these data could be obtained by linking the details of suppliers to each payment made from NDIS support budgets);
- market entrants and exits;
- profitability and other financial metrics from financial statements of providers; and
- supply conditions such as the total expenditure of participants on supports by location.

3.12. Gathered supply data can be used to assist the NDIA determine pricing caps in the short term and enable better informed decision making when considering deregulation of markets in the medium to long term. As transitional pricing is above long run competitive equilibrium prices, it may also be reasonable to oblige providers to participate in data collection, as a form of 'dividend'. To gain access to transitional prices, providers would need to participate in data collection in good faith (i.e. provide accurate responses).

3.13. Providers also need to be given the tools to achieve long run efficiencies, by being able to properly understand the performance of their own organisation and to accurately compare their performance to that of their peers. This requires good accounting and governance standards and practices and the ability to compare performance across providers. The NDIA and the NDIS Q&SC can assist providers to do this by requiring providers to adopt better accounting and governance standards and practices over time as part of the provider registration process. The NDIA can also support the establishment of independent performance and financial benchmarking services and provider's participation in those services, especially where providers are operating in thinner markets. The NDIA can also incentivise participation in such performance and financial benchmarking services, and the development of better accounting and governance standards practices, by making access to the transitional price level loading (Transitional Support Payment), or at least a part of that loading, contingent on such activities.

3.14. Going forward, consumer and outcomes data should be collected and published on a regular basis to enable consumers to get a detailed view of provider performance and enable future moves towards outcomes based pricing. Information collected could include:

- satisfaction with individual supports received;
- outcomes (for example, employment gained and engagement with the community);
- ease of market access (measuring any potential supply shortages);
- level of participant empowerment; and
- plan utilisation and any reasons plan budgets were not fully expended (especially where these indicate undersupply).

3.15. Collecting such additional consumer data can be used to both measure the performance of disability support providers in the longer-term transition to outcomes based pricing, and can help identify any areas in which undersupply is occurring in the short term.

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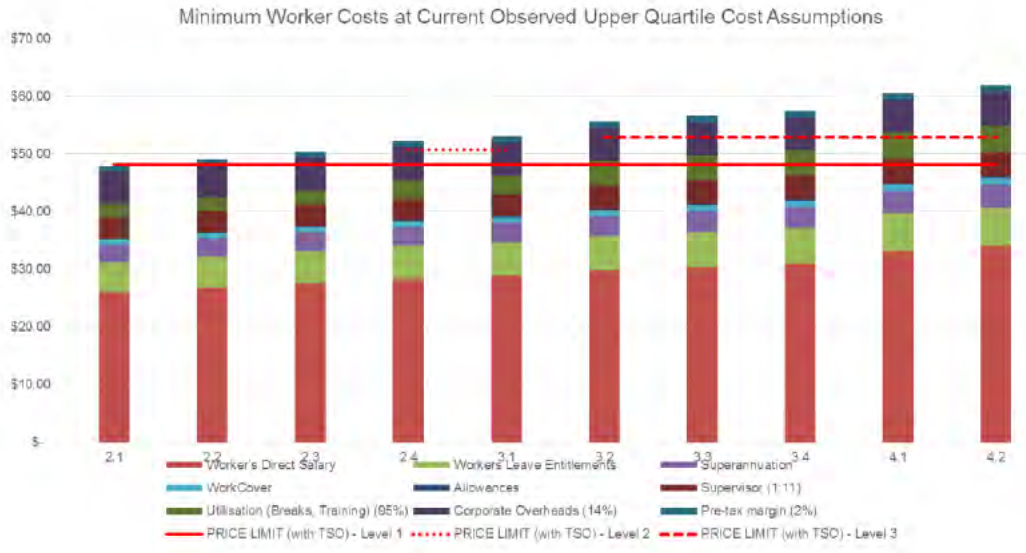
DISCLOSURE LOG

3.16. The current price limits for attendant care and participation are set according to the following assumptions:

	East Price Guide			West Price Guide		
	Standard Level 1	Level 2	Level 3	Standard Level 1	Level 2	Level 3
EFFICIENT COST						
Worker						
Classification (SCHADS Award)	2.3	2.4/3.1	3.2	2.3/2.4	3.1	3.2
Working Days in Year	220					
Shift Loadings	Award					
Permanent share of workforce	80%					
Casual Loadings	Award					
Utilisation	94.5%	93.2%	91.9%	94.5%	93.2%	91.9%
Manager						
Classification (SCHADS Award)	3.2	4.2	4.2	3.2	4.2	4.2
Working Days in Year	220					
Shift Loadings	Award					
Utilisation	94.5%	89.0%	87.7%	94.5%	89.0%	87.7%
Management ratio	1:15					
Salary on costs						
Superannuation	9.5%					
Workers compensation	3.0%					
Payroll Tax	0.0%					
Cost of non-client personnel	5% of direct labour costs of Week Day Rate					
Cost of other corporate overheads	5% of direct labour costs of Week Day Rate					
Pre-tax margin (% of other costs)	2%					
TEMPORARY SUPPORT FOR OVERHEADS						
TSO (on 30 June 2018 rate)	2.5%	=Level 1 TSO	=Level 1 TSO	2.5%	=Level 1 TSO	=Level 1 TSO

3.17. These assumptions are not in line with the current level of provider performance, and this is threatening withdrawal of services and decline in supply.

3.18. The Figure below shows how the worker costs for providers in the top 25 percentile of performers in the AbleInsight Benchmarking Survey are currently higher than the current price limits (including the TSO). The costs of other providers are significantly higher.



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DISCLOSURE LOG

3.19. It is therefore recommended that the NDIS

- RESET REASONABLE Prices based on the operational structures of the most efficient (25th percentile providers) currently operating the sector
- REPLACE the TSO with a Conditional Adjustment Payment of 7.5% (phasing out over five years) in recognition that average providers in the sector are a long way short of the efficient providers and require time to adjust – including the additional costs of the Scheme administration and the Commission. (the CAP represents the difference between the 25th and 50th percentile provider costs)
- RESET REASONABLE Prices each year based on observed 25th percentile
- REDUCE the CAP overtime to increase pressure for efficiency (1.25% a year)
- REQUIRE provider who access the CAP to take part in the annual benchmarking survey – to inform above decisions – and to better publish their prices and offerings.

3.20. The new price limits for attendant care and participation are set according to the following assumptions:

	Standard Level 1	Level 2	Level 3
EFFICIENT COST			
Worker			
Classification (SCHADS Award)	2.3	2.4/3.1	3.2
Working Days in Year		220	
Shift Loadings		Award	
Permanent share of workforce		80%	
Casual Loadings		Award	
Utilisation	92.0%	89.0%	87.7%
Manager			
Classification (SCHADS Award)	3.2	4.2	4.2
Working Days in Year		220	
Shift Loadings		Award	
Utilisation	92.0%	89.0%	87.7%
Management ratio		1:11	
Salary on costs			
Superannuation		9.5%	
Workers compensation		3.0%	
Payroll Tax		0.0%	
Cost of non-client personnel		5.25% of direct labour costs of Week Day Rate	
Cost of other corporate overheads		5.25% of direct labour costs of Week Day Rate	
Pre-tax margin (% of other costs)		2.0%	
TEMPORARY SUPPORT FOR OVERHEADS			
TSO (on 30 June 2018 rate)	7.5%	7.5%	7.5%

3.21. The Table below illustrates the impact of the adoption of the new pricing model on the weekday price limits for attendant care.

	Current Base	Current + TSO 2.5%	New Base	New + TSO 7.5%	Increase in Base	Increase in Base + TSO
Level 1	$47.02	$48.14	$50.57	$54.37	7.6%	12.9%
Level 2	$49.61	$50.73	$54.69	$58.79	10.2%	15.9%
Level 3	$51.86	$52.98	$57.45	$61.75	10.8%	16.6%

Board deliberations relating to its statutory functions are confidential – see Board Resolution of 4 September 2017

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4. Risks

4.1. The WA Market Review has not yet reported. It will be part of the communication strategy for these changes to indicate that the decision to move to a single price guide does not prejudge the outcomes of that review.

4.2. Outcomes of this review represent a shift from recommendations made in the Independent Price Review (which were accepted). This risk has been mitigated through robust consultation with the sector, and the provision of a broader data set allowing for new and different insights.

5. Impact

5.1. Scheme Actuary has estimated that the effect of adopting recommendations 2.1 to 2.5 above is to raise expenditure in the Scheme by 5.0 per cent – equating to between $789 million in 2019-20 (see Attachment A).

5.2. The increase in the price limits for attendant care and community participation will improve access to services for participants.

6. Responsibility and next steps

6.1. Information on the proposed changes in pricing for attendant care and community participation will be communicated in accordance with the overall communication strategy for poring increases at Attachment B.

6.2. The increases in the price limits, and the adjustment of plans, will occur from 1 July 2019 as part of the annual indexation of prices and plan values.

6.3. The Head of Markets, Provider and Sector Development will be responsible for overseeing implementation.

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Attachments

Attachment A: Analysis by Scheme Actuary

Attachment B: Communication Strategy

Internal use only –removed for meeting

Prepared by:	[Action Officer]	Approved by:	[GM Name]
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Cleared by EMG	**[ELT date]**		

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DISCLOSURE LOG

Date: 21 March 2019

Owner: Sarah s47F - personal privacy (Scheme Actuary)

Contact: s47F - personal privacy

DOCUMENT 3.1

Estimated impact of proposed price increases

Understanding of the proposed changes

It is proposed that the following changes will be implemented from 1 July 2019:

- Attendant care
  - Increase of 7.3% (Standard supports or Level 1), 6.9% (High Intensity or Level 2) and 8.9% (Very High Intensity or Level 3) on prices in the 2018-19 price guide for providers delivering assistance with self-care activities (one-to-one) and assistance to access community, social and recreational activities (one-to-one).[1] This does not apply to Supported Independent Living (SIL) supports or group supports.
  - Increase to Temporary Support for Overheads (TSO) from 2.5% to 7.5%, reducing in future years by either 2.5%, 1.25% or 1.1% a year. A scenario where there is no reduction in the TSO is also considered.
- Therapy
  - Increase to therapy price from $179.26 (2018-19 price guide) to $190. Introduction of a Psychology item, with a price of $210 in the East and $230 in the West. Introduction of a Physiotherapy item, with a price of $190 in the East and $200 in the West.

Testing impact

The impact of the proposed changes on Scheme costs is tested using the projected payments from the 2017-18 financial sustainability report for the 2019-20 year onwards. This approach assumes:

- That the inflation and superimposed inflation adopted for the 2018-19 financial year (8.80% in total) sufficiently covers the price increase from 2017-18 to the current 2018-19 price guide, as well as other expected sources of superimposed inflation. High level analysis suggests that this is likely to be the case.

Assumptions

A number of assumptions are required to test the impact of the proposed changes:

- For attendant care, these include:
  - The proportion of supports likely to be impacted by the pricing increase
    - As at 31 December 2018, 45% of payments for the 2017-18 support year related to daily activities and social participation (excluding SIL supports)
    - Of these, 75% were provided one-to-one.
  - Current distribution of supports into Level 1-3
    - The three levels of supports were introduced in February 2019. As a result, there is no data available to assess the potential split between each of the three levels.

[1] Note that these price increases will vary slightly depending on the time/day in which the support is delivered and whether participants were previously classified as in the East or West. These differences have not been modelled as the impact is minor given the uncertainty surrounding the other assumptions.

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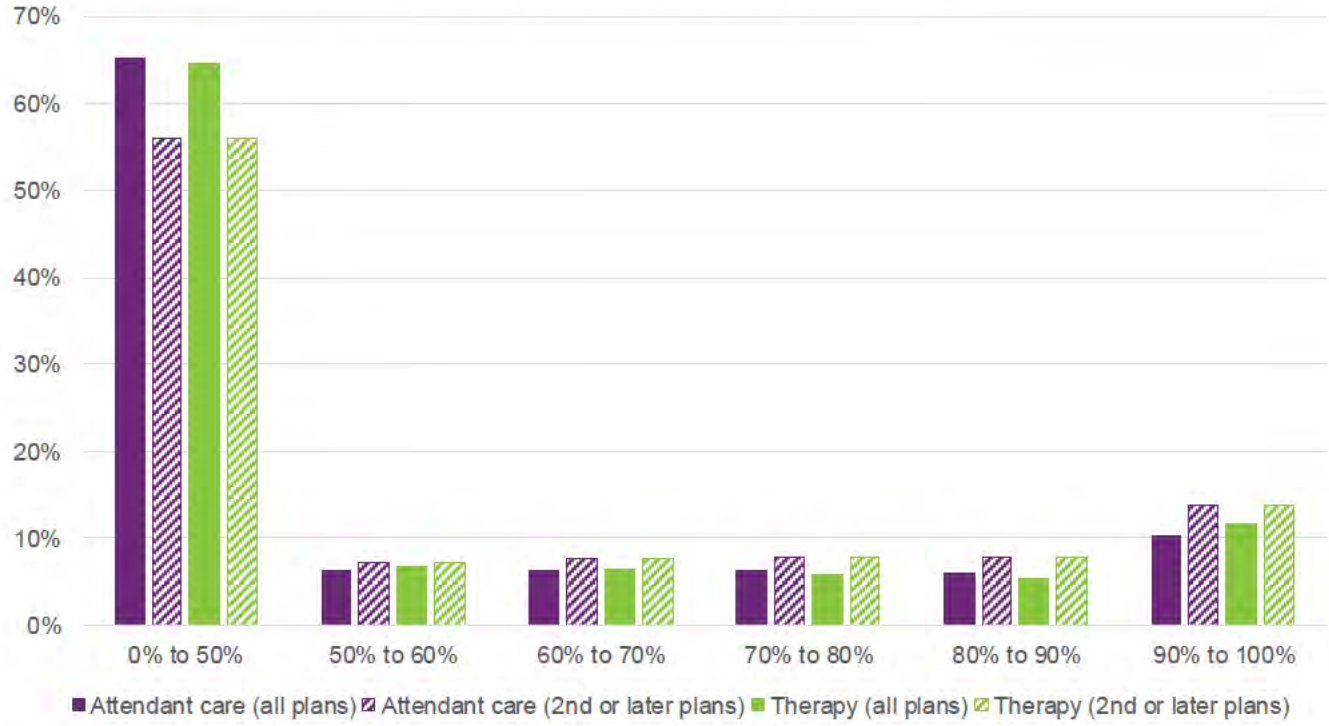
        - Data on the split between Standard and Complex participants under the previous price guide was used as a proxy and alternative splits tested as a scenario.
        - It is assumed that two-thirds of individual supports are Standard (Level 1) and one-third of individual supports are complex, split between High Intensity (Level 2) and Very High Intensity (Level 3).
    - The impact of the increase to the TSO is assessed using the proportion of supports that are impacted by the TSO (estimated to be 36.4%), the increase from 2.5% to 7.5% and the delay in unwinding the previous assumption (the 2017-18 FSR assumed that the TSO would be partly unwound in 2020 and fully unwound by 2021).
- For therapy, these include:
    - The proportion of *Capacity Building - Daily Activities* payments related to the general therapy line item. Based on payments for the 2017-18 support year, this is assumed to be 43%.
    - The proportion of therapy relating to psychology and physiotherapy. There is currently no data collected on this. Therapy supports split by age and disability have been examined as a proxy for the potential split (currently assuming 2% of general therapy supports relate to psychology and 10% relate to physiotherapy).

Results

- At full scheme (2023), the increase in attendant care prices results in an estimated increase of between **$661 million (2.5%)** to Scheme costs if the TSO is unwound over three years to **$1,076 million (4.0%)** if the TSO is unwound over seven years. If the TSO is not unwound, Scheme costs would increase by $1,387 million (5.2%) at 2023.
- The estimated impact of the increase in therapy prices is much smaller, leading to a **$76 million (0.3%)** increase in Scheme costs at 2023.
- At an individual level, participants could receive up to a 14% increase in cost for attendant care supports. This would occur if all of their attendant care supports were subject to the TSO (an increase of 5%) and provided one-on-one at Level 3 (an increase of 8.9%). Analysis of the utilisation of attendant care supports indicates that around 16% (Figure 1) of participants receiving these supports have utilised more than 80% and therefore may require a plan review if the price changes are put through. Note that the percentage of participants who have utilised over 80% of their supports is higher when considering those on second or later plans only.
- Similarly, participants may typically receive a 6% - 8% increase in the cost of therapy supports, assuming the split between psychology, physiotherapy and other therapy supports at a Scheme level is also reflective of individual usage. This would mean that the 12% (Figure 1) of participants receiving therapy supports who have a utilisation rate of 90% to 100% may require a plan review. However if the participant is living in the West and only uses the general therapy line item for psychology services, as an example, the price charged could increase as much as 28%. The proportion of participants who would require a plan review in those circumstances would increase to 23% (Figure 1).

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Figure 1 Distribution of utilisation for attendant care and therapy supports



Sensitivities

The following tables show the impact of changing a number of the assumptions related to the proposed attendant care and therapy price increases on Scheme costs between 2020 and 2023.

The scenarios for attendant care include:

- Lower TSO: assumes the proportion of supports that the TSO impacts is smaller (30%)
- Higher TSO: assumes the proportion of supports that the TSO impacts is higher (50%)
- No normal inflation in 2020: if there is no further inflation increase on 1 July 2020 (as assumed in the 2017-18 FSR), then the impact is reduced
- More favourable split of levels for attendant care: if more supports are delivered at Level 1 and less at Level 2 and 3
- Less favourable split of levels for attendant care: if less supports are delivered at Level 1 and more at Level 2 and 3

Table 1 Total scheme costs projected in the 2017-18 FSR

Year	2020	2021	2022	2023
2017-18 FSR Scheme Cost	15,638m	19,992m	23,371m	26,593m

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Table 2 Cost impact of attendant care price changes (difference relative to 2017-18 FSR)

3 year TSO unwind (difference from 2017-18 FSR)	2020		2021		2022		2023	
	$	%	$	%	$	%	$	%
Adopted assumptions	745m	4.8%	861m	4.3%	794m	3.4%	**661m**	**2.5%**
Lower TSO	682m	4.4%	797m	4.0%	757m	3.2%	661m	2.5%
Higher TSO	878m	5.6%	997m	5.0%	873m	3.7%	661m	2.5%
No normal inflation in 2020	535m	3.4%	594m	3.0%	481m	2.1%	305m	1.1%
More favourable split of levels for attendant care	741m	4.7%	856m	4.3%	788m	3.4%	654m	2.5%
Less favourable split of levels for attendant care	749m	4.8%	866m	4.3%	800m	3.4%	669m	2.5%

5 year TSO unwind (difference from 2017-18 FSR)	2020		2021		2022		2023	
	$	%	$	%	$	%	$	%
Adopted assumptions	745m	4.8%	934m	4.7%	964m	4.1%	**952m**	**3.6%**
Lower TSO	682m	4.4%	857m	4.3%	897m	3.8%	901m	3.4%
Higher TSO	878m	5.6%	1,097m	5.5%	1,107m	4.7%	1,060m	4.0%
No normal inflation in 2020	535m	3.4%	666m	3.3%	651m	2.8%	596m	2.2%
More favourable split of levels for attendant care	741m	4.7%	928m	4.6%	958m	4.1%	945m	3.6%
Less favourable split of levels for attendant care	749m	4.8%	939m	4.7%	970m	4.2%	959m	3.6%

7 year TSO unwind (difference from 2017-18 FSR)	2020		2021		2022		2023	
	$	%	$	%	$	%	$	%
Adopted assumptions	745m	4.8%	965m	4.8%	1,037m	4.4%	**1,076m**	**4.0%**
Lower TSO	682m	4.4%	883m	4.4%	957m	4.1%	1,003m	3.8%
Higher TSO	878m	5.6%	1,140m	5.7%	1,207m	5.2%	1,231m	4.6%
No normal inflation in 2020	535m	3.4%	697m	3.5%	724m	3.1%	720m	2.7%
More favourable split of levels for attendant care	741m	4.7%	960m	4.8%	1,031m	4.4%	1,069m	4.0%
Less favourable split of levels for attendant care	749m	4.8%	970m	4.9%	1,043m	4.5%	1,083m	4.1%

No TSO unwind (difference from 2017-18 FSR)	2020		2021		2022		2023	
	$	%	$	%	$	%	$	%
Adopted assumptions	745m	4.8%	1,043m	5.2%	1,219m	5.2%	**1,387m**	**5.2%**
Lower TSO	682m	4.4%	947m	4.7%	1,107m	4.7%	1,260m	4.7%
Higher TSO	878m	5.6%	1,247m	6.2%	1,458m	6.2%	1,659m	6.2%
No normal inflation in 2020	535m	3.4%	775m	3.9%	906m	3.9%	1,031m	3.9%
More favourable split of levels for attendant care	741m	4.7%	1,038m	5.2%	1,213m	5.2%	1,380m	5.2%
Less favourable split of levels for attendant care	749m	4.8%	1,048m	5.2%	1,226m	5.2%	1,394m	5.2%

For therapy, there is minimal impact in changing the assumptions around the split of psychology and physiotherapy supports, as shown in the table below.

- Scenario 1 assumes 5% of therapy supports are related to psychology and 25% are related to physiotherapy.
- Scenario 2 assumes 10% of therapy supports are related to psychology and 30% are related to physiotherapy.

Table 3 Cost impact of therapy price changes (difference relative to 2017-18 FSR)

Therapy Scenarios	2020		2021		2022		2023	
	$	%	$	%	$	%	$	%
Adopted assumptions	45m	0.3%	57m	0.3%	67m	0.3%	**76m**	**0.3%**
Higher % of psychology and physiotherapy (1)	48m	0.3%	61m	0.3%	71m	0.3%	81m	0.3%
Higher % of psychology and physiotherapy (2)	52m	0.3%	66m	0.3%	78m	0.3%	88m	0.3%

Limitations

As discussed above, there are a number of limitations to this analysis:

- There is no data on the split between Levels 1-3 of attendant care supports. In addition, using the split between standard and complex supports from previous price guides may not be appropriate if there are behavioural impacts from providers as the result of the recent introduction of Level 3.

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- There is currently no data on psychology and physiotherapy supports. The analysis uses therapy supports received by participants with a psychosocial disability as a proxy for psychology supports, and therapy supports received by participants with physical disabilities as a proxy for physiotherapy supports.
- The utilisation analysis does not consider the fungibility of core supports (the ability of participants to use core supports flexibly) which may impact the percentage of participants who require a plan review.

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Pricing Announcements Staged Releases

Purpose

- Outline how the Annual Price Review (APR) will be supported through coherent, consistent staged communications to the launch of the new Price Guides, active 1 July

Communications position

- Demonstrate the NDIA's commitment to pricing and price controls that encourages a thriving and competitive market with fair return to providers while supporting participants to achieve their goals.

Key messages (focussing on Release 1)

- The NDIA takes its commitment as market steward seriously.
- The Pricing Reference Group continues to monitor the market, consulting and taking feedback and using benchmarking methodologies to guide our decision-making.
- The NDIA is building market confidence by balancing certainty through the Annual Price Review process with the need to review and adapt to market conditions through ad hoc and special price review arrangements.
- These adjustments to price settings will stimulate supply and encourage innovation in the market and allow providers to continue supporting participants in achieving their goals.

Attendant care

- Substantive increases to price controls for attendant care are proposed in 2019/20 to better reflect new evidence about the current efficient price and the providers' ongoing need for temporary support overhead.
- These increases ensure the stimulation of adequate supply in the attendant care market.

Therapy Review outcomes

- The Therapy Review was an opportunity to do a deep dive and understand the specific challenges in this market.
- Variations in the market were discovered, including those based on geography and other factors related to labour markets. These variations have been reflected in the price limits.
- Psychology and physiotherapy have higher and differentiated regional caps based on analysis of existing NDIS providers and the open market. These caps align with adjacent markets and will encourage providers to enter the Scheme.

Special conditions

- In order to access new price limits, providers must agree to abide by updated Price Guide terms – including providing data, participating in benchmarking surveys, and publicly providing their price lists.
- Provider participation in benchmark surveys enables the NDIA to continue building the evidence base about efficient pricing assumptions.
- Other requirements will promote greater transparency of provider information about pricing to ensure participants understand and can engage in discussions about price and value for money.

Communications overview

- There are a number of price and policy changes being introduced for the 2019/20 financial year.

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- These changes are driven by three key pieces of work:
    - Annual Price Review
    - Therapy Review
    - WA Market Review
- The Price Guide is being redeveloped to be user-friendly. It will be easier to navigate, with refreshed content and improved layout.
- The number of Price Guides is being reduced from four to three versions: National, Remote, Very Remote.
- As part of the APR, a consumer-oriented Price Guide will also be prepared to provide better transparency for participants.

Content of communications releases

Release 1 – end-March
- Therapy Review outcomes – implement as part of APR
- Attendant care price changes and conditional adjustment payments introduction
- Policies to be investigated and/or clarified for 2019/20
    - Cancellations
    - Centre-based care, including community outings
    - Use of volunteers
    - Travel
    - Group-based supports
    - How policy consultations will be held
- Update to price guide
- Date of next announcement

Release 2 – beginning-June
- Reinforce Therapy Review outcomes
- WA Market Review outcomes
- Announce price changes
- Announce policy clarifications
- Announce date of Price Guide launch

Release 3 – end-June
- Price Guide now live
- When system updates will occur

Release 4 – beginning-July
- System updates live

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Pricing Reference Group

Minutes of the Meeting of 14 May 2019

Members present

- Antonia [redacted]
- Jim [redacted] PSM, Independent Member
- David [redacted]
- Daniel [redacted] (proxy for Michael [redacted]
- Graeme [redacted] AM, Independent Member
- Sarah [redacted]
- Louise [redacted] (proxy for Vicki [redacted]
- Victor [redacted]

Apologises

- Anthony [redacted]

Secretariat

- David Cullen

Item 1.2 – Conflicts of interest

1. The Pricing Reference Group (PRG) **NOTED** that Graeme [redacted] was:
   (a) a member of the Board of Life Without Barriers;
   (b) a member of the Board of the Summer Foundation;
   (c) a member of the Board of Joblife Employment;
   (d) a member of the Board of Attitude Foundation; and
   (e) [redacted]

Item 1.3 – Minutes of meeting of 14 March 2019

2. The PRG **ENDORSED** the minutes of the previous meeting.

Item 2.1 – Terms of Reference for the Specialist Disability Accommodation (SDA) Limited Assumptions Price Review

3. The PRG **NOTED** the consultation with the SDA Reference Group for the Terms of Reference.
4. The PRG **NOTED** the Terms of Reference and the proposed timing for the Review.

Item 2.2 – Annual Indexation of Price Controls

5. The PRG **ENDORSED** the method of indexation of support items as per the below.
   (a) Support items with workers covered by the Social, Community, Home Care And Disability Services Industry Award 2010 (SCHADS) will be indexed by:
      – 80% Fair Work Commission Increase to Minimum Wage + 20% Consumer Price Index (CPI)
   (b) Support items with workers that are not covered by the SCHADS will be indexed by:

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– 80% Wage Price Index (WPI) + 20% CPI

(c) Support items that fall under Capital items, including SDA will be indexed by:

– 100% CPI

Item 2.3 – Simplified Quoting Arrangements for Assistive Technology and Home Modifications (AT&HM)

6. The PRG **AGREED** that participants/providers may claim up to $5000 for AT&HM items included in a participant's plan, after they have fulfilled assessment requirements and have a valid quote.

7. The PRG **AGREED** to the creation of new support item codes with a benchmark value of $5,000, to enable the inclusion of reasonable and necessary AT&HM supports, but ensure basic categorisation of AT spending, to give effect to recommendation 2.1.

8. The PRG **AGREED** that one quote is sufficient for decision-making capability for AT&HM between $5,000 and $15,000, where that quote is tested against the AT&HM Funding Estimate Tool (as appropriate).

9. The PRG **AGREED** that these arrangements be reviewed at the end of 2019, including the impacts on the AT&HM quote assessment numbers.

Item 2.4 – Individual Living Options (ILOs)

10. The PRG **DISCUSSED** the transitioning of ILOs to the National Disability Insurance Scheme (NDIS) and the model for ILO packages offered in the sector currently.

11. The PRG **NOTED** that a paper for pricing ILOs in the NDIS intends to be presented to the PRG in July 2019.

Item 2.5 – Basic Skill Development (as part of community participation supports)

12. The PRG **AGREED** to conduct further work for basic skill development supports.

Item 2.6 – Subscription-based Supports

13. The PRG **AGREED** to conduct further work for subscription-based supports.

Item 3.1 – Preliminary Report on the Western Australia (WA) Market Review

14. The PRG **NOTED** the update on the WA Market Review.

15. The PRG **AGREED** further discussion on preliminary recommendations at the next PRG meeting.

Item 3.2 – Annual Review of Price Controls (Update)

16. The PRG **NOTED** the update on the Annual Review of Price Controls.

17. The PRG **NOTED** further discussion at the next PRG meeting to discuss the outcomes of the Annual Review of Price Controls.

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Matter for decision

Inflationary indexation methodology

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 To seek the agreement of the Pricing Reference Group (PRG) on the inflationary indexation methodology to be used for each financial year when indexing National Disability Insurance Scheme (NDIS) support line items.

2. Recommendations

2.1 That PRG **AGREE** to the indexation methodologies for support categories to be 80% labour and 20% non-labour, except in the case of the Consumables support category which will be 100% non-labour.

2.2 That PRG **AGREE** that the support line items within the support categories for Transport, Assistive Technology and Home Modifications are not indexed. This is with the exception of Specialist Disability Accommodation (SDA).

3. Background

3.1 At 1 July every year, the National Disability Insurance Agency (NDIA) adjusts price controls and supports present in the NDIS Support Catalogue for inflation for the next financial year.

3.2 The inflationary indexes proposed to be used are listed below:

(a) Fair Work Commission's (FWC's) increase to minimum wage.

(b) Equal Remuneration Order (ERO). This is for transition from State and Territory Awards to the Social, Community, Home Care And Disability Services Industry Award 2010 (SCHADS Award) and the support workers subject to this. These are applied from 1 December each year until the transition is complete.

(c) Wage Price Index (WPI). Salary inflation index to be used for support categories where workers are not subject to the SCHADS Award.

(d) Consumer Price Index (CPI). An index of the variation in prices for goods and other items. In the context of this methodology, it is the non-labour component of supports on offer.

4. Issues

4.1 The FWC's increase to minimum wage is announced within the first three weeks of June, so the indexation percentage will not be known until such point in time.

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4.2 The ERO percentage increase for 1 December 2019 will not be known until this is released by the FWC closer to this date. Until such time, this may only be estimated.

4.3 As such, if the NDIA would like to proactively account for this figure, it can be based on the previous year's ERO increase.

5. Discussion

Methodology

5.1 It is proposed that the NDIA use the indexation methodologies for support categories at 80% labour and 20% non-labour, except in the case of the Consumables support category which will be 100% non-labour.

5.2 This is as the many of supports in the NDIS Support Catalogue (excluding Assistive Technology) are labour-intensive, however, there is consideration given to the non-labour components of many supports offered.

5.3 Labour indexes can be split into two categories:

(a) Labour option 1: SCHADS-related labour refers to FWC increase to minimum wage + ERO; and

(b) Labour option 2: WPI

5.4 Non-labour index refers to:

(a) CPI

5.5 The calculations for the indexation value is below:

(a) (80% multiplied by Labour index) + (20% multiplied by non-labour index);

(b) 100% multiplied by non-labour index; or

(c) No indexation

5.6 Attachment A explains the support categories effected in the NDIS Support Catalogue for inflationary indexation and the relevant option used based on the methodology as above.

Reasoning

5.7 Within Support Categories 1 and 4, the majority of supports with workers are covered under the SCHADS Award.

5.8 Within Support Categories 7 to 15, employees here are generally not subject to the SCHADS Award, but are still subject to wage inflation, thus Labour Option 2 is necessary.

5.9 In the case of Consumables, majority of these supports are goods that do not reference workers, so the proposal is for 100% non-labour.

5.10 Support Category 2 – Transport will not be indexed, as these support items are funding amounts. Should these funding amounts change, the NDIS Support Catalogue will be updated to reflect.

5.11 Support Categories 5 and 6 are not subject to price controls and are funding amounts the NDIA sets at market prices for these support line items. This is informed through work in the Assistive Technology and Home Modifications space within the Agency.

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DISCLOSURE LOG

Exceptions

5.12 SDA will be indexed for 100% non-labour, as the NDIA has previously indicated that SDA prices will be adjusted for inflation each year – *SDA Decision Paper on Pricing and Payment (June 2016).*

5.13 There are in-kind support line items that appear in the NDIS Support Catalogue within support categories that are subject to indexation. Such items will not be subject to indexation; as in-kind supports have different arrangements associated with them under the NDIS.

6. Implementation and communication

6.1 Inflationary indexation methodology will be communicated to the sector along with the outcomes from the Annual Review of Price Control.

7. Sensitivities

7.1 Final prices for the NDIS Support Catalogue will not be known until the FWC's release for the increase to minimum wage, so final indexation percentages will not be known shortly before the NDIS Support Catalogue is due for updating in the CRM.

7.2 Due to the unknown timeframe, the methodology sign off will enable the calculations to be carried forth when the final percentages are received.

Attachment(s):

A Inflationary i*ndexation methodology for each support category*

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DISCLOSURE LOG

Attachment A

Below are the support categories effected in the NDIS Support Catalogue for inflationary indexation and the relevant option used based on the methodology as stated previously.

For the purposes to clarify which labour effects which category, labour options are referenced as per section 5.3.

Use of methodology 5.5. a) using Labour Option 1

(a) Support Category 1 - Assistance with Daily Life (Includes SIL)

(b) Support Category 4 - Assistance with social and community participation

Use of methodology 5.5. a) using Labour Option 2

(a) Support Category 7 - Coordination of Supports

(b) Support Category 8 - Improved Living Arrangements

(c) Support Category 9 - Increased Social and Community Participation

(d) Support Category 10 - Finding and Keeping a Job

(e) Support Category 11 - Improved Relationships

(f) Support Category 12 - Improved Health and Well-being

(g) Support Category 13 - Improved Learning

(h) Support Category 14 - Choice & Control (Improved Life Choices)

(i) Support Category 15 - Improved Daily Living

Use of methodology 5.5. b) using 100% non-labour

(a) Support Category 3 – Consumables

(b) Within Support Category 6 – SDA

Use of methodology 5.5. c) for no indexation

(a) Support Category 2 - Transport

(b) Support Category 5 - Assistive Technology

(c) Support Category 6 - Home Modifications (not including SDA)

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DISCLOSURE LOG

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Matter for noting

Update of the Annual Review of Price Controls

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 To update the Pricing Reference Group (PRG) on progress with the Annual Review of Price Controls in the National Disability Insurance Scheme (NDIS).

2. Recommendations

2.1 That PRG **NOTE** the update on the Annual Review of Price Controls.

3. Background

3.1 On 30 March 2019, the National Disability Insurance Agency (NDIA) announced major reforms to the price control arrangements, which will take effect from 1 July 2019. The new price limits include a minimum increase of almost $11 per hour for therapists and up to a 15.4 per cent price increase to the base limit for attendant care and community participation.

3.2 The announcement included the introduction of a new 7.5 per cent Temporary Transformation Payment for attendant care (which is replacing the Temporary Support for Overheads payment) to further assist providers to meet the additional costs associated with transforming their businesses under the NDIS. The announcement also clarified that increases will be further indexed for wage inflation prior to implementation.

3.3 The outcomes of the Annual Review of Price Controls, including indexation and the Western Australia (WA) Market Review, will be considered by the PRG on 28 May 2019 and then the Board on 6 June 2019.

4. Discussion

4.1 On Monday, 6 May 2019, the NDIA commenced consultations on the next phase of the Annual Review of Price Controls, following the announcements on price control arrangements for attendant care and therapy supports.

4.2 The NDIA is now seeking to consult with the sector on the implementation of those changes with a call for submissions. In particular, the NDIA is consulting on:

(a) the eligibility criteria that should apply to the new Temporary Transformation Payment; and

(b) the price control arrangements for Therapy Assistants.

4.3 The NDIA is also consulting on the price control arrangements for:

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(a) provider travel;

(b) cancellations; and

(c) Group and Centre-based Supports.

4.4 Submissions are due at midnight AEST 26 May 2019.

4.5 The NDIA is also setting up a number of working groups with providers to look at the following issues in the next three weeks:

(a) the eligibility criteria that should apply to the Level 1, level 2 and Level 3 supports in High Intensity Crae;

(b) the eligibility criteria that should apply to the new Temporary Transformation Payment;

(c) the price control arrangements for Therapy Assistants;

(d) the price control arrangements for Group and Centre-based Supports; and

(e) price control arrangements such as provider travel, cancellations and the definition of billable hours under the NDIS.

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Pricing Reference Group

Minutes of the Meeting of 28 May 2019

Members present

- Antonia [redacted]
- Jim [redacted] PSM, Independent Member
- David Cullen
- Graeme [redacted] AM, Independent Member
- Sarah [redacted]
- Louise [redacted] (proxy for Vicki Rundle)
- Megan [redacted] (proxy for Anthony Vella)

Apologises

- Michael [redacted]
- Victor [redacted]

Secretariat

- David Cullen

Item 1.2 – Conflicts of interest

1. The Pricing Reference Group (PRG) **NOTED** that Graeme [redacted] was:

   (a) a member of the Board of Life Without Barriers;

   (b) a member of the Board of the Summer Foundation;

   (c) a member of the Board of Joblife Employment;

   (d) a member of the Board of Attitude Foundation; and

   (e) [redacted]

Item 1.3 – Minutes of meeting of 14 May 2019

2. The PRG **ENDORSED** the minutes of the previous meeting.

Item 2.1 – Outcomes from the Western Australia (WA) Market Review

3. The PRG **AGREED** that from 1 July 2019, the new national price limits should apply to WA, noting that WA should be classified as a smaller market for therapy price controls.

4. The PRG **ENDORSED** that the National Disability Insurance Agency (NDIA) should work with the relevant Commonwealth and State/Territory Departments to monitor economic conditions in WA (and Queensland and South Australia) to proactively manage any potential supply issues and make temporary adjustments to price controls.

5. The PRG **ENDORSED** that, from 1 July 2019, the remote and very remote loadings on price limits and plan funding amounts increase from 20% to 40%, and from 25% to 50% respectively.

6. The PRG **NOTED** whether a loading should be applied to price limits and plan-funding amounts in outer regional areas is intended to be examined in the 2019-20 Annual Review of Price Controls.

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7. The PRG **ENDORSED** amending the geographic classification arrangements so that all towns that are currently classified as Outer Regional by the NDIA and are surrounded by remote or very remote areas should be classified as remote areas for planning and price control purposes.

8. The PRG **ENDORSED** NDIA engagement with WA participants and providers to determine appropriateness to allow shared management arrangements within the National Disability Insurance Scheme (NDIS), and to develop mechanisms to support the delivery of these arrangements.

9. The PRG **NOTED** the examination of the implications of the WA "domestic worker" exception in the Industrial Relations Act 1979 (WA) for the delivery of disability supports under the NDIS in the 2019-20 Annual Review of Price Controls.

Item 2.2 – Outcomes from the Annual Review of Price Controls

10. The PRG **ENDORSED** establishing a working group of providers to review the eligibility criteria and implementation arrangements for the three levels of High Intensity Attendant Care and Community Participation supports.

11. The PRG **ENDORSED** that the price limits for Community and Centre Based supports should be modified to ensure providers of these supports are also eligible for the Temporary Transformation Payment (TTP).

12. The PRG **ENDORSED** that the billing rules for cancellations, provider travel and non-face-to-face time should be modified and clarified. These include:

    (a) Clarity on billing for non-face-to-face time.

    (b) Providers billing for short notice cancellations to a participant's plan when the cancellation happens:
        – Without two clear business days' notice for support that is for less than eight continuous hours and worth less than $1,000; and
        – Without five clear business days' notice in all other cases.

    (c) The maximum amount of travel time that providers can bill a participant's plan for in respect of each support has been increased from 20 minutes to 30 minutes for travel in Modified Monash Model (MMM) Areas 1-3 and from 45 minutes to 60 minutes in MMM Areas 4-5.

13. The PRG **NOTED** that as part of the 2019-20 Annual Price Review, the NDIA should examine:

    (a) The indexation arrangements for capacity building supports, other than therapy supports.

    (b) The price limits for capacity building supports, other than therapy supports, and including nursing, noting that these price limits have not been reviewed since the NDIS commenced.

    (c) The price limits for therapy assistants, including whether different price limits might be appropriate for different shifts.

    (d) Arrangements to allow therapists and other providers to recover the costs of consumables provided to participants as part of a support.

    (e) The adequacy of the current establishment fee arrangements.

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(f) The price limits and funding amounts for Plan Management, noting that these price limits have not been reviewed since the NDIS commenced.

Item 2.3 – Updated ATHM Support Codes and Benchmark Pricing

14. The PRG **ENDORSED** to reclassify AT&HM supports using new codes and descriptions in the NDIA Support Catalogue.
15. The PRG **NOTED** that the proposed codes are in line with the PRG decision of 14 May 2019.
16. The PRG **ENDORSED** the methodology that the new codes have a benchmark price (quotable) that is the median plus one standard deviation derived from NDIS market payment data (where available), or uses a unit rate of $100 (e.g. for low cost AT budgets).
17. The PRG **AGREED** that the benchmark price of AT&HM items be reviewed at least annually.
18. The PRG **NOTED** that a Complex Home Modification (CHM) Funding Estimate Tool is in beta testing with Service Delivery Support Alliance (SDSA) SDSA and will be presented to the PRG for wider implementation at a later date.
19. The PRG **AGREED** that further review is required on the new pricing benchmarks in regards to the number of quotes required.

Item 3.1 – Creation of support items for In-kind Hearing Services Programs (HSP) for 1 July 2020

20. The PRG **NOTED** that in-kind HSP arrangements cease on 30 June 2020.
21. The PRG **AGREED** to the inclusion of six new support items across two support categories (Capacity Building and Capital) for funding arrangements from 1 July 2019, in preparation for 1 July 2020.
22. The PRG **NOTED** that during the In-Kind period (1st July 2019 – 30th June 2020), these items will only be allowed to be put into plans, with the claiming of these supports not allowed. The funding will only be accessible/claimed from 1st July 2020.
23. The PRG **AGREED** to a review and/or set price controls for HSPs prior to 1 July 2020.

Item 3.2 – Support Coordination Pricing Arrangements

24. The PRG **NOTED** that Support Coordinators provide services that are covered under the NDIS Pricing Arrangements (provider travel, cancellations and report writing).
25. The PRG **AGREED** to extend the NDIS Pricing Arrangements (provider travel, cancellations and report writing) to include Support Coordinators (under Support Category 3.09 – Support Coordination).
26. The PRG **AGREE** the NDIS Pricing Arrangements for Support Coordination are incorporated into the Price Guide, effective 1 July 2019.
27. The PRG **AGREED** that the flags for Support Category 3.09 – Support Coordination be updated in the Support Catalogue.
28. The PRG **AGREED** that the Price Limit for '*CB and Training in Plan and Financial Management*' is aligned to the Price Limit for *'Support Connection*'.

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Item 3.3 – Activity-based Transport

29. The PRG **NOTED** that providers incur costs when providing transportation for a participant.

30. The PRG **ENDORSED** that further examination is required for Activity-based Transport.

Item 3.4 – Other Price Guide and Support Catalogue Changes

31. The PRG **AGREED** to the implementation of the Therapy price limit changes for the Early Childhood Early Intervention (ECEI) supports, in addition to previously discussed changes as per the Review of Therapy Pricing.

32. The PRG **NOTED** the changes proposed for Supported Employment, previously endorsed at the PRG 14 March 2019 meeting. This was not implemented for 1 July 2019, with a revised policy to be put to the Board at a later date.

33. The PRG **AGREED** that wording for Improved Daily Living Support Category, and support item for Individual Assessment, Therapy And/Or Training (Includes Assistive Technology) (15_048_0128_1_3) be updated to include the word “Recommendations”

34. The PRG **NOTED** the changes proposed for Assistive Technology as per previously endorsed changes at the 14 March 2019 meeting.

35. The PRG **NOTED** that the line item 14_032_0127_8_3 (Financial and Service Intermediary – Set Up Costs) would be decommissioned as to reflect the planning guidance that has been provided since 2017.

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Pricing Reference Group

Minutes of the Meeting of 30 July 2019

Members present

- Liz [redacted] (Chair, A/g Head of MPSD)
- Jim [redacted] PSM, Independent Member
- David Cullen
- Graeme [redacted] AM, Independent Member
- James [redacted] (proxy for Michael Francis)
- Sarah [redacted]
- Louise [redacted] (proxy for Vicki Rundle)

Apologises

- Victor [redacted] (A/g CRO)
- Melissa [redacted] (A/g CFO)

Secretariat

- David Cullen

Item 1.2 – Conflicts of interest

1. The Pricing Reference Group (PRG) **NOTED** that Graeme [redacted] was:

   (a) a member of the Board of Life Without Barriers;

   (b) a member of the Board of the Summer Foundation;

   (c) a member of the Board of Joblife Employment;

   (d) a member of the Board of Attitude Foundation; and

   (e) s47F - personal privacy, s22(1)(a)(ii) - irrelevant material

Item 1.3 – Minutes of meeting of 28 May 2019

2. The PRG **ENDORSED** the minutes of the previous meeting.

Item 2.1 – PRG Governance, Membership and Consultation Arrangements

3. The PRG **DISCUSSED** the Terms of Reference, the role and decision-making ability of the PRG.

4. The PRG **DISCUSSED** the roles and functions of existing members, the reduction of National Disability Insurance Agency (NDIA) senior executive presence, and expansion of the PRG to include more independent industry experts.

5. The PRG **DISCUSSED** the types of consultation processes that could be used with the sector to be more involved on an ongoing basis in price control matters considered by the PRG.

6. The PRG **DISCUSSED** that PRG meetings and any consultation processes should be based on the forward work plan on NDIS price controls, which is intended to be presented in greater detail at the next PRG meeting for further discussion.

Item 2.2 – Specialist Disability Accommodation (SDA) Limited Cost Assumption Review

7. The PRG **NOTED** the issues raised by stakeholders in their submissions to the review.

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8. The PRG **NOTED** the summary of findings from the SDA Limited Cost Assumptions Review.

9. The PRG **ENDORSED/AGREE TO RECOMMEND TO THE BOARD** the proposal to increase the location factors for certain SA4 locations in Sydney and Melbourne.

10. The PRG **ENDORSED/AGREE TO RECOMMEND TO THE BOARD** the proposal to increase the construction cost assumptions for the Robust design category across all build types.

    (a) This is to be monitored to determine its effectiveness on the market supply.

11. The PRG **NOTED** the proposal to increase the construction cost assumptions for the Fully Accessible design category across all build types intends to be considered further at the next PRG meeting.

12. The PRG **ENDORSED/AGREE TO RECOMMEND TO THE BOARD** the proposal of no changes in the current modelling assumptions that were considered for property management, finance and cohabitation with non-participants.

Item 2.3 – Work Plan for Annual Review of Price Controls

13. The PRG **NOTED** the forward work plan for NDIS price controls will be outlined and presented, in greater detail, at the next PRG meeting for discussion.

Item 2.4 – Temporary Transformation Payment (TTP) implementation (Benchmarking)

14. The PRG **NOTED** the arrangements previously presented to the PRG on 28 May 2019.

15. The PRG **DISCUSSED** the arrangements and timelines for the Benchmarking Requirement of the TTP condition by 1 January 2020 for providers claiming TTP supports.

Item 3.1 – Changes to the NDIS Price Guide/Support Catalogue post 1 July 2019

16. The PRG **NOTED** the NDIS Support Catalogue is to be updated at certain points of time, which will be further discussed in the forward working plan of price controls at the next PRG meeting.

17. The PRG **NOTED**:

    a) A planned future update to the Modified Monash Model (MMM) to reference the 2019 MMM compared to 2015 MMM which is currently in the NDIS systems.

    b) A content update for Supported Independent Living providers using the latest SIL Tool template.

    c) A content update for Early Childhood Early Intervention (ECEI)

    d) Registration Groups description alignment to the NDIS Quality and Safeguards Commission naming conventions.

    e) Removal of the price limit for Establishment Fee For Personal Care/Community Access.

    f) Removal of the quote function of nine Assistive Technology (AT) support line items – including creation of nine new line items for replacement.

    g) Alignment of the price limit for Capacity Building and Training in Plan and Financial Management from $58.52 to $60.16.

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h) Adjust the support item description for one AT item.

18. The PRG **AGREED** that operational maintenance items do not need to be presented to the PRG, but may be reported to the PRG where deemed necessary.

Item 3.2 – Geographic reclassification of some isolated outer regional areas

19. The PRG **NOTED** that the geographical reclassification that was recommended from the Western Australian (WA) Market Review would be implemented across the isolated outer regional areas across Australia, not just those in WA.

20. The PRG **NOTED** that 38 localities would have their MMM rating reclassified to MMM 6 (Remote).

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Matter for noting

Price Guide and Support Catalogue Changes

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 To inform the Pricing Reference Group (PRG) that a number of changes need to occur in the National Disability Insurance Scheme (NDIS) Price Guide and Support Catalogue.

2. Recommendations

2.1 That PRG **NOTE** the following changes will occur in the **Price Guide; Attachment A**:

a) Update the reference and link from Doctor Connect to the Health Workforce Locator.

b) Content update for Supported Independent Living (SIL) providers using the latest SIL Tool template.

c) Content updates for Early Childhood Early Intervention (ECEI).

2.2 That PRG **NOTE** the following changes will occur in the **Support Catalogue**; **Attachment B**:

a) Aligning the Registration Groups to the descriptions listed in the NDIS Quality and Safeguards Commission (NDIS Commission).

b) Remove the price limit for Establishment Fee For Personal Care/Community Access.

c) Remove the quote function of nine Assistive Technology (AT) support line items.

- This requires the decommissioning of nine items and creation of nine new items to replace them.

d) Change the price limit for Capacity Building and Training in Plan and Financial Management from $58.52 to $60.16 as per previous PRG agreement.

- This support links to two support line items, one delivered by Support Coordinators and the other by Plan Managers.

e) Adjust the support item descriptions for eight ECEI items.

f) Adjust the support item description for one AT item to remove confusion in the market.

3. Discussion – Recommendation 2.1 a)

Update the reference and link from Doctor Connect to the Health Workforce Locator.

3.1 The latest and previous versions of the Price Guide have referenced 'DoctorConnect' from the Department of Health website. The 'DoctorConnect' webpage is a resource that helps providers

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look up the Modified Monash Model (MMM) area for particular locations. It is used to distinguish between the seven different MMM zones based on the location of the service delivery; this helps providers to determine the correct loading for the support they are delivering.

3.2 The Department of Health recently replaced the 'DoctorConnect' webpage with an updated version tool called 'Health Workforce Locator'. It still retains the same functionality of 'DoctorConnect', but has a slightly different interface and a number of reclassified MMM rated zones.

(a) I.e. Warren NSW 2824 was listed as MMM 5 in the 2015 dataset and has been reclassified as a MMM 6 in the 2019 dataset.

3.3 The 'Health Workforce Locator' was updated and released on the 1 July 2019, when the NDIS Price Guide (version 1.1) was published on 28 June 2019.

3.4 Refer to the Version Control in **Attachment A**.

4. Discussion – Recommendation 2.1 b)

Content update for Supported Independent Living (SIL) providers using the latest SIL Tool template.

4.1 The latest and previous versions of the Price Guide have instructed SIL providers to use previous SIL templates for quoting purposes.

4.2 The business area have advised that a new SIL template has been developed and that the National Disability Insurance Agency (NDIA/Agency) will only accept SIL quotes using that template, which can be downloaded from the NDIS website. The benefits to providers using the latest template will increase the processing speed by the Agency, allow for greater detailed quotes and reduce delay times.

4.3 The NDIS Price Guide will reference the new content for SIL providers; refer to the Version Control in **Attachment A**.

5. Discussion – Recommendation 2.1 c)

Content updates for Early Childhood Early Intervention (ECEI).

5.1 The ECEI business area have advised, regarding ECEI content in the Price Guide, that content updates should include and reflect the work and involvement of the 'key worker model'.

5.2 A 'key worker' has expertise in child development, learning and wellbeing more generally as well as professional qualifications, including special/early childhood education, speech pathology, occupational therapy, psychology, social work and physiotherapy.

5.3 A 'key worker' should work in collaboration with the family/carer to provide a 'team around the child'.

5.4 The Price Guide will reference the new content for ECEI providers; refer to the Version Control in **Attachment A**.

6. Discussion – Recommendation 2.2 a)

Align the Registration Groups to the descriptions for the NDIS Quality and Safeguards Commission (NDIS Commission).

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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6.1 The previous and existing Support Catalogue contain additional text or variations to the Registration Groups that are outlined in the NDIS Provider Guide to Suitability. A number of providers have raised queries regarding those variations and investigation was conducted by the Price Controls Team to compare the naming convention of those Registration Groups.

6.2 For clarity purposes, the Support Catalogue will aim to align to registration group naming conventions as outlined by the NDIS Commission as outlined in the table below for the effected registration group names which will be amended.

Registration Group Number	Registration Group Name from existing and previous Support Catalogues	NDIS Commission Registration Group Name
0102	Assist To Access/Maintain Employ/Ed (Assist Access/Maintain Employ)	Assistance to Access and Maintain Employment or Higher Education
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	High Intensity Daily Personal Activities
0107	Daily Personal Activities (Assist Personal Activities)	Assistance with Daily Personal Activities
0110	Behaviour Support	Specialist Positive Behaviour Support
0111	Home Modification Design and Construction	Home Modifications
0114	Community Nursing Care For High Needs	Community Nursing Care
0117	Development of Daily Living and Life Skills	Development of Daily Care and Life Skills
0123	Assistive Products for Household Tasks	Assistive Products in Household Tasks
0126	Exercise Physiology And Physical Wellbeing Activities (Physical Wellbeing)	Exercise Physiology and Personal Training
0127	Management Of Funding For Supports In Participants Plan	Management of Funding for Supports in Participant's Plans
0130	Assistance Animals (Other Innovative Supports)	Assistance Animals
0132	Support Coordination	Specialised Support Coordination

6.3 The Support Catalogue will highlight those registration groups for changing; refer to the Version Control in **Attachment B**.

7. Discussion – Recommendation 2.2 b)

Remove the price limits for Establishment Fee For Personal Care/Community Access.

7.1 The current Price Guide (version 1.1) refers to an Establishment fee for personal care/community access. This establishment fee is claimable by the provider who assists the participant with the implementation of their NDIS Plan, delivers a minimum of 20 hours per month of personal care/community access support and has made an agreement with the participant to supply these services.

7.2 A budget of $750 is included in the first plan for NDIS participants, in case they need this type of assistance from providers to design and implement support arrangements.

7.3 The Support Catalogue (version 1.1) referred to this support as a price controlled item with published price limits, with an amount of $861.13 that is creating confusion in the market as this differs from the NDIS Price Guide.

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7.4 Previously, it has not been price controlled and price limits have not been published.

7.5 The Support Catalogue will highlight the changes to occur; refer to the Version Control in **Attachment B**.

8. Discussion – Recommendation 2.2 c)

Remove the quote function of nine Assistive Technology (AT) support line items.

8.1 The Support Catalogue (version 1.1) contains nine AT support line items that need to be decommissioned and replaced with new support line items (with new codes). The nature of these items will change from Quotable to Fixed.

8.2 This is an implementation change after discussion with the relevant business area, post 1 July 2019 implementation of previously agreed to changes by the PRG at the 14 and 28 May 2019 meetings.

8.3 The nature of the supports are not changing; rather it is to better reflect the PRG decision made previously and to assist the business area as intended.

8.4 The Support Catalogue will highlight the changes to occur for those AT items; refer to the Version Control in **Attachment B**.

9. Discussion – Recommendation 2.2 d)

9.1 As per the agreement at the 28 May 2019 PRG meeting, the following support line items will be aligned to the price limit of Support line item 07_001_0106_8_3 (Level 1: Support Connection):

(a) 07_003_0117_8_3 - CB and Training in Plan and Financial Management by a Support Coordinator; and

(b) 14_031_0127_8_3 - CB and Training in Plan and Financial Management by a Plan Manager

9.2 This was overlooked for the 1 July 2019 updates and will be updated in NDIS systems and Support Catalogue to reflect the PRG decision.

10. Discussion – Recommendation 2.2 e)

10.1 Item Descriptions for eight ECEI support line items will be amended to reflect the intended description as per the business area's request to better clarify the supports in the early childhood intervention space.

10.2 The support being offered is not changing for these items.

10.3 The Support Catalogue will highlight the changes to occur for those AT items; refer to the Version Control in **Attachment B**.

11. Discussion – Recommendation 2.2 f)

11.1 The business area would like a name clarification for 05_061203111_0135_1_2 (Orthotic - Foot Support/Orthotic Footwear (Prefabricated)) which was created to combine two previous support line items that are being decommissioned.

11.2 This has created confusion with suppliers of these goods due to the decommissioning of the previous items and replacement using the above-mentioned item. This may be clarified to providers with a Support Line Item description update to:

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(a) Orthotic - Foot (all types) and Prefabricated Orthotic Footwear

11.3 This is not intended to change the nature of the support, just clarify what the claimable support is.

12. Implementation and communication

12.1 This year the Price Guide and Support Catalogue introduced Version Controls that outline changes within those documents. Significant or material changes may require an official Communique and coordination from the Communications team.

Attachment(s):

A NDIS *Price Guide 2019-20 v1.2*

B *Support Catalogue 2019-20 v1.2*

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DISCLOSURE LOG

DOCUMENT 10

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Matter for Discussion

Work Plan for Annual Monitoring and Review of Price Controls

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 To seek the agreement of the Pricing Reference Group (PRG) to when and how prices are changed, and to discuss the work agenda and structure of the Price Controls Team (PCT).

2. Recommendations

2.1 That PRG **DISCUSS** the following ways price controls are reviewed:

(a) The Price Guide and associated documents will be updated at most four times per year, ideally only twice a year. Updates will occur at the beginning of each quarter.

(b) There will be up to two major releases - 1 July will be the major update, and planning for the July update will commence straight away with research and consultation on issues deferred from the 2018-19 Annual Review of Price Controls (APR). However, should needs arise, a major update can also be implemented in February. April and September updates will be intended for minor clarifications, amendments and bedding down of preceding major updates.

(c) Updated Price Guide documents should be made available at least six weeks prior to date of effect. One exception is where price controls are dependent on external bodies such as the Fair Work Commission. In which case, policy changes and codes will still be released six weeks in advance, and price controls (where applicable) will be released as soon as practicable after decisions by relevant authorities.

(d) There should be a provider consultation process prior to major recommendations being presented to PRG. This should not just include policy discussions with well-informed peak bodies, but cognitive testing of draft recommendations with a representative sample of individual providers.

(e) Barring necessities, proposals for new support items should have a six-month lead-time.

2.2 That PRG **DISCUSS** deferred recommendations from the 2018-19 APR and proposal to establish a working group to investigate therapy travel.

2.3 That PRG **DISCUSS** deferred recommendations from the Western Australia (WA) Market Review that were not implemented in the 2018-19 APR.

2.4 That PRG **DISCUSS** other proposed research items for the PCT in Financial Year 2019-20, with a view that planning for the 2019-20 APR should begin now.

2.5 That PRG **NOTE** proposed revisions to the PCT structure.

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3. Background

3.1 Throughout the running of the APR, there have been some lessons learned and some recommendations for how to improve moving forward. These include:

(a) The need to re-balance the role of the economist toward core responsibilities

(b) The need for additional enabling support from the Agency to ensure relevant business areas are responsible for management of change impacts that appropriately sit in their work area.

(c) The need for better understanding/visibility of Agency processes and key contacts;

(d) Additional resources in the PCT;

(e) Better understanding that changes require lead time, and rushed changes can result in errors;

(f) Need for added investment in establishment and enforcement of process (e.g. front door process);

(g) Refinements to the engagement model; and

(h) More technical support (e.g. test environments, support writing technical test cases).

4. Discussion - Recommendation 2.1: Update cycles

4.1 The PCT proposes to research potential major changes and consult with the sector about these over the course of the year rather than deferring all changes to the last three months of the financial year, which proved undesirable during the 2017-18 and 2018-19 APRs.

4.2 Equally, it is not ideal to implement major changes once a year. Where changes may confer substantial benefits to providers, participants or the Agency, there should be scope that these changes do not need to wait up to a year for implementation. Accordingly, it is proposed that major changes could also be introduced in February (1 January would not be feasible due to end of year shutdowns and providers not being available for consultation).

4.3 Conversely, major price control changes may still only be actioned up to twice a year, in February and July, as the NDIA does not want to inflict changes too often for providers (change fatigue). July will always see significant price control changes, following annual revisions to the minimum wage by the Fair Work Commission and inflationary indexation as released by the Australian Bureau of Statistics (ABS). It is intended that changes will only be made in April and September to address issues arising from major changes in February and July, such as unintended consequences or provider confusion, and emergency matters.

4.4 Substantial changes should also have appropriate lead time. The PCT propose that – in the normal course of events – proposals for new substantial changes should have a six-month lead-time. This will allow for research, sector consultation on changes, drafting responses, cognitive testing of draft responses with affected providers and system coding.

4.5 In addition, updated Price Guide documents should be made available at least six weeks prior to date of effect. This will give adequate lead-time for providers to communicate with participants and conduct necessary training and system changes. One exception is where price controls are dependent on external bodies such as the Fair Work Commission. In which case, policy changes and codes will still be released six weeks in advance, and prices will be released as soon as practicable after decisions by relevant authorities.

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MR25/01967 FOI 24/25-2242

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- Consideration could be given to implementing inflationary indexation on 1 October (three months after announcement), to allow providers adequate lead time for adjusting to changes and updating service agreements and systems.

5. Discussion - Recommendation 2.2: Additional items from FY18/19 APR

5.1 Findings from the 2018-19 APR suggested that the NDIA should examine the following areas as part of the 2019-20 APR:

(a) The indexation arrangements for capacity building supports, other than therapy supports, noting that providers have suggested that the workers who deliver these supports are covered by the Social Community Home Care and Disability Services Industry Award and that the price limits for these supports should therefore be indexed in line with supports in the Activities of Daily Living support category;

(b) The price limits for capacity building supports, other than therapy supports, and including nursing, noting that these price limits have not been reviewed since the NDIS commenced;

(c) The price limits for therapy assistants, including whether different price limits might be appropriate for different shifts;

(d) Arrangements to allow therapists and other providers to recover the costs of consumables provided to participants as part of a support;

(e) The adequacy of the current establishment fee arrangements; and

(f) The price limits and funding amounts for Plan Management, noting that these price limits have not been reviewed since the NDIS commenced and submissions from plan managers that the current arrangements are inadequate.

5.2 While not specifically included in the above recommendations, during consultations for the 2018-19 APR, the PCT committed to establish a working group to investigate travel for therapy providers. Providers argued that there is strong evidence for the effectiveness of providing treatment to participants from providers who specialise in their condition, or who have an ongoing relationship, rather than those who happen to be in a particular travel radius.

5.3 Accordingly, PRG recommended to ELT that as providers were already operating in competitive open markets, they should be allowed to quote for travel. However, ELT did not accept full deregulation at this stage, so alternative avenues for partial deregulation need to be investigated.

5.4 PRG should agree to include these items in the 2019-20 APR. The PCT would aim to conduct research and have discussions with providers over the remainder of this calendar year.

6. Discussion - Recommendation 2.3: Additional items from the WA Price Review

6.1 The WA Price Review made a number of recommendations apart from those that were addressed in the 2018-19 APR:

(a) Recommendation 2: The NDIA should work with the relevant Commonwealth and State/Territory Departments to monitor the economic conditions in Western Australia (and Queensland and South Australia) with a view to making temporary adjustments to price controls to proactively manage any potential impacts on the supply of disability goods and services from economic trends in those states that were contra cyclical to national trends.

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(b) *Recommendation 3: The NDIA should … should examine in the 2019-20 Annual Price Review whether a loading should be applied to price limits and plan funding amounts in outer regional areas.*

(c) *Recommendation 5: The NDIA should engage with the WA participants and providers to determine whether it would be appropriate to allow share management arrangements within the NDIS, and mechanisms to support the delivery of these arrangements.*

(d) *Recommendation 6: The NDIA should examine the implications of the WA "domestic worker" exception in the Industrial Relations Act 1979 (WA) for the delivery of disability supports under the NDIS.*

6.2 Of these recommendations, Recommendation 2 and Recommendation 3 fall within the responsibility of, and should be actioned by, the PCT. The team plans to conduct research and consultation on these items in the second half of 2019.

6.3 The PCT will also liaise with relevant sections of the Agency or the Commonwealth that have carriage of the matters in Recommendations 5 and 6 to ensure appropriate actions are taken to address these concerns.

7. Discussion - Recommendation 2.4: Suggested work plan for the PCT in 2019-20

7.1 There are a number of other issues that arose during the 2018-19 APR that the PCT should consider for further investigation:

(a) **Group based care** - Rather than use an arbitrary formula to cover non face-to-face time entailed in delivering services, the Review recommended the introduction of a specific item for this component, which providers could accurately bill time. This would allow the cost of direct service provision to group participant to be 1/x where x is the number of participants, rather than (1/x) plus y, were y was a fixed component for non-face to face time. However, while this is both simpler and more accurate, this would potentially decrease current price limits. Accordingly, alternative approaches need to be considered.

(b) **Activity-based transport** - Consider the case where a provider takes a participant to a craft group, where the session is for an hour and transport time is 15 minutes each way. Currently, the entire 90 minutes is billed against Community Participation. This is fine for accounting for the workers' time. However, if the worker uses their own car, the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award) requires them to be paid 78 cents per kilometre by their employer for the costs associated with running the car. This is difficult when there is no specific travel component. Accordingly, the Review recommended that the outing could have a drop down box for the activity itself and one for transport. This would also allow costs such as parking and tolls to allocate against transport. However, this recommendation required further consideration as these costs were considered included in the overhead component of the price limits. The idea of separating activities from associated transport (and travelling in worker's vehicle) may still be useful for understanding provider finances, even if only time costs are allowed.

(c) **High Intensity Supports** - During consultations for the Review, providers agreed that there should be three levels of prices for high intensity services. However, during the available time it was not possible to clarify upon descriptions and appropriate thresholds. Further consultations are required.

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(d) **Contingencies** - There are unexpected events, which while not frequent enough to include in participant plans, can have significant impacts. For example, a previously peaceable participant may suddenly develop anger management issues requiring separate accommodation. As the Agency may only manage funds on behalf of participants, there is no "bucket" that can be dipped into for such emergencies. However, one solution may be to develop a 're-insurance' item. Providers could elect to pay, say, $6 a week per participant to an insurer who would agree to cover the costs of stipulated emergency services.

7.2 There are also a number of issues the PCT would like to conduct further work on that did not arise as part of the APR

(a) **Appropriate benchmarks for pricing reasonable and necessary supports** - Whether a participant does or does not need, for example, 10 hours a week of assistance with daily living is not within the remit of PCT. However, whether the price limits for those hours should be set against efficient prices or sustainable prices should be. Ideally, planners should determine reasonable and necessary types and quanta of services, and let the system determine budgets. This would allow participants, in theory, to choose whether to have that number of hours from an average quality provider, or fewer hours from a high quality provider. However, planners frequently set not only the types and number of services, but the amounts too (based on price limits). This denies participants the choice of using certain providers.

(b) **PCT would like to develop a calculator for travel budgets -** This could take the location of the participant, and determine how many providers are within a given number of minutes of travel time away, including allowing for congestion costs in peak periods. This could allow participants to choose between more services from a closer (and therefore cheaper) provider, or fewer from a more distant, but possibly higher quality, provider.

(c) **A SIL cost model** - At present, providers argue that their costs should be the same as those for daily activities/community participation services. While there are some differences, the costs are similar; however, without an explicit SIL model, the PCT do not really know the extent of the differences and as such should be further explored.

(d) **Mental Health Supports** - Mental health providers have asked the Agency to develop an item for psychosocial recovery coaches. This appears to have some merit, as it could reduce future outlays in this area if participants are successfully treated. Other sectors of the Agency are liaising with the sector to develop competency standards to define such a support. Should that be successful, the PCT will investigate appropriate price controls if appropriate.

7.3 For reference, PRG should also note current ongoing work of the PCT:

(a) Changing the remoteness classification of towns, which regardless of being surrounded by remote or very remote areas are still classified as outer regional. From 1 August 2019, these towns will be classified as remote in the Agency's system.

(b) Creating a Consumer Price Guide. At present if participants want to know about pricing policies, they have to look in the provider section of the NDIS website. The current Guide, while providing all the technical details required by providers, is not particularly user-friendly for participants. For example, it does not explain to participants what they are allowed to buy.

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(c) Reforming the Provider Price Guide. The current Guide could be more user-friendly for providers too – with the release for 1 July 2019 a step towards this. The PCT are providing clarifications, worked examples and links to the Support Catalogue.

(d) Work is underway to develop tenders for benchmarking services.

- One tender component would be to provide a minimal set of such services free to providers who were unwilling or unable to pay for a full suite of such services from a market provider. This would enable such providers to qualify for the TTP, but not to receive a report comparing them against sector benchmarks.
- The second tender component will be for a provider who will take all the information from both the commercial and the free benchmarking services and compile an annual report for the Agency (and such providers who have paid for full benchmarking). Initially agreement will have to be reached with the sector on what is required for the minimum data set (MDS). The PCT do not expect this to be substantially different from the MDS the Agency has been using to survey providers for some years now. The PCT intend to survey providers and analyse data in the third quarter of FY2019-20 so results can inform 1 July changes.

(e) The PCT team will shortly be releasing a number of publications. A pricing strategy paper; the WA Pricing Review report and the Review of Therapy Pricing report. The next paper planned to be drafted will be on pricing methodologies.

Schedule

7.4 For changes the PCT propose to recommend for 1 July 2020, the very high-level timetable is as follows (based on FY2019-20).

1. Set up (e.g. contracts, tender, recruitment) - Now
2. Idea (e.g. research, collation, options analysis) – (Q1, Q2)
3. Analysis (e.g. market testing, financial modelling) - (Q1, Q2)
4. Feasibility (e.g. internal and external impact assessment) - (Q1, Q2)
5. Recommendations (Presentation of recommended changes) - (Q1, Q2)
6. Endorsement (e.g. PRG, Board)
7. Implementation planning (e.g. technical, process, legal, documentation, internal and external engagement) (Q3, Q4)
8. Stakeholder learning & enablement (e.g. forums, FAQs, test understanding of policy, development of limited support materials – reliant on Agency contribution) (Q3, Q4)
9. Execution of changes (e.g. computer changes and review and test) (Q4)
10. Review (e.g. lessons learned) (Q1 FY 2020-21)

7.5 For a given major change – an example may be seen in Attachment A, changes to provider travel restrictions.

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8. Discussion - Recommendation 2.5: Note changes to the size and structure of the PCT in FY2019-20

8.1 The PCT is expanding in size and structure to undertake the above work agenda this financial year. This will include three teams (largely contractors) with responsibility for Policy, Deployment and Engagement.

8.2 The Policy function will include capacity for research and qualitative analysis, and for data collection and modelling. The main data responsibility would be the annual benchmarking survey.

8.3 The Deployment function would include technical support (possibly with IT/programming skills). This unit will also assemble working groups of providers where major changes are proposed (for example, complexity thresholds for high intensity services.)

8.4 The Engagement function would have internal and external engagement responsibilities. Internal engagement would liaise with other areas of the Agency affected by price control changes – both those we need to explain changes to, and those we need support and ownership to make changes happen. External engagement would not directly interact with externals, but would prepare material for those sections of the Agency that do. However, where external questions have scope to require policy responses, the team would become involved. This unit would also conduct cognitive testing of proposed changes with the provider consultation group.

(a) **Standing consultation groups** - While the PCT forms expert working groups from time to time to deal with specific issues, it would be helpful to explore the use of having ongoing groups to interact with at a broader level, for example particular types of suppliers or a group that can consider smaller technical issues.

8.5 PCT also provides secretariat services for the PRG and therefore requires capacity for administrative assistance.

Attachment:

A – An example of proposed steps to a change – in this case, for provider travel restrictions

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Attachment A – An example of proposed steps to a change – in this case, for provider travel restrictions

Examples of Activities

ToR
Draft Terms of Reference (ToR)
ToR Reviewed
ToR endorsed by Pricing Reference Group (PRG)
Tender
Issue Tender
Submissions received
Submissions assessed
Tender awarded
Issues Paper
Research
Draft Issues Paper
Review Issues Paper
Preparation for internal stakeholder engagement
Engage internal stakeholders
Actions from internal stakeholder engagement
Consultations
Consultation strategy
Consultation strategy approval
Receive submissions
Workshop
Workshop preparation
Workshop recruitment
Conduct workshop
Consolidation of insights
Consolidation of insights
Analysis of insights
Engage internal stakeholders
Discussion Paper
Draft Discussion Paper (DP)
Write Release strategy
Approval of release strategy
Release discussion paper
Receive information from discussion paper
communications plan for implementation
Change management plan for implementation
Recommendations
Consolidation of all information
Final report
Review final report
Write recommendations
Impact assessment
Report submission to PRG
Engage internal stakeholders
Sign-off

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DISCLOSURE LOG

DOCUMENT 11

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Matter for noting

Social, Community, Home Care and Disability Services Industry Award 2010 Review

Prepared by: David Cullen, Chief Economist

1. Purpose

1. To provide an update to the Pricing Reference Group (PRG) on the current review of the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award).

2. Recommendations

2.1 That PRG **NOTE** the information provided in this paper regarding the review of the SCHADS Award.

3. Background

3.1 New provisions to the Fair Work Act enable parties to put forward claims to modify Award clauses at any point, rather than needing to wait for the four-yearly review conducted on Modern Awards. This will lead to submissions that are more frequent from union and industry representatives, and enable amendments to clauses that may not be consist with the emerging needs of the sector.

3.2 In April 2019, the FWC commenced reviewing claims to amend the SCHADS Award. Key claims include:

(a) Allowing workers to be paid overtime for those who have worked over eight hours

(b) Accruing time in lieu at the overtime rate for Monday to Friday excursions where accrual of time is agreed to instead of payment for overtime

(c) Variation to prohibit rosters from being altered to avoid payment to public holiday entitlements

(d) Inserting a new allowance for use of community language skills

(e) Payment for registration and attendance costs where employees are required to update their first aid certificate

(f) Variation for payment of casual loading for casual employees in addition to Saturday and Sunday penalty rates (and also in addition to the public holiday penalty)

(g) Variation for casual employees to receive their casual loading in addition to overtime rates

(h) Payment of an allowance or penalty rate to employees working broken shifts

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DISCLOSURE LOG

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(i) Limiting the number of broken shifts to a maximum of two

(j) Payment of travel time between the homes of clients

(k) Remuneration where permanent staff are required to work additional hours at short notice

(l) Imposing a penalty on employers for employer-proposed changes to the roster

(m) Minimum shift lengths of four-hours for all rostered shifts

(n) Payment of shift allowances where employees work afternoon or night shifts regardless of the day of the week.

3.3 A decision on some of these claims (sub points a to g) is expected to be made in early 2020, with the remaining claims (sub points h to n) still to be reviewed by the FWC for decision in late 2020.

3.4 Decisions on up to 32 claims are expected in early 2020.

4. Discussion – Recommendation 2.1

4.1 The majority of claims in front of the FWC, which are predominately from unions, are a response to the reported insecurity of working in the National Disability Insurance Scheme (NDIS).

(a) Submissions include evidence of the uncertainty workers are facing, including increasing casual contracts, and reduced and unstable hours.

4.2 Industry-led submissions argue that the requests made by unions to alter the SCHADS Award will compound existing difficulties experienced by NDIS providers. Submissions from industry since the new NDIS Price Guide (Price Guide) took effect on 1 July 2019 contend that price limits still do not accurately reflect the costs that providers face in delivering services. These costs include:

(a) High rates of worker turnover (several times higher than other occupations)[1]

(b) Extensive workforce coordination required to deliver consumer-driven services

(c) Pricing arrangements that are not reflective of the costs associated with staff training, professional development and leadership.[2]

4.3 The key issues being considered by the FWC include:

(a) Reducing the flexibility around minimum and broken shift clauses and applying penalties to employer-proposed changes to the roster

i. This would put pressure on providers to better coordinate their workforce, which is better employer practice, but potentially reduces the flexibility of arrangements that can be offered to participants

(b) Payment of travel time between home care visits

[1] Preliminary research conducted by the department using Australian Bureau of Statistics (ABS) Participation, Job Search and Mobility (PJSM) survey (2018), Department of Health (DOH) Aged Care Workforce report (2016), Workforce Wizard (Feb 2017) and the Australian Disability Workforce Report.

[2] Australian Industry Group Reply Submission to the 4-yearly review of Modern Awards 13 July 2019.

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DISCLOSURE LOG

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i. This would compensate workers for time spent working, but more accurate travel times would need to be reflected in the Price Guide to avoid shifting costs onto providers

(c) Changing the cancellation policy

i. Unions have requested stronger penalties for employer-made changes to the roster, while industry representatives are requesting greater flexibility to employers so they can reschedule shifts that have been cancelled without any penalty

ii. Both union and industry requests are driven by the higher rates of cancellation under a consumer-driven model.

4.4 The respective submissions of unions and industry reflect the tensions associated with the transition of the disability services from a block-funded model to a fee-for-service model, with providers bound by regulated prices. The NDIS market is also required to grow rapidly alongside other major human services markets, including aged care and childcare.

4.5 The latest estimates from the analysis indicate that the NDIS workforce will require up to an additional 90,000 full-time equivalent (FTE) workers by 2023. Disability service providers report concerns that disability care workers may transfer to the aged care sector, which can be less physically and emotionally demanding and sometimes offer higher pay.[3]

4.6 It is possible for policy settings to strike a balance between improving conditions for workers and reducing costs for providers operating in a transitioning market. The department supports action to alleviate some of the cost pressure on providers so they can offer conditions that are more favourable to workers.

4.7 To the extent that changes to the Award result in increased costs for providers, there would be pressure for these to be reflected in the NDIS Price Guide under the current market-setting model.

(a) Other actions to reduce costs to providers associated with the payment system, such as fostering the development of e-market tools to reduce the cost of transacting, could offset some cost pressures

5. Sensitivities

5.1 NDIS price controls and the NDIS Price Guide will need to be monitored and should consider as claims to change the SCHADS Award are decided over the next six to 12 months.

3 Stakeholder feedback provided during the department's Workforce Analysis project (2019).

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Pricing Reference Group

Minutes of the Meeting of 14 August 2019

Members present

- Liz [redacted] (Chair)
- Jim [redacted] PSM, Independent Member
- David Cullen
- Graeme [redacted] AM, Independent Member
- Sarah [redacted]
- Louise [redacted] (proxy for Vicki [redacted]
- Victor [redacted]
- Melissa [redacted]

Secretariat

- Scott [redacted]

Presenters

- Tobie [redacted]

Apologises

- James [redacted] (proxy for Michael [redacted]

Item 1.1 – Conflicts of interest

1. The Pricing Reference Group (PRG) **NOTED** that Graeme [redacted] was:

   (a) a member of the Board of Life Without Barriers;

   (b) a member of the Board of the Summer Foundation;

   (c) a member of the Board of Joblife Employment;

   (d) a member of the Board of Attitude Foundation; and

   (e) s47F - personal privacy, s22(1)(a)(ii) - irrelevant material

Item 1.2 – Specialist Disability Accommodation (SDA) Limited Cost Assumption Review

2. **That PRG NOTED** the draft final report from the SDA Limited Cost Assumptions Review, which sets out the matters considered by the review.

3. **That PRG AGREED TO RECOMMEND TO THE NDIA BOARD** the following proposed adjustments to the SDA Price Guide:

   (a) **Location factors:** Increases to location factors in accordance with the recommended outcomes from the review.

   (b) **Base assumptions:**

   – An increase in the construction cost assumptions for the Fully Accessible design category by **16.0% across all build types**, noting that this will result in an increase in the price limits of Fully Accessible design of between **10.1% and 16.4%** depending on the build type; and

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– An increase in the construction cost assumptions for the Robust design category by **14.0% across all build types**, noting that this will result in an increase in the price limits of Fully Accessible design of between **9.4% and 14.1%** depending on the build type.

4. **THAT PRG NOTED** that the estimated long-run impact of these combined changes is to increase the annual expenditure on SDA by 14.1%, with peak liability (in 2036-37) increasing from $678.0 million to $758.1 million.

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Pricing Reference Group

Minutes of the Meeting of 19 September 2019

Members present

- Melissa [redacted] (Chair, A/g CFO)
- Jim [redacted] PSM, Independent Member
- David Cullen
- Graeme [redacted] AM, Independent Member
- Sarah [redacted]
- James [redacted] (proxy for Michael [redacted]
- Louise [redacted] (proxy for Vicki [redacted]

Apologises

- Liz [redacted] (Chair, A/g Head of MPSD)
- Victor [redacted] (A/g CRO)

Secretariat

- Scott [redacted]

Item 1.2 – Conflicts of interest

1. The Pricing Reference Group (PRG) **NOTED** that Graeme [redacted] was:

   (a) a member of the Board of Life Without Barriers;

   (b) a member of the Board of the Summer Foundation;

   (c) a member of the Board of Joblife Employment;

   (d) a member of the Board of Attitude Foundation; and

   (e) s47F - personal privacy, s22(1)(a)(ii) - irrelevant material

Item 1.3 – Minutes of meeting of 30 July 2019 and 14 August 2019

2. The PRG **ENDORSED** the minutes of the meetings (PRG-20190919 - Item 1.3-A and PRG-20190919 - Item 1.3-B).

Item 2.1 – Review of PRG Terms of Reference and Membership Update

3. The PRG had a preliminary discussion of its Terms of Reference and membership with a view to a more detailed discussion at its next meeting.

Item 2.2 – PRG Engagement Strategy

4. The PRG had a preliminary discussion of its engagement strategy with a view to a more detailed discussion at its next meeting.

Item 2.3 – Efficient Cost Model for Disability Support Workers

5. The PRG **AGREED TO RECOMMEND TO THE BOARD** that the paper (PRG-20190919 - Item 2.3-A) describing the Efficient Cost Model for Disability Support Workers used by the PRG to determine price limits should published to facilitate ongoing consultation with the sector and to improve transparency.

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Item 3.1 – Annual Price Review Terms of Reference and Timeline

6. The PRG had a preliminary discussion of the terms of reference, timeline and engagement strategy for the Annual Price Review with a view to a more detailed discussion at its next meeting.

Item 3.2 – Publication of Review Reports

7. The PRG **NOTED** the public release of the Western Australia Market Review (PRG-20190919 - Item 3.2-A) and Review of Therapy Pricing Arrangements (PRG-20190919 - Item 3.2-B).

Item 4.1 – Disability-Related Health Supports

8. The PRG **AGREED TO RECOMMEND TO THE BOARD** the price limits set out in PRG-20190919 - Item 4.1 -A for the Disability-Related Health Supports that the NDIS will become responsible for from 1 October 2019.

9. The PRG **NOTED** that the costing of disability-related health conditions that had been prepared earlier by the Scheme Actuary did not encompass the entire list at present, and that the Agency should monitor expenditure on health supports on an ongoing basis.

Item 4.2 – Implications of SCHADS Award Review

10. The PRG **AGREED TO RECOMMEND TO THE BOARD** that the price limits for Saturday and Sunday supports should be increased by 1.1% and 0.8% respectively from 1 December 2019 in recognition of the impact of FWCFB 6067 on the cost of delivering services.

11. The PRG **AGREED TO RECOMMEND TO THE BOARD** that existing plans should not be increased as a result of this change in price limits, but that plan utilisation rates should be monitored to ensure that participants with high levels of usage of weekend supports are not disadvantaged.

12. The PRG **AGREED TO RECOMMEND TO THE BOARD** that service bookings should not be amended as a result of this change in price limits, as they reflect the agreements between providers and participants and should only be changed with the express agreement of both parties.

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Matter for Noting

Efficient Cost Model

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 That the Pricing Reference Group (PRG) notes Efficient Cost Model for Disability Support Workers paper (attached), which will shortly be considered by the Board for publication.

2. Recommendations

2.1 THAT PRG **NOTE** the Efficient Cost Model for Disability Support Workers.

3. Background

3.1 The Agency has developed an efficient model which estimates the full costs, to an efficient provider, of engaging workers covered by the Social, Community, Housing and Disability Services (SCHADS) Award.

3.2 The main use of the model is develop price limits for disability support workers (DSW) engaged in providing relevant supports, principally assistance with daily care, and assistance with social and community engagement.

3.3 However, the workings of the model have never been made publically available. The Board recently decided that a paper describing the methodology, input parameters, sources and assumptions be published in order to support transparency

4. Attachment(s):

A National Disability Insurance Scheme (2019) *Efficient Cost Model for Disability Support Workers*

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National Disability Insurance Scheme

Efficient Cost Model for Disability Support Workers

June 2019

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Terms that we use

DSW	Disability Support Worker
ECM	Efficient Cost Model
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDIS Q&SC	National Disability Insurance Scheme Quality and Safeguards Commission

Further information

Further information on pricing in the National Disability Insurance Scheme can be found at the NDIS website

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Contents

1 Introduction 5

2 Disability Support Worker Efficient Cost Model 6

2.1 Applicable Industrial Award 6

2.2 Base Pay 6

2.3 Shift Loadings 7

2.4 Days Worked Versus Days Paid 7

2.5 Salary On-costs 8

2.6 Supervision costs 9

2.7 Permanent v Casual Workers 9

2.8 Utilisation 10

2.9 Overheads 10

2.10 Margins 11

3 Pricing Model 12

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1 Introduction

One of the principal objectives of the National Disability Insurance Scheme (NDIS) is for people with disability to exercise choice and control over how, and with which providers, they spend their available budgets. The role of pricing in the NDIS is therefore very important. Prices, or more precisely participants' choices in response to the prices they face in the market, reflect the preferences and relative values that different participants place on different types of supports. The aggregation of these individual responses in turn signals to providers the quantity and mix of supports to supply. Prices also affect the purchasing power of participants. Higher prices reduce the supports participants can purchase within a given support budget. Prices also affect the total costs of the NDIS and therefore its financial sustainability, and the allocation of resources to the NDIS (and therefore possible production), relative to other sectors. Pricing can also affect providers' choices, including by providing incentives: for entering the market; for upskilling and right-skilling; for innovation; and for improvements in service quality and outcomes.

As the markets for disability goods and services develop and operate more effectively, it is expected that the National Disability Insurance Agency (NDIA), as market steward for the NDIS, will be less interventional. However, deregulation will necessarily occur at different points in time for different markets and may not be feasible in some cases. Currently, the NDIA varies its approach to the regulation of prices between:

- **No regulation** (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- **The imposition of price limits**: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care.
- **Quotable supports**: in which participants are expected to obtain quotations from suppliers to provide to the NDIA as part of verifying that prices are fair and reasonable. This approach is typically used in the case of highly specialised, differentiated supports that may not have a high level of competition – for example, assistive technology. They are also used in cases, such as supported independent living, where a bundle of supports or quasi-outcome is being purchased. In these situations, providers have greater flexibility to adjust how they achieve the required outcomes in response to the input costs they face.

The purpose of this document is to set out the Efficient Cost Model (ECM) that the NDIA uses to inform its pricing decisions for those supports delivered by Disability Support Workers (DSWs) on which it imposes price limits.

The methodology used to inform the NDIA's pricing decisions for those supports delivered by therapists on which it imposes price limits are set out in the *Review of Therapy Pricing Arrangements*.

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2 Disability Support Worker Efficient Cost Model

This Chapter sets out the assumptions and methodology of the Efficient Cost Model (ECM) that the NDIA uses to estimate the costs to disability service providers of employing Disability Support Workers (DSWs) to deliver supports through the NDIS. The ECM estimates the cost of delivering a billable hour of support taking into account all of the costs associated with every billable hour, including: base pay; shift loadings; holiday pay; salary on costs; supervision costs; utilisation (non-billable activities); corporate overheads and margin.

The NDIA recognises that providers have to employ DSWs with different skill levels and levels of experience to meet the different needs of participants. It therefore has different sets of cost assumptions for three types of workers, referred to as:

- Standard or Level 1 DSWs;
- High Intensity or Level 2 DSWs; and
- Very High intensity or Level 3 DSWs.

2.1 Applicable Industrial Award

The national award for DSWs is the *Social, Community, Home Care and Disability Services Industry Award 2010*.[1] The NDIA recognises that some DSWs are employed under Enterprise Bargaining Agreements (EBAs). However, these EBAs have to leave the worker no worse off overall than they would be under the relevant Award and, in general, any additional benefits offered by EBAs over the Award have been voluntarily agreed to by providers and are often offset by productivity gains. The NDIA therefore considers the conditions set out in the SCHADS Award to be the appropriate foundation for the ECM.

Note: the nomenclature of Level 1 DSW, Level 2 DSW and Level 3 DSW used in the ECM should not be confused with the classification of workers under the SCHADS Award.

2.2 Base Pay

Table 1 sets out the ECMs assumptions with respect to the base pay of DSWs.[2]

Table 1: NDIS DSW Levels, Assumed SCHADS Classifications and Pay Rates

	Assumed SCHADS Classification	Award pay 1 December 2018
Level 1 (Standard) DSW	2.3	$27.61
Level 2 (High Intensity) DSW	2.4/3.1	$28.63
Level 4 (Very High Intensity) DSW	3.2	$29.74

1 http://awardviewer.fwo.gov.au/award/show/MA000100

2 https://www.fairwork.gov.au/ArticleDocuments/872/social-community-home-care-and-disability-services-industry-award-ma000100-pay-guide.pdf.aspx

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2.3 Shift Loadings

Table 2 sets out the ECM's assumptions with respect to shift loadings. These assumptions are in line with the SCHADS Award and are applied to all DSWs and supervisors in the ECM. In line with SCHADS Award, the ECM also provides a 17.5% loading for annual leave to compensate workers for the shifts they would have otherwise taken. The ECM does not provide for any other allowances payable to DSWs.

Table 2: SCHADS Shift Loadings

Shift	Permanent Loading	Casual Loading	Difference
Weekday	0.0%	25.0%	25.0%
Saturday	50.0%	50.0%	0.0%
Sunday	100.0%	100.0%	0.0%
Public Holiday	150.0%	175.0%	25.0%
Afternoon Shift	12.5%	37.5%	25.0%
Night Shift	15.0%	40.0%	25.0%

2.4 Days Worked Versus Days Paid

The ECM recognises that a permanent worker works on 220 days a year, but is also paid for:

- 20 days of annual leave and 10 days of public holidays;
- Up to 10 days of personal leave – the ECM assumes all workers utilise all of their personal leave entitlement each year;
- 4⅓ days of long service leave (if they have qualifying service) – the ECM assumes 18% of permanent workers and 10% of casual workers qualify for long service leave.[3]

As Table 3 shows, leave costs increase the costs per billable hour of a permanent DSW on a weekday by 20.1% over the base salary rate.

Table 3: Impact of Leave on the Cost per Billable Hour of a Permanent DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Standard Hourly Rate	**$27.61**	**$28.63**	**$29.74**
Allowance for Annual leave			
a. No. hours leave in a year (hrs/yr)	152	152	152
b. Loading	17.5%	17.5%	17.5%
c. Proportion of leave taken	100.0%	100.0%	100.0%
Cost	**$2.95**	**$3.06**	**$3.18**
Allowance for Personal leave			
a. No. hours leave in a year (hrs/yr)	76	76	76
b. Loading	0.0%	0.0%	0.0%
c. Proportion of leave taken	100.0%	100.0%	100.0%
Cost	**$1.26**	**$1.30**	**$1.35**

[3] Australian Bureau of Statistics. (2019). *Participation, Job Search and Mobility, Australia, Feb 2019.*

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	Level 1 DSW	Level 2 DSW	Level 3 DSW
Allowance for Public Holiday leave			
a. No. hours leave in a year (hrs/yr)	76	76	76
b. Loading	0.0%	0.0%	0.0%
c. Proportion of leave taken	100.0%	100.0%	100.0%
Cost	**$1.26**	**$1.30**	**$1.35**
Allowance for Long Service leave			
a. No. hours leave in a year (hrs/yr)	32.93	32.93	32.93
b. Loading	0.0%	0.0%	0.0%
c. Proportion of leave taken	18.0%	18.0%	18.0%
Cost	**$0.10**	**$0.10**	**$0.10**
Cumulative cost per hour, after leave costs	**$33.17**	**$34.39**	**$35.73**
Increase from permanent standard hourly rate	20.1%	20.1%	20.1%

Note: Columns may not sum due to rounding.

2.5 Salary On-costs

The ECM recognises that providers incur other costs related to the salaries, including:

- Superannuation at the statutory 9.5% of base salary, including leave;[4] and
- Workers compensation insurance at 3% of base salary, including leave, which is higher than the national average for the Health and Community Services Sector of 1.5%[5].

The ECM does not provide for payroll tax as most jurisdictions exempt not for profit and smaller organisations from payroll tax.

As Table 4 shows, salary on-costs and the costs discussed above increase the costs per billable hour of a permanent DSW on a weekday by 35.1% over the base salary rate.

Table 4: Impact of Salary On-costs on the Cost per Billable Hour of a Permanent DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, before on-costs	**$33.17**	**$34.39**	**$35.73**
Superannuation			
Superannuation Rate (%)	9.5%	9.5%	9.5%
Superannuation ($)	$3.15	$3.27	$3.39
Workers Compensation			
Premium Rate (%)	3.0%	3.0%	3.0%
Premium Cost ($)	$1.00	$1.03	$1.07
Cumulative cost per hour, after on-costs	**$37.31**	**$38.69**	**$40.19**
Cumulative increase from permanent standard hourly rate	35.1%	35.5%	35.1%

[4] https://www.ato.gov.au/Business/Super-for-employers/How-much-to-pay/

[5] Safe Work Australia: www.safeworkaustralia.gov.au/workers-compensation/comparing-workers-compensation-scheme-performance

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2.6 Supervision costs

The ECM recognises that DSWs require support and supervision and assumes that supervisors have the same shift loadings, leave entitlements and salary on-costs as the workers they manage, and that higher skilled workers require higher skilled supervisors. The ECM also assumes a span of control (ratio of workers per supervisor) of 11 to 1. The average for the sector is reported in the most recent AbleInsight Benchmarking Survey as 9.5 to 1.[6]

As Table 5 illustrates, supervision costs together with the costs discussed above increase the costs per billable hour of a permanent Standard DSW on a weekday by 48.3% over the base salary rate.

Table 5: Impact of Supervision on Cost per Billable Hour of a Permanent DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, before supervision	**$37.31**	**$38.69**	**$40.19**
Supervisor			
Level of supervisor (SCHADS Equivalent)	3.2	4.2	4.2
Base Salary	$29.74	$33.92	$33.92
Leave costs	$5.99	$6.83	$6.83
Salary-on costs	$4.47	$5.09	$5.09
Span of control			
Span of control	11	11	11
Cost of supervision ($)	$3.65	$4.17	$4.17
Cumulative cost per hour, after supervision	**$40.97**	**$42.86**	**$44.36**
Cumulative increase from permanent standard hourly rate	48.4%	49.7%	49.2%

Note: Columns may not sum due to rounding.

2.7 Permanent v Casual Workers

The ECM assumes that 80% of the DSW workforce is permanently employed. As Table 6 illustrates, casual loadings and the other costs discussed above increase the costs per billable hour of employing a Standard DSW on a weekday by 49.5% over the base salary rate. The impact is slightly higher (50.3%) for a Level 2 (Very high Intensity) DSW.

Table 6: Impact of Casual Loading on the Cost per Billable Hour of a DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, at 100% permanent	**$40.97**	**$42.86**	**$44.36**
Cumulative cost per hour, at 80% permanent	$41.28	$43.19	$44.70
Effect of casual loading	**0.8%**	**0.8%**	**0.8%**
Cumulative increase from permanent standard hourly rate	49.5%	50.7%	50.3%

[6] AbleInsight. (2019). *Sector Summary Report: National Disability Service Providers Benchmarking Survey – Collection 3 (2017/18).*

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2.8 Utilisation

The ECM recognises that not all working hours are billable. For example, the SCHADS Award provides that a DSW should have a ten minute paid break from work every four hours. DSWs also need to undertake training and attend to other issues. The ECM assumes that higher skilled workers with more responsibilities may require more non-billable hours, to maintain their skills and deal with other issues.

The ECM assumes that supervisors have the same rate of non-billable hours as DSWs.

As Table 7 illustrates, utilisation costs together with the costs discussed above increase the costs of employing a permanent Standard DSW on a weekday by 62.5% over the base salary rate. The impact is higher (71.4%) for a Level 2 (Very high Intensity) DSW.

Table 7: Impact of Utilisation on the Cost per Billable Hour of a DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, before utilisation adjustment	**$41.28**	**$43.19**	**$44.70**
Utilisation rates			
Breaks	4.17%	4.17%	4.17%
Training	3.29%	6.58%	7.89%
Other	0.54%	0.25%	0.24%
Total Utilisation (%)	92.0%	89.0%	87.7%
Cost of utilisation ($)	$3.59	$5.34	$6.27
Cumulative cost per hour, after utilisation	**$44.87**	**$48.53**	**$50.97**
Cumulative increase from permanent standard hourly rate	62.5%	69.5%	71.4%

Note: Columns may not sum due to rounding.

2.9 Overheads

The ECM assumes that corporate overheads are 10.5% of direct costs (all those above).

As Table 8 illustrates, overhead costs together with the costs discussed above increase the costs of employing a permanent Standard DSW on a weekday by 79.6% over the base salary rate. The impact is higher (89.2%) for a Level 2 (Very high Intensity) DSW.

Table 8: Impact of Overheads on the Cost per Billable Hour of a DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, before overheads	**$44.87**	**$48.53**	**$50.97**
Overhead			
Overheads as a share of direct costs (%)	10.5%	10.5%	10.5%
Cost of overheads ($)	$4.71	$5.09	$5.35
Cumulative cost per hour, after overheads	**$49.58**	**$53.62**	**$56.32**
Cumulative increase from permanent standard hourly rate	79.6%	87.3%	89.2%

Note: Columns may not sum due to rounding.

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2.10 Margins

The ECM currently assumes a 2% margin on other costs. This equates to a rate of return of 8% against working capital equivalent to three month's wages and entitlements.

As Table 9 illustrates, margin costs together with the costs discussed above increase the costs of employing a permanent Standard DSW on a weekday by 83.2% over the base salary rate. The impact is higher (93.2%) for a Level 2 (Very high Intensity) DSW.

Table 9: Impact of Margins on the Cost per Billable Hour of a DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, before margin	**$49.58**	**$53.62**	**$56.32**
Margin			
Margin as a share of other costs (%)	2.0%	2.0%	2.0%
Cost of margin ($)	$0.99	$1.07	$1.13
Cumulative cost per hour, after margin	**$50.57**	**$54.69**	**$57.45**
Cumulative increase from permanent standard hourly rate	83.2%	91.0%	93.2%

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3 Pricing Model

In order to set price limits for 2019-20, the NDIA indexed the results of the Efficient Cost Model for costs on 30 June 2019 for the expected results of wage inflation over 2019-20.

The assumptions underpinning this indexation are set out in Table 10.

Table 10: Indexation arrangements

Component	Value
Labour costs	
Fair Work Commission Increase to Minimum Wage (1 July 2019)	3.0%
Equal Remuneration Order (1 December 2019)	2.2%
Total expected increase to labour costs	**5.3%**
Capital costs	
CPI	1.3%
Labour Share of costs	**80%**
Total indexation (weighted average)	**4.5%**

Table 11 shows the ECM results for the cost of supports by each DSW level and shift, and the indexed price limits for 2019-20 (without the Temporary Transformation Payment).

Table 11: Indexed Price Limits

Shift	DSW Level	Efficient Cost 2018-19	Indexed Base Price Limit 2019-20
Weekday	Level 1	$50.57	$52.85
Saturday	Level 1	$69.56	$72.69
Sunday	Level 1	$90.45	$94.52
Public Holiday	Level 1	$113.24	$118.34
Afternoon Shift	Level 1	$55.80	$58.31
Night Shift	Level 1	$56.84	$59.40
Weekday	Level 2	$54.69	$57.15
Saturday	Level 2	$75.24	$78.63
Sunday	Level 2	$97.83	$102.24
Public Holiday	Level 2	$122.46	$127.97
Afternoon Shift	Level 2	$60.34	$63.06
Night Shift	Level 2	$61.47	$64.24
Weekday	Level 3	$57.45	$60.04
Saturday	Level 3	$79.02	$82.58
Sunday	Level 3	$102.75	$107.37
Public Holiday	Level 3	$128.63	$134.42
Afternoon Shift	Level 3	$63.38	$66.23
Night Shift	Level 3	$64.56	$67.47

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Matter for Decision

Price Limits for Disability-Related Health Supports from 1 October 2019

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 For the Pricing Reference Grttpoup (PRG) to agree to the pricing arrangements for Disability-Related Health Supports, as the NDIS is to assume responsibility for these supports from 1 October 2019, following a decision of Council of Australian Governments' Disability Reform Council (DRC) on 28 June 2019.

2. Recommendations

2.1 That PRG **AGREE TO RECOMMEND TO THE BOARD** the price limits set out in Attachment A for the Disability-Related Health Supports that the National Disability Insurance Scheme (NDIS) will become responsible for from 1 October 2019.

3. Background

3.1 On 28 June 2019, the DRC agreed that, from 1 October 2019, the NDIS will fund a range of disability-related health supports where they are part of the participant's daily life and result directly from the participant's disability.

3.2 The current health conditions these supports intend to assist include the below, noting this list is not exhaustive:

(a) Dysphagia: for participants who have trouble eating, drinking or swallowing on a daily basis

(b) Respiratory: for participants requiring help with their breathing

(c) Nutrition: for participants requiring help with the way they eat or understanding the food they need

(d) Diabetes: for participants who have daily problems with how much sugar is in their blood

(e) Continence: for participants who need daily assistance with toileting

(f) Wound & Pressure Care: for participants who need daily wound and pressure care (resulting from pressure wounds or swollen limbs)

(g) Podiatry & Foot Care: for participants who require help looking after their feet and the way they walk

(h) Epilepsy: for participants who need daily help managing the way epilepsy affects the way their brain and nerves work

(i) Botox & Splinting: for participants requiring short-term relief from muscle spasticity

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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4. Discussion

4.1 Five types of disability related health supports have been identified:

(a) Provision of Disability Related Health Supports by Disability Support Workers (DSWs);

(b) Assessment, planning and the provision of Disability Related Health Supports by therapists;

(c) Assessment, planning and the provision of Disability Related Health Supports by nurses;

(d) Consumables related to Disability Related Health Supports; and

(e) Assistive Technology related to Disability Related Health Supports:

Disability-Related Health Supports Provision by Disability Support Workers

4.2 These supports can be delivered through the current High Intensity Registration Group Attendant care items (including the TTP items) in the Daily Activities core support category. Indeed, some of these supports are already delivered within the Scheme by these support items. There is no evidence that the DSWs who deliver these types of supports are paid under different arrangements to the DSWs who deliver other NDIS supports.

4.3 There are already three different price limits for DSWs in the High Intensity Registration Group Attendant care items (Standard, High intensity and Very High Intensify), which will ensure that DSWs with the appropriate skills and experience will be able to be employed to deliver these Disability Related Health Supports.

Disability-Related Health Assessment, Planning and Provision Supports by therapists

4.4 These supports already exist in the current Support Catalogue and their price limits already take into account the prices paid for these types of services in the health sector.

Disability-Related Health Nursing Supports

4.5 Thirty new support items have been developed in the registration group for Community Nursing Care for:

(a) five classifications of nurses: Enrolled Nurse (EN); Registered Nurse (RN); Clinical Nurse (CN); Clinical Nurse Consultant (CNC) – Clinical Nurse Consultants are called Advanced Practice Nurses in some jurisdictions; and Nurse Practitioner (NP); and

(b) six times of day and week: Weekday, Afternoon, Night, Saturday, Sunday and Public Holiday.

4.6 In line with the findings of the Review of Pricing Arrangements in Therapy Services, the NDIS will be a price taker rather than a price setter in the market for nurses, as it will account for only a small fraction of the total nursing effort in Australia.

4.7 The proposed price limits for the five classification of nurses have therefore been modelled based on the wages at the upper end of each rank of nursing paid under the major health sector enterprise bargaining agreements across Australia.

4.8 This conservative approach has been taken because, like therapy, there is a well-functioning market for nurses and Disability Related Health Supports are materially different to core supports. If a participant does not receive necessary medication or respiratory assistance, for example, they may die.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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4.9 There is variation between State EBAs but not sufficient variation to warrant different price limits, especially given the tight timeframe for implementation

4.10 The following Table sets out the other assumptions that were made in the cost model of the delivery of nursing supports.

Table 12: Efficient cost model parameters

	EN	RN	CN	CNC	NP
Worker					
Wage (per hour)	$36.42	$45.75	$52.48	$63.83	$67.16
Working Days in Year	220				
Shift Loadings	In line with the Nurses Award 2010				
Permanent share	80%				
Casual Loadings	In line with the Nurses Award 2010				
Utilisation	80.04%	80.04%	80.04%	80.04%	80.04%
Manager					
Classification	RN	CN	CNC	CNC	CNC
Working Days in Year	220				
Shift Loadings	In line with the Nurses Award 2010				
Utilisation	80.4%	80.4%	80.4%	80.4%	80.4%
Management ratio	1:7	1:7	1:7	1:7	1:7
Salary on costs					
Allowances	0.56%	0.44%	0.39%	0.32%	0.30%
Superannuation	9.5%	9.5%	9.5%	9.5%	9.5%
Workers compensation	3.0%	3.0%	3.0%	3.0%	3.0%
Payroll Tax	0.0%	0.0%	0.0%	0.0%	0.0%
Overheads (% of salary and salary on costs)	20.0%	20.0%	20.0%	20.0%	20.0%
Pre-tax margin (% of other costs)	2.0%	2.0%	2.0%	2.0%	2.0%

4.11 The proposed price limits for nursing supports that are generated by these assumptions range from $86.62 per hour for the delivery of Disability Related Health Supports by an Enrolled Nurse on a weekday daytime to $284.61 per hour for the delivery of Disability Related Health Supports by a Nurse Practitioner on a public holiday. The following Table details all of the proposed price limits.

Proposed Nursing Price Limits, by level and shift, from 1 October 2019

Level*	Weekday	Saturday	Sunday	Public Holiday	Afternoon	Night
Enrolled Nurse (EN)	$86.62	$123.57	$142.05	$160.52	$95.55	$97.33
Registered Nurse (RN)	$107.25	$153.05	$175.95	$198.85	$118.31	$120.51
Clinical Nurse (CN)	$124.05	$177.03	$203.53	$230.02	$136.84	$139.40
Clinical Nurse Consultant (CNC)	$146.72	$209.47	$240.84	$272.21	$161.86	$164.88
Nurse Practitioner (NP)	$153.39	$219.00	$251.81	$284.61	$169.21	$172.37

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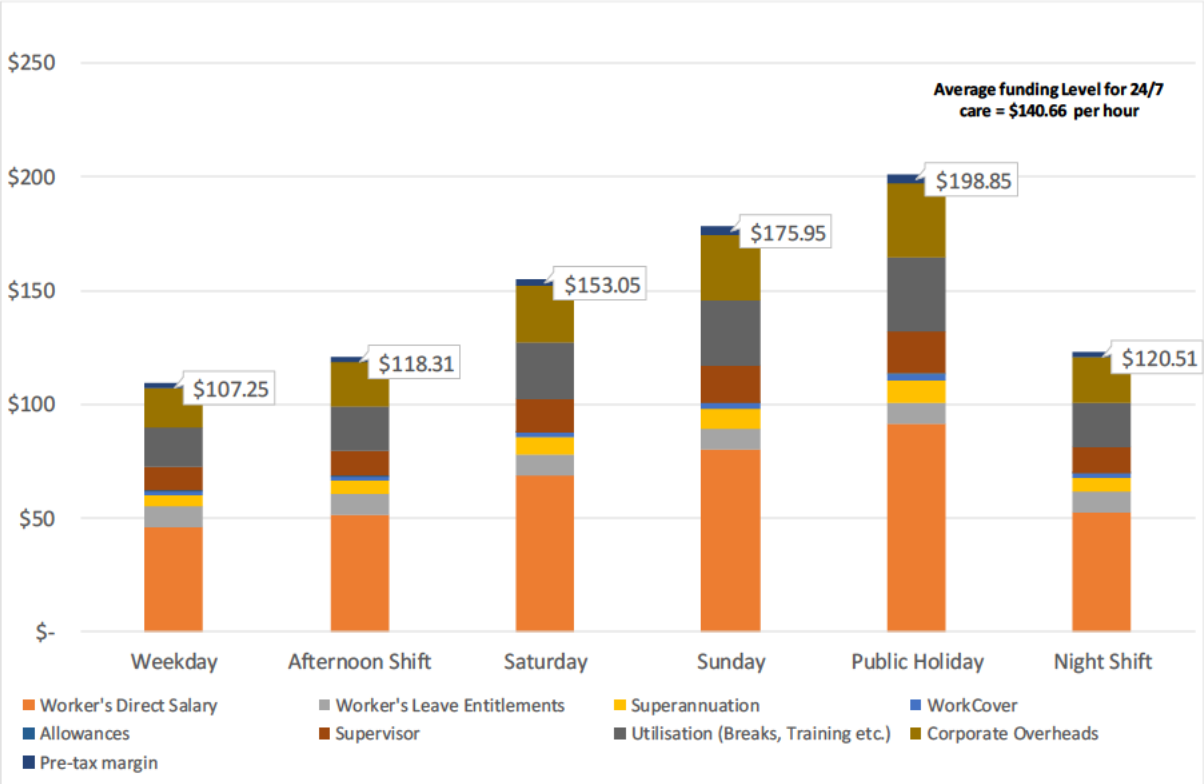
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4.12 While nurses' direct pay is the largest individual component of the price limits, the majority of costs are accounted for by other factors (Figure 1).

Figure 1: Components of Registered Nursing Price Limits



4.13 It is also proposed to align the price limit for the existing support item - Community Nursing Care for Continence Aid support –to the Weekday Daytime price limit for the new Clinical Nurse support item – an increase from $99.83 to $124.05.

4.14 This increase reflects feedback from the sector that the current price limit is too low for this support, with some providers withdrawing from the market.

Disability-Related Health Consumable Supports

4.15 Two support items have been developed for Disability Related Health Support Consumables – such as wound dressings – in the registration group for Assistive Products for Personal Care and Safety:

(a) A support item for high cost consumables where the price is not set in a well-developed market. It is proposed that the price of each of these consumables should be determined by quotation when each participant's plan is built; and

(b) A support item for low cost consumables where the price is set in a well-developed market. It is proposed that this support item should not be subject to price control.

4.16 Two other support items will allow providers to claim for the delivery of equipment and consumables and for the set up and training of disability-related health equipment and consumables. It is not proposed that these items be subject to price controls as they are minor, highly variable and delivered in a competitive environment.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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Disability-Related Health Assistive Technology Supports

4.17 Ten new support items have been created in the Assistive Products for Personal Care and Safety registration group for Disability-Related Health Assistive Technology Supports that are not currently covered under the NDIS.

4.18 These are for:

(a) Machines to assist with disability-related respiratory problems.

- Includes respirators, aspirators and supplementary items.
- This includes a rental item, to allow for trialling machines or potential leasing of machines.

(b) Air-filled garments and compression units to manage circulation problems, and

(c) Repairs and maintenance for disability-related health machines.

4.19 Six of these items are high cost and it is proposed that the price of each of these items should be determined by quotation when each participant's plan is built;

(a) Respirators - Invasive Ventilation For Continuous Use

(b) Respirators - Supplemental Ventilation Support (Including CPAP and BPAP)

(c) Aspirators

(d) Cough Assist Machine

(e) Air-Filled Garments And Compression Units For Managing Circulation Problems

4.20 It is not proposed that the other four items be subject to price controls as they are minor, highly variable and delivered in a competitive environment.

(a) Repairs And Maintenance - Disability-Related Health Machines

(b) Powered Respirator Rental

(c) Filters And/Or Humidifiers For Respirators

(d) Replacement Garments And Compression Sleeves For Cyclic Pressure Units

5. Implementation and communication

5.1 An agency-wide communication plan has been developed for the implementation of disability-related health supports.

5.2 The new and changes to existing support items will be communicated as part of the NDIS Price Guide and NDIS Support Catalogue, to be effective from 1 October 2019.

Interim Arrangements for Disability-Related Health Nursing Supports within Core

5.3 As the decision for NDIS implementation of disability-related health supports was made on 28 June 2019 for 1 October 2019 implementation, the NDIA determined that this timeframe was insufficient to have all existing participants reviewed for any additional reasonable necessary needs.

5.4 As such, from an implementation perspective, the Pricing team following discussions with relevant areas in the Agency, proposes to replicate certain capacity building supports for

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

assessments and planning (delivered by therapists, dieticians and early childhood intervention providers) and the new nursing items described above within the Core support category of *Assistance with Daily Living*.

5.5 This will allow for immediate claiming from 1 October 2019 for a smoother transition of existing participants, without the requirement for an immediate plan review, as participants will be able to utilise unspent core funding until reviews can be arranged.

5.6 The intention is for these replicated items to remain in Core for a 12-month period that will allow for adequate time for affected plans to be reviewed to include such supports where reasonable and necessary within the Capacity Building budgets.

6. Sensitivities

6.1 The Agency is still in discussions with Commonwealth, State and Territory Governments around the arrangements for disability-related health supports, and the separation from the Health system. This may affect the range of supports funded and claimable from the NDIS post 1 October 2019. OSA has costed the impact of disability-related health supports [amount to be advised].

Attachment

A *Proposed disability-related health supports for 1 October 2019*

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Support Item Code	Support Item Name	Support Category	Unit of Measure	National Price Limit (if applicable)	Quote Required?	Registration Groups
03_040000111_0103_1_1	High Cost Disability-Related Health Consumables	Consumables	EA	N/A	Yes	Assistive Products for Personal Care and Safety
03_040000919_0103_1_1	Low Cost Disability-Related Health Consumables	Consumables	EA	N/A	No	Assistive Products for Personal Care and Safety
03_710400001_0103_1_1	Disability-Related Health Equipment and Consumables Delivery	Consumables	EA	N/A	No	Assistive Products for Personal Care and Safety
03_710400002_0103_1_1	Disability-Related Health Equipment and Consumables - Set Up/Training	Consumables	EA	N/A	No	Assistive Products for Personal Care and Safety
05_040300159_0103_1_1	Repairs And Maintenance - Disability-Related Health Machines	Assistive Technology	EA	N/A	No	Assistive Products for Personal Care and Safety
05_040312111_0103_1_1	Respirators - Invasive Ventilation For Continuous Use	Assistive Technology	EA	N/A	Yes	Assistive Products for Personal Care and Safety
05_040312112_0103_1_1	Powered Respirator Rental	Assistive Technology	WK	N/A	No	Assistive Products for Personal Care and Safety
05_040312211_0103_1_1	Respirators - Supplemental Ventilation Support (Including CPAP and BPAP)	Assistive Technology	EA	N/A	Yes	Assistive Products for Personal Care and Safety
05_040313111_0103_1_1	Filters And/Or Humidifiers For Respirators	Assistive Technology	EA	N/A	No	Assistive Products for Personal Care and Safety
05_040321111_0103_1_1	Aspirators	Assistive Technology	EA	N/A	Yes	Assistive Products for Personal Care and Safety
05_040322111_0103_1_1	Cough Assist Machine	Assistive Technology	EA	N/A	Yes	Assistive Products for Personal Care and Safety
05_040609111_0103_1_1	Air-Filled Garments And Compression Units For Managing Circulation Problems	Assistive Technology	EA	N/A	Yes	Assistive Products for Personal Care and Safety
05_040609171_0103_1_1	Replacement Garments And Compression Sleeves For Cyclic Pressure Units	Assistive Technology	EA	N/A	No	Assistive Products for Personal Care and Safety
15_400_0114_1_3	Delivery Of Health Supports By An Enrolled Nurse - Weekday Daytime	Improved Daily Living Skills	H	$86.62	No	Community Nursing Care
15_401_0114_1_3	Delivery Of Health Supports By An Enrolled Nurse - Weekday Afternoon	Improved Daily Living Skills	H	$95.55	No	Community Nursing Care
15_402_0114_1_3	Delivery Of Health Supports By An Enrolled Nurse - Saturday	Improved Daily Living Skills	H	$123.57	No	Community Nursing Care
15_403_0114_1_3	Delivery Of Health Supports By An Enrolled Nurse - Sunday	Improved Daily Living Skills	H	$142.05	No	Community Nursing Care

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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Support Item Code	Support Item Name	Support Category	Unit of Measure	National Price Limit (if applicable)	Quote Required?	Registration Groups
15_404_0114_1_3	Delivery Of Health Supports By An Enrolled Nurse - Public Holiday	Improved Daily Living Skills	H	$160.52	No	Community Nursing Care
15_405_0114_1_3	Delivery Of Health Supports By An Enrolled Nurse - Active Overnight	Improved Daily Living Skills	H	$97.33	No	Community Nursing Care
15_406_0114_1_3	Delivery Of Health Supports By A Registered Nurse - Weekday Daytime	Improved Daily Living Skills	H	$107.25	No	Community Nursing Care
15_407_0114_1_3	Delivery Of Health Supports By A Registered Nurse - Weekday Afternoon	Improved Daily Living Skills	H	$118.31	No	Community Nursing Care
15_408_0114_1_3	Delivery Of Health Supports By A Registered Nurse - Saturday	Improved Daily Living Skills	H	$153.05	No	Community Nursing Care
15_409_0114_1_3	Delivery Of Health Supports By A Registered Nurse - Sunday	Improved Daily Living Skills	H	$175.95	No	Community Nursing Care
15_410_0114_1_3	Delivery Of Health Supports By A Registered Nurse - Public Holiday	Improved Daily Living Skills	H	$198.85	No	Community Nursing Care
15_411_0114_1_3	Delivery Of Health Supports By A Registered Nurse - Active Overnight	Improved Daily Living Skills	H	$120.51	No	Community Nursing Care
15_412_0114_1_3	Delivery Of Health Supports By A Clinical Nurse - Weekday Daytime	Improved Daily Living Skills	H	$124.05	No	Community Nursing Care
15_413_0114_1_3	Delivery Of Health Supports By A Clinical Nurse - Weekday Afternoon	Improved Daily Living Skills	H	$136.84	No	Community Nursing Care
15_414_0114_1_3	Delivery Of Health Supports By A Clinical Nurse - Saturday	Improved Daily Living Skills	H	$177.03	No	Community Nursing Care
15_415_0114_1_3	Delivery Of Health Supports By A Clinical Nurse - Sunday	Improved Daily Living Skills	H	$203.53	No	Community Nursing Care
15_416_0114_1_3	Delivery Of Health Supports By A Clinical Nurse - Public Holiday	Improved Daily Living Skills	H	$230.02	No	Community Nursing Care
15_417_0114_1_3	Delivery Of Health Supports By A Clinical Nurse - Active Overnight	Improved Daily Living Skills	H	$139.40	No	Community Nursing Care
15_418_0114_1_3	Delivery Of Health Supports By A Clinical Nurse Consultant - Weekday Daytime	Improved Daily Living Skills	H	$146.72	No	Community Nursing Care
15_419_0114_1_3	Delivery Of Health Supports By A Clinical Nurse Consultant - Weekday Afternoon	Improved Daily Living Skills	H	$161.86	No	Community Nursing Care
15_420_0114_1_3	Delivery Of Health Supports By A Clinical Nurse Consultant - Saturday	Improved Daily Living Skills	H	$209.47	No	Community Nursing Care

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Support Item Code	Support Item Name	Support Category	Unit of Measure	National Price Limit (if applicable)	Quote Required?	Registration Groups
15_421_0114_1_3	Delivery Of Health Supports By A Clinical Nurse Consultant - Sunday	Improved Daily Living Skills	H	$240.84	No	Community Nursing Care
15_422_0114_1_3	Delivery Of Health Supports By A Clinical Nurse Consultant - Public Holiday	Improved Daily Living Skills	H	$272.21	No	Community Nursing Care
15_423_0114_1_3	Delivery Of Health Supports By A Clinical Nurse Consultant - Active Overnight	Improved Daily Living Skills	H	$164.88	No	Community Nursing Care
15_424_0114_1_3	Delivery Of Health Supports By A Nurse Practitioner - Weekday Daytime	Improved Daily Living Skills	H	$153.39	No	Community Nursing Care
15_425_0114_1_3	Delivery Of Health Supports By A Nurse Practitioner - Weekday Afternoon	Improved Daily Living Skills	H	$169.21	No	Community Nursing Care
15_426_0114_1_3	Delivery Of Health Supports By A Nurse Practitioner - Saturday	Improved Daily Living Skills	H	$219.00	No	Community Nursing Care
15_427_0114_1_3	Delivery Of Health Supports By A Nurse Practitioner - Sunday	Improved Daily Living Skills	H	$251.81	No	Community Nursing Care
15_428_0114_1_3	Delivery Of Health Supports By A Nurse Practitioner - Public Holiday	Improved Daily Living Skills	H	$284.61	No	Community Nursing Care
15_429_0114_1_3	Delivery Of Health Supports By A Nurse Practitioner - Active Overnight	Improved Daily Living Skills	H	$172.37	No	Community Nursing Care
15_051_0114_1_3	Community Nursing Care For Continence Aid	Improved Daily Living Skills	H	$124.05	No	Community Nursing Care

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

DOCUMENT 16

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Matter for Endorsement

Implications of SCHADS Award Review for 1 December 2019

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 For PRG to **ENDORSE** the proposed increases (from 1 December 2019) in price limits for some supports to accommodate announced increases by the Fair Work Commission (FWC) in casual loadings on weekends in the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award) (Decision FWCFB 6067).

2. Recommendations

2.1 THAT PRG **AGREE TO RECOMMEND TO THE BOARD** that the price limits for Saturday and Sunday supports should be increased by 1.1% and 0.8% respectively from 1 December 2019 in recognition of the impact of FWCFB 6067 on the cost of delivering services.

2.2 THAT PRG also **AGREE TO RECOMMEND TO THE BOARD** that existing plans should not be increased as a result of this change in price limits, but that plan utilisation rates should be monitored to ensure that participants with high levels of usage of weekend supports are not disadvantaged.

2.3 THAT PRG further **AGREE TO RECOMMEND TO THE BOARD** that service bookings should not be amended as a result of this change in price limits, as they reflect the agreements between providers and participants and should only be changed with the express agreement of both parties.

3. Background

3.1 The Efficient Cost Model, which the NDIA uses to set Price limits principally for assistance with daily care, and assistance with social and community engagement, is driven in part by the shift loadings and minimum pay rates in the SCHADS Award. The SCHADS Award grants casual workers a 25% loading, to compensate them for not receiving annual and personal leave. However, there is currently a specific exemption for weekends.

Table 1: SCHADS Shift Loadings – as paid currently

Shift	Permanent Loading	Casual Loading	Difference
Weekday	0.0%	25.0%	25.0%
Saturday	50.0%	50.0%	0.0%
Sunday	100.0%	100.0%	0.0%
Public Holiday	150.0%	175.0%	25.0%
Afternoon Shift	12.5%	37.5%	25.0%

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MR25/01967 FOI 24/25-2242

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Shift	Permanent Loading	Casual Loading	Difference
Night Shift	15.0%	40.0%	25.0%

3.2 The Fair Work Commission (FWC) has made a draft Decision [2019] (FWCFB 6067) that will increase casual loadings for workers employed under the SCHADS Award in two tranches. The first will take place on 1 December 2019; the second will take place from 1 July 2020. From 1 July 2020, casual workers under the SCHADS Award will also receive a 25% additional loading on weekends. The first tranche, in December, will provide a 10% increase. See Table 2.

Table 2: Changes from FWC Decision on SCHADS Shift Loadings - 1 July 2020

Shift	Casual Loading 1/7/2019	Casual Loading 1/12/2019	Casual Loading 1/7/2020
Saturday	50.0%	60.0%	75.0%
Sunday	100.0%	110.0%	125.0%

4. Implications for prices

4.1 The Efficient Cost Model assumes that 80% of Disability Support Workers are casual. A change in the casual loading therefore has an implication for the efficient cost – which flows onto a change in the NDIS Base Price Limit and the NDIS TTP Price Limit for Saturdays and Sundays.

4.2 Table 3 and Table 4 below indicates current Agency price limits for affected shifts, and the impact of applying the new loadings to those limits. The 10% increase in casual loadings translates to a 1.1% increase in the price limit on Saturdays and a 0.8% increase on Sundays.

Table 3: Proposed Base Price limits - 1 Dec 2019 to 30 June 2020

Shift	Level	Current	From 1-Dec	Increase ($)	Increase (%)
Saturday	Level 1	$72.69	$73.49	$0.80	1.1%
Sunday	Level 1	$94.52	$95.32	$0.80	0.8%
Saturday	Level 2	$78.63	$79.48	$0.85	1.1%
Sunday	Level 2	$102.24	$103.09	$0.85	0.8%
Saturday	Level 3	$82.58	$83.48	$0.90	1.1%
Sunday	Level 3	$107.38	$108.27	$0.89	0.8%

Table 4: Proposed TTP Price limits - 1 Dec 2019 to 30 June 2020

Shift	Level	Current	From 1-Dec	Increase ($)	Increase (%)
Saturday	Level 1	$78.14	$79.00	$0.86	1.1%
Sunday	Level 1	$101.61	$102.47	$0.86	0.8%
Saturday	Level 2	$84.08	$84.99	$0.91	1.1%
Sunday	Level 2	$109.33	$110.24	$0.91	0.8%
Saturday	Level 3	$88.03	$88.99	$0.96	1.1%
Sunday	Level 3	$114.47	$115.42	$0.95	0.8%

4.3 The Group based community and centre based price limits will also increase as they are derived formulaically from these rates.

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DISCLOSURE LOG

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4.4 The full effect from 1 July 2020 translates to a 2.7% increase on Saturdays, and a 2.1% increase on Sundays. This effect will be considered into the 2020-21 Annual Review of Price Controls.

4.5 [Insert OSA costing when available]

5. Sensitivities

5.1 The current Efficient Cost Model assumes an 80/20 permanent/casual split on all shifts. This may not be true for Saturday and Sunday shifts. It may also not be true for some providers who have relatively more casual workers. This means that some providers may face higher cost increases than the proposed increases in the price limits. This issue will be considered further in the 2020-21 Annual Review of Price Controls.

6. Implementation Issues

6.1 It is proposed that existing plan budgets, and the Typical Support Packages that guide the making of new plans, should not be increased in response to this increase in price limits. The impact on most participants is very small because supports are not often delivered on the weekend and the impact on the price limits of weekend supports is itself very small. In many cases, participants also have some choice as to when they receive their supports and so can manage the impact of this increase to an extent.

6.2 It is proposed that plan utilisation rates should instead be actively monitored with proactive intervention in cases where participants are consuming their plans at a greater rate than expected. This is in line with the approach taken with the changes being made with respect to Disability Related Health Supports and the Temporary Transformation Payment.

6.3 It is also proposed that service bookings should not be amended as a result of this change in price limits, as they reflect the agreements between providers and participants and should only be changed with the express agreement of both parties.

6.4 Once agreed by the Board, the proposed increases in price limits will be communicated to providers and then implemented for effect on 1 December 2019.

6.5 As noted above, the second tranche of increases in loadings will be considered a part of the 2020-21 Annual Review of Price Controls.

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Pricing Reference Group

Minutes of the 16 October 2019 Meeting

Members present

- Liz [redacted] (Chair, A/g Head of MPSD)
- Deb [redacted] (proxy for Scott [redacted])
- Jim [redacted] PSM, Independent Member
- David Cullen
- Graeme [redacted] AM, Independent Member
- Sarah [redacted]
- Victor [redacted]
- Melissa [redacted]

Apologies

- Oliver [redacted]

Presenters

- Greg [redacted]

Secretariat

- Scott [redacted]

Item 1.2 – Conflicts of interest

1. The Pricing Reference Group (PRG) **NOTED** that Graeme [redacted] was:

   (a) a member of the Board of Life Without Barriers;

   (b) a member of the Board of the Summer Foundation;

   (c) a member of the Board of Joblife Employment;

   (d) a member of the Board of Attitude Foundation; and

   (e) s47F - personal privacy, s22(1)(a)(ii) - irrelevant material

Item 1.3 – Minutes of meeting of 19 September 2019

2. The PRG endorsed the minutes of the previous meeting (PRG-20190919 - Item 1.3).

Item 1.4 – Proposed meeting dates 2020

3. The PRG noted the 2020 proposed meeting dates (PRG-20190919 – Item 1.4).

Item 2.1 – Review of PRG Terms of Reference and Membership Update

4. The PRG discussed options to strengthen and clarify the role of the PRG through amendments to its Terms of Reference and membership.

Item 2.2 – Temporary Transformation Payment - Implementation

5. The PRG noted the key milestones and timings for the Temporary Transformation Payment (TTP) Benchmarking Survey.

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Item 2.3 – Short Term Accommodation Price Limits

6. The PRG noted that the National Disability Insurance Agency (NDIA) intends to change the name of "Short Term Accommodation and Assistance" (STA) to 'Short Term Accommodation and Assistance (Including Respite)' and that the names and descriptions of support items in the NDIS Price Guide and Support Catalogue will be amended accordingly.

7. The PRG agreed to recommend to the Board that in future, all price limits derived from a combination of components should have their price limits set based on the price limits of their component parts, rather than through indexation.

8. The PRG agreed to recommend to the Board that, as per Option D under paragraph 5.5 (PRG-20190919 – Item 2.3) that:

   (a) current STA price limits should be amended for the individual components of the support;

   (b) more appropriate and sustainable accommodation costs levels are used; and

   (c) consideration be given to introduction of a new set of STA support items based on standard (level 1) price limits in the NDIS Price Guide and Support Catalogue, with its usage for participants requiring less supervision and support whilst in the STA.

9. The PRG agreed to recommend to the Board that:

   (a) existing plans should not be automatically increased because of this change in price limits, because most participants only use STA on an occasional overnight basis. Plan utilisation is intended to be monitored, with plans reviewed if necessary, to ensure that participants with high levels of usage of STA supports are not disadvantaged; and

   (b) service bookings should not be amended because of this change in price limits, as they reflect the agreements between providers and participants and should only be changed with the express agreement of both parties.

Item 2.4 – Medium Term Accommodation Price Limits

10. The PRG agreed to recommend to the Board that a new support line item for Medium Term Accommodation (MTA) be included in the NDIS Price Guide and Support Catalogue from 1 December 2019. The intended usage is for longer periods when a participant requires transitional accommodation before moving into a more permanent setting (for example, at hospital discharge). The proposed MTA price limit will cover only the accommodation component of the care, with the participant responsible for their usual living costs and the NDIS supports delivered through existing support items.

11. The PRG noted that further work is required around the regulation of the fees that MTA providers may charge participants for their contribution to the costs of everyday living.

12. The PRG agreed to recommend to the Board that the current limit of 14 consecutive days of Short Term Accommodation (STA) should be extended to 28 days for child participants at risk of entering Voluntary Out Of Home Care (VOOHC).

Item 2.5 – Supported Employment Services

13. The PRG noted that:

   (a) 42 price controlled Supported Employment support items will be introduced to the NDIS Price Guide and Support Catalogue, effective from 1 March 2020; and

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(b) the new price control framework for Supported Employment is broadly in line with previously in principle agreement of the PRG on 14 March 2019 (PRG - 20190314 – Item 4.3). This is with the exception that there is only a single price control for each support ratio (rather than differentiating community and centres), and that higher support ratios (up to 1:7) will be introduced.

14. The PRG agreed that the billing arrangements for the new Supported Employment supports would allow claiming for cancellations, NDIA-reporting and non-face-to-face support time.

Item 2.6 – Coordinated Commissioning

15. The PRG noted that a cross-NDIA working group is being established to consider the use of coordinated commissioning for very limited cohorts of participants in thin market circumstances.

16. The PRG noted that the identification of thin markets, where coordinated commissioning might apply, would need to complement PRG's identification of market circumstances that warrant other actions (e.g. price controls).

17. The PRG noted that the working group would include 'quotable packages of supports' as part of its first set of projects, which addresses a NDIA Board direction flowing from the Independent Pricing Review (IPR).

Item 3.1 – Annual Review of Price Controls - Terms of Reference and Timeline

18. The PRG agreed to recommend to the Board the proposed Terms of Reference for the Annual Review of Price Controls 2020-21 (PRG-20190919 - Item 3.1-A) and draft timeline (PRG-20190919 - Item 3.1-B).

Item 4.1 – 1 October 2019 – Publication of Price Guide and Support Catalogue

19. The PRG discussed the publication of the NDIS Price Guide and Support Catalogue, effective from 1 October 2019.

Item 4.2 – NDIS Implementation of the Modified Monash Model (Geographical classification)

20. The PRG agreed that one additional locality – Merriden in WA – should be reclassified as a remote location in the NDIS Modified Monash Model (MMM) system: changing from a MMM category 5 (outer regional) to MMM category 6 (remote).

21. The PRG noted that:

(a) five additional locations have been identified within the isolated localities that have already been reclassified and that the NDIA's system will be updated to properly classify participants in these locations as remote; and

(b) a comprehensive review of the NDIS MMM system and status of all localities will be undertaken as a part of the Annual Review of Price Controls 2020-21.

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DISCLOSURE LOG

DOCUMENT 18

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Matter for Decision

NDIS Annual Review of Price Controls 2020-21

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 To seek the agreement of Pricing Reference Group (PRG) to the Terms of Reference and timeline for the National Disability Insurance Scheme (NDIS) Annual Review of Price Controls (ARPC).

2. Recommendation

2.1 That PRG **AGREE TO RECOMMEND TO THE BOARD** the proposed Terms of Reference for the Annual Review of Price Controls 2020-21 (Attachment A) and the draft timeline (Attachment B).

3. Background

3.1 As part of its market stewardship role, the National Disability Insurance Agency (NDIA) monitors and reviews price controls and other market settings to determine whether they are still appropriate.

4. Discussion – Scope of the Review

4.1 It is proposed that the Review has seven broad aims:

(a) Review the price control framework for core supports;

(b) Review the price control framework for capacity building supports, including therapy supports;

(c) Review the price control framework for plan management supports;

(d) Review the price control framework for Supported Independent Living (SIL);

(e) Review the geographic classification component of the NDIS pricing control framework; and

(f) Re-examine current billing arrangements.

5. Discussion – Conduct of the Review

5.1 It is proposed that the Review will commence in November 2019, pending endorsement of the PRG and Board agreement of the Terms of Reference and Issues Paper prior to release.

5.2 The intention is to deliver recommendations to the PRG in April 2020 to go to the Board in May 2020, for implementation from 1 July 2020.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

5.3 It is proposed that the Review be conducted through research and consultation with industry, community and government stakeholders, including through:

(a) The release of the Terms of Reference and timeframe for the Review together with an Issues Paper and call for submissions;

(b) Targeted consultations with industry, community and government stakeholders both directly with key providers and peak bodies and through national working groups;

(c) The development and release of a Draft Findings Paper with a further opportunity for comment, including through submissions and targeted consultations; and

(d) The analysis of the results of the Annual Temporary Transformation Payment Financial Benchmarking Study.

5.4 The following table sets out the timeframes for the key elements of the review.

November 2019	Release of Terms of Reference Release of Issues Paper and call for submissions
November 2019 to February 2020	Public Submissions Consultation with stakeholders Working Groups on Review Themes
February 2020	Release of draft findings and call for submissions Release of preliminary findings of the Annual Temporary Transformation Payment Financial Benchmarking Study
March 2020	Public submissions Consultation with industry representatives Working Groups on Review Themes
April 2020 – May 2020	Consideration of Recommendations by the Pricing Reference Group and NDIA Board
By 31 May 2020	Release of NDIS Price Guide and Support Catalogue (all support items and policy finalised)
June 2020	Release of final prices, immediately after the Fair Work Commission's Minimum Wage Decision
1 July 2020	Intended implementation of new arrangements

Attachments:

A *Terms of Reference for the NDIS Annual Review of Price Controls 2020-21*

B *Timeline for the NDIS Annual Review of Price Controls 2020-21*

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Annual Review of Price Controls 2020-21

Terms of Reference

Overview

1. The supply of disability goods and services in Australia is undergoing significant reform with the phased creation, commencing from 1 July 2013, of the National Disability Insurance Scheme (NDIS). The National Disability Insurance Agency (NDIA) has responsibility for administering the NDIS, including (together with the NDIS Quality and Safeguards Commission) regulating the markets for disability goods and services.

2. Where possible, the NDIA utilises market mechanisms to deliver the level of supply required to meet participant demand and deliver the required mix of goods/services, produced at market clearing (efficient) prices, to meet the needs of participants. However, in underdeveloped or non-existent markets, reliance on deregulated market mechanisms may not meet participant demands; may not deliver adequate supply; may not deliver the required mix of disability supports and may not produce efficient prices. To address these issues, the NDIA has a role, as market steward, to create an efficient and sustainable marketplace through a diverse and competitive range of suppliers who are able to meet the structural changes created by a consumer-driven market.

3. As part of its market stewardship role, the NDIA caps the prices that registered providers can charge for some supports and applies other price controls, including billing rules. During transition, price controls are in place to ensure that participants receive value for money in the supports that they receive. In the short to medium term, price controls are required for some disability supports because the markets for disability goods and services are not yet fully developed. The longer-term goal of the NDIA is to remove regulatory mechanisms from the markets for disability supports.

4. The NDIA continually monitors and reviews its price control framework and other market settings to determine whether they are still appropriate. The Annual Review of Price Controls is an important part of that monitoring and review.

Scope of the Review

5. The Review will examine, through research and consultation with industry, community and government stakeholders, whether the existing price control framework and other market settings under the NDIS continue to be appropriate or should be modified.

6. In particular, the Review will:

   (a) Review the price control framework for core supports, by examining:

      (i) the assumptions and parameters outlined in the *NDIS Cost Model for Disability Support Workers*, including through analysis of the financial benchmarking data collected through the Temporary Transformation Payment arrangements; and

      (ii) the methodology for deriving the price controls for group-based supports from the price controls for 1:1 supports;

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(b) Review the price control framework for capacity building supports, including therapy supports, by examining:

(i) how price limits for capacity building supports, other than therapy supports, should be indexed or otherwise determined annually;

(ii) how price limits for therapy supports should be adjusted annually, given the outcomes of the Review of Therapy Pricing Arrangements in the NDIS;

(iii) whether different price limits might be appropriate for different times the day, or days of the week, for some capacity building supports, including for therapy assistants and for capacity building supports delivered by disability support workers;

(iv) whether the price limits for nursing supports require adjustment; and

(v) options to allow therapists and other capacity building providers to recover the costs of consumables provided to participants as part of a support;

(c) Review the price control framework for plan management supports;

(d) Review the price control framework for Supported Independent Living (SIL), by examining:

(i) the extent to which the costs of delivering SIL differ from the costs of delivering other types of disability supports; and

(ii) whether and how vacancy management costs should be accounted for in the SIL price control framework;

(e) Review the geographic classification component of the NDIS pricing control framework to examine whether:

(i) modifications are required to the NDIA's implementation of the Modified Monash Model to account for specific disability service related costs, including the treatment of "isolated locations" and islands under the MMM; and

(ii) a loading should be applied to price limits and plan funding amounts in outer regional areas to account for the higher cost of service delivery, if any, in those areas;

(f) Re-examine current billing arrangements, including:

(i) Cancellation rules;

(ii) Provider travel time limits, including examining whether it is possible to develop an approach that is more sensitive to local conditions;

(iii) Non-labour costs associated with provider travel and participant transport; and

(iv) Establishment fee arrangements.

7. In framing its recommendations, the Review will be cognisant of the objects and principles of the NDIS, as set out in the *National Disability Insurance Scheme Act 2013*, including that the NDIS should:

(a) Support the independence and social and economic participation of people with disability;

(b) Enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports;

(c) Facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability;

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(d) Promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community;

(e) Adopt an insurance based approach, informed by actuarial analysis, to the provision and funding of supports for people with disability; and

(f) Be financially sustainable.

Process and timing

8. The Review will commence in November 2019 and deliver recommendations to the NDIA's Pricing Reference Group and Board in April/May 2020, for implementation from 1 July 2020.

Indicative Timeline

November 2019	Release of Terms of Reference Release of Issues Paper and call for submissions
November 2019 to February 2020	Public Submissions Consultation with stakeholders Working Groups on Review Themes
February 2020	Release of draft findings and call for submissions Release of preliminary findings of the Annual Temporary Transformation Payment Financial Benchmarking Study
March 2020	Public submissions Consultation with industry representatives Working Groups on Review Themes
April 2020 – May 2020	Consideration of Recommendations by the Pricing Reference Group and NDIA Board
By 31 May 2020	Release of NDIS Price Guide and Support Catalogue (all support items and policy finalised)
June 2020	Release of final prices, immediately after the Fair Work Commission's Minimum Wage Decision
1 July 2020	Intended implementation of new arrangements

Further information

9. Further information on the Review is found at WEBPAGEADDRESS.

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DISCLOSURE LOG

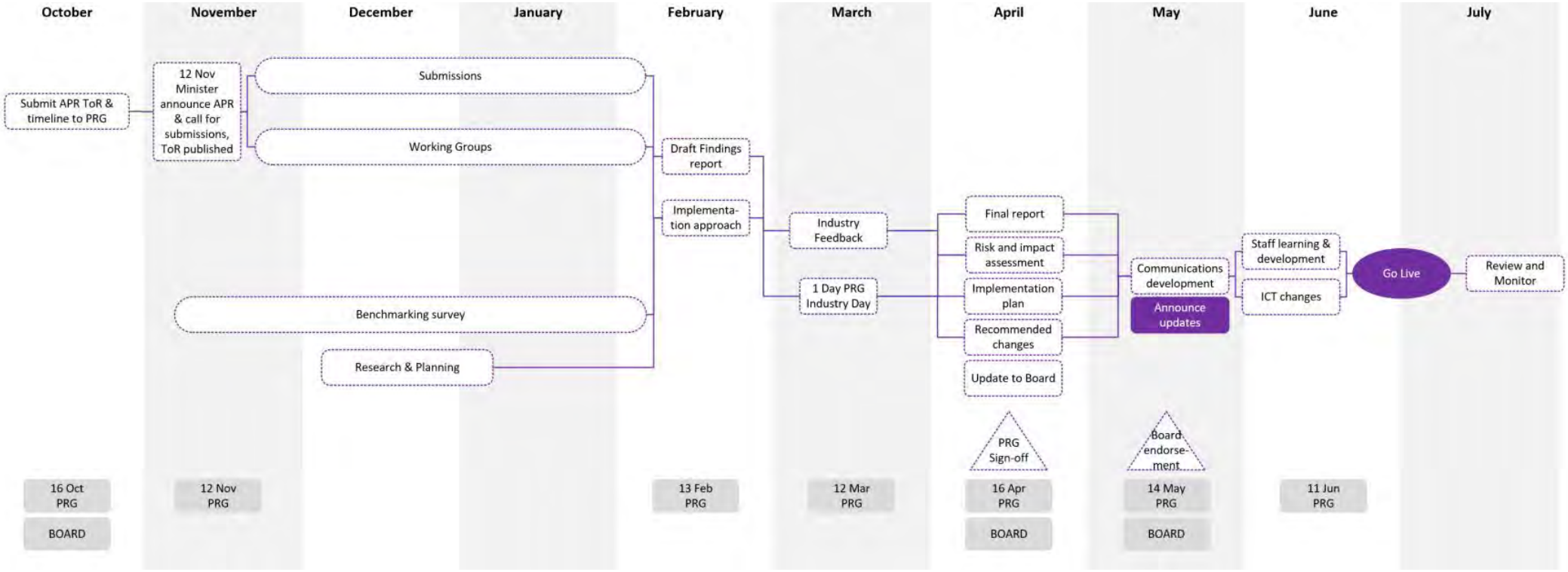
Runway for the Review

Date	Activity
November 2019	• Release Issues Paper and call for submissions
November 2019 to February 2020	• Public submissions • Consultation with providers (provider meetings in each state) • Consultation with participants (peak bodies) • Working groups on review themes (providers nominated by peak bodies) • Data collection and analysis for Financial Benchmarking study
February 2020	• **PRG and Board consideration of Draft Findings Report** • Release of draft findings and call for submissions
March 2020	• Second round of Public submissions • Second round of consultations with providers and participants • Release of preliminary findings of the Financial Benchmarking study • Development of Agency Implementation plan for Review outcomes • Establish Cross Agency Steering Group (MPSD, OSA, OCIO, PPEG, Finance)
April 2020	• **PRG and Board preliminary consideration of Review's Recommendations** • OSA Costings of Recommendations • Implementation (MPSD, OSA, OCIO, PPEG, Finance)
May 2020	• **PRG and Board final consideration of Review's Recommendations** • Implementation (MPSD, OSA, OCIO, PPEG, Finance)
By 31 May 2020	• Release of NDIS Price Guide and Support Catalogue (all items and policy finalised)
June 2020	• Release of final prices, after the Fair Work Commission's Minimum Wage Decision
1 July 2020	• **Implementation of new arrangements**

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DISCLOSURE LOG

Indicative Timeline for the 2020-21 NDIS Annual Review of Price Controls



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Activity Descriptions (in order of timeline)

Annual Review of Price Controls Terms of Reference (ToR) – High-level scope and terms for the Annual Review of Price Controls.

Publish Terms of Reference – Approved ToR will be published for public viewing on the NDIA website.

Submissions - A two-month public submission intake will be held throughout November to February 2020. A request for submissions will be uploaded to the NDIA website.

Working groups – from November 2019, approximately five working groups will be established to gather insights from stakeholder groups.

Benchmarking survey – Cost data will be collected from selected Providers on the costs of providing services.

Research and planning – Qualitative research, for example, analysis of Provider enquiries through the Provider Network. Planning activities, for example, recruiting labour hire for working groups.

Draft findings report – Draft findings report summarising the feedback from public submissions, working groups, and other research and analysis.

Implementation approach – A high-level implementation approach outlining the considerations for implementation based on the Findings report. This may include the identification of risks and issues.

Industry feedback – After the draft findings report has been published, Industry feedback will be sought during the month of March.

One day PRG Industry Day – Industry feedback will be presented to the PRG.

Update to Board – Upon request, an update can be provided on the key findings from submissions, working groups and other research and analysis.

Final Findings report – An updated findings report will be presented to PRG on the 16th April. Industry feedback on the Draft Findings report will be incorporated in to the report.

Recommended changes – The recommended changes to pricing rules will be presented to the PRG. This will include changes to the Support Catalogue and Price Guide.

Implementation plan – An implementation plan describing how the changes will be rolled out. This may include a high-level timeline and technical changes required to facilitate changes.

Risk and impact assessment – Identification of risks and impact of the proposed changes on stakeholders. This may include prioritisation and mitigation strategies.

Communications development – Communications will be developed based on the inputs to date. Communications material will cater for the needs identified in the impact assessment and implementation plan, and support staff Learning and Development.

Staff Learning & Development – Material will be created to support frontline staff post release. This may include Agency forums to assist in the development of materials.

Information and Communications Technology (ICT) changes – This will include technical changes to the Portal, upload of the revised Price Guide and Support Catalogue to the NDIA website and other technical changes required to implement changes and go live.

Review and Monitor – Updates will be reviewed from July onwards. Minor edits and clarifications may be required during this phase.

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Matter for decision

Annual Review of Price Controls

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 To seek the agreement of the Pricing Reference Group (PRG) to recommend to the Board the Annual Review of Price Controls Issues Paper as set out in Attachment 3.1-A.

2. Recommendations

2.1 That the PRG **AGREE TO RECOMMEND TO THE BOARD** to publish the Issues Paper as set out in Attachment 3.1-A.

3. Background

3.1 The National Disability Insurance Agency (NDIA/Agency) will undertake the 2020 Annual Review of Price Controls (the Review) to examine the current National Disability Insurance Scheme (NDIS) Price Guide. The Agency will seek consultation and feedback from providers and participants to assess whether the current price controls and market settings remain adequate for the disability sector.

3.2 The Review intends to examine, through research and consultation with industry, community and government stakeholders, the state of the markets for the delivery of disability goods and services.

3.3 The Review is also interested in revising a number of existing rules and co-designing potential new rules with consultation from the sector, as part of the Agency's market stewardship approach. The Review is therefore seeking evidence on, but not limited to:

(a) Cost Model for Disability Support Workers

(b) Group Supports

(c) Capacity Building Supports

(d) Plan Management Supports

(e) Supported Independent Living (SIL)

(f) Geographical Framework

(g) Provider Billing Arrangements (Including Cancellations, Provider Travel, Participant Transport and Establishment Fees)

(h) Price Guide and Support Catalogue

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4. Issues

4.1 Cost Model for Disability Support Workers (DSWs)

(a) The Agency recently released its DSW Cost Model. The model uses 'efficient costs' as its basis. These are generally the costs of the most efficient quartile of providers for each variable. However, the Temporary Transformation Payment (TTP) is designed to bring prices limits into line with the costs of a provider (with average cost efficiency) over a five year transitionary period.

(b) Most of these costs are derived from benchmarking surveys. However, as some these surveys were small and/or out-dated the Agency would like to examine the assumptions and parameters used in the DSW Cost Model to ensure their representation of organisations within the sector.

4.2 Group Supports

(a) The current NDIS price limits for group supports are based upon the DSW Cost Model, accounting for provision of additional administration time when delivering group based supports (for multiple participants). This is currently included in the non-utilisation time (also known as non-face-to-face time) that the provider spends with the participant in a group setting – as such, providers are not permitted to bill for non-face-to-face services as the hourly price limits include this.

(b) This is assumed to be approximately six (6) additional minutes per hour, per participant. This cost is apportioned across the number of participants within the group, before being included in the hourly price limit.

(c) Through the Review, the NDIA intends to more accurately capture non-face-to-face time required for group supports and allow clearer billing rules for providers.

4.3 Capacity building supports

(a) The Agency seeks to review the price control frameworks for capacity building supports, including therapy supports, by examining:

4.3.a.1. how price limits for therapy supports should be adjusted annually, given the outcomes of the Review of Therapy Pricing Arrangements in the NDIS;

4.3.a.2. how price limits for capacity building supports, other than therapy supports, should be indexed or otherwise determined annually;

4.3.a.3. whether different price limits might be appropriate for different times the day, or days of the week, for some capacity building supports, including for therapy assistants and for capacity building supports delivered by disability support workers;

4.3.a.4. whether the price limits for nursing supports require adjustment;

4.3.a.5. options to allow therapists and other capacity building providers to recover the costs of consumables provided to participants as part of a support; and

4.3.a.6. consideration of non-labour activity costs for capacity building supports.

4.4 Plan Management Supports

(a) The Agency intends to examine the appropriateness of the current price control framework for plan management supports in response to feedback received during the last Annual

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Review of Price Controls by examining the price limits and costs associated with the plan managers.

4.5 Supported Independent Living (SIL)

(a) The Agency is interested in examining the current arrangements for SIL, with this chapter intending to re-evaluate several components for SIL, including the price calculation element.

(b) As SIL is quotable, this means it is not price controlled, as it is based on the individual participant receiving the support. However, the NDIA intends to review the pricing framework that lies behind the SIL Tool and the costs involved with delivering such supports, to ensure ongoing adequacy of the tool being used for quotes.

(c) In addition to the above, the Review intends to examine the below two facets of SIL in more detail:

4.5.c.1. the extent to which the costs of delivering SIL differ from the costs of delivering other types of disability supports; and

4.5.c.2. whether and how vacancy management costs should be accounted for in the SIL price control framework;

4.6 Geographical Framework

(a) The Agency intends to review the geographic classification that sits behind the NDIS price control framework. Specifically, this is in relation to:

4.6.a.1. Possible modifications to the NDIA's implementation of the Modified Monash Model (MMM) to account for specific disability service related costs, including the treatment of "isolated locations" and islands under the MMM; and

4.6.a.2. Should a loading should be applied to price limits and funding amounts in outer regional areas to account for potentially higher costs of service delivery.

4.7 Provider Billing Arrangements (Including Cancellations, Provider Travel, Participant Transport and Establishment Fees)

(a) The Agency seeks to re-examine the current billing arrangements, including:

4.7.a.1. Cancellation rules;

4.7.a.2. Provider travel time limits, including examining whether it is possible to develop an approach that is more sensitive to local conditions;

4.7.a.3. Non-labour costs associated with provider travel; and

4.7.a.4. Establishment fee arrangements.

4.8 Price Guide and Support Catalogue

(a) The Agency endeavours to keep improving the presentation and clarity of these documents to become more user-friendly for the end user to navigate and understand the content.

Attachment(s):

A *2020 Annual Review of Price Controls Issues Paper*

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Matter for Decision

Additional Disability Personal Care and Support for Participants Living in Residential Aged Care Facilities

Prepared by: Deb Connock, Branch Manager, Scheme Policy & David Cullen, Chief Economist

1. Purpose

1.1 To seek the agreement of the Pricing Reference Group to the proposed price limits for National Disability Insurance Scheme (NDIS) support item(s) delivered as additional disability personal care and support (ADPCS) to NDIS participants living in Residential Aged Care Facilities (RACFs).

2. Recommendation

2.1 That the Pricing Reference Group **AGREE TO RECOMMEND TO THE NATIONAL DISABILITY INSURANCE AGENCY (NDIA) BOARD** that the price limits for the attendant care items listed in **Attachment A** when those items are delivered as ADPCS in RACFs should be the same as when the items are delivered in the community.

3. Background

3.1 NDIS participants living in RACFs are supported under both the *Aged Care Act 1997* (the Aged Care Act) and the *National Disability Insurance Scheme Act 2013* (the NDIS Act). As at 31 December 2019, there were 5,053 NDIS participants living in RACFs.

3.2 Consistent with the NDIS Act, NDIS participants in aged care are assessed by the NDIA for reasonable and necessary supports, which are stated in plans and provided to participants, additional to the services provided by aged care.

3.3 RACFs are funded by the Department of Health (DoH) under the Aged Care Act. For in-scope NDIS supports provided by a RACF to NDIS participants, the NDIA reimburses the DoH through a cross billing arrangement.

3.4 It is expected that RACFs provide appropriate 'personal care' supports to participants as per their responsibility under the Aged Care Act.

3.5 ADPCS, as referred to by the NDIA, is support generally referred to as 'personal care' by the Aged Care system but above the level required under the Aged Care Act. These supports are expected to be what is considered personal care under the NDIS ("Assistance with self-care activities").

3.6 There have been occasions where the NDIA has included additional funding for ADPCS in a participant's NDIS plan where the delegate has identified that the level of care provided by the RACF is insufficient to meet the participant's reasonable and necessary support needs.

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3.7 In these circumstances, supports have been decided on a case by case basis and funded using existing support category items. These services may be purchased from a provider other than the provider of residential aged care.

3.8 The Australian Government's Younger People in Residential Aged Care (YPIRAC) Action Plan committed the NDIA to develop a formal process to provide ADPCS to participants in a RACF. A Joint Agency Taskforce has been established to ensure the YPIRAC Action Plan goals are achieved, including the implementation of ADPCS.

3.9 The NDIA and Minister have received communication from individual participants and advocacy groups on the issue, seeking clarity, consistency and resolution.

3.10 The Royal Commission into Aged Care held witness hearings in September 2019 regarding young people living in aged care. Subsequently, the NDIA has been asked to respond to a query from the Royal Commission drawing comparison between levels of support provided to a participant living in the community, including those living in Specialist Disability Accommodation (SDA) and/or receiving Supported Independent Living (SIL) supports, and a participant living in a RACF.

3.11 In January 2020, the NDIA Policy Committee agreed to develop a formal operational process to fund ADPCS for participants in RACF, where the delegate determines it is reasonable and necessary. The NDIA has committed to make ADPCS available to participants by March 2020.

4. Discussion

4.1 The Pricing Reference Group is requested to determine the price regulation arrangements for ADPCS. The Agency proposes that the current price limits for the attendant care items in **Attachment A** are appropriate for services delivered as ADPCS to participants in RACFs.

4.2 The benefits of this approach are that ADPCS will leverage existing support line items, simplify and reduce administrative burden on providers across different sets of support line items for delivering a similar support.

4.3 New providers of ADPCS can register to deliver such support under the existing registration groups for Daily Personal Activities (0107) and High Intensity Daily Personal Activities (0104). In addition, existing providers registered in these categories will be immediately able to respond to demand for ADPCS. This will mean support is available to participants sooner, and the YPIRAC Action Plan commitments will be achieved within committed timeframes.

4.4 The costs of delivering ADPCS is seen as similar to that of "assistance with self-care activities", as these may be delivered by disability support workers. These costs are considered similar to those in the NDIS Cost Model for Disability Support Workers that determine relevant price limits.

4.5 There is a risk that the price limits for ADPCS will not be appropriate for the costs of delivering services into RACFs. However, this risk is not considered significant for providers and participants as it is most likely that the costs of delivering services into RACFs will not be higher than delivering services into people's own homes and may, because of economies of scale, be lower.

(a) The Office of the Scheme Actuary has provided advice that it is possible ADPCS may impose additional costs on the NDIS of up to $205 million per year. This estimate is considered to be a 'worst case' costing and is based on allowance of one hour per day of ADPCS for every participant living in RACF, and an additional 50% for support-related travel costs.

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DISCLOSURE LOG

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(b) Over the long-term, the number of participant plans with ADPCS will reduce, as the number of participants in aged care is reduced in line with the YPIRAC Action Plan. This financial impact is therefore likely to reduce over time, given the Government's focus that no younger people will be living in aged care by 2025.

4.6 Under the proposed approach, it will be difficult to track directly the volume and prices of the additional supports provided to participants in RACFs. However, this issue can be ameliorated through a number of workarounds.

4.7 In summary under the recommended approach participants will be able to access ADPCS more quickly, with greater choice and control than alternatives such as developing an entire new suite of supports. In addition, there is a lower market impact for existing providers of ADPCS and reduced implementation impact for the NDIA. Any attendant risk of market distortion with RACF is time limited and diminishing noting the action plan requires, apart from exceptional circumstances, NDIS participants to be exited from RACF by 2025.

4.8 NDIS participants will be supported in exiting RACF if they choose to. Further, as labour constitutes the majority of support costs, and wage rates under the Social, Community, Homecare and Disability Services (SCHADS) Industry Award are similar to those under the Aged Care Award any existing price differentials should not be substantial.

5. Sensitivities

5.1 ADPCS may lead to an increase of NDIS service providers attending RACFs. The NDIA will work closely with the Department of Health and the NDIS Quality and Safeguards Commission to ensure providers comply with their regulatory obligations and with facility access requirements of RACFs.

5.2 Implementing the recommended approach will ensure NDIS participants living in RACF are able to receive all reasonable and necessary supports within a residential aged care setting. It will also mitigate the risk that the NDIA may not be meeting its legislative compliance regarding assessment of reasonable and necessary supports for NDIS participants living in RACFs.

6. Implementation and communication

6.1 ADPCS is to be implemented by March 2020. An implementation plan has been developed which includes the following key activities:

(a) An impact assessment to monitor the effect of introducing ADPCS;

(b) development of an operational policy with associated guidelines and operating procedures to guide planners in the application of ADPCS; and

(c) a change and communication plan to ensure a smooth and efficient deployment of ADPCS for participants, planners, RACF and providers.

6.2 With respect to price regulation, the *NDIS Price Guide and Support Catalogue* will be amended to make it clear that the relevant supports can be delivered as ADCPS in residential aged care where appropriate.

Attachment(s):

A *Proposed support items (existing) for ADPCS*

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Attachment A – Proposed support items (existing) for ADPCS

Pricing Reference Group **20 February 2020** **Item 3.1**

Support Item Number	Support Item Name	Support Category Name	Unit	Quote Required	Registration Group Name	Price Limit
01_002_0107_1_1	Assistance With Self-Care Activities - Standard - Active Overnight	Assistance with daily life	H	N	Daily Personal Activities	$59.40
01_002_0107_1_1_T	Assistance With Self-Care Activities - Standard - Active Overnight - TTP	Assistance with daily life	H	N	Daily Personal Activities	$63.85
01_011_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Daytime	Assistance with daily life	H	N	Daily Personal Activities	$52.85
01_011_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Daytime - TTP	Assistance with daily life	H	N	Daily Personal Activities	$56.81
01_012_0107_1_1	Assistance With Self-Care Activities - Standard - Public Holiday	Assistance with daily life	H	N	Daily Personal Activities	$118.34
01_012_0107_1_1_T	Assistance With Self-Care Activities - Standard - Public Holiday - TTP	Assistance with daily life	H	N	Daily Personal Activities	$127.21
01_013_0107_1_1	Assistance With Self-Care Activities - Standard - Saturday	Assistance with daily life	H	N	Daily Personal Activities	$72.69
01_013_0107_1_1_T	Assistance With Self-Care Activities - Standard - Saturday - TTP	Assistance with daily life	H	N	Daily Personal Activities	$78.14
01_014_0107_1_1	Assistance With Self-Care Activities - Standard - Sunday	Assistance with daily life	H	N	Daily Personal Activities	$94.52
01_014_0107_1_1_T	Assistance With Self-Care Activities - Standard - Sunday - TTP	Assistance with daily life	H	N	Daily Personal Activities	$101.61
01_015_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Afternoon	Assistance with daily life	H	N	Daily Personal Activities	$58.31
01_015_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Afternoon - TTP	Assistance with daily life	H	N	Daily Personal Activities	$62.69
01_300_0104_1_1	Assistance With Self-Care Activities - Level 1 - Weekday Daytime	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$52.85
01_300_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Weekday Daytime - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$56.81
01_301_0104_1_1	Assistance With Self-Care Activities - Level 1 - Weekday Afternoon	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$58.31
01_301_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Weekday Afternoon - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$62.69
01_302_0104_1_1	Assistance With Self-Care Activities - Level 1 - Saturday	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$72.69
01_302_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Saturday - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$78.14
01_303_0104_1_1	Assistance With Self-Care Activities - Level 1 - Sunday	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$94.52
01_303_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Sunday - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$101.61
01_304_0104_1_1	Assistance With Self-Care Activities - Level 1 - Public Holiday	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$118.34
01_304_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Public Holiday - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$127.21
01_305_0104_1_1	Assistance With Self-Care Activities - Level 1 - Active Overnight	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$59.40
01_305_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Active Overnight - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$63.85
01_400_0104_1_1	Assistance With Self-Care Activities - Level 2 - Weekday Daytime	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$57.15

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Support Item Number	Support Item Name	Support Category Name	Unit	Quote Required	Registration Group Name	Price Limit
01_400_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Weekday Daytime - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$61.11
01_401_0104_1_1	Assistance With Self-Care Activities - Level 2 - Weekday Afternoon	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$63.06
01_401_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Weekday Afternoon - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$67.44
01_402_0104_1_1	Assistance With Self-Care Activities - Level 2 - Saturday	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$78.63
01_402_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Saturday - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$84.08
01_403_0104_1_1	Assistance With Self-Care Activities - Level 2 - Sunday	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$102.23
01_403_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Sunday - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$109.32
01_404_0104_1_1	Assistance With Self-Care Activities - Level 2 - Public Holiday	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$127.97
01_404_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Public Holiday - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$136.84
01_405_0104_1_1	Assistance With Self-Care Activities - Level 2 - Active Overnight	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$64.24
01_405_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Active Overnight - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$68.69
01_500_0104_1_1	Assistance With Self-Care Activities - Level 3 - Weekday Daytime	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$60.04
01_500_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Weekday Daytime - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$64.00
01_501_0104_1_1	Assistance With Self-Care Activities - Level 3 - Weekday Afternoon	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$66.23
01_501_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Weekday Afternoon - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$70.61
01_502_0104_1_1	Assistance With Self-Care Activities - Level 3 - Saturday	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$82.58
01_502_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Saturday - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$88.03
01_503_0104_1_1	Assistance With Self-Care Activities - Level 3 - Sunday	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$107.37
01_503_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Sunday - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$114.46
01_504_0104_1_1	Assistance With Self-Care Activities - Level 3 - Public Holiday	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$134.42
01_504_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Public Holiday - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$143.29
01_505_0104_1_1	Assistance With Self-Care Activities - Level 3 - Active Overnight	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$67.47
01_505_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Active Overnight - TTP	Assistance with daily life	H	N	High Intensity Daily Personal Activities	$71.92

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National Disability Insurance Agency (NDIA) Pricing Reference Group

Minutes

NDIA Offices Level 9, 300 Elizabeth Street, Surry Hills, NSW

Date: Thursday 20 February 2020 **Time:** 1000 – 1300

Members

Name	Title/Position
Liz s47F - person	Chair, A/g Head of Markets, Provider and Sector Development (MPSD)
Graeme s47F - pers AM	Independent Member
Jim s47F - p PSM	Independent Member
Julie s47F - personal priva PSM	Independent Member
Presenters	
David Cullen	Chief Economist
Deb s47F - personal pr	Branch Manager, Scheme Policy
Aaron s47F - perso	General Manager, Government
Marita s47F - persona	Strategic Advisor, Contemporary and Innovative Approaches
Bernadette s47F - perso	Branch Manager, Market Settings
Secretariat	
David Cullen, Chief Economist	

1.0 Formalities

1.1 Apologies

No apologies noted

1.2 Declaration of Conflicts of Interest

By: Chair **For:** Noting **Format:** *Verbal*

The Pricing Reference Group **NOTED** that Graeme s47F - pers is:

- a member of the Board of Life Without Barriers;
- a member of the Board of the Summer Foundation;
- a member of the Board of Joblife Employment;
- a member of the Board of Attitude Foundation; s47F - personal privacy, s22(1)(a)(ii) - irrelevant material

2.0 Updates

2.2 Annual Price Review

By: David Cullen **For:** Discussion **Format:** *Verbal*

The Pricing Reference Group **DISCUSSED** that the Annual Price Review submissions have been received and are currently being summarised with a view for a more detailed discussion at its next meeting including feedback from Working Groups and Provider Forums.

2.3 Future Meeting Dates

By: David Cullen **For:** Noting **Format:** *Verbal*

The Pricing Reference Group **NOTED** the proposed future meeting dates including an additional meeting on Wednesday 11 March 2020 for presentations by provider representatives with a view to discuss further dates once all new members are in place. **NOTED**

Current membership was **DISCUSSED** with a view to possibly expand the NDIA representation on the Pricing Reference Group to include the Scheme Actuary. ***FURTHER DISCUSSION WITH CEO***

ACTIONS

Chair to discuss with the NDIA Chief Executive Officer (CEO) regarding expanding NDIA representation on the Pricing Reference Group to include the Scheme Actuary.	**By:**11 March 2020	**Who:** Chair

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3.0 Major Items

3.1 Additional Disability Personal Care and Support (ADPCS) for Participants Living in Residential Aged Care Facilities (RACFs) — **By:** Aaron s47F - perso/Deb s47F - personal pr/David Cullen **For**: Decision **Format:** *Paper*

The Pricing Reference Group **AGREED TO RECOMMEND TO THE NDIA BOARD** that the existing attendant care support items and associated price limits as outlined in PRG-201200220 3.1 - Attachment A are appropriate for ADPCS delivered in RACFs. — **AGREED TO RECOMMEND TO THE BOARD**

3.2 Individual Living Options (ILOs) — **By:** Marita s47F - persona **For:** Decision **Format:** *Paper*

a) The Pricing Reference Group **AGREED TO RECOMMEND TO THE NDIA BOARD** that two new support line items should be created for "Exploration and Design" and "ILO Support Model" within the Assistance with Daily Living Support Category as set out within PRG-201200220 3.2 - Item 2.1 - A to come into effect from 1 July 2020. — **AGREED TO RECOMMEND TO THE BOARD**

ACTION

The Pricing Reference Group **NOTED** further consideration to be given to registration groups for "Exploration and Design" prior to implementation of the two new support line items as set out within PRG-201200220 3.2 - Item 2.1 - A. — **By:**11 March 2020 — **Who: Marita** s47F - persona

b) The Pricing Reference Group **AGREED TO RECOMMEND TO THE NDIA BOARD** that ILO – Exploration and Design support item should allow the following claim types: Direct service, Cancellation, Travel, Mandatory report writing and Non-face-to-face time. — **AGREED TO RECOMMEND TO THE BOARD**

3.3 Specialist Disability Accommodation *(non-eligible participants and non-participants)* — **By:** David Cullen **For**: Decision **Format:** *Paper*

The Pricing Reference Group **AGREED TO ENDORSE IN PRINCIPAL TO THE BOARD** as per as set out in PRG-201200220 3.3 - Items 2.1 to 2.6. — **AGREED TO ENDORSE IN PRINCIPAL TO THE BOARD**

ACTION

The Pricing Reference Group **NOTED** an out-of-session paper setting out the principles of the proposal will be circulated prior to consideration by the NDIA Board — **By:** 27 Feb 2020 — **Who:** Pricing Reference Group

4.0 Other Matters

4.1 Activity-Based Transport — **By:** David Cullen **For:** Noting **Format:** *Paper*

a) The Pricing Reference Group **NOTED** the creation of several support items (one for each relevant provider registration group) to support "activity based transport" – that is, to allow providers to claim for the non-labour costs that they incur in transporting participants to and from activities. — **NOTED**

b) The Pricing Reference Group **NOTED** that these "activity based transport" support items should not be price limited (noting current transport line items are not price limited), but that guidance will be provided in the NDIS Price Guide about the reasonable level of these costs. — **NOTED**

4.2 Assistive Technology Flexible Arrangements — **By:** Bernadette s47F - perso **For:** Noting **Format:** *Paper*

The Pricing Reference Group **NOTED** anupdate on the development of the Assistive Technology Flexible Arrangements. — **NOTED**

5.0 Next Meeting

The next Pricing Reference Group Meeting will be held Thursday 12th March 2020.

Meeting Closed: 12:20pm

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DISCLOSURE LOG

DOCUMENT 22

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Matter for Noting

Annual Price Review – Summary of Submissions

1. Purpose

1.1 To inform the Pricing Reference Group of the main issues raised in submissions to the Annual Price Review (APR).

2. Recommendations

2.1 That the Pricing Reference Group **NOTE** the main issues of concern to providers, participants and other parties who lodged submissions to the APR.

2.2 That the Pricing Reference Group **NOTE** a more detailed summary of submissions will be developed for the APR's draft findings report in March.

3. Background

3.1 A total of 96 submissions were received by closing date of 2 February 2020. A further 40 late submissions were accepted in the next few weeks. This summary is based on submissions that were received by the due date. Late submissions are still being summarised and will be included in the draft findings report. (All the major peak bodies lodged their submissions before the deadline.)

3.2 Figure 1 below shows responses according to their chapters in the APR Issues Paper. By far the chapter that received the most attention was 1:1 Core – Supports (Chapter 3), recieving nearly a quarter of all responses. Of this, the great majority of comments related to the Disability Support Worker (DSW) Cost Model.

3.3 Capacity Building (Chapter 5) was the second most common issue – mostly focused on therapy issues. Even though less than 1% of service claims are cancellations (Chapter 9), this was the third most commented upon issue. Plan Management (Chapter 6) was another popular topic - mostly arguing that plan managers do not get paid enough.

3.4 Travel (Chapter 10), Group based supports (Chapter 4) participant flexibility and provider administration (Chapter 2), and establishment fees (Chapter 11) each received less than 10% of total comments. Geographical issues (Chapters 7 and 8) received less than 5% of comments between them, which may reflect that few participants live in outer regional or remote areas. Finally, it is also encouraging that less than 10% of responses were about non-pricing issues.

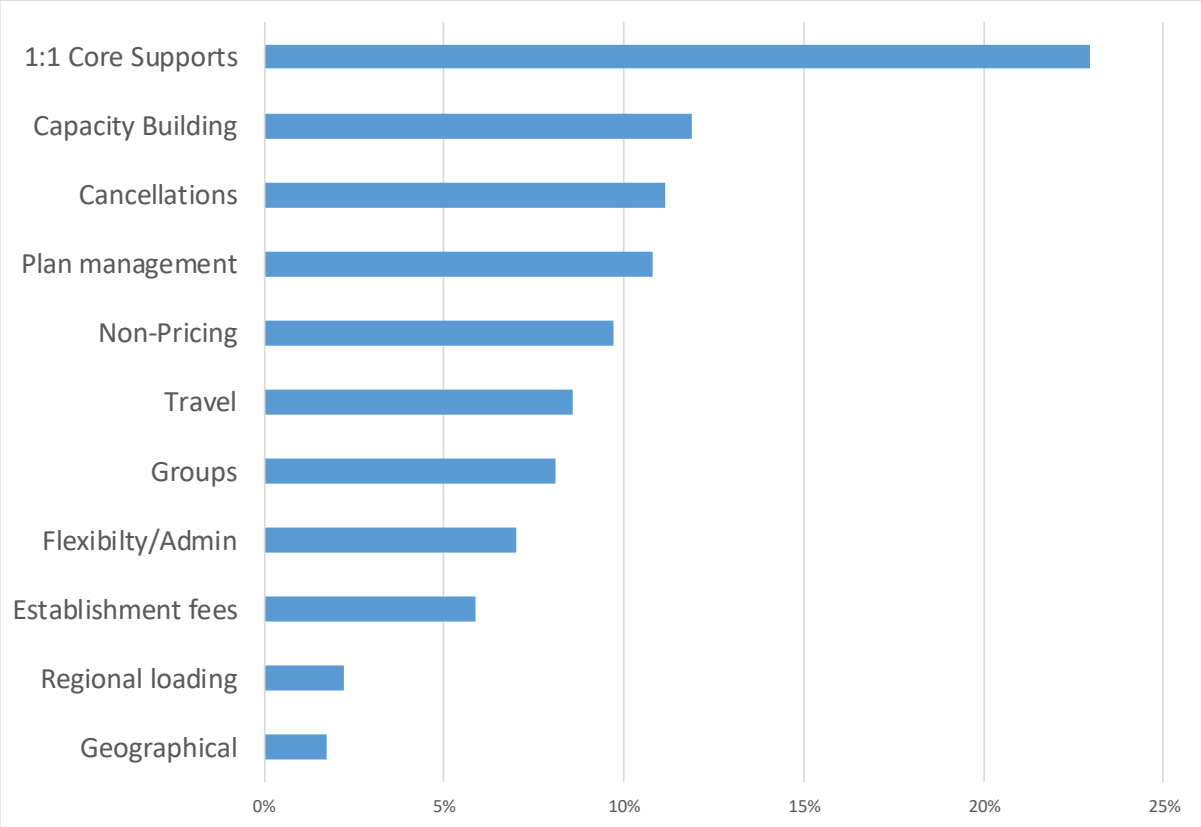
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Figure 1: Issues addressed in submissions



4. Increasing flexibility for participants and reducing administration for providers (Chapter 2 of Issues Paper)

4.1 The most common pricing administrative issue for providers was that the Support Catalogue is too large and complex. A number of providers also asked if the category codes could be rationalised.

4.2 Several submissions complained about payment delays and the administrative burdern of complying with Agency systems, however these are not pricing issues per se.

4.3 One provider suggested that the best way to reduce pricing-related administrative burderns would be to remove all price limits.

4.4 A few submissions called for increased fungibilty, especially for transport. The recent introduction of Activity Based Transport should allay many concerns with transport fungibility, and the Agency proposes to make all support categories fungible from 1 July 2020.

4.5 One submission asked for a participant's price guide, arguing it would help participants make better use of their budgets if they were more able to understand available supports.

5. 1:1 Core Supports (Chapter 3)

5.1 Three quarters of responses for this Chapter related to the DSW efficient cost model, with over 100 responses on various aspects of the model.

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5.2 Submissions argued that the 10% allowance for overheads in the model was too low, with 20% to 25% being the most commonly cited figures. Although, there was a wide range of estimates for overheads, from 15% to 35%.

5.3 Many submissions stated that the assumption of 80% permanent to 20% casual staff was unrealistic, with some saying that the other way round would be more accurate. Until recently, this would not have mattered overly, as the actual cost of employment has been very similar for each type. However, the Fair Work Commission decided in December 2019 to increase the relative cost of employing casual workers on weekends and public holidays.

5.4 Assumed utilisation rates in the model, of 90% or higher, were also criticised as being too high. Submissions argued that increasing use of casual labour results in higher training costs, and that utilisation rates around 80% would be more realistic.

5.5 Some submissions claimed that the model's ratio of supervisors to workers was also too low.

~~5.5~~5.6 Conversely, there are considerably fewer providers claiming the Temporary Transformation Payment (TTP) than the Agency originally expected. This indicate that existing price limits are sufficient for many providers, and they would prefer to undercut their less efficient competitors by not claiming the TTP. For example, the submission from All About Caring stated "our organisation generally has no issues with the hourly rate the NDIS has set for the types of services we provide, we had no need to charge the TTP nor the travel component between service to service."

~~5.6~~5.7 Other issues raised where that it was not always clear when high intensity price limits should apply, with some respondents saying they do not use these rates as it is too difficult.

~~5.7~~5.8 A couple of submissions requested that the Price Guide used exactly the same shift definitions as the SCHADS Award.

6. Group-based core supports (Chapter 4)

6.1 A common theme was that trying to calculate ratios was difficult. Ratios can change on a daily basis, especially when actual ratios may not be known until the day itself.

6.2 A number of submissions requested the alternative of allowing group providers to claim Non-face to face (NF2F) time – instead of the fixed allowance for this built into the pricing formula as at present.

6.3 Allowance for capital costs in centres was claimed to be insufficient - particularly for more specialised groups or larger groups.

6.4 Submissions also called for clearer guidance for group cancellations. (The Agency is proposing to introduce program bookings, whereby participants book a block of sessions and pay for them all even if they do not turn up. This should help with regard to group cancellations.)

7. Capacity building supports (Chapter 4)

7.1 Several providers wanted consumables to be claimable by Capacity Building therapists. The most common proposal to achieve this was though a separate Consumables budget item.

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7.2 Interestingly, there were more comments about time and day price limits for therapy than there were for core supports (Chapter 3). Therapists under Award arrangements are paid varying rates for evenings, weekends and public holiday delivery. Many submissions indicated that they do not offer Capacity Building outside of Mon - Fri 9am-5pm as it is financially unviable to do so given the price limits versus the staff cost. Further, Capacity Building is often most beneficial when delivered at home / in the community which frequently occurs outside of the Mon - Fri 9am-5pm time period.

7.3 Most therapy providers claimed that indexation of price limits is currently not adequate. Submissions argued that the gap between the current arrangements and the increases in staff costs under Award / EBA agreements was narrowing the gap (to negative in many instances) between the actual cost of delivery and the price limit.

7.4 Not unexpectedly, the most common responses was that Capacity Building prices are too low. However, little by way of concrete evidence was furnished to support this (other than time and day above.)

7.5 Similarly, many categories of therapists argued that they should be paid more relative to other categories (for example exercise physiologists vs other allied health professionals). Again with little objective evidence.

7.6 As with last year's APR, therapists argued that they should be able to quote for travel, as theirs is a competitive market. Some stated that they have ceased to provide support beyond allowable travel ranges.

8. Plan Management (Chapter 6)

8.1 Most respondents argued that funding was insufficient for plan management.

8.2 Many also argued that the flat monthly fee does not reflect different participant needs. The fixed monthly service fee does not account for complex plans, plans running for over a year, or plans for new participants requiring additional effort. Suggestions for changes to pricing structure included pricing based on transaction volume, a loading rate for plans over $100k, and a combination of monthly fees plus additional fees based on transaction or plan value.

8.3 One provider requested a $12 fee per participant when the price guide changes.

8.4 Another common request was that if a participant switches plan managers, claiming for a second establishment fee against that participant's plan should be allowed, as this will facilitate switching between providers and thus both competition and participant satisfaction.

8.5 Providers also complained that the indexation rate for plan management services is insufficient, and out of line with other professions. The increase equates to $2 per monthly fee, or just $24 per year.

8.6 Plan managers also said they should be able to bill for provider travel and non face to face time when providing capacity building and training in plan administration and management supports.

8.7 However, comments on building capacity in plan management were notable by their absence. One provider noted that less than 1% of their participants had such capacity building in their plans.

9. Classifying regional and remote areas (Chapter 7)

9.1 A couple of providers request that, when changing to Modified Monash Model (MMM) 2019, towns losing their Remote classification should be allowed 12 months to transition to lower prices.

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9.2 A few submissions questioned the overall applicability to disability services of the MMM system. They argued it might work passably well for disability support workers, but was manifestly inadequate for therapists, who generally only provide services in cities or large towns.

9.3 One provider noted that thin markets and MMM classifications are not always synonymous, with some thin markets existing in MMM 3-5 regions.

10. Costs in outer regional areas (Chapter 8)

10.1 . Responses argued that dealing effectively with outer regional areas would be more effectively dealt with by commission, rather than raising price limits a little.

10.2 Increasing travel time / distance limits was also considered a high priority.

11. Cancellation rules (Chapter 9

11.1 Providers argued they should be able to recover 100% of cancellation fees. One submission put it eloquently “Where exactly do you find a replacement participant in short notice? It is not like calling a different plumber."

11.2 Providers also disliked the way the CRM in some cases only pays 90% of a cancellation fee, as this create bad debts.

11.3 Predictably, providers argued that cancellation periods should be increased, while participants argued they should be shortened.

11.4 However, some providers stated they were empathetic to participants and were often not charging cancellation fees, especially if participants fell ill (which is the most common cause of cancellations). Cancellation claims appear to be unexpectly low, at under 1%. This may indicate that in many cases, providers are indeed chosing not to charge for cancellations.

11.5 Participants also found cancellation rules were complex.

12. Travel costs (Chapter 10)

12.1 Travel is a major issue in the delivery of NDIS supports either due to distance and time (regional, remote) or time (metropolitan). To the point that several submissions had indicated that services had been withdrawn due to inability to claim, and continue to absorb, travel costs. Participant understanding of travel is also low and can cause friction between participant and provider. A system where all travel can be claimed (per km, time) was commonly requested, including associated travel costs i.e. parking and tolls.

12.2 Providers claimed a significant number of travel episodes exceed the maximum travel limits. This is not only in regional and remote areas but also in major metropolitan centres where traffic has become a serious issue. Many respondents stated they have ceased or severely limited service delivery if it would involve travelling beyond claimable limits. They are concerned that this is impacting on participants choice and control.

12.3 Some providers will organise a group or substantial cohort in a geographical area to alleviate travel costs. However this can then get complicated if there are cancellations,

12.4 Some submissions provided evidence on proportion of claimable travel, this ranged from 10% to 80% as much as the direct cost of service . The higher proportions related to providers based non-metro areas.

12.5 Respondents wanted provider travel to be treated the same way as activity based transport. Specifically, with recovery for non-labour costs using the SCHADS award rate of $0.78 per kilometre, as well as including parking fees and tolls.

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13. Establishment Fees (Chapter 11)

13.1 Of the providers that responded to this topic, all them were in agreement that there is a cost associated with establishing new clients for any type of support and that establishment fees are appropriate for this purpose.

13.2 However, only two submitters felt that the current rules were fair, with the remainder arguing that fees should be claimable whenever a participant changes providers or has an updated plan.

13.3 Further, the general consensus was that an establishment fee (of some amount) should be claimable for all supports. Multi-disciplinary supports, supported employment (SIL, respite and support co-ordination were all cited as being particularly complex in terms of establishing a new client.

13.4 The main issue identified with the current price limits was the way in which the total claimable amount is apportioned between the first and second plans (or providers). Most providers are of the opinion that the cost for establishing any new client is the same and that the claimable amount in any instance should reflect this.

13.5 Interestingly, one provider from NSW remarked that due to the early rollout of the NDIS in this jurisdiction, most of their participants have already exhausted their entitlement to an establishment fee (making this an irrelevant consideration for that state).

13.6 There was agreement amongst providers that there is a relationship between the costs of establishing new clients and staff wages. It was suggested therefore that increases to establishment fees should be linked to the CPI.

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Delivered by the National Disability Insurance Agency

National Disability Insurance Agency (NDIA) Pricing Reference Group

Minutes

NDIA Offices Tower B, 280 Elizabeth Street, Surry Hills, NSW

Date: Thursday 12 March 2020 **Time:** 1030 – 1250

Attendees

Chair	Position
Liz s47F - personal	General Manager, Provider and Markets
Pricing Reference Group Members	**Position**
Graeme s47F - perso AM	Independent Member
Jim s47F - pe PSM	Independent Member
Julie s47F - personal privacy PSM	Independent Member
Participating observers nominated by NDIA's CEO	**Position**
David Cullen	Chief Economist
Sarah s47F - personal priv	Scheme Actuary
Secretariat	**Position**
Scott s47F - personal p	Director, Price Regulation Unit

1.0 Formalities

1.2 Declaration of Conflicts of Interest **By:** Chair **For:** Noting **Format:** *Verbal*

The Pricing Reference Group **NOTED** that Graeme s47F - perso is:

- a member of the Board of Life Without Barriers;
- a member of the Board of the Summer Foundation;
- a member of the Board of Joblife Employment;
- a member of the Board of Attitude Foundation; and
- a participant of the National Disability Insurance Scheme (NDIS).

NOTED

1.3 Confirmation of Minutes 20 February 2020 **By:** Chair **For:** Decision **Format:** *Paper*

The Pricing Reference Group **ENDORSED** the minutes of the previous meeting (PRG-20200220 - Item 1.3). **ENDORSED**

2.0 Updates

2.1 Update by the Chair **By:** Chair **For:** Noting **Format:** *Verbal*

The Pricing Reference Group **NOTED** the principles as set out in 'PRG-201200220 3.3 Specialist Disability Accommodation' were agreed to by the NDIA Board. **NOTED**

2.2 TTP Market Benchmarking Survey Update **By:** Scott s47F - personal p **For:** Noting **Format:** *Verbal*

The Pricing Reference Group **NOTED** the key findings to date for the TTP Benchmarking Survey. **NOTED**

The Pricing Reference Group **NOTED** that the TTP Benchmarking Survey would have a grace period until 30 June 2020 for providers to complete the survey to meet compliance conditions. **NOTED**

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3.0 Annual Price Review

3.1 Provider Presentations Discussion	**By:** Chair	**For**: Discussion	**Format:** *Verbal*
The Pricing Reference Group **DISCUSSED** the Provider Peak Presentation session that was held on Wednesday, 11 March 2020			**DISCUSSED**
3.2 Summary of Annual Price Review Submissions	**By:** Scott 47F - personal	**For:** Discussion	**Format:** *Paper*
The Pricing Reference Group **DISCUSSED** the preliminary findings for 'PRG - 20200312 - Item 3.2 - Annual Price Review - Summary of Submissions'.			**DISCUSSED**
3.3 Efficient Cost Model for Disability Support Workers	**By:** David Cullen/Scott 47F - personal	**For**: Discussion	**Format:** *Paper*
The Pricing Reference Group **DISCUSSED** the 'PRG - 20200312 - Item 3.3 - Efficient Cost Model for Disability Support Workers' paper.			**DISCUSSED**
3.4 Establishment Fees – Initial Findings	**By:** Dominic 47F - pers	**For**: Discussion	**Format:** *Paper*
The Pricing Reference Group **DISCUSSED** 'PRG - 20200312 - Item 3.5 - Annual Price Review - Establishment Fees' and current establishment fee pricing arrangements.			**DISCUSSED**

4.0 Major Items

4.1 Modified Monash Model and Geographical Reclassification	**By:** Scott 47F - personal	**For:** Decision	**Format:** *Paper*
The Pricing Reference Group **AGREED TO RECOMMEND TO THE BOARD, THROUGH THE CEO,** the adoption of the MMM 2019-classification system and future such updates as released from the Department of Health.			**AGREED**
The Pricing Reference Group **NOTED** further consideration is to be given around MMM classification adjustments for isolated areas.			**NOTED**

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Term of Reference for the APR	Discussion
Examine options to increase flexibility for participants and reduce administrative burdens for providers	**RECOMMENDATION** • Amend the Price Guide from 1 July 2020, to make clear that providers are allowed to enter into contracts for the provision of ***programs of supports (up to 12 weeks)***. Where a participant does not attend one part of a program they are billed as though they did occur – that is, this is not a cancellation, as long as the provider had the capacity to deliver the support. o Decreases administrative burden o Allows providers to better manage their workforce o Other participants are not impacted by cancellations - otherwise if a 3 person group has one person drop out then the others are charged 1:2 even though they signed up for 1:3 (Helps with ADE issues.) • Other simplifications to the price guide (including removal of ratio rates, see below) • The timing of the Annual Price Review should move to run from October to December, reporting in January to the Board to: o Give providers adequate notice of proposed policy changes; and o Allow movements in pricing arrangements to inform the Commonwealth Budget process. o TTP survey in October • The annual indexation of price limits should occur independently of the Annual Price Review and should continue to occur on 1 July each year subject to the following indexation arrangements: o Price limits for supports delivered by DSWs should be set by the Efficient Cost Model following the Fair Work Commission's minimum wage decision; o Price limits for Capital supports should be indexed by movements in the CPI over the 12 months to the March Quarter preceding the indexation date; and o Price limits for other supports should be indexed by movements in the AWE over the 12 months to the March Quarter preceding the indexation date.
Review the assumptions and parameters outlined in the *NDIS Cost Model for Disability Support Workers*	<u>Review of parameters by comparison to TTP Survey</u> • Share of staff who are permanent o Model Assumption 80% o 25th percentile 71.7% ; Average 43.8% o Assumption is a little high, and could be lowered to 70% • Utilisation rate o Model Assumption 92% o 25th percentile 92.5% ; Average 79.8% o Assumption supported by efficient practice • Span of control o Model Assumption 11 o 25th percentile 15 ; Average 12 o Assumption is generous – but supports quality

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Term of Reference for the APR	Discussion

	• Margin
	  ○ Model Assumption 2.0%
	  ○ 25th percentile 0.2% ; Average 0.5%
	  ○ Need to be considered in concert with the overhead
	<u>Overheads</u>
	• TTP survey indicates overhead assumption is only major risk
	  ○ Model assumption 10.5%
	  ○ 25th percentile 19.8%
	  ○ Average 27.7%
	  ○ Standard Deviation 11.8%
	  ○ Skew -0.01 (very balanced)
	  ○ Kurtosis -0.01 (very concentrated about the average)
	• Only 59.6% of eligible providers claim the TTP
	• Only 49.7% of relevant funds are paid to TTP providers
	• Estimated 47.3% of eligible items are claimed at the TTP rate
	• I have estimated the distribution of all overhead rates from those reported in the TTP survey – a bootstrapped mixed distribution by shifting the observed TTP distribution to the right for non-claimers
	  ○ 25th percentile 15.5% (on volume of services)
	  ○ 50th percentile 23.7% (on volume of services)
	• This argues for a 5% increase in the overheads assumption
	• It also shows the sustainability gap = 50th – 25th percentile hasn't closed – would argues for maintaining the TTP at 7.5%
	• However, the bootstrap probably overestimates the top end of the overhead distribution of non-TTP providers.
	• There are also a number of other costs that some providers are showing in their overheads which are better dealt with elsewhere in the price guide – which would shift overhead distributing to the left (see provider travel, cancellations and establishment fees)
	• Finally, our rates appear high compared to some other insurance schemes (standard hourly rate), noting that fees can operate differently in different contexts (e.g. according to whether or not services are commissioned, and what other fees are also billable):
	  ○ NDIS non TTP - $58.14
	  ○ NDIS TTP - $62.49
	  ○ Victorian TAC - $50.56 (Commissioning rate + allow provider travel)
	• Our rates also appear high compared to providers in the aged care sector (noting again the difficulties with comparisons)
	  ○ Australian Unity Aged Care - $53.00 + management fees (about $2 per hour)
	  ○ Blue Care - $50.75 plus management fees (about $6 per hour)
	
	RECOMMENDATIONS

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Term of Reference for the APR	Discussion

	• The cost overhead assumption in the Cost Model should not be changed at this time – with parameters to be reconsidered when the uncertainty of future economic conditions has resolved itself.
	• The permanent/casual staff ratio assumption in the Cost Model should be changed to 70%
	• Some minor amendments should be made to parameters
	  ○ Change the award loading assumptions for Saturdays and Sundays in line with recent Fair Work Commission decision (takes effect 1 July 2020)
	  ○ Increase the assumption about Long Service Leave to 100% uptake recognising the introduction of portable long service leave arrnagements in some jurisdictions.
	• The TTP should be reduced as currently planned from 7.5% to 6% on 1 July, in order to continue pressures towards improved efficiency.

Review the methodology for deriving the price controls for group-based supports from the price controls for 1:1 supports	• General agreement from providers consulted that they are now ready to move to a standard hourly rate plus the right to charge for non-face to face time **RECOMMENDATIONS** • Align the hourly price limits for group support with the hourly price limits for 1:1 supports. • Allow providers or group supports to bill of non-face-to-face supports. • Simplify the Price Guide by only publishing the 1:1 hourly rates. If a provider offers a 1:3 group (for example) they bill for this by apportioning the time between the three participants, not by billing at the 1:3 rate.
Determine indexation arrangements for price limits for capacity building supports, including therapy supports.	**RECOMMENDATIONS** • A review of therapy prices should be conducted every two year, starting with the next Annual Price Review. Price limits for therapy services should be indexed by AWE between comprehensive reviews. • The DSW indexation arrangements should be used for all services delivered by DSWs • Maintain current link to AWE for therapy services • Follow up with TAC about benchmarking study done by TAC
Should different price limits be introduced for different times of the day, or days of the week, for some capacity building supports, including for therapists, therapy assistants and for capacity building supports delivered by disability support workers.	**RECOMMENDATION** • This matter should be further examined over the next twelve months, with particular focus on the impact of the current on best practice interventions, in ECEI and other settings.
Determined whether therapists and other capacity building providers should be able to recover the costs of indirect consumables provided to participants as part of a support	• Already built into hourly rate • Use analogy of tools of trade and make clear we are not talking about consumables that are specific to the participant (e.g. the wound dressing) just the scissors and sticky tape used by the nurse.

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Term of Reference for the APR	Discussion
Review the price control framework for plan management supports	• No changes at this time given likely changes in plan management arrangements
Are modifications required to the NDIA's implementation of the Modified Monash Model (MMM) to account for specific disability service-related costs, including the treatment of "isolated locations" and islands?	• Move to MMM2019 so that geographical classification most accurately represents current market conditions (already agreed by Data Management Committee)
Determine if a loading should be applied to price limits and plan funding amounts in outer regional areas to account for the higher cost of service delivery, if any, in those areas.	• No evidence at this time that a loading is will improve the supply of services. • Better addressed through the two provider travel responses discussed below
Re-examine cancellation rules	**RECOMMENDATIONS** • Amend the Price Guide to allow providers to claim for 100% of the agreed fee for a short-notice cancellation. (Implemented as part of COVID-19 response.) • Postpone review of the appropriateness of the definition of short-notice cancellations until after the COVID-19 changes have been repealed
Re-examine provider travel time limits, including examining whether it is possible to develop an approach that is more sensitive to local conditions	• No clear evidence to support change at this time • Travel continues to be a major barrier to the delivery of supports in remote and very remote areas and in some MMM4-5 regions. • Commissioning of travel brokers for MMM 6-7 and some MMM4-5 regions may allow these costs to be funded outside plans and drive efficiencies by coordinating participants and providers. **This could ameliorate the need to commission other services. It also simplifies the planning process as it is not necessary to work out travel amounts when planning.** **RECOMMENDATION** • The NDIS should trial the commissioning of a travel broker arrangement in the Northern Territory, Queensland and Western Australia to coordinate participants and providers and pay for travel costs.
Re-examine allowing providers to claim for non-labour costs associated with provider travel	• Addressing this issue helps address the complaint about the overhead allowance being insufficient as these costs are currently absorbed into the overhead. (Provider non-labour transport costs can be as much as 10% of the cost of service delivery for home based services.) • It aligns with the already agreed activity based transport arrangements. **RECOMMENDATION** • The Price Guide should be amended from 1 July 2020 so that providers can claim for the non-labour costs associated with provider travel in line with the activity based transport arrangements.

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DISCLOSURE LOG

Term of Reference for the APR	Discussion
Review establishment fee arrangements	• Establishment fee is still set at the same level as it was when the scheme commenced. • Establishment fee is only payable once, whereas providers need to establish clients in the system (service booking etc) every plan. • Addressing this issue helps address the complaint about the overhead allowance being insufficient as these costs are currently absorbed into the overhead. **RECOMMENDATIONS** • The Price Guide should be amended from 1 July 2020 so that: o Establishment Fee are indexed each year in line with the indexation rate for Disability Support Workers. o A lower level establishment fee is claimable for second and subsequent plans to recognise provider's costs in establishing service booking etc. o Establishment fee are billable by any provider who provides a significant amount of personal care/community access to a participant (say more than 20 hours a month) • Planning arrangements should take into account the need to pay establishment fees in subsequent plans in establishing the value of plans.

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DISCLOSURE LOG

DOCUMENT 25

Date: 14 April 2020

Owner: Sarah [redacted] (Scheme Actuary)

Contact: [redacted]

Estimated impact of proposed 2019-20 Annual Pricing Review and other changes

Summary of Key Results

A review of the proposed 2019-20 pricing changes and new support items was undertaken. It should be noted that this review does not include the impact of annual indexation as determined by the Fair Work Commission, or as included as adjustments to the Consumer Price Index or Average Weekly Earnings.

The following table summarises the impact of each of the proposed pricing changes on the projected participant costs for the 2020-21 year[1]. The 'best estimate' is shown, as well as the possible range of results (demonstrated by the 'low' and 'high' modelled scenarios, which largely reflect possible behavioural risks as a result of the pricing changes).

IMPACT OF PROPOSED 2019-20 PRICING CHANGES ON PROJECTED 2020-21 PARTICIPANT COSTS

		Impact (%)			Impact ($ million)		
Section	Proposed 2019-20 pricing change	Best Estimate	Low Scenario	High Scenario	Best Estimate	Low Scenario	High Scenario
1.1	Non-labour costs for provider travel	0.46%	0.33%	0.99%	99.1	71.2	212.8
1.2	Efficient cost model	0.33%	0.33%	0.33%	71.3	71.3	71.3
1.3	Geographical classification (MMM changes)	-0.01%	-0.01%	-0.01%	-2.1	-2.1	-2.1
1.4	Group rates	0.00%		0.50%	0.0	0.0	107.7
1.5	Indexation for DSW capacity building supports	0.01%	-0.02%	0.04%	1.3	-3.9	7.7
1.6	Commission travel	0.00%			0.0	0.0	0.0
1.7	Establishment fee	0.03%	0.01%	0.06%	6.9	2.8	13.8
1.8	Program-based supports	0.00%			0.0	0.0	0.0
Total impact of all proposed pricing changes		**0.82%**	**0.65%**	**1.91%**	**176.6**	**139.3**	**411.3**

Note: MMM stands for Modified Monash Model and DSW stands for Disability Support Worker.

The total impact of all the proposed pricing changes is an increase in projected participant costs of 0.82% (or $176.6 million) in 2020-21, with the non-labour costs for provider travel[2] being the most material change.

The table below shows how the proposed new support items from the Pricing Regulation Unit (PRU) would affect projected participant costs for the 2020-21 year.

[1] Based on the December 2019 AFSR update, projected participant costs were $21.5 billion for 2020-21.
[2] Providers will be able to claim for the costs incurred (in addition to the cost of a worker's time) when traveling to and/or from each participant to deliver a support e.g. petrol, toll roads, parking fees etc.

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DISCLOSURE LOG

IMPACT OF PROPOSED NEW SUPPORT ITEMS ON PROJECTED 2020-21 PARTICIPANT COSTS

		Impact (%)			Impact ($ million)		
#	Proposed new support items	Best Estimate	Low Scenario	High Scenario	Best Estimate	Low Scenario	High Scenario
1	Psychosocial recovery coaches support items	0.00%			0.0	0.0	0.0
2	New hearing support items	0.20%	0.00%	0.40%	43.0	0.0	86.1
Total impact of all proposed new support items		**0.20%**	**0.00%**	**0.40%**	**43.0**	**0.0**	**86.1**

For the psychosocial recovery coaches support items, the change is expected to be cost-neutral in the shorter term, with potential cost savings in the medium to longer term. For the hearing support items, the estimated impact is based on the potential for more lower-cost participants with a hearing impairment entering the Scheme, rather than directly due to the introduction of the new support items.

There are some behavioural risks (from planners, providers and potential participants) associated with the introduction of these proposed new support items and also with the proposed change in non-labour costs for provider travel. Therefore, it will be important to monitor the emerging experience from 1 July 2020 and update costings once there is more applicable information available.

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1. Proposed 2019-20 annual price review changes

1.1 Non-labour costs for provider travel[3]

It is proposed that from 1 July 2020, providers will be able to claim for the non-labour costs associated with provider travel in line with the activity based transport arrangements. These are the costs incurred in addition to the cost of a worker's time when traveling to each participant (and for capacity building providers, when travelling from the last participant of the day back to their usual place of work). This travel time is limited to 30 minutes for participants in MMM1-3[4] areas and 60 minutes in MMM4-5 areas.

The following guidelines are given in the current NDIS Price Guide regarding reasonable non-labour travel costs for activity based transport:

- up to $0.85 a kilometre for a vehicle that **is not** modified for accessibility
- up to $2.40 a kilometre for a vehicle that is modified for accessibility or a bus
- other forms of transport or associated costs up to the full amount, such as road tolls, parking, public transport fares.

Allowing providers to claim non-labour costs for travel helps address complaints about the overhead allowance built into support prices being insufficient, as some of these costs are currently absorbed into the overhead[5]. It also aligns with the already agreed activity based transport arrangements.

Assumptions for costing non-labour costs for provider travel

Average non-labour costs of travel

- The average non-labour costs claimed per worker per annum is $1,250. This is based on results from the TTP survey which show average travel allowances for disability support workers are $2,500 per annum. This covers all provider travel, both to the participant (i.e. provider travel), and travel to accompany and/or transport a participant to an activity (i.e. activity based transport). It is assumed that travel costs are, on average, equally split between provider travel and activity based transport.

- Appendix A shows that a $1,250 annual travel allowances equates to approximately 12 minutes of provider travel per day or 3% of total support time.

- It is possible that the actual non-labour costs of provider travel will be higher, either due to an underestimation of total costs allocated to provider travel (compared to activity-based transport) or because providers may change their behavior once they are able to claim non-labour costs e.g.

[3] In March 2020, changes were made to the NDIS Price Guide to allow providers to claim non-labour costs for activity-based transport. This is different to provider travel, which is travel to and/or from a participant to deliver a support, as activity-based transport refers to transporting a participant to and from community activities funded in their NDIS plan.
[4] Modified Monash Model (MMM) is a geographical categorisation.
[5] Provider feedback during a pricing review working group indicated that provider non-labour transport costs can be as much as 10% of the cost of service delivery for home based services.

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travelling further distances, more likely to use toll roads etc. The second sensitivity scenario shows the impact of increasing average annual costs by 50%.

Proportion of providers claiming travel

- Providers are assumed to claim non-labour costs for provider travel at different rates according to the support type being delivered. This is because not all providers will travel to provide support to participants e.g. for therapy provided in a clinic, participants will travel to the provider and bear this cost, whereas providers are likely to claim the cost of their travel when therapy is provided in the home.
- Reliable data is not currently available to determine the proportion of providers who claim for provider travel, so a range of reasonable assumptions have been made that represent a best estimate, low take-up and high take-up scenario.
- Support types that are not eligible to claim provider travel e.g. SIL, SLES etc. are assumed to have 0% of providers claiming travel.

Summary of assumptions

Assumption	Best Estimate	Sensitivity 1: Fewer providers claim for travel	Sensitivity 2: All providers claim travel at higher cost
Annual non-labour costs per worker	$1,250	$1,250	$1,875
Claim rate for non-labour costs			
Attendant care (non-SIL)	100%	90%	100%
Delivery of health-related supports	100%	90%	100%
Other assistance with daily life	100%	90%	100%
Community & social activities – Individual	75%	50%	100%
Community & social activities – Group based	25%	0%	100%
Therapy supports* – Individual	50%	25%	100%
Therapy supports* – Group based	25%	0%	100%

* Includes early childhood intervention supports

Results

The table below shows that the estimated increase in Scheme costs as a result of allowing providers to claim the non-labour costs of provider travel is between $99 million and $213 million (0.34% and 0.99% of Scheme costs) in FY2020-21.

Estimated cost impact	FY2020/21 cost impact ($m)	% of total Scheme cost
Best estimate	99	0.46%
Sensitivity 1: Low claim rate	71	0.33%
Sensitivity 2: High claim, high cost	213	0.99%

Note that the cost estimates above do not include the impact of the COVID-19 10% price loading on selected supports. If this price loading was included, the cost impact would be reduced.

Other considerations

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The data available for this analysis has not been robust and only five days were available to undertake the analysis, hence robust monitoring after implementation is required to better understand impacts. Risks around these costings are that the annual non-labour costs for provider travel will be higher than expected. Furthermore, there is a risk that providers will change their behaviour once they can claim for non-labour travel costs rather than absorbing these costs into their overhead. For example, providers may choose to travel longer distances or incur more incidental costs such as parking fees or road tolls.

There are also risks related to the guidelines for claiming non-labour costs for transport in the Price Guide. Providers can claim significantly higher costs for travel if they have a vehicle that is modified for accessibility. There is potential for these rules to be exploited if providers make minor modifications to their vehicles in order to claim the higher travel rate. Hence, audits of provider travel claims should be undertaken to ensure that guidelines are followed appropriately.

The benefits of this change are that it may encourage more providers to deliver supports to participants in community or mainstream environments rather than in clinical settings. This is particularly important for early childhood intervention, as evidence-based research shows that therapeutic supports delivered in the home or community are more effective in improving outcomes for children than clinic-based supports. Furthermore, providers generally incur less cost to travel compared to participants so encouraging increased provider travel may reduce overall transport costs for the Scheme in the long term.

It is recommended that more work is done to better understand how providers claim both labour and non-labour costs of travel, and to monitor how this changes over time. This could be through TTP surveys or by improving data capture on payment claims for provider travel.

1.2 Efficient cost model

The assumptions and parameters that underline the NDIS Cost Model for Disability Support Workers (cost model) have been reviewed for the 2019-20 Annual Price Review, and the following changes have been recommended:

- Changing the award loading assumptions for Saturdays and Sundays in line with the recent Fair Work Commission decision (takes effect 1 July 2020). This has already been costed by the OSA[6].
- Changing the permanent/casual staff ratio assumption in the cost model from 80% to 70% with the 25th percentile of the TTP Benchmarking Survey
- Increase the assumption about Long Service Leave to 100% uptake recognising the introduction of portable long service leave arrangements in some jurisdictions.
- Decrease the assumed workers compensation premium percentage from 3% to 1.7% in line with the 25th percentile observed in the TTP Benchmarking Survey, noting that this is equal to the average premium percentage observed across the health and community sector.

[6] See file note attached in Appendix B *Estimated impact of proposed changes to the SCHADS award*, dated 17 September 2019.

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DISCLOSURE LOG

- Increase the assumed overheads percentage from 10.5% to 12% to better align with the estimated overheads of efficient providers in the sector.
- Increase the supervision ratio from 11 to 15 in line with the 25th percentile observed in the TTP Benchmarking Survey.
- Increase the provision of allowances (other than travel allowances) for support workers and supervisors from 0% to 1% of base salary, in line with the average level observed in the TTP Benchmarking Survey.

The temporary transformation payment (TTP) loading will also be reduced as currently planned from 7.5% to 6.0% on 1 July 2020, in order to continue pressures towards improved efficiency.

The impact on Scheme costs for each of the changes to the cost model have been estimated based on actual cash payments made for supports delivered by disability support workers over the 2018-19 financial year. This payment information is used to derive the proportion of supports likely to be impacted by the change to attendant care price limits, noting that in-kind payments have been excluded from the analysis. It is assumed that in-kind payments do not have a material impact, despite a large proportion of them being related to attendant care, as prices for these supports have already been agreed in the Full Scheme bilateral agreements.

The table below shows that the proposed changes to the efficient cost model are estimated to increase total Scheme costs by $71 million (0.33%) in FY2020-21. The assumption change with the largest impact on Scheme costs is the increase in the worker to line manager supervision ratio from 11 to 15 which decreases Scheme costs by 1.74%. This increase reflects the results of the TTP Benchmarking Survey, also noting that the non-face-to-face claiming rules permit some interactions between supervisors and staff to be claimed directly when they relate to the specific direct care needs of a participant.

Estimated incremental cost impact	FY2020/21 cost impact ($m)	% of total Scheme costs
Changes to award loading	77	0.36%
Change in permanent/casual staff ratio assumption	59	0.28%
Change in Long Service Leave uptake assumption	184	0.85%
Change in workers compensation premium assumption	-176	-0.82%
Change in overhead loading assumption	204	0.95%
Change in supervision ratio assumption	-373	-1.74%
Change in non-travel staff allowance assumption	96	0.45%
Total impact	**71**	**0.33%**

In addition, the impact of reducing the TTP loading is an estimated $99 million (0.46%) reduction in payments during the 2021-22 financial year. However, this has not been included in the estimate of Scheme costs above, as this payment reduction has already been allowed for in projections of Scheme sustainability.

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1.3 Geographical classification - Modified Monash Model changes

The NDIA uses the Modified Monash Model (MMM) to determine regional, remote and very remote areas. In general, price limits are 40% higher in remote areas and 50% higher in very remote areas. There is no additional loading applied for supports in metropolitan areas, regional centres or regional areas. Geographic locations for the purpose of pricing are currently based on the 2015 MMM, and not the most recent 2019 MMM.

The PRU are recommending to update the NDIA's MMM classifications in accordance with the 2019 MMM classification released from the Department of Health. The net impact of moving to the MMM 2019 classification is estimated to be a decrease in total plan budgets of 0.01% (or $2.1 million reduction in projected participant costs for the 2020-21 year).

There is one behavioural aspect to consider for this change. Those participants in areas who are currently receiving funded supports with the remote or very remote loadings according to MMM 2015 and will have their geographical location changed to a non-remote area under MMM 2019 would likely receive a reduction in the dollar amount of their funding on plan review. The price of supports should also reduce by the same percentage amount as the funding. However, there is a risk that through either participant or planner behaviours, the plan review will try to adopt the same dollar value of support from previous plans.

1.4 Group rates

Providers of group-based supports currently use group prices published in the NDIS Price Guide to charge participants for supports. The ratios of workers to participants included in the price guide are 1:2, 1:3, 1:4 and 1:5, and where the actual support ratio differs the providers can discuss and agree on pricing with the participant. Providers of group-based supports are not permitted to bill for non-face-to-face services as the hourly price limits for these supports include an allowance for non-face-to-face services. Currently this equates to an additional seven minutes per hour for each participant in the group.

It is proposed that from 1 July 2020, the following changes be made to pricing for group-based supports:

- Group prices will no longer be included as line items in the Price Guide. Instead, providers will claim at the hourly price limits for 1:1 supports and apportion the costs between the number of participants in the group.

- Providers of group-based supports will be able to bill for non-face-to-face supports

These changes will simplify the NDIS Price Guide, and will align pricing rules for individual and group providers by allowing group providers to charge for non-face-to-face services.

It has been assumed that this will not have a material impact on Scheme costs as the proposed changes simply remove the proxy costs for non-face-to-face supports from the group prices and allows the provider to claim them as a separate expense. However, there is a risk that group providers may claim for non-face-

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to-face supports in excess of the assumed seven minutes per hour per participant which would result in an increase to overall Scheme costs.

Sensitivity scenarios are provided in the table below, showing the increase in Scheme costs as a result of additional time spent on non-face-to-face supports for group-based activities. An increase of 3-5 minutes spent on non-face-to-face supports (in excess of the 7 minutes already assumed) would be expected to increase costs by $65 million (0.3%) to $108 million (0.5%) in the 2020-21 financial year.

Group rates sensitivity analysis	Payments ($m)	% of total Scheme costs
Total projected payments FY2020/21	21,522	100%
Projected group-based support payments FY2020/21*	1,443	6.7%
Impact of additional time spent on non-face-to-face supports		
3 minutes per person	65	0.3%
5 minutes per person	108	0.5%

* Reflects payments for Core – Assistance with Social and Community Participation supports, where supports are delivered in a Centre or in the community

1.5 Indexation for DSW capacity building supports

Currently, all Capacity Building (CB) support price limits are being indexed based on the annual growth in Average Weekly Earnings (AWE)[7]. This assumes that all capacity building supports are provided by therapy professionals. However, there are some capacity building supports that are delivered by Disability Support Workers (DSWs). The indexation rate for DSWs differs from therapy, in that it is calculated as 80% of the annual growth in labour costs[8] and 20% of the annual growth in capital costs[9].

While it is proposed that most capacity building supports continue to be indexed based on AWE, those supports that are aligned with the DSW support price limits in the Core support class should be indexed in the same way. The following table shows the impact of indexing support items that are delivered by DSWs according to the DSW support price limits, instead of therapy price limits.

[7] In the twelve months to November 2019, Full-Time Adult Average Weekly Ordinary Time Earnings increased by 3.2% to $1,658.70. The Full-Time Adult Average Weekly Total Earnings in November 2019 was $1,720.90, an increase of 3.1% from the same time last year.
[8] This is represented by Fair Work Commission minimum wage increase decisions. From 1 July 2019, this was a 3.0% increase to the minimum wage.
[9] This is represented by the increase in the Consumer Price Index (CPI). From the December 2018 quarter to the December 2019 quarter, this was 1.8% (for all groups CPI).

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IMPACT OF CHANGE IN INDEXATION RATES FOR CAPACITY BUILDING SUPPORTS DELIVERED BY DSWS

	% of annual payments (CY 2019)	Gap in indexation rates between DSW and therapy -0.5%		1.0%	
		Impact (%)	Impact ($m)	Impact (%)	Impact ($m)
Support items delivered by Disability Support Workers (DSWs)[1]	0.6%	-0.003%	-0.7	0.006%	1.3
(plus) Support items that may also be delievered by DSWs[2]	3.6%	-0.018%	-3.9	0.036%	7.7

1. For the full list of support items underlying this analysis, please see Table 1 in Appendix C.
2. For the full list of support items underlying this analysis, please see Tables 1 and 2 in Appendix C.
Note: the impact of 0.006% is considered the 'best estimate'.

- If DSW price limits were 0.5% lower than therapy price limits, the impact on annual participant costs is a decrease of between 0.003% and 0.018% (or $0.7 million to $3.9 million for the 2020-21 projection year). This scenario is reflective of the approximate indexation rates that would be calculated based on recent inflation rates.

- However, if DSW price limits were 1.0% higher than therapy price limits, the impact on annual participant costs is an increase of between 0.006% and 0.035% (or $1.3 million to $7.7 million for the 2020-21 projection year).

This analysis indicates that the impact of this change in indexation is immaterial.

1.6 Commission travel

Travel continues to be a major barrier to the delivery of supports in remote and very remote areas and in some MMM4-5 regions. Commissioning of travel brokers for MMM6-7 and some MMM4-5 regions may allow these costs to be funded outside plans and drive efficiencies by coordinating participants and providers. This could ameliorate the need to commission other services. It also simplifies the planning process as it is not necessary to work out travel amounts when planning.

It has been proposed that the NDIS trial the commissioning of a travel broker arrangement in the Northern Territory, Queensland and Western Australia to coordinate participants and providers and pay for travel costs. It is expected that this trial will only apply to the delivery of capacity building supports rather than core supports as this is the area where participants face the highest barriers to access. This trial has not been costed by the OSA for the purposes of this review, noting that the impact would be quite small, as less than 1.5% of participants live in remote and very remote areas.

It is recommended that costs and outcomes be analysed post-trial to assess suitability of rolling out commission travel arrangements more broadly or for other support types.

1.7 Establishment fee

For each new participant, providers (who supply the participant with over 20 hours a week of personal care and community access supports) receive an establishment fee of $500. If the participant switches to another provider within their first plan, the new provider receives an establishment fee of $250. These

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amounts have remained unchanged since Scheme inception and is only payable for participants new to the Scheme (i.e. on their first plan).

However, providers have overhead costs with every participant new to their services – regardless of plan number – as they need to establish clients in the system (e.g. set up service bookings). Extending the establishment fee to be available for any provider[10] regardless of the participant's plan number would help address the complaint about the overhead allowance being insufficient[11].

To model the impact of this recommendation, three scenarios were considered. In each scenario, the majority (or 82%) of all active participants on subsequent plans with *Core – Daily Activities* or *Capacity Building – Social Community and Civic* are assumed to receive over 20 hours support. However, this is a conservative assumption; there will be some double-counting as participants may receive both *Core – Daily Activities* and *Capacity Building – Social Community and Civic*.

Of these participants considered,

- 2% change their provider with a new plan, and another 1% change their provider during the same plan ("Low" scenario)
- 5% change their provider with a new plan, and another 2.5% change their provider during the same plan ("Medium" scenario)
- 10% change their provider with a new plan, and another 5% change their provider during the same plan ("High" scenario)

The following table shows that the estimated impact on annual participant costs ranges from 0.01% to 0.06% (or $2.8 million to $13.8 million for the 2020/21 projection year).

IMPACT OF EXTENDING THE ESTABLISHMENT FEE TO NEW CLIENTS ON SUBSEQUENT PLANS

Projected 2020/21 participant costs	Low	Medium	High
Impact (%)	0.01%	0.03%	0.06%
Impact ($ million)	2.8	6.9	13.8

Note: the "Medium" scenario is considered the 'best estimate'.

Thus, the impact of this recommendation on participant costs is expected to be immaterial.

1.8 Program based supports

It is proposed that the NDIS Price Guide be amended from 1 July 2020 to allow providers to enter into contracts with participants for the provision of programs of supports of up to 12 weeks. Where a participant does not attend the program (or part of the program) they are billed as though they did attend – that is, this is not a cancellation, as long as the provider had the capacity to deliver the support. This decreases administrative burden for providers and allows them to better manage their workforce.

[10] Supplying over 20 hours a week of personal care and community access supports to a participant.
[11] These costs are currently absorbed into the overhead for providers.

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It is not yet clear what the guidelines will be to determine whether a support classifies as a 'program of support' however it is expected that it will cover most group-based Core – Assistance with Social and Community Participation supports and may also encompass supports provided in an Australian Disability Enterprise. Payments for these supports made up approximately 7% of total Scheme payments in the 12 months to 31 December 2019. It is not expected that therapy supports would classify as a program based support.

It is expected that this change will not have a material impact on Scheme costs. Under the current Price Guide, providers have been able to pass on the costs of cancellations to other people in the program i.e. instead of charging 1:3 rate they could charge 1:2 rate to the participants who attended. In this case, the proposed change will simply divert the cost of cancellation from the participants who show up to those who cancelled. However, there is a risk that up until now providers have chosen to absorb the costs of cancellations rather than pass them onto the other participants in the group. If this is the case, the new rules relating to program-based cancellations will result in an increase to Scheme costs. This impact has not been costed due to a lack of data and the timeframe available for analysis.

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2. Proposed new support items

Psychosocial recovery coach support items

Background

At the 9 October 2019 COAG DRC meeting it was agreed to introduce new support items for Psychosocial Recovery Coaching[12]. Six new support items are proposed to be added to the NDIS Support Catalogue from 1 July 2020[13].

The support items would be subject to national price limits[14], subject to remote and very remote loadings but not subject to the Temporary Transformation Payment or the Temporary 10% COVID-19 loading. Recovery coach competencies require minimum levels of tertiary qualifications and a minimum of two years' experience in mental health-related work, although recovery coaches will not be required to be allied health professionals. The proposed PRU assumptions lead to a 2019-20 daytime hourly price limit for psychosocial recovery coaches of $78.17, compared to $63.03 for a Disability Support Worker classified delivering Level 3 support with daily activities and compared to $98.06 for allied health professionals.

It has also been proposed that an Activity Based Transport support item for providers of psychosocial supports also be created in the relevant Support Category[15]. This carries some risk as Support Coordinators are in the same registration group as that proposed for psychosocial recovery coaches and they are not currently permitted to bill for activity based transport[16].

Discussion

At 31 March 2020 there were 34,210 active participants with psychosocial disability as their primary disability, about 9.3% of total active Scheme participants, and accounting for about 9.7% of annualised plan budgets within the Scheme. There are also a material number of participants who have a psychosocial disability as a secondary disability. The new support items therefore have the potential to impact a large proportion of participants.

The paper being prepared for the Pricing Reference Group (PRG) on 16 April 2020 assumes that the adoption of the psychosocial recovery coach approach within the NDIS should deliver higher levels of

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[12] This form of support and motivation is widely used in mental health and psychosocial disability services through the application of recovery principles to help deliver better outcomes for these people.
[13] The support items to be added will be for Support Category 7 (Support coordination) to support participants achieve outcomes in Outcome Domain 8 (Social and community participation) as shown in Appendix D.
[14] Per the Standard Disability Support Worker Cost Model with standard parameters except support worker pay point 4.4, support worker utilisation rate 805, Supervisor pay point 5.1 and supervisor utilisation rate 80%. The support items are proposed to be able to be claimed for Direct Service Provision; non-Face-to-Face Service Provision; Provider Travel, Cancellations and NDIA Report Writing, subject to the standard rules for those claims set out in the NDIS Price Guide. The six different price limits correspond to standard definitions of time of day and day of week in the NDIS Price Guide.
[15] Psychosocial recovery coaches may not only need to travel to meet participants in the community but may also need to transport participants as part of delivering their supports (for example, accompanying the participant to establish a relationship with another provider).
[16] It is proposed to deal with this issue by specifying in the description of the new Activity Based Transport support item that it can only be used for activities associated with psychosocial recovery coach supports

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self-management, lower plan management costs, and contribute to social and economic participation and higher levels of throughput for people with psychosocial disabilities in the Scheme. This would mean that the introduction of the proposed support items should help reduce long run outlays for these participants.

While the PRG paper's anecdotal discussion does not mention any evidence-based outcomes, the approach has strong support from the community mental health sector and state and territory governments. The recovery approach is particularly suited to the episodic nature of mental illness over a person's lifetime and other literature suggests recovery rates[17] of over 50%. It is therefore important that the funded supports and outcomes for participants with a psychosocial disability[18] are monitored over time. This will assist in assessing evidence-based outcomes associated with the use of psychosocial recovery coaches. In addition, this monitoring would assist in the early detection of any behavioural impacts associated with the implementation of these new support items.

There is an expectation that the role of psychosocial recovery coaches would replace support coordinators for participants with psychosocial disability, however there may be other behavioural factors which mean a duplication of that role, especially given that these will be separate support items in the NDIS Price Guide. Monitoring will help to better understand these behaviours. Under a COVID-19 environment, and given the relative immaturity of the market[19], there may not be significant initial take-up of these supports in the shorter term from July 2020.

The main control mechanism relating to financial sustainability is the ability to limit plan supports to the Typical Support Package of participants, particularly in relation to the capacity building component. Given that the TSP is a guide, rather than a rule, this approach to risk mitigation would need to be monitored.

Based on the above discussion, there is an expectation that the change will be cost-neutral in the shorter term, with an expectation of financial cost savings in the medium and longer term. However, this will likely depend on the behaviours of planners, providers and potential participants. The potential positive impact over the medium to longer term is premised on the achievement of longer term outcomes through the adoption of the recovery approach, and this should be monitored. No formal costing of this proposal has been undertaken, although once there has been enough experience, say in 12 months' time, a formal costing would be appropriate.

Hearing support items

The PRU has proposed the introduction of 8 new support items related to the provision of hearing aids and audiologist supports in the NDIS Price Guide from 1 July 2020.

To assist in costing the impact of this the following information has been provided:

- Advice from the *Director – Hearing Team, Subject Matter Experts and Advice* suggests an expectation of about 8,000 additional participants to get hearing supports from the NDIS, plus

[17] Recovery here refers to a person no longer having mental ill-health symptoms, not taking psychotropic medications, and are limited in only one of several domains.
[18] Including those participants with psychosocial disability as a secondary disability.
[19] Anecdotally, the market for the delivery of psychosocial recovery coaching supports is no better developed, and probably less well developed, than the general market for supports delivered by disability support workers.

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potentially another 2,000 to 3,000 who are currently privately funding their hearing needs as they are not eligible for the Commonwealth Hearing Services Program (HSP). There will also likely be some participants (unknown) that may request supports above what can be provided by HSP.

In addition, the following points are noted:

- There are currently about 17,500 active participants in the Scheme with hearing impairment as their primary disability. These participants have an average package of supports of about $15k, although on average about 60% of their plans are utilised.

- The HSP is currently included as an in-kind program within the Scheme and is due to "cash out" at 30 June 2020. The in-kind offset being applied to participants currently in the Scheme is estimated to be over $20 million for the 2019-20 financial year. This amount should be used as an offset to any direct increase in plan costs from the implementation of the new support item codes.

- The following table shows the projected number of future participants with a hearing impairment as their primary disability according to the Office of the Scheme Actuary's latest financial sustainability projections. These projections have an expectation of an additional 13,600 participants identified as having a hearing impairment as their primary disability between 1 July 2020 and 30 June 2023.

Latest Financial Sustainability Projections - Hearing Impairment

	2020	2021	2022	2023
Participant numbers at 30 June	19,369	24,807	29,208	32,993
Total projected cost	$227m	$299m	$361m	$413m
Average projected cost	$11,732	$13,556	$13,379	$13,269

The expected increase in participants to 30 June 2023 is not dissimilar to the estimates expected from the Director of the Hearing Team. The financial sustainability projections assume a gradual increase in participants over the three years from 1 July 2020. The cessation of the HSP in-kind program may lead to an intake pattern which is faster than projected above and this may have a financial sustainability impact over the shorter term.

Furthermore, if more participants with a hearing impairment than expected entered the Scheme as a result of the new hearing support items, this would be an additional unanticipated Scheme cost. Presumably, if these participants met the eligibility criteria for the Scheme then they would also be eligible for other supports.

The conclusion from this discussion and analysis is that the introduction of the eight new support categories are unlikely to have a significant financial impact on the Schemes financial sustainability, although there are a couple of key risk areas to consider.

This conclusion is premised on:

1. The projected number of new participants to enter the Scheme appears to be relatively consistent with the current financial sustainability projections.

2. The cost of the new support items is expected to be similar to the current in-kind offset applied to the Scheme through the HSP program (which is being cashed out from 1 July 2020).

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3. If there were to be higher numbers of participants with a hearing disability accessing the Scheme then it is likely that the average cost of the new supports will be low relative to current plan sizes.

The key risk is that the number of participants with hearing impairment entering the Scheme is higher than expected. The adherence to internal guidance around managing the eligibility criteria for people entering the Scheme with a hearing impairment should be closely monitored. Costings indicate that if an additional 5,000 to 10,000 participants were to enter the Scheme with a hearing impairment then this could equate to an additional 0.2% to 0.4% of Scheme cost during 2021-22. In terms of projected participant costs for the 2020-21 year, this would be $43.0 million to $86.1 million.

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Appendix A – Methodology for estimating non-labour costs for provider travel

The table below shows the assumed travel time per day and percentage of time spent travelling based on a $1,250 annul provider travel allowance.

Assumed travel time per day	
1. Average annual provider travel allowance	$1,250
2. Assumed cost of travel per km	$0.85
3. Average km travelled per year (1÷2)	1,471
4. Assumed average speed kmph	40
5. Average hours travelled per year (3÷4)	37
6. Average working hours per year	1368
7. Number working days per year (6÷7.5)	182
8. Average minutes travelled per day (5÷7*60)	12
9. % support time spent travelling (5÷6)	3%

The following approach has been used to calculate the cost impact of allowing providers to claim the non-labour costs of provider travel:

1. Only support types that are eligible for provider travel are included in the analysis[20]. These are:
    - Attendant care (non-SIL),
    - Delivery of health-related supports
    - Other assistance with daily life
    - Community & social activities
    - Therapy supports (including ECEI)

2. Calculate the average cost per hour for each support type based on non-remote prices in the NDIS price guide (note this is the price guide effective from 1 March 2020 to 24 March 2020 prior to the COVID-19 price loadings). Average costs per support type are determined based on the payment distribution of each individual support line item associated with that support type over the period 1 January 2019 to 31 December 2019.

3. Adjust average costs for the proportion of participants living in remote areas (40% payment loading) and very remote areas (50% payment loading). This is based on the distribution of total payments by MMM classification over the period 1 January 2019 to 31 December 2019.

4. Calculate the average annual costs per worker by multiplying average cost per hour by average working hours in a year. This is 1,368 hours based on results from the TTP provider survey.

5. The percentage increase per support type is calculated as the estimated annual non-labour costs per worker ($1,250), divided by the estimated average labour cost per worker (from Step 4)

6. The estimated increase in total Scheme costs is calculated by:
    - Multiplying the percentage increase per support type by the proportion of total Scheme payments for that support type (based on distribution of actual payments over 1 January 2019 to 31 December 2019)

[20] Note that while most capacity building supports will be eligible for provider travel (excluding ADE, SLES and plan management fees), the resulting price increases are assumed to be represented by changes in therapy supports which represent 88% of all eligible capacity building payments.

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- Adding together the estimated increases across each of the relevant support types.

Appendix B – Estimated impact of proposed changes to the SCHADS award filenote



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Appendix C – Indexation of support items within Capacity Building

TABLE 1: CAPACITY BUILDING (CB) SUPPORT ITEMS DELIVERED BY DISABILITY SUPPORT WORKERS

Support Item Number	Support Item Name	Support Item Description
09_007_0117_6_3	Skills Development In A Group	Training for the participant in a group of 2 or more to increase their independence in daily personal activities.
09_009_0117_6_3	Individual Skills Development And Training	Individual life skills development and training including public transport training and support, developing skills for community, social and recreational participation.
09_010_0125_6_3	Community Participation Activities	Participation in community based activities that build skills and independence.
11_024_0117_7_3	Individual Social Skills Development	Social skills development with an individual, for participation in community and social activities.
15_037_0117_1_3	Individual Skill Development And Training Including Public Transport Training	Individual training provided in the home for general life skills to increase independence.
15_038_0117_1_3	Training For Carers/Parents	Training for carers in matters related to caring for a person with disability.

TABLE 2: CAPACITY BUILDING (CB) SUPPORT ITEMS THAT MIGHT ALSO BE DELIVERED BY DISABILITY SUPPORT WORKERS

Support Item Number	Support Item Name	Support Item Description
07_001_0106_8_3	Level 1: Support Connection	Assistance for participants to implement their plan by strengthening the ability to connect with the broader systems of supports and understand the purpose of the funded supports and participate in the community. Support Connection will assist a participant to understand the aspects of the plan, assisting in ongoing management of supports, and answer questions as they arise.
07_002_0106_8_3	Level 2: Coordination Of Supports	Further qualifications/experience required to strengthen a participant's ability to design and the build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment. Coordination of Supports is to focus on supporting participants to direct their lives, not just their services. This may include resolving points of crisis, and developing resilience in the participant's network.

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07_003_0117_8_3	CB and Training in Plan and Financial Management by a Support Coordinator	Capacity building and training in plan administration and management with a participant to strengthen their ability to undertake tasks associated with the management of their supports. Providers of this support are to assist the participant to build capacity to undertake all aspects of plan administration and management, including: engaging providers; developing service agreements; maintaining records; claiming payments from the NDIA; and paying providers.
08_005_0106_2_3	Assistance With Accommodation And Tenancy Obligations	Support is provided to guide, prompt or undertake activities to ensure the participant obtains and/or retains appropriate accommodation. May include assisting to apply for a rental tenancy or to undertake tenancy obligations.
09_006_0106_6_3	Life Transition Planning Incl. Mentoring, Peer-Support And Indiv Skill Develop	Establishing volunteer assistance within the participant's home or community to develop skills. For instance, assistance in attending appointments, shopping, bill paying, taking part in social activities and maintaining contact with others.
10_016_0102_5_3	Individual Employment Support	This support can be applied to any working age participant (including students reaching working age) with an employment goal.
10_017_0102_5_3	Employment Preparation And Support In A Group - Group Of 3	These support can be applied to any working age, as above, but is offered in a group environment.
13_030_0102_4_3	Transition Through School And To Further Education	Provision of skills training, advice, assistance with arrangements and orientation to assist a person with disability moving from school to further education.
14_031_0127_8_3	CB and Training in Plan and Financial Management by a Plan Manager	Capacity building and training in plan administration and management with a participant to strengthen their ability to undertake tasks associated with the management of their supports. Providers of this support are to assist the participant to build capacity to undertake all aspects of plan administration and management, including: engaging providers; developing service agreements; maintaining records; claiming payments from the NDIA; and paying providers.
15_035_0106_1_3	Assistance With Decision Making, Daily Planning and Budgeting	Provision of time limited support to assist a person to develop and maintain daily budget, including assisting in planning purchases (including COVID19 loading).

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Appendix D – Proposed psychosocial support items

Support Item Number	Support Item Name	Support Item Description
07_101_0106_6_3	Psychosocial Recovery Coaching - Weekday Daytime	Assistance for participants to foster hope, build capacity and resilience, by working collaboratively with participants, families and other services to identify, plan, design and coordinate supports. Assistance to maintain engagement through periods of increased support needs due to the episodic nature of mental illness. Psychosocial recovery coach work requires both lived and learnt experience. They must have tertiary qualifications in peer work or mental health (minimum of Certificate IV in Mental Health Peer Work) or equivalent training; and a minimum two years of experience in mental health-related work.
07_102_0106_6_3	Psychosocial Recovery Coaching – Weekday Afternoon/Evening	
07_103_0106_6_3	Psychosocial Recovery Coaching - Saturday	
07_104_0106_6_3	Psychosocial Recovery Coaching - Sunday	
07_105_0106_6_3	Psychosocial Recovery Coaching – Public Holiday	
07_106_0106_6_3	Psychosocial Recovery Coaching – Night	

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Matter for Decision

Review of Pricing Arrangements for Supported Independent Living

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 To seek the endorsement of the Pricing Reference Group (PRG) for the recommendations of the Review of Pricing Arrangements for Supported Independent Living (SIL), as outlined in the draft report at Attachment A.

2. Recommendations

2.1 That PRG **AGREE TO RECOMMEND TO THE NDIA BOARD, THROUGH THE CHIEF EXECUTIVE OFFICER**, no changes to the current SIL pricing arrangements as the efficient costs of delivering supports in SIL are essentially identical to the efficient costs of delivering activities of daily living in a non-SIL setting.

2.2 That PRG **AGREE TO RECOMMEND TO THE NDIA BOARD, THROUGH THE CHIEF EXECUTIVE OFFICER**, that the Operational Guideline for SIL should be reviewed to provide further information on non-pricing related issues:

(a) clearer advice on the circumstances in which high intensity supports and sleepover/active overnight supports will be included in SIL plans;

(b) for change of circumstance reviews when vacancies materially impact the cost of delivering supports to participants in SIL settings; and

(c) agreed timeframes for plan review in SIL, with greater certainty for providers about revenue when plan reviews are not completed or billing issues are not addressed in an appropriate timeframe.

- This includes providers to be able to claim for the appropriate support worker to participant ratio when vacancies arise until a plan review is conducted if appropriate.

3. Background

Supported Independent Living Supports

3.1 Within the NDIS, Supported Independent Living is one type of help or supervision with daily tasks to help participants live as independently as possible, while building their skills.

(a) SIL is paid personal support that includes things like someone to help with personal care tasks or cooking meals. SIL can help build these skills too. SIL provides assistance with, or supervision of, tasks of daily life in a shared living environment, with a focus on developing the skills of each individual to live as autonomously as possible. The support is provided to each person living in the shared arrangement in accordance with their need. Supported Independent Living does not include rent, board and lodging or other day-to-day usual

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DISCLOSURE LOG

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living expenses such as food and activities. It also does not include the capital costs associated with a participant's accommodation.

3.2 SIL is similar to assistance with daily living supports in many ways, the main differences being that SIL is intended for participants who require 24/7 care and live in shared living arrangements with other NDIS participants. Other contemporary living models exist for participants, including the use of assistive technology and home modifications, or Individualised Living Options (ILO).

3.3 Before July 2020, a SIL quote would cover a whole year, whereas assistance with daily life supports are charged by the hour when it was delivered.

3.4 On 1 July 2020, the NDIA replaced the previous quotation pricing arrangements for Supported Independent Living with price limits based on 'assistance with self-care' supports. These changes made for Supported Independent Living were designed to increase transparency and equity of how SIL supports are funded, as well as to simplify previously administratively complex processes.

3.5 Different price limits apply depending on the Time of Day and Day of Week on which the support is delivered, and whether the supports are High Intensity Supports.

The Review

3.6 The purposes of the Review were to:

(a) examine the cost drivers and differences that arise in the delivery of personal support in a shared living arrangement,

(b) seek perspectives on the appropriateness of the assumptions and parameters used in the Disability Support Worker Cost Model for personal support supports in shared living arrangements and,

(c) seek to refine the assumptions and parameters for setting SIL price limits.

3.7 The Review engaged in extensive consultations with industry, community and government stakeholders and undertook a program of research.

(a) This includes 92 submissions received in response to an Issues Paper that was released by the Review. For reference, the Issues Paper is found at Attachment B.

3.8 The primary data source used for analyses in the Review was the 2019-20 Financial Benchmarking Survey data comprising of a sample of 848 providers, with 221 SIL providers. Secondary data sources used were financial deep dive information received through Deloitte Access Economics (n=9), who assisted the Agency conducting the Review, Alliance20 (n=11) and Ability First (n=13).

3.9 Further information on the background and methodology can be found in the draft report at Attachment A.

4. Discussion – Recommendation 2.1

4.1 The draft report at Attachment A goes through all topics under review for SIL pricing arrangements, with the analyses based on quantitative evidence (Financial Benchmarking Survey and financial deep dives) and qualitative information (responses to the Issues Paper and consultations).

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4.2 The Review found that there was evidence to suggest that, compared to activities of daily living services delivered in a non-SIL setting by an efficient provider, an efficient SIL provider faces:

(a) higher rates of permanent employment (85.1% compared to 70.0%);

(b) higher workers compensation premiums (2.4% compared to 1.7%);

(c) higher average utilisation rates (94% compared to 92%);

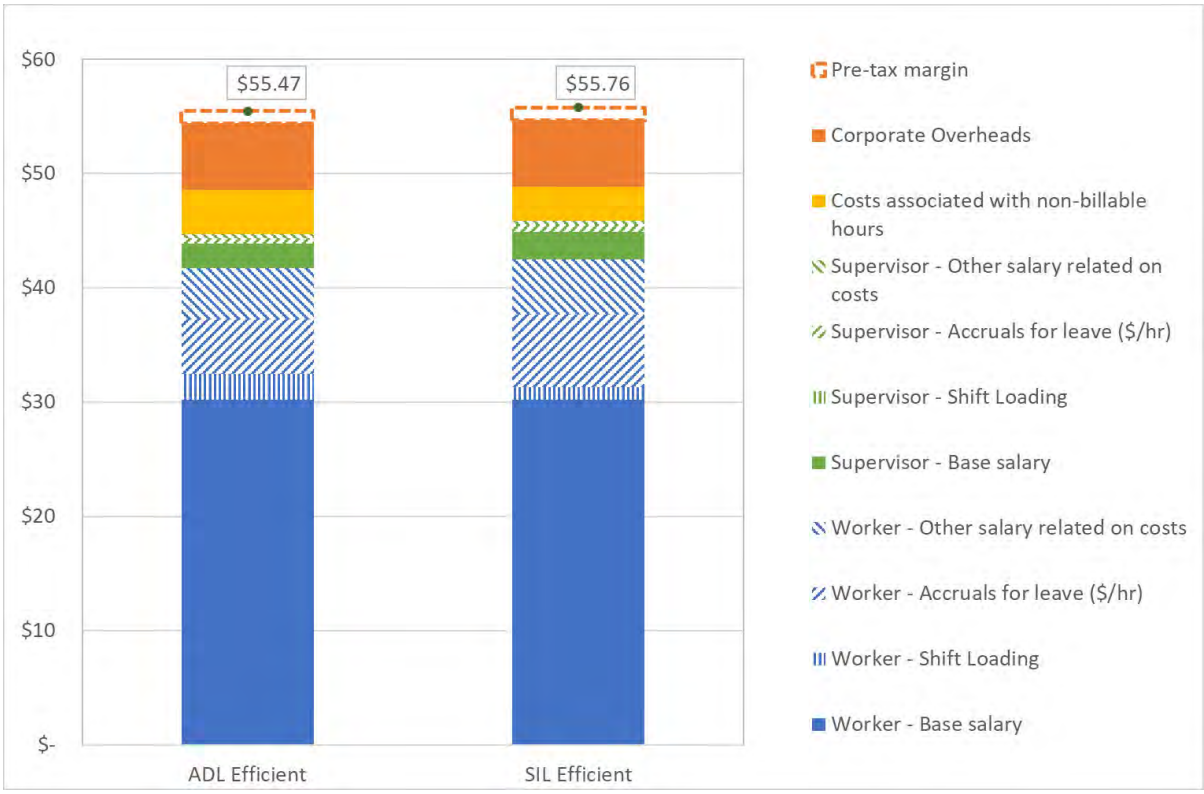
(d) higher base wages for supervisors (11.9% higher on average); and

(e) higher annual leave costs associated with great leave entitlement (5 weeks per year compared to 4 weeks per year).

4.3 Some of these effects add to the cost of service provision whereas others reduce that cost. The net effect, as Exhibit 30 (taken from the draft report) shows is that the fully loaded costs of efficient service provision in SIL and non-SIL settings are essentially identical. That is, $55.47 for efficient assistance with daily living providers compared to $55.76 for efficient SIL providers.

4.4 As such, the Review does not recommend any changes in the current SIL pricing arrangements.

Exhibit 30: Efficient Costs in SIL and Non-SIL Settings



5. Discussion – Recommendation 2.2

5.1 The Review acknowledges that providers and planners do not always agree on whether the cost of a SIL roster of care should be calculated using the standard or high intensity price limits or whether the cost of a SIL roster of care should include active overnight or a sleepover.

5.2 While these affect the value of the SIL plan, they are not a pricing issue, and the Review considers that this is a matter best addressed through the Operational Guideline for SIL.

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5.3 Further, the Review also recognises that providers are required to continue to provide support to an existing resident participant during the period of a plan review and that there is therefore a risk that they will provide supports at a different support ratio to those that are eventually approved as part of the plan review.

5.4 The Review acknowledges that vacancies present issues for providers and participants, however, this should not be considered a deficiency in the unit price limit, but rather in the planning arrangements which do not always adjust participant plans to maintain supports in response to vacancies.

5.5 If vacancies were relatively uniform across the sector then it would be possible to adjust the unit price for vacancy risk. However, the available data does not indicate that vacancies are uniformly distributed and so this issue is best addressed through plan review rather than through a change in the pricing arrangements.

5.6 The Review considers that there are strong arguments for this risk to be shared by the provider and the NDIA, so that if the NDIA does not complete the planning review within an agreed timeframe then the provider should be entitled to be paid for the supports that they are delivering until the plan review is completed.

5.7 Therefore, the Review recommends that the Operational Guideline for SIL should be reviewed to provide:

(a) clearer advice on the circumstances in which high intensity supports and sleepover/active overnight supports will be included in SIL plans;

(b) for change of circumstance reviews when vacancies materially impact the cost of delivering supports to participants in SIL settings; and

(c) agreed timeframes for plan review in SIL, with greater certainty for providers about revenue when plan reviews are not completed or billing issues are not addressed in an appropriate timeframe.

6. Next steps

6.1 The draft report, through the CEO, will be presented to the NDIA Board at the 25 May 2021 meeting.

6.2 The Price Regulation Unit is responsible for working with other areas of the Agency to roll out the recommendations of the Review, including advice for participants, providers, partners and NDIA staff.

6.3 If approved, recommendations will be implemented from 1 July 2021, with the intention to be published four weeks prior to implementation.

6.4 A communications plan will be developed to support the publication of the report for the pricing arrangements for SIL.

7. Risks

7.1 Due to existing Scheme sustainability concerns, the sector may view the current Review of Pricing Arrangements for SIL as a “cost-cutting” exercise. These concerns can be mitigated through ongoing communications for the Review, as this Review is only a small component of a much larger ongoing program to make improvements to the way participants receiving supports in shared living arrangements are supported.

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7.2 The wider improvements to SIL will seek to improve participant choice and control, simplify NDIA processes, and address pressures to Scheme sustainability. Improvements will be made through a series of changes, and will undertake a series of consultations with participants, providers and the wider sector as these changes are considered.

Attachment(s):

A Review of Pricing Arrangements for Supported Independent Living Draft Report

B Review of Pricing Arrangements for Supported Independent Living Issues Paper

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National Disability Insurance Scheme

Review of Supported Independent Living Price Controls

Issues Paper

August 2020

Delivered by the National Disability Insurance Agency

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Issues Paper

The National Disability Insurance Agency (NDIA) has released this Issues Paper seeking inputs to inform the cost parameters required to estimate the fully loaded cost of the delivering an hour of personal care in a shared living arrangement.

This issues paper invites submissions from providers of SIL services and impacted stakeholders on a range of issues which will be considered in developing price limits for SIL services. Individuals and organisations should not feel that they are restricted to comment only on matters raised in the Issues Paper.

Key date

Due date for submissions: **Sunday 25 October 2020, 11:59pm AWST**

Submissions can be lodged by email to: Pricing@ndis.gov.au

Contact details for administrative and other matters:

NDIS Contact Centre

Monday to Friday, 8am – 8pm (local time)

Phone: 1800 800 110

Email: enquiries@ndis.gov.au

Website: Have your say on the NDIS website

Further information

Further information on pricing in the National Disability Insurance Scheme can be found at the NDIS website.

Terms that we use

NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
SIL	Supported Independent Living

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Contents

Introduction **4**

Definitions 5

Responding to the Review 5

Issues for Participants **7**

Issues for Providers **8**

Wages and on-costs 8

Workforce mix 9

Utilisation 10

Supervision cost 10

Overheads 11

Supply costs specific to SIL services 11

Other costs 13

Appendix A: Schematic overview – NDIS Disability Support Worker Cost Model **14**

Appendix B: Current arrangements **15**

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Introduction

One of the principal objectives of the National Disability Insurance Scheme (NDIS) is for people with disability to exercise choice and control over how, and with which providers, they spend their available budgets. The role of pricing in the NDIS is therefore very important. Prices, or more precisely participants' choices in response to the prices they face in the market, reflect the preferences and relative values that different participants place on different types of supports. The aggregation of these individual responses in turn signals to providers the quantity and mix of supports to supply. Prices also affect the purchasing power of participants. Higher prices reduce the supports participants can purchase within a given support budget. Prices also affect the total costs of the NDIS and therefore its financial sustainability, and the allocation of resources to the NDIS (and therefore possible production), relative to other sectors. Pricing can also affect providers' choices, including by providing incentives: for entering the market; for upskilling and right-skilling; for innovation; and for improvements in service quality and outcomes.

As the markets for disability goods and services develop and operate more effectively, the National Disability Insurance Agency (NDIA), as market steward for the NDIS, will be able to be less interventional. However, deregulation will necessarily occur at different points in time for different markets and may not be feasible in some cases. Currently, the NDIA varies its approach to the regulation of prices between:

- No regulation (deregulated markets): this applies in cases where markets are highly competitive – for example, transport.
- The imposition of price limits: these represent a maximum allowable price payable by participants for types of supports. This approach applies in a significant number of markets, which are still developing and growing, such as those for attendant care.
- Quotable supports: in which participants are expected to obtain quotations from suppliers to provide to the NDIA as part of verifying that prices are fair and reasonable. This approach typically applies in the case of highly specialised, differentiated supports that may not have a high level of competition – for example, assistive technology.

The NDIS Disability Support Worker (DSW) Cost Model is one methodology that the NDIA uses to inform its pricing decisions for those supports delivered by Disability Support Workers on which it imposes price limits. A copy of the NDIS DSW Cost Model is at: link to NDIS DSW Cost Model. A schematic overview of the Model is at Appendix A.

On 1 July 2020, the NDIA replaced the previous quotation pricing arrangements for Supported Independent Living with price limits based on 'assistance with self-care' supports. These changes made for Supported Independent Living were designed to increase transparency and equity of how SIL supports are funded, as well as to simplify previously administratively complex processes.

The NDIA is committed to improving transparency and fairness in its processes and decision -making, and is conducting a review of the price controls for Supported Independent Living with the outcomes to come into effect later in 2020. The Review is tasked with suggesting improvements to the structure of the NDIS Disability Support Worker Cost Model, including:

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- identifying whether there are different costs that arise in the delivery of attendant care supports in a shared living arrangement that do not arise in other settings; and
- quantifying any differences that may be required in the key parameters of the NDIS Disability Support Worker Cost Model for attendant care supports in sharing living arrangements, given the different cost structures of delivering supports in shared living arrangements compared to other settings .

The NDIA is seeking input from the sector and interested parties to this Review to inform the cost parameters required to estimate the fully loaded cost of delivering an hour of SIL supports in a shared living arrangement.

This review of prices for SIL supports **is not about reducing funding for reasonable and necessary SIL supports**. Neither is it about the volume of supports that participants receive. The purpose of this review is simply to seek your feedback on whether the current price limits per hour of SIL support delivered are appropriate.

This review is also only a small component of a much larger ongoing program to make improvements to the way participants receiving supports in shared living arrangements are supported. The wider improvements to SIL will seek to improve participant choice and control, simplify NDIA processes, and address pressures to Scheme sustainability. Improvements will be made through a series of changes, and will undertake a series of consultations with participants, providers and the wider sector as these changes are considered.

Definitions

The Price Guide defines SIL as follows:

"These support items provide assistance with, or supervision of, tasks of daily life in a shared living environment, with a focus on developing the skills of each individual to live as autonomously as possible. The support is provided to each person living in the shared arrangement in accordance with their need. Support Independent Living does not include rent, board and lodging or other day-to-day usual living expenses such as food and activities. It also does not include the capital costs associated with a participant's accommodation."

SIL is similar to attendant care in many ways, the main differences being that SIL is intended for participants who require 24/7 care and live in shared living arrangements with other NDIS participants. (There is a small amount of SIL provided outside of group houses, as a legacy of previous state schemes.)

Before July 2020, a SIL quote would cover a whole year, whereas attendant care is charged by the hour when it was delivered.

The NDIS Price Guide can be found at: link to NDIS Price Guide

Responding to the Review

The NDIS Disability Support Worker Cost Model estimates the efficient cost of delivering a billable hour of support taking into account all of the costs associated with every billable hour, including: base pay; shift loadings; leave pay; salary on costs; supervision costs;

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utilisation (non-billable activities); employee allowances; corporate overheads and margin. These estimates are the basis of the price limits set by the NDIA for supports delivered by Disability Support Workers.

In adapting the NDIS Disability Support Worker Cost Model to set price limits for SIL services, there are a number of aspects of the Cost Model that may need to be adapted or refined. The following sections outline the key areas and invite feedback from providers on a range of targeted questions. Some of these areas relate to differential supply costs for delivering non-SIL compared to SIL services, while other areas relate to cost drivers that are unique to providing SIL services.

Providers are also welcome to provide feedback on any other issues that they consider relevant to this review. Providers are encouraged to refer to or send in data and/or evidence to support statements that are made in responding to each/any of the questions. This includes any applicable cost models for relevant SIL services. Information marked as commercial-in-confidence will not be published.

Submissions can be lodged by email to: Pricing@ndis.gov.au . Submissions must be lodged by Sunday, 25 October 2020, 11:59pm AWST.

Confidential submissions

Submissions to the Agency that are marked as commercial-in-confidence will not be published.

The NDIA has engaged Deloitte Access Economics to assist the Agency in undertaking this review. If preferred, respondents may give confidential information, including commercial-in-confidence data/information, directly to the team from Deloitte Access Economics at SILpricingreview@deloitte.com.au. This information will not be provided to the NDIA unless the submitter gives their consent, and any reference to this information by Deloitte in their reports to the Agency will maintain the anonymity of the source.

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Issues for Participants

Under the quotable support arrangements for Supported Independent Living that were in place before 1 July 2020, participants did not always have a high degree of control over the services offered by the group house in which they lived.

The Agency wants to empower participants to have more involvement in selecting their reasonable and necessary supports and who supports them to undertake daily activities in their home. We also want to simplify the process for providers. The changes that were made to the pricing arrangements on 1 July 2020 for Supported Independent Living were designed to increase transparency and equity of how SIL supports are funded, as well as to simplify previously administratively complex processes. In addition to the implementation of price limits, operational changes and guidance were also released to increase participant involvement and understanding of their SIL supports.

The aim of these consultations is to understand how the move from quotable supports to price limits may impact on participant experience of engaging service providers and receiving services within a Supported Independent Living environment, and the potential impact that price limits may have on improving participant choice and control.

Your views will be considered in the review and reflected in reports developed during the process.

1) What do you consider are the potential advantages or disadvantages for participants with regards to this new approach to Supported Independent Living?
2) Are there particular factors you think the Agency should be aware of regarding how Supported Independent Living and related supports are defined, costed and charged to participants?

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Issues for Providers

Wages and on-costs

The NDIS Disability Support Worker Cost Model recognises that wages and on-costs are the largest cost driver for providing disability support services. The NDIA is therefore seeking detailed evidence on whether there are material differences between the base hourly wages paid to, and the on-costs associated with, SIL workers and non-SIL workers.

Base hourly wage refers to the minimum hourly rate of pay received by a worker, not including any shift or leave loading, superannuation or allowances.

Salary on-costs refers to costs such as superannuation, workers compensation premiums, payroll tax, and employee allowances.

Base Wages

3) Is there a material difference in the base hourly wages paid to workers delivering SIL services compared to workers delivering non-SIL services?

   Does this reflect different levels of required training, the nature of the work, or some other reason? How large is this difference?

On-costs

4) Are salary on-costs different for workers delivering SIL services compared to workers delivering non-SIL services?

   What aspects of each service type necessitate this difference? How large is this difference?

Overtime

5) Do you observe significant differences in the rate of overtime costs between staff delivering SIL services compared to non-SIL services?

   What aspects of each service type necessitate this difference? How large is this difference?

Leave costs

6) Are leave costs different for workers delivering SIL services compared to workers delivering non-SIL services?

   What aspects of each service type necessitate this difference? How large is this difference?

Enterprise Bargaining Agreements (EBAs)

7) Does your organisation currently operate an WBA for some or all of its employees:

   Do the EBA conditions differ for workers delivering SIL services compared to non-SIL services?

   Which conditions are different, and why? How large is this difference?

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Workforce mix

The NDIS Disability Support Worker Cost Model recognises that the costs of employing casual and permanent workers are different. The NDIA is therefore seeking detailed evidence on whether there are material differences in these arrangements between SIL workers and non-SIL workers.

Casual staff

8) Is there a material difference in the proportion of employees employed on a casual basis between employees providing SIL and non-SIL services?

   If there is a difference, which aspects of SIL service delivery are suited to more (or fewer) permanent employees relative to casual employees? How large is this difference?

9) What is the average number of hours per week that a casual staff member is employed in your organisation?

10) Is there a material difference in the average number of hours per week that a casual staff member is employed in your organisation between employees providing SIL and non-SIL services?

    If there is a difference, how large is this difference?

Part-time staff

11) Is there a material difference in the proportion of employees employed on a part-time basis between employees providing SIL and non-SIL services?

    If there is a difference, which aspects of SIL service delivery are suited to more (or fewer) part-time permanent employees relative to full-time permanent employees? How large is this difference?

12) What is the average number of hours per week that a part-time staff member is employed in your organisation?

13) Is there a material difference in the average number of hours per week that a part-time staff member is employed in your organisation between employees providing SIL and non-SIL services?

    If there is a difference, how large is this difference?

Agency staff / temporary replacement staff

14) Are temporary replacement staff engaged more or less often for SIL services?

    If there is a difference, what are the key drivers of this difference? How large is this difference?

15) Is the cost of the temporary replacement staff different between SIL services and non-SIL services?

    If there is a difference, what are the key drivers of this difference? How large is this difference?

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Level of staff

16) What level of worker do you use for standard vs higher requirements, and when do you decide if a participant requires higher-intensity support?

Utilisation

The NDIS Disability Support Worker Cost Model recognises that staff need to spend some working time undertaking non-billable work, including breaks and training. The NDIA is therefore seeking detailed evidence on whether there are material differences in these arrangements between SIL workers and non-SIL workers.

Training requirements

17) Do training requirements – and associated costs – for workers differ between SIL services and non-SIL services?

    If there is a difference, what are the key drivers of this difference? What aspects of delivering SIL services require more (or less) staff training? How large is this difference?

18) Do initial training requirements – and associated costs – for new workers differ between SIL services and non-SIL services?

    If there is a difference, what are the key drivers of this difference? What aspects of delivering SIL services require more (or less) staff training? How large is this difference?

Other non-billable activities

19) Is there a material difference in the non-direct care activities that staff in SIL services, compared to staff in non-SIL services, are required to undertake (for example: handover between shifts and/or note-taking specific to the individual).

    If there are differences, what are the key drivers of these differences? How large are these differences?

Supervision cost

The NDIS Disability Support Worker Cost Model recognises that staff require direct supervision of the care that they provide, as well as management support. They key parameters in the Cost Model associated with supervision are the wages and conditions of the supervisor, and the supervision ratio. The NDIA is therefore seeking detailed evidence on whether there are material differences in these arrangements between SIL workers and non-SIL workers.

Supervisor wages and on-costs

20) Is there a material difference in the wages and on-costs of supervisor in SIL services compared to non-SIL services?

    If there is a difference, what are the key drivers of these differences? How large is the difference?

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Supervision ratio

21) Is there a difference in the number of workers per supervisor for SIL services compared to non-SIL services?

    If there is a difference, what aspects of service delivery mean that more or fewer supervisors are required? How large is the difference?

Overheads

The NDIS Disability Support Worker Cost Model that providers incur a number of costs ("overheads") that not directly attributable to worker salaries and on-costs. The NDIA is therefore seeking detailed evidence on whether there are material differences in these costs between SIL workers and non-SIL workers.

Corporate overheads

22) Is there a difference in the level of corporate overheads that are incurred in delivering SIL services compared to non-SIL services?

    If so, what aspects of the SIL operating environment drive this difference? How large is the difference?

Turnover rates

23) Do staff turnover rates differ between staff who deliver SIL services compared to non-SIL services?

    If so, what aspects of the SIL operating environment drive this difference? How large is the difference?

24) What costs are incurred when staff turnover? Do these costs differ between staff who deliver SIL services compared to non-SIL services?

    If so, what aspects of the SIL operating environment drive this difference? How large is the difference?

Supply costs specific to SIL services

The NDIA recognises that there may be a number of supply cost considerations that are specific to delivering SIL services. The NDIA is therefore seeking detailed evidence on these costs and their drivers.

Vacancy management

25) What is the average vacancy rate across your properties?

26) Is the vacancy rate of a property influenced by factors such as the complexity of participants in each property, the rurality of the property, and the number of rooms in the property?

27) What factors are considered in optimising the number of participants per SIL property? What impact does this have on costs?

28) What approach is used to optimise vacancy levels across your properties?

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Vacancy costs

29) How do vacancies impact the costs of delivering SIL services?

    Please quantify these costs for your organisation?

30) Some costs associated with vacancies can be considered to be "fixed" – for example, an inactive sleepover for a three bedroom house has the same cost whether there are two or three participants in the house. Other costs can be considered to be more "variable" – for example, the vacancy costs of a three bedroom house with three residents each receiving 1:1 supports can, in general, be managed through change in rostering.

    What proposition of vacancy costs are fixed or variable in your organisation?

Participant complexity

31) What impact does participant complexity have on the costs of delivering supports in the SIL environment?

32) What approach is used to optimise the allocation of participants with different support needs across your properties?

Shift costs

33) How many shifts are provided in a 24-hour period? To what extent is the number of shifts driven by factors such as the number of participants in the property, the mix of support needs within the property, or other factors?

34) How do sleepover and crossover shifts impact on supply costs?

Establishment costs

35) On an annual basis, how often is a new participant established in a property?

36) Is there a material difference in the costs of establishing a participant between SIL and non-SIL services?

    If so, what aspects of the SIL operating environment drive this difference? How large is the difference?

    How is this influenced by factors such as the complexity of the participant's needs, the existing number of participants and/or rooms within a property, or other factors?

Location differences

37) Do costs for delivering SIL services differ significantly between metropolitan centres versus regional, rural and remote areas? If so, what is the average cost differential, and what elements of the cost drive this difference?

Other supply costs

38) In delivering SIL services, what proportion of Disability Support Worker time is spent on providing support to participants? Note that this includes time directly interacting with participants, as well as tasks which do not involve direct interaction with participants such as preparing meals or sleepover shifts.

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Other costs

39) Are there any additional costs incurred in non-SIL or SIL services, which are not currently captured in the Cost Model?

Please provide details.

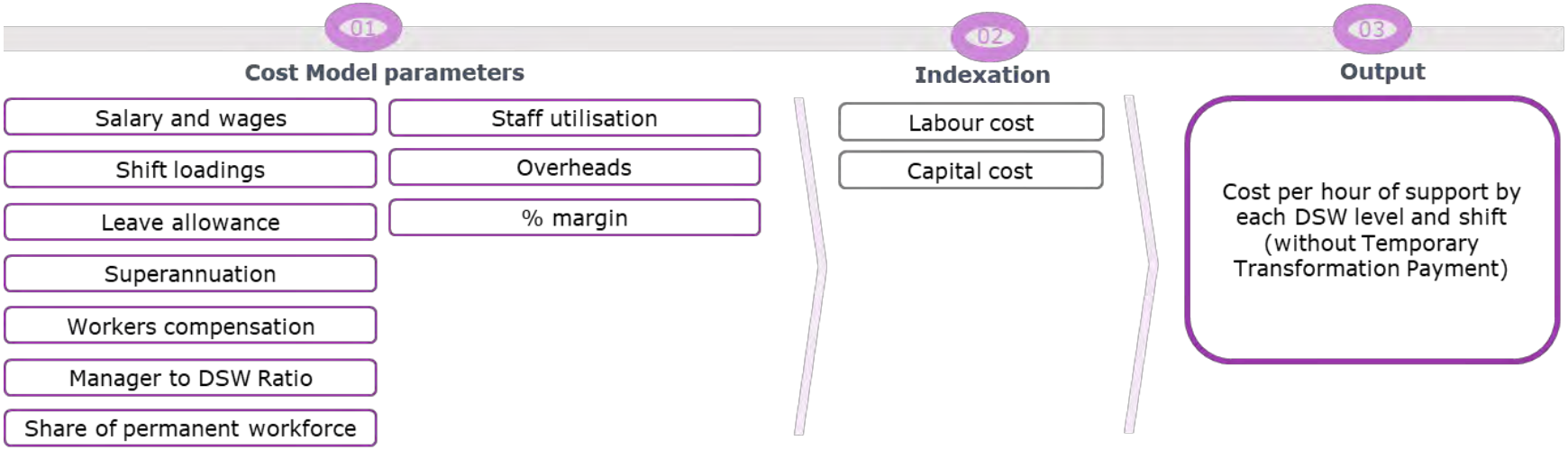
40) What additional costs are being incurred as a result of COVID-19?

Please provide details.

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DISCLOSURE LOG

Appendix A: Schematic overview – NDIS Disability Support Worker Cost Model



	Parameter	How is this reflected in the Cost Model?
1	Base pay	Four DSW levels (2.3, 2.4/3.1, 3.2 and 4.4) based on SCHADS classification
2	Shift loadings	Applies a loading for permanent staff working on weekends, public holidays, afternoons, and nights. Applies a casual loading for weekdays, weekends, public holidays, afternoons, and nights.
3	Leave allowance	Includes annual leave, personal leave, public holiday, long service leave
4	On-costs	Superannuation (9.5%) , workers compensation (1.7%), employee allowance (1.0%)
5	Supervision costs	Base pay + leave costs + on-costs for supervisors with four levels of supervisor pay. Supervisor to DSW ratio of 1 to 15
6	Permanent workforce	Assumes 70% of workforce
7	Utilisation	Incorporating breaks, training, and other. Varies across staff levels.
8	Overheads	Assumes 12.0% of direct cost
9	Margins	Assumes 2%
10	Indexation	Fair Work Commission, Equal Remuneration, CPI

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Appendix B: Current arrangements

The Supported Independent Living support items in the NDIS Support Catalogue provide participants with assistance with, or supervision of, tasks of daily life in a shared living environment, with a focus on developing the skills of each individual to live as autonomously as possible. The support is provided to each person living in the shared arrangement in accordance with their need.

These support items can be delivered to individual participants subject to the rules set out in the *NDIS Price Guide*.

As well as direct service provision, these support items can be used to claim for Non-Face-to-Face Support Provision; Provider Travel and Short Notice Cancellations. Providers of these supports can also claim for the non-labour costs Provider Travel.

Different price limits, as set out in the following Table, apply depending on the Time of Day and Day of Week on which the support is delivered, and whether the supports are High Intensity Supports.

Item Number	Item Name and Notes	Unit	Price limits		
			National	Remote	Very Remote
01_801_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Daytime	Hour	$54.30	$76.02	$81.45
01_802_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Evening	Hour	$59.77	$83.68	$89.66
01_803_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Night	Hour	$60.87	$85.22	$91.31
01_804_0115_1_1	Assistance in Supported Independent Living - Standard - Saturday	Hour	$76.18	$106.65	$114.27
01_805_0115_1_1	Assistance in Supported Independent Living - Standard - Sunday	Hour	$98.06	$137.28	$147.09
01_806_0115_1_1	Assistance in Supported Independent Living - Standard - Public Holiday	Hour	$119.94	$167.92	$179.91
01_811_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Daytime • Must be a **high intensity support**.	Hour	$58.68	$82.15	$88.02
01_812_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Evening • Must be a **high intensity support**.	Hour	$64.59	$90.43	$96.89
01_813_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Night • Must be a **high intensity support**.	Hour	$65.77	$92.08	$98.66
01_814_0115_1_1	Assistance in Supported Independent Living - High Intensity - Saturday • Must be a **high intensity support**.	Hour	$82.32	$115.25	$123.48
01_815_0115_1_1	Assistance in Supported Independent Living - High Intensity - Sunday • Must be a **high intensity support**.	Hour	$105.96	$148.34	$158.94
01_816_0115_1_1	Assistance in Supported Independent Living - High Intensity - Public Holiday • Must be a **high intensity support**.	Hour	$129.61	$181.45	$194.42
01_832_0115_1_1	Assistance in Supported Independent Living - Night-Time Sleepover	Each	$231.06	$323.48	$346.59

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Pricing Reference Group

Meeting: 16 April 2020

Minutes

Date: Thursday, 16 April 2020 **Time:** 1030 – 1250

Location: Microsoft Teams Meeting (Video Conference)

Attendees	
Chair	
Liz s47F - perso	General Manager, Provider and Markets
Pricing Reference Group Members	
Jim s47F - pPSM	Independent Member
Julie s47F - personal p PSM	Independent Member
Graeme s47F - pe AM	Independent Member
Participating Observers nominated by CEO	
Sarah s47F - persona	Scheme Actuary
David Cullen	Chief Economist
Secretariat	
Scott s47F - person	Director, Pricing Policy and Economics

Apologies

The Pricing Reference Group (PRG) **NOTED** that Sarah Johnson was an apology.

Declaration of Conflicts of Interest

The PRG **NOTED** that Graeme s47F - pers is:

- a member of the Board of Life Without Barriers;
- a member of the Board of the Summer Foundation;
- a member of the Board of Joblife Employment;
- a member of the Board of Attitude Foundation;
- a member of the Advisory Board for Probono News; and
- s47F - personal privacy, s22(1)(a)(ii) - irrelevant material

Confirmation of Minutes of 12 March 2020

The PRG **ENDORSED** the minutes of the previous meeting (*PRG - 20200312 - Item 1.3*).

Update by the Chair

The Chair informed that PRG that:

- the NDIA Board had made some temporary changes in the NDIS pricing arrangements in response to the COVID-19 pandemic; and
- the NDIA would shortly commence an Expression of Interest process to appoint the final two independent members of the PRG.

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DISCLOSURE LOG

Temporary Transformation Payment

The paper *PRG - 20200416 - Item 3.1 - Temporary Transformation Payment*, was presented to the PRG by:

- Scott s47F - personal p Director, Pricing Policy and Economics
- Dr David Cullen, Chief Economist

The PRG **DISCUSSED** the paper and **AGREED** to the recommendations proposed in the paper without amendment, see Attachment A to these Minutes

Annual Price Review

The paper *PRG - 20200416 - Annual Pricing Review - Final Draft Report*, was presented to the PRG by:

- Dr David Cullen, Chief Economist

The PRG **DISCUSSED** the paper and **AGREED** to the recommendations proposed in the paper without amendment, see Attachment B to these Minutes

Reform of Supported Independent Living

The paper *PRG - 20200416 - Item 4.2- Reform of Supported Independent Living* was presented to the PRG by:

- Matthew s47F - person Branch Manager, Operations and Housing Support

The PRG **DISCUSSED** the paper.

Supports in Employment

The paper *PRG – 20200416 - Item 4.3 - Supports in Employment* was presented to the PRG by:

- Jo s47F - persona Branch Manager, Employment Outcomes
- Ken s47F - perso Strategic Advisor - Employment
- Dr David Cullen, Chief Economist

The PRG **DISCUSSED** the paper and **AGREED** to the recommendations proposed in the paper without amendment, see Attachment C to these Minutes

Psychosocial Recovery Coaches

The paper *PRG – 20200416 - Item 4.4 Psychosocial Recovery Coaches* was presented to the PRG by:

- Gerry s47F - personal priv Strategic Advisor
- Scott s47F - personal p Director, Pricing Policy and Economics

The PRG **DISCUSSED** the paper and **AGREED** to the recommendations proposed in the paper without amendment, see Attachment D to these Minutes

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DISCLOSURE LOG

Attachment A – Temporary Transformation Payment

1. The PRG **NOTED** the preliminary findings from the Temporary Transformation Payment (TTP) Survey.

2. The PRG **NOTED** that the level of the TTP will be stepped down from 7.5% to 6.0% from 1 July 2020 as previously agreed.

3. The PRG **AGREED to recommend to the Board of the National Disability Insurance Agency (NDIA), through the NDIA's Chief Executive Officer (CEO)**, that because of the impact of COVID-19 on providers and participants, the deadline for completion of the 2019-20 TTP Survey should be extended to 30 June 2020, and that all providers of relevant supports should continue to be eligible to access the higher TTP price limits until that date.

4. The PRG **AGREED to recommend to the Board, through the CEO**, that from 1 July 2021:

   4.1 providers of relevant supports who were active in 2019-20:

      4.1.1 should only be eligible to access the higher TTP price limits in 2020-21 if they have indicated to the NDIA before 1 July 2021 that:

         - they have published, and will continue to publish, their service prices in accordance with the NDIS Price Guide;
         - they have listed their business contact details in the Provider Finder and will continue to ensure that those details are kept up-to-date; and
         - will participate in the 2020-21 TTP Benchmarking Survey; and

      4.1.2 should cease to be eligible to access the higher TTP price limits from the closing date of the 2020-21 TTP Benchmarking Survey if they do not take part in it;

   4.2 providers of relevant supports who were <u>not</u> active in 2019-20 and who become active <u>before</u> the closing date of the 2020-21 TTP Benchmarking Survey should be subject to the same eligibility criteria as set out in paragraph 2.4(a), except that they should be required to indicate their intention to accept the eligibility conditions before they first make a TTP claim, rather than before 1 July 2020; and

   4.3 providers of relevant supports who were <u>not</u> active in 2019-20 and who become active <u>after</u> the closing date of the 2020-21 TTP Benchmarking Survey should be subject to the same eligibility criteria as set out in paragraph 2.4(b), except that they should cease being eligible to access the higher TTP price limits from the closing date of the 2021-22 TTP Benchmarking Survey.

5. The PRG **AGREED to recommend to the Board, through the CEO**, that from 1 July 2021, Plan Managers should be required to only process claims from providers for items subject to the higher TTP price limits if the provider has attested to the Plan Manager that they are eligible to access the higher TTP price limits.

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DISCLOSURE LOG

Attachment B – Annual Pricing Review

1. The PRG **NOTED** the report of the Annual Pricing Review.
2. The PRG **AGREED to recommend to the Board of the NDIS, through the CEO,** the recommendations set out in the Report of the Annual Pricing Review.

RECOMMENDATION 1) Annual Pricing Review

1) That the NDIA should not undertake an Annual Pricing Review in 2020-21 but instead monitor economic conditions carefully as the COVID-19 pandemic progresses and the economy recovers and promptly respond to any emerging issues.
2) That the NDIA should undertake the Annual Pricing Review from July to December each year (commencing 2021), reporting in February/March of the following year to the Board of the NDIA, through the Chief Executive Officer, with changes to take effect from the following 1 July.

RECOMMENDATION 2) Annual Indexation of Price Limits

1) That the NDIA should index price limits on 1 July each year to maintain their real value through the following indexation arrangements:
    i) Price limits for supports delivered by Disability Support Workers should be set by the NDIS Disability Support Worker Cost Model following the Fair Work Commission's Annual Wage Review;
    ii) Price limits for Capital supports – Support Categories 2 (Transport), 3 (Consumables), 5 (Assistive Technology) and 6 (Home Modifications and Specialised Disability Accommodation) – should be indexed in line with the movement in the ABS Consumer Price (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter preceding the indexation date; and
    iii) Price limits for other supports should be indexed in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses) and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter preceding the indexation date (with an 80/20 weighting).
2) That in addition to the annual indexation arrangements, the NDIA should also reset all price limits determined by the NDIS Disability Support Worker Cost Model whenever the Fair Work Commission makes a determination that materially affects the key parameters of the NDIS Disability Support Worker Cost Model, with effect from the date of effect of the Fair Work Commission's determination.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

RECOMMENDATION 3) Programs of Supports

That the NDIA should amend the *NDIS Price Guide* from 1 July 2020, to make clear that providers are allowed to enter into contracts for the provision of programs of supports subject to the following safeguards:

i) that programs of support cannot be for longer than 12 weeks (unless specifically allowed for in the NDIS Price Guide); and

ii) that participants should be able to exit from an agreed program of supports without cost, subject to an agreed notice period that can be no longer than four (4) weeks.

RECOMMENDATION 4) NDIS Disability Support Worker Cost Model

1) That the NDIA should continue to use the NDIS Disability Support Worker Cost Model to determine the base (non-TTP) price limits for supports delivered by Disability Support Workers.

2) That the NDIA should amend the NDIS Disability Support Worker Cost Model (and the price limits determined by the cost model), from 1 July 2020, by:

i) Decreasing the ratio of permanent to casual staff to 70/30%;

ii) Increasing the share of staff assumed to take up their long service leave entitlements to 100%;

iii) Decreasing the workers compensation premium percentage to 1.7%;

iv) Increasing the overheads percentage to 12.0%;

v) Increasing the supervision ratio to 15:1; and

vi) Increasing the allowance provision for support workers and supervisors to 1.0% of salary.

3) That the NDIA should also amend the NDIS Disability Support Worker Cost Model (and the price limits determined by the cost model), from 1 July 2020, by adjusting the shift loadings for casual workers on Saturdays and Sundays in the model in line with the Fair Work Commission's Decision [2019] (FWCFB 7096).

RECOMMENDATION 5) Temporary Transformation Payment

That the NDIA should reduce the level of the Temporary Transformation Payment from 7.5% to 6.0% on 1 July 2020 as previously announced.

RECOMMENDATION 6) Definition of the Levels of High Intensity Supports

That the definitions of Level 1, Level 2 and Level 3 supports in the *NDIS Price Guide* should be amended as follows:

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Level 1 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified as a Social and Community Services Employee level 2 (below the maximum pay point) if they were employed under the SCHADS Award.

Level 2 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified as a Social and Community Services Employee level 2 (at the maximum pay point) or as a Social and Community Services Employee level 3 (at the maximum pay point) if they were employed under the SCHADS Award.

Level 3 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified above a Social and Community Services Employee level 3 (at the minimum pay point) if they were employed under the SCHADS Award.

RECOMMENDATION 7) Definitions of Time of Day and Day of Week

That the definitions of Time of Day and Day of Week in the *NDIS Price Guide* should be amended as follows:

Time of Day and Day of Week

In determining which price limit is applicable to a support, the important consideration is when the support is provided to the participant, not the shift of the worker used to deliver that support as determined by the applicable Industry Award or Enterprise Bargaining Agreement (EBA).

For NDIS billing purposes the provider must first determine the day of the week on which the support was provided on and then the time of the day during which the support was delivered. (Note: weekday means Monday, Tuesday, Wednesday, Thursday or Friday).

- *A **Night-time Sleepover Support** is any support to an individual participant delivered on a weekday, a Saturday, a Sunday or a Public Holiday that:*
  - commences before midnight on a given day and finishes after midnight on that day; and
  - is for a continuous period of eight (8) hours or more; and
  - the worker is allowed to sleep when they are not providing support.
- *A **Public Holiday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Public Holiday and ends before or at midnight of that Public Holiday (unless that support is a Night-time Sleepover Support).*
- *A **Saturday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Saturday and ends before or at*

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

midnight of that Saturday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).

- *A **Sunday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Sunday and ends before or at midnight of that Sunday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).*
- *A **Standard Day Support** is any other support, and is either:*
  - A **Weekday Support** is any support to an individual participant that starts at or after 6:00 am and ends before or at 8:00 pm on a single weekday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).
  - An **Afternoon/Evening Support** is any support to an individual participant that finishes after 8:00 pm and at or before midnight on a single weekday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).
  - An **Active Overnight Support** is any support to an individual participant that commences at or before midnight on a weekday and finishes after midnight on that weekday, or commences before 6:00 am on a weekday and finishes on that weekday (unless that support is a Public Holiday Support, Saturday Support, Sunday Support or a Night-time Sleepover Support).

If a support to an individual participant does not meet one of the above criteria then it needs to be billed as two or more separate supports.

Night-time Sleepover Supports

Night-time Sleepover Supports have a price limit that is inclusive of the cost of two hours of any supports provided to the participant for the duration of the period. Providers may claim for third or additional hour at Saturday rates on weekdays, or at applicable rates on other days (Saturday, Sunday or Public Holidays)

Note, Night-time Sleepover Supports apply to any day of the week and on public holidays, pending criteria met as described previously.

RECOMMENDATION 8) Group Based Supports

1) That the NDIA should amend the pricing arrangements for group based supports so that providers no longer use the various worker to participant ratio support items but instead claim all supports against the appropriate 1:1 support items by apportioning the time spent with the group among the members of the group.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

2) That the NDIA should also amend the pricing arrangements for group based supports so that providers can claim for non-face-to-face supports under the usual conditions, rather than having an allowance for non-face-to-face supports built into the price limit.

RECOMMENDATION 9) Capacity Building Supports

1) That the NDIA should maintain the price limits for therapy supports at their current levels pending a comprehensive review to be undertaken as part of the next Annual Pricing Review commencing in July 2021.

2) That the NDIA should index the price limits for capacity building supports that are delivered by Disability Support Workers limits by reference to the Disability Support Worker Cost Model.

RECOMMENDATION 10) Plan Management

That the NDIA should amend the conditions attached to the support items:

i) 04_031_0127_8_3 (Capacity Building and Training in Plan and Financial Management by a Plan Manager); and

ii) 07_003_0117_8_3 (Capacity Building and Training in Plan and Financial Management by a Support Coordinator)

In the *NDIS Support Catalogue* so that providers can claim for provider travel and non-face-to-face supports with respect to these supports.

RECOMMENDATION 11) Geographic Classification

That the NDIA should adopt the MMM 2019 classification system, and any future updates to the MMM classification system as released by the Department of Health, (subject to the NDIS Isolated Town arrangements) as the basis of determining the pricing arrangements in the NDIS Price Guide, including:

i) whether remote and very remote loadings should be applied to price limits and plan funding amounts; and

ii) which travel time limits apply to the supports delivered to participants.

RECOMMENDATION 12) Cancellation Fees

That the NDIA should permanently amend the claiming rules in the *NDIS Price Guide* to allow providers to claim for 100% of the agreed fee for a short-notice cancellation.

RECOMMENDATION 13) Provider Travel

1) That the *NDIS Price Guide* and the *NDIS Support Catalogue* should be amended from 1 July 2020 so that providers can claim for the non-labour costs associated with provider travel in line with the activity based transport arrangements.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

2) That the NDIA should trial the commissioning of a travel broker arrangement in the Northern Territory, Queensland and Western Australia to coordinate participants and providers and pay for travel costs.

RECOMMENDATION 14) Establishment Fees

1) That the NDIA should amend the current Establishment Fee arrangements in the *NDIS Price Guide* so that:

   i) An Establishment Fee to assist with the non-ongoing costs of establishing arrangements and assisting participants in implementing their plan is claimable from a participant's plan by a provider who:

      - is in one or more of the Registration Groups 0104 (High Intensity Daily Personal Activities), 0107 (Daily Personal Activities), 0125 (Participation in community, social and civic activities) and 0136 (Group and Centre Based Activities);
      - has made an agreement with the participant to supply at least 20 hours of support – in Support Categories 1 (Assistance with Daily Life) and/or Support Category 4 (Assistance with Social and Community Participation) – to the participant per month for the duration of the plan;
      - assists the participant with the implementation of their NDIS Plan.

   ii) Each provider can only claim an Establishment Fee in respect of a participant once across all plans.

   iii) More than one provider is able to claim for an Establishment Fee against a given plan provided each provider meets the other criteria above.

   iv) The amount of the Establishment Fee should be negotiated by the participant and the provider but cannot be greater than an amount equal to ten times the hourly weekday price limit for a disability support worker as determined by the Standard NDIS Disability Support Worker Cost Model with the standard parameters ($528.50 in 2019-20).

2) That the NDIA should introduce New Maintenance Establishment Fee arrangements into the *NDIS Price Guide* so that:

   i) A Maintenance Establishment Fee to assist with the non-ongoing costs of maintaining arrangements and assisting participants in implementing their plan (after a plan review) is claimable from a participant's plan by a provider who:

      - is in one or more of the Registration Groups 0104 (High Intensity Daily Personal Activities), 0107 (Daily Personal Activities), 0125 (Participation in community, social and civic activities) and 0136 (Group and Centre Based Activities);

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- has made an agreement with the participant to supply at least 20 hours of support – in Support Categories 1 (Assistance with Daily Life) and/or Support Category 4 (Assistance with Social and Community Participation) – to the participant per month for the duration of the plan;
- assists the participant with the implementation of their NDIS Plan;
- has previously claimed an Establishment Fee in respect of the participant;
- has not claimed an Establishment Fee in respect of the participant for the plan;
- has not previously claimed a Maintenance Establishment Fee in respect of the participant for the plan; and
- has not previously claimed a Maintenance Establishment Fee in respect of the participant in the same financial year.

ii) Each provider can only claim a Maintenance Establishment Fee in respect of a participant once per plan.

iii) More than one provider is able to claim for a Maintenance Establishment Fee against a given plan provided each provider meets the other criteria above.

iv) The amount of the Maintenance Establishment Fee should be negotiated by the participant and the provider but cannot be greater than an amount equal to five times the hourly weekday price limit for a disability support worker as determined by the Standard NDIS Disability Support Worker Cost Model with the standard parameters ($264.25 in 2019-20).

3) That the NDIA should add several price-limited support items to the *NDIS Support Catalogue* to allow providers in the Registration Groups 0104 (High Intensity Daily Personal Activities, 0107 (Daily Personal Activities), 0125 (Participation in community, social and civic activities) and 0136 (Group and Centre Based Activities) who are delivering services in Support Categories 1 (Assistance with Daily Life) and/or Support Category 4 (Assistance with Social and Community Participation) to be able to claim Establishment Fees and Maintenance Establishment Fees.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

3. The PRG **ALSO AGREED to recommend to the Board, through the CEO**, that from 1 July 2020:

3.1 the following support item be added to the *NDIS Support Catalogue* in Support Category 2 (Assistance with Social & Community Participation) to support participants achieve outcomes in Outcome Domain 5 (Work):

Support Item Number	Support Item Name	Support Item Description
02_811_0133_5_1	Supports in Employment - Establishment Fee	Administrative establishment fee, paid when a participant starts with a Supports in Employment provider.

3.2 the support item in this recommendation should be subject to price regulation;

3.3 the national price limit should be set at an amount equal to eight times the hourly weekday price limit for a disability support worker as determined by the Standard Disability Support Worker Cost Model with the standard parameters (subject to paragraph 2.3(e) below; and

3.4 the support item in this recommendation should be subject to the following conditions:

3.4.1 an establishment fee for Supports in Employment is billable by any provider who has a service agreement with a participant to provide a significant amount of Supports in Employment to a participant (more than 20 hours a month for three or more months);

3.4.2 an establishment fee for Supports in Employment is only billable once by a given provider per plan;

3.4.3 more than one provider is able to bill for an establishment for Supports in Employment against a given plan provided each provider meets the other criteria in this sub-paragraph; and

3.4.4 where a provider has already billed a participant an establishment fee for Supports in Employment then the price limit for any subsequent establishment fee is half the standard price limit for this support item.

4. The PRG **ALSO AGREED to recommend to the Board, through the CEO**, that from 1 July 2020:

4.1 the following support item be added to the *NDIS Support Catalogue* in Support Category 2 (Assistance with Social & Community Participation) to support participants achieve outcomes in Outcome Domain 5 (Work):

Support Item Number	Support Item Name	Support Item Description
01_821_0133_5_1	Activity Based Transport	A provider can transport one or more participants to and/or from a community based support as part of a Supports in Employment support.

4.2 the support item in this recommendation should not be subject to price regulation; and

4.3 the support item in this recommendation should be subject to the standard rules for activity based transport set out in the NDIS Price Guide.

5. The PRG **ALSO AGREED to recommend to the Board, through the CEO,** that from 1 July 2020:

5.1 the following support item be added to the *NDIS Support Catalogue* in Support Category 2 (Assistance with Social & Community Participation) to support participants achieve outcomes in Outcome Domain 5 (Work):

Support Item Number	Support Item Name	Support Item Description

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

01_891_0133_5_1	Supports in Employment – Transitional Funding Arrangements	This support item can be used by ADEs who have decided to continue to claim under the pre-1 July 2020 ADE pricing arrangements.

5.2 the support item in this recommendation should not be subject to price regulation.

6. The PRG **NOTED** that the following support items will be deactivated from 1 July 2020:

Support Item Number	Support Item Name	Support Item Description
10_012_0133_5_3	Assistance In Specialised Supported Employment Level 1 DMI	Assistance in specialised supported employment Level 1 DMI
10_013_0133_5_3	Assistance In Specialised Supported Employment Level 2 DMI	Assistance in specialised supported employment Level 2 DMI
10_014_0133_5_3	Assistance In Specialised Supported Employment Level 3 DMI	Assistance in specialised supported employment Level 3 DMI
10_015_0133_5_3	Assistance In Specialised Supported Employment Level 4 DMI	Assistance in specialised supported employment Level 4 DMI
10_018_0133_5_3	Supported Employment Start-Up Fee (ADE)	Supported employment administrative start-up fee, paid only once when a participant starts with an ADE.
10_020_0133_5_3	Support In Employment (ADE)	Support in employment (ADE)

7. The PRG **ALSO NOTED** that from 1 July 2020, a technical amendment will made to the following support item to set its units to "per hour" rather than "each" as currently:

Support Item Number	Support Item Name	Support Item Description
10_011_0128_5_3	Employment Related Assessment And Counselling	This support is designed to provide workplace assessment and/or counselling to assist participants successfully engage in employment. For workplace assessments - if a participant is employed and on award wages, then in most instances a work place assessment is available through the Employment Assistance Fund administered by JobAccess and is a free service to employers. For employment related counselling, this service may benefit participants who have, for example, experienced traumatic injury and need significant support (over and above a mainstream employment related service) to develop a new work pathway.

Pricing Arrangements for Hearing Supports

The paper *PRG - 20200423 – Out of Session – Hearing Supports*, was circulated to the PRG.

The PRG **DISCUSSED** the paper and **AGREED** to the recommendations proposed in the paper without amendment. See *PRG - 202000424 –Out of Session Minutes*

Commented [EA1]: Added here – hopefully wording is ok

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Attachment C - Recommendations on the Pricing Arrangements for Supports in Employment

8. The PRG **AGREED to recommend to the Board of the NDIS, through the CEO,** that from 1 July 2020:

8.1 the following support items be added to the *NDIS Support Catalogue* in Support Category 2 (Assistance with Social & Community Participation) to support participants achieve outcomes in Outcome Domain 5 (Work):

Support Item Number	Support Item Name	Support Item Description
02_801_0133_5_1	Supports in Employment - Weekday – Daytime	Supports in Employment include: • assessments related to the work impact of a person's disability; • job customisation; • on-the-job training and support with daily work tasks; • direct supervision and/or group-based support to enable meaningful participation at work; • physical assistance and personal care delivered in the workplace; • supports to manage disability-related behaviour or complex needs at work; and • non face-to-face activities that are directly related to supporting a participant's employment.
02_802_0133_5_1	Supports In Employment-Weekday – Weekday Afternoon/Evening	
02_803_0133_5_1	Supports In Employment-Weekday - Saturday	
02_804_0133_5_1	Supports In Employment-Weekday - Sunday	
02_805_0133_5_1	Supports In Employment-Weekday – Public Holiday	

8.2 the support items in this recommendation should be subject to price regulation;

8.3 the support items in this recommendation should be subject to national price limits, with the price limits determined by the Standard Disability Support Worker Cost Model with the standard parameters;

8.4 the price limits of the support items in this recommendation should be subject to the standard remote and very remote loadings;

8.5 the support items in this recommendation should be subject to the standard definitions of time of day and day of week set out in the NDIS Price Guide;

8.6 the support items in this recommendation should be able to be claimed for Direct Service Provision; non-Face-to-Face Service Provision; Provider Travel, Cancellations and NDIA Report Writing, subject to the standard rules for those claims set out in the NDIS Price Guide;

8.7 the support items in this recommendation should be eligible for the Temporary Transformation Payment even though their cost models are determined by the Disability Support Worker Cost Model; and

8.8 the support items in this recommendation should be eligible for the Temporary 10% COVID-19 Loading.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Attachment D – Psychosocial Recovery Coaches

1. The PRG **AGREED to recommend to the Board, through the CEO**, that from 1 July 2020:

   1.1 the following support items be added to the *National Disability Insurance Scheme (NDIS) Support Catalogue* in Support Category 7 (Support coordination) to support participants achieve outcomes in Outcome Domain 8 (Social and community participation):

Support Item Number	Support Item Name	Support Item Description
07_101_0106_6_3	Psychosocial Recovery Coaching - Weekday Daytime	Assistance for participants to build capacity and resilience through strong and respectful relationships to support people with psychosocial disability to live a full and contributing life. Assistance to maintain engagement through periods of increased support needs due to the episodic nature of mental illness. This support will work collaboratively with participants, families, carers and other services to identify, plan, design and coordinate NDIS supports. Psychosocial recovery coach work requires lived and/or learnt experience. Recovery coaches must have tertiary qualifications in peer work or mental health (minimum of Certificate IV in Mental Health Peer Work or Certificate IV in Mental Health) or equivalent training; and/or a minimum two years of experience in mental health-related work.
07_102_0106_6_3	Psychosocial Recovery Coaching – Weekday Afternoon/Evening	
07_103_0106_6_3	Psychosocial Recovery Coaching - Saturday	
07_104_0106_6_3	Psychosocial Recovery Coaching - Sunday	
07_105_0106_6_3	Psychosocial Recovery Coaching – Public Holiday	
07_106_0106_6_3	Psychosocial Recovery Coaching – Night	

   1.2 the support items in this recommendation should be subject to price regulation;

   1.3 the support items in this recommendation should be subject to national price limits, with the price limits determined by the Standard Disability Support Worker Cost Model with the standard parameters, except as specified below:

   1.3.1 Support worker pay point 4.4
   1.3.2 Support worker utilisation rate 80%
   1.3.3 Supervisor pay point 5.1
   1.3.4 Supervisor utilisation rate 80%

   1.4 the price limits of the support items in this recommendation should be subject to the standard remote and very remote loadings;

   1.5 the support items in this recommendation should be subject to the standard definitions of time of day and day of week set out in the NDIS Price Guide;

   1.6 the support items in this recommendation should be able to be claimed for Direct Service Provision; non-Face-to-Face Service Provision; Provider Travel, Cancellations and NDIA Report Writing, subject to the standard rules for those claims set out in the NDIS Price Guide;

   1.7 the support items in this recommendation, as Capacity Building Support items, should NOT be eligible for the Temporary Transformation Payment even though their cost models are determined by the Disability Support Worker Cost Model; and

   1.8 the support items in this recommendation should NOT be eligible for the Temporary 10% COVID-19 Loading.

2. The PRG **ALSO AGREED to recommend to the Board, through the CEO**, that from 1 July 2020:

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

2.1 the following support item be added to the *NDIS Support Catalogue* in Support Category 7 (Support coordination) to support participants achieve outcomes in Outcome Domain 8 (Social and community participation):

Support Item Number	Support Item Name	Support Item Description
07_501_0106_6_3	Activity Based Transport	A provider can transport one or more participants to and/or from a community based support as part of a psychosocial recovery coaching support.

2.2 the support item in this recommendation should not be subject to price regulation; and

2.3 the support item in this recommendation should be subject to the standard rules for activity based transport set out in the NDIS Price Guide.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

DOCUMENT 28

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Matter for Decision

Psychosocial Recovery Coaches

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 To seek the agreement of the Pricing Reference Group (PRG) to the creation of several new support items for Psychosocial Recovery Coaching.

2. Recommendations

2.1 That PRG **AGREE to recommend to the Board of the National Disability Insurance Agency (NDIA), through the NDIA's Chief Executive Officer (CEO)**, that from 1 July 2020:

(a) the following support items be added to the *National Disability Insurance Scheme (NDIS) Support Catalogue* in Support Category 7 (Support coordination) to support participants achieve outcomes in Outcome Domain 8 (Social and community participation):

Support Item Number	Support Item Name	Support Item Description
07_101_0106_6_3	Psychosocial Recovery Coaching - Weekday Daytime	Assistance for participants to build capacity and resilience through strong and respectful relationships to support people with psychosocial disability to live a full and contributing life. Assistance to maintain engagement through periods of increased support needs due to the episodic nature of mental illness. This support will work collaboratively with participants, families, carers and other services to identify, plan, design and coordinate NDIS supports. Psychosocial recovery coach work requires lived and/or learnt experience. Recovery coaches must have tertiary qualifications in peer work or mental health (minimum of Certificate IV in Mental Health Peer Work or Certificate IV in Mental Health) or equivalent training; and/or a minimum two years of experience in mental health-related work.
07_102_0106_6_3	Psychosocial Recovery Coaching – Weekday Afternoon/Evening	
07_103_0106_6_3	Psychosocial Recovery Coaching - Saturday	
07_104_0106_6_3	Psychosocial Recovery Coaching - Sunday	
07_105_0106_6_3	Psychosocial Recovery Coaching – Public Holiday	
07_106_0106_6_3	Psychosocial Recovery Coaching – Night	

(b) the support items in Recommendation 2.1(a) should be subject to price regulation;

(c) the support items in Recommendation 2.1(a) should be subject to national price limits, with the price limits determined by the Standard Disability Support Worker Cost Model with the standard parameters, except as specified below:

- Support worker pay point 4.4
- Support worker utilisation rate 80%
- Supervisor pay point 5.1
- Supervisor utilisation rate 80%

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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(d) the price limits of the support items in Recommendation 2.1(a) should be subject to the standard remote and very remote loadings;

(e) the support items in Recommendation 2.1(a) should be subject to the standard definitions of time of day and day of week set out in the NDIS Price Guide;

(f) the support items in Recommendation 2.1(a) should be able to be claimed for Direct Service Provision; non-Face-to-Face Service Provision; Provider Travel, Cancellations and NDIA Report Writing, subject to the standard rules for those claims set out in the NDIS Price Guide;

(g) the support items in Recommendation 2.1(a), as Capacity Building Support items, should NOT be eligible for the Temporary Transformation Payment even though their cost models are determined by the Disability Support Worker Cost Model; and

(h) the support items in Recommendation 2.1(a) should NOT be eligible for the Temporary 10% COVID-19 Loading.

2.2 That the PRG **ALSO AGREE to recommend to the Board of the National Disability Insurance Agency (NDIA), through the NDIA's Chief Executive Officer (CEO)**, that from 1 July 2020:

(a) the following support item be added to the *NDIS Support Catalogue* in Support Category 7 (Support coordination) to support participants achieve outcomes in Outcome Domain 8 (Social and community participation):

Support Item Number	Support Item Name	Support Item Description
07_501_0106_6_3	Activity Based Transport	A provider can transport one or more participants to and/or from a community based support as part of a psychosocial recovery coaching support.

(b) the support item in Recommendation 2.2(a) should not be subject to price regulation; and

(c) the support item in Recommendation 2.2(a), should be subject to the standard rules for activity based transport set out in the NDIS Price Guide.

3. Background

3.1 Mental Health Australia, with strong support from the community mental health sector and state and territory governments, has argued that Scheme design did not take into account recovery-orientated practice and the improvements in functioning it can achieve.

3.2 Key messages from a review of the Australian and international literature are:

(a) People with severe and persistent mental illness will experience multiple episodes of mental illness over their lifetime with 29.7% having a good recovery and 31.8% a partial recovery between episodes;

(b) Less than one-third (30.5%) of people living with psychosis have a continuous chronic form of illness; and

(c) Recovery rates vary between 53% and 68% where recovery refers to those individuals who after many years: no longer have mental ill-health symptoms; do not take psychotropic medications; and are limited in only one of several functional domains.

3.3 Evidence highlights the variability of functional impairments, the higher prospects for improvement in functional abilities than in many other disability groups, the critical

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importance of participant agency and active engagement with getting better and the positive contribution of recovery-orientated practice in reducing years of active funding in the Scheme.

3.4 Psychosocial recovery coaching is a specific form of support that is used in mental health and psychosocial disability services. Through the innovative application of recovery principles, it delivers better outcomes in regard to increased motivation and engagement and assists people to take more control of their lives and manage the complex behaviours involved in the management of psychosocial disability issues. Recovery coaches build capacity and resilience through strong and respectful relationships. They facilitate self-management, enhance informed choice and control, and enable social and economic participation. Recovery coaches work collaboratively with people with disabilities, families and other services to identify, plan, design and coordinate supports. They also understand the episodic nature of mental illness and collaborate with relevant services to plan and maintain engagement through periods of increased support needs.

3.5 There is good evidence of the efficacy of recovery coaches.[1]

3.6 At its meeting on 9 October 2019, the Council of Australian Governments' (COAG) Disability Reform Council (DRC) agreed:

(a) to the introduction of a new support item called the psychosocial recovery coach by 1 July 2020;

(b) to the development of specifications for the psychosocial recovery coach, including specifications related to supporting shared care planning and coordination with clinical mental health services and other mainstream interface systems; and

(c) that the psychosocial recovery coach role will be informed by the new national Psychosocial Disability Recovery Framework.

3.7 At its meeting on 24 September 2019, the Board of the NDIA agreed proposed improvements for psychosocial disabilities as well as an implementation plan that included the development of psychosocial recovery coach supports.

3.8 There is wide acceptance of the role of psychosocial recovery coaches within the sector and providers are already building the development and implementation of this approach into their business planning.

3.9 The Agency has developed a draft set of role descriptors for psychosocial recovery coaches following consultations with the sector and with States and Territories through the DRC Senior Officers Working Group. Recovery coach competencies are based on the Domains and capabilities of recovery-oriented service delivery set out in the Australian Health Ministers' Advisory Council's *National framework for recovery-oriented mental health services*.[2] It is

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1 Hayes, L; Brophy, L; Harvey, C; Tellez, JJ; Herrman, H.; & Killackey, E. (2018). Enabling choice, recovery and participation: evidence-based early intervention support for psychosocial disability in the National Disability Insurance Scheme. *Australasian Psychiatry*, 26(6), 578–585. https://doi.org/10.1177/1039856218759407

Mental Health Australia. (2018). Optimising Psychosocial Supports Project Report. https://mhaustralia.org/sites/default/files/docs/optimising_psychosocial_supports_project_report_final_web.pdf

2 Australian Health Ministers' Advisory Council. (2013). *A national framework for recovery-oriented mental health services: Guide for Practitioners and Providers*.

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proposed that lived experience recovery coaches will have a lived experience of mental ill health and recovery and appropriate tertiary qualifications (for example a minimum Certificate IV in Mental Health Peer Work and a minimum two years of experience in mental health-related work).

3.10 Psychosocial recovery coach work requires both lived experience and learnt experience. It is proposed that they should have tertiary qualifications in peer work or mental health (minimum of Certificate IV in Mental Health Peer Work or Certificate IV in Mental Health) or equivalent training; and a minimum two years of experience in mental health-related work.

3.11 It is proposed that psychosocial recovery coaching supports should be delivered by providers in Registration Group 106 (Assistance in coordinating or managing life stages, transition and supports). This registration group includes short and long-term supports that focus on strengthening the participant's ability to coordinate their supports, and to assist them to live at home and participate in their community. This includes: support connection; coordination of supports; assistance with accommodation and tenancy obligations; life transition planning including mentoring, peer support and individual skill development; and assistance with decision making, daily planning, and budgeting.

3.12 The following types of workers deliver the supports covered by this Registration Group: Disability Support Workers (including Mental Health or Peer Workers); Welfare workers; Developmental Educators; Social Workers and Aboriginal Health Workers.

3.13 While there is some commonalities with support co-ordination, recovery coaching deals with different issues to support co-ordination. It is important to recognise that people with severe and persistent mental illness will have periods of psychosis throughout their lives in the Scheme, where their behaviour is impacted by distortions in thinking, perception, emotions, language and sense of self. Common experiences during these periods include hallucinations, hearing voices or seeing things that are not there, delusions and fixed false beliefs (WHO, 2018). Planners and Local Area Coordinators skilled in mental health and psychosocial disability and recovery coaches with competencies to support people to manage during these periods are the recommended way of dealing with this common element of psychosocial disability.

4. Issues

4.1 In line with the DRC decision (paragraph 3.6 above refers) it is intended that the psychosocial recovery coach supports should be available in the NDIS from 1 July 2020.

Price regulation

4.2 The Price Regulation Unit and the NDIA's Strategic Adviser Mental Health have held extensive consultations with psychosocial disability providers on the appropriate price control arrangements for the proposed psychosocial recovery coaching support items.

4.3 The consultations indicated that the market for the delivery of psychosocial recovery coaching supports was no better developed, and probably less well developed, that the general market for supports delivered by disability support workers.

https://www1.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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4.4 It is therefore recommended that the proposed new psychosocial recovery coach support items should be subject to price regulation.

Price controls

4.5 There was broad agreement in the consultations that psychosocial recovery coaches did not need to be allied health professionals, but did require either lived or learnt experience, and must therefore have tertiary qualifications in peer work or mental health (minimum of Certificate IV in Mental Health Peer Work or Certificate IV in Mental Health) or equivalent training; and a minimum two years of experience in mental health-related work. The level of competency required was generally agreed to be higher than currently allowed for within the NDIS Disability Support Worker Cost Model (where the highest (Level 3) workers are assumed to have the competencies of a worker classified as a level 3.2 under the Social, Community, Home Care and Disability (SCHADS) Award. Providers currently employing workers in the role of a psychosocial recovery coach indicated that these staff were appropriately classified at the SCHADS pay point 4.4.

4.6 There was also broad agreement in the consultations that workers who supported participants with mental health conditions often needed to debrief and be supported at the end of their shifts to support their own mental well-being, which lowered their own and their supervisors' utilisation rates. Agency data shows that psychosocial participants are more than twice as likely (59%) to be streamed as Intensive to Super Intensive than are other participants (28%). Of participants with a psychosocial disability, the majority (55%) have schizophrenia. Providers' data showed that the average utilisation rate for recovery coaches was 75%, noting that the Cost Model currently has an 87.7% utilisation rate for level 3 DSW. However, given the cost model is based on efficient practice, rather than average practice, an 80% utilisation rate is considered to be a reasonable assumption for efficient providers. At least one provider out of the three who presented internal financial data achieved this rate.

4.7 It is therefore recommended that the price limits for the proposed new psychosocial recovery coach support items should be determined by the Standard Disability Support Worker Cost Model with the standard parameters, except as specified below:

- Support worker pay point 4.4
- Support worker utilisation rate 80%
- Supervisor pay point 5.1
- Supervisor utilisation rate 80%

4.8 Because the price limits are determined by the Standard Disability Support Worker Cost Model it is further recommended, that the price limits should apply nationally and should be subject to the standard remote and very remote loadings.

4.9 These assumptions would lead to a 2019-20 daytime hourly price limit for psychosocial recovery coaches of $78.17, compared to $63.03 for a Disability Support Worker classified delivering Level 3 support with daily activities.

4.10 Some providers have argued that the role of recovery coaches is more similar to that of a Level 2 Support Coordinator, for which the NDIS price limit is currently $98.06 per hour. The NDIA does not support this approach, support coordination is usually undertaken by psychologists, occupational therapists or other allied health professionals, and most of the

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providers considered that recovery coaches should not have to be required to be allied health professionals.

4.11 Providers also argued that supervision ratios should be lower for psychosocial recovery coaches – 1 supervisor to 8 support workers, rather than the 1 to 11 in the Standard Cost Model. However, the NDIA considers that there is no strong evidence for this lower supervision ratio, especially given the lower utilisation rate for supervisors already proposed for these support items.

4.12 Some providers argued that the overhead allowance in the Disability Support Worker Cost Model was insufficient, especially for providers who maintained fleets of vehicles for their staff to use in delivering supports to participants in the community. However, no compelling evidence was provided that the overheads of providers delivering psychosocial recovery coaching would be any different from other disability services. It should also be noted that for most providers, psychosocial recovery coaching services will only form a part of their service offering. This issue, including the issue of provider travel, will be dealt with generally in the Annual Price Review.

Variable time of day and day of week support provision

4.13 To be able to fulfil their peer support role for participants when their mental health conditions become acute, it is important to allow for higher rates of pay outside of standard working hours, especially as most psychosocial recovery coaches will be employed either under the SCHADS Award or under Enterprise Bargaining Agreements governed by the SCHADS Award.

4.14 It is therefore recommended that six different price limits be established for the psychosocial recovery coach support items subject to the standard definitions of time of day and day of week in the NDIS Price Guide.

Non direct supports

4.15 In order to be most effective, psychosocial recovery coaches will also need to be able to travel to meet with participants and provide other non-face-to-face supports.

4.16 It is therefore recommended that the psycho social recovery coach support items should be able to be claimed for Direct Service Provision; non-Face-to-Face Service Provision; Provider Travel, Cancellations and NDIA Report Writing.

Temporary Transformation Payment

4.17 The Temporary Transformation Payment (TTP) was introduced for some providers of core supports because of the need to balance the drive towards efficiency and the requirement to swiftly expand supply. Markets for core disability supports are continuing to develop, with both increases in market supply and improvements in production efficiency required. While improvements to production efficiency imply reductions to costs in the long run, expansion of market supply necessitates higher short to medium term prices. To maintain and expand production volumes of disability supports, higher short-term prices are thus needed to maintain existing supply and as an incentive to redirect the allocation of resources to the NDIS from other sectors in the economy.

4.18 The TTP was not applied to capacity building supports and was not applied to those core supports (Supported Independent Living) where a rapid growth in demand for support was not expected and the need to drive efficiency outweighed any supply expansion pressure.

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4.19 Because the psychosocial recovery coach support items are capacity building supports, and because higher price limits are already recommended for these support, it is therefore recommended that the proposed psychosocial recovery coach support items in Recommendation 2.1(a), should not be eligible for the Temporary Transformation Payment even though their cost models are determined by the Disability Support Worker Cost Model.

4.20 Applying the TTP to these supports would increase pressure from other providers of capacity building supports, including support coordination, for an expansion of the TTP, and there is no clear evidence of supply shortages in these sectors.

COVID-19 Loading

4.21 The Temporary 10% COVID-19 Loading was introduced from critical supports because of pressures on the cash flows of providers that were being reported due to impact of COVID-19 on worker availability and participant demand.

4.22 The psychosocial recovery coach items will only be introduced on 1 July 2020 and will take some time to establish, by which time the effect of the COVID-19 will be better understood.

4.23 It is therefore recommended that the proposed psychosocial recovery coach support items in Recommendation 2.1(a) should NOT be eligible for the Temporary 10% COVID-19 Loading.

4.24 Applying the Temporary 10% COVID-19 Loading to these supports would increase pressure from other providers of capacity building supports, including support coordination, for an expansion of the Temporary 10% COVID-19 Loading. The NDIA will continue to monitor the market for these supports to determine whether further interventions are necessary.

Activity Based Transport

4.25 Psychosocial recovery coaches may not only need to travel to meet participants in the community but may also need to transport participants as part of delivering their supports (for example, accompanying the participant to establish a relationship with another provider).

4.26 It is therefore recommended that an Activity Based Transport support item for providers of psychosocial supports be created in the relevant Support Category (Recommendation 2.2 above refers).

4.27 There is some risk in this recommendation as other providers (Support Coordinators) in this Support Category are in the same Registration Group (106) as that proposed for psychosocial recovery coaches and are not currently permitted to bill for Activity Based Transport. It is proposed to deal with this issue by specifying in the description of the new Activity Based Transport support item that it can only be used for activities associated with psychosocial recovery coach supports.

5. Risks

5.1 The major risk in implementing this initiative is workforce related. The community mental health support services sector reports that it has experienced a significant departure of experienced workers with the skills and experience to undertake this role over the past three years. This is why it is important that the level of base salary supported by the price control be sufficient to attract staff with the experience and skills needed.

5.2 The NDIA will monitor the uptake of the psychosocial recovery coach support items and respond as appropriate, including by reviewing price control arrangements, if necessary.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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6. Impact on Scheme sustainability

6.1 The adoption of the psychosocial recovery coach approach within the NDIS should deliver higher levels of self-management, lower plan management costs, and contribute to social and economic participation and higher levels of throughput for people with psychosocial disabilities in the Scheme. The introduction of the proposed support items therefore has the potential to help reduce long run outlays for these participants.

6.2 Internal Consultations

6.3 The Strategic Advice, Research and Inclusion Division was consulted in the development of this paper.

6.4 The Office of the Scheme Actuary were consulted on the implications of the paper's recommendations for Scheme sustainability.

7. Next steps

7.1 The new support items will be active in the *NDIS Support Catalogue* from 1 July 2020.

7.2 The Price Regulation Unit is responsible for working with other areas of the Agency to roll out the price control aspects of the psychosocial recovery coach approach across the NDIS, including advice for participants, providers, partners and NDIA staff.

(a) It is currently intended to release the new *NDIS Price Guide* and *NDIS Support Catalogue,* including the psychosocial recovery coach support items and other matters flowing from the Annual Price Review, on 31 May 2020.

(b) New price limits for items dependent on the Disability Support Worker Cost Model, including the psychosocial recovery coach support items, will be calculated and announced as soon as the Fair Work Commission (FWC) releases the results of the Annual Wage Review 2019-20, noting that the FWC is currently reviewing the timing of the Annual Wage Review 2019-20 in response to requests that its determination be delayed until after the economic impact of COVID -19 are better understood.

(c) The new price limits will come into effect from 1 July or at a time determined by the Board, if the Fair Work Commission decides to delay the operative date of its decision past 1 July 2020.

7.3 The Strategic Advice, Research and Inclusion Division is responsible for working with other areas of the Agency to roll out the psychosocial recovery coach approach across the NDIS, including the development of guidance for participants, providers, partners and planners on all of the non-price control aspects of the psychosocial recovery coach supports.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

DOCUMENT 29

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Matter for Decision

Reform of Supported Independent Living

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 To seek the agreement of the Pricing Reference Group (PRG) to the creation of several new support items to support the reform of funding of Supported Independent Living.

2. Recommendations

2.1 That PRG **AGREE to recommend to the Board of the National Disability Insurance Agency (NDIA), through the NDIA's Chief Executive Officer (CEO)**, that from 1 July 2020:

(a) the following support items be added to the *National Disability Insurance Scheme (NDIS) Support Catalogue* in Support Category 1 (Assistance with Daily Life) to support participants achieve outcomes in Outcome Domain 1 (Daily Life):

Support Item Number	Support Item Name	Support Item Description
01_801_0115_1_1	Assistance With Self-Care Activities - Level 1 - Weekday Daytime	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Level 1 support items should be used if the worker who dleivers the support is someone who has the skills and experience that would mean that they would be classified as a Social and Community Services Employee level 2 (below the maximum pay point) if they were employed under the SCHADS Award.
01_802_0115_1_1	Assistance With Self-Care Activities —Level 1 - Weekday Afternoon/Evening	
01_803_0115_1_1	Assistance With Self-Care Activities - Level 1 - Saturday	
01_804_0115_1_1	Assistance With Self-Care Activities - Level 1 - Sunday	
01_805_0115_1_1	Assistance With Self-Care Activities - Level 1 - Public Holiday	
01_806_0115_1_1	Assistance With Self-Care Activities - Level 1 – Active Night	
01_811_0115_1_1	Assistance With Self-Care Activities - Level 2 - Weekday Daytime	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Level 2 support items should be used if the worker who dleivers the support is someone who has the skills and experience that would mean that they would be classified as a Social and Community Services Employee level 2 (at the maximum pay point) or as a Social and Community Services Employee level 3 (at the maximum pay point) if they were employed under the SCHADS Award.
01_812_0115_1_1	Assistance With Self-Care Activities —Level 2 - Weekday Afternoon/Evening	
01_813_0115_1_1	Assistance With Self-Care Activities - Level 2 - Saturday	
01_814_0115_1_1	Assistance With Self-Care Activities - Level 2 - Sunday	
01_815_0115_1_1	Assistance With Self-Care Activities - Level 2 - Public Holiday	

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Support Item Number	Support Item Name	Support Item Description
01_816_0115_1_1	Assistance With Self-Care Activities - Level 2 – Active Night	
01_821_0115_1_1	Assistance With Self-Care Activities - Level 3 - Weekday Daytime	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Level 3 support items should be used if the worker who dleivers the support is someone who has the skills and experience that would mean that they would be classified above a Social and Community Services Employee level 3 (at the minimum pay point) if they were employed under the SCHADS Award.
01_822_0115_1_1	Assistance With Self-Care Activities —Level 3 - Weekday Afternoon/Evening	
01_823_0115_1_1	Assistance With Self-Care Activities - Level 3 - Saturday	
01_824_0115_1_1	Assistance With Self-Care Activities - Level 3 - Sunday	
01_825_0115_1_1	Assistance With Self-Care Activities - Level 3 - Public Holiday	
01_826_0115_1_1	Assistance With Self-Care Activities - Level 3 – Active Night	
01_831_0115_1_1	Assistance With Self-Care Activities –Night-Time Sleepover	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible where overnight support is needed, but the care giver can sleep when not required to provide support.

(b) the support items in Recommendation 2.1(a) should be subject to price regulation;

(c) the support items in Recommendation 2.1(a) should be subject to national price limits, with the price limits determined by the Standard Disability Support Worker Cost Model with the standard parameters;

(d) the price limits of the support items in Recommendation 2.1(a) should be subject to the standard remote and very remote loadings;

(e) the support items in Recommendation 2.1(a) should be subject to the standard definitions of time of day and day of week set out in the *NDIS Price Guide*;

(f) the support items in Recommendation 2.1(a) should be subject to the standard definitions of Level 1, Level 2 and Level 3 worker set out in the *NDIS Price Guide*;

(g) the support items in Recommendation 2.1(a) should be able to be claimed for Direct Service Provision; non-Face-to-Face Service Provision; Provider Travel, Cancellations and NDIA Report Writing, subject to the standard rules for those claims set out in the *NDIS Price Guide*;

(h) the support items in Recommendation 2.1(a) should NOT be eligible for the Temporary Transformation Payment even though their cost models are determined by the Disability Support Worker Cost Model; and

(i) the support items in Recommendation 2.1(a) should NOT be eligible for the Temporary 10 per cent COVID-19 Loading.

2.2 That the PRG **ALSO AGREE to recommend to the Board of the National Disability Insurance Agency (NDIA), through the NDIA's Chief Executive Officer (CEO)**, that from 1 July 2020:

(a) the following support items be added to the *National Disability Insurance Scheme (NDIS) Support Catalogue* in Support Category 1 (Assistance with Daily Life) to support participants to achieve outcomes in Outcome Domain 1 (Daily Life):

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MR25/01967 FOI 24/25-2242

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Support Item Number	Support Item Name	Support Item Description
01_841_0115_1_1	Activity Based Transport	A provider can transport one or more participants to and/or from a community based support as part of that support.

(b) the support item in Recommendation 2.2(a) should not be subject to price regulation; and

(c) the support item in Recommendation 2.2(a), should be subject to the standard rules for activity based transport set out in the NDIS Price Guide.

3. Background

3.1 To date, the NDIS has funded two service models for participants to support their daily living activities:

(a) Assistance with Daily Living (ADL) are support services that are assistance with self-care activities during the day or evening.

- ADL support items represent hourly units of support and are subject to price controls determined by the Disability Support Worker Cost Model.

(b) Supported Independent Living (SIL), which is the provision of help with and/or supervision of daily tasks to develop the skills of an individual to live as independently as possible. These are supports provided to a participant in their home, regardless of property ownership, and can be in a shared or individual arrangement.

- The current SIL funding and pricing mechanism is based on legacy operating models, and is no longer fit-for-purpose due to its limits on choice and control and rigid funding structure. SIL is funded based on a weekly (24/7) Roster of Care. SIL is a stated and quotable item; providers submit a quote to the Agency, who assess the price (based on ADL rates). Consequently, SIL rates are not specified in the NDIS Price Guide.

3.2 The intent of ADL and SIL models are similar– to provide support for participants undertaking daily living activities. The difference is derived from the pricing, operational and billing components. While the sector favoured the SIL model (due to a better understanding compared to ADL and easier payment), it has had a number of challenges, including:

(a) Participants do not appear to have sufficient choice & control about key assumptions contained in the quotation including matters contained in the roster of care;

(b) SIL costs are one of the top risks to Scheme Sustainability with:

- year-on-year inflation of 18-19 per cent, and payments forecast to grow at 1.2-1.9 per cent month-on-month;
- the highest average annualised plan budget compared to similar models;

(c) NDIA processes are inconsistent and complex with:

- significant administrative effort including approximately 40 per cent of quotes received having errors;
- decision making rationale on support and funding levels is variable, opaque and planner dependent;

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- providers negotiating on the SIL quote value, and quoting above the ADL rates

(d) The current model having shifted from being participant focussed to house/site driven.

3.3 To address these issues, the NDIA Board and Executive Leadership Team have endorsed a series of actions with the intent to:

(a) Improve participant choice and control, and experience and outcomes;

(b) Address pressures to Scheme sustainability; and

(c) Improve Agency processes to reduce administrative burden for providers and the NDIA.

3.4 To deliver on these actions, a proposed end-state has been developed.

Proposed end state

3.5 Attendant care in both shared and individual living arrangements will be provided under the Assistance with Daily Living (ADL) product. ADL is defined as the provision of support and/or supervision of daily tasks to develop the skills of an individual to live as independently as possible.

3.6 ADL can be considered:

(a) In a shared arrangement or for participants living independently;

(b) For participants who require intensive supports or shared ratios of care; and

(c) Along a spectrum of supports, from discrete hours/modules in the day (intermittent care) to continuous care throughout the week (24/7 support typically through a Roster of Care).

4. Issues

4.1 It is intended that the new SIL supports should be available in the *NDIS Support Catalogue* from 1 July 2020.

Price regulation

4.2 The market for SIL is not mature, or at least no more mature than the delivery of supports for Assistance with Daily Life on an hourly basis. It is therefore recommended that the proposed new support items should be subject to price regulation.

Price controls

4.3 There are a number of factors that determine the input costs for providers that indicate that the costs of SIL providers are similar to those of providers of Assistance with Daily Life supports.

4.4 The available evidence from the AbleInsight Benchmarking Survey 2019 indicates that SIL providers and providers of Assistance with Daily Life providers pay similar or slightly lower salary rates:

(a) Actual labour costs are higher in SIL:

- The average actual hourly rate of pay (including loadings) of support workers was $36.92 in SIL compared with $33.75 (SIL is higher by 9.4 per cent)

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- The average actual hourly rate of pay (including loadings) of line managers was $44.76 in SIL compared with $41.69 (SIL is higher by 7.4 per cent)

(b) However, this is because of the greater use of overtime and the 24/7 nature of SIL service delivery:

- The share of salary related costs associated with shift penalties is 35.1% in SIL compared to 11.6% for those delivering support with daily activities or community participation.
- The share of salary related costs associated with overtime is 1.4% in SIL compared to 1.0% for those delivering support with daily activities or community participation;

(c) When these effects are taken into account,

- The average base hourly rate of pay (without loadings) of support workers was $29.58 in SIL compared with $29.89 (SIL is lower by 1 per cent); and
- The average base hourly rate of pay (without loadings) of line managers was $39.17 in SIL compared with $37.49 (SIL is higher by 4.5 per cent).

4.5 There is therefore no reason to make different assumptions about base salary rates in the hourly cost models for SIL and providers of Assistance with Daily LIfe supports. The data does underline the importance, however, of maintaining differential price limits for different shifts.

4.6 The utilisation rates (billable hours as a share of available hours) are similar for SIL providers and providers of Assistance with Daily LIfe supports (94.5 per cent compared with 92.5 per cent).

4.7 Supervision ratios (the number of support worker per line manager) are also similar – 16.5 on average for SIL providers and 16.2 on average for providers of Assistance with Daily Life supports.

4.8 There is some evidence that the organisational overheads of SIL providers could be lower than those of providers of Assistance with Daily Life supports.

(a) Several factors should reduce administrative costs, including recruitment and training:

- The average tenure for support workers with SIL providers is 46.4 months compared with 38.0 months for providers of Assistance with Daily Life supports.
- A greater proportion of SIL staff are permanent (71.6% compared with 58.5%)

(b) It is also less likely that SIL providers need to maintain fleets of vehicles so that their staff can visit participants to deliver services.

4.9 There are, however, some costs which arise for SIL providers that providers of Assistance with Daily Life supports do not face. Consultations with the sector, including as part of the WA Market Review, have indicated that vacancy costs are a significant additional cost for providers. For example, if a SIL house of three residents has a worker sleeping at the house overnight, then if one resident leaves the costs of inactive overnight stay do not decrease (it isn't possible to have the worker sleeping there for only 2/3 of the night). The same difficulty arises with residents who need the presence of a worker continually for safety reasons and that cost is normal shared between all of the residents in the SIL dwelling. Again the absence of a resident does not reduce the total cost of the support.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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4.10 Consultations with the sector indicate that an uplift factor of about 5% is necessary to cover these costs.

4.11 On balance it appears that the various factors may well cancel each other out and that it is appropriate to use the hourly price limits for daily activities and community participation as the basis for SIL hourly price limits.

4.12 It is therefore recommended that the price limits for the proposed new SIL support items should be determined by the Standard Disability Support Worker Cost Model with the standard parameters.

4.13 Because the price limits of the support items in Recommendation 2.1(a) are determined by the Standard Disability Support Worker Cost Model it is further recommended, that:

(a) the price limits should apply nationally;

(b) the price limits should be subject to the standard remote and very remote loadings;

(c) the support items should be subject to the standard definitions of time of day and day of week set out in the *NDIS Price Guide*;

(d) the support items should be subject to the standard definitions of Level 1, Level 2 and Level 3 worker set out in the *NDIS Price Guide*; and

(e) the support items should be able to be claimed for Direct Service Provision; non-Face-to-Face Service Provision; Provider Travel, Cancellations and NDIA Report Writing, subject to the standard rules for those claims set out in the *NDIS Price Guide*.

Temporary Transformation Payment

4.14 The Temporary Transformation Payment (TTP) was introduced for some providers of core supports because of the need to balance the drive towards efficiency and the requirement to swiftly expand supply. Markets for core disability supports are continuing to develop, with both increases in market supply and improvements in production efficiency required. While improvements to production efficiency imply reductions to costs in the long run, expansion of market supply necessitates higher short to medium term prices. To maintain and expand production volumes of disability supports, higher short-term prices are thus needed to maintain existing supply and as an incentive to redirect the allocation of resources to the NDIS from other sectors in the economy.

4.15 The TTP was not applied to capacity building supports and was not applied to those core supports (Supported Independent Living) where a rapid growth in demand for support was not expected and the need to drive efficiency outweighed any supply expansion pressure.

4.16 It is therefore recommended that the proposed support items in Recommendation 2.1(a), should not be eligible for the Temporary Transformation Payment even though their cost models are determined by the Disability Support Worker Cost Model.

COVID-19 Loading

4.17 The Temporary 10% COVID-19 Loading was introduced from critical supports because of pressures on the cash flows of providers that were being reported due to impact of COVID-19 on worker availability and participant demand.

4.18 Alternative arrangements are currently being introduced to support SIL providers deal with these issues including in cases where management of a COVID19+ Participant is required.

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DISCLOSURE LOG

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4.19 It is therefore recommended that the proposed new support items in Recommendation 2.1(a) should NOT be eligible for the Temporary 10% COVID-19 Loading as the additional costs faced by these providers are being dealt with through other measures.

Activity Based Transport

4.20 Providers who deliver Assistance with Daily Life supports may need to transport participants as part of delivering their supports. It is therefore recommended that an Activity Based Transport support item for providers of SIL be created in the relevant Support Category (Recommendation 2.2 above refers).

5. Impact on Scheme sustainability

5.1 The new pricing arrangements are being developed as part of a strategy to reduce the pressures on Scheme sustainbility from the growth in SIL payments.

6. Internal Consultations

6.1 The DCEO, Design, Digital and Strategy and Operations and Housing Division were consulted in the development of this paper.

7. Next steps

7.1 The new support items will be active in the *NDIS Support Catalogue* from 1 July 2020.

7.2 The Price Regulation Unit is responsible for working with other areas of the Agency to roll out the price control aspects of the new SIL approach, including advice for participants, providers, partners and NDIA staff.

(a) It is currently intended to release the new *NDIS Price Guide* and *NDIS Support Catalogue,* including the new SIL support items and other matters flowing from the Annual Price Review, on 31 May 2020.

(b) New price limits for items dependent on the Disability Support Worker Cost Model, including the new SIL support items, will be calculated and announced as soon as the Fair Work Commission (FWC) releases the results of the Annual Wage Review 2019-20, noting that the FWC is currently reviewing the timing of the Annual Wage Review 2019-20 in response to requests that its determination be delayed until after the economic impact of COVID -19 are better understood.

(c) The new price limits will come into effect from 1 July or at a time determined by the Board, if the Fair Work Commission decides to delay the operative date of its decision past 1 July 2020.

7.3 The Startegy and Priorities Division is responsible for working with other areas of the Agency to roll out the new SIL approach across the NDIS, including the development of guidance for participants, providers, partners and planners on all of the non-price control aspects of the new approach.

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National Disability Insurance Scheme

Annual Pricing Review 2020-21

Final Report

May 2020

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Terms that we use:

Acronym	Full name
ABS	Australian Bureau of Statistics
CPI	ABS Consumer Price Index
DSW	Disability Support Worker
MMM	Modified Monash Model
NDIA/Agency	National Disability Insurance Agency
NDIS/Scheme	National Disability Insurance Scheme
Review	Annual Pricing Review
SCHADS Award	Social, Community, Home care And Disability Services Industry Award 2010
TTP	Temporary Transformation Payment
WPI	ABS Wage Price Index

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Contents

Executive Summary **7**

Conduct of the review *7*

Findings and recommendations *8*

1. Introduction **26**

Terms of Reference *27*

Conduct of the review *28*

2. Provider Administration and Participant Flexibility **36**

Current Arrangements *36*

Consultations *36*

Discussion *37*

Recommendations *40*

3. Price limits for 1:1 core supports **42**

Current Arrangements *42*

Consultations *45*

Research *53*

Discussion *57*

Recommendations *65*

4. Price limits for group-based core supports **68**

Current Arrangements *68*

Consultations *69*

Research *71*

Discussion *72*

Recommendation *73*

5. Capacity Building Supports **74**

Current Arrangements *74*

Consultations *75*

Research *77*

Discussion *79*

Recommendation *83*

6. Plan Management Supports **84**

Current Arrangements *84*

Consultations *85*

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Discussion *89*

Recommendation *91*

7. Classifying Regional, Remote and Very Remote **92**

Current Arrangements *92*

Consultations *94*

Research *95*

DIscussion *95*

Recommendation *95*

8. Costs in Outer Regional Areas **96**

Current Arrangements *96*

Consultations *96*

Research *96*

Discussion *98*

9. Cancellation Rules **99**

Current Arrangements *99*

Consultations *100*

Discussion *101*

Recommendation *101*

10. Provider Travel Rules **102**

Current Arrangements *102*

Consultations *103*

Research *105*

Discussion *106*

Recommendation *109*

11. Establishment Fees **110**

Current Arrangements *110*

Consultations *111*

Research *112*

Discussion *113*

Recommendation *115*

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Figures

Figure 1 - Distribution of Submissions by Number of Participants and NDIS Revenue of Respondent 29

Figure 3 – Distribution of Topics Raised in Submissions to the Annual Pricing Review 30

Figure 4 - Nous Group Study of Back-Office Expenses of Not For Profit Organisations 56

Figure 4 - Claims for group activities in a centre 72

Figure 7 - Number of provider claims per quarter from 2016 to 2019 89

Figure 8 - NDIS revenue claimed by plan managers from monthly fees, buy Quarter, 2019-2019 90

Figure 9 - Relative Cost of Delivering Services by Remoteness Classification 97

Tables

Table 1 - Distribution of Submissions Received by the Annual Pricing Review 29

Table 6 - FWC Decision on SCHADS Shift Loadings - 1 July 2020 38

Table 2 - NDIS Disability Support Worker Cost Model – Key Assumptions 45

Table 5 - Distribution of Results from the TTP Survey 53

Table 3 - NDIS hourly price limits for non-TTP and TTP support items 54

Table 4 - Comparative Scheme hourly fees 54

Table 7 - Capacity Building Supports That May Be Delivered By Disability Support Workers 77

Table 8 - NDIS therapy price limit comparison with other Schemes, hourly rates 80

Table 9 – Definitions of the Modified Monash Model Geographic Areas 92

Table 10 – Regions where price limits change between MMM2015 and MMM2019 93

Table 11 - Relative cost of living across Queensland 98

Table 12 - Relative cost of living across Western Australia 98

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

DISCLOSURE LOG

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

Executive Summary

The National Disability Insurance Agency (NDIA) continually monitors and reviews its price control framework and other market settings to determine whether they remain appropriate. The NDIA is also committed to the continuous improvement of the methodologies underpinning the NDIS price control framework. In line with this commitment, the Annual Pricing Review 2020-21 was required to examine, through research and consultation with industry, community and government stakeholders, whether the existing price control framework and other market settings under the NDIS continue to be appropriate or should be modified.

CONDUCT OF THE REVIEW

The Review engaged in extensive consultations with industry, community and government stakeholders and undertook a program of research.

- An *Issues Paper* was released on 28 November 2019 together with a public call for submissions. The formal closing date for submissions was 2 February 2020, but submissions received up until 8 April 2020 were taken into account in the Review. Some 96 submissions were received by the closing date. A total of 139 submissions had been received and analysed by 8 April 2020.
- Face to face consultations were held with 29 groups of providers in each State and Territory. After 23 March 2020, these consultations were held by teleconference/ videoconference for safety reasons.
- Six working groups (involving 108 providers and peak bodies) were established with representatives from the sector to discuss concerns and proposals for change.
- On 11 March 2020, the NDIA's Pricing Reference Group (PRG) met with members of the six provider peak groups.
- On 15 April 2020, the NDIA's PRG met with members of three participant peak groups. Other participant representative groups were invited, but were unable to attend due to having to address COVID-19 issues.
- Consultations were also held with, and desktop analysis undertaken of, ten other state based and national schemes to compare pricing arrangements for attendant care and therapy services.

Deloitte Access Economics were engaged by the NDIA to conduct a financial benchmarking survey of Temporary Transformation Payment (TTP) providers and to analyse the results, with a particular emphasis on the parameters that underlie the NDIS Disability Support Worker Cost Model that determines many of the NDIS price limits. As at 15 March 2020, when the survey closed, Deloitte had received 615 completed surveys. As of 31 March 2020, an additional 231 responses had been received. However, these additional responses were not received in time to be included in the analyses in this report.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

The Review also conducted research as set out in this Report, including of the extent to which providers were choosing not to charge the TTP and were agreeing fees with participants below the price limits.

FINDINGS AND RECOMMENDATIONS

Provider Administration and Participant Flexibility

The Review was required by its Terms of Reference to examine the price control framework to identify opportunities to increase flexibility for participants and reduce administrative burdens for providers.

The Review considers that there would be considerable merit in changing the timing of the Annual Pricing Review so that providers were aware earlier of any policy changes that the NDIA intended to make. The Review also considers that given the uncertainty around economic conditions during the COVID-19 pandemic and as Australia emerges from the pandemic that the NDIA should not undertake an Annual Pricing Review in 2020-21 but should instead monitor economic conditions carefully and promptly respond to emerging issues.

The Review also sees merit in the NDIA publishing the indexation methodology for price limits so that providers can better estimate their future budgets, recognising that the NDIA is not able to index and announce price limits until after the Fair Work Commission has made its Annual Minimum Wage Decision, which usually occurs in the middle of June each year.

The Review supports the introduction of programs of supports, whereby providers enter into contracts for the provision of programs of supports, especially where the program of supports is towards the achievement of specified outcomes. Where a participant does not attend one part of a program the provider is able to claim as though they did attend – that is, this is not a cancellation, as long as the provider had the capacity to deliver the support. The Review considers that it is important to include safeguards in these arrangements, including that programs of support cannot be for longer than 12 weeks (unless specifically allowed for in the *NDIS Price Guide*) and that participants should be able to exit from an agreed program of supports without cost, subject to an agreed notice period that can be no longer than two (2) weeks. Supports delivered as part of a program of supports would not be subject to the short notice cancellation rules.

The Review recognises the concerns raised in consultations with participant representative organisations that the programs of support approach should not be permitted to be used by providers to return themselves to a quasi-form of block funding. Participant representatives did acknowledge, however, that the program concept was common in the commercial world and that it could be beneficial for other participants taking part in a program as they would have a greater certainty that the program would operate fully throughout its term. On balance, the Review considers that the advantages outweigh the risks, but recommends that the introduction of programs of support approach be carefully evaluated and that guidance material be produced by the NDIA for participants, including on their right to choose not to

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

engage their provider through a program of support. In the first instance, program of supports should only be able to be offered for group supports.

The Review also considers that there are other opportunities to simplify the *NDIS Support Catalogue* by removing the various worker to participant ratio support items. Providers would divide the number of worker hours by the number of participant hours to derive their own fractions of hours to charge participants and would claim for these hours against the relevant 1:1 support item and subject to the relevant price limit. For example, one worker delivering a one-hour session on a Saturday to three participants would be claimed as 1/3 of an hour per participant subject to the 1:1 Saturday price limit rather than as currently where an hour is claimed for each participant but subject to a reduced 1:3 Saturday price limit.

RECOMMENDATION 1) Annual Pricing Review

1) The NDIA should not undertake an Annual Pricing Review in 2020-21 but instead monitor economic conditions carefully as the COVID-19 pandemic progresses and the economy recovers and promptly respond to any emerging issues.

2) The NDIA should undertake the Annual Pricing Review from July to December each year (commencing 2021), reporting in February/March of the following year to the Board of the NDIA, through the Chief Executive Officer, with changes to take effect from the following 1 July.

RECOMMENDATION 2) Annual Indexation of Price Limits

1) The NDIA should increase price limits during 2020 to maintain their real value through the following indexation arrangements:

    i) Price limits for supports delivered by Disability Support Workers should be set by the NDIS Disability Support Worker Cost Model from the operative date of the Fair Work Commission's Annual Wage Review;

    ii) Price limits for Capital supports – Support Categories 2 (Transport), 3 (Consumables), 5 (Assistive Technology) and 6 (Home Modifications and Specialised Disability Accommodation) – should be indexed on 1 July 2020 in line with the movement in the ABS Consumer Price (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter preceding the indexation date; and

    iii) Price limits for other supports should be indexed on 1 July 2020 in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses) and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter preceding the indexation date (with an 80/20 weighting).

2) That in addition to the annual indexation arrangements, the NDIA should also reset all price limits determined by the NDIS Disability Support Worker Cost Model in

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

response to the following Fair Work Commission determinations, with effect from the date of effect of the Fair Work Commission's determination:

i) 1 December 2020, for the final tranche of the Fair Work Commission's Equal Remuneration Order (MA000100 PR525485); and

ii) 1 July 2020, for the adjustment of the shift loadings for casual workers on Saturdays and Sundays in the SCHADS Award (Fair Work Commission Decision [2019] FWCFB 7096).

RECOMMENDATION 3) Programs of Supports

The NDIA should amend the *NDIS Price Guide* from 1 July 2020, to make clear that providers are allowed to enter into service agreements for the provision of programs of supports, where those supports are group supports, subject to the following safeguards:

i) that programs of support cannot be for longer than 12 weeks (unless specifically allowed for in the *NDIS Price Guide*);

ii) that participants should be able to exit from an agreed program of supports without cost, subject to an agreed notice period that can be no longer than two (2) weeks;

iii) the introduction of programs of supports should be carefully evaluated; and

iv) guidance material should be produced for participants before programs of supports are introduced.

Price limits for 1:1 core supports

The price limits for core supports are determined by the application of the NDIS Disability Support Workers Cost Model. The Review was required by the its Terms of Reference to examine the assumptions and parameters outlined in the NDIS Disability Support Worker Cost Model, including through analysis of the financial benchmarking data collected through the Temporary Transformation Payment (TTP) arrangements.

The full details of the NDIS Disability Support Workers Cost Model were published in June 2019. The cost model estimates the cost of delivering a billable hour of support taking into account all of the costs associated with every billable hour, including: base pay; shift loadings; holiday pay; salary on costs; supervision costs; utilisation (non-billable activities); corporate overheads and margin. Base rates of pay under the model are set in accordance with the *Social, Community, Home Care and Disability Services Industry Award 2010*. The cost model also contains a range of key assumptions and parameters that determine the level of the price limits.

The cost model also varies according to a range of factors, including: the intensity of support, the level of skills and experience of the worker delivering the support, whether the worker is

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

permitted to sleep over, the time of day and day of the week the support is delivered and whether or not the provider claims the Temporary Transformation Payment (TTP).

The Review does not support the request by some providers that the price limit for support items should be determined by the complexity of the participant's needs rather than by the skills and experience of the support worker, as currently. The Review accepts that participants with complex needs will often require more funding, both for more supports and for more skilled or experienced support workers. However, this is a planning issue, not a pricing issue. From a price control perspective the important issue is the input costs of the provider, which are largely determined by the skills and experience of the support worker who delivers the support.

The Review also does not support the request by some providers that the price limit should be determined by the shift of the worker rather than by the time of day that the support is delivered. It is important that participants know what price limit applies to each support that they purchase and they cannot know this if the price limit can also vary according to the shift that the employer has engaged the employee to work. In the end, workforce rostering is a matter for providers to manage. It is important to note, however, that when a particular support crosses a shift boundary and the same worker delivers the entire support then the provider is entitled to use the highest price limit for the entire support.

Given that baseline price limits are intended to represent efficient costs the TTP survey results, taken on their own, provide some evidence that the NDIS Disability Support Worker Cost Model may not be correctly estimating efficient costs – although some of the effects are countervailing.

- The average Permanent Share of the workforce among survey respondents (43.8%) is considerably lower than the current Model assumption (90%). Moreover, the efficient 25th percentile estimate (71.7%) is also lower than the Model assumption.
- The average utilisation rate among survey respondents (79.8%) is lower than the current Model assumptions (87.7% to 92.0%). However, the efficient 25th percentile estimate (90.0%) is in line with the current Model assumptions.
- The average overheads percentage (as a loading on direct care costs) among survey respondents (27.7%) is higher than the current Model assumptions (10.5%). Moreover, the efficient 25th percentile estimate (19.8%) is also higher than the current Model assumption.
- The average span of control among survey respondents (11.8:1) is slightly higher than the current Model assumptions (11:1). Moreover, the efficient 25th percentile estimate (15:1) is considerably higher than the current Model assumption.
- The NDIS Disability Support Worker Cost Model does not currently provide for allowances paid to workers on top of their salaries (other than shift loadings and superannuation). This in not in line with the TTP Benchmarking Survey which indicates

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

that these allowances can typically be in the order of 1.0% of the base salary payable to the worker.

However, the TTP survey does not include results for providers who are not accessing the higher TTP price limits, and who, prima facie, are likely to have lower costs (and hence be more efficient) since they have not chosen to access the higher TTP price limits. Only around half of eligible providers (59.6%) claim the TTP and then less than half of TTP claimants completed the survey by the due date. Thus, the survey provides results for only around a quarter of those NDIS providers who employ Disability Support Workers. Assuming that the distribution of overheads among non-TTP claiming providers is similar to the distribution among TTP claiming providers, but with a lower average representing their lower costs then it is possible to generate a mixed statistical distribution of all providers. The Review estimates that in this distribution the efficient (25th percentile) provider would have overheads of between 14.4% and 16.7% of direct costs (with a median estimate of 15.2%).

Moreover, some of these overheads relate to provider transport non-labour costs, which are currently not separately claimable by providers. The TTP benchmarking survey found that the average cost of travel expenses across respondents was $1,000 per worker per year. A DSW Level 1 paid at $27.61 per hour, with a 38-hour week, has an annual income of $54,557. With salary related on costs and supervision costs this equates to direct care expenditure of about $70,000. Travel expenses of $1,000 would represent a 1.4% increase on this, and would currently be shown in the overheads of the provider.

There is also strong evidence that some providers are managing to operate at or below the current price limits, with almost 40% of eligible providers choosing not to access the higher TTP price limits. Moreover, more than 25% of all claims by these providers were below the relevant lower non-TTP price limit and about 9% of claims were more than 10% below the relevant lower non-TTP price limits.

Finally, the current price limits in the NDIS are higher than some of those that apply in other schemes. However, it is not clear to what extent these fees can be compared to NDIS price limits, given that fees can operate differently in different contexts (e.g. according to whether or not services are commissioned, and what other fees – including co-payments – are also billable).

On balance, therefore, the Review considers that there is no reason to increase the current set of price limits, although it would be appropriate to make some minor modifications to the NDIS Disability Support Worker Cost Model to:

- Decrease the ratio of permanent to casual staff assumed in the cost model to 70/30% in line with the 25th percentile of the TTP Benchmarking Survey;
- Increase the share of staff assumed to take up their long service leave entitlements to 100% in recognition of the existence of portable long service leave schemes in some states and territories;

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- Decrease the assumed workers compensation premium percentage from 3.0% to 1.7% in line with the 25th percentile observed in the TTP Benchmarking Survey, noting that this is equal to the average premium percentage observed across the health and community sector;
- Increase the assumed overheads percentage to 12.0% to better align with the estimated overheads of efficient providers in the sector, noting that other recommendations being made by the Review will directly address some of the costs that providers are currently carrying in their overheads;
- Increase the supervision ratio from 11 to 15 in line with the 25th percentile observed in the TTP Benchmarking Survey, noting that the non-face-to-face claiming rules permit some interactions between supervisors and staff to be claimed directly when they relate to the specific direct care needs of a participant; and
- Increase the provision of allowances (other than travel allowances) for support workers and supervisors to 1.0% of salary, in line with the average level observed in the TTP Benchmarking Survey.

The level of the TTP loading was set at 7.5% for 2019-20 to be reduced by 1.5%age points each 1 July thereafter in line with the NDIS Pricing Strategy. The Review considers that there is more than sufficient evidence that the market for disability supports is continuing to grow and become more efficient, noting again that more than 40% of providers chose not to access the TTP accounting for almost half of all claims (by dollar) against relevant support items, and that of those providers who chose to operate under the lower non-TTP price limits, more than 25% of all claims were below the relevant lower price limit.

The Review also considers that the assurance arrangements around claiming the higher TTP price limits should be strengthened and that Plan Managers should be required to receive an attestation from a provider who is seeking to make a claim against an item subject to the higher TTP price limits that they are eligible to access the higher price limits before the Plan Manager processes the claim.

RECOMMENDATION 4) NDIS Disability Support Worker Cost Model

1) The NDIA should continue to use the NDIS Disability Support Worker Cost Model to determine the base (non-TTP) price limits for supports delivered by Disability Support Workers based on the performance of efficient providers.
2) The NDIA should amend the NDIS Disability Support Worker Cost Model (and the price limits determined by the cost model), from 1 July 2020, by:
    i) Decreasing the ratio of permanent to casual staff to 70/30%;
    ii) Increasing the share of staff assumed to take up their long service leave entitlements to 100%;
    iii) Decreasing the workers compensation premium percentage to 1.7%;

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

iv) Increasing the overheads percentage to 12.0%;

v) Increasing the supervision ratio to 15:1; and

vi) Increasing the allowance provision for support workers and supervisors to 1.0% of salary.

RECOMMENDATION 5) Temporary Transformation Payment

The NDIA should reduce the level of the Temporary Transformation Payment from 7.5% to 6.0% on 1 July 2020 as previously announced.

RECOMMENDATION 6) Definition of the Levels of High Intensity Supports

That the definitions of Level 1, Level 2 and Level 3 supports in the *NDIS Price Guide* should be amended as follows:

Level 1 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified as a Social and Community Services Employee level 2 (below the maximum pay point) if they were employed under the SCHADS Award.

Level 2 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified as a Social and Community Services Employee level 2 (at the maximum pay point) or as a Social and Community Services Employee level 3 (at the minimum pay point) if they were employed under the SCHADS Award.

Level 3 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified above a Social and Community Services Employee level 3 (at the minimum pay point) if they were employed under the SCHADS Award.

RECOMMENDATION 7) Definitions of Time of Day and Day of Week

That the definitions of Time of Day and Day of Week in the *NDIS Price Guide* should be amended as follows:

Time of Day and Day of Week

In determining which price limit is applicable to a support, the important consideration is when the support is provided to the participant, not the shift of the worker used to deliver that support as determined by the applicable Industry Award or Enterprise Bargaining Agreement (EBA).

For NDIS billing purposes the provider must first determine the day of the week on which the support was provided on and then the time of the day during which the support was delivered. (Note: weekday means Monday, Tuesday, Wednesday, Thursday or Friday).

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- *A **Night-time Sleepover Support** is any support to an individual participant delivered on a weekday, a Saturday, a Sunday or a Public Holiday that:*
    - commences before midnight on a given day and finishes after midnight on that day; and
    - is for a continuous period of eight (8) hours or more; and
    - the worker is allowed to sleep when they are not providing support.
- *A **Public Holiday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Public Holiday and ends before or at midnight of that Public Holiday (unless that support is a Night-time Sleepover Support).*
- *A **Saturday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Saturday and ends before or at midnight of that Saturday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).*
- *A **Sunday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Sunday and ends before or at midnight of that Sunday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).*
- *A **Standard Day Support** is any other support, and is either:*
    - A **Weekday Support** is any support to an individual participant that starts at or after 6:00 am and ends before or at 8:00 pm on a single weekday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).
    - An **Evening Support** is any support to an individual participant that finishes after 8:00 pm and at or before midnight on a single weekday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).
    - An **Active Overnight Support** is any support to an individual participant that commences at or before midnight on a weekday and finishes after midnight on that weekday, or commences before 6:00 am on a weekday and finishes on that weekday (unless that support is a Public Holiday Support, Saturday Support, Sunday Support or a Night-time Sleepover Support).

If a support to an individual participant does not meet one of the above criteria then it needs to be billed as two or more separate supports.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Night-time Sleepover Supports

Night-time Sleepover Supports have a price limit that is inclusive of the cost of two hours of any supports provided to the participant for the duration of the period. Providers may claim for third or additional hour at Saturday rates on weekdays, or at applicable rates on other days (Saturday, Sunday or Public Holidays)

Note, Night-time Sleepover Supports apply to any day of the week and on public holidays, pending criteria met as described previously.

Price limits for group-based core supports

The Review was required by its Terms of Reference to examine the methodology for deriving the price controls for group-based supports from the price controls for 1:1 supports. Currently, the price limit for community-based group supports apply to each hour of support and are based on the price limit of the relevant 1:1 community participation support (for each level of support and time of day and day of week). The price limit for the relevant 1:1 support is P then the price limit P_n for the 1:n community based support is given by the following equation:

$$P_n = \frac{P + (n-1) \times 0.12 \times P}{n}$$

For each additional person in the group (after the first) an additional 12% of the 1:1 price limit (essentially seven minutes) is added to the price limit. This reflects the time that the provider may need to spend writing a report on each participant in the group after the group has finished. Because of this built-in loading, providers of group based supports are not permitted to claim for non-face-to-face time. For 1:1 supports, non-face-to-face activities are part of delivering a specific disability support to that participant (rather than a general activity such as enrolment, administration or staff rostering).

The price limit for centre-based group supports are calculated by adding a fixed capital allowance amount to the relevant community based group support. In 2019-20, the amount of the fixed capital allowance was $2.10 per participant per hour. The amount of the fixed capital allowance is indexed on 1 July each year in line with movements in the Consumer Price Index (CPI).

The Review considers that there is considerable merit in replacing the current group based pricing arrangements with simplified arrangements, whereby providers can claim for both direct service provision and non-face-to-face supports as they are provided. Providers would divide the number of worker hours by the number of participant hours to derive their own fractions of hours to charge participants and would claim for these hours against the 1:1 support item and subject to the standard price limit. For example, one worker to three participants for a one-hour session would be claimed as 1/3 of an hour per participant subject to the 1:1 price limit rather than as currently where hour is claimed for each

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

participant but subject to a reduced 1:3 price limit. Providers of centre based care would claim for the fixed capital allowance for each participant through a separate support item.

The Review notes that when this change was suggested last year the sector did not accept it. It appears, however, that the sector has become much more comfortable with the non-face-to-face claiming arrangements and can now see the opportunities that can arise from the proposed simplification. Currently there are over 220 support items for group-based supports in the *NDIS Support Catalogue*. Under the proposed amendments, some 200 of these support items would no longer be needed. The proposed new arrangements for "programs of supports" would also reduce the administrative burden of providers.

The Review does not consider that the evidence about the capital costs of centre-based care is sufficiently strong to justify a change in the amount of the fixed capital allowance, but could be investigated further in a future Annual Pricing Review.

RECOMMENDATION 8) Group Based Supports

1) The NDIA should amend the pricing arrangements for group based supports so that providers no longer use the various worker to participant ratio support items but instead claim all supports against the appropriate 1:1 support items by apportioning the time spent with the group among the members of the group. Providers of centre based care would claim for the fixed capital allowance for each participant in a group through a separate support item.

2) The NDIA should also amend the pricing arrangements for group based supports so that providers can claim for non-face-to-face supports under the usual conditions, rather than having an allowance for non-face-to-face supports built into the price limit.

Capacity Building Supports

The Review was required by the its Terms of Reference to review the price control framework for capacity building supports, including therapy supports, by examining:

- how price limits for capacity building supports, other than therapy supports, should be indexed or otherwise determined annually;
- how price limits for therapy supports should be adjusted annually, given the outcomes of the Review of Therapy Pricing Arrangements;
- whether different price limits might be appropriate for different times of the day, or days of the week, for some capacity building supports, including for therapists, therapy assistants and for capacity building supports delivered by disability support workers; and
- whether therapists and other capacity building providers should be able to recover the costs of consumables provided to participants as part of a support.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

The *Review of NDIS Therapy Pricing Arrangements* ("the Therapy Review"), which reported in 2019, found that the NDIS accounts for about 2.4% of Australia's established national therapy market, suggesting that it has limited capacity to influence market prices for therapy services and is instead a "price taker". The Therapy Review also found that while there are early signs of some competition in the NDIS market for therapy services, around 70% of claims continued to be made at the price cap. It found that the distribution of claims also remains significantly different from the private market distribution. On the basis of the evidence on market conditions and the sector consultations and benchmarking analysis outlined above, and in line with the principles of the *National Disability Insurance Scheme Act 2013*, including that a funded support must represent "value for money in that the costs of the support are reasonable, relative to both the benefits achieved and the cost of alternative support", the Therapy Review recommended that the NDIA should maintain price caps on therapy services at least until the transition to the NDIS is complete and there is evidence that the distribution of NDIS payment claims is broadly in line with the distribution of prices observed in the private billing market.

The current Review agrees with the conclusions of the Therapy Review. It is also concerned that there is some evidence that the NDIS price limits for therapy service may be distorting the market for therapy services. NDIS price limits appear high compared to some other state compensable schemes, which warrants further investigation. The Review therefore considers that a comprehensive review of therapy pricing should be undertaken as part of the next Annual Pricing Review and every two years thereafter.

The proposed comprehensive review of therapy pricing should also give further consideration to the question of whether different support items (and price limits) need to be created to encourage the delivery of therapy supports outside of usual business hours, with a particular focus on the impacts that the current arrangements have on best practice delivery, especially for Early Childhood Early Intervention supports. The current Review received mixed evidence on this issue and does not consider that it can be resolved in isolation from an analysis of the entire billing practices of other schemes. The Review notes, for example, that most other schemes do not include different payment rates for out of business hours consultations, but structure their billing arrangements around the complexity of the consultation (say 30-60 minutes) rather than the precise duration.

The Review also considers, given the disparity between NDIS price limits and the rates payable in other schemes, that therapy price limits should not be indexed this financial year.

Currently the price limits for capacity building supports are indexed on 1 July each year by the 80/20 weighted average of the movements in the ABS Wage Price Index and the ABS Consumer Price Index over the 12 months to the March Quarter preceding the indexation date. However, 15 Capacity Building supports are delivered by workers employed under the SCHADS Award or a similar industrial agreement. These workers are subject to the Fair Work Commission's increase to minimum wage that occurs every year, which is included in the current methodology for applicable core supports. The Review considers that it would

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

therefore be more appropriate for the price limits of these supports to be set by the Disability Support Worker Cost Model.

The Review received a number of submissions about the cost of consumables used by therapists. The Review considers that it is important to distinguish between "tools of the trade" of the therapist and consumables used in the treatment of the specific participant. This is in line with the approaches taken by some other schemes. Worksafe Victoria, for example, "expects that health professionals will not invoice for consumables (i.e. tape, ultrasound gel, dry needles, wax therapy) used as a part of in-rooms treatment" but does permit billing for items "intended to be supplied for the worker to take home to assist with the management of their work-related injury or illness". The Review understands that consumables that are provided to the participant are, in general, claimable against the participant's NDIS plan. The Review considers that tools of the trade are already accounted for within the price limits for therapy support items. The Review notes, for example, that the NDIS Nursing Cost Model includes an overheads provision of 20%.

RECOMMENDATION 9) Capacity Building Supports

1) The NDIA should undertake a comprehensive review of therapy pricing arrangements as a part of the Annual Pricing Review every two years, with the next comprehensive review to commence in July 2021. Pending the outcomes of that review:

    i) the NDIA should not index the price limits for therapy supports on 1 July 2020; and

    ii) the NDIA should index the price limits for therapy supports on 1 July 2021 in accordance with the indexation methodology set out in Recommendation 2.1(iii).

2) The NDIA should index the price limits for capacity building supports that are delivered by Disability Support Workers by reference to the NDIS Disability Support Worker Cost Model.

Plan Management Supports

NDIS participants can choose to have a registered Plan Management provider to manage their funding and budget for the supports in their plan. Plan Managers are bound to the *NDIS Price Guide* and are able to connect participants with both NDIS registered providers and providers that are not registered with the NDIS. The Review was required by its Terms of Reference to examine the price control framework for plan management supports.

In 2018-19, claims for plan management supports totalled $86 million – of this 28% was claimed by the top five (5) plan management providers. There are currently 809 active registered providers offering plan management services (7% of all NDIS registered providers.) Some 33% of NDIS participants have their funds managed by a plan manager, with total managed funds totalling approximately $5.5 billion.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

The Review found little evidence that current price limits for plan management are inadequate. The number of NDIS registered providers offering plan management services increased from less than 50 to just over 800 between 2016 and 2019. The revenue earned by plan managers from the monthly account fee has also grown significantly, in line with the growth of the Scheme. The scale of plan management organisations is also growing with the average number of participants per plan management organisation increasing from 18 in the third quarter of 2016, to 133 in the fourth quarter of 2019. The largest five plan management providers now service approximately 30% of the market. At least two of these five providers were established in the last 36 months. Few plan management providers have exited the market and early research indicates that those who have exited may not have had the growth required to operate at sustainable margins. Most providers that have exited made a total of less than 25 claims over their lifetime of up to 3.5 years.

On balance, the Review concludes that there is no evidence of a gap in supply for plan management services. Competition is strong with new competitors entering the market; there is also strong growth in the sector both in terms of revenue and customer numbers. Some early signs of innovation can also be seen. The current flat fee structure is simple, has been iterated over time from less successful arrangements including quoting, and has been implemented on a national scale. A flat fee structure (as opposed to hourly rate) is appropriate for financial administration tasks as it can encourage efficiency.

There is some evidence that the *capacity building and training in plan administration and management* support item may not be functioning as intended. There are strong arguments why providers should be able to claim for non-face-to-face time and provider travel for this support item. The argument for an increase in the price limit for this item is less strong, given that it is already higher than the standard Disability Support Worker price limit and is aligned with the Level 1: Support Connection price limit.

RECOMMENDATION 10) Plan Management

The NDIA should amend the conditions attached to the support items:

i) 07_003_0117_8_3 (Capacity Building and Training in Plan and Financial Management by a Support Coordinator); and

ii) 14_031_0127_8_3 (Capacity Building and Training in Plan and Financial Management by a Plan Manager)

In the *NDIS Support Catalogue* so that providers can claim for provider travel and non-face-to-face supports with respect to these supports.

Classifying Regional, Remote and Very Remote

The Review was required by its Terms of Reference to examine the geographic classification component of the NDIS price control framework to examine whether modifications are required to the NDIA's implementation of the Modified Monash Model (MMM) to account

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

for specific disability service-related costs, including the treatment of "isolated locations" and islands under the MMM.

The Review considers that the MMM is explicitly based on distance to the nearest labour supply centre and so should in general be well suited as a mechanism to estimate the availability of the disability support workforce and the need for higher price limits to compensate providers for the higher costs associated with attracting workers. Note the NDIS Review of the WA Market did find that the cost of service delivery in isolated centres – centres that are currently not classified as remote or very remote by the MMM but that are completely surrounded by remote or very remote areas – were, in general, higher than in other non-remote areas. Consequently, the NDIA has modified the MMM so that areas (or groups of areas) that are currently not classified as remote or very remote by the MMM but that are completely surrounded by remote or very remote areas ("Isolated towns") are classified as remote areas for planning and pricing purposes.

The Review recognises that thin markets operate in remote, very remote and some regional areas, especially for more specialised services. However, the Review considers that the solution to this issue lies through a greater use of commissioning, rather than through increases in price limits, especially where the thinness of the market is due to the low number of participants. In these circumstances, individual participants will never have sufficient purchasing power to attract service provision with the efficiencies of aggregation that can be generated through commissioning.

The Review also considers that the argument for a delay in implementing any change in the MMM rating of a region is not strong, given that both price limits and plan funding loadings are driven by the same loadings. Thus, while participants who might be reclassified into non-remote areas might have smaller plans they would also face lower price limits.

RECOMMENDATION 11) Geographic Classification

The NDIA should adopt the MMM 2019 classification system, and any future updates to the MMM classification system as released by the Department of Health, (subject to the NDIS Isolated Town arrangements) as the basis of determining the pricing arrangements in the NDIS Price Guide, including:

i) whether remote and very remote loadings should be applied to price limits and plan funding amounts; and

ii) which travel time limits apply to the supports delivered to participants.

Costs in Outer Regional Areas

The Review was required by its Terms of Reference to examine whether a loading should be applied to price limits and plan funding amounts in outer regional areas to account for the higher cost of service delivery, if any, in those areas. The Review does not consider that there is sufficient evidence to conclude that the costs of service delivery are higher in regional areas than in metropolitan areas, except in respect of travel costs. It therefore

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

considers that any supply issues in these areas are better addressed through the revised travel and coordinated commissioning arrangements proposed elsewhere in the Review.

Cancellation Rules

NDIS providers are not permitted to collect deposits or bonds from participants, or to retain these funds in the event of the participant cancelling a service booking for a support or failing to turn up for a support. They are permitted to charge cancellation fees in certain circumstances. The Review was required by its Terms of Reference to examine the current price control arrangements for cancellations within the Scheme.

In 2018-19, cancellation payments totalled $12.3 million or 0.1% of Scheme expenditure. Only 27.9% of providers made a cancellation claim. For these providers, cancellation claims represented, on average, 4.9% of all their claims (by number) and 3.6% of all their claims (by value). For 1 in 10 providers who claimed for cancellations, cancellation claims represented, more than 11.1% of all their claims (by number) and 8.3% of all their claims (by value).

The Review heard evidence that:

- The current arrangements - whereby providers are required to claim for 100% of the agreed fee for a cancelled service but the NDIS only pays them 90% of the agreed fee - results in accounting anomalies in their accounts showing the NDIS as bad debtor.
- Plan managers faced difficulties in balancing their accounts when the invoices presented by providers, which they pass onto the NDIS, do not match the payments made by the NDIS.
- Providers should be able to recover the full cost of the service that was cancelled, where they have not been able to replace the participant, as they face all of the costs associated with the appointment.

The Review therefore considers providers should be able to claim 100% of the agreed fee when a support is cancelled without sufficient notice.

There was little consensus among submissions as to whether the current cancellation periods were adequate. It is therefore not proposed to change these at this time. Note, to help providers to continue to deliver supports to participants through the COVID-19 pandemic, the NDIA amended the definition of short notice cancellation so that from 25 March 2020, participants are required to give 10 business days' notice for a cancellation if they want to avoid paying the full fee for a cancelled service. This change in the definition of short notice cancellations is for a six-month period (25 March 2020 to 25 September 2020), with an initial review at three months to determine if it continues to be appropriate. When reviewing, the NDIA will consider a range of factors, including the current status of the COVID-19 pandemic.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

RECOMMENDATION 12) Cancellation Fees

The NDIA should permanently amend the claiming rules in the *NDIS Price Guide* to allow providers to claim for 100% of the agreed fee for a short-notice cancellation.

Provider Travel Rules

The NDIA recognises that supports are often best delivered in the community or the participant's own home. The price control arrangements therefore allow providers to charge for the time spent travelling to participants to deliver supports in some case. The Review was required by its Terms of Reference to examine the current claiming rules for provider travel within the Scheme, including:

- Provider travel time limits, including examining whether it is possible to develop an approach that is more sensitive to local conditions; and
- Non-labour costs associated with provider travel.

In general, the Review considers that, because the Modified Monash Model geographical classification is based on distance from labour supply centres, it should form a reasonable basis for the time limits on provider travel, which are meant to encourage participants to access providers closer to them where possible. Indeed, the Review considers that the fundamental difficulty in the supply of services in outer regional, remote and very remote areas is the sparsity of participants requiring services and that this is a problem not best resolved through increasing price limits or provider travel time limits as these solutions do nothing to aggregate demand and ensure efficient delivery of services.

The Review considers that there would be considerable advantages in the NDIS adopting a commissioning approach for the provision of travel funding to visiting service providers in outer regional, remote and very remote areas and other thin markets. This approach could ameliorate the need to commission other services, or assist in the commissioning of those services. It could also simplify the planning process, as it would not be necessary for planners to work out travel amounts for plans.

The Review recognises that providers incur significant non-labour costs associated with provider travel either because they maintain their own fleets or because they are required by the SCHADS Award to reimburse their employees when they use their own cars to deliver supports to participants. These costs can either be recognised within the overheads of providers or as a separate expense similar to the arrangements for non-labour costs of Activity Based Transport. On balance, the Review considers that it is more appropriate to recognise these costs as they occur rather than as part of the provider's overhead, since they are not evenly distributed between providers. Recognising these costs separately also ensures that providers do not have an incentive to cut community based supports in order to lower their overheads.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

RECOMMENDATION 13) Provider Travel

1) The *NDIS Price Guide* and the *NDIS Support Catalogue* should be amended from 1 July 2020 so that providers can claim for the non-labour costs associated with provider travel in line with the activity based transport arrangements. Claims should only be able to be made for the non-labour costs associated with provider travel where the rules governing provider travel allow a claim for provider travel to be made.

2) The NDIA should further examine the option of the commissioning of travel broker arrangements to coordinate participants and providers and pay for travel costs.

Establishment Fees

The Review was required by its Terms of Reference to examine the current arrangements for Establishment Fees within the Scheme.

NDIS providers who are providing a significant amount (at least 20 hours per month) of daily activity and community participation supports to a participant are permitted to charge that participant's plan an Establishment Fee when they commence providing services to the participant. This recognises the non-ongoing and not otherwise claimable costs that providers incur in establishing arrangements and assisting participants in implementing their plan, including assessing the participant's needs, agreeing a service agreement with the participant and setting up service bookings in the NDIA system.

In 2018-19, Establishment Fees were claimed in respect of 17,157 participants, at a total cost of $6.39 million (19,357 total individual claims). Establishment Fees were claimed by 984 different providers in 2018-19. Some 88 providers claimed 50 or more Establishment Fees. These providers accounted for 54.3% of the total number of Establishment Fees claimed by providers and for 51.8% of the total value of all Establishment Fees claimed by providers ($3.3 million of $6.39 million).

The Review has identified some technical deficiencies in the current arrangements, which prevent some providers from claiming the Establishment Fees that they should have been able to claim. The Review also considers that Establishment Fees should be able to be claimed from a participant's plan in second and subsequent plans if they choose to change providers. This will also help empower participants within the NDIS provider market.

Finally, the Review considers that the current level of the Establishment Fee is appropriate, but that it would be better expressed through a link to the standard hourly rate of Disability Support Worker support items.

RECOMMENDATION 14) Establishment Fees

1) The NDIA should amend the current Establishment Fee arrangements in the *NDIS Price Guide* so that:

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

i) An Establishment Fee to assist with the non-ongoing costs of establishing arrangements and assisting participants in implementing their plan is claimable from a participant's plan by a provider who:

- is in one or more of the Registration Groups 0104 (High Intensity Daily Personal Activities), 0107 (Daily Personal Activities), 0125 (Participation in community, social and civic activities) and 0136 (Group and Centre Based Activities);
- has made an agreement with the participant to supply at least 20 hours of support – in Support Categories 1 (Assistance with Daily Life) and/or Support Category 4 (Assistance with Social and Community Participation) – to the participant per month for the duration of the plan;
- assists the participant with the implementation of their NDIS Plan.

ii) Each provider can only claim an Establishment Fee in respect of a participant once across all plans.

iii) More than one provider is able to claim for an Establishment Fee against a given plan provided each provider meets the other criteria above.

iv) The amount of the Establishment Fee should be negotiated by the participant and the provider but cannot be greater than an amount equal to ten times the hourly weekday price limit for a disability support worker as determined by the Standard NDIS Disability Support Worker Cost Model with the standard parameters ($528.50 in 2019-20).

2) The NDIA should add several price-limited support items to the *NDIS Support Catalogue* to allow providers in the Registration Groups 0104 (High Intensity Daily Personal Activities, 0107 (Daily Personal Activities), 0125 (Participation in community, social and civic activities) and 0136 (Group and Centre Based Activities) who are delivering services in Support Categories 1 (Assistance with Daily Life) and/or Support Category 4 (Assistance with Social and Community Participation) to be able to claim Establishment Fees and Maintenance Establishment Fees.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

1. Introduction

The National Disability Insurance Agency (NDIA) has responsibility for administering the National Disability Insurance Scheme (NDIS), including managing the markets for disability goods and services. As part of its market stewardship role, the NDIA limits the prices that registered providers can charge for some supports and applies other price controls, including rules about the circumstances in which providers can claim payments from the NDIA for supports that they have delivered. During transition, price controls are in place to ensure that participants receive value for money in the supports that they receive. In the short to medium term, price controls are required for some disability supports because the markets for disability goods and services are not yet fully developed. The longer-term goal of the NDIA is to remove the need for price controls for disability supports.

The NDIA has recently published the *NDIS Pricing Strategy* and the *Review of Therapy Pricing Arrangements.*[1] Together they detail the important role that pricing plays in the NDIS by empowering people supported by the NDIS to exercise choice and control; maintaining and expanding the supply of high quality disability supports; driving efficiency and innovation in the market for those supports; and supporting the transition of the NDIS over the longer term to a more deregulated outcomes-based approach. Currently, the NDIA varies its approach to the regulation of prices, depending on market conditions, between:

- **No regulation** (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- **The imposition of price limits**: this represents a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care. The price control arrangements for the NDIS are set out in the *NDIS Price Guide* and the *NDIS Support Catalogue*.[2]
- **Quotable supports**: in which participants are expected to obtain quotations from suppliers to provide to the NDIA as part of verifying that prices are fair and reasonable.

The NDIA continually monitors and reviews its price control framework and other market settings to determine whether they are still appropriate. The NDIA is also committed to improvement of the methodologies underpinning the NDIS price control framework. Each year the NDIA undertakes an Annual Pricing Review as an important part of that monitoring and review. The terms of reference of the Annual Pricing Review 2020-21 are set out below.

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1 NDIA. (2019). *NDIS Pricing Strategy*. https://www.ndis.gov.au/media/1820/download

NDIA. (2019). *Review of Therapy Pricing Arrangements*. https://www.ndis.gov.au/media/1662/download

2 NDIA. (2019). *NDIS Price Guide 2019-20 v2.2* (25 March 2020). https://www.ndis.gov.au/media/2213/download

NDIA. (2019). *NDIS Support Catalogue 2019-20 v2.2.1* (27 March 2020). https://www.ndis.gov.au/media/2214/download

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

TERMS OF REFERENCE

1. The Annual Pricing Review 2020-21 (the Review) will examine, through research and consultation with industry, community and government stakeholders, whether the existing price control framework and other market settings under the NDIS continue to be appropriate or should be modified.

2. In particular, the Review will:

   (a) Review the price control framework to increase flexibility for participants and reduce administrative burdens for providers (see Chapter **Error! Reference source not found.**);

   (b) Review the price control framework for core supports, by examining:

      (i) the assumptions and parameters outlined in the *NDIS Disability Support Worker Cost Model*, including through analysis of the financial benchmarking data collected through the Temporary Transformation Payment arrangements (see Chapter **Error! Reference source not found.**); and

      (ii) the methodology for deriving the price controls for group-based supports from the price controls for 1:1 supports (see Chapter 0);

   (c) Review the price control framework for capacity building supports, including therapy supports, by examining (see Chapter **Error! Reference source not found.**):

      (i) how price limits for capacity building supports, other than therapy supports, should be indexed or otherwise determined annually;

      (ii) how price limits for therapy supports should be adjusted annually, given the outcomes of the *Review of Therapy Pricing Arrangements*;

      (iii) whether different price limits might be appropriate for different times of the day, or days of the week, for some capacity building supports, including for therapists, therapy assistants and for capacity building supports delivered by disability support workers; and

      (iv) whether therapists and other capacity building providers should be able to recover the costs of consumables provided to participants as part of a support;

   (d) Review the price control framework for plan management supports (see Chapter **Error! Reference source not found.**);

   (e) Review the geographic classification component of the NDIS price control framework to examine whether:

      (i) modifications are required to the NDIA's implementation of the Modified Monash Model (MMM) to account for specific disability service-related costs, including the treatment of "isolated locations" and islands under the MMM (see Chapter **Error! Reference source not found.**); and

      (ii) a loading should be applied to price limits and plan funding amounts in outer regional areas to account for the higher cost of service delivery, if any, in those areas (see Chapter **Error! Reference source not found.**);

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

(f) Re-examine current billing arrangements, including:

(i) Cancellation rules (see Chapter 1);

(ii) Provider travel time limits, including examining whether it is possible to develop an approach that is more sensitive to local conditions (see Chapter **Error! Reference source not found.**);

(iii) Non-labour costs associated with provider travel (see Chapter **Error! Reference source not found.**); and

(iv) Establishment fee arrangements (see Chapter RECOMMENDATION 13)2)).

3. In framing its recommendations, the Review will be cognisant of the objects and principles of the NDIS, including that the NDIS should:

(a) Support the independence and social and economic participation of people with disability;

(b) Enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports;

(c) Facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability;

(d) Promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community;

(e) Adopt an insurance-based approach, informed by actuarial analysis, to the provision and funding of supports for people with disability; and

(f) Be financially sustainable.

CONDUCT OF THE REVIEW

The Review has engaged in extensive consultations with industry, community and government stakeholders and undertook a program of research.

Submissions from Participants and Providers

An *Issues Paper* was released on 28 November 2019 together with a public call for submission.[3] The formal closing date for submissions was 2 February 2020, but submissions received up until 8 April 2020 were taken into account in the Review. Some 109 submissions were received by the closing date. A total of 139 submissions had been received and analysed by 8 April 2020. Most submissions (100) were from registered providers, including 12 from providers who were predominantly plan managers. A further 14 submissions were received from provider peak bodies. The participant voice was also heard, with 13 submissions from participant advocacy bodies and 10 from participants or their nominees.

[3] https://www.ndis.gov.au/media/2029/download

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

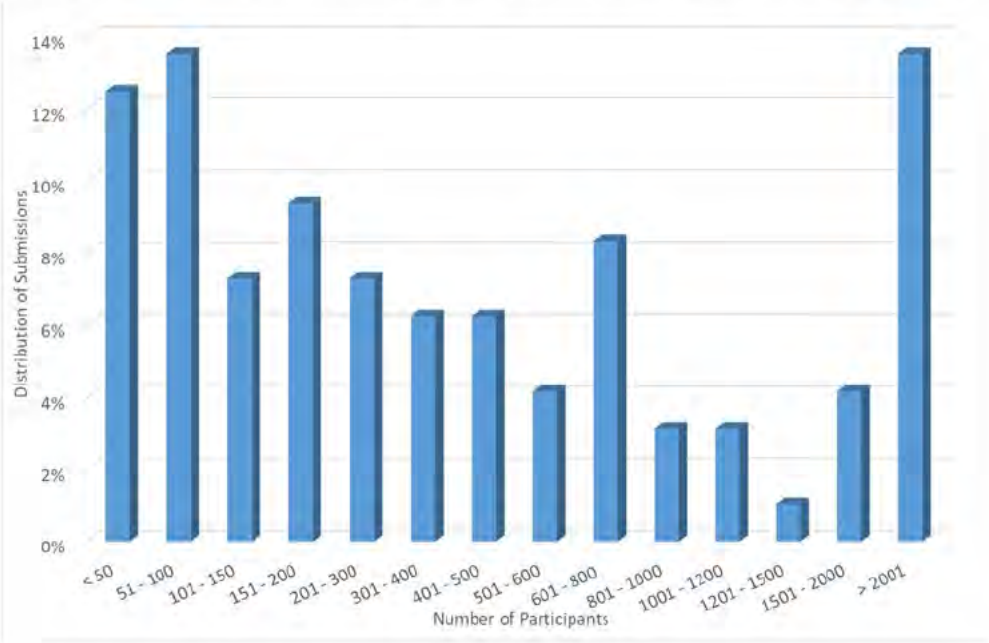
Some 96 of the registered providers who made submissions to the Review had made claims for payment from the NDIS. Submissions from these providers were divided evenly between for-profit (46) and not-for-profit providers (50). Submissions from providers were received from all states and territories (roughly in line with participant numbers - see Table 1). Some 68% of providers who made submissions had participants in more than one state/territory

Table 1 - Distribution of Submissions Received by the Annual Pricing Review

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Share of NDIS revenue in TTP Survey	41.4%	20.6%	16.1%	11.2%	6.4%	2.2%	1.9%	0.2%
Share of Active Participants (201920Q2)	33.5%	26.8%	18.2%	9.2%	7.1%	2.3%	2.1%	0.8%

Providers who made submissions ranged in size from servicing under 10 participants, to over 10,000, with the average being 899 and the median 284. They also ranged from having under $10,000 in NDIS revenue to over $50 million, with the average being around $15 million and the median being around $5 million (see Figure 1).

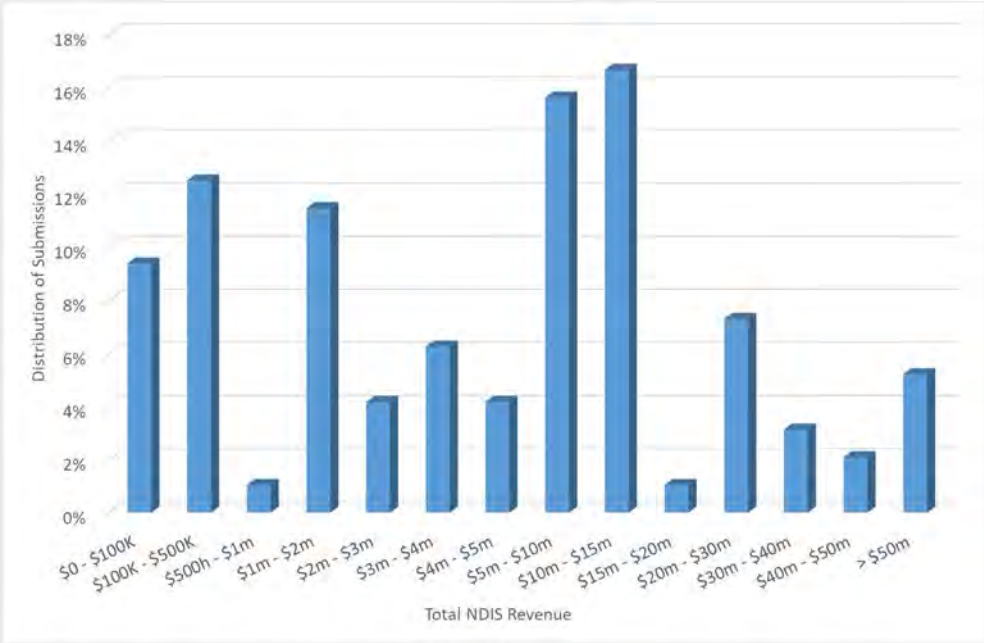
Figure 1 - Distribution of Submissions by Number of Participants and NDIS Revenue of Respondent



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MR25/01967 FOI 24/25-2242

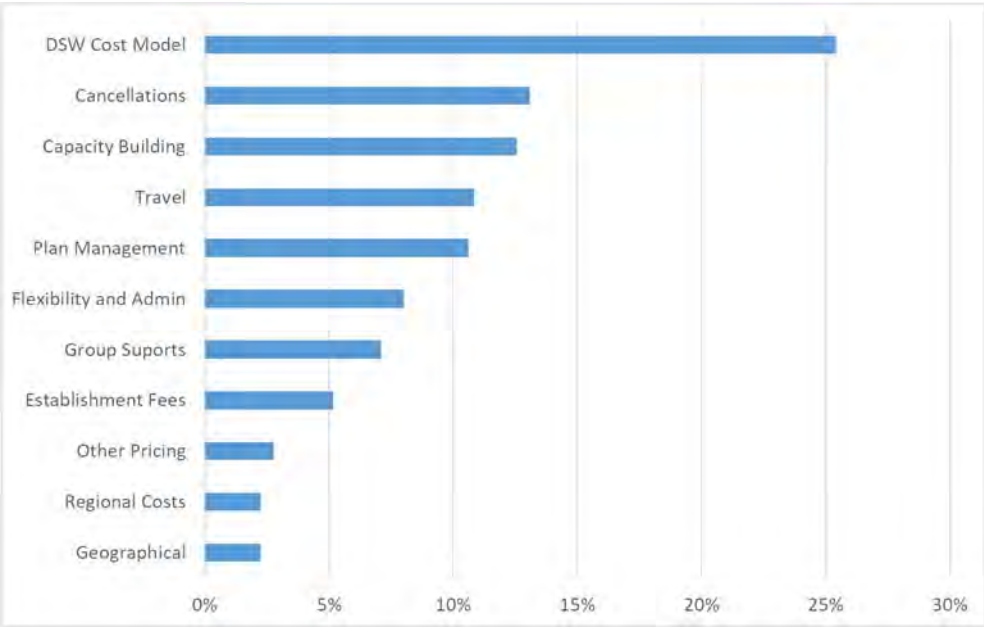
DISCLOSURE LOG



Across the whole group of providers who made submissions, some 88% of their revenue from the NDIS was from the delivery of core supports, with 11% from the delivery of capacity building supports and about 1% from the delivery of capital supports. (Note: this analysis excludes NDIS revenue from Supported Independent Living and Specialist Disability Accommodation as these were not in the scope of the Annual Pricing Review.)

By far the greatest number of responses to the *Issues Paper* pertained to 1:1 core supports, mostly to do with the NDIS Disability Support Worker Cost Model. Capacity building, cancellations and plan management were also popular issues. The least commented upon topics were regional loadings and other geographical issues. Figure 2 illustrates the distribution of issues raised in the submissions.

Figure 2 – Distribution of Topics Raised in Submissions to the Annual Pricing Review



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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

The views of respondents to the *Issues Paper* are presented in the appropriate chapters of this report.

Provider Consultations

Face-to-face consultations were held with groups of providers in each State and Territory. After 23 March 2020, these consultations were held by teleconference/videoconference for safety reasons following the emergence of the COVID-19 pandemic.

30 September 2019	Adelaide, South Australia
8 October 2019	Launceston, Tasmania
9 October 2019	Hobart, Tasmania
30 October 2019	Darwin, Northern Territory
31 October 2019	Darwin, Northern Territory
6 November 2019	Alice Springs, Northern Territory
7 November 2019	Alice Springs, Northern Territory
18 November 2019	Perth, Western Australia
19 November 2019	Perth, Western Australia
25 November 2019	Sunshine Coast, Queensland
9 December 2019	Perth, Western Australia
10 December 2019	Perth, Western Australia
31 January 2020	Melbourne, Victoria
1 February 2020	Melbourne, Victoria
10 February 2020	Perth, Western Australia
11 February 2020	Perth, Western Australia
20 February 2020	Sydney, New South Wales
25 February 2020	Adelaide, South Australia
16 March 2020	Townville, Queensland
17 March 2020	Brisbane, Queensland
23 March 2020	Darwin, Northern Territory
24 March 2020	Darwin, Northern Territory
25 March 2020	Canberra, Australian Capital Territory
30 March 2020	Alice Springs, Northern Territory
31 March 2020	Alice Springs, Northern Territory
14 April 2020	Launceston, Tasmania
15 April 2020	Hobart, Tasmania
21 April 2020	Perth, Western Australia
22 April 2020	Perth, Western Australia

The views of attendees are presented in the appropriate chapters of this report.

Working Groups

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Six working groups were set up, with representatives from the sector[4], to discuss concerns and proposals for change in their relevant topics as listed below:

- The NDIS Disability Support Worker Cost Model - 30 organisations and peaks;
- Geographical issues – 13 organisations and peaks;
- Group supports – 13 organisations and peaks;
- Billing rules – 24 organisations and peaks;
- Capacity-building (including therapy) supports – 20 organisations and peaks; and
- Plan management supports – 18 organisations and peaks.

The views of members of the various Working Groups are presented in the appropriate chapters of this report.

Participant and Provider Challenges

On 11 March 2020, the NDIA's Pricing Reference Group (PRG) met with members of the following provider peak groups:

- National Disability Services;
- Ability First;
- Alliance 20;
- Allied Health Professions Australia;
- Mental health providers (represented by Aftercare and Mind Australia); and
- Disability Intermediaries Australia.

Each group was able to present their issues and concerns directly to the PRG with follow up questions from PRG members.

On 15 April 2020, the NDIA's PRG also met with representatives of a number of participant peak groups.

- Consumer Action Law Centre;
- JFA Purple Orange; and
- Inclusion Australia.

Other participant representative groups were invited, but were unable to attend due to having to address COVID-19 issues. As with the provider challenge, members of the

[4] The *Issues Paper* invited responders to self-nominate for several working groups. The Agency also wrote to peak groups inviting them to nominate members for particular working groups.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

participant challenge also had one on one meetings with the PRG, however, proceedings had to be conducted by videoconference.

Consultations with Other Schemes

Teleconferences were held with officers of the following Schemes to compare therapy and attendant care pricing methodologies:

- Department of Veterans Affairs.[5]
- icare New South Wales.[6]
- State Insurance Regulatory Authority New South Wales.[7]
- Victorian Transport Accident Commission.[8]
- Worksafe Victoria.[9]
- WorkCover Queensland.[10]

Desktop reviews were also undertaken of the pricing arrangements of the following schemes:

- Comcare – which covers employees of Commonwealth Government agencies and statutory authorities (excluding Australian Defence Force); ACT Government and its agencies; and Self-insured corporations.[11]
- Medicare Benefits Schedule.[12]
- Return to Work South Australia.[13]
- South Australian Lifetime Support Authority.[14]

5 https://www.dva.gov.au/providers/fees-and-payments/dental-and-allied-health-fee-schedules
https://www.dva.gov.au/sites/default/files/files/providers/cn/CNO/community-nursing-schedule-of-fees-effective-1-january-2020.pdf

6 https://www.icare.nsw.gov.au/-/media/icare/unique-media/treatment-and-care/info-for-service-and-hp/requesting-services-on-behalf-of-an-injured-person/media-files/files/download-module/lifetime-care-payment-codes---2017.pdf

7 https://www.sira.nsw.gov.au/resources-library/list-of-sira-publications/accordion/workers-compensation-publications/fees-orders/fees-and-rates-orders-2020

8 https://www.tac.vic.gov.au/providers/invoicing-and-fees/fee-schedules

9 https://www.worksafe.vic.gov.au/providers

10 https://www.worksafe.qld.gov.au/service-providers/allied-health-fees

11 https://www.comcare.gov.au/service-providers/medical-allied-health/treatment-rates

12 http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

13 https://www.rtwsa.com/service-providers/provider-registration-and-payments/fee-schedules

14 https://lifetimesupport.sa.gov.au/wp-content/uploads/2019-20LSSAttendantCareRates.pdf

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- Workcover Western Australia.[15]

Desktop Research

The Review also conducted research into:

- A comparison of NDIS attendant care price limits and input cost drivers to those of other schemes and sectors.
- The level of market competition, as evidence by the proportion of capacity building and core support services are being supplied below the maximum prices stipulated in the *NDIS Price* Guide and the *NDIS* Support *Catalogue*.
- Administrative burdens, as indicated by payment delays and claim rejection rates.
- Comparison of non-face-to-face costs in one to one and group supports.
- For plan management, trends in average numbers of participants per provider, and in average number of services provided.
- The differences between the 2015 and 2019 versions of the Modified Monash Model.
- Numbers and trends in service cancellations, by support categories.
- How many participants change providers in their first year, or pay Establishment Fees to multiple providers at the same time.

The research is reported in the appropriate chapters of this report.

Temporary Transformation Payment Benchmarking Survey

Providers of attendant care and community participation supports who meet the eligibility criteria set out below have access to a set of higher price limits through a Temporary Transformation Payment (TTP). This conditional loading is meant to assist providers to continue transforming their businesses in the move towards a more competitive marketplace. In order to access the higher TTP price limits, providers have to participate annually in an Agency-approved market benchmarking survey. They also have to publish their service prices and keep their business contact details up to date in the Provider Finder.

Deloitte Access Economics were engaged by the NDIA to conduct a financial benchmarking survey of TTP providers and to analyse the results, with a particular emphasis on the parameters that underlie the NDIS Disability Support Worker Cost Model that determines many of the NDIS price limits. Only de-identified data was passed on to the Agency.

On 21 February 2020, Deloitte sent out on-line invitations to the 3,039 providers who were then enrolled in eligible registration groups. This included 1,580 providers who had claimed for one or more TTP support items in 2019-20.

[15] https://www.workcover.wa.gov.au/resources/rates-fees-payments/

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

As at 15 March 2020, when the survey closed, Deloitte had received 615 completed surveys. As of 31 March 2020, an additional 231 responses had been received. However, these additional responses were not received in time to be included in the analyses in this report.

The results of the TTP Benchmarking Survey, together with an analysis of providers who did not make responses to the TTP Benchmarking Survey, are presented in the appropriate chapters of this report.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

2. Provider Administration and Participant Flexibility

The Review was required by its Terms of Reference to examine the price control framework to identify opportunities to increase flexibility for participants and reduce administrative burdens for providers.

CURRENT ARRANGEMENTS

Two of the fundamental principles underlying the NDIA's approach to price controls are minimising complexity and bureaucracy for providers and minimising restrictions on participant choice and control. The Agency is concerned with striking the right balance between these two principles. The Agency is also aware that price control frameworks can impose administrative burdens on providers, and wishes to explore ways to reduce transactional costs through ease and simplicity in design of price control arrangements.[16] Equally, the Agency must ensure that participants are fully informed and empowered to achieve maximum flexibility to use their budgets to meet their goals as they see fit.

CONSULTATIONS

The *Issues Paper* asked respondents to indicate:

- If there were changes that could be made to the *NDIS Price Guide* and the *NDIS Support Catalogue* that could reduce transactional costs for providers – without reducing participants' choice and control?
- If there was scope for changes in the price controls framework that would give participants greater discretion over use of their budgets – without substantially increasing costs to providers?
- If there were any other issues where the current price control framework created unnecessary bureaucracy for providers or restricted participant flexibility?

The most common pricing-related administrative issue for respondents was that the *NDIS Support Catalogue* was too large and complex to understand. It was also suggested that the language could be revised to make it more readable for both participants and providers. A few submissions suggested that the coding system used for supports could be more logical, where the code says more about the support itself linked to that line item.

However, some respondents thought administrative burden could be better addressed by adding new items to the Support Catalogue. For example, some respondents suggested that adding non-standard support ratios (e.g. 2:1 or 2:5) would make it easier for them. Two respondents suggested the best way to reduce pricing-related administrative burden is to remove price limits altogether.

[16] The *Issues Paper* noted that administration costs of the Agency's claiming system are not within scope of Annual Pricing Review, and are being addressed through a separate process

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

A number of submissions asked for the *NDIS Price Guide* to be made easier to understand from a consumer perspective for participants. Two submissions specifically asked for a participant's version of the Price Guide. Some respondents were concerned that any increase in participant flexibility might come at a higher administrative cost to providers, such as for group support cancellations. Providers suggested that they should be able to offer programs of support to participants, whereby the participant agreed to attend a series of supports, especially group supports, and also agreed that they should be claimed for those supports even if they did not attend a session.

Some providers also asked that the NDIS set its prices much earlier as the Boards of providers were typically making their decisions about the next financial year in the third quarter of a financial year and the current release schedule did not allow them to be fully informed in their decision making.

DISCUSSION

Timing of the Annual Pricing Review and Indexation

The Review considers that there would be considerable merit in changing the timing of the Annual Pricing Review so that providers were aware earlier of any policy changes that the NDIA intended to make. The Review also considers that given the uncertainty around economic conditions during the COVID-19 pandemic and as Australia emerges from the pandemic, that the NDIA should not undertake an Annual Pricing Review in 2020-21 but should instead monitor economic conditions carefully and promptly respond to emerging issues.

The Review also sees the merit in the NDIA publishing the indexation methodology for price limits so that providers can better estimate their future budgets, recognising that the NDIA is not able to index and announce price limits until after the Fair Work Commission has made its Annual Minimum Wage Decision, which usually occurs in the middle of June each year.

The Review considers that it is most appropriate for price limits to continue to be indexed as follows:

- Price limits for supports delivered by Disability Support Workers should be set by the Disability Support Worker Cost Model on 1 July each year, noting that the Cost Model is based on the minimum wage rates specified in the SCHADS Award.
- Price limits for Capital supports – Support Categories 2 (Transport), 3 (Consumables), 5 (Assistive Technology) and 6 (Home Modifications and Specialised Disability Accommodation) – should be indexed in line with the movement in the ABS Consumer Price (All Groups, weighted average of eight capital cities)[17] over the 12 months to the March Quarter preceding the indexation date.

[17] https://www.abs.gov.au/ausstats/abs@.nsf/mf/6401.0

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- Price limits for other supports should be indexed in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses)[18] and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter preceding the indexation date (with an 80/20 weighting).

The Review has examined the other Fair Work Commission determinations that have materially affected the key parameters of the Disability Support Worker Cost Model, and considers that, the price limits for supports delivered by Disability Support Workers should also be increased on:

- 1 July 2020 to take account of any changes flowing from the Fair Work Commission's Annual Wage Review 2019-20;[19] and
- 1 December 2020 for the final tranche of the Fair Work Commission's Equal Remuneration Order (MA000100 PR525485).[20]

The Fair Work Commission (FWC) has made a Decision [2019] (FWCFB 7096) that will increase casual loadings for workers employed under the SCHADS Award from 1 July 2020 (see Table 2).[21]

Table 2 - FWC Decision on SCHADS Shift Loadings - 1 July 2020

	Saturday	Sunday	Public Holiday
Casual Loading – 1/7/2019	50.0%	100.0%	150.0%
Casual Loading – 1/7/2020	75.0%	125.0%	175.0%

The Review notes that the Agency has already indicated that the NDIS Disability Support Worker Cost Model (and the relevant price limits) will be adjusted accordingly from 1 July 2020.

Programs of Supports

The Review also supports the introduction of programs of supports, whereby providers enter into contracts for the provision of programs of supports, especially where the program of support is towards the achievement of specified outcome. Under the program of support approach, providers claim for participants who do not attend one part of a program as though they did attend – that is, this is not a cancellation, as long as the provider had the capacity to deliver the support. The Review considers that it is important to include safeguards in these arrangements, including that programs of support cannot be for longer than 12 weeks (unless specifically allowed for in the *NDIS Price Guide*) and that participants

18 https://www.abs.gov.au/ausstats/abs@.nsf/mf/6345.0

19 https://www.fwc.gov.au/awards-agreements/minimum-wages-conditions/annual-wage-reviews/annual-wage-review-2019-20

20 https://www.fwc.gov.au/documents/sites/remuneration/decisions/pr525485.htm

21 https://www.fwc.gov.au/documents/decisionssigned/html/2019fwcfb7096.htm

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

should be able to exit from an agreed program of supports without cost, subject to an agreed notice period that can be no longer than two (2) weeks. Supports delivered as part of a program of supports would not be subject to the short notice cancellation rules.

The Review considers that these arrangements would be administratively easier for providers and participants and would allow providers to better manage their workforce. It would also reduce the impact on other participants of the current short notice cancellation rules. Under the current arrangements, if a participant who has agreed to attend a group session with, say two, other participants gives proper notice then they do not have to pay a cancellation fee for the support that they do not attend. If the provider is not able to find another participant to join the group at short notice then the remaining two participants may be asked to pay for the group session at the 1:2 rate rather than at the 1:3 rate for which they have budgeted. Under the program of supports arrangement, where cancellations occur, it may also be possible for the participant and provider to re-schedule some supports so that the participant receives their services at a later date, while also allowing the provider to manage staff more cost efficiently.

A number of studies in other sectors have illustrated the efficiencies that can be driven by a "programs of supports" approach. In its 2018 submission to the Medicare Benefits Schedule Review Allied Health Reference Group, Allied Health Professions Australia identified cancellations to group services as having an outsized detrimental effect on the finances of providers and argued that:

> *Group allied health services belonging to this subgroup require adjustment to ensure that providers are able to offer group services without undue risk of income loss due to cancellations by participants, an issue that is currently limiting their use.*[22]

The Review recognises the concerns raised in consultations with participant advocates that the programs of support approach should not be permitted to be used by providers to return themselves to a quasi-form of block funding. Participant advocates did acknowledge, however, that the program concept was common in the commercial world and that it could be beneficial for other participants taking part in a program as they would have a greater certainty that the program would operate fully throughout its term. On balance, the Review considers that the advantages outweigh the risks, but recommends that the introduction of programs of support approach be carefully evaluated and that guidance materials be produced by the NDIA for participants, including on their right to choose not to engage their provider through a program of support. In the first instance, program of supports should only be able to be offered for group supports.

Group Rates

The Review also considers that there are other opportunities to simplify the *NDIS Support Catalogue* by removing the various worker to participant ratio support items. Providers

[22] Allied Health Professions Australia. (2018). *Improving the accessibility and efficiency of allied health services*. https://ahpa.com.au/wp-content/uploads/2018/07/180719-MBS-Review-Framework.pdf

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

would divide the number of worker hours by the number of participant hours to derive their own fractions of hours to charge participants and would claim for these hours against the 1:1 support item and subject to the standard price limit. For example, one worker delivering a one-hour session on a Saturday to three participants would be claimed as 1/3 of an hour per participant subject to the 1:1 Saturday price limit rather than as currently where an hour is claimed for each participant but subject to a reduced 1:3 Saturday price limit. This is discussed further in Chapter 4.

RECOMMENDATIONS

RECOMMENDATION 1) Annual Pricing Review

1) The NDIA should not undertake an Annual Pricing Review in 2020-21 but instead monitor economic conditions carefully as the COVID-19 pandemic progresses and the economy recovers and promptly respond to any emerging issues.

2) The NDIA should undertake the Annual Pricing Review from July to December each year (commencing 2021), reporting in February/March of the following year to the Board of the NDIA, through the Chief Executive Officer, with changes to take effect from the following 1 July.

RECOMMENDATION 2) Annual Indexation of Price Limits

1) The NDIA should increase price limits during 2020 to maintain their real value through the following indexation arrangements:

   i) Price limits for supports delivered by Disability Support Workers should be set by the NDIS Disability Support Worker Cost Model from the operative date of the Fair Work Commission's Annual Wage Review;

   ii) Price limits for Capital supports – Support Categories 2 (Transport), 3 (Consumables), 5 (Assistive Technology) and 6 (Home Modifications and Specialised Disability Accommodation) – should be indexed on 1 July 2020 in line with the movement in the ABS Consumer Price (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter preceding the indexation date; and

   iii) Price limits for other supports should be indexed on 1 July 2020 in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses) and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter preceding the indexation date (with an 80/20 weighting).

2) That in addition to the annual indexation arrangements, the NDIA should also reset all price limits determined by the NDIS Disability Support Worker Cost Model in response to the following Fair Work Commission determinations, with effect from the date of effect of the Fair Work Commission's determination:

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

i) 1 December 2020, for the final tranche of the Fair Work Commission's Equal Remuneration Order (MA000100 PR525485); and

ii) 1 July 2020, for the adjustment of the shift loadings for casual workers on Saturdays and Sundays in the SCHADS Award (Fair Work Commission Decision [2019] FWCFB 7096).

RECOMMENDATION 3) Programs of Supports

The NDIA should amend the *NDIS Price Guide* from 1 July 2020, to make clear that providers are allowed to enter into service agreements for the provision of programs of supports, where those supports are group supports, subject to the following safeguards:

i) that programs of support cannot be for longer than 12 weeks (unless specifically allowed for in the *NDIS Price Guide*);

ii) that participants should be able to exit from an agreed program of supports without cost, subject to an agreed notice period that can be no longer than two (2) weeks;

iii) the introduction of programs of supports should be carefully evaluated; and

iv) guidance materials should be produced for participants before programs of supports are introduced.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

3. Price limits for 1:1 core supports

The Review was required by the its Terms of Reference to examine the assumptions and parameters outlined in the NDIS Disability Support Worker Cost Model, including through analysis of the financial benchmarking data collected through the Temporary Transformation Payment (TTP) arrangements.

CURRENT ARRANGEMENTS

The price limits for core supports are determined by the application of the NDIS Disability Support Worker Cost Model. The full details of the cost model were published in June 2019.[23] The cost model estimates the cost of delivering a billable hour of support taking into account all of the costs associated with every billable hour, including: base pay; shift loadings; holiday pay; salary on costs; supervision costs; utilisation (non-billable activities); corporate overheads and margin.

Base rates of pay under the model are set in accordance with the *Social, Community, Home Care and Disability Services Industry Award 2010*.[24] The cost model also contains a range of key assumptions and parameters that determine the level of the price limits.

The cost model also varies according to a range of factors, including: the intensity of support, the level of skills and experience of the worker delivering the support, whether the worker is permitted to sleep over, the time of day and day of the week the support is delivered and whether or not the provider claims the TTP.

The definitions of these concepts are set out in the current *NDIS Price Guide* as follows:

> *A hierarchy of price limits applies to this group of supports, based on:*
>
> - *the time of day that the support is delivered;*
> - *the day of week that the support is delivered;*
> - *whether the support is Standard Intensity or High Intensity;*
> - *if the support is High Intensity then whether it is a Level 1 (Standard), Level 2 (High Intensity) or Level 3 (Very High Intensity) support; and*
> - *whether the provider is eligible for the Temporary Transformation Payment.*

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23 NDIA. (2019). *Disability Support Worker Cost Model*. https://www.ndis.gov.au/media/1821/download

24 The national award for Disability Support Workers (DSWs) is the *Social, Community, Home Care and Disability Services (SCHADS) Industry Award 2010*. The NDIA recognises that some DSWs are employed under Enterprise Bargaining Agreements (EBAs). However, these EBAs have to leave the worker no worse off overall than they would be under the relevant Award and, in general, any additional benefits offered by EBAs over the Award have been voluntarily agreed to by providers and are often offset by productivity gains. The NDIA therefore considers the conditions set out in the SCHADS Award to be the appropriate foundation for the CM.

Note: the nomenclature of Level 1 DSW, Level 2 DSW and Level 3 DSW used in the cost model and *NDIS Price Guide* should not be confused with the classification of workers under the SCHADS Award.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Time of day and day of week

In determining which price limit is applicable to a support, providers should note that a support is considered to be:

- *a Daytime Support is it is delivered between 6 am and 8 pm;*
- *an Afternoon (formerly Evening) Support if it is delivered after 8 pm and before 12 midnight; and*
- *an Overnight Support is it is delivered between 12 midnight and 6 am.*

In determining which price limit is applicable to a support, providers should also note:

- *a weekday is Monday to Friday;*
- *the extra rates paid for Saturday, Sunday and Public holidays are in substitution for, and not cumulative upon, the shift premiums payable for afternoon and overnight supports; and*
- *the extra rates for Saturday/Sunday/Public holidays do not increase further when the support finishes after 8pm.*

High intensity supports

A support is considered a high intensity support if the participant requires assistance from a support worker with additional qualifications and experience relevant to the participant's complex needs. The high intensity price limits may be considered when:

- *frequent (at least 1 instance per shift) assistance is required to manage challenging behaviours that require intensive positive behaviour support; and/or*
- *continual active support is required due to high medical support needs (such as unstable seizure activity or respiratory support)*

In determining which price limit for High Intensity Supports should apply to a given support, the provider should consider the skills and experience of the worker delivering the support. In general, the Level 2 price limit applies to most high intensity supports. However, if the particular instance of support is delivered by a worker who does not have the skills and experience to deliver a high intensity support then the Level 1 price limit should be applied. If the particular instance of the support is delivered by a more highly skilled or experienced worker then the provider can consider applying the Level 3 price cap, with the participant's prior agreement.

Temporary Transformation Payment (TTP)

Providers of attendant care and community participation supports who meet the eligibility criteria set out below will have access to a higher price limit through a Temporary Transformation Payment (TTP).[25] *This conditional loading will assist providers to continue*

[25] The TTP loading was set at 7.5% in 2019-20 and is to be reduced by 1.5%age points each financial year.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

transforming their businesses in the move towards a more competitive marketplace. This replaces the Temporary Support for Overheads. In order to access the higher TTP price limits, providers will have to:

- *publish their service prices;*
- *list their business contact details in the Provider Finder and ensure those details are kept up-to-date; and*
- *participate annually in an Agency-approved market benchmarking survey.*

Providers must meet those three TTP requirements, and to include in their contractual arrangements with their participants that they are entitled to use the TTP support items (and price limits).

That is, in the first year, providers can commence making claims using the TTP items from 1 July 2019, and will have until 31 March 2020 to meet the three compliance requirements. In later years, providers will need to be compliant by the start of the financial year, noting that the Benchmarking Requirement is met up until 31 December of any year by the provider's intention to take part in the next Benchmarking Survey, and after that date by actual participation in the most recent Benchmarking Survey. Providers who become non-compliant during a financial year should not claim for TTP items while they are non-compliant.

Every support item in scope of the TTP has two support items and two price limits. The non-TTP items should be used by providers who are not compliant with the TTP conditions. The TTP items should be used by providers who are compliant with the TTP conditions, an example is given in the following Table.

01_011_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Daytime
01_011_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Daytime - TTP

There will be no formal registration process for TTP providers. Providers indicate that they intend to fulfil the TTP conditions by making a claim for a TTP support item through the payment system. They will be required to acknowledge compliance to the Price Guide terms, including the TTP terms if applicable, when submitting a payment request through the Myplace Provider Portal. By claiming TTP items through the NDIA payment system, or from a plan manager, providers are warranting that they have complied with the TTP conditions, or intend to comply with the TTP conditions by the relevant time.

Plan managers will not be responsible for ensuring providers are TTP compliant. They can accept the claim for a TTP support item by a registered provider as proof of TTP compliance. However, non-registered providers are not eligible for the TTP and plan managers should not use TTP line items to claim for services delivered by non-registered providers.

Table 3 sets out the key assumptions of the current NDIS Disability Support Worker Cost Model.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Table 3 - NDIS Disability Support Worker Cost Model – Key Assumptions

	Standard Support (Level 1)	High Intensity Support (Level 2)	Very High Intensity Support (Level 3)
Disability Support Worker	-	-	-
Salary costs	-	-	-
Award Rate from SCHADS Award	2.3	2.4/3.1	3.2
Working Days in Year	220	220	220
Shift Loadings	As per Award	As per Award	As per Award
Ratio of permanent to casual (percentage)	80/20	80/20	80/20
Salary on costs	-	-	-
Superannuation	9.5%	9.5%	9.5%
Workers compensation	3.0%	3.0%	3.0%
Utilisation rate for DSW	92.0%	89.0%	87.7%
Supervisor	-	-	-
Salary costs	-	-	-
Classification (SCHADS Award)	3.2	4.2	4.2
Working Days in Year	220	220	220
Shift Loadings	As per Award	As per Award	As per Award
Salary on costs	-	-	-
Superannuation	9.5%	9.5%	9.5%
Workers compensation	3.0%	3.0%	3.0%
Utilisation rate	92.0%	89.0%	87.7%
Management ratio (FTE basis)	1:11	1:11	1:11
Overheads (ratio to costs)	10.5%	10.5%	10.5%
Pre-tax margin (ratio to costs + overheads)	2.0%	2.0%	2.0%

CONSULTATIONS

The *Issues Paper* presented a number of issues that had been raised by the sector, including:

- Whether it is easy to determine the level of intensity of a support?
- Whether it is easy to determine the time of day / day of week a support is provided?
- Whether providers pay allowances to disability support workers on top of their salaries?
- Whether the allowance for workers compensation costs is adequate?
- Whether providers were liable to pay payroll tax?
- Whether the assumed mix of permanent to casual workers is reasonable?
- Whether the assumed supervision ratio is reasonable?
- Whether the assumed utilisation rates are appropriate?

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- Whether casual to permanent staff ratios, utilisation rates and supervision ratios vary by day of the week, or level of workers?
- Whether the provision for overheads are adequate?
- Whether the allowance for margin is sufficient?

High intensity supports

Feedback from the provider community indicated a desire for reform of the definitions used in the *NDIS Price Guide*. Most providers considered that the definition of higher intensity supports were unclear and too complex, in addition to creating difficulty for participants. A number of submissions suggested that an assessment tool should be developed to aid in the classification of the intensity of supports and some providers had actually developed such tools for internal use.

Some providers recommended collapsing the distinction between intensity levels, either entirely or in part as a means of lowering the administrative burden and saving time. It was further suggested that providers should be able to rely on reports from medical specialists to determine the appropriate intensity level of a support. There were also suggestions that the level of intensity of supports needs to be agreed upon when developing participants' plan and included in the plan for ease of interpretation and application to agreements.

One provider pointed out that some of the current criteria for high intensity supports created a perverse incentive to manage participants' needs sub-optimally. Some providers also argued that some higher intensity supports are conditioned on the number of instances of challenging behaviours requiring management per shift, whereas effective care would ideally result in fewer instances of these behaviours. If those behaviours were successfully managed, the support would attract a lower rate of remuneration under the current criteria. Accordingly, the provider recommended adopting guidelines for supporting clients with behaviours of concern that did not rely on a "frequent and continual" criterion but instead relied on the strategies put in place by the provider or a behaviour support specialist.

Some submissions argued that registered providers cannot deliver supports to participants with high intensity needs without the required skills and training. Therefore, they suggested that support levels should be linked to the requirements of the participant and that classification according to the level of skill and experience of the worker should be removed. Submissions to the review also argued for an increase in the price limits for higher intensity supports to reflect their additional cost of delivery. The majority of providers consulted, however, favoured price limits linked to the skills ad competencies of staff.

Leave Provisions and Shift Definitions

The vast majority of submissions indicated that there were no difficulties in determining the time of day and day of week that a support was provided. The demarcations outlined in the *SCHADS Award* were considered to be very clear and easy to comply with in practice. The only area of confusion surrounded afternoon and night rates. It was suggested the afternoon

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

rate start time be brought forward to commence from 6pm, because the term "afternoon" was causing some confusion for participants given it currently commences at 8pm.

Some providers indicated that time of day provisions were problematic. If a worker was required to provide a support past 8pm then the award required they be paid at the penalty rate for the entire shift. A lot of supports are provided at 8pm. Other providers indicated that they understood that it was their responsibility to manage their workforce and that the current arrangements, which were concerned with the time that the support was delivered rather than the shift that the worker was employed on, were appropriate. Not all providers were aware of the provision in the *NDIS Price Guide* that allowed providers to charge a higher rate for an entire support if the support crossed over the boundary between two pricing points.

Providers highlighted that some states and territories have additional public holidays, leading to inconsistency in the application of the cost model across states and higher labour costs for organisations in those states. One provider noted that Queensland had 13.25 gazetted public holidays in the 2020 calendar year and that an adjustment should be made for this in the cost model. Another provider noted that workers in the Northern Territory are typically permitted one or two additional weeks of annual leave. Some providers further mentioned that some regional areas have half day public holidays and that these were not provided for in the model. In relation to public holidays more generally, it was suggested that disclaimers should be provided in plans, outlining that higher rates would be charged for public holidays.

Some providers highlighted that under the SCHADS Award workers were entitled to an additional week of annual leave if they worked in excess of 10 weekends in a year. The current cost model currently makes no explicit allowance for that entitlement because it assumes businesses will run their operations efficiently and only incur this additional liability where the benefits of doing so outweigh the cost. One provider reported providing an additional week of leave for worker supporting participants with complex needs. Providers also complained that the cost model made no explicit provision for overtime payments.

Feedback from providers indicated concern about broken shifts. Broken shifts occur when supports are provided by workers across less than the full extent of a shift. Some providers reported that splitting shifts was difficult due to the additional time it took to roster and claim exactly, and that it led them to incur losses when splitting claims across shifts. It was recommended that if any part of a shift falls into a penalty rate, then the penalty rate should apply to the whole shift. It was argued that this would align claiming to wage costs.

Only limited feedback was received in submissions on the issue of whether the casual to permanent staff ratio, utilisation rate and supervision ratios varied depending on the day of the week, or for different levels of workers. Some providers suggested it was reasonable to assume that the elements of the cost model were constant across the days of the week, and for different levels of workers. However, there was feedback to suggest that more casuals were engaged to provide supports on weekends and evenings and that flexibility should be provided for cost model assumptions to vary by day of the week and level of worker.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Casual and permanent staff mix

Many providers indicated that the 80% permanent to 20% casual staff ratio used in the cost model was no longer appropriate and that there was a strong trend toward increased casual employment in the sector. Permanent to casual ratios reported by providers varied widely across submissions and averaged out around a roughly even split. However, subject to the caveat that there were limited responses, submissions tended to point toward modalities within the industry of either 80-20 permanent to casual, or 20-80 permanent to casual. Members of the Working Group on the Cost Model agreed that the current casual ratio assumption is too low. They considered casuals were closer to 40% - across metro, regional and remote areas.

A number of submissions indicated that the permanent to casual split could change throughout the year and depended of a range of factors, particularly the availability of staff, and that staff employed on public holidays and weekends were virtually always casuals. Feedback from providers also pointed to the ratio of permanent to casual staff varying widely depending on the nature of the service being provided. The increased casualization of the workforce was being driven by participant demand and participant expectations for flexibility. Providers also pointed out that evening supports made a high use of casuals, which raised costs for providers and that the current cost model assumption that the ratio of permanent to casual staff was the same for all shifts was not appropriate.

Some providers indicated that they were attempting to move to a more permanent workforce but this is difficult in a sector where flexibility is often required. Some providers reported that they were innovating and experimenting with permanent casual arrangements. Such workers have guaranteed minimum hours, with the choice of working more when they wish to.

Some members of the Cost Model Working Group called for the cost model to allow for agency workers, who are around 25% more expensive, but as “rostering is more of an art than a science” sometimes need to be used when casuals are not available. Although others noted they never used agency workers.

Utilisation

The cost model recognises that not all working hours are billable. Allowances are made in the cost model for legally required break periods, staff training and administrative tasks. The cost per billable hour for disability support workers in the cost model is inflated to account for less than complete labour utilisation. Training requirements are assumed to be higher for high intensity and very high intensity workers, so allowances for training time in the cost model is reflected in lower levels of utilisation for these workers.

Provider submissions challenged the operating benchmarks used in the cost model with respect to utilisation rates. The cost model assumes an efficient utilisation rate of 92% for standard intensity disability support workers and lower rates for higher intensity workers. Feedback from most providers indicated that the rate of utilisation assumed in the model

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

was too high, with some providers further suggesting that the cost model did not adequately reflect sufficient time for training and development of staff. A number of providers also contended that staff turnover increased training time and that the cost model had to make allowance for training associated with staff turnover.

However, while there was almost universal feedback from providers that the efficient rates of labour utilisation assumed in the cost model were too high, there were very limited responses outlining actual rates of staff utilisation.

Feedback from some providers indicated that utilisation rates were lower for part-time workers. The inability to schedule therapy sessions with participants back to back results in lower levels of utilisation, as does travel between shifts.

Some members of the Cost Model Working Group commented that they had 30-40% turnover in a year and that training and induction time is close to double with such turnover compared to a stable team. This is exacerbated with complex needs and behaviour, as there is higher turnover of staff. Higher complexity also requires much more training, team meetings, debriefs and compulsory personal development, which all lower utilisation.

Supervision ratios

The cost model provides for the cost of supervising disability support workers. The cost model assumes an efficient ratio of workers to supervisors of 11 to 1. The cost model assumes that supervisors have the same shift loadings, leave entitlements and salary on-costs as the workers they manage, and that higher skilled workers require higher skilled supervisors.

Submissions from most providers contended that the supervision ratio used in the cost model was too high and unrealistic compared to actual ratios. However, some providers indicated that they were able to achieve higher spans of control but at the expense of much higher hourly rates of remuneration. Limited feedback was provided in submissions on the actual ratio of supervisors to workers achieved by providers.

Spans of control were reported to differ markedly depending on the number of casual staff employed by a provider. Workforces dominated by casual staff could have supervision ratios orders of magnitude higher than the 11 to 1 benchmark. There were suggestions that the supervision ratio should be based on headcount rather than the number of full-time equivalent workers, in part because providers maintained that disability support workers rarely work full-time hours. One provider counselled that the supervision ratio is actually more closely linked to the number of participants serviced, rather that the number of staff supervised.

The supervision ratio was also reported to varying depending on the nature of the particular support provided, the experience level of staff and the quality of care. Some providers advised that participants who required level 2 and level 3 supports required more intensive support and in turn more intensive supervision, they suggested that the supervision ratio should be elevated for more intensive supports. There appeared to be considerable

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

agreement amongst providers that it was difficult to set a generic assumption for the supervision ratio, in part because it varied as a result of a range of factors, particularly the rate of casualization of the workforce.

Members of the Cost Model Working Group raised two further issues.

- Supervision ratios were higher for casuals. More casuals are required to deliver the same number of hours and each requires supervision. Thus, twice as much supervision could be required for casuals over full-time employees.
- One provider indicated that it was possible to have 3 or 4 workers completing the total hours of one full-time employee, and it is the number of people supervised that matters for costs, not the number of hours delivered.

Allowances

Submissions indicated that providers paid a range of additional worker allowances that were not by required by law. These entitlements individually were not significant but collectively were non-trivial. Some providers indicated that they were around 1% of base salary costs. The allowances paid by providers were broad-ranging, and included:

- travel allowances;
- regional allowances;
- telephone allowances;
- meal allowances;
- standby allowance;
- shift leader allowances;
- foul linen allowances;
- dirty work allowances;
- forklift allowances;
- district allowances;
- performance allowances;
- immunisation allowances;
- flu vaccination allowance;
- professional development leave; and
- provision for wellness days.

One member of the Cost Model Working Group mentioned that they pay for First Aid training, and pay the attendant allowance for all attendant care workers who do home visits.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Payroll Tax

The cost model does not include an allowance for payroll tax as most jurisdictions exempt not for profit and smaller organisations from payroll tax. The vast majority of submissions reported that providers did not pay payroll tax because they were exempt from the tax. However, a minority of providers reported they were paying payroll tax.

Workers' Compensation premiums

The cost model allows for other costs related to the salaries of disability support workers. An allowance is made for superannuation, set at the current statutory rate of 9.5% of salary including leave. Provision is also made for workers compensation insurance at a rate of 3.5% of base salary including leave.

Those submissions that detailed the workers compensation premiums paid by providers, reported they were on average 3.5% of salary costs, in line with the cost model. Conversely, members of the Cost Model Working Group reported that premiums are generally lower than 3%, but this varies by state. They also argued that the complexity of supports offered leads to higher workers compensation premiums. Workers delivering high complexity supports are more likely to make claims, leading to higher premiums and that therefore workers' compensation premiums for workers providing high complexity support are between 3 and 5.5%.

Overheads

The corporate overheads allowance in the cost model is set at 10.5% of direct costs. The overheads allowance is intended to cover costs not otherwise explicitly provided for in the cost model, as such, it covers expenses for land and building costs, corporate fleet, marketing, administration costs, IT and other costs.

Submissions from providers indicated widespread dissatisfaction with respect to the level of overheads allowed for by the cost model. Of those providers that reported their overheads levels in submissions, the vast majority indicated that their actual level of overheads considerably exceeded the 10.5% level assumed in the model. The average overheads of those providers who revealed their actual costs in submissions was just above 20% but the level varied considerably, suggesting significant heterogeneity within the sector in terms of operating business models and potentially levels of efficiency. Overheads levels reported in submissions ranged from 10.5% to 43%.

However, only a minority of submissions reported the actual overheads levels of providers. Of all the submissions, only around one in eight specified the level of their overheads and only a slightly higher proportion indicated that the overheads allowance was inadequate. Roughly 20% of those submissions that reported actual overheads costs indicated that they were operating in line with, or very close to, the 10.5% benchmark.

NDS reported that a survey they had conducted of 70 providers showed that the median overheads was 16% with the range stretching up to 30%.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

One member of the Cost Model Working Group commented that providers are subsidising worker travel by paying the 78 cents per kilometre required by the SCHADS Award. They estimated that if this was included in the models' definition of overheads that would increase it by around 5%. There was concern that as the current allowance for overheads in the model does not cover travel allowances, this advantaged organisations who did not have to travel much or far.

Margins

The cost model incorporates an allowance for the profit margins that providers need to earn to attract and retain capital in the disability sector. The cost model provides for a 2% margin on top of other costs. This equates to a rate of return of 8% against working capital equivalent to three month's wages and entitlements.

A majority of submissions that broached the issue reported that profit margins were negative at the moment and many were incurring significant financial losses. Some providers further highlighted that their margins had been negative since the NDIS was rolled out.

However, only a limited number of total submissions responded to the issue of profit margins. Feedback on an appropriate level of profit margins was even more limited in submissions, the paucity of comment that was offered tended to suggest a level of around 5% was the minimum required to ensure viability of efficiently run providers.

Other cost model issues

There was feedback in submissions that the demand for suitably qualified workers in the disability support sector had led most providers to adopt industrial agreements that set rates of pay in excess of the *SCHADS Award*. It was contended that labour market conditions were such that the award rates of pay upon which the cost model was predicated were no longer appropriate. Accordingly, some providers recommended that the funding model should reflect average industry pay and conditions rather than those set out in the award

NDS noted in their submission that a growing number of states and territories are introducing portable long service leave.

Some members of the Cost Model Working Group were concerned about the portable long service leave loading in some jurisdictions. They noted that most staff left after five or six years, so long service leave was not accrued and thus not a major cost currently. Members considered it was difficult to predict the exact cost of long service leave but estimated it at roughly 2% of wages. Other members noted that the different systems for long service leave between states led to higher administrative and compliance costs for providers.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

RESEARCH

Temporary Transformation Payment Benchmarking Survey

Deloitte Access Economics were engaged by the NDIA to conduct the survey and analyse the results. Only de-identified data was passed onto the Agency. On 21 February 2020, Deloitte sent out on line invitations to the 3,039 providers who were then enrolled in eligible registration groups (104, 107, 125 and 136). As at 15 March 2020, when the survey closed, Deloitte had received 615 completed surveys. That is, only 38.9% of providers who had claimed for the TTP completed the survey by the cut-off date.[26]

Table 4 indicates the distribution of results from the TTP survey for the key parameters in the NDIS Disability Support Worker Cost Model.

Table 4 - Distribution of Results from the TTP Survey

	Permanent Employment Rate	Utilisation Rate	Overheads (multiplier of direct costs)	Implied Margin[27] (multiplier of other costs)	Span of control
Cost Model Assumption					
	80%	Level 1 = 92.5% Level 2 = 90.0% Level 3 = 87.7%	10.5%	2.0%	11
Survey results					
Average	43.8%	79.8%	27.7%	1.7%	11.8
STD	32.9%	12.0%	11.8%	1.6%	11.3
Skew	0.3	-0.5	-0.1	1.5	3.4
Kurtosis	-1.3	-0.2	-0.8	1.7	19.8
0th percentile	100%	100%	1.1%	7.9%	116.0
5th percentile	100%	97.9%	7.7%	5.1%	30.7
10th percentile	94.8%	95.0%	10.7%	4.4%	22.7
25th percentile	71.7%	90.0%	19.8%	2.3%	15.0
50th percentile	40.0%	80.0%	28.1%	1.2%	9.0
75th percentile	12.5%	71.0%	36.4%	0.5%	5.0
90th percentile	5.2%	64.4%	44.2%	0.2%	2.1
95th percentile	0.0%	59.0%	46.5%	0.1%	1.0
100th percentile	0.0%	50.0%	49.2%	0.0%	0.0

NOTE: Implied margin is margin required to generate a rate of return of 8% on working capital.

Comparison to other Schemes

Table 5 and NOTES: Rates as published excluding temporary measures (NDIS – COVID 10% increase).

[26] As of 31 March 2020, an additional 231 responses had been received. These responses are not included in the analysis.

[27] Implied margin is the margin required to generate a rate of return of 8% on working capital.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Table 6 compare the non-TTP and TTP price limits for NDIS supports for attendant care that applied, from 1 July 2019 to 24 March 2020 (before the temporary COVID19 loading was introduced), with the fees that were payable on 1 July 2019 by:

- icare, the New South Wales workers compensation scheme;
- Victorian Transport Accident Commission (TAC);
- Worksafe Victoria;
- WorkCover Queensland;
- South Australian Lifetime Support Authority ; and
- Veterans Home Care Program of the Department of Veterans' Affairs.

Table 5 - NDIS hourly price limits for non-TTP and TTP support items

	NDIS Level 1	NDIS TTP Level 1	NDIS Level 2	NDIS TTP Level 2	NDIS Level 3	NDIS TTP Level 3
Weekday	$52.85	$56.81	$57.15	$61.11	$60.04	$64.00
Evening	$58.31	$62.69	$63.06	$67.44	$66.23	$70.61
Night	$59.40	$63.85	$64.24	$68.69	$67.47	$71.92
Saturday	$72.69	$78.14	$78.63	$84.08	$82.58	$88.03
Sunday	$94.52	$101.61	$102.23	$109.32	$107.37	$114.46
Public holiday	$118.34	$127.21	$127.97	$136.84	$134.42	$143.29
Inactive overnight	$214.03	$214.03	$214.03	$214.03	$214.03	$214.03
Establishment fee	$500.00	$500.00	$500.00	$500.00	$500.00	$500.00

NOTES: Rates as published excluding temporary measures (NDIS – COVID 10% increase).

Table 6 - Comparative Scheme hourly fees

	icare NSW	TAC (IQRS)*	WorkSafe Victoria (IQRS)	WorkCover Queensland	SA Lifetime Support Authority	Veterans Home Care**
Weekday	$49.18	$50.56	$48.88	$49.00	$48.31	$69.45
Evening			$53.60		$52.60	$69.45
Night	$56.74	$50.56	$54.54		$53.34	$85.50
Saturday	$63.25	$67.12	$67.80	$71.00	$65.02	$85.50
Sunday	$80.35	$67.12	$86.76	$71.00	$81.71	$85.50
Public holiday	$95.90	$114.33	$105.68		$98.40	$85.50
Inactive overnight	$222.17	$142.22	$212.90		$202.83	-
Establishment fee	$1,214.06	$1,328.17	$1,207.32			

NOTES: The IQRS rates are payable when then services are Independently Reviewed against Quality Standards.
Rates as published excluding temporary measures (NDIS – COVID 10% increase).
* For TAC clients there is no limit on the co-payment that the client can be asked to pay by the provider.
** Recipients of Veterans Home Care can also be asked to make a co-payment of $5.00 per hour, up to certain limits.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

The NDIS Weekday standard rate (without TTP) is between 4.5% and 9.4% higher than those of the comparable state schemes (average 7.5%). It is 23.9% lower than the DVA fee. The NDIS Saturday standard rate (without TTP) is between 2.4% and 14.9% higher than those of the comparable state schemes (average 8.9%). It is 15.0% lower than the DVA fee.

However, it is not clear to what extent the fees payable by other schemes can be compared to NDIS price limits, given that fees can operate differently in different contexts (e.g. according to whether or not services are commissioned, and what other fees – including client co-payments - are also billable).

Icare, for example, engage providers through a tender process. Consultations with icare indicate that providers are able to bill icare directly for training costs and supervision costs on top of the hourly rates for attendant care. By contrast, these costs are fully loaded into the hourly price limits published by the NDIS. Within the NDIS Disability Support Worker Cost Model these costs are represented by the utilisation (billable hours) parameter and the supervision ratio parameter. If these parameters, and the overheads assumption, are adjusted to match the icare billing practices then the benchmark attendant care price limit produced by NDIS Disability Support Worker Cost Model is within 0.04% of the icare benchmark hourly rate.

Workers Compensation Premiums

The NDIS Disability Support Worker Cost Model assumes workers compensation premiums of 3% of salary expenses. This assumption is higher than both the standardised all industries Australian average premium rate of 1.5% the standardised 1.7% national average for the Health and Community Services sector (averaged over 2010-11 to 2014-15).[28] The TTP Survey similarly found that the average workers compensation premium among respondents was 2.6%, with a median of 2.3% and a 25th percentile of 1.7%.

Portable Long Service Leave Schemes

From January 2020, NDIS-funded activities were included in the 'community services work' portable long service leave scheme in Victoria.[29] A levy of 1.65% applies to the 'ordinary pay' of both permanent and casual workers. The ACT has a similar scheme with a levy of 1.2% of the gross ordinary wages.[30] The Queensland Government has introduced legislation to establish a new portable long service leave scheme available for community services workers. If passed by Parliament, the scheme is proposed to start on 1 July 2020. The proposed levy for that scheme 1.35% of a worker's ordinary wage.[31]

[28] Safe Work Australia, *Comparing Workers' Compensation Scheme Performance*, Tuesday 14 November 2017, https://www.safeworkaustralia.gov.au/workers-compensation/comparing-workers-compensation-scheme-performance (accessed 24 March 2020).

[29] https://www.vic.gov.au/portable-long-service-community-services-sector

[30] https://actleave.act.gov.au/

[31] https://www.qleave.qld.gov.au/

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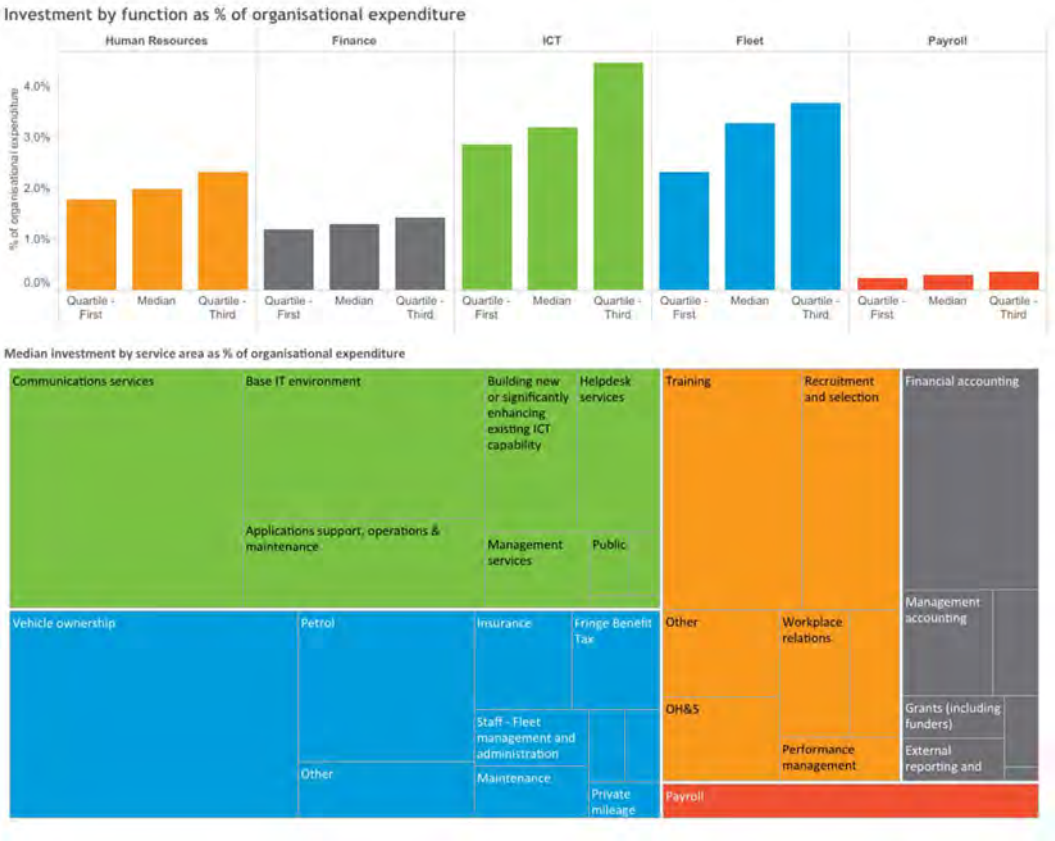
MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Overheads

The results of a major benchmarking study of non-for-profit organisations in Australia by Nous Group are illustrated in the following diagram.[32] The study found the median share of organisation revenue spent on back of house functions among the reporting organisations was 10.2%, with 25% spending less than 8.4% of their expenses on back of house functions.

Figure 3 - Nous Group Study of Back-Office Expenses of Not For Profit Organisations



An earlier study by National Disability Services, which considered facility costs and general administration as well as back office costs, found that overheads accounted on average for 13.3% of the revenue of the reporting organisations.[33]

Evidence on Adherence to Price Limits

An analysis of all successful claims for payment from the NDIS payment system in the second quarter of 2019-20 for support items that are eligible for the TTP indicates that:

- 59.6% of eligible active providers chose to use the TTP higher price limits (1,580 out of 2,649 providers); and

[32] http://benchmarking.nfpstrategy.com.au/explore

[33] National Disability Services. (2015). *NDS Productivity Tool: A Summary Report for the 2012-13 Financial Year* http://www.industrydevelopmentfund.org.au/images/ProductivityTool_Report2012-13.pdf

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- 49.7% of all claims (by dollar) were claimed against support items eligible for the higher price limits ($1,217 billion out of $2.451 billion).

That is, almost 40% of eligible providers (delivering almost 50% of all supports) have decided not to access the higher TTP price limits. Some providers have indicated that they preferred not to raise their prices so that they could undercut competitors who did, and thus increase their market share.

Moreover, for those providers who chose to operate under the lower non-TTP price limits, more than 25% of all claims were below the relevant lower non-TTP price limit and about 9% of all claims were more than 10% below the relevant lower non-TTP price limits.

Even among providers who chose to access the higher TTP price limits, more than 10% of all claims were below the relevant higher TTP price limit and about 5% of all claims were more than 5% below the relevant lower non-TTP price limits.

DISCUSSION

NDIS Disability Support Worker Cost Model

The publication of the structure of the NDIS Disability Support Worker Cost Model has provided the disability sector with full transparency regarding the setting of price limits under the Scheme and has allowed providers to benchmark their operations against the assumed efficient costs outlined in the model.

Given that baseline price limits are intended to represent efficient costs the TTP survey results, taken on their own, provide some evidence that the NDIS Disability Support Worker Cost Model may not be correctly estimating efficient costs – although some of the effects are countervailing.

- The average Permanent Share of the workforce among survey respondents (43.8%) is considerably lower than the current Model assumption (90%). Moreover, the efficient 25th percentile estimate (71.7%) is also lower than the Model assumption.
- The average utilisation rate among survey respondents (79.8%) is lower than the current Model assumptions (87.7% to 92.0%). However, the efficient 25th percentile estimate (90.0%) is in line with the current Model assumptions.
- The average overheads percentage (as a loading on direct care costs) among survey respondents (27.7%) is higher than the current Model assumptions (10.5%). Moreover, the efficient 25th percentile estimate (19.8%) is also higher than the current Model assumption.
- The average span of control among survey respondents (11.8:1) is slightly higher than the current Model assumptions (11:1). Moreover, the efficient 25th percentile estimate (15:1) is considerably higher than the current Model assumption.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- The NDIS Disability Support Worker Cost Model does not currently provide for allowances paid to workers on top of their salaries (other than shift loadings and superannuation). This in not in line with the TTP Benchmarking Survey which indicates that these allowances can typically be in the order of 1.0% of the base salary payable to the worker.

However, the TTP survey does not include results for providers who are not accessing the higher TTP price limits, and who, prima facie, are likely to have lower costs (and hence be more efficient) since they have not chosen to access the higher TTP price limits. Only around half of eligible providers (59.6%) claim the TTP and then less than half of TTP claimants completed the survey by the due date. Thus, the survey provides results for only around a quarter of those NDIS providers who employ Disability Support Workers. Assuming that the distribution of overheads among non-TTP claiming providers is similar to the distribution among TTP claiming providers, but with a lower average representing their lower costs then it is possible to generate a mixed statistical distribution of all providers. The Review estimates that in this distribution the efficient (25th percentile) provider would have overheads of between 14.4% and 16.7% of direct costs (with a median estimate of 15.2%).[34]

Moreover, some of these overheads relate to provider transport non-labour costs which are currently not separately claimable by providers. The TTP benchmarking survey found that the average cost of travel expenses across respondents was $1,000 per worker per year. A DSW Level 1 paid at $27.61 per hour, with a 38 hour week, has an annual income of $54,557. With salary related on costs and supervision costs this equates to direct care expenditure of about $70,000. Travel expenses of $1,000 would represent a 1.4% increase on this, and would currently be shown in the overheads of the provider.

There is also strong evidence that some providers are managing to operate at or below the current price limits, with almost 40% of eligible providers choosing not to access the higher TTP price limits. Moreover, more than 25% of all claims by these providers were below the relevant lower non-TTP price limit and about 9% of claims were more than 10% below the relevant lower non-TTP price limits.

Finally, the current price limits in the NDIS compare very favourably with those that apply in other schemes. However, it is not clear to what extent these fees can be compared to NDIS price limits, given that fees can operate differently in different contexts (e.g. according to whether or not services are commissioned, and what other fees are also claimable). The Review also notes that the NDIS price limits seem relatively high compared to the prices charged in the aged care sector but that these arrangements also include co-payments. Australian Unity Aged Care, for example, lists an hourly rate for personal care of $53.00 +

[34] The distribution of overheads for non-TTP providers is estimated by left-shifting the distribution of overheads for TTP providers. The median estimate on the 25th percentile of the entire distribution is estimated by left-shifting the distribution of overheads for TTP providers by 7.5 percentage points if the overheads percentage is above the 25th percentile of the TTP distribution and by 2.5 percentage points if the overheads percentage is between the 10th and the 25th percentiles of the TTP distribution.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

management fees and Blue Care lists an hourly rate of $50.75 plus management fees (of about $6 per hour).

On balance, therefore, the Review considers that there is no reason to increase the current set of price limits, although it would be appropriate to make some minor modifications to the NDIS Disability Support Worker Cost Model to better reflect the costs structures of efficient (25th percentile) providers[35] by:

- Decreasing the ratio of permanent to casual staff assumed in the cost model to 70/30% in line with the 25th percentile of the TTP Benchmarking Survey;
- Increasing the share of staff assumed to take up their long service leave entitlements to 100% in recognition of the move towards portable long service leave scheme sin some states and territories;
- Decreasing the assumed workers compensation premium percentage from 3.0% to 1.7% in line with the 25th percentile observed in the TTP Benchmarking Survey, noting that this is equal to the average premium percentage observed across the health and community sector;
- Increasing the assumed overheads percentage to 12.0% to better align with the estimated overheads of efficient providers in the sector, noting that other recommendations being made by the Review will directly address some of the costs that providers are currently carrying in their overheads[36];
- Increasing the supervision ratio from 11 to 15 in line with the 25th percentile observed in the TTP Benchmarking Survey, noting that the non-face-to-face claiming rules permit some interactions between supervisors and staff to be claimed directly when they relate to the specific direct care needs of a participant; and

[35] The review considers that it is appropriate to estimate the cost structure of overall efficient (25th percentile) providers by reference to the 25th percentile of all providers' performance against each of the key parameters because there is little collinearity observed between the parameters in the TTP Benchmarking Survey results. The determinant of the Pearson product-moment correlation coefficient matrix (see below) is 87.1%.

	A = Permanent Share of Workforce	B = Supervision Ratio	C = Non travel allowances	D = Workers Compensation Premium	E = Utilisation percentage	F = Overheads percentage
A	1.00	-0.09	-0.13	0.06	-0.04	0.08
B	-0.09	1.00	-0.07	0.00	0.19	0.08
C	-0.13	-0.07	1.00	-0.02	-0.14	-0.18
D	0.06	0.00	-0.02	1.00	-0.02	0.02
E	-0.04	0.19	-0.14	-0.02	1.00	0.09
F	0.08	0.08	-0.18	0.02	0.09	1.00

[36] The recommendations to allow providers to claim for the non-labour costs associated with provider travel; to increase the fee payable in the case of a short notice cancellation to 100% of the agreed fee; and to expand the availability of establishment grants will all allow providers to better recover costs that are currently attributed to overheads within the provider's budget.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- Increasing the provision of allowances (other than travel allowances) for support workers and supervisors to 1.0% of salary, in line with the average level observed in the TTP Benchmarking Survey.

The Review notes the concerns raised by some providers that the ratio of permanent to casual staff differs by shift. The Review accepts that these variations, if they exist, are not accounted for in the NDIS Disability Support Worker Cost Model but the Review does not have sufficient data available to it to determine if these practices make a material difference to the overall costs of employers. The Review suggests that these matters should be investigated further in the next TTP Financial Benchmarking Survey.

The Review also notes the concerns raised by some providers that the NDIS Disability Support Worker Cost Model does not take into account the additional costs of employing Agency Staff. The Review does not accept this criticism as these costs are by and large, within the control of providers who are responsible for managing the rostering of their workforce. The Review therefore considers that any such additional costs are best attributed against the provider's overheads in the NDIS Disability Support Worker Cost Model.

High Intensity Supports

The Review does not support the request by some providers that the price limit for support items should be determined by the complexity of the participant's needs rather than by the skills and experience of the support worker, as currently. The Review accepts that participants with complex needs will often require more funding, both for more supports and for more skilled or experienced support workers. However, this is a planning issue, not a pricing issue. From a price control perspective the important issue is the input costs of the provider, which are largely determined by the skills and experience of the support worker who delivers the support.

The Review understands that some providers would prefer greater guidance as to when they may use the Level 1, Level 2 and Level 3 price limits. Currently the *NDIS Price Guide* says that:

> *A support is considered a high intensity support if the participant requires assistance from a support worker with additional qualifications and experience relevant to the participant's complex needs. The high intensity price limits may be considered when:*
>
> - *frequent (at least 1 instance per shift) assistance is required to manage challenging behaviours that require intensive positive behaviour support; and/or*
> - *continual active support is required due to high medical support needs (such as unstable seizure activity or respiratory support)*
>
> *In determining which price limit for High Intensity Supports should apply to a given support, the provider should consider the skills and experience of the worker delivering the support. In general, the Level 2 price limit applies to most high intensity supports. However, if the particular instance of support is delivered by a worker who does not have the skills and experience to deliver a high intensity support then the Level 1 price limit*

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

should be applied. If the particular instance of the support is delivered by a more highly skilled or experienced worker then the provider can consider applying the Level 3 price cap, with the participant's prior agreement.

An alternative approach would be for the Price Limit levels to be linked to the skills and competencies set out in the SCHADS Award.

Level 1 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified as a Social and Community Services Employee level 2 (below the maximum pay point) if they were employed under the SCHADS Award.

Level 2 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified as a Social and Community Services Employee level 2 (at the maximum pay point) or as a Social and Community Services Employee level 3 (at the minimum pay point) if they were employed under the SCHADS Award.

Level 3 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified above a Social and Community Services Employee level 3 (at the minimum pay point) if they were employed under the SCHADS Award.

On balance, the Review considers that the alternative approach is more appropriate. Providers have expressed concerns that many of them do not currently employ workers under the SCHADS Award, but the proposed definitions are only linked to the competencies set out in the SCHADS Award as a point of reference.

Time of Day and Day of Week

The Review does not support the request by some providers that the price limit should be determined by the shift of the worker rather than by the time of day that the support is delivered. It is important that participants know what price limit applies to each support that they purchase and they cannot know this if the price limit can also vary according to the shift that the employer has engaged the employee to work. In the end, workforce rostering is a matter for providers to manage.

As an exception to this general rule, the Review sees merit in the current arrangement whereby when a support for a participant crosses a shift boundary and the same worker delivers the entire support then the provider is entitled to use the highest price limit for the entire support. To avoid any confusion the Review suggests that the relevant section of the NDIS Price Guide should be rewritten as follows:

Time of Day and Day of Week

In determining which price limit is applicable to a support, the important consideration is when the support is provided to the participant, not the shift of the worker used to deliver

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

that support as determined by the applicable Industry Award or Enterprise Bargaining Agreement (EBA).

For NDIS billing purposes the provider must first determine the day of the week on which the support was provided on and then the time of the day during which the support was delivered. (Note: weekday means Monday, Tuesday, Wednesday, Thursday or Friday).

- *A **Night-time Sleepover Support** is any support to an individual participant delivered on a weekday, a Saturday, a Sunday or a Public Holiday that:*
    - commences before midnight on a given day and finishes after midnight on that day; and
    - is for a continuous period of eight (8) hours or more; and
    - the worker is allowed to sleep when they are not providing support.
- *A **Public Holiday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Public Holiday and ends before or at midnight of that Public Holiday (unless that support is a Night-time Sleepover Support).*
- *A **Saturday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Saturday and ends before or at midnight of that Saturday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).*
- *A **Sunday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Sunday and ends before or at midnight of that Sunday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).*
- *A **Standard Day Support** is any other support, and is either:*
    - A **Weekday Support** is any support to an individual participant that starts at or after 6:00 am and ends before or at 8:00 pm on a single weekday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).
    - An **Evening Support** is any support to an individual participant that finishes after 8:00 pm and at or before midnight on a single weekday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).
    - An **Active Overnight Support** is any support to an individual participant that commences at or before midnight on a weekday and finishes after midnight on that weekday, or commences before 6:00 am on a weekday and finishes on that weekday (unless that support is a Public Holiday Support, Saturday Support, Sunday Support or a Night-time Sleepover Support).

If a support to an individual participant does not meet one of the above criteria then it needs to be billed as two or more separate supports.

Night-time Sleepover Supports

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Night-time Sleepover Supports have a price limit that is inclusive of the cost of two hours of any supports provided to the participant for the duration of the period. Providers may claim for third or additional hour at Saturday rates on weekdays, or at applicable rates on other days (Saturday, Sunday or Public Holidays)

Note, Night-time Sleepover Supports apply to any day of the week and on public holidays, pending criteria met as described previously.

Public Holidays and Annual Leave

The Review notes the concerns raised by providers that the number of public holidays differs by state and territory and that it is a long standing practice of employers in the Northern Territory to allow their workers one or two additional weeks of annual leave. The Review also notes that the SCHADS Award provides for an additional week of annual leave for employees who work for more than four ordinary hours on 10 or more weekends during the yearly period in respect of which their annual leave accrues.

The Review accepts that these variations are not accounted for in the NDIS Disability Support Worker Cost Model but it does not have sufficient data available to it to determine if these practices make a material difference to the overall costs of employers. The Review suggests that these matters should be investigated further in the next TTP Financial Benchmarking Survey.

Temporary Transformation Payment (TTP)

The TTP loading was introduced for some providers of core supports because of the need to balance the drive towards efficiency and the requirement to swiftly expand supply. Markets for core disability supports are continuing to develop, with both increases in market supply and improvements in production efficiency required. While improvements to production efficiency imply reductions to costs in the long run, expansion of market supply necessitates higher short to medium term prices. To maintain and expand production volumes of disability supports, higher short-term prices are thus needed to maintain existing supply and as an incentive to redirect the allocation of resources to the NDIS from other sectors in the economy.

The level of the TTP loading was set at 7.5% for 2019-20 to be reduced by 1.5%age points each 1 July thereafter in line with the NDIS Pricing Strategy that said:

Price caps should be set in accordance with the movements in transitional price levels … to recognise the costs providers are facing in adjusting to the new arrangements, the time required to unwind established agreements, and to encourage growth in supply while driving efficiency. This should be done through an explicit and decreasing loading on sustainable price levels – the Temporary Transformation Payment (TTP) of about 7.5% – with a clear statement to the market of the expected glide path over five years to efficient price levels through the phased reduction of the TTP. Detailed ongoing monitoring of markets should also be conducted to determine whether short-term price increases have

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

been sufficient to expand supply, attract new entrants and increase competitive pressure. In the longer term, it is expected that competition between providers will result in a reduction of prices towards the long run efficient price. As market prices reduce towards long run efficient prices, the price caps imposed are expected to no longer be binding, in which case their removal can be considered.

The Review considers that there is more than sufficient evidence that the market for disability supports is continuing to grow and become more efficient, noting again that more than 40% of providers chose not to access the TTP accounting for almost half of all claims (by dollar) against relevant support items, and that of those providers who chose to operate under the lower non-Temporary Transformation Payment price limits, more than 25% of all claims were below the relevant lower price limit.

The Review also considers that the eligibility requirements to access the higher TTP price limits should therefore be strengthened and suggests that:

- Providers of relevant supports who were active in 2019-20:
  - Should only be eligible to access the higher TTP price limits in 2020-21 if they have indicated to the NDIA before 1 July 2020 that:
    - they have published, and will continue to publish, their service prices in accordance with the NDIS Price Guide;
    - they have listed their business contact details in the Provider Finder and will continue to ensure that those details are kept up-to-date; and
    - will participate in the 2020-21 TTP Benchmarking Survey; and
  - Should cease to eligible to access the higher TTP price limits from the closing date of the 2020-21 TTP Benchmarking Survey if they do not take part in the 2020-21 TTP Benchmarking Survey;
- Providers of relevant supports who were not active in 2019-20 and who become active before the closing date of the 2020-21 TTP Benchmarking Survey should be subject to the same eligibility criteria as set out in the dot point immediately above, except that they should be required to indicate their intention to accept the eligibility conditions before they first make a TTP claim, rather than before 1 July 2020; and
- Providers of relevant supports who were not active in 2019-20 and who become active after the closing date of the 2020-21 TTP Benchmarking Survey should be subject to the same eligibility criteria as set out in the dot point immediately above, except that they should cease being eligible to access the higher TTP price limits from the closing date of the 2021-22 TTP Benchmarking Survey.

The Review also suggests that Plan Managers should be required to receive an attestation from a provider who is seeking to make a claim against an item subject to the higher TTP price limits that they are eligible to access the higher price limits before the Plan Manager processes the claim.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

RECOMMENDATIONS

RECOMMENDATION 4) NDIS Disability Support Worker Cost Model

1) The NDIA should continue to use the NDIS Disability Support Worker Cost Model to determine the base (non-TTP) price limits for supports delivered by Disability Support Workers based on the performance of efficient providers.

2) The NDIA should amend the NDIS Disability Support Worker Cost Model (and the price limits determined by the cost model), from 1 July 2020, by:

   i) Decreasing the ratio of permanent to casual staff to 70%/30%;

   ii) Increasing the share of staff assumed to take up their long service leave entitlements to 100%;

   iii) Decreasing the workers compensation premium percentage to 1.7%;

   iv) Increasing the overheads percentage to 12.0%;

   v) Increasing the supervision ratio to 15:1; and

   vi) Increasing the allowance provision for support workers and supervisors to 1.0% of salary.

RECOMMENDATION 5) Temporary Transformation Payment

The NDIA should reduce the level of the Temporary Transformation Payment from 7.5% to 6.0% on 1 July 2020 as previously announced.

RECOMMENDATION 6) Definitions of the Levels of High Intensity Supports

That the definitions of Level 1, Level 2 and Level 3 supports in the *NDIS Price Guide* should be amended as follows:

Level 1 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified as a Social and Community Services Employee level 2 (below the maximum pay point) if they were employed under the SCHADS Award.

Level 2 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified as a Social and Community Services Employee level 2 (at the maximum pay point) or as a Social and Community Services Employee level 3 (at the minimum pay point) if they were employed under the SCHADS Award.

Level 3 support items should be used if the worker who delivers the support is someone who has the skills and experience that would mean that they would be classified above a Social and Community Services Employee level 3 (at the minimum pay point) if they were employed under the SCHADS Award.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

RECOMMENDATION 7) Definitions of Time of Day and Day of Week

That the definitions of Time of Day and Day of Week in the *NDIS Price Guide* should be amended as follows:

Time of Day and Day of Week

In determining which price limit is applicable to a support, the important consideration is when the support is provided to the participant, not the shift of the worker used to deliver that support as determined by the applicable Industry Award or Enterprise Bargaining Agreement (EBA).

For NDIS billing purposes the provider must first determine the day of the week on which the support was provided on and then the time of the day during which the support was delivered. (Note: weekday means Monday, Tuesday, Wednesday, Thursday or Friday).

- *A **Night-time Sleepover Support** is any support to an individual participant delivered on a weekday, a Saturday, a Sunday or a Public Holiday that:*
  - commences before midnight on a given day and finishes after midnight on that day; and
  - is for a continuous period of eight (8) hours or more; and
  - the worker is allowed to sleep when they are not providing support.
- *A **Public Holiday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Public Holiday and ends before or at midnight of that Public Holiday (unless that support is a Night-time Sleepover Support).*
- *A **Saturday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Saturday and ends before or at midnight of that Saturday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).*
- *A **Sunday Support** is any support to an individual participant that starts at or after midnight on the night prior to a Sunday and ends before or at midnight of that Sunday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).*
- *A **Standard Day Support** is any other support, and is either:*
  - A **Weekday Support** is any support to an individual participant that starts at or after 6:00 am and ends before or at 8:00 pm on a single weekday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- An **Evening Support** is any support to an individual participant that finishes after 8:00 pm and at or before midnight on a single weekday (unless that support is a Public Holiday Support or a Night-time Sleepover Support).
- An **Active Overnight Support** is any support to an individual participant that commences at or before midnight on a weekday and finishes after midnight on that weekday, or commences before 6:00 am on a weekday and finishes on that weekday (unless that support is a Public Holiday Support, Saturday Support, Sunday Support or a Night-time Sleepover Support).

If a support to an individual participant does not meet one of the above criteria then it needs to be billed as two or more separate supports.

Night-time Sleepover Supports

Night-time Sleepover Supports have a price limit that is inclusive of the cost of two hours of any supports provided to the participant for the duration of the period. Providers may claim for third or additional hour at Saturday rates on weekdays, or at applicable rates on other days (Saturday, Sunday or Public Holidays)

Note, Night-time Sleepover Supports apply to any day of the week and on public holidays, pending criteria met as described previously.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

4. Price limits for group-based core supports

The Review was required by its Terms of Reference to examine the methodology for deriving the price controls for group-based supports from the price controls for 1:1 supports.

CURRENT ARRANGEMENTS

NDIS price limits for group supports delivered by Disability Support Workers and their equivalents in the Assistance with Daily Life Support Category and the Assistance with Social and Community Participation Support Category vary according to the same factors as 1:1 supports (see the previous chapter) and two additional factors:

- Price limits vary according to the ratio of support workers to participants – there are different price limits for 1:2; 1:3; 1:4 and 1:5 supports; and
- Price limits also vary depending on whether the support is delivered in a centre or in the community.

The *NDIS Price Guide* currently says that:

> *Assistance to access community, social and recreational activities is often provided in a group setting, either in the community or in a centre.*
>
> - *A hierarchy of price limits applies to group based supports, based on:*
> - *the time of day that the support is delivered;*
> - *the day of week that the support is delivered;*
> - *whether the support is Standard Intensity or High Intensity (complex);*
> - *whether the provider is eligible for the Temporary Transformation Payment;*
> - *the size of the group and ratio of staff to participants; and*
> - *whether the support is provided in a Centre or in the community.*
>
> *For support ratios that are not stated in this Guide (e.g. two workers for three participants), participants and providers should discuss and agree the most appropriate line item to be used for payments, and the appropriate price to be paid (which might be lower than the price limit for that line item).*
>
> *Providers of group-based supports are not permitted to bill for non-face-to-face services as the hourly price limits for these supports include an allowance for non-face-to-face services.*

The price limit for community-based group supports apply to each hour of support and are based on the price limit of the relevant 1:1 community participation support (for each level of support and time of day and day of week). The price limit for the relevant 1:1 support is P

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

then the price limit P_n for the 1:n community based support is given by the following formulae:

$$P_n = \frac{P + (n-1) \times 0.12 \times P}{n}$$

For each additional person in the group (after the first) an additional 12% of the 1:1 price limit (essentially seven minutes) is added to the hourly price limit. This is meant to reflect the time that the provider may need to spend writing a report on each participant in the group after the group has finished or in preparing or setting up for the group session. Because of this built-in loading, providers of group based supports are not permitted to claim for non-face-to-face time. For 1:1 supports, non-face-to-face activities that are part of delivering a specific disability support to that participant (rather than a general activity such as enrolment, administration or staff rostering) are claimable against the participant's plan.

The price limit for centre-based group supports are calculated by adding a fixed capital allowance amount to the relevant community based group support. In 2019-20, the amount of the fixed capital allowance was $2.10 per participant per hour. The amount of the fixed capital allowance is indexed on 1 July each year in line with movements in the ABS Consumer Price Index.

CONSULTATIONS

The *Issues Paper* sought feedback on a number of issues with the current arrangements that had been raised by the sector.

- Some stakeholders have expressed a concern that the current price control arrangements for group-based supports provide an unintended incentive for larger groups. Other stakeholders have suggested that the "built-in" allowance for non-face to face time, while possibly appropriate for supports that are only one hour long, may not be appropriate for longer support. A provider delivering a 1:5 support to five participants for four hours, for example, is effectively paid for 5.9 hours of work, as the current arrangements assume that they will spend 28.8 minutes of non-face-to-face time for every participant in the group (after the first participant).
- An alternative approach would be for the base price for 1:n supports to be calculated as a simple proportion (1/n) of the base price of 1:1 supports but allow providers to claim for any non-face-to-face supports that they actually provided.
- Some stakeholders have also expressed concerns that the capital allowance is too small and should vary according to the quality of the infrastructure being used to deliver the services. Conversely, other stakeholders have expressed concerns that the capital allowance is too large and provides an unintended incentive for centre-based supports.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Group based rates

The *Issues Paper* asked respondents to identify the additional administrative and other tasks were involved in offering group based supports and to indicate whether those costs would be best recognised by:

- Developing a separate Disability Support Worker Cost Model for Group-Based Supports with different utilisation, supervision and overheads assumptions. If this was the preferred approach then respondents were asked to identify what different assumptions should be made with respect to these key variables and why?
- Moving to a simpler ratio-based approach to setting group-based price limits, and allowing providers to claim for non-face-to-face time.
- Maintaining the current approach, of an in-built administration time in each group support. If this was the preferred approach then respondents were asked if the amount of administration time should be fixed for each group support or be longer for longer supports?

Many submissions received did not select an individual option, but were supportive of a simpler ratio based approach to group supports and claiming non-face-to-face tasks. A few submissions mentioned the highly variable nature of some additional tasks to assist the participant and that an ability to claim for these non-face-to-face tasks would assist recouping the true costs faced by providers. There was very little support for Option C in submissions.

One provider argued that the tasks were highly variable dependent on the size of the group supported but included “tracking and reporting of attendance, time taken with paperwork associated with medication dispensing, progress noting, incident reporting / management and updating of profile information”. They argued that “administration time should be longer for those supporting complex/high support people due to additional paperwork that goes with them.”

Another respondent argued that the additional administrative tasks for group based supports stemmed from the regular duplication of work brought on by the number of participants in the group. Tasks can include (but were not limited to) communicating with all group participants and/or their families around events, activities and times; collating of activity planners; booking community venues, and so on. The amount of time this can take varies vastly from month-to-month, group-to-group, and is dependent on the number of participants per activity, compatibility, staff needs, etc. due to a varying number of complexities. The most common suggested proportion of administrative time was 10%, with other responses ranging from 7% to 25%.

There was a general concern by some responses that the nature of the price limits for increasing group ratios may lead to larger groups being prioritised. Although this is ultimately the choice of the participant, there was a sense that profit margins for bigger groups would incentivise this.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Members of the Working Group on Group Supports raised the same concerns as had been raised in submissions to the *Issues Paper*. Some requested having no fixed ratio at all to allow ultimate flexibility. Providers could then charge for the time each support took and then divide by the number of participants or by the average ratio across the time the support took. National Disability Services (NDS) suggested that the NDIS should keep both options with providers choosing which was best for them, but most providers within the working group wanted to move towards claiming for non-face-to-face time as needed separately to the direct support time.

Capital allowance

Respondents were also asked whether the current capital allowance arrangements for group-based supports were adequate. Some responses to this question suggested that current capital allowance was not adequate, as it does not reflect the asset maintenance or refurbishment costs, particularly for purpose-built facilities. One respondent provided a range of dollar values per hour to maintain their facilities, ranging below and above the NDIS capital allowance. Another submission proposed that the capital allowance was adequate for the facilities they were providing their facilities.

Members of the Working Group reported that actual centre based costs depended on ownership and capital investment, and can vary largely. One provider, with a number of centres, noted that while the average was $2.50 per participant hour, it ranged from as high as $4 down to $1.

Other issues

Several providers raised the issue of cancellations for group activities and how this may pose a greater administrative burden than with standard 1:1 supports, as it affects the way the group is structured and delivered. Moreover, some activities may be reliant on a set number of participants and any short-notice cancellations hinder the group activity going ahead. In general, providers were attracted to the “programs of support” approach (see Recommendation 3) as the best way to address this issue as it gave greater certainty to both providers and the other participants in the group.

RESEARCH

Figure 4 illustrates the trend in usage of group activities at increasingly larger ratios. Generally, after 1:3, there are relatively fewer supports claimed at the 1:4 and 1:5 level.

- The distribution of complex group activities in the in the community and in a centre reveals a standard linear decline in the demand for increasingly larger group activities. This does not support the notion that the cost model incentivises larger groups over 1:1 which was an initial concern.
- The distribution of standard group activities in a centre and in the community is slightly different, with an increased usage of 1:3 ratios. This may be reflective of the

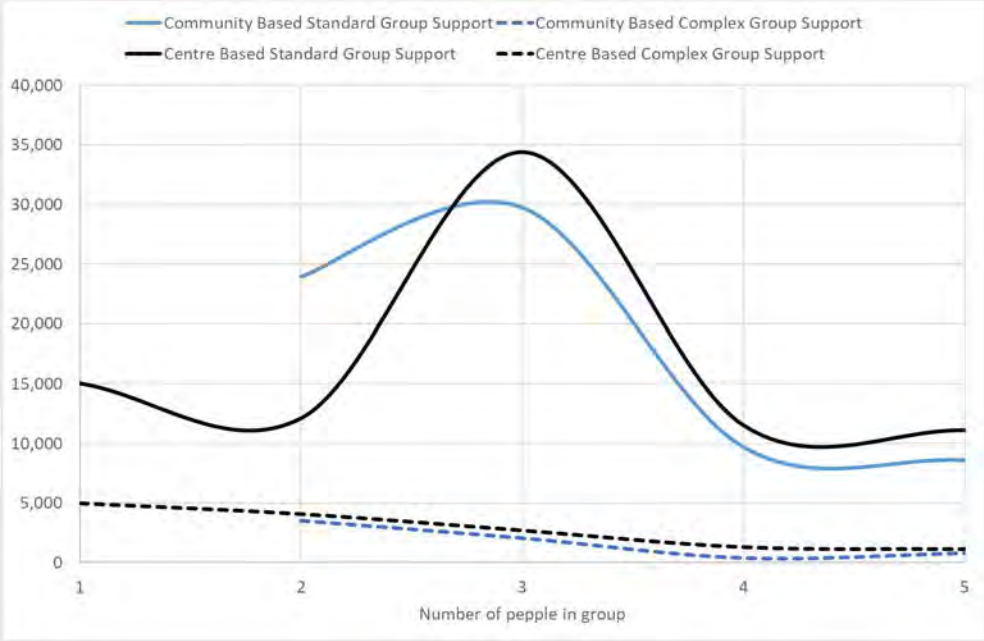
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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

preferred size of group for these type of supports and could offer support for the application of group support packages that allowed providers to provide a group based activity that over time averages out to 1:3 ratios but with the flexibility to provide at a greater or lesser ratio where cancellations or other contingencies force changes in specific situations.

Figure 4 - Claims for Group Activities



DISCUSSION

The Review considers that there is considerable merit in replacing the current group based pricing arrangements with simplified arrangements, whereby providers can claim for both direct service provision and non-face-to-face supports as they are provided. Providers would divide the number of worker hours by the number of participant hours to derive their own fractions of hours to charge participants and would claim for these hours against the 1:1 support item and subject to the standard price limit. For example, one worker to three participants for a one-hour session would be claimed as 1/3 of an hour per participant subject to the 1:1 price limit rather than as currently where the hour is claimed for each participant but subject to a reduced 1:3 price limit. Providers of centre based care would claim for the fixed capital allowance for each participant through a separate support item.

The Review notes that when this change was suggested last year the sector did not accept it. It appears, however, that the sector has become much more comfortable with the non-face-to-face claiming arrangements and can now see the opportunities that can arise from the proposed simplification. Currently there are over 220 support items for group based supports in the *NDIS Support Catalogue*. Under the proposed amendments, some 200 of these support items would no longer be needed.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

The Review does not consider that the evidence about the capital costs of centre-based care is sufficiently strong to justify a change in the amount of the fixed capital allowance, but requires further investigation.

RECOMMENDATION

RECOMMENDATION 8) Group-Based Supports

1) The NDIA should amend the pricing arrangements for group based supports so that providers no longer use the various worker to participant ratio support items but instead claim all supports against the appropriate 1:1 support items by apportioning the time spent with the group among the members of the group. Providers of centre based care would claim for the fixed capital allowance for each participant in a group through a separate support item.

2) The NDIA should also amend the pricing arrangements for group based supports so that providers can claim for non-face-to-face supports under the usual conditions, rather than having an allowance for non-face-to-face supports built into the price limit.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

5. Capacity Building Supports

The Review was required by its Terms of Reference to review the price control framework for capacity building supports, including therapy supports, by examining:

- how price limits for capacity building supports, other than therapy supports, should be indexed or otherwise determined annually;
- how price limits for therapy supports should be adjusted annually, given the outcomes of the Review of Therapy Pricing Arrangements;
- whether different price limits might be appropriate for different times of the day, or days of the week, for some capacity building supports, including for therapists, therapy assistants and for capacity building supports delivered by disability support workers; and
- whether therapists and other capacity building providers should be able to recover the costs of consumables provided to participants as part of a support.

CURRENT ARRANGEMENTS

Capacity building supports can be broadly split into two categories:

- Therapy supports, including Early Intervention Supports for Early Childhood (ECEI) supports – these supports are delivered by the following Registration Groups: Therapeutic Supports (0128); Early Intervention Supports for Early Childhood (0118); Community Nursing Care (0114); Customised Prosthetics (0135); Exercise Physiology & Personal Well-being Activities (0126); and Specialist Positive Behaviour Support (0110); and
- All other capacity-building supports.

Capacity building supports are delivered through the following support categories (for more information on each individual support category, please refer to the *NDIS Price Guide*):[37]

- Support Coordination
- Improved Living Arrangements – support to help a participant find and maintain an appropriate place to live;
- Increased Social and Community Participation – development and training to increase a participant's skills so they can participate in community, social and recreational activities;
- Finding and Keeping a Job – employment-related support, training and assessments that help a participant find and keep a job;

[37] The support items in the Improved Life Choices support category are considered in chapter 6.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- Improved Relationships – support to help a participant develop positive behaviours and interact with others;
- Improved Health and Wellbeing – including exercise or diet advice to manage the impact of the participant's disability;
- Improved Learning – including training, advice and help for the participant to move from school to further education; and
- Improved Daily Living Skills – assessment, training or therapy to help increase the participant's skills, independence and community participation.

CONSULTATIONS

The *Issues Paper* presented a number of issues with the current arrangements that had been raised by the sector, including:

- Whether the price limits for capacity building supports represent value for money for participants and allow providers to recover the costs of delivering these supports?
- Whether different price limits might be appropriate for different times of the day, or days of the week, for some capacity building supports, including for therapy assistants and capacity building supports delivered by disability support workers?
- Whether therapists and other capacity-building providers should be able to recover the costs of consumables provided to participants as part of a support? Currently, if providers of capacity building supports also want to claim for the cost of any consumables used in the delivery of the support then they are also required to register for the relevant assistive technology and equipment registration group. Some stakeholders have argued that providers of therapy and other capacity building supports should be able to recover the costs of consumables provided to the participant as part of the primary support.
- Whether the current indexation arrangements for the price limits for capacity building supports appropriately maintain their value? Currently, the price limits for capacity building supports are increased on 1 July each year in line the weighted increase over the previous twelve months in the ABS Wage Price Index and the Consumer Price Index (with an 80/20 weighting).

The most common concern raised by providers was that there was a lack of alignment between the price limits for core and capacity building supports, where those supports were delivered by Disability Support workers. It was noted that the employer does not differentiate when paying the support worker regardless of the support delivered. The support line items 15_035_0106_1_3 (Assistance with decision making, daily planning and budgeting) and 15_037_0117_1_3 (Individual training in the home for general life skills to increase independence) were raised in several submissions.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Respondents also suggested that the introduction of intensity levels and the TTP for core supports should be considered for capacity-building supports. One respondent suggested that some capacity-building supports require similar levels of competency to Level 2 and 3 core supports.

A few respondents asked for support coordination price limits to be aligned to therapy price limits, as allied health professionals can also perform this role.

Some respondents also argued that the NDIA should consider introducing out-of-hours price limits for some capacity building supports in line with the arrangements for core supports. Some considered these supports unviable other than during weekday business hours because of the current arrangements and do not offer services outside of those times. There was a concern that this might reduce participant choice. Conversely, other respondents raised the concern that introducing differing rates would add complexity to pricing arrangements.

A significant number of respondents argued that consumables should be claimable by capacity building providers where the provider may also provide the consumable. There was, however, a wide variety of suggestions in how to achieve this. Suggestions included:

- Claim under the Quality and Safeguard Commissions guidelines;
- If the consumable is under a set monetary level, then it could be claimable by the provider;
- A separate consumables NDIS plan budget that providers could claim from; or
- Capacity building budgets should include both support and relevant consumables.

Several members of the Working Group for Capacity Building Supports commented that therapists in some similar schemes, workers' compensation schemes and traffic accident compensation schemes, were allowed to claim for consumables up to a small dollar amount, usually up to $200.

The majority of respondents suggested that the current indexation was inadequate in maintaining the value of capacity building price limits, particularly relative to the inflation applied to core supports. There was a variety of suggestions on the appropriate indexation method to apply. Several suggested adopting the same procedure that is done with core supports due to crossover in the workers used who are affected by the Fair Work Commission's minimum wage decisions and the increases built into the SCHADS Award

Another submission suggested linking inflationary indexation to the most appropriate industry rather than the general economy.

Several respondents requested that providers of Capacity Building Increased Community Participation Supports should be able to claim for non-face-to-face time and report writing, with the former claimable for similar supports under core (although comparable core group supports currently have non-face-to-face time inclusive in the price limit).

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Exercise and Sports Science Australia raised two issues with the current price control arrangements for exercise physiology:

- the hourly price limit for exercise physiology in the NDIS ($166.99 between 1 July 2019 and 24 March 2020) is lower than the price limit for other therapy services in the NDIS (from $193.99 for Other Therapy Services to $243.83 for psychological services); and
- unlike other therapies funded by the NDIS, exercise physiology is not, in general GST-free, as it is not one of the listed 'other health services' that can be GST-free in its own right under section 38-10 of the *A New Tax System (Goods and Services Tax) Act 1999*.

RESEARCH

Capacity Building Supports Delivered by Disability Support Workers

The Table below identifies the 15 Capacity Building supports that the Review has identified as likely to be delivered by Disability Support Workers employed under the SCHADS Award or a similar industrial agreement.

Table 7 - Capacity Building Supports That May Be Delivered By Disability Support Workers

Support Item Number	Support Item Name	Support Item Description
07_001_0106_8_3	Level 1: Support Connection	Assistance for participants to implement their plan by strengthening the ability to connect with the broader systems of supports and understand the purpose of the funded supports and participate in the community. Support Connection will assist a participant to understand the aspects of the plan, assisting in ongoing management of supports, and answer questions as they arise.
07_002_0106_8_3	Level 2: Coordination Of Supports	Further qualifications/experience required to strengthen a participant's ability to design and the build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment. Coordination of Supports is to focus on supporting participants to direct their lives, not just their services. This may include resolving points of crisis, and developing resilience in the participant's network.
07_003_0117_8_3	Capacity Building and Training in Plan and Financial Management by a Support Coordinator	Capacity building and training in plan administration and management with a participant to strengthen their ability to undertake tasks associated with the management of their supports. Providers of this support are to assist the participant to build capacity to undertake all aspects of plan administration and management, including: engaging providers; developing service agreements; maintaining records; claiming payments from the NDIA; and paying providers.
08_005_0106_2_3	Assistance With Accommodation And Tenancy Obligations	Support is provided to guide, prompt or undertake activities to ensure the participant obtains and/or retains appropriate accommodation. May include assisting to apply for a rental tenancy or to undertake tenancy obligations.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Support Item Number	Support Item Name	Support Item Description
09_006_0106_6_3	Life Transition Planning Incl. Mentoring, Peer-Support And Individual Skill Develop	Establishing volunteer assistance within the participant's home or community to develop skills. For instance, assistance in attending appointments, shopping, bill paying, taking part in social activities and maintaining contact with others.
09_007_0117_6_3	Skills Development In A Group	Training for the participant in a group of 2 or more to increase their independence in daily personal activities.
09_009_0117_6_3	Individual Skills Development And Training	Individual life skills development and training including public transport training and support, developing skills for community, social and recreational participation.
10_016_0102_5_3	Individual Employment Support	This support can be applied to any working age participant (including students reaching working age) with an employment goal. This may include supports to: • explore what work would mean for them (discovery) • build essential foundation skills for work • managing complex barriers to obtaining and sustaining employment • specialised job customisation • supports to transition from an ADE to open employment. • develop a career plan • other capacity building supports which are likely to lead to successful engagement in a DES.
10_017_0102_5_3	Employment Preparation And Support In A Group - Group Of 3	
11_024_0117_7_3	Individual Social Skills Development	Social skills development with an individual, for participation in community and social activities.
13_030_0102_4_3	Transition Through School And To Further Education	Provision of skills training, advice, assistance with arrangements and orientation to assist a person with disability moving from school to further education.
14_031_0127_8_3	Capacity Building and Training in Plan and Financial Management by a Plan Manager	Capacity building and training in plan administration and management with a participant to strengthen their ability to undertake tasks associated with the management of their supports. Providers of this support are to assist the participant to build capacity to undertake all aspects of plan administration and management, including: engaging providers; developing service agreements; maintaining records; claiming payments from the NDIA; and paying providers.
15_035_0106_1_3	Assistance With Decision Making, Daily Planning and Budgeting	Provision of time limited support to assist a person to develop and maintain daily budget, including assisting in planning purchases (including COVID19 loading).
15_037_0117_1_3	Individual Skill Development And Training Including Public Transport Training	Individual training provided in the home for general life skills to increase independence.
15_038_0117_1_3	Training For Carers/Parents	Training for carers in matters related to caring for a person with disability.

Consumables

Some comparable schemes allow therapists to claim for the costs of consumables in some cases. Others do not. For example, Worksafe Victoria and the Transport Accident Commission Victoria consider that the hourly rate of Community Nursing includes travel and consumables. WorkSafe Victoria for example says that:

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

The Agent expects that health professionals will not invoice for consumables (i.e. tape, ultrasound gel, dry needles, wax therapy) used as a part of in-rooms treatment - the approved items are intended to be supplied for the worker to take home to assist with the management of their work-related injury or illness.[38]

Conversely, Workcover Queensland permits allied health professionals to claim the following expenses, on top of the fee for service: reasonable charges for incidental items the worker takes with them up to $57 per claim without prior approval; reasonable charges for supportive devices up to $199 per claim without prior approval; and hire equipment to be negotiated prior.[39]

- Items that considered to be reasonable incidental expenses by Workcover Queensland are those that the worker actually takes with them – including bandages, elastic stockings, tape, crutches, theraputty, theraband, grippers, hand weights, audio tapes/CD, education booklets, and disposable wound management kits. Tape may only be charged where a significant quantity is used. Items considered reasonable supportive device expenses must be shown to be necessary items for successful treatment of the compensable injury.
- Workcover Queensland will not pay for: items regarded as consumables used during the course of treatment – including towels, pillowcases, antiseptics, gels, tissues, disposable electrodes, bradflex tubing, and small non-slip matting; and for items/procedures that are undertaken in the course of normally doing business – including autoclaving/sterilisation of equipment, and laundry.

DISCUSSION

Price regulation

The *Review of NDIS Therapy Pricing Arrangements* (the Therapy Review), which reported in 2019, found that the NDIS accounts for an estimated 2.4% of Australia's established national therapy market, suggesting that it has limited capacity to influence market prices for therapy services and is instead a "price taker". The Therapy Review also found that while there are early signs of some competition in the NDIS market for therapy services, around 70% of claims continued to be made at the price cap. It found that the distribution of claims also remains significantly different from the private market distribution. On the basis of the evidence on market conditions and the sector consultations and benchmarking analysis outlined above, and in line with the principles of the *National Disability Insurance Scheme Act 2013*, including that a funded support must represent "value for money in that the costs of the support are reasonable, relative to both the benefits achieved and the cost of alternative support", the Therapy Review recommended that the NDIA should maintain price

[38] https://www.worksafe.vic.gov.au/equipment-and-related-services-policy

[39] https://www.worksafe.qld.gov.au/__data/assets/excel_doc/0008/178091/AlliedHealth-TOC-Item-Numbers-1-Jul-2019.xls

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

caps on therapy services at least until the transition to the NDIS is complete and there is evidence that the distribution of NDIS payment claims is broadly in line with the distribution of prices observed in the private billing market. The current Annual Pricing Review agrees with the conclusions of the Therapy Review.

The current Annual Pricing Review is however concerned that there is some evidence that the NDIS price limits for therapy service may be distorting the market for therapy services. Table 8 compares the NDIS price limits with the fees paid by comparable schemes for occupational therapy, physiotherapy, psychology, speech pathology and exercise physiology.

Table 8 - NDIS Therapy Price Limit Comparison with Other Schemes, Hourly Rates

		Occupational Therapy	Physio-therapy	Psychology	Speech Pathology	Exercise Physiology**
	NDIS (ACT/NSW/QLD/VIC)	**$193.99**	**$193.99**	**$214.41**	**$193.99**	**$166.99**
	NDIS (NT/SA/TAS/WA)	**$193.99**	**$224.62**	**$234.83**	**$193.99**	**$166.99**
NSW	State Insurance Regulatory Authority	-	$196.80	$195.60	-	$157.20
VIC	Transport Accident Commission	$106.47	$122.29	$166.12	$96.90	$97.37
VIC	Worksafe Victoria	*$107.25	*$128.29	$170.76	$97.07	$110.23
QLD	WorkCover Queensland	$183.00	$183.00	$183.00	$183.00	$183.00
SA	Return to Work South Australia	$185.40	$185.40	$185.40	$185.40	$147.00
WA	WorkCover Western Australia	$198.20	$200.25	$253.70	*$139.35	$200.25
TAS	Comcare	-	*$205.80	*$242.50	-	-
ACT	Comcare	-	*$191.12	*$242.50	-	-
NT	Comcare	-	$181.98	*$242.50	-	-
	Department of Veterans Affairs	$89.70 per consultation	$65.30 per consultation	$104.60 per consultation	$109.20	$65.30 per consultation
	Medicare Benefits Schedule*** (consultation > 20 minutes)	$63.25 per consultation	$63.25 per consultation	$63.25 per consultation	$63.25 per consultation	$63.25 per consultation

NOTES: Current hourly maximum rates as published excluding temporary measures (NDIS – COVID 10% increase).
* Hourly rates estimated where consultation rates stated in fee schedule.
**Rates for other schemes are the GST exclusive rate; rates for the NDIS are the GST inclusive rate.
*** Medicare Benefits Schedule Fee for Allied Health Services for Chronic Disease Management

In brief:

- The NDIS price limits for New South Wales are on par with the fees published by the State Insurance Regulatory Authority for physiotherapy and exercise physiology (adjusting for GST) but are higher for psychology.
- The NDIS price limits for Victoria are much higher (62.0% on average) than those of the two Victoria schemes across all of the allied health disciplines.
- The NDIS price limits for Queensland are slightly higher (8.8% on average) than those of WorkCover Queensland across all of the allied health disciplines except exercise physiology, where the WorkCover Queensland rate is 20.5% higher than the NDIS rate (adjusted for GST).
- The NDIS price limits for South Australia are all higher (12.1% on average) than those of Return to Work South Australia across all of the allied health disciplines.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- The NDIS price limits for Western Australia are higher (25.7 % on average) than those for WorkCover Western Australia for physiotherapy and speech pathology; and lower (11.3% on average) for occupational therapy, psychology and exercise physiology (adjusted for GST).

These differences warrant further investigation. It can, however, be very difficult to compare NDIS price limits with the fees payable in other Schemes as those fees are not always expressed as hourly rates and there may be other payments also made to providers. The complexity of the different arrangements for physiotherapy, as an example, is as follows:

- NDIS – The hourly rate is $193.99 in ACT/NSW/QLD/VIC and $224.62 per hour in NT/SA/TAS/WA. Providers can also claim for the time that they spend travelling at the hourly rate, up to certain limits. They cannot, however, seek separate reimbursement of any non-labour costs associated with their travel.
- State Insurance Regulatory Authority New South Wales – The regulated fee is $83.30 for a standard consultation and treatment; $125.50 for a consultation and treatment of two distinct areas; and $166.30 for complex treatment. An hourly rate of $196.80 is also published. A higher fee (19% higher on average) is claimable for each consultation performed out of rooms to cover travel costs. In addition, providers can claim $0.68 per kilometre for travel.
- Victorian Transport Accident Commission – The fees payable for consultations performed in the clinician's rooms are $55.63 for each standard consultation; $69.59 for extended consultations (between 31 and 40 minutes of direct patient contact time); and $111.16 for extended consultations (greater than 40 minutes of direct patient contact time). An hourly rate of $122.29 is also published. A higher fee (50% higher) is claimable for consultations performed out of rooms to cover travel costs.
- Worksafe Victoria – The fees payable are $58.33 for a Standard Consultation; and $116.67 for a Restricted Consultation (History, examination and complex treatment for workers with specific injuries based on prior approval). In addition, providers can claim $2.72 per kilometre for travel in Melbourne and $1.84 per kilometre for travel in regional and rural areas.
- Workcover Queensland – The fees payable are $58.00 for a Level A Consultation; $77.00 for a Level B Consultation; $111.00 for a Level C Consultation; and $147.00 for a Level D Consultation. An hourly rate of $183.00 is also published. Time spent travelling can also be claimed at a lower rate of $134.00 per hour.
- Workcover Western Australia – The fees payable are $70.55 for a standard consultation and treatment; and $89.15 for the treatment of two distinct areas. An hourly rate of $200.25 is also published. Time spent travelling can also be claimed at a lower rate of $160.30 per hour.
- Return to Work South Australia – The fees payable are $68.00 for a standard consultation and treatment; $92.90 for a long consultation; and $185.40 for a

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

restricted consultation. An hourly rate of $185.40 is also published. Time spent travelling can also be claimed at a lower rate of $157.40 per hour.

- Comcare (Tasmania) – The guidance on the upper limit of fees is $68.35 for a standard consultation and treatment; $102.55 for the treatment of two distinct areas; and $170.90 for complex treatment requiring more than 45 minutes direct contact.
- Comcare (ACT) – The guidance on the upper limit of fees is $80.46 for a standard consultation and treatment; $120.24 for a consultation and treatment of two distinct areas; and $159.27 for complex treatment.
- Comcare (Northern Territory) – The guidance on the upper limit of fees is $181.98 per hour for standard level 1 complex services and $227.49 per hour for standard level 2 complex services.
- Department of Veterans Affairs – The fee payable is $65.30 per consultation.
- Medicare Benefits Schedule – The Scheduled Fee is $63.25 per consultation.

The Review therefore considers that a comprehensive of therapy pricing should be undertaken as part of the 2021-22 Annual Pricing Review and every two years thereafter. The proposed comprehensive review of therapy pricing should also give further consideration to the question of whether different support items (and price limits) need to be created to encourage the delivery of therapy supports outside of usual business hours, with a particular focus on the impacts that the current arrangements have on best practice delivery, especially for Early Childhood Early Intervention supports. The current Review received mixed evidence on this issue and does not consider that it can be resolved in isolation from an analysis of the entire billing practices of other schemes. The Review notes, for example, that most other schemes do not include different payment rates for out of business hours consultations, but structure their billing arrangements around the complexity of the consultation (say 30-60 minutes) rather than the precise duration. The Review also notes that some other schemes pay a lower hourly rate for travel than they pay for direct service provision.

The Review also considers, given the disparity between NDIS price limits and the rates payable in other schemes, that therapy price limits should not be indexed this financial year, noting that they have been increased by the temporary 10% COVID-19 Loading and that no evidence was submitted to the Review of supply shortages in therapy services.

Capacity Building Supports Delivered by Disability Support Workers

Currently, the price limits for capacity building supports are indexed on 1 July each year by the 80/20 weighted average of the movements in the ABS Wage Price Index and the ABS Consumer Price Index over the 12 months to the March Quarter preceding the indexation date. However, as discussed above, 15 Capacity Building supports are delivered by workers employed under the SCHADS Award or a similar industrial agreement. These workers are subject to the Fair Work Commission's increase to minimum wage that occurs every year,

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

which is included in the current methodology for applicable core supports. The Review considers that it would therefore be more appropriate for the price limits of these supports to be set by the Disability Support Worker Cost Model.

Consumables

In understanding the issue of consumables, the Review considers that it is important to distinguish between "tools of the trade" of the therapist and consumables used in the treatment of the specific participant. The Review understands that consumables that are provided to the participant are, in general, claimable against the participant's NDIS plan. The Review considers that tools of the trade are already accounted for within the price limits for therapy support items. The Review notes, for example, that the NDIS Nursing Cost Model includes an overheads provision of 20%.

Exercise Physiology

The Review notes that the NDIS current price limit for Exercise Physiology is higher than the average current rate payable by most comparable schemes (see Table 8 above) even accounting for GST. The Review also notes that the price limit for Exercise Physiology was increased by 12.3% between 1 July 2018 and 1 July 2019 in recognition of the fact that Exercise Physiology was not, in general, GST free. The Review does not therefore consider that there is any need for a further increase in the price limit for Exercise Physiology at this time. Whether or not Exercise Physiology services supplied to NDIS participants should be GST-free is a matter for Government and not within the scope of the Annual Pricing Review.

RECOMMENDATION

RECOMMENDATION 9) Capacity Building Supports

1) The NDIA should undertake a comprehensive review of therapy pricing arrangements as a part of the Annual Pricing Review every two years, with the next comprehensive review to commence in July 2021. Pending the outcomes of that review:
    i) the NDIA should not index the price limits for therapy supports on 1 July 2020; and
    ii) the NDIA should index the price limits for therapy supports on 1 July 2021 in accordance with the indexation methodology set out in Recommendation 2.1(iii).
2) The NDIA should index the price limits for capacity building supports that are delivered by Disability Support Workers by reference to the NDIS Disability Support Worker Cost Model.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

6. Plan Management Supports

The Review was required by its Terms of Reference to examine the price control framework for plan management supports.

CURRENT ARRANGEMENTS

NDIS participants can choose to have a registered Plan Management provider to manage their funding and budget for the supports in their plan. Plan Managers are bound to the *NDIS Price Guide* and are able to connect participants with both NDIS registered providers and providers that are not registered with the NDIS.

The *NDIS Price Guide* currently says that:

> ***Plan Management – Financial Administration***
>
> *Plan Management – Financial Administration funding applies to registered providers who undertake financial administration of a plan on behalf of a participant.*
>
> *Plan Management – Financial Administration funding includes a setup fee to establish the payment arrangements with providers and a monthly processing fee. This support assists a participant by:*
>
> - *Giving increased control over plan implementation and utilisation with plan financial assistance;*
> - *Managing and monitoring budgets over the course of the plan;*
> - *Managing NDIS claims and paying providers for delivered service;*
> - *Maintaining records and producing regular (at least monthly) statements showing the financial position of the plan; and*
> - *Providing access to a wider range of service providers, including non-registered providers whilst remaining in line with the price limits contained within this Guide.*
>
> *A Plan Management – Financial Administration provider will possess bookkeeping / accounting skills and qualifications. They will have systems in place for efficiently processing payments on behalf of a participant.*
>
> ***Capacity Building and Training in Plan and Financial Management by a Plan Manager***
>
> *This reasonable and necessary support focusses on strengthening the participant's ability to undertake tasks associated with the management of their supports. This includes:*
>
> - *Building financial skills*
> - *Organisational skills*
> - *Enhancing the participant's ability to direct their supports*
> - *Develop self-management capabilities*

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Plan and Financial Capacity Building providers are expected to assist the participant to develop their skills for self-management in future plans, where this is possible. As a part of this capacity building support, providers are to assist the participant to build capacity in the overall management of the plan including engaging providers, developing service agreements, paying providers and claiming payment from the NDIA and maintain records.

Plan managers are currently able to claim for three types of services. These are:

- A one-off (per plan) Establishment Fee for setting up of the financial management arrangements for managing of funding of supports – support item 14_033_0127_8_3, with a current price limit of $227.53;
- A monthly fee for the ongoing maintenance of the financial management arrangements for managing of funding of supports – support item 14_034_0127_8_3 with a current price limit of $102.28; and
- Capacity building and training in plan administration and management with a participant to strengthen their ability to undertake tasks associated with the management of their supports – support item 14_031_0127_8_3 with a current price limit of $60.16 per hour.

The price limits for capacity building supports are increased on 1 July each year in line the weighted increase over the previous twelve months in the ABS Wage Price Index and the ABS Consumer Price Index (with an 80/20 weighting).

With respect to the capacity building support item, plan managers are not permitted to claim for provider travel, non-face-to-face activities and NDIA reports. They are permitted to claim for short notice cancellations.

In 2018-19, claims for plan management supports totalled $86 million. There are currently 809 active registered providers offering plan management services – 7% percent of all NDIS registered providers. Some 33% of NDIS participants (101,119) have their funds managed by a plan manager, with total managed funds totalling approximately $5.5 billion.

CONSULTATIONS

The *Issues Paper* presented a number of issues with the current arrangements that had been raised by the sector, including:

- Whether the price limit for the Establishment Fee is reasonable, and whether more than one plan manager should be able to claim for an Establishment Fee if a participant changes plan managers?
- Whether the price limit for the monthly fee for the ongoing maintenance of the financial management arrangements is reasonable?
- Whether the hourly price limit for capacity building and training in plan administration and management is reasonable?

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- Whether the current indexation arrangements for the price limits for plan management supports appropriately maintain their value?
- Whether plan managers should be able to claim for provider travel and non-face-to-face activities with respect to support item 14_031_0127_8_3, with the agreement of the participant?

In consultations and in the Working Group on Plan Management, providers stated that the role of plan managers had changed from simple bookkeeping to much more like support coordination. They said that a major reason for the rapid growth in plan management was that many participants do not have support coordination and Plan Managers are filling this role – for much less money. Additionally, they stated that many Local Area Coordinators are not providing the level of support required either, adding to demands on plan managers.

Some members of the Working Group on Plan Management felt that the ultimate goal of plan management should be to get as many participants self-managing as possible, agreeing with the Tune Review. Others however commented that many participants did not want to become self-managing – or could not – but were using plan managers for flexibility. All agreed that few of their clients had transitioned to self-management.

Establishment Fee

The majority of submissions commented that the plan management Establishment Fee arrangements appeared inadequate in some form, though suggested remedies varied. These included:

- A second Establishment Fee should be claimable if participants change plan managers, and this should be limited to two changes per year;
- Establishment fee costs could be inclusive in the monthly fee; and
- A suggested price limit increase to $350.

Some respondents suggested that current Establishment Fees were adequate for basic establishment such as the initial meeting and entering related participant information into databases. Many respondents suggested that the current fee doesn't take into account other tasks required, including payroll services, sourcing information from planners and support coordinators, assisting participants understand their NDIS plans and plan management and setting up service agreements, service bookings and IT systems.

A few respondents suggested that the current Establishment Fee does not account for complex plans, longer duration plans or new participants, suggesting a tiered structure based on complexity and budget size.

Members of the Working Group on Plan Management argued that Establishment Fees should be higher for participants who do not have a support coordinator, or for where travel is required for a first face to face meeting.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Monthly fee

Respondents generally suggested that the current monthly fee was not sufficient, and claimed that they provided a range of services that cannot be recovered within the existing price limit. The main concern raised within submissions is that the time spent with participants seemed to be the largest contributor to costs, with one submission commenting that labour costs were 70% of their total costs.

Services and costs mentioned by respondents included:

- updating service bookings;
- providing advice, guidance and consultation;
- providing participants with a summary of plan budgets;
- presenting invoices to NDIS systems;
- remitting payments to providers;
- reconciling payments monthly;
- providing participants with invoices;
- ongoing monthly IT system costs; and
- software updates.

Members of the Working Group on Plan Management argued that the current monthly fee was not adequate for the role that Plan Managers sometimes play, including; acting as lawyers to interpret the NDIA legislation, particularly section 34; correcting invoices; and teaching people how to read the *NDIS Price Guide* and create correct invoices.

Several submissions commented that time costs are relative to the number of invoices processed for any one participant, ranging from small numbers to up to 50 invoices for processing per month. One respondent suggested that, on average, updating service bookings alone represented a cost of $7.21 per month per participant to them. Another respondent suggested that 10 hours of work per month was required for participants with higher support needs.

Most submissions commented that a fee based on the number of transactions was a better pricing structure than the fixed monthly fee. Several submissions suggested that a tiered-fee structure based on the complexity of a participant's support needs could be introduced – to be determined by the Agency so as to capture the majority of complex plans.

Some respondents preferred a transaction-based approach to a total plan value-based approach, with one submission suggesting a 20% loading for plans over $100,000 and increasing by 20% per $100,000 to a cap to reflect the potential complexity and transactions.

There was also a combined solution put forth for both a monthly fixed fee plus additional fees based on the value of the plan, number of transactions or number of providers.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Conversely, there was also opposition to the transaction-based approach with several submissions asking to keep the current fee structure in place. These submissions noted that changes may add further administration time and complexity to services; the costs of monitoring transactions need to be considered; and it may adversely affect participants.

Members of the Working Group on Plan Management also discussed whether a flat rate was the best approach for fees, or whether fees should be proportional to plan budgets or participant complexity. Some members argued fees should be proportional to plan budgets, as participants with big plans take more time to manage. Conversely, some argued that plans could be over a million dollars, but still very simple if it is mostly assistive technology.

Hourly Fee

The majority of respondents requested for a higher price limit for the capacity building and training in plan administration and management support item. Comments included that the current rate is only slightly higher than a Disability Support Worker hourly price limit, however the qualifications required for this support were considerably higher than for a Disability Support Worker. It was noted by one respondent that their average wage rate for a bookkeeper was $30 per hour. Their average service charge was approximately $70 per hour, with some services over $100 per hour.

Indexation

Many respondents commented that indexation for plan management supports was too low, despite having the same inflationary percentage adjustment as other capacity building supports. Some responses compared the dollar value changes to other capacity building and core supports. One submission suggested that the Fair Work Commission's minimum wage decision adjustment be applied to plan management supports. Providers who attended the Working Group on Plan Management agreed that plan management fees should be indexed by CPI.

Non-face-to-face services

The majority of submissions received suggested that plan management providers should be able to claim for provider travel. Several respondents commented that travel arrangements should be the same as support coordinators, noting that travel time is a cost to deliver support. It was also proposed by some submissions that this change would encourage plan managers to provide more face-to-face services to participants. It was also mentioned that participants might expect training to occur on their own computer, which may not be replicated in an office, and that plan managers should have the option to work alongside a participant.

One submission commented that plan management providers should not be able to claim for provider travel as the majority of tasks do not require face-to-face interactions.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Many submissions from plan management providers suggested that they should be able to claim for non-face-to-face supports when providing capacity building and training in plan administration and management supports, including for:

- the creation of personalised resources, templates and tools;
- developing budgets or forecasts;
- providing clarifications and explanation on budgets and spends over the phone; and
- creating training videos specific to the participants needs.

Other issues

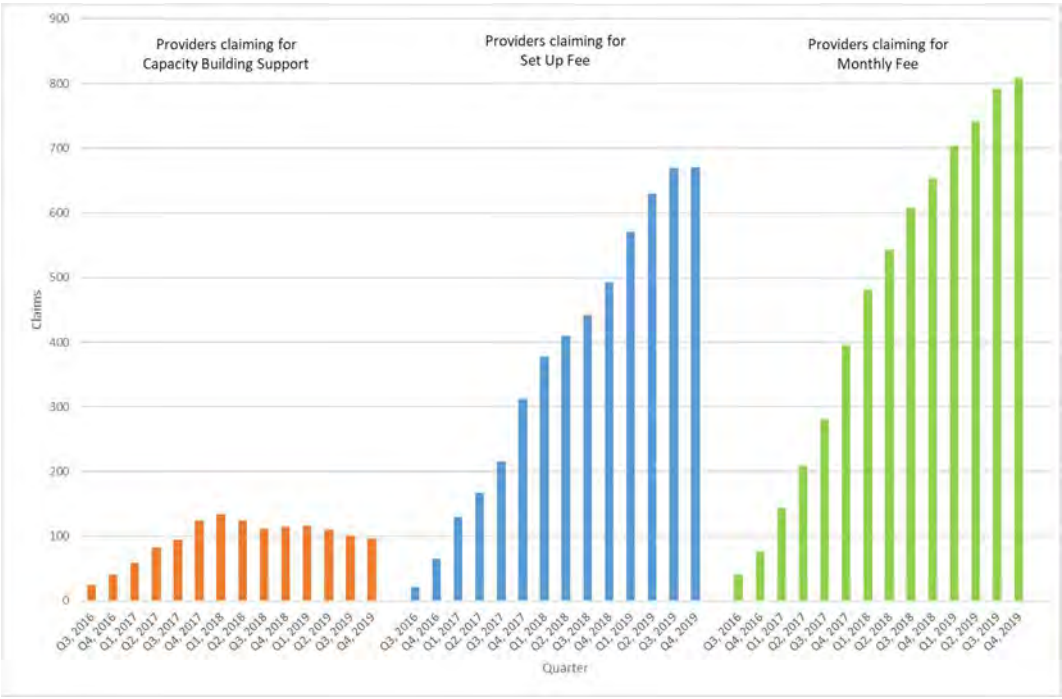
Other issues raised by respondents on plan management supports included:

- Payment portal functionality;
- Difficulties updating service bookings when required;
- More clarification required on the role of the plan manager; and
- Guidelines for supports and what they encompass.

DISCUSSION

There is little evidence that current price limits for plan management are inadequate. The number of NDIS registered providers offering plan management services increased from less than 50 to just over 800 between 2016 and 2019 (see Figure 5). However, the number of providers offering capacity building supports has not grown significantly over that period.

Figure 5 - Number of Providers Claiming per Quarter from 2016 to 2019



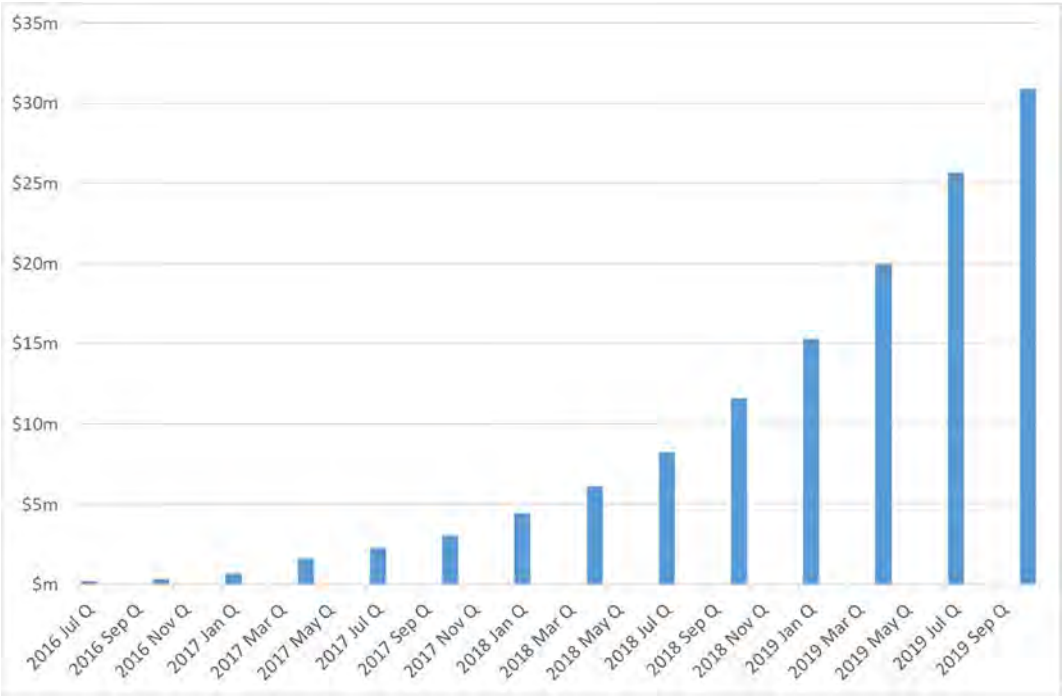
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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

The NDIS revenue earned by plan managers from the monthly account fee has also grown significantly, in line with the growth of the Scheme (see Figure 6).

Figure 6 - NDIS Revenue Claimed by Plan Managers from Monthly Fees, by Quarter, 2019-2019



The scale of plan management organisations is also growing with the average number of participants per plan management organisation increasing from 41 in September 2016, to 204 in September 2019. The largest five plan management providers now service approximately 30% of the market. Four of these five providers were established in the last 48 months.

Few plan management providers have exited the market and early research indicates that those who have exited may not have had the growth required to operate at sustainable margins. Most providers that have exited made a total of less than 24 claims over their lifetime of up to 3.5 years.

Another perspective on the adequacy of the current price limits can be gained from an analysis of Googles Ads. An analysis by the Review of Google Ads data showed a cost per click of $6.32, with 201,000 searches for plan management per month. There are over 8 search engine pages with businesses offering plan management services. The amount of online advertising indicates a high level of competition. The cost per click of $6.32 indicating a willingness of providers to pay for new customers of $63.20 based on a 20% click to call conversion rate, and 50% call to booking conversion rate.

There are some early signs of innovation in the plan management industry. Examples include allowing instantaneous payment to providers at the point of service for some therapy supports, and integrated mobile applications allowing participants to easily access information on their supports.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Early findings indicate that most Plan Managers are likely to charge the price limit for services, despite increased competition. There are few incentives for participants to consider price when choosing a plan management provider, as plan management services are added on top of the participant's typical support package, and are stated.

On balance, the Review concludes that there is no evidence of a gap in supply for plan management services. Competition is strong with new competitors entering the market, there is also strong growth in the sector both in terms of revenue and customer numbers. There also see early signs of innovation. The current flat fee structure is simple, has been iterated over time from less successful arrangements including quoting, and has been implemented on a national scale. A flat fee structure (as opposed to hourly rate) is appropriate for financial administration tasks as it can encourage efficiency.

There is some evidence that the *capacity building and training in plan administration and management* support item may not be functioning as intended. There are strong arguments why providers should be able to claim for non-face-to-face time and provider travel for this support item. The argument for an increase in the price limit for this item is less strong, given that it is already higher than the standard Disability Support Worker price limit and is aligned with the Level 1: Support Connection price limit.

RECOMMENDATION

RECOMMENDATION 10) Plan Management

The NDIA should amend the conditions attached to the support items:

i) 07_003_0117_8_3 (Capacity Building and Training in Plan and Financial Management by a Support Coordinator); and

ii) 14_031_0127_8_3 (Capacity Building and Training in Plan and Financial Management by a Plan Manager)

In the *NDIS Support Catalogue* so that providers can claim for provider travel and non-face-to-face supports with respect to these supports.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

7. Classifying Regional, Remote and Very Remote

The Review was required by its Terms of Reference to examine the geographic classification component of the NDIS price control framework to examine whether modifications are required to the NDIA's implementation of the Modified Monash Model (MMM) to account for specific disability service-related costs, including the treatment of "isolated locations" and islands under the MMM.

CURRENT ARRANGEMENTS

The NDIA uses the 2015 version of the Modified Monash Model (MMM2015) to determine regional, remote and very remote areas. The MMM geographic classification of a locality is principally based with the distance from that locality to the nearest population centre and the size of that population centre (see Table 9).

Table 9 – Definitions of the Modified Monash Model Geographic Areas

Description	Zones	MMM	Inclusion
Metropolitan	MMM1	1	All areas categorised as Major Cities of Australia.
Regional Centres	MMM2-3	2	Areas categorised as Inner Regional Australia or Outer Regional Australia that are in, or within 20km road distance, of a town with population >50,000.
Regional Centres	MMM2-3	3	Areas categorised as Inner Regional Australia or Outer Regional Australia that are not in MMM 2 and are in, or within 15km road distance, of a town with population between 15,000 and 50,000.
Regional Areas	MMM4-5	4	Areas categorised as Inner Regional Australia or Outer Regional Australia that are not in MMM 2 or MMM 3, and are in, or within 10km road distance, of a town with population between 5,000 and 15,000.
Regional Areas	MMM4-5	5	All other areas in Inner Regional Australia or Outer Regional Australia.
Remote	MMM6	6	All areas categorised Remote Australia that are not on a populated island that is separated from the mainland and is more than 5km offshore.
Very Remote	MMM7	7	All other areas – that being Very Remote Australia and areas on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.

The MMM rating of a location can be determined using the Health Workforce Locator tool on the Department of Health's website.[40]

In general, price limits are 40% higher in remote areas and 50% higher in very remote areas. There is no additional loading applied for supports in metropolitan areas, regional centres or regional areas.

Price limits are based on where the support is delivered, which is not necessarily where the participant lives. For example, if a participant living in a remote location visits a therapist in

[40] https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator/health-workforce-locator#hwc-map

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

their capital city, the therapist should not attempt to claim a price that is higher than the price limit for the support in that city. On the other hand, if the therapist was to visit the participant in their local area to deliver the support, then the therapist could claim a price that is within the 'remote' price limit.

The NDIS Review of the WA Market found that the cost of service delivery in isolated centres – centres that are currently not classified as remote or very remote by the MMM but that are completely surrounded by remote or very remote areas – were, in general, higher than in other non-remote areas.[41] As a consequence, from1 August 2019, the NDIA has modified the MMM so that areas (or groups of areas) that are currently not classified as remote or very remote by the MMM but that are completely surrounded by remote or very remote areas ("Isolated towns") are classified as remote areas for planning and pricing purposes.

A new version of the Modified Monash Model (MMM2019) based on the results of the most recent census is now available. From 1 January 2020, programs in the Australian Department of Health will transition to the MMM2019 classification system.

A number of locations have different MMM classifications under the MMM2015 and the MMM2019 systems. This is because some labour supply centres have changed size, and so areas are now closer to or further from the nearest labour supply centre of a given size. Further, islands which are less than five kilometres offshore, but not connected to the mainland by a bridge, and that have a population of less than 1,000 are classified as at least MMM6 under the new MMM2019.

The following Table provides details of the Urban Centres and Localities that will change classification between MMM2015 and MMM2019 to such an extent that the loading that the NDIS applies for planning and price control purposes will be affected. Note, however, that some of these locations (Cardwell, Duaringa and Leeton) would be eligible to be classified as remote under the NDIS isolated town policy.

Table 10 – Regions where Price Limits change between MMM2015 and MMM2019

State	Urban Centres and Localities	MMM2015	MMM2019	MMM2015 Loading	MMM2019 Loading	MMM2019 Loading (Isolated Towns)
NSW	Bourke	7	6	50%	40%	40%
NSW	Cobar	7	6	50%	40%	40%
NSW	Dangar Island	5	6	0%	40%	40%
Vic	Hopetoun	6	5	40%	0%	0%
Qld	Arcadia Bay, Magnetic Island	7	5	50%	0%	0%
Qld	Cardwell	6	5	40%	0%	40%
Qld	Coochiemudlo Island	5	6	0%	40%	40%
Qld	Duaringa	6	5	40%	0%	40%
Qld	Dunwich	5	6	0%	40%	40%

[41] NDIA. (2019). *NDIS WA Market Review Final Report*. https://www.ndis.gov.au/media/1661/download

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

State	Urban Centres and Localities	MMM2015	MMM2019	MMM2015 Loading	MMM2019 Loading	MMM2019 Loading (Isolated Towns)
Qld	Glenden	5	6	0%	40%	40%
Qld	Hideaway Bay - Dingo Beach	6	5	40%	0%	0%
Qld	Horseshoe Bay, Magnetic Island	7	5	50%	0%	0%
Qld	Injune	7	6	50%	40%	40%
Qld	Karragarra Island	5	6	0%	40%	40%
Qld	Lamb Island	5	6	0%	40%	40%
Qld	Nebo	6	5	40%	0%	0%
Qld	Nelly Bay, Magnetic Island	7	5	50%	0%	0%
Qld	Picnic Bay, Magnetic Island	7	5	50%	0%	0%
SA	Penneshaw	6	7	40%	50%	50%
WA	Broome	7	6	50%	40%	40%
WA	Carnarvon	6	7	40%	50%	50%
WA	Green Head	6	5	40%	0%	0%
WA	Kununurra	6	7	40%	50%	50%
WA	Leeman	6	5	40%	0%	40%
NT	Gunbalanya (Oenpelli)	7	6	50%	40%	40%

CONSULTATIONS

The issues paper presented a number of issues with the current arrangements:

- What transitional arrangements, if any, should be put in place for locations that are currently classified as remote under MMM2015 and would no longer be classified as remote under MMM2019?
- Are there any other issues with the geographic classification system used by the NDIS for pricing and planning purposes?

Respondents acknowledged the need for timely changes to geographic classifications but noted that frequent changes can disrupt service delivery by providers.

A number of submissions suggested that a transition period be available for providers to adjust their operations. The most common suggestion was a 12-month notice period, to allow time for most providers to transition, particularly where geographical reclassification lowers MMM ratings, as this also impacts engaging new participants in such locations.

Respondents were also concerned that the MMM does not consider the proximity to disability providers, provider operation costs in MMM4-5 areas, and workforce attraction and retention. They proposed that the NDIA consider the proximity of a town located to other well-populated towns and a number of community services and health providers.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

RESEARCH

There are 5,673 participants who will be affected by MMM 2019 changes. Of these, 306 participants will reclassified into or out of MMM 6-7 and thus experience the loss or gain of a geographical loading on their price limits and plan funding amounts.

- 121 participants will be reclassified from outer regional (MMM5) to remote (MMM6) and gain the 40% remote loading;
- 43 participants will be reclassified from remote (MMM6) to outer regional (MMM5) and lose the 40% remote loading;
- 59 participants will be reclassified from remote (MMM6) to very remote (MMM7) and move from the 40% remote loading to the 50% very remote loading; and
- 83 participants will be reclassified from very remote (MMM7) to remote (MMM6) and move from the 50% very remote loading to the 40% remote loading.

DISCUSSION

The MMM is explicitly based on distance to the nearest labour supply centre and so should be well suited as a mechanism to estimate the availability of the disability support workforce and the need for higher price limits to compensate providers for the higher costs associated with attracting workers. The Review recognises that thin markets operate in remote, very remote and some regional areas, especially for more specialised services. However, the Review considers that the solution to this issue lies through a greater use of commissioning, rather than through increases in price limits, especially where the thinness of the market is due to the low number of participants. In these circumstances individual participants will never have sufficient purchasing power to attract service provision with the efficiencies of aggregation that can be generated through commissioning.

The Review also considers that the argument for a delay in implementing any change in the MMM rating of a region is not strong, given that both price limits and plan funding loadings are driven by the same loadings. Thus, while participants who might be reclassified into non-remote areas might have smaller plans they would also face lower price limits.

RECOMMENDATION

RECOMMENDATION 11) Geographic Classification

The NDIA should adopt the MMM 2019 classification system, and any future updates to the MMM classification system as released by the Department of Health, (subject to the NDIS Isolated Town arrangements) as the basis of determining the pricing arrangements in the NDIS Price Guide, including:

i) whether remote and very remote loadings should be applied to price limits and plan funding amounts; and

ii) which travel time limits apply to the supports delivered to participants.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

8. Costs in Outer Regional Areas

The Review was required by its Terms of Reference to examine whether a loading should be applied to price limits and plan funding amounts in outer regional areas to account for the higher cost of service delivery, if any, in those areas

CURRENT ARRANGEMENTS

In 2019, the *NDIS Western Australian Market Review* ("the WA Market Review") found that costs in remote and very remote areas were substantially higher than those in other areas. As a result, the NDIS increased the price limit and plan funding loadings for remote and very remote areas from 20% and 25% to 40% and 50%, respectively.

The WA Market Review also found that costs did not suddenly rise when a provider crossed the boundary from an outer regional area to a remote area. Rather, costs rose in line with the distance from capital cities – although not necessarily in a linear manner.

CONSULTATIONS

Most respondents suggested that the cost of delivering supports in regional areas is more expensive due to the increased travel costs and limited transport options in regional areas, accommodation costs of workers (where applicable), and wage costs. Several submissions suggested that the issues faced in regional areas are better aligned to remote areas. Another submission argued that providers in MMM4-5 areas face higher start-up and ongoing costs associated with establishing, supporting and sustaining a business in regional locations, particularly for small providers.

Respondents were asked to indicate what would be an appropriate loading to cover any additional costs associated with the delivery of services in regional areas. Submissions suggested a 10% to 20% loading, with one suggesting a 50% loading. Another submission suggested quoting for regional services, rather than a loading. However, submissions did not provide strong evidence for these estimates.

RESEARCH

The Commonwealth Grants Commission (CGC) conducted research into the actual costs of placing government employees in remote locations.[42] The CGC found that costs varied linearly with distance – rather than into just three discrete groups. The CGC also found that placing staff in very remote areas could cost almost double what it cost to place them in

[42] Commonwealth Grants Commission. (2015). *Report on GST Revenue Sharing Relativities 2015 Review – Volume 2 – Assessment of State Fiscal Capacities*.

The CGC's regional cost scale is based on schools and police data (the only comparable data across states and territories available when they were developed). The general regional cost scale is derived from the average of the schools and police scales, which is then discounted 25% due to uncertainty with its fit to other service delivery areas. The data have not been updated as the CGC considers that relative costs between states are unlikely to have significantly changed and the previous data request was a significant burden on states.

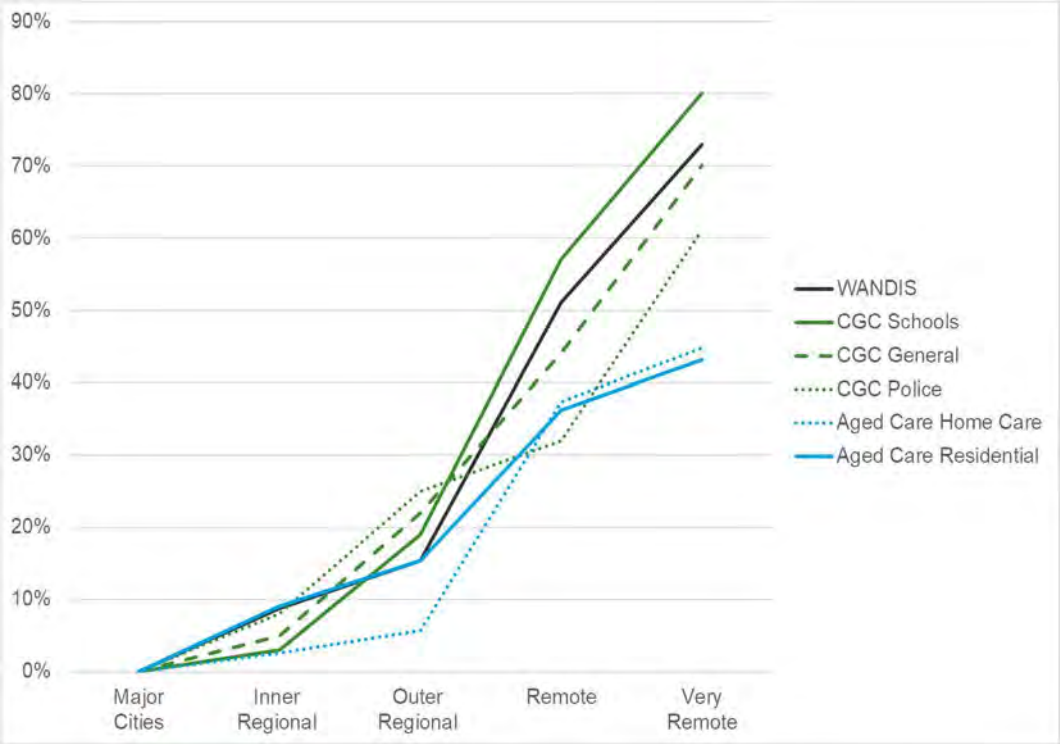
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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

cities. Figure 7 from the WA Market Review compares the CGC's estimates of the costs of delivering services in regional, remote and very remote areas with metropolitan areas. It also shows the price loadings that applied at the time of the WA Market Review in the WA NDIS and in the Commonwealth's residential and community aged care programs.

Figure 7 - Relative Cost of Delivering Services by Remoteness Classification



In all cases, the cost loadings were significantly greater than the price limit and plan funding loadings that were applicable in the NDIS at the time of the WA Market Review. Because of this evidence, the WA Market Review found that the costs of delivering services in remote and very remote areas were significantly higher than in metropolitan areas, and the difference in costs were greater than were then provided for in the NDIS planning and pricing arrangements. The WA Market Review also found that the costs of delivering services in regional areas might also be higher than in metropolitan areas, but that further research on the magnitude and significance of this difference was required. This matter was referred to the Annual Price Review 2020-21 for further consideration.

The Department of Education, Employment and Workplace Relations conducted a study into their regional loadings in 2011.[43] That study considered the model for factoring in components of regional service delivery at regional campuses such as staff numbers, class size, total enrolment and geographic features of the locale. Their recommended hierarchy for loading was as follows: Remote and Very Remote = 20%; Darwin specific = 15%; Outer Regional = 10%; and Inner Regional = 5%.

[43] https://docs.education.gov.au/system/files/doc/other/regional_loading_final_report.pdf

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

A detailed study published in 2014 by the Queensland Government Statistician, reported in Table 11, found that, in general, the cost of living in regional areas was lower than in metropolitan areas.[44]

Table 11 - Relative Cost of Living across Queensland

City/Town	Relative Cost of Living Index		City/Town	Relative Cost of Living Index
Brisbane	**100.0**		Gympie	92.1
Ayr	93.7		Kingaroy	89.1
Beaudesert	93.3		Longreach	94.9
Bowen	94.8		Mackay	99.4
Bundaberg	94.3		Maryborough	88.8
Cairns	103.6		Moranbah	99.4
Cannonvale	98.9		Mount Isa	102.6
Charleville	97.1		Rockhampton	96.6
Charters Towers	92.6		Roma	99.7
Dalby	94.5		Sunshine Coast	103.8
Emerald	91.3		Toowoomba	99.5
Gatton	96.1		Townsville	97.7
Gladstone	98.9		Warwick	92.2
Gold Coast	100.2		Weipa	126.4

The Regional Cost Index developed by the Western Australian Department of Primary Industries and Regional Development similarly shows that, in general, the cost of living in regional areas are not significantly higher than in metropolitan areas (see Table 12).[45]

Table 12 - Relative Cost of Living across Western Australia

Region	Relative Cost of Living Index		City/Town	Relative Cost of Living Index
Perth	**100.0**		Goldfields-Esperance	101.3
Kimberly	112.9		Wheatbelt	101.7
Pilbara	110.7		Peel	97.4
Gasgoyne	109.1		Southwest	101.6
Midwest	101.2		Great Southern	100.2

DISCUSSION

The Review does not consider that there is sufficient evidence to conclude that the costs of service delivery are higher in regional areas than in metropolitan areas, except in respect of travel costs. It therefore considers that any supply issues in these areas are better addressed through the revised travel and commissioning arrangements proposed elsewhere in the Review.

[44] https://www.qgso.qld.gov.au/issues/2886/index-retail-prices-qld-regional-centres-2013.pdf

[45] http://www.drd.wa.gov.au/Publications/Documents/Regional%20Price%20Index%202017.pdf

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

9. Cancellation Rules

The Review was required by its Terms of Reference to examine the current price control arrangements for cancellations within the Scheme.

CURRENT ARRANGEMENTS

NDIS providers are not permitted to collect deposits or bonds from participants, or to retain these funds in the event of the participant cancelling a service booking for a support or failing to turn up for a support. However, they are permitted to charge cancellation fees against a participant's plans in certain circumstances.

The *NDIS Price Guide* currently says:

> *Where a provider has a short notice cancellation (or no show) they are able to recover 90% of the fee associated with the activity, subject to the terms of the service agreement with the participant. Providers are only permitted to charge for a short notice cancellation (or no show) if they have not found alternative billable work for the relevant worker and are required to pay the worker for the time that would have been spent providing the support.*
>
> *A cancellation is a short notice cancellation if the participant:*
>
> - *does not show up for a scheduled support within a reasonable time, or is not present at the agreed place and within a reasonable time when the provider is travelling to deliver the support; or*
> - *has given less than two (2) clear business days' notice for a support that meets both of the following conditions:*
>   - *the support is less than 8 hours continuous duration; AND*
>   - *the agreed total price for the support is less than $1000; or*
> - *has given less than five (5) clear business days' notice for any other support.*[46]

In 2018-19, cancellation payments totalled $12.4 million or 0.1% of Scheme expenditure. Only 27.2% of providers made a cancellation claim. For these providers, cancellation claims represented, on average, 4.9% of all their claims (by number) and 3.6% of all their claims (by value). For 1 in 10 providers who claimed for cancellations, cancellation claims represented, more than 11.1% of all their claims (by number) and 8.3% of all their claims (by value).

[46] To help providers to continue to deliver supports to participants through the COVISD-19 pandemic, the NDIA has amended the definition of short notice cancellation from 25 March 2020. Participants are now required to give 10 business days' notice for a cancellation if they want to avoid paying the full fee for a cancelled service. This change in the definition of short notice cancellations is for a six-month period (25 March 2020 to 25 September 2020), with an initial review at three months to determine if it continues to be appropriate. When reviewing, the NDIA will consider a range of factors, including the current status of the COVID-19 pandemic. Providers are also paid 100% of the agreed fee for cancellations.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

CONSULTATIONS

The *Issues Paper* presented a number of issues with the current arrangements that had been raised by the sector, including:

- Some providers have argued that the current arrangements - whereby they are required to claim for 100% of the agreed fee for a cancelled service but the NDIS only pays them 90% of the agreed fee - results in accounting anomalies in their accounts showing the NDIS as bad debtor.
- Plan managers have also reported that they face difficulties in balancing their accounts when the invoices presented by providers, which they pass onto the NDIS, do not match the payments made by the NDIS.
- Some providers have also argued that they should be able to recover the full cost of the service that was cancelled, where they have not been able to replace the participant, as they face all of the costs associated with the appointment.
- Some stakeholders have questioned whether the NDIS cancellation rules should not be better aligned to those that apply in the general economy.

It was noted by many respondents that it was difficult to make alternative arrangements when a short-notice cancellation occurs, particularly when this occurs last minute (i.e. no show). Common concerns raised included:

- Difficulty replacing participants due to nature of support;
- If no replacement found, staff were allocated other types of tasks internally (i.e. administration); and
- Depending on the customer base and rostering, it may be difficult to replace cancelled appointments.

A few submissions provided approximate numbers of how often alternative arrangements could be made following a cancellation, which included some noting 25 to 30% of the time, others noting up to 70 and 95% of the time. One respondent mentioned it can often be done, but depends on individual circumstances. Almost all submissions indicated that they spent a lengthy time attempting to replace a short-notice cancellation. A few submissions noted that associated administration time could range between 30 minutes to two hours, and even up to a day to reschedule a worker.

Most providers argued that it was inappropriate to reduce the fee claimable for a short notice cancellation because the cost structures were the same whether or not the service was delivered. This view was not unanimous, however. Other respondents commented that the current arrangement was a fair balance between participant and provider. One suggested the removal of the cancellation fee.

A particular problem with the current arrangements noted by several providers was that providers were required to claim for 100% of the fee but were only paid for 90% of this. Thus

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

meant that their financial systems were showing a debt by the NDIS of 10% of the fee and additional administrative work was required to balance their books to satisfy their auditors.

Some providers indicated that two days' notice was typically adequate. Others argued that this is insufficient notice when the respondent also coordinates with schools, day programs, and other service providers. Another issue was that rostering may be complex and that two days' notice may not provide adequate time for adjustment. Some respondents suggested shortening the timeframe to 24 hours while others suggested expansion with proposals ranging from three days to five days.

The majority of responses indicated that the same cancellation rules should apply to all supports. One submission noted cancellations should also apply to interpreter service under the NDIS, as organisations are still required to pay an interpreter for short notice cancellations, yet cannot charge a cancellation fee under the NDIS. Other respondents asked for clarity around cancellations for Supported Independent Living (SIL) and group supports as this impacts other participants and more difficult to arrange available resource.

DISCUSSION

There was little consensus among submissions as to whether the current cancellation periods were adequate. It is therefore not proposed to change these at this time.

The arguments for changing the payment rate to 100% of the agreed fee are much stronger. The Review considered whether it might also be able to resolve provider's accounting difficulties by improved claiming arrangements in the NDIS systems, but on balance considered that providers' arguments about their incurred costs being invariable if they could not find alternative work were considered to be stronger. Especially as providers can incur additional costs after no shows or prolonged cancellations through their duty of care, which requires then to assure themselves that the cancelling participant is not incapacitated.

RECOMMENDATION

RECOMMENDATION 12) Cancellation Fees

> The NDIA should permanently amend the claiming rules in the *NDIS Price Guide* to allow providers to claim for 100% of the agreed fee for a short-notice cancellation.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

10. Provider Travel Rules

The Review was required by its Terms of Reference to examine the current claiming rules for provider travel within the Scheme, including:

- Provider travel time limits, including examining whether it is possible to develop an approach that is more sensitive to local conditions; and
- Non-labour costs associated with provider travel.

CURRENT ARRANGEMENTS

The NDIA recognises that supports are often best delivered in the community or the participant's own home. The price control arrangements therefore allow providers to charge for the time spent travelling to participants to deliver supports in some case.

The *NDIS Price Guide* currently says:

> *Providers can only claim travel costs from a participant in respect of the delivery of a support item if:*
>
> - the Support Catalogue indicates that providers can claim for Provider Travel in respect of that support item;
> - the provider has the agreement of the participant in advance (i.e. the service agreement between the participant and provider should specify the travel costs that can be claimed); and
> - the provider is required to pay the worker delivering the support for the time they spent travelling as a result of the agreement under which the worker is employed; or the provider is a sole trader and is travelling from their usual place of work to or from the participant, or between participants.
>
> *Where a provider claims for travel time in respect of a support then the maximum amount of travel time that they can claim for the time spent travelling to each participant (for each eligible worker) is 30 minutes in MMM1-3 areas and 60 minutes in MMM4-5 areas. (Note the relevant MMM classification is the classification of the area where the support is delivered.)*
>
> *In addition to the above travel, capacity building providers who are permitted to claim for provider travel can also claim for the time spent travelling from the last participant to their usual place of work. The maximum amount of travel time that they can claim for the time spent on return travel (for each eligible worker) is 30 minutes in MMM1-3 areas and 60 minutes in MMM4-5 areas. (Note the relevant MMM classification is the classification of the area where the support is delivered.)*

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Where a worker is travelling to provide services to more than one participant in a 'region' then the provider can apportion that travel time (including the return journey where applicable) between the participants, with the agreement of each participant in advance.

Claims for travel in respect of a support must be made separately to the claim for the primary support (the support for which the travel is necessary) using the same line item as the primary support and the "Provider Travel" option in the Myplace portal. When claiming for travel in respect of a support, a provider should use the same hourly rate as they have agreed with the participant for the primary support (or a lower hourly rate for the travel if that is what they have agreed with the participant) in calculating the claimable travel cost.

CONSULTATIONS

The issues paper presented a number of issues with the current arrangements that had been raised by the sector, including:

- That the current limits on the claimable travel time may restrict services to participants because providers will be unwilling to deliver services if they are unable to recover their travel costs.
- That providers are not currently permitted to claim for unavoidable non-labour travel costs, which include the overall general cost for running and maintaining the cost of the vehicle, including allowances payable to workers for the use of their own cars, or the cost of maintaining fleet vehicles and road tolls.

Providers were asked to indicate the proportion of travel episodes related to the delivery of NDIS supports by their organisation that exceeded the claimable time limits specified in the *NDIS Price Guide* and the *NDIS Support Catalogue*. Some respondents indicated that they were able to work within the limits through selecting participants in serviceable areas. However, other respondents indicated that they stopped delivering services to participants in their home or place of residence if the cost of travel far outweighed the financial incentive for the business to do so.

Some respondents who provided an estimate on the amount of travel to participants that exceeded the *NDIS Price Guide* limits suggested that this occurs for five (5) to 10% of services delivered. Others indicated it might go up to 30 and 50% in some instances. Several respondents noted that travel limits were mostly exceeded in regional areas, and in areas that are dispersed (not necessarily regional, remote or very remote). An example was given of travel occur in an MMM1-3 zone that took an hour, but for which only up to 30 minutes was claimable. Some respondents said they generally absorbed travel costs (not charging the participants) where long travel distances are required and there are no alternative supports available.

Some submissions argued that the distances within a MMM classification can vary substantially and are not reflective of the kilometres travelled. Others argued that there is an increasing travel cost associated with metropolitan areas, due to traffic congestion, road

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

tolls and lack of adequate parking availability, compared to kilometres travelled in regional and remote areas.

Respondents identified outer regional areas are particularly difficult to service due to travel costs. One submission requested that the travel limit for therapy services should be removed for regional areas. Some respondents indicated that it was not viable for them to provide service to participants living more than 45 minutes away. Further, travel to some locations further away from the organisation base required overnight accommodation or alternative travel such as flights or ferries, which add to the travel costs.

Provider submissions also raised concerns relating to isolated communities that are classified as MMM6-7. Respondents were concerned that the NDIS planning arrangements for remote and very remote participants do not adequately provide for the high cost of travelling in those regions, which could leave the participant with minimal funding for support hours, or make it financially unviable to deliver services. There were also issues of efficiency with the current arrangements, with each participant individually organising expensive travel from providers which might be a better shared cost. Some support coordinators tried to perform the role of maximising the number of participants seen by a visiting providers but they were not always best placed to do this.

Providers argued that in order to make the delivery of supports viable in thin markets they need to find and group other participants in an area to defray costs. This can work very well as semi-regular arrangements. As an example, in the Tiwi Islands there are 12 children on the main island, Melville Island. Therapists worked with the school to establish service agreements for all 12 participants. A therapist visits six times during the school term, on average 8 children are present. Fees are charged on that basis. However, considerable non-claimable hours are needed in preparation for a trip to remote areas - organise on ground support, appropriate times, communicate with people in communities, accommodation etc. For each individual remote trip, there are up to six hours of planning.

Respondents were also asked to indicate what proportion of the travel costs associated with the delivery of an NDIS support (labour and non-labour costs) that they currently recovered from the NDIS. One submission indicated that they are able to recover all costs related to travel. Another respondent suggested that 80% of travel costs were recovered from the NDIS. The principal issues raised by respondents was that they were only able to claim for the worker's time currently, and that they had to absorb non-labour costs such as vehicle fleets and mileage. These providers pointed out that the SCHADS Award requires them to pay their workers 78 cents per kilometre when the worker used their own car for provider travel, yet the *NDIS Price Guide* does not allow this to be claimed. Providers also indicated that it was, in general, less expensive and often safer, to maintain a fleet of vehicles of their support workers to use, but that these costs added significantly to the level of their overheads as they were not claimable from the NDIS. One respondent noted that for travel, their costs were 29% non-labour and 71% labour.

Respondents also indicated that the non-labour costs associated with provider travel depended on the type of vehicle and were higher for disability-modified vehicles. One

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

submission noted that the cost of fuel in regional areas are typically higher than metropolitan areas. Other submissions noted that the costs of travelling to remote areas can be much higher given the poor state of the roads in those areas.

The majority of submissions suggested a per kilometre basis as the most appropriate and consistent method for claiming non-labour travel costs. It was suggested that this is the most transparent for participants receiving travel for their support, as well as being the administratively efficient method for providers.

RESEARCH

There is no common approach to provider travel across comparable schemes.

- WorkCover Queensland allows therapy providers to bill for travel time at a reduced rate equal to about 72% of the standard hourly rate "where the provider is required to leave their normal place of practice to provide a service to a worker at their place of residence, rehabilitation facility, hospital or the workplace; for visits to multiple workers or facilities, divide the travel charge accordingly between workers assessed/treated at each location".[47] There is no provision for provider travel costs associated with the delivery of attendant care services.
- Victorian Transport Accident Commission (TAC) will pay for the time therapists spend travelling to conduct treatment in the community, where this is clinically justified, but only from the provider's practice address and the patient's residence. Where more than one patient is visited in a single travel period, total travel costs is required to be apportioned equally between patients. The TAC does not pay for provider travel time for attendant care supports, except for the reasonable cost of attendant carer travel when accompanying a client to a transport accident injury related hospital, medical or rehabilitation appointment. (Note, within the NDIS this would be classified as Activity Based Transport rather than Provider Travel.)
- The State Insurance Regulatory Authority of New South Wales does not in general, allow therapists to charge for the time that they spend travelling. They do allow the reimbursement of vehicle costs "in accordance with the "Use of private motor vehicle" set out in Item 6 of Table 1 (Rates and Allowances) to Part B (Monetary Rates) of the Crown Employees (Public Service Conditions of Employment) Reviewed Award 2009, at 68 cents per kilometre.
- Return to Work South Australia allows therapy providers to bill for travel time at a reduced rate equal to about 85% of the standard hourly rate.[48]

[47] https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0009/178083/2019-Occupational-Therapy-table-of-costs.pdf

[48] https://www.rtwsa.com/service-providers/provider-registration-and-payments/fee-schedules

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

DISCUSSION

Travel Time Limits

The Modified Monash Model geographical classification is based on distance from labour supply centres. In general, therefore, it should form a reasonable basis for the time limits on provider travel, which are meant to encourage participants to access providers closer to them where possible.

- MMM1 regions – The Review understands that traffic congestion can make travel in metropolitan areas time consuming. However, the Review considers that it is important to continue to encourage participants to seek services from providers closer them to improve Scheme sustainability and notes that the market for disability services is continuing to show strong growth, especially in metropolitan areas.
- MMM2-4 regions – The Review notes that:
    - Locations in regions classified as MMM2 are in, or within 20km road distance, of a town with population >50,000;
    - Locations in regions classified as MMM3 are in, or within 15km road distance, of a town with population between 15,000 and 50,000; and
    - Locations in regions classified as MMM4 are in, or within 10km road distance, of a town with population between 5,000 and 15,000.

  The Review considers that in each of these cases this means that participants are sufficiently close to a labour supply source that non-specialist services should be able to be delivered to them within the time limits set out in the *NDIS Price Guide*.
- MMM 5 regions – The Review notes that some people living in regions classified as MMM5 may live a considerable distance from services, but considers that this issue is best resolved through the more targeted approaches suggested below rather than through an increase in the provider travel time limits.

The Review also understands that more specialised services often require more travel than other services, given that they are located in fewer locations. Again, however, the Review considers that this issue is best resolved through the more targeted approaches suggested below rather than through an increase in the provider travel time limits, noting that capacity building providers are already permitted to make a separate claim for the return travel from the last client of the day.

Coordinated Commissioning

The Review considers that the fundamental difficulty in the supply of services in outer regional, remote and very remote areas is the sparsity of participants requiring services. This is a problem not best resolved through increasing price limits or provider travel time limits as these solutions do nothing to aggregate demand and ensure efficient delivery of services.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

A model for an alternative approach to managing the costs of travel and improving the efficiency of service provision in remote and very remote areas is provided by CheckUp, a Queensland Fund Holder for the Commonwealth's Rural Health Outreach Fund. Fundholders for the Rural Health Outreach Fund are appointed through a competitive process and are then required to undertake detailed needs assessment and planning in consultation with communities and local organisations. Based on the outcomes of the planning, Fundholders develop proposals for service delivery and once proposals are approved, Fundholders are responsible for the delivery of services in accordance with the approved plans.

Under these arrangements, CheckUp provides funding to health professionals visiting eligible locations to cover out of pocket expenses relating to the following

- Travel costs: airfares, car hire, mileage for use of personal car, taxi hire;
- Accommodation (per night);
- Meals Allowance (per meal): Breakfast, Lunch, Dinner and Incidentals;
- Administration Support (daily rate): administrative costs associated with the delivery of outreach services, such as the organisation of appointments, processing of correspondence and follow up with patients, at the outreach location;
- Upskilling: informal or formal educational and upskilling activities that are provided at the outreach service location;
- Cultural awareness and safety training: support to undertake this training, if required;
- Equipment lease: Subject to approval; and
- Telehealth services: hire of venue and equipment.[49]

These payments are on top of any fees that may be charged to the patient or the MBS and reduce costs for the patient and increase the availability of services.

Return to Work South Australia also provides a schedule for travel reimbursement arguing that this allows for more flexibility in addressing the unique travel challenges of regions located further away to deliver services:

> *A case manager may require a service to be delivered at a location greater than 100km from the provider's closest place of business. In these circumstances, a case manager may approve reimbursement of the following travel expenses: economy airfares, overnight accommodation and reasonable cost for meals associated with the overnight stay, taxi fares, car parking and car hire expenses (excluding fuel costs and vehicle mileage).*[50]

[49] https://www.checkup.org.au/page/Initiatives/Outreach_Services/Outreach_Provider_Information/

[50] https://www.rtwsa.com/__data/assets/pdf_file/0009/99657/return-to-work-services-fee-schedule.pdf

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Checkup also has a role in improving the coordination of services at the location where the service is provided. They aggregate the needs of individuals and match these to visiting professionals to ensure the most efficient use of resources.

The Review considers that there would be considerable advantages in the NDIS adopting a similar coordinated commissioning approach for the provision of travel funding to visiting service providers in outer regional, remote and very remote areas and other thin markets. This approach could ameliorate the need to commission other services, or assist in the commissioning of those services.[51] It could also simplify the planning process, as it would not be necessary for planners to work out travel amounts for plans.

Non-labour travel costs

Providers incur significant non-labour costs associated with provider travel either because they maintain their own fleets or because they are required by the SCHADS Award to reimburse their employees when they use their own cars to deliver supports to participants.

Absent commissioning arrangements for travel in thin markets as discussed above, these costs can either be recognised within the overheads of providers or as a separate expense similar to the arrangements for non-labour costs of Activity Based Transport as set out in the *NDIS Price Guide*:

> *If a provider incurs costs, in addition to the cost of a worker's time, when accompanying and/or transporting participants in the community (such as road tolls, parking fees and the running costs of the vehicle), they may negotiate with the participant for them to make a reasonable contribution towards these costs. The NDIA considers that the following would be reasonable contributions:*
>
> - up to $0.85 a kilometre for a vehicle that is not modified for accessibility
> - up to $2.40 a kilometre for a vehicle that is modified for accessibility or a bus
> - other forms of transport or associated costs up to the full amount, such as road tolls, parking, public transport fares.

On balance, the Review considers that it is more appropriate to recognise non-labour provider travel costs as they occur rather than within the overheads assumption, since they are not evenly distributed between providers. Recognising these costs separately also ensures that providers do not have an incentive to cut community based supports in order to lower their overheads. Providers, should however, only be able to claim for the non-labour costs associated with provider travel where the rules governing provider travel allow a claim for provider travel to be made. That is, when the provider is required to pay the worker delivering the support for the time they spent travelling as a result of the agreement

[51] The Review recognises that transient service provision can be less effective than local service provision. However, in some thin markets local service provision may not exist and in those cases coordinated commissioning will, in general, offer a more efficient and effective solution than individualised commissioning. This should, however, operate alongside efforts at local capacity building.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

under which the worker is employed; or the provider is a sole trader and is travelling from their usual place of work to or from the participant, or between participants.

RECOMMENDATION

RECOMMENDATION 13) Provider Travel

1) The *NDIS Price Guide* and the *NDIS Support Catalogue* should be amended from 1 July 2020 so that providers can claim for the non-labour costs associated with provider travel in line with the activity based transport arrangements. Claims should only be able to be made for the non-labour costs associated with provider travel where the rules governing provider travel allow a claim for provider travel to be made.

2) The NDIA should further examine the option of the commissioning of travel broker arrangements to coordinate participants and providers and pay for travel costs.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

11. Establishment Fees

The Review was required by its Terms of Reference to examine the current arrangements for Establishment Fees within the Scheme.

CURRENT ARRANGEMENTS

NDIS providers who are providing a significant amount (at least 20 hours per month) of daily activity and community participation supports to a participant are permitted to charge that participant's plan an Establishment Fee when they commence providing services to the participant. This recognises the non-ongoing and not otherwise claimable costs that providers incur in establishing arrangements and assisting participants in implementing their plan, including assessing the participant's needs, agreeing a service agreement with the participant and setting up service bookings in the NDIA system.

The *NDIS Price Guide* currently says that the Establishment Fee arrangements apply:

> *… to all new NDIS participants in their first plan where they receive at least 20 hours of personal care/community access support per month. This payment is to cover non-ongoing costs for providers establishing arrangements and assisting participants in implementing their plan.*
>
> *An Establishment Fee is claimable by the provider who assists the participant with the implementation of their NDIS Plan, delivers a minimum of 20 hours per month of personal care/community access support and has made an agreement with the participant to supply these services.*
>
> *A budget of $750 is included in the first plan for NDIS participants, in case they need this type of assistance from providers to design and implement support arrangements. Providers can draw against this budget as follows:*
>
> - *If the participant is new to the NDIS and new to the provider, then the provider can charge a maximum of $500 against the participant's plan;*
> - *If the participant is new to the NDIS but is an existing client of the provider, then the provider can charge a maximum of $250 against the participant's plan; and*
> - *If the participant is choosing to change providers, then the new provider can charge a maximum of $250 against the participant's plan to assist the participant in changing providers.*

The *NDIS Support Catalogue* provides the following support item for eligible providers to claim an Establishment Fee.

Support Item Number	Support Item Name	Support Item Description
01_049_0107_1_1	Establishment Fee For Personal Care/Community Access	Establishment Fee for Personal Care/Community Access (20 hours per month).

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

In 2018-19, Establishment Fees were claimed by 984 different providers. Some 88 providers claimed 50 or more Establishment Fees. These providers accounted for 54.3% of the total number of Establishment Fees claimed by providers and for 51.8% of the total value of all Establishment Fees claimed by providers. Establishment Fees were claimed in respect of 17,157 participants, at a total cost of $6.39 million (19,357 total individual claims).

- 15,480 participants had one Establishment Fee claimed from their plans in 2018-19. This accounted for 90.2% of those participants who had one or more Establishment Fees deducted from their plan in 2018-19.
- 1,390 participants had two Establishment Fees claimed from their plans in 2018-19. This accounted for 8.1% of those participants who had one or more Establishment Fees deducted from their plan in 2018-19.
- 287 participants had three or more three or more Establishment Fees claimed from their plans in 2018-19. This accounted for 1.7% of those participants who had one or more Establishment Fees deducted from their plan in 2018-19.

CONSULTATIONS

The *Issues Paper* sought feedback on a number of issues with the current arrangements that had been raised by stakeholders, including:

- Whether providers should be able to charge an Establishment Fee to a participant if they commence to provide services to the participant in their second or subsequent plan?
- Whether more than one provider should be able to charge an Establishment Fee at the same time – if, for example, a participant has more than one provider who is supplying at least 20 hours per month of daily activity and community participation supports?
- Whether a third or subsequent provider in a given year should be able to charge an Establishment Fee if a participant chooses to change provider more than once?
- Whether the current amount payable for Establishment Fees represented value for money for participants and allowed providers to recover the costs of establishing services for participants, including establishing service bookings in the NDIA payment system?
- Whether other types of providers should be able to charge an Establishment Fee?

In response to the *Issues Paper*, some submissions from providers argued that Establishment Fees should be payable whenever a participant starts receiving services from a provider, regardless on whether the participant was on their first or subsequent NDIS plan. Submissions suggested that it was the need to establish arrangements for a new participant to the provider that triggered the relevant costs.

Some submissions also argued that the current rules were not clear and appeared complex, and could be simplified. Submissions also argued that providers should also be able to

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

charge an Establishment Fee, perhaps at a reduced rate, for second and subsequent plans, as providers have to re-establish service agreements with participants and service bookings in the NDIA system at the start of each plan.

Other submissions suggested that Establishment Fees should also be payable in respect of other supports in the *NDIS Support Catalogue*. Suggestions ranged from specific capacity building supports ('Improved Learning', 'Support Coordination' and 'Improved Relationships'), to all capacity-building supports and even all support categories.

There were mixed views on the adequacy of the current Establishment Fee arrangements. Respondents who indicated that the current price limits were adequate, suggested that the same price limit should apply to all new and revised plans or that to all new participants to a provider. Some respondents who indicated that the current price limits were inadequate, suggested that the price limit should be increased by $250. Others suggested an increase in the minimum price limit to establish supports for a new customer, or a tiered system based on higher intensity needs of participants. Other submissions suggested that the current arrangements do not adequately consider the number of hours required to establish services for a participant or the service type of support.

Almost all submissions suggested that the amount of the Establishment Fee should be indexed. It was suggested that the most appropriate way to index Establishment Fees was to link it to the type of support that it best aligns.

Several submissions raised concerns such as inconsistencies across the *NDIS Price Guide* and the *NDIS Support Catalogue* and that the Establishment Fee only appears in the Daily Activities support category for claiming, limiting claiming by community access providers.

RESEARCH

The NDIA has identified that Establishment Fees for similar services are payable in some other schemes, including (as at 1 July 2019):

- icare New South Wales – A one-off Program Establishment Fee for participants who receive support from a provider for more than three months of $1,214.06 for participants receiving up to 34 hours of support per week and $1,517.58 for participants receiving more than 34 hours of support per week. The payment is intended to assist with the costs associated with recruitment campaigns, the organisation of additional training for support workers, and time to visit and collaborate with the participant to develop the attendant care program.
- Victorian Transport Accident Commission (TAC) – A one-off Establishment Fee of up to $1,328.17 is payable to a service provider who provides a TAC Client with four hours or more of services per billing period, for more than three consecutive months. The payment is intended to assist with the costs of the recruitment of new personnel, the development of a care plan and training plan, as well as compliance with Occupational Health and Safety site audit requirements.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- Worksafe Victoria – An Establishment Fee of up to $1,207.32 payable after a provider has provided at least four hours of attendant care in three consecutive billing periods to assist with the costs of the recruitment of new personnel. The payment is intended to assist with the costs of the development of support and training plans; and compliance with OHS site requirements.[52]

Note, however, that NDIS Establishment Fees are not intended to cover many of the costs identified above (potential recruitment costs of new personnel, training of staff and development of a care plan). In general the NDIS arrangements view these costs as part of the normal operating costs of providers. Participant specific training is claimable through the NDIS non-face-to-face claiming arrangements.

DISCUSSION

Who should be able to claim for Establishment Fees?

There are technical deficiencies in the current arrangements. First, the *NDIS Price Guide* says that Establishment Fees may be claimed by providers in respect of "all new NDIS participants in their first plan where they receive at least 20 hours of personal care/community access support per month." However, the terms "personal care" and "community access" are not defined in the *NDIS Price Guide*. Moreover, because the Establishment Fee support item is linked to Registration Group 0107 (Daily Personal Activities) only providers registered in that Registration Group can currently claim for Establishment Fees. In particular, providers in the Registration Groups 0104 (High Intensity Daily Personal Activities), 0125 (Participation in community, social and civic activities) and 0136 (Group and Centre Based Activities) cannot currently claim Establishment Fees unless they are also in Registration Group 0107.

The Review considers that this issue should be addressed by more clearly specifying in the *NDIS Price Guide* that providers in these four Registration groups are entitled to claim for Establishment Fees if they meet the relevant eligibility requirements. It would also be necessary to create new Establishment Fee support items in Support Category 1 (Assistance with Daily Life) and Support Category 4 (Assistance with Social and Community Participation) for the relevant Registration Groups.

Although several submissions suggested that providers of other types of support should also be able to claim for Establishment Fees, the Review does not consider that the arguments for this change were strong. Most other types of support are unlikely to meet the eligibility requirement of at least 20 hours a month for the duration of the plan. In addition, most capacity building supports already have a considerable allowance for non-billable hours built into their price limits and the ability to claim for non-face-to-face supports.

[52] https://www.worksafe.vic.gov.au/attendant-care-services-policy
https://www.worksafe.vic.gov.au/attendant-care-services-fee-schedule

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

When should Establishment Fees be claimable?

Currently, Establishment Fees are only claimable during a participant's first plan and are only claimable by "the provider who assists the participant with the implementation of their NDIS Plan" and "delivers a minimum of 20 hours per month".

There is some evidence that providers face additional establishment (or maintenance) costs in second and subsequent plans. First, whether or not a participant is on their first or a later plan, if they are new to a provider then that provider will still face the usual establishment costs. Second, even if a participant stays with a provider for their second or subsequent plan, the provider may still face some establishment costs with each plan as they must negotiate a service offering and agreement with the participant and enter new service bookings into the NDIS system. Currently providers need to absorb these costs into their overheads.

On balance, the Review considers that Establishment Fees should be able to be claimed from a participant's plan in second and subsequent plans if they choose to change providers. This will also help empower participants within the NDIS provider market. The Review does not consider that there is a strong argument for providers to be able to claim a second Establishment Fee in respect of a participant. A provider's relationship with a participant should continually evolve and the costs of managing that relationship are part of the normal cost structure of delivering services.

How much should the Establishment Fee be?

Currently, the base rate of the Establishment Fee is $500, but this is only payable if the participant is both new to the NDIS and new to the provider. A lower Establishment Fee of $250 is payable If the participant is new to the NDIS but is an existing client of the provider, or if the participant is choosing to change providers. These amounts have not been changed since the Scheme's commencement.

There are a number of deficiencies in the current arrangements. First, the class of participants who are new to the NDIS but known to the provider, while an important consideration in the roll out of the NDIS, when many participants transitioned into the NDIS from other schemes while staying with their former providers, is now increasingly less relevant given that the Scheme is almost fully rolled out. Second, the amount of the Establishment Fee has not been increased since the Scheme's commencement. Although there is no explicit evidence that the current level of the Establishment Fee is inadequate it is clear that the costs of establishing clients, as a labour based activity, will have increased and will continue to increase over time. Third, as noted above, the cost of establishing a participant with a provider depends on whether or not the participant and provider have had a previous relationship much more than whether or not the participant is new to the NDIS. Finally, the current arrangements are not in line with the participant-centric focus of the Scheme as they specify the amount of the Establishment Fee rather than allow participants and providers to agree that fee. It would be more appropriate to price regulate these items, given the immaturity of the overall market for disability supports and the information asymmetries between providers and participants.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

The Review therefore considers that there is a strong argument that the Establishment Fee items should be more clearly indicated to be price regulated. The Review also considers that the current level of the Establishment Fee is appropriate, but that it would be better expressed through a link to the standard hourly rate of Disability Support Worker support items.

Should the amount of the Establishment Fee be indexed annually?

As noted above, it is clear that establishment costs, as a labour-based activity, will increase over time. A simple way to ensure that the Establishment Fee maintains its value would be to link it to other price limits within the support category that are increased annually in line with provider input costs.

RECOMMENDATION

RECOMMENDATION 14) Establishment Fees

1) The NDIA should amend the current Establishment Fee arrangements in the *NDIS Price Guide* so that:

   i) An Establishment Fee to assist with the non-ongoing costs of establishing arrangements and assisting participants in implementing their plan is claimable from a participant's plan by a provider who:

      - is in one or more of the Registration Groups 0104 (High Intensity Daily Personal Activities), 0107 (Daily Personal Activities), 0125 (Participation in community, social and civic activities) and 0136 (Group and Centre Based Activities);
      - has made an agreement with the participant to supply at least 20 hours of support – in Support Categories 1 (Assistance with Daily Life) and/or Support Category 4 (Assistance with Social and Community Participation) – to the participant per month for the duration of the plan;
      - assists the participant with the implementation of their NDIS Plan.

   ii) Each provider can only claim an Establishment Fee in respect of a participant once across all plans.

   iii) More than one provider is able to claim an Establishment Fee against a given plan provided each provider meets the other criteria above.

   iv) The amount of the Establishment Fee should be negotiated by the participant and the provider but cannot be greater than an amount equal to ten times the hourly weekday price limit for a disability support worker as determined by the Standard NDIS Disability Support Worker Cost Model with the standard parameters ($528.50 in 2019-20).

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

2) The NDIA should add several price-limited support items to the *NDIS Support Catalogue* to allow providers in the Registration Groups 0104 (High Intensity Daily Personal Activities, 0107 (Daily Personal Activities), 0125 (Participation in community, social and civic activities) and 0136 (Group and Centre Based Activities) who are delivering services in Support Categories 1 (Assistance with Daily Life) and/or Support Category 4 (Assistance with Social and Community Participation) to be able to claim Establishment Fees and Maintenance Establishment Fees.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

DOCUMENT 31

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Matter for Decision

Update to the NDIS Cost Model for Disability Support Workers for the Equal Renumeration Order

Presented by: David Cullen, Chief Economist

1. Purpose

1.1 To seek the Pricing Reference Group's (PRG) approval of the changes in price limits for supports delivered by disability support workers that are proposed for 1 December 2020 as a result of the NDIA Board's agreement to the recommendation of the Annual Pricing Review 2020-21 that those price limits should be increased on 1 December 2020 to take accont of the final tranche of the Fair Work Commission's Equal Remuneration Order (ERO) of 22 June 2012 [MA000100 PR525485.

2. Recommendations

2.1 That the PRG **AGREE** that the price limits in the Tabe below should apply to supports delivered by disability support workers and determined or drrived from the NDIS Disability Support Worker Cost Model (see Attachment A) from 1 December 2020

	Weekday Daytime	Weekday Evening	Weekday Night	Saturday	Sunday	Public Holiday
Level 1	$55.47	$61.05	$62.17	$77.81	$100.16	$122.51
Level 2	$60.02	$66.07	$67.27	$84.20	$108.39	$132.57
Level 3	$63.21	$69.58	$70.85	$88.68	$114.15	$139.62
Level 4	$83.15	$91.53	$93.20	$116.65	$150.15	$183.65

3. Background

3.1 In its consideration of Annual Pricing Review 2020-21, the Board of the NDIA accepted the Review's recommendation that price limits that are determined by the NDIS Disability Support Worker Cost Model should increase on 1 December 2020 to account for the effect of the final tranch of the Equal Remuneration order.

3.2 There are 369 support items in the NDIS Price Guide and Support Catalogue that are currently either determined directly by, or derived fromm the NDIS Disability Support Worker Cost Model (see Attachment A).

4. Discussion

4.1 The ERO provided for nine annual increases in the minimum wages of some workers, including those covered by the Social, Community, Home Care And Disability Services Industry Award

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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2010 (SCHADS Award), on top of those that flowed from the annual National Wage Cases. The final increase due to the ERO is due to occur on 1 December 2020.

4.2 The ERO determined what percentage increase should occur, over a nine year period, to award minimum wages (see Column 5 of the following Table). From 1 December 2020, the ERO will be implemented by adding a Final Equal Remuneration Payment equal to the defined percentage of the Award Minisum wage (at any given time) to that Award Minimum Wage. The following Table sets out these calculations ande detmeined for each pay point in the Award what the Final Minimum Award Wage (including ERO) will be form 1 December 2020.

Social and community services employee level	1/07/2020 Award Minimum Wage	1/07/2020 Award Minimum Wage PLUS Transitional Equal Remuneration Payment	1/12/2020 Award Minimum Wage PLUS Final Equal Remuneration Payment	Final effect of ERO	Expected Increase on 1/12/2020
1.1	$819.60	$819.60	$819.60	0%	0.00%
1.2	$847.30	$847.30	$847.30	0%	0.00%
1.3	$877.60	$877.60	$877.60	0%	0.00%
2.1	$877.60	$1,057.02	$1,079.45	23%	2.12%
2.2	$905.10	$1,090.14	$1,113.27	23%	2.12%
2.3	$932.60	$1,123.27	$1,147.10	23%	2.12%
2.4	$957.60	$1,153.38	$1,177.85	23%	2.12%
3.1	$957.60	$1,178.92	$1,206.58	26%	2.35%
3.2	$985.10	$1,212.77	$1,241.23	26%	2.35%
3.3	$1,006.10	$1,238.62	$1,267.69	26%	2.35%
3.4	$1,026.70	$1,263.98	$1,293.64	26%	2.35%
4.1	$1,054.20	$1,354.06	$1,391.54	32%	2.77%
4.2	$1,081.80	$1,389.52	$1,427.98	32%	2.77%
4.3	$1,109.60	$1,425.22	$1,464.67	32%	2.77%
4.4	$1,134.30	$1,456.95	$1,497.28	32%	2.77%
5.1	$1,162.00	$1,544.17	$1,591.94	37%	3.09%
5.2	$1,186.90	$1,577.26	$1,626.05	37%	3.09%
5.3	$1,214.60	$1,614.07	$1,664.00	37%	3.09%
6.1	$1,242.30	$1,684.01	$1,739.22	40%	3.28%
6.2	$1,269.70	$1,721.15	$1,777.58	40%	3.28%
6.3	$1,297.20	$1,758.43	$1,816.08	40%	3.28%
7.1	$1,324.70	$1,819.25	$1,881.07	42%	3.40%
7.2	$1,352.50	$1,857.43	$1,920.55	42%	3.40%
7.3	$1,380.00	$1,895.20	$1,959.60	42%	3.40%
8.1	$1,407.50	$1,970.50	$2,040.88	45%	3.57%
8.2	$1,435.10	$2,009.14	$2,080.90	45%	3.57%
8.3	$1,462.90	$2,048.06	$2,121.21	45%	3.57%

4.3 The Following Table shows the result of including these new Award Wage levels into the NDIS Disability Support Worker Cost Model.

	Weekday Daytime	Weekday Evening	Weekday Night	Saturday	Sunday	Public Holiday
Level 1	$55.47	$61.05	$62.17	$77.81	$100.16	$122.51
Level 2	$60.02	$66.07	$67.27	$84.20	$108.39	$132.57
Level 3	$63.21	$69.58	$70.85	$88.68	$114.15	$139.62
Level 4	$83.15	$91.53	$93.20	$116.65	$150.15	$183.65

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4.4 It is proposed that the PRG agree to these new price limits, and to the relevant changes othe price limits derviced formthese price limits, from 1 December 2020.

4.5 The following table illustrates the percentage changes in price limits from 1 July 2020 to 1 December 2020. The average percentage increase of the price limits across all Cost Model determined price limits is 2.2%, assuming the mix of support items stays as it currently is.

Percentage Increase in Price Limits from 1 July 2020 to 1 December 2020 after ERO Application

N/A	Weekday Daytime	Weekday Evening	Weekday Night	Saturday	Sunday	Public Holiday
Level 1	2.2%	2.1%	2.1%	2.1%	2.1%	2.1%
Level 2	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%
Level 3	2.3%	2.3%	2.3%	2.3%	2.3%	2.4%
Level 4	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%

5. Impact on Scheme Sustainability

5.1 The impact of this change on Scheme sustainability was considered by the NDIA Board in its consideration of the recommendations of the Annual Pricing review 2020-21.

6. Next steps

6.1 The Price Regulation Unit is responsible for rolling out the changes to the NDIS DSW Cost Model and its increases to price limits across all impacted items.

(a) It is currently intended to release the new *NDIS Price Guide* and *NDIS Support Catalogue* on 1 November 2020.

(b) The new price limits will come into effect from 1 December 2020.

6.2 The Office of the Scheme Actuary will consider indexation of participant plans in line with ERO changes to price limits.

Attachment(s):

A *Price Limits Determined by the NDIS Disability Support Worker Cost Model*

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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Attachment A – Price Limits Determined by the NDIS Disability Support Worker Cost Model

The following Table sets out how the price limits for each relevant NDIS support item is related to the NDIA's estimates of the efficient costs of delivering supports. Further information can be found in the *NDIS Disability Support Worker Cost Model 2020-21*.

Support Item Number	Support Item Name	Methodology	Basic Model	Loading
01_002_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Night	Determined by DSW model	DSW 1	Night Loading
01_002_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Night - TTP	Derived from DSW Model	DSW 1	Night Loading
01_010_0107_1_1	Assistance With Self-Care Activities - Night-Time Sleepover	Derived from DSW Model	DSW 1	
01_011_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Daytime	Determined by DSW model	DSW 1	
01_011_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
01_012_0107_1_1	Assistance With Self-Care Activities - Standard - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading
01_012_0107_1_1_T	Assistance With Self-Care Activities - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
01_013_0107_1_1	Assistance With Self-Care Activities - Standard - Saturday	Determined by DSW model	DSW 1	Saturday Loading
01_013_0107_1_1_T	Assistance With Self-Care Activities - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
01_014_0107_1_1	Assistance With Self-Care Activities - Standard - Sunday	Determined by DSW model	DSW 1	Sunday Loading
01_014_0107_1_1_T	Assistance With Self-Care Activities - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
01_015_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading
01_015_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading
01_045_0115_1_1	STA And Assistance (Inc. Respite) - 1:4 - Weekday	Derived from DSW Model	DSW 2	
01_049_0104_1_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1	
01_049_0107_1_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1	
01_051_0115_1_1	STA And Assistance (Inc. Respite) - 1:4 - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
01_052_0115_1_1	STA And Assistance (Inc. Respite) - 1:4 - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
01_053_0115_1_1	STA And Assistance (Inc. Respite) - 1:4 - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
01_054_0115_1_1	STA And Assistance (Inc. Respite) - 1:2 - Weekday	Derived from DSW Model	DSW 2	
01_055_0115_1_1	STA And Assistance (Inc. Respite) - 1:2 - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
01_056_0115_1_1	STA And Assistance (Inc. Respite) - 1:2 - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
01_057_0115_1_1	STA And Assistance (Inc. Respite) - 1:2 - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
01_058_0115_1_1	STA And Assistance (Inc. Respite) - 1:1 - Weekday	Derived from DSW Model	DSW 2	
01_059_0115_1_1	STA And Assistance (Inc. Respite) - 1:1 - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
01_060_0115_1_1	STA And Assistance (Inc. Respite) - 1:1 - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
01_061_0115_1_1	STA And Assistance (Inc. Respite) - 1:1 - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
01_062_0115_1_1	STA And Assistance (Inc. Respite) - 1:3 - Weekday	Derived from DSW Model	DSW 2	
01_063_0115_1_1	STA And Assistance (Inc. Respite) - 1:3 - Saturday	Derived from DSW Model	DSW 2	Saturday Loading

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
01_064_0115_1_1	STA And Assistance (Inc. Respite) - 1:3 - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
01_065_0115_1_1	STA And Assistance (Inc. Respite) - 1:3 - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
01_200_0115_1_1	Assistance With Self-Care Activities in a STA - Weekday Daytime	Determined by DSW model	DSW 1	
01_201_0115_1_1	Assistance With Self-Care Activities in a STA - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading
01_202_0115_1_1	Assistance With Self-Care Activities in a STA - Saturday	Determined by DSW model	DSW 1	Saturday Loading
01_203_0115_1_1	Assistance With Self-Care Activities in a STA - Sunday	Determined by DSW model	DSW 1	Sunday Loading
01_204_0115_1_1	Assistance With Self-Care Activities in a STA - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading
01_205_0115_1_1	Assistance With Self-Care Activities in a STA - Weekday Night	Determined by DSW model	DSW 1	Night Loading
01_300_0104_1_1	Assistance With Self-Care Activities - Level 1 - Weekday Daytime	Determined by DSW model	DSW 1	
01_300_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
01_301_0104_1_1	Assistance With Self-Care Activities - Level 1 - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading
01_301_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading
01_302_0104_1_1	Assistance With Self-Care Activities - Level 1 - Saturday	Determined by DSW model	DSW 1	Saturday Loading
01_302_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
01_303_0104_1_1	Assistance With Self-Care Activities - Level 1 - Sunday	Determined by DSW model	DSW 1	Sunday Loading
01_303_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
01_304_0104_1_1	Assistance With Self-Care Activities - Level 1 - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading
01_304_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
01_305_0104_1_1	Assistance With Self-Care Activities - Level 1 - Weekday Night	Determined by DSW model	DSW 1	Night Loading
01_305_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Weekday Night - TTP	Derived from DSW Model	DSW 1	Night Loading
01_400_0104_1_1	Assistance With Self-Care Activities - Level 2 - Weekday Daytime	Determined by DSW model	DSW 2	
01_400_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
01_401_0104_1_1	Assistance With Self-Care Activities - Level 2 - Weekday Evening	Determined by DSW model	DSW 2	Evening Loading
01_401_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Weekday Evening - TTP	Derived from DSW Model	DSW 2	Evening Loading
01_402_0104_1_1	Assistance With Self-Care Activities - Level 2 - Saturday	Determined by DSW model	DSW 2	Saturday Loading
01_402_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
01_403_0104_1_1	Assistance With Self-Care Activities - Level 2 - Sunday	Determined by DSW model	DSW 2	Sunday Loading
01_403_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
01_404_0104_1_1	Assistance With Self-Care Activities - Level 2 - Public Holiday	Determined by DSW model	DSW 2	Public Holiday Loading
01_404_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
01_405_0104_1_1	Assistance With Self-Care Activities - Level 2 - Weekday Night	Determined by DSW model	DSW 2	Night Loading
01_405_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Weekday Night - TTP	Derived from DSW Model	DSW 2	Night Loading
01_500_0104_1_1	Assistance With Self-Care Activities - Level 3 - Weekday Daytime	Determined by DSW model	DSW 3	

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
01_500_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Weekday Daytime - TTP	Derived from DSW Model	DSW 3	
01_501_0104_1_1	Assistance With Self-Care Activities - Level 3 - Weekday Evening	Determined by DSW model	DSW 3	Evening Loading
01_501_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Weekday Evening - TTP	Derived from DSW Model	DSW 3	Evening Loading
01_502_0104_1_1	Assistance With Self-Care Activities - Level 3 - Saturday	Determined by DSW model	DSW 3	Saturday Loading
01_502_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Saturday - TTP	Derived from DSW Model	DSW 3	Saturday Loading
01_503_0104_1_1	Assistance With Self-Care Activities - Level 3 - Sunday	Determined by DSW model	DSW 3	Sunday Loading
01_503_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Sunday - TTP	Derived from DSW Model	DSW 3	Sunday Loading
01_504_0104_1_1	Assistance With Self-Care Activities - Level 3 - Public Holiday	Determined by DSW model	DSW 3	Public Holiday Loading
01_504_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Public Holiday - TTP	Derived from DSW Model	DSW 3	Public Holiday Loading
01_505_0104_1_1	Assistance With Self-Care Activities - Level 3 - Weekday Night	Determined by DSW model	DSW 3	Night Loading
01_505_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Weekday Night - TTP	Derived from DSW Model	DSW 3	Night Loading
01_790_0106_8_3	Level 1: Support Connection	Determined by DSW model	DSW 3	
01_801_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Daytime	Determined by DSW model	DSW 1	
01_802_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading
01_803_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Night	Determined by DSW model	DSW 1	Night Loading
01_804_0115_1_1	Assistance in Supported Independent Living - Standard - Saturday	Determined by DSW model	DSW 1	Saturday Loading
01_805_0115_1_1	Assistance in Supported Independent Living - Standard - Sunday	Determined by DSW model	DSW 1	Sunday Loading
01_806_0115_1_1	Assistance in Supported Independent Living - Standard - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading
01_811_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Daytime	Determined by DSW model	DSW 2	
01_812_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Evening	Determined by DSW model	DSW 2	Evening Loading
01_813_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Night	Determined by DSW model	DSW 2	Night Loading
01_814_0115_1_1	Assistance in Supported Independent Living - High Intensity - Saturday	Determined by DSW model	DSW 2	Saturday Loading
01_815_0115_1_1	Assistance in Supported Independent Living - High Intensity - Sunday	Determined by DSW model	DSW 2	Sunday Loading
01_816_0115_1_1	Assistance in Supported Independent Living - High Intensity - Public Holiday	Determined by DSW model	DSW 2	Public Holiday Loading
01_832_0115_1_1	Assistance in Supported Independent Living - Night-Time Sleepover	Derived from DSW Model	DSW 1	
04_049_0104_1_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1	
04_049_0125_1_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1	
04_049_0133_5_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1	
04_049_0136_1_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1	
04_102_0125_6_1	Access Community Social And Rec Activities - Standard - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading
04_102_0125_6_1_T	Access Community Social And Rec Activities - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_102_0136_6_1	Group Activities - Standard - Weekday Daytime	Determined by DSW model	DSW 1	
04_102_0136_6_1_T	Group Activities - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
04_103_0125_6_1	Access Community Social And Rec Activities - Standard - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading
04_103_0125_6_1_T	Access Community Social And Rec Activities - Standard - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_103_0136_6_1	Group Activities - Standard - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading
04_103_0136_6_1_T	Group Activities - Standard - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_104_0125_6_1	Access Community Social And Rec Activities - Weekday Daytime	Determined by DSW model	DSW 1	
04_104_0125_6_1_T	Access Community Social And Rec Activities - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_104_0136_6_1	Group Activities - Standard - Saturday	Determined by DSW model	DSW 1	Saturday Loading
04_104_0136_6_1_T	Group Activities - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_105_0125_6_1	Access Community Social And Rec Activities - Standard - Saturday	Determined by DSW model	DSW 1	Saturday Loading
04_105_0125_6_1_T	Access Community Social And Rec Activities - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_105_0136_6_1	Group Activities - Standard - Sunday	Determined by DSW model	DSW 1	Sunday Loading
04_105_0136_6_1_T	Group Activities - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_106_0125_6_1	Access Community Social And Rec Activities - Standard - Sunday	Determined by DSW model	DSW 1	Sunday Loading
04_106_0125_6_1_T	Access Community Social And Rec Activities - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_106_0136_6_1	Group Activities - Standard - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading
04_106_0136_6_1_T	Group Activities - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_111_0136_6_1	Group Activities In The Community - 1:2 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1	
04_111_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_112_0136_6_1	Group Activities In The Community - 1:2 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading
04_112_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_113_0136_6_1	Group Activities In The Community - 1:2 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading
04_113_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_114_0136_6_1	Group Activities In The Community - 1:2 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading
04_114_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_116_0104_6_1	Group Activities In The Community - 1:2 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2	
04_116_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_117_0104_6_1	Group Activities In The Community - 1:2 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
04_117_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_118_0104_6_1	Group Activities In The Community - 1:2 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
04_118_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_119_0104_6_1	Group Activities In The Community - 1:2 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading
04_119_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_120_0136_6_1	Group Activities In The Community - 1:3 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1	

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
04_120_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_121_0136_6_1	Group Activities In The Community - 1:3 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading
04_121_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_122_0136_6_1	Group Activities In The Community - 1:3 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading
04_122_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_123_0136_6_1	Group Activities In The Community - 1:3 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading
04_123_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_124_0104_6_1	Group Activities In The Community - 1:3 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2	
04_124_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_125_0104_6_1	Group Activities In The Community - 1:3 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
04_125_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_126_0104_6_1	Group Activities In The Community - 1:3 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
04_126_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_127_0104_6_1	Group Activities In The Community - 1:3 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading
04_127_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_128_0136_6_1	Group Activities In The Community - 1:2 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading
04_128_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_129_0136_6_1	Group Activities In The Community - 1:3 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading
04_129_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_130_0104_6_1	Group Activities In The Community - 1:2 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
04_130_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
04_131_0104_6_1	Group Activities In The Community - 1:3 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
04_131_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
04_136_0136_6_1	Group Activities In The Community - 1:4 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1	
04_136_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_137_0136_6_1	Group Activities In The Community - 1:4 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading
04_137_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_138_0136_6_1	Group Activities In The Community - 1:4 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading
04_138_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_139_0136_6_1	Group Activities In The Community - 1:4 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading
04_139_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_140_0136_6_1	Group Activities In The Community - 1:4 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading
04_140_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
04_141_0136_6_1	Group Activities In The Community - 1:5 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1	
04_141_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_142_0136_6_1	Group Activities In The Community - 1:5 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading
04_142_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_143_0136_6_1	Group Activities In The Community - 1:5 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading
04_143_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_144_0136_6_1	Group Activities In The Community - 1:5 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading
04_144_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_145_0136_6_1	Group Activities In The Community - 1:5 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading
04_145_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_146_0104_6_1	Group Activities In The Community - 1:4 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2	
04_146_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_147_0104_6_1	Group Activities In The Community - 1:4 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading
04_147_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_148_0104_6_1	Group Activities In The Community - 1:4 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
04_148_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_149_0104_6_1	Group Activities In The Community - 1:4 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
04_149_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_150_0104_6_1	Group Activities In The Community - 1:4 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
04_150_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
04_151_0104_6_1	Group Activities In The Community - 1:5 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2	
04_151_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_152_0104_6_1	Group Activities In The Community - 1:5 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading
04_152_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_153_0104_6_1	Group Activities In The Community - 1:5 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
04_153_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_154_0104_6_1	Group Activities In The Community - 1:5 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
04_154_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_155_0104_6_1	Group Activities In The Community - 1:5 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
04_155_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
04_160_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Weekday	Derived from DSW Model	DSW 1	
04_160_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_161_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
04_161_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_162_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading
04_162_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_163_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading
04_163_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_164_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading
04_164_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_165_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1	
04_165_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_166_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading
04_166_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_167_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading
04_167_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_168_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading
04_168_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_169_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading
04_169_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_170_0136_6_1	Group Activities In A Centre - 1:3 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1	
04_170_0136_6_1_T	Group Activities In A Centre - 1:3 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_171_0136_6_1	Group Activities In A Centre - 1:3 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading
04_171_0136_6_1_T	Group Activities In A Centre - 1:3 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_172_0136_6_1	Group Activities In A Centre - 1:3 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading
04_172_0136_6_1_T	Group Activities In A Centre - 1:3 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_173_0136_6_1	Group Activities In A Centre - 1:3 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading
04_173_0136_6_1_T	Group Activities In A Centre - 1:3 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_174_0136_6_1	Group Activities In A Centre - 1:3 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading
04_174_0136_6_1_T	Group Activities In A Centre - 1:3 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_175_0136_6_1	Group Activities In A Centre - 1:4 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1	
04_175_0136_6_1_T	Group Activities In A Centre - 1:4 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_176_0136_6_1	Group Activities In A Centre - 1:4 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading
04_176_0136_6_1_T	Group Activities In A Centre - 1:4 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_177_0136_6_1	Group Activities In A Centre - 1:4 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading
04_177_0136_6_1_T	Group Activities In A Centre - 1:4 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
04_178_0136_6_1	Group Activities In A Centre - 1:4 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading
04_178_0136_6_1_T	Group Activities In A Centre - 1:4 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_179_0136_6_1	Group Activities In A Centre - 1:4 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading
04_179_0136_6_1_T	Group Activities In A Centre - 1:4 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_180_0136_6_1	Group Activities In A Centre - 1:5 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1	
04_180_0136_6_1_T	Group Activities In A Centre - 1:5 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_181_0136_6_1	Group Activities In A Centre - 1:5 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading
04_181_0136_6_1_T	Group Activities In A Centre - 1:5 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_182_0136_6_1	Group Activities In A Centre - 1:5 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading
04_182_0136_6_1_T	Group Activities In A Centre - 1:5 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_183_0136_6_1	Group Activities In A Centre - 1:5 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading
04_183_0136_6_1_T	Group Activities In A Centre - 1:5 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_184_0136_6_1	Group Activities In A Centre - 1:5 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading
04_184_0136_6_1_T	Group Activities In A Centre - 1:5 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_185_0104_6_1	Group Activities In A Centre - 1:1 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2	
04_185_0104_6_1_T	Group Activities In A Centre - 1:1 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_186_0104_6_1	Group Activities In A Centre - 1:1 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading
04_186_0104_6_1_T	Group Activities In A Centre - 1:1 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_187_0104_6_1	Group Activities In A Centre - 1:1 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
04_187_0104_6_1_T	Group Activities In A Centre - 1:1 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_188_0104_6_1	Group Activities In A Centre - 1:1 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
04_188_0104_6_1_T	Group Activities In A Centre - 1:1 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_189_0104_6_1	Group Activities In A Centre - 1:1 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
04_189_0104_6_1_T	Group Activities In A Centre - 1:1 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
04_190_0104_6_1	Group Activities In A Centre - 1:2 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2	
04_190_0104_6_1_T	Group Activities In A Centre - 1:2 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_191_0104_6_1	Group Activities In A Centre - 1:2 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading
04_191_0104_6_1_T	Group Activities In A Centre - 1:2 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_192_0104_6_1	Group Activities In A Centre - 1:2 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
04_192_0104_6_1_T	Group Activities In A Centre - 1:2 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_193_0104_6_1	Group Activities In A Centre - 1:2 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
04_193_0104_6_1_T	Group Activities In A Centre - 1:2 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_194_0104_6_1	Group Activities In A Centre - 1:2 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
04_194_0104_6_1_T	Group Activities In A Centre - 1:2 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
04_195_0104_6_1	Group Activities In A Centre - 1:3 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2	
04_195_0104_6_1_T	Group Activities In A Centre - 1:3 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_196_0104_6_1	Group Activities In A Centre - 1:3 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading
04_196_0104_6_1_T	Group Activities In A Centre - 1:3 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_197_0104_6_1	Group Activities In A Centre - 1:3 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
04_197_0104_6_1_T	Group Activities In A Centre - 1:3 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_198_0104_6_1	Group Activities In A Centre - 1:3 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
04_198_0104_6_1_T	Group Activities In A Centre - 1:3 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_199_0104_6_1	Group Activities In A Centre - 1:3 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
04_199_0104_6_1_T	Group Activities In A Centre - 1:3 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
04_200_0104_6_1	Group Activities In A Centre - 1:4 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2	
04_200_0104_6_1_T	Group Activities In A Centre - 1:4 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_201_0104_6_1	Group Activities In A Centre - 1:4 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading
04_201_0104_6_1_T	Group Activities In A Centre - 1:4 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_202_0104_6_1	Group Activities In A Centre - 1:4 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
04_202_0104_6_1_T	Group Activities In A Centre - 1:4 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_203_0104_6_1	Group Activities In A Centre - 1:4 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
04_203_0104_6_1_T	Group Activities In A Centre - 1:4 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_204_0104_6_1	Group Activities In A Centre - 1:4 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
04_204_0104_6_1_T	Group Activities In A Centre - 1:4 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
04_205_0104_6_1	Group Activities In A Centre - 1:5 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2	
04_205_0104_6_1_T	Group Activities In A Centre - 1:5 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_206_0104_6_1	Group Activities In A Centre - 1:5 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading
04_206_0104_6_1_T	Group Activities In A Centre - 1:5 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_207_0104_6_1	Group Activities In A Centre - 1:5 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading
04_207_0104_6_1_T	Group Activities In A Centre - 1:5 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_208_0104_6_1	Group Activities In A Centre - 1:5 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading
04_208_0104_6_1_T	Group Activities In A Centre - 1:5 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_209_0104_6_1	Group Activities In A Centre - 1:5 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading
04_209_0104_6_1_T	Group Activities In A Centre - 1:5 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
04_300_0104_1_1	Access Community Social And Rec Activities - Level 1 - Weekday Daytime	Determined by DSW model	DSW 1	
04_300_0104_1_1_T	Access Community Social And Rec Activities - Level 1 - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
04_301_0104_1_1	Access Community Social And Rec Activities - Level 1 - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading
04_301_0104_1_1_T	Access Community Social And Rec Activities - Level 1 - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_302_0104_1_1	Access Community Social And Rec Activities - Level 1 - Saturday	Determined by DSW model	DSW 1	Saturday Loading
04_302_0104_1_1_T	Access Community Social And Rec Activities - Level 1 - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_303_0104_1_1	Access Community Social And Rec Activities - Level 1 - Sunday	Determined by DSW model	DSW 1	Sunday Loading
04_303_0104_1_1_T	Access Community Social And Rec Activities - Level 1 - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_304_0104_1_1	Access Community Social And Rec Activities - Level 1 - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading
04_304_0104_1_1_T	Access Community Social And Rec Activities - Level 1 - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
04_400_0104_1_1	Access Community Social And Rec Activities - Level 2 - Weekday Daytime	Determined by DSW model	DSW 2	
04_400_0104_1_1_T	Access Community Social And Rec Activities - Level 2 - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_401_0104_1_1	Access Community Social And Rec Activities - Level 2 - Weekday Evening	Determined by DSW model	DSW 2	Evening Loading
04_401_0104_1_1_T	Access Community Social And Rec Activities - Level 2 - Weekday Evening - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_402_0104_1_1	Access Community Social And Rec Activities - Level 2 - Saturday	Determined by DSW model	DSW 2	Saturday Loading
04_402_0104_1_1_T	Access Community Social And Rec Activities - Level 2 - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_403_0104_1_1	Access Community Social And Rec Activities - Level 2 - Sunday	Determined by DSW model	DSW 2	Sunday Loading
04_403_0104_1_1_T	Access Community Social And Rec Activities - Level 2 - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_404_0104_1_1	Access Community Social And Rec Activities - Level 2 - Public Holiday	Determined by DSW model	DSW 2	Public Holiday Loading
04_404_0104_1_1_T	Access Community Social And Rec Activities - Level 2 - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading
04_500_0104_1_1	Access Community Social And Rec Activities - Level 3 - Weekday Daytime	Determined by DSW model	DSW 3	
04_500_0104_1_1_T	Access Community Social And Rec Activities - Level 3 - Weekday Daytime - TTP	Derived from DSW Model	DSW 3	
04_501_0104_1_1	Access Community Social And Rec Activities - Level 3 - Weekday Evening	Determined by DSW model	DSW 3	Evening Loading
04_501_0104_1_1_T	Access Community Social And Rec Activities - Level 3 - Weekday Evening - TTP	Derived from DSW Model	DSW 3	Evening Loading
04_502_0104_1_1	Access Community Social And Rec Activities - Level 3 - Saturday	Determined by DSW model	DSW 3	Saturday Loading
04_502_0104_1_1_T	Access Community Social And Rec Activities - Level 3 - Saturday - TTP	Derived from DSW Model	DSW 3	Saturday Loading
04_503_0104_1_1	Access Community Social And Rec Activities - Level 3 - Sunday	Determined by DSW model	DSW 3	Sunday Loading
04_503_0104_1_1_T	Access Community Social And Rec Activities - Level 3 - Sunday - TTP	Derived from DSW Model	DSW 3	Sunday Loading
04_504_0104_1_1	Access Community Social And Rec Activities - Level 3 - Public Holiday	Determined by DSW model	DSW 3	Public Holiday Loading
04_504_0104_1_1_T	Access Community Social And Rec Activities - Level 3 - Public Holiday - TTP	Derived from DSW Model	DSW 3	Public Holiday Loading
04_600_0104_6_1	Group Activities - High Intensity - Weekday Daytime	Determined by DSW model	DSW 2	
04_600_0104_6_1_T	Group Activities - High Intensity - Weekday Daytime - TTP	Derived from DSW Model	DSW 2	
04_601_0104_6_1	Group Activities - High Intensity - Weekday Evening	Determined by DSW model	DSW 2	Evening Loading
04_601_0104_6_1_T	Group Activities - High Intensity - Weekday Evening - TTP	Derived from DSW Model	DSW 2	Evening Loading
04_602_0104_6_1	Group Activities - High Intensity - Saturday	Determined by DSW model	DSW 2	Saturday Loading

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
04_602_0104_6_1_T	Group Activities - High Intensity - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading
04_603_0104_6_1	Group Activities - High Intensity - Sunday	Determined by DSW model	DSW 2	Sunday Loading
04_603_0104_6_1_T	Group Activities - High Intensity - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading
04_604_0104_6_1	Group Activities - High Intensity - Public Holiday	Determined by DSW model	DSW 2	Public Holiday Loading
04_604_0104_6_1_T	Group Activities - High Intensity - Public Holiday - TTP	Determined by DSW model	DSW 2	Public Holiday Loading
04_801_0133_5_1	Supports in Employment - Weekday Daytime	Determined by DSW model	DSW 1	
04_801_0133_5_1_T	Supports in Employment - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
04_802_0133_5_1	Supports In Employment - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading
04_802_0133_5_1_T	Supports In Employment - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading
04_803_0133_5_1	Supports In Employment - Saturday	Determined by DSW model	DSW 1	Saturday Loading
04_803_0133_5_1_T	Supports In Employment - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading
04_804_0133_5_1	Supports In Employment - Sunday	Determined by DSW model	DSW 1	Sunday Loading
04_804_0133_5_1_T	Supports In Employment - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
04_805_0133_5_1	Supports In Employment - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading
04_805_0133_5_1_T	Supports In Employment - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
07_001_0106_8_3	Level 1: Support Connection	Determined by DSW model	DSW 3	
07_003_0117_8_3	CB and Training in Plan and Financial Management by a Support Coordinator	Determined by DSW model	DSW 3	
07_101_0106_6_3	Psychosocial Recovery Coaching - Weekday Daytime	Determined by DSW model	DSW 4	
07_102_0106_6_3	Psychosocial Recovery Coaching - Weekday Evening	Determined by DSW model	DSW 4	Evening Loading
07_103_0106_6_3	Psychosocial Recovery Coaching - Weekday Night	Determined by DSW model	DSW 4	Night Loading
07_104_0106_6_3	Psychosocial Recovery Coaching - Saturday	Determined by DSW model	DSW 4	Saturday Loading
07_105_0106_6_3	Psychosocial Recovery Coaching - Sunday	Determined by DSW model	DSW 4	Sunday Loading
07_106_0106_6_3	Psychosocial Recovery Coaching - Public Holiday	Determined by DSW model	DSW 4	Public Holiday Loading
08_005_0106_2_3	Assistance With Accommodation And Tenancy Obligations	Determined by DSW model	DSW 3	
09_006_0106_6_3	Life Transition Planning Incl. Mentoring Peer-Support And Indiv Skill Develop	Determined by DSW model	DSW 3	
09_009_0117_6_3	Skills Development And Training	Determined by DSW model	DSW 3	
10_016_0102_5_3	Employment Support	Determined by DSW model	DSW 3	
10_801_0133_5_1_D	Supports in Employment - Weekday Daytime	Determined by DSW model	DSW 1	
10_801_0133_5_1_T_D	Supports in Employment - Weekday Daytime - TTP	Derived from DSW Model	DSW 1	
10_802_0133_5_1_D	Supports In Employment - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading
10_802_0133_5_1_T_D	Supports In Employment - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading
10_803_0133_5_1_D	Supports In Employment - Saturday	Determined by DSW model	DSW 1	Saturday Loading
10_803_0133_5_1_T_D	Supports In Employment - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading
10_804_0133_5_1_D	Supports In Employment - Sunday	Determined by DSW model	DSW 1	Sunday Loading
10_804_0133_5_1_T_D	Supports In Employment - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading
10_805_0133_5_1_D	Supports In Employment - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading
10_805_0133_5_1_T_D	Supports In Employment - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading
11_024_0117_7_3	Individual Social Skills Development	Determined by DSW model	DSW 3	
13_030_0102_4_3	Transition Through School And To Further Education	Determined by DSW model	DSW 3	
14_031_0127_8_3	CB and Training in Plan and Financial Management by a Plan Manager	Determined by DSW model	DSW 3	
15_035_0106_1_3	Assistance With Decision Making Daily Planning and Budgeting	Determined by DSW model	DSW 1	
15_037_0117_1_3	Individual Skill Development And Training Including Public Transport Training	Determined by DSW model	DSW 1	
15_038_0117_1_3	Training For Carers/Parents	Determined by DSW model	DSW 3	

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Matter for Noting

Publication of the NDIS Cost Model for Disability Support Workers 2020-21

Presented by: David Cullen, Chief Economist

1. Purpose

1.1 To provider the Pricing Reference Group (PRG) with a copy of the *NDIS Cost Model for Disability Support Workers 2020-21*.

2. Recommendation

2.1 That the PRG **NOTE** that the *NDIS Cost Model for Disability Support Workers 2020*-21 has been published on the NDIS website.

3. Background

3.1 The NDIA publishes the *NDIS Cost Model for Disability Support Workers* in order to improve the transparency of its pricing regulation arrangements

4. Next steps

4.1 A revised version of the NDIS Cost Model for Disability Support Workers will be published on 1 December 2020, after price limits are adjusted for the Fair Work Commission's Equal Remuneration Order.

Attachment(s):

A *NDIS Disability Support Worker Cost Model*

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National Disability Insurance Scheme

Disability Support Worker Cost Model 2020-21

Valid from: 1 July 2020

(Version 1.0 - Publication Date: 27 July 2020)

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Terms that we use

DSW	Disability Support Worker
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
TTP	Temporary Transformation Payment

Further information

Further information on pricing in the National Disability Insurance Scheme can be found at the NDIS website

Footnotes

Footnotes are included in Appendix 1 – Footnotes at the end of this report

Version Control

The NDIS Cost Model for Supports Delivered by Disability Support Workers is subject to change. The latest version of the NDIS Cost Model is available on the NDIS website.

Version	Page	Details of Amendment	Release Date	Operative Date
1.0		First Operative Edition	27 July 2020	1 July 2020

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DISCLOSURE LOG

Contents

Introduction **5**

Disability Support Worker Cost Model **8**

Applicable Industrial Award 8

Base Pay 8

Shift Loadings 9

Days Worked Versus Days Paid 9

Salary On-costs 10

Supervision costs 11

Permanent v Casual Workers 12

Utilisation 12

Overheads 13

Margins 14

Price Limits Determined by the Cost Model **15**

Notes 29

1. Temporary Transformation Payment (TTP) 29
2. Assistance with Self Care Activities - Night-Time Sleepover Support 29
3. Establishment Fee for Personal Care/Participation 29
4. Short Term Accommodation and Assistance (including the respite care) 29
5. Group Activities (Transitional Arrangement) 29

Appendix 1 – Footnotes **31**

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DISCLOSURE LOG

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Introduction

The purpose of this document is to set out the methodology and assumptions of the Cost Model that the NDIA uses to inform its pricing decisions for supports that are delivered by Disability Support Workers (DSWs). The methodology used to inform the NDIA's pricing decisions for supports that are delivered by therapists are set out in the *Review of Therapy Pricing Arrangements*.[1]

One of the principal objectives of the National Disability Insurance Scheme (NDIS) is for people with disability to exercise choice and control over how, and with which providers, they spend their available budgets. The role of pricing in the NDIS is therefore very important. Prices, or more precisely participants' choices in response to the prices they face in the market, reflect the preferences and relative values that different participants place on different types of supports. The aggregation of these individual responses in turn signals to providers the quantity and mix of supports to supply. Prices also affect the purchasing power of participants. Higher prices reduce the supports participants can purchase within a given support budget. Prices also affect the total costs of the NDIS and therefore its financial sustainability, and the allocation of resources to the NDIS (and therefore possible production), relative to other sectors. Pricing can also affect providers' choices, including by providing incentives: for entering the market; for upskilling and right-skilling; for innovation; and for improvements in service quality and outcomes.

As the markets for disability goods and services develop and operate more effectively, it is expected that the National Disability Insurance Agency (NDIA), as market steward for the NDIS, will be less interventional. However, deregulation will necessarily occur at different points in time for different markets and may not be feasible in some cases. Currently, the NDIA varies its approach to the regulation of prices between:

- **No regulation** (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- **The imposition of price limits**: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care.
- **Quotable supports**: in which participants are expected to obtain quotations from suppliers to provide to the NDIA as part of verifying that prices are fair and reasonable.

Price controls need to take into account efficiency and the need to expand supply. Markets for disability supports are continuing to develop, with both increases in market supply and improvements in production efficiency required. While improvements to production efficiency imply reductions to costs in the long run, expansion of market supply necessitates higher short to medium term prices. To maintain and expand production volumes of disability supports, higher short-term prices are thus needed. This will serve as an incentive to redirect the allocation of resources to the NDIS from other sectors in the economy. Without price growth, supply side shortages will likely exist.

[1] https://www.ndis.gov.au/media/1662/download

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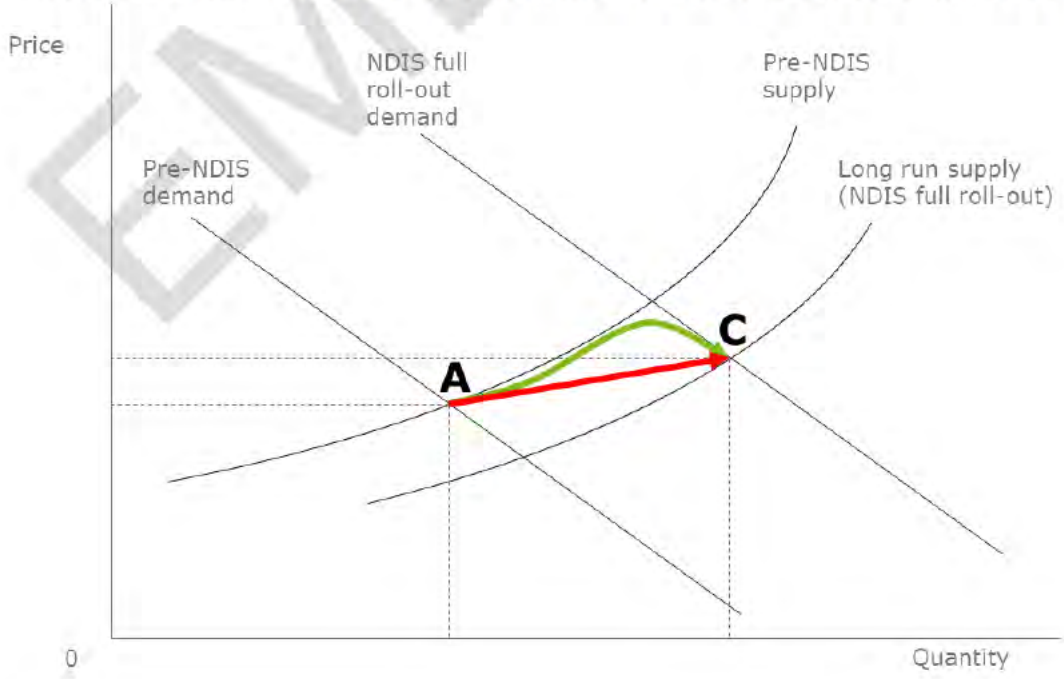
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The NDIS Pricing Strategy is best understood in terms of four different concepts of pricing:

- **Efficient price levels** – Price levels that represent the long run minimum cost of production. Sufficient production at efficient price level is only expected to be achievable in the long run in mature markets, with strong competition between providers.
- **Sustainable price levels** – Price levels that represent, at a given time, the price at which a firm operating at current levels of efficiency is viable (even if inefficient against the long run efficient technology). In the short term, prices at or above sustainable levels are required to ensure that current supply levels remain stable and providers with costs somewhat above the most efficient level remain viable.
- **Transitional price levels** – Price levels that represent, at a given time, the price necessary to attract new providers to enter the market or to reduce exits from the market. Transitional price levels represent the price required to attract economic resources from other parts of the economy to expand provider supply. Transitional price levels are above sustainable price levels, but should only be adopted where, as is the case in the NDIS transition period, a significant expansion of supply is required.
- **Price caps** – Upper limits on prices, used to reduce the potential exercise of market power.

Figure 1 below shows the market clearing equilibrium price and quantity of disability supports prior to the NDIS (at point A) and the long run market clearing equilibrium price and quantity of disability supports including the NDIS demand (at point C). It also illustrates the paths that sustainable price levels (red arrow) and transitional price levels (green arrow) will take in real terms over the transition to the long run market clearing equilibrium price, recognising the potential inefficiency of some current providers and the need to significantly expand and not unnecessarily disrupt the supply of services to people with disabilities.

Figure 1: Transition from equilibrium prior to the NDIS to the long run NDIS equilibrium



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In the longer term, efficient price levels are the best representation of the reasonable cost of the provision of a support. However, in the short to medium term, sustainable price levels are the best representation of the reasonable cost of the provision of a support. In the long run, sustainable price levels tend towards efficient price levels. In the short to medium term, however, as the market matures and expands, price caps need to be sufficient to both maintain current supply and attract new supply. That is, price caps for the NDIS need, in the short to medium-term at least, to be set with regard to transitional price levels, rather than sustainable and long run efficient price levels. Price caps are therefore set in accordance with the movements in transitional price levels (the green arrow in Figure 1), to recognise the costs providers are facing in adjusting to the new arrangements, the time required to unwind established agreements, and to encourage growth in supply while driving efficiency. This is done through an explicit and decreasing loading on sustainable price levels – the Temporary Transformation Payment (TTP).

- Sustainable price levels are set with reference to the revealed economics of current providers. They are determined by the outcomes achieved by the most efficient (the 25th percentile) of providers. This means that at least 25 per cent of providers in the sector are currently operating at better than this cost benchmark.[2] The NDIA therefore considers that these benchmarks therefore represent reasonable targets for providers to aim for in the delivery of their services.
- The original level of the TTP (and hence transitional price levels were initially set at the amount to ensure that at least 50 per cent of providers in the sector were operating at better than this cost benchmark. The level of the TTP is being reduced over time to encourage providers to become more efficient and to achieve better value for money for participants and taxpayers.

Further information on the NDIA's approach to pricing be found in the NDIA's *Pricing Strategy*[3] and in the report of the *Annual Pricing Review 2020-21*.[4]

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2 The NDIA considers that it is appropriate to estimate the cost structure of overall efficient (25th percentile) providers by reference to the 25th percentile of all providers' performance against each of the key parameters because there is little collinearity observed between the parameters in the TTP Benchmarking Survey results. The determinant of the Pearson product-moment correlation coefficient matrix (see below) is 87.1%.

	A = Permanent Share of Workforce	B = Supervision Ratio	C = Non travel allowances	D = Workers Compensation Premium	E = Utilisation percentage	F = Overheads percentage
A	1.00	-0.09	-0.13	0.06	-0.04	0.08
B	-0.09	1.00	-0.07	0.00	0.19	0.08
C	-0.13	-0.07	1.00	-0.02	-0.14	-0.18
D	0.06	0.00	-0.02	1.00	-0.02	0.02
E	-0.04	0.19	-0.14	-0.02	1.00	0.09
F	0.08	0.08	-0.18	0.02	0.09	1.00

See p.58 of the *Annual Pricing Review 2020-21*.

3 https://www.ndis.gov.au/media/1820/download

4 https://www.ndis.gov.au/media/2413/download

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Disability Support Worker Cost Model

This Chapter sets out the assumptions and methodology of the Cost Model that the NDIA uses to estimate the costs to disability service providers of employing Disability Support Workers (DSWs) to deliver supports through the NDIS. The Cost Model estimates the cost of delivering a billable hour of support taking into account all of the costs associated with every billable hour, including: base pay; shift loadings; holiday pay; salary on costs; supervision costs; utilisation (non-billable activities); employee allowances; corporate overheads and margin. These estimates are the basis of the price limits set by the NDIA for supports delivered by DSWs, with price limit set at the level that can be achieved by providers who match the benchmarks set by their reasonable efficient competitors. Of course, the costs of providers are driven by a number of different factors, all of which are reflected in the Cost Model. Providers may overachieve on some benchmarks and underachieve on others.

The NDIA recognises that providers have to employ DSWs with different skill levels and levels of experience to meet the different needs of participants. The Cost Model therefore has different sets of cost assumptions for four types of workers.

Applicable Industrial Award

The national award for DSWs is the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award).[5] The NDIA recognises that some DSWs are employed under Enterprise Bargaining Agreements (EBAs). However, these EBAs have to leave the worker no worse off overall than they would be under the relevant Award. Any additional benefits offered by EBAs over the Award have been agreed to by providers and are often offset by productivity gains. The NDIA therefore considers the conditions set out in the SCHADS Award to be the appropriate foundation for the Cost Model.

Base Pay

Table 1 sets out the Cost Model's assumptions with respect to the base pay of DSWs.[6]

Table 1: Assumed SCHADS Classifications and Pay Rates, 1 July 2020

	Assumed SCHADS Classification	Award Hourly Rate
DSW 1	2.3	$29.56
DSW 2	2.4/3.1	$30.69
DSW 3	3.2	$31.92
DSW 4	4.4	$38.34

[5] Fair Work Commission, *Social, Community, Home Care and Disability Services Industry Award 2010*, incorporating all amendments up to and including 30 June 2020.

[6] https://www.fairwork.gov.au/ArticleDocuments/872/social-community-home-care-and-disability-services-industry-award-ma000100-pay-guide.pdf.aspx

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Shift Loadings

Table 2 sets out the Cost Model's assumptions with respect to shift loadings. These assumptions are based on the SCHADS Award.[7]

Table 2: Shift Loadings, 1 July 2020

Shift	Permanent Loading	Casual Loading
Weekday	0.0%	25.0%
Saturday	50.0%	75.0%
Sunday	100.0%	125.0%
Public Holiday	150.0%	175.0%
Evening Shift	12.5%	37.5%
Night Shift	15.0%	40.0%

Days Worked Versus Days Paid

The Cost Model recognises that under the SCHADS Award a permanent worker's ordinary hours of work will be 38 hours per week[8], and that they will be available to work on 220 days a year, because under the National Employment Standards[9] they must be paid for:

- 20 days of annual leave;[10]
- 10 days of public holidays;[11] and
- Up to 10 days of personal leave.[12]

The Cost Model recognises that providers need to accrue the revenue to meet the costs of these leave accruals during the billable hours of the DSW.

The Cost Model also recognises that workers accrue Long Service Leave entitlements when they work and that again providers need to accrue the revenue to meet the costs of this

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7 SCHADS Award: Clauses 10.4(b), 26 and 29.3.

8 SCHADS Award: Clause 25.1.

9 The National Employment Standards govern leave and several other conditions in Awards, and also may not be reduced by EBAs. https://www.fairwork.gov.au/employee-entitlements/national-employment-standards

10 https://www.fairwork.gov.au/leave/annual-leave

11 https://www.fairwork.gov.au/leave/public-holidays

Note: The Agency recognises that there are more than 10 public holidays in each year, and that the number of public holidays varies by jurisdiction. However, some public holidays occur on weekends and it is unlikely that any worker in their ordinary working hours would be rostered to have worked on more than 10 public holidays.

12 https://www.fairwork.gov.au/leave/sick-and-carers-leave/paid-sick-and-carers-leave

Note: The Cost Model slightly overestimates provider's cost with respect to this parameter as it assumes all workers utilise all of their personal leave entitlement each year even though some workers may not use their entitlement.

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leave accrual during the billable hours of the DSW. The Cost Model assumes that workers accrue 4⅓ days of long service leave each year.[13]

In line with SCHADS Award, the Cost Model also provides a 17.5% loading for annual leave to compensate workers for the shifts they would have otherwise taken.[14]

Table 3: Impact of Leave on the Cost per Worked Hour of a Permanent DSW

	DSW 1	DSW 2	DSW 3	DSW 4
Standard Hourly Rate	**$29.56**	**$30.69**	**$31.92**	**$38.34**
Allowance for Annual leave				
a. No. hours leave accrued in a year (hrs/yr)	152	152	152	152
b. Loading	17.5%	17.5%	17.5%	17.5%
c. Proportion of leave taken	100.0%	100.0%	100.0%	100.0%
Cost per worked hour	**$3.16**	**$3.28**	**$3.41**	**$4.10**
Allowance for Personal leave				
a. No. hours leave in a year (hrs/yr)	76	76	76	76
b. Loading	0.0%	0.0%	0.0%	0.0%
c. Proportion of leave taken	100.0%	100.0%	100.0%	100.0%
Cost per worked hour	**$1.34**	**$1.39**	**$1.45**	**$1.74**
Allowance for Public Holiday leave				
a. No. hours leave accrued in a year (hrs/yr)	76	76	76	76
b. Loading	0.0%	0.0%	0.0%	0.0%
c. Proportion of leave taken	100.0%	100.0%	100.0%	100.0%
Cost per worked hour	**$1.34**	**$1.39**	**$1.45**	**$1.74**
Allowance for Long Service leave				
a. No. hours leave accrued in a year (hrs/yr)	32.93	32.93	32.93	32.93
b. Loading	0.0%	0.0%	0.0%	0.0%
c. Proportion of leave taken	100.0%	100.0%	100.0%	100.0%
Cost per worked hour	**$0.58**	**$0.60**	**$0.63**	**$0.76**
Cumulative cost per hour, after leave costs	**$35.98**	**$37.35**	**$38.86**	**$46.68**
Increase from permanent standard hourly rate	21.7%	21.7%	21.7%	21.8%

Salary On-costs

The Cost Model recognises that providers incur other costs related to the salaries, including:

- Superannuation at the statutory 9.5% of base salary, including while on leave;[15]

[13] https://www.fairwork.gov.au/leave/long-service-leave

Note: The Cost Model overestimates provider's cost with respect to this parameter as it assumes all permanent workers and casual workers qualify for LSL accruals and that all workers will eventually access their long service leave entitlement. This reflects the rollout of portable long service leave schemes in some jurisdictions.

[14] SCHADS Award: Clause 31.3

[15] https://www.ato.gov.au/Business/Super-for-employers/How-much-to-pay/

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- Workers compensation insurance at 1.7% of base salary, including while on leave;[16] and
- Employee allowances at 1.0% of base salary.[17]

The Cost Model does not provide for payroll tax as most jurisdictions exempt not-for-profit and smaller organisations from payroll tax.

Table 4: Impact of Salary On-costs on the Cost per Worked Hour of a Permanent DSW

	DSW 1	DSW 2	DSW 3	DSW 4
Cumulative cost per hour, before on-costs	**$35.98**	**$37.35**	**$38.86**	**$46.68**
Superannuation				
Superannuation Rate (%)	9.5%	9.5%	9.5%	9.5%
Superannuation ($)	$3.42	$3.55	$3.69	$4.43
Workers Compensation				
Premium Rate (%)	1.7%	1.7%	1.7%	1.7%
Premium Cost ($)	$0.61	$0.64	$0.66	$0.79
Employee Allowances				
Allowance Rate (%)	1.0%	1.0%	1.0%	1.0%
Allowance Cost ($)	$0.30	$0.31	$0.32	$0.38
Cumulative cost per hour, after on-costs	**$40.31**	**$41.85**	**$43.53**	**$52.28**
Cumulative increase from standard hourly rate	36.4%	36.4%	36.4%	36.4%

Supervision costs

The Cost Model recognises that DSWs require support and supervision and assumes that supervisors have the same shift loadings, leave entitlements and salary on-costs as the workers they manage, and that higher skilled workers require higher skilled supervisors. The Cost Model also assumes a span of control (ratio of workers per supervisor) of 15 to 1.[18]

[16] The *Annual Pricing Review 2020-21* (page 54) found that, averaged over 2010-11 to 2014-15, the standardised Australian average workers compensation premium rate was 1.5% for all industries and 1.7% for the Health and Community Services sector. The Benchmarking Study undertaken as part of the Annual Pricing Review 2020-21 found that the average workers compensation premium among respondents in the disability sector was 2.6%, with a median of 2.3% and a 25th percentile of 1.7%. In line with the *NDIS Pricing Strategy*, this Cost Model parameter has been set at the level achieved by efficient (25th percentile) providers.

[17] The *Annual Pricing Review 2020-21* (page 57) found that allowances in the sector were typically in the order of 1.0% of the base salary payable to the worker.

[18] The Benchmarking Study undertaken as part of the *Annual Pricing Review 2020-21* (page 52) found that the average span of control among respondents in the disability sector was 11.8:1 with a 25th percentile of 15:1. In line with the *NDIS Pricing Strategy*, this Cost Model parameter has been set at the level achieved by efficient (25th percentile) providers.

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Table 5: Impact of Supervision on Cost per Worked Hour of a Permanent DSW

	DSW 1	DSW 2	DSW 3	DSW 4
Cumulative cost per hour, before supervision	**$40.31**	**$41.85**	**$43.53**	**$52.28**
Supervisor				
Level of supervisor (SCHADS Equivalent)	3.2	4.2	4.2	5.1
Base Salary	$31.92	$36.57	$36.57	$40.64
Leave costs	$6.94	$7.95	$7.95	$8.84
Salary-on costs	$4.67	$5.35	$5.35	$5.95
Span of control				
Span of control	15	15	15	15
Cost of supervision ($)	$2.90	$3.32	$3.32	$3.70
Cumulative cost per hour, after supervision	**$43.21**	**$45.18**	**$46.86**	**$55.98**
Cumulative increase from standard hourly rate	46.2%	47.2%	46.8%	46.0%

Permanent v Casual Workers

The Cost Model assumes that 70% of the DSW workforce is permanently employed.[19]

Table 6: Impact of Casual Loading on the Cost per Worked Hour of a DSW

	DSW 1	DSW 2	DSW 3	DSW 4
Cumulative cost per hour, at 100% permanent	**$43.21**	**$45.18**	**$46.86**	**$55.98**
Cumulative cost per hour, at 70% permanent	$43.73	$45.71	$47.41	$56.65
Effect of casual loading	**1.2%**	**1.2%**	**1.2%**	**1.2%**
Cumulative increase from standard hourly rate	47.9%	48.9%	48.5%	47.8%

Utilisation

The Cost Model recognises that not all worked hours are billable. For example, the SCHADS Award provides that a DSW should have a ten minute paid break from work every four hours. DSWs also need to undertake training and attend to other issues. The Cost Model assumes that higher skilled workers with more responsibilities may require more non-billable hours, to maintain their skills and deal with other issues. Accordingly, the Cost Model sets the utilisation level at 92.0% for DSW 1s, 89.0% for DSW 2s; 87.7% for DSW 3s; and 80% for DSW 4s.[20]

[19] The Benchmarking Study undertaken as part of the *Annual Pricing Review 2020-21* (page 52) found that the average casual employment share among respondents in the disability sector was 43.8% with a 25th percentile of 71.7%. In line with the *NDIS Pricing Strategy*, this Cost Model parameter has been set at the level achieved by efficient (25th percentile) providers.

[20] The Benchmarking Study undertaken as part of the *Annual Pricing Review 2020-21* (page 52) found that the average utilisation among respondents in the disability sector was 79.8% with a 25th percentile of 90.0%. In line with the *NDIS Pricing Strategy*, this Cost Model parameter has been set at the level achieved by efficient (25th percentile) providers.

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The Cost Model assumes that supervisors have the same rate of non-billable hours as DSWs.

Table 7: Impact of Utilisation on the Cost per Billable Hour of a DSW

	DSW 1	DSW 2	DSW 3	DSW 4
Cumulative cost per hour, before utilisation	**$43.73**	**$45.71**	**$47.41**	**56.65**
Utilisation rates				
Breaks	4.17%	4.17%	4.17%	4.17%
Training	3.29%	6.58%	7.89%	7.89%
Other	0.54%	0.25%	0.24%	7.94%
Total Utilisation (%)	92.0%	89.0%	87.7%	80.0%
Cost of utilisation ($)	$3.80	$5.65	$6.65	$14.16
Cumulative cost per hour, after utilisation	**$47.53**	**$51.36**	**$54.06**	**$70.81**
Cumulative increase from standard hourly rate	60.8%	67.4%	69.4%	84.7%

Overheads

The Cost Model assumes that corporate overheads are 12.0% of direct costs (all those above).[21]

Table 8: Impact of Overheads on the Cost per Billable Hour of a DSW

	DSW 1	DSW 2	DSW 3	DSW 4
Cumulative cost per hour, before overheads	**$47.53**	**$51.36**	**$54.06**	**$70.81**
Overhead				
Overheads as a share of direct costs (%)	12.0%	12.0%	12.0%	12.0%
Cost of overheads ($)	$5.70	$6.16	$6.49	$8.50
Cumulative cost per hour, after overheads	**$53.23**	**$57.52**	**$60.55**	**$79.31**
Cumulative increase from standard hourly rate	80.1%	87.4%	89.7%	106.9%

Because the Benchmarking Study did not disaggregate its results between DSWs 1, 2 and 3 the efficient utilisation rates have been estimated for each DSW Level around the sector wide 25th percentile with the utilisation rate decreasing slightly with the seniority of the worker.

The utilisation rate for DSW 4s was set after consultations with providers who were currently employing workers in the role of a psychosocial recovery coach. These providers indicated that these staff were appropriately classified at the SCHADS pay point 4.4. They also indicated that workers who supported participants with psychosocial disabilities often needed to debrief and be supported at the end of their shifts to support their own mental well-being, which lowered their own and their supervisors' utilisation rates.

[21] The *Annual Pricing Review 2020-21* (page 58) found that the overheads percentage should be increased to 12.0% to better align with the estimated overheads of efficient providers in the sector, as observed in the Benchmarking Study adjusted for that survey's unrepresentativeness and that other recommendations being made by the Review would directly address some of the costs that providers are currently carrying in their overheads

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Margins

The Cost Model assumes a 2% margin on other costs. This equates to a rate of return of 8% against working capital, equivalent to three month's wages and entitlements.

Table 9: Impact of Margins on the Cost per Billable Hour of a DSW

	DSW 1	DSW 2	DSW 3	DSW 4
Cumulative cost per hour, before margin	**$53.23**	**$57.52**	**$60.55**	**$79.31**
Margin				
Margin as a share of other costs (%)	2.0%	2.0%	2.0%	2.0%
Cost of margin ($)	$1.06	$1.15	$1.21	$1.59
Cumulative cost per hour, after margin	**$54.30**	**$58.68**	**$61.76**	**$80.90**
Cumulative increase from standard hourly rate	83.7%	91.2%	93.5%	110.0%

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DISCLOSURE LOG

Price Limits Determined by the Cost Model

The following Table sets out how the price limits for each relevant NDIS support item is related to the NDIA's estimates of the efficient costs of delivering supports. Further information can be found in the NDIA's *Price Guide 2020-21*.[22]

Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
01_002_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Night	Determined by DSW model	DSW 1	Night Loading	
01_002_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Night - TTP	Derived from DSW Model	DSW 1	Night Loading	See Note 1
01_010_0107_1_1	Assistance With Self-Care Activities - Night-Time Sleepover	Derived from DSW Model	DSW 1		See Note 2
01_011_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Daytime	Determined by DSW model	DSW 1		
01_011_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 1
01_012_0107_1_1	Assistance With Self-Care Activities - Standard - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading	
01_012_0107_1_1_T	Assistance With Self-Care Activities - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 1
01_013_0107_1_1	Assistance With Self-Care Activities - Standard - Saturday	Determined by DSW model	DSW 1	Saturday Loading	
01_013_0107_1_1_T	Assistance With Self-Care Activities - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 1
01_014_0107_1_1	Assistance With Self-Care Activities - Standard - Sunday	Determined by DSW model	DSW 1	Sunday Loading	
01_014_0107_1_1_T	Assistance With Self-Care Activities - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 1
01_015_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading	
01_015_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 1
01_045_0115_1_1	STA And Assistance (Inc. Respite) - 1:4 - Weekday	Derived from DSW Model	DSW 2		See Note 4
01_049_0104_1_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1		See Note 3
01_049_0107_1_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1		See Note 3
01_051_0115_1_1	STA And Assistance (Inc. Respite) - 1:4 - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 4
01_052_0115_1_1	STA And Assistance (Inc. Respite) - 1:4 - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 4
01_053_0115_1_1	STA And Assistance (Inc. Respite) - 1:4 - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 4

22 https://www.ndis.gov.au/providers/price-guides-and-pricing#ndis-price-guide-2020-21-effective-1-july-2020

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
01_054_0115_1_1	STA And Assistance (Inc. Respite) - 1:2 - Weekday	Derived from DSW Model	DSW 2		See Note 4
01_055_0115_1_1	STA And Assistance (Inc. Respite) - 1:2 - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 4
01_056_0115_1_1	STA And Assistance (Inc. Respite) - 1:2 - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 4
01_057_0115_1_1	STA And Assistance (Inc. Respite) - 1:2 - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 4
01_058_0115_1_1	STA And Assistance (Inc. Respite) - 1:1 - Weekday	Derived from DSW Model	DSW 2		See Note 4
01_059_0115_1_1	STA And Assistance (Inc. Respite) - 1:1 - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 4
01_060_0115_1_1	STA And Assistance (Inc. Respite) - 1:1 - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 4
01_061_0115_1_1	STA And Assistance (Inc. Respite) - 1:1 - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 4
01_062_0115_1_1	STA And Assistance (Inc. Respite) - 1:3 - Weekday	Derived from DSW Model	DSW 2		See Note 4
01_063_0115_1_1	STA And Assistance (Inc. Respite) - 1:3 - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 4
01_064_0115_1_1	STA And Assistance (Inc. Respite) - 1:3 - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 4
01_065_0115_1_1	STA And Assistance (Inc. Respite) - 1:3 - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 4
01_200_0115_1_1	Assistance With Self-Care Activities in a STA - Weekday Daytime	Determined by DSW model	DSW 1		
01_201_0115_1_1	Assistance With Self-Care Activities in a STA - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading	
01_202_0115_1_1	Assistance With Self-Care Activities in a STA - Saturday	Determined by DSW model	DSW 1	Saturday Loading	
01_203_0115_1_1	Assistance With Self-Care Activities in a STA - Sunday	Determined by DSW model	DSW 1	Sunday Loading	
01_204_0115_1_1	Assistance With Self-Care Activities in a STA - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading	
01_205_0115_1_1	Assistance With Self-Care Activities in a STA - Weekday Night	Determined by DSW model	DSW 1	Night Loading	
01_300_0104_1_1	Assistance With Self-Care Activities - Level 1 - Weekday Daytime	Determined by DSW model	DSW 1		
01_300_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 1
01_301_0104_1_1	Assistance With Self-Care Activities - Level 1 - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading	
01_301_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 1
01_302_0104_1_1	Assistance With Self-Care Activities - Level 1 - Saturday	Determined by DSW model	DSW 1	Saturday Loading	
01_302_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 1
01_303_0104_1_1	Assistance With Self-Care Activities - Level 1 - Sunday	Determined by DSW model	DSW 1	Sunday Loading	
01_303_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 1
01_304_0104_1_1	Assistance With Self-Care Activities - Level 1 - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading	

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
01_304_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 1
01_305_0104_1_1	Assistance With Self-Care Activities - Level 1 - Weekday Night	Determined by DSW model	DSW 1	Night Loading	
01_305_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Weekday Night - TTP	Derived from DSW Model	DSW 1	Night Loading	See Note 1
01_400_0104_1_1	Assistance With Self-Care Activities - Level 2 - Weekday Daytime	Determined by DSW model	DSW 2		
01_400_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 1
01_401_0104_1_1	Assistance With Self-Care Activities - Level 2 - Weekday Evening	Determined by DSW model	DSW 2	Evening Loading	
01_401_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Weekday Evening - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 1
01_402_0104_1_1	Assistance With Self-Care Activities - Level 2 - Saturday	Determined by DSW model	DSW 2	Saturday Loading	
01_402_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 1
01_403_0104_1_1	Assistance With Self-Care Activities - Level 2 - Sunday	Determined by DSW model	DSW 2	Sunday Loading	
01_403_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 1
01_404_0104_1_1	Assistance With Self-Care Activities - Level 2 - Public Holiday	Determined by DSW model	DSW 2	Public Holiday Loading	
01_404_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 1
01_405_0104_1_1	Assistance With Self-Care Activities - Level 2 - Weekday Night	Determined by DSW model	DSW 2	Night Loading	
01_405_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Weekday Night - TTP	Derived from DSW Model	DSW 2	Night Loading	See Note 1
01_500_0104_1_1	Assistance With Self-Care Activities - Level 3 - Weekday Daytime	Determined by DSW model	DSW 3		
01_500_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Weekday Daytime - TTP	Derived from DSW Model	DSW 3		See Note 1
01_501_0104_1_1	Assistance With Self-Care Activities - Level 3 - Weekday Evening	Determined by DSW model	DSW 3	Evening Loading	
01_501_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Weekday Evening - TTP	Derived from DSW Model	DSW 3	Evening Loading	See Note 1
01_502_0104_1_1	Assistance With Self-Care Activities - Level 3 - Saturday	Determined by DSW model	DSW 3	Saturday Loading	
01_502_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Saturday - TTP	Derived from DSW Model	DSW 3	Saturday Loading	See Note 1
01_503_0104_1_1	Assistance With Self-Care Activities - Level 3 - Sunday	Determined by DSW model	DSW 3	Sunday Loading	
01_503_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Sunday - TTP	Derived from DSW Model	DSW 3	Sunday Loading	See Note 1
01_504_0104_1_1	Assistance With Self-Care Activities - Level 3 - Public Holiday	Determined by DSW model	DSW 3	Public Holiday Loading	
01_504_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Public Holiday - TTP	Derived from DSW Model	DSW 3	Public Holiday Loading	See Note 1
01_505_0104_1_1	Assistance With Self-Care Activities - Level 3 - Weekday Night	Determined by DSW model	DSW 3	Night Loading	
01_505_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Weekday Night - TTP	Derived from DSW Model	DSW 3	Night Loading	See Note 1

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
01_790_0106_8_3	Level 1: Support Connection	Determined by DSW model	DSW 3		
01_801_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Daytime	Determined by DSW model	DSW 1		
01_802_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading	
01_803_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Night	Determined by DSW model	DSW 1	Night Loading	
01_804_0115_1_1	Assistance in Supported Independent Living - Standard - Saturday	Determined by DSW model	DSW 1	Saturday Loading	
01_805_0115_1_1	Assistance in Supported Independent Living - Standard - Sunday	Determined by DSW model	DSW 1	Sunday Loading	
01_806_0115_1_1	Assistance in Supported Independent Living - Standard - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading	
01_811_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Daytime	Determined by DSW model	DSW 2		
01_812_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Evening	Determined by DSW model	DSW 2	Evening Loading	
01_813_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Night	Determined by DSW model	DSW 2	Night Loading	
01_814_0115_1_1	Assistance in Supported Independent Living - High Intensity - Saturday	Determined by DSW model	DSW 2	Saturday Loading	
01_815_0115_1_1	Assistance in Supported Independent Living - High Intensity - Sunday	Determined by DSW model	DSW 2	Sunday Loading	
01_816_0115_1_1	Assistance in Supported Independent Living - High Intensity - Public Holiday	Determined by DSW model	DSW 2	Public Holiday Loading	
01_832_0115_1_1	Assistance in Supported Independent Living - Night-Time Sleepover	Derived from DSW Model	DSW 1		See Note 2
04_049_0104_1_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1		See Note 3
04_049_0125_1_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1		See Note 3
04_049_0133_5_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1		See Note 3
04_049_0136_1_1	Establishment Fee For Personal Care/Participation	Derived from DSW Model	DSW 1		See Note 3
04_102_0125_6_1	Access Community Social And Rec Activities - Standard - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading	
04_102_0125_6_1_T	Access Community Social And Rec Activities - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 1
04_102_0136_6_1	Group Activities - Standard - Weekday Daytime	Determined by DSW model	DSW 1		
04_102_0136_6_1_T	Group Activities - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 1
04_103_0125_6_1	Access Community Social And Rec Activities - Standard - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading	
04_103_0125_6_1_T	Access Community Social And Rec Activities - Standard - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 1
04_103_0136_6_1	Group Activities - Standard - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading	
04_103_0136_6_1_T	Group Activities - Standard - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 1
04_104_0125_6_1	Access Community Social And Rec Activities - Weekday Daytime	Determined by DSW model	DSW 1		

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
04_104_0125_6_1_T	Access Community Social And Rec Activities - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 1
04_104_0136_6_1	Group Activities - Standard - Saturday	Determined by DSW model	DSW 1	Saturday Loading	
04_104_0136_6_1_T	Group Activities - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 1
04_105_0125_6_1	Access Community Social And Rec Activities - Standard - Saturday	Determined by DSW model	DSW 1	Saturday Loading	
04_105_0125_6_1_T	Access Community Social And Rec Activities - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 1
04_105_0136_6_1	Group Activities - Standard - Sunday	Determined by DSW model	DSW 1	Sunday Loading	
04_105_0136_6_1_T	Group Activities - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 1
04_106_0125_6_1	Access Community Social And Rec Activities - Standard - Sunday	Determined by DSW model	DSW 1	Sunday Loading	
04_106_0125_6_1_T	Access Community Social And Rec Activities - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 1
04_106_0136_6_1	Group Activities - Standard - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading	
04_106_0136_6_1_T	Group Activities - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 1
04_111_0136_6_1	Group Activities In The Community - 1:2 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1		See Note 5
04_111_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 5
04_112_0136_6_1	Group Activities In The Community - 1:2 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_112_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_113_0136_6_1	Group Activities In The Community - 1:2 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_113_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_114_0136_6_1	Group Activities In The Community - 1:2 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_114_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_116_0104_6_1	Group Activities In The Community - 1:2 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2		See Note 5
04_116_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 5
04_117_0104_6_1	Group Activities In The Community - 1:2 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_117_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_118_0104_6_1	Group Activities In The Community - 1:2 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_118_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_119_0104_6_1	Group Activities In The Community - 1:2 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_119_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 5

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
04_120_0136_6_1	Group Activities In The Community - 1:3 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1		See Note 5
04_120_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 5
04_121_0136_6_1	Group Activities In The Community - 1:3 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_121_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_122_0136_6_1	Group Activities In The Community - 1:3 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_122_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_123_0136_6_1	Group Activities In The Community - 1:3 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_123_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_124_0104_6_1	Group Activities In The Community - 1:3 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2		See Note 5
04_124_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 5
04_125_0104_6_1	Group Activities In The Community - 1:3 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_125_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_126_0104_6_1	Group Activities In The Community - 1:3 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_126_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_127_0104_6_1	Group Activities In The Community - 1:3 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_127_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_128_0136_6_1	Group Activities In The Community - 1:2 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_128_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_129_0136_6_1	Group Activities In The Community - 1:3 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_129_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_130_0104_6_1	Group Activities In The Community - 1:2 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_130_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_131_0104_6_1	Group Activities In The Community - 1:3 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_131_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_136_0136_6_1	Group Activities In The Community - 1:4 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1		See Note 5
04_136_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 5
04_137_0136_6_1	Group Activities In The Community - 1:4 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading	See Note 5

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04_137_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_138_0136_6_1	Group Activities In The Community - 1:4 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_138_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_139_0136_6_1	Group Activities In The Community - 1:4 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_139_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_140_0136_6_1	Group Activities In The Community - 1:4 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_140_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_141_0136_6_1	Group Activities In The Community - 1:5 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1		See Note 5
04_141_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 5
04_142_0136_6_1	Group Activities In The Community - 1:5 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_142_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_143_0136_6_1	Group Activities In The Community - 1:5 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_143_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_144_0136_6_1	Group Activities In The Community - 1:5 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_144_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_145_0136_6_1	Group Activities In The Community - 1:5 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_145_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_146_0104_6_1	Group Activities In The Community - 1:4 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2		See Note 5
04_146_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 5
04_147_0104_6_1	Group Activities In The Community - 1:4 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_147_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_148_0104_6_1	Group Activities In The Community - 1:4 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_148_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_149_0104_6_1	Group Activities In The Community - 1:4 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_149_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_150_0104_6_1	Group Activities In The Community - 1:4 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_150_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
04_151_0104_6_1	Group Activities In The Community - 1:5 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2		See Note 5
04_151_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 5
04_152_0104_6_1	Group Activities In The Community - 1:5 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_152_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_153_0104_6_1	Group Activities In The Community - 1:5 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_153_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_154_0104_6_1	Group Activities In The Community - 1:5 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_154_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_155_0104_6_1	Group Activities In The Community - 1:5 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_155_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_160_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Weekday	Derived from DSW Model	DSW 1		See Note 5
04_160_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 5
04_161_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_161_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_162_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_162_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_163_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_163_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_164_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_164_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_165_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1		See Note 5
04_165_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 5
04_166_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_166_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_167_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_167_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_168_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
04_168_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_169_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_169_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_170_0136_6_1	Group Activities In A Centre - 1:3 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1		See Note 5
04_170_0136_6_1_T	Group Activities In A Centre - 1:3 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 5
04_171_0136_6_1	Group Activities In A Centre - 1:3 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_171_0136_6_1_T	Group Activities In A Centre - 1:3 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_172_0136_6_1	Group Activities In A Centre - 1:3 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_172_0136_6_1_T	Group Activities In A Centre - 1:3 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_173_0136_6_1	Group Activities In A Centre - 1:3 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_173_0136_6_1_T	Group Activities In A Centre - 1:3 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_174_0136_6_1	Group Activities In A Centre - 1:3 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_174_0136_6_1_T	Group Activities In A Centre - 1:3 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_175_0136_6_1	Group Activities In A Centre - 1:4 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1		See Note 5
04_175_0136_6_1_T	Group Activities In A Centre - 1:4 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 5
04_176_0136_6_1	Group Activities In A Centre - 1:4 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_176_0136_6_1_T	Group Activities In A Centre - 1:4 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_177_0136_6_1	Group Activities In A Centre - 1:4 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_177_0136_6_1_T	Group Activities In A Centre - 1:4 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_178_0136_6_1	Group Activities In A Centre - 1:4 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_178_0136_6_1_T	Group Activities In A Centre - 1:4 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_179_0136_6_1	Group Activities In A Centre - 1:4 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_179_0136_6_1_T	Group Activities In A Centre - 1:4 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_180_0136_6_1	Group Activities In A Centre - 1:5 - Standard - Weekday Daytime	Derived from DSW Model	DSW 1		See Note 5
04_180_0136_6_1_T	Group Activities In A Centre - 1:5 - Standard - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 5
04_181_0136_6_1	Group Activities In A Centre - 1:5 - Standard - Weekday Afternoon	Derived from DSW Model	DSW 1	Evening Loading	See Note 5
04_181_0136_6_1_T	Group Activities In A Centre - 1:5 - Standard - Weekday Afternoon - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 5

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
04_182_0136_6_1	Group Activities In A Centre - 1:5 - Standard - Saturday	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_182_0136_6_1_T	Group Activities In A Centre - 1:5 - Standard - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 5
04_183_0136_6_1	Group Activities In A Centre - 1:5 - Standard - Sunday	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_183_0136_6_1_T	Group Activities In A Centre - 1:5 - Standard - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 5
04_184_0136_6_1	Group Activities In A Centre - 1:5 - Standard - Public Holiday	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_184_0136_6_1_T	Group Activities In A Centre - 1:5 - Standard - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 5
04_185_0104_6_1	Group Activities In A Centre - 1:1 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2		See Note 5
04_185_0104_6_1_T	Group Activities In A Centre - 1:1 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 5
04_186_0104_6_1	Group Activities In A Centre - 1:1 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_186_0104_6_1_T	Group Activities In A Centre - 1:1 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_187_0104_6_1	Group Activities In A Centre - 1:1 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_187_0104_6_1_T	Group Activities In A Centre - 1:1 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_188_0104_6_1	Group Activities In A Centre - 1:1 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_188_0104_6_1_T	Group Activities In A Centre - 1:1 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_189_0104_6_1	Group Activities In A Centre - 1:1 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_189_0104_6_1_T	Group Activities In A Centre - 1:1 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_190_0104_6_1	Group Activities In A Centre - 1:2 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2		See Note 5
04_190_0104_6_1_T	Group Activities In A Centre - 1:2 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 5
04_191_0104_6_1	Group Activities In A Centre - 1:2 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_191_0104_6_1_T	Group Activities In A Centre - 1:2 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_192_0104_6_1	Group Activities In A Centre - 1:2 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_192_0104_6_1_T	Group Activities In A Centre - 1:2 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_193_0104_6_1	Group Activities In A Centre - 1:2 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_193_0104_6_1_T	Group Activities In A Centre - 1:2 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_194_0104_6_1	Group Activities In A Centre - 1:2 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_194_0104_6_1_T	Group Activities In A Centre - 1:2 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_195_0104_6_1	Group Activities In A Centre - 1:3 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2		See Note 5

UNDER REVIEW

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
04_195_0104_6_1_T	Group Activities In A Centre - 1:3 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 5
04_196_0104_6_1	Group Activities In A Centre - 1:3 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_196_0104_6_1_T	Group Activities In A Centre - 1:3 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_197_0104_6_1	Group Activities In A Centre - 1:3 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_197_0104_6_1_T	Group Activities In A Centre - 1:3 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_198_0104_6_1	Group Activities In A Centre - 1:3 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_198_0104_6_1_T	Group Activities In A Centre - 1:3 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_199_0104_6_1	Group Activities In A Centre - 1:3 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_199_0104_6_1_T	Group Activities In A Centre - 1:3 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_200_0104_6_1	Group Activities In A Centre - 1:4 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2		See Note 5
04_200_0104_6_1_T	Group Activities In A Centre - 1:4 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 5
04_201_0104_6_1	Group Activities In A Centre - 1:4 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_201_0104_6_1_T	Group Activities In A Centre - 1:4 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_202_0104_6_1	Group Activities In A Centre - 1:4 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_202_0104_6_1_T	Group Activities In A Centre - 1:4 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_203_0104_6_1	Group Activities In A Centre - 1:4 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_203_0104_6_1_T	Group Activities In A Centre - 1:4 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_204_0104_6_1	Group Activities In A Centre - 1:4 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_204_0104_6_1_T	Group Activities In A Centre - 1:4 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_205_0104_6_1	Group Activities In A Centre - 1:5 - Complex - Weekday Daytime	Derived from DSW Model	DSW 2		See Note 5
04_205_0104_6_1_T	Group Activities In A Centre - 1:5 - Complex - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 5
04_206_0104_6_1	Group Activities In A Centre - 1:5 - Complex - Weekday Afternoon	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_206_0104_6_1_T	Group Activities In A Centre - 1:5 - Complex - Weekday Afternoon - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 5
04_207_0104_6_1	Group Activities In A Centre - 1:5 - Complex - Saturday	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_207_0104_6_1_T	Group Activities In A Centre - 1:5 - Complex - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 5
04_208_0104_6_1	Group Activities In A Centre - 1:5 - Complex - Sunday	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5
04_208_0104_6_1_T	Group Activities In A Centre - 1:5 - Complex - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 5

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
04_209_0104_6_1	Group Activities In A Centre - 1:5 - Complex - Public Holiday	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_209_0104_6_1_T	Group Activities In A Centre - 1:5 - Complex - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 5
04_300_0104_1_1	Access Community Social And Rec Activities - Level 1 - Weekday Daytime	Determined by DSW model	DSW 1		
04_300_0104_1_1_T	Access Community Social And Rec Activities - Level 1 - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 1
04_301_0104_1_1	Access Community Social And Rec Activities - Level 1 - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading	
04_301_0104_1_1_T	Access Community Social And Rec Activities - Level 1 - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 1
04_302_0104_1_1	Access Community Social And Rec Activities - Level 1 - Saturday	Determined by DSW model	DSW 1	Saturday Loading	
04_302_0104_1_1_T	Access Community Social And Rec Activities - Level 1 - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 1
04_303_0104_1_1	Access Community Social And Rec Activities - Level 1 - Sunday	Determined by DSW model	DSW 1	Sunday Loading	
04_303_0104_1_1_T	Access Community Social And Rec Activities - Level 1 - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 1
04_304_0104_1_1	Access Community Social And Rec Activities - Level 1 - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading	
04_304_0104_1_1_T	Access Community Social And Rec Activities - Level 1 - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 1
04_400_0104_1_1	Access Community Social And Rec Activities - Level 2 - Weekday Daytime	Determined by DSW model	DSW 2		
04_400_0104_1_1_T	Access Community Social And Rec Activities - Level 2 - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 1
04_401_0104_1_1	Access Community Social And Rec Activities - Level 2 - Weekday Evening	Determined by DSW model	DSW 2	Evening Loading	
04_401_0104_1_1_T	Access Community Social And Rec Activities - Level 2 - Weekday Evening - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 1
04_402_0104_1_1	Access Community Social And Rec Activities - Level 2 - Saturday	Determined by DSW model	DSW 2	Saturday Loading	
04_402_0104_1_1_T	Access Community Social And Rec Activities - Level 2 - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 1
04_403_0104_1_1	Access Community Social And Rec Activities - Level 2 - Sunday	Determined by DSW model	DSW 2	Sunday Loading	
04_403_0104_1_1_T	Access Community Social And Rec Activities - Level 2 - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 1
04_404_0104_1_1	Access Community Social And Rec Activities - Level 2 - Public Holiday	Determined by DSW model	DSW 2	Public Holiday Loading	
04_404_0104_1_1_T	Access Community Social And Rec Activities - Level 2 - Public Holiday - TTP	Derived from DSW Model	DSW 2	Public Holiday Loading	See Note 1
04_500_0104_1_1	Access Community Social And Rec Activities - Level 3 - Weekday Daytime	Determined by DSW model	DSW 3		
04_500_0104_1_1_T	Access Community Social And Rec Activities - Level 3 - Weekday Daytime - TTP	Derived from DSW Model	DSW 3		See Note 1
04_501_0104_1_1	Access Community Social And Rec Activities - Level 3 - Weekday Evening	Determined by DSW model	DSW 3	Evening Loading	
04_501_0104_1_1_T	Access Community Social And Rec Activities - Level 3 - Weekday Evening - TTP	Derived from DSW Model	DSW 3	Evening Loading	See Note 1
04_502_0104_1_1	Access Community Social And Rec Activities - Level 3 - Saturday	Determined by DSW model	DSW 3	Saturday Loading	

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
04_502_0104_1_1_T	Access Community Social And Rec Activities - Level 3 - Saturday - TTP	Derived from DSW Model	DSW 3	Saturday Loading	See Note 1
04_503_0104_1_1	Access Community Social And Rec Activities - Level 3 - Sunday	Determined by DSW model	DSW 3	Sunday Loading	
04_503_0104_1_1_T	Access Community Social And Rec Activities - Level 3 - Sunday - TTP	Derived from DSW Model	DSW 3	Sunday Loading	See Note 1
04_504_0104_1_1	Access Community Social And Rec Activities - Level 3 - Public Holiday	Determined by DSW model	DSW 3	Public Holiday Loading	
04_504_0104_1_1_T	Access Community Social And Rec Activities - Level 3 - Public Holiday - TTP	Derived from DSW Model	DSW 3	Public Holiday Loading	See Note 1
04_600_0104_6_1	Group Activities - High Intensity - Weekday Daytime	Determined by DSW model	DSW 2		
04_600_0104_6_1_T	Group Activities - High Intensity - Weekday Daytime - TTP	Derived from DSW Model	DSW 2		See Note 1
04_601_0104_6_1	Group Activities - High Intensity - Weekday Evening	Determined by DSW model	DSW 2	Evening Loading	
04_601_0104_6_1_T	Group Activities - High Intensity - Weekday Evening - TTP	Derived from DSW Model	DSW 2	Evening Loading	See Note 1
04_602_0104_6_1	Group Activities - High Intensity - Saturday	Determined by DSW model	DSW 2	Saturday Loading	
04_602_0104_6_1_T	Group Activities - High Intensity - Saturday - TTP	Derived from DSW Model	DSW 2	Saturday Loading	See Note 1
04_603_0104_6_1	Group Activities - High Intensity - Sunday	Determined by DSW model	DSW 2	Sunday Loading	
04_603_0104_6_1_T	Group Activities - High Intensity - Sunday - TTP	Derived from DSW Model	DSW 2	Sunday Loading	See Note 1
04_604_0104_6_1	Group Activities - High Intensity - Public Holiday	Determined by DSW model	DSW 2	Public Holiday Loading	
04_604_0104_6_1_T	Group Activities - High Intensity - Public Holiday - TTP	Determined by DSW model	DSW 2	Public Holiday Loading	See Note 1
04_801_0133_5_1	Supports in Employment - Weekday Daytime	Determined by DSW model	DSW 1		
04_801_0133_5_1_T	Supports in Employment - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 1
04_802_0133_5_1	Supports In Employment - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading	
04_802_0133_5_1_T	Supports In Employment - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 1
04_803_0133_5_1	Supports In Employment - Saturday	Determined by DSW model	DSW 1	Saturday Loading	
04_803_0133_5_1_T	Supports In Employment - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 1
04_804_0133_5_1	Supports In Employment - Sunday	Determined by DSW model	DSW 1	Sunday Loading	
04_804_0133_5_1_T	Supports In Employment - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 1
04_805_0133_5_1	Supports In Employment - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading	
04_805_0133_5_1_T	Supports In Employment - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 1
07_001_0106_8_3	Level 1: Support Connection	Determined by DSW model	DSW 3		
07_003_0117_8_3	CB and Training in Plan and Financial Management by a Support Coordinator	Determined by DSW model	DSW 3		

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Support Item Number	Support Item Name	Methodology	Basic Model	Loading	Adjustment
07_101_0106_6_3	Psychosocial Recovery Coaching - Weekday Daytime	Determined by DSW model	DSW 4		
07_102_0106_6_3	Psychosocial Recovery Coaching - Weekday Evening	Determined by DSW model	DSW 4	Evening Loading	
07_103_0106_6_3	Psychosocial Recovery Coaching - Weekday Night	Determined by DSW model	DSW 4	Night Loading	
07_104_0106_6_3	Psychosocial Recovery Coaching - Saturday	Determined by DSW model	DSW 4	Saturday Loading	
07_105_0106_6_3	Psychosocial Recovery Coaching - Sunday	Determined by DSW model	DSW 4	Sunday Loading	
07_106_0106_6_3	Psychosocial Recovery Coaching - Public Holiday	Determined by DSW model	DSW 4	Public Holiday Loading	
08_005_0106_2_3	Assistance With Accommodation And Tenancy Obligations	Determined by DSW model	DSW 3		
09_006_0106_6_3	Life Transition Planning Incl. Mentoring Peer-Support And Indiv Skill Develop	Determined by DSW model	DSW 3		
09_009_0117_6_3	Skills Development And Training	Determined by DSW model	DSW 3		
10_016_0102_5_3	Employment Support	Determined by DSW model	DSW 3		
10_801_0133_5_1_D	Supports in Employment - Weekday Daytime	Determined by DSW model	DSW 1		
10_801_0133_5_1_T_D	Supports in Employment - Weekday Daytime - TTP	Derived from DSW Model	DSW 1		See Note 1
10_802_0133_5_1_D	Supports In Employment - Weekday Evening	Determined by DSW model	DSW 1	Evening Loading	
10_802_0133_5_1_T_D	Supports In Employment - Weekday Evening - TTP	Derived from DSW Model	DSW 1	Evening Loading	See Note 1
10_803_0133_5_1_D	Supports In Employment - Saturday	Determined by DSW model	DSW 1	Saturday Loading	
10_803_0133_5_1_T_D	Supports In Employment - Saturday - TTP	Derived from DSW Model	DSW 1	Saturday Loading	See Note 1
10_804_0133_5_1_D	Supports In Employment - Sunday	Determined by DSW model	DSW 1	Sunday Loading	
10_804_0133_5_1_T_D	Supports In Employment - Sunday - TTP	Derived from DSW Model	DSW 1	Sunday Loading	See Note 1
10_805_0133_5_1_D	Supports In Employment - Public Holiday	Determined by DSW model	DSW 1	Public Holiday Loading	
10_805_0133_5_1_T_D	Supports In Employment - Public Holiday - TTP	Derived from DSW Model	DSW 1	Public Holiday Loading	See Note 1
11_024_0117_7_3	Individual Social Skills Development	Determined by DSW model	DSW 3		
13_030_0102_4_3	Transition Through School And To Further Education	Determined by DSW model	DSW 3		
14_031_0127_8_3	CB and Training in Plan and Financial Management by a Plan Manager	Determined by DSW model	DSW 3		
15_035_0106_1_3	Assistance With Decision Making Daily Planning and Budgeting	Determined by DSW model	DSW 1		
15_037_0117_1_3	Individual Skill Development And Training Including Public Transport Training	Determined by DSW model	DSW 1		
15_038_0117_1_3	Training For Carers/Parents	Determined by DSW model	DSW 3		

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Notes

1. Temporary Transformation Payment (TTP)

The 2020-21 price limit for each TTP support item is higher than the price limit for the equivalent non-TTP item. In 2020-21, the TTP additional amount is equal to 6 per cent of the DSW 1 Cost for each time of day and day of week.

2. Assistance with Self Care Activities - Night-Time Sleepover Support

The 2020-21 price limit for these support items is equal to the SCHADS Award Sleepover Allowance[23] plus three times the DSW 1 Night Cost.

3. Establishment Fee for Personal Care/Participation

The 2020-21 price limit for this support item is 10 times the DSW 1 Weekday Cost.

4. Short Term Accommodation and Assistance (including the respite care)

The 2020-21 price limits for each 1:n weekday support item is the sum of

- $181.41 for the non-labour costs of food and accommodation;
- 1/n times 8 times the DSW 2 Daytime Cost;
- 1/n times 8 times the DSW 2 Weekday Evening Cost;
- 1/n times 8 times the DSW 2 Weekday Night Cost.

The 2020-21 price limits for each 1:n Saturday support item is the sum of

- $181.41 for the non-labour costs of food and accommodation;
- 1/n times 24 times the DSW 2 Saturday Cost.

The 2020-21 price limits for each 1:n Sunday support item is the sum of

- $181.41 for the non-labour costs of food and accommodation;
- 1/n times 24 times the DSW 2 Sunday Cost.

The 2020-21 price limits for each 1:n Public Holiday support item is the sum of

- $181.41 for the non-labour costs of food and accommodation;
- 1/n times 24 times the DSW 2 Public Holiday Cost.

5. Group Activities (Transitional Arrangement)

The price limit for community-based group supports apply to each hour of support and are based on the price limit of the relevant 1:1 community participation support (for each level of support and time of day and day of week). If the price limit for the relevant 1:1 support is P then the price limit P_n for the 1:n community based support is given by the following formulae:

$$P_n = \frac{P + (n-1) \times 0.12 \times P}{n}$$

[23] https://www.fairwork.gov.au/pay/minimum-wages/social-and-community-services-industry-pay-rates

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For each additional person in the group (after the first) an additional 12% of the 1:1 price limit (essentially seven minutes) is added to the hourly price limit.

The price limit for centre-based group supports are calculated by adding a fixed capital allowance amount to the relevant community based group support. In 2020-21, the amount of the fixed capital allowance is $2.15 per participant per hour.

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Appendix 1 – Footnotes

1. https://www.ndis.gov.au/media/1662/download
2. The NDIA considers that it is appropriate to estimate the cost structure of overall efficient (25th percentile) providers by reference to the 25th percentile of all providers' performance against each of the key parameters because there is little collinearity observed between the parameters in the TTP Benchmarking Survey results. The determinant of the Pearson product-moment correlation coefficient matrix (see below) is 87.1%.

	A = Permanent Share of Workforce	B = Supervision Ratio	C = Non travel allowances	D = Workers Compensation Premium	E = Utilisation percentage	F = Overheads percentage
A	1.00	-0.09	-0.13	0.06	-0.04	0.08
B	-0.09	1.00	-0.07	0.00	0.19	0.08
C	-0.13	-0.07	1.00	-0.02	-0.14	-0.18
D	0.06	0.00	-0.02	1.00	-0.02	0.02
E	-0.04	0.19	-0.14	-0.02	1.00	0.09
F	0.08	0.08	-0.18	0.02	0.09	1.00

See p.58 of the *Annual Pricing Review 2020-21*.

3. https://www.ndis.gov.au/media/1820/download
4. https://www.ndis.gov.au/media/2413/download
5. Fair Work Commission, *Social, Community, Home Care and Disability Services Industry Award 2010*, incorporating all amendments up to and including 30 June 2020.
6. https://www.fairwork.gov.au/ArticleDocuments/872/social-community-home-care-and-disability-services-industry-award-ma000100-pay-guide.pdf.aspx
7. SCHADS Award: Clauses 10.4(b), 26 and 29.3.
8. SCHADS Award: Clause 25.1.
9. The National Employment Standards govern leave and several other conditions in Awards, and also may not be reduced by EBAs. https://www.fairwork.gov.au/employee-entitlements/national-employment-standards
10. https://www.fairwork.gov.au/leave/annual-leave
11. https://www.fairwork.gov.au/leave/public-holidays

Note: The Agency recognises that there are more than 10 public holidays in each year, and that the number of public holidays varies by jurisdiction. However, some public holidays occur on weekends and it is unlikely that any worker in their ordinary working hours would be rostered to have worked on more than 10 public holidays.

12. https://www.fairwork.gov.au/leave/sick-and-carers-leave/paid-sick-and-carers-leave

Note: The Cost Model slightly overestimates provider's cost with respect to this parameter as it assumes all workers utilise all of their personal leave entitlement each year even though some workers may not use their entitlement.

13. https://www.fairwork.gov.au/leave/long-service-leave

Note: The Cost Model overestimates provider's cost with respect to this parameter as it assumes all permanent workers and casual workers qualify for LSL accruals and that all

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workers will eventually access their long service leave entitlement. This reflects the rollout of portable long service leave schemes in some jurisdictions.

14. SCHADS Award: Clause 31.3

15. https://www.ato.gov.au/Business/Super-for-employers/How-much-to-pay/

16. The *Annual Pricing Review 2020-21* (page 54) found that, averaged over 2010-11 to 2014-15, the standardised Australian average workers compensation premium rate was 1.5% for all industries and 1.7% for the Health and Community Services sector. The Benchmarking Study undertaken as part of the Annual Pricing Review 2020-21 found that the average workers compensation premium among respondents in the disability sector was 2.6%, with a median of 2.3% and a 25th percentile of 1.7%. In line with the *NDIS Pricing Strategy*, this Cost Model parameter has been set at the level achieved by efficient (25th percentile) providers.

17. The *Annual Pricing Review 2020-21* (page 57) found that allowances in the sector were typically in the order of 1.0% of the base salary payable to the worker.

18. The Benchmarking Study undertaken as part of the *Annual Pricing Review 2020-21* (page 52) found that the average span of control among respondents in the disability sector was 11.8:1 with a 25th percentile of 15:1. In line with the *NDIS Pricing Strategy*, this Cost Model parameter has been set at the level achieved by efficient (25th percentile) providers.

19. The Benchmarking Study undertaken as part of the *Annual Pricing Review 2020-21* (page 52) found that the average casual employment share among respondents in the disability sector was 43.8% with a 25th percentile of 71.7%. In line with the *NDIS Pricing Strategy*, this Cost Model parameter has been set at the level achieved by efficient (25th percentile) providers.

20. The Benchmarking Study undertaken as part of the Annual Pricing Review 2020-21 (page 52) found that the average utilisation among respondents in the disability sector was 79.8% with a 25th percentile of 90.0%. In line with the NDIS Pricing Strategy, this Cost Model parameter has been set at the level achieved by efficient (25th percentile) providers.

Because the Benchmarking Study did not disaggregate its results between DSWs 1, 2 and 3 the efficient utilisation rates have been estimated for each DSW Level around the sector wide 25th percentile with the utilisation rate decreasing slightly with the seniority of the worker.

The utilisation rate for DSW 4s was set after consultations with providers who were currently employing workers in the role of a psychosocial recovery coach. These providers indicated that these staff were appropriately classified at the SCHADS pay point 4.4. They also indicated that workers who supported participants with psychosocial disabilities often needed to debrief and be supported at the end of their shifts to support their own mental well-being, which lowered their own and their supervisors' utilisation rates.

21. The *Annual Pricing Review 2020-21* (page 58) found that the overheads percentage should be increased to 12.0% to better align with the estimated overheads of efficient providers in the sector, as observed in the Benchmarking Study adjusted for that survey's unrepresentativeness and that other recommendations being made by the Review would directly address some of the costs that providers are currently carrying in their overheads.

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22. https://www.ndis.gov.au/providers/price-guides-and-pricing#ndis-price-guide-2020-21-effective-1-july-2020

23. https://www.fairwork.gov.au/pay/minimum-wages/social-and-community-services-industry-pay-rates

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Pricing Reference Group

Meeting: 10 September 2020

Minutes

Date: Thursday, 10 September 2020 **Time:** 1030 – 1230

Location: Microsoft Teams Meeting (Video Conference)

Attendees	
Chair	
Gerrie s47F - perso	General Manager, Provider and Markets
Pricing Reference Group Members	
Jim s47F - pe PSM	Independent Member
Julie s47F - personal privacy PSM	Independent Member
Graeme s47F - perso AM	Independent Member
Participating Observers nominated by CEO	
Sarah s47F - personal priv	Scheme Actuary
David Cullen	Chief Economist
Secretariat	
Alison s47F - personal pri	Project Officer, Price Regulation Unit

Declaration of Conflicts of Interest

The PRG **NOTED** that Graeme s47F - person is:

- a member of the Board of Life Without Barriers;
- a member of the Board of Joblife Employment;
- a member of the Board of Attitude Foundation;
- a member of the Advisory Board for Probono News; and
- s47F - personal privacy, s22(1)(a)(ii) - irrelevant material

It was **NOTED** that Graeme was no longer a member of the Board of the Summer Foundation.

Confirmation of the Previous Meeting's Minutes

The PRG **ENDORSED** the minutes of the previous meeting (*PRG - 20200416 and 20200424 "Out of Session Consideration"- Item 1.3*).

Update by the Chair

The Chair informed that PRG that:

- the NDIA Board has continued with the temporary changes in the NDIS pricing arrangements in response to the COVID-19 pandemic;
- the Price Regulation Unit (PRU) have commenced work on simplifying the NDIS Price Guide – preliminary PRG consideration of issues to come in the near future;
- Expression of Interest for remaining independent PRG members in the final process of checks, and appointments to the PRG will be made shortly;

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- SIL Review of Price Controls had discussions with4 working groups of providers to provide feedback and information to the Review, informing an Issues Paper that was released. Timeline for the Review was being reviewed as well; and
- Financial analysis of providers from the Financial Benchmarking Survey intended to be discussed at a PRG meeting in December 2020.

Forward Work Plan

The paper PRG - 20200910 - Item 3.1 - Forward Work Plan**,** was presented to the PRG by:

- Dr David Cullen, Chief Economist

The PRG **DISCUSSED** the paper and **AGREED** to proposed plan in the paper without amendment.

Update to the NDIS Cost Model for Disability Support Workers

The paper *PRG - 20200910 - Item 3.2 - Update to the NDIS Cost Model for Disability Support Workers*, was presented to the PRG by:

- Dr David Cullen, Chief Economist

The PRG **DISCUSSED** the paper and **AGREED** to the recommendations proposed in the paper without amendment, see Attachment A to these Minutes

Geographical Reclassification for Remote Areas

The paper *PRG - 20200910 - Item 3.3 - Geographical Reclassification for Remote Areas* was presented to the PRG by:

- David s47F - personal priv Director of Operations, Price Regulation Unit

The PRG **DISCUSSED** the paper and **AGREED** further impact analysis is required, see Attachment B to these Minutes.

Update on Operational Changes for under $5,000 Assistive Technology and Home Modifications

The paper *PRG - 20200910 - Item 4.1 - Update on Operational Changes for Assistive Technology and Home Modifications Quoting Processes* was presented to the PRG by:

- Matthew s47F - personal pr Branch Manager, Operations and Housing Support

The PRG **DISCUSSED** the paper, with another review and update to the PRG intended to occur in six months.

2019-20 Assistive Technology Quote Benchmarking Report

The paper *PRG - 20200910 - Item 4.2 - Assistive Technology Benchmark Review 2020-21* was presented to the PRG by:

- Dr David Cullen, Chief Economist

The PRG **DISCUSSED** the paper.

Publication of NDIS Disability Support Worker Cost Model 2020-21

The paper *PRG - 20200910 - Item 4.3 - NDIS Cost Model for DSWs 2020-21* was presented to the PRG by:

- Dr David Cullen, Chief Economist

The PRG **DISCUSSED** the paper.

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Attachment A – Update to the NDIS Cost Model for Disability Support Workers

1.1 The PRG **AGREED** that the price limits in the Table below should apply to supports delivered by disability support workers and determined or derived from the NDIS Disability Support Worker Cost Model from 1 December 2020

	Weekday Daytime	Weekday Evening	Weekday Night	Saturday	Sunday	Public Holiday
Level 1	$55.47	$61.05	$62.17	$77.81	$100.16	$122.51
Level 2	$60.02	$66.07	$67.27	$84.20	$108.39	$132.57
Level 3	$63.21	$69.58	$70.85	$88.68	$114.15	$139.62
Level 4	$83.15	$91.53	$93.20	$116.65	$150.15	$183.65

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Attachment B – Geographical Reclassification for Remote Areas

1.2 The PRG **DISCUSSED** the current Isolated Towns Modification policy and work through the issues outlined in section **Error! Reference source not found.** of this paper.

1.3 The PRG **AGREED** to a **FURTHER REVIEW** of the current Isolated Towns Modification policy published in the NDIA Price Guide to the following:

"For the purpose of planning and pricing, the NDIA modifies the Modified Monash Model (MMM) classification of some locations that are not already classified as Remote or Very Remote. Locations, or groups of adjacent locations, that are not already classified as Remote or Very Remote, and that are both:

- *surrounded by Remote and/or Very Remote areas; and*
- *not contiguous with a Metropolitan area*

will be reclassified by the NDIA as Remote.

In determining whether to reclassify a location on the coast of mainland Australia (including mainland Tasmania) the ocean is considered to be a Remote region."

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Pricing Reference Group

Forward Work Plan

PRG Dates	Forward Workplan
12 November 2020	• Participant Consultations, including with IAG • SIL Pricing Review – preliminary consideration • Price deregulation – presentation by DSS • Simplifying the Price Guide – preliminary consideration
11 December 2020	• Provider Challenge Session • Survey of Providers on Pricing Arrangements, including programs of Support – Design • Benchmarking Survey – Design
11 February 2021	• Provider Challenge Session – SIL • SIL Pricing Review – further consideration • Simplifying the Price Guide – further consideration
11 March 2021	• Participant Consultations, including with IAG • SIL Pricing Review - consideration of final report • Survey of Providers on Pricing Arrangements, including programs of Support – consideration of results
15 April 2021	• Provider Challenge Session • Benchmarking Survey – consideration of results • 2021-22 Prices – consideration of advice to Board • Simplifying the Price Guide – final consideration
13 May 2021	• Review of PRG Terms of Reference, • Terms of Reference for Annual Pricing Review • Terms of Reference for Review of Therapy Pricing Arrangements • Price deregulation – consideration of advice to Board
10 June 2021	• TBA

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Pricing Reference Group

Meeting: 15 October 2020

Minutes

Date: Thursday, 15 October 2020 **Time:** 1000 – 1145

Location: Microsoft Teams Meeting (Video Conference)

Attendees	
Chair	
Gerrie s47F - perso	General Manager, Provider and Markets
Pricing Reference Group Members	
Deborah s47F - perso	Independent Member
Graeme s47F - perso AM	Independent Member
Jim s47F - pe PSM	Independent Member
Julie s47F - personal privacy PSM	Independent Member
Lynne s47F - personal priv	Independent Member
Participating Observers nominated by CEO	
Sarah s47F - personal priv	Scheme Actuary
David Cullen	Chief Economist
Secretariat	
Alison s47F - personal pri	Project Officer, Price Regulation Unit
Other Attendees	
Lisa s47F - personal priv	DCEO, Markets, Government and Engagement

Declaration of Conflicts of Interest

The PRG **NOTED** that Graeme s47F - person is:

- a member of the Board of Life Without Barriers;
- a member of the Board of Joblife Employment;
- a member of the Board of Attitude Foundation;
- a member of the Advisory Board for Probono News; and
- s47F - personal privacy, s22(1)(a)(ii) - irrelevant material

The PRG **NOTED** that Deborah s47F - person has:

- relatives who deliver services to NDIS participants.

Confirmation of the Previous Meeting's Minutes

The PRG raised one change to the previous meeting's minutes, to capture the agreement for future discussion of the forward work plan (in *Item 1.3 - Minutes of Meeting of 10 September 2020).*

The proposed amendment to the official Minutes of Meeting of 10 September 2020 is found at Attachment A.

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Update by the Chair

The Chair informed the PRG that:

- At the next PRG meeting that there will be a presentation by a representative from Department of Social Services on price deregulation work underway; and
- the continued temporary measures in the NDIS pricing arrangements in response to the COVID-19 pandemic and new Price Guide Addendum to capturing impacted locations as updated by State and Territory Governments.

Financial Benchmarking Survey update

The paper *PRG - 20201015 - Item 2.2 – Financial Benchmarking Survey update*, was presented to the PRG by:

- Scott s47F - personal privacy Director of Policy and Economics, Price Regulation Unit

The PRG **NOTED** the item, with the intention to be informed on further information for the upcoming Financial Benchmarking Survey at an upcoming PRG meeting.

Update for Supported Independent Living Review of Price Controls

The paper *PRG - 20201015 - Item 3.1 - Update for Supported Independent Living (SIL) Review of Price Controls*, was presented to the PRG by:

- Scott s47F - personal privacy Director of Policy and Economics, Price Regulation Unit

The PRG **NOTED** the item.

Capacity Building supports for early childhood intervention in natural settings

The paper *PRG - 20201015 - Item 3.2 - Capacity Building supports for early childhood intervention in natural settings* was presented to the PRG by:

- Christine s47F - personal privacy, s22(1 Branch Manager of Early Childhood Services

The PRG **DISCUSSED** the paper and **AGREED to recommend to the Board of the NDIA, through the NDIA's Chief Executive Officer, subject to other financial authorities signing off on their relevant areas,** with amendment to the recommended delegates, see Attachment B to these Minutes.

The PRG also **ENDORSED** that a review should be conducted after implementation, subject to Board approval, to monitor if best practice is supported by these changes.

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Attachment A – Minutes for Item 3.1. Forward Work Plan - 10 Septemeber 2020 Meeting

Forward Work Plan

The paper PRG - 20200910 - Item 3.1 - Forward Work Plan**,** was presented to the PRG by:

- Dr David Cullen, Chief Economist

The PRG **DISCUSSED** the paper and **AGREED** to further discussion of the forward work plan at a future PRG meeting.

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Attachment B – Capacity Building supports for early childhood intervention in natural settings

1.1 That PRG **AGREED to recommend to the Board of the NDIA, through the NDIA's Chief Executive Officer, subject to other financial authorities signing off on their relevant areas** to the introduction of three new support items for 'Capacity Building Supports for Early Childhood Intervention in natural settings'.

1.2 That PRG **AGREED to recommend to the Board of the NDIA, through the NDIA's Chief Executive Officer, subject to other financial authorities signing off on their relevant areas** that from 1st December 2020:

1.2.1 the following support items be added to the *NDIS Support Catalogue* in Support Category – 'Capacity Building – Improved Daily Living' to support participants achieve outcomes in Outcome Domain – 'Daily Living':

Support Item Number	Support Item Name	Support Item Description
15_XXX_0118_1_3*	Capacity Building Supports for Early Childhood Interventions in natural settings – Other Therapy	Supports must be delivered by a suitably qualified allied health professional or early childhood educator in the child's natural settings. Natural settings include the home, community, and early childhood education centres.
15_XXX_0118_1_3*	Capacity Building Supports for Early Childhood Interventions in natural settings – Physiotherapy	Supports must be delivered by a Physiotherapist. Natural settings include the home, community, and early childhood education centres.
15_XXX_0118_1_3*	Capacity Building Supports for Early Childhood Interventions in natural settings – Psychologist	Supports for Early Childhood Interventions must be delivered by a Psychologist. Natural settings include the home, community, and early childhood education centres.

*Final item codes to be determined prior to implementation

1.2.2 the support items in Recommendation 1.2(a) should be subject to price regulation;

1.2.3 the support items in Recommendation 1.2(a) should be subject to price limits, aligned to existing ECI Capacity Building supports for the relevant therapist;

1.2.4 the price limits of the support items in Recommendation 2.2(a) should be subject to the standard remote and very remote loadings;

1.2.5 the support items in Recommendation 1.2(a) should **not** be subject to the standard definitions of time of day and day of week set out in the NDIS Price Guide;

1.2.6 the support items in Recommendation 1.2(a) should be able to claim for Direct Service Provision; Non-Face-to-Face Service Provision; Provider Travel, Cancellations and NDIA Report Writing, subject to the standard rules for those claims set out in the NDIS Price Guide; and

1.2.7 The support items in Recommendation 1.2(a) should **not** be eligible for the Temporary Transformation Payment (TTP).

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Matter for Noting

Financial Benchmarking Survey update

Presented by: Scott Mitchell, Director Policy and Pricing, Price Regulation Unit

1. Purpose

1.1 For the Pricing Reference Group (PRG) to note an update to the findings from the Financial Benchmarking Survey 2019-20 at Attachment A.

2. Recommendations

2.1 That PRG **NOTE** the update to findings from the Financial Benchmarking Survey.

3. Background

3.1 The Financial Benchmarking Survey (the Survey) is designed to collect information on staffing numbers, costs and profits of support providers in the National Disability Insurance Scheme (NDIS). The National Disability Insurance Agency (NDIA) uses the data collected to inform its Cost Model by gathering supply data from providers, and to monitor the broader market for possible market failures or opportunities for future deregulation.

3.2 Participation in the Survey is a criterion for providers of attendant care and community participation supports who claim the Temporary Transformation Payment (TTP) loading on NDIS supports. This conditional loading is meant to assist providers to continue transforming their businesses in the move towards a more competitive marketplace.

3.3 The NDIA engaged Deloitte Access Economics to design and field the Financial Benchmarking Survey, in consultation with the NDIA and an expert reference group. The survey contained 30 questions which covered a range of financial and staffing data: staff numbers, base rates of pay, the number of hours worked, utilisation, revenue, and expenses.

3.4 The initial survey fielding period took place from 21 February 2020 to 15 March 2020. During this timeframe, a total count of 615 complete responses were received, 590 responses received through this survey and 25 respondents participated in the Ability Roundtable. This formed the basis of a report published by the NDIA in May 2020, available on the NDIS website.

3.5 The Survey was re-opened on 18 May 2020 through to 30 June 2020, where an additional 233 complete responses were recorded, bringing the total survey sample size to 848 providers.

4. Discussion

4.1 Using the 848 responses, there was an update to the report and its accompanying analyses at Attachment A. Noting, the final report is not yet publically available.

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4.2 The following table indicates the distribution of results from the Survey for key parameters in the NDIS Disability Support Worker (DSW) Cost Model.

Survey Results	Permanent Employment Rate	Utilisation Rate	Overheads (multiplier of direct costs)	Margin (multiplier of other costs)	Span of control
Average	44.2%	79.4%	27.1%	1.7%	11.5
Standard Deviation	33.2%	3.2% to 10.1% (different variables)	0.1%	1.7%	10.8
25th percentile	12.5%	90%	18.6%	0.5%	5
50th percentile (Median)	40.1%	80%	27.1%	1.2%	8.6
75th percentile	72.6%	70%	36%	2.4%	15

4.3 For comparison, the below table is the current assumptions in the NDIS DSW Cost Model for these same key parameters. These parameter assumptions are aligned to what is considered an efficient provider from findings of the Survey at the time of the Annual Pricing Review 2020-21.

Cost Model	Permanent Employment Rate	Utilisation Rate	Overheads (multiplier of direct costs)	Margin (multiplier of other costs)	Span of control
Assumption	70%*	80% to 92% (varies on DSW level)	12%	2%	15*

*For an efficient provider, generally the 25th percentile is the proxy. However, in some cases, efficiency is better represented by the 75th percentile (e.g. permanent employment rate and span of control).

Provider size, State and Remoteness analyses

4.4 Some findings of the further analyses conducted are listed below, noting further analyses can be found in Attachment A.

(a) Large providers had, on average, 17 per cent more permanent staff (55 per cent) than small providers (38 per cent);

(b) Large providers had, on average, 7 per cent higher utilisation (83 per cent) than small providers (76 per cent);

(c) Large providers had, on average, 2 per cent higher overheads (28 per cent) than smaller providers (26 per cent);

(d) Remote providers (MMM 6-7) had, on average, 10 per cent higher overheads (37 per cent) than metro (MMM 1-3) providers (27 per cent); and

(e) Direct costs (DSW plus supervisors) did not appear to vary significantly across States (allocating providers to the State where they received their highest revenue).

Attachment(s):

A *Final Financial Benchmarking Survey Report at September 2020*

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Pricing Reference Group

Meeting: 12 November 2020

Minutes

Date: Thursday, 12 November 2020 **Time:** 1000 – 1245

Location: Microsoft Teams Meeting (Video Conference)

Attendees	
Chair	
Sarah Johnson	Scheme Actuary
Pricing Reference Group Members	
Deborah s47F - perso	Independent Member
Graeme s47F - perso AM	Independent Member
Jim s47F - pe PSM	Independent Member
Julie s47F - personal privacy PSM	Independent Member
Lynne s47F - personal priv	Independent Member
Participating Observers nominated by CEO	
David Cullen	Chief Economist
Secretariat	
Alison s47F - personal pri	Project Officer, Price Regulation Unit
Other Attendees	
Kitsa s47F - personal privacy, s22(1)(a	Branch Manager of Market Commissioning and Intervention
Andrew s47F - personal priva Erin s47F - personal pr Corin s47F - personal	Department of Social Services

Apologies

Apologies: Gerrie s47F - person

Declaration of Conflicts of Interest

The PRG **NOTED** that Graeme s47F - persona is:

- a member of the Board of Life Without Barriers;
- a member of the Board of Joblife Employment;
- a member of the Board of Attitude Foundation;
- a member of the Advisory Board for Probono News; and
- s47F - personal privacy, s22(1)(a)(ii) - irrelevant material

The PRG **NOTED** that Deborah s47F - person has:

- relatives who deliver services to NDIS participants.

Confirmation of the Previous Meeting's Minutes

The PRG **ENDORSED** the minutes of the previous meeting *PRG - 20201015 - Item 1.3 - Minutes of Meeting of 15 October 2020*

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Update by the Chair

The Chair informed the PRG that:

- Information for upcoming Financial Benchmarking Survey and SIL Pricing Review to be discussed in this meeting.
- ECI in natural settings considered at the last meeting has been delayed.

Update Financial Benchmarking Survey update

The *PRG - 20201112 - Item 2.2- Financial Benchmarking Survey update*, was verbally presented to the PRG by:

- Scott s47F - personal privacy Director of Policy and Economics, Price Regulation Unit

The PRG **NOTED** the item.

Price Deregulation

The *PRG - 20201112 - Item 3.1 - Price Deregulation,* was verbally presented to the PRG by:

- Andrew s47F - personal privacy Erin Sendall, Corin Moffatt, Department of Social Services

The PRG **NOTED** the item.

Overview of Market Interventions and Commissioning Branch

The *PRG - 20201211 - Item 3.2 - Overview of Market Interventions and Commissioning Branch*, was verbally presented to the PRG by:

- Kitsa s47F - personal privacy, s22(1)(a)(ii) - Branch Manager of Market Commissioning and Intervention

The PRG **NOTED** the item.

Update for Supported Independent Living (SIL) Review of Price Controls

The PRG - 20201112 - Item 3.3 - Update for Supported Independent Living (SIL) Review of Price Controls, was verbally presented to the PRG by:

- Scott s47F - personal privacy Director of Policy and Economics, Price Regulation Unit

The PRG **DISCUSSED** progress of the SIL review, but did not make any recommendations.

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Matter for Discussion

Update to the Supported Independent Living (SIL) Review of Price Controls

Prepared by: Scott Mitchell, Director, Price Regulation Unit

1. Purpose

1.1 For Pricing Reference Group (PRG) members to discuss an update for the Supported Independent Living (SIL) Review of Price Controls.

2. Background

2.1 SIL and Specialist Disability Accommodation (SDA) provide funding for NDIS participants who have some of the highest disability support needs. Currently, over 24,000 participants receive SIL, or 6% of all NDIS participants. Total annualised committed supports for SIL on 30 June 2020 was $8.3 billion, which was 30% of all total annualised committed supports across the NDIS on that date. Most SIL participants also receive SDA funding.

2.2 On 1 July 2020, the NDIA replaced the previous quotation pricing arrangements for Supported Independent Living with price limits based on 'assistance with self-care' supports. These changes designed to increase transparency of, and equity in, how SIL supports are funded, as well as to simplify previously administratively complex processes.

2.3 The Review initially met with participant and provider peak bodies where the key topics discussed centred on the issue of whether the move to hourly price limits could improve the participant experience, both in the experience of engaging service providers and in receiving services within a SIL environment.

2.4 This review is a small component of a much larger ongoing program to make improvements to the way participants receiving supports in SIL are supported. There is a concurrent review focusing on improving participant experience in SIL.

2.5 Consultations with dozens of individual providers of differing sizes and geographic location were undertaken which focused on differences in the costs of providing attendant care in the community (AC) and SIL services, and on potential adaptations to the Cost Model.

2.6 Consultation with other schemes that pay for attendant care in shared living arrangements took place (Transport Accident Commission Victoria, SA Lifetime Support Authority, Worksafe Victoria, iCare NSW and Department of Veteran' Affairs).

3. Response to the Issues Paper

3.1 In August 2020, an Issues Paper was released seeking submissions from the sector to help inform estimates of the fully loaded cost of delivering an hour of attendant care in a shared living arrangement.

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3.2 The closing date for submissions from the Issues Paper was 25 October 2020. As of 30 October 2020, there have been 91 submissions. Late submissions are continuing to arrive in small numbers.

3.3 Attached are the submissions provided by the Provider Peak bodies of National Disability Services (NDS), Alliance20 and Ability First to be points of discussion for this paper, found at Attachments A-D.

4. Deloitte Access Economics Financial Analysis

4.1 Deloitte Access Economics were engaged to assist the Chief Economist with two particular tasks for the SIL Review of Price Controls.

4.2 The first was to provide an independent expert analysis of the Disability Support Worker Cost Model (the Cost Model) that is used to pay for attendant care in the community. The second task was to assess what changes might be needed to adapt the Cost Model for SIL – that is, paying for attendant care in a shared living environment.

4.3 For the first task, Deloitte used data obtained on actual provider cost structures obtained from its running of the 2020 Financial Benchmarking Survey on behalf of the Agency. Overall, Deloitte found the Cost Model was a good fit, with some minor differences.

- As some jurisdictions include superannuation as wages when they levy workers' compensation premiums, there is an argument that the Cost Model should do so too. However, the difference is immaterial (an increase in hourly rates of 0.01 %.)
- Overheads are a mix of labour (e.g. HR staff) and capital (e.g. computers). Currently, the Cost Model indexes overheads using the same formula that it applies for wage indexation – rather than using CPI for the capital component of overheads. However again, in practice, Deloitte found the difference would be immaterial (a saving of 0.01%)
- In most jurisdictions, if a worker leaves before obtaining long service leave (LSL) the provider keeps any accruals. However, some jurisdictions have portable long service leave (LSL) schemes, where the accrual follows the worker. The Cost Model follows the latter approach. Prima facie, this could overcompensate providers in jurisdictions without portable schemes. However, Deloitte found there was is no significant difference in LSL costs between portable and non-portable jurisdictions.
- The Cost Model does not cover payroll tax. Deloitte estimated that including payroll tax would increase total costs by 5%. However, the majority of providers are either not for profit (thus exempt from payroll tax) or for-profit but too small to pay payroll tax).

4.4 Further, there was some analysis done based on the results from the Financial Benchmarking Survey data. This was based on proportion of services claimed from the NDIS for SIL supports compared to attendant care or community participation supports from respondents.

(a) Noting the Benchmarking Survey was not specific for SIL providers, rather for attendant care and community participation providers as a requirement for those claiming the Temporary Transformation Payment.

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4.5 Based on the benchmark proxies for efficient providers in SIL versus in AC[1] used to deliver SIL, Deloitte found that some substantiative changes would need to be made to the Cost Model, should the agency want the Model to match actual SIL cost structures.

(a) SIL providers have higher workers' compensation premiums – 2.3% compared to AC of 1.7%.

(b) SIL supervisors are paid more (0.6%) than their community counterparts. Possibly this is because SIL participants are usually higher intensity than AC participants.

(c) SIL providers do spend more on training, commensurate with higher needs participants. However, overall utilisation rates in SIL are not lower than community attendant care, so this does not translate into a cost difference.

(d) There were also no statistically significant differences between SIL and AC for overheads, profit margins, span of control, or SIL frontline support worker wages compared to their non-SIL peers.

(e) SIL does have a higher proportion of its workers who are permanent (40%) than community attendant care (30%). This results in a slight cost saving (0.3%). This saving may also increase once higher weekend and public holiday penalty rates come into effect in December.

4.6 Deloitte also conducted a deep dive into the finances of a small number of providers (9) who were willing to share their data confidentially. While the sample size was too small to draw statistical inferences from, it did tend to yield similar results to SIL providers in the Financial Benchmarking Survey. For example, both populations had average workers compensation premiums of 3.0%.

4.7 One finding from the deep dive that was not available in the Financial Benchmarking Survey was vacancy rates. The average SIL vacancy rate found in this financial analysis was 5.5%.

4.8 More information on this financial analysis can be found at Attachment E, noting provider identities remain confidential from the Agency.

5. Next Steps

5.1 Once the Price Regulation Unit has finished summarising the major concerns received from the responses received to the Issues Paper, participants from the first round of consultations will be invited to a second round of consultations in November/December

5.2 A final report is expected to be completed for the Pricing Reference Group in March 2021.

5.3 PRG recommendations will be conveyed for the Board's meeting in April 2021.

5.4 Any pricing changes agreed by the Board will be announced in May or June 2021

5.5 This will allow providers at least a month's notice before price changes are implemented on 1 July 2020.

[1] There were 221 respondents who provided SIL services as well as community attendant care. To help isolate SIL factors, Deloitte weighted its analysis by providers' ratios of SIL to non-SIL services.

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DISCLOSURE LOG

6. Attachments

A National Disability Services Submission to the SIL Pricing Review

B Ability First Submission to the SIL Pricing Review

C Alliance20 Submission to the SIL Pricing Review

D Alliance20 - PwC Analysis of SIL Pricing

E Deloitte Access Economics Financial Analysis

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Pricing Reference Group

Meeting: 10th and 11th February 2021

Minutes

Date: Wednesday 10 and Thursday 11 February 2021

Time: Wed: 0900 – 1230
Thurs:1100 – 1600

Location: Microsoft Teams Meeting (Video Conference)

Attendees	
Chair	
Gerrie s47F - perso	General Manager, Provider and Market Development Division
Pricing Reference Group Members	
Deborah s47F - perso	Independent Member
Graeme s47F - perso AM	Independent Member
Jim s47F - pe PSM	Independent Member
Julie s47F - personal privacy PSM	Independent Member
Lynne s47F - personal priv	Independent Member
Secretariat	
David s47F - personal p	Director, Pricing Operations, Price Regulation Unit
Other Attendees	
Scott s47F - personal p	Director, Policy and Economics, Price Regulation Unit
Apologies	
David Cullen	Chief Economist
Sarah Johnson	Scheme Actuary

1.1 Participant and Provider Feedback Sessions

The Pricing Reference Group held discussions with several bodies over two days. Provider Peak Bodies met with were National Disability Service (NDS), Ability First Australia and Alliance20. Participant Peak bodies met with were Inclusion Australia and Carers Australia. NDIS Providers met with were Knoxbrooke, MiLife and Stride.

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Pricing Reference Group

Provider Peak Feedback Sessions

Date: Wednesday 10 February 2021 **Time: 0900 - 1230**
Microsoft Teams

Attendees	
Chair	
Gerrie [redacted]	General Manager, Provider and Market Development Division
Pricing Reference Group Members	
Deborah [redacted]	Independent Member
Jim [redacted] PSM	Independent Member
Julie [redacted] PSM	Independent Member
Lynne [redacted]	Independent Member
Secretariat	
David [redacted]	Director, Pricing Operations, Price Regulation Unit
Other Attendees	
Scott [redacted]	Director, Policy and Economics, Price Regulation Unit
Apologies	
Davin Cullen	Chief Economist
Graeme [redacted] AM	Independent Member
Guest Speakers – Provider Peaks	
National Disability Service (NDS)	
David Moody	CEO
Philippa Angley	Head of Policy
Ability First Australia	
Andrew [redacted]	CEO
Alliance20	
Drew [redacted]	CEO Possability
Leanne [redacted]	CEO Sylvanvale Foundation
Heath [redacted]	Head of Stakeholder Relations - Disability Services Australia (DSA)
Alliance 20 Secretariat support:	
Chris [redacted] Steve [redacted] and Nelson [redacted]	Life Without Borders
John [redacted]	Possability

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Notes

National Disability Service (NDS)

- NDS supports 1100 members, majority of active supports are under the NDIS and incorporate TTP into their prices.
- Cynical about 25th percentile as Providers mostly cannot achieve this.
- Highly transactional scheme. People in SIL have been there for 10 20 30 years, therefore finding it hard to find new participants suggesting less influx in the future.
- Span of control may reduce quality and safety,:1:1 vs 1:15
- Planners will not fund actual number of public holidays as only 12 are funded, when Vic has 13.
- It was suggested that Participants should be able to purchase all R&N supports, so plans should be funded at TTP levels
- Price needs to consider cost of innovation
- Philippa Angley advised that a major problem with SIL is how to apply individual funding in group situations, many require more support than R&N for individuals. Maybe all members of a house should have their plans developed at the same time?
- Community participation not seeing the expected inflows. New groups not being adopted. Providers may exit or only supply 1:1
- Community participation is all over the place whereas Aged Care it happens in one location
- SIL behaviours of concern was moderated when we didn't have to get them all out the door first thing in the morning during Covid as some prefer stay home, but still need support worker.
- NF2F has to be charged directly to the individuals, big administrative burden, shared equally to all participants, if there is an incident, and then charge should be to that individual. Group pricing is generally inadequate, the $7 makes it work. Costs of admin, may exceed NF2F.
- When the Scheme first rolled out no one expected how complex the administration would be, adjusting every hour for actual support ratios.
- NDS concerned about perverse incentives in current model for larger and large groups, suggest ceiling of 1:5.
- Stated 9% to 13% overhead magic number which is minimal infrastructure minimal services – for example new small medium business – work from home, out of shop front low overhead.
- Overhead of 20% more realistic (to open a new service or new site included (enthusiasm to expand))
- A meeting with all SIL stakeholders would be positive
- Would like TTP retained at current level

PRG Comments:

- Some of what NDS considers overheads, should be allocated to particular activities. Better way to get on top of costs.
- Our position on overheads, seems to be contradicted by our own methodology, uncomfortable.
- TTP there does need to be a focus on improving efficiency. Other Schemes use rewards for providers who improve their efficiency

Ability First

- 13 providers, $1.4 billion, 80 years disability, 23% of NDIS market from participant perspective. Very focused on the complex end.
- More efficiency can be found from providers
- Workforce issues challenging
- NDIS learning to listen & respect service providers
- Efficiencies suggested: Clear rules – families have different interpretations of supports, streamline claiming process, Innovation needs to be priced in
- DHL industry works on 3% margin, cost model considers 2%
- Need to invest to attract younger participants – but as they don't stay can create virtuous vacancies
- 4 key groups in SIL: resident, participant age/type of disability, landlord, others in the house
- Wanted SDA/SIL aligned? - Aligning SIL and SDA groups difficult, high level vacancy, no high level SIL participants.
- Quality and Safety Compliance an administrative burden, a lot of reporting required, for example: 3 people now looking at restricted practice reporting.
- It would be easy for us if all SIL was "Portal" managed - no other plan managers. Rosters, agreeing the ROC good process for setting the core hours.
- Struggling with current system of claiming, having to record every participant every hour, sort SIL, irregular SIL, core. Takes away choice and control, workers find it too hard to do anything outside agreed ROC / routine.

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- 18% considered more realistic overheads
- SIL at weekly funding was easier
- 1 to 2% increase in administration costs
- Innovation vacancy management, average vacancy rate and vacancy levels both high, and eat into profitability.
- Still very manual processes, go into a SIL house, lots of filing cabinets.
- Use tech to do monitoring, rather than having to go through support coordinator chain.
- Organisations are making big investments to attract more young people. Those more mobile, don't stay in SIL forever.

PRG Comments:

- People are starting to get smarter about using data for decisions, stop doing things manually, even using AI to drive down overheads.
- How do you drive innovation? Innovation needs to be priced in, can't do it if no margin, just living hand to mouth.
- Struggling for survival does also drive innovation.
- This isn't an Apple product where you can launch something and it doesn't sell, its human services, with all its quality and safety requirements.
- Distribution lowest margin in commercial chains, disability asked to deal with less margin, but human services issues.
- What would be the top three efficiencies the sector could make? One would be for the Agency to keep a pricing regime in place for three or four years.
- Clarity of rules, planners and support coordinators often have different interpretations. Streaming claiming and quoting processes, especially make it clearer for families.
- Improving the efficiency of the QSC, very manual, very labour intensive.
- Northcott and others have also inherited expensive, inefficient, govt workforces.
- Compliance costs, if Agency reduced these, what impact on overheads? Amanda, in the last couple of years, have recruited a number of people specifically to deal with QSC requirements, some people specifically just doing restrictive practice reporting. Could reduce overheads by around 4%.

Sylvanvale

- SIL used to be 200 transactions per week to process now is 33,000 per week!
- Workers get 5 weeks leave more than 4
- Need to increase training allowance's
- 17% overheads more realistic
- 25% percentile at 19% operating at 12% in the model
- Non billable charges:
- Handover complexity, shift notes, incident management, comprehensive health cover, liaise with Doctors etc., vacancy level `11%
- There is innovation uncertainty
- Highly trained staff are needed
- No breakthroughs in Capacity building

Alliance 20

- 22 of the biggest providers, 17 do SIL, probably around 25% of SIL market
- Reported that DSW Cost Model is a significant, useful tool.
- SIL is not the only thing that happens to be provided in one place, but a whole range of supports, depending on participants' varying needs and wishes
- SIL is essential, 24/7, cannot stop operating, regardless of life changes or pandemics. You cannot manage risk by choosing not to provide services.
- Whole of life, provider of last resort. SIL has to become intrinsically involved in a range of other services, requires a high order of thinking.
- Shared support, inherent range of impacts on other participants, as one participants needs, wants or goals change. Not like seeing one participant in their own home in the community

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- 1/3 SIL high intensity vs 1/5 community AC
- SIL lot more complex behavioural and medical care needs.
- SIL working within operational guidelines of Roster of Care (RoC) designed to cover whenever not in external community activities, groups or employment.

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Pricing Reference Group

Provider Peaks Feedback Session

Date: Wednesday 10 February 2021 **Time: 0900 - 1230**
Microsoft Teams

Time	Provider Peaks	Presenters
0900 - 1000	National Disability Service (NDS)	David s47F - personal CEO Philippa s47F - personal Head of Policy
1015 - 1130	Ability First Australia	Andrew s47F - personal p CEO
11:30 – 12:30	Alliance20	• Drew s47F - personal pr CEO Possibility • Leanne s47F - personal p CEO Sylvanvale Foundation • Heath s47F - personal p Head of Stakeholder Relations - Disability Services Australia (DSA) Also present for the presentation will be the Alliance 20 Secretariate support: • Chris s47F - personal privacy, s22 Steve Slone and myself (Nelson s47F - personal priva from Life Without Barriers • John s47F - personal pr from Possibility
1600	**Close**	

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Pricing Reference Group

Participant Peaks Feedback Session

Date: Thursday 11 February 2021 **Time: 1100 - 1230**

Microsoft Teams

Attendees	
Chair	
Gerrie s47F - perso	General Manager, Provider and Market Development Division
Pricing Reference Group Members	
Deborah s47F - perso	Independent Member
Jim s47F - pe PSM	Independent Member
Julie s47F - personal privacy PSM	Independent Member
Graeme s47F - perso AM	Independent Member
Lynne s47F - personal priv	Independent Member
Secretariat	
David s47F - personal p	Director, Pricing Operations, Price Regulation Unit
Other Attendees	
Scott s47F - personal p	Director, Policy and Economics, Price Regulation Unit
Apologies	
Davin Cullen	Chief Economist
Guest Speakers – Participant Peaks	
Inclusion Australia	
Catherine s47F - personal privac	CEO
Carers Australia	
Lisa s47F - pers	CEO Carers ACT

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Notes

Inclusion Australia

- SIL Participants (especially those with intellectual disability, who are a large proportion) have no capacity to negotiate Roster of Care, no choice and control, end up living with people they don't want to live with.
- SIL pricing change, blunt instrument, people are very stressed.
- SLES inflexible – keep participants in classroom instead of jobs, learning on the job is more important.
- What are we doing to prevent people going into SIL. Not everyone with intellectual disability (ID) needs SIL. Prevention is key strategy to divert away from SIL. Lots of supports would be required to obtain this.
- Couples example given: Participants a couple living in 2 different houses – want to live together, this is arranged, however what happens if they break up there is no hold on their previous locations
- Neither SLES or DES follow the evidence in what works to get people with Intellectual Disabilities to get jobs. No evidence that Cert 1, II at TAFE gets people jobs. SLES has been completely taken over by day service providers. Was designed to feed into DES. People with Intellectual Disabilities leave school, no work experience, apart from maybe ADEs. Sustainability of the Scheme depends on people with Intellectual Disabilities ability to get employment.
- Need to assume young people with Intellectual Disabilities can work, stay home, with appropriate support.
- We can achieve both aims. Reduce cost to Scheme and increase employment participation.
- We would prefer to see not 24/7 hrs of support, in return for rental assistance, build capacity to cook, clean, shop.
- Group home model is an old model, not consistent with UN Convention, too expensive, not ticking any boxes.
- Not ethical for NDIS to ignore affordability of housing, Ben Gauntlet HRC, security of housing is fundamental to everything else, can't get a job without an address.
- We are concerned that the short term approach to SIL is not achieving any of its aims.
- You can take a 60 year old, give them some capacity building support, and they can move out.
- Some SIL residents have been institutionalised since birth, this cohort need a tailored approach.
- Prevention is a very important strategy, stop people going into SIL.
- Some people think that people with Intellectual Disabilites shouldn't live with other people with Intellectual Disabilites, But, people live with their peers. People with Intellectual Disabilites do not have to live on their own, with appropriate, flexible supports in place.
- Royal Commission, people are actually safer outside of group homes, if in small communities where they are known and cared for.
- Even with access to education, will at best get low paid jobs.
- People with Intellectual Disabilites are one of the biggest groups on DSP.

PRG Feedback

- SLES, it's also a problem for DES's, use funding to send people to eternal education programs, rather than find them jobs.

Carers Australia

- Carers Australia were part of the ACT trial, so seen the whole thing through.
- Run aged care, respite, support coordination, also run a day program, community access, day care.
- The challenge that happens for providers when the Price Guide changes is not understanding why things have changed. Often also leads to a change in service providers, as some leave the market. Destabilises participants.

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Pricing Reference Group

Provider (*Group Supports*) Feedback Session

Date: Thursday 11 February 2021 **Time: 1400 - 1600**

Microsoft Teams

Attendees	
Chair	
Gerrie s47F - perso	General Manager, Provider and Market Development Division
Pricing Reference Group Members	
Julie s47F - personal privacy PSM	Independent Member
Graeme s47F - perso AM	Independent Member
Lynne s47F - personal priv	Independent Member
Secretariat	
David s47F - personal p	Director, Pricing Operations, Price Regulation Unit
Other Attendees	
Scott s47F - personal p	Director, Policy and Economics, Price Regulation Unit
Apologies	
Davin Cullen	Chief Economist
Jim s47F - pe PSM	Independent Member
Deborah s47F - perso	Independent Member
Guest Speakers – Participant Peaks	
Knoxbrooke	
Kristian s47F - personal priva	CEO
Fiona s47F - personal priv	Manager Support Options
Claire s47F - persona	Regional Manager West Gippsland
MiLife	
Therese s47F - persona	CEO
Ross s47F - personal p	Chief Finance Officer
Stride(formaly known as Aftercare)	
Dr. Andrew Young	CEO

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Notes

Knoxbrooke

- Fair to say organisations stagnated under state govt not for profit, group funding diminished, innovation eroded.
- Crisis helps organisations focus on core fundamentals, went from Birdsville model to JV Van Den Dep model - from allied health centralised hierarchical, to decentralied, smaller units, closer to clients home, staff freedom to make decisions.
- NDIS pricing so lean, made it unviable for us. If our services were as well funded as had been under states, would have kept same model. But required a lot of understanding of participants and their families.
- Durung COVID closed group supports and did not reopen.
- The majority of people getting no support, staying home, or getting the limited 1:1 support their plans can fund.
- Medium to high risk clients are getting help at home, through our 365 service, unqualified workers.
- Retrenched workers were mostly the highly skilled.
- Conditions more favourable – 6 weeks leave, higher pay levels.
- Cross subsidising via op shops to remain viable.
- Unstable pricing forcing disability services to move to a business footing, and start being more selective about who we take on.
- Having to engage local accountant to review each of our businesses, because we have been eating into cash reserves.
- NF2F is an admin burden would like to know what constitutes this. Some guidance from the Agency on what is reasonable would be very helpful.
- Group ratios change during the day hard to administer.

MiLife

- Worked on outcomes based programs since 2002.
- All aims at capacity building with a huge range of programs, durations and times
- We spent a long time thinking about what made up NF2F time, research and planning before hand, setup, writing up of reports, journal notes, diary notes. Came in around 12%.
- In the Cost Model there is a utilisation component, Disability Consulting also said that for every one hour of support, the Cost Model expected between 7 and 8 minutes.
- From a pricing point of view, unfair to charge same for one-off planning to one that has lots of complex planning. Split into routine, standard / moderate and complex.
- Program viability spreadsheet, determines optimal number of people per activity,
- In some cases, we have cross-subsidised, but only if a minor loss.
- Overall the feedback is positive, now six weeks into first block of 12.
- Clients don't want to do what families selected for them always.
- During Covid, those who just sat at home in the front of the TV for nine weeks, went backwards very quickly
- No one is complaining about price too much, as overall much the same. Some are a bit more expensive, but demonstrate more complex, or higher ratios.
- Some have gone overboard, picking up everything, run out of funds.
- We find that a lot of choices are not the participants, but the family , or the staff at the SIL house.

PRG Feedback

GM- We will take it on board to give you some feedback on how PoS are going in general.

Stride

- Aftercare, Mental Health, 100 staff, half revenue from NDIS. Prevoiusly academic analysisng charity data. PhD in math.
- The NDIA has in my opinion made great steps forward with transparency on the Price Model
- Argues that in fact, Agency prices according to market response, not Cost Model

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Pricing Reference Group

Meeting: 15 April 2021

Minutes

Date: Thursday, 15 April 2021

Time: 1030 – 1300

Location: NDIA Offices, Level 9 300 Elizabeth Street, Surry Hills, NSW

Members		
Chair		
Gerrie s47F - perso	General Manager, Provider and Market Development Division	Present
Pricing Reference Group Members		
Deborah s47F - perso	Independent Member	Present
Graeme s47F - perso AM	Independent Member	Present
Jim s47F - pe PSM	Independent Member	Present
Julie s47F - personal privacy PSM	Independent Member	By Teams
Lynne s47F - personal priv	Independent Member	Present
Participating Observer nominated by CEO		
David Cullen	Chief Economist	Present
Sarah s47F - personal priv	Scheme Actuary	Apology
Secretariat		
David s47F - personal p	Director, Pricing Operations, Price Regulation Unit	

1.2 Declaration of Conflicts of Interest

The PRG **NOTED** that Graeme Innes is:

- a member of the Board of Life Without Barriers;
- a member of the Board of Joblife Employment;
- a member of the Board of Attitude Foundation;
- a member of the Advisory Board for Probono News; and
- s47F - personal privacy, s22(1)(a)(ii) - irrelevant material

The PRG **NOTED** that Deborah Cope has:

- relatives who deliver services to NDIS participants.

1.3 Confirmation of the Previous Meeting's Minutes

The PRG **ENDORSED** the minutes of the previous meeting: *PRG Minutes of Meeting 10 and 11 February 2021.*

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2.1 Update by the Chair

The Chair informed the PRG that:

- A process of consultation has begun around the future of Supported Independent Living (SIL), and the development of projects around the different models that may represent SIL in the future.

3.1 SIL Review

The paper *20200415 - Item 3.2 - Review of Pricing Arrangements for SIL* was presented to the PRG by:

- David Cullen, Chief Economist

The PRG **DISCUSSED** the paper, and **AGREED** to reconsider the paper at its next PRG meeting when the preliminary results of the current financial benchmarking survey would be available.

The PRG **INDICATED** that:

- It broadly supported the Review's conclusion that the available evidence did not reveal any significant differences in the operational costs structures of SIL and non-SIL providers, but noted that the available evidence had not been collected for the purposes of comparing SIL and non-SIL costs and so was subject to qualification;
- It considered there would be value in waiting until the results of the 2019-20 financial benchmarking study were available to make a final decision, given that that survey was collecting data specifically for the purpose of comparing SIL and non-SIL costs;
- It considered that vacancy costs were a significant difference between SIL and non-SIL providers and would like to see further analysis of these costs and their distribution, with a preference for any issues associated with vacancies to be resolved at the pricing level (but not at the unit price) rather than through further disruption of the remaining residents of the SIL dwelling; and
- It considers that there may be opportunities for reducing the administrative burden on SIL providers and that further work should be undertaken on this issue.

3.2 Therapy Review

An update on the preliminary findings of the review was given by:

- David Cullen, Chief Economist

The PRG **DISCUSSED** the issues raised in the presentation.

Next Meeting: Thursday 13th May 2021, via videoconference using Microsoft Teams, 10:30 – 14:00

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ACTIONS ARISING			
	Meeting	Issues	Status
1	15 April 2021	Agency to provide any available reports on consultations with participants on the changes to the Scheme	Open

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DOCUMENT 45

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Matter for Decision

Review of Pricing Arrangements for Supported Independent Living

Prepared by: David Cullen, Chief Economist

1. Purpose

1.1 To seek the endorsement of the Pricing Reference Group (PRG) for the recommendations of the Review of Pricing Arrangements for Supported Independent Living (SIL), as outlined in the draft report at Attachment A.

2. Recommendations

2.1 That PRG **AGREE TO RECOMMEND TO THE NDIA BOARD, THROUGH THE CHIEF EXECUTIVE OFFICER**, no changes to the current SIL pricing arrangements as the efficient costs of delivering supports in SIL are essentially identical to the efficient costs of delivering activities of daily living in a non-SIL setting.

2.2 That PRG **AGREE TO RECOMMEND TO THE NDIA BOARD, THROUGH THE CHIEF EXECUTIVE OFFICER**, that the Operational Guideline for SIL should be reviewed to provide further information on non-pricing related issues:

(a) clearer advice on the circumstances in which high intensity supports and sleepover/active overnight supports will be included in SIL plans;

(b) for change of circumstance reviews when vacancies materially impact the cost of delivering supports to participants in SIL settings; and

(c) agreed timeframes for plan review in SIL, with greater certainty for providers about revenue when plan reviews are not completed or billing issues are not addressed in an appropriate timeframe.

- This includes providers to be able to claim for the appropriate support worker to participant ratio when vacancies arise until a plan review is conducted if appropriate.

3. Background

Supported Independent Living Supports

3.1 Within the NDIS, Supported Independent Living is one type of help or supervision with daily tasks to help participants live as independently as possible, while building their skills.

(a) SIL is paid personal support that includes things like someone to help with personal care tasks or cooking meals. SIL can help build these skills too. SIL provides assistance with, or supervision of, tasks of daily life in a shared living environment, with a focus on developing the skills of each individual to live as autonomously as possible. The support is provided to each person living in the shared arrangement in accordance with their need. Supported Independent Living does not include rent, board and lodging or other day-to-day usual

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living expenses such as food and activities. It also does not include the capital costs associated with a participant's accommodation.

3.2 SIL is similar to assistance with daily living supports in many ways, the main differences being that SIL is intended for participants who require 24/7 care and live in shared living arrangements with other NDIS participants. Other contemporary living models exist for participants, including the use of assistive technology and home modifications, or Individualised Living Options (ILO).

3.3 Before July 2020, a SIL quote would cover a whole year, whereas assistance with daily life supports are charged by the hour when it was delivered.

3.4 On 1 July 2020, the NDIA replaced the previous quotation pricing arrangements for Supported Independent Living with price limits based on 'assistance with self-care' supports. These changes made for Supported Independent Living were designed to increase transparency and equity of how SIL supports are funded, as well as to simplify previously administratively complex processes.

3.5 Different price limits apply depending on the Time of Day and Day of Week on which the support is delivered, and whether the supports are High Intensity Supports.

The Review

3.6 The purposes of the Review were to:

(a) examine the cost drivers and differences that arise in the delivery of personal support in a shared living arrangement,

(b) seek perspectives on the appropriateness of the assumptions and parameters used in the Disability Support Worker Cost Model for personal support supports in shared living arrangements and,

(c) seek to refine the assumptions and parameters for setting SIL price limits.

3.7 The Review engaged in extensive consultations with industry, community and government stakeholders and undertook a program of research.

(a) This includes 92 submissions received in response to an Issues Paper that was released by the Review. For reference, the Issues Paper is found at Attachment B.

3.8 The primary data source used for analyses in the Review was the 2019-20 Financial Benchmarking Survey data comprising of a sample of 848 providers, with 221 SIL providers. Secondary data sources used were financial deep dive information received through Deloitte Access Economics (n=9), who assisted the Agency conducting the Review, Alliance20 (n=11) and Ability First (n=13).

3.9 Further information on the background and methodology can be found in the draft report at Attachment A.

4. Discussion – Recommendation 2.1

4.1 The draft report at Attachment A goes through all topics under review for SIL pricing arrangements, with the analyses based on quantitative evidence (Financial Benchmarking Survey and financial deep dives) and qualitative information (responses to the Issues Paper and consultations).

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4.2 The Review found that there was evidence to suggest that, compared to activities of daily living services delivered in a non-SIL setting by an efficient provider, an efficient SIL provider faces:

(a) higher rates of permanent employment (85.1% compared to 70.0%);

(b) higher workers compensation premiums (2.4% compared to 1.7%);

(c) higher average utilisation rates (94% compared to 92%);

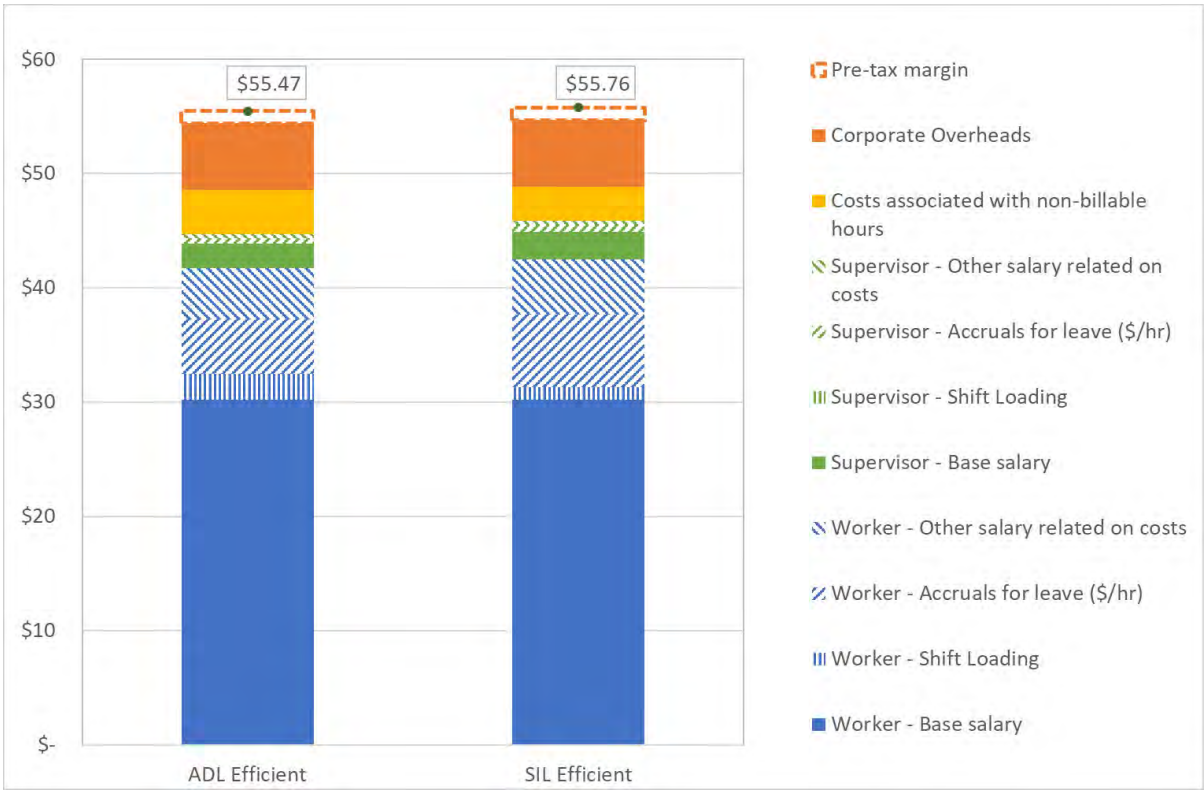
(d) higher base wages for supervisors (11.9% higher on average); and

(e) higher annual leave costs associated with great leave entitlement (5 weeks per year compared to 4 weeks per year).

4.3 Some of these effects add to the cost of service provision whereas others reduce that cost. The net effect, as Exhibit 30 (taken from the draft report) shows is that the fully loaded costs of efficient service provision in SIL and non-SIL settings are essentially identical. That is, $55.47 for efficient assistance with daily living providers compared to $55.76 for efficient SIL providers.

4.4 As such, the Review does not recommend any changes in the current SIL pricing arrangements.

Exhibit 30: Efficient Costs in SIL and Non-SIL Settings



5. Discussion – Recommendation 2.2

5.1 The Review acknowledges that providers and planners do not always agree on whether the cost of a SIL roster of care should be calculated using the standard or high intensity price limits or whether the cost of a SIL roster of care should include active overnight or a sleepover.

5.2 While these affect the value of the SIL plan, they are not a pricing issue, and the Review considers that this is a matter best addressed through the Operational Guideline for SIL.

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5.3 Further, the Review also recognises that providers are required to continue to provide support to an existing resident participant during the period of a plan review and that there is therefore a risk that they will provide supports at a different support ratio to those that are eventually approved as part of the plan review.

5.4 The Review acknowledges that vacancies present issues for providers and participants, however, this should not be considered a deficiency in the unit price limit, but rather in the planning arrangements which do not always adjust participant plans to maintain supports in response to vacancies.

5.5 If vacancies were relatively uniform across the sector then it would be possible to adjust the unit price for vacancy risk. However, the available data does not indicate that vacancies are uniformly distributed and so this issue is best addressed through plan review rather than through a change in the pricing arrangements.

5.6 The Review considers that there are strong arguments for this risk to be shared by the provider and the NDIA, so that if the NDIA does not complete the planning review within an agreed timeframe then the provider should be entitled to be paid for the supports that they are delivering until the plan review is completed.

5.7 Therefore, the Review recommends that the Operational Guideline for SIL should be reviewed to provide:

(a) clearer advice on the circumstances in which high intensity supports and sleepover/active overnight supports will be included in SIL plans;

(b) for change of circumstance reviews when vacancies materially impact the cost of delivering supports to participants in SIL settings; and

(c) agreed timeframes for plan review in SIL, with greater certainty for providers about revenue when plan reviews are not completed or billing issues are not addressed in an appropriate timeframe.

6. Next steps

6.1 The draft report, through the CEO, will be presented to the NDIA Board at the 25 May 2021 meeting.

6.2 The Price Regulation Unit is responsible for working with other areas of the Agency to roll out the recommendations of the Review, including advice for participants, providers, partners and NDIA staff.

6.3 If approved, recommendations will be implemented from 1 July 2021, with the intention to be published four weeks prior to implementation.

6.4 A communications plan will be developed to support the publication of the report for the pricing arrangements for SIL.

7. Risks

7.1 Due to existing Scheme sustainability concerns, the sector may view the current Review of Pricing Arrangements for SIL as a “cost-cutting” exercise. These concerns can be mitigated through ongoing communications for the Review, as this Review is only a small component of a much larger ongoing program to make improvements to the way participants receiving supports in shared living arrangements are supported.

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DISCLOSURE LOG

7.2 The wider improvements to SIL will seek to improve participant choice and control, simplify NDIA processes, and address pressures to Scheme sustainability. Improvements will be made through a series of changes, and will undertake a series of consultations with participants, providers and the wider sector as these changes are considered.

Attachment(s):

A Review of Pricing Arrangements for Supported Independent Living Draft Report

B Review of Pricing Arrangements for Supported Independent Living Issues Paper

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National Disability Insurance Scheme

Review of Pricing Arrangements for Supported Independent Living

Report

April 2021

Delivered by the National Disability Insurance Agency

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Terms that we use

Acronym	Description
DSW	Disability Support Worker
EBA	Enterprise Bargaining Agreement
FLS	Front Line Supervisor
ILO	Individualised Living Options
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
SCHADS Award	Social, Community, Home Care and Disability Services Award 2010
SIL	Supported Independent Living

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Contents

1 Introduction 7

1.1 Context 7

1.2 Conduct of the Review 11

1.3 Methodology 12

2 Findings 16

2.1 Wages and on-costs 16

2.2 Workforce mix 22

2.3 Utilisation 25

2.4 Supervision costs 29

2.5 Overheads 33

2.6 Supply costs specific to SIL services 35

3 Conclusions 40

DRAFT

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List of Exhibits

Exhibit 1: Average Annualised Plan Budgets, 30 September 2020 8
Exhibit 2: Average Annualised Payments, 2019-20 9
Exhibit 3: Schematic overview – NDIS Disability Support Worker Cost Model 10
Exhibit 4: Representativeness of the 2019-20 Financial Benchmarking Survey Data 13
Exhibit 5: Breakdown of provider categories used in this analysis 14
Exhibit 6: Box Plot – Base Wages of Disability Support Workers 17
Exhibit 7: Summary Statistics – Base Wages of Disability Support Workers 17
Exhibit 8: Regression Analysis – Base Wages of Disability Support Workers 18
Exhibit 9: Box Plot – Workers Compensation Premiums 19
Exhibit 10: Summary Statistics – Workers Compensation Premiums 19
Exhibit 11: Regression Analysis – Workers' Compensation Premiums 20
Exhibit 12: Box Plot – Permanent Employment Share 23
Exhibit 13: Summary Statistics – Permanent Employment Share 23
Exhibit 14: Regression Analysis – Permanent Employment Share 24
Exhibit 15: Box Plot – Staff Utilisation Rate 26
Exhibit 16: Summary Statistics – Staff Utilisation Rate 27
Exhibit 17: Regression Analysis – Staff Utilisation Rate 27
Exhibit 18: Box Plot – Time spent training as a share of non-billable hours 28
Exhibit 19: Summary Statistics – Time spent training as a share of non-billable hours 28
Exhibit 20: Regression Analysis – Time spent training as a share of non-billable hours 29
Exhibit 21: Box Plot – Base Wages of Supervisors 30
Exhibit 22: Summary Statistics – Base Wages of Supervisors 30
Exhibit 23: Regression Analysis – Base Wages of Supervisors 31
Exhibit 24: Box Plot – Supervision Ratio 32
Exhibit 25: Summary Statistics – Supervision Ratio 32
Exhibit 26: Regression Analysis – Supervision Ratio 32
Exhibit 27: Box Plot – Overhead Costs 33
Exhibit 28: Summary Statistics – Overhead Costs 34
Exhibit 29: Regression Analysis – Overhead Costs 34
Exhibit 30: Efficient Costs in SIL and Non-SIL Settings 40

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Executive Summary

On 1 July 2020, the National Disability Insurance Agency (NDIA) introduced new pricing arrangements for Supported Independent Living (SIL) – support with activities of daily living in a shared living arrangement. A quotation process, whereby the Agency and provider negotiated an individual price for each SIL participant, was replaced by a fairer and more transparent process whereby the Agency determined the reasonable and necessary supports for each participant in line with the relevant legislation, Under the new arrangements, the maximum price that the Agency was willing to pay for the component hourly supports of SIL were determined by the NDIS Disability Support Worker Cost Model in line with all other supports for activities of daily living.

The Review was established to suggest improvements to the way in which the NDIA estimates the fully loaded cost of delivering an hour of support in a SIL setting. This included identifying whether there were different costs that arise in the delivery of activities of daily living supports in a shared living arrangement that do not arise in other settings; and quantifying any differences, given the different cost structures of delivering supports in shared living arrangements compared to other settings.

The Review engaged in extensive consultations with industry, community and government stakeholders and undertook a program of research including an analysis of the Financial Benchmarking Survey data held by the Agency to examine whether cost parameters differed between providers that do and do not provide SIL services?

The Review has found that there is evidence to suggest that, compared to activities of daily living delivered in a non-SIL setting by an efficient provider, an efficient SIL provider faces:

- higher rates of permanent employment (85.1% compared to 70.0%);
- higher workers compensation premiums (2.4% compared to 1.7%);
- higher average utilisation rates (94% compared to 92%);
- higher base wages for supervisors (11.9% higher on average); and
- higher annual leave costs associated with great leave entitlement (5 weeks per year compared to 4 weeks per year).

Some of these effects add to the cost of service provision whereas other reduce that cost. The net effect is that the fully loaded costs of service provision in SIL and non-SIL settings are essentially identical.

The Review therefore does not recommend any changes in the current SIL pricing arrangements.

The Review acknowledges that vacancies can present issues for providers as expenditure is not always able to be adjusted in line with changes in revenue. The Review does not consider this to be a deficiency in the unit price limit, but a challenge for the planning arrangements, which do not always adjust participant plans to maintain supports in response to vacancies.

Because plan reviews can take some time to occur it may be appropriate, when a vacancy occurs, for providers to have the ability to claim for the applicable ratio of supports of the

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remaining participants receiving supports in SIL for a period of time after the vacancy occurs. Allowing this flexibility will assist providers to more immediately recover incurred rostered staff costs when a vacancy occurs. However, any such arrangement would need to be managed carefully to reduce incentives for providers to not fill vacancies. This could best be done by restricting the period of time for which providers could bill the reminding participants at a higher support ratio.

Allowing providers to bill remaining participants more when vacancies occur will likely exhaust remaining participants' plans sooner than anticipated, so it may also be sensible to undertake a change of circumstances review for all participants receiving supports in the affected SIL arrangement. This will assist in coordinating the funding amounts for the participants to ensure they have support continuity and their shared supports in SIL are aligned to each other.

The Review also recognises that providers are required to continue to provide support to an existing resident participant during the period of a plan review and that there is therefore a risk that they will provide supports at a different support ratio to those that are eventually approved as part of the plan review. The Review considers that there are strong arguments for this risk to be shared by the provider and the NDIA, so that if the NDIA does not complete the planning review within an agreed timeframe then the provider should be entitled to be paid for the supports that they are delivering until the plan review is completed.

The Review recommends that the Operational Guideline for SIL should be reviewed to provide:

- **clearer advice on the circumstances in which high intensity supports and sleepover/active overnight supports will be included in SIL plans;**
- **for change of circumstance reviews when vacancies materially impact the cost of delivering supports to participants in SIL settings; and**
- **agreed timeframes for plan review in SIL, with greater certainty for providers about revenue when plan reviews are not completed or billing issues are not addressed in an appropriate timeframe.**

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1 Introduction

The National Disability Insurance Agency (NDIA) has responsibility for administering the National Disability Insurance Scheme (NDIS), including managing the markets for disability goods and services. Within the NDIS, **Supported Independent Living (SIL)** is one type of help or supervision with daily tasks to help participants live as independently as possible, while building their skills. SIL is a specialised form of the more general category of supports with activities of daily living. It is intended for participants who require 24/7 support and live in shared living arrangements with other NDIS participants. Other contemporary living models exist for participants, including the use of assistive technology and home modifications, or Individualised Living Options (ILOs).

On 1 July 2020, the NDIA introduced new pricing arrangements for SIL. A quotation process, whereby the Agency and provider negotiated an individual price for each SIL participant, was replaced by a fairer and more transparent process whereby the Agency determined the reasonable and necessary supports for each participant in line with the relevant legislation, Under the new arrangements, the maximum price that the Agency was willing to pay for the component hourly supports of SIL were determined by the NDIS Disability Support Worker Cost Model in line with all other supports for activities of daily living.

The purpose of the current Review was to suggest improvements to the way in which the NDIA estimates the fully loaded cost of delivering an hour of SIL supports in a shared living arrangement. This included identifying whether there were different costs that arise in the delivery of activities of daily living supports in a shared living arrangement that do not arise in other settings; and quantifying any differences, given the different cost structures of delivering supports in shared living arrangements compared to other settings.

1.1 Context

Supported Independent Living

SIL is paid personal support. It includes things like someone to help with personal care tasks or cooking meals. SIL can help build these skills too. Support is provided to each person living in the shared arrangement in accordance with their need. SIL does not cover costs such as rent, board and lodging or other day-to-day ordinary costs such as food and activities. It also does not pay for the capital costs associated with a participant's accommodation – these are either an ordinary costs of living, or, where related to the disability of the participant, may be supported by the NDIS through Specialist Disability Accommodation payments.[1]

[1] Further details can be found in the Operational Guideline at https://ourguidelines.ndis.gov.au/supports-you-can-access-menu/home-and-living-supports/supported-independent-living

In brief, the following supports are included in SIL: Support with supervision, safety and security; Assistance with personal care tasks; Assistance with capacity building tasks (for example, meal prep and cooking, cleaning, routine development); Behaviour support and social skill development; Administration of medication;

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There were 412,543 active participants with an approved plan in the Scheme at 30 September 2020. Of these, 23,457 (5.7% of all participants) had SIL included in their plans.[2] A total of $29.3 billion of annualised committed support was in participant plans as at 30 September 2020, with some $8.3 billion committed in participant plans for SIL participants (28% of all commitments).[3]

For the year to September 2020, the average plan budget for participants in SIL arrangements was $352,000 compared to $54,000 for participants not in SIL, with the largest plan budgets found in participants living in the Northern Territory. The results for each state and territory are provided in Exhibit 1 below.[4]

Exhibit 1: Average Annualised Plan Budgets, 30 September 2020

State/Territory	Participants in SIL	Participants not in SIL	All participants
New South Wales	$357,000	$51,000	$71,000
Victoria	$325,000	$54,000	$64,000
Queensland	$364,000	$60,000	$77,000
Western Australia	$314,000	$58,000	$74,000
South Australia	$347,000	$50,000	$68,000
Tasmania	$376,000	$53,000	$83,000
ACT	$367,000	$46,000	$63,000
Northern Territory	$593,000	$86,000	$137,000
National	**$352,000**	**$54,000**	**$71,000**

For financial year 2019-20, the average payment for participants in SIL arrangements was $315,000, compared to $35,000 for participants not in SIL, with the largest payments being made from participants living in Northern Territory. The results for each state and territory are provided in Exhibit 2 below.[5] Note these reported values included all supports in a plan, not just supports specific to SIL.

Support for medical appointments; Community access that is not routine or regular (for example, support to complete personal tasks); Support to get to and from community access activities.

The following supports are excluded from SIL: Cost of groceries; Rent, board or lodging costs; Utilities – gas, electricity, water, telephone, internet; Household budgeting/bill paying activities; Expenses related to holidays, including travel costs; Personal care supports while the participant is in hospital; Specialist Disability Accommodation related costs (such as property maintenance costs, repairs, vacancy costs); Regular community access; Specific funding for staff to attend training for the participant's support needs (which is built into the price limit); Shadow shifts; Organisational management costs; Allied Health staff, including those employed by SIL provider; Vehicle costs; Justice related supports; Community supervision orders; Nursing, medical care and other health related supports; Items covered in other sections of the NDIS Price Guide (such as transport costs, assistive technology, personal care while in the workplace, plan management, financial intermediary supports, clinical or allied health services).

2 NDIA. (2020). NDIS Quarterly Report to disability ministers 30 September 2020, p.539-540.

3 Ibid, p.541.

4 Ibid, p.61.

5 Ibid, p.61.

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Exhibit 2: Average Annualised Payments, 2019-20

State/Territory	Participants in SIL	Participants not in SIL	All participants
New South Wales	$321,000	$35,000	$55,000
Victoria	$302,000	$33,000	$46,000
Queensland	$322,000	$40,000	$58,000
Western Australia	$228,000	$32,000	$43,000
South Australia	$324,000	$29,000	$49,000
Tasmania	$339,000	$32,000	$64,000
ACT	$326,000	$31,000	$48,000
Northern Territory	$535,000	$45,000	$99,000
National	**$315,000**	**$35,000**	**$52,000**

NDIS Pricing Arrangements and the Disability Support Worker Cost Model

One of the principal objectives of the NDIS is for people with disability to exercise choice and control over how, and with which providers, they spend their available budgets. The role of pricing in the NDIS is therefore very important. Prices reflect the preferences and relative values that different participants place on different types of supports. Prices also affect the total costs of the NDIS and therefore its financial sustainability. Pricing can also affect providers' choices, including by providing incentives: for entering the market; for upskilling/right-skilling; for innovation; and for improvements in service quality and outcomes.

As the markets for disability goods and services develop and operate more effectively, it is expected that the NDIA, as market steward for the NDIS, will be less interventional. Currently, the NDIA varies its approach to the regulation of prices between:

- **No regulation** (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- **The imposition of price limits**: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for assistance with daily living activities.
- **Quotable supports**: in which participants are expected to obtain quotations from suppliers to provide to the NDIA as part of verifying that prices are fair and reasonable.

Further information on the NDIA's approach to pricing be found in the NDIA's *Pricing Strategy*[6] and in the report of the *Annual Pricing Review 2020-21*.[7]

The NDIS Disability Support Worker (DSW) Cost Model is one methodology that the NDIA uses to inform its pricing decisions for those supports delivered by Disability Support Workers on which it imposes price limits.[8] Exhibit 3 provides a schematic overview of the NDIS Disability Support Worker (DSW) Cost Model.

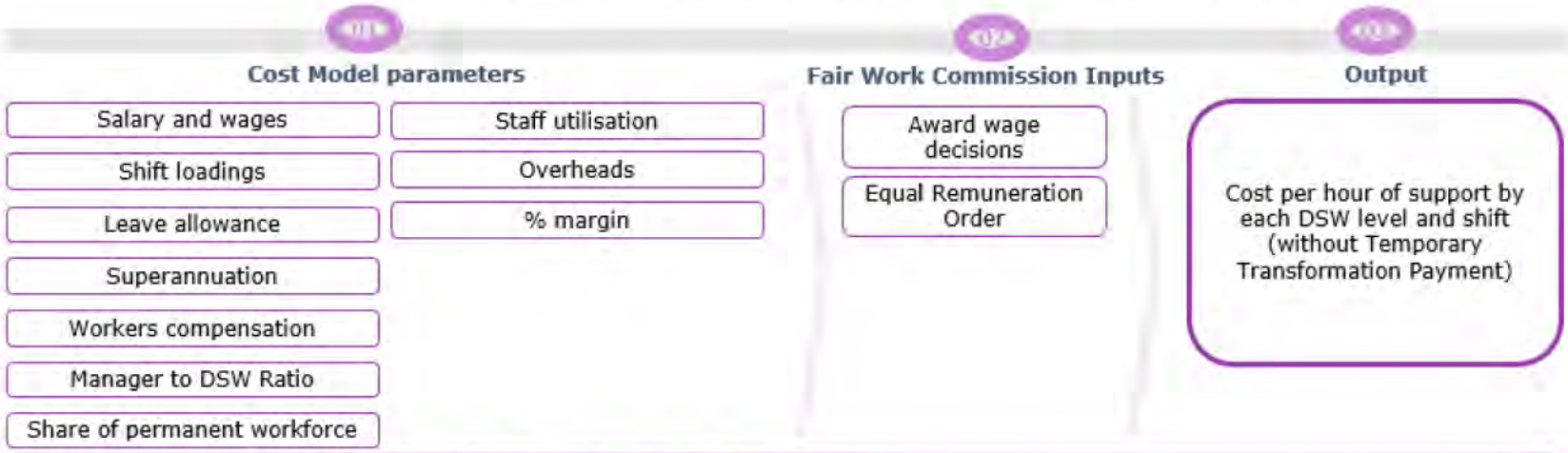
6 https://www.ndis.gov.au/media/1820/download

7 https://www.ndis.gov.au/media/2413/download

8 https://www.ndis.gov.au/providers/price-guides-and-pricing

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Exhibit 3: Schematic overview – NDIS Disability Support Worker Cost Model



	Parameter	How is this reflected in the Cost Model?
1	Base pay	Four DSW levels (2.3, 2.4/3.1, 3.2 and 4.4) based on SCHADS classification.
2	Shift loadings	As per the SCHADS Award, applies a loading for permanent staff working on weekends, public holidays, afternoons, and nights, and applies a casual loading for weekdays, weekends, public holidays, afternoons, and nights.
3	Leave allowance	As per the SCHADS Award and the National Employment Standards (NES), includes annual leave, personal leave, public holiday, long service leave
4	On-costs	Superannuation (9.5%) , workers compensation (1.7%), employee allowance (1.0%)
5	Supervision costs	Base pay + leave costs + on-costs for supervisors with three levels of supervisor pay (DSW levels 3.2, 4.2 and 5.1). As with frontline staff, based on SCHADS and NES. Supervisor to DSW ratio of 1 to 15
6	Permanent workforce	Assumes 70% of workforce.
7	Utilisation	Incorporating breaks, training, and other. Varies across staff levels (92% for DSW level 1, to 80% for DSW Level 4).
8	Overheads	Assumes 12.0% of direct cost.
9	Margins	Assumes 2%. Applied to (direct costs plus overheads).
10	FWC Inputs	Each year, the Fair Work Commission determines increases for Award wage rates. The current iteration of the Cost Model also includes the last stage of the FWC's Equal Remuneration Order.

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1.2 Conduct of the Review

The Review engaged in extensive consultations with industry, community and government stakeholders and undertook a program of research.

Issues Papers and Submissions

An Issues Paper was released on 31 August 2020 together with a public call for submissions. The closing date for submissions was initially 13 September 2020, later formally extended to 25 October 2020. Some 84 submissions were received by the closing date. A total of 92 submissions had been received and analysed by 31 December 2020.

Most submissions (81) were from service providers, with one received from a builder of Specialist Disability Accommodation. A further four submissions were received from provider peak bodies. One submission was received from a workers union. The participant voice was also heard, with three submissions from participant advocacy bodies and two from participants or their family/nominees.

Providers who made submissions ranged in size from servicing just one single participant in SIL arrangements to over 500 participants in SIL arrangements, with the average being 82 SIL participants and the median 38 SIL participants. They also ranged from having under $50,000 in NDIS revenue to over $100 million, with the average being around $16.15 million and the median being around $7.39 million.

Consultations with peak bodies

In addition to releasing the Issues Paper, the Review held virtual consultations with sector stakeholders across Australia. This included meetings with Provider and Participant peak bodies as listed below.

On 26 August 2020, the Review met with members of the following participant peak groups: Australian Federation of Disability Organisations; Disability Advocacy Network Australia; Inclusion Australia; and JFA Purple Orange.

On 28 July 2020, the Review met with members of the following provider peak groups: Ability First; Alliance 20; and National Disability Services.

Working Groups

Four working groups were also set up, involving 39 representatives from the sector, to discuss their concerns. These working groups met a total of three times each, two times before the release of the Issues Paper and once after it closed.

- Smaller Providers – 8 organisations (10 August, 17 August, 15 December 2020);
- Larger Providers – 18 organisations (11 August, 17 August, 14 December 2020);
- Very Large Providers – 8 organisations (10 August, 17 August, 15 December 2020); and
- Rural/Remote Providers – 5 organisations (11 August, 17 August, 14 December 2020).

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Consultations with Other Schemes

A virtual meeting was held with officers of the following Schemes on 13 August 2020 to compare pricing methodologies and arrangements for supports for activities of daily living and supported independent living:

- Department of Veterans Affairs;
- icare New South Wales;
- Lifetime Support Authority of South Australia;
- SeaCare;
- State Insurance Regulatory Authority New South Wales;
- Victorian Transport Accident Commission;
- WorkCover Queensland; and
- Worksafe Victoria.

Desktop Research

The Review also conducted a comparative study of employment conditions in the Social, Community, Home Care and Disability Sector Industry Award 2010 and some publically available enterprise bargaining agreements of organisations who offer SIL supports. It also compared price limits for supports for activities of daily living and similar supported independent living supports and input cost drivers in other schemes and sectors.

1.3 Methodology

The analyses in this report seeks to understand the degree to which key cost parameters differ between the delivery of SIL and community activities of daily living services. The nature of the data available for this analysis means that it was not possible to fully isolate the costs of supplying SIL services from the costs of supply activities of daily living services. As such, for each parameter of interest the analysis addressed the following questions:

- Do cost parameters differ between providers that do and do not provide SIL services?
- Is a concentration in SIL service provision associated with changing cost parameters?

The first question seeks to understand the baseline differences in service characteristics associated with providers that offer some SIL services, compared to those that do not offer any SIL services. The second question seeks to understand the relationship between service cost and the degree of SIL services delivered by providers.

The Review had access to two types of data sources. The Financial Benchmarking Survey was large, with 221 SIL providers. But it was not specifically targeted at SIL. The other data source was financial data deep dives. These were specifically targeted at SIL, but with very small numbers of providers: Deloitte (n=9), Alliance20 (n=11), and Ability First (n=13). Qualitative data from submissions and consultations was also employed to triangulate against this quantitative data

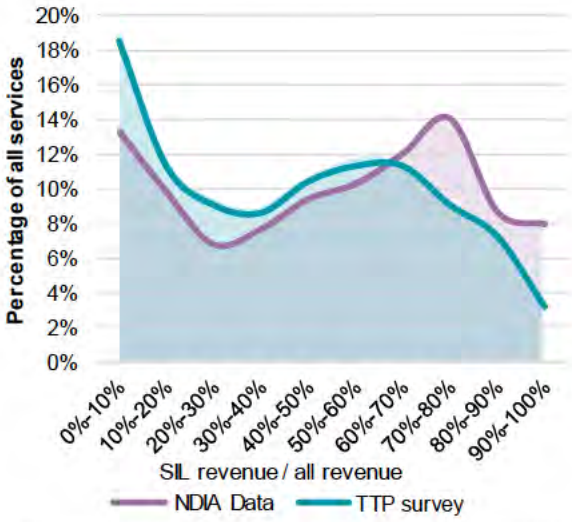
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The 2019-20 Financial Benchmarking Survey Data

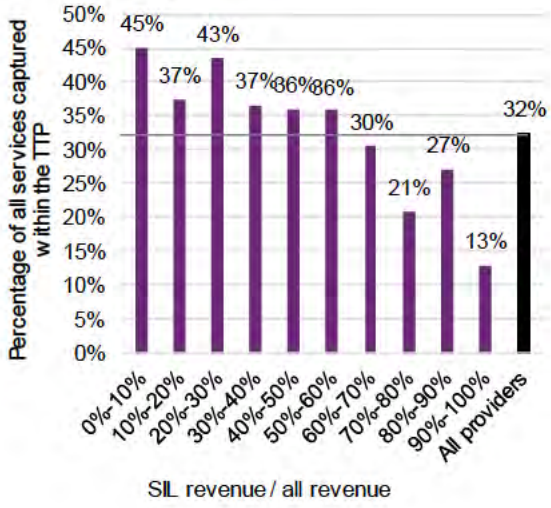
Deloitte Access Economics were engaged by the NDIA to conduct a financial benchmarking survey of providers for FY2019-20, with a particular emphasis on the parameters that under lie the NDIS Disability Support Worker (DSW) Cost Model. This dataset captures data from a sample of 848 providers. The representativeness of the data is displayed in Exhibit 4. Overall, the dataset represents the sector well. While the survey dataset slightly underrepresents providers that primarily offer SIL care (majority-SIL providers), the analysis confirms the characteristics of majority-SIL providers captured in the Financial Benchmarking Survey align with the population.

Exhibit 4: Representativeness of the 2019-20 Financial Benchmarking Survey Data

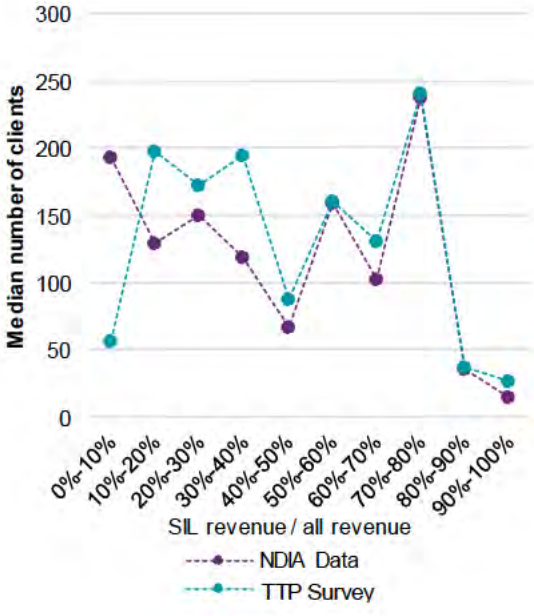
a) Distribution of SIL revenue within TTP survey and NDIA database



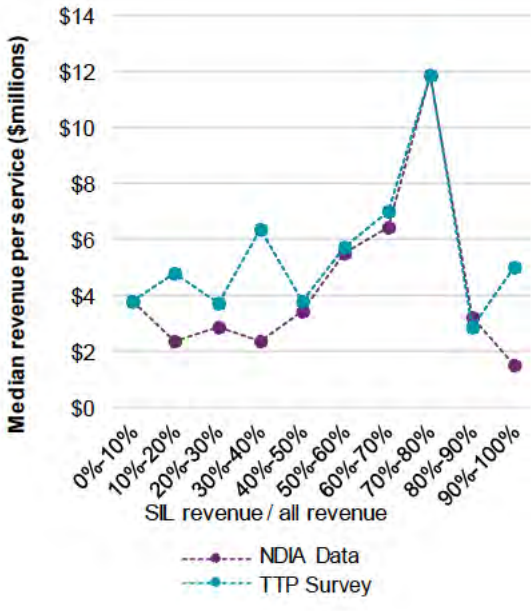
b) Percentage of all services captured within the TTP Survey



c) Median number of clients serviced by organisations providing SIL services



d) Median revenue per service

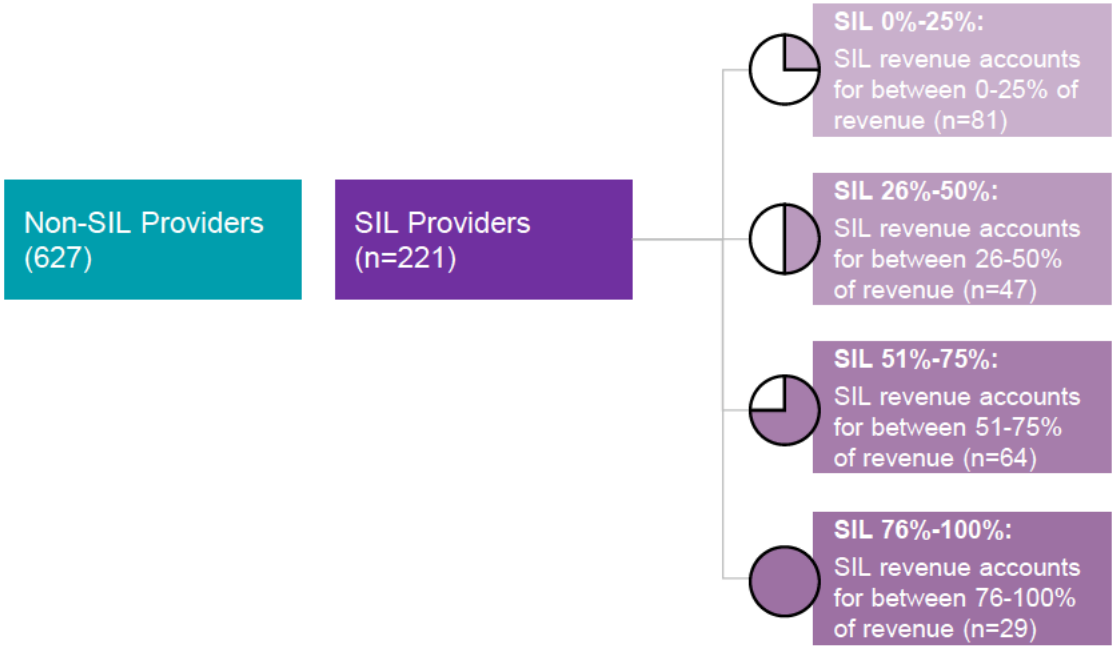


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2.2 Differences between SIL and non-SIL providers in the survey

The unique financial benchmarking survey dataset represents the best available evidence for undertaking the analysis.[9] The key limitation of this dataset is that the benchmarking survey did not seek to differentiate between costs for community activities of daily living services and SIL services. As most providers supply a mix of services including community activities of daily living, SIL, and other services such as capacity building, the analysis has divided providers into two categories and four sub-categories as presented in Exhibit 5.

Exhibit 5: Breakdown of provider categories used in this analysis



A three-step process was followed for identifying differential costs between SIL and non-SIL services:

1. Analysis was undertaken to identify a relationship between the provision of SIL services and the cost parameters.
2. Analysis was undertaken to identify the cost for provision of SIL services:
3. The efficient provider principle: Parameters within the Cost Model are set equivalent to what is determined to be the 'efficient provider'. For most parameters, this is the parameter level at the 25th (or 75th) percentile of the distribution of the parameter.

Data collected from non-SIL providers were considered to be a reasonable proxy for the costs associated with the provision of community activities of daily living services. For SIL-related costs, there were a low number of providers in the financial benchmarking survey that obtained 100% of their revenue from SIL.

[9] Where appropriate, the findings from the analysis have been triangulated with findings from the far smaller 2017-18 AbleInsight survey, which aims to identify cost benchmarks for service providers across the NDIS sector. The AbleInsight survey is available at https://www.ndis.gov.au/providers/price-guides-and-pricing/benchmarking-surveys-and-reports

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2.3 Statistical analysis of 2019-20 Financial Benchmarking Survey

The analysis used the following statistical techniques to identify relationships between the variables:

- Confidence intervals for percentiles were estimated throughout the analysis to understand the range within which the population value of the percentile is likely to fall. Further, confidence intervals allow for a comparison across groups within a sample of the statistical equivalence of the value of a percentile in the broader population.
- Linear regression is a technique that allows for an assessment of whether a particular explanatory variable has a statistically significant linear relationship with the conditional mean of a cost parameter; meaning that a change in an explanatory variable is associated with a change in the cost parameter, holding other variables constant. Linear regression analysis is used throughout the report to understand relationships between explanatory variables and the mean of a cost-parameter.
- Quantile regression is a technique that allows for an assessment of whether an explanatory variable has a statistically significant relationship with a cost parameter throughout different points (or quantiles) of the conditional distribution of the cost parameter. In general, quantile regression analysis attempts to isolate statistically significant linear relationships between a change in an explanatory variable and the conditional quantile of a cost parameter (25th, 50th and 75th percentile). Quantile regression analysis is used throughout this report to understand relationships between explanatory variables and the percentile representing the 'efficient cost parameter'.
  - Quantile regression uses bootstrap standard errors.
  - Pseudo R^2 is reported for the quantile regression analysis.

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2 Findings

The purpose of the Review was to suggest improvements to the structure of the NDIS Disability Support Worker Cost Model to estimate the fully loaded cost of delivering an hour of SIL supports in a shared living arrangement. The Review sought to:

- Identify whether there were different costs that arise in the delivery of activities of daily living supports in a shared living arrangement that do not arise in other settings; and
- quantify any differences that may be required in the key parameters of the NDIS Disability Support Worker Cost Model, given the different cost structures of delivering supports in shared living arrangements compared to other settings.

This chapter assesses the available qualitative and quantitative evidence on various costs directly included in the cost model.

2.1 Wages and on-costs

The NDIS Disability Support Worker Cost Model recognises that wages and on-costs are the largest cost driver for providing disability support services. This section considers whether there are material differences between the base hourly wages paid to, and the on-costs associated with, SIL workers and non-SIL workers.[10]

The key questions for the Review, as outlined in the Issues Paper, are:

- Is there a material difference in the **base hourly wages** paid to workers delivering SIL services compared to workers delivering non-SIL services? Does this reflect different levels of required training, the nature of the work, or some other reason? How large is this difference?
- Are **salary on-costs** different for workers delivering SIL services compared to workers delivering non-SIL services? What aspects of each service type necessitate this difference? How large is this difference?
- Are there differences in **overtime costs** between staff delivering SIL services compared to non-SIL services? What aspects of each service type necessitate this difference? How large is this difference?
- Are **leave costs** different for workers delivering SIL services compared to workers delivering non-SIL services? What aspects of each service type necessitate this difference? How large is this difference?
- Do organisations operate under an **Enterprise Bargaining Agreement** (EBA) or under an Award? Do the EBA conditions differ for workers delivering SIL services compared to non-SIL services? Which conditions are different, and why? How large is this difference?

[10] Base hourly wage refers to the minimum hourly rate of pay received by a worker, not including any shift or leave loading, overtime, superannuation or allowances.

Salary on-costs refers to costs such as superannuation, workers compensation premiums, payroll tax, and employee allowances.

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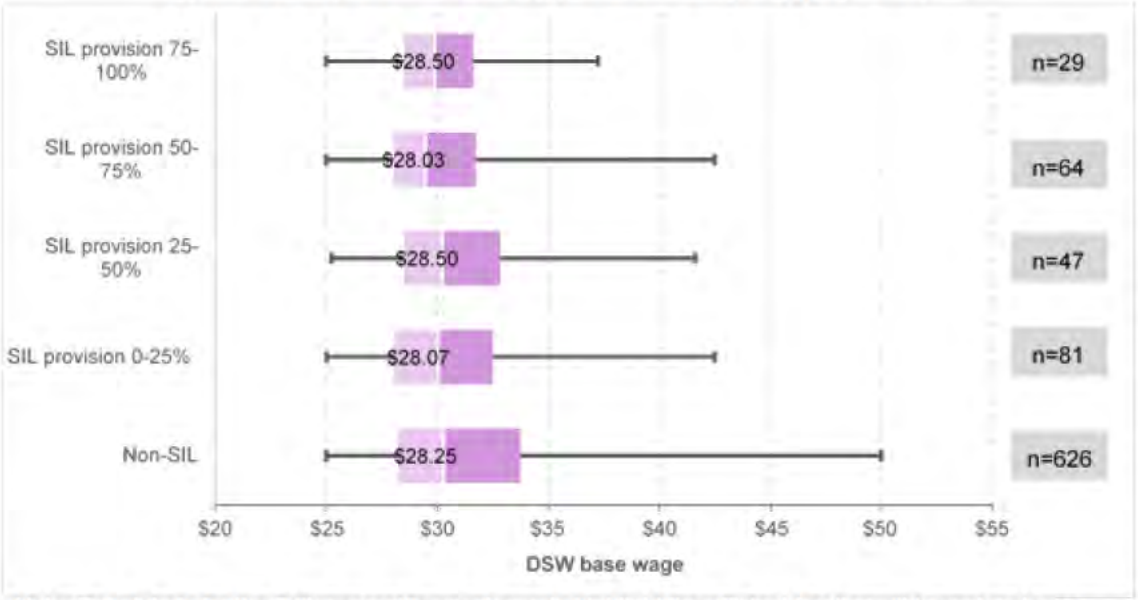
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Base hourly wages

A number of submissions to the Review argued that staff in SIL were, in general, paid a higher wage than staff delivering other activities of daily living supports because participants in SIL tended to have a higher level of complexity than other participants receiving supports with daily activities and therefore more highly qualified staff were needed to deliver support. Some providers commented that they were more comfortable with experienced workers who were more likely to be able to deliver these services seamlessly. The view that workers in SIL tended to be more qualified and higher paid than other workers delivering supports with activities of daily living was not, however, supported by all submissions.

However, analysis of the Financial Benchmarking Survey data does not support the contention that base salaries are higher in SIL settings (see Exhibit 6 and Exhibit 777). Indeed the available evidence indicates that the average base salary paid by SIL providers is lower than the average base salary paid by non-SIL providers. It should also be noted that the 25th percentiles for base salaries are almost equivalent for SIL and non-SIL providers.

Exhibit 6: Box Plot – Base Wages of Disability Support Workers



Note: Data labels for the 25th percentile are shown to highlight the efficient frontier within each category

Exhibit 7: Summary Statistics – Base Wages of Disability Support Workers

Respondent type	Sample size	Mean	Median	25th percentile	75th percentile
All respondents	847	$31.04	$30.12	$28.23	$33.11
Non-SIL respondents	626	$31.30	$30.30	$28.25	$33.70
Mixed (SIL/ADL) respondents	221	$30.38	$29.89	$28.14	$32.14
0-25% SIL respondents	81	$30.36	$30.03	$28.07	$32.49
26-50% SIL respondents	47	$30.72	$30.22	$28.50	$32.84
51-75% SIL respondents	64	$30.17	$29.46	$28.03	$31.73
76-100% SIL respondents	29	$30.33	$29.89	$28.50	$31.62

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Regression analysis (Exhibit 8) confirms that there is no clear relationship between the extent to which a provider is engaged in the provision of SIL and the average base wage that the provider pays to their disability support worker employees. The coefficients for the SIL indicator variable and SIL share variable are both not statistically significantly different from zero. There is some evidence that average base wages are slightly lower for larger organisations.

Exhibit 8: Regression Analysis – Base Wages of Disability Support Workers[11]

Regression variables	Mean	Median	25th percentile	75h percentile
SIL provider indicator	-0.32	0.31	0.03	-0.43
Percentage of revenue sourced from SIL	0.93	0.74	0.88	0.02
Number of clients (log)	0.83**	0.60	0.85**	0.70
Number of staff (log)	-1.84**	-2.04**	-1.23**	-2.32**
Staff-supervisor ratio (log)	0.14	0.39	0.83**	-0.38
R^2	**4.5%**	**3.2%**	**2.8%**	**4.9%**

Note: * and ** indicate the variable is significant at 10% and 5% thresholds respectively (586 observations).

On-costs

The principal on-costs recognised in the NDIS DSW Cost Model are:

- Superannuation;
- Workers Compensation; and
- Employee Allowances.

The Review found no evidence that the costs of either superannuation or employee allowances varied between SIL and non-SIL providers.

There was consensus among providers that workers' compensation costs were higher in the SIL environment. In part, they argued, this is driven because SIL providers are sometimes classified into a different workers compensation risk pool than non-SIL providers. For example, in New South Wales, SIL providers are sometimes classified in the Residential Care Services (not elsewhere classified) sector whereas most providers of activities of daily living supports are classified as part of the Non-Residential Care Services (not elsewhere classified) sector. The basic NSW Workers Compensation Industry Classification Rates, prior to adjustments for size and experience, for these two sectors in 2021 are 4.07% and 2.2% respectively.

[11] The equation regresses the average base wage for the disability support workers of a provider against:

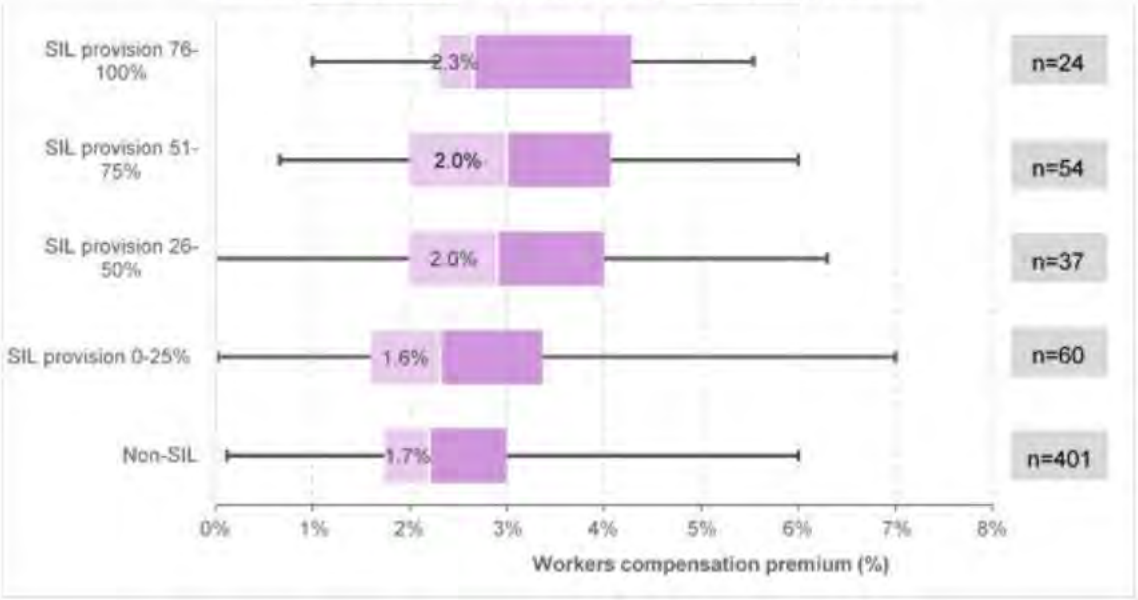
- the SIL provider indicator variable (1 if the provider delivers SIL, 0 otherwise);
- the percentage of the provider's revenue sourced from SIL;
- Log of the number of participants supported by the provider;
- Log of the number of direct support staff (DSWs and FLSs) employed by the provider; and
- Log of the supervision ratio of the provider – Log of the ratio of the number of DSWs (headcount)) and the number of FLSs (head count).

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Analysis of the Financial Benchmarking Survey data confirms that SIL providers tend to have a higher rate of workers compensation premium as a percentage of wages and salaries than non-SIL providers (Exhibit 9 and Exhibit 10). The data indicates that the average provider that offers SIL services pays a workers compensation premium of 2.8% of their total wages and salaries, compared to 2.5% for the median provider that offers no SIL services. However, the level of workers compensation premium increases, on average, in line with the share of SIL provision. In particular, providers for whom SIL makes up more than 75% of their business have an average workers compensation premium of 3.2%.

A similar relationship is seen for efficient providers, with the 25th percentile of non-SIL providers having a workers compensation premium of 1.7% compared to 2.0% for the 25th percentile of all SIL providers and 2.3% for efficient providers for whom SIL makes up more than 75% of their business.

Exhibit 9: Box Plot – Workers Compensation Premiums



Note: Data labels for the 25th percentile are shown to highlight the efficient frontier within each category

Exhibit 10: Summary Statistics – Workers Compensation Premiums

Respondent type	Sample size	Mean	Median	25th percentile	75th percentile
All respondents	576	2.6%	2.3%	1.8%	3.5%
Non-SIL respondents	401	2.5%	2.2%	1.7%	3.0%
Mixed (SIL/ADL) respondents	175	2.8%	2.6%	2.0%	4.0%
0-25% SIL respondents	60	2.5%	2.3%	1.6%	3.4%
26-50% SIL respondents	37	3.0%	2.9%	2.0%	4.0%
51-75% SIL respondents	54	3.1%	3.0%	2.0%	4.1%
76-100% SIL respondents	24	3.2%	2.6%	2.3%	4.3%

Regression analysis (Exhibit 11) further confirmed a positive relationship between SIL provision and workers compensation premiums paid as a percentage of wages and salaries.

There are no inherent structural differences between providers that offer some SIL services to those that do not offer SIL services that would contribute to differences in the level of

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workers compensation premiums paid by a provider. This is indicated by the fact that the indicator variable for SIL provision is not significantly different than zero across the regression equations. However, there is a statistically significant relationship to the share of revenue from SIL increases, as this increases, so do workers' compensation premiums.

A one percentage point increase in the proportion of revenue received from SIL services by an organisation is associated with a 0.009 percentage point increase in the workers compensation premium paid by an organisation, on average. For example, if an organisation that received 0% of their revenue from SIL had a workers compensation premium of 1.7%, then an otherwise identical organisation with 100% revenue sourced from SIL would be expected to have a workers compensation premium of 2.6%. A similar effect, but slightly smaller difference, is observed for efficient (25th percentile) providers. So given the observed average workers compensation premium for efficient non-SIL providers is 1.7% (see Exhibit 10) then the expected average workers compensation premium for efficient SIL providers is 2.4%

Exhibit 11: Regression Analysis – Workers' Compensation Premiums[12]

Regression variables	Mean	Median	25th percentile	75h percentile
SIL provider indicator	0.002	-0.001	-0.000	0.002
Percentage of revenue sourced from SIL	0.009**	0.011**	0.007*	0.017**
Number of clients (log)	-0.004**	-0.004**	-0.001	-0.006**
Staff-supervisor ratio (headcount) (log)	-0.000	-0.000	-0.000	-0.000
Average base wage (Front line supervisor)	-0.000	-0.000	-0.000	-0.000
Average base wage (DSW)	-0.001*	-0.000	-0.000	-0.000
QLD provider indicator	-0.011**	-0.013**	-0.008**	-0.012**
NSW provider indicator	-0.004*	-0.006*	-0.005	-0.000
VIC provider indicator	-0.007**	-0.009**	-0.006**	-0.004
SA provider indicator	-0.000	-0.002	-0.000	-0.004
WA provider indicator	-0.002	-0.001	-0.003	-0.000
R^2	**13.8%**	**10.1%**	**7.3%**	**13.9%**

Note: * and ** indicate the variable is significant at 10% and 5% thresholds respectively (428 observations).

Overtime costs

Generally overtime costs were reported by providers as being higher in SIL than non SIL services. This was mostly attributed by providers to the support needs of SIL participants.

[12] The equation regresses the workers compensation premium (as a percentage of labour costs) paid by a provider against:

- the SIL provider indicator variable (1 if the provider delivers SIL, 0 otherwise);
- the percentage of the provider's revenue sourced from SIL;
- Log of the number of participants supported by the provider;
- Average base wage paid to DSWs employed by the provider;
- Average base wage paid to FLSs employed by the provider; and
- State Dummy Variables (1 if the state is where the largest share of the provider's revenue is derived, 0 otherwise).

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Providers argued that that when a staff member could not fulfil a shift the provider did not have the option to let the participant go without support. As a result, workers were sometimes required to continue beyond the end of their shift. The wrap around nature of SIL also meant that workers were more inclined to be asked to work overtime. The range of reported overtime was varied but a number of providers considered it common to see 10 – 20 hours of overtime per house per week.

Submissions reported that households with complex participants or challenging behaviours were more likely to have higher levels of overtime, as staff cannot leave the participant unattended, or cannot leave until the participant is comfortable. Providers generally reported that they preferred to minimise rostering overtime where possible, as excessive overtime was seen to negatively impact the level of care due to staff fatigue.

The Review understands the arguments presented by providers that overtime may be more common in SIL settings than in non-SIL settings. However, the Review did not have an empirical base on which to estimate the materiality of this difference. The Review recommends that future financial benchmarking surveys should examine the use of overtime by efficient SIL and non-SIL providers.

Leave costs

The Review notes that under the Social, Community, Home Care and Disability Services Award 2010 (SCHADS Award), workers who work on ten or more weekends or public holidays a year are defined as “shift workers” and entitled to an extra week’s annual leave.

Submissions to the Review consistently argued that SIL supports were much more likely to be delivered on weekends and public holidays than other activities of daily living supports, and that this resulted in more workers qualifying as shift workers. Providers also pointed out that shift workers are entitled to be paid their weekend loadings even when on leave.

Ability First’s submission, which contained financial benchmarking data from their providers, stated that “the majority of DSWs (95%) meet the threshold for five weeks annual leave under the Award.”

The Review acknowledges that the nature of supporting participants in a SIL arrangement may require many workers of a SIL provider to work over the threshold of weekends required by the SCHADS Award to classify the worker as a shift worker, thus requiring an additional week of annual leave. This finding will be considered in Chapter 3.

Enterprise Bargaining Agreements (EBAs)

In keeping with the fact that many, if not most, providers do not have EBAs, the Review received fewer submission responses on this topic than others. Of those who did respond, about a third had their own EBA. Providers reported that it was taking longer to transition out of inherited EBAs than they had expected. Moreover, when they were successfully able to do so, this sometimes resulted in higher incidence of staff turnover. The limited analysis that could be conducted across recent ‘SCHADS-compatible’ EBAs did not identify any significant systemic differences between the treatment of SIL and non-SIL workers.

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2.2 Workforce mix

The DSW Cost Model recognises that the costs of employing casual and permanent workers are different. The Review therefore sought evidence on whether there were material differences in these distribution or permanent and casual employment arrangements between SIL providers and non-SIL providers.

The key questions for the Review, as outlined in the Issues Paper, are:

- Is there a material difference in the proportion of employees employed on a **casual** basis between employees providing SIL and non-SIL services? If there is a difference, which aspects of SIL service delivery are suited to more (or fewer) permanent employees relative to casual employees? How large is this difference? What is the average number of hours per week that a casual staff member is employed? Is there a material difference in the average number of hours per week that a casual staff member is employed between employees providing SIL and non-SIL services? If there is a difference, how large is this difference?
- Is there a material difference in the proportion of employees employed on a **part-time** basis between employees providing SIL and non-SIL services? If there is a difference, which aspects of SIL service delivery are suited to more (or fewer) part-time permanent employees relative to full-time permanent employees? How large is this difference? What is the average number of hours per week that a part-time staff member is employed? Is there a material difference in the average number of hours per week that a part-time staff member is employed between employees providing SIL and non-SIL services? If there is a difference, how large is this difference?
- Are **temporary** replacement staff engaged more or less often for SIL services? If there is a difference, what are the key drivers of this difference? How large is this difference? Is the cost of the temporary replacement staff different between SIL services and non-SIL services? If there is a difference, what are the key drivers of this difference? How large is this difference?
- What **level** of worker is employed for standard and higher requirements?

Casual / Permanent Staff Mix

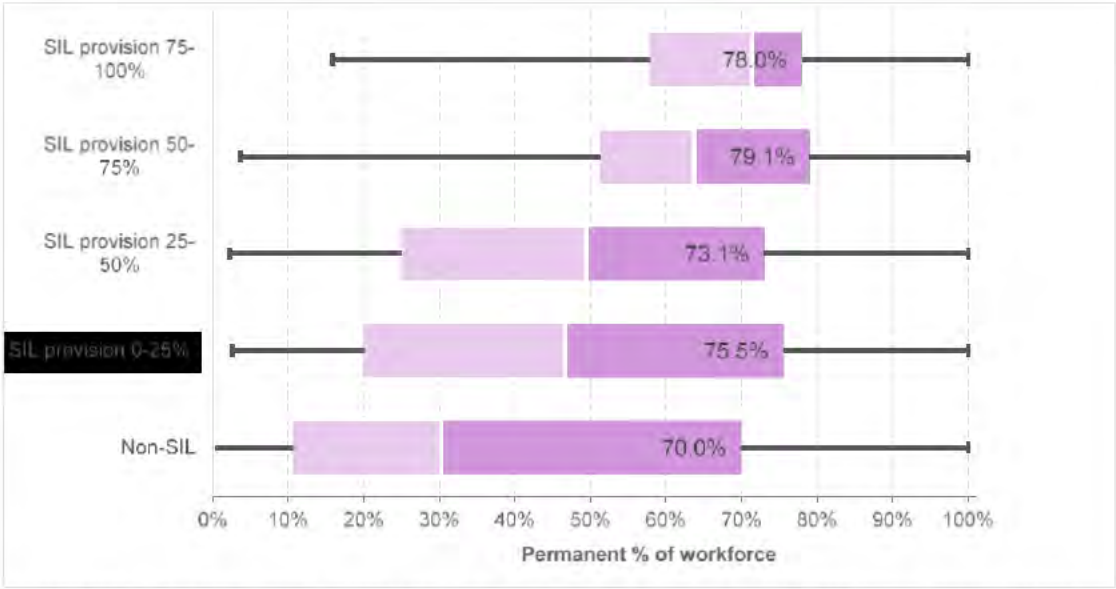
Many submissions to the Review argued that SIL providers were, in general, likely to have a higher proportion of permanent workers than non-SIL providers. The same point was made in consultations with providers. Casualization was typically reported as lower in SIL than in non-SIL settings because there was a preference for higher skilled, more experienced workers and permanence owing to the requirement for 24/7 services. Permanent employment rates were reported to be higher the more skilled the position was (such as team leaders). A few providers noted that the National Disability Services' *Provider Benchmarking Survey 2017-18* found the mix of the SIL workforce was 72% permanent compared to 59% permanent in supports for activities of daily living. Ability First suggested that on average 78% of all hours delivered in SIL are delivered by permanent staff.

Analysis of the Financial Benchmarking Survey Data (Exhibit 12 and Exhibit 13) confirms that SIL providers do tend to employ a larger proportion of their workforce on a permanent basis. The median provider of SIL services employs 59% of their workforce on a permanent basis, compared to 30% for the median provider that provides no SIL services. For efficient

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providers (the 25th percentile) SIL providers employ 77.5% of their workforce on a permanent basis, compared to 70.0% for non-SIL providers.

Exhibit 12: Box Plot – Permanent Employment Share



Note: Data labels for the 25th percentile are shown to highlight the efficient frontier within each category

Exhibit 13: Summary Statistics – Permanent Employment Share

Respondent type	Sample size	Mean	Median	25th percentile	75th percentile
All respondents	837	44.3%	40.2%	12.5%	72.6%
Non-SIL respondents	617	40.5%	30.2%	10.5%	70.0%
Mixed (SIL/ADL) respondents	220	54.5%	59.3%	30.0%	77.5%
0-25% SIL respondents	81	48.3%	46.6%	20.0%	75.5%
26-50% SIL respondents	47	50.5%	49.4%	25.5%	73.1%
51-75% SIL respondents	64	61.8%	63.7%	51.2%	79.1%
75-100% SIL respondents	28	65.2%	71.3%	57.7%	78.0%

Regression analysis (Exhibit 14) further confirms a positive relationship between SIL service provision and the percentage of the workforce that is employed on a permanent basis. The regression analysis also indicates that there are no inherent structural differences, between providers that offer any SIL services to those that offer none, which have a significant impact on the permanent share of a provider's workforce. However, the data does show that as the share of revenue from SIL increases, so does the permanent share of the workforce.

A one percentage point increase in the proportion of revenue received from SIL services by an organisation is associated with a 0.41 percentage point increase in the proportion of an organisation's workforce that is employed on a permanent basis, on average. For example, if an organisation that received 0% of their revenue from SIL had a permanent workforce share of 40.5%, then an otherwise identical organisation with 100% revenue sourced from SIL would be expected to have a permanent workforce share of 81.5%. A similar effect, but smaller difference, is observed for efficient (75th percentile) providers. If an organisation that received 0% of their revenue from SIL had a permanent workforce share of 70.0%, then an

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otherwise identical organisation with 100% revenue sourced from SIL would be expected to have a permanent workforce share of 85.1%.

Exhibit 14: Regression Analysis – Permanent Employment Share[13]

Regression variables	Mean	Median	25th percentile	75th percentile
SIL provider indicator	0.03	0.08	-0.01	0.20
Percentage of revenue sourced from SIL	0.81**	0.86**	1.05**	0.39*
Number of clients (log)	0.22**	0.25**	0.31**	0.24**
Average base wage (DSW) (log)	-1.82**	-1.96**	-0.46	-3.89**
Staff-supervisor ratio (headcount) (log)	-0.39**	-0.54**	-0.37**	-0.51**
Labour time spent on billable work (% of all time)	0.92*	0.88	0.80	1.27*
Labour time spent training (% of all time)	-0.52	1.00	0.96	0.50
Labour time spent client admin (% of all time)	1.60**	1.27	2.10**	2.24*
Labour time spent on admin (% of all time)	1.91**	1.65	0.93	3.51**
R^2	**21.6%**	**16.9%**	**17.2%**	**10.9%**

Note: * and ** indicate the variable is significant at 10% and 5% thresholds respectively (477 observations).

Part time staff

Most providers indicated that part-time employment was the most common type of employment in a SIL arrangement. Many providers stated that the majority of their staff were permanent part time, with some indicating that 70%-80% of their staff were permanent part time. Part time staff hours were reported to range between 15–40 hours per week, with the most common range between 18–28 hours per week. Offering standard full-time contracts was perceived to be difficult given the atypical hours associated with SIL work.

This issue was considered in depth in AbleInsight's 2017-18 Financial Benchmarking Survey Report. That Report found that, on average, 53.1% of all disability support worker hours in SIL (and 74.1% of all permanent disability support worker hours in SIL) were delivered by part-time workers. This compared to 42.7% of all disability support worker hours (and 73.0% of all permanent disability support worker hours) in non-SIL settings.

[13] The equation regresses the log of the ratio of the number of permanent workers (headcount) and casual workers (headcount) employed by a provider against:

- the SIL provider indicator variable (1 if the provider delivers SIL, 0 otherwise);
- the percentage of the provider's revenue sourced from SIL;
- Log of the number of participants supported by the provider;
- Log of the Average base wage paid to DSWs employed by the provider;
- Average base wage paid to FLSs employed by the provider;
- Log of the ratio of the number of DSWs (headcount) and FLSs (headcount) employed by the provider;
- Percentage of labour time spent on billable work by DSWs employed by the provider;
- Percentage of labour time spent on training by DSWs employed by the provider;
- Percentage of labour time spent on client administration by DSWs employed by the provider; and
- Percentage of labour time spent on general administration by DSWs employed by the provider.

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Although there may some additional administrative costs involved in a workforce with a larger share of part-time workers, the Review did not find any evidence of significant differences in costs in this regard between SIL and non-SIL providers.

Agency staff / temporary replacement staff

It was fairly common for providers to report in response to the Issue Paper that they did not use Agency or temporary staff at all. Organisations that did report employing these types of staff said that they are more likely to do so for SIL than non-SIL services. All respondents who used Agency or temporary staff said that they were more expensive and that this sometimes de-incentivised providers from using them. Based on data from five providers, Alliance 20 reported that agency staff hours accounted for about 2.8% of all hours. Ability First suggested that there was pressure to keep houses fully staffed in SIL. They argued that this can necessitate the use of agency staff, overtime, increased wages and recruitment costs. One provider argued that as agency staff often had to be used instead of full-time employees and that this should be accounted for in the Cost Model.

On balanced, the Review did not consider that there was significant evidence of a material difference in the cost structures of SIL and non-SIL settings in respect to this cost driver.

Level of staff

Many respondents to the Issues Paper argued that the average level of worker used in SIL was much higher than that allowed for the NDIS Disability Support Worker Cost Model. One provider suggested that in SIL services, they employ staff around SCHADS level 4. They argued that this was because more experience was needed to deal with the challenges - and at times volatility - experienced in the SIL environment. Aspects of care such as medication management and the delivery of specialised services are tasks that require training and experience, so providers wanted experienced staff who were more likely to be able to deliver these services effectively.

These claims are not, however, supported by the evidence on base pay rates in SIL and non-SIL settings discussed above. The Financial Benchmarking Survey data does not support the contention that base salaries are higher in SIL settings (see Exhibit 6 and Exhibit 7 above). Indeed the average base salary paid by SIL providers is lower than the average bases salary paid by non-SIL providers. It should also be noted that the 25th percentiles for base salaries are almost equivalent for SIL and non-SIL providers. These findings are not consistent with a consistently higher use of more qualified staff in SIL settings.

2.3 Utilisation

The NDIS Disability Support Worker Cost Model recognises that staff need to spend some working time undertaking non-billable work, including breaks and training. The NDIA therefore sought evidence on whether there were material differences in these arrangements between SIL providers and non-SIL providers.

The key questions for the Review, as outlined in the Issues Paper, are:

- Do **training requirements** – and associated costs – for workers differ between SIL services and non-SIL services? If there is a difference, what are the key drivers of this difference? How large is this difference?

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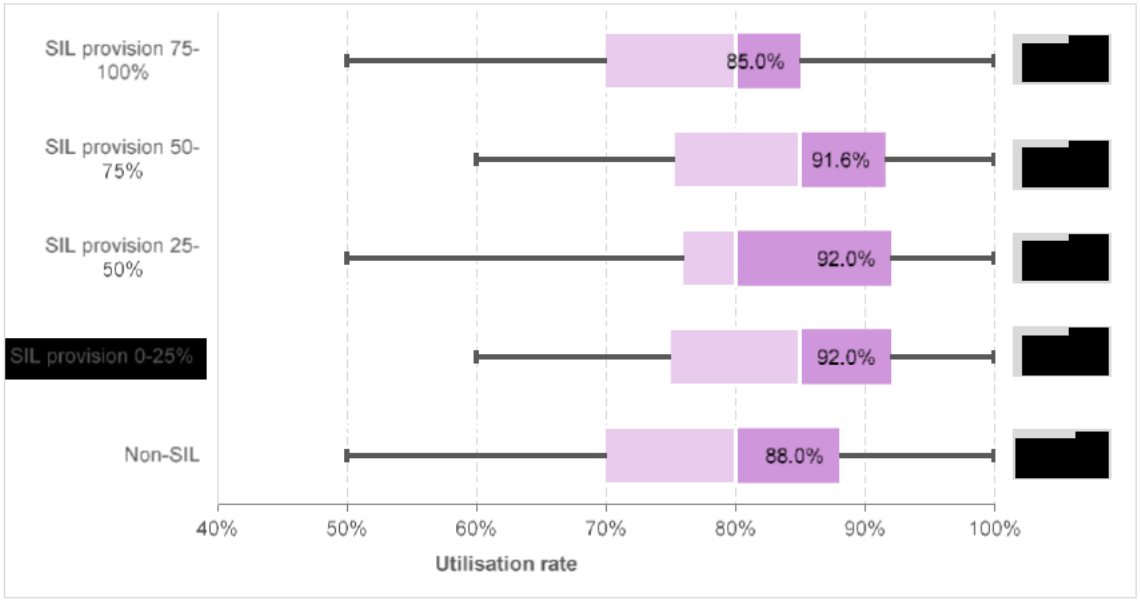
- Is there a material difference in the **non-direct care activities** that staff in SIL services, compared to staff in non-SIL services, are required to undertake? What are the key drivers of these differences? How large are these differences?

Utilisation (billable v unbillable hours)

Most respondents to the Issues Paper mentioned that workers spent the great majority of their time delivering supports, with most responses between 80-95%. Although providers noted that this could vary substantially between participants. Respondents suggested that SIL staff were more often engaged in unbillable activities than were other staff supporting activities of daily livings, because of an increased emphasis on quality and safeguarding in SIL settings. This includes team meetings, handover, increased reporting, coordination of stakeholders and household management. SIL arrangements were reported to also entail a lot of external stakeholder involvement, family meetings, and communication back and forth with other providers that cannot be attributed directly to the participant. Ability First reported that family/ stakeholder engagement accounts for 1.5% of disability support worker hours for standard participants and 2.1% for high intensity participants. In addition, they reported that liaising and coordinating with other supports and services accounts for 1% of disability support worker hours for standard participants and 1.2% in high intensity participants.

The Financial Benchmarking Survey Data (Exhibit 15 and Exhibit 16) tends to indicate that SIL providers do tend to have slightly higher utilisation rates than other providers of activities of daily living supports. The median provider of SIL services achieved an utilisation rate of 84% compared to 80% for the median provider that provides no SIL services. For efficient providers (the 25th percentile) SIL providers achieved utilisation rates of 91% compared to 88% for non-SIL providers.

Exhibit 15: Box Plot – Staff Utilisation Rate



Note: Data labels for the 25th percentile are shown to highlight the efficient frontier within each category

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Exhibit 16: Summary Statistics – Staff Utilisation Rate

Respondent type	Sample size	Mean	Median	25th percentile	75th percentile
All respondents	698	79.4%	80.0%	70.0%	90.0%
Non-SIL respondents	495	77.9%	80.0%	70.0%	88.0%
Mixed (SIL/ADL) respondents	203	82.7%	84.0%	75.0%	91.0%
0-25% SIL respondents	75	83.5%	85.0%	75.0%	92.0%
26-50% SIL respondents	41	82.1%	80.0%	76.0%	92.0%
51-75% SIL respondents	61	83.4%	85.0%	75.3%	91.6%
75-100% SIL respondents	26	78.9%	80.0%	70.0%	85.0%

Deeper regression analysis seems to show, however, that utilisation rates do not differ significantly between SIL and non-SIL providers, for median providers (Exhibit 17) as the regression coefficient for the relevant variables are not statistically significantly different from zero.

The observed differences are driven by correlations with other factors. These findings align with survey results from the AbleInsight survey of 2017-18, which showed the average SIL provider had a comparable utilisation rate (95%) to the average non-SIL provider (93%).

Exhibit 17: Regression Analysis – Staff Utilisation Rate[14]

Regression variables	Mean	Median	25th percentile	75h percentile
SIL provider indicator	0.03	0.03	0.04	0.05*
Percentage of revenue sourced from SIL	0.15	0.11	0.23	0.05
Percentage of revenue sourced from SIL (squared)	-0.24**	-0.17	-0.36**	-0.15
Number of clients (log)	-0.01	-0.00	-0.02	-0.00
Number of supervisors (log)	-0.05**	-0.06**	-0.04	-0.05**
Number of direct staff (log)	0.03**	0.08**	0.08**	0.09**
Average base wage (FLS)	0.00	-0.00	0.00	-0.00
Average base wage (DSW)	-0.00	-0.01**	-0.00)	-0.00
R^2	**10.9%**	**4.8%**	**6.9%**	**5.9%**

Note: * and ** indicate the variable is significant at 10% and 5% thresholds respectively (518 observations).

[14] The equation regresses the percentage of labour time that is spent by DSWs employed by the provider on billable work against:

- the SIL provider indicator variable (1 if the provider delivers SIL, 0 otherwise);
- the percentage of the provider's revenue sourced from SIL;
- the square of the percentage of the provider's revenue sourced from SIL;
- Log of the number of participants supported by the provider;
- Log of the number of FLSs employed by the provider;
- Log of the number of DSWs employed by the provider;
- Average base wage paid to FLSs employed by the provider; and
- Average base wage paid to DSWs employed by the provider.

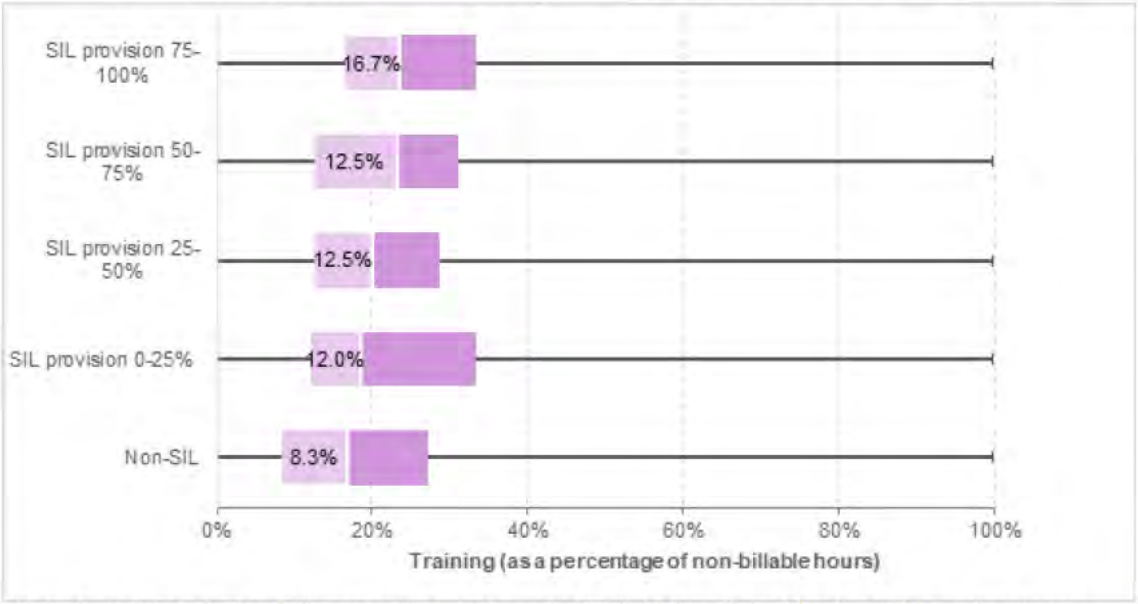
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In the regression analysis, the coefficient for the SIL provider indicator variable for efficient providers (25th percentile) is statistically significant but the coefficient for the percentage of revenue sourced from SIL variable is not statistically significant. That implies there is structural difference in utilisation rates between SIL and non-SIL providers of about 5%. However, the regression analysis also indicates that the relationship between utilisation and the percentage of revenue sourced from SIL may be quadratic, which means relations are not completely well fitted by regression. On balance, the Review finds that utilisation is slightly higher (two percentage points) in SIL settings.

Training

The Financial Benchmarking Survey data indicates that time spent on training as a proportion of non-billable time is slightly higher, on average, for providers that offer SIL services compared to those that did not (Exhibit 18 and Exhibit 19Exhibit 20). Employees of mixed SIL/non-SIL providers spend, on average, 20.5% of non-billable time on training, compared to 18.3% for employees of non-SIL providers.

Exhibit 18: Box Plot – Time spent training as a share of non-billable hours



Note: Data labels for the 25th percentile are shown to highlight the efficient frontier within each category

Exhibit 19: Summary Statistics – Time spent training as a share of non-billable hours

Respondent type	Sample size	Mean	Median	25th percentile	75th percentile
All respondents	680	19.0%	18.0%	9.6%	26.9%
Non-SIL respondents	480	18.3%	16.7%	8.0%	25.0%
Mixed (SIL/ADL) respondents	200	20.5%	20.0%	11.1%	27.8%
0-25% SIL respondents	73	18.9%	16.7%	10.0%	25.0%
26-50% SIL respondents	41	19.9%	20.0%	10.0%	25.0%
51-75% SIL respondents	61	21.1%	20.2%	11.1%	29.1%
76-100% SIL respondents	25	24.1%	21.7%	16.7%	33.3%

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A simple T-test confirmed there is a statistical difference between the proportions of time spent on training as a percentage of non-billable hours for SIL providers when compared to non-SIL providers at the 1% significance level.[15]

However, regression analysis (Exhibit 20) indicates that there is no statistically significant relationship between the proportion of revenue from SIL services and time spent on training as a percentage of non-billable hours. It may be that the drivers of time spent on training were not well captured by the regression specification. However, additional regression specifications failed to find a better suited regression model.[16]

Exhibit 20: Regression Analysis – Time spent training as a share of non-billable hours[17]

Regression variables	Mean	Median	25th percentile	75h percentile
SIL provider indicator	0.01	0.02	0.04	-0.00
Percentage of revenue sourced from SIL	0.05	0.06	0.02	0.08
Number of clients (log)	-0.01	-0.03	-0.03	-0.01
Number of supervisors (log)	-0.02	-0.01	0.02	-0.04
Number of direct staff (log)	0.02	0.00	0.02	0.02
Average base wage (FLS)	-0.00	0.00	0.00	-0.00
Average base wage (DSW)	-0.00	-0.00	-0.00	-0.00
R^2	**1.8%**	**2.2%**	**2.1%**	**1.3%**

Note: * and ** indicate the variable is significant at 10% and 5% thresholds respectively (478 observations).

2.4 Supervision costs

The NDIS Disability Support Worker Cost Model recognises that staff require direct supervision of the care that they provide, as well as management support. They key parameters in the Cost Model associated with supervision are the wages and conditions of the supervisor, and the supervision ratio. This section considers whether there are material differences in these parameters between SIL and non-SIL settings.

The key questions for the Review, as outlined in the Issues Paper, are:

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[15] The T-test compared the mean time spent on training as a percentage of non-billable hours between providers that did offer SIL services (n=200) and providers that did not offer SIL services (n=480). P-value of right tail T-test was 0.00, indicating that SIL providers had a greater mean value than non-SIL providers at 1% significance level.

[16] Additional model specifications included; overhead costs as a percentage of total direct costs; direct costs; and permanent employment rates.

[17] The equation regresses the percentage of labour time that is spent by DSWs employed by the provider on training against:

- the SIL provider indicator variable (1 if the provider delivers SIL, 0 otherwise);
- the percentage of the provider's revenue sourced from SIL;
- Log of the number of participants supported by the provider;
- Log of the number of FLSs employed by the provider;
- Log of the number of DSWs employed by the provider;
- Average base wage paid to FLSs employed by the provider; and
- Average base wage paid to DSWs employed by the provider.

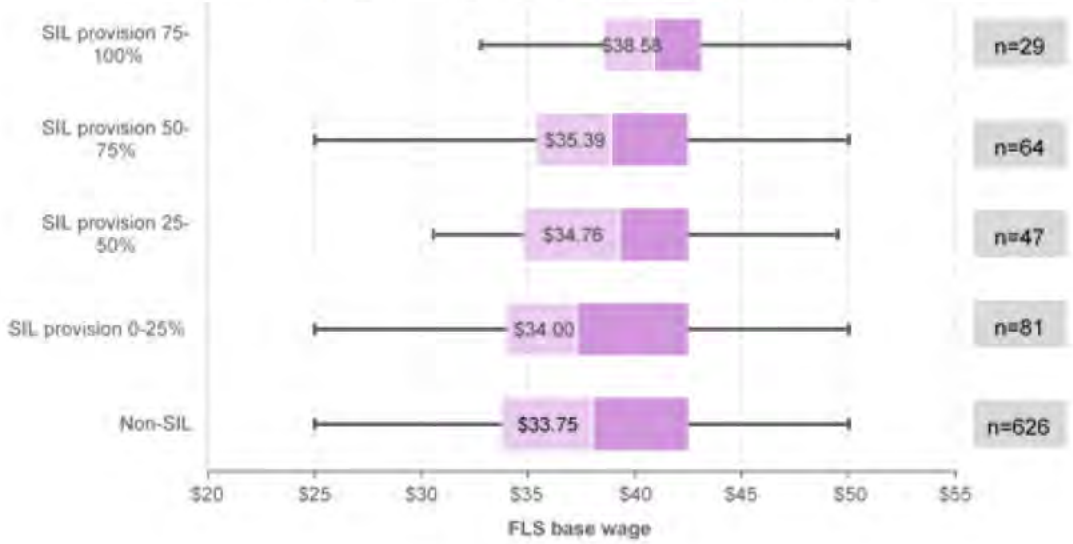
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- Is there a material difference in the **wages and on-costs of supervisors** between SIL services and non-SIL services? If there is a difference, what are the key drivers of these differences? How large is the difference?
- Is there a difference in the **supervision ratio** (the number of workers per supervisor) between SIL services and non-SIL services? If there is a difference, what are the key drivers of these differences? How large is the difference?

Base wages – Supervisors

There is some evidence from the Financial Benchmarking Survey that SIL providers may pay higher base wages for supervisors than non-SIL providers (Exhibit 21 and Exhibit 22).

Exhibit 21: Box Plot – Base Wages of Supervisors



Note: Data labels for the 25th percentile are shown to highlight the efficient frontier within each category

Exhibit 22: Summary Statistics – Base Wages of Supervisors

Respondent type	Sample size	Mean	Median	25th percentile	75th percentile
All respondents	846	$38.40	$38.50	$33.80	$42.50
Non-SIL respondents	625	$38.21	$37.74	$33.75	$42.49
Mixed (SIL/ADL) respondents	221	$38.89	$38.74	$34.99	$42.49
0-25% SIL respondents	81	$38.16	$37.24	$34.00	$42.49
26-50% SIL respondents	47	$38.85	$39.24	$34.76	$42.49
51-75% SIL respondents	64	$38.83	$38.86	$35.39	$42.45
75-100% SIL respondents	29	$41.14	$40.88	$38.58	$43.09

Regression analysis (Exhibit 23) confirms that there is a positive relationship between the proportion of revenue from SIL services and the average base wage paid to supervisors. On average, the base wages of supervisors in efficient (25th percentile) SIL settings are $4.00 per hour – 11.9% – higher than in non-SIL settings. The regression analysis also indicates

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that supervisor wages increase with the log of the number of clients serviced by the organisation but decrease with the log of the number of staff employed by the organisation.

The analysis also indicates other statistically significant relationships that the average wage paid to supervisors increases with the log of the number of clients of the provider and log of the number of staff to supervisor ratio but decreases as the number of staff that a supervisor is expected to supervise increases. These could be further investigated on structural differences to base wages of supervisors of SIL organisations and other variables that could describe this difference due to the low R^2 (variables in the model do not explain the base wages of supervisors well).

Exhibit 23: Regression Analysis – Base Wages of Supervisors[18]

Regression variables	Mean	Median	25th percentile	75h percentile
SIL provider indicator	0.04	0.0	-0.89	-0.63
Percentage of revenue sourced from SIL	2.8**	3.2*	4.89**	2.36
Number of clients (log)	1.05**	0.73	1.90**	0.49
Number of staff (log)	-2.72**	-2.74**	-2.25**	-4.81**
Staff-supervisor ratio (log)	2.23**	2.97**	1.93**	1.98**
R^2	**4.6%**	**3.7%**	**2.9%**	**4.0%**

Note: * and ** indicate the variable is significant at 10% and 5% thresholds respectively (586 observations).

Supervision ratios

There is some evidence from the Financial Benchmarking Survey that supervisors in SIL settings have higher spans of controls than in non-SIL settings (Exhibit 24 and Exhibit 25).

Supervisors in non-SIL settings have an average span of control of 10.9 to 1 while supervisors in mixed SIL/ADL settings have an average span of control of 13.0 to 1. A similar difference is apparent amongst efficient providers, where the spans of control in SIL and non-SIL settings are 16.7 to 1 and 14.5 to 1 respectively.

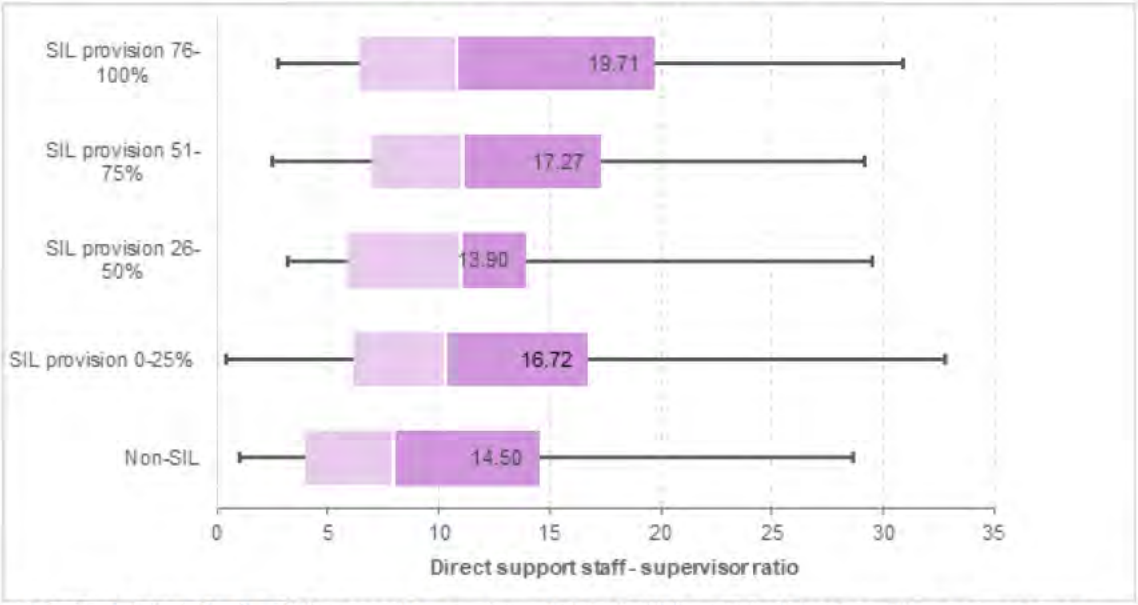
However, regression analysis indicates that once differences in numbers of clients, numbers of staff per client, utilisation and skill level of supervisors are controlled for, there is no statistically significant difference in the levels of staff-supervisor ratios between SIL and non-SIL providers (Exhibit 26). This finding aligns with survey results from the AbleInsight survey 2017-18, which showed that there were not material differences in the average level of staff-supervisor ratios between SIL and non-SIL providers.

[18] The equation regresses the average base wages of supervisors employed by the provider against:

- the SIL provider indicator variable (1 if the provider delivers SIL, 0 otherwise);
- the percentage of the provider's revenue sourced from SIL;
- Log of the number of participants supported by the provider;
- Log of the number of DSWs employed by the provider; and
- Log of the ratio of the number of FLSs (headcount) and DSWs (headcount) employed by the provider.

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Exhibit 24: Box Plot – Supervision Ratio



Note: Data labels for the 25th percentile are shown to highlight the efficient frontier within each category

Exhibit 25: Summary Statistics – Supervision Ratio

Respondent type	Sample size	Mean	Median	25th percentile	75th percentile
All respondents	794	11.47	8.55	5.00	15.00
Non-SIL respondents	580	10.89	8.00	4.00	14.50
Mixed (SIL/ADL) respondents	214	13.02	10.75	6.40	16.67
0-25% SIL respondents	78	13.59	10.29	6.17	16.72
26-50% SIL respondents	46	11.87	10.96	5.90	13.90
51-75% SIL respondents	63	12.84	11.10	7.00	17.27
75-100% SIL respondents	27	13.76	10.79	6.40	19.71

Exhibit 26: Regression Analysis – Supervision Ratio[19]

Regression variables	Mean	Median	25th percentile	75th percentile
SIL provider indicator	-0.10**	-0.13**	-0.07	-0.10
Percentage of revenue sourced from SIL	0.03	0.01	0.03	-0.08
Number of clients (log)	0.34**	0.39**	0.34	0.34**
Average base wage (FLS)	0.01**	0.01**	0.01**	0.01**
Number of staff-client (log)	0.35**	0.43**	0.35**	0.37**
Labour time spent on billable work (% of all time)	0.38**	0.29**	0.50**	0.22
R^2	**33.1%**	**19.0%**	**20.9%**	**15.2%**

Note: * and ** indicate the variable is significant at 10% and 5% thresholds respectively (477 observations).

[19] The equation regresses the log of the ratio of the number of FLSs (headcount) and DSWs (headcount) employed by the provider against:

- the SIL provider indicator variable (1 if the provider delivers SIL, 0 otherwise);

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2.5 Overheads

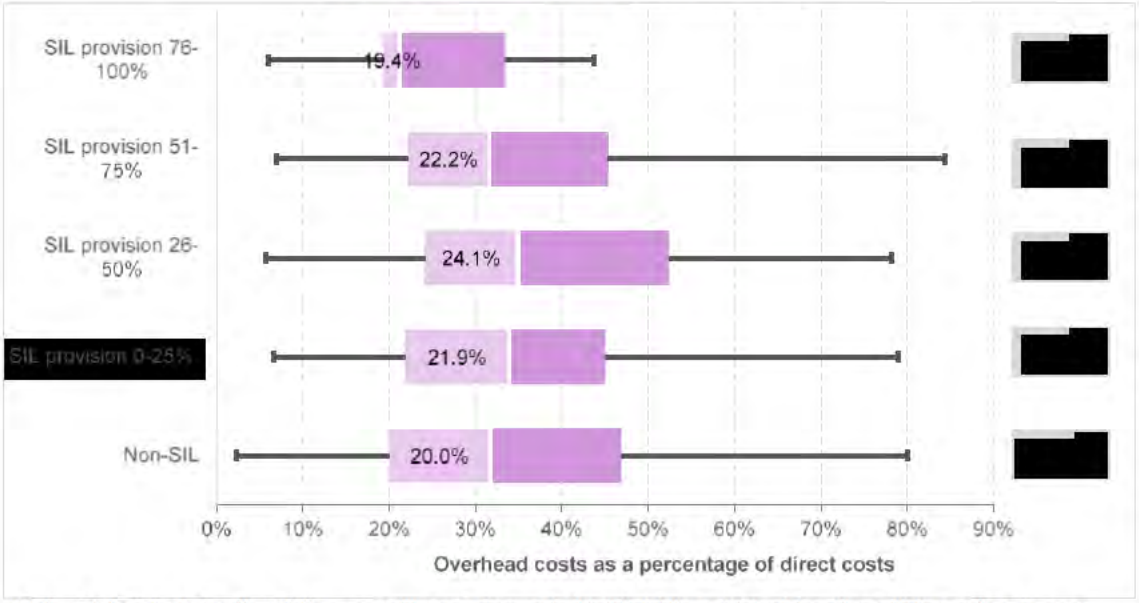
The NDIS Disability Support Worker Cost Model recognises that providers incur a number of costs ("overheads") that not directly attributable to worker salaries and on-costs. This section considers whether there are material differences in overhead costs between SIL and non-SIL settings. The key questions for the Review, as outlined in the Issues Paper, was:

- Is there a difference in the level of **corporate overheads** that are incurred in delivering SIL services compared to non-SIL services? If so, what aspects of the SIL operating environment drive this difference? How large is the difference?

Corporate overheads

Although some providers raised the issue of overheads in their submissions to the Review, they did not provide any significant evidence that different levels of corporate overheads are incurred in delivering SIL services. The Financial Benchmarking Survey (Exhibit 27 and Exhibit 28) suggests that overheads (as a share of costs) are slightly lower, on average, for SIL providers compared to non-SIL providers. It also suggests that for efficient providers, overheads (as a share of costs) might be slightly higher for SIL v non-SIL providers.

Exhibit 27: Box Plot – Overhead Costs



Note: Data labels for the 25th percentile are shown to highlight the efficient frontier within each category

- the percentage of the provider's revenue sourced from SIL;
- Log of the number of participants supported by the provider;
- Average base wage paid to FLSs employed by the provider
- Log of the ratio of the number of DSWs employed by the provider and the number of participants supported by the provider; and
- Percentage of labour time spent on billable work by DSWs employed by the provider.

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Exhibit 28: Summary Statistics – Overhead Costs

Respondent type	Sample size	Mean	Median	25th percentile	75th percentile
All respondents	551	35.1%	32.1%	20.7%	46.2%
Non-SIL respondents	379	35.5%	31.2%	20.0%	46.8%
Mixed (SIL/ADL) respondents	172	34.3%	33.1%	21.4%	44.3%
0-25% SIL respondents	63	35.7%	33.9%	21.8%	45.0%
26-50% SIL respondents	39	38.1%	34.9%	24.1%	52.3%
51-75% SIL respondents	48	33.7%	31.6%	22.1%	45.4%
76-100% SIL respondents	22	24.7%	21.2%	19.3%	33.4%

Regression analysis (Exhibit 29) shows that there is no systemic difference in overheads between SIL and non-SIL providers as the coefficients of both the SIL provider indicator variable and the percentage of revenue sourced from SIL variable are not statistically significant different from zero. This finding holds both on average and for efficient providers.

The statistically significant relationship that can be observed in the data with respect to the direct cost per client (log) variable and the average base wage (DSW) variable is not unexpected as overheads are, in general, driven more by the headcount of workers rather than the individual wage rates of those workers and so as wage expenditure increases, overhead expenditure as a percentage of direct costs can decrease.

Exhibit 29: Regression Analysis – Overhead Costs[20]

Regression variables	Mean	Median	25th percentile	75th percentile
SIL provider indicator	-0.01	-0.02	-0.04	-0.01
Percentage of revenue sourced from SIL	0.10	0.16	0.02	0.39
Percentage of revenue sourced from SIL (squared)	-0.19	-0.27*	-0.06	-0.51*
Number of clients (log)	0.06**	0.01	0.05**	-0.01
Direct cost per client (log)	-0.04**	-0.05*	-0.03	-0.08**
Labour time spent on billable work (% of all time)	-0.02	0.04	0.06	-0.2
Staff-supervisor ratio (log)	-0.02	-0.02	-0.03	-0.01
Average base wage (FLS)	-0.00	0.00	0.00	-0.00
Average base wage (DSW)	-0.01**	-0.01	-0.01**	-0.00
R^2	**5.5%**	**4.3%**	**4.6%**	**4.4%**

Note: * and ** indicate the variable is significant at 10% and 5% thresholds respectively (374 observations).

[20] The equation regresses the log of the ratio of the overhead costs of the provider to the direct costs of the provider against:

- the SIL provider indicator variable (1 if the provider delivers SIL, 0 otherwise);
- the percentage of the provider's revenue sourced from SIL;
- the square of the percentage of the provider's revenue sourced from SIL;
- Log of the number of participants supported by the provider;
- Log of the direct costs per participant for the provider;

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2.6 Supply costs specific to SIL services

To test whether there were any supply cost considerations that are specific to delivering SIL services and that are not accounted for in the current NDIS Disability Support Worker Cost Model, the Review sought evidence on these costs and their drivers. In particular, the Issues Paper sought responses to the following questions:

- **Vacancy rates** – What is the average vacancy rate across your properties? Is the vacancy rate of a property influenced by factors such as the complexity of participants in each property, the rurality of the property, and the number of rooms in the property? What factors are considered in optimising the number of participants per SIL property? What impact does this have on costs? What approach is used to optimise vacancy levels across your properties?
- **Vacancy costs** – How do vacancies impact the costs of delivering SIL services? Please quantify these costs for your organisation? Some costs associated with vacancies can be considered to be "fixed" – for example, an inactive sleepover for a three bedroom house has the same cost whether there are two or three participants in the house. Other costs can be considered to be more "variable" – for example, the vacancy costs of a three bedroom house with three residents each receiving 1:1 supports can, in general, be managed through change in rostering. What proposition of vacancy costs are fixed or variable in your organisation?
- **Participant complexity** – What impact does participant complexity have on the costs of delivering supports in the SIL environment? What approach is used to optimise the allocation of participants with different support needs across your properties?
- **Shift costs** – How many shifts are provided in a 24-hour period? To what extent is the number of shifts driven by factors such as the number of participants in the property, the mix of support needs within the property, or other factors? How do sleepover and crossover shifts impact on supply costs?
- **Establishment costs** – On an annual basis, how often is a new participant established in a property? Is there a material difference in the costs of establishing a participant between SIL and non-SIL services? If so, what aspects of the SIL operating environment drive this difference? How large is the difference? How is this influenced by factors such as the complexity of the participant's needs, the existing number of participants and/or rooms within a property, or other factors?
- **Location differences** – Do costs for delivering SIL services differ significantly between metropolitan centres versus regional, rural and remote areas? If so, what is the average cost differential, and what elements of the cost drive this difference?
- **Other supply costs** – In delivering SIL services, what proportion of Disability Support Worker time is spent on providing support to participants? Note that this includes time

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- Percentage of labour time spent on billable work by DSWs employed by the provider;
- Log of the ratio of the number of FLSs (headcount) and DSWs (headcount) employed by the provider;
- Average base wage paid to FLSs employed by the provider; and
- Average base wage paid to DSWs employed by the provider.

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directly interacting with participants, as well as tasks which do not involve direct interaction with participants such as preparing meals or sleepover shifts.

Vacancy rates and costs

The financial deep dives conducted by Deloitte for the Review supplied some data on vacancy rates. The data indicated a mean of occupancy rate of 94.4% (median of 94.5%), meaning a vacancy rate of 5.6%. Alliance20 financial information from their sample of nine providers indicated the average proportion of vacancies was 9.2% for SIL. Ability First received similar vacancy rate numbers to Alliance20, with their average vacancy rate for members being 9.3%.

Vacancy costs are incurred for SIL arrangements when a house is not operating at its full capacity of residents/participants that may be supported in its SIL arrangement. In response to the Issues Paper, providers reported vacancy rates, at an organisational level, of between 5-10%. Some respondents suggested vacancies of zero or close to zero. Ability Roundtable, who represent 20 large organisations, had an average of 6.9% vacancy rate.

Providers also reported a significant variation in the length time that vacancies tended to persist. From the Ability First data, the average vacancy length was around 100 days for participants with standard needs and 150 days for participants with high intensity needs.

The majority of provider responses on this issue indicated that complexity of participants affected the vacancy rate. Rurality and number of rooms in the property were also cited as important but less significant factors.

Respondents reported that at the individual property level between 75% and 90% of vacancy costs are fixed because they are related to the irremediable minimum staffing level of the house and so were not affected by the presence of vacancy.

Ability First data also showed that vacancy management contributed 0.6% (Standard), and 0.9% (High Intensity) to the overhead, and further costs for the vacancy risk. The Review, notes, however that, as discussed above, the Financial Benchmarking Data does not show any statistically significant difference in overheads between SIL and non-SIL settings.

Participant complexity

The consensus from consultations and submissions was that participant complexity increases the cost of delivering supports in the SIL environment. The most commonly raised impacts were more training required for staff supporting participants with higher needs, and the need for more qualified or experienced staff. Further, owing to the intensity and impact of the work carried out, staff turnover, non-billable time and supervision were all said to be greater with complex participants.

These factors are already recognised in the NDIS Disability Support Worker Cost Model, which varies these parameters according to whether or not a participant has high intensity support needs. The hourly price limit for average high intensity support (level 2) is 8.2% higher than the price limit for standard support.

The Review acknowledges that providers and planners do not always agree on whether the cost of a SIL roster of care should be calculated using the standard or high intensity price limits. While this affects the value of the SIL plan it is not a pricing issue, and the Review considers that this is a matter best addressed through the Operational Guideline for SIL.

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Shift costs

The NDIS Price Guide provides that a **Weekday Support** can be either:

- A **Weekday Daytime Support**, which is any support to an individual participant that starts at or after 6:00 am and ends before or at 8:00 pm on a single weekday (unless that support is a Public Holiday Support or a Night-time Sleepover Support); or
- A **Weekday Evening Support,** which is any support to an individual participant that starts after 8:00 pm and finishes at or before midnight on a single weekday (unless that support is a Public Holiday Support or a Night-time Sleepover Support); or
- A **Weekday Night Support,** which is any support to an individual participant that commences at or before midnight on a weekday and finishes after midnight on that weekday, or commences before 6:00 am on a weekday and finishes on that weekday (unless that support is a Public Holiday Support, Saturday Support, Sunday Support or a Night-time Sleepover Support).

Additionally, supports in SIL may also relate to the Night-time Sleepover support when a worker is allowed to sleep while not delivering support. A **Night-time Sleepover Support** is any support to an individual participant delivered on a weekday, a Saturday, a Sunday or a Public Holiday that:

- commences before midnight on a given day and finishes after midnight on that day; and
- is for a continuous period of eight (8) hours or more; and
- the worker is allowed to sleep when they are not providing support.

For pricing purposes, supports provided on a Public Holiday, Saturday or Sunday are claimed at the relevant rate as the costs do not change based on the time during that day it is delivered.

Submissions indicated that most providers did in fact use 3 shifts per 24 hour period. Generally the split was a morning-afternoon shift, afternoon-evening and overnight/sleepover shift. However, a substantial minority reported 4-6 shifts and a few had 7-8 shifts. Several providers mentioned that this is highly dependent on participant support needs. The financial deep dives submitted to Deloitte Access Economics, had a mean of 3.4 shifts and a median of 3 shifts per 24 hour period (7 respondents).

Sleepovers were raised as an issue whenever the participant is active overnight, as then the provider has to pay the worker for an active overnight shift, not just the sleepover allowance as per the Award. The unpredictability of participants, particularly participants with higher needs, can cause high supply costs for sleepovers and crossover shifts, given the higher overtime rates needing to be paid to the worker (as per the Award). However, providers argued these impacts are not necessarily funded in the Roster of Care. This suggests such concerns are better addressed through planning, as pricing mechanisms do not hinder recovering costs when such support is delivered.

The Review notes that the NDIS Price Limit for Night-Time Sleepover supports includes two hours of overtime support provided during this time, with third and additional hours to be claimed as rates stipulated in the NDIS Price Guide. Potentially, this could lead to higher payments than if the shift had been active overnight. So while SIL workers may have more

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interrupted sleeps than their community activities of daily living counterparts, providers should still be effectively reimbursed if claiming correctly.

The Review acknowledges that providers and planners do not always agree on whether the cost of a SIL roster of care should include an active overnight or sleepover supports. While this affects the value of the SIL plan it is not a pricing issue and the Review considers that this is a matter best addressed through the Operational Guideline for SIL.

Establishment costs

Providers noted that the frequency of establishing new participants is correlated with the size of the residence. Most respondents did not record high turnover, and it was common to see respondents say they would only establish a new resident every three to six months although it is not clear if this is partly owing to the size of their organisation. One large provider said they establish a new participant every three to four weeks.

Examples of the establishment costs involved included orientation, induction and intake which require a level of nuance regarding individual participant needs. For particular participant needs, there could also be different types of training required related to medication management and other specialised training to support participants. Ability First members reporting the time taken to establish a new participant in a SIL home is approximately three to six months.

The Review, notes, however that, as discussed above, the Financial Benchmarking Data does not show any statistically significant difference in overheads or utilisation (where these additional costs would become apparent) between SIL and non-SIL settings.

Location differences

The majority of respondents to the Issues Paper suggested there was a greater cost to providing SIL supports in rural and remote areas than in metropolitan areas. This was mainly driven by difficulties attracting and retaining staff and the potential length of vacancies in rural SIL arrangements.

The Review notes, however, that both the NDIS Western Australian Market Review 2019 and the NDIS Annual Pricing Review 2020-21 concluded that there was no compelling evidence to support increasing regional price limits versus metropolitan price limits. The Review also notes that remote and very remote price limits are already 40% and 50% higher than metropolitan price limits.

This Review also considers that workforce concerns may be better addressed through non-pricing mechanisms. In particular, issues arising from general rural and regional workforce shortages is better dealt with by larger workforce initiatives, such as *Boosting the Local Care Workforce Program*[21] that encourages greater workforce supply, rather than using NDIS pricing mechanisms to compete for the existing supply.

[21] https://blcw.dss.gov.au/.

The Boosting the Local Care Workforce Program (BLCW Program) is funded by the Department of Social Services and delivered by Ernst & Young, with the First Peoples Disability Network (Australia), and the

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Other costs

Respondents to the Issues Paper noted the cost of maintaining registration with the NDIS Quality and Safeguard Commission can be a costly exercise and required considerable amounts of time to complete required audits. Some respondents stated that at least half of their supervisors' time is spent dealing with issues flowing from the Commission. Other organisations stated they have engaged staff to handle the quality and safeguarding requirements specifically for their NDIS participants. Providers considered that Quality and Safeguards compliance require a range of administrative tasks that are significantly time consuming.

Respondents noted that SIL organisations often had to resolve safety incidents not directly associated with a SIL's own services. They stated they were often key in managing incidents and complaints relating to a participant's external interactions with employment, day programs, community access etc. This is an important safeguard for many participants who may not have strong informal supports, but it is not without cost.

In relation to costs associated with the NDIS Quality and Safeguards, the majority consensus in submissions was that SIL providers are impacted more so than activities of daily living and Community Support providers. Ability First's submission estimated that these quality and safeguard costs added 1.3% to 1.8% in additional costs (for Standard and High Intensity SIL supports, respectively) over Activities of daily living.

The Review notes that in so far as these costs are encountered by providers then they have already been addressed in the analysis above of overheads and utilisation rates for staff.

Providers identified a number of other costs they considered were not directly captured in the Cost Model, and which they considered the overhead component should be increased to cover. Examples were:

- Restrictive interventions
- Property maintenance and costs incurred due to property damage
- Costs involved with stakeholder management and coordinating or discussing plans with family and/or carers
- Buddy shifts

In so far as these costs exist, the Review considers that any differences in these costs between SIL and nom-SIL settings will already have been captured in the analysis above or utilisation rates and overheads.

Community Services Industry Alliance. The BLCW Program aims to develop the capacity of disability and aged care service providers to operate effectively and expand their workforce.

The BLCW Program has three main objectives:

- Reduce barriers that impact providers' ability and willingness to start, continue or grow their service offer.
- Improve the operation and efficiency of labour markets by better matching supply and demand through measures such as providing information, resources and links to relevant government programs.
- Provide local-level knowledge on the disability and aged care service provider and workforce markets.

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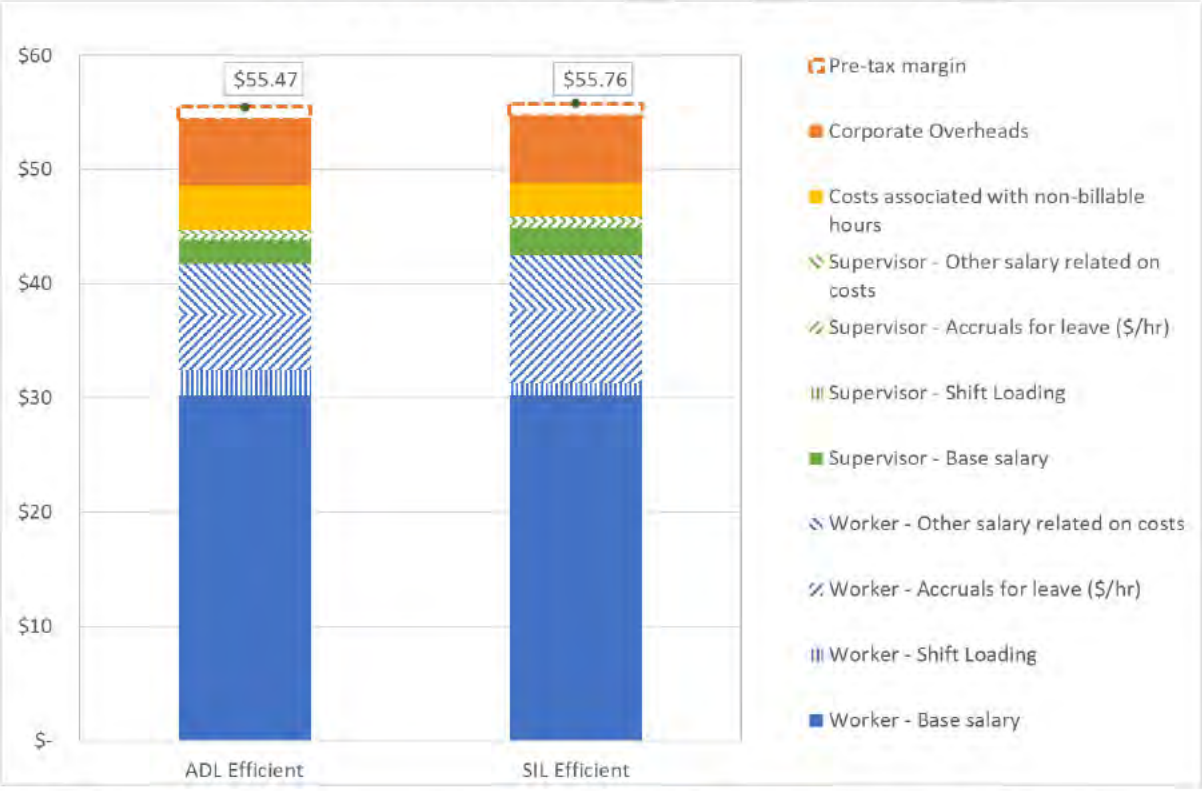
3 Conclusions

The Review has found that there is evidence to suggest that, compared to activities of daily living delivered in a non-SIL setting by an efficient provider, an efficient SIL provider faces:

- higher rates of permanent employment (85.1% compared to 70.0%);
- higher workers compensation premiums (2.4% compared to 1.7%);
- higher average utilisation rates (94% compared to 92%);
- higher base wages for supervisors (11.9% higher on average); and
- higher annual leave costs associated with great leave entitlement (5 weeks per year compared to 4 weeks per year).

Some of these effects add to the cost of service provision whereas others reduce that cost. The net effect, as Exhibit 30 shows is that the fully loaded costs of service provision in SIL and non-SIL settings are essentially identical.

Exhibit 30: Efficient Costs in SIL and Non-SIL Settings



The Review therefore does not recommend any changes in the current SIL pricing arrangements.

The Review acknowledges that vacancies can present issues for providers as expenditure is not always able to be adjusted in line with changes in revenue. The Review does not consider this to be a deficiency in the unit price limit, but rather in the planning arrangements which do not always adjust participant plans to maintain supports in response to vacancies. If, for example, three people in a house are being funded for 24/7 1:3 support and there is a vacancy then the Review acknowledges that the number of workers cannot be reduced,

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since all of the participants have been identified as having a need for 24/7 support. The problem is not, however, with the unit price paid per hour of support but rather that a change of circumstance means that the funding in the two remaining participant's plans has no longer been appropriately determined to meet their reasonable and necessary needs.

If vacancies were relatively uniform across the sector then it would be possible to adjust the unit price for vacancy risk. However, the available data does not indicate that vacancies are uniformly distributed and so this issue is best addressed through plan review rather than through a change in the pricing arrangements.

Because plan reviews can take some time to occur it may be appropriate, when a vacancy occurs, for providers to have the ability to claim for the applicable ratio of supports of the remaining participants receiving supports in SIL for a period of time after the vacancy occurs. Allowing this flexibility will assist providers to more immediately recover incurred rostered staff costs when a vacancy occurs. However, any such arrangement would need to be managed carefully to reduce incentives for providers to not fill vacancies. This could best be done by restricting the period of time for which providers could bill the reminding participants at a higher support ratio,

Allowing providers to bill remaining participants more when vacancies occur will likely exhaust remaining participants' plans sooner than anticipated, so it may also be sensible to undertake a change of circumstances review for all participants receiving supports in the affected SIL arrangement. This will assist in coordinating the funding amounts for the participants to ensure they have support continuity and their shared supports in SIL are aligned to each other.

The Review also recognises that providers are required to continue to provide support to an existing resident participant during the period of a plan review and that there is therefore a risk that they will provide supports at a different support ratio to those that are eventually approved as part of the plan review. The Review considers that there are strong arguments for this risk to be shared by the provider and the NDIA, so that if the NDIA does not complete the planning review within an agreed timeframe then the provider should be entitled to be paid for the supports that they are delivering until the plan review is completed.

The Review recommends that the Operational Guideline for SIL should be reviewed to provide:

- **clearer advice on the circumstances in which high intensity supports and sleepover/active overnight supports will be included in SIL plans;**
- **for change of circumstance reviews when vacancies materially impact the cost of delivering supports to participants in SIL settings; and**
- **agreed timeframes for plan review in SIL, with greater certainty for providers about revenue when plan reviews are not completed or billing issues are not addressed in an appropriate timeframe.**

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National Disability Insurance Scheme

Review of Supported Independent Living Price Controls

Issues Paper

August 2020

Delivered by the National Disability Insurance Agency

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Issues Paper

The National Disability Insurance Agency (NDIA) has released this Issues Paper seeking inputs to inform the cost parameters required to estimate the fully loaded cost of the delivering an hour of personal care in a shared living arrangement.

This issues paper invites submissions from providers of SIL services and impacted stakeholders on a range of issues which will be considered in developing price limits for SIL services. Individuals and organisations should not feel that they are restricted to comment only on matters raised in the Issues Paper.

Key date

Due date for submissions: **Sunday 25 October 2020, 11:59pm AWST**

Submissions can be lodged by email to: Pricing@ndis.gov.au

Contact details for administrative and other matters:

NDIS Contact Centre

Monday to Friday, 8am – 8pm (local time)

Phone: 1800 800 110

Email: enquiries@ndis.gov.au

Website: Have your say on the NDIS website

Further information

Further information on pricing in the National Disability Insurance Scheme can be found at the NDIS website.

Terms that we use

NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
SIL	Supported Independent Living

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Contents

Introduction **4**

Definitions 5

Responding to the Review 5

Issues for Participants **7**

Issues for Providers **8**

Wages and on-costs 8

Workforce mix 9

Utilisation 10

Supervision cost 10

Overheads 11

Supply costs specific to SIL services 11

Other costs 13

Appendix A: Schematic overview – NDIS Disability Support Worker Cost Model **14**

Appendix B: Current arrangements **15**

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Introduction

One of the principal objectives of the National Disability Insurance Scheme (NDIS) is for people with disability to exercise choice and control over how, and with which providers, they spend their available budgets. The role of pricing in the NDIS is therefore very important. Prices, or more precisely participants' choices in response to the prices they face in the market, reflect the preferences and relative values that different participants place on different types of supports. The aggregation of these individual responses in turn signals to providers the quantity and mix of supports to supply. Prices also affect the purchasing power of participants. Higher prices reduce the supports participants can purchase within a given support budget. Prices also affect the total costs of the NDIS and therefore its financial sustainability, and the allocation of resources to the NDIS (and therefore possible production), relative to other sectors. Pricing can also affect providers' choices, including by providing incentives: for entering the market; for upskilling and right-skilling; for innovation; and for improvements in service quality and outcomes.

As the markets for disability goods and services develop and operate more effectively, the National Disability Insurance Agency (NDIA), as market steward for the NDIS, will be able to be less interventional. However, deregulation will necessarily occur at different points in time for different markets and may not be feasible in some cases. Currently, the NDIA varies its approach to the regulation of prices between:

- No regulation (deregulated markets): this applies in cases where markets are highly competitive – for example, transport.
- The imposition of price limits: these represent a maximum allowable price payable by participants for types of supports. This approach applies in a significant number of markets, which are still developing and growing, such as those for attendant care.
- Quotable supports: in which participants are expected to obtain quotations from suppliers to provide to the NDIA as part of verifying that prices are fair and reasonable. This approach typically applies in the case of highly specialised, differentiated supports that may not have a high level of competition – for example, assistive technology.

The NDIS Disability Support Worker (DSW) Cost Model is one methodology that the NDIA uses to inform its pricing decisions for those supports delivered by Disability Support Workers on which it imposes price limits. A copy of the NDIS DSW Cost Model is at: link to NDIS DSW Cost Model. A schematic overview of the Model is at Appendix A.

On 1 July 2020, the NDIA replaced the previous quotation pricing arrangements for Supported Independent Living with price limits based on 'assistance with self-care' supports. These changes made for Supported Independent Living were designed to increase transparency and equity of how SIL supports are funded, as well as to simplify previously administratively complex processes.

The NDIA is committed to improving transparency and fairness in its processes and decision -making, and is conducting a review of the price controls for Supported Independent Living with the outcomes to come into effect later in 2020. The Review is tasked with suggesting improvements to the structure of the NDIS Disability Support Worker Cost Model, including:

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- identifying whether there are different costs that arise in the delivery of attendant care supports in a shared living arrangement that do not arise in other settings; and
- quantifying any differences that may be required in the key parameters of the NDIS Disability Support Worker Cost Model for attendant care supports in sharing living arrangements, given the different cost structures of delivering supports in shared living arrangements compared to other settings .

The NDIA is seeking input from the sector and interested parties to this Review to inform the cost parameters required to estimate the fully loaded cost of delivering an hour of SIL supports in a shared living arrangement.

This review of prices for SIL supports **is not about reducing funding for reasonable and necessary SIL supports**. Neither is it about the volume of supports that participants receive. The purpose of this review is simply to seek your feedback on whether the current price limits per hour of SIL support delivered are appropriate.

This review is also only a small component of a much larger ongoing program to make improvements to the way participants receiving supports in shared living arrangements are supported. The wider improvements to SIL will seek to improve participant choice and control, simplify NDIA processes, and address pressures to Scheme sustainability. Improvements will be made through a series of changes, and will undertake a series of consultations with participants, providers and the wider sector as these changes are considered.

Definitions

The Price Guide defines SIL as follows:

"These support items provide assistance with, or supervision of, tasks of daily life in a shared living environment, with a focus on developing the skills of each individual to live as autonomously as possible. The support is provided to each person living in the shared arrangement in accordance with their need. Support Independent Living does not include rent, board and lodging or other day-to-day usual living expenses such as food and activities. It also does not include the capital costs associated with a participant's accommodation."

SIL is similar to attendant care in many ways, the main differences being that SIL is intended for participants who require 24/7 care and live in shared living arrangements with other NDIS participants. (There is a small amount of SIL provided outside of group houses, as a legacy of previous state schemes.)

Before July 2020, a SIL quote would cover a whole year, whereas attendant care is charged by the hour when it was delivered.

The NDIS Price Guide can be found at: link to NDIS Price Guide

Responding to the Review

The NDIS Disability Support Worker Cost Model estimates the efficient cost of delivering a billable hour of support taking into account all of the costs associated with every billable hour, including: base pay; shift loadings; leave pay; salary on costs; supervision costs;

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utilisation (non-billable activities); employee allowances; corporate overheads and margin. These estimates are the basis of the price limits set by the NDIA for supports delivered by Disability Support Workers.

In adapting the NDIS Disability Support Worker Cost Model to set price limits for SIL services, there are a number of aspects of the Cost Model that may need to be adapted or refined. The following sections outline the key areas and invite feedback from providers on a range of targeted questions. Some of these areas relate to differential supply costs for delivering non-SIL compared to SIL services, while other areas relate to cost drivers that are unique to providing SIL services.

Providers are also welcome to provide feedback on any other issues that they consider relevant to this review. Providers are encouraged to refer to or send in data and/or evidence to support statements that are made in responding to each/any of the questions. This includes any applicable cost models for relevant SIL services. Information marked as commercial-in-confidence will not be published.

Submissions can be lodged by email to: Pricing@ndis.gov.au . Submissions must be lodged by Sunday, 25 October 2020, 11:59pm AWST.

Confidential submissions

Submissions to the Agency that are marked as commercial-in-confidence will not be published.

The NDIA has engaged Deloitte Access Economics to assist the Agency in undertaking this review. If preferred, respondents may give confidential information, including commercial-in-confidence data/information, directly to the team from Deloitte Access Economics at SILpricingreview@deloitte.com.au. This information will not be provided to the NDIA unless the submitter gives their consent, and any reference to this information by Deloitte in their reports to the Agency will maintain the anonymity of the source.

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Issues for Participants

Under the quotable support arrangements for Supported Independent Living that were in place before 1 July 2020, participants did not always have a high degree of control over the services offered by the group house in which they lived.

The Agency wants to empower participants to have more involvement in selecting their reasonable and necessary supports and who supports them to undertake daily activities in their home. We also want to simplify the process for providers. The changes that were made to the pricing arrangements on 1 July 2020 for Supported Independent Living were designed to increase transparency and equity of how SIL supports are funded, as well as to simplify previously administratively complex processes. In addition to the implementation of price limits, operational changes and guidance were also released to increase participant involvement and understanding of their SIL supports.

The aim of these consultations is to understand how the move from quotable supports to price limits may impact on participant experience of engaging service providers and receiving services within a Supported Independent Living environment, and the potential impact that price limits may have on improving participant choice and control.

Your views will be considered in the review and reflected in reports developed during the process.

1) What do you consider are the potential advantages or disadvantages for participants with regards to this new approach to Supported Independent Living?
2) Are there particular factors you think the Agency should be aware of regarding how Supported Independent Living and related supports are defined, costed and charged to participants?

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Issues for Providers

Wages and on-costs

The NDIS Disability Support Worker Cost Model recognises that wages and on-costs are the largest cost driver for providing disability support services. The NDIA is therefore seeking detailed evidence on whether there are material differences between the base hourly wages paid to, and the on-costs associated with, SIL workers and non-SIL workers.

Base hourly wage refers to the minimum hourly rate of pay received by a worker, not including any shift or leave loading, superannuation or allowances.

Salary on-costs refers to costs such as superannuation, workers compensation premiums, payroll tax, and employee allowances.

Base Wages

3) Is there a material difference in the base hourly wages paid to workers delivering SIL services compared to workers delivering non-SIL services?

   Does this reflect different levels of required training, the nature of the work, or some other reason? How large is this difference?

On-costs

4) Are salary on-costs different for workers delivering SIL services compared to workers delivering non-SIL services?

   What aspects of each service type necessitate this difference? How large is this difference?

Overtime

5) Do you observe significant differences in the rate of overtime costs between staff delivering SIL services compared to non-SIL services?

   What aspects of each service type necessitate this difference? How large is this difference?

Leave costs

6) Are leave costs different for workers delivering SIL services compared to workers delivering non-SIL services?

   What aspects of each service type necessitate this difference? How large is this difference?

Enterprise Bargaining Agreements (EBAs)

7) Does your organisation currently operate an WBA for some or all of its employees:

   Do the EBA conditions differ for workers delivering SIL services compared to non-SIL services?

   Which conditions are different, and why? How large is this difference?

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Workforce mix

The NDIS Disability Support Worker Cost Model recognises that the costs of employing casual and permanent workers are different. The NDIA is therefore seeking detailed evidence on whether there are material differences in these arrangements between SIL workers and non-SIL workers.

Casual staff

8) Is there a material difference in the proportion of employees employed on a casual basis between employees providing SIL and non-SIL services?

   If there is a difference, which aspects of SIL service delivery are suited to more (or fewer) permanent employees relative to casual employees? How large is this difference?

9) What is the average number of hours per week that a casual staff member is employed in your organisation?

10) Is there a material difference in the average number of hours per week that a casual staff member is employed in your organisation between employees providing SIL and non-SIL services?

    If there is a difference, how large is this difference?

Part-time staff

11) Is there a material difference in the proportion of employees employed on a part-time basis between employees providing SIL and non-SIL services?

    If there is a difference, which aspects of SIL service delivery are suited to more (or fewer) part-time permanent employees relative to full-time permanent employees? How large is this difference?

12) What is the average number of hours per week that a part-time staff member is employed in your organisation?

13) Is there a material difference in the average number of hours per week that a part-time staff member is employed in your organisation between employees providing SIL and non-SIL services?

    If there is a difference, how large is this difference?

Agency staff / temporary replacement staff

14) Are temporary replacement staff engaged more or less often for SIL services?

    If there is a difference, what are the key drivers of this difference? How large is this difference?

15) Is the cost of the temporary replacement staff different between SIL services and non-SIL services?

    If there is a difference, what are the key drivers of this difference? How large is this difference?

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Level of staff

16) What level of worker do you use for standard vs higher requirements, and when do you decide if a participant requires higher-intensity support?

Utilisation

The NDIS Disability Support Worker Cost Model recognises that staff need to spend some working time undertaking non-billable work, including breaks and training. The NDIA is therefore seeking detailed evidence on whether there are material differences in these arrangements between SIL workers and non-SIL workers.

Training requirements

17) Do training requirements – and associated costs – for workers differ between SIL services and non-SIL services?

    If there is a difference, what are the key drivers of this difference? What aspects of delivering SIL services require more (or less) staff training? How large is this difference?

18) Do initial training requirements – and associated costs – for new workers differ between SIL services and non-SIL services?

    If there is a difference, what are the key drivers of this difference? What aspects of delivering SIL services require more (or less) staff training? How large is this difference?

Other non-billable activities

19) Is there a material difference in the non-direct care activities that staff in SIL services, compared to staff in non-SIL services, are required to undertake (for example: handover between shifts and/or note-taking specific to the individual).

    If there are differences, what are the key drivers of these differences? How large are these differences?

Supervision cost

The NDIS Disability Support Worker Cost Model recognises that staff require direct supervision of the care that they provide, as well as management support. They key parameters in the Cost Model associated with supervision are the wages and conditions of the supervisor, and the supervision ratio. The NDIA is therefore seeking detailed evidence on whether there are material differences in these arrangements between SIL workers and non-SIL workers.

Supervisor wages and on-costs

20) Is there a material difference in the wages and on-costs of supervisor in SIL services compared to non-SIL services?

    If there is a difference, what are the key drivers of these differences? How large is the difference?

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Supervision ratio

21) Is there a difference in the number of workers per supervisor for SIL services compared to non-SIL services?

    If there is a difference, what aspects of service delivery mean that more or fewer supervisors are required? How large is the difference?

Overheads

The NDIS Disability Support Worker Cost Model that providers incur a number of costs ("overheads") that not directly attributable to worker salaries and on-costs. The NDIA is therefore seeking detailed evidence on whether there are material differences in these costs between SIL workers and non-SIL workers.

Corporate overheads

22) Is there a difference in the level of corporate overheads that are incurred in delivering SIL services compared to non-SIL services?

    If so, what aspects of the SIL operating environment drive this difference? How large is the difference?

Turnover rates

23) Do staff turnover rates differ between staff who deliver SIL services compared to non-SIL services?

    If so, what aspects of the SIL operating environment drive this difference? How large is the difference?

24) What costs are incurred when staff turnover? Do these costs differ between staff who deliver SIL services compared to non-SIL services?

    If so, what aspects of the SIL operating environment drive this difference? How large is the difference?

Supply costs specific to SIL services

The NDIA recognises that there may be a number of supply cost considerations that are specific to delivering SIL services. The NDIA is therefore seeking detailed evidence on these costs and their drivers.

Vacancy management

25) What is the average vacancy rate across your properties?

26) Is the vacancy rate of a property influenced by factors such as the complexity of participants in each property, the rurality of the property, and the number of rooms in the property?

27) What factors are considered in optimising the number of participants per SIL property? What impact does this have on costs?

28) What approach is used to optimise vacancy levels across your properties?

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Vacancy costs

29) How do vacancies impact the costs of delivering SIL services?

    Please quantify these costs for your organisation?

30) Some costs associated with vacancies can be considered to be "fixed" – for example, an inactive sleepover for a three bedroom house has the same cost whether there are two or three participants in the house. Other costs can be considered to be more "variable" – for example, the vacancy costs of a three bedroom house with three residents each receiving 1:1 supports can, in general, be managed through change in rostering.

    What proposition of vacancy costs are fixed or variable in your organisation?

Participant complexity

31) What impact does participant complexity have on the costs of delivering supports in the SIL environment?

32) What approach is used to optimise the allocation of participants with different support needs across your properties?

Shift costs

33) How many shifts are provided in a 24-hour period? To what extent is the number of shifts driven by factors such as the number of participants in the property, the mix of support needs within the property, or other factors?

34) How do sleepover and crossover shifts impact on supply costs?

Establishment costs

35) On an annual basis, how often is a new participant established in a property?

36) Is there a material difference in the costs of establishing a participant between SIL and non-SIL services?

    If so, what aspects of the SIL operating environment drive this difference? How large is the difference?

    How is this influenced by factors such as the complexity of the participant's needs, the existing number of participants and/or rooms within a property, or other factors?

Location differences

37) Do costs for delivering SIL services differ significantly between metropolitan centres versus regional, rural and remote areas? If so, what is the average cost differential, and what elements of the cost drive this difference?

Other supply costs

38) In delivering SIL services, what proportion of Disability Support Worker time is spent on providing support to participants? Note that this includes time directly interacting with participants, as well as tasks which do not involve direct interaction with participants such as preparing meals or sleepover shifts.

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Other costs

39) Are there any additional costs incurred in non-SIL or SIL services, which are not currently captured in the Cost Model?

Please provide details.

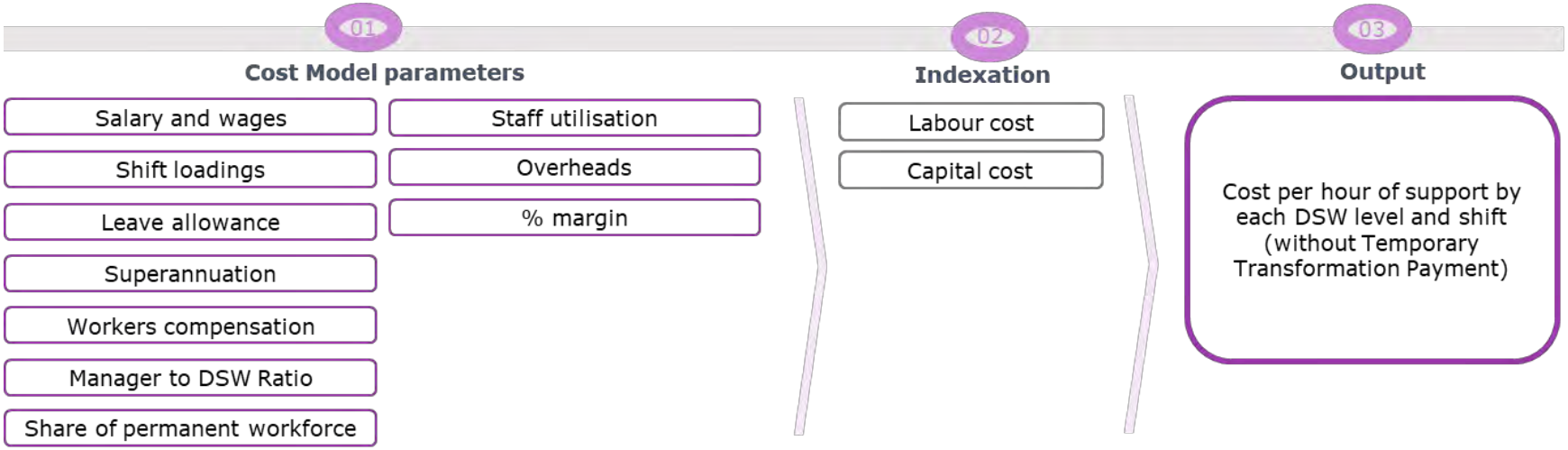
40) What additional costs are being incurred as a result of COVID-19?

Please provide details.

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DISCLOSURE LOG

Appendix A: Schematic overview – NDIS Disability Support Worker Cost Model



	Parameter	How is this reflected in the Cost Model?
1	Base pay	Four DSW levels (2.3, 2.4/3.1, 3.2 and 4.4) based on SCHADS classification
2	Shift loadings	Applies a loading for permanent staff working on weekends, public holidays, afternoons, and nights. Applies a casual loading for weekdays, weekends, public holidays, afternoons, and nights.
3	Leave allowance	Includes annual leave, personal leave, public holiday, long service leave
4	On-costs	Superannuation (9.5%) , workers compensation (1.7%), employee allowance (1.0%)
5	Supervision costs	Base pay + leave costs + on-costs for supervisors with four levels of supervisor pay. Supervisor to DSW ratio of 1 to 15
6	Permanent workforce	Assumes 70% of workforce
7	Utilisation	Incorporating breaks, training, and other. Varies across staff levels.
8	Overheads	Assumes 12.0% of direct cost
9	Margins	Assumes 2%
10	Indexation	Fair Work Commission, Equal Remuneration, CPI

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Appendix B: Current arrangements

The Supported Independent Living support items in the NDIS Support Catalogue provide participants with assistance with, or supervision of, tasks of daily life in a shared living environment, with a focus on developing the skills of each individual to live as autonomously as possible. The support is provided to each person living in the shared arrangement in accordance with their need.

These support items can be delivered to individual participants subject to the rules set out in the *NDIS Price Guide*.

As well as direct service provision, these support items can be used to claim for Non-Face-to-Face Support Provision; Provider Travel and Short Notice Cancellations. Providers of these supports can also claim for the non-labour costs Provider Travel.

Different price limits, as set out in the following Table, apply depending on the Time of Day and Day of Week on which the support is delivered, and whether the supports are High Intensity Supports.

Item Number	Item Name and Notes	Unit	Price limits		
			National	Remote	Very Remote
01_801_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Daytime	Hour	$54.30	$76.02	$81.45
01_802_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Evening	Hour	$59.77	$83.68	$89.66
01_803_0115_1_1	Assistance in Supported Independent Living - Standard - Weekday Night	Hour	$60.87	$85.22	$91.31
01_804_0115_1_1	Assistance in Supported Independent Living - Standard - Saturday	Hour	$76.18	$106.65	$114.27
01_805_0115_1_1	Assistance in Supported Independent Living - Standard - Sunday	Hour	$98.06	$137.28	$147.09
01_806_0115_1_1	Assistance in Supported Independent Living - Standard - Public Holiday	Hour	$119.94	$167.92	$179.91
01_811_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Daytime • Must be a **high intensity support**.	Hour	$58.68	$82.15	$88.02
01_812_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Evening • Must be a **high intensity support**.	Hour	$64.59	$90.43	$96.89
01_813_0115_1_1	Assistance in Supported Independent Living - High Intensity - Weekday Night • Must be a **high intensity support**.	Hour	$65.77	$92.08	$98.66
01_814_0115_1_1	Assistance in Supported Independent Living - High Intensity - Saturday • Must be a **high intensity support**.	Hour	$82.32	$115.25	$123.48
01_815_0115_1_1	Assistance in Supported Independent Living - High Intensity - Sunday • Must be a **high intensity support**.	Hour	$105.96	$148.34	$158.94
01_816_0115_1_1	Assistance in Supported Independent Living - High Intensity - Public Holiday • Must be a **high intensity support**.	Hour	$129.61	$181.45	$194.42
01_832_0115_1_1	Assistance in Supported Independent Living - Night-Time Sleepover	Each	$231.06	$323.48	$346.59

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Pricing Reference Group
Meeting: 13 May 2021

Minutes

Date: Thursday, 13 May 2021

Time: 1030 – 1400

Location: Microsoft Teams

Members		
Chair		
Gerrie [redacted]	General Manager, Provider and Market Development Division	By Teams
Pricing Reference Group Members		
Deborah [redacted]	Independent Member	By Teams
Graeme [redacted] AM	Independent Member	By Teams
Jim [redacted] PSM	Independent Member	By Teams
Julie [redacted] PSM	Independent Member	By Teams
Lynne [redacted]	Independent Member	By Teams
Participating Observer nominated by CEO		
Lisa [redacted]	DCEO, Markets, Government and Engagement	By Teams
Sarah [redacted]	Scheme Actuary	By Teams
David Cullen	Chief Economist	By Teams
Secretariat		
David [redacted]	Director, Pricing Operations, Price Regulation Unit	

1.2 Declaration of Conflicts of Interest

The PRG **NOTED** the register of members' interests.

1.3 Confirmation of the Previous Meeting's Minutes

The PRG **ENDORSED** the minutes of the previous meeting: *PRG Minutes of Meeting 15 April 2021.*

The PRG **NOTED** that all actions arising from previous meetings had been closed.

2.1 Update by the Chair

The Chair updated the PRG on recent developments in the NDIS.

2.2 Financial Benchmarking Survey

An update on the preliminary findings of the survey was given by David Cullen, Chief Economist.

The PRG **DISCUSSED** the issues raised in the presentation and **AGREED** that:

- there would be value in undertaking a Financial Benchmarking Survey for the 2020-21 financial year to inform the next pricing review, which is scheduled for the first half of 2021-22;
- consideration should be given to extending the survey to include Support Coordination Providers; Therapy and ECEI Providers; and Non-registered providers of in-scope supports (subject to a materiality test); and

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- consideration should be given to options to increase the response rate to the survey, including by increasing the value of the survey to providers by providing an individualised benchmarking report to each provider who completes the survey comparing their key metrics to their peers.

3.1 Review of Therapy Pricing Arrangements

The paper *20210513 - Item 3.1 - Review of Pricing Arrangements for Therapy Supports* was presented to the PRG by David Cullen, Chief Economist.

The PRG **DISCUSSED** the paper, and **AGREED** to **RECOMMEND TO THE BOARD THROUGH THE CEO** (subject to the Pricing Regulation Unit further investigating the statistical differences between psychologist and other therapist pricing) that**:**

- The price limits for therapy supports should be reset based on the results of the *Review of Pricing Arrangements for Therapy Supports* so that:
  - An hourly price limit of $185.70 (in 2020-21 prices) is applied to therapeutic supports delivered by:
    - Audiologists
    - Podiatrists
    - Physiotherapists
    - Psychologists
    - Occupational Therapists
    - Speech Pathologists;
  - An hourly price limit of $142.31 (in 2020-21 prices) is applied to therapeutic supports delivered by:
    - Audiometrists
    - Art Therapists
    - Counsellors
    - Development educators
    - Dietitians
    - Exercise Physiologists
    - Music Therapists
    - Orthoptists
    - Rehabilitation counsellors
    - Social Workers
    - Teachers;
  - The hourly price limits for Therapy Assistants and Physical Trainers are not adjusted in real terms; and
  - The current rules with respect to non-face to face services, report writing, provider travel and cancellations, and the current loadings for supports delivered in remote and very remote areas, are maintained; and
- the Board should consider phasing in the transition to the new pricing arrangements or otherwise ensure there was no unnecessary disruption to access to supports for participants.

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3.2 Review of Pricing Arrangements for Supported Independent Living (SIL)

The paper *20210513 - Item 3.2 - Review of Pricing Arrangements for SIL* was presented to the PRG by David Cullen, Chief Economist.

The PRG **DISCUSSED** the paper and **AGREED** to **RECOMMEND TO THE BOARD THROUGH THE CEO** that:

- no changes should be made to the current SIL pricing arrangements as there is no evidence at this time that the efficient costs of delivering activities of daily living supports in a SIL setting are significantly different to the efficient costs of delivering activities of daily living supports in a non-SIL setting;
- as part of the next Annual Pricing Review, which is due to be undertaken in the first half of 2021-22, the NDIA should work with relevant stakeholders to:
  - examine the impact of vacancies on the operational costs of SIL providers and the appropriateness of allowing SIL providers to claim from the NDIS for the irremediable cost of a vacancy for a period of time after a participant leaves a dwelling if insufficient notice has been given;
  - examine the costs of SIL providers in complying with the Commission's reporting and other requirements and whether these costs are appropriately accounted for in the Disability Support Worker Cost Model; and
  - repeat the comparative analysis of SIL and non-SIL providers that was undertaken on the 2018-19 financial benchmarking survey results;
- the NDIA should continue to improve its administrative processes and give further consideration to:
  - publishing clearer advice on the circumstances in which high intensity supports and sleepover/active overnight supports will be included in SIL plans;
  - providing greater certainty for providers about revenue when plan reviews are not completed or billing issues are not addressed in an appropriate timeframe; and
  - developing and implementing enhanced program of support arrangements for SIL (to reduce administrative burden and improve outcomes for participants) with a view to implementation from 1 October 2021.

3.3 Pricing Arrangements for Support Coordination

The paper *20210513 - Item 3.3 - Pricing Arrangements for Support Coordination* was presented to the PRG by David Cullen, Chief Economist

The PRG **DISCUSSED** the paper and **AGREED** to **RECOMMEND TO THE BOARD THROUGH THE CEO** that, subject to the development of mitigation strategies to address transitional issues, the price limits for support coordination supports should be reformed by:

- decommissioning the Level 1: Support Connection item and tasking Local Area Coordinators (LACs) with the delivery of this support;
- lowering the price limit of the Level 2: Coordination of Supports support item, which is delivered by providers in Registration Group 0106 (Assistance in coordinating or managing life stages), to the current price limit for psychosocial recovery coaches; and
- reforming the support items available to providers in Registration Group 0132 (Support Coordination) – who deliver support coordination services to the participants with the most complex needs – so that there were two support items for these providers:
  - A new Level 2: Coordination of Supports price limit, which would be used for supports delivered by the provider that do not require specific therapeutic skills; and

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- A new Level 3: Support Coordination price limit (equal to the therapy price limit) which would be used for supports delivered by the provider that required the specific skills of the therapist delivering the support.

The PRG **NOTED** that if the proposed changes to the pricing arrangements are accepted by the Board then it is intended that participants who currently have funding in their plans for:

- Level 1: Support Connection would continue to be able to use that support until their next plan review;
- Level 2: Coordination of Supports would have the remaining funding in their current plans reduced proportionally to the new price limit, so that they have access to the same level of assistance; and
- Level 3: Support Coordination would continue to be able to use that support as currently until their next plan review; and at their next plan review the funding amount included in their plans would be based on the mix of the two new Level 3: Support Coordination items that is found to be reasonable and necessary.

3.4 Pricing Arrangements for Group Based Supports

The paper 20210513 - Item 3.4 - Pricing Arrangements for Group Based Supports was presented to the PRG by David Cullen, Chief Economist

The PRG **DISCUSSED** the paper and **AGREED** to **RECOMMEND TO THE BOARD THROUGH THE CEO** that:

- the current transitional pricing arrangements for core group supports be extended for a further 12 months while a comprehensive review is undertaken of any unintended consequences of the new arrangements in different circumstances and situations, including the extent to which the new arrangements have affected overhead costs and administrative complexity for providers and families ¬– with that review to be undertaken in consultation with providers and participants as part of the next Annual Price Review, which is scheduled for the first half of 2021-22;
- the price limits for the transitional group supports should not be indexed on 1 July 2021, and the price limits for 1:4 and 1:5 transitional group supports should be reduced by 2% in real terms, to begin to address some of the inequities in the transitional group support price limits and to provide an incentive for providers to transition to the new group support arrangements; and
- the NDIA should facilitate the sharing of information on best practice from providers who have successfully transferred to the new arrangements to other providers.

3.5 Temporary Transformation Payment (TTP)

The paper *20210513 - Item 3.5 - Temporary Transformation Payment* was presented to the PRG by David Cullen, Chief Economist

The PRG **DISCUSSED** the paper and **AGREED** that there was:

- good evidence that the reasons for the introduction of the Temporary Transformation Payment Loading no longer obtained; and
- some merit in phasing the withdrawal of the TTP rather than immediate withdrawal.

The PRG considered three phasing options (compared to the current four-year trajectory of reducing the current 6% sequentially to 4.5%, 3% 1.5% and 0%):

- setting the loading to 0% from 1 July 2021;
- a 12 month trajectory ending on 1 July 2022 with two annual steps of 3% and 0%; and
- an 18 month trajectory ending on 1 January 2023 with four six monthly steps of 4.5%, 3%, 1.5% and 0%.

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The PRG **AGREED** to **RECOMMEND TO THE BOARD THROUGH THE CEO** that **t**he TTP Loading should be withdrawn more rapidly than initially intended, with the phasing to take into account the need to balance sustainability with disruption to business planning. The PRG did not support the immediate withdrawal option.

3.6 NDIS Guide to Pricing Arrangements 2021-22

The paper *20210513 - Item 3.6 - NDIS Guide to Pricing Arrangements* was presented to the PRG by David Cullen, Chief Economist

The PRG **NOTED** the paper, including that it was intended:

- to rename the NDIS Price Guide as the *NDIS Pricing Arrangements and Price Limits* to reinforce to providers and participants that the document is not a voluntary guide, but rather sets the boundaries of commercial behaviour within which registered providers must operate;
- to include definitive statements in the *NDIS Pricing Arrangements and Price Limits* that:
  - the NDIA does not set the prices that providers charge participants and that providers should not indicate in any way to participants that the prices that they charge are set by the NDIA;
  - where the prices that a provider charges for a support delivered to an NDIA participant is different to the price that the provider would charge for the same support if it was delivered to a person who was not an NDIA participant then the provider should ensure that the participant is aware of this difference; and
  - providers should not seek to impose conditions on participants through Service Agreements that are not in line with those set out in the NDIS Pricing Arrangements and Price Limits;
- to provide further clarification of the circumstance sin which a provider can claim for more than one worker to deliver a support;
- to provide greater certainty to providers and to reduce administrative burden for providers by replacing the current blanket rule for written permission from the NDIA for pre-payments with a more nuanced approach; and
- detail the new requirements on plan managers they capture the ABN of service providers when making payment requests for plan-managed supports, even where the service provider is not a registered provider.

3.7 NDIS Guide to Pricing Arrangements for Specialist Disability Accommodation 2021-22

The paper *20210513 - Item 3.7 - NDIS Guide to Pricing Arrangements for SDA* was presented to the PRG by David Cullen, Chief Economist

The PRG **NOTED** the paper, including that it was intended:

- to rename the NDIS SDA Price Guide as the *NDIS SDA Pricing Arrangements and Price Limits* to reinforce to providers and participants that the document is not a voluntary guide, but rather sets the boundaries of commercial behaviour within which registered providers must operate; and
- to increase SDA Price Limits and Refurbishment Thresholds on 1 July 2021 in line with movements in the Consumer Price Index to the year to 31 March 2021 – that is, by 1.1 per cent.

Next Meeting: July 2021, Date to be advised

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ACTIONS ARISING			
	Meeting	Issues	Status
1	15 April 2021	Agency to provide any available reports on consultations with participants on the changes to the Scheme	Closed 13/5/21
2	13 May 2021	Consideration should be given to including questions on self-insurance for workers compensation in the new financial benchmarking survey.	Open
3	13 May 2021	Provide information to members of the provision of services for autism through the MBS and whether these and other autism services were transitioning into the NDIS	Open

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Delivered by the National Disability Insurance Agency

Pricing Reference Group
Meeting: 6 August 2021

Minutes

Date: Friday, 6 August 2021

Time: 1000 – 1130

Location: Microsoft Teams

Members		
Chair		
Gerrie s47F - perso	General Manager, Provider and Market Development Division	By Teams
Pricing Reference Group Members		
Deborah s47F - perso	Independent Member	By Teams
Graeme s47F - perso AM	Independent Member	By Teams
Julie s47F - personal privacy PSM	Independent Member	By Teams
Pricing Reference Group Members Apologies		
Jim s47F - pe PSM	Independent Member	Apologies
Lynne s47F - personal priv	Independent Member	Apologies
Participating Observer nominated by CEO		
Sarah s47F - personal priv	Scheme Actuary	By Teams
David Cullen	Chief Economist	By Teams
Secretariat		
David s47F - personal p	Director, Pricing Operations, Price Regulation Unit, Provider and Markets Division	
Mardi s47F - personal priva	Project Assistant, Pricing Operations, Price Regulation Unit, Provider and Markets Division	

1.2 Declaration of Conflicts of Interest

The PRG **NOTED** the register of members' interests.

1.3 Confirmation of the Previous Meeting's Minutes

The PRG **ENDORSED** the minutes of the previous meeting: *PRG Minutes of Meeting 13 May 2021.*

The PRG **NOTED** that the open items will be held over to the next meeting.

2.1 Update by the Chair

The Chair updated the PRG on recent developments in the NDIS.

3.1 Annual Price Review 2022/2023

The paper 20210806 - Item 3.1 – Annual Pricing Review was presented to the PRG by:

- David Cullen, Chief Economist

The PRG **DISCUSSED** the paper and **AGREED**:

- There would be value in undertaking the methodology and engagement strategy presented for the Annual Pricing Review

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The PRG **INDICATED**:

- It considered the work load to be considerable and queried if achievable in the timeframe. It also considered if a staggered approach would not be more applicable. The Chief Economist agreed to develop a comprehensive schedule for the first 6 months to allay these concerns.

- It considered there is a need for the NDIA to work closely with participants and participant advocates, including developing better channels of communication, to ensure participants needs are met.

- It supported the need for further education and communication to help participants navigate the Pricing Arrangements more effectively.

- It considered the Chair's statement meetings in the future could be shorter and more frequent. The Chief Economist outlined a preliminarily view the next two meetings could occur in November 2021 and February 2022, and the November PRG meeting could consider meeting with advocacy groups.

- It considered that the role of the PRG in the Annual Price Review process is to add value by being an independent voice, giving credibility to decisions and adding quality and expertise.

Next Meeting: 9 November 2021, 9.30am to 11am

ACTIONS ARISING			
	Meeting	**Issues**	**Status**
1	13 May 2021	Consideration should be given to including questions on self-insurance for workers compensation in the new financial benchmarking survey.	Open
2	13 May 2021	Provide information to members of the provision of services for autism through the MBS and whether these and other autism services were transitioning into the NDIS	Open
3	6 August 2021	Chief Economist to develop a schedule for members regarding key milestones and meetings. It will outline the first 6 months of the Annual Price Review 2022/23	Open

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Pricing Reference Group

Meeting: 9 November 2021

Minutes

Date: Tuesday, 9 November 2021

Time: 930 – 1100

Location: Microsoft Teams

Members		
Chair		
Gerrie s47F - perso	General Manager, Provider and Market Development Division	By Teams
Pricing Reference Group Members		
Deborah s47F - pers	Independent Member	By Teams
Julie s47F - personal privac PSM	Independent Member	By Teams
Lynne s47F - personal p	Independent Member	By Teams
Jim s47F - p PSM	Independent Member	By Teams
Pricing Reference Group Members Apologies		
Graeme s47F - pers AM	Independent Member	
Participating Observer nominated by CEO		
Lisa s47F - personal pr	DCEO, Markets, Governments and Engagement	By Teams
Sarah s47F - personal p	Scheme Actuary	By Teams
David Cullen	Chief Economist	By Teams
Stephen s47F - personal privac	Branch Manager, Provider Engagement	By Teams
Secretariat		
Vincent s47F - persona	A/g Director, Pricing Operations, Price Regulation Unit, Provider and Markets Division	
Mardi s47F - personal pr	Project Assistant, Pricing Operations, Price Regulation Unit, Provider and Markets Division	

1.2 Declaration of Conflicts of Interest

The PRG **NOTED** the register of members' interests.

1.3 Confirmation of the Previous Meeting's Minutes

The PRG **ENDORSED** the minutes of the previous meeting: *PRG Minutes of Meeting 6 August 2021.*

The PRG **NOTED** that all open items are now closed.

2.1 Update by the Chair

The Chair informed the PRG:

- Consultants were appointed to facilitate the Annual Pricing Review and Financial Benchmarking Survey.
- Increased activity regarding providers folding or putting themselves into voluntary administration. For example, Disability Services Australia who is one of the larger providers in New South Wales went into voluntary administration. The NDIA is aware it is not just the bigger providers facing challenges, but there is a number of providers changing business structures. There are several other providers raising financial issues.

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- A WA provider is attempting to have their EB extinguished because it's well above the SCHADS Award and is awaiting a Fair Work Commission ruling. This may have ripple effects in the sector were other providers to follow suit.
- It was reiterated that the NDIA was not setting prices to enable inefficient businesses to stay in the market.

The Scheme Actuary informed the PRG:

- The NDIS Annual Financial Sustainability Report was released at the same time as it was provided to Commonwealth Government, in early October. It was closely reviewed in consultation with the States and Territories, including the Disability Reform Ministers meeting and a subgroup of senior officials working with an independent actuary, Taylor s47F - perso The modelling was considered sound.
- High levels of concern were raised on the projection of total participant costs that are estimated to be $29.2 billion in 2021-22, growing to $41.4 billion in 2024-25, and $59.3 billion in 2029-30.
- The Parliamentary Budget Office also had similar projections for scheme costs at an estimated amount of $29-30 billion in 2021-22.
- Increased forward projections are based on updated expectations the number of participants in the Scheme will reach 670,400 at the end of June 2025, increasing to 859,300 at the end of June 2030.

The DCEO, Markets, Government and Engagement informed the PRG:

- NDS launched a campaign on the economic value of the scheme. This campaign makes some assumptions regarding the benefits of the Scheme that could be questioned.

3.1 Annual Price Review 2021/2022

The paper PRG 20211109 - Update on the Pricing Review Item 3.1 was presented to the PRG by the Chief Economist.

The Chief Economist provided an update regarding the progress of the Annual Pricing Review and the Financial Benchmarking Survey.

Annual Pricing Review:

Appointed Consultant

- Ernst Young (EY) were successfully appointed to assist the Chief Economist with the Annual Pricing Review.

Working Groups

- The Chief Economist will chair and lead the discussion for the working groups and EY will facilitate those working groups and assist with writing papers chapters for those groups.
- About 35 providers will attend each of these working groups from a list of 350 providers. There are 11 official working groups and others that involve State and Territory Government representatives; so there will be additional working groups.
- Each of these working groups will meet three times for two to three hours per meeting. There will be a week of working groups every month.

Final Report

- The reports from each of the working groups will represent a chapter in the final report for the Annual Pricing Review.
- The intention is to write the final report by the end of March 2022. This will then be put forward to PRG members in early April 2022, and then to the Board at the end of April 2022.

Submissions

- Approximately 30 submissions were received as at 9 November 2021. There is an expectation that a spike of submissions will be received by the closure date (28 November 2021).

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Financial Benchmarking Survey:

Appointed Consultant

- Deloitte were successfully appointed to assist the Chief Economist with the Financial Benchmarking Survey.

Survey

- The Survey is expected to go live on 29 November 2021. Providers were notified of the survey via email on 12 November 2021. An interactive seminar will be hosted by Deloitte Access Economics on 25 November to assist providers to prepare for and complete the survey. Providers will have until 4 February 2022 to fill it in.

Additional Survey

- There will be an additional Benchmarking Survey, specifically for plan managers and support coordinators. This will be launched in January-February 2022 so will have some real information about what their constructions are, which are expected to be different to other providers.

The PRG **DISCUSSED** general matters regarding the Annual Pricing Review:

- Broad discussions on collaboration and co-design were raised regarding the working groups. PRG members noted that there would be varying levels of co-design required based on the working group topic. For instance, reducing the administrative complexity has higher elements of co-design on what improves the experience for providers compared to reviewing the DSW cost model.
- PRG emphasised that a balanced view of each working group must be faithfully reflected to the Board, but the decision sits with the Board.
- Group discussion to consider PRG members attending some of the working groups; whether one, two or more would be appropriate. DSS will be in attendance, plus EY and some key members of the NDIA.
- Concerns were raised by members regarding the timeline for the working groups, the Benchmarking Survey and the closing of the consultation paper. The May 2022 timeline was considered tight but manageable.
- The NDIA's Private therapy dataset now has 7,000 data points. A large proportion of private therapy providers don't publish their prices. Of the providers that do publish their prices, there is often a different price for NDIS participants.

Next Meeting: Determined after the meeting.

ACTIONS ARISING			
#	Meeting	Issues	Status
1	20211109	Coordinate PRG members to attend working groups; including costs/sitting fees. GM to make contact to see what session people may be interested in attending.	Closed
2	20211109	Email PRG members David's presentation and links to: • Quarterly Reports | NDIS • Annual Financial Sustainability Reports | NDIS • False Economy: The economic benefits of the NDIS and the consequences of government cost-cutting - Per Capita	Closed

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MR25/01967 FOI 24/25-2242
DISCLOSURE LOG

ndis

ANNUAL PRICING REVIEW

UPDATE TO THE PRICING REFERENCE GROUP

01 February 2022

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DISCLOSURE LOG

ANNUAL PRICING REVIEW

- September 2021: Annual Pricing Review Terms of Reference released and Consultation Paper open for submissions
- 28 November 2021: submissions closed
  - Over 400 submissions received
- November 2021: first meetings of Review Working Groups
  - 400 members invited across 12 working groups

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DISCLOSURE LOG

FINANCIAL BENCHMARKING STUDY 2021-22

- Deloitte Access Economics survey and analysis
  - Survey open 29 November 2021 to 4 February 2022
  - Designed to collect information on staffing numbers, costs and profits of support providers in the NDIS
  - Mandatory for Temporary Transformation Payment claimants
- As at 27 January 2022:
  - 307 completed surveys
  - 759 further surveys 'in progress'
  - Reminders sent by DAE and by NDIA
- First cut of survey analysis scheduled for 21 Feb
- To increase responses by not asking for already known data, DAE has requested NDIA revenue and participant data by jurisdiction, rurality and relevant registration groups

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DISCLOSURE LOG

PLAN MANAGEMENT AND SUPPORT COORDINATION BENCHMARKING STUDY

- Disability Intermediaries Australia (DIA) undertook a national collection of information on the drivers and operating parameters from many plan managers and support coordinators, which closed in November 2021
- This was voluntarily done by DIA as there was no known national data set on the operational costs for Plan Managers and Support Coordinators.
- 803 unique submissions for drivers and operating costs for these supports for Financial Year 2020-21
  - 430 Plan Management responses
  - 373 Support Coordination responses
- DIA provided a cleaned, de-identified dataset of survey responses to NDIA in January 2022
- Provided to DAE for analysis, and comparison with Financial Benchmarking Survey

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DISCUSSION OF SUBMISSIONS AND WORKING GROUPS

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DISCLOSURE LOG

DSW COST MODEL AND PRICING ARRANGEMENTS

Common claims made by stakeholders, across 59 submissions and 30 non-NDIA attendees to WG3 include:

- Some concern that setting the efficient provider as one in the top quartile for all domains is too high a bar
- Providers argue DSW Level 1 salary base rate too low
- Argue supervisor span of control should be on FTE, not headcount
- Commonly raised that overheads are too low (only parameter not set directly from survey)
- Claims worker intensity and utilisation too high, insufficient allowance for overtime
- No allowance for payroll tax, barrier to for-profit providers
- Fair Work four-yearly review may require more than cosmetic changes (eg, broken shift allowance, two hour minimum shift)

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DISCLOSURE LOG

QUALITY AND SAFEGUARDING COSTS

Common claims made by stakeholders, across 39 submissions and 35 non-NDIA attendees to WG4 include:

- Claims that Cost Model does not allow for increasing Commission compliance burden
  - estimated ~ 5% total costs
  - audit costs said to be difficult for small providers ~ $10k p.a. direct costs, $50 hours time costs
- Providers report that incident reporting getting more onerous, examples of 1 FTE per 100 SIL clients now required
- Commission standards require substantial training, and complex clients require a lot of coordination with health professionals. Providers feel neither is covered adequately in CM.
- Need to develop clinical governance teams, with high cost health professionals. Claim CM overheads should be increased for.

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CORE GROUP SUPPORTS

Common claims made by stakeholders, across 39 submissions and 18 non-NDIA attendees to WG5 include:

- Submissions suggested the pricing structure improved transparency and accuracy, but at the cost of administrative burden and increased complexity
- There was suggested to be several costs associated with implementing the new pricing structure and its billing
- Some providers claimed to have faced a decrease in revenue, as the costs of their group-based core supports could not recoup costs by the change in billing for non-face-to-face time
- There was mention of challenges associated with interacting with plan managers and support coordinators in the working group meeting.

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TEMPORARY TRANSFORMATION PAYMENT

Common claims made by stakeholders, across 33 submissions and 16 non-NDIA attendees to WG6 include:

- Assists with innovation, and promotes capability building and competition
- Providers asserted that additional costs associated with being a registered provider in the NDIS were not temporary and not diminishing over time.
- Providers suggested the current underutilisation of TTP support items was, in part at least, due to barriers to accessing and claiming the TTP. This includes:
  - Administrative burden and cost of applying for and claiming TTP.
  - High complexity in claiming TTP as well as explaining it to participants.
  - Additional funding for TTP is not available in participant plans.
- Submissions claimed that TTP protects providers from financial losses, but does not support reinvestment opportunities to transform and streamline operations

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DISCLOSURE LOG

THERAPY SUPPORTS

Common claims made by stakeholders, across 56 submissions and 41 non-NDIA attendees to WG7 include:

- Current prices limits were suggested to be below standard market rates for some types of therapy supports, increasing so due to limited workforce supply (i.e. Clinical Psychologists).
- Inflationary indexation was suggested to occur every year (currently only when therapy pricing is reviewed)
- Suggested that travel limits were insufficient - metropolitan has congestion issues, also not adequate to cover participants living in rural or remote settings
- Current price limits were claimed to not allow for rising costs associated with training, supervising and upskilling staff such as university students and junior staff
- There was suggested to be higher administrative burden associated with NDIS participants than non-NDIS clients (i.e. reporting and compliance)
- Utilisation for therapists was suggested to be lower as a result of the associated tasks, reporting and additional administration for NDIS participants.
- Overheads was suggested to be higher for therapy organisations.
- There was claims that there are high costs associated with registration and audits for therapists.

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DISCLOSURE LOG

ABILITY FIRST'S PROPOSED THERAPY COST MODEL SUMMARY

- Ability First Australia is estimated to represent 20% of the NDIS Therapy support market in 2020-21 financial year.
- **Suggested therapy costs:**
- Psychologist = $226.43 per hour
- Other allied health = $200.79 per hour
  - Based upon weighted average of Social worker ($213.84), Speech pathologist ($201.60), Occupational therapy ($200.92) and Physiotherapist ($193.79)
- The primary drivers of the hourly costs of service provision were wages and utilisation. The cost difference was suggested to be mainly driven by higher base pay rate for psychologists (approx. 76% of the difference in cost per hour).
- The cost of service delivery in regional and rural areas for non-psychology allied health services was claimed to be $10.10 per hour more than in metropolitan regions (attributed to more time spent supervising and training).
- Points to note:
  - Parameters used are based on group weighted averages – not the efficient provider.
  - From participating organisations, highest proportion of FTE servicing jurisdictions were WA (37.6%), NSW (23%) and SA (21.1%).

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DISCLOSURE LOG

NURSING SUPPORTS

Common claims made by stakeholders, across 5 submissions and 9 non-NDIA attendees to WG8 include:

- Minimum shift for nurses is two hours, participant can only be billed for actual time
- Nurses have to be paid for broken shifts, and often work overtime, which cannot be claimed
- Complaints that costs have not been indexed for two years
- Travel budgets claimed to be too low, especially for non-metro areas

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DISCLOSURE LOG

PLAN MANAGEMENT

Common claims made by stakeholders, across 23 submissions and 23 non-NDIA attendees to WG9 include:

- Suggestions that when a participant moves Plan Managers halfway through their plan, the plan set-up fee has already been claimed by the initial Plan Manager. The new Plan Manager has no funding to claim for set-up costs, absorbing these costs.
- Plan Managers also claim to undertake additional, unfunded work beyond processing invoices. These activities include:
  - Acting as a defacto Support Coordinator when the participant requires educating or has enquiries about the use of funds in their plans
  - Providing additional support to complex needs, disadvantaged and/or Culturally and Linguistically Diverse (CALD) participants which require additional hours

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DISCLOSURE LOG

DIA'S PROPOSED PLAN MANAGEMENT COST MODELS

- Chapter 3.4 (from page 33) outlines the assumptions made for DIA's proposed cost model for plan managers.
- Proposed monthly price limit $135.70
  - $74.93 cost per hour multiplied by 1.48 average hours of support per month.
  - $19.36 per month for set up costs (NDIA price limit divided by 12 months) for changing plan managers during a plan without loss of set-up costs.

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DISCLOSURE LOG

SUPPORT COORDINATION

Common claims made by stakeholders, across 44 submissions and 28 non-NDIA attendees to WG10 include:

- Submissions suggest providers are unclear on their scope of role, activities undertaken, and expectations of service
- Claim there is a lack of flexibility to adapt to changes in circumstances or a crisis (e.g. a participant dies)
- There was claims that Level 1 was rarely used relative to other levels.
- Raised concerns on planning arrangements where they believe the level of support is sometimes not appropriate for highly complex participants
- Suggested additional travel limits were required for metropolitan, rural, regional and remote areas
- Claim to have higher overheads, particularly smaller organisations
- Claim to have high administration burden such as when resolving Agency errors or wading through red tape (e.g. specifics of a policy)

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DISCLOSURE LOG

DIA'S PROPOSED SUPPORT COORDINATION COST MODELS

- Chapter 4.3 (from page 65) outlines the assumptions made for DIA's proposed cost model for support coordinators.
- Proposed hourly price limits:
  - Level 1 / Capacity Building and Training in Plan and Financial Management - $68.33
  - Level 2 - $110.04
  - Level 3 - $199.67

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DISCLOSURE LOG

REGIONAL AND REMOTE SUPPORTS

Common claims made by stakeholders, across 31 submissions and 17 non-NDIA attendees to WG11 include:

- Providers would like the Scheme to contribute towards accommodation costs for workers in remote areas, as they need to offer this to attract workers.
- Best practice therapy is often to visit the participants in their natural environment, but travel costs are claimed not to be sufficient to cover this in remote areas.
- Providers consider span of control ratios should be lower in remote areas, as supervisors often have to travel between workers.
- Providers think allowance should be made for long travel distances for training.

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QUEENSLAND, SOUTH AUSTRALIA AND WESTERN AUSTRALIA

Common claims made by stakeholders, across 13 submissions and 35 non-NDIA attendees to WGs 12A, 12B and 12C include:

- Providers noted that Covid hard border closures have made it very difficult to recruit workers from interstate or overseas
- WA and QLD are having a mining boom, with attendant high wages the sector is having trouble competing with.
- The boom is also driving up the costs of other services, such as audits.
- Housing in remote areas (much of WA and QLD) becoming scarce and expensive
- One WA provider noted a 50% reduction in utilisation of plans outside metro areas due to inability to keep staff.
- QLD has 16 public holidays, but the Cost Model only allows 12.
- Unlike any other State, SA half-day holidays, and does not recognise Christmas Day if it falls on a weekend.

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DISCLOSURE LOG

NEXT STEPS

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DISCLOSURE LOG

ANNUAL PRICING REVIEW

- Early February 2022: second meetings of Review Working Groups
- Late February / Early March 2022: third meetings of Review Working Groups
- April 2022: Announce results of Annual Pricing Review
- June 2022: Release final price limits

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Pricing Reference Group

Meeting: 1 February 2022

Minutes

Date: Tuesday, 1 February 2022

Time: 10:00-13:00

Location: Microsoft Teams

Members		
Chair		
Gerrie s47F - perso	General Manager, Provider and Market Development Division	By Teams
Pricing Reference Group Members		
Deborah s47F - pers	Independent Member	By Teams
Julie s47F - personal privac PSM	Independent Member	By Teams
Lynne s47F - personal p	Independent Member	By Teams
Jim s47F - p PSM	Independent Member	By Teams
Graeme s47F - pers AM	Independent Member	By Teams
Pricing Reference Group Members Apologies		
No Apologies		
Participating Observer nominated by CEO		
Lisa s47F - personal pr	DCEO, Markets, Governments and Engagement	By Teams
David Gifford	A/g Scheme Actuary	By Teams
David Cullen	Chief Economist	By Teams
Tanuja s47F - per	A/g Branch Manager, Pricing	By Teams
Stephen s47F - personal privac	Branch Manager, Provider Engagement	By Teams
Secretariat		
Vincent s47F - persona	A/g Director, Pricing Operations, Price Regulation Unit	
Mardi s47F - personal pr	Project Assistant, Pricing Operations, Price Regulation Unit	

1.2 Declaration of Conflicts of Interest

The PRG **NOTED** the register of members' interests.

- Lynn s47F - personal priva declared that she is Chair of the Liver Foundation.

1.3 Confirmation of the Previous Meeting's Minutes

The PRG **ENDORSED** the minutes of the previous meeting: *PRG Minutes of Meeting 9 November 2021.*

The PRG **NOTED** that all open items are now closed.

2.1 Update by the Chair

The Chair informed the PRG:

- Introduction of David s47F - personal pr who will be Acting Deputy Scheme Actuary and will replace Sarah Johnson as a PRG member. Sarah Johnson will be Acting Deputy CEO for Design, Digital and Strategy (DDS) from Monday 31 January, but remains the official Actuary for the Scheme.
- Introduction of Dr Tanuja s47F - perso as the Acting Branch Manager, Pricing.

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- Four new members have been appointed to the NDIA Board with effect from 1 January 2022. Jim s47F - personal will serve as Acting Chair until a permanent appointment is made.
- The external environment for the disability sector is changing, with an increased spotlight on the aged care, disability and health care sectors as we respond to COVID-19 and pressures on wage and people resources.
- Department of Social Services (DSS) continues engaging with states and territories on various matters including the path to price deregulation and the overarching pricing framework.

2.2 Update on Annual Pricing Review

- The Chief Economist presented:
  - Over 400 provider submissions received and summary documents sent to PRG Members of those submissions.
  - Held first round of working groups with providers and other stakeholders; the second round of working group meetings to commence in February. Summary documents of the first round of working groups have been sent to PRG members.
  - The Agency's findings will be provided to the Board in around March or April. Decisions on recommendations and any subsequent announcement will follow.

2.3 Update on Financial Benchmarking Study

- The Pricing Branch Manager presented:
  - The survey is being administered and analysed by Deloitte Access Economics, and is on track to receive a similar number of responses to those received last year.
  - Overall, the survey response rate is approx. 25% of providers claiming for Temporary Transformation Payment (TTP).
  - The Agency will receive a survey dataset from Deloitte Access Economics for subsequent analysis by the Agency.
- The PRG asked about the response rate, and compliance with the obligations associated with claiming the Temporary Transformation Payment.

2.4 Update on Plan Management and Support Coordination Benchmarking Study

- The Pricing Branch Manager presented:
  - 803 surveys were received by Disability Intermediaries Australia (DIA) with 430 responses from plan managers and 373 responses from support coordinators.
  - DIA survey and submission argues that they should receive a price rise. They provided a de-identified dataset of survey responses to the Agency where analysis is concentrated on efficient providers as opposed to average providers. This data suggests the substitution of average plan managers with efficient plan managers into the Cost Model leads to our prices being too high.
  - PRG discussed the analysis of an efficient provider going forward and if continuing to set price limits at the 25th percentile would potentially reduce market supply in the long term.

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3.0 Discussion of Submissions and Working Groups

WG03 – DSW Cost Model and Pricing Arrangements

- PRG discussed requiring further clarity on overheads and potentially setting these costs somewhere between the median and the 25th percentile.
- PRG discussed issues regarding payroll tax where some providers pay it and others do not. The efficiency difference realised between profit and not-for-profit providers can be significant, which may drive inefficiency into the sector as a whole.

WG04 – Quality and Safeguarding Costs

- PRG discussed potential cost impacts on: 1) registered providers that have the cost of quality and safeguarding compliance costs, and 2) unregistered providers that do not have these costs. The proportion of registered and unregistered providers may be used as an indicator to measure the impact of compliance costs to providers over time.

WG05 – Core Group Supports

- PRG discussed the suggestion of a menu of contracts that demonstrate the bundle of costs of services compared to providers delivering bespoke supports. The bundled approach can be applied through programs of support. However, there isn't a lot of evidence to suggest that providers are having the conversation with participants about potential bundled supports. This goes to developing a culture change for providers where they actively engage their participants regarding prices and the supports delivered.

WG06 – Temporary Transformation Payment (TTP)

- The PRG briefly touched on non-compliance of the survey that was addressed in point 2.3 Update on Financial Benchmarking Study.
- The PRG discussed that there is a general misconception regarding the purpose of TTP amongst providers.
- The Agency clearly set out the economic position that TTP did not represent the efficient rate but would support inefficient providers until their cost structures became efficient. Generally, providers think TTP is there to cover existing costs.
- The Agency noted recent initiatives (for example, COVID initiatives) have allowed NDIS funds to be spent outside of participant plans as direct payments to providers. This could be an alternative approach to change provider behaviour.
- PRG discussed that innovation is incentivised within some other government and government-funded schemes that would be worth investigating.

WG07 – Therapy Supports

- The PRG heard working group feedback that therapy providers want a price increase as prices were last indexed in July 2020.

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- The Chief Economist delivered a presentation to the PRG outlining the results of 8,000 therapy prices advertised by NDIS providers on their website for non-NDIA prices. A subset of that data set is 4,000 prices for weekdays, in their rooms, travel rates, and so on. A model has been developed now that splits the country into 3 sets of therapy prices; WA and QLD; VIC and SA.

WG08 – Nursing Supports

- The PRG heard that there has been approximately $40-50 million spent on nurses and that there are 5 different nursing items that capture different skill levels and complexity.
- The PRG discussed that this is an area of significant uncertainty because of the unknowns regarding the impact of the pandemic on the public health system and the impact on the supply of nurses coming into the Scheme.

WG09 – Plan Management

- The PRG discussed concerns regarding the distinction between plan management and support coordination and the overlapping advice they provide to participants. Both groups want to factor in that provision into the price limit, which raises a dilemma of double counting that cost and who's providing the service.
- When the NDIA's proposed Point of Sale system is implemented, it will play a role in the Plan Management and Support Coordination space on their role and functions.
- The PRG heard that DIA's submission suggested to stop paying a customer acquisition fee just for setting them up (part of ongoing business operations) and rather build this into the monthly fee.

WG10 – Support Coordination

- The PRG heard that DIA's modelling showed very low utilisation and high overheads. Level 3 rates are on par with the therapy rates of $194.
- The PRG discussed how consideration may be given to support coordinators in circumstances after a participant dies. The *National Disability Insurance Scheme Act 2013* (NDIS Act) has a section for a deceased participant and that a participant's plan ceases to exist when that occurs. The Agency's current policy is that plan managers and support coordinators are not able to bill the plan for services provided.

WG11 – Regional and Remote Supports

- The PRG heard that significant parts of regional Australia are quite isolated and current travel rules are not adequate to meet the necessary demand in those areas.
- The PRG discussed that planning practices do not consider travel costs during the planning stage, but this may need to be reviewed for regional participants. This approach may not be adequate for remote participants where consideration for an off plan travel allowance may need to be accessible for providers servicing participants in those isolated areas.
- The PRG discussed that support coordinators can assist with the regional and remote solution by linking participants and providers in certain areas and minimising travel expenditure of the Scheme; greater focus may be placed on this going forward.

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WG12/13/14 – QLD SA WA

- The PRG heard the Agency's current thinking that the mining boom in Western Australia was unlikely to affect the disability worker market in that state; however, border closures have limited the pool of bringing in disability workers from other states and overseas.

Next Meeting:

- Thursday, 3 March 2022, 10:00-13:00

ACTIONS ARISING			
#	Meeting	Issues	Status
1	20220201	Notify members when the Department of Social Services (DSS) releases its public consultation on Scheme pricing framework.	Open
2	20220201	Share the Deloitte Access Economics Financial Benchmarking Survey analysis with members.	Open
3	20220201	Payroll tax paper to be circulated to members before the next PRG meeting.	Open
4	20220201	Share presentation slides on therapy prices with members.	Attached
5	20220201	Share APR slides used during the PRG meeting with members.	Attached
6	20220201	Undertake analysis of the proportion of registered to non-registered providers over time.	Open
7	20220201	Follow up with PRG members for details of government and government-funded schemes with an allowance or an incentive for innovation.	Open

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DISCLOSURE LOG
OFFICIAL
DOCUMENT 51

ndis

ANNUAL PRICING REVIEW

UPDATE TO THE PRICING REFERENCE GROUP

03 March 2022

OFFICIAL
Page 524 of 1049

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Updates by the Chair

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Discussion of draft chapters

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Plan Management consultation

Common claims made by stakeholders, across submissions and non-NDIA attendees to WG9 include:

- Suggestions that when a participant moves Plan Managers halfway through their plan, the plan set-up fee has already been claimed by the initial Plan Manager. The new Plan Manager has no funding to claim for set-up costs, absorbing these costs.
- Plan Managers also claim to undertake additional, unfunded work beyond processing invoices. These activities include:
  - Acting as a defacto Support Coordinator when the participant requires educating or has enquiries about the use of funds in their plans
  - Providing additional support to complex needs, disadvantaged and/or Culturally and Linguistically Diverse (CALD) participants which require additional hours

DIA's Cost Model proposal

- Proposed monthly price limit $135.70
  - $74.93 cost per hour multiplied by 1.48 average hours of support per month.
  - $19.36 per month for set up costs (NDIA price limit divided by 12 months) for changing plan managers during a plan without loss of set-up costs.

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Plan Management preliminary findings

- In 2020-21, more than half (51.8%) of all active participants (participants who made a claim from their plan in 2020-21) used a Plan Manager for some or all of their plan.
- The number of Plan Managers continue to grow. 251 plan management providers commenced operations in 2020-21 and 129 plan management providers commenced operations in the first two quarters of 2021-22.
- The results of Disability Intermediaries Australia's survey show that a significant number of providers are making a healthy return on their investment under the current NDIS price limits – with 46% of Plan Managers achieving a 2020-21 EBITDA above 10%.
- There is a lack of uptake on the Capacity Building and Training in Plan and Financial Management by a Plan Manager support item. Of the 258,981 participants who made a claim for a plan management support item in the first half of 2021-22, only 251 (0.1%) made a claim for this support.

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Plan Management draft recommendations

The Review proposes:

- That the Agency should simplify the pricing arrangements for plan management supports from 1 July 2022 by:
  - Replacing the current monthly fee and establishment fee arrangements by a single monthly fee arrangement, which amortises the current establishment fee support item into the monthly fee support item.
  - Decommissioning the Capacity Building and Training in Plan and Financial Management support item, and broadening the scope of the current core support item 01_134_0117_8_1 to Capacity Building and Training in Self Management and Plan Management.
- That the price limits for plan management supports should be indexed on 1 July each year (commencing 1 July 2022) using the PI-X (price index minus productivity) approach for labour supports.
- That the Agency should ensure that Plan Managers have complete access to all parts of a plan that relate to the components the plan that a participant has appointed them to manage, including any relevant information on the intent of the plan.

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Plan Management draft recommendations continued

The Review proposes:

- That the Agency should publish a clear statement of the respective responsibilities of participants, providers and Plan Managers with respect to ensuring that Scheme funds are only spent on supports that are reasonable and necessary and in accordance with the intent of the plan.
- That the Agency should allow Plan Managers to bill the agreed monthly plan management fee for up to three months after a participant's death – so that they can finalise the participant's outstanding invoices, etc.
- That the Agency should establish a working group to further examine and address any issues in the current pricing arrangements that inhibit the uptake of shared management arrangements.
- That the Agency should explore options to ensure the longer plans, and plans that are rolled over, appropriately account for any material changes in price limits that have occurred or might occur during the duration of the plan.

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Quality and Safety costs (QSC)

- The Quality and Safety Commission is responsible for setting and enforcing safety and quality standards.
- The Agency needs to ensure costs of complying are covered in the Cost Model.
- (This does not necessarily include the costs of non-compliance)

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QSC consultation

Common claims made by stakeholders, across submissions and non-NDIA attendees to WG4 include:

- Claims that NDIS disability support worker (DSW) Cost Model does not allow for increasing Commission compliance burden
  - estimated ~ 5% total costs
  - audit costs said to be difficult for small providers ~ $10k p.a. direct costs, $50 hours time costs
- Providers report that incident reporting getting more onerous, examples of 1 FTE per 100 SIL clients is now required.
- Suggest Commission standards require substantial training, and complex clients require a lot of coordination with health professionals. Providers feel neither is covered adequately in the DSW Cost Model.
- Claimed there was a need to develop clinical governance teams, with high cost health professionals. Claim DSW Cost Model overheads should be increased for.

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Growth in QSC compliance costs

- Preliminary findings:
  - While the idea was that one national uniform set of safety regulations should reduce compliance costs, near universal feedback is that the opposite has happened.
  - A number of providers report compliance costs had increased by orders of magnitude.
  - The Review estimates that compliance costs have increased by 0.75% of total costs since the introduction of the Commission in 2019.
  - Many providers stated that more time was required for supervision and training to meet increasing safety regulation.
  - However, the financial benchmarking survey indicates that utilisation is not decreasing for either DSWs or front line supervisors (FLS)

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Impact of QSC compliance costs

- Stakeholder feedback:
  - Several submissions indicated that smaller providers – especially sole practitioner therapists – were not able to cover the costs of QSC registration.
  - Assistance with Daily Living (ADL) providers complained that it was not fair that unregistered providers did not have to face the same compliance costs, and wanted the DSW Cost Model to differentiate between registered and unregistered providers.
  - Some providers suggested the number of QSC practice standards is excessive. They noted the National Standards for Disability Services had 6 standards and 40 quality indicators, but some providers now faced 62 standards and 297 quality indicators.
  - However, while the costs of Commission regulations is within the purview of the Review: the efficacy of such regulations is not.

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QSC draft recommendations

The Review proposes:

- That the Agency should increase the price limits of core supports to recognise the increased costs that providers face in ensuring that the supports that they deliver are of high quality and safe. This should be done by increasing the overheads loading in the NDIS DSW Cost Model from 12% to 13%.
- To not recommend different prices for registered and unregistered providers.
- To not recommend reducing utilisation levels in the DSW Cost Model for quality and safeguarding compliance hours.

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Nursing support consultation

Common claims made by stakeholders, across submissions and non-NDIA attendees to WG8 include:

- Minimum shift for nurses is two hours, participant can only be billed for actual time
- Nurses have to be paid for broken shifts, and often work overtime, which cannot be claimed
- Complaints that costs have not been indexed for two years
- Travel budgets claimed to be too low, especially for non-metro areas

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Nursing supports – preliminary findings

- In 2020-21, 14,997 agency-managed and plan-managed participants received NDIS funded nursing supports (3.4% of all participants who made a claim for one or more supports in 2020-21).
- In total, the Scheme expended $85.8 million on nursing supports in 2020-21.
- Most nursing supports were delivered by Registered Nurses (68.3% by value of support) and by Enrolled Nurses (19.0%).
- The current NDIS price limits for nursing supports do not allow providers to pay competitive nurses wages with the public system, this has become more acute during the COVID pandemic.
- Employment statistics confirm that there is currently a high demand for nurses across Australia.
- Current NDIS definitions of time of day (Evening and Night shifts) do not align with the shift definitions in the Nursing Award.

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Nursing supports draft recommendations

The Review proposes:

- The price limits for nursing supports delivered by enrolled nurses and registered nurses should be significantly increased (by 27.1% and 25.5% respectively for weekday services). It also proposes similar increases for other types of nurses and other shifts.
- The price limits for nursing supports should be indexed on 1 July each year (commencing 1 July 2022) using the PI-X (price index minus productivity) approach for labour supports.
- That the Agency should align the shift definitions for nursing supports with those set out in the *Nurses Award 2020*.
- That the Agency should amend the definitions for the different level of nursing supports to provide greater clarity to providers.
- That the Agency considers that nursing providers should be able to claim from a participant's plan for the time the nurse spends travelling if, and only if, certain conditions are met.

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Temporary Transformation Payment (TTP)

- Registered providers have access to higher price limits.
- Eligibility conditions are publish service prices; list contact details in Provider
- Participate annually in financial benchmarking survey
- Currently 4.5%. Scheduled to reduce to 3% on 1 July 2022
- For following registration groups
  - 0104 High Intensity Daily Personal Activities
  - 0107 Daily Personal Activities
  - 0125 Participation in Community, Social and Activities
  - 0133 Specialised Supported Employment
  - 0136 Group and Centre Based Activities

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TTP consultation

Common claims made by stakeholders, across submissions and non-NDIA attendees to WG6 include:

- Assists with innovation, and promotes capability building and competition.
- Providers asserted that additional costs associated with being a registered provider in the NDIS were not temporary and not diminishing over time.
- Providers suggested the current underutilisation of TTP support items was, in part at least, due to barriers to accessing and claiming the TTP. This includes:
  - Administrative burden and cost of applying for and claiming TTP.
  - High complexity in claiming TTP as well as explaining it to participants.
  - Additional funding for TTP is not available in participant plans.
- Providers were concerned that support coordinators were advising participants not to use TTP items, because plans are not increased for TTP.

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Future of the TTP

- Stakeholder feedback:
  - A number of submissions argued the TTP has been successful in promoting efficiency – and thus that it should be retained to promote further development.
  - A number of providers felt that there would be value in maintaining the TP as a recognition of the increasing difference in compliance costs faced between registered and unregistered providers.
  - The TTP Working Group considered that the TTP should be replaced by a higher set of base prices, which recognise the ongoing nature of Agency and Commission compliance costs.
  - There is now stronger evidence that the average cost of service delivery is at or below the current price limit.

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TTP usage in 2020-21

- 18.4 million TTP-eligible supports claimed
- Worth $7.0 billion.
- Delivered by 62,219 registered and unregistered providers to 198,298 participants (45% of all Scheme participants).
- 52% of claims for TTP-eligible supports were for a TTP item
- 43% of expenditure on TTP-eligible supports was on TTP items

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TTP usage in 2021-22

- Only 47% of claims for TTP-eligible supports were for TTP items.
- Only 38% of expenditure on TTP-eligible supports on TTP items.
- TTP items account for:
  - 29% of expenditure on TTP-eligible supports in Assistance with Daily Life;
  - 47% of expenditure on TTP-eligible supports in Community Participation
  - 65% of expenditure on TTP-eligible Supports in Employment
- $70m spent on TTP loading in first half 2021-22

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TTP compliance

- Only 64% of providers who claimed the TTP in 2020-21 completed the financial benchmarking survey.
- Conversely, 19% of registered providers who could have - but didn't - claim the TTP in 2020-21 voluntarily agreed to take part in the survey.

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TTP draft recommendations

The Review proposes:

- That the Agency should cease the TTP from 1 July 2022.
- That the Agency should partner with the sector to:
  - sponsor an annual financial benchmarking survey; and
  - address the information asymmetries facing participants by publishing localised prices for specific supports.

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NDIA Financial Benchmarking Survey preliminary results

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NDIA Financial Benchmarking Survey 2020-21 Preliminary Results – Base rate of pay

Parameter	Mean	Median	25 PC	75 PC	DSW CM
Base rate of pay - DSW ($)	31.28	30.67	28.75	33.43	$30.94 (DSW A) $32.16 (DSW B) $33.48 (DSW C) $40.39 (DSW D)
Base rate of pay - FLS ($)	41.09	39.37	35.00	45.00	$33.48 (DSW A) $38.52 (DSW B) $38.52 (DSW C) $42.94 (DSW D)

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NDIA Financial Benchmarking Survey 2020-21 Preliminary Results – Span of control

Parameter	Mean	Median	25 PC	75 PC	DSW CM
Span of control (HC)	10.61	7.46	13.23	4.00	15.00
Span of control (FTE)	6.06	4.33	7.58	2.00	

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NDIA Financial Benchmarking Survey 2020-21 Preliminary Results – Workforce

Parameter	Mean	Median	25 PC	75 PC	DSW CM
Permanent employment rate (%)	60.02	63.83	28.69	94.51	70.00
Permanent employment rate - DSW (%)	46.36	45.28	5.26	84.48	70.00
Permanent employment rate - FLS (%)	94.41	100.00	100.00	100.00	Not stated, assumed 100

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NDIA Financial Benchmarking Survey 2020-21 Preliminary Results – Salary on-costs

Parameter	Mean	Median	25 PC	75 PC	DSW CM
Superannuation (%)	9.48	9.50	9.50	9.50	*10.00
Workers compensation premium (%)	3.13	2.39	1.70	4.00	1.70

NOTE: Superannuation was 9.5% in DSW CM for the period surveyed.

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NDIA Financial Benchmarking Survey 2020-21 Preliminary Results – Standard hours of work and Leave

Parameter	Mean	Median	25 PC	75 PC	DSW CM
Hours per day (hrs)	7.46	7.60	7.50	7.60	7.60
Annual leave (hrs)	163.59	152.00	152.00	190.00	152.00
Personal leave (hrs)	76.70	76.00	76.00	76.00	76.00
Long service leave (hrs)	37.23	32.94	10.00	38.00	32.93 = 4.33 hours annually
Proportion of DSW entitled to more Annual leave (%)	16.00	0.00	0.00	20.00	N/A
Proportion of DSW entitled to more Personal leave (%)	7.24	0.00	0.00	0.00	N/A

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NDIA Financial Benchmarking Survey 2020-21 Preliminary Results – DSW Utilisation

Parameter	Mean	Median	25 PC	75 PC	DSW CM
Total utilisation (%)	82.34	85.00	92.00	75.00	92.0 (A), 89.0 (B), 87.7 (C), 80.0 (D)
Billable time (exc. travel) (%)	77.23	80.00	90.00	70.00	N/A
Billable travel (%)	5.11	3.00	8.00	0.00	N/A
Non billable travel time (%)	2.73	1.00	5.00	0.00	N/A
Training (%)	4.12	3.00	5.00	1.17	3.29 (A), 6.58 (B), 7.89 (C), 7.89 (D)
Breaks (%)	2.62	1.00	5.00	0.00	4.17
Non-billable client-related administration (%)	4.17	3.00	5.00	0.00	N/A
Non-billable gen. admin. / other tasks (%)	4.03	3.00	5.00	1.00	0.54 (A), 0.25 (B), 0.24 (C), 7.94 (D)

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NDIA Financial Benchmarking Survey 2020-21 Preliminary Results – FLS Utilisation

Parameter	Mean	Median	25 PC	75 PC	DSW CM
Total utilisation (%)	31.72	24.00	53.00	5.00	92.00 (DSW A) to 80.00 (DSW D)
Time spent providing direct support to clients (%)	28.66	20.00	50.00	5.00	N/A
Billable travel time associated with direct support to clients (%)	3.05	0.00	5.00	0.00	N/A
Other travel time (%)	3.03	1.00	5.00	0.00	N/A
Time spent supervising or training other staff (%)	16.75	10.00	25.00	5.00	N/A
Self-training (%)	4.62	5.00	5.00	1.00	3.29 (DSW A) to 7.89 (DSW D)
Breaks (%)	3.20	2.00	5.00	0.00	4.17
Client-related administration (%)	26.63	20.00	40.00	10.00	N/A
General administration and other tasks (e.g. team meetings) (%)	14.04	10.00	20.00	5.00	0.24 (DSW C) to 7.94 (DSW D). DSW A = 0.54

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NDIA Financial Benchmarking Survey 2020-21 Preliminary Results – Overheads and Profits

Parameter	Mean	Median	25 PC	75 PC	DSW CM
Overheads % as a loading on direct costs	43.83	35.82	21.62	56.27	12.00
Overheads (excluding interest and depreciation) as a share of costs	*30.47	*26.37	*17.78	*36.01	*10.71
EBITDA as a % of total costs	13.08	10.78	20.94	4.03	Margin = 2.00

NOTE: Imputed from overheads as a share of direct costs.

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DISCLOSURE LOG

NEXT STEPS

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Pricing Reference Group (PRG)

Meeting: 29 March 2022

Minutes

Date: Tuesday, 29 March 2022

Time: 11.00am – 12.00pm

Location: Microsoft Teams

Members

Chair		
Gerrie [redacted]	General Manager, Provider and Markets Division	By Teams
Pricing Reference Group Members		
Deborah [redacted]	Independent Member	By Teams
Julie [redacted] PSM	Independent Member	By Teams
Lynne [redacted]	Independent Member	By Teams
Jim [redacted] PSM	Independent Member	By Teams
Graeme [redacted]	Independent Member	By Teams
Participating Observer nominated by CEO		
Lisa [redacted]	DCEO, Markets, Government and Engagement Group	By Teams
David Gifford	A/g Deputy Scheme Actuary	By Teams
Tanuja [redacted]	A/g Branch Manager, Pricing	By Teams
David Cullen	Chief Economist	By Teams
Stephen [redacted]	Branch Manager, Provider Engagement	By Teams
Secretariat		
Vincent [redacted]	A/g Director, Pricing Operations	By Teams
Jodie [redacted]	Snr Engagement Officer, Provider Engagement Branch	By Teams
Scott [redacted]	Director, Annual Price Review Team	By Teams
Dominic [redacted]	A/g Assistant Director, Annual Price Review Team	By Teams

1.2 Declaration of Conflicts of Interest

The Chair **ASKED** members if they had any updates of conflicts of interest to declare. PRG members did not have any updates.

1.3 Confirmation of the Previous Meeting's Minutes

The PRG **ENDORSED** the minutes of the previous meeting: *PRG Minutes of Meeting 3 March 2022.*

The Chair **NOTED** that one action item remains open, which is to undertake analysis of activity in the non-registered providers for the National Disability Insurance Scheme (NDIS). This work is ongoing within the National Disability Insurance Agency (NDIA). The remaining action items are closed.

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2.1 Update by the Chair

The Chair **INFORMED** the PRG:

- that Minister Reynolds had recently announced the appointment of Dr Denis s47F - personal privacy AO as Chair of the NDIA Board
- about the approach NDIA would take to seek the NDIA Board's agreement of Annual Pricing Review (APR) recommendations. PRG members offered their assistance in briefing the NDIA Board.

3.1 Core Supports – Disability Support Worker (DSW) Cost Model

The Acting Branch Manager of Pricing referred to the paper circulated on the DSW Cost model and spoke to the findings and recommendations.

The PRG **DISCUSSED** the DSW Cost Model paper including:

- suggestions for additional detail to justify the proposed cost model, and clarification about the timing and implications of the Fair Work Commission announcements
- pricing arrangements for GST-registered and non-registered providers and how other schemes approach this, and likely implications for for-profit and not-for-profit providers.

The Chair/PRG **NOTED** that there would be further clarification on the proposed price limit changes.

3.2 High Intensity Supports

The Chief Economist referred to the paper circulated on High Intensity Supports and spoke to the findings and recommendations.

The PRG **DISCUSSED** the High Intensity Supports paper including:

- the benefits of consistency in definitions and likely implications for support workers and participants
- the need to monitor the market in light of any changes in response to the proposed arrangement.

3.3 Group-based Core Supports

- The Acting Branch Manager of Pricing referred to the paper circulated on Group-based Core Supports and spoke to the findings and recommendations.

The PRG **DISCUSSED** the Group-based Core Supports paper, including:

- the main contributing factors to the low number of providers that have transitioned to the new pricing arrangements
- how the NDIA could simplify the transition process, including interactions between this and other recommendations for billing
- the importance of maintaining participant-centric principles
- the NDIA's proposed intensive provider communications/education piece, and how the NDIA could demonstrate best practice from the different models already introduced as part of provider education.

3.4 Therapy Supports

The Chief Economist referred to the paper circulated on Therapy Supports and spoke to the findings and recommendations.

The PRG **DISCUSSED** the Therapy Supports paper, including:

- how NDIA's pricing arrangements aligned with those of other public schemes

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- the extent to which NDIS therapy support providers required additional or specialised skills compared to therapists more broadly, and where NDIS therapy providers may need additional hours
- the extent to which arrangements in this sector are specific to people with disabilities, and where there are opportunities to explore more mainstream arrangements
- the implications of consistency between pricing arrangements for therapy supports and for nursing supports.

3.5 Nursing Supports

The Acting Branch Manager of Pricing referred to the paper circulated on Nursing Supports and spoke to the findings and recommendations.

The PRG **DISCUSSED** the paper on Nursing Supports, including:

- the need to recognise the different qualification levels and types of nurses, and the implications for benchmarking, analysis, and the interaction with pricing arrangements for Allied Health.

3.6 Support Coordination Supports

The Chief Economist referred to the paper circulated on Support Coordination Supports and spoke to the findings and recommendations.

The PRG **DISCUSSED** the paper on Support Coordination Supports, including:

- the implications of greater clarity on the roles and responsibilities of Support Coordinators and Plan Managers.

3.7 Plan Management Supports

The Acting Branch Manager of Pricing referred to the paper circulated on Plan Management and spoke to the findings and recommendations.

The PRG **DISCUSSED** the paper on Plan Management Supports, including:

- the implications of greater clarity on the roles and responsibilities of Support Coordinators and Plan Managers
- the need to identify and address any conflicts of interest by plan managers.

Final Comments

The Chair thanked everyone who attended the meeting and acknowledged its short duration due to scheduling constraints and to ensure PRG's views were gathered prior to going to the Board. The Chair welcomed further comments or feedback from members via the Secretariat by close of business Tuesday 29 March 2022.

Next Meeting:

Thursday 21 April 2022, 10.00am to 1.00pm.

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DOCUMENT 53

Delivered by the National Disability Insurance Agency

Pricing Reference Group

Meeting Agenda

Date: Thursday 21 April 2022 **Time: 10:00am – 1:00pm**
Meeting: Videoconference using Microsoft Teams (Refer meeting invitation for details)

Members		
Chair		
Gerrie [s47F - personal]	General Manager, Provider and Markets Division	By Teams
Pricing Reference Group Members		
Deborah [s47F - persona]	Independent Member	By Teams
Julie [s47F - personal privacy, s22(1] PSM	Independent Member	By Teams
Lynne [s47F - personal privacy,]	Independent Member	By Teams
Jim [s47F - pers] PSM	Independent Member	By Teams
Graeme [s47F - personal] AM	Independent Member	By Teams
Participating Observer nominated by CEO		
Lisa [s47F - personal privacy, s]	DCEO, Markets, Government and Engagement Group	By Teams
David Gifford	A/g Deputy Scheme Actuary	By Teams
Tanuja [s47F - persona]	A/g Branch Manager, Pricing	By Teams
David Cullen	Chief Economist	By Teams
Stephen [s47F - personal privacy, s22(1]	Branch Manager, Provider Engagement	By Teams
Participating Observer nominated by Department of Social Services		
Luke [s47F - personal privacy, s22]	GM, Strategic Policy, Markets and Safeguards	By Teams
Secretariat		
Dominic [s47F - personal p]	A/g Assistant Director, Annual Price Review Team	By Teams
Jodie [s47F - personal priva]	Snr Engagement Officer, Provider Engagement Branch	By Teams
Scott [s47F - personal privacy]	Director, Annual Price Review Team	By Teams

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DISCLOSURE LOG

Time	Item	Topic	Presenter/s	Matter for	Format
		Formalities			
10.00am	1.1	Welcome and apologies	Chair	Noting	Verbal
	1.2	Declaration of conflicts of interest	Chair	Noting	Verbal
	1.3	Minutes / Actions Arising	Chair	Decision	Paper
	1.4	Update by the Chair	Chair	Noting	Verbal
		Discussion of reports			
10.10am	2.1	Summary of consultation of Annual Pricing Review (APR)	David Cullen	Discussion	Paper
10.40am	3.1	Financial Benchmarking Survey	Tanuja Doss	Noting	Paper
11.00am	4.1	Review Report of APR	David Cullen	Discussion	Paper
1.00pm		**Close**	Chair		

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DISCLOSURE LOG

Pricing Reference Group (PRG)

Meeting: 29 March 2022

Minutes

Date: Tuesday, 29 March 2022

Time: 11.00am – 12.00pm

Location: Microsoft Teams

Members

Chair		
Gerrie [s47F - persona]	General Manager, Provider and Markets Division	By Teams
Pricing Reference Group Members		
Deborah [s47F - person]	Independent Member	By Teams
Julie [s47F - personal privacy, s2] PSM	Independent Member	By Teams
Lynne [s47F - personal priva]	Independent Member	By Teams
Jim [s47F - pe] PSM	Independent Member	By Teams
Graeme [s47F - person]	Independent Member	By Teams
Participating Observer nominated by CEO		
Lisa [s47F - personal privacy]	DCEO, Markets, Government and Engagement Group	By Teams
David Gifford	A/g Deputy Scheme Actuary	By Teams
Tanuja [s47F - perso]	A/g Branch Manager, Pricing	By Teams
David Cullen	Chief Economist	By Teams
Stephen [s47F - personal privacy, s2]	Branch Manager, Provider Engagement	By Teams
Secretariat		
Vincent [s47F - personal pr]	A/g Director, Pricing Operations	By Teams
Jodie [s47F - personal pr]	Snr Engagement Officer, Provider Engagement Branch	By Teams
Scott [s47F - personal priva]	Director, Annual Price Review Team	By Teams
Dominic [s47F - persona]	A/g Assistant Director, Annual Price Review Team	By Teams

1.2 Declaration of Conflicts of Interest

The Chair **ASKED** members if they had any updates of conflicts of interest to declare. PRG members did not have any updates.

1.3 Confirmation of the Previous Meeting's Minutes

The PRG **ENDORSED** the minutes of the previous meeting: *PRG Minutes of Meeting 3 March 2022.*

The Chair **NOTED** that one action item remains open, which is to undertake analysis of activity in the non-registered providers for the National Disability Insurance Scheme (NDIS). This work is ongoing within the National Disability Insurance Agency (NDIA). The remaining action items are closed.

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DISCLOSURE LOG

2.1 Update by the Chair

The Chair **INFORMED** the PRG:

- that Minister Reynolds had recently announced the appointment of Dr Denis Napthine AO as Chair of the NDIA Board
- about the approach NDIA would take to seek the NDIA Board's agreement of Annual Pricing Review (APR) recommendations. PRG members offered their assistance in briefing the NDIA Board.

3.1 Core Supports – Disability Support Worker (DSW) Cost Model

The Acting Branch Manager of Pricing referred to the paper circulated on the DSW Cost model and spoke to the findings and recommendations.

The PRG **DISCUSSED** the DSW Cost Model paper including:

- suggestions for additional detail to justify the proposed cost model, and clarification about the timing and implications of the Fair Work Commission announcements
- pricing arrangements for GST-registered and non-registered providers and how other schemes approach this, and likely implications for for-profit and not-for-profit providers.

The Chair/PRG **NOTED** that there would be further clarification on the proposed price limit changes.

3.2 High Intensity Supports

The Chief Economist referred to the paper circulated on High Intensity Supports and spoke to the findings and recommendations.

The PRG **DISCUSSED** the High Intensity Supports paper including:

- the benefits of consistency in definitions and likely implications for support workers and participants
- the need to monitor the market in light of any changes in response to the proposed arrangement.

3.3 Group-based Core Supports

- The Acting Branch Manager of Pricing referred to the paper circulated on Group-based Core Supports and spoke to the findings and recommendations.

The PRG **DISCUSSED** the Group-based Core Supports paper, including:

- the main contributing factors to the low number of providers that have transitioned to the new pricing arrangements
- how the NDIA could simplify the transition process, including interactions between this and other recommendations for billing
- the importance of maintaining participant-centric principles
- the NDIA's proposed intensive provider communications/education piece, and how the NDIA could demonstrate best practice from the different models already introduced as part of provider education.

3.4 Therapy Supports

The Chief Economist referred to the paper circulated on Therapy Supports and spoke to the findings and recommendations.

The PRG **DISCUSSED** the Therapy Supports paper, including:

- how NDIA's pricing arrangements aligned with those of other public schemes

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- the extent to which NDIS therapy support providers required additional or specialised skills compared to therapists more broadly, and where NDIS therapy providers may need additional hours
- the extent to which arrangements in this sector are specific to people with disabilities, and where there are opportunities to explore more mainstream arrangements
- the implications of consistency between pricing arrangements for therapy supports and for nursing supports.

3.5 Nursing Supports

The Acting Branch Manager of Pricing referred to the paper circulated on Nursing Supports and spoke to the findings and recommendations.

The PRG **DISCUSSED** the paper on Nursing Supports, including:

- the need to recognise the different qualification levels and types of nurses, and the implications for benchmarking, analysis, and the interaction with pricing arrangements for Allied Health.

3.6 Support Coordination Supports

The Chief Economist referred to the paper circulated on Support Coordination Supports and spoke to the findings and recommendations.

The PRG **DISCUSSED** the paper on Support Coordination Supports, including:

- the implications of greater clarity on the roles and responsibilities of Support Coordinators and Plan Managers.

3.7 Plan Management Supports

The Acting Branch Manager of Pricing referred to the paper circulated on Plan Management and spoke to the findings and recommendations.

The PRG **DISCUSSED** the paper on Plan Management Supports, including:

- the implications of greater clarity on the roles and responsibilities of Support Coordinators and Plan Managers
- the need to identify and address any conflicts of interest by plan managers.

Final Comments

The Chair thanked everyone who attended the meeting and acknowledged its short duration due to scheduling constraints and to ensure PRG's views were gathered prior to going to the Board. The Chair welcomed further comments or feedback from members via the Secretariat by close of business Tuesday 29 March 2022.

Next Meeting:

Thursday 21 April 2022, 10.00am to 1.00pm.

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The contents of this document are OFFICIAL.

National Disability Insurance Scheme

Annual Pricing Review 2021-22

DRAFT Report on Consultations

April 2022

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Table of Contents

1 Introduction 5
1.1 Terms of Reference of the Review 5
1.2 Consultation Paper 7
1.3 Working Groups 7
2 Core Pricing Arrangements 9
2.1 Pricing Strategy 9
2.2 Key Parameters of the Cost Model 11
2.3 Fair Work Commission's 4 yearly review of the SCHADS Award 2010 24
2.4 Claiming Rules 27
2.5 Planning and other Issues 32
3 Group Based Core Supports 35
3.1 Value of Group Based Programs 35
3.2 Pros and Cons of the New and Transitional Pricing Arrangements 35
3.3 Costs of delivering group-based supports 40
3.4 Programs of Support 41
3.5 Capital and other costs 43
3.6 Options for change 44
4 Temporary Transformation Payment 48
4.1 Support for the TTP 48
4.2 Barriers to accessing and claiming the TTP 50
4.3 Future of the TTP 53
5 Quality and Safeguarding Costs 57
5.1 Provider registration and ongoing compliance audits 57
5.2 Practice standards 59
5.3 Incident and restrictive practice reporting 61
5.4 Training and Professional Development 65
5.5 Supervision 68
5.6 Other issues 70
6 Therapy Supports 72
6.1 Pricing Arrangements 72

DRAFT

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

6.2 Compliance and administration 76
6.3 Comparisons to other schemes 78
6.4 Planning Issues 79
6.5 Major Therapy Provider Submission 81

7 Nursing Supports 84
7.1 Price limits 84
7.2 Pricing Arrangements 86
7.3 Provider Travel 86
7.4 Planning Issues 87

8 Plan Management Supports 89
8.1 Disability Intermediaries Australia Submission and Survey 89
8.2 Role and Value of Plan Managers 92
8.3 Pricing Arrangements 92
8.4 Indexation 100
8.5 Other Issues 101

9 Support Coordination 105
9.1 Disability Intermediaries Australia Submission and Survey 105
9.2 Role and Value of Support Coordinators 109
9.3 Pricing Arrangements 111
9.4 Other Issues 115

10 Location Specific Issues 118
10.1 Workforce Attraction, Training and Retention 118
10.2 Operating costs 121
10.3 Other Issues 126

Appendix A – List of Submissions 129

Appendix B – Working Group Members 134

DRAFT

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1 Introduction

This document summarises the evidence that was provided to the Agency 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 Agency. We have produced this report to provide a summary of the feedback we have received during the extensive consultations that were undertaken as part of the 2021-22 Annual Pricing Review. We have done this so you are able to see what people have told us during consultation.

The Agency's response to the issues raised in the consultations will be 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 Agency to examine, through engagement with participants, providers and community and government stakeholders and targeted research, whether the Scheme's existing price control framework (pricing arrangements and price limits) continues to be appropriate or should be modified.

In particular, the Agency 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.

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

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- 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
  - 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 Agency 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] NDIA. (2019). *NDIS Western Australia Market Review*. Download here.

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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.

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 agency 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 Agency 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 Agency to examine the design and key parameters use by the NDIS Disability Support Worker Cost Model to set price limits in the Scheme; 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 Agency 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 Agency 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 Agency 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 Agency to examine the extent of competition in the market for therapy supports and options to improve the effectiveness and efficiency of those supports.

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- Working Group 6 (Nursing Supports) was established to assist the Agency 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 Agency 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 Agency 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 Agency 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 Agency 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 Agency 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 Agency 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 Agency is grateful to all the individuals and organisations who brought their considerable experience and expertise to the Working Groups.

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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 Scheme'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;
- Claiming Rules; and
- Other Issues.

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.

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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 Agency:

> *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 Scheme 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,

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1 Avivo, Submission S112, p. 3.

2 Empowered Futures, Submission S065, p. 2.

3 genU, Submission S219, p. 5.

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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 Scheme'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 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).*[3]

---

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

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

3 Tulgeen, Submission S029, p. 3.

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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.*[1]

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 scheme, 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 workforce providing SIL support is represented by shift workers, who represent 60% of Crosslinks workforce.[2]

---

1 Ability Options, Submission S218, p. 29.

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

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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%.[1]

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.*[2]

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.*[3]

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.*[4]

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.*[5]

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.*[6]

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

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

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

3 Beacon Support, Submission S022, p. 4.

4 Kyeema, Submission S226 (email).

5 Rocky Bay, Submission S141, p. 7.

6 Mercy Connect, Submission S106, p. 6.

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...

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, have become increasingly frustrated and at times "acted out". 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.

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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 subsided by lower rates from other parts of their business (e.g. office workers).

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. The considered that this would allow providers flexibility in either paying higher workers compensation rates,

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

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

3 Tulgeen, Submission S029, p. 2.

DRAFT

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or investing in better risk management practices and having lower workers compensation 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 Coat 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:

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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.

DRAFT

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> *… 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]

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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.

DRAFT

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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 onboarding 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 Agency 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.

DRAFT

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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:

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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.

DRAFT

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> *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.

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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.

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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 Agency:

> *… 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

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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.

DRAFT

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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 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.

DRAFT

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> *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.' 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 Model*[4]

The submission from Hireup also stated that any move to include an allowance for payrioll 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 NDIS DSW Cost Model, providers who employ their support workers would be able to

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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.

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cover the full cost of hiring workers and will also be able to 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.

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A number of submission 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.

DRAFT

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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 rule sin the NDIS for short notice cancellations should be amended to align with the new award conditions.

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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.

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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.

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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 possinle, 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.

DRAFT

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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

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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).

DRAFT

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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 Agency 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:

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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.

DRAFT

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> *… 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]

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1 Ibid.

2 Beacon Support, Submission S022, p. 9

3 Hireup, Submission S107, p. 15.

4 Wellways Australia, Submission S222, p. 8.

DRAFT

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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 t 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 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

1 Lizard Centre, Submission S056, p. 2.

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

3 Kurrajong, Submission S094, p. 30.

DRAFT

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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 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.*[2]

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.*[3]

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.*[4]

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.[5]

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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).

2 HelpingMinds, Submission S085, p. 4

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

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

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

DRAFT

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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.

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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.

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 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

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

DRAFT

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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]
- Lack of choice and control if certain group programs are no longer viable under new pricing arrangements.[5]

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

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).

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

DRAFT

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- 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.*[1]

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 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:

[1] Rocky Bay, Submission S141, p. 11.

DRAFT

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> *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 Agency 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.
- 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.

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)).

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- 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 hours … .*[2]

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]

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).

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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.

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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).
- 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.[2]

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

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

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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 a 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.[1]

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.[2]

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.[3]

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.*[4]

A number of providers also reported that Programs of Support were administratively costly to implement, and that the Agency has provided insufficient information regarding how Programs of Support can be implemented and operate practically.[5] 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*

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1 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).

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

3 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).

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

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

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> *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.*[1]

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.*[2]

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.*[3]

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 particpants:

> *… 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.*[4]

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

> *… cater for individuals who wish to secure an annual program of supports at a fixed rate and reduce administrative overheads on all parties.*[5]

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.[6] Additionally, some submissions suggested

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1 Kurrajong, Submission S094, p. 30.

2 Tulgeen, Submission S029, p. 5.

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

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

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

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

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further clarity and guidance was required relating to the claiming rules associated with Programs of Support.[1]

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.*[2]

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 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.

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

2 Beacon Supports, Submission S022, p. 8

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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]

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.*[7]

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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.

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

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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.[1] 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.*[2]

Submissions were concerned that further development costs might be required if the Agency was to again significantly alter the group-based pricing arrangements. They also reported that providers had been provided insufficient support and notice to transition.[3]

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.*[4]

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.*[5]

Additionally, submissions suggested that the information that is provided by the Agency 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 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.*[6]

The submission from genU similarly reported:

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

2 Vision Australia, Submission S109, p. 6.

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

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

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

6 Bedford, Submission S145, p. 9.

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> *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."*[1]

The submission from Novita suggested that to provide certainty for participants, providers and future investment, the Agency 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.*[2]

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 Agency 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 Scheme, 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.

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1 genU, Submission S219, p. 15.

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

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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 Agency covering what non-face-to-face supports can be charged for would be beneficial.

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4 Temporary Transformation Payment

Some 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.

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 core operating systems is necessary and ongoing to ensure the long-term viability of their business, particularly to address constant changes by the Agency to rules and processes.[4]

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

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

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

4 Beacon Support, Submission S022, p. 11.

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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.*[1]

The submission from Avivo also indicated that they believed transformation costs were on-going, 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.*[2]

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.*[3]

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.*[4]

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 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.[5]

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

2 Avivo, Submission S112, pp. 16-17.

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

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

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

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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.[1]

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.*[2]

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.*[3]

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".*[4]

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.*[5]

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.[6]

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:

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1 genU, Submission S219, p. 17.

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

3 Mind Australia, Submission S105, p. 12.

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

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

6 Jobs Are Us, Submission S129 (email).

DRAFT

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> *… 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.*

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:

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.

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> *… 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 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

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.

DRAFT

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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 scheme.*[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:

> *… 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.*[5]

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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.

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

DRAFT

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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.* [1]

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.*[2]

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.*[3]

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.*[4]

The submission from Action on Disability within Ethnic Communities also recommended that that TTP should continue for providers who meet the criteria post 2024.[5]

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:

> *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.*[6]

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

1 Vision Australia, Submission S109, p. 7.

2 Tulgeen, Submission S029, p. 7.

3 Jobs Are Us, Submission S129 (email).

4 Tulgeen, Submission S029, p. 7.

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

6 Merri Health, Submission S061, p. 4.

DRAFT

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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 Scheme 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 Agency 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 Agency and the Commission, as well as other regulators, were making that were increasing the administration requirements of working within the Scheme.

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 (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

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organisations to implement the ongoing changes to the Agency's rules and ways of operating. The working group considered that the TTP arrangements were one of the few initiatives under the Scheme 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 Scheme. 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 Scheme, 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 Scheme 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 Agency to reward/incentivise investments in desired areas by modifying the eligibility criteria for the TTP.

The working group considered that, while the Agency 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 Agency 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.

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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;
- Supervision; and
- Other issues.

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]

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

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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.

DRAFT

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> *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]

Providers also made a number of suggestions as to how the current quality and safeguarding arrangements could be improved to reduce unnecessary compliance activity

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1 Ability First, 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.

DRAFT

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whilst still ensuring that services were safe and of the highest quality. In particular, Ability First 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".

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 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*

[1] Ability First, Submission S229, p. 28.

DRAFT

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> *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 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 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.*[4]

A number of other providers also suggested that the new practice standards have increased their operating costs to meet quality and safeguarding requirements.5 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.*[6]

Another provider made a confidential submission along the same lines:

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1 Ability First, Submission S229, p. 14.

2 Avivo, Submission S112, p. 13.

3 genU, Submission S219, p. 11.

4 Ability First, Submission S229, p. 16.

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

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

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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*
- *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 onboard, train and supervise our staff (as this has been largely employer discretion) to now regulated requirements for some training and

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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 in November 2020 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 December 2019 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).*

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).*

1 Cerebral Palsy Alliance, Submission S248 (email).

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

DRAFT

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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.

In July 2021, 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 in August 2021. However, this provider then withdrew the service and the search continued until an appropriate provider was engaged in early October 2021. 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 in November 2021. (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 in February 2022. 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

[1] Sylvanvale, Supplementary Submission S250a (email).

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> *and monthly reporting requirements which change by the day and month, therefore are difficult to quantify.*[1]

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.*[2]

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.*[3]

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 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.*[4]

Several submissions suggested that the Commission's incident and restrictive practice requirements should be acknowledged and allowed for within the DSW Cost Model.[5]

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.[6]

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

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

2 HelpingMinds, Submission S085, p. 2.

3 Rocky Bay, Submission S141, p. 3.

4 Cara Inc., Submission S249 (email).

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

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

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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 here 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.

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:

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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.

DRAFT

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> *… needs to be prioritised through a combined commitment between the NDIA, the Quality and Safeguards Commission, disability service providers and employees...*[1]

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.[2]

Qualified practitioners also require substantial training to meet the quality and safeguarding requirements of the Scheme. 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.*[3]

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.*[4]

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, supervision).[5]

The submission from Ability First 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'.* [6]

	Standard	High Intensity
Shift Handover	2.2%	2.7%

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

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

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

4 Vision Australia, Submission S109, p. 8.

5 Rocky Bay, Submission S141, p. 3.

6 Ability First, Submission S229, pp. 12-13.

DRAFT

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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]*[1]

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.[2]

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.*[3]

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.*[4]

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 Agency 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.[5]

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1 Carers ACT, Submission S147, p. 1.

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

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

4 Sylvanvale, Submission S092, p. 3.

5 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).

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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.*[1]

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 sector workforce is sufficiently qualified to deliver services in accordance with the NDIS Codes of Practice and Practice Standards.[2] 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.[3]

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.*[4]

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.[5]

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.[6]

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.[7]

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:

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

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

3 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.

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

5 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).

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

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

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> *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.*[1]

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.*[2]

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.*[3]

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.[4]

For example, Greenacres Disability Services suggested that supervisors should be calculated at Level 4.3 of SCHADS Award.[5]

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.[6]

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.[7]

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

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

3 Kyeema, Submission S226 (email).

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

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

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

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

DRAFT

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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.[1] The submission from Allied Health Professions Australia (AHPA) indicated that this was particularly true for sole practitioners. AHPA suggested that the Agency 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.[2]

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.*[3]

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.[4]

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 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.*[5]

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.

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1 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).

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

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

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

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

DRAFT

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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 Agency'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 Agency 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.

DRAFT

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6 Therapy Supports

The Review received a total of 122 submissions that spoke to pricing arrangements for Therapy Supports. Details of the submissions are at Appendix A. A working group of providers and other stakeholders was also established, comprising 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.

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]

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

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

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

DRAFT

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> *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 cochlear implant therapists 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. The price limits were considered to be particularly low for clinical psychologists, neuropsychologists and forensic psychologists. It was also argued that exercise physiologists should not have a lower price limit than other therapists, as their services were equally valuable and required an equivalent level of training 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 will lose skilled allied health practitioners to the public health system who can provide higher salaries and working conditions.[5]

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

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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.

5 IoT, Submission S125, p. 7

DRAFT

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than that of exercise physiologists ($166.99). The submission stated that at these rates, personal trainers find it unviable to offer services through the scheme, discouraging providers from participating.[1]

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 Scheme.

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%.

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 provider 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.*[2]

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:

- 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.[3]
- 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.[4]

The Australian Podiatry Association argued that:

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1 Extra Mile PT, Submission S155 (email).

2 Living My Way, Submission S120, p. 11

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

4 Lime Therapy, Submission S157 (email).

DRAFT

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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.[1]

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.[2]

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.[3]

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, 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.[4]

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.

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

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

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

4 Australian Physiotherapy Association, Submission S098, p. 8

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The submission from Allied Health Professionals Association called on the Agency 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.[1]

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 Scheme 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.*[2]

The submission from NeuroRehab Allied Health Networkalso 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.[3]

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 complete mandatory training modules, all of which give rise to costs that are also not factored into the current pricing structure.[4]

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.[5]

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

2 Lime Therapy, Submission S157 (email).

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

4 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).

5 Australian Association of Psychologists Inc., Submission S213, p. 6

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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.*[1]

To address these issues, the submission from Allied Health Professionals Australia called on the Agency 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.[2]

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%.[3]

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.*[4]

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.[5]

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.[6]

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

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

3 Merri Health, Submission S061, p. 5

4 Vision Australia, Submission S109, p. 8

5 First Voice, Submission S088, p. 4

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

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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).*[1]

The submission from Kurrajong also suggested that continual changes by the NDIA to the scheme, along with confusing pricing arrangements and ambiguous guidelines, have increased administration workload.[2]

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 can charge rates above the specified price in the schedule and recover the 'gap'.

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

[1] Lime Therapy, Submission S157 (email).

[2] Kurrajong, Submission S094, p. 44

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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;

In the context of physiotherapy and comparing NDIS price limits to other schemes, the Australian Physiotherapy Association submission noted several reasons why these comparisons are inappropriate. They suggested that physiotherapists utilise less experienced staff in schemes with lower fees. 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.[2]

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 preparation, as well as assistance with advocacy.[4] 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.[5]

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.

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

4 See: Australian Association of Psychologists Inc. (S213), Can:Do Group (S091), Dieticians' Australia (S239), and Roslyn Thorpe Occupational Therapist (S212).

5 Australian Community Support Organisation, Submission S062, p. 7

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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.

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 Sydnrome 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*

1 First Voice, Submission S088, p. 3

2 Australian Music Therapy Association, Submission S211, p. 4

3 Down Syndrome Australia, Submission S128, p. 5

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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.[1]

6.5 Major Therapy Provider Submission

A major joint submission on the pricing arrangements for therapy supports was received from Ability First, 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.[2]

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).

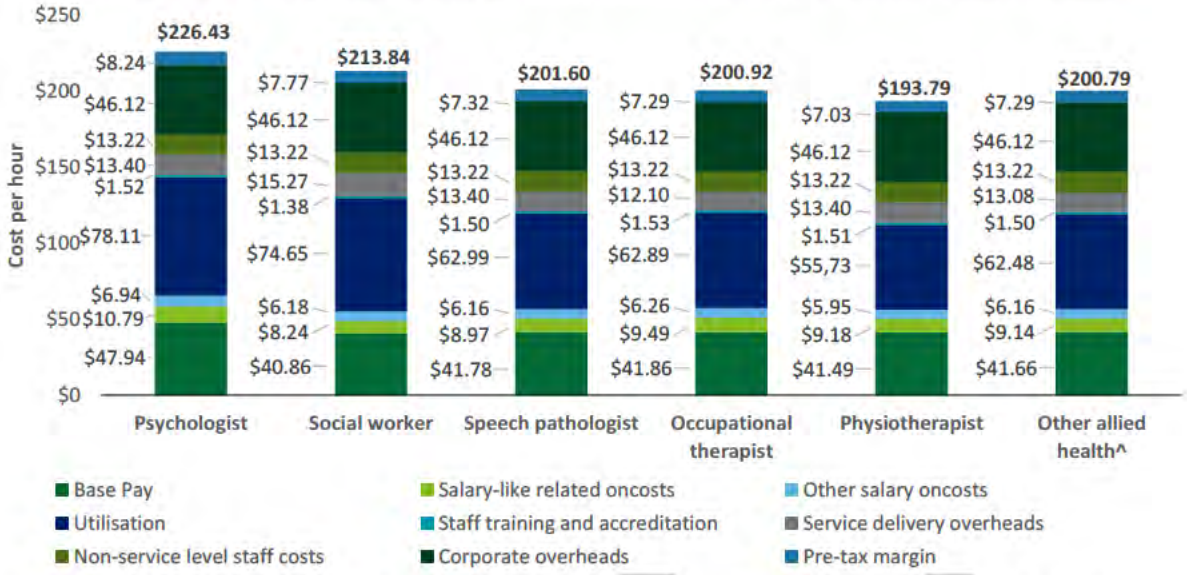
1 Vision 2020, Submission S234, p. 9

2 Major Therapy Providers, Joint Submission S241.

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EXHIBIT 3: DELOITTE ACCESS ECONOMICS ESTIMATE COST PER HOUR OF ALLIED HEALTH SERVICES UNDER THE NDIS



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 Agency:

- Don't reduce the current price cap. Based on the findings in the Deloitte report, and noting that the Agency 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 (eg capital metros).
- Reconsider the Agency's approach to benchmarking price with other jurisdictions, including which jurisdictions it considers appropriate to benchmark with. Further, it recommends that the Agency undertake research into the underlying cost structures of

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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 Agency 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.

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7 Nursing Supports

A total of seven (7) submissions were received about the pricing arrangements for nursing supports in response to the Consultation Paper (see 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 (see Appendix B).

The key topics raised in the consultations were:

- Price limits;
- Pricing Arrangements;
- Provider Travel; and
- Planning Issues.

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 Scheme'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

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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 Oncosts (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 and utilities, Computer Hardware, Software and Clinical Software	$192.23
Total cost for a four hour Continence Assessment	**$770.71**
Total cost per hour	**$192.68**

1 Continence Foundation of Australia, Submission S100, p. 5.

2 Continence Foundation of Australia, Supplementary Submission S100a, p.1.

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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 Scheme'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.

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.

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 Scheme's pricing arrangements.[4] The Continence Foundation of Australia stated that:

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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).

4 At Home Care Pty Ltd, Submission S054. p. 5.

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> *… 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.*[1]

The Continence 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.[2]

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.*[3]

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.
- 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.

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1 Continence Foundation of Australia, Submission S100, p. 6

2 Continence Foundation of Australia, Submission S100, p. 6

3 At Home Care Pty Ltd, Submission S054, p. 5.

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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 Agency 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]

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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.

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8 Plan Management Supports

A total of 69 submissions 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;
- Indexation; and
- Other Issues.

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 deidentified version of the data set to the Agency. 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.

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The DIA submission argued that registered Plan Managers represented value for money for participants and the Scheme.

> *In 2020-21 RPMPs managed approximately $12.43bn of committed Scheme funds.*
>
> *For the same period RPMPs billed the Scheme $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:

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1 Disabilities Intermediaries Australia, Submission S161, p. 42

2 Ibid, pp. 19-20.

3 Ibid, pp. 27-29.

4 Ibid, pp. 20-21.

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> *… 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 Agency 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.

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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 the 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. Members of the working group also argued that Plan Managers play a key role in Scheme integrity by working with the Agency 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 of the working group defined the role of the Plan Manager 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 Agency. 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.

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 Agency should commission a market review of Plan Management fees.[3]

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*

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.

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> *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 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 defacto 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 Agency 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 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.[6]

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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.

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

DRAFT

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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.*[1]

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.[2]

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 Agency were to benefit from the streamlining and efficiency gains that were available from technology.[3]

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.*[4]

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.*[5]

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 Scheme.

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1 Action on Disability within Ethnic Communities, Submission S055, p. 12.

2 See: Action on Disability within Ethnic Communities (S055) and Living My Way (S120).

3 Disability Intermediaries Australia, Submission S161, p. 28.

4 Action on Disability within Ethnic Communities, Submission S055, p. 11.

5 Connect Plan Management, Submission S127, p. 2.

DRAFT

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One member of the working group stated that there were a lot of participants within the Scheme 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 Agency 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 Agency and communicate the issues to the Agency 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 Agency 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 Scheme] 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 Agency's expectations with respect to checking invoice evidence and preventing fraud. They called for a clear statement to be issued by the Agency 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 Agency 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

DRAFT

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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 Agency's back-end portal. Members stressed that the lack of correlation between the information that a Plan Manager has access to and that the Agency'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 Agency'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 Agency, 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 Agency.
- **Manual Claims:** Members stated the difficulties with processing manual claims with the Agency'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 Agency 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 Agency.
- **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 Agency 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

DRAFT

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> Agency. 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 Scheme 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 Agency 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 submissions proposed that monthly fee should be restructured to more accurately reflect the level of work undertaken for large and complex plans.[4]

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*

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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.

4 See: Action on Disability within Ethnic Communities (S055), Disabilities Intermediaries Australia (S161), First2Care (S093), Living My Way (S120), Merri Health (S061), and Tulgeen (S029).

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> *capacity building, daily, social and employment – with multiple weekly payments to a variety of providers.*[1]

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.[2] 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.*[3]

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.[4]

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.[5] 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 inadequate as plan management supports go over and beyond the standard processing of payment claims and issuing regular financial reports to participants.*[6]

A number of submissions proposed that the Agency should consider replacing the existing flat monthly fee price limit with a price limit that was either proportionate to the total value of a participants plan to reflect the additional workload from processing a larger number of

1 Avivo, Submission S112, p. 18.

2 See: The Disability Trust (S159), and Action on Disability within Ethnic Communities (S055).

3 Action on Disability within Ethnic Communities, Submission S055, p. 11.

4 Dennluc8 Pty Ltd, Submission S008.

5 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.

6 Living Right, Submission S221.

DRAFT

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MR25/01967 FOI 24/25-2242

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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.[1]

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.[2] 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.[3]

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.[4]

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.[5] 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.[6] This was supported by some members of the Working Group as it would allow Plan Managers that take on a new client mid-plan to recoup some of the plan management establishment costs.

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1 See: Action on Disability within Ethnic Communities (S055), Avivo (S112), Disabilities Intermediaries Australia (S161), and First2Care (S093).

2 See: Connect Plan Management (S127), Disabilities Intermediaries Australia (S161), and Spinal Cord Injuries of Australia (S235).

3 Disabilities Intermediaries Australia, Submission S161, p. 41.

4 Connect Plan Management, Submission S127, p. 2.

5 Spinal Cord Injuries of Australia, Submission S235, p. 3.

6 Disabilities Intermediaries Australia, Submission S161, p. 42 and p.100.

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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 Agency 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 Scheme 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]

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

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.

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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 Agency 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 Agency implementing the new Claims at Point of Support (CPOS) system. However, they also raised concerns about the potential impact of the CPOS system and how it will affect the costs and role of Plan Managers and participants.[2]

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1 Avivo, Submission S112, p. 19.

2 See: Avivo (S112), Connect Plan Management (S127), First2Care (S093), and Support Care Management Services (S005).

DRAFT

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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.*[1]

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.[2]

The submission from Connect Plan Management was concerned that CPOS has the potential to escalate technology costs for Plan Managers.[3]

The submission from Avivo proposed that the Agency should offer CPOS as an option for participants, rather than a replacement for plan management. They urged the Agency 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. [4]

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 Agency 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 Agency, particularly for smaller organisations who do not have the ability to invest. They stated the importance of addressing this challenge when the Agency rolls out CPOS and the need to acknowledge organisations may be operating on different technology platforms.

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1 First2Care, Submission S093, p. 3.

2 Avivo, Submission S112, p. 4 and p. 20.

3 Connect Plan Management, Submission S127, p. 2.

4 Avivo, Submission S112, p. 20.

DRAFT

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Another Member raised the inherent costs incurred by providers whenever the Agency 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 in the Southwest), and during this wait time, they feel that they cannot source another provider as they have already signed a service agreement.*[3]

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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).

3 CPS Choice Plan Services, Submission S013 (email).

DRAFT

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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 Agency or the Commission had not led to satisfactory outcomes. They said that when they have reported Plan Managers to the Agency, they have been told that the Agency 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 Agency 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 Scheme.

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9 Support Coordination

The Review received a total of 88 submissions that spoke to 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.

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 89.

The DIA submission argued that:

> *i. Intermediary Service Providers deliver extremely cost-effective services providing exceptional value for money to the NDIS Participants and the Scheme;*
>
> *ii. 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;*
>
> *iii. 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*
>
> *iv. 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]

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

[1] Disabilities Intermediaries Australia, Submission S161, p. 10

DRAFT

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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 his 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%;[5]
- three-fifths of Level 2 coordinators reported utilisation between 71% and 75%;[6] and
- just over one half of Level 3 coordinators reported utilisation between 71% and 75%.[7]

With respect to overheads, the DIA survey found average reported overheads (as a share of direct costs) of 27% (with a median of 26%).[8]

1 Ibid, p. 47-8.
2 Ibid, pp. 58-59.
3 Ibid, pp. 49-50.
4 Ibid, p. 55.
5 Ibid, p. 59.
6 Ibid, p. 60.
7 Ibid, p. 61.
8 Ibid, p. 57.

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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

	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

	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

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	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

	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**	

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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.

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 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

1 See: Action on Disability Within Ethnic Communities (S055) and genU (S219).

2 Action on Disability Within Ethnic Communities, Submission S055, p. 10.

DRAFT

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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 Agency 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 Scheme 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:

> *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*

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.

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> *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]

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

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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.

DRAFT

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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:

> *…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*

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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.

DRAFT

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> *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 Scheme, 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 [sic] 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 contact by the participant to the Support Coordinator reporting assault and theft by his house mate*

[1] Living My Way, Submission S120, p. 10.

[2] Australian Community Industry Alliance, Submission Sx025, p. 7.

DRAFT

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- *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]

Submissions outlined the challenges with attracting and retaining staff as a result of the inability to compete with salary packages of other sectors.[5]

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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).

5 See: Council of Regional Disability Services (S072), Mercy Connect (S106), Mind Australia Limited (S105) and Rocky Bay (S141).

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MR25/01967 FOI 24/25-2242

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> *…the current price limit does not allow providers to be competitive to attract and recruit staff who are able to effectively undertake this role.*[1]

Another provider noted they often need to pay a higher salary (SCHADS L4-I6) to attract the necessary higher-qualified staff members 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.*[2]

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 Scheme by creating confusion amongst participants and skewing the market away from registered and qualified staff.[3]

One submission stated that unregistered providers are the catalyst for staff shortages and *"skewing the market towards unregulated and inexperienced Support Coordinators."*[4] 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].*[5]

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:

> *[T]here is far from adequate time allocations in order to facilitate the actual needs of this area of the support coordination process.*[6]

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

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1 Rocky Bay, Submission S141, p. 15.

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

3 See: Australian Community Support Organisation (S082), genU (S219), Merriwa (S223), and National Disability Services (S152).

4 genU, Submission S219, p. 18.

5 Merriwa, Submission S223 (email).

6 Australian Community Industry Alliance, Submission S025, p. 7.

DRAFT

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where *"their most at risk customers, have no support coordination funded in plans leaving these participants without the opportunity to build their own capacity".*[1]

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.[2]

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 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

1 Council of Regional Disability Services, Submission S072, p. 12.

2 See: Action on Disability Within Ethnic Communities (S055), CPS Choice Plan Services (S013) and Merri Health (S061).

DRAFT

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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.*

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10 Location Specific Issues

The Review received a total of:

- 16 submissions that spoke to pricing arrangements for supports delivered in Queensland, South Australia and Western Australia; and
- 34 submissions that spoke to 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 comprised 9 members from 8 organisations. It met twice by video-conference, on 7 December 2021 and 8 February 2022.
- The working group on South Australia supports comprised 9 members from 8 organisations. It met twice by video-conference, on 7 December 2021 and 8 February 2022.
- The working group on Western Australia supports comprised 17 members from12 organisations. It met twice by video-conference, on 7 December 2021 and 8 February 2022.
- The working group on Regional, Remote and Very Remote supports comprised 24 members from 19 organisations. It met twice by video-conference, on 7 December 2021 and 8 February 2022.

Details of the members of the working group are provided in Appendix B.

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.

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*

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> *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 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 Studt") 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.
- **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

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.

DRAFT

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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 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.

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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).

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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]

In the Western Australia working group meeting, members gave examples of:

- a worker being offered $40,000 to work for fewer hours in mining; and
- 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 recognised that Western Australia's hard border and strict reopening strategy meant that there were a limited number of workforce candidates overall.

In the Queensland working group meeting, members 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".

10.2 Operating costs

Related to the workforce attraction and retention issues, members of all four working groups considered that the Disability Support Worker Costs 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 needed to spend time travelling between a widely distributed workforce.

Consultations also revealed pressures related to provider travel and other costs.

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1 Rocky Bay, Submission S141, p. 16.

2 Avivo, Submission S112, p. 23.

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Travel

Members of the working group agreed that it was necessary and beneficial to visit participants in their homes where they reside and feel most at ease, but providers are 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 noted the MMM Model did not 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 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]

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.[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 before COVID-19, noting that the physiotherapist and the provider couldn't reach an agreement, resulting in participants on King Island going without service:

> *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.* [4]

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

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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.

4 Australian Physiotherapy Association, Submission S098, p. 6.

DRAFT

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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.[1] 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.

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> *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.* [2]

The submission from Vison 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.* [3]

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 baulk at the cost. They are also reluctant to pay for the non-face-to-face supports they receive; again these are often absorbed by providers.*[4]

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.[5]

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1 See: National Disability Services (S152), Oncall Accommodation Services (S124), Rocky Bay (S141), Vision Australia (S109), and Wellways (S222).

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

3 Vision Australia, Submission S109, p. 10.

4 National Disability Services, Submission S152, p. 14.

5 See: Avivo (S112), Dieticians' Australia (S239), National Aboriginal Community Controlled Health Organisation (S150), and Rocky Bay (S141).

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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.*"[1]

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).[2]

The Australian Orthotic and Prosthetic Association's submission stated that the current NDIA provider travel policy means it is difficult for providers to establish efficient and sustainable provider travel. Absorbing these costs is unsustainable and has resulted in some providers:

- Reducing the number of outreach clinics;
- Refusing to operate any outreach clinics; and
- Relying on state-based support to operate clinics.[3]

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.[4] It further detailed that the implementation of 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.

1 National Aboriginal Community Controlled Health Organisation, Submission S150, p. 3.

2 Australian Orthotic Prosthetic Association, Submission S064, p. 8

3 Ibid.

4 Vision Australia, Submission S109, p. 5.

DRAFT

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> *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-whell 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 Agency."

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 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.

[1] Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, Submission 096, p. 3.

DRAFT

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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].*
>
> *[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.*[5]

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.

5 National Aboriginal Community Controlled Health Organisation, Submission S150, p. 4.

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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 types* [1]

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.* [2]

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.[3] The submission from Crosslinks Disability Support Services, for example, proposed that the Agency consider offering a higher hourly rate to enable Western Australian providers to compete with the mining sector by offering comparable salaries and conditions.[4]

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.*[5]

One member of the working group proposed that the Agency 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 classified as regional but every sense of the word in terms of the challenges unique to remote towns, they are remote.*

Another member requested 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

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1 Ibid., p. 8.

2 Ibid., p. 8.

3 See: Avivo (S112), Council of Regional Disability Services (S072), Crosslinks Disability Support Services (S217), Western Australia Department of Communities (S231), and Mind Australia (S105).

4 Crosslinks Disability Support Services, Submission S217, p. 22.

5 Avivo, Submission S112, p. 4.

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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]

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[1] Avivo, Submission S112, p. 22.

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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

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DISCLOSURE LOG

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 (ESSA)
S071	Participant Representative	NDIS Participant's Father
S072	Provider Peak Body	Council of Regional Disability Services (CORDS)
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 (ACSO)
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

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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 (SILC)
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 (NACCHO)
S151	Provider	Galway Trading
S152	Provider Peak Body	National Disability Services (NDS)
S153	Provider	Mental Illness Fellowship of Australia
S154	Provider	Novita

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DISCLOSURE LOG

Reference	Type of Respondent	Respondent
S155	Individual Support Worker/Therapist	Extra Mile PT
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 TA 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

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DISCLOSURE LOG

Appendix A – List of Submissions

Reference	Type of Respondent	Respondent
S209	Provider	Veritable
S210	Provider	Multicultural Services Centre of WA
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	Department of Communities WA
S232	Provider	MJD Foundation
S233	Provider	New Horizons
S234	Provider Peak Body	Vision 2020 Australia
S235	Provider Peak Body	Spinal Cord Injuries Australia (SCIA)
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 (SPA)
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

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Appendix B – Working Group Members

Working Group 1 – Core Pricing Arrangements

Organisation represented	Attendee to at least one session
Ability First	Andrew Rowley
Ability First	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	Lliam 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	Andrew Rowley
Ability First	Jennifer Luff
Ability First	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

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DISCLOSURE LOG

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	Andrew Rowley
Ability First	Michael Bink
Allevia	Philip Petrie
Autism Spectrum Australia (Aspect)	Ben James
Bedford	Stefanie Veitch
Centacare	Kaylene Moore

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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	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	Andrew Rowley
Ability First	Michael Bink
Allied Health Professions Australia	Dr Chris Atmore
AMTA	Helen Cameron
Autism Spectrum Australia (Aspect)	Maryanne Pease
Autism Spectrum Australia (Aspect)	Rachel Kerslake
Autism Spectrum Australia (Aspect)	Rebecca Keane
Audiology Australia	Feiya Zhang

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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

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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

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Organisation represented	Attendee to at least one session
Facilitatrix	Caroline Marshall
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	Lliam 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
WA Department of Communities	Suzanne Velarde

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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

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Pricing Arrangement Reference Group (PARG)

Meeting: 7 February 2023

Minutes

Date: Tuesday, 7 February 2023

Time: 11.30am – 12.30pm

Location: Microsoft Teams

Members		
Chair		
David Gifford	A/g Scheme Actuary	By Teams
Pricing Reference Group Members		
Deborah s47F - perso	Independent Member	By Teams
Julie s47F - personal privacy PSM	Independent Member	By Teams
Lynne s47F - personal priv	Independent Member	By Teams
Jim s47F - pe PSM	Independent Member	By Teams
Participating Observer nominated by CEO		
Gerrie s47F - person	General Manager, Provider and Market Development	By Teams
Kee s47F - personal pr	A/g Branch Manager, Economics and Pricing	By Teams
Jenny s47F - perso	Director, Economics and Pricing Branch	By Teams
Secretariat		
Davor s47F - personal privac	A/g Director, Economics and Pricing Branch	By Teams
Vincent s47F - personal p	A/g Director, Economics and Pricing Branch	By Teams

1.2 Declaration of Conflicts of Interest

The Chair **ASKED** members if they had any updates of conflicts of interest to declare. PARG members did not have any updates.

1.3 Apologies

- Dr. Lynn s47F - personal priva

2.1 Update by the Chair

The Chair **INFORMED** the PARG:

- The recent membership appointment of Graeme s47F - personal AM to the NDIA Board. Alongside Graeme's appoint, the Board welcomed Kurt s47F - personal privacy, s2 as the new Chairman, Ms Maryanne s47F - personal privacy AO and of Dr Denis s47F - personal privacy AO.
- Ms Rebecca Falkingham was recently appointed as the Chief Executive Officer.
- The NDIS Review will look at the design, operations, and sustainability of the NDIS. It will also look at ways to make the market and workforce more responsive, supportive, and sustainable.
- The PARG will discuss the NDIA's approach to the Annual Pricing Review (APR) for 2022-23.

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3.1 Annual Pricing Review (APR) 2022-23

The Chair walked members through key points of the paper:

- The outcome of the Board's decision from the 2021-22 APR introduced a 3.7% temporary price loading. This percentage is a combination of 1.7% relating to changes in the SCHADS award and temporary loading of 2% applied by the NDIA.
- Therapy support price limits have not been updated for some time and was last changed on 1 July 2019. The economy has entered a high inflationary environment that has been compounded by the COVID pandemic causing supply chain issues for providers. Having not received a price change for some time has put financial pressure on providers. Therapy providers are anticipating that Consumer Price Index (CPI) is passed onto therapy price limits for 1 July 2023.
- The Cost of the Scheme is becoming a point of interest and has increased from $22 billion to $34 billion from last year and is projected to reach $90 billion by 2032. This currently represents a 1.5% of Gross Domestic Product (GDP) and could reach 2.5% by 2032.
- The NDIS Review is running concurrently with the APR and there are areas overlapping with the 2022-23 APR. The 2022-23 APR will work with the NDIS Review Secretariat to ensure any 2022-23 APR directions will not foreshadow outcomes of the NDIS Review.
- Minimum wage for Aged Care overlaps heavily with disability market; the price gap between the two is closing.
- The outcomes of the Specialist Disability Accommodation (SDA) Pricing Review 2022-23 will be effective from 1 July 2023 and is a separate process to the 2022-23 APR. The SDA Pricing Review occurs every 5 years and will examine pricing arrangements for SDA related areas only.

The General Manager, Provider and Market Development, raised comments relating to:

- The NDIA is facing the challenge of managing the market expectations regarding support price limits that have not increased, such as therapy supports including support coordination and plan management. Explaining the current market conditions and factors affecting support price limits may need to be addressed through a communication plan to maintain market confidence.
- There has been an uplift in the number of provider mergers and acquisitions across the disability market. This is evident in the media with Anglicare in Tassie and Encompass in Geelong.
- Traditionally, the providers who complete the Financial Benchmarking Survey (FBS) will be eligible for Temporary Transformation Payment (TTP) loading. This year, the Agency has adopted a new approach of working closely with the sector to gauge data required to update the Disability Support Worker (DSW) Cost Model.

The PARG members **DISCUSSED** the Annual Price Review 2022-23 paper, including:

- Members understand the decision not to run the FBS to allow the sector to take carriage of that process in the market. Concerns were raised about the risks of not able to update the efficient cost model in the absence of FBS.
- There is an understanding from one member that the efficient cost has been achieved through the NDIA price limits.
- Questions were raised around the optimal level of efficiency and its movements with time. Also, the NDIS should be aware of the ongoing inflationary changes to prices which might in turn impact those efficient prices.
- Managing the expectations of the market will be challenging with recent changes to the SCHADS awards, and accounting for things like split shifts into the DSW Cost Model.
- Members seek clarification of the consideration of the option of passing on Fair Work Commission's minimum wage increase minus 2%. The 2% for COVID was a temporary loading. However, making it a permanent addition would require strong arguments. The productivity

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factor, which is broken down into two components would support argument for the removal of the loading, because:

- 1) catch up efficiency (Direct cost of the equipment), and
- 2) labour productivity (discounting real increases) People not being able to work as much as willing e.g., due to member of the household being unwell or in other words, people today tend to be overly cautious when making decision when to work

Final Comments

The Chair thanked everyone who attended the meeting and acknowledged its short duration due to scheduling constraints. The Chair welcomed further comments or feedback from members via the PARG Secretariat.

4.1 Next Meeting

The next PARG is expected to occur in March 2023 with details confirmed closer to the date.

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Pricing Arrangement Reference Group 7 February 2023

Annual Pricing Review 2022-23

Matters for Discussion

Presented by: David Gifford, Deputy Scheme Actuary

1. Purpose

1.1 To seek feedback from the Pricing Arrangement Reference Group (PARG) on the proposed Annual Pricing Review (APR) 2022-23 approach and considerations.

2. Recommendations

2.1 That PARG **NOTES** the APR 2022-23 approach and the context for which the decision is made.

3. Background

3.1 Annual Pricing Review history

- The National Disability Insurance Agency (NDIA) has a role, as market steward for the National Disability Insurance Scheme (NDIS), to create an efficient and sustainable consumer driven marketplace for the supply of disability supports. It regulates the commercial relationships between providers and participants, including through price regulation.
- The NDIA monitors and periodically reviews its pricing arrangements and price limits and other market settings to determine whether they remain appropriate. The APR is the main annual vehicle via which these arrangements are reviewed. It examines whether the NDIS's existing pricing arrangements and price limits remain appropriate or should be modified through engagement with providers, participants and community and government stakeholders and targeted research and analysis.
- The most recent APR took place over the 2021-22 financial year and was announced in June 2022 and implemented in July 2022. It incorporated extensive consultations and tailored pricing changes to disability supports which totalled 9%, comprising wage increases under the SCHADS award plus allowance for increases in compulsory superannuation and an additional 3.7%. No changes in prices were made for therapy supports, support coordination or plan management. Prices for capital items were increased with CPI. The cohort receiving the 9% price rise includes Supported Independent Living (SIL) which contributes to the most significant portion of Scheme spend.
- Full reviews were conducted over 2016-17, 2017-18, 2019-20 and 2021-22.

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3.2 Heightened costs of living pressures

- The CPI rose by 7.3% over the twelve months to the September 2022 quarter, the highest annual change in the last 10 years.
- Supply chain issues have been made significantly worse by the COVID-19 pandemic which is likely to impact on disability providers.
- Therapy, Support Coordination level 2 and 3 as well as Plan Management supports have not had any inflationary increase since July 2019, July 2020 and July 2022 respectively. There has been strong feedback from the sector arguing that their business is no longer viable in the absence of price increases.

3.3 Annual Financial Sustainability Report (AFSR) shows that the Scheme expenses is set to continue growing and the risks is on the upside

- The 2021-22 AFSR projected total Scheme expenses on an accrual basis are $34.0 billion in 2022-23, increasing to $89.4 billion in 2031-32. This represents 1.48% of Gross Domestic Product (GDP) in 2022-23, increasing to 2.55% of GDP in 2031-32. The upward growth in Scheme expenses means any further price increase more than inflation for APR 22-23 will further impact sustainability.
- The range of plausible outcomes also widen into the future due to the increased uncertainty of cost drivers and assumptions. This is reflected by the range of 1.38% to 1.63% of GDP between the 5th and 95th percentile for 2022-23 projections, compared to 2.07% to 3.28% of GDP between the 5th and 95th percentile for 2031-32.
- It's also important to note that the 2031-32 projections from the 2021-22 AFSR is 31.4% higher than the forecast for the same period from the previous 2020-21 AFSR. The third most significant driver is due to the 2021-22 APR where major price increases were implemented including a 9% increase to DSW supports.

3.4 NDIS Review (Review) is currently underway and the timing overlaps with the APR 2022-23

- The Minister for the NDIS announced the NDIS Review in October 2022. The Review is yet to finalise a detailed work plan but it is expected that it will be considering matters including:
  - The current state of price regulation and considerations around moving towards a more deregulated approach to pricing
  - Provider registration, and pricing implications of various provider regulation scenarios
  - The current pricing structure which is essentially fee-for-service and the opportunity to move towards other options such as capitation or outcome-based structures
- Each of these issues, as well as other issues likely to be considered by the review have the potential to have significant strategic implications for pricing arrangements in the future.

3.5 Specialist Disability Accommodation (SDA) Pricing Review is happening concurrently

- The NDIA is also currently undertaking the SDA Pricing Review 2022-23, separately to the 2022-23 APR. The SDA Pricing Review occurs every 5 years and will examine pricing arrangements for SDA related areas only.

3.6 Aged care minimum wage review

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- On 4 November 2022, the Fair Work Commission (FWC) increased the minimum wages of the direct care classifications in the Aged Care Award and Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award) and for nurses working in aged care covered by the Nurses Award. The majority of the disability support workers delivering NDIS supports are paid under Schedule B of the SCHADS Award which is a higher rate than aged care workers (even with the 15% increase).
- The 2022-23 APR will consider impacts of the minimum wage pay rise in the aged care sector.

4. Proposed APR 2022-23 approach

4.1 In light of the contextual factors outlined in the background section, the proposed 2022-23 APR will be limited in scope, whilst largely maintaining prices in real terms. An initial expectation for the APR 2022-23, in line with the recommendation from the 2021-22 APR is that:

- Potential increase in prices for DSW related supports by (a) passing the full minimum wage increases announced by the FWC; (b) FWC minimum wage increases minus 2%.
- Potential removal of the 2% temporary loading for DSW related supports from July 2023. The AFSR assumes that the 2% loading will be removed from July 2023, and so any decision to do otherwise would lead to an unforeseen increase in Scheme cost.
- Prices for capital supports be increased by CPI.
- Prices for other supports such as therapy, support coordination and plan management, consideration should be given to either (a) no increase again; or (b) potential increase in by 80% Wage Price index (WPI)/20% CPI.

5. Discussion and considerations

5.1 How will the sector consultation be undertaken including messaging, audience and delivery?

5.2 Should the 2% temporary loading for DSW related supports be removed from July 2023?

5.3 The APR 2021-22 recommended to assess the impact of the changes in SCHADS award. The award changes include increased minimum shift for part-time and casual workers and longer cancellation notice period. The NDIA propose to conduct initial research around the impact but any policy changes will be considered in the future.

5.4 Issues of interests from ministerial correspondence and media suggest that unregistered providers shouldn't be charging up to the same price limit as registered providers given they don't have the same compliance costs. Other feedback include changes to Support Coordination and Plan Management. Given the Review is currently underway, the NDIA propose to wait for the Review's completion before further review of these supports.

5.5 Some stakeholders raised whether the APR 2022-23 should pass on inflation for some therapists and less than inflation for other therapists based on individual sector performance.

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- Prior to July 2019, all types of therapists had the same price limit. The Review of Therapy Pricing Arrangements in 2019[1] recommended division of psychology, physiotherapists and other therapists each with their respecitive price limits due to different market rates.
- The Review of Therapy Pricing Arrangements recommended not to differentiate prices further due to a lack of compelling evidence and implementation challenges. The APR 2021-22 also considered therapy pricing arrangements, in which there was comparison to private provider billing rates and other government funded schemes.
- Furthermore, any further analysis will involve more extensive consultations and longer timeframe than the intended APR 2022-23.

6. Risks

6.1 Price increases in excess of base (price and wage inflation) place further upward pressure on Scheme cost.

6.2 If price increases are perceived by the sector as too low, market exits may increase and service availability may reduce.

6.3 Lack of clarity between the 2022-23 APR process and the NDIS Review may create confusion amongst sector stakeholders.

7. Next steps

7.1 The APR 2022-23 approach will be discussed at the Pricing Interdepartmental Committee (IDC) in early February 2023. The IDC is a newly established forum to discuss strategic NDIA pricing issues and impacts across the broader market. The IDC comprises members from the Department of Social Services, Department of Finance, Treasury as well as the NDIS Quality and Safeguards Commission to enable cross agency perspectives.

7.2 Future PARG meetings are proposed to be held in late February and early April and May 2023.

7.3 Indicative timeframes for the APR 2022-23 are outlined in Table 1.

Table 1: APR 2022-23 indicative timeframe

Milestones	Indicative timing/completion
Seek feedback from the Board, PARG and IDC	February 2023
PARG meeting – IDC feedback and final stakeholder consultation plan	February 2023
Possible release of issues paper – seeking feedback from providers/ sector	End of February to end of March 2023
Board meeting – feedback from PARG and Pricing IDC, stakeholder engagement plan	March 2023
Selected stakeholder engagement	March 2023

[1] Pricing review archive | NDIS under pricing review documents 2018-19 section

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Milestones	Indicative timing/completion
Board meeting – stakeholder engagement outcomes and draft APR recommendations	April 2023
PARG meeting – final APR recommendations before May Board meeting	May 2023
Board meeting – final APR recommendations	May 2023
Final APR report and implementation	June 2023

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Pricing Arrangement Reference Group (PARG)

Meeting: 2 March 2023

Minutes

Date: Thursday, 2 March 2023

Time: 4:00pm – 5:00pm

Location: Microsoft Teams

Members		
Chair		
David Gifford	A/g Scheme Actuary	By Teams
Pricing Reference Group Members		
Deborah [redacted]	Independent Member	By Teams
Julie [redacted] PSM	Independent Member	By Teams
Lynne [redacted]	Independent Member	By Teams
Jim [redacted] PSM	Independent Member	By Teams
Participating Observer nominated by CEO		
Jo [redacted]	A/g General Manager, Provider and Market Development	By Teams
Kee [redacted]	A/g Branch Manager, Economics and Pricing	By Teams
Jenny [redacted]	Director, Economics and Pricing Branch	By Teams
Secretariat		
Vincent [redacted]	A/g Director, Economics and Pricing Branch	By Teams

1.2 Apologies

- Kee [redacted] A/g Branch Manager, Economics and Pricing
- Gerrie [redacted] General Manager, Provider and Market Development

2.1 Annual Pricing Review 2022-23 Consultation Paper

- The Group discussed the need to broaden the consultation paper to recognise other stakeholders while targeting more specific feedback through the questions.
- The questions in the consultation paper need more nuanced and solution-focused; such as asking for the best way to address workforce issues. Members acknowledged the importance of soliciting input from a range of stakeholders to ensure the consultation process is inclusive and thorough.
- It was noted that there is a risk of asking questions or seeking feedback on things that are outside the scope of the paper. This could potentially undermine the credibility of the consultation process and lead to frustration among stakeholders.
- The Group agreed that it was important to clearly define the purpose of the document and identify the types of information that are likely to influence the Board's consideration.
- It was suggested that the Group should acknowledge previous feedback and indicate how it was considered. The Group agreed that this approach would demonstrate a commitment to being responsive to stakeholders' concerns.

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- Members also noted that the consultation paper should recognise the existence and role of the NDIS review. The questions relating to both support coordination and plan management. It was noted that both are being examined by the review, but stakeholders should still be given the change to provide general perspectives. The consensus by the Group was to be clear through the process that any information provided is not directly factored into the decision considered by the NDIS Review.
- Concerns for the need for better communication and engagement with Aboriginal and Torres Strait Islanders to acknowledge their interest and perspectives.
- In terms of the main workforce issues facing the sector, members suggested asking stakeholders what the most important single thing that could change would be. This would provide a more pointed question and elicit more specific responses.
- Additionally, members noted that the sector is time-poor, and asking stakeholders to provide detailed submissions on things when the process is intended to be a minimum review carries reputational risks The Group agreed that it was important to consider the time constraints of stakeholders and ensure that the consultation process efficient and effective.

3.1 Annual Pricing Review Research Plan

Updates on Market Changes

- The Group discussed the major changes in disability services, including the split shift allowance, NDIS registration compliance costs, plan management, and workforce training. The Group suggested analysing workforce demographics, such as ethnicity and training, as well as monitoring market changes, including the impact of new software providers, and mergers and acquisitions.

Impact of Market Changes on Pricing

- The Group discussed the impact of market changes on pricing, including the changing shape of the market and the number of participant services by providers. The Group agreed that it was important to consider registered versus unregistered providers when determining pricing.

4.1 Next Meeting

The next PARG is expected to occur in April with details confirmed closer to the date.

ACTIONS ARISING			
#	Meeting	Issues	Status
1	20230302	Revise the consultation paper by broadening the questions to recognise other stakeholders (other than providers) and to narrow the scope of the questions.	Open
2	20230302	Ensure the consultation paper recognises the NDIS Review	Open
3	20230302	The consultation will clearly define the purpose of the document and identify the types of information that are likely to influence the Board's consideration.	Open
4	20230302	Clarify that stakeholders can still provide general perspectives on support coordination and plan management, and that any information provided will be considered by the NDIS Review.	Open
5	20230302	The paper should acknowledge Aboriginal and Torres Strait Islanders.	Open
6	20230302	Consideration to add market monitoring changes and to analyse workforce demographics; this includes the impact of market changes on pricing.	Open

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Agenda Item: 2.2

Agenda Item: Annual Pricing Review 2022-23

Paper Type: For Noting

SLT Sponsor: David Gifford, Scheme Actuary

1. Purpose

1.1. To provide the Pricing Arrangement Reference Group (PARG) with feedback from public consultation of the Annual Pricing Review (APR) 2022-23; and to present key evidence and research findings of areas that are currently being reviewed.

2. Recommendation

2.1 That PARG notes the feedback from public consultation and key findings to date.

3. Background and context

3.1. The 2022-23 APR approach has been presented to the IDC in March 2023. It was agreed to adopt an overall minimalist approach given the broader NDIS Review is running concurrently. Areas being reviewed in the currently APR are: *Disability Support Worker* (DSW) related supports, *therapy*, *support coordination* and *plan management*.

4. Feedback from public consultation

4.1. A Consultation Paper was released on Friday 17 March 2023 with consultation closing on Thursday 13 April 2023. In total, 276 submissions were received up to 11.59pm 13 April 2023. Most submissions were from provider organisations (186), advocacy groups (3) and individual therapists or support workers (53). Submissions were also received from participants and their representatives (12), professional bodies (12) provider peak bodies (5) and Government (4) and a workers union (1).

4.2. Providers across all service areas expressed concerns about inflation and rising costs of supply. They also noted greater difficulty in attracting, training and retaining staff.

4.3. For *DSW related supports*, the main concerns were that the cost of disability support workers are not adequately covered in the DSW Cost Model and there is still ongoing adjustment for many providers on costs related to COVID and SCHADS Award changes.

4.4. In terms of *therapy services*, many respondents suggested it is difficult to handle increased costs as NDIS price limits have not changed since 2019, with the biggest driver being higher supply costs and wages. Some providers stated that NDIS participants are charged more than due to the greater complexity in delivering services to NDIS participants, whereas others say they charge the same across both cohorts.

4.5. Submissions for *support coordination supports* suggested price limits should be increased for level 2 and 3 support coordination. Concerns were raised about the fragmented nature of supports offered by Support Coordinators and unbillable hours associated with some administrative work.

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4.6. Many *plan managers* suggested the monthly fee is insufficient for the work they are doing, which extend beyond just paying invoices. There were still suggestions of clearer guidelines on the role of *plan managers* which should be covered by the NDIS Review.

Research and analysis

Refer to Appendix A for more analysis

5.1. Domestic economic conditions and care sector expenditure

5.1.1. While Australia has withstood the pandemic well, it is not immune to the intensifying global challenges. While the economy is forecast to grow by 3¼% in 2022–23, the weaker global outlook, high inflation, cost-of-living pressures, and higher interest rates are expected to slow growth to 1½% in 2023–24.[1]

5.1.2. While the outlook of the broader Australian economy remains subdued, the Federal Government's expenditure for the Health Care and Social Assistance (HCSA) industry is set to grow, with the NDIS growth rate projected to outpace sectors such as pension, Medicare, aged care and pharmaceutical benefits scheme (PBS).

5.1.3. The HCSA industry has contributed to around 8% of the Australian GDP in terms of Gross Value Add (GVA) in recent years, outperforming the average of all other industries.

5.1.4. Internationally, Australian public spending on disability, as captured by the Organization for Economic Cooperation and Development (OECD), sits at 2.9% of GDP, the 8th highest of 38 OECD countries.

5.1.5. One of the key challenges facing the economy is higher interest rates and heightened costs of living. Australia's annual rate of inflation has risen to 7.8% in December 2022. Moreover, the Reserve Bank of Australia has forecast inflation to ease going forward.[2]

5.1.6. The economic outlook remains subdued whilst the care sector continues to grow, suggesting a tighter fiscal environment, coupling with the challenges of higher costs of living. These conditions could potentially intensified competition in terms of labour with other care sectors, which could put more pressure on supply going forward.

5.2. DSW related supports

5.2.1. The number of participants receiving DSW related supports has increased by 17% in the six months to December 2022. Over the same corresponding period saw a growth of 29% for number of active providers.[3]

[1] Budget Statement 1, 2022-23, Commonwealth Treasury (Page 5).
[2] RBA February Statement of Monetary Policy.
[3] We considered both providers registered with the NDIS Quality and Safegard commission and unregistered providers in this case

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5.2.2. NDIS providers utilise the same labour market pool for disability workers as the aged care and childcare sector. Therefore, wage changes in one sector will impact worker availability in the other sectors. Analysis on major online employment platforms as at April 2023 suggests that the average hourly pay of DSW workers ($28.80 to $40) is higher than average hourly pay of aged care workers ($24.20 to $35) and childcare workers ($24.40 to $30).

5.2.3. The Fair Work Commission has handed down its decision to lift the Aged Care Award and relevant Award workers' wages by 15% from 1 July 2023. Currently, the weekday daytime wage for Level 1 DSW in the NDIS DSW Cost Model is based on the full and part time Social, Community, Home Care and Disability Services Industry Award (SCHADS Award) Level 2.3, which is $32.37 per hour. This is compared to the Aged Care Award Level 4 due to similar qualifications and responsibilities at $24.76 per hour.[4] This currently equates to the DSW earning $7.61 per hour more (31% higher). After accounting for the aged care 15% increase post 1 July 2023, the DSW will still be earning more by $3.90 per hour (14%).

5.2.4. From 1 July 2022, a special 2% temporary loading was handed down, recognising variable costs of COVID and other costs such as adjusting to changes to the SCHADS Award. Sustainability impact assessment has been undertaken to assess the impacts of various options. It is estimated that keeping the 2% temporary loading again this year would add $573 million (1.4%) to the total Scheme expenses; whilst a gradual reduction of 1% this year would add $286 million (0.7%) to the total Scheme expenses.

5.3. Therapy supports

5.3.1. In the six months to 31 December 2022, 325,319 participants[5] purchased therapy supports through their plans. These supports were delivered by 46,434 active providers, representing $1.6 billion in total payments. Compared to $1.3 billion paid in July to December 2021, therapy payments increased by 26% from a year ago.

5.3.2. The proportion of registered providers remains significant, with 72% of therapy payments for July to December 2022 being claimed by registered providers.

5.3.3. The Jobs and Skills Australia (formerly known as National Skills Commission) projects employment growth for therapy to continue for the next 5 years. Aged and Disabled Carers is the 13th fastest growing occupation area, expected to grow by 28% to 2026. The top 3 fastest growing therapists are Audiologists and Speech Pathologists (34.7% growth, close to four times the projected rate of growth of the entire workforce), Podiatrists and Physiotherapists (31.8% and 28.7% growth).

[4] Fair Work Ombudsman pay guides.
[5] 57% of all active participants at 31 December 2022.

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5.3.4. The NDIA has engaged with sixteen Commonwealth and State therapy Schemes to obtain their therapy pricing as comparison to NDIS limits. Overall, NDIS prices are in line or at the higher end for most types of therapies. However, results this year indicate that many types of therapies have been indexed by other schemes over the past year of up to 5%.

5.3.5. Another key change from the previous year is for exercise physiologists, preliminary data suggests that there have been some adjustments from other Schemes, and the NDIS rate for exercise physiologists is now less in comparison.

5.3.6. Comparison of private billing rates will be undertaken, to be provided for the May Board meeting.

5.4. Support coordination and plan management

5.4.1. The number of NDIS participants with support coordinators, the total number of active support coordination providers as well as total amount claimed by support coordination have increased by 15%, 34% and 15% respectively in the six months to December 2022. This brings the total amount claimed to $428 million over the same six months period.

5.4.1.1. Preliminary evidence points to a steady increase in the number of active providers[66] for support coordination.

5.4.2. The number of NDIS participants with plan managers, the total number of plan management providers as well as total plan management fees have increased by 27%, 13% and 14% respectively in the six months to December 2022. This brings the total plan management fees to $227.7 million over the same six months period, July 2022 to December 2022.

5.2.2.1. Early data suggest that not only is the number of plan managers increasing, there has been healthy entrants to the market. Data also suggest that plan managers might be expanding the participants they support.

5.4.3. Plan management remains the most popular option with 58% of all NDIS payments made by a plan manager in the December 2022 quarter. This has increased by 13% since 2020. Self-management remains stable from 32% in the December 2020 quarter (30% 2022). Agency management has declined from 24% in the December 2020 quarter to 12% in 2022.

6. Responsibility and next steps

6.1 The feedback from public consultation and key research findings to date will be shared with the Pricing Interdepartmental Committee (IDC) before being presented to the Board on 28 April 2023.

[6] Includes registered and unregistered providers.

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Final recommendations will be discussed with the PARG on 12 May 2023 and the Pricing IDC on 19 May 2023 prior to seeking endorsement at the Board meeting on 25 May 2023.

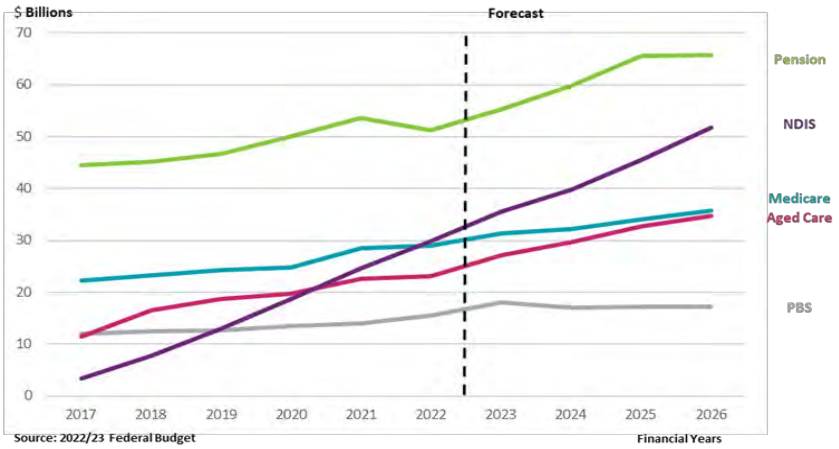
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Attachment A
Annual Pricing Review 2022-23
Research and analysis

1. Domestic economic conditions and the care economy

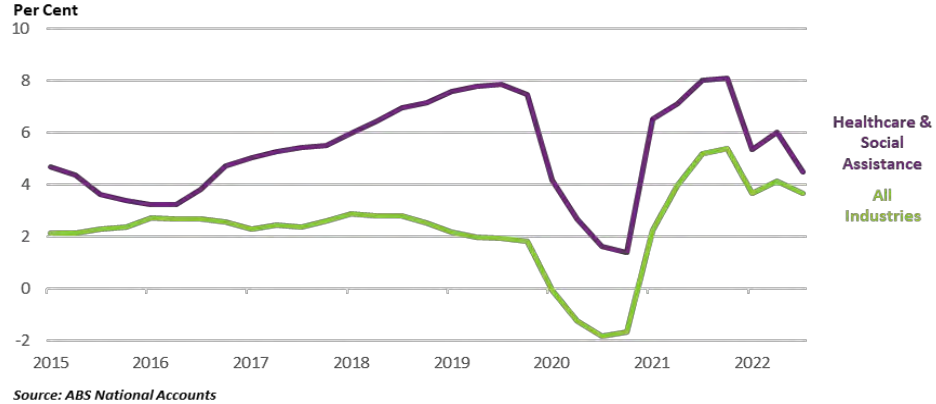
1.1 Federal Government expenditure for the Health Care and Social Assistance (HCSA) industry continues to grow. Figure 1 shows the actual and projected spending on NDIS, pension, Medicare, aged care and pharmaceutical benefits scheme (PBS). The growth in expenditure of the NDIS expected to outpace other Health Care and Social Assistance industries.

FIGURE 1: FEDERAL GOVERNEMENT EXPENDITURE ON HEALTHCARE AND SOCIAL SERVICES INDUSTRIES, 2017-2026



1.2 The GVA measures the economic output of an industry or sector where the HCSA sector has consistently outperformed the average of the rest of the economy in terms of Gross Value Add (GVA) in recent years, contributing around 8% of the Australian GDP as shown in Figure 2.

FIGURE 2: GROSS VALUE ADD FOR THE HCSA SECTOR, AGAINST ALL INDUSTRIES, 2015 – 2022



1.3 The HCSA sector is the largest employing industry in the economy. It has had more annual employment growth than the average of all other industries on average and will

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continue to grow significantly (Figure 3). Over 2022, employment in HCSA grew at its fastest rate on record. On average, this was 9.9% more than the number employed in 2021. Both output and employment growth did not turn negative during the pandemic for the HCSA sector, unlike all industries.

FIGURE 3: ANNUAL EMPLOYMENT GROWTH FOR HCSA AGAINST ALL INDUSTRIES, 2013 – 2022



Source: ABS Labour Force Survey

2. Disability Support Workers (DSW) related supports

2.1 The number of participants receiving DSW related supports continues to grow. The total amount claimed in this section are based on line items related to DSW to ensure greater accuracy tailored to the scope of the APR. The support category level includes mostly DSW but also some non DSW line items that are not in scope of the current analysis.

TABLE 1: DSW RELATED SUPPORT STATISCIS FOR JULY TO DECEMBER 2021 AND JULY TO DECEMBER 2022

	Jul - Dec 2022	Jul - Dec 2021	Growth
Total number of NDIS participants	225,873	192,523	17%
Total number of active providers (includes registered and unregistered providers)	85,040	66,037	29%
Total amount claimed	$7.2 billion	$5.6 billion	29%

Source: NDIS internal administrative data

2.2 Skills and qualifications are considered fairly transferable between disability support, aged care and childcare support positions. Table 2 outlines the wages offered by the major job platforms as at April 2023, with DSW wages being the highest compared to aged and child carer.

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TABLE 2: RELATIVE WAGES OF DSW, AGED CARERS AND CHILD CARERS

Occupation	Employment	Wages ($/hour, Australian average)		
		Seek	Indeed	PayScale
DSW	241,000 (2020)	$30 - $40	$35.4	$28.8
Aged carer	195,000 (2020)	$25 - $35	$32.1	$24.2
Child carer	216,619 (2021)	$25 - $30	$31.0	$24.4

Source: NDIS Workforce Plan, CEDA, ECEC National Workforce Census. Estimates exclude nurses and allied health professionals. Wages from Seek; Indeed; PayScale

2.3 Table 3 provides a summary showing the costing impact relative to the Scheme projections for the different temporary loading scenarios. As previously discussed, the Scheme projection assumes that the full 2% temporary loading will be removed on 1 July 2023, so there is no financial impact for the first scenario.

TABLE 3: SUSTAINABILITY IMPACT ASSESSMENTS OF OPTIONS TO PHASE OUT THE 2% TEMPORARY LOADING

Impact ($m)	2023/24
AFSR Scheme Expenses	$41,053m
Temporary loading scenario	
($ Impact)	
1. Remove 2% loading from 1 July 2023	-$0m
2. Reduce to 1% from 1 July 2023 then remove from 1 July 2024	+$286m
3. Keep 2% until 1 July 2024 then remove from that data onwards	+$573m
Temporary loading scenario	
(% Impact)	
1. Remove 2% loading from 1 July 2023	0.0%
2. Reduce to 1% from 1 July 2023 then remove from 1 July 2024	0.7%
3. Keep 2% until 1 July 2024 then remove from that data onwards	1.4%

Source: Internal NDIS estimates

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3. Therapy supports

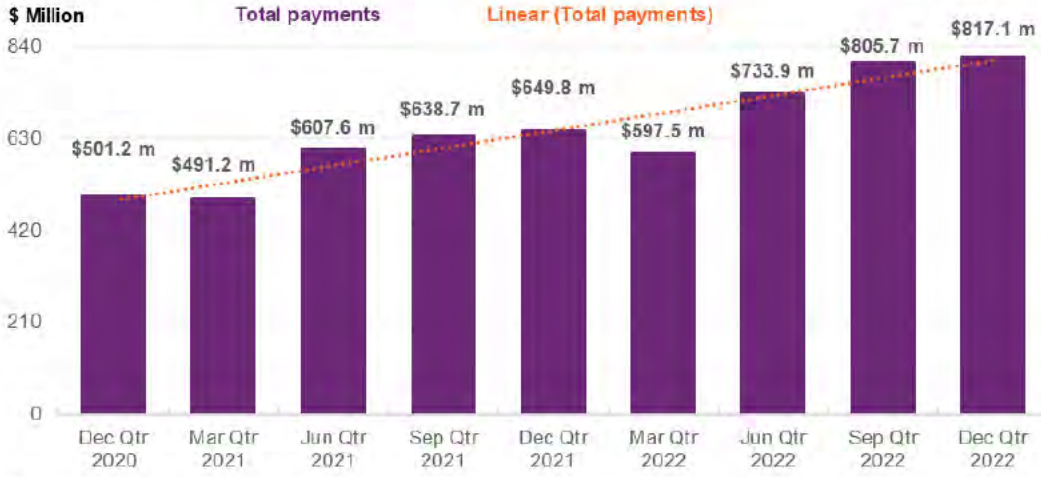
3.1 In the six months to 31 December 2022, 325,319 participants (57% of all active participants) purchased therapy supports through their plans. These service supports were delivered by 46,434 providers who received a payment during July to December 2022. The number of providers who delivered therapy services and were paid in July to December 2021 was 40,744, indicating a 14% increase to provider numbers from a year ago (both registered and unregistered with NDIS commission). Expenditure on therapy supports during July to December 2022 equates to $1.6 billion, accounting for almost 10% of all expenditure by the NDIS during this six-month period. Compared to $1.3 billion paid in July to December 2021, therapy payments increased by 26% from the previous year (Figure 4).

TABLE 4: THERAPY STATISCS FOR JULY TO DECEMBER 2021 AND JULY TO DECEMBER 2022

	Jul - Dec 2022	Jul - Dec 2021	Growth
Total number of NDIS participants	325,319	279,098	17%
Total number of active providers	46,434	40,744	14%
Total amount claimed	$1.6 billion	$1.3 billion	26%

Source: NDIS internal administrative data

FIGURE 4: SCHEME EXPENDITURE ON THERAPY, OCTOBER 2020 – DECEMBER 2022



Source: NDIS internal administrative data

3.3 The largest five types of therapy support during July to December 2022 based on total payments, are:

- Occupational Therapy ($281 million)
- Early Childhood ($248 million)
- Behaviour ($208 million)

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- Physiotherapy ($167 million)
- Psychology ($139 million).

Payments for the top 5 supports amounted to $1.0 billion, comprising 64% of the total Scheme spend on therapy in the six months to 31 December 2022.

3.4 Exercise physiologists is currently lower than most other types of therapies in NDIS ($167 compared with $193.99) in Pricing Arrangement and Price Limits. The Department of Veterans Affair last year had a standard 30 mins session, now reported as 20 minutes. This is an increase of hourly rate from $133.80 to $203.85 since last year. ComCare did not provide information for exercise physiologists in the last APR but have this year reported a pricing range from $96.47 to $216.70 depending on location. Moreover, MBS's effective hourly rate of around $198.

3.5 The Jobs and Skills Australia (formerly known as National Skills Commission) projects employment growth of the entire Australian workforce for five years to November 2026 at 9.1%. The growth in the therapy space will continue over this period with therapists making up three of the 11 fastest growing occupations, those being Audiologists and Speech Pathologists (34.7%, close to four times the projected rate of growth of the entire Australian workforce over that period), Podiatrists (31.8%) and Physiotherapists (28.7%) between 2021 and 2026 (Table 1).

TABLE 5: EMPLOYMENT LEVELS BY OCCUPATION, 2021 AND NSC PROJECTIONS, 2021 TO 2026

Occupation Code	Occupation	Employment level - November 2021 ('000)	National Skills Commission Projections		
			Projected employment level - November 2026 ('000)	Projected employment growth - five years to November 2026	
				('000)	(%)
2527	Audiologists and Speech Pathologists/Therapists	12.3	16.6	4.3	34.7
2526	Podiatrists	6.4	8.5	2.1	31.8
2525	Physiotherapists	32.8	42.2	9.4	28.7
2522	Complementary Health Therapists	6.3	8.0	1.8	27.9
2721	Counsellors	24.4	27.8	3.5	14.2
2723	Psychologists	31.0	35.1	4.1	13.3
2524	Occupational Therapists	23.9	25.6	1.8	7.4
2511	Nutrition Professionals	7.9	8.5	0.6	7.2

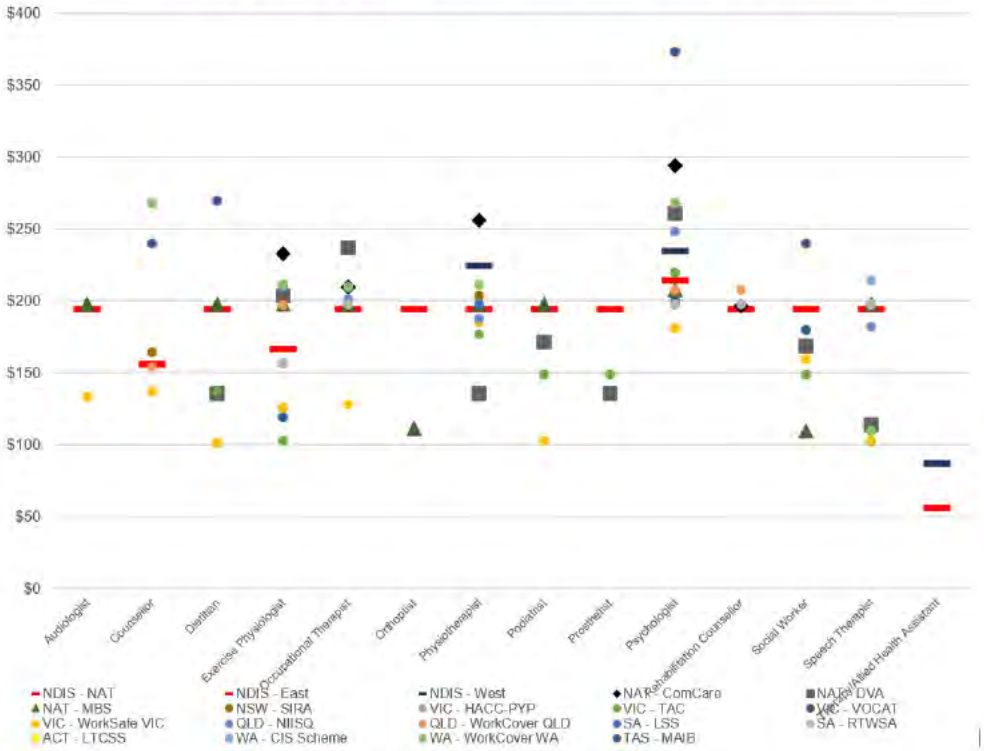
3.6 A comparison to other therapy schemes shows a general indexation of prices compared to the 2021-22 APR, across the following types of therapies (Figure 6):

- Audiologists
- Counsellors
- Dietitians
- Exercise Physiologists

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- Occupational Therapists
- Physiotherapists
- Podiatrists
- Prosthetists
- Psychologists
- Social Workers
- Speech Therapists
- Therapy/Allied Health Assistants.

FIGURE 6: OTHER SCHEME PRICING COMPARED TO NDIS 2022-23



4. Support Coordination and Plan management

4.1 Table 6 summarises the number of participants, providers and amount claimed for support coordination over the six months to 2022.

TABLE 6: SUPPORT COORDINATION SCHEME STATISTICS

	July - Dec 2022	July - Dec 2021	Growth

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Total number of NDIS participants	210,909	182,938	15%
Total number of active providers	7,023	5,232	34%
Total amount claimed	$428 million	$372 million	15%

Source: Internal NDIS data, April 2023.

4.2 Table 6 summarises the amount of participants, providers and amount claimed for plan management over the six months to December 2022. Table 7 shows that in the six months preceding to 31 December 2022, payments of $227.7 million for plan management fees were made. In the same six months, 1,797 active plan managers paid service providers on behalf of the 333,077 participants (58% of all active participants).

TABLE 7: PLAN MANAGEMENT SCHEME STATISTICS

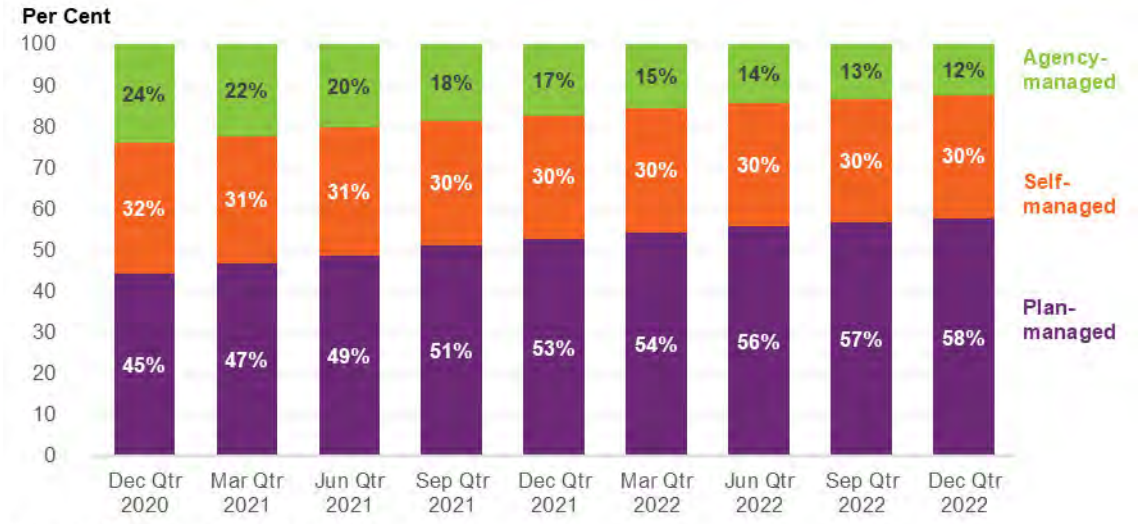
	July - Dec 2022	July - Dec 2021	Growth
Total number of NDIS participants	333,077	262,915	27%
Total number of active providers	1,797	1,588	13%
Total Plan Management fees	$228 million	$200 million	14%

Source: Internal NDIS data, April 2023.

4.3 Over half of all participants used a plan manager (58%) during December quarter 2022, and nearly half of payments made from plan budgets were by a plan manager (49%).

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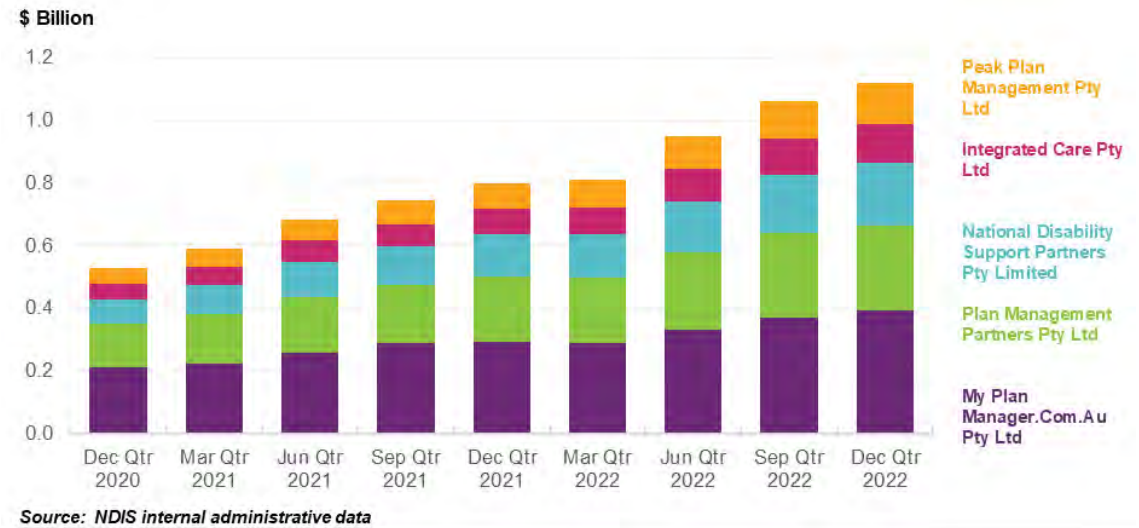
FIGURE 7: DISTRIBUTION OF PAYMENTS BY METHOD OF PLAN MANAGEMENT
OCTOBER 2020 – DECEMBER 2022



Source: NDIS internal administrative data

4.4 Out of the 1,797 plan managers that provided services, the largest five plan managers received $2.2 billion payments during July to December 2022, which is 27% of total plan managed payments. These top five plan managers have dominated the market over the past nine quarters having consistently stayed in the top ten.

FIGURE 8: SCHEME EXPENDITURE FOR THE LARGEST FIVE PLAN MANAGERS (BASED ON TOTAL PAYMENTS)
OCTOBER 2020 – DECEMBER 2022



Source: NDIS internal administrative data

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Pricing Arrangement Reference Group (PARG)

Meeting: 20 April 2023

Minutes

Date: Thursday, 20 April 2023

Time: 1:00pm – 2:00pm

Location: Microsoft Teams

Members		
Chair		
David Gifford	A/g Scheme Actuary	By Teams
Pricing Reference Group Members		
Deborah [redacted]	Independent Member	By Teams
Julie [redacted] PSM	Independent Member	By Teams
Lynne [redacted]	Independent Member	By Teams
Jim [redacted] PSM	Independent Member	By Teams
Participating Observer nominated by CEO		
Gerrie [redacted]	General Manager, Provider and Markets Division	By Teams
Kee [redacted]	A/g Branch Manager, Economics and Pricing	By Teams
Jenny [redacted]	Director, Economics and Pricing Branch	By Teams
Secretariat		
Vincent [redacted]	A/g Director, Economics and Pricing Branch	By Teams

1.1 Welcome and apologies

- No apologies received

1.2 Declaration of conflicts of interest

- No conflicts of interest received

1.3 Update by the Chair

- The Chair begins by acknowledging members on the call and mentions that today's meeting is an important step in the progress of the Annual Pricing Review, and that they will be speaking to the NDIS review in a few weeks' time.
- The Chair acknowledges the high level of interest in the consultation period, which received over 300 responses. A high-level summary of the consultation and initial research is planned for the upcoming Board Meeting and the aim is to have final recommendations by the end of May.
- The Chair acknowledges the ongoing public discussion around the cost of the NDIS but emphasises that price decisions should be made independently of that context while

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keeping it in mind. Members note that the price review needs to balance participants' needs and the scheme's financial sustainability.

- The Chair had conversations with sector stakeholders, including the CEO of NDS, who acknowledged the NDIS review and framed the annual price review as less extensive than last year. While this does not affect the review process, knowing that some sector stakeholders share the same perspective is helpful.

2.1 Acceptance of Minutes from last meeting

- The acceptance of minutes from the last meeting is also discussed, including some feedback about things that were discussed but not included in the minutes – notably ambiguity around the efficient price.

2.2 Annual Pricing Review (APR) 2022-23 Update

- The speaker, Kee, summarises feedback from public consultation, with most of the input being tilted towards concerns over increasing costs and difficulty attracting skilled staff members. The Agency also received feedback on ongoing challenges from COVID and the SCHADS Award and concerns over the lack of price increases for therapy services and support and coordination services. Overall, the feedback highlights various challenges and complexities in the industry.

Financial Benchmarking

- The APR received a submission from AbilityFirst that included a financial benchmarking survey, but its sample size was only around 20, and the information will be summarised and presented later. The feedback from the public consultation highlighted increasing cost pressures, inflation, and workforce concerns in the disability support sector. A member inquired whether the AbilityFirst report represented a considerable share of the market (i.e., the larger providers) so it might have more value than suggested by the sample size. The member noted that sound data is difficult to gather consistently across providers, and that other indicators are important to consider, notably how many providers are entering and leaving the market.

- The Chair commented on the difficult decision that needs to be made regarding the temporary 2% component of the price increase of disability supports from last year, which could be either completely, partially, or not unwound based on the evidence that has not been entirely wrapped up yet. The pressure on disability support providers was acknowledged and emphasised through the consultation process.

- A member noted that while most submissions are from providers, it is important to note that some are from participants and government representatives. Even though the number of submissions from these sources is smaller, their perspectives will be important to consider, and we should include this narrative in the subsequent version.

- The Chair notes the challenge of balancing quantitative evidence and qualitative feedback from stakeholders to support decision-making, which is a difficult exercise.

Costs to the Scheme

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- A member highlighted three main issues: scheme costs, staff retention, and balancing entry vs cost pressures.
    - Scheme Costs: The cost of the scheme could be driven up by factors other than price, such as an increase in the number of participants, so it is crucial to analyse the data correctly to determine the cause; caution is needed when using the price to address the cost problem, as it may have unintended consequences.
    - Staff retention: Observation of potential workforce pressures in the sector, with a need to pay above the award to attract staff due to a tight labour market and the complexity of the industry's growing sector of small business owners.
    - Entry vs cost pressure: Entry data needs to be examined more closely to determine whether the increase in providers is due to actual new entrants or former employees of large organisations starting their businesses, which could be a response to low wages being paid through an award payment rather than increasing competition from new businesses entering from outside the sector.
- The speaker acknowledges the valuable points raised by members regarding the need for more specific data on provider entrance and exits to understand the workforce challenges in the sector better. Kee also mentioned that analysis around wages and awards is being considered. Still, the Fair Work Commission will guide the Agency and providers. The Agency is interested in exploring the impact of rising costs on providers, which will be discussed further under economic conditions.
- A member agreed that volume problems should not be confused with price issues, and the data in the appendix shows that there does not seem to be an underlying cost issue driving the problem. Members suggest that understanding the complexity of participant needs is essential and that the substantial cost difference for Government between options must be considered.

SCHADS and the efficient Price Limit

- The pricing issue is linked to the efficient price based on the award paid. Any changes in award increases must be considered in determining price changes, also noting potential productivity increases over time. The complexity issue is reflected in the higher wages paid to higher-level staff members, but it could also reflect changes in the support workers being used. The comment about plan managers expanding participants needs to be clarified.
- The data shows that the number of participants using plan managers and the number of participants per provider is increasing. However, it is still early data, and the interpretation should not be pushed too hard.
- A member noted that the data shows that self-management remains relatively stable, indicating that capacity-building efforts may need to be more practical. Additionally, the fact that people are switching from Agency to outsourced plan management does not necessarily mean they are becoming more capable of managing themselves.

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Additional Analysis

- A member wanted to understand what additional analysis would be presented before making decisions, being concerned that necessary evidence may still be forthcoming and so not wanting to rush into debating solutions. The member was specifically interested in whether there will be an update on the efficient costs in the following presentation.
- Kee plans to have a more robust conceptual framework for the four sectors they are reviewing, which includes presenting data uniformly to make it easier to follow. The Agency also wants to focus on the dynamic of the market and the health of providers, as well as price monitoring and comparisons with other sectors.
- Kee states they have a vision for the current mission and are considering updating the pricing strategy document.

DSW Cost model and 2% temporary loading

- A member asked about updating the efficient cost to the DSW cost model, essential in supporting the 2% loading. They believe that by doing that work, it would be easier to address whether the 2% should continue, and he is concerned about this.
- A member suggested using either a benchmarking approach or modelling approach to update the efficient cost model for NDIS services. For some services, benchmarking against similar services in other sectors may be appropriate, while for others, such as Support Manager or plan manager roles, benchmarking may not be possible. In those cases, updating for inflation and reviewing the cost mix into the service may be more appropriate. Inflation could be factored in using known inflators, such as SCHADS award shifts and CPI. Updating the cost model this way could give an idea of what costs would look like now, assuming the business price structure was the same.
- A committee member highlighted the limitations of the data being used. Benchmarking can be helpful when the data needs to be more solid and reliable. Additionally, it is essential to consider productivity gains when updating cost bases, as they can significantly impact the overall cost structure. Finally, modelling from other data sources, such as starting from scratch, can also be helpful when dealing with poor-quality data. It is essential to approach cost modelling cautiously and consider all relevant factors, including neoclassical symptoms and indicators such as entries and exits.

Economic conditions

- Kee discussed the section about economic conditions in the paper, highlighting the subdued economy and potential pressure on supply in the care sector due to competition for labour. She also mentioned that inflationary pressures are expected to ease in the second half of this year.
- A member noted that open borders for immigration may mitigate the potential pressure on supply in the care sector and suggested looking at immigration statistics to assess how this might change the future relative to the past. She also noted comments provided separately to the Agency by email, on the papers being considered at the meeting.

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- Kee discussed the sustainability impact assessment on a 2% temporary loading related to DSW support and the option to keep or gradually reduce it. They noted that this decision is complex and depends on the decision for the other four areas under review. They suggested revisiting it once more data is available while highlighting it as an area to watch out for.
- It was noted that the 2% increase was initially introduced as a COVID adjustment and not an inflation adjustment. Still, people often need clarification on different issues and may push back on them if they feel they need to keep up with inflation. Whether to keep it depends on whether the original reason for its introduction is still valid.
- The Chair summarised that the challenge is to face the tension between those who are using the 2% loading to stay afloat and those who are genuinely using it for its intended purpose, and that decision-makers need to consider the risk and safety aspects of the disability support providers and the potential consequences of market entries and exits in that segment. The Chair emphasised the importance of keeping this in mind as they decide.
- The decision on whether providers need extra funding is not just based on quantitative data but on the overall evidence we have on the market and sector. It is essential to consider the vulnerable participants at risk and be conscious of the decisions made.
- Kee comments on David's last point, emphasising the importance of understanding the perspectives of consumers and other groups to understand better their needs and whether a price increase would address their concerns.

4.1 Next Meeting

The next PARG is expected to occur on 12th May 2023 with details confirmed closer to the date.

ACTIONS ARISING			
#	Meeting	Action	Status
1	20230302	Revise the consultation paper by broadening the questions to recognise other stakeholders (other than providers) and to narrow the scope of the questions.	Closed
2	20230302	Ensure the consultation paper recognises the NDIS Review	Closed
3	20230302	The consultation will clearly define the purpose of the document and identify the types of information that are likely to influence the Board's consideration.	Closed
4	20230302	Clarify that stakeholders can still provide general perspectives on support coordination and plan management, and that any information provided will be considered by the NDIS Review.	Closed
5	20230302	The paper should acknowledge Aboriginal and Torres Strait Islanders.	Closed
6	20230302	Consideration to add market monitoring changes and to analyse workforce demographics; this includes the impact of market changes on pricing.	Open

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Pricing Arrangement Reference Group (PARG)

Meeting: 12 May 2023

Minutes

Date: Friday, 12 May 2023

Time: 4:00pm – 5:30pm

Location: Microsoft Teams

Members		
Chair		
David Gifford	Scheme Actuary	By Teams
Pricing Reference Group Members		
Deborah s47F - perso	Independent Member	By Teams
Julie s47F - personal privacy, PSM	Independent Member	By Teams
Lynne s47F - personal priv	Independent Member	By Teams
Jim s47F - pe PSM	Independent Member	By Teams
Participating Observer nominated by CEO		
Gerrie s47F - person	General Manager, Provider and Markets Division	By Teams
Kee s47F - personal pr	A/g Branch Manager, Economics and Pricing	By Teams
Jenny s47F - perso	Director, Economics and Pricing Branch	By Teams
Secretariat		
Vincent s47F - personal p	A/g Director, Economics and Pricing Branch	By Teams

1.1 Welcome and apologies

- Apologies for Lynne s47F - personal priva who was absent from the meeting

1.2 Declaration of conflicts of interest

- No conflicts of interest received

1.3 Update by the Chair

- The Chair emphasized the importance of acknowledging the authority, pressure, and budget constraints surrounding the scheme, including recent announcements and ongoing scrutiny. They suggested briefly accepting these factors without delving into an extensive discussion, recognizing their impact on the current environment.
- The Chair acknowledged that the government had set a target of 8% to reduce expenditure growth from 1 July 2026, but there currently needs to be more detail regarding this target. They stated that the target's impact on pricing is expected to be insignificant for the 2022-2023 price review. The Chair expressed comfort with the draft recommendations and sought frank and informed feedback from the Group. They highlighted the importance of

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the disability support price and the decision regarding the temporary loading as key focus areas.

2.1 Acceptance of Minutes from last meeting

- Minutes of the meeting held on 20 April 2023 were accepted by all members.

2.2 Annual Pricing Review (APR) 2022-23 Update

- Kee provided an update on the draft report, requesting feedback on the recommendations based on data and evidence. They mentioned ongoing work to strengthen the evidence and additional topics to be discussed later in the session.

Inactive providers

- A member discussed the missing critical information regarding business dynamism and access in the paper, explicitly addressing the approximation of business exit using transaction and payment data. They highlighted a low level of inactivity (0.5% per annum) in the support coordination sector compared to previous payment activity. They intended to include this data to strengthen the argument in that section.
- Kee mentioned that the term "inactivity" is used in the draft report instead of "exit" to describe providers who have not received payments in the observed six months, although some historical claims may exist. She acknowledged the imperfection of this indicator.
- Gerrie raised concerns about the potential impact of no increase in support coordinators' rates on driving the market towards smaller traders and unregistered providers. They suggested considering the criticism that this could lead to a shift towards operating as sole traders and potentially compromise quality, although there is currently no proxy for quality.

Pricing Strategy Refresh

- Kee emphasized the importance of including a section on pricing strategy refresh and suggested implementing mandatory reporting, like the aged care sector, to improve monitoring and performance assessment.
- A member inquired about the powers of the NDIA to enforce mandatory reporting. They speculated that an independent price-setting authority for disability supports would likely have similar capabilities to entities such as the hospital and aged care pricing authority. They emphasized the need to consider whether the NDIA's powers around price setting should differ from those of an independent authority, especially given the ongoing review. The member acknowledged the potential challenges and costs of obtaining such powers, particularly for small providers, but highlighted the importance of raising the question and potentially pursuing legislative changes to address this issue.

Temporary Transformation Payment (TTP)

- A member raised concerns about the need for more information regarding the TTP and its requirement for providers to report pricing in the report. They stressed the importance of mentioning the TTP as a potential data source, regardless of the scheduled omission. The placement of the recommendation in the report was deemed peculiar. Another issue

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highlighted was the need for more powers tof enforce the survey, leading to incomplete responses.

- The Chair advised that the market has responded to the available information, with Ability First and Stuart Brown being notable players in benchmarking for aged care and disability supports. It is essential to acknowledge their contributions without devaluing their roles. The project presents an opportunity to initiate discussions on benchmarking in disability supports, considering the differences in power and price-setting structures.

Cancellations

- Kee raised that the seven-day cancellation rule has generated media attention and public concerns regarding its applicability during the COVID-19 pandemic. While most providers have been able to find alternative shifts for their workers, reports of participants being charged have emerged. Due to time constraints, a detailed recommendation cannot be provided, but further analysis will be conducted to address the issue, particularly about workers under the SCHADS award. It is necessary to clarify coverage under the current policy and explore potential solutions to bridge gaps, considering the complexities of differentiating between SCHADS-covered and non-SCHADS-covered workers. The Fair Work Commission's ruling also requires careful consideration before concluding.

Inflation

- A member raises concerns about the assumptions made regarding ongoing efficiencies in the sector and the lack of indexation for various cost categories, except for disability support workers and a specific aspect of support coordination. They emphasize the need for a philosophical discussion regarding these assumptions and the potential need for indexing to account for inflation and wage increases.

- The member points out the challenge of assuming providers can absorb inflation without evidence supporting this claim. They specifically highlight the difference in the benchmarking approach for therapy supports compared to an efficient cost model used previously. They mention the change in the positioning of NDIS prices and the current cost structures and prices used for benchmarking. They raise concerns about setting prices for the next year without considering the impact of inflation in the past 12 months and the expected future inflation.

- A member highlights the deficiencies in the costings derived from DSW Cost Model, acknowledging the lack of adjustments for 20% of costs beyond wages. They emphasize the necessity of incorporating CPI increases for administration, utilities, and other expenses, as the current models lack such adjustments except for additional supports.

- A member acknowledges the difficulty in selling the current approach when adjustments are only made for specific support categories, such as allied health, while others are excluded. They highlight the potential for workforce shortages and inefficiencies if benchmarking is inconsistent across all categories. The member emphasizes the need for a more precise and comprehensive explanation or discussion regarding the adjustments and their rationale to avoid confusion and dissatisfaction among providers. They propose incorporating operational costs and CPI adjustments for disability workers to create a stronger argument and a more coherent framework for decision-making.

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- Kee acknowledges the concerns raised and intends to address the issues in the write-up for support and other support categories. They mention the challenge of managing indexation for other items within the given timeframe and consider the possibility of structural changes or alternative approaches to tackling these issues.

DSW Cost Model

- A member suggested presenting the model for Disability Support Workers and making necessary updates to specific data points without changing the entire model as a possible solution. It was suggested that the report be more explicit about how the Cost Model works and clarify that all components are done as a percentage of the labour spent. This suggestion was made in response to concerns raised about the transparency of the model.
- A member highlighted the importance of explaining that the cost components are increasing to reflect the wage rise, as other regulatory areas usually index prices or model components accordingly. Regarding therapy supports, they mentioned the need to consider the duration before implementing CPI increases, considering providers' profitability and current inflation. Additionally, they advised caution in waiting until providers exit the market before adjusting prices, suggesting that adjustments should be made before reaching that point to avoid disruptions, particularly in plan management with multiple large providers.

Support Coordination

- Based on the information and observations gathered, the Chair expressed their belief that potential changes in support coordination are more vital than plan management and therapy. They noted that support coordination might have a stronger argument due to its cost-plus nature and the involvement of support coordinators on the board. However, they acknowledged that this belief is not backed by scientific evidence and emphasized that the existing recommendations still stand.

Recommendations 1 and 2

- A member commented on the first recommendation regarding the awards, expressing agreement and emphasizing the importance of presenting the cost model to support the case. They questioned the evidence and strong argumentation for the recommendation concerning efficient costs, suggesting the need to consider presenting options to the board with their respective advantages and disadvantages.
- The Chair acknowledges the challenge of quantifying the proportion of additional costs absorbed by providers due to COVID and temporary SCHADS changes. They recognize that the impact of COVID has diminished but note the difficulty in precisely quantifying it to justify the reduction from 2% to 1%. They suggest exploring broader measures in the economy or data points to demonstrate the unwinding effect of COVID and provide further justification for the reduction.
- A member suggested looking into the aged care sector for potential data on the impact of COVID-related costs. They mention that residential care facilities in aged care have faced similar challenges with vulnerable populations and support workers needing to stay home.

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They propose exploring if the aged care sector has monitored and documented the impact of COVID-related costs, which could provide valuable data to support the 1% reduction argument. They highlighted that the aged care sector, like disability, is politically sensitive due to concerns surrounding the well-being of vulnerable individuals, particularly about COVID-19.

- Another member highlighted those specific changes in COVID-related protocols had decreased the intensity and extent of response required, resulting in reduced costs. They suggest pointing out these changes as a justification for cost reduction to provide evidence for the decision.
- The member seeks clarification on the meaning of "pending the review" about the framework and the timing of price structure adjustments. They want to know if it implies waiting for the review recommendations before making changes or if it involves working on the framework while considering the review outcomes. Kee acknowledges aligning decisions with the upcoming review and ensuring coherence and feasibility.

Recommendation 3

- Members agreed with including the new family and domestic violence leave in the cost model while acknowledging some uncertainty about the 0.1% loading.

Recommendation 4

- All members expressed agreement with the recommendation regarding aged care award changes, noting that there would be no immediate impact as the SCHADS award is of a general nature. A member did request clarification on a graph in the report that compares prices and includes the 15% increase in the aged care sector.

Recommendation 5

- All members expressed agreement with the recommendation of managing expectations and gradually phasing out the TTP. A member acknowledged the initial reasons for its implementation and highlighted the importance of maintaining consistency. Another member supported phasing out the TTP as intended, emphasizing the need to contain and swiftly eliminate the payment. A different member suggested that allowing previous claimants to reclaim the payment while excluding new claimants seemed like a defensible approach.

Recommendations 6 and 7

- A member raised concerns about participants' access to a full range of services and the difficulty in finding providers due to no price increase. Public consultation submissions highlighted that participants' feedback mainly focused on the perceived high fees charged by therapy providers rather than accessing supports. The member acknowledged the importance of addressing these concerns and expressed scepticism about the feasibility of delaying indexing this year as the final year, indicating the need for alternative approaches in the future.

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- Another member agreed with not raising the pricing, acknowledging the upcoming year as the final opportunity for adjustments. They raised a particular concern regarding the paperwork and assessment costs in allied health professional services, suggesting a need for a review to assess their impact. The member suggested a further breakdown of services and funding allocation, particularly in early childhood intervention related to NDIS access.
- The remaining member agreed with the previous points and emphasized that this might be the last year without increased therapy support. They highlighted that the data indicates the pricing is approaching the market price, signalling the need for action in the future. A member noted that the modelling is based on advertised rates, which may reflect something other than the actual rates charged for government programs. While compliance costs with government programs tend to be higher, the modelling focuses on private patient charges.

4.1 Next Meeting

The next PARG is expected to occur on 16th May 2023 from 4.00pm.

ACTIONS ARISING			
#	Meeting	Action	Status
1	20230302	Revise the consultation paper by broadening the questions to recognise other stakeholders (other than providers) and to narrow the scope of the questions.	Closed
2	20230302	Ensure the consultation paper recognises the NDIS Review	Closed
3	20230302	The consultation will clearly define the purpose of the document and identify the types of information that are likely to influence the Board's consideration.	Closed
4	20230302	Clarify that stakeholders can still provide general perspectives on support coordination and plan management, and that any information provided will be considered by the NDIS Review.	Closed
5	20230302	The paper should acknowledge Aboriginal and Torres Strait Islanders.	Closed
6	20230302	Consideration to add market monitoring changes and to analyse workforce demographics; this includes the impact of market changes on pricing.	Open
7	20230512	Recommendation to present the DSW Cost Model to the Board. It was suggested that the report be more explicit about how the Cost Model works and clarify that all components are done as a percentage of the labour spent	Open
8	20230512	Regarding Recommendation 1, suggest the need to consider presenting options to the board with their respective advantages and disadvantages.	Open
9	20230512	Suggestion to use aged care sector for potential data on the impact of COVID-related costs.	Open
10	20230512	Provide clarification on the meaning of "pending the review".	Open
11	20230512	Regarding Recommendation 4, clarification on a graph in the report that compares prices and includes the 15% increase in the aged care sector.	Open

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Pricing Arrangement Reference Group (PARG)

Meeting: 16 May 2023

Minutes

Date: Tuesday, 16 May 2023

Time: 4:00pm – 5:00pm

Location: Microsoft Teams

Members		
Chair		
David Gifford	Scheme Actuary	By Teams
Pricing Reference Group Members		
Deborah [redacted]	Independent Member	By Teams
Julie [redacted] PSM	Independent Member	By Teams
Lynne [redacted]	Independent Member	By Teams
Jim [redacted] PSM	Independent Member	By Teams
Participating Observer nominated by CEO		
Gerrie [redacted]	General Manager, Provider and Markets Division	By Teams
Kee [redacted]	A/g Branch Manager, Economics and Pricing	By Teams
Jenny [redacted]	Director, Economics and Pricing Branch	By Teams
Secretariat		
Vincent [redacted]	A/g Director, Economics and Pricing Branch	By Teams

1.1 Welcome and apologies

- No apologies

1.2 Declaration of conflicts of interest

- No conflicts of interest received

1.3 Update by the Chair

- The Chair opened the meeting by acknowledging recommendations from the previous meeting, such as the disability support worker and therapy recommendations, confirming all members' support for the recommendations up to that point to be recorded in the minutes. The focus of this meeting is to continue discussing the remaining recommendations for support coordination and plan management.

2.2 Annual Pricing Review (APR) 2022-23 Update - Continued

Recommendation 8

- All members expressed agreement with the recommendation.

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- Feedback was provided regarding the need for more explanation for the differentiation in treatment between levels one, two, and three for support coordination. Additionally, concerns were raised about the necessity of level one considering the limited number of claims, emphasizing the need to clarify why a specific part of the sector is being treated differently for indexation.
- A member acknowledged the concern raised and expressed empathy toward the potential quality or safety issues. They highlighted the need to consider the consistency of indexation across different groups and evaluate the arguments for differential treatment.
- A member pointed out two key aspects of support coordination: a higher proportion of workers whose pay is tied to the award and a greater participant safety risk. They argued that these statements could be applied to support coordination compared to therapy and plan management supports.
- Another member agreed with this viewpoint, emphasizing that splitting the sector seems difficult to justify. They suggest estimating the number of people on the SCHADS award in the sector and proportioning the increase accordingly, which could result in a lower percentage. They emphasize the importance of developing a cost model for this group to address the issue effectively.
- A member suggests leaving the recommendation as it is and committing to developing a cost model as soon as possible. They believe the quality and safety aspect needs to be improved to differentiate support coordination from other services. This highlights the uncertainty regarding the data on workers tied to the SCHADS Award, indicating the need for more comprehensive information.

Recommendation 9

- All members expressed agreement with the recommendation.
- A member suggested including a consumer element, such as participant satisfaction ratings, to explore the relationship between quality and provider size, along with anecdotes highlighting individual experiences and perspectives on working in smaller startups compared to larger organizations within the NDIA. They also raised the idea of conducting a consumer survey to gather further insights if one still needs to be created.
- The Chair acknowledged that the distribution of providers and a potential shift towards smaller providers might not directly indicate a change in quality. Instead, it could reflect the ability of smaller providers, such as sole traders, to offer services more efficiently due to lower overhead costs. This perspective suggests that the market dynamics and provider choices are influenced by economic factors rather than directly reflecting quality.
- A member explained that assessing whether participants are receiving the services they desire and whether the model of small providers is cost-effective and generates satisfactory outcomes is essential. Evaluating participant outcomes is crucial for determining if pricing strategies promote better value for money or potentially undermine it.
- A member suggested regional variations in outcomes and pricing, where it is essential to analyse the data specific to different regions, particularly in rural and remote areas, to develop tailored strategies that address the unique needs of each region.

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Recommendation 10

- All members expressed agreement with the recommendation.
- Gerrie mentioned the challenges in plan management when using scheme funds after a participant's death, emphasizing the need to consider legal implications. Evaluating how support coordination can be legally funded was suggested and adopting the recommendation accordingly. The wording of the recommendation may require adjustment based on legal advice received to ensure a suitable funding approach.
- A member raised concerns about the wording of recommendation 10, suggesting that it needed more specificity and clarity. It was proposed that the recommendation clearly outline when and how the action will be taken, consider the relevant factors, and provide the context and rationale for the recommendation based on feedback from the sector.

Recommendation 11

- All members expressed agreement with the recommendation.
- A member acknowledged the cost of cybersecurity as a necessary business expense, although no immediate changes are needed on page 61. They emphasize the significance of addressing ongoing and increasing cybersecurity costs in future considerations. Regarding the sentence on page 62 about difficulties in attracting and retaining staff due to the rising cost of living, the participant suggests revising the statement to provide better clarity, particularly regarding wage competitiveness and its impact on staff recruitment and retention.

Recommendation 12

- All members expressed agreement with the recommendation.
- Regarding the recommendation and the review process, a member questioned the intention to conduct the review annually, starting from the upcoming year (next year) and continuing in subsequent years. This implies that a review process will be completed each year after the initial review.
- Another member raised the importance of providing a more detailed explanation for the adopted indexation method to support the recommendation and ensure transparency and understanding among stakeholders.

Recommendation 13

- All members expressed agreement with the recommendation.

4.1 Next Meeting

The Chair thanked everyone for their valuable feedback and discussions throughout the process. Once the report is sent to the board, it will be provided to members for reference. The Chair emphasized the importance of the group's role in providing confidence in the recommendations and acknowledged the entire team's hard work. The next PARG meeting will reconvene in the coming months, likely around August or September, to discuss the work plan for the following year.

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ACTIONS ARISING			
#	Meeting	Action	Status
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8	20230512	Regarding Recommendation 1, suggest the need to consider presenting options to the board with their respective advantages and disadvantages.	Open
9	20230512	Suggestion to use aged care sector for potential data on the impact of COVID-related costs.	Open
10	20230512	Provide clarification on the meaning of "pending the review".	Open
11	20230512	Regarding Recommendation 4, clarification on a graph in the report that compares prices and includes the 15% increase in the aged care sector.	Open
12	20230516	Create a tracker for better monitoring and follow-up on recommendations and their status.	Open
13	20230516	Consider exploring the use of the Herfindahl-Hirschman Index (HHI) to measure market concentration and assess the presence of market power.	Open
14	20230516	Explore data on the market distribution within the last six months or a year to understand the current landscape and market dynamics.	Open

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Pricing Arrangement Reference Group (PARG)

Meeting: 18 May 2023

Minutes

Date: Thursday, 18 May 2023
Time: 1:00pm – 2:00pm
Location: Microsoft Teams

NDIA		
David Gifford	Chair, Scheme Actuary	By Teams
Kee [redacted]	Branch Manager, Economics and Pricing	By Teams
Vincent [redacted]	PARG Secretariat	By Teams
PARG Members		
Deborah [redacted]	Independent Member	By Teams
Jim [redacted]	Independent Member	By Teams
Julie [redacted]	Independent Member	By Teams
Lynne [redacted]	Independent Member	By Teams
NDIS Review Chairs		
Bruce [redacted]	Co-chair	By Teams
Lisa [redacted]	Co-chair	By Teams
Stephen [redacted]	Member	By Teams
NDIS Review Secretariat		
James [redacted]	First Assistant Secretary	By Teams
Joanna [redacted]	Assistant Secretary	By Teams
James [redacted]	NDIS Review Secretariat	By Teams

1.1 Welcome and apologies

- Acknowledgment of Country.
- Apologies for Lisa [redacted] who was absent from the meeting.

1.2 Introductions

- The Chair took a moment to introduce members present from the Agency, the four members of the Pricing Arrangements Reference Group and the NDIS Review panel members (including the secretariat in the NDIS Review).

2.2 Overview of the meeting

- The Chair provided an overview of the meeting's purpose to discuss the progress of the 2022-23 Annual Price Review and the role of the Pricing Arrangement Reference Group.

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- Given the NDIS review's significance, the reference group expressed interest in engaging with the Review panel, sharing their perspectives, and seeking general conversation. The Agency has adopted a minimalist approach to the price review, considering the ongoing NDIS review and draft recommendations will be presented to the board on the 25th May. Once approved, a briefing with the panel will be scheduled to discuss the recommendations in detail.

2.2 Reflection from PARG members

PARG member 1

- The first PARG member highlighted the historical concern about providers not being adequately paid, leading to the introduction of Temporary Transformation Payments being phased out. The concern now revolves around whether sufficient funding is provided for efficient service costs, with challenges in obtaining accurate provider data. Additionally, there has been a focus on ensuring participant access to therapists and health professionals, resulting in generous payments now being balanced due to inflation. The member suggests it may be time to consider alternative approaches and gather more informed insights.

PARG member 2

- The second PARG member noted several pricing-related challenges. The availability of accurate and enforceable information for pricing decisions is a concern, like the approach taken in the aged care sector. The pricing complexity, including numerous items and considerations, creates difficulties for participants and providers alike. Simplifying the process, exploring alternative models such as outcome-based pricing, and addressing quality issues are important considerations. Additionally, ensuring pricing remains competitive within the broader market, including aged care, is crucial to avoid market displacement.

PARG member 3

- The third PARG member agreed with the points raised by the other members and highlighted three key aspects for discussion.
- Firstly, there is a need to consider using pricing to manage scheme costs carefully. It is crucial to analyse the underlying factors driving cost increases and ensure that pricing policies do not inadvertently push quality providers out of the market. Understanding the cost drivers is essential for effective decision-making.
- Secondly, the market structure is evolving, with a noticeable growth in the number of small providers. While this may bring certain benefits, such as personalized service, further work on examining prices and how registration requirements impact market dynamics is required. Overheads and pricing mechanisms can influence provider decisions, potentially leading to variations in cost structures. Additionally, caution must be used when evaluating the implications of mandatory registration and explore alternative quality control mechanisms to avoid driving providers into the unregulated market.
- Lastly, there is a need for cautious consideration of long-term price deregulation. While it has been a goal of the NDIS to achieve deregulation as the market develops, while acknowledging the balance between supply and demand. Without strong activation of the demand side and robust

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quality control measures, deregulation could lead to price pressures and potential exploitation by unscrupulous providers. Drawing lessons from previous experiences, such as Victoria's vocational education and training issues, prioritising quality control and ensuring that demand incentives are aligned.

PARG member 4

- The last PARG member agreed with all points raised by the previous member and listed three additional perspectives. Firstly, the pricing complexity in the disability services sector needs to be acknowledged, as it differs significantly from other areas, such as acute care or primary care. Activity-Based Funding (ABF) models may not be appropriate for social services and must carefully consider how to approach pricing in this unique environment.
- Secondly, there is much to learn from European countries, particularly Norway, Sweden, and Denmark, who have made significant progress in this field. Exploring their pricing methodologies and experiences could provide valuable insights and inform pricing strategies.
- Lastly, when discussing pricing, it is crucial to integrate it effectively within the broader context of the NDIS budget. While volumes and prices are interconnected, there needs to be more discussion on how to manage this interaction. The interplay between prices and volumes will ensure a comprehensive and well-rounded approach.

2.2 Questions and Answers for NDIS Review members

NDIS Pricing – short to medium term

- A NDIS Review member addressed pricing improvement in the short to medium term and exploring longer-term and alternative payment approaches. They highlighted the importance of information and complexity in this context. Specifically, they raised the issue of needing more data and its impact on pricing models, emphasizing the need for a solution between full registration and a lack of data. They proposed the idea of minimal information tied to payment devices, drawing parallels to the Medicare system's transparency and efficiency.

Obtaining provider data

- A PARG member highlighted the critical nature of obtaining data in the disability sector and shared their personal experience as a health economics and social policy expert, stating that pricing disability services have been the most challenging task. They discussed three possible approaches within the meeting: collecting data from the sector, addressing compliance issues, and obtaining outcomes data from community sector participants. The member expressed the need to balance costs with outcomes and quality, citing Norway, Sweden, and Denmark as countries that have made progress in these areas but noting the consideration of their higher GDP spending on disability services.
- The Chair acknowledged the importance of information and expressed their involvement in the work this year, highlighting the lack of comprehensive data on cost structures and competition in the market of disability service providers. They mentioned the previous survey conducted by the Agency and the emerging data collection within the disability sector but noted the limitations and

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issues associated with self-collected information. They emphasized the need for information in areas such as disability supports with therapy, support coordination, and plan management.

- A PARG member raised two quick points. Firstly, they highlighted the need to explore the agency's powers and authority to collect information, acknowledging it as a significant issue. Secondly, they acknowledged the challenge of ensuring compliance, particularly with many small providers.
- A NDIS Review Secretariat questioned the challenges in obtaining the necessary information, speculating that perhaps the problem is the need for providers' systems to align with a standardized approach for data submission.
- A PARG member highlighted the difficulties in aligning data collection methods, reporting formats, and accounting perspectives, resulting in a need for uniformity in the data obtained. They also mentioned the compliance issue, where providers were expected to report accurately but faced significant challenges in meeting the requirements.

NDIA as sole purchaser

- A NDIS Review member expressed interest in leveraging the NDIA's position as the sole purchaser to improve pricing and service provision. They suggested a more proactive approach by providing a list of eligible providers and transparent price lists agreed upon through a tender process. Drawing a comparison to the pharmaceutical industry, they highlighted the potential benefits of adopting a selective listing approach, like New Zealand, to encourage competitive pricing and quality service delivery.
- The Chair highlighted the importance of leveraging the NDIA's position as a significant purchaser in certain markets, such as lower-cost capital items and support coordination. They acknowledged the need to approach the economics of these markets differently from other areas and expressed support for using the NDIA's purchasing power to maximize value. The Chair also mentioned the recent budget announcements as an opportunity to explore further and make recommendations on this matter.

NDIS Review Paper

- A PARG member mentioned their recent publication on assistive technology and suggested referencing it for further information. However, their main point was to inquire about the progress of the ongoing review and its implications for the PARG. They expressed interest in understanding how the review outcomes would influence the decisions and recommendations presented in the forthcoming report.
- It was mentioned that the review on pricing and payments is about to release a paper that addresses the challenges discussed in the meeting. They emphasized that the review's findings and recommendations align with the issues raised and suggested referring to the upcoming paper for further details.

Participant Choice and Control

- A PARG member highlighted two constraints in using negotiation to achieve better value. Firstly, certain products, like wheelchairs, may require customization based on individual needs, making it challenging to standardize negotiations. Secondly, the concept of choice and control in the current implementation of the scheme allows participants to make their own decisions, regardless of the

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scheme's recommendations. They raised whether providing information and price lists for participants to make informed choices would be sufficient or if mandating choices from the list would be necessary.

- A NDIS Review member acknowledged that when it comes to specific cases like wheelchair requirements, individual needs and preferences can vary significantly. It highlights the complexity of implementing tendering or negotiation processes, as each person's situation may require a tailored approach. The details and complexities of individual cases need to be carefully considered to ensure that the pricing and procurement methods are effective and appropriate for diverse needs.

NDIS Pricing – long term

- A NDIS Review Secretariat noted the importance of price regulation in the long term for NDIS services. It was acknowledged that while there may be practical and policy constraints, price controls are necessary to ensure sustainability and address price responsiveness and cost pressures. The upcoming release of a consultation paper by the review was mentioned, which will further explore the topic. The need for evidence and exploration of alternative reforms, such as budget adjustments and contestable arrangements, was also highlighted.

Supply and Demand

- A PARG member acknowledged that budget constraints are crucial to instil demand discipline in the market. Without a budget constraint, individuals may not be concerned about the cost and may even opt for higher-priced services assuming they are of better quality. However, implementing a hard budget constraint poses a policy challenge as the NDIS needs to be flexible enough to accommodate changing needs over time. Distinguishing between necessary budget increases due to changing support requirements and increases resulting from excessive spending would be difficult in practice regarding credibility and administrative management.
- The Chair highlighted the challenge of implementing a hard budget constraint within the current budget-setting framework. The observation is that there is a high level of "inter-plan inflation" where participants overspend their plan and seek a review to obtain an increase. This raises concerns about the potential risks associated with deregulated pricing, considering the existing patterns of plan overspending. While there may be ways to address these challenges, knowing the risks involved in the current context is important.

Closing comments

- The NDIS Review Co-Chair addressed the group with two comments to ponder.
- Firstly, the acknowledged the challenge of balancing budget constraints and flexibility of the NDIS. The potential benefits of a tight budget constraint, such as price sensitivity and innovation, were acknowledged, but concerns were raised about the additional stress it may impose on participants. Further examination and collaboration were deemed necessary to find a viable solution that ensures sufficient funding while considering the well-being of individuals with disabilities.
- Secondly, the Co-Chair delved into the issue of price regulation in the NDIS market. The imperfect nature of the market raised doubts about the effectiveness of price regulation. Concerns were

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raised about the impact of setting prices too low, which may lead to a focus on volume rather than quality.

4.1 Next Meeting

- The Chair thanked everyone for their valuable contributions and engaging discussion. It was acknowledged that further conversations were needed, especially considering the upcoming release of the NDIS Review paper.
- The Chair proposed scheduling the next meeting in early to mid-June, ensuring sufficient time for productive dialogue.

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NDIA Board meeting of 25 May 2023

The contents of this document are OFFICIAL: SENSITIVE

Agenda Item: #

Agenda Item: Annual Pricing Review 2022-23

Paper Type: **For Decision**

SLT Sponsor: David Gifford, Scheme Actuary

1. Purpose

1.1. To seek approval on the Annual Pricing Review (APR) 2022-23 draft recommendations and the release of the draft report (Attachment A).

2. Recommendation

2.1. That the Board approves the APR 2022-23 draft recommendations; and approves the draft report for release.

3. Research and analysis

3.1. An overview of the APR's research and analysis was presented to the Board on 28 April 2023. Research and analysis have now been completed.

3.2. A summary of the feedback from the Consultation Paper was provided at the last Board meeting on 28 April 2023. After incorporating late submissions, we have now received 304 submissions through the consultation process.

3.3. Business dynamism was analysed which examines the level of business inactivity for Disability Support Worker (DSW), therapy, support coordination and plan management.

3.4. Ability Roundtable conducted a comprehensive benchmarking survey, with 24 providers participating (mainly large providers that dominate the market), on topics including SCHADS Award changes, COVID-19 impacts, and compliance costs. The results have been incorporated into the APR report.

3.5. Private billing rates across all types of NDIS therapy supports was undertaken to compare the NDIS prices with the private sector. Regression analyses have been undertaken to estimate the average fully loaded hourly cost of therapy supply.

4. Draft recommendations

Below are the key draft recommendations. For the full list please refer to the Executive Summary of the report (Attachment A).

4.1. *DSW Related Supports*

Recommendation 1

The NDIA, subject to any specific recommendation arising from the current Annual Pricing Review and any future reviews, should increase the price limits for supports that are determined by the NDIS Disability Support Worker Cost Model on 1 July each year to reflect any changes in the minimum wages specified in the Social, Community, Home Care And Disability Services Industry Award 2010 (SCHADS Award) following the Fair Work Commission's Annual Wage Review and any increase in the Superannuation Guarantee Charge.

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Recommendation 2

The NDIA should reduce the temporary loading applied to the NDIS Disability Support Worker Cost Model to 1% from 1 July 2023, with the temporary loading to cease from 1 July 2024.

Recommendation 3

The NDIA should include consideration of paid family and domestic violence leave into the Disability Support Worker Cost Model to better reflect the new entitlements for workers in the industry. Consequently, the average price limit for an hour of standard, weekday daytime disability support should increase by 0.1% from 1 July 2023.

4.2. *Temporary Transformation Payment Loading*

Recommendation 5

The NDIA should maintain its current pricing strategy including the scheduled reduction over the next year of the Temporary Transformation Payment (TTP) loading to 1.5% on 1 July 2023. The TTP loading should cease to apply from 1 July 2024.

The NDIA should allow registered providers who have been claiming for the TTP in financial year 2022-23 can continue to do so in financial year 2023-24 until cessation. Providers who were not claiming for TTP in financial year 2022-23 should not claim for TTP in financial year 2023-24.

4.3. *Therapy Supports*

Recommendation 6

The NDIA should not make any structural adjustment to the pricing arrangements for therapy supports at this time and should not index the price limits for therapy supports on 1 July 2023.

4.4. *Support Coordination*

Recommendation 8

The NDIA should not make any structural adjustment to the NDIS pricing arrangements for support coordination at this time and should:

- Index the price limits for the Level 1: Support Connection services on 1 July 2023, in line with the indexation of supports determined by the NDIS Disability Support Worker Cost Model in recommendation 1, and
- Not index the price limits for the Level 2: Coordination of Supports services and Level 3: Specialist Support Coordination services on 1 July 2023.

4.5. *Plan Management Supports*

Recommendation 11

The NDIA should not make any structural adjustment to the NDIS pricing arrangements for plan management at this time and should not index the price limits for plan management fees on 1 July 2023.

4.6. *Other Supports*

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Recommendation 12

The NDIA, subject to any specific recommendation arising from the current Annual Pricing Review and any future reviews, should:

- Increase the price limits for other supports, not covered by Disability Support Worker-related supports, on 1 July each year in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses) and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter immediately preceding the indexation date (with an 80/20 weighting).

5. Risks

5.1. Price limits for therapy has not increased since 2019 while price limits for support coordination Level 2 and Level 3 as well as plan management have not been increased since 2020. There is a risk that the sector will react strongly as there may have been expectations of a price limit increase and some service providers may withdraw from the market.

5.2. The 2% temporary loading introduced from 1 July 2022 was intended to be a temporary measure to assist providers to adjust to costs associated from ongoing COVID management and SCHADS Award changes. The APR recommends for the loading to decrease to 1% from 1 July 2023 and be removed on 1 July 2024. There is a potential risk that the stakeholders may have anticipated more assistance.

5.3. The TTP was initially introduced on 1 July 2019 at 7.5% to allow time for the providers transit to more efficient prices as the NDIS markets continue to mature. The reduction from 3% to 1.5% from 1 July 2023 is per the original timeline but there may still have pushback from stakeholders who expected it to be phased out at a slower rate.

6. Sustainability Impacts

6.1. Assuming all the recommendations put forward to the Board are endorsed, the Sustainability Impact Assessment (SIA) of the APR recommendations would impose an additional expenditure of $48 million for 2023-24 relative to the most recent Annual Financial Sustainability Report (AFSR) projections at 30 November 2022 and a total saving of $929 million over the forward estimates to 2026-27. This base case scenario is estimated by assuming the Fair Work Commission National Minimum Wage (NMW) decision is 3.9%, plus the Superannuation Guarantee increase of 0.5%, in line with what is assumed in the November 2022 interim AFSR update. The additional expenditure comprises:

- $326 million additional expenditure for 2023-24 and $452 million over the forward estimates to 2026-27 for Attendant Care. This includes allowance for Domestic Violence leave of 0.1% and unwinding the temporary loading of 2%, included on last year's review, over two years. The AFSR assumed the 2% temporary loading would be removed from 1 July 2023 hence retaining this loading at 1% for an additional year effectively would imply an increase in expenditure of 1.1% for 2023-24 compared to the AFSR.

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- Increase in expenditure of $1 million for 2023-24 and $6 million over the forward estimates to 2026-27 for non-SCHADS support using the indexation of 80%WPI /20%CPI. The CPI for the 12-month period to March 2023 was 7.0%. The Wage Price Index (WPI) for the 12-month period to March 2023 was 3.7%.
- Savings of $212 million for therapy, $24 million for plan management and $44 million for support coordination for 2023-24 and a total saving of $1,060 million for therapy, $119 million for plan management and $222 million for support coordination over the forward estimates to 2026-27. The AFSR assumes therapy, plan management and support coordination (levels 2 and 3) are indexed annually.

6.2. The actual financial impact from the APR will be largely based on the NMW decision. As part of the sensitivity analysis, we have also estimated sustainability impacts based on 5% and 7% NMW decisions. Under a 5% NMW assumption, the total cost impact of the APR recommendations is estimated to be $375 million for 2023-24 and $696 million over the forward estimates to 2026-27. Under a 7% NMW assumption, the total cost impact of all the APR recommendations is estimated to $969 million for 2023-24 and $3,652 million over the forward estimates to 2026-27.

6.3. The TTP allowance has been recommended to reduce as previously planned, to 1.5% from 1 July 2023 and to 0% from 1 July 2024. This is the current assumption within the AFSR, therefore there is no financial impact.

6.4. The indexation approach for Capital supports are currently being estimated through a separate process.

6.5. The NDIS budget initiatives announced 9 May 2023 assumed $1.5 billion in savings relating to price changes over the forward estimates, based on the estimated impact of freezing prices for therapy, plan management and support coordination for two years. At the base estimate (6.1 above), the draft recommendations for the 2023-24 financial year in this year's APR are expected to deliver $0.9 billion in savings over the forward estimates, or 62% of the total budgeted savings. Future APRs will provide an opportunity to review subsequent year assumptions and achieve further savings relative to the November 2022 interim AFSR update where appropriate.

7. Next steps

7.1. Once approved by the Board, communication materials will be developed to support the release of the final recommendations in June 2023. The final recommendations will be published in the 2022-23 APR Report in June 2023 for a 1 July 2023 implementation. Plan indexation will take place in early July 2023 to ensure relevant balances in participants' plans are increased appropriately.

Attachments

Attachment A: Draft 2022-23 Annual Pricing Review report

Internal use only – removed for meeting

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NDIA Board meeting of 25 May 2023

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National Disability Insurance Scheme

2022-23 Annual Pricing Review Report

June 2023

Delivered by the National Disability Insurance Agency

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Acknowledgement

The NDIA acknowledges and pays respect to the past, present and future Traditional Custodians and Elders of this nation and the continuation of cultural, spiritual and educational practices of Aboriginal and Torres Strait Islander peoples.

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The National Disability Insurance Agency expects that you will only use the information in this document to benefit people with disability.

Terms that we use

Acronym	Meaning
ABS	Australian Bureau of Statistics
APR	Annual Pricing Review
CPI	Consumer Price Index
DSW	Disability Support Worker
FWC	Fair Work Commission
NDIA or Agency	National Disability Insurance Agency
NDIS or Scheme	National Disability Insurance Scheme
NDIS Commission	National Disability Insurance Scheme Quality and Safeguards Commission
SCHADS Award	*Social, Community, Home Care and Disability Services Industry Award 2010*
SDA	Specialist Disability Accommodation
SIL	Supported Independent Living
WPI	Wage Price Index

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Table of Contents

1 Executive summary 4

2 Introduction 14

3 Domestic economic conditions and the care economy 20

4 Disability Support Worker related supports 26

5 Therapy supports 40

6 Support coordination 55

7 Plan management supports 64

8 NDIS Pricing 72

Appendix A – Feedback from the Consultation Paper 79

Appendix B – Domestic and family violence research 94

Appendix C – Non-wage Aged Care reforms 95

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1 Executive summary

The National Disability Insurance Scheme (NDIS) was established in 2013 to support people with disability to pursue their goals, to help them to realise their full potential, to assist them to participate in and contribute to society, and to empower them to exercise choice and control over their lives and futures. The NDIS provides funding to eligible individuals ("participants") so that they can purchase, in the open market, the disability related goods and services ("supports") that they need.

The National Disability Insurance Agency (NDIA) monitors and reviews its price control framework and other market settings to determine whether they are still appropriate and reflect the current market conditions.

Annual Pricing Reviews (APRs) are an important part of the monitoring and review process. The NDIA Board developed a Terms of Reference of the 2022-23 APR to guide the approach. This requires 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.

As part of the 2022-23 APR, extensive consultations with participants, providers and other stakeholders were completed, including:

- Publishing a Consultation Paper and completing analysis of the 304 submissions received.
- Consultations with other government insurance and funding schemes.
- Consultations with the Pricing Arrangements Reference Group.
- Consultations with the Pricing Interdepartmental Committee.
- Consultations with the Department of Veterans' Affairs and the Chief Allied Health Officer.

A summary of submissions to the Consultation Paper can be found in Appendix A.

Disability Support Worker (DSW) related supports

In setting price limits, the NDIA uses the NDIS DSW Cost Model to estimate the costs that a reasonably efficient provider would incur in delivering a billable hour of support. The Cost Model takes account of all the costs associated with every billable hour, including base pay; shift loadings; salary on costs; operational overheads such as supervision costs and utilisation; corporate overheads and margin. It uses these estimates to set the price limits of supports that are delivered by DSWs, with price limit set at the level that can be achieved by providers who match the benchmarks. The outputs from the Cost Model considers minimum employment standards and efficient costs to provide DSW-related supports in Australia.

Growth in the total number of DSW participants (15%), providers (28%) and payments (34%) continued over the six months to December 2022 compared to the six months to December 2021.

A total of 59 submissions on DSW-related supports were received through Public Consultation. One of main themes raised was that adjustments for many providers on costs continue to relate to quality, safeguards, and compliance, COVID and *Social, Community,*

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Home Care and Disability Services Industry Award 2010 (SCHADS Award) changes. Reponses from participants raised the concern of varying skills of support workers who were providing supports, but generally still charging at the NDIS price limit.

In determining the price limit for DSW-related supports, analysis using data of the Health Care and Social Assistance (HCSA) industry was undertaken to understand the sector which disability support workers operate in. The analyses suggest that the labour market for the care sector remains tight. These conditions could potentially intensify competition in terms of labour with other care sectors, which could put more pressure on supply going forward.

Despite the overall sector growth, the sector is still being impacted by COVID. The results from the 2022-23 Ability Roundtable survey shows that most surveyed providers (71%) reported that COVID was still impacting on their costs in 2022. The average percentage increase in costs due to COVID was reported at 1.5%, in line with the 1.5% cost impact estimate in the 2021-22 APR. This data is based on survey responses from 24 providers, with an average revenue of between $50 and $100 million.

Similarly, the impact of the SCHADS Award changes from 1 July 2022 included changes to minimum shift time, broken shift allowances and cancelled shift policies. The Ability Roundtable survey found 62% of respondents reported an increase in staffing numbers to deal with the rostering impact. Two-thirds of respondents reported that their bottom-line costs had increased as a result with the average cost increase reported by all respondents at 1.5%, aligned to estimated cost impact from the 2021-22 APR. However, most reported that those increases in costs had been one-offs in nature, including purchasing new software and changing rosters.

The 2% temporary loading introduced from 1 July 2022 in the DSW Cost Model was intended to be a temporary measure to assist providers adjust to costs associated from ongoing COVID management and SCHADS Award changes. Analysis and data suggest that there are merits in favour of retaining the loading at a reduced rate to ease providers' transition. The following considerations have been given:

- It should be recognised that COVID related restrictions in the economy have been wound back. However, COVID is still active and is disrupting supports being delivered to NDIS participants. Providers incur some costs when these arise (such as PPE and RAT tests). The NDIS sector also represents some of the most vulnerable groups in the community and the adjustments from COVID has been somewhat slower than the rest of the nation.
- It appears many of the adjustments needed for the SCHADS Award changes were one-off costs for providers. It is considered that there is still ongoing adjustment being made by the sector as these major Award changes are still relatively recent. The NDIA recognises there is some cost impact that can still be borne by providers as it takes time for a sector to fully adjust systems and processes to major Award changes.

The NDIA considers that the majority of these costs have been addressed and/or wound back over the past year. COVID costs are reducing post pandemic and many of the costs from the changes to the SCHADS Award were one-off adjustments. However, the NDIA acknowledges there remains the potential to impact participant safety as some providers are still facing transition costs associated with both.

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Evidence suggests that many providers have already adjusted, but some are still implementing adjustments associated with COVID and SCHADS Awards changes. On balance, the NDIA considers it necessary to extend the temporary loading for a further 12 months at 1% from 1 July 2023 with this ceasing on 1 July 2024, to allow providers more time for the transition.

Recommendation 1

The NDIA, subject to any specific recommendation arising from the current Annual Pricing Review, should increase the price limits for supports that are determined by the NDIS Disability Support Worker Cost Model from 1 July 2023 to reflect any changes in the minimum wages specified in the Social, Community, Home Care And Disability Services Industry Award 2010 (SCHADS Award) following the Fair Work Commission's Annual Wage Review and any increase in the Superannuation Guarantee Charge.

Recommendation 2

The NDIA should extend the temporary loading for a further 12 months at 1% from 1 July 2023 with this ceasing on 1 July 2024.

DSW Cost Model changes

The DSW Cost Model is updated annually alongside any changes to the superannuation contribution, which will increase from 10.5% to 11% from 1 July 2023. This increase will be passed on in full to the DSW Cost Model.

An additional consideration this year is the new paid family and domestic violence leave introduced by the Fair Work Commission. Based on previous surveys and studies, the NDIA estimates an upper bound number of workers accessing family and domestic violence leave to be 2.3%, with those accessing the leave assumed to be accessing the entire minimum entitlement. Incorporating this into the 2022-23 DSW Cost Model, holding everything else constant, this equates to a 0.1% increase to an hour of the standard, weekday daytime disability support worker. The NDIA acknowledges this may be an overestimation of the actual uptake of this leave in the sector as it is implemented and will continue monitoring its impact into the future.

Recommendation 3

The NDIA should include the paid family and domestic violence leave into the Disability Support Worker Cost Model - an increase of 0.1% from 1 July 2023 to reflect the new entitlements for workers in the industry.

Aged Care Award changes

The Fair Work Commission has lifted the aged care worker wages in relevant Awards by 15% from July 2023. The Award rates for DSWs are still estimated to be higher than comparable aged care workers. However, there could be greater attraction of workers to the aged care workforce as the disability sector and aged care sector share the same pool of workers. Although the NDIA expects the impact of these changes to be limited, the NDIA should continue to monitor the impact of these changes.

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Recommendation 4

The NDIA should continue to work with the sector to monitor the impact of changes to the Aged Care Award that come into effect on 1 July 2023 with a view to further addressing these costs in the future if necessary.

Temporary Transformation Payment loading

The Temporary Transformation Payment (TTP) was initially setup to allow providers time to assist transitioning to more efficient systems and prices. The NDIA has conducted extensive financial benchmarking over the last six years, and consequently, the NDIA did not consider it necessary to conduct a financial benchmarking survey in 2022-2023.

As per the initial pricing strategy framework, the NDIA does not see a need to change the timeline of the TTP to ensure balance is maintained between incentivising providers to achieve greater efficiencies while considering differing cost structures of providers. In the absence of a NDIS Financial Benchmarking Survey, is it reasonable to assume those who were accessing the TTP in FY2022-23 may continue to need access to assist transitioning systems.

The NDIA will continue to work closely with the sector in monitoring market conditions and cost structures.

Recommendation 5

The NDIA should maintain its current pricing strategy including the scheduled reduction over the next year of the Temporary Transformation Payment (TTP) loading to 1.5% on 1 July 2023. The TTP loading should cease to apply from 1 July 2024.

The NDIA should allow registered providers who have been claiming for the TTP in financial year 2022-23 to continue to do so in financial year 2023-24 until cessation.

Therapy supports

In the six months to December 2022, 325,319 participants (57% of active participants in the same period) purchased therapy supports through their NDIS plans. These service supports were delivered by 46,434 providers, a 14% increase to provider numbers compared to the six months to December 2021. Expenditure on therapy supports over the six months to December 2022 equated to $1.6 billion, accounting to almost 10% of all expenditure by the NDIS ($16.8 billion), an increase of 26% compared to the six months to December 2021.

In terms of employment, as of February 2023, the Department of Health and Aged Care reported that the total number of several Allied Health professionals registered with Australian Health Practitioners Registration Agency (AHPRA) grew significantly, by 26%, from 2017 to 2021. This trend is set to continue with Jobs and Skills Australia forecasting growth for several types of Allied Health professionals of between 7% to 35% in the next five years.

As with the 2021-22 APR, the NDIA conducted a comparison of therapy pricing to 16 other government insurance and funding schemes to understand where the NDIS price stands against other funding sources. Overall, current NDIS price limits are broadly consistent with the effective hourly rates paid by other government insurance and funding schemes for therapy, once account is taken of duration of service, co-payments and provisions for travel and consumables. Although the results this year indicate that many types of therapies have

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been indexed by other schemes over the past year, the NDIS price limits remain in the middle or upper range for most therapies.

Another key aspect of the therapy analysis is the comparison to the private billing rates. A sample of 2,857 billing rates were used across all types of NDIS therapy supports and several regression models were run to analyse private therapy billing rates. The private billing market data suggests that the average fully loaded hourly cost of most types of therapy professionals is $189, still slightly lower than the current NDIS price limit of $193.99.

There were 174 public consultation submissions related to therapy supports. Many providers noted the biggest cost driver has been the increasing supply costs and wages. Other costs involved attracting, training and retaining staff, as well as quality, safeguarding and compliance costs. Many participants and their representatives who responded to the Consultation Paper suggested that they were charged more than non-NDIS clients and generally supported no further price increase at this time.

On balance, available therapy data inputs suggests that the current NDIS therapy price limits should be maintained. Some comparable government insurance schemes have revised their price limits, and the average fully loaded hourly cost of most types of therapy professionals in the private billing market is estimated to be $189, which remains below the current NDIS price limits. Data analysis suggests that price limits of certain therapy supports could be decreased slightly. However, a decrease is likely to disrupt the provision of supports to participants in some regions and impact professionals considering moving into the sector to support NDIS participants.

What is evident is the vast and diverse nature of the therapy market. As the NDIS Review is currently examining non-price related solutions, the NDIA should consider structural changes to therapy pricing arrangements after any relevant recommendations from the NDIS Review.

Recommendation 6

The NDIA should not make any structural adjustment to the pricing arrangements for therapy supports at this time and should not index the price limits for therapy supports on 1 July 2023.

Recommendation 7

The NDIA should consider the structure of therapy support pricing arrangements after any relevant recommendations from the NDIS Review. This is intended to better incentivise quality service provision to NDIS participants and create greater market efficiencies.

Support coordination

When comparing the six months to December 2022 to the six months to December 2021, the number of participants receiving support coordination and the payments claimed from participant plans both increased, by 15% (to 210,909 participants and $428.4 million in payments, respectively). Over the six months to December 2022 compared to the six months to December 2021, the number of active providers has increased significantly by 34% to 7,023 providers, demonstrating a steady increase to the supply of support coordination to NDIS participants.

Considering these changes over time, the average number of participants being serviced per provider has reduced from 48 participants per provider to 32 participants per provider

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between December 2020 and December 2022. This ratio of providers servicing participants has decreased largely due to the 29% overall growth of provider numbers in the same period, including 31% growth rate in unregistered providers.

A total of 99 submissions received during the consultation process addressed support coordination. Providers raised concerns about NDIS price limits relating to support coordination and the fragmented nature of supports offered and unbillable hours associated with their work.

A key theme from both participants and representatives and providers is that greater clarity is needed for the roles of support coordinator and plan managers. In line with previous recommendations from the 2021-22 APR, these will be considered by the NDIS Review. The NDIA should consider any appropriate structural changes after recommendations are received from the NDIS Review.

Data analysis and evidence suggest that there are new entrants to the market and the current price limits remain viable for most providers to deliver the service. Given the market for support coordination is still not yet mature and continuing to grow, on balance, an increase in price limits for Level 2: Coordination of Supports services and Level 3: Specialist Support Coordination services is not recommended at this time.

Recommendation 8

The NDIA should not make any structural adjustment to the NDIS pricing arrangements for support coordination at this time and should:

- *Index the price limits for the Level 1: Support Connection services on 1 July 2023, in line with the indexation of supports determined by the NDIS Disability Support Worker Cost Model in recommendation 1 and*
- *Not index the price limits for the Level 2: Coordination of Supports services and Level 3: Specialist Support Coordination services on 1 July 2023.*

A major submission was again received from Disability Intermediaries Australia (DIA), the industry group for providers of Intermediary supports (plan management and support coordination). This submission included summary results of a survey of plan management and support coordination providers on the costs of providing service. The NDIA sees merit in the benchmarking survey conducted by DIA in better capturing the specific cost drivers faced by support coordination providers. This is considering 92% of respondents for support coordination reported to have employees under the SCHADS Award.

Recommendation 9

After the outcomes of the NDIS Review are announced, the NDIA should work with the sector and other appropriate stakeholders to develop Cost Models for Level 2: Coordination of Supports and Level 3: Specialist Support Coordination.

The NDIA also considers that there may be instances where support coordinators could be required to undertake work following the death of a participant or including the administrative work associated with gathering information, returning equipment, and completing forms. In addition, other significant changes or situations (such as interactions with justice or health services) may require additional administrative work including responding to subpoenas or

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providing critical details where required. As such, the NDIA should examine options to allow support coordinators to claim for reasonable payments related to these events.

Recommendation 10

The NDIA should examine options on billable work required by support coordinators that is required after a participant's death or other key events.

Plan management supports

Participants can choose to have a registered plan management provider to manage their funding and budget for the supports in their NDIS plan. Plan managers are bound to the *NDIS Pricing Arrangements and Price Limits* and can connect participants with both NDIS registered providers and providers that are not registered with the NDIS.

The proportion of participants using plan management has increased as the preferred method over several years, from 45% in the December 2020 quarter to 58% in the December 2022 quarter.

In the six months to December 2022, 333,077 participants used a plan manager for some or all their NDIS plan, a 26% growth compared to 262,915 participants in the six months to December 2021. In the six months to December 2022, payments were made to 1,797 plan managers, a 13% rise compared to the six months to December 2021.

In the six months to December 2022, $8.1 billion, that is, 48% of NDIS funds spent was through plan managers, consisting of $228 million for plan management fees. The largest five plan managers received more than a quarter (27%) of this.

As participant numbers have increased relative to provider numbers, the average number of participants being serviced per provider has increased from 178 to 214 participants between December 2020 quarter and December 2022 quarter.

In total, 81 submissions were received through the Public Consultation on plan management. Most respondents suggested the monthly fee for plan management is insufficient for the work they are doing, which is said to encompass activities outside of what they believe is expected of them. There were also suggestions of clearer guidelines on the role of plan managers which was a common sentiment raised in the 2021-22 APR and is anticipated to be in the scope of the NDIS Review.

As the market continues to mature, it is clear that the roles and expectations of plan managers are still evolving. In line with previous recommendations from the 2021-22 APR, the role of plan managers is to be considered by the NDIS Review and the NDIA should consider any appropriate structural changes after recommendations from the NDIS Review.

Further, available data signals growth in both participants accessing, and providers delivering, plan management supports over the past two years. The growth of providers seen over this period signals economic feasibility in delivering these services for most providers, with increasing number of participants accessing these supports ensuring growing demand for plan management services if this remains as is.

Considering available information, on balance, the growth of plan management participants and providers over the past two years suggests this market is still viable and does not support an increase to plan management supports until the roles and expectations of plan managers are further defined. The NDIA should continue to monitor the movement of providers claiming for plan management supports in future quarters if this becomes a trend.

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Recommendation 11

The NDIA should not make any structural adjustment to the NDIS pricing arrangements for plan management supports at this time and should not index the price limits for plan management fees on 1 July 2023.

Other supports

In the absence of specific focus within the APR cycle, the NDIA considers the need to maintain the real value of NDIS price limits for support to maintain the supply of supports to NDIS participants. Furthermore, there is also a need to allow further innovation of providers to achieve greater efficiencies and improve the quality and safety of supports delivered.

The NDIA acknowledges there are a range of supports that are not under scope of the 2022-23 APR and are not linked to the DSW Cost Model, which are not price limited or benchmarked.

Nursing supports are considered as part of this category. Examples of supports in this category include several within the core and capacity building support categories such as personal domestic cleaning, house and/or yard maintenance. There is the need to maintain the real value of NDIS price limits for support to maintain the supply of these supports to NDIS participants.

This is particularly relevant for nursing supports, with aged care reforms including a 15% wage increase for those working in aged care as well as other potential increases to the Nursing Award. It is imperative that the NDIA ensures these supports remain competitive to other markets. It may pose a risk to participants receiving these supports if there is no pricing increase, and thus is deemed necessary to increase the price limits of these supports in line with previous year's indexation methodology.

It noted that prices for capital items are not in scope for this review and will be the subject of a separate review process.

Recommendation 12

The NDIA, subject to any specific recommendation arising from the current Annual Pricing Review, should:

- *Increase the price limits for supports other than capital items and those covered by previous recommendations, on 1 July 2023 in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses) and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter immediately preceding the indexation date (with an 80/20 weighting).*

NDIS cancellation policy

The 2021-22 APR changed the NDIS cancellation policy from 2 days to 7 days to aligning to changes to the SCHADS Award from 1 July 2022. The policy was updated to ensure staff are protected from any impact of short notice cancellations. Following the implementation of this change, feedback received from participants and their representatives reflected that the 7 days is too long to account for sudden illnesses or events outside of a participant's control. It is important to note that the 7-day cancellation policy is the maximum allowable cancellation length by the NDIA, providers can include shorter cancellation periods.

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Analysis of NDIA claims data from July 2020 to December 2022 shows that cancellations accounted for around 0.6% of DSW claims over this period. This has remained stable throughout this period with no significant change since the policy update.

It is too early to understand the impact of the changes to the NDIS cancellation policy to NDIS participants based on current data. The NDIA should continue to work closely with the sector to investigate the appropriateness of the current NDIS cancellation policy post the 2022-23 APR. The NDIA should also consider relevant Industry Awards, employment standards and other relevant industry legislation when setting pricing policy.

Recommendation 13

The NDIA should work with the sector to investigate the appropriateness of the NDIS cancellation policy for NDIS supports post the 2022-23 APR.

The NDIS Review

The Minister for the NDIS, the Hon Bill Shorten MP, announced the NDIS Review in October 2022. The NDIS Review is likely to have significant strategic implications for NDIS pricing arrangements in the future.

As the NDIS Review is running concurrently with the 2022-23 APR, the NDIA is committed to working with the NDIS Review Team throughout the NDIS Review process. The NDIA acknowledges this may impact some supports and outcomes under the scope of the APR, which should be considered in line with upcoming recommendations from the NDIS Review expected in October 2023.

Recommendation 14

The NDIA should continue to work with the NDIS Review team on relevant topics and issues involving structural changes to the current NDIS pricing arrangements.

NDIS Pricing Strategy refresh

The pricing arrangements for the NDIS are governed by the *NDIS Pricing Strategy*, which was adopted by the NDIA Board in 2019. Since the release of the *NDIS Pricing Strategy* in 2019, there has been rapid growth in the provision of supports across many types of support markets delivering supports to NDIS participants, which was needed in the roll-out of the NDIS.

Other changes include:

- The growth in size and scope of the NDIS,
- number of participants supported by the Scheme has grown,
- increase in registered and unregistered providers offering supports and services in the market,
- shifting support market dynamics facilitated by external events and changes to economic drivers.

Given the extent of the changes to the NDIS and the people it supports, a refresh of the 2019 NDIS Pricing Strategy is appropriate so that any future reviews can accommodate these factors and is better placed to consider what market interventions would be effective.

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There is a spectrum of market intervention options available to the NDIA, such as market facilitation, market regulation or alternative commissioning. Which intervention to use depends on the characteristics of the market and how it is functioning. A market that is considered well-functioning requires less intervention.

Therefore, the NDIA should examine what might be the most appropriate measures to apply across different markets delivering NDIS supports based on the current market maturity, economic conditions as well as Scheme trajectory.

Recommendation 15

The NDIA should refresh its NDIS Pricing Strategy to ensure its appropriateness given the current state of NDIS support markets, giving consideration to the outcomes from the NDIS Review.

Financial reporting by NDIS providers

The NDIA believes it is imperative that as a market steward, it is important to monitor and track the financial performance of providers within the sector to ensure that they remain financially viable.

Previous attempts to conduct surveys to gauge providers' financial bottom lines have resulted in poor response rates and therefore the survey results are not considered to be representative of the entire provider sector.

While a financial benchmarking survey of the provider market is not part of the scope of the 2022-23 APR, it is important to note that the NDIA is beginning to work with the sector to introduce financial benchmarking activity to support providers to better understand their financial position when compared to their peers in the market.

An effective price setting mechanism is critically underpinned by the Agency's ability to track, monitor, and benchmark the financial performance of the sector, which helps with Government policy planning and development. This ensures there is representation across a range of organisations with different cost bases, sizes, and locations. Moving forward, a model to consider is the current mandatory financial reporting requirements in the aged care sector.

The NDIA should explore options with the NDIS Review on the possibility of creating mandatory financial requirements. This is to ensure the NDIA has sufficient information available on the financial position of providers to assist in its role as market steward and inform its pricing review process.

Recommendation 16

The NDIA should explore options with the NDIS Review on the potential for mandatory financial reporting from NDIS providers on certain financial metrics.

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2 Introduction

2.1 General

The National Disability Insurance Scheme (NDIS, Scheme) was established to support people with disability to pursue their goals, to help them to realise their full potential, to assist them to participate in and contribute to society, and to empower them to exercise choice and control over their lives and futures. The Scheme is administered by the National Disability Insurance Agency (NDIA, Agency).

The Scheme has been in operation for 9 years, with the first three years being the trial period, followed by a transition phase until 1 July 2020, when the Scheme became operational in all areas of Australia. At the end of the trial period, 30 June 2016, the Scheme included 29,719 participants. The Scheme has grown significantly since, with 573,342 participants as of 31 December 2022.[1]

Total payments have increased over the last three years, from $10.5 billion in the year to 30 June 2019 to $28.6 billion in the year to 30 June 2022. Payments in the six months to December 2022 were $16.8 billion.

The average payments for twelve months to December for all participants have increased from $47,800 in 2019 to $57,600 in 2022, a 6.4% increase per annum. Specifically, average payments are much higher for participants in Supported Independent Living (SIL) than those not in SIL ($357,300 versus $41,000 respectively, in the twelve months to December 2022). Average payments are also higher for adults compared with children ($64,400 for participants not in SIL aged 25 to 64 versus $18,900 for those aged 0 to 14 years, in the twelve months to December 2022).

$31 billion in support has been provided in the twelve months to December 2022. The largest support categories by expenditure are:

- 54% ($16.7 billion) on core daily activities
- 20% ($6.1 billion) on social and community participation
- 13% ($3.9 billion) on capacity building daily activities (therapy services).

2.2 Terms of Reference of the Review

The Terms of Reference of the 2022-23 Annual Pricing Review (APR) require 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 framing its recommendations, the APR will be cognisant of the objects and principles set out in the National Disability Insurance Scheme Act 2013, including that the NDIS should:

(a) Support the independence and social and economic participation of people with disability.

[1] NDIS Quarterly Report to Ministers found here.

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(b) Enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports.

(c) Facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability.

(d) Promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community.

(e) Adopt an insurance-based approach, informed by actuarial analysis, to the provision and funding of supports for people with disability.

(f) Be financially sustainable.

Considering this, the APR will review the pricing arrangements and price limits:

1. that apply to supports delivered by disability support workers by updating the NDIS Cost Model for Disability Support Worker, with a particular emphasis on the Temporary Loading of 2.0% and the impact of the changes that were made to the *Social, Community, Homecare and Disability Services Industry Award 2010* (SCHADS Award) in 2022 (AM2018/26).
2. for therapy supports to ensure participants receive value for money, while providers strive to improve quality of service and increase efficiency.
3. for support coordination to encourage innovation, improve quality of service and ensure value for money.
4. for plan management to encourage innovation, improve quality of service and ensure value for money.

Moreover, the 2022-23 APR encompasses a comprehensive examination of contextual factors that have emerged from the NDIS Review, the 2021-22 APR, the projections outlined in the most recent Annual Financial Sustainability Report (AFSR), and the aged care minimum wage review.

The NDIS Review

The Minister for the NDIS, the Hon Bill Shorten MP, announced the NDIS Review (Review) in October 2022. There will be two parts to the Review.

- Part 1 will examine the design, operations and sustainability of the NDIS covering issues outlined in the full-Scheme bilateral agreements between the Commonwealth and jurisdictions.
- Part 2 will examine ways to build a more responsive, supportive, and sustainable market and workforce.

Each of these parts, as well as other matters likely to be considered by the Review, have the potential to have significant strategic implications for pricing arrangements in the future, noting the Review is expected to report in October 2023.

As the Review is running concurrently with the 2022-23 APR, the scope of the APR has been carefully defined to limit any potential overlap with the Review or the prejudging of the Review's recommendations.

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The extensive 2021-22 APR

The previous APR took place over the 2021-22 financial year and was implemented from 1 July 2022. It incorporated extensive consultations through public consultation, regular industry engagement and numerous workshops.

The recommendations included tailored pricing changes to disability supports totalling 9%, comprising wage increases under the SCHADS Award, plus allowance for increases in compulsory superannuation, a 2% temporary loading and a 1.7% increase to base price limits. The disability support worker support cohort receiving the 9% price limit increase included SIL. The Temporary Transformation Payment was also reduced for eligible supports from 4.5% to 3% for FY2022-23.

No changes in price limits were made for therapy supports, support coordination or plan management. Prices for capital items were increased by Consumer Price Index (CPI).

2021-22 Annual Financial Sustainability Report (AFSR)

The AFSR is an annual report that provides an assessment of the financial sustainability of the National Disability Insurance Scheme using data as of 30 June each year.

Using data as of 30 June 2022, the AFSR projected that the total Scheme expense on an accrual basis is $34.0 billion in 2022-23 increasing to $89.4 billion in 2031-32. This represents 1.48% of Gross Domestic Product (GDP) in 2022-23 before increasing to 2.55% of GDP in 2031-32 in the baseline forecasts. Additionally, the number of scheme participants is projected to almost double to 1,017,522 at the end of June 2032. The upward growth in Scheme expenses means any further price increase for 2022-23 APR will further impact sustainability.

Aged care worker minimum wage review

On 4 November 2022, the Fair Work Commission (FWC) announced a 15% increase to the minimum wages of the direct care classifications in the *Aged Care Award*, SCHADS Award and for nurses working in aged care covered by the *Nurses Award*. It has since been decided by the FWC to provide this 15% increase to workers in the Aged Care sector from July 2023 onwards.

There are other non-wage related reforms being undertaken in the Aged Care sector which also need to be considered for aged care worker conditions. More details are discussed in disability support worker-related supports section of the report.

2.3 Consultations

Consultations involved advocacy groups, carers, employees, government, participants/representatives, plan managers, professional bodies, providers, provider peak bodies, researchers as well as workers' unions, through:

- The publication of a Consultation Paper and the careful analysis of submissions received.
- Consultations with other government insurance and funding schemes.
- Consultations with the Pricing Arrangements Reference Group.
- Consultations with the Pricing Interdepartmental Committee.

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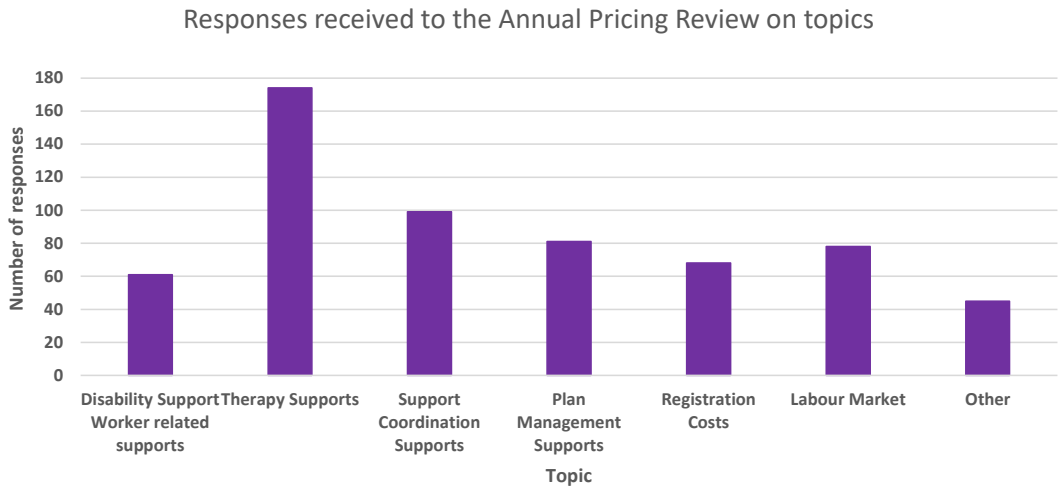
- Consultations with the Department of Veterans' Affairs and the Chief Allied Health Officer.

Consultation Paper and submissions

A Consultation Paper was released on 17 March 2023 to assist stakeholders in preparing submission to the APR. Submissions were required to be lodged by AEST 11:59pm Thursday 13 April 2023. In total, 304 submissions were received including those submitted after the deadline.

Most submissions were from provider organisations (165) and employees/workers (96). A small number of submissions (15) were received from participants and their representatives. Submissions were also received from professional bodies (15), provider peak bodies (9), state and territory governments (3), advocacy groups (3) and worker unions (1). The number of responses providing feedback on each topic is shown in Figure 1. Appendix A includes a summary of the public submissions.

FIGURE 1: NUMBER OF SUBMISSIONS RECEIVED TO THE PUBLIC CONSULTATION AND TOPICS COVERED



Source: Submissions to the APR received by the NDIA, NDIS internal data, April 2023

Consultations with other government insurance and funding schemes

The NDIA has reached out and worked with sixteen other government insurance and funding schemes to update the analysis done in the 2021-22 APR.

Schemes that assisted with information were:

- Catastrophic Injuries Support (CIS) Scheme,
- ComCare,
- Department of Veterans' Affairs (DVA),
- Home and Community Care Program for Younger People (HACC-PYP),
- Lifetime Support Scheme (LSS),
- Lifetime Care and Support Scheme (LTCSS),
- Motor Accidents Insurance Board (MAIB),
- Medicare Benefit Scheme (MBS),

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- National Injury Insurance Scheme Queensland (NIISQ),
- Return To Work SA (RTWSA),
- State Insurance Regulatory Authority (SIRA),
- Victorian Transport Accident Commission (TAC),
- Victims of Crime Assistance Tribunal (VOCAT),
- WorkCover QLD,
- WorkSafe VIC, and
- WorkCover WA.

Pricing Arrangement Reference Group

The work of the APR was overseen by the NDIA's Pricing Arrangement Reference Group, which provides advice, through the Chief Executive Officer of the NDIA, to the NDIA Board on price control arrangements for the NDIS. This is to ensure price regulation activities and decisions are coordinated to support the best possible outcomes for NDIS participants during the transition to a competitive marketplace[2]. The current members of the Pricing Arrangement Reference Group are:

- Ms Deborah Cope, who has a background in economics, price regulation, regulatory processes, and rural and remote service delivery.
- Mr James Cox PSM, who is Deputy Chair of the Australian Energy Regulator and has extensive experience in price regulation, economics, and social policy issues.
- Ms Julie Hulcombe PSM, who has experience in allied health reform and has made significant contributions to improving high quality care access in Queensland, and
- Dr Lynne Pezzullo, who brings experience in market development, health economics, price regulation and the disability sector.

Pricing Interdepartmental Committee

The Pricing Interdepartmental Committee was established in November 2022 to discuss strategic matters related to pricing in the NDIS and its wider implications within the current economic environment. This forum allows the NDIA to proactively work with key Australian Public Service stakeholders with broader Government considerations to NDIS pricing-related matters.

The committee consists of representatives from Department of Social Services, Department of Finance, NDIS Quality and Safeguards Commission (NDIS Commission) and the Commonwealth Treasury.

2.4 Annual Pricing Review (APR) decision making framework

The NDIA monitors and reviews its price control framework and other market settings to determine whether they are still appropriate. The APR is an important part of that process. Figure 2 outlines the APR conceptual framework that leads to the final recommendations.

[2] Information on the NDIA's Pricing Reference Group can be found here.

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FIGURE 2: APR CONCEPTUAL FRAMEWORK



Research into the following areas provided the quantitative and qualitative aspects of evidence to inform the APR decisions:

- The current Australian economic climate including the healthcare and disability sectors. Detailed labour force and wage data for NDIS occupations and industries, and for comparable occupations and industries.
- Extensive consultations with a range of internal and external stakeholders through the Public Consultation, Pricing Arrangement Reference Group, Pricing Interdepartmental Committee as well as other government engagements.
- Impact from the global pandemic, impact of the SCHADS Award changes, the *Aged Care Award* reforms and the newly introduced family and domestic violence leave. All these form part of the DSW-related supports research.
- Scheme statistics for each of the topic in scope (DSW-related supports, therapy, plan management and support coordination). The statistics include the movements in terms of participant numbers and payments made.
- Analysing business dynamism of topics in scope, examining the number of provider entrants and exits as well as the general market dynamics.
- Additional benchmarking analysis for therapy in terms of comparison to other government insurance and funding schemes and private market billing rates.

All these factors were considered in developing the 2022-23 APR recommendations to ensure the decisions are robust and evidence based.

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3 Domestic economic conditions and the care economy

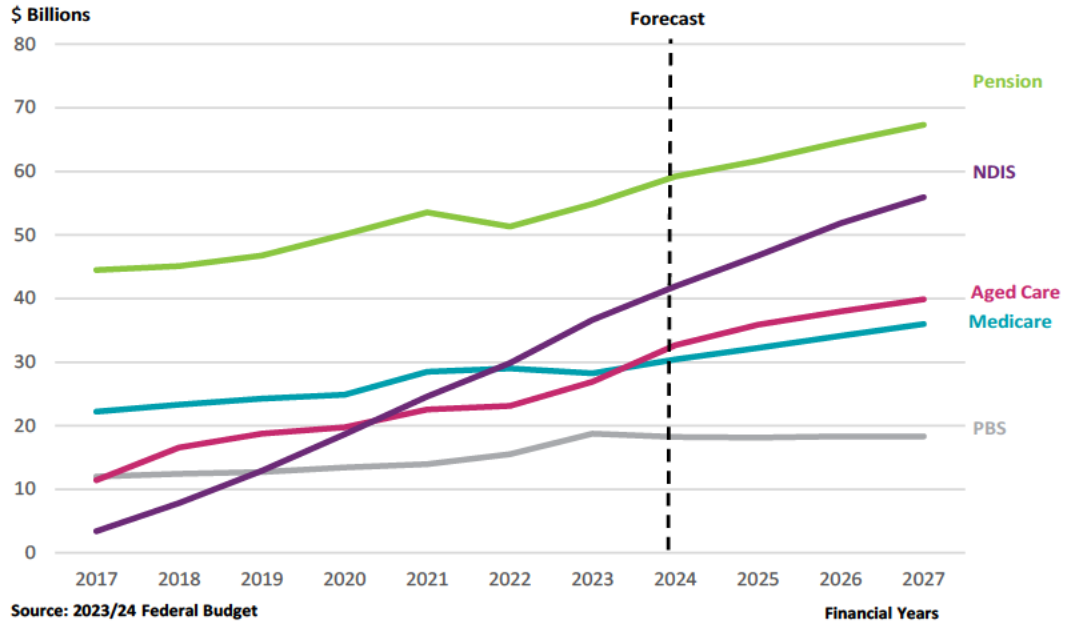
3.1 Outlook

While Australia has withstood the impacts of the global pandemic, it is not immune to the intensifying global challenges. While the national economy is forecast to grow by 3.25% in 2022–23, the weaker global outlook, high inflation, cost-of-living pressures, and higher interest rates are expected to slow growth to 1.5% in 2023–24.[3]

The National Disability Insurance Scheme (NDIS) exists within the broader care economy, which includes services that provide support to people with disabilities across various ages, as well as early childhood and aged care. Care economy services are delivered by a complex network of businesses, Government and Non-Government Organisations (NGOs), and individual workers. Care economy workers are employed across a diverse set of occupations at different skill levels. Often different segments of the care economy compete for workers.[4]

Expenditure on the NDIS has grown rapidly since 2016. As of 2021-22, the NDIS had outstripped expenditure on Medicare and Aged Care. In 2022-23 the NDIS spend was $36.6 billion (or 1.44% of Gross Domestic Product (GDP). The 2023-24 Federal budget projects expenditure on the NDIS will reach $55.9 billion in 2026-27 (or 1.91% of GDP). [5]Total NDIS expenditure is expected to grow at a faster rate than Government spending on the Pension, Medicare, Aged Care, and the Pharmaceutical Benefits Scheme (PBS) (Figure 3).

FIGURE 3: FEDERAL GOVERNMENT EXPENDITURE ON HEALTHCARE AND SOCIAL SERVICE INDUSTRIES FROM 2016-17 TO PROJECTED 2026-27.



[3] 2023/24 Federal Budget Estimates

[4] The Australian and New Zealand Standard Classification of Occupations (ANZSCO) classification can be accessed here

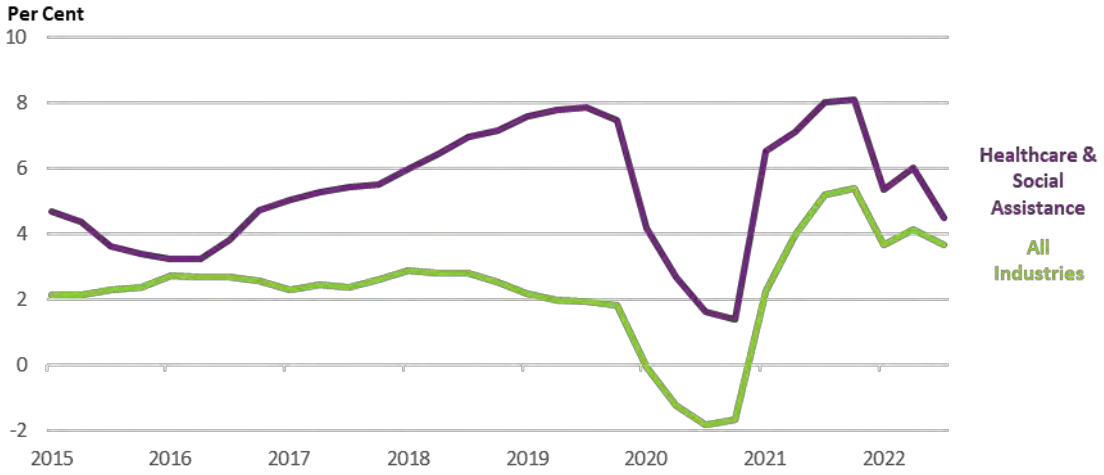
[5] 2023/24 Federal Budget Estimates

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Internationally, Australian public spending on disability, as captured by the Organization for Economic Cooperation and Development (OECD), sits at 2.9% of GDP[6], the 8th highest of 38 OECD countries. The OECD captures this information under "spending on incapacity", which refers to public spending due to sickness, disability, and occupational injury. The highest public spending in this category is in Denmark and Norway, which each spend 4.5% of GDP. This is above Australia's ranking of 11th on health expenditure out of 28 OECD countries.

Gross Value Add (GVA) measures the economic output of an industry or sector, where the Healthcare and Social Assistance (HCSA) sector consistently outperforms the rest of the economy over recent years in term of annual average growth (Figure 4). Due to their 'non-discretionary' nature, the demand for health care and social assistance is relatively inelastic, meaning the HCSA industry is less likely to be as heavily impacted by economic shocks. Whilst output and employment growth did not turn negative during the pandemic for the HCSA sector, they are not fully immune to the general economic downturn.

FIGURE 4: MOVING ANNUAL AVERAGE GROWTH OF GROSS VALUE ADD FOR HEALTHCARE AND SOCIAL ASSISTANCE SECTOR COMPARED TO AVERAGE OF ALL INDUSTRIES



Source: ABS National Accounts

3.2 Inflationary pressures

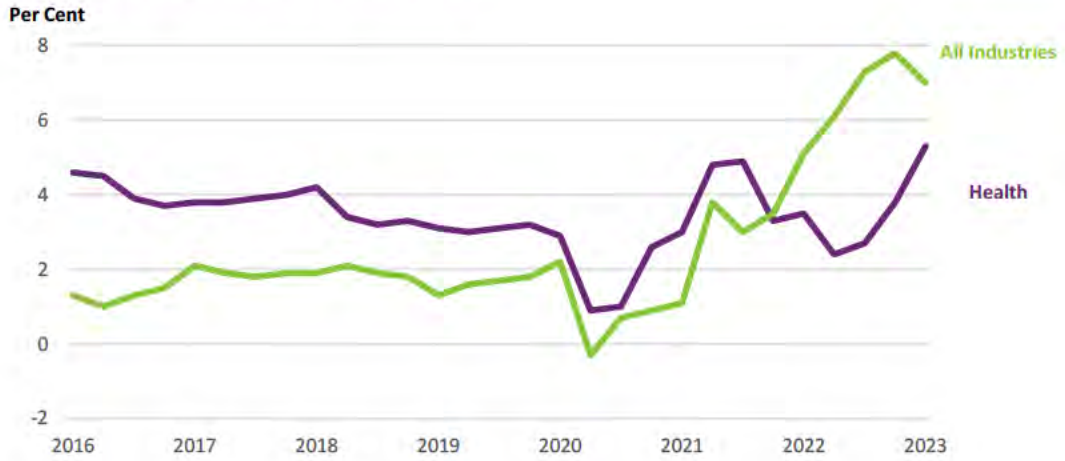
One of the key challenges facing the economy is inflationary pressures where the Australian economy has experienced a sharp rise in the cost of living, with inflation rising to a multi-decade high post pandemic. This can lead to increasing cost pressures on providers delivering supports to NDIS participants, such as energy, supply chain, logistics, increased interest rates and property costs. This could negatively impact the availability and quality of goods and services provided as the cost of providing goods and services increases.

The health component of Consumer Price Index (CPI) in Australia has generally run above the economy wide CPI rate over the past seven years (Figure 5). This trend ended in 2022, with total CPI outstripping the health component of CPI. However as of the March quarter 2023, the health component has risen 5.3% through the year, and the gap between all industries and health CPI appears to be closing.

[6] OECD data on public spending on incapacity can be accessed here

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FIGURE 5: OVERALL AND HEALTH SPECIFIC CPI



Source: ABS Consumer Price Index

3.3 *Labour market conditions*

Australia's labour market has been resilient with a record low unemployment rate of 3.5% recorded in February 2023. The HCSA industry is the largest employing industry in the economy, employing 2.13 million persons in February 2023[7]. Overall, by employment, the HCSA industry has been one of the fastest growing industries of the last ten years[13], growing at 4.1% per annum on average, compared to an average of 1.7% per annum for all industries (Figure 6).

While quarterly employment did fall on two occasions over 2020 and 2021 coupled with a spike in underemployment, in general, the pandemic and associated restrictions did not impact the industry as much as other parts of the economy. Over 2022, employment in Healthcare & Social Assistance industry grew at its fastest rate on record[15]. On average, there were 9.9% more persons employed in HCSA than the number employed in 2021.

FIGURE 6: MOVING ANNUAL AVERAGE EMPLOYMENT GROWTH



Source: ABS Labour Force Survey

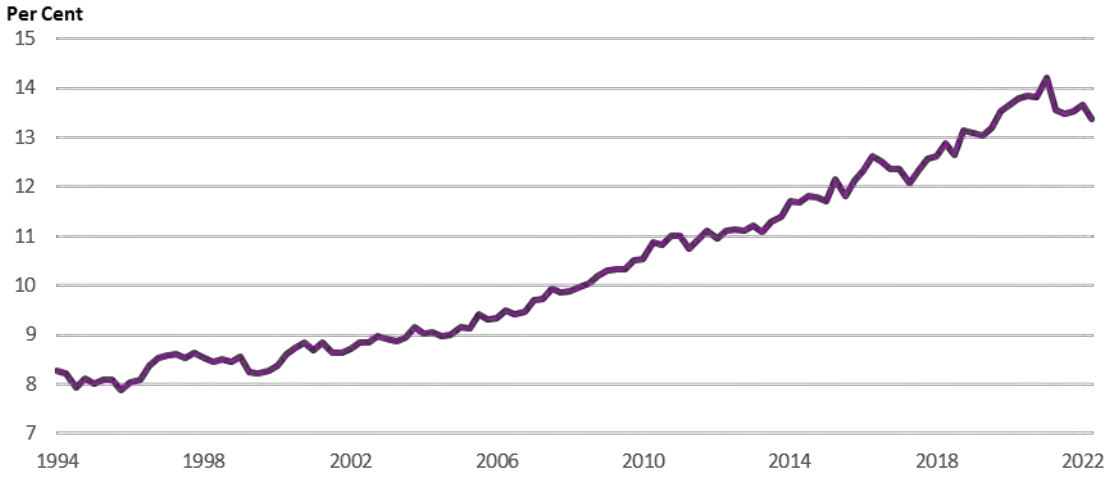
[7] ABS Labour Force Survey, February 2023

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Strong employment growth is a key feature of the HCSA sector – it is observed that the proportion of persons that work in the HCSA sector has lifted from 11.9% of total employment in 2012 to 14.0% in 2022 (Figure 7).[8] Factors that may have contributed to this growth are:

- The build-up of unmet demand for care services
- Growing demand underpinned by an aging population
- The continued expansion of the NDIS, and
- Strong demand for mental healthcare services[9].

FIGURE 7: PERCENTAGE OF THE WORKFORCE IN THE HEALTHCARE AND SOCIAL ASSISTANCE SECTOR



Source: ABS Labour Account Australia

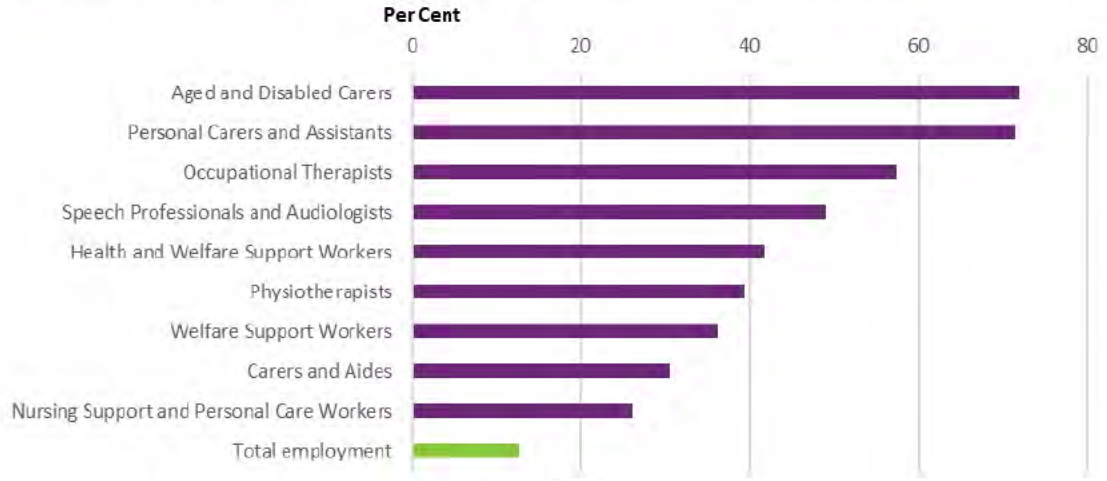
Analysis of ABS Census data shows strong employment growth between the 2016 and 2021. This includes Aged and Disabled Carers (227,535 in 2021, an increase of 72% since 2016), Occupational therapists (19,429 in 2021, an increase of 57%) and Speech Professionals & Audiologists (13,613 in 2021, an increase of 49%) see (Figure 8).

[8] There are other professions in the ANZSIC Healthcare & Social Assistance industry that are not directly involved with the provision of care, such as accountants and administration workers.

[9] Productivity Commission Inquiry Report – Mental Health, 2020

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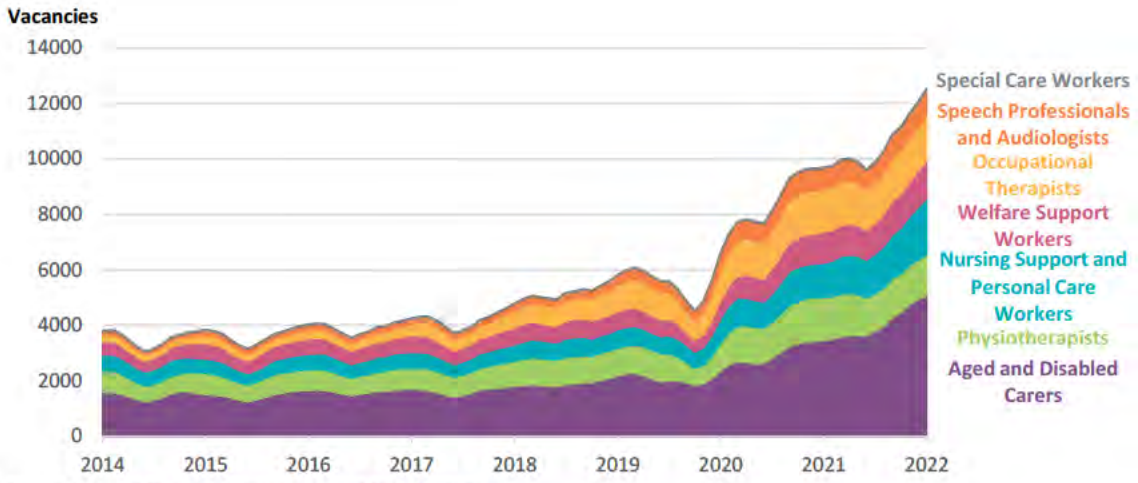
FIGURE 8: GROWTH IN NDIS RELATED OCCUPATIONS BETWEEN 2016 AND 2021 CENSUSES.



Source: 2016 and 2021 Census

Mirroring this trend, the number of vacant positions in NDIS related occupations sector is also at record highs, indicating strong demand for workers in the sector (Figure 9). This further highlights the demand for workers in the HCSA industry and NDIS more specifically, with job vacancies in the industry doubling compared to pre-pandemic levels, averaging 66,000 over 2022, and the underemployment rate falling to 6.7%, the lowest rate since 2008.

FIGURE 9: JOB VACANCIES IN NDIS RELATED OCCUPATIONS



Source: National Skills Commission (Jobs and Skills Australia)

Over the 4 years prior to the pandemic, nominal wages in HCSA industry were the fastest growing of all industries. Despite this, wages for those in the sector have also been growing at a slower rate than the price of goods and services meaning real wages have declined. However, relative to 2004 real wage growth in the HCSA sector remains above that of total real wage growth. This trend has made it challenging for some organisations to attract and retain staff as workers seek higher wages to compensate. This is an issue that all industries across Australia may be facing, not just within the disability and broader HCSA industry.

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FIGURE 10: INDEX OF REAL WAGE GROWTH IN THE HCSA SECTOR AND ALL INDUSTRIES (2004 = BASE OF 100)



3.4 Future sector demand for support and workforce growth

As the Scheme continues to grow, the importance of a strong workforce to support the growing demand for services is highlighted. The Australian Government projects employment in HCSA sector to grow by 301,000 (or 15.8%) over the five years to November 2026[10], the second fastest growth of all 19 Australian and New Zealand Standard Industrial Classification (ANZSIC) industries. The Care Workforce Labour Market Study predicts that the care and support workforce will reach 3.9% of total employment by 2049-50, up from 2.9% in 2019-20[18].

The National Skills Commission (now Jobs and Skills Australia) published the 2022 Skills Priority List Key Findings Report in October 2022. Many of the largest care related occupations by employment were found to be in shortage, including Aged or Disabled Carer, Nursing Support Worker and Personal Care Assistant.

Several reports project persistent skills shortages in the care economy into the future. The Care Workforce Labour Market Study from the National Skills Commission (Jobs and Skills Australia) forecasts a shortfall of about 100,000 care workers across the aged, disability and mental health care sectors by 2027-28, blowing out to 212,000 by 2050. A Centre for Economic Development (CEDA) report warns of a cumulative shortfall of 110,000 direct age care workers by 2030[11].

Migration is an important pillar supporting the growth in the care economy workforce. Overseas-born workers comprise around 40% of the care and support workforce in Australia[12]. For this reason, the pandemic and associated restrictions on migration could have exacerbated labour shortages in the care economy. However, migration has rebounded strongly and is likely to alleviate some of the existing shortages.

In summary, these conditions suggest a strong demand going forward and a very tight labour market, which could pose challenges for businesses in finding workers to fill open positions.

[10] Labour Market Insights webpage for Healthcare and Social Assistance

[11] Duty of Care: Meeting the Age Care Workforce Challenge, CEDA, 2021

[12] Care Workforce Labour Market Study, 2022, National Skills Commission

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4 Disability Support Worker related supports

4.1 Context

The National Disability Insurance Agency (NDIA) uses the National Disability Insurance Scheme (NDIS) Disability Support Worker (DSW) Cost Model 2022-23[13] to estimate the costs that a reasonably efficient provider would incur in delivering a billable hour of support. The Cost Model takes account of all the costs associated with a billable hour of support.

Parameters of the DSW Cost Model

The NDIS DSW Cost Model was simplified in 2022. No significant revisions to the Cost Model were undertaken this year given the scope of the current APR. The inputs to the current model are outlined below:

- Base salary and shift loading costs, including shift loadings. Note that in the Cost Model, costs are based on permanent worker costs. These are linked to *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award) wage levels 2.3, 2.4/3.1, 3.2 and 4.4.
- Direct on-costs, which covers those costs of employment associated with Superannuation entitlements, Annual Leave entitlements (20 days), Personal Leave entitlements (10 days), Long Service Leave entitlements (4.3 days) and Employee Allowances.
- Operational overheads, which covers those costs that are in the operational control of the provider and include supervision costs, quality and safeguarding costs, utilisation costs (billable versus unbillable hours), training costs, workers compensation costs, and workforce rostering costs including those related to share of the workforce that is permanent or casual, and the extent to which overtime is used.
- Corporate overheads, which covers those costs incurred to run the administrative side of a business. These costs include the accounting, human resources, legal, marketing, and information technology functions.
- Margin, which represents the return that the provider makes because of the provision of working capital to the business.
- Temporary loading introduced on 1 July 2022 to recognises the variable costs of COVID and of adjusting to the new provisions in the SCHADS Award.

The DSW Cost Model is driven by relevant DSW wages from the SCHADS Award, with the DSW Cost Model being multiplicative after salary and direct on-costs are calculated. What this means is that any changes to DSW wage inputs will have a flow on effect throughout the Cost Model's calculations. That is, Overheads (Operational and Corporate) are calculated as a percentage of direct costs in the Cost Model. Margin is applied as a percentage of all costs to that point, with the Temporary Loading applied as a percentage of all costs at the end of calculations.

[13] NDIA. (2022). NDIS Disability Support Worker Cost Model 2022-23

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The DSW Cost Model is one factor considered in NDIS price setting along with other factors such as market conditions, the SCHADS Award, minimum wage conditions and mandatory superannuation contributions.

Proposed changes are suggested to incorporate the new family and domestic violence leave reforms, which were introduced from February 2023, see section 4.9.

Applicable industrial award

The national award for DSWs is the SCHADS Award.[14] The NDIA recognises that some DSWs are classified as Home Care Employees and others are classified as Social and Community Services Employees under the SCHADS Award. The Cost Model take its parameters from the Social and Community Services Employees section for the SCHADS Award, which covers those costs that are in the operational control of the provider.

The NDIA recognises that providers can employ DSWs with different skill levels and levels of experience to meet the different needs of participants. The Cost Model therefore has different sets of cost assumptions for four types of workers (DSW Level 1, DSW Level 2, DSW Level 3 and DSW Level 4). This does not mean these are the only types of workers who can deliver NDIS supports through DSW-related supports.

4.2 Market overview

DSWs sit within the Healthcare and Social Assistance (HCSA) sector. In terms of employment, the HCSA has been the fastest growing industry of the last 30 years. As of February 2023, the HCSA industry accounted for 15.0% of employment and 7.6% of Australia's total Gross Value Add (GVA). The industry is Australia's largest, with over 2 million people and contains broad range of occupations, from surgeons to child carers. For this reason, caution should be used drawing parallels between changes in the growth of the HCSA industry and the DSW workforce.

The Department of Social Services and AlphaBeta provides the most recent direct estimate of the size of DSW workforce; as 241,000 disability support workers in 2020[15]. This represented 13% of total HCSA employment at the time. Assuming DSW growth has been in line with growth of the HCSA industry, there would be roughly 280,000 DSW by the start of 2023. This is likely a lower bound estimate, evidence[16] suggests the number of DSW workers likely grew faster than total HCSA employment in recent years.

Given that skills and qualifications are transferable between disability support, aged care and childcare support position, the NDIS providers compete for workers with aged care and childcare providers and changes in demand and wages for one care occupation can impact worker availability in the other care occupations.

Analysis of the wages offered by the major job platforms as at April 2023 shows that DSW wages are above that of aged care and childcare workers (Table 1). Analysis on major online employment platforms as of April 2023 suggests that the average hourly pay of DSW

[14] SCHADS award can be accessed here (incorporating all amendments up to and including 15 March 2023.)

[15] NDIS National Workforce Plan: 2021 – 2025

[16] Aged and disabled carers occupation grew faster between the 2016 and 2021 census than the HCSA industry over the same period.

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workers ($28.80 to $40.00) is higher than average hourly pay of aged care workers ($24.20 to $35.00) and childcare workers ($24.40 to $30.00). However, the NDIA acknowledges there are several non-monetary factors could influence workers decisions choosing one occupation over another, such as the trials and challenges of the specific type of work, leave benefits and job stability.

TABLE 1: RELATIVE ADVERTISED WAGES OF DSW, CHILD AND AGED CARERS AS AT APRIL 2023 (AUSTRALIAN AVERAGE WAGES $/HOUR)

Occupation	Employment	Seek	Indeed	PayScale
DSW	241,000 (2020)	$30 - $40	$35.43	$28.80
Aged carer	195,000 (2020)	$25 - $35	$32.12	$24.20
Child carer	216,619 (2021)	$25 - $30	$31.04	$24.40

Source: NDIS Workforce Plan, CEDA, ECEC National Workforce Census. Estimates exclude nurses and allied health professionals. Wages from Seek; Indeed; PayScale[17]

4.3 Scheme Statistics

As shown in Table 2, in the six months to December 2022, the NDIS had 252,637 participants receiving DSW-related supports from 97,608 providers. This is an increase of 15% and 28% respectively compared to the six months to December 2021. Additionally, the total amount claimed in the six months to December 2022 equates to $10.2 billion, an increase of 34% compared to the six months to December 2021. This represents a healthy growth to the demand and supply of the DSW market.

TABLE 2: DSW-RELATED SUPPORT SCHEME STATISTICS

Statistics	July – December 2021	July – December 2022	Percentage Change
Total number of NDIS participants	219,083	252,637	+15%
Total number of active providers (includes registered and unregistered providers)	76,064	97,608	+28%
Total amount claimed	**$7.6 billion**	**$10.2 billion**	**+34%**

Source: NDIS internal administrative data

Table 3 shows a breakdown of the type of supports related to DSW and the number of active registered providers for each category. Over the six months to December 2022 compared to the six months to December 2021, all categories increased except one. The categories that experienced the largest supply growth were High Intensity Daily Personal Activities (21%), Assistance with Daily Life Tasks in a Group or Shared Living Arrangement (21%) and Participation in Community, Social and Civic Activities (17%). This demonstrates strong growth in most of the relevant registration groups with DSW-related supports.

[17] Disability support worker wages can been found here for Seek, Indeed, PayScale (Accessed March 2023)

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

TABLE 3: NUMBER OF ACTIVE REGISTERED PROVIDERS BY CATEGORY FROM WHICH THEY PURCHASED DSW SUPPORTS, 31 DECEMBER 2022

Category	Support	Number of active providers July – December 2021	Number of active providers July – December 2022	Percentage Change
0104	High Intensity Daily Personal Activities	3,111	3,759	+21%
0115	Assistance with Daily Life Tasks in a Group or Shared Living Arrangement	2,721	3,302	+21%
0125	Participation in Community, Social and Civic Activities	5,080	5,965	+17%
0107	Daily Personal Activities	6,056	6,760	+12%
0106	Assistance in Coordinating or Managing Life Stages, Transitions and Supports	3,005	3,341	+11%
0102	Assistance to Access and Maintain Employment or Higher Education	333	364	+9%
0136	Group and Centre Based Activities	2,510	2,642	+5%
0117	Development of Daily Living and Life Skills	2,938	3,053	+4%
0133	Specialised Supported Employment	611	578	-5%

Source: NDIS internal administrative data

Note: The data is not collected from unregistered providers. Providers are duplicated where more than one service is provided.

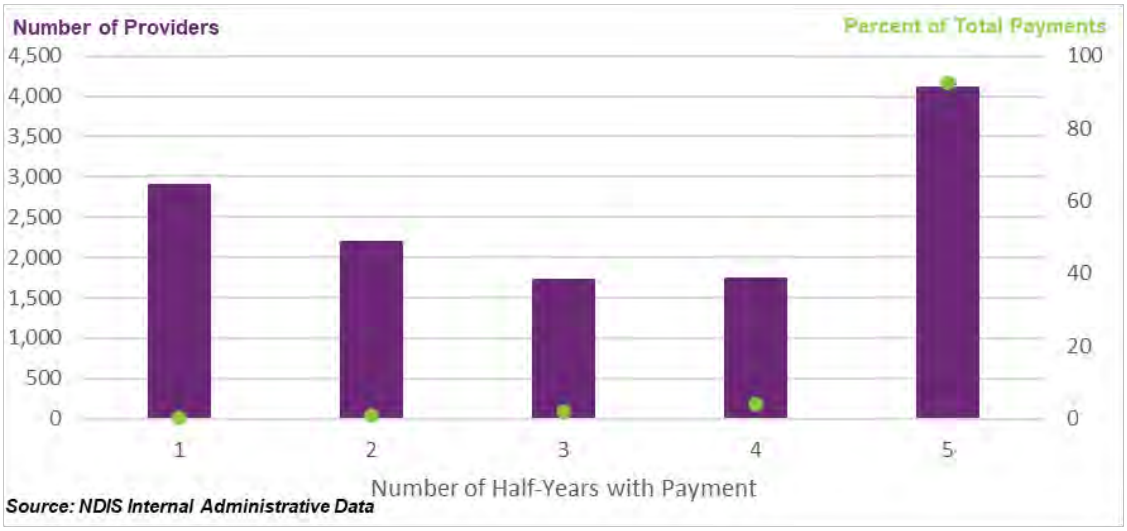
4.4 Business Dynamism

To supplement the Scheme statistics, the NDIA has analysed registered provider payment activity. That is, payments made against Agency and Plan Managed plans are considered to be made by registered providers.

Figure 11 shows the number of registered DSW providers with the payments between July 2020 and December 2022, split by the number of half-year periods in which each provider received a payment. Half-years are defined as the six-month interval from January to June and July to December. As seen in Figure 11, 4,096 out of 12,636 (32%) registered providers have payments in all five half-years between July 2020 and December 2022. These providers account for 93% of the total payments across the two-and-a-half-year period.

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FIGURE 11: REGISTERED DSW PROVIDER HALF-YEARLY PAYMENTS HISTOGRAM, JUNE 2020 – DECEMBER 2022

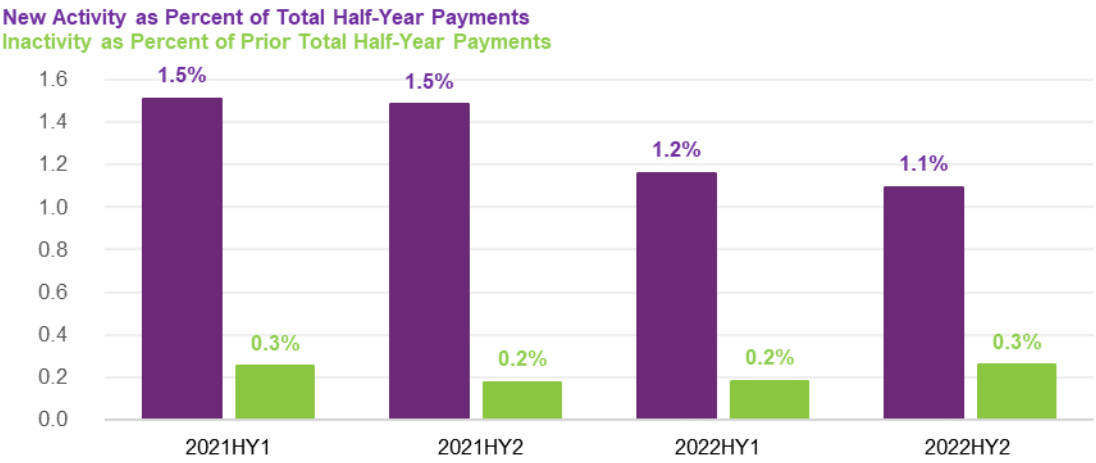


Source: NDIS Internal Administrative Data

To further assess the current state of the provider market, payment activities of registered providers across the two-year period from January 2021 to December 2022 were analysed. Providers with New Activity in a half-year are defined as providers with payments who did not have payments in the prior half-year. Similarly, Inactivity in the half-year is defined as providers without a payment who had payments in the prior half-year. Activity for each provider is expressed as a percentage of the total payments for that half-year (for New Activity) or prior half-year (for Inactivity). The NDIA acknowledges that this is not a perfect measure of market exits but the closest approximation given available data.

Results suggest that over the past two years, inactive registered providers in each half-year contributed to less than 0.3% of total payments. In contrast, providers with new activity in a half-year have contributed between 1.1% and 1.5% of total payments over the same period.

FIGURE 12: DSW REGISTERED PROVIDER ACTIVITY MOVEMENTS, JANUARY 2021 – DECEMBER 2022



Source: NDIS Internal Administrative Data

Further analyses indicate that on average, inactive registered providers received $11,932 in payments in the half-year prior to becoming inactive, with 86% of registered providers receiving less than $5,000 in the half-year prior to becoming inactive. In contrast, active registered providers received on average $786,138 of payments in each half-year period, highlighting that inactive registered providers have been claiming lesser amounts on average relative to new and existing registered providers.

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4.5 Ability Roundtable benchmarking survey

Ability Roundtable conducts a comprehensive benchmarking survey. In 2023, 24 providers responded to the survey with data from the 2021-22 financial year. Not all respondents answered every question available in the survey, so the useable sample size was slightly smaller on each topic (SCHADS Award changes, COVID impacts, and Quality, Safeguarding and Compliance costs). Although the total sample of providers is small, these providers service a large part of the disability market which should be considered when interpreting the results. The collective revenue in 2022 was over $2.7 billion, with the average respondent reporting an operating loss of 3.7% in 2022.

Information received from the Ability Roundtable survey will be discussed further in this chapter. In summary, the Ability Roundtable survey reported uncertainties such as COVID and SCHADS related adjustments driving up costs with the magnitude very similar to the considerations that informed the 2% temporary loading that was granted from the 2021-22 APR.

4.6 Cost Impact of COVID

The impact of COVID was analysed through economic research as well as the Ability Roundtable survey.

In the 2021-22 APR, the impact of COVID was estimated to continue to increase for providers in the medium to long term. It was estimated that the base costs associated with COVID including PPE, additional overtime or leave usage at the time would increase for providers by 1.5%. This was considered in the 9% price rise to DSW from the 2021-22 APR.

In terms of domestic economic research on the impact of COVID since the last APR, the HCSA sector, the best proxy for the disability sector, performed relatively well during the pandemic compared to other sectors in Australia. Businesses in this industry were largely classified as essential, and as such, many workers in this industry continued working to provide critical healthcare and support services to the community. While there were challenges and disruptions to service delivery due to lockdowns and restrictions, the sector was able to adapt relatively quickly to new ways of working, such as telehealth and virtual consultations.

That said, during the pandemic, businesses operating in the care economy faced increasing COVID related costs. Temporary costs included those associated with PPE mandates, testing requirements, establishing new ways of working, such as telehealth, associated overtime and greater utilization of sick leave. However, all States and Territories have now lifted COVID public health orders, restrictions, directives, and mandates on businesses[18], with the majority ending in late 2022 or early 2023. Accordingly, some of the costs associated with Government COVID orders, such as PPE gear, and testing, have now dissipated. Nevertheless, an ongoing cost, referred to in several submissions from the public consultation is the cost of sick leave associated with staff contracting COVID and rostering to cover sick staff.

Although some providers experienced supply chain disruptions, the majority of NDIS services are labour intensive (that is, not reliant upon goods and capital equipment), hence a modest 11% of Healthcare & Social Assistance businesses reported supply chain

[18] Public health order can be accessed here: NSW, VIC, QLD, WA, SA, TAS, ACT, NT.

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disruptions, compared to 41% of all businesses[19]. However, many care economy businesses reported having difficulty finding staff, 26% at both June 2021 and June 2022. The most common factors were lack of job applicants (79%) and applicants not having the relevant experience and qualifications (59%). This trend was likely driven by the decrease in migration over 2020 and 2021, which is an important source of disability workers, but also the decline in workforce participation. However, both migration and participation have since rebounded close to pre-pandemic levels.

Ability Roundtable survey on continuing impact of COVID on provider costs.

Most providers responding to the Ability Roundtable survey (71%) reported that COVID was still impacting on their costs in 2022. The other 29% reported that COVID was no longer affecting their businesses.

For providers who were reporting COVID was still impacting their costs, the average increase was 2.5% (median 2.0%). However, across all respondents providing estimates of cost impacts, the average increase in costs was 1.7%, and the median was 1.0%.

Unlike the impacts of SCHADS Award changes and Quality and Safeguarding compliance costs, which are more likely to be ongoing, qualitative responses indicated that COVID impacts are mostly temporary.

The most common reported cause of cost increases (30%) was PPE, RATs and other consumables. This was closely followed by staff sick leave costs (20%). Administrative, cleaning, agency staff, allowances and penalties accounted for 5 to 10%. Around another 10% was accounted for in commentary on training, quality and safeguarding and reporting costs, which are more likely to be ongoing.

In summary, the estimated cost impacts of COVID in 2022 by these providers surveyed was 1.7%. This is slightly higher than the last APR's estimate of 1.5%.

It appears that many costs associated with COVID are fading post-pandemic and have more likely been temporary in nature. However, it should be acknowledged that COVID is still present in Australian but to a lesser degree than what it was this time last year.

4.7 Impact of SCHADS Award changes

On 1 July 2022, several significant changes to the SCHADS Award were implemented. In particular, casual and part-time workers were granted a minimum two-hour shift with other changes including increases in broken shift allowances, and on call and remote allowances. Information on the impacts of the SCHADS Award changes are still currently limited outside of qualitative feedback received and the benchmarking survey conducted by Ability Roundtable.

Most respondents to the survey (62%) reported that responding to the SCHADS Award changes had necessitated staffing number increases. However, a minority (24%) reported that the changes had resulted in decreased staffing.

Two thirds of respondents reported that their bottom-line costs had increased because of the SCHADS Award changes. Although it is worth noting that one third also reported that their costs had not increased as a result of the changes.

[19] ABS Business Conditions Survey 2022

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For those respondents reporting cost increases from the SCHADS Award changes, the average cost increase was 2.4%, and the median 2.0%. (One statistical outlier was removed.)

Across all respondents, the average cost increase was 1.5% (median 0.5%). It should be considered in the context of these survey respondents, as they may not be an accurate representation of the overall NDIS market. However, this information is still valuable for the Agency to understand the cost drivers, and how this might impact providers in general.

40% of those who said their staff numbers had decreased also reported that their costs had increased. This implies that the SCHADS Award changes also increased costs other than those directly related to staff costs. For example, a few respondents indicated having to spend more on software for new rostering systems.

A total of 60% of those who reported that staffing numbers had decreased also reported that bottom line costs had not increased. However, it is not possible to determine whether decreased staffing numbers translated into net cost savings, as the survey question only asked if costs had increased, not whether they had decreased.

It is important to distinguish between one-off adjustment costs from implementing a change, and on-going costs incurred thereafter. The most common comment (33%) on why costs had increased following the SCHADS Award changes were one-offs. These included matters such as purchasing new software, retraining current employees on the new rules, and changing rosters. Conversely, only a small minority (18%) of explanations of cost increases mentioned the new minimum two-hour shift requirement, which is a permanent change.

In summary, data-based analysis from Ability Roundtable indicates that the estimated impact of SCHADS Award changes on provider costs, average impact is 1.5% of total costs, was similar to what was anticipated by the 2021-22 APR. It is also considered that much of these costs borne by providers are likely one-off adjustments to the SCHADS Award changes.

4.8 Increases to superannuation contributions

From 1 July 2023, employer superannuation contributions will rise from 10.5% of wages to 11.0%.[20]

Using the 2022-23 DSW Cost Model, the NDIA estimates this superannuation contribution increase to be, holding everything else constant, a raise to the cost of a standard hour of disability support worker supports from $62.17 to $62.45, or an increase of 0.45%

4.9 Impact of the new domestic and family leave reforms

The Australian Government has introduced paid family and domestic violence leave for all employees. Across Australia from 1 February 2023, employees of non-small business employers (15 or more employees) can access a minimum of 10 days of paid family and domestic violence leave in a 12-month period. Employees of small businesses will be able to access the same family and domestic violence leave entitlements from 1 August 2023. This is available to full-time, part-time and casual employees but will not be pro-rated for part-time or casual employees. For more information see the Fair Work Ombudsman's Family and Domestic Violence Leave page.

[20] As determined by the Australian Tax Office

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Previous surveys and studies provide a useful reference point, with an estimate take up of family and domestic violence leave of 0.05% to 0.8% of employees. See Appendix B for more information on NDIA review of information on prevalence of domestic violence and surveys conducted on the utilisation of this leave in Australia.

In their submission the Australian Services Union suggested the use of a take up rate of 0.05% of employees, referencing the Fair Work Commission's Survey[21]. Note, this figure considers the take-up of unpaid leave, which may not be reflective of take-up for paid leave.

There is consideration that reported figures may be an underestimate of future adoption of the family and domestic violence leave by workers. Country wide adoption of family and domestic violence leave will likely result in Domestic and Family Violence leave being more widely known and better understood, which may reduce the stigma associated with accessing this type of leave.

Additionally, given the NDIS workforce is highly skewed toward female employees (77% from the 2021 Australian Census survey), consideration is given to the higher likelihood of those identifying as women experiencing violence and/or abuse.

On balance, the NDIA estimates an upper bound on the average number of workers accessing family and domestic violence leave to be 2.3%, with those accessing the leave assumed to be accessing the entire minimum entitlement.

Using the 2022-23 DSW Cost Model, the NDIA estimates this to be, holding everything else constant, an increase of 7 cents, or a 0.1% increase to the hourly standard, weekday daytime disability support.

The NDIA acknowledges this may be an overestimation of the actual up-take of this leave in the sector as it is implemented and will continue monitoring this into the future.

4.10 Anticipated Impact of Aged Care Award Change

The Fair Work Commission's decision to lift the Aged Care Award and relevant workers' wages by 15% will impact wages to workers in the Aged Care sector from July 2023 onwards. Given there are some skills overlaps between aged care and disability support, the NDIA anticipates a flow-on impact to the cost of disability support workers in the disability sector, and the NDIS. However, we expect the impact to limited.

The Award system is a substantial driver of wages, and thus the cost of support in the sector, by setting the minimum wages for the relevant industry. Many of the disability support workers delivering NDIS supports are paid under Schedule B of the SCHADS Award, which is a higher rate than aged care workers (even with the 15% increase). The NDIA's DSW Cost Model uses a SCHADS Award, social and community services employee, Level 2, pay point 3 as the basis of setting the Standard disability support worker.

It is reasonable to consider this to be appropriately matched with the Aged Care Award Level 4 worker. The NDIA does acknowledge some supports delivered to NDIS participants could be delivered by other types of workers classified across other types of aged care employees, such as level 3 or level 5.

[21] Fair Work Commission Survey Analysis for the Family and Domestic Violence Leave Review 2021, view here.

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This matching is based on the type of work generally performed by this type of worker (personal care tasks by a "personal care worker grade 3") and personal care support provided require working under limited supervision. Further the Aged Care Award level 4 worker can require a Certificate 3 or higher, while the SCHADS Award Level 2 worker requires a certificate 4 or higher.[22]

Comparison of these Award worker wages highlights the difference that exists between the two Awards. From 1 July 2022, for a weekday daytime hourly wage, the full and part time SCHADS Award Level 2, pay point 3 is $32.37 per hour while the full and part time Aged Care Award Level 4 is $24.76 per hour.[23] This currently equates to a difference of $7.61 per hour, or the SCHADS Level 2.3 worker rate to being 31% higher.

This current wage differential means with the 15% increase to the Aged Care workers, it will likely see the gap narrow between the two sectors with disability workers still higher by $3.90 per hour or 14%.

There are also non-wage reforms[24] ongoing in the Aged Care sector aimed at improving the quality of care. These may have flow on impacts upon the available workforce for NDIS participants and the disability sector more broadly, but again the NDIA expects the impact to be limited. More information about these potential impacts on the NDIS can be found in Appendix C.

Overall, the NDIA acknowledges that the 15% increase to Aged Care worker wages and other reforms being undertaken in aged care are expected to make working in the aged care sector relatively more attractive than previously. On balance, the NDIA anticipates this is unlikely to have a major impact on the cost of similarly skilled workers, but workforce availability should continue to be monitored as these reforms are rolled out.

4.11 Impact of quality, safeguarding and compliance costs

The Ability Roundtable survey asked whether 'the costs of complying with NDIS Quality and Safeguards Commission (NDIS Commission) regulations increased over the last 12 months and if so, by approximately what percent'. The majority (80%) of respondents reported that operating under the NQSC had raised their compliance costs over the past year.

For respondents reporting an increase in compliance costs, the average increase was 24% (median 21%). Across all respondents providing numerical estimates of cost increases, the average increase was 18% (median increase was 10%).

In summary, evidence from the Ability Roundtable indicates that compliance related costs are not a one-off and have been increasing over time.

4.12 Temporary Transformation Payment

The Temporary Transformation Payment (TTP) for many disability support worker-related supports was introduced 1 July 2019 to assist providers with transitioning their businesses into the NDIS. Transitional price levels represent the price necessary to attract new

[22] SCHADS award can be accessed here (incorporating all amendments up to and including 15 March 2023.)

[23] Fair Work Ombudsman pay guides

[24] For example, improvements to the Aged Care Quality Standards, which can be found here

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

providers to enter the market or to reduce exits from the market. They represent the price required to attract economic resources to expand supply. Transitional price levels are above sustainable price levels but should only be adopted where a significant expansion of supply is required.

In line with the NDIS Pricing Strategy, the base price limits for supports delivered by disability support workers have, since 1 July 2019, been set in line with the estimated efficient costs of delivery. The TTP loading has been used to adjust these efficient prices to transition levels. The level of the loading was initially set at an amount equal to the difference between the estimated efficient cost of delivery and the estimated average cost of delivery. It was always intended that this amount would decrease over time as providers became more efficient.

Providers can claim for TTP under following groups of supports:

- Access Community Social and Recreational Activities
- Assistance With Self-Care Activities
- Group Activities
- Supports in Employment.

Given there are more than 150 different lines of supports related to TTP, more information on the specific price limits for the TTP loadings can be found in the current version of the Pricing Arrangements and Price Limits published on the NDIS website.

Scheme statistics

In the six months to December 2022, there were 8,287 active providers servicing over 107,480 participants (19% of the 573,342 active participants as of 31 December 2022), claiming over $1.84 billion in funding. Over the six months to December 2021, payments were made to 7,189 providers (15% less compared to the six months to December 2022) and amounted to $1.7 billion to pay services of 107,067 participants. The average amount claimed per provider decreased from $230k in the six months to December 2021 to $222k per provider in the six months to December 2022.

Table 4 below illustrates TTP Scheme statistics.

TABLE 4: TEMPORARY TRANSFORMATION PAYMENT SCHEME STATISTICS

Statistics	July – December 2021	July – December 2022	Percentage Change
Total number of NDIS participants	107,067	107,480	+0%
Total number of active providers	7,189	8,287	+15%
Total amount claimed	$1.65 billion	$1.84 billion	+11%
Average amount claimed per provider	$229,617	$221,540	-4%

Source: NDIS internal administrative data

As reported in the 2021-22 APR report, a significant number of providers who claimed for the TTP did not meet the TTP eligibility requirements. Only 64.1% of providers who claimed the TTP in 2020-21 completed the benchmarking survey for the 2019-20 financial year, and only 37.1% of providers who claimed TTP in the first half of 2021-22 completed the benchmarking survey for the 2020-21 financial year.

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These numbers signalled there was a low response rate. The results suggest that using TTP in current form to encourage take up of the financial benchmarking survey has not been as successful as anticipated to collate information on providers' financial bottom line.

4.13 Feedback from consultations

Of 304 submissions received, 19% (59) discussed disability support worker related supports. One of main themes raised was that there is still ongoing adjustment for many providers on costs related to quality, safeguards, and compliance, COVID and SCHADS Award changes. Participants also felt that there was a wide variance of skills among support workers delivering supports, and that these workers were generally paid at the NDIS price limit.

See Appendix A for more details on common themes raised in submissions to the 2022-23 APR Consultation Paper.

4.14 Recommendations

In determining the price limit for DSW-related supports, analyses suggest that the labour market for the care sector remains tight. These conditions could potentially intensify competition in terms of labour with other care sectors, which could put more pressure on supply going forward.

To ensure NDIS participant's wellbeing and safety, it is considered appropriate to pass on minimum Award wages and national employment standard changes to superannuation for this to occur.

Recommendation 1

The NDIA, subject to any specific recommendation arising from the current Annual Pricing Review, should increase the price limits for supports that are determined by the NDIS Disability Support Worker Cost Model from 1 July 2023 to reflect any changes in the minimum wages specified in the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award) following the Fair Work Commission's Annual Wage Review and any increase in the Superannuation Guarantee Charge.

The 2% temporary loading introduced from 1 July 2022 in the DSW Cost Model was intended to be a temporary measure to assist providers adjust to costs such as COVID and SCHADS Award changes. The following considerations have been given:

- It should be recognised that COVID related restrictions in the economy have been wound back. However, COVID is still active in Australia and is likely to continue to disrupt supports being delivered to NDIS participants. Providers incur some costs when these arise (such as PPE and RAT tests). The NDIS sector also represents some of the most vulnerable groups in the community and the adjustments from the impacts of COVID has somewhat been slower than the rest of the nation.
- It appears many of the adjustments needed for the SCHADS Award changes were one-off costs for providers. It is considered that there is still ongoing adjustment being made by the sector as these major Award changes are still relatively recent. The NDIA recognises there is some cost impact that can still be borne by providers as it takes time for a sector to fully adjust systems and processes to major Award changes.

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The NDIA considers that the majority of these costs have been addressed and/or winding back over the past year. COVID costs have been reducing post pandemic and many of the costs from the changes to the SCHADS Award were one-off adjustments. However, the NDIA acknowledges these have the potential to impact participant safety as some providers are still facing transition costs associated with both. Therefore, the NDIA considers it necessary to extend the temporary loading for a further 12 months at 1% from 1 July 2023 with this ceasing on 1 July 2024, to allow providers more time to adjust to these.

Recommendation 2

The NDIA should extend the temporary loading for a further 12 months at 1% from 1 July 2023 with this ceasing on 1 July 2024.

An additional consideration this year is the new paid family and domestic violence leave introduced by the Fair Work Commission. Based on previous surveys and studies, the NDIA estimates an upper bound number of workers accessing family and domestic violence leave to be 2.3%, with those accessing the leave assumed to be accessing the entire minimum entitlement.

The NDIA acknowledges this may be an overestimation of the actual up-take of this leave in the sector as it is implemented and will continue monitoring this into the future.

Recommendation 3

The NDIA should include the paid family and domestic violence leave into the Disability Support Worker Cost Model - an increase of 0.1% from 1 July 2023 to reflect the new entitlements for workers in the industry.

The Fair Work Commission has lifted the Aged Care Award wages by 15% from July 2023. The DSW Award rates are still estimated to be higher than the comparable Aged Care Award rates. However, there could be greater attraction of workers to the aged care workforce as the disability sector and aged care sector share the same pool of workers. Although the NDIA expects the impact of these changes to be limited, the NDIA should continue to monitor their impact.

Recommendation 4

The NDIA should continue to work with the sector to monitor the impact of changes to the Aged Care Award that come into effect on 1 July 2023 with a view to further addressing these costs in the future if necessary.

The TTP loading was initially setup to allow providers time to assist transitioning to more efficient systems and prices. The NDIA has conducted extensive financial benchmarking over the last six years to monitor this, and consequently, the NDIA does not consider that it is necessary to conduct a financial benchmarking survey in 2022-2023.

As per the initial pricing strategy framework, the NDIA does not see a need to change the timeline of the TTP to ensure balance is maintained between incentivising providers to achieve greater efficiencies while considering differing cost structures of providers. In the absence of a NDIS Financial Benchmarking Survey, is it reasonable to assume those who were accessing the TTP in FY2022-23 may continue to need access to assist transitioning systems.

Therefore, the NDIA considers it reasonable to continue reducing the TTP loading in the future as planned, from the current 3.0% to 1.5% on 1 July 2023 and then 0% from 1 July

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2024. The NDIA will continue to work closely with the sector in monitoring market conditions and cost structures in the absence of a NDIS Financial Benchmarking Survey.

Recommendation 5

The NDIA should maintain its current pricing strategy including the scheduled reduction over the next year of the Temporary Transformation Payment (TTP) loading to 1.5% on 1 July 2023. The TTP loading should cease to apply from 1 July 2024.

The NDIA should allow registered providers who have been claiming for the TTP in financial year 2022-23 to continue to do so in financial year 2023-24 until cessation.

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5 Therapy supports

5.1 Context

Therapy supports are important to participants and to the NDIS. They assist participants to build capacity to achieve their goals and they have the potential to reduce long term costs in the NDIS as they can support participants to improve capacity over time.

Therapy services are among the important supports available to NDIS participants. These supports are mainly delivered by Art Therapists, Audiologists, Counsellors, Developmental Educators, Dietitians, Exercise Physiologists, Music Therapists, Occupational Therapists, Orthoptists, Physiotherapists, Podiatrists, Psychologists, Rehabilitation Counsellors, Social Workers, and Speech Pathologists.

Therapy services can also be delivered by Therapy Assistants working under the delegation and direct supervision at all times of a therapist. Where a support is delivered by a therapy assistant, the therapy assistant must be covered by the professional indemnity insurance of the supervising therapist (or the therapist's or therapy assistant's employing provider).

Within the NDIS, most therapy is delivered under three provider registration groups:

- Therapeutic Supports (0128): Provision of a mix of therapies, to assist participants aged from 7 years to apply their functional skills to improve participation and independence in daily, practical activities in areas such as language and communication, personal care, mobility and movement, interpersonal interactions and community living.
- Early Intervention Supports for Early Childhood (0118): Provision of a mix of therapies, and a key worker for the family. Supports children 0-6 years with developmental delay or disability and their families to achieve better long-term outcomes, regardless of diagnosis.
- Exercise Physiology & Personal Well-being Activities (0126): Physical wellbeing activities promote and encourage physical well-being, including exercise.

Therapists also deliver supports under the following registration groups:

- Specialist Positive Behaviour Support (0110): Includes support items provided by allied health professionals with specialist skills in positive behaviour support including assessment and the development of a comprehensive plan that aims to reduce and manage behaviours of concern.
- Custom Prostheses and Orthoses (0135): Prescription and manufacture of customised prostheses or orthoses requiring specialist skills.
- Specialised Hearing Services (0119): Specialised hearing services for children and adults with complex needs.
- Hearing Services (0134): Hearing services for children and adults.

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There are currently 14 different therapy support items within the Capacity Building Support Categories.[25] [26] These supports can be delivered to individual participants or to groups of participants. Where supports are delivered to groups of participants the hourly price limit is divided by the number of participants in the group. Price limits do not vary according to the Time of Day / Day of Week that the support is delivered. However, they do vary by state/territory and according to the Type of Therapist that delivers the support.

As well as direct service provision, therapists can claim for Non-Face-to-Face Support Provision, Provider Travel, Short Notice Cancellations and NDIA Requested Reports. They can also claim for any non-labour costs associated with claimable Provider Travel.

As Table 5 included below shows, there are separate price limits for supports delivered by:

- Art therapists, Audiologists, Dietitians, Developmental Educators, Music Therapists, Occupational Therapists, Orthoptists, Podiatrists, Social Workers, Speech Pathologists and Other Professionals
- Counsellors
- Exercise Physiologists
- Psychologists
- Physiotherapists
- Therapy Assistants.

[25] Seven (7) of these therapy supports are duplicated in the Activities of Daily Living Core Support Category

[26] The Exercise Physiologist and Dietitian supports are also duplicated in the Improved Health and Wellbeing Capacity Building Support Category.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

TABLE 5: 2022-23 PRICE LIMITS FOR THERAPY SUPPORTS

Type of Therapist	NSW / VIC / QLD / ACT	SA / WA / TAS / NT	Remote	Very Remote
Art Therapists	$193.99	$193.99	$271.59	$290.99
Audiologists	$193.99	$193.99	$271.59	$290.99
Dietitians	$193.99	$193.99	$271.59	$290.99
Developmental Educators	$193.99	$193.99	$271.59	$290.99
Music Therapists	$193.99	$193.99	$271.59	$290.99
Occupational Therapists	$193.99	$193.99	$271.59	$290.99
Orthoptists	$193.99	$193.99	$271.59	$290.99
Podiatrists	$193.99	$193.99	$271.59	$290.99
Social Works	$193.99	$193.99	$271.59	$290.99
Speech Pathologists	$193.99	$193.99	$271.59	$290.99
Other Professionals	$193.99	$193.99	$271.59	$290.99
Counsellors	$156.16	$156.16	$218.62	$234.24
Exercise Physiologists	$166.99	$166.99	$233.79	$250.49
Physiotherapists	$193.99	$224.62	$314.47	$336.93
Psychologists	$214.41	$234.83	$328.76	$352.25
Therapy Assistants – Level 1	$56.16	$56.16	$78.62	$84.24
Therapy Assistants – Level 2	$86.79	$86.79	$121.51	$130.19

This chapter examines the pricing arrangements for therapy supports in the NDIS, including the extent to which they are appropriately aligned with those in comparable schemes, and with the private market for therapy supports.

5.2 Scheme Statistics

In the six months to December 2022, 325,319 participants (57% of the 573,342 active participants as of 31 December 2022) purchased therapy supports through their plans. These supports were delivered by 46,434 providers who received a payment in the six months to December 2022, a 14% increase to provider numbers compared to six months to December 2021.

The amount claimed rose by 26% to $1.6 billion over the six months to December 2022 compared to the six months to December 2021. More therapy support statistics can be seen in Table 6.

TABLE 6: THERAPY SUPPORTS SCHEME STATISTICS

Statistics	July – December 2021	July – December 2022	Percentage Change
Total number of NDIS participants	279,098	325,319	+17%
Total number of active providers	40,744	46,434	+14%
Total amount claimed by active providers of Therapy supports	$1.3 billion	$1.6 billion	+26%
Number of active registered providers of Therapy supports	8,833	8,900	+1%

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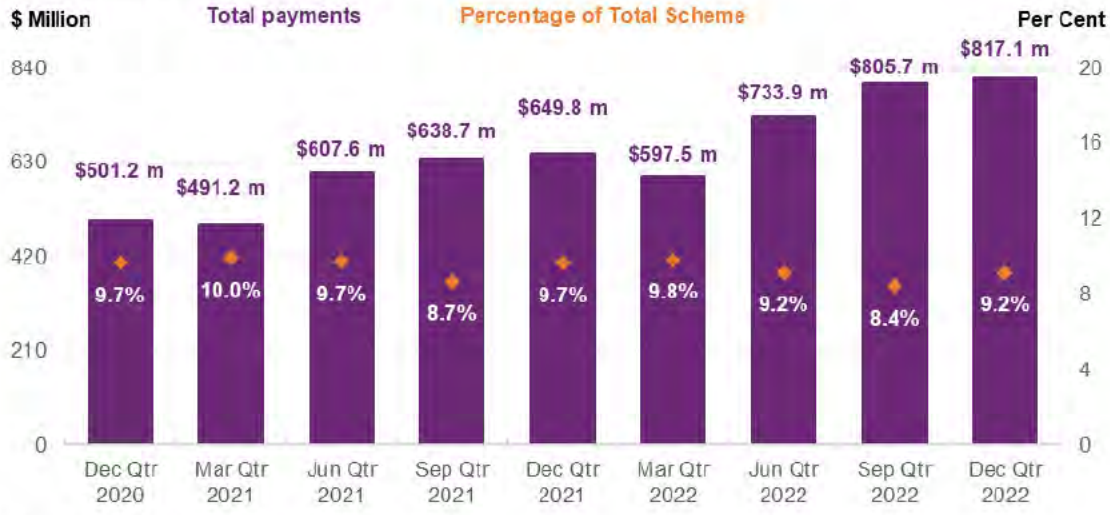
Statistics	July – December 2021	July – December 2022	Percentage Change
Number of active unregistered providers of Therapy supports	32,133	38,114	+19%
Average amount claimed by all active providers of Therapy supports	$31,627	$34,947	+10%
Total amount claimed by registered providers of Therapy supports	$0.99 billion	$1.16 billion	+18%
Average amount claimed by registered providers of Therapy supports	$112,093	$130,738	+17%
Total amount claimed by unregistered providers of Therapy supports	$0.29 billion	$0.45 billion	+55%
Average amount claimed by unregistered providers of Therapy supports	$9,043	$11,790	+30%

Source: NDIS internal administrative data

Note: Please note the number of 'active registered providers of Therapy supports and number of 'active unregistered providers of Therapy supports' do not align with the total number of 'active providers'. There are two reasons for this; 1) One provider can provider multiple supports with being registered for some types of support provided and unregistered for others (different registration groups) in the same period so they are accounted for in both groups of providers; 2) Providers with the unknown registration are captured in total amounts but not presented in this table as they make up less than 1% of total payments.

Figure 13 below shows the quarterly breakdown of Scheme expenditure on therapeutic supports and proportion of the overall Scheme expenditure. Therapeutic supports make 9.7% or $817.1 million of total scheme costs in the three months to December 2022. As shown on the chart above, these supports hover around 9.4% of the total Scheme costs for the last 9 quarters.

FIGURE 13: NDIS EXPENDITURE ON THERAPY SUPPORTS SINCE DECEMBER 2020 QUARTER RELATIVE TO TOTAL NDIS EXPENDITURE



Source: NDIS internal administrative data

Participants

From the 325,319 participants with a claim for therapy supports from their plan in the six months to December 2022, the most common therapist support is for "Other Professionals" ($254.4 million claimed), followed by Occupational Therapists (for $280.9 million claimed)

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and Physiotherapy ($248.0 million). Noting participants can use and claim more than one type of therapist/therapy. A more detailed breakdown can be seen in Table 7.

The overall average payment for a participant receiving therapy supports in the six months to December 2022 was $4,988, up 8% compared to $4,617 in the six months to December 2021. The average amount claimed per provider over the six months to December 2022 was $34,947, up 10% compared to the six months to December 2021 ($31,627).

TABLE 7: SCHEME EXPENDITURE BY TYPE OF THERAPY, JULY TO DECEMBER 2022

Type of Therapist	Number of Participants	Number of Providers	Total Amount Claimed
Occupational Therapists	162,532	7,279	$280.9 m
Other Professionals	179,476	25,544	$254.4 m
Early Childhood	69,250	10,362	$248.0 m
Behavioural Therapists	42,385	1,290	$207.7 m
Physiotherapists	85,965	10,249	$166.5 m
Psychologists	82,372	11,631	$138.7 m
Speech Therapists	89,033	5,896	$135.4 m
Exercise Physiologists	36,197	4,704	$64.9 m
Therapy Assistants	35,066	3,576	$35.5 m
Counsellors	20,043	4,552	$26.9 m
Dietitians	19,875	2,052	$15.9 m
Social Workers	8,101	1,356	$11.4 m
Travel	50,863	7,596	$8.9 m
Miscellaneous	4,628	2,777	$7.4 m
Podiatrists	20,111	2,483	$6.4 m
Music Therapists	3,907	819	$5.2 m
Art Therapists	3,539	1,033	$4.2 m
Development Educators	2,132	333	$3.4 m
Orthoptists	1,206	280	$0.6 m
Rehabilitation Counsellors	443	280	$0.3 m
Audiologists	729	181	$0.3 m
TOTAL July-December 2022	**325,319**	**46,434**	**$1.6 b**

Source: NDIS internal administrative data

Note: Please note the above totals for number of participants and number of providers are based on unique participants and providers over the six months to December 2022. The group of "Other Professionals" delivering therapy encapsulate assessments, recommendations, and group therapies which could have been delivered by a range of therapists not otherwise listed.

This section has highlighted the growing demand of participants accessing therapy supports in the NDIS (up 14% in the six months to December 2022 compared to six months to December 2021). Many of whom require access to a wide range of therapy services delivered in the NDIS to support different participant needs. As such, the NDIS requires a diverse range and stable supply of therapists to best support participants and ensure they receive quality outcomes.

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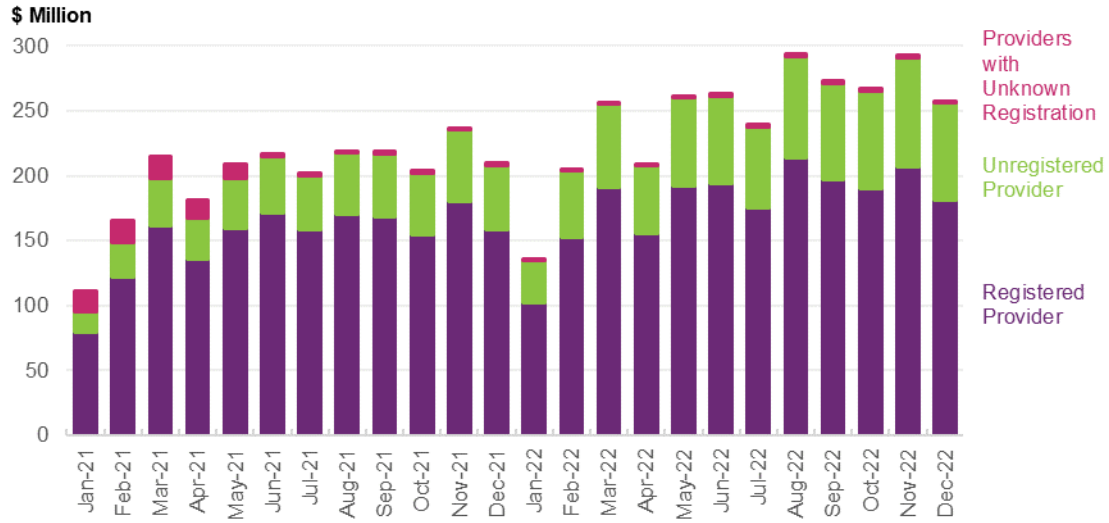
Providers

As seen in Table 7 above, were 46,434 providers who claimed for therapy services in the six months to December 2022. The therapist supports with the highest number of providers claiming these supports were for “Other Professionals” (25,544), Psychologists (11,631), Professionals delivering Early Childhood supports (10,362) and Physiotherapists (10,249).

In the six months to December 2022, there were 8,900 registered providers who delivered therapy services compared to 8,833 in the six months to December 2021. However, of the $1.6 billion claimed by providers in the six months to December 2022, $1.2 billion was made to registered providers, up from $990 million in the six months to December 2021.

This, however, represents a drop in the proportion of therapy payments being made to registered providers compared to the same period in the previous year (77% compared to 72%). This was due to the number of payments being made to unregistered providers increasing from 23% to 28% across these periods. A monthly breakdown can be seen in Figure 14.

FIGURE 14: TOTAL PAYMENTS FOR THERAPY SUPPORT ITEMS BY PROVIDER REGISTRATION, 2021 – 2022



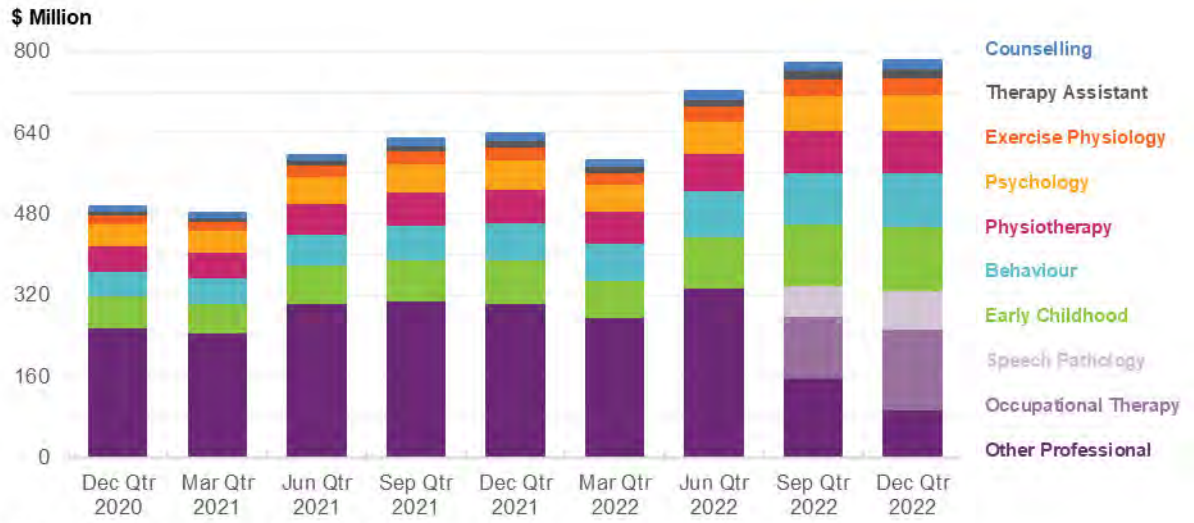
Source: NDIS internal administrative data

In the six months to December 2022, the top five types of therapists (excluding “Other Professionals”) claimed against in the NDIS, based on total payments, were Occupational Therapist ($280.9 million), Professionals delivering Early Childhood ($248.0 million), Behavioural Therapists ($207.7 million), Physiotherapists ($166.5 million) and Psychologists ($138.7 million). These five types of therapists accounted for $1.0 billion worth of claims, comprising 64%, close to two thirds of the $1.6 billion NDIS expenditure on therapy.

It should be noted that prior to 1 July 2022, many types of therapists were not categorised into individual support items and were included in the “Other Therapy” support. The breakdown of these types of therapists were not captured until after this date. Since 1 July 2022, it can be reasonably assumed that many of the supports delivered under “Other Professionals” were likely through Occupational Therapists and Speech Pathologists. The other most claimed types of therapies delivered appear to be relatively stable since December 2020 quarter. These are shown in Figure 15.

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FIGURE 15: LARGEST TEN THERAPY TYPES BASED ON TOTAL PAYMENTS, OCTOBER 2020 – DECEMBER 2022



Source: NDIS internal administrative data

Note: Please note in the above chart Occupational Therapy and Speech therapy are introduced as standalone lines of supports from July 2022. Before July 2022 these lines of supports were claimed by providers under other groups of therapy without clear indicators of supports provided.

This section has shown the increase in supply of providers delivering therapy supports to NDIS participants. However, with the growing number of NDIS participants receiving therapy supports, this may put pressure on the number of therapists needed to continue supporting NDIS participants.

5.3 Employment Statistics

On current reported data through Australian Health Practitioners Registration Agency (AHPRA), as of February 2023, the Department of Health and Aged Care's Allied Health Factsheets Dashboard[27] stated there are:

- 41,791 Psychologists registered with AHPRA. The number of registrations grew by 20.3% between 2017 (34,752) and 2021.
- 38,882 Physiotherapists registered with AHPRA in 2021, up by 25.8% from 30,916 in 2017.
- 26,904 Occupational Therapists registered with AHPRA. The number of registrations grew by 33.6% between 2017 (20,145) and 2021 (26,904).
- 5,819 Podiatrists registered with AHPRA, up by 18.8% from 4,900 in 2017.

The total number of Psychologists, Physiotherapists, Occupational Therapists and Podiatrists registered with AHPRA has grown significantly in the last five years, up 26% from 90,713 in 2017 to 113,396 in 2021, whilst those registered with AHPRA and are employed has increased by 26% from 73,350 in 2017 to 92,406 in 2021 (see Figure 16).

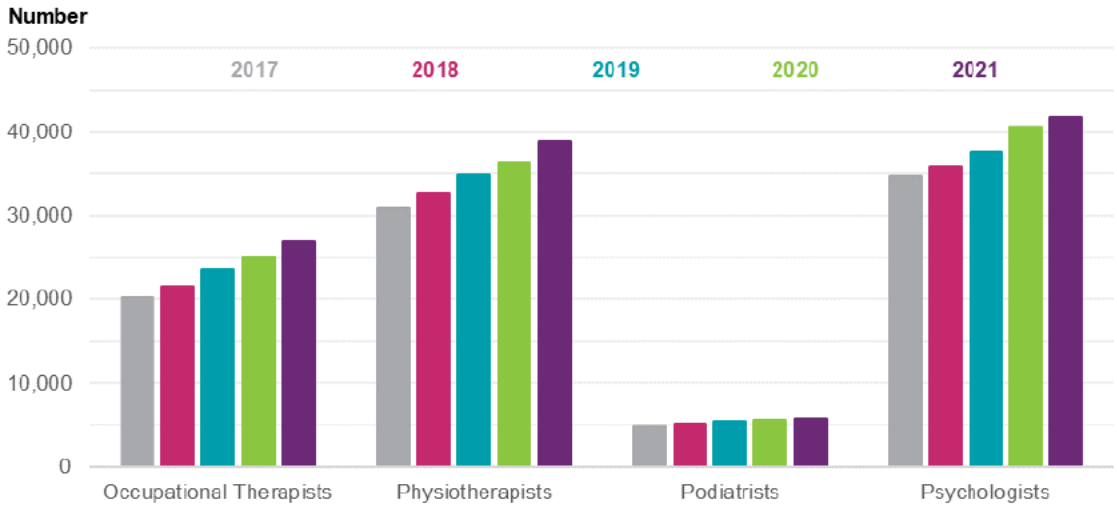
[27] Found at Allied Health factsheets and Department of Health and Aged Care Dashboards

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

FIGURE 16: NUMBER OF REGISTERED THERAPISTS, 2017 TO 2021



Source: Department of Health and Aged Care

Jobs and Skills Australia (formerly known as National Skills Commission) projects employment growth of the entire Australian workforce for five years to November 2026 at 9.1%. The growth in the therapy space will continue over this period with therapists making up three of the 11 fastest growing occupations, those being Audiologists and Speech Pathologists (34.7%, close to four times the projected rate of growth of the entire Australian workforce over that period), Podiatrists (31.8%) and Physiotherapists (28.7%), as shown in Table 8.

TABLE 8: GROWTH IN EXPENDITURE ON THERAPY BY FUNDING SOURCE, 2016-17 TO 2019-20

Occupation Code	Occupation	Employment level – November 2021	JSA Projected employment level – November 2026	JSA Projected employment growth – five years to November 2026	JSA Projected employment growth – five years to November 2026
2527	Audiologists and Speech Pathologists/Therapists	12,300	16,600	4,300	34.7%
2526	Podiatrists	6,400	8,500	2,100	31.8%
2525	Physiotherapists	32,800	42,200	9,400	28.7%
2522	Complementary Health Therapists	6,300	8,000	1,800	27.9%
2721	Counsellors	24,400	27,800	3,500	14.2%
2723	Psychologists	31,000	35,100	4,100	13.3%
2524	Occupational Therapists	23,900	25,600	1,800	7.4%
2511	Nutrition Professionals	7,900	8,500	600	7.2%

Source: Employment Projections | National Skills Commission (now Job and Skills Australia)[28]

These projections highlight strong future demand for therapists in Australia, with the NDIS being one of the contributors to this demand.

[28] Found at www.nationalskillscommission.gov.au/topics/employment-projections

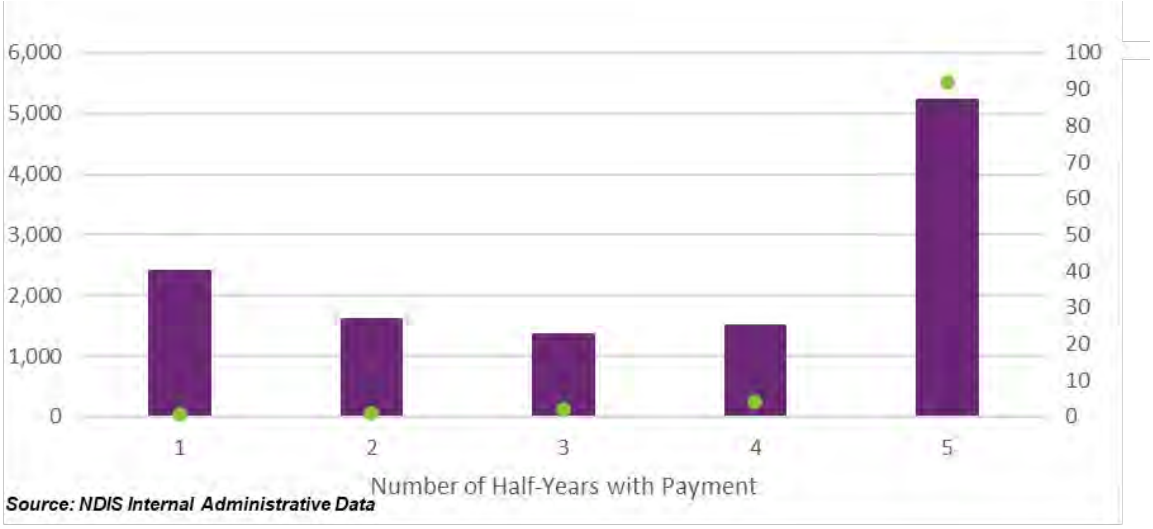
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5.4 Business Dynamism

To supplement the Scheme statistics, the NDIA has analysed registered provider payment activity. That is, payments made against Agency and Plan Managed plans are considered to be made by registered providers.

Figure 17 shows the number of registered Therapy providers with the payments between July 2020 and December 2022, split by the number of half-year periods in which each provider received a payment. Half-years are defined as the six-month time intervals from January to June and July to December. As seen in Figure 17 below, 5,219 out of 12,112 (43%) registered providers have received payments in all five half-years between July 2020 and December 2022. These providers account for 92% of the total payments across the two-and-a-half-year period.

FIGURE 17: REGISTERED THERAPY PROVIDER HALF-YEARLY PAYMENTS HISTOGRAM, JUNE 2020 – DECEMBER 2022



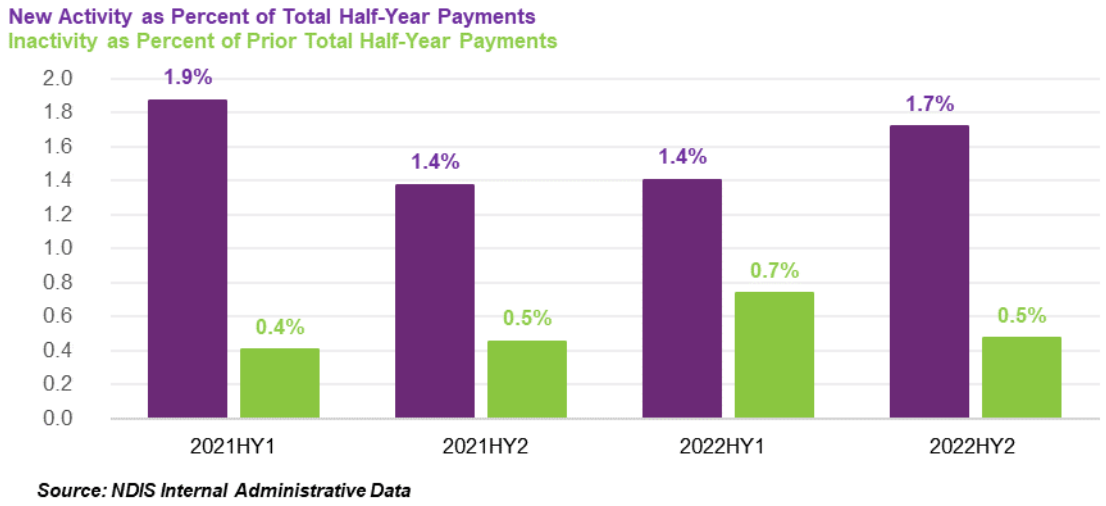
Source: NDIS Internal Administrative Data

To further assess the current state of the provider market, payment activities of registered providers across the two-year period from January 2021 to December 2022 were analysed. Providers with New Activity in a half-year are defined as providers with payments who did not have payments in the prior half-year. Similarly, Inactivity in the half-year is defined as providers without a payment who had payments in the prior half-year. Activity for each provider is expressed as a percentage of the total payments for that half-year (for New Activity) or prior half-year (for Inactivity). The NDIA acknowledges that this is not a perfect measure of market exits but the closest approximation given available data.

Results suggest that over the past two years, inactive registered providers in each half-year contributed to less than 0.7% of total payments. In contrast, registered providers with new activity in a half-year have contributed between 1.4% and 1.9% of total payments for that same period.

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FIGURE 18: THERAPY REGISTERED PROVIDER ACTIVITY MOVEMENTS, JANUARY 2021 – DECEMBER 2022



Source: NDIS Internal Administrative Data

Further analyses indicate that on average, inactive registered providers received $4,234 in payments in the half-year prior to becoming inactive, with 84% of registered providers receiving less than $5,000 in the half-year prior to becoming inactive. In contrast, active registered providers received on average $107,199 of payments in each half-year period, highlighting that inactive registered providers have been claiming lesser amounts on average relative to new and existing registered providers.

5.5 Comparable Government Insurance and Funding Schemes

The NDIA conducted a comparison of therapy price limits and arrangements across other comparable public schemes. This is based on the NDIA's calculations using information published by other schemes as of 31 March 2023; and additional information obtained directly through engagement with other schemes. The NDIA has engaged with sixteen Commonwealth and State Schemes to obtain their therapy pricing as comparison to NDIS limits.

The main Medicare Benefits Schedule (MBS) items for allied health have a scheduled fee of $65.85 per 20 minutes session. This equates to an effective hourly rate of $197.55 which is slightly higher than the NDIS hourly price limit. Note, the Commonwealth funding (MBS benefit) for the hour is $167.92, but co-payments are common in the MBS and the scheduled fee is a better estimate of the total cost of the support – or at least of the Australian Government's public position on the appropriate cost of the support.

To calculate the effective hourly price limit, NDIA sought information about the regulated length of therapy sessions (for example, the NDIS' price limits for therapy are per hour). Where this was not already available, this information was requested directly from other schemes. For comparability, the NDIA generally used standard or subsequent consultations where possible whilst noting many Schemes have differentiated items and/or pricing for initial consultations and standard/extended consultations.

The NDIA were able to calculate the effective hourly price where the length of a session was provided as a required length (for example, price per 20 minutes); as a required minimum length (for example, price for at least 20 minutes); or as an average session time expected based on the observed length of sessions. In all other cases, the NDIA were unable to

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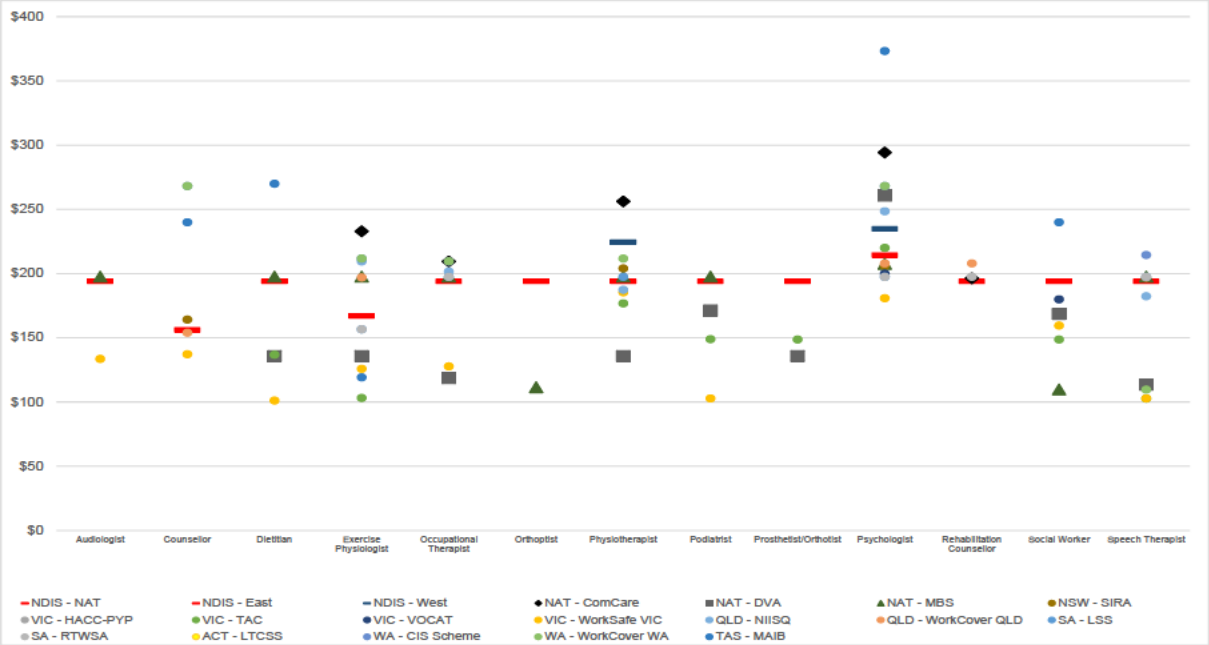
DISCLOSURE LOG

calculate the effective hourly price, and not able to directly compare these prices, so these do not appear in Figure 19 below.

Overall, NDIS prices are in line for most types of therapies. As Figure 19 illustrates, the current NDIS price limits are broadly consistent with the effective hourly rates paid by other schemes, once proper account is taken of duration of service, co-payments and provisions for travel and consumables.

However, results this year indicate that many types of therapies have been indexed by other schemes over the past year. This appears to have put NDIS into the middle/lower range for some therapies offered by Professionals, such as Counsellors, Occupational Therapists and Rehabilitation Counsellors.

FIGURE 19: OTHER SCHEME PRICING COMPARED TO NDIS, 2022-23



Source: Data from other schemes with NDIA internal calculations

5.6 Private Billing Rates

This section analyses a data set of 6,053 private billing rates for therapy services, including 2,857 billing rates for weekday in-room services.

The private billing dataset was compiled by the NDIA by scanning provider websites across Australia. Prices for weekend, initial and telehealth consultations were excluded from the dataset. Outliers were also removed from the dataset[29] as well as some therapy services, including Teachers, Personal training, Osteopathy, and Therapy assistants. The billing rates were converted to effective hourly rates based on the length of consultation. Some 34% of the sample observed billing rates were from non-metropolitan areas.

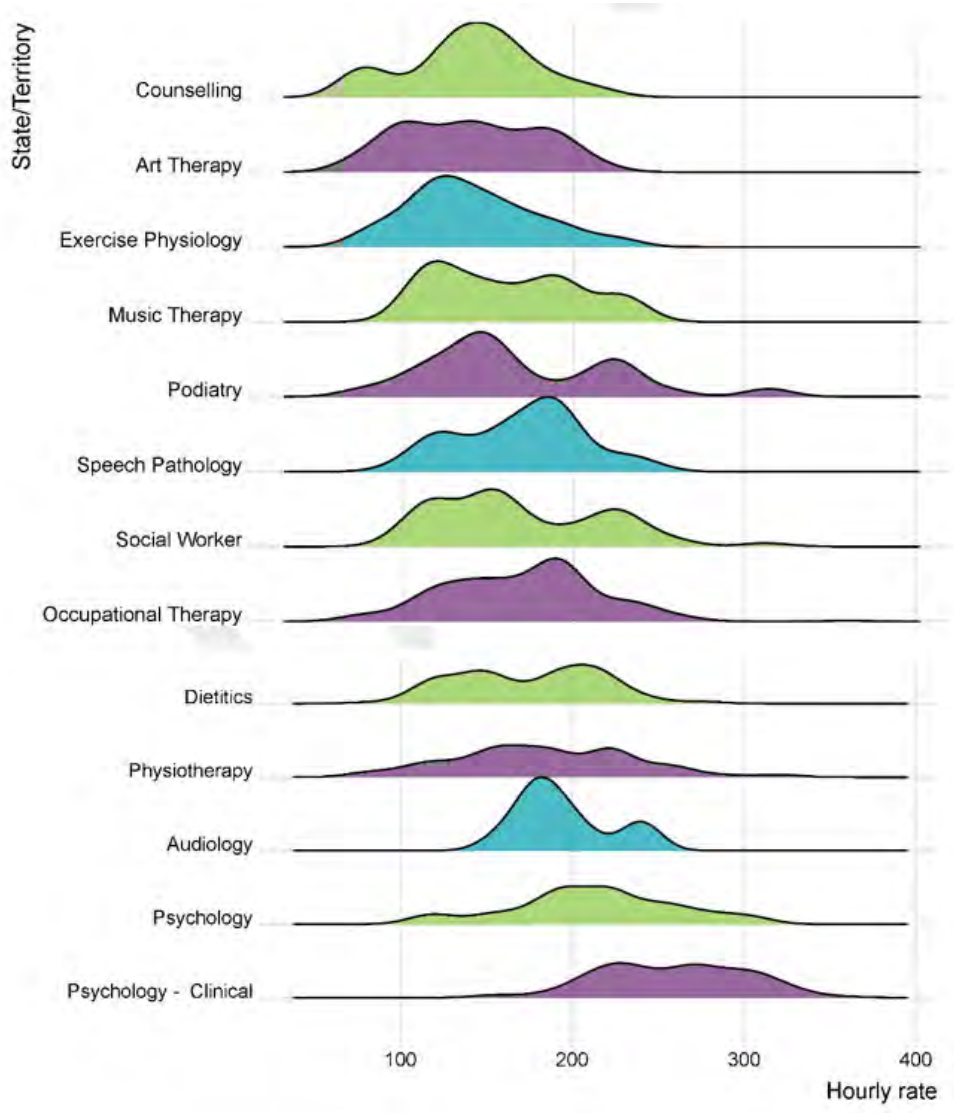
Among therapy services, the top four therapists in the sample were Physiotherapists (17.6%), Psychologists (15.2%), Clinical Psychologists (10.2%) and Dietitians (10.0%). Art Therapists and Music Therapists each accounted for less than 3% of the sample. There

[29] The study excluded outliers where the value of hour rate was either greater than Quartile 3 +1.5*Interquartile or was smaller than Quartile 1 – 1.5*Interquartile.

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were at least 80 observations for each type of therapists besides Art Therapists (33). Figure 20 shows the distribution of the sample for types of therapies, some of which have widely dispersed and significant overlap in pricing.

FIGURE 20: DISTRIBUTION OF PRVIATE BILLING RATES BY THERAPY TYPE



The geographic distribution of the sample observations was slightly skewed towards Victoria (30% of the sample) and Queensland (32%) with New South Wales underrepresented (15%). Australian Capital Territory was the only state or territory with less than 30 observations (18). Figure 21 for the distribution of private billing rates across states, which show significant overlap in dispersion and overlap. It is also clear some states and territories show multi-model distribution in pricing (such as the Northern Territory and Tasmania), which aligns to different pricing for different therapies in the sample.

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FIGURE 21: DISTRIBUTION OF PRIVATE BILLING RATES BY STATE

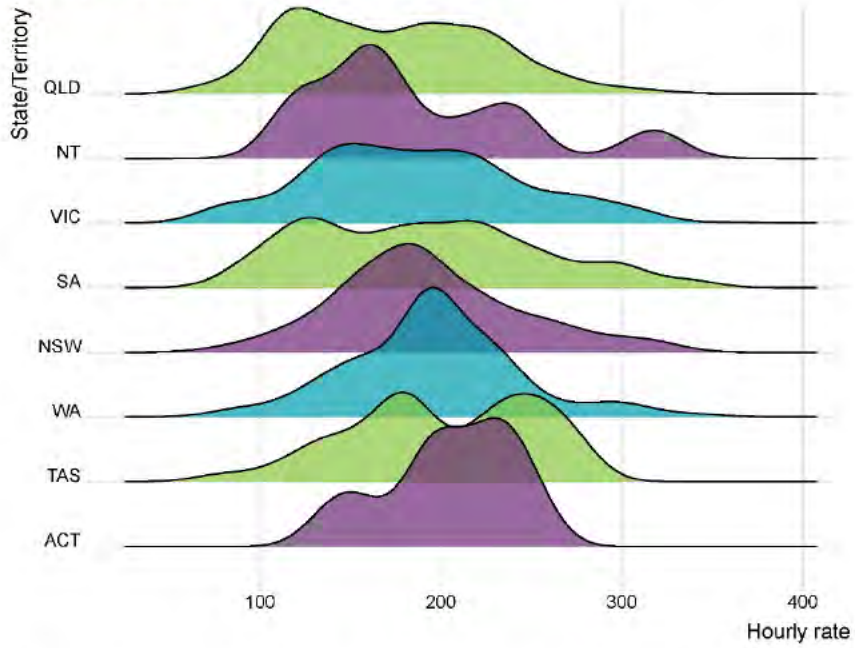


Table 9 displays summary distributional statistics of the sample of private billing rates. The average effective hourly rate for weekday in-room therapists in the sample was $184 (median $185). The smallest effective hourly rate that was observed in the data set was $73 and the largest was $360.

TABLE 9: SUMMARY STATISTICS OF PRIVATE BILLING RATE SAMPLE, BY THERAPY TYPE

Type of Therapy	Count	Mean	Standard Deviation	Minimum	25th percentile	Median	75th percentile	Maximum
Art Therapists	33	$140.2	39	$73.3	$100.0	$135.0	$177.5	$216.0
Audiologists	90	$194.6	26	$156.7	$175.0	$187.5	$210.0	$240.0
Counsellors	186	$138.8	36	$75.0	$120.0	$140.0	$160.0	$220.0
Dietitians	287	$174.9	41	$80.0	$140.0	$180.0	$210.0	$280.0
Exercise Physiologists	190	$140.7	36	$73.3	$119.0	$134.2	$167.0	$227.0
Music Therapists	81	$161.1	41	$100.0	$119.0	$154.0	$194.0	$240.0
Occupational Therapists	237	$169.3	42	$75.0	$140.0	$172.0	$194.0	$264.0
Physiotherapists	502	$183.9	51	$75.0	$150.0	$180.0	$220.0	$322.0
Podiatrists	184	$168.4	55	$75.0	$130.0	$150.0	$220.4	$313.5
Psychologists	434	$212.8	47	$108.0	$189.8	$215.5	$246.5	$312.0
Psychologists – Clinical	292	$258.4	42	$150.0	$228.0	$260.4	$291.6	$360.0
Social Workers	107	$169.2	49	$93.3	$120.0	$156.2	$216.0	$312.0
Speech Pathologists	234	$169.0	36	$95.0	$140.0	$174.2	$193.3	$250.0
Total Sample	**2,857**	**$184.4**	**55**	**$73.3**	**$140.0**	**$185.0**	**$220.0**	**$360.0**

Statistical models were built for the private billing data set (see Table 10). A series of Tukey's range tests were undertaken to group therapy types with similar private billing

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means. The test found that Audiologists, Dietitians, Music Therapists, Occupational Therapists, Physiotherapists, Podiatrists, Social Workers, Speech Pathologists (group 1 – base case) had similar means, while Counsellors, Exercise Physiologists and Art Therapists (group 2), also had similar means. The modelling began with indicator variables for each state/territory (model 1), plus a regional indicator variable (model 2) and one including the aforementioned variables and groups of therapies (model 3). Model 4 was also run that includes all states, a regional indicator and all therapy types individually, with New South Wales and Occupational Therapists as the base case. Sensitivity testing was also run on various interaction terms between the States and Territories, regional indicator and therapy types were also investigated, many of which were insignificant.

TABLE 10: STATISTICAL MODELS OF PRIVATE BILLING RATES

Variable	(1)	(2)	(3)	(4)
Constant	193.1***	202.2***	188.9***	183.8***
Victoria	-6.1	-12.1***	-8.9***	-11.0***
Queensland	-20.6***	-20.8***	-19.2***	-18.4***
South Australia	-3.3	-9.2	-10.9**	-12.4**
Western Australia	3.0	-3.4	-7.5*	-7.6*
Northern Territory	-6.0	-0.7	-6.9**	9.0*
Australian Capital Territory	12.0	2.9	-7.9	-6.5
Tasmania	8.2	12.9	19.2**	13.7*
Regional	N/A	-19.5***	-11.9***	-12.5**
Exercise Physiologists, Counsellors & Art Therapists	N/A	N/A	-34.9***	N/A
Psychologists	N/A	N/A	38.7***	44.5***
Clinical Psychologists	N/A	N/A	80.7***	85.6***
Art Therapists	N/A	N/A	N/A	-30.4***
Audiologists	N/A	N/A	N/A	25.9***
Counsellors	N/A	N/A	N/A	-32.5***
Dietitians	N/A	N/A	N/A	5.4
Exercise Physiologists	N/A	N/A	N/A	-25.3***
Music Therapists	N/A	N/A	N/A	-3.9
Physiotherapists	N/A	N/A	N/A	12.8***
Podiatrists	N/A	N/A	N/A	-1.1
Social Workers	N/A	N/A	N/A	3.5
Speech Pathologists	N/A	N/A	N/A	-1.3
Adjusted R^2	0.024	0.048	0.369	0.38
F Statistic	11.03	19.04	152.8	87.9
Observations	2,857	2,857	2,857	2,857

(* = p <0.05, ** = p < 0.01, *** = p<0.001)

Model 3 is preferred to Model 4 as the small increase in R-squared between Model 3 and Model 4 does not adequately compensate for many variables in Model 4 being insignficant at the 5% level.

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The explanatory power of model is only 37%, which suggest that there are many other factors affecting therapy pricing that are not currently captured in the model.

The results suggests the average hourly price of $189 for the majority of therapists in New South Wales, with most other states and territories suggested to be at lower price. This suggests that the NDIS price limits are still adequate for most therapists. Results also show that price limits of non-clinical Psychologists, Counsellors and Exercise Physiologists appear on par with NDIS price limits.

5.7 Consultation feedback

The topic of therapy supports received the most feedback through public consultation, with 174 submissions out of 304 (57%) documenting concerns and commentary. Many providers suggested the biggest cost driver has been the increasing supply costs and wages. Other costs involved attracting, training, and retaining staff, as well as quality, safeguarding and compliance costs. Many participants and their representatives who responding through the consultation process suggested that they were charged more than non-NDIS clients and generally supported no further price increase at this time.

See Appendix A for more details on common themes raised in submissions to the 2022-23 APR Consultation Paper.

5.8 Recommendations

On balance, available therapy data suggest that NDIS price limits for therapy supports are currently adequate. Available evidence from comparable government insurance and funding schemes and private market billing rates supports this.

The recommendations also consider the growing demand of NDIS participants claiming for therapy supports (17%) is being met to an extent by growth in the providers claiming for therapy supports (14%). There has been growth in several Therapy Professionals in the past few years, and further supply growth is anticipated in a number of therapists in the coming years which should assist with potential easing of workforce shortages that may exist in certain regions.

It is also evident that the therapy market is vast and diverse in nature as are the needs of NDIS participants. As the NDIS Review is currently examining non-price related solutions, the NDIA should consider structural changes to therapy pricing arrangements after any relevant recommendations from the NDIS Review.

Recommendation 6

The NDIA should not make any structural adjustment to the pricing arrangements for therapy supports at this time and should not index the price limits for therapy supports on 1 July 2023.

Recommendation 7

The NDIA should consider the structure of therapy support pricing arrangements after any relevant recommendations from the NDIS Review. This intends to better incentivise quality service provision to NDIS participants and create greater market efficiencies.

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6 Support coordination

6.1 Context

Support coordination is a capacity building support that is funded by the NDIS. It plays an important role in helping participants to make the most of their NDIS plans and to pursue their goals. Support coordinators help participants in various ways depending on what the individual participant's goals, needs and circumstances are.

This can include helping a participant connect to NDIS funded and mainstream supports, by brokering supports and services in line with a participant's wishes and their plan budget. Support coordinators can also help with building a participant's capacity and capability to understand their plan, navigate the NDIS and make their own decisions. In addition, they monitor plan budgets and support effectiveness.

Support coordinators require a detailed understanding of what service offerings are available in a participant's local market, and to actively help participants to find service providers who meet their needs and preferences. This can include sourcing and connecting participants to alternative service providers, which can be integral for participants to maintain continuity of supports and services. Support coordinators also need to be able to link participants to mainstream, community and informal supports where appropriate. They should be innovative and take initiative when helping participants to broker supports and services in line with their support preferences and plan budgets. Support coordinators must comply with the NDIS Code of Conduct, which requires, among other things, that supports and services are provided in a safe and competent manner, with care and skill. Support coordinators are not required to be registered. However, support coordinators who are registered to deliver supports in registration group 106 (Assistance in coordinating or managing life stages, transitions, or supports) must comply with the Core module of the NDIS Practice Standards. The Core module includes standards for the rights of participants and responsibilities of providers, provider governance and management and the way that support is provided. Support coordinators registered to deliver supports in registration group 132 (Specialised Support Coordination), must also comply with Module 4 of the NDIS Practice Standards. Module 4 includes additional standards for the provision of support and management of conflict of interest.

The NDIA has developed a pricing framework that considers the different levels of support coordination required by participants, ranging from support connection to high-level Specialist support coordination. The pricing arrangement for support coordinators in the NDIS intends to offer a fair and sustainable funding model for the delivery of support coordination services, allowing participants to receive the assistance they need to lead fulfilling lives.

Support coordinators are currently able to claim for the following four types of services:

- Level 1: Support Connection assists a participant to implement their plan by strengthening their ability to connect with the broader systems of supports and to understand the purpose of the funded supports.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

- Level 2: Coordination of Supports strengthens a participant's ability to design and then build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment.
- Level 3: Specialist Support Coordination utilises an expert or specialist approach, necessitated by specific high complex needs or high-level risks in a participant's situation.
- Capacity Building and Training in Self-Management and Plan-Management support assists the participant to build capacity to administer and manage their plan.

The price limits for these supports are set out in Table 11 below.

TABLE 11: PRICE LIMITS FOR SUPPORT COORDINATION SUPPORTS

Item Number	Item Name and Notes	Unit	Non-Remote	Remote	Very Remote
07_001_0106_8_3	Support Coordination Level 1: Support Connection	Hour	$70.87	$99.22	$106.31
07_002_0106_8_3	Support Coordination Level 2: Coordination of Supports	Hour	$100.14	$140.19	$150.21
07_004_0132_8_3	Support Coordination Level 3: Specialist Support Coordination	Hour	$190.54	$266.75	$285.80
01_134_0117_8_1	Capacity Building and Training in Self-Management and Plan Management	Hour	$70.87	$99.22	$106.31

Support coordinators are also permitted, subject to the rules set out in the *NDIS Pricing Arrangements and Price Limits,* to claim for provider travel (labour and non-labour costs); non-face-to-face activities, NDIA requested reports and short notice cancellations.

This chapter analyses the pricing arrangements for support coordination, with a focus on their effectiveness in promoting innovation, enhancing service quality, and ensuring value for money. It examines current pricing arrangements, usage statistics, providers and markets, stakeholder concerns, and draws conclusions on potential changes to the pricing framework. The objective is to provide a comprehensive understanding of the pricing framework and its impact on NDIS participants.

6.2 Scheme Statistics

Some 7,023 unique providers delivered support coordination supports (including capacity building and training support and provider travel items) to 210,909 participants in the six months to December 2022, 37% of active participants. This equated to payments amounting to $428.4 million in payments (3% of total scheme spend), an increase of 15% compared to the six months to December 2021 ($372.4 million). Table 12 below displays the change in some of these statistics the six months to December 2021 and the six months to December 2022.

TABLE 12: SUPPORT COORDINATION SCHEME STATISTICS

Statistics	July – December 2021	July – December 2022	Percentage Change
Total number of NDIS participants	182,938	210,909	+15%

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Statistics	July – December 2021	July – December 2022	Percentage Change
Total number of active providers	5,232	7,023	+34%
Total amount claimed	$372 million	$428 million	+15%

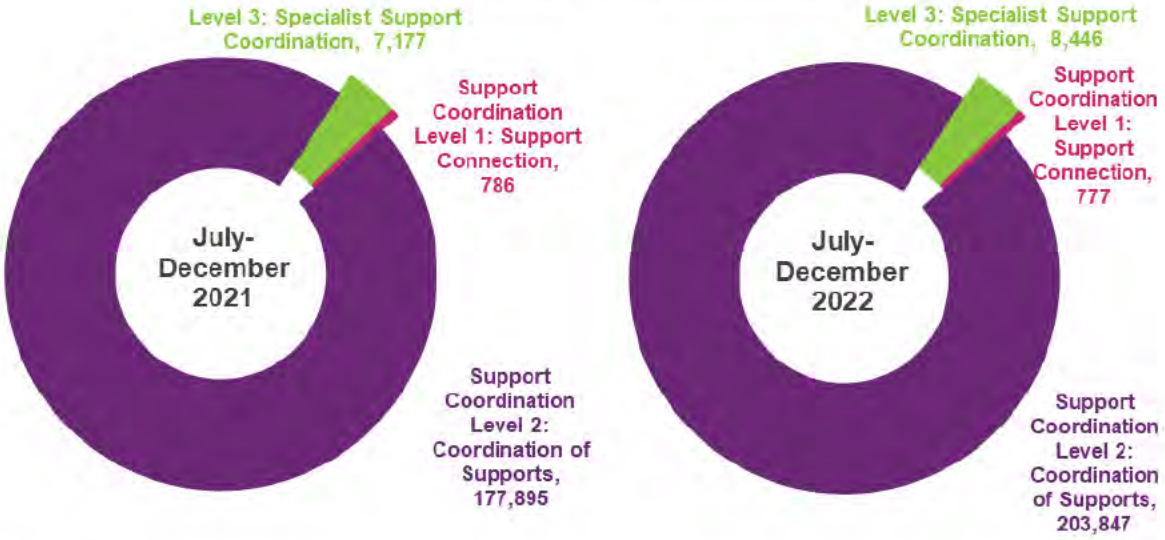
Source: NDIS internal administrative data

Participants

Most of the 210,909 participants used Level 2: Coordination of Supports (203,847 participants). There were 8,446 participants that used Level 3 Specialist Support Coordination and 777 participants using Level 1 Support Connection in the six months to December 2022, as shown in Figure 22 below.

Noting one participant can receive multiple levels of support coordination at the same time.

FIGURE 22: PARTICIPANTS USING SUPPORT COORDINATORS BY LEVELS



Source: NDIS internal administrative data

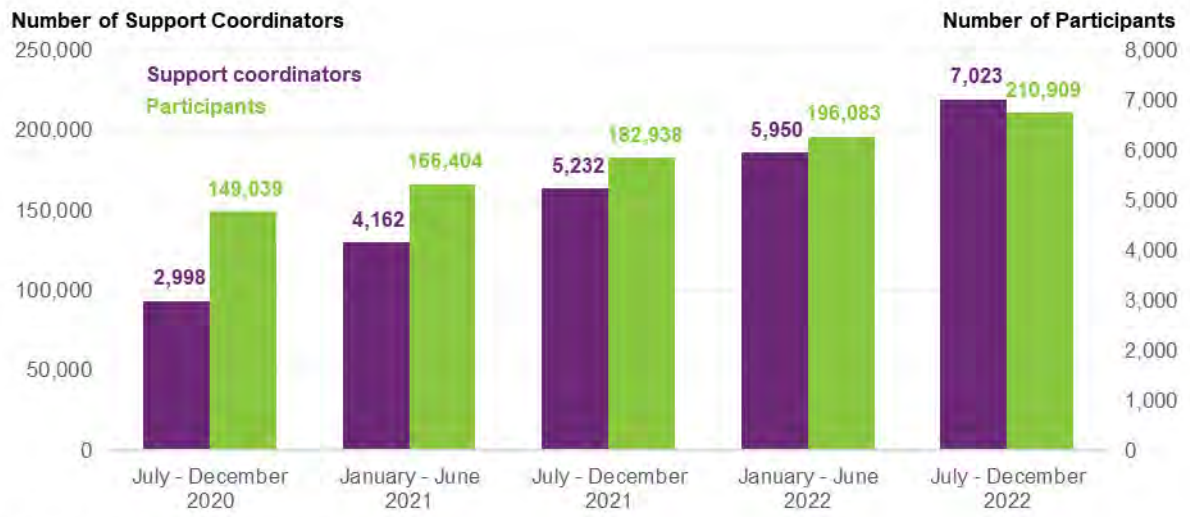
During the period between December 2020 quarter to December 2022 quarter, the number of participants being supported by support coordinators increased from 138,665 to 196,328 – a quarterly average increase of 4.5%. This is based on active claiming in each quarter.

Providers

The number of unique providers delivering support coordination supports increased from 2,998 in the six months to December 2020 to 7,023 in the six months to December 2022, an overall six-month average increase of 24%. This represents providers who have claimed for support coordination supports (including capacity building and training support and provider travel items. As shown in Figure 23, results suggest that the number of support coordinators has been increasing over time. Despite the ratio of registered providers to total number of providers dropping from 71% to 49%, registered providers delivering support coordination supports still make close to 90% of total cost of claims for support coordination supports.

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FIGURE 23: DISTRIBUTION OF PARTICIPANTS AND PROVIDERS CLAIMING SUPPORT COORDINATION SUPPORTS, DECEMBER 2020 – DECEMBER 2022



Source: NDIS internal administrative data

Figure 24 shows the split of providers delivering different levels of support coordination supports. Please note there is potential for a provider to appear in multiple categories, that is providers can deliver different levels of support coordination in the same period of time.

Providers delivering Level 2: Coordination of Supports continues to grow at a rapid pace, more than doubling over the two-year period to December 2022. Providers delivering Level 1 and Level 3 are growing at a slower pace over the same time frame.

FIGURE 24: SUPPORT COORDINATION BY LEVEL OF SUPPORT, DECEMBER 2020 – DECEMBER 2022



Source: NDIS internal administrative data

As provider numbers have increased relative to participant numbers, the average number of participants being serviced per provider has reduced over the two-year period to December 2022 from 50 participants per support coordination provider, in the same six months period, to 30 participants per support coordination provider. This ratio of servicing per providers has decreased largely due to overall growth of providers (mainly driven by unregistered providers).

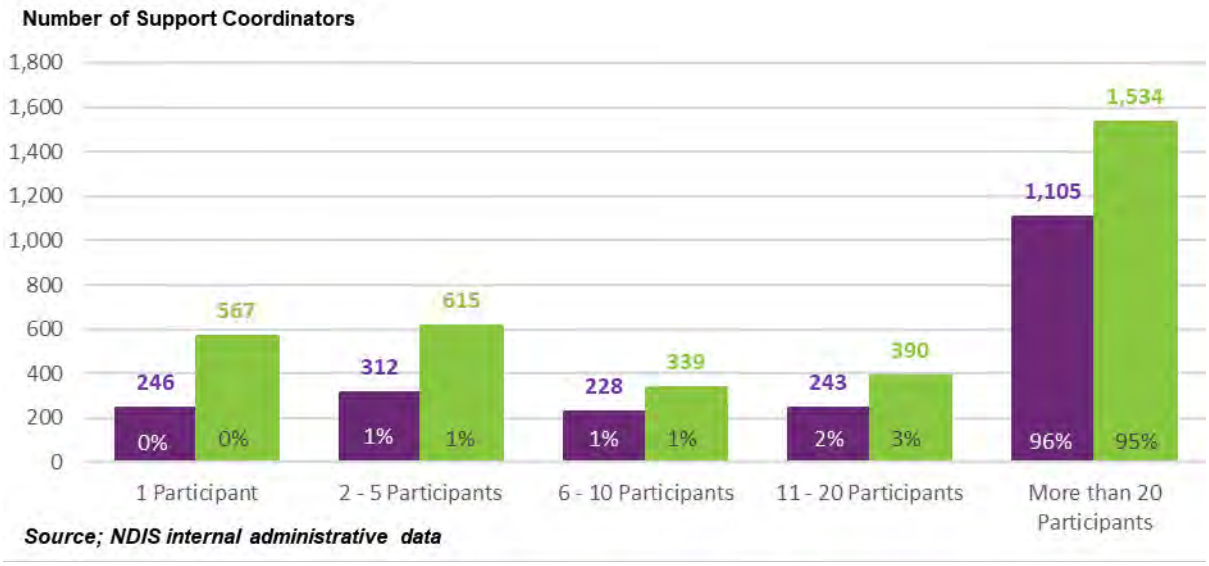
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6.3 Business Dynamism

To supplement the Scheme statistics, the NDIA has analysed registered provider payment activity. That is, payments made against Agency and Plan Managed plans are considered to be made by registered providers.

Figure 25 shows the breakdown of registered providers by the number of participants they have been servicing and the percentage claimed of their services, where the general profile of the registered support coordinators appears to have not changed significantly from the first half of 2020 to second half of 2022. Half-years are defined as the six-month time intervals from January to June and July to December.

FIGURE 25: REGISTERED PROVIDERS OF SUPPORT COORDINATION AND NUMBER OF PARTICIPANTS CLAIMED, JANUARY 2020 – DECEMBER 2022

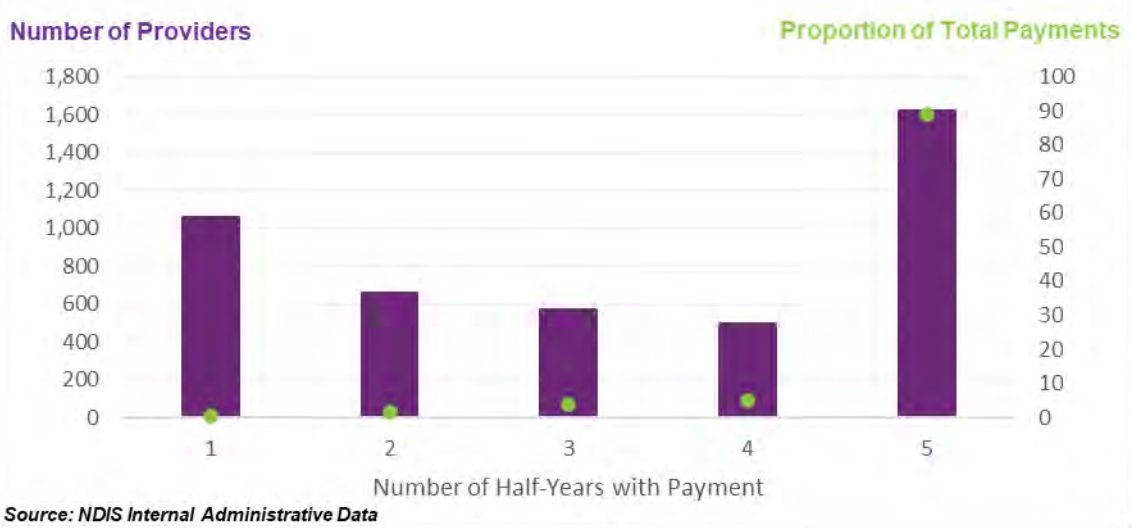


Source; NDIS internal administrative data

Figure 26 below shows the number of registered support coordination providers with payments between July 2020 and December 2022, split by the number of half-year periods in which each provider received a support coordination payment. Half-years are defined as the six-month time intervals from January to June and July to December. As seen in Figure 26, 1,620 out of 4,407 (37%) registered providers have payments in all five half-years between July 2020 and December 2022. These providers account for 89% of the total payments across the two-and-a-half-year period.

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FIGURE 26: REGISTERED SUPPORT COORDINATION PROVIDER HALF-YEARLY PAYMENTS HISTOGRAM, JUNE 2020 – DECEMBER 2022



Source: NDIS Internal Administrative Data

To further assess the current state of the provider market, payment activities of registered providers across the two-year period from January 2021 to December 2022 were analysed. Providers with New Activity in a half-year are defined as providers with payments who did not have payments in the prior half-year. Similarly, Inactivity in the half-year is defined as providers without a payment who had payments in the prior half-year. Activity for each provider is expressed as a percentage of the total payments for that half-year (for New Activity) or prior half-year (for Inactivity). The NDIA acknowledges that this is not a perfect measure of market exits but the closest approximation given available data.

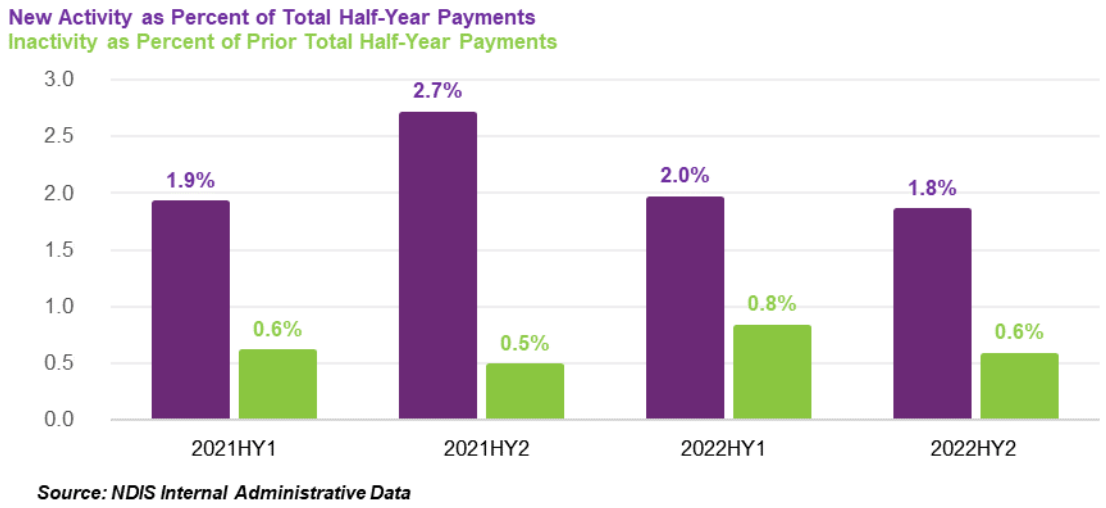
Results suggest that over the past two years, inactive registered support coordination providers in each half-year contributed to less than 1% of total payments. In contrast, registered support coordination providers with new activity in a half-year have contributed between 1.8% and 2.7% of total payments for that same period.

Additionally, on average, inactive registered providers in the half-year period prior to becoming inactive were servicing 7 participants. However, 60% of these inactive registered providers were only servicing 1 participant prior to becoming inactive, another 8% of inactive registered providers serviced more than 20 participants prior to becoming inactive.

In contrast, in half-year period up to December 2022, 16% of active registered providers were servicing only 1 participant, whereas there were 45% of active registered providers servicing more than 20 participants, who account for 97% of the total payments made to registered support coordination providers in the half-year period to December 2022. This shows that registered providers that are becoming inactive have different distribution of participants they are servicing when compared to active registered providers that service 60 participants on average.

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FIGURE 27: SUPPORT COORDINATION REGISTERED PROVIDER ACTIVITY MOVEMENTS, JANUARY 2021 – DECEMBER 2022



Source: NDIS Internal Administrative Data

Further results indicate that on average, inactive registered support coordination providers received $6,790 in payments in the half-year prior to becoming inactive, with 79% of support coordination providers receiving less than $5,000 in the half-year prior to becoming inactive. In contrast, active registered providers received on average $116,328 of payments in each half-year period, highlighting that inactive registered providers have been claiming for lesser amounts on average relative to new and existing registered providers.

6.4 Consultation feedback

Of 304 submissions received, 33% (99) discussed support coordination. The most raised concern was suggestions that the NDIS price limits of support coordination were insufficient. Another common sentiment was the fragmented nature of supports offered and suggested that there are additional unbillable hours associated with their work.

See Appendix A for more details on common themes raised in submissions to the 2022-23 APR Consultation Paper.

Disability Intermediaries Australia (DIA) submission

In its submission to the 2022-23 APR, DIA reported on a survey of plan managers and support coordinators raising concerns of financial viability of these providers. Some 454 support coordinators responded to the survey. The NDIA also received a number of letters of support by stakeholders in support of DIA's submission.

From the Survey responses, 91% of respondents were For-Profit providers, with at least 30 respondents from each state and territory. Almost half of the respondents were "Medium" sized providers.

The DIA submission reported that 20% of support coordinators who responded to the survey indicated that they had made a profit in 2021-22 with a further 18% indicating that they had broken even in 2021-22. At the same time, 62% of support coordinators reported a loss in 2021-22. This was reported at a higher proportion for larger organisations (65%) compared to medium and small organisations (61% and 55%, respectively).

There was also an increase in the number of support coordinators reporting to be paying workers under the SCHADS Award from 89% to 92% (up by 3%).

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DIA's submission suggested that providers delivering support coordination appear to be considerably less than NDIA reported numbers, suggesting two different registration groups may conflate these figures. They also commented that the relative growth of support coordination providers is overall less than that of other types of supports delivered in the NDIS.

Another point raised was that perceived growth of providers may capture the potential situation where, for example, one provider of support coordination exits NDIS services, but there are entrants of new, smaller providers claiming for support coordination from the staff of the exited provider. DIA suggested an estimate of 80% of 'new providers' entering the market are employees of exited providers.

DIA also raised concerns on unfunded work undertaken by support coordinators, as well as the bereavement cost of support coordinators delivering supports after the death of a participant.

6.5 Recommendations

The NDIA considers that there is still growth occurring in the supply of providers delivering support coordination, with the main growth being driven by unregistered providers delivering these services (this is approximately a 50/50 split between number of registered providers and unregistered providers).

The ratio of participants serviced per providers of support coordination has decreased over the two-year period to December 2022, largely due to 29% overall growth in provider numbers, which has outpaced the growth rate of participants receiving these supports in the same period. This signals a healthy market metric. The NDIA notes the claim by DIA that the growth of providers may be due to the staff of exited providers now delivering the supports and will continue to monitor any further development in this space.

Further, a theme that continued to be echoed by both participants and representatives and providers is that greater clarity is needed for the roles of support coordinator to plan managers in the NDIS. In addition, there is the fragmented nature of the supports offered by support coordinators, some of which are unfunded to best support participants.

The NDIS Review is currently considering the role of intermediaries, which is in line with recommendations 30 and 33 from the 2021-22 APR. As such, the NDIA should consider any appropriate structural changes to support coordination support pricing arrangements after outcomes from the NDIS Review are delivered.

On balance, the NDIA does not consider that an increase in the price limits for Level 2: Coordination of Supports services and Level 3: Specialist Support Coordination services price limit is required. Paired with the NDIS Review still underway; the NDIA has considered the increase in provider numbers in delivering support coordination supports to NDIS participants. It is therefore recommended that the price limits for support coordination should not be changed on 1 July 2023, except for the Level 1: Support Connection support item. This is because Level 1: Support Connection is set by the NDIS DSW Cost Model and should continue to align to this Cost Model.

Recommendation 8

The NDIA should not make any structural adjustment to the NDIS pricing arrangements for support coordination at this time and should:

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- *Index the price limits for the Level 1: Support Connection services on 1 July 2023, in line with the indexation of supports determined by the NDIS Disability Support Worker Cost Model in recommendation 1, and*
- *Not index the price limits for the Level 2: Coordination of Supports services and Level 3: Specialist Support Coordination services on 1 July 2023.*

The NDIA sees merit in the benchmarking survey conducted by DIA to be able to better capture the specific cost drivers faced by support coordination providers. This also considers that 92% of respondents for support coordination reported to have employees under the SCHADS Award. This makes it reasonable to justify having a Cost Model for Level 2: Coordination of Supports and Level 3: Specialist Support Coordination, after the outcomes of the NDIS Review, which is looking at the roles of intermediaries in the NDIS, are received.

Recommendation 9

After the outcomes of the NDIS Review are announced, the NDIA should work with the sector and other appropriate stakeholders to develop Cost Models for Level 2: Coordination of Supports and Level 3: Specialist Support Coordination.

The NDIA also considers that there may be instances where support coordinators could be required to undertake work following the death of a participant or including the administrative work associated with gathering information, returning equipment, and completing forms. In addition, other significant changes or situations (such as interactions with justice or health services) may require additional administrative work including responding to subpoenas or providing critical details where required. As such, the NDIA should examine options to allow support coordinators to claim for reasonable payments.

Recommendation 10

The NDIA should examine options on billable work required by support coordinators that is required after a participant's death or other key events.

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7 Plan management supports

7.1 Context

Plan managers play a crucial role in the NDIS ensuring a sustainable and efficient system, whilst assisting participants manage their NDIS plan funding. This chapter closely examines the extent to which these arrangements promote innovation, enhance service quality, and ensure value for money for participants.

The funding for supports that is provided by the NDIS under a participant's plan can be managed wholly or in part by the participant; or by a registered plan management provider ("plan manager"); or by the NDIA; or by a plan nominee (if one has been appointed).

Currently, participants can choose (subject to the terms of any plan nominee appointment) to engage a registered plan manager to manage some or all the funding for supports in their plan. If a participant makes this choice, then the NDIA is currently required to give effect to the participant's choice. The NDIA also then includes funding in the participant's plan so that they can engage their preferred registered plan manager.

The NDIS Act requires plan managers to be registered with the NDIS Quality and Safeguards Commission (NDIS Commission) in order to manage the funding of supports under a participant's plan. As a result, they are required to: demonstrate compliance with the Core Module of the NDIS Practice Standards; comply with the NDIS Code of Conduct; have an in-house complaints management and resolution system to record and manage complaints, and support NDIS participants or other relevant parties to make a complaint; have an in-house incident management system, and notify the NDIS Commission should a reportable incident occur (including alleged reportable incidents); and fulfil the worker screening requirements where relevant.

Plan managers are also bound by the NDIS Pricing Arrangements and Price Limits. Plan-managed participants can only purchase supports that are listed in the NDIS Support Catalogue and are subject to the same billing rules and price limits as agency-managed participants. However, plan-managed participants can purchase supports from registered and/or unregistered providers (except where the NDIS Commission has determined that providers must be registered in order to deliver a particular type of support).

Plan managers receive funds from the NDIS and disburse funds on behalf of a participant to providers of other services received by the participant. They can assist a participant by: claiming directly from the funds in the participant's plan to pay providers on behalf of the participant; paying providers for the supports that the participant purchases; helping the participant keep track of their funds; and taking care of financial reporting for the participants. In some cases, plan managers also help participants choose their providers.

Plan managers must provide the Australian Business Number (ABN) of the service provider who delivers the support for all payment requests, except where the service provider is exempt from quoting an ABN under Australian Taxation Office (ATO) rules. Exempt providers must complete the ATO's Statement by a Supplier form. Plan managers are expected to keep a copy of the completed form. Plan managers must always ensure that a valid tax invoice is included with each payment request and that the tax invoice includes

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relevant information about the goods and/or services purchased. A plan manager may be liable to pay back any amount not spent in accordance with a participant's plan.

Plan managers can claim for three types of services:

- A one-off (per plan) establishment fee for setting up the financial management arrangements for a participant
- A monthly fee for the ongoing maintenance of the financial management arrangements for a participant and
- Ad hoc capacity building and training in plan administration and management support to strengthen a participant's ability to undertake tasks associated with the management of their supports.

The price limits for these supports are set out in Table 13 below.

TABLE 13: PRICE LIMITS FOR PLAN MANAGEMENT SUPPORTS

Item Number	Item Name and Notes	Unit	Non-Remote	Remote	Very Remote
14_033_0127_8_3	Plan Management – Set Up Costs • A one-off (per plan) fee for setting up the financial management arrangements	Each	$232.35	$325.29	$348.54
14_034_0127_8_3	Plan Management – Monthly Fee • A monthly fee for the ongoing maintenance of the financial management arrangements	Month	$104.45	$146.23	$156.67
01_134_0117_8_1	Capacity Building and Training in Self-Management and Plan Management	Hour	$70.87	$99.22	$106.31

If a plan manager is engaged to deliver the Capacity Building and Training in Self-Management and Plan Management support (01_134_0117_8_1) to a participant then they are also permitted, subject to the rules set out in the NDIS Pricing Arrangements and Price Limits, to claim for provider travel (labour and non-labour costs); non-face-to-face activities and short notice cancellations.

This chapter analyses the pricing arrangements for plan managers, with a focus on their impact on service quality and cost-effectiveness. It examines current pricing arrangements, usage statistics, providers and markets, stakeholder concerns, and draws conclusions on potential changes to the pricing framework. The objective is to provide a comprehensive understanding of the pricing framework and its impact on NDIS participants.

7.2 Scheme Statistics

In the six months to December 2022, payments were made to some 1,797 plan managers that were registered at the time of providing the service according to the requirement of NDIS Commission. This amounted to $8.1 billion, 48% of Scheme spend, and consisted of $227.7 million for plan management services, and the remainder of the $7.8 billion was for plan managers to pay service providers on behalf of the 333,077 participants (58% of the 573,342 active participants as of 31 December 2022). Table 14 below shows the change in some of these statistics in the six months to December 2021 and in the six months to December 2022.

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TABLE 14: PLAN MANAGEMENT SCHEME STATISTICS

Statistics	July – December 2021	July – December 2022	Percentage Change
Total number of NDIS participants	262,915	333,077	+27%
Total number of active providers	1,588	1,797	+13%
Total plan management fees claimed	$200 million	$228 million	+14%
Total number of active providers claiming fees	1,185	1,318	+11%
Average amount claimed fees per provider	$168,605	$172,793	+1%

Source: NDIS administrative data

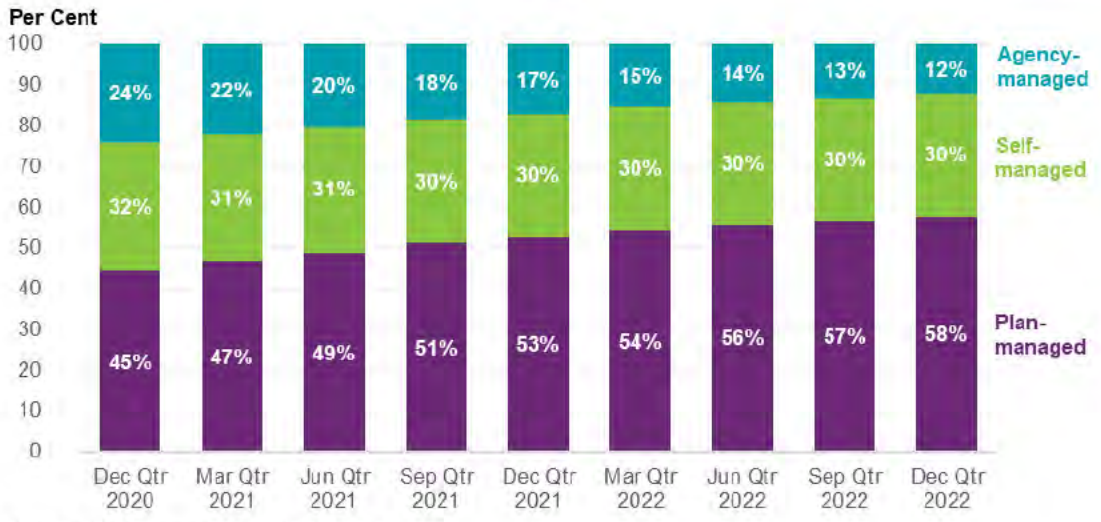
Note figures above are based on payments made for relevant plan management supports. Therefore, the figures above may differ from the actual number of plan managers registered with NDIS Commission to deliver plan management supports. The total number of NDIS active participants who are partly or fully plan-managed may differ to number of participants that used plan management services in the time periods presented above.

Participants

Over half of all participants used a plan manager (58%) during December quarter 2022, and nearly half of payments made from NDIS plan budgets were claimed by a plan manager (49%). These have increased from 45% and 35%, respectively, since the December 2020 quarter.

Figure 28 below illustrates the share of participants plan-managed and Figure 29 shows the share of payments processed by plan mangers increased significantly in the last two years.

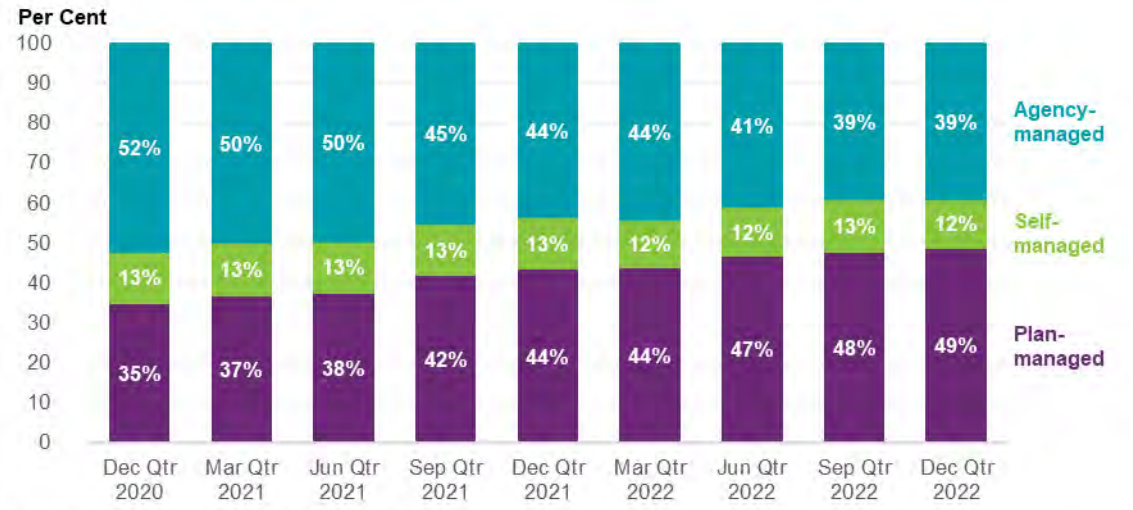
FIGURE 28: DISTRIBUTION OF PARTICIPANTS BY METHOD OF PLAN MANAGEMENT OCTOBER 2020 – DECEMBER 2022



Source: NDIS internal administrative data

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FIGURE 29: DISTRIBUTION OF PAYMENTS BY METHOD OF PLAN MANAGEMENT OCTOBER 2020 – DECEMBER 2022



Source: NDIS internal administrative data

Providers

During the period December 2020 to December 2022, the number of plan managers increased from 1,098 in the six months to December 2020 to 1,797 in the six months to December 2022, an average six-month increase of 14%. Aside from most recent six months, there has been growth in providers of plan management supports. See Figure 30 for the trend over this period. Data suggests a slight reduction in the number of plan managers in the six months to December 2022 and the NDIA will continue to monitor the health of the plan management market.

Over the same time, the number of participants partly or fully plan-managed increased from 189,229 to 333,077 – an average six-month increase of 15%. This indicates that while new plan managers are entering the market and increasing participant choice, many plan managers are also expanding as the ratio of participants to providers has increased. The participant to provider ratio in the six months to December 2022 is 185 participants per provider of plan management supports.

FIGURE 30: DISTRIBUTION OF PARTICIPANTS AND PROVIDERS WITH A PLAN MANAGER, DECEMBER 2020 – DECEMBER 2022



Source: NDIS internal administrative data

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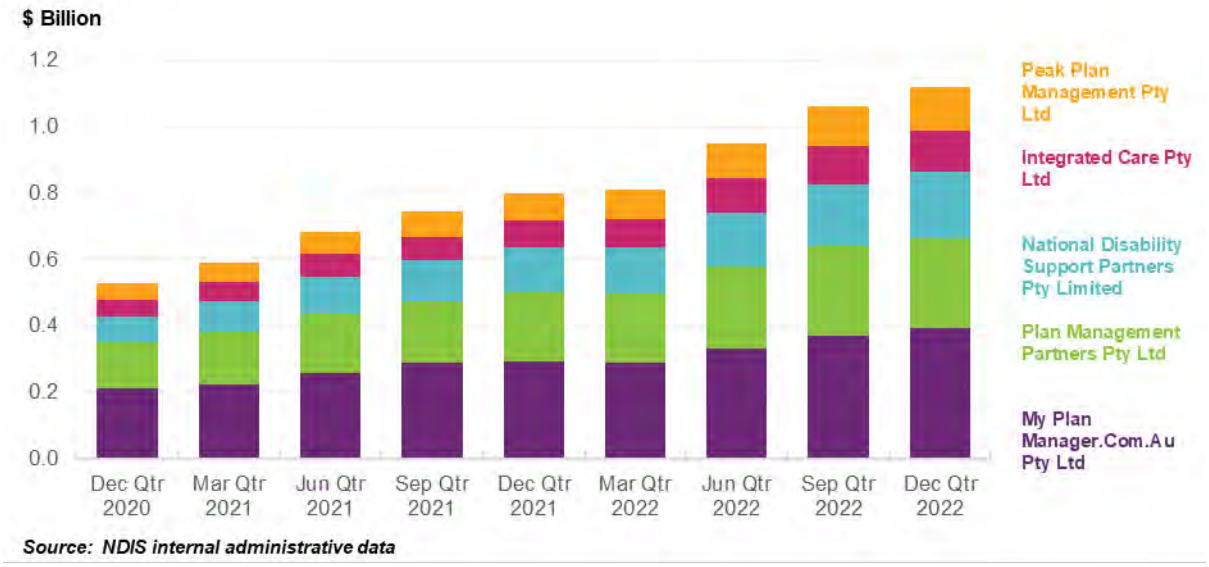
Market health indicators

To understand the current health of the plan manager market within the above context, NDIS payment data of the top five plan managers were also analysed.

The top five plan managers processed 28 million transactions during the July to December 2022 period, including 2 million transactions for plan management fees. In the six months to December 2022, the average amount claimed by provider, per participant, was $126,734.

Out of the 1,797 providers that have claimed for plan management supports during the six months to December 2022, the largest five plan managers received $2.2 billion in payments, more than a quarter (27%) of the $8.1 billion of plan-managed payments (inclusive of fees). These top five plan managers have dominated the market over the past nine quarters having consistently stayed in the top ten, with payments processed in Figure 31.

FIGURE 31: SCHEME EXPENDITURE FOR LARGEST FIVE PLAN MANAGERS (BASED ON TOTAL PAYMENTS) OCTOBER 2020 – DECEMBER 2022



Source: NDIS internal administrative data

Participant to providers of plan management support ratios have also seen a larger number of participants, on average, being covered by a provider of plan management supports. As participant numbers have increased relative to provider numbers, the average number of participants being serviced per provider has increased from 178 to 214 participants between December 2020 quarter and December 2022 quarter. This ratio of servicing per providers has increased largely due to overall growth of provider numbers by 64% being more than offset by the 76% growth in participant numbers.

However, in the six months to December 2022 the number of providers claiming for plan management decreased by 2%, which contrasts the previous 35% growth seen in the six months to December 2021. The NDIA should continue to monitor the movement of providers claiming for plan management supports in future quarters to determine if this is a trend.

Further, the average funds management ratio (the ratio of the total costs of monthly plan management fees to the costs of the supports purchased through the plan managers) was, on average, 3.6% in FY2021-22. This is a decrease from the FY2020-21 where the average management ratio to the total costs purchased was 3.9%. This means the total cost of monthly plan management fees claimed has decreased in proportion to the cost of supports purchased through plan managements. This may be due to a range of reasons such as the

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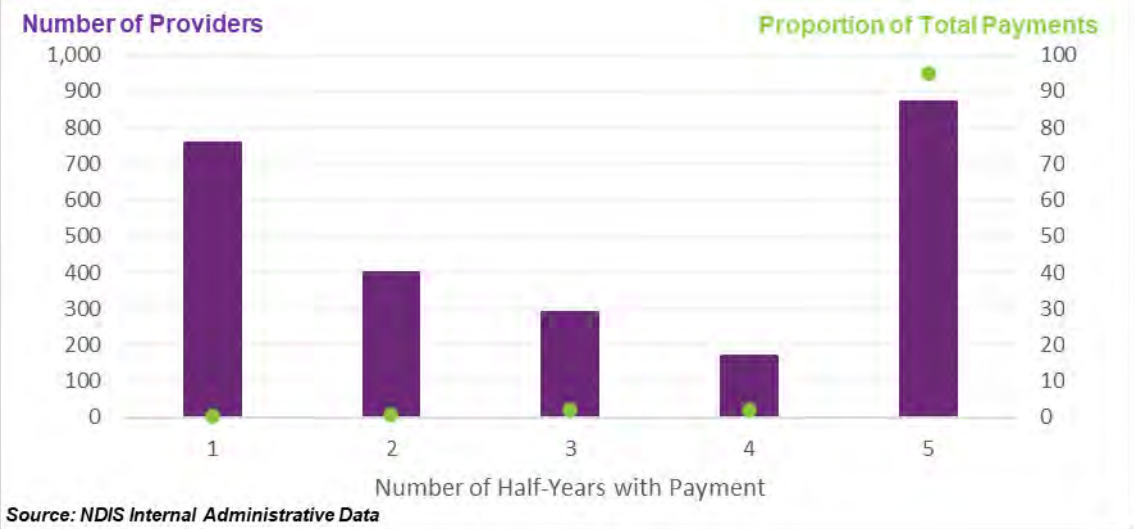
increase in number of participants and higher volume of NDIS funds being plan-managed, potential efficiencies being made by providers of plan management supports or other reasons.

7.3 Business Dynamism

To supplement the Scheme statistics, the NDIA has analysed registered provider payment activity. That is, payments made against agency-managed and plan-managed plans are considered to be made by registered providers.

Figure 32 below shows the number of registered plan managers with payments between July 2020 and December 2022, split by the number of half-year periods in which each plan manager received a payment. Half-years are defined as the six-month time intervals from January to June and July to December. As seen in Figure 32, 872 out of 2,491 (35%) plan managers have payments made in all five half-year periods between July 2020 and December 2022. These plan managers account for 95% of the total payments across the two-and-a-half-year period.

FIGURE 32: PLAN MANAGER PROVIDER HALF-YEARLY PAYMENTS HISTOGRAM, JUNE 2020 – DECEMBER 2022



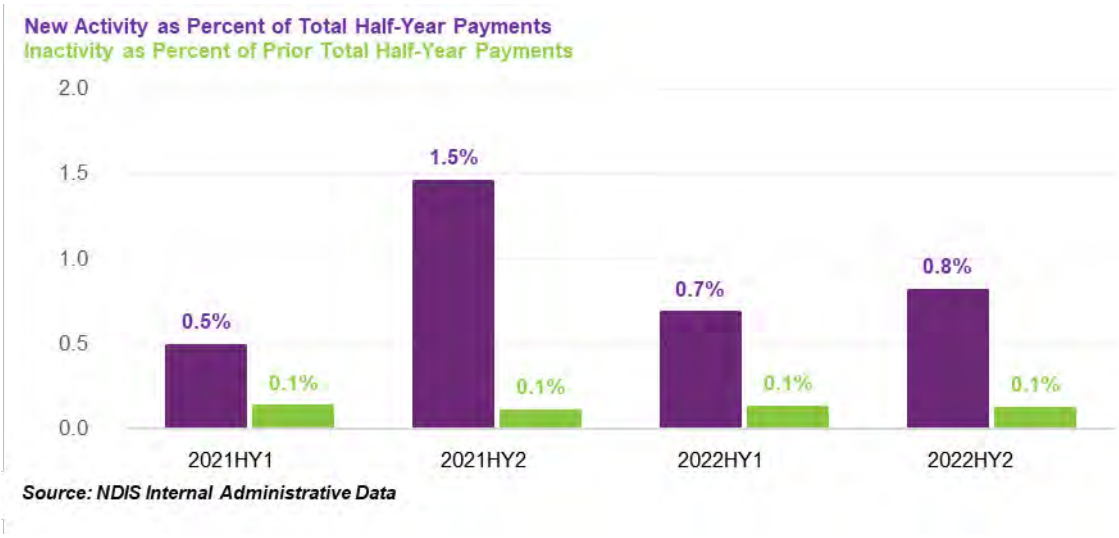
Source: NDIS Internal Administrative Data

To further assess the current state of the plan manager market, payment activities of registered plan managers across the two-year period from January 2021 to December 2022 were analysed. Providers with New Activity in a half-year are defined as providers with payments who did not have payments in the prior half-year. Similarly, Inactivity in the half-year is defined as providers without a payment who had payments in the prior half-year. Activity for each provider is expressed as a percentage of the total payments for that half-year (for New Activity) or prior half-year (for Inactivity). The NDIA acknowledges that this is not a perfect measure of market exits but the closest approximation given available data.

Results suggest that over the past two years, inactive plan managers in each half-year contributed to 0.1% of total payments. In contrast, plan managers with new activity in a half-year have contributed between 0.5% and 1.5% of total payments for that same period.

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FIGURE 33: PLAN MANAGER ACTIVITY MOVEMENTS, JANUARY 2021 – DECEMBER 2022



Source: NDIS Internal Administrative Data

Further results indicate that on average, inactive registered plan managers claimed for $32,526 in payments in the half-year prior to becoming inactive, with 59% of registered providers claiming for less than $5,000 in the half-year prior to becoming inactive. In contrast, active registered plan managers have claimed for $3,839,694 in payments, on average, in each half-year period, highlighting that inactive registered providers have been claiming for lesser amounts on average relative to new and existing registered providers.

7.4 Consultation feedback

In total, 81 submissions out of 304 (27%) were received through the Public Consultation process responding to the topic of plan management supports. Most respondents suggested the monthly fee for plan management is insufficient for the work they are doing, said to encompass activities outside of what they believe is expected of them. There were also suggestions of clearer guidelines on the role of plan managers which was also frequently raised in the 2021-22 APR and is anticipated to be covered by the NDIS Review.

See Appendix A for more details on common themes raised in submissions to the 2022-23 APR Consultation Paper.

Disability Intermediaries Australia (DIA) submission

In its submission to the 2022-23 APR, DIA reported on a survey that it has undertaken of plan managers and support coordinators raising concerns about the financial viability of these providers. Some 511 plan managers responded to the survey. The NDIA also received several letters of support by stakeholders in support of DIA's submission.

From the survey responses received by DIA, 77% of respondents were For-Profit providers, with at least 50 respondents from each state and territory. 79% of respondents were "Medium" sized providers, with only 4% considered "Large". There has been a move of respondents towards the SCHADS Award, however, almost half of respondents still use other Awards or Industrial Agreements.

The DIA submission reported that 45% of plan managers who responded to the survey indicated that they had made a profit in 2021-22 with a further 17% indicating that they had broken even in 2021-22. At the same time, 38% of plan managers reported a loss in 2021-

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22. DIA suggested the organisation structure/size played only a minor factor in determining financial outcome.

DIA raised concerns on the clarification of the NDIA in the 1 July 2022 Pricing Arrangements and Price Limits where plan management set up fees were not claimable for NDIS plans that were extended. In addition to this, concerns were also raised on the technological transition costs associated with NDIS' new PACE system and the increased requirement of cyber security and its cost to plan managers.

7.5 Recommendations

The available information suggests that the market of supports for plan management is relatively healthy.

Besides the December 2022 quarter, there was strong growth in providers of plan management supports in the previous 9 quarters to keep pace with participant demand. The NDIA acknowledges the increase in the average number of participants being serviced per provider of plan management supports. This number should consider that it includes participants who are both fully and partly plan-managed.

Through feedback received through public consultations, there was suggestions of clearer guidelines on the role of plan managers which was a common sentiment raised in the previous 2021-22 APR, from both participants and providers.

In line with previous recommendations from the 2021-22 APR, the role of plan managers is to be considered by the NDIS Review and the NDIA should consider any appropriate structural changes after recommendations from the NDIS Review.

On balance, the NDIA believes there is insufficient evidence to support an increase to plan management supports currently. The growth of participants and providers of plan management supports over the past two years suggests this market is still viable and does not support an increase to plan management supports until the roles and expectations of plan managers are further defined. The NDIA should continue to monitor the movement of providers claiming for plan management supports in future quarters to see if this decrease was a one-off or the start of a trend.

Recommendation 11

The NDIA should not make any structural adjustment to the NDIS pricing arrangements for plan management supports at this time and should not index the price limits for plan management fees on 1 July 2023.

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8 NDIS Pricing

The National Disability Insurance Agency (NDIA) acknowledges this Annual Pricing Review (APR) has a targeted scope of supports as outlined in the Terms of Reference. Some of the recommendations within this chapter are outside the scope of the current APR but forms an important part of the overarching pricing considerations for the NDIA. These recommendations have the potential to improve future pricing review processes and promotes greater transparency.

8.1 Non-SCHADS Labour Supports, particularly Nursing supports

In the absence of specific review within the APR cycle, the NDIA considers the need to maintain the real value of NDIS price limits for support to maintain the supply of supports to NDIS participants. Further innovation by providers is encouraged to achieve greater efficiencies and improve the quality and safety of supports delivered.

The NDIA acknowledges there are a range of supports that are not under scope of the 2022-23 APR and are not linked to the DSW Cost Model (*non-Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award), are not price limited or benchmarked.

Nursing supports are considered as part of this category. Examples of supports in this category include several within the core and capacity building support categories such as personal domestic cleaning, house and/or yard. There is the need to maintain the real value of NDIS price limits for support to maintain the supply of supports to NDIS participants.

This is particularly the case for nursing supports, considering the aged care reforms including wage increases through the 15% increase to aged care workers and other potential increases to the Nursing Award. It is imperative that the NDIA ensures these supports remain competitive to other markets.

It may pose a risk to participants receiving these supports if there is no pricing increase, and thus is deemed necessary to increase the price limits of these supports in line with previous year's indexation methodology.

Recommendation 12

The NDIA, subject to any specific recommendation arising from the current Annual Pricing Review and any future reviews, should:

- *Increase the price limits for other supports, not covered by Disability Support Worker-related supports or Capital supports, on 1 July 2023 in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses) and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter immediately preceding the indexation date (with an 80/20 weighting).*

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8.2 NDIS Cancellation Policy

The 2021-22 APR changed the National Disability Insurance Scheme (NDIS) cancellation policy from 2 days to 7 days to align to the change made by the SCHADS Award from 1 July 2022. The policy was updated to ensure staff are protected from any impact of short notice cancellations of their shifts. Since the change was implemented, the NDIA have received feedback from stakeholders regarding the matter.

The current NDIS policy states that providers should find alternative billable work for the staff at first instance. The alternative work can be for multiple participants across multiple locations. If no alternative work is found, and if Short Notice Cancellations are agreed with the participant in the Service Agreement in advance, only then can the providers claim the amount. This is to allow providers to pay the staff the amount they would have received had the shift not been cancelled as mandated by the SCHADS Award. It is also important to note that the 7-day cancellation policy is the maximum allowable cancellation length by the NDIA, providers can include shorter cancellation periods subject to establishing service agreement with participants.

Following the implementation of this change, feedback received from participants and their representatives reflected that the 7 days is too long to account for sudden illnesses or events outside of a participant's control. It is important to note that the 7-day cancellation policy is the maximum allowable cancellation length by the NDIA, providers can include shorter cancellation periods.

Analysis of NDIA claims data from July 2020 to December 2022 indicates that cancellations accounted around 0.6% of DSW claims over this period. This has remained stable throughout this period with no significant change since the policy update.

The NDIA should consider relevant Industry Awards, employment standards and other relevant industry legislation when setting pricing policy. The NDIA understands not all supports are delivered under the SCHADS Award, and many providers may not have the same obligations to their workers for cancelled shifts. On the other hand, careful consideration needs to be given if the NDIA policy is to deviate from the SCHADS Award as it may create inconsistency and confusion.

It is too early to understand the impact of the changes to the NDIS cancellation policy to NDIS participants based on current data. The NDIA should continue to work closely with the sector to investigate the appropriateness of the current NDIS cancellation policy post the 2022-23 APR. This includes exploring the possibility of undertaking a survey to gauge the impact of current settings.

Recommendation 13

The NDIA should work with the sector to investigate the appropriateness of the NDIS cancellation policy for NDIS supports post the 2022-23 APR.

8.3 NDIS Review

The Minister for the NDIS, the Hon Bill Shorten MP, announced the NDIS Review in October 2022. The NDIS Review is likely to have significant strategic implications for NDIS pricing arrangements in the future., noting the NDIS Review is expected to report in October 2023.

As the NDIS Review is running concurrently with the 2022-23 APR, the NDIA is committed to working with the NDIS Review Team throughout the NDIS Review process. The NDIA

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acknowledges this may impact some supports and outcomes under the scope of the APR, which should be considered in line with upcoming recommendations from the NDIS Review expected in October 2023.

Recommendation 14

The NDIA should continue to work with the NDIS Review on relevant topics and issues involving structural changes to the current NDIS pricing arrangements.

8.4 NDIS Pricing Strategy Refresh

The pricing arrangements for the NDIS are governed by the *NDIS Pricing Strategy*[30], which was adopted by the NDIA Board in 2019. The Strategy recognises that in the short to medium term the NDIS's pricing arrangements must consider both the need for value-for-money (and hence for efficiency in provider operations) and the need to ensure continued access to supports (including the need to rapidly expand supply during the roll-out of the NDIS).

During the roll out of the NDIS, the market for disability supports needed to develop at pace, with both significant increases in market supply, improvements in quality and improvements in production efficiency. While improvements to production efficiency (at a given quality level) will, all other things being equal, reduce costs in the long run, expansion of market supply in the short term necessitates higher prices (especially where, as in the case of the NDIS, supply must be maintained to ensure participants can continue to receive critical supports). The *NDIS Pricing Strategy* therefore recognised higher short-term price limits would be needed to maintain and expand the production of disability supports by providing an incentive for the redirection of resources to the NDIS from other sectors of the economy.

In the long run, the market for disability supports will mature so that high quality services are delivered at efficient price levels. Efficient price levels represent the long run minimum cost of production of a good or service whose quality is acceptable to the purchasers of the good or service. They are the best representation of the reasonable cost of the provision of a quality support and will, eventually, be the price levels best suited for the development of plans, which are concerned with efficient, effective, and appropriate supports.

Since the release of the *NDIS Pricing Strategy* in 2019, there has been rapid growth in the provision of supports across many types of support markets delivering supports to NDIS participants which was needed in the roll-out of the NDIS. This has been accompanied with growth in some innovative service delivery models, such as online platforms for disability support worker-related supports. Such innovations encourage competition between providers, and new service delivery models can also facilitate transparent and accessible communication to participants. At the same time, the NDIA has been working to better inform participants to make more informed decisions.

There has been a significant change in size of the NDIS, number of participants and providers and a change in various support market dynamics since the initial publication of the NDIS Pricing Strategy in 2019. There is a spectrum of market intervention options available to the NDIA, such as market facilitation, market regulation or alternative commissioning. Which intervention to use depends on the characteristics of the market and

[30] Found at Making pricing decisions | NDIS

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how it is functioning. A market that is considered well-functioning requires less intervention. Therefore, the NDIA should examine what might be the most appropriate measures to apply across different markets delivering NDIS supports based on the current market maturity, economic conditions as well as Scheme trajectory.

Recommendation 15

The NDIA should refresh its NDIS Pricing Strategy to ensure its appropriateness on the current state of NDIS support markets, in consideration to the outcomes from the NDIS Review.

8.5 Financial Reporting by NDIS providers

The NDIA believes it is imperative that as a market steward, it is important to monitor and track the financial performance of providers within the sector to ensure that they remain financially viable.

As noted in section 4.12, previous attempts to conduct surveys to gauge providers financial bottom line has resulted in poor response rates and therefore the survey results are not considered to be representative of the entire provider sector. The NDIA does not consider that it is necessary to conduct a financial benchmarking survey in 2022-2023 given the current APR has a tailored scope. Moreover, the NDIA has begun to work with the sector to support financial benchmarking surveys to assist providers to compare themselves to their peers. The current partnerships include the surveys by the National Disability Services (NDS), partnering with StewartBrown, and the Ability Roundtable.

There are some data limitations when it comes to gauging the health of the provider market such as a full picture of provider financials. This has the potential impact the supply of services to participants. These data limitations can lead to feedback through public consultation and other channels that doesn't always necessarily align with analyses undertaken.

An effective price setting mechanism is critically underpinned by the Agency's ability to track, monitor, and benchmark the financial performance of the sector. Ideally, there would be more information available for the NDIA on the true financial position of the providers delivering services within the sector, which helps with Government policy planning and development. This ensures there is representation across a range of organisations with different cost bases, sizes, and locations. The NDIA's ability to gauge the health of the market is greatly reduced in the absence of these information.

One model to consider is the mandatory financial reporting requirements in the aged care sector. Aged care businesses are legally bound by the *Aged Care Act 1997* and *Aged Care Quality and Safety Commission Act 2018* which stipulate the financial reporting obligations. This means that an approved provider is deemed non-compliant if it fails to provide information on its financial position. These laws establish the standards and guidelines that businesses must adhere to when preparing and submitting financial reports.

The NDIA should explore options with the NDIS Review on the possibility of creating a new mandatory financial requirements. As a start, pilots should be undertaken in areas such as disability support worker-related supports. This is to ensure the NDIA has sufficient information available on the financial position of providers to assist in its role as market steward and inform its pricing review process.

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Recommendation 16

The NDIA should explore options with the NDIS Review on the potential for mandatory financial reporting from NDIS providers on certain financial metrics to assist the NDIA in its market steward role.

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Appendix A – Feedback from the Consultation Paper

Overview

A Consultation Paper was released on 17 March 2023 to assist stakeholders to prepare a submission to the APR. Submissions closed on AEST 11:59pm Thursday 13 April 2023 with 304 submissions received in total.

Most submissions were from provider organisations (165) and employees/workers (96). A small number of submissions (12) were received from participants and their representatives. Submissions were also received from professional bodies (15), provider peak bodies (9), government entities (3), advocacy groups (3) and workers unions (1).

Labour market

Of 304 submissions received, 76 related to the labour market. These responses were submitted by providers of various supports, plan managers, employees/workers, professional bodies, and provider peak bodies with one submission from an advocacy group and one from a government body.

Providers

It was widely recognised by providers that the labour market, not just in the disability and NDIS sectors, but also in the broader economy, has become increasingly tight in recent years. This observation has been repeatedly highlighted in various submissions, where employers have expressed difficulties in attracting and retaining staff due to the ongoing escalation of the cost of living. This situation has led to a situation where wages have not kept in pace with the increasing expenses, creating an unsustainable environment for both employees and employers.

An exercise physiologist stated in a submission that:

> *The lack of indexing fees against CPI has eroded the sustainability of providing high level support to NDIS patients through more experienced professionals and resulted in them being serviced by less experienced physiologists.*

Providers noted on several occasions that experienced professionals are taking up higher paid jobs elsewhere and in different sectors as there has been a disconnect between pricing arrangements and wages.

Multiple Sclerosis Australia in their submission stated:

> *Staff turnover is primarily driven by staff moving to higher paid positions. To offer competitive wages results in a significant loss.*

One provider noted that the NDIS pricing arrangements and price limits have not assisted them to hire and retain workers compared to other sectors and the private market.

It was noted by providers that the current mandatory requirements for working in the sector can be complex and difficult to navigate, which can create barriers for workers looking to move between different roles or providers. To address this, it has been suggested that efforts be made to simplify these requirements, and to ensure that skills and training obtained in one setting are recognised and transferable to others.

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One provider in their submission recommended that:

> *Support work should be made a career and not a job with pay to reflect a job; and to simplify the mandatory requirements so that skills and training are transferable.*

Provider peak bodies

Provider peak bodies held similar sentiment that workforce turnover was high and that there needs to be a particular focus on how to attract, retain and enhance workers capabilities for the disability sector over the long term.

It was highlighted that a significant proportion of disability support workers lack formal qualifications, with many instead opting to attend TAFE courses to obtain certification before entering the workforce. However, it has been noted that many workers will subsequently leave their roles with providers after only a few months, to establish themselves as independent practitioners.

Ability Roundtable stated that:

> *Roundtable data provides clear evidence that many employees recruited and trained within the disability workforce are leaving the workforce, particularly employees under 30 years of age and those who have been in the NDIS workforce for less than 3 years.*

This was supported by National Disability Services who advised that the impact of labour shortages and wage growth directly influences a provider's bottom line, and the Aged Care Award increase will make it more difficult to attract DSW workers.

Professional bodies

The shortage of skilled labour in the disability support sector was also echoed by professional bodies, particularly as many qualified workers can command higher rates by working independently due to their lower overhead costs.

Several submissions have put forward a proposal to address the labour shortage in the disability sector by investing more efforts to attract students who might be interested in pursuing careers in allied health. To achieve this, it has been suggested that practical and relevant experience be integrated into the curricula of relevant courses, to demonstrate the viability of a career in this industry.

By providing students with the opportunity to gain practical experience in the disability sector, it is hoped that they will be better equipped to make informed decisions about their future career pathways. Moreover, the development of such opportunities can also help to address the current shortage of skilled labour in the sector by nurturing a pipeline of talent that is well-versed in the specific needs and challenges faced by the industry.

Registration costs

There were 66 submissions relating to registration costs including quality and safeguarding. These came from providers of various supports, plan managers, employees/workers, professional bodies and provider peak bodies and an advocacy group.

Providers

Numerous providers indicated that the registration process is perceived as both time-consuming and costly for businesses, irrespective of the size of the business. Providers stated that they face a significant administrative burden as they dedicate resources to monitor and ensure compliance, onboard new staff, and implement complex administration

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systems, which detracts from their core business activities. Several submissions highlight the need for businesses to hire additional staff to manage the compliance and registration requirements and propose for simpler and a more streamlined registration and compliance process.

The submission from Spinal Cord Injuries Australia stated that:

The administration tasks associated with compliance obligations, registration and managing the Clinical Governance Committee are complex, time consuming and costly. The high costs associated with registration are not currently reflected in the pricing structure of the NDIS. This creates challenges for registered providers to remain financially sustainable in the long term.

Another provider noted that:

> *Generally the time spent on NDIS administrative/registration tasks have increased over the last year. While worker and participant numbers have largely remained stable during this period; compliance tasks have increased.*

A common theme seen in many submissions from providers surrounded the confusion caused by changes to the NDIS price guide due to the changes in SCHADS award.

One provider in their submission stated that:

> *The complexity of this inter-relationship is a high cost to any business trying to navigate a compliant approach with multiple agencies.*

Although stakeholders raised many concerns about the lengthy and costly nature of the administration and registration process, some have noted that it has motivated them to enhance their service standards. This is due to the regulatory requirement for each provider to formally review their processes on a semi-regular basis. Overall, there was a positive sentiment expressed towards these processes as they provided participants and providers with a sense of assurance that they were complying with relevant standards and regulations, despite the associated costs. One provider noted:

> *It is beneficial for our organisation to be a registered NDIS provider. Registration ensures compliance and safeguarding for participants. Audits should be something that are welcome in the sector, but they come as an additional cost burden for registered providers.*

Professional bodies

Many provider peak bodies observed that the benefits of being a registered provider are decreasing due to a decline in the number of agency-managed participants. The associated costs, time, and uncertainty around the future of agency-managed participants pose significant challenges for providers. Additionally, registered providers perceive themselves to be at a disadvantage when competing with unregistered providers who are not burdened with the same costs and time constraints. This creates an uneven playing field in the market, which can lead to further challenges for registered providers.

The submission from Speech Pathology Australia (SPA) stated that:

> *The process of registering as a NDIS provider is felt by speech pathologist to be out of reach for many, both in terms of financial costs and time burden to fulfill all the requirements.*

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This was supported by many other bodies including Australian Physiotherapy Association who had questions about the benefits of registration, with some physiotherapists feeling that the cost of registration is high and that there is little evidence to suggest that registration increased quality or safety for participants.

Another challenge that many provider peak bodies note is the complexity of compliance. The frequent changes in NDIS Quality and Safeguards Commission (NDIS Commission) standards and the lack of consistency of the standard of service amongst registered providers were identified as a major issue that require substantial time and effort to comprehend. The intricate interplay between these factors was noted to be a significant cost for businesses seeking to navigate a compliant approach with multiple agencies.

According to several business managers, the past year has seen an increase in registration and administrative tasks, leading many businesses to hire additional staff to handle the workload. One of the primary reasons for this increased burden was the shift of NDIS participants to plan management, which resulted in an escalation of administrative tasks required to cater to these participants.

Occupational Therapy Australia in their submission stated that:

> *Some registered providers are concerned about inequity in the scheme because they undergo stringent registration requirements and bear registration costs, when compared to non-registered providers. There are also concerns that the presence of unregistered providers across the scheme, who can charge variable rates, also erodes public trust in the scheme, and impacts the public expectation that participants are accessing quality, trusted, regulated services.*

DSW-related supports

A total of 57 submissions on the DSW-related supports, including the DSW Cost Model and the SCHADS award, were received in response to the Consultation Paper. Submissions were made by providers, plan managers, the Australian Workers Union and a number of participants and/or their representatives.

Providers

Several providers stated that the new DSW Cost Model was easier to comprehend, more transparent and simplified internal budget calculations. Some also felt that the ability to pay staff at a higher rate impacted their business positively. Other aspects of the DSW Cost Model such as the full increase in superannuation guarantee was also considered positive.

On the other hand, some providers thought the DSW Cost Model was not clear enough, made it more difficult to benchmark their prices and was inflexible in allowing staff to negotiate their own rates. Several noted that the DSW Cost Model does not account for the complexity of some participants, especially in regional and remote areas. One provider stated:

> *The impact of the simplified DSW Cost Model has been mixed. On one hand, the model has provided greater transparency and predictability around funding, which has helped to better plan and budget for services. The simplified model has also reduced some of the administrative burden, which has freed up resources that can be used to improve the quality of services. On the other hand the model does not adequately account for the complexity of the services being provided or the needs of*

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the participants we support. This has led to some participants receiving less funding than they require which can result in a reduction in the quality of care provided.

Many providers felt that the DSW Cost Model is insufficient to cover the costs of all tasks involved. These include costs associated with legislative and compliance requirements, insurance, recruitment and ongoing workforce training. The DSW Cost Model does not allow for capital investment in IT infrastructure and vehicles. Providers stated that these factors result in a lower profit margin than one being assumed in the DSW Cost Model.

It was noted that the 2021-22 DSW Cost Model separately identified the contribution of workers compensation costs, utilisation costs, supervision costs and measures in relation to the share of permanent or casual staff. The simplified DSW Cost Model covers these items in the operational overheads category. Some providers felt that they no longer have visibility of how the broader cost categories are calculated.

Allowances for annual leave, accumulated leave, long service leave and public holidays were felt to be insufficient by several providers. For example, several submissions pointed out that the DSW Cost model of 20 annual leave days does not accommodate the five-week shift worker allowance. Additionally, long service leave is different between states, as are the number of public holidays.

Providers spoke of challenges with the rostering of staff for overnight and split shifts which some believe are not adequately covered by the DSW Cost Model loading and added complexities to administration. A provider mentioned:

The split shift allowance has added a considerable amount to the payroll. This made it hard to be able to roster, including trying to eliminate the split shifts. If someone calls in sick, it is a lot harder to fill. With the extra administration time as well as the extra costs, doing smaller shifts is becoming harder to keep viable.

Several providers felt that changes to the SCHADS Award and cost-of-living pressures along with worker shortages have created an environment where workers have and want greater control over their working conditions. As a result, more workers are choosing to work on a casual basis because the take home pay is higher. In addition, workers can now decline shifts on public holidays. As one provider stated:

The provider must pay them for a shift worked as well as the second staff member to replace the shift not worked by the original staff member.

Workforce recruitment and retention along with training and development was a recurring theme in the feedback, with several providers stating that the DSW Cost Model does not consider the increased cost of these activities.

Provider peak bodies

A Financial and Workforce Benchmarking was conducted by Ability Roundtable with 24 DSW provider organisations, noting not all respondents answered every question available in the survey. Thus, the useable sample size was slightly smaller on each topic (SCHADS Award changes, COVID impacts, and Quality, Safeguarding and Compliance costs). Albeit the total sample of providers is small, their collective revenue in 2022 was over $2.7 billion, with the average respondent reporting an operating loss of 3.7% in 2022.

Data captured in the benchmarking also indicates that the estimated impact of SCHADS Award changes on provider costs, was on average is 1.5% of total costs.

The Australian Services Union also addressed training and workforce development:

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> *The NDIS DSW Cost Model has had significant consequences for training and development in the sector and for the capacity of providers to participate actively in providing a high standard of training and supervision. There have been cutbacks in the time allocated for training; team meetings have all but disappeared; supervision has been severely curtailed; and large numbers of casual workers are being newly employed with almost no supervision at all.*

Increased competition and staff mobility had contributed to the difficulty in attracting skilled staff under the SCHADS award. This was suggested to have been intensified in thin markets and rural and regional areas.

Participants

Several participants or their representatives felt that there was a wide variance of skills among support workers even though they were paid at the same rate.

The 7-day cancellation rules were also of concern for some providers and participants alike. When appointments are cancelled, there are additional costs to the provider through overtime and the casual loadings.

A participant said:

> *I lost a good support worker because the hospital kept altering their appointments on me which in turn messed with her own timetable until she was essentially required to seek other more reliable work.*

Impact of COVID

COVID has continued in the past year to create challenges for some providers. This includes costs due to increased absenteeism. It was reported that agency staff and additional casual staff are required to backfill shifts and that sick leave was being exhausted. This is exacerbated for providers of Supported Independent Living and Specialised Disability Accommodation.

Several providers mentioned the ongoing cost of staff training, infection control methods and the maintenance of PPE stockpiles are difficult to account for under the DSW Cost Model. Furthermore, cancellations due to COVID were said to have increased.

Other providers reported that COVID costs had been absorbed into current business arrangements. The Australian Psychosocial Alliance stated that overall, their members had reported a reduction in COVID associated costs over the past six months. However, there remained an overhead burden in planning COVID responses across all areas of a business.

Impact of Aged Care Award increases

Some providers feel that increases to the Aged Care Award will not have a direct impact on the disability workforce demands and costs. One provider of both aged care and disability support services stated:

> *We do not anticipate there will be any marked shift of disability support staff wanting to exit to Aged Care services.*

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Therapy supports

There were 173 submissions related to Therapy supports. These were received from all stakeholder groups including, providers of both therapy and other supports, plan managers and other workers/employees, participants and/or their representatives, provider peak bodies, professional bodies, an advocacy group, and a government organisation.

Providers

Many providers claim the hourly rate for therapy services has not increased for three years and the cost of living has increased significantly, resulting in a rise in operational costs, rising material costs, and other associated costs. Time spent on administration, audit and liaising with support coordinators, families, and carers of participants is under-costed, and administration costs around intake are high but not claimable. There is the added problem of staff shortages with ongoing issues in retention and recruitment across the labour market in general.

Some providers argued that they charge a higher price for NDIS participants than non-NDIS clients due to the greater complexity in assisting them. On the other hand, some claimed there is no difference between the rates charged to NDIS and non-NDIS clients. A provider stated:

> *Our pricing rates for NDIS participants is slightly higher when compared to non-NDIS participants $150 per hour however does not consider travel and the increased complexity clients with disability versus private clientele.*

Several providers who responded stated that they charge NDIS price limits for exercise physiotherapy is less than other comparable schemes and stated that the NDIS price limit should be increased in line with other types of therapies.

Varying responses were received from providers regarding the proportion of therapy revenue that is derived from NDIS compared to other funding sources, ranging from 5% to 100%. Many providers reported approximately 80-95% of their revenue comes from NDIS participants, however, there are some providers who reported lower percentages, such as 5%, 20% or 33%. Providers of children supports were amongst those that reported 100%, whilst a psychologist reported as little as 5-10% comes from NDIS funding. The range in percentages highlights the diversity of therapy supports and the different ways in which providers rely on NDIS funding to support their services. Other sources of provider's funding include private funding, MBS, My Aged Care and iCare.

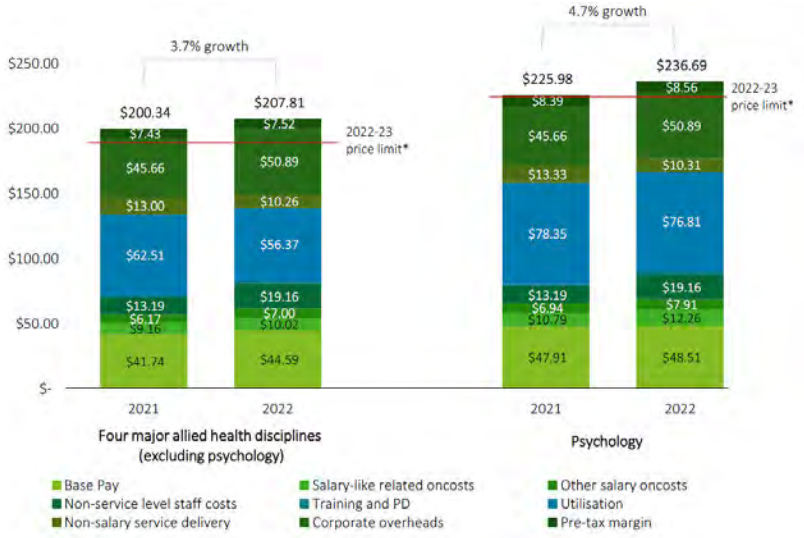
Provider peak bodies

A major submission on the pricing arrangements for therapy supports was received from Ability Roundtable. They provided a report from Deloitte Access Economics who, in partnership with 13 participating organisations, updated their Allied Health Cost Model. The participating organisations collectively represent around 20% of NDIS therapy supports revenue. It is important to note that the providers in this study have a significantly different cost structure to many other therapy providers, who are typically much smaller.

Their Cost Model (as at 31 December 2022) identifies the baseline costs of service delivery for therapy supports under the NDIS, with a particular focus on large clinical training organisations. The report also draws on data from the Ability Roundtable's Allied Health benchmarking group. Figure 34 provides some detail of the cost modelling undertaken by Deloitte Access Economics.

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FIGURE 34: DELOITTE ACCESS ECONOMICS ESTIMATED COST PER HOUR OF ALLIED HEALTH SERVICES UNDER THE NDIS, 2021 (LEFT HAND SIDE) COMPARED TO 2022 (RIGHT HAND SIDE)



Source: Deloitte Access Economics estimates based on information provided by the 13 organisations surveyed

Notes: Four major allied health disciplines (excluding psychology) are the weighted average of social worker, speech pathologist, occupational therapist and physiotherapist. *2022-23 price limits are the calculated weighted average price limit for each group based on the location and allied health disciplines of organisations within the sample, using NDIS Pricing Arrangements and Price Limits 2022-23.

The key findings of the Deloitte Access Economics Report include:

- At an overall level, the Cost Model shows that the fully loaded cost of service delivery in 2022 increased by approximately 3.7% for the four major allied health disciplines (excluding psychology) and 4.7% for psychology.
- Labour-related costs increased by 15% for the four major allied health disciplines and 12% for psychology, primarily attributed to growth in wages and salary oncosts and investment in recruitment and training of new staff.
- Overhead costs increased by 11% across all major allied health disciplines, primarily driven by growth in IT costs, HR costs and quality compliance costs.
- To offset these impacts, providers found savings through operational efficiencies with improved utilisation rates, reduced spend on non-labour costs such as training and supervision, and back-office restructures.

Most providers surveyed suggest they are unable to break even as they are operating at costs above the current NDIS prices limits for therapy supports in 2022.

A peak body for early childhood intervention stated unfunded activities that are not billable include child protection referrals, involvement in subpoenas and family law court proceedings and mandatory reporting requirements.

Based on a small survey conducted by the National Disability Services (NDS), there are significant price gaps between NDIS price limits and the real costs of service delivery in various support categories. They mentioned:

> *The NDS State of the Sector (2022) report based on our Annual Market Survey shows that the past year has been a difficult one for providers. Operating conditions*

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have generally worsened, and less than half of those responding to the Annual Market Survey recorded a surplus in the previous year.

Professional bodies

Several professional bodies reported pricing arrangements for therapeutic supports under the NDIS are not reflective of true costs for providers especially when considering inflation, workforce shortages, impact of COVID and NDIS client complexity. These costs are felt more acutely in rural and regional areas due to factors such as competition around wages, housing shortages and increased costs of travel and consumables.

Many professional bodies suggested the increase in NDIS therapy support payments may be the result of increasing provider numbers and participants having more knowledge, choice and control over how they invest their funds. NDIS providers often provide unpaid or underpaid labour to subsidise a participant's plan, which can impact their business and result in higher costs.

Allied Health Professions Australia (AHPA), who represents some 200,000 allied health professionals, stated data recently gathered from more than 700 speech pathologists, showed that less than a quarter report charging a higher rate for NDIS participants, with the majority charging all clients the same fee. Some therapy providers, particularly physiotherapists, report charging non-NDIS clients a higher fee, as it reflects the true costs of the service. The reasons given for charging higher fees include the complexity of the supports being offered, the level of skill involved and experience of the provider, and additional supervision and professional development requirements. Their submission states:

Therapy providers are overwhelmingly de-registering and choosing to see only self-managed and plan-managed clients due to the untenable burden.

Of those who are not registered, just under 95% indicated that they were not intending to register.

This was concurred by another peak body Speech Pathology Australia who also stated for those who do have differentiated prices, this was frequently referred to in terms of offering a discount to people and families who are unable to access any funding, and for whom therapy would therefore be out of reach.

The Australian Association of Psychologists Incorporated performed a survey in November 2022, with results indicating there has been a significant increase in demand for services in the disability sector. The psychologists' recommended fees are considerably higher than the price caps for NDIS therapy items, suggesting that psychology is funded at levels that are low, given the education, training, and business costs associated with registration and practice as a psychologist.

Australian, New Zealand and Asian Creative Arts Therapies Association (ANZACATA), a professional body on creative arts therapies, stated that group Art Therapy services under the NDIS is not viable due to the use of more materials, time spent writing more case notes, and the expertise required to facilitate and keep participants safe. The episodic nature of psycho-social disability and its impact on service provision also poses a challenge as participants often have irregular attendance patterns, making it hard to support regular work conditions and contracts and attract staff.

Participants

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More than half of the participants that responded stated they are charged more than non-NDIS clients by their providers. A participant who receives supports from both Disability Support Workers and Therapists responded:

> *However, regarding therapy supports, as soon as you advise the provider you are NDIS client you automatically get charged the maximum NDIS price no matter which provider I went to ask about cost per hour of service.*
>
> *Meanwhile members of the public who are not NDIS clients receiving the same length of time and service for a Physiotherapist or Exercise Physiologist are charged less than myself.*

Whilst another, who was self-managed, stated that now they are plan-managed they are charged double the hourly rate for podiatry and physiotherapy sessions under the plan-managed system.

A respondent suggested not to increase the maximum amount an Occupational Therapist can charge for their service as the respondent believes Occupational Therapists are currently overcharging.

Another participant's response follows:

> *NDIS Participants are forced to pay higher prices than other customers/patients because providers tend to charge the maximum price limit. Regrettably, this is what happens when demand for services exceeds the supply of providers so that there is no competition among providers for services to Participants and no incentive to charge them less than the NDIS Pricing Arrangements and Price Limits stipulated maximum amounts.*

Advocacy groups

An advocacy group stated the current pricing system for therapy services is inconsistent and does not align with the true costs of hiring allied health professionals. Providers may also face increased after-hours staffing costs and travel expenses for clients in rural and remote locations, which are not currently covered under the NDIS. This, coupled with increased administrative requirements, has led to an increased workload for providers.

Support coordination

A total of 99 submissions addressed support coordination. Submissions were made by participants, providers, plan managers, employees/workers, provider peak bodies and an advocacy group.

Providers

A common theme raised by providers is the lack of price limit increase in support coordination level 2 and 3 by the NDIA, combined with SCHADS Award increases have reduced margins for providers prompting considerations on the financial sustainability for their businesses.

Cost increases, such as Workcover, registration, audits, portable long service leave, COVID related leave, superannuation, utilities and rent are all impacting support coordination's sustainability amongst providers.

In addition, the pricing model does not adequately consider the fragmented nature of support coordination. Unbillable hours spent on phone calls, emails, invoicing, and filing are

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impacting providers, with an average of 20 hours of unpaid work per week. One provider suggested they:

> *work on average 20 hours of paid work per week, with another 20 hours of unpaid work, which is spent on the following activities: Phone calls, emails, invoicing, and filing. Travel time is not claimed but is an expense incurred by the provider (up to 6 of the 20 additional hours per week).*

Support coordinators also suggested they undertake unfunded work following the death of a participant, including the administrative work associated with gathering information, returning equipment and completing forms. Submission asked whether these services can be claimed. This is currently being investigated by the NDIA.

Providers raised that further investment in support coordination can be made by the NDIA. Some poor standards of service in support coordination may result in potential fraud. Other concerns are that some participants are not receiving necessary supports either due to limited hours in their plan for more complex needs or through ineffective operators. One provided suggested:

> *When participants don't have support coordination built into their plans, they rely on service delivery and plan management to answer their questions around NDIS funding.*

High turnover, the ability to attract and retain staff has been a challenge for support coordination and the price limit has not increased since 2020 whilst all other organisational costs have increased. An increase in the unit price is suggested to continue the high-quality support.

Participants

A theme echoed by both participant and provider is the need for more standards in the provision of support coordination. The clarity of role of support coordinator compared to a plan manager was a recurring theme since the last APR and one which may be considered by the NDIS Review. One participant suggested:

> *Support coordinators must have experience, they must be appropriately qualified and registered accordingly (or with a relevant professional body). They should not be given as much money as they do.*

Plan management supports

In total, 81 submissions addressed plan management supports. These were received from providers of plan management supports, providers of other supports, plan managers and other workers/employees, participants as well as an advocacy group and two provider peak bodies.

Providers

Plan management providers reported that the biggest cost drivers have been due to increased participant and provider communication and invoicing. Labour costs also contributed to the increase in costs including increased wages, superannuation and long service leave, compliance and registration costs, training and IT.

One provider stated:

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> *The fact that the fees we receive from NDIS for providing plan management services have not increased for the past couple of years, along with the corresponding increased costs of providing service has resulted in a real reduction of available funds each year for direct service.*

Some providers detailed the work required by plan managers and the challenges of an increased demand in services. This involves briefing participants/carers and support coordinators in understanding and applying NDIS price guidelines. They also report that participants with complex and diverse physical and mental health needs tend to require more time in dealing with their NDIS claims issues.

Spinal Cord Injuries Australia reported:

> *The current pricing structure does not adequately cover the increased time required to manage complex clients, leading to higher levels of staffing. Plan managers are required to implement plans, process invoices, provide budget reports, assist in gathering information for planning meetings, and ensure prompt payments to service providers. The increase in invoice requests has led to the employment of additional resources in frontline and support staff as well as technology.*

Like providers of other support services, plan managers are finding it increasingly difficult to attract and retain suitable staff. They also reported an increase in competition among providers which impacts the ability to recruit qualified staff. In some cases, maturing client tenure has led to increased service expectations. High staff turnover was also reported by several providers with the Australian Workers Union stating:

> *The DSW industry is characterised by short term tenure with multiple employers but, paradoxically, long-term service within the industry. This contributes to staff turnover.*

A provider of plan management supports stated:

> *Plan management is not a skill set easily found in the existing job market. Although it is primarily a clerical function, we have found that it takes a plan manager 3 months to 6 months to acquire enough NDIS knowledge to enable the application of the NDIS price guide to be effective.*

Changes to set up fees were also addressed by some respondents, particularly regarding the 12-month duration of participant plans and the automatic extension arrangement. Some providers reported that the workload per participant has increased when setting up plans and that additional work is created when a participant completes their current plan, and a renewed plan is in place. It was said that plan managers are not notified when a review occurs and sometimes, the participant is not aware of the new plan. This creates delays in processing invoices and supports. Plan managers reported that invoice payment could be slow, with some claims taking months to be processed.

Plan managers felt there was no recognition of the work involved in preparing larger plans, especially if those plans involve Supported Independent Living or Specialist Disability Accommodation. They felt that there could be an excessive amount of invoicing for some participants. Plan managers also said that they do not have the authority to control the ad hoc supports that participants request and only learn of them when an invoice is received.

Providers reported IT and software issues and the time it took to resolve issues. There were also increased training demands not only in systems and software and verification requirements, but on how to manage and detect potential instances of fraud, responding to

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customer conflicts of interest and responding to privacy related matters. In addition, training is needed to maintain certification in first aid and mental health first aid, understanding child safety indicators, cultural awareness training and training in NDIS processes and the NDIS Pricing Arrangements and Price Limits framework. Several plan management providers noted they would like clearer guidelines on the role of plan managers to assist in reducing administrative burden as well as help in the understanding of fraud prevention. More clearly defined roles for plan managers may be in scope of the NDIS Review.

Participants

One participant, who was previously self-managed, stated that the fee for group therapy doubled with the introduction of a plan manager. They also felt they lost the independence in running their own affairs. The participant stated:

> *My physiotherapist charged me $50 to be a part of a group hydrotherapy session when I self-managed my NDIS plan. This group included aged care and injury recovery clients. It was held in a sectioned off part of the pool. Now that my plan has a plan manager, the group hydrotherapy session is just NDIS clients, is in the public side of the pool, and now costs my NDIS Plan $100.*

This participant also believed that Plan reviews should take place over a longer period to 'make for a smoother and more timely running of the NDIS plan':

> *Plan Reviews could include a meeting between the NDIS participant, family/carers, the Local Area Co-ordinator, the Occupational Therapist and the NDIS so the plan is comprehensive and meets all needs of the person with the disability. To save time and money, these meetings could happen via the internet.*

Other commentary

Providers

Travel continues to be a commonly raised topic across stakeholders. Concerns were raised by providers around the cost of travel increasing, particularly in regional and remote areas.

One provider queried that the Modified Monash Model (MMM) classification often does not reflect the actual distance travelled. This leads to situations where potentially travel is undertaken but is unable to be claimed due to NDIS pricing arrangements but is still an expense incurred by the provider.

Nexus Support Coordination provided an example, suggesting consideration be given to remote areas surrounded by very remote areas:

> *For example, Geraldton (MMM3) has been given the NDIS MMM 6 Rating purely based on only being surrounded by Remote (MMM6) areas. Geraldton is a large regional centre with a population of nearly 40,000 and only around 4 hours' drive to travel the 420km between Perth and Geraldton. In comparison, Karratha has an estimated population of 22,000, although this figure varies significantly given the transient nature of the town. Karratha is over 1,530km drive or a 2-hour flight from Perth. This covers significant stretches of Very Remote areas and requires 2 days drive when avoiding travelling at night due to livestock and fatigue. The flights have been capped due to the WA State Government's Regional Airfare Zone Cap with $299 per person one way. These capped flights only exist for local residents, so even*

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> *if the NDIA was trying to build the therapy services market, the sheer cost of flights to get to the northwest is not affordable.*

Another provider raised concerns that NDIS processes and systems can lead to barriers in claiming, such as the time it takes for plan reviews/renewals or how plans have been built.

There were concerns raised by a few providers over participants and their representatives who are self-managing NDIS funds around getting paid in a timely manner for supports delivered.

Provider peak bodies

Ability Roundtable provided a submission around Supported Independent Living (SIL) supports from their benchmarking survey, with one of the main concerns raised around vacancy management. The submission by Ability Roundtable reported that from their benchmarking survey:

> *This reveals a startling increase in SIL vacancies over the past two years, with vacancies increasing from a median of 7.3% to 10% in 2021-22 (see Figure 2.1). This trend therefore highlights a growing problem of lost accommodation options for SIL participants as well as lost revenue generation opportunities for service providers annually.*

Professional bodies

NDIS price limits being inclusive of GST had a few professional bodies raising concerns around this including Exercise and Sport Scientists Australia (ESSA).

ANZACATA's submissions raised that:

> *Services such as Art Therapy have the same price limits as Audiology, Dietitians, Physiotherapy, and Social Work services in the NDIS Therapy Supports. However, the supply of their services is GST taxable and is included in the price limit. This decreases the effective hourly rate that ANZACATA members earn.*

Suggesting that:

> *The NDIS Annual Pricing Review 2021-2022 final report recognised the problem and recommended an "off-plan" GST payment approach to ensure the NDIS price limits are set GST-exclusive*

There were suggestions raised that NDIS price limits should consider the increased measures taken to bolster cyber security scheme-wide as well ongoing system transition to PACE.

Another stakeholder raised concerns that is a need for greater clarity around participant plans and funding, particularly regarding non-face to face, travel, and cancellations, to avoid tensions and misunderstandings between both parties (providers and participants).

Participants

A participant raised concerns over the NDIS pricing arrangements for provider travel report-writing, suggesting current arrangements were too high and negatively impacting plan budgets.

One participant suggested that the NDIS pricing arrangements and price limits document is a useful resource for them, but they have difficulty navigating it:

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As someone who is blind and needs to use a screen reader app to read digital content, I have found the NDIS price limits document difficult to navigate. As a self-managed participant I am not subject to the pricing caps, but it is nevertheless useful to consult the current pricing caps in the NDIS marketplace.

Another participant also suggested that the NDIA should consider that competitive markets may not be feasible for all supports, and some regulatory mechanisms should remain.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Appendix B – Domestic and family violence

10.1 Research

Australian Bureau of Statistics' (ABS's) Personal Safety Report (2021)[31] provides insights into the prevalence of domestic violence and/or emotional abuse in Australia. The data shows that in the 12 months before the survey, **5.0% of women and 2.6% of men** experienced violence or emotional abuse or economic abuse by a cohabiting partner.[32]

Table 15 provides a summary of surveys on the current utilisation of domestic violence leave in Australian companies with existing family and domestic violence leave entitlements.

TABLE 15: CURRENT UTILISATION OF DOMESTIC VIOLENCE LEAVE

Company (Year of survey)	Unique aspects of survey	Average leave usage by employees	Other Data
Fair Work Commission (2021)	Survey of employers across multiple industries in 2021	0.05% of employees	7.3 employers responded that they had provided DV *unpaid* leave in the past 12 months to at least one employee
Bank of Queensland (2021)	856 employees are entitled to 10 days of paid and 10 days of unpaid leave	Over the 3 years from 2018-2021, 21 employees had taken up the leave (2.5% of employees or 0.8 per cent of employees per year)	3 days was the average number of days claimed with only one employee claiming the full 10 days.
Western Australian Government (2021)	155,000 staff in the government were entitled up to 10 days of paid leave and 2 days of unpaid leave	0.5% of employees took up some form of leave	In the 12 months from August 2020 to August 2021, a total of 869 days of leave was taken by all employees
Victorian Government (2022)	Up to 20 days of paid domestic violence leave is provided to all employees	0.3% of employees took up some DV leave	An average of 8.56 out of the total 20 days of leave was taken
New Zealand Government Survey (2021)	The New Zealand government has legislated domestic violence leave for a couple of years. An informal survey of 19,000 employees was taken in 2021 to assess the take up rate of the leave.	0.5% of employees took up some form of the leave	The average usage was under 5 days out of the 10 days that each employee was eligible for.

Source: Fair Work Commission (Domestic and violence leave review 2021) published 16 May 2022, DVFREE

Stanford (2016)[33] conducted a study that estimated the likelihood of taking leave if a person is experiencing violence or abuse to be approximately 53.8% for women and 29.3% for men. A potential reason provided was that for the companies surveyed, domestic violence and

[31] The ABS Personal Safety survey 2021 can be accessed here

[32] Personal Safety Australia, 2021-22, Table 2.3 of National prevalence and time series (Tables 1 to 8)

[33] Jim Stanford, Economic Aspects of Paid Domestic Violence Leave Provisions, 2016.

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family leave might not have been widely known or understood by all employees, or there may have been a stigma associated with the use of the leave.

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Appendix C – Non-wage Aged Care reforms

In addition to the 15% increase to relevant wages in Aged Care-related Awards, there are other reforms being introduced to improve the quality of care of those receiving aged care supports.

Specifically, the Government has committed to introducing:

- mandatory 200 minutes of care time, per resident, per day (including 40 minutes by a Registered Nurse) from October 2023.
- mandatory 215 minutes of care time, per resident, per day (including 44 minutes by a Registered Nurse) from October 2024.

A recent study by CSIRO in 2021[34] found one in ten Australian Residential Aged Care Facilities met this recommended number of care time suggested by the Royal Commission.

What this will mean is that many aged providers would likely need to hire additional staff to meet these new, mandatory requirements. There is the potential for these changes to have flow on implication to the current and potential future worker pool of support workers to deliver supports to NDIS participants.

Additionally, the Federal Government has an ongoing review into Aged Care Quality Standards and are currently consulting on a new model for regulating Aged Care will likely spur further reforms aimed at improving the quality-of-service provision to participants receiving aged care supports.[35] These reforms are expected to further impact demand for aged care staff, which again may have flow on impacts on the current and potential pool of disability support workers.

These non-wage reforms are expected to have workforce impacts to the disability sector, but they should be monitored over the following years to see the real impacts with worker mobility and total workforce numbers. The NDIA also acknowledges that there is expected to be assistance provided by the Government to assist aged care providers with these proposed aged care reforms.

The 2023/24 budget projects expenditure on Aged Care services to rise by 21% in 2023-24 to $32.7 billion, followed by a 9.9% jump in 2023-24. Driving the large growth in 2023-24 is the implementation of the Fair Work Commission's decision on the *Aged Care Work Value Case* which increased minimum award wages by 15 per cent from 30 June 2023 for many aged care workers.[36]

[34] Considering the new minimum staffing standards for Australian residential aged care (csiro.au)

[35] Review of the Aged Care Quality Standards | Australian Government Department of Health and Aged Care

[36] 2023-24 Federal Budget (Statement 6: Expenses and Net Capital Investment)

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Pricing Arrangement Reference Group (PARG)

Meeting: 28 September 2023

Minutes

Date: Thursday, 28 September 2023

Time: 2:00pm-3:00pm

Meeting: Microsoft Teams

Members

Chair		
David Gifford	Scheme Actuary	By Teams
Pricing Arrangement Reference Group Members		
Deborah s47F - perso	Independent Member	By Teams
Julie s47F - personal privacy PSM	Independent Member	By Teams
Lynne s47F - personal priv	Independent Member	By Teams
Participating Observer		
Kirstyn s47F - perso	Proxy for Andrew Parsons	By Teams
Kee s47F - personal pr	A/g Branch Manager, Economics and Pricing	By Teams
Jenny s47F - perso	Director, Economics and Pricing Branch	By Teams
Dominic s47F - person	A/g Director, Economics and Pricing Branch	By Teams
Davor s47F - personal privac	A/g Director, Economics and Pricing Branch	By Teams
Scott s47F - personal p	Assistant Director, Economics and Pricing Branch	By Teams
Secretariat		
Vincent s47F - personal p	A/g Director, Economics and Pricing Branch	By Teams

1.1 Welcome and apologies

- The chair noted that Jim Cox was unable to attend the meeting and sent his apology in advance. Participating observers, Andrew Parsons and Anne Skordis were also an apology. Kirsten Flynn was proxy for Andrew.

1.2 Declaration of conflicts of interest

- No conflicts of interest received.

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1.3 Update by the Chair

- The **Disability Royal Commissions' Final Report** has been released, marking a significant moment after four years of hearings. This comprehensive report covers a wide range of issues within the disability sector. While the report's scope extends far beyond the PARG's area of focus, it is important to note it is release as it may have implications on the Annual Pricing Review (APR).
- The **NDIS Review** is now in its final stages, with the final report scheduled to be handed to the government in October. This review has garnered substantial attention and discussion in various forums, including town hall-style meetings within the disability sector. It is expected that some aspects of the Review will directly impact the APR, making it an essential contextual factor for the committee to consider.
- Government focus on the **NDIS Scheme's sustainability** is still a top priority. The NDIA Review will undoubtedly shape future discussion and decisions related to the scheme's financial aspects.
- The NDIA recently published the results of the **APR**. The recommendations were presented to the NDIS Board and approved, and the results were made public in June 2023. Subsequently, there has been substantial feedback from stakeholders, particularly from providers.
- Feedback on **Support Coordination pricing** has been a focal point, involving multiple meetings with Jess Harper, CEO of Disability Intermediaries Australia (DIA). The feedback received has been balanced, highlighting the possible consequences of maintaining unchanged prices and providers may discontinue services if prices are not adjusted. There is consideration of a potential out-of-cycle pricing decision associated with the new model, involving consultations with sector representatives.
    - A member noted the significance of the support coordination cost model emphasising the necessity for a clear distinction between plan management and support coordination. The recognition that both services provide similar functions poses a challenge when developing a cost model for one without considering the other.
- There has been broader discussion around **therapy prices**, including references to "price gouging" where providers charge different prices to NDIS participants than others; adding to the complexity of pricing considerations.
- The decision to extend the **temporary loading** for disability support prices for another year at a reduced rate of 1% has been well-received, striking a balance between supporting providers and recognising financial hardship.

2.1 Annual Pricing Review (APR) 2023-24

Draft Terms of Reference (ToR)

- Members discussed the draft ToR, highlighting topics that require deeper examination, including: DSW, Therapy, Plan Management, and Support Coordination.
- A member noted the need for flexibility when framing the APR process to align with the Royal Commission and the NDIS Review. There is concern about starting a consultation process and having it shift due to changing government priorities.

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- Regarding the Introduction, it was advised to provide less detailed background on deregulation to align with the different government reviews.
- Other topics for consideration included Cancellation policy, Provider Travel, and Short-Term Accommodation (STA).

Cancellations:

- Members expressed interest in understanding the rate of cancellations, the reasons behind cancellations, and the impact on providers. Questions were raised about setting a maximum number of cancellations and the potential for excessive cancellations.

Provider Travel:

- Impact on thin markets was discussed where providers in remote and very remote areas may be more affected, and potential consequences of providers refusing to serve those areas due to costs was raised. Strategies such as shared service models and hubs need to be explored to aggregate demand effectively, enabling providers to undertake extended journeys to provide service. It was noted that while most providers likely optimise their routes, there might be cases where providers do not.

Short Term Accommodation (STA)

- Concerns about STA pricing have arisen due to potential misuse and fraud. The current pricing for STA is complex and includes both accommodation and labour costs, making it difficult to distinguish appropriate claims.
- Fraud and integrity issues are growing challenges for the scheme as it expands and addressing them requires both pricing clarity and effective compliance measures.
- Definitional clarity in pricing a service is crucial to enable compliance teams to identify inappropriate claims. Attempting to deter fraud by lowering prices may have unintended consequences, such as inadequate funding for legitimate services.

Consultation process

- Members discussed the consultation process outlining plans for virtual meetings, which will include separate sessions for participants and providers. Plans were mentioned to create distinct consultation papers for participants and providers, emphasising the diverse needs of participants. The approach of collaborating with internal colleagues such as Provider and Engagement and Participant Advocate to facilitate smooth forums was shared. Additionally, there was consideration of using technology to gather real-time feedback during live sessions.
    - It was agreed that members could attend the workshops to gain a firsthand account of participant and provider concerns.
    - Define the information needed for engagement based on its potential impact and be transparent about what participants can influence to avoid wasting their time.
    - Provide a range of feedback channels to accommodate different information types and participant preferences.

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2.2 Membership, timeline, and future meetings

- The current panel's membership has reached its maximum term as panel members' contracts are set to expire by December 2023. The process for appointments is underway, including the additional membership to replace Graham Innes. An Expression of Interest round will be run, and all members will need to reapply for their positions as part of the process.
- Future meetings will be set up with more certainty on the conclusion of the procurement process.

3.1 Actions

#	Meeting	Action	Status
1	20230928	Consultation process: Define the information needed for engagement based on its potential impact and be transparent about what participants can influence to avoid wasting their time.	Open
2	20230928	Organise and send invitations to members for the upcoming APR consultation workshop sessions.	Open

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Annual Pricing Review 2023-24

Matters for Discussion

Chair: David Gifford, Scheme Actuary

1. Purpose

1.1. To seek feedback from the Pricing Arrangement Reference Group (PARG) on the proposed Annual Pricing Review (APR) 2023-24 Terms of Reference (ToR) (Attachment A).

2. Recommendations

2.1. That PARG **NOTES** the APR 2023-24 ToR.

3. Context and update since the release of the last APR

3.1. Following the APR release in June 2023, the Economics and Pricing branch held internal sessions across the National Disability Insurance Agency (NDIA) to communicate the APR outcomes. This was to ensure staff are better equipped to handle sector queries. Four external sessions were held with the sector with approximately 150 attendees each to explain how the APR decisions were derived to the public.

3.2. Since the announcement of the APR, feedback has been received through various engagement channels such as ministerial correspondence, queries to the National Call Centre, and letters to the senior NDIA executives. Topics of interest include the impact of the cancellation policy, static pricing for therapy, support coordination and plan management, concerns about price discrimination against NDIS participants and sharp practice by the providers.

3.3. It is important to note that the following two reports will be released soon, which might impact the Terms of Reference of the next APR:

- The NDIS Review will provide a final report to the Disability Reform Ministers' meeting by October 2023.
- The Royal Commission (Commission) will report to the Governor-General on 28 September 2023.

4. 2023-24 APR Terms of Reference

4.1. In developing the 2023-24 APR ToR, the Economics and Pricing branch held internal consultation sessions seeking feedback from internal stakeholders such as the Participants, Providers, Early Childhood and Fraud areas. The proposed topics have been generally supported.

4.2. Proposed topics for inclusion in the 2023-24 APR are:

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- **Disability Support Worker related supports**: The NDIS Disability Support Worker Cost Model determines the price limits for disability support workers. Minimum wage decisions from the Fair Work Commission will be considered. The impact of the 15% increase to the Aged Care award and its potential impact on workforce supply will be monitored.
- **Therapy**: Half of the Schemes active participants access therapy. The therapy market has not received a price increase over the past four APR cycles and the gap between NDIA price limits, other government schemes and private billing rates was closing.
- **Plan management**: Participants accessing plan managers has significantly increased over the past few years. Plan managers have not received a price cap increase over the past three APR cycles.
- **Support coordination**: Level 2 and level 3 support coordination have not received a price cap increase over the past three APR cycles. A recommendation from the 2022-23 APR was that the NDIA would develop a support coordination cost model.
- **Cancellation policy**: Cancellation policies impact participants' flexibility when arranging supports to be delivered at the right time and in the right place. The 2022-23 APR recommended that the NDIA work with the sector to understand the appropriateness of the current 7-day policy and if changes should be made.

4.3. In addition to the proposed topics as outlined in 4.2, the following two standalone topics have been raised based on feedback from internal consultations:

- **Provider travel**: Policies allow providers to claim the labour costs (salary) and non-labour costs (fuel, parking etc) when there is a cancellation. Providers billing for travel can have a significant impact on a participant's plan utilisation. Internal feedback was raised that given the 7-day cancellation and the ability to find alternative work in most cases due to high service demand, provider travel claims should only be made in necessary circumstances. Feedback also notes that providers should visit multiple participants (NDIS and non-NDIS) within the same area on the same day to minimise the impact of the cancellation and ensure travel cost is distributed more economically.
- **Short Term Accommodation (including the provision of respite care) (STA)**: Concern has been raised around some STA funding being used inappropriately for holidays and Airbnb. Internal feedback suggested that the current price limits are too generous, or these support items have been used for unintended purposes.

5. Proposed 2023-24 APR Consultation Approach

5.1. It is proposed for the 2023-24 APR to have a longer and more in-depth consultation period. The timeframe is expected to occur from the middle of November 2023 to the beginning of February 2024. The approach will include two key phases which will run concurrently:

- Consultation paper to encourage written submission from the public.
- National workshops with participants/nominees/families, advocates, providers, and peak bodies. The aim is to maximise diversity including attendees from indigenous and Culturally and Linguistically Diverse backgrounds and regional and remote locations. This is an additional avenue for participants to share feedback that may be more accessible than written submissions.

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5.2. The 2022-23 APR consultation paper only received 12 (4%) participant responses. To further encourage feedback from participants/nominees/families, it is proposed that the 2023-24 APR have a separate consultation paper for participants to bring in their perspectives.

6. Next steps

6.1. The 2023-24 APR ToR will be discussed at the Pricing Interdepartmental Committee (IDC) before seeking approval from the Board in October 2023.

6.2. Future PARG meetings are proposed to be held in late February and early April 2024.

6.3. Indicative timeframes for the APR 2023-24 are outlined in Table 1.

Table 1: 2023-24 APR indicative timeframe

Milestones	Indicative timing/completion
Seek feedback from the PARG and IDC on ToR	September – October 2023
Board meeting – Approval of Terms of Reference	October 2023
Possible release of ToR and consultation paper. Commencement of public consultation and workshops.	November 2023
Consultations close	February 2024
PARG meeting – update on consultation feedback and APR research	February 2024
PARG meeting – final APR recommendations	April 2024
Board meeting – final APR recommendations	May 2024
Final APR report and implementation	June 2024

Attachments

Attachment A: Annual Pricing Review 2023-24 Draft Terms of Reference

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2023-24 Annual Pricing Review

Terms of Reference

Overview

1. The supply of disability goods and services in Australia has undergone significant reform since the creation of the National Disability Insurance Scheme (NDIS), commencing from 1 July 2013. The National Disability Insurance Agency (NDIA) has responsibility for administering the NDIS and facilitating the markets for disability goods and services. Further information on the markets for disability goods and services can be found on the NDIS website.

2. Where possible, the NDIA utilises market mechanisms to deliver the level of supply required to meet participant demand and deliver the required mix of goods and services. These are produced at market clearing prices, also known as the efficient prices, to meet the needs of participants. However, in non-existent or underdeveloped markets, reliance on deregulated market mechanisms may not meet participant demands, deliver adequate supply, deliver the required mix of disability supports or produce efficient prices.

3. To address these issues, the NDIA has a role, as market steward, to create an efficient and sustainable marketplace through a diverse and competitive range of suppliers who are able to meet the structural changes created by a consumer-driven market. As market steward the NDIA has responsibility for:

   (a) empowering people supported by the NDIS to exercise choice and control.

   (b) maintaining and expanding the supply of high-quality disability supports.

   (c) driving efficiency and innovation in the market for those supports.

   (d) Supporting the transition of NDIS over the longer term to a more deregulated outcomes-based approach.

4. As part of its market stewardship role, the NDIA caps the prices that registered providers can charge for some supports and applies other price controls, including billing rules. These are set out in the *NDIS Pricing Arrangements and Price Limits* and associated documents, which are available on the NDIS website.

5. During transition, price controls are in place to ensure that participants receive value for money care. In the short to medium term, price controls are required for some disability supports because the markets for disability goods and services are not yet fully developed. The longer-term goal of the NDIA is to remove regulatory mechanisms from the markets for disability supports.

6. The NDIA continually monitors and reviews its price control framework and other market settings to determine whether they are still appropriate. The Annual Pricing Reviews (APR) are an important part of that monitoring and review process.

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The National Disability Insurance Scheme Review

7. The NDIS Review (Review) is expected to provide a final report to the Disability Reform Ministers' Meeting by October 2023. The report will make findings and recommendations which may require a revision to the 2023-24 APR Terms of Reference (ToR).

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

8. The Royal Commission is due to report to the Governor-General on Thursday, 28 September. The Royal Commission recommendations may require a revision to the 2023-24 APR Terms of Reference (ToR).

Scope of the Annual Pricing Review

9. The APR will examine, through engagement with participants, providers and community and government stakeholders and targeted research, whether the Scheme's existing price control framework (pricing arrangements and price limits) continue to be appropriate or if modification is required.

10. In particular, the APR will review the pricing arrangement and price limits:

    (a) that apply to supports delivered by disability support worker (DSW) by updating the *NDIS Cost Model for Disability Support Workers,* with a particular emphasis on the Temporary Loading of 1%;

    (b) for therapy supports to ensure participants receive value for money, while providers strive to improve quality of service and increase efficiency, with a particular emphasis on pricing benchmarks;

    (c) for plan management to encourage innovation, improve quality of service and ensure value for money;

    (d) for support coordination to promote service quality and value for money, with a focus on participants experiences when utilising support coordinators to oversee their supports;

    (e) of the NDIS Cancellation policy, which changed from two days to seven days in line with the Social, Community, Home Care and Disability Services (SCHADS) Award. The analysis will examine the impact on participants choice and control;

    (f) for provider related travel when cancellations occur; and

    (g) for Short Term Accommodation including the delivery of respite care with a view to ensuring that the funds are appropriately used on reasonable and necessary supports.

11. In framing its recommendations, the Annual Pricing Review will be cognisant of the objects and principles set out in the National Disability Insurance Scheme Act 2013, including that the NDIS should:

    (a) support the independence and social and economic participation of people with disability;

    (b) enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports;

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(c) facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability;

(d) promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community;

(e) adopt an insurance based approach, informed by actuarial analysis, to the provision and funding of supports for people with disability; and

(f) be financially sustainable.

Process and timing

12. The APR will commence in November 2023 and deliver updates and recommendations to the NDIA's Board, for implementation from 1 July 2024.

Key Dates

Date	Activity
13 November 2023	Release of Terms of Reference and Consultation Paper
Sunday 4 February 2024	Closing date for submissions to the APR public consultation
June 2024	Announce results of the APR Release the NDIS Pricing Arrangements and Price Limits for 2023-24 Release the final price limits (after the Fair Work Commission's Annual Minimum Wage Decision expected in early to mid June 2024)
1 July 2024	Implementation of new pricing arrangements

Further information

13. Further information on the Review is found on the NDIS website on the Annual Pricing Review page.

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NDIA Board meeting of 24 October 2023

The contents of this document are OFFICIAL: SENSITIVE

Agenda Item: #

Agenda Item: 2023-24 Annual Pricing Review Terms of Reference

Paper Type: For Decision

SLT Sponsor: David Gifford, Scheme Actuary

Draft resolution: That the NDIA Board approves the 2023-24 Annual Pricing Review Terms of Reference

1. Purpose

1.1. To seek the NDIA Board approval to publish the 2023-24 Annual Pricing Review (APR) Terms of Reference (ToR).

2. Recommendation

2.1. That the NDIA Board approves the 2023-24 APR ToR.

3. Background and context

3.1. Last year's APR was limited in scope due to the NDIS Review running concurrently.

3.2. Following the 2022-23 APR release in June 2023, the Economics and Pricing branch held internal sessions across the National Disability Insurance Agency (NDIA) to communicate the APR outcomes. This was to ensure staff are better equipped to handle sector queries. Four external sessions were held with the sector with approximately 150 attendees each session to explain to the public on how the APR decisions were derived.

3.3. Since the announcement of the 2022-23 APR, feedback has been received through various engagement channels such as ministerial correspondence, queries to the National Call Centre, letters to the senior NDIA executives. Topics of interest included the impact of the cancellation policy, static pricing for therapy, support coordination and plan management, participant's concern on price discrimination by providers against NDIS participants and sharp practice by the providers.

3.4. It is important to note that release of the following two reports might impact the ToR of the next APR:

- The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Royal Commission) reported to the Governor-General on 28 September 2023.
- The NDIS Review will provide a final report to the Disability Reform Ministers' meeting by October 2023.

4. 2023-24 APR Terms of Reference

4.1. In developing the 2023-24 APR ToR, the Economics and Pricing branch held internal consultation sessions to seek feedback from internal stakeholders such as the Participants, Providers, Early Childhood and Fraud areas. The proposed topics have been generally supported.

4.2. Proposed topics for inclusion in the 2023-24 APR are:

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- Disability Support Worker related supports: The NDIS Disability Support Worker Cost Model determines the price limits for disability support workers. The impact of the 15% increase to the Aged Care award and its potential impact on workforce supply will be monitored.
- Therapy: Half of the Schemes active participants access therapy. The therapy market has not received a price increase over the past four APR cycles and the gap between NDIA prices and other government schemes as well as the private billing rates was closing.
- Plan management: Participants accessing plan managers has significantly increased over the past few years. Plan managers have not received a price cap increase over the past three APR cycles.
- Support coordination: Level 2 and level 3 support coordination has not received a price cap increase over the past three APR cycles. A recommendation from the 2022-23 APR was that the NDIA would develop a support coordination cost model which is in progress.
- Cancellation policy: Cancellation policies impact the flexibility that participants have when arranging supports to be delivered at the right time and in the right place. The 2022-23 APR recommended that the NDIA work with the sector to understand the appropriateness of the current 7-day policy and if changes should be made.
- Provider travel: Policies allow providers to claim the labour costs (salary) and non-labour costs (fuel, parking etc) when there is a cancellation. Providers billing for travel can have a significant impact on a participants plan utilisation. Internal feedback raised that given the 7-day cancellation and the ability to find alternative work in most cases due to high service demand, provider travel claim should only be made in necessary circumstances. Feedback also notes that providers should visit multiple participants (NDIS and non-NDIS) within the same area on the same day to minimise the impact of cancellation and ensure travel cost is distributed more economically.

Most topics are consistent with the 2022-23 APR, with the exception of two new standalone topics (cancellation and travel).

4.3. The 2023-24 APR ToR were presented to the Pricing Arrangement Reference Group (PARG) on 28 September. The PARG was generally supportive of the draft ToR. PARG members were keen to be informed of the outcomes from both the Royal Commission and NDIS Review.

4.4. The Pricing Interdepartmental Committee (IDC) will be presented the 2023-24 APR ToR for feedback on 9 October 2023.

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5. Proposed 2023-24 APR Consultation Approach

5.1. It is proposed for the 2023-24 APR to have a longer and more in-depth consultation period. The timeframe is expected to occur from the middle of November 2023 to the beginning of February 2024. The approach will include two key phases which will run concurrently:

- Consultation paper to encourage written submissions from the public.
- National workshops with participants/nominees/family, advocates, providers and peak bodies. The aim is to maximise diversity including attendees from indigenous and Culturally and Linguistically Diverse backgrounds as well as regional and remote locations. This serves as an additional avenue for participants to share feedback which may be more accessible than written submissions.

5.2. The 2022-23 APR consultation paper only received 12 (4%) responses from participants. To further encourage feedback from participants/nominees/families, it is proposed that the 2023-24 APR consultation paper to have specific questions for participants to bring in participant's perspective.

5.3. PARG members were supportive of the consultation approach, especially developing a targeted consultation paper for participants in addition to the provider consultation paper. Feedback from PARG members on the consultation approach included members interested in understanding the main impetus for frequency of cancellations.

6. Risks

6.1. In previous APRs, the NDIA has received feedback that the APR consultation periods being too short, or not broad enough. If the ToR approval was delayed till the Nov Board meeting, the consultation period would run into the Christmas holiday break and it is likely to be too short for a genuine consultative approach.

7. Next steps

7.1. Following NDIA Board approval of the 2023-24 APR ToR, the ToR will be sent to the Minister's Office for noting before release in mid-November 2023.

7.2. Indicative timeframes for the APR 2023-24 are outlined in Table 1.

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Table 1: 2023-24 APR indicative timeframe

Milestones	Indicative timing/completion
Board meeting – approval of ToR	October 2023
Possible release of ToR and consultation paper Commencement of public consultation and workshops	November 2023
Consultations close	February 2024
Board meeting – approval of 2023-24 APR final report and recommendations	May 2024
Final APR report release and implementation	June 2024

Attachments

Attachment A: Draft Annual Pricing Review 2023-24 Terms of Reference

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

DOCUMENT 65.1

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2023-24 Annual Pricing Review Report

June 2024

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Acknowledgement

The National Disability Insurance Agency (NDIA) acknowledges the Aboriginal and Torres Strait Islander people of this nation and the Traditional Custodians of the lands across which our Agency conducts our business. We pay our respects to the custodians of the land on which we work as well as their ancestors and Elders, past, present and emerging.

The NDIA is committed to honouring Aboriginal and Torres Strait Islander Peoples' unique cultural and spiritual relationships to the land, waters, and seas and their rich contribution to society.

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Terms that we use

Acronym	Meaning
ABS	Australian Bureau of Statistics
APR	Annual Pricing Review
CPI	Consumer Price Index
DRC	The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
DSW	Disability Support Worker
FWC	Fair Work Commission
NDIA or Agency	National Disability Insurance Agency
NDIS or Scheme	National Disability Insurance Scheme
NDIS Commission	National Disability Insurance Scheme Quality and Safeguards Commission
SCHADS Award	Social, Community, Home Care and Disability Services Industry Award 2010
SIL	Supported Independent Living
WPI	Wage Price Index

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Table of Contents

2023-24 Annual Pricing Review Report 1

1. Executive summary 6
2. Introduction 15
3. Domestic economic conditions and the care economy 20
4. Disability Support Worker related supports 35
5. Therapy Supports 58
6. Support Coordination 87
7. Short Notice Cancellation Policy 104
8. Feedback from the Participant Consultation Paper 117
9. Appendix A - Feedback from the Provider Consultation Paper 127

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1. Executive summary

The National Disability Insurance Agency (NDIA) monitors and reviews National Disability Insurance Scheme (NDIS) price control framework and other market settings to determine whether they are appropriate and reflect the current market conditions.

Annual Pricing Reviews (APRs) are an important part of the monitoring and review process. This requires the NDIA to examine, through engagement with participants, providers and community and government stakeholders, and targeted research, whether the NDIS' existing price control framework (pricing arrangements and price limits) continues to be appropriate or should be modified.

As part of the 2023-24 APR, extensive consultations with participants, providers and other stakeholders were completed, including:

- Publishing a Consultation Paper and completing analysis of the 912 submissions received.
- Consultations with other government insurance and funding schemes.
- Consultations with the Pricing Arrangements Reference Group.
- Consultations with the Pricing Interdepartmental Committee.
- Consultations with the Department of Veterans' Affairs and the Chief Allied Health Officer.

A summary of submissions to the Consultation Paper can be found in Appendix A and throughout the report.

1.1 NDIS Review

On 7 December 2023, the Minister for the NDIS released the independent NDIS Review. The report maps out 26 recommendations with 139 actions to help restore trust, ensure the Scheme's sustainability, and deliver a better NDIS experience for participants. Together with the Government, the NDIA will take the time to carefully consider all recommendations and ensure that reforms are done in a measured and considered way.

1.2 The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (DRC) was established in April 2019 in response to community concern about widespread reports of violence against, and the neglect, abuse and exploitation of people with disability. The final report was tabled on 29 September

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2023. The report consists of 12 volumes outlining 222 recommendations. It contains recommendations on how to improve laws, policies, structures, and practices to create a more inclusive and just society. A Government taskforce has been established to consider the recommendations, with the NDIA represented within this group.

1.3 Disability Support Worker related supports

The provider market has demonstrated significant growth and flexibility to meet increasing demand. In the six months to December 2023, 44% (283,406) of active NDIS participants accessed Disability Support Worker (DSW) related supports, a 12% increase from the same period in 2022. This period also saw a 21% increase in the number of active providers, totalling 122,857. Financially, payments for DSW-related supports during this timeframe amounted to $13 billion, accounting for 64% of the total $20.4 billion in payments made to providers, which reflects a 27% growth in DSW-related support payments year-over-year.

This significant growth within the market is underscored by the performance between different provider categories: registered providers experienced a slight decline in their numbers but an increase in payment amounts, while unregistered providers saw a substantial increase in both numbers and payment amounts. This highlights a growing market that continues to meet increasing demand.

The NDIA uses the DSW Cost Model to set price limits for DSW-related supports. This model is designed to reflect the costs of a reasonably efficient provider would likely incur per billable hour of support. It includes base salary and shift loadings aligned with the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award), direct on-costs such as superannuation and leave entitlements, operational overheads like supervision and training, and corporate overheads which account for essential Human Resources and Information Technology.

The SCHADS Award sets the minimum standards for DSWs, stipulating wage levels and conditions that are foundational in establishing NDIS price limits for DSW-related supports in conjunction with broader market trends and regulatory requirements. The multiplicative nature of the model means that when the NDIA passes on increases to minimum wages, as set by the Fair Work Commission through the SCHADS Award, it flows through to the final output of the model. This implies that wage changes and other cost components flow through the model, partially reflecting challenges of doing business in the current economic environment even in the absence of direct adjustment to the overhead and margin parameters.

Feedback received from the sector and peak bodies highlights challenges in alignment to evolving economic conditions and provider realities. Stakeholder feedback has suggested a potential underestimation of corporate and operational overheads, such as insurance and compliance costs given the model is currently

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based on previous benchmarking survey results. The feedback received through the APR consultation and ministerial correspondence, has raised concerns that the current price limits may not fully accommodate the delivery of more specialised and complex supports for some NDIS participants, which may restrict providers' ability to recover adequate costs.

The NDIA is actively enhancing the DSW Cost Model by integrating more robust and diverse data sources. This includes partnerships with industry stakeholders on benchmarking surveys and leveraging mandatory financial reports submitted to the Australian Charities and Not-for-profits Commission (ACNC). On balance, these new data offer insights into providers financial performances from different perspectives, which ultimately enriches the decision-making process. This is important so that the varied and evolving conditions of the NDIS provider market are considered. The NDIA should work with the sector, providers, and other stakeholders to consider options for setting prices for Disability Supports, including but not limited to exploration of a new pricing approach. This should include exploration of methods to obtain objective information to inform potential approaches.

Analyses in this report highlight that there is considerable variability in financial performance among organisations and the persistent tightness in the care and support workforce. In the absence of representative data of the NDIS provider population, the NDIA does not have sufficient evidence to support a structural change to the DSW Cost Model currently.

It is noted that pricing reform work is happening across the Australian Government. This includes the Department of Social Services' led 'Pricing and Payments Framework' and the work to be undertaken by the Independent Health and Aged Care Pricing Authority (IHACPA) to reform NDIS pricing arrangements, including reviewing existing pricing approaches and developing a pricing data strategy.

Therefore, it is considered appropriate to pass on minimum Award wages and national employment standard changes to superannuation at this time, which include an increase in employer superannuation contributions from 11% to 11.5%, effective from 1 July 2024.

Recommendation 1

The NDIA, subject to any specific recommendation arising from the current Annual Pricing Review, should increase the price limits for supports that are determined by the NDIS Disability Support Worker Cost Model from 1 July 2024 to reflect any changes in the minimum wages specified in the Social, Community, *Home Care and Disability Services Industry Award 2010* (SCHADS Award) following the Fair Work Commission's Annual Wage Review and any increase in the Superannuation Guarantee Charge.

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1.3.1 Temporary Loading

The temporary loading of 2% was introduced on 1 July 2022 to the DSW Cost Model as a short-term measure to assist providers in managing the increased costs associated with COVID-19 and changes stemming from the SCHADS Award changes. As COVID specific supports continue to wane in other sectors in the economy, it is recommended that this temporary measure ends as scheduled and as recommended in the 2022-23 APR.

Recommendation 2

The NDIA should cease the temporary loading applied to the NDIS Disability Support Worker Cost Model from 1 July 2024.

1.3.2 Other labour related supports

The NDIA recognises there are supports that are not within the scope of the 2023-24 APR, nor tied to the DSW Cost Model and are neither price limited nor benchmarked. Notably, nursing supports fall into this category, alongside other core and capacity-building supports like personal domestic cleaning and house or yard maintenance.[1]

Given the recent aged care reforms, which include up to a 25% wage increase for aged care workers and potential future adjustments to the Nursing Award, it is crucial that these supports remain in line with their applicable markets. Failing to adjust the price limits, particularly nursing supports, could risk the adequacy of support for NDIS participants. Therefore, it is proposed that the price limits for these supports be increased, following the methodology used in previous years' indexation. It should be noted that capital items are excluded from the APR and are addressed by a separate process.

Recommendation 3

The NDIA, subject to any specific recommendation arising from the current Annual Pricing Review and any future reviews, should increase the price limits for nursing and other supports, not covered by Disability Support Worker-related supports or Capital supports, on 1 July 2024 in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses) and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter immediately preceding the indexation date (with an 80/20 weighting). This recommendation does not include Plan Management.

[1] This does not include Plan Management supports.

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1.4 Therapy supports

The Australian therapy market encompasses a wide array of services provided by allied health professionals, who are typically university-educated with specialised expertise in preventing, diagnosing, and treating various conditions and illnesses. While the NDIS forms an important part of this landscape, allied health services extend beyond NDIS funding. These services are also accessed through various other arrangements, including Medicare subsidies, private health insurance, where it is common for out-of-pocket payments to be made by the consumer, other government schemes, and the Department of Veterans Affairs (DVA).

The NDIS therapy market continues to expand significantly. In the six months to December 2023, 59% (379,296) of the total 646,449 active participants, received therapy supports through their plans. During this period, the number of providers delivering therapy supports grew to 52,736, reflecting a 14% increase from the same period in 2022. Notably, payments made to unregistered providers increased by 60%, although registered providers still received the majority of payments - 65% or $1.3 billion of total payments. This demonstrates growth in both the provider base and financial volume within the therapy sector.

The NDIS therapy market operates in a manner that closely aligns with the characteristics of a deregulated, or private market, more so than other NDIS sub-markets. These price limits are closely linked to the dynamics of the private market, ensuring that NDIS pricing remains competitive and reflective of current service costs. Accordingly, other government schemes and the private billing market serve as suitable comparators to assess the appropriateness of the NDIS price limits.

The 2023-24 APR analysis of other schemes showed that while some have increased their pricing or funding levels, NDIS price limits remain consistent with the majority of therapies provided across these schemes. It is important to note, that there is significant variation in therapy pricing and funding levels among different schemes.

The analysis of private billing rates for NDIS-related weekday in-room therapy services in the 2023-24 period offers detailed insights into the therapy market. The dataset, consisting of 1,791 observations, was compiled by the NDIA from provider websites across Australia. This sample size is derived from previous annual pricing reviews, ensuring continuity and comparability over time.

The sample reveals a wide distribution of therapy types, with physiotherapists, psychologists, clinical psychologists, and dietitians the most common observation. This diversity highlights the varied therapeutic needs catered to by the NDIS, reflecting the scheme's comprehensive coverage. Such insights are vital for the NDIA as it aims to ensure that the NDIS price limits are competitive and equitable, aligning closely with the market rates to adequately support providers while ensuring affordability for participants.

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Overall, the private billing rates analysis provides a crucial benchmarking tool for the NDIA, helping to align NDIS pricing structures with the market and ensuring the sustainability of therapy services under the scheme. This analysis indicates that NDIS price limits generally match or exceed the rates for most therapies nationwide. However, regression analysis highlights statistically significant variances among therapies, which could correspond to differences among therapy professionals such as in qualifications, skills, and experience.

1.4.1 Psychology

After reviewing the current price limits for Psychologists against private billing rates and other comparable government schemes, it is apparent that the current limits generally sit below the prevailing market rates.

Analysis reveals that the mean billing rate for psychologists exceeds the NDIS price limits in both state groupings, with a mean rate of $228.6 and $260.3 for Psychologists and Clinical Psychologists, respectively. Similarly, median billing rates for these professionals surpass NDIS limits, standing at $228.0 and $255.0. Moreover, the 75th percentile billing rates indicate that a significant portion of appointments exceed NDIS price limits, highlighting a clear difference between market rates and NDIS price limits. This suggests that it is appropriate for the NDIS to increase price limits to better align with prevailing market rates and ensure fair compensation for psychology services.

> Recommendation 4
>
> The NDIA should increase the price limits for supports delivered by a Psychologist on 1 July 2024 in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses) and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter immediately preceding the indexation date (with an 80/20 weighting). Specifically, this should be for support line items: ‘Assessment Recommendation Therapy or Training – Psychologist (15_054_0128_1_3), ‘Early Childhood Supports – Psychologist (15_001_0118_1_3)’, and ‘Specialist Behaviour Intervention Support (11_022_0110_7_3)’.

1.4.2 Other Therapists

Review of the alignment of the NDIS price limits for other therapists against the private billing rates and other comparable schemes suggests a general compatibility between the NDIS price limits and prevailing market rates. In general, for most therapists, mean and median billing rates closely mirror the NDIS hourly price limits, which are set at $193.99 in most regions, suggesting that the current NDIS price limits adequately reflect market norms. Even when considering some therapies at the mean, median and 75th percentile, billing rates exceed NDIS price limits, the

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frequency of such instances does not indicate a systemic pricing concern that hinder participants from accessing these services relative to other clientele.

Recommendation 5

The NDIA should not make any further structural adjustments to the pricing arrangements for therapy supports at this time and should not index the price limits for all other therapy-related supports on 1 July 2024.

1.5 Support coordination

Support coordinators play a pivotal role in the NDIS by helping participants understand, navigate, and effectively use their NDIS plans to achieve their personal goals. These professionals tailor services to individual needs within the framework of participants' plan budgets. Support coordination is categorised into three levels based on complexity and participant needs, with corresponding price limits set to ensure a balanced pricing model.

The support coordination market is experiencing significant growth, reflected in the number of providers and the volume of payments. From the first half of 2022 to the same period in 2023, there was an 18% increase in payments amounting to $531 million, demonstrating a growth in demand for support coordination. The market is characterised by a mix of registered and unregistered providers, underscoring a market that is decreasing in concentration.

Providers report a range of challenges, including the financial implications of compliance and registration, which influence their operational costs and pricing strategies. On the participant side, there is a spectrum of satisfaction levels with support coordination services. Positive feedback often highlights the crucial support in navigating NDIS processes, while criticisms tend to focus on issues like the high turnover of coordinators and inconsistency in service quality.

Feedback through the APR captured the complexities of the support coordination sector, reflecting both its critical role in enabling participant outcomes and the operational challenges faced by providers. The dynamic growth of the market, coupled with the feedback from stakeholders, suggests ongoing adjustments and evaluations are necessary to align the services with the evolving needs of participants and the operational realities of providers.

It is considered reasonable that Level 1 support coordination supports currently determined by the DSW Cost Model, continue to be done so, including any applicable changes that occurs for DSW supports.

Recommendation 6

The NDIA should index the price limits for Level 1: Support Connection services and Psychosocial Recovery Coaches services in line with the

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indexation of supports determined by the Disability Support Worker Cost Model in recommendation 1 on 1 July 2024.

Analyses in the chapter highlights that whilst the market for support coordination continues to evolve, there is no evidence to suggest that supply is not meeting demand. In light of significant upcoming reforms recommended by the NDIS Review, which aim to enhance service integration and improve participant outcomes, there is a strong rationale to mitigate potential market disruptions during this transformative period. Any changes to pricing at this point of time would be up for further changes until the reforms in the intermediary sector settle. On balance, it is not recommended to change the price limits of Level 2 and Level 3 support coordinators to ease undue disruption.

Recommendation 7

In alignment with strategic outcomes from the NDIS Review and recognising the current period of significant reform, it is recommended that the NDIA maintain existing price limits for Level 2: Coordination of Supports and Level 3: Specialist Support Coordination.

1.6 NDIS short notice cancellation policy

The NDIS short-notice cancellation policy is designed to protect service providers from financial losses when participants cancel appointments within a 7-day window. Providers can claim up to 100% of the agreed fee if a participant cancels late or fails to show, provided certain conditions are met. These include having a pre-existing agreement with the participant, adherence to the NDIS Pricing Arrangements and Price Limits, and the inability of the provider to find alternative billable work for the affected staff. This policy aligns with the SCHADS Award, which supports fair labour practices and helps manage financial risks for providers.

There is a need to consider a balance in the short-notice cancellation policy for the market. One that allows providers sufficient ability to recover costs with incentives to work with the participants they are supporting to minimise the number of short notice cancellations that occur. Meanwhile, participants are given reasonable time to provide notice for cancellations considering unforeseen circumstances to minimise using NDIS funding to pay for supports they do not receive. This includes unexpected illness, urgent appointments, or changes in personal circumstances.

In the three years from 2020-21 to 2022-23, the costs linked to short notice cancellations nearly doubled, increasing from about $60 million to just under $120 million. This rise highlights the need for effective management of such cancellations. Additionally, therapeutic, and early childhood supports, which account for 37% of all claims, are identified as the categories most affected by cancellations.

Feedback on the cancellation policy from providers and participants indicates varying experiences. Providers note a diverse range of cancellation policies within the NDIS

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market, which can lead to confusion among participants, some of whom only understand the financial implications after being charged for a cancelled service. The diversity in policies reflects varying levels of understanding and implementation across providers. Participants have expressed concerns about the sudden need to cancel due to unpredictable circumstances such as illness or emergencies, leading to calls for more flexible cancellation practices that consider the unpredictable nature of participants' lives.

Providers delivering DSW-related supports, may incur such costs when unable to redeploy employees to other work or set up a make-up shift for the employee. This is as these workers are generally under the SCHADS Award, which has a legislative requirement regarding client cancellations. This requirement is unique for employees engaged under the SCHADS Award in the care sector.

On balance, these observations underscore the operational and financial challenges presented by the NDIS short-notice cancellation policy. The policy aims to balance provider and participant interests, but the required costs and varied experiences suggest a need for continuous evaluation and adaptation to ensure it achieves its goals effectively and fairly.

Recommendation 8

The NDIA should retain the existing 7-day short notice cancellation policy for applicable supports determined by or derived from the Disability Support Worker Cost Model from 1 July 2024. Providers of Disability Support Worker supports must continue to make reasonable effort to find alternative billable work for the staff involved.

For non-DSW related supports (non-SCHADS related), such as therapy services, lack a standardised legislative or Award requirement for client cancellations. Through consultation and research conducted, there is a case that the maximum of 7-day policy may not be necessary for non-DSW supports. There appears to be a greater usage of a 2-day cancellation policy in the sector, particularly among therapy providers, which supports a potential for a shorter cancellation policy.

On balance, the NDIA believes there to be mechanisms and methods already being utilised by the sector to assist participants limiting cancellations which could make the reduction in notice period feasible.

Recommendation 9

The NDIA should adjust the 7-day short-notice cancellation policy for non-Disability Support Worker-related supports to two clear business days from 1 July 2024.

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2. Introduction

2.1 Context

The NDIS was established in 2013 to support people with disability to pursue their goals, to help them to realise their full potential, to assist them to participate in and contribute to society, and to empower them to exercise choice and control over their lives and futures. The NDIS provides funding to eligible individuals ("participants") so that they can purchase, in the open market, the disability related goods and services ("supports") that they need.

The National Disability Insurance Agency (NDIA) monitors and reviews its price control framework and other market settings to determine whether they are still appropriate and reflect the current market conditions.

2.1.1 NDIS Review

On 7 December 2023, the Minister for the NDIS released the independent NDIS Review. The report maps out 26 recommendations with 139 actions to help restore trust, ensure the Scheme's sustainability, and deliver a better NDIS experience for participants.

The Review's recommendations included legislative reform to return the Scheme to its original intent and improve the experience of participants. This included legislation to improve eligibility and access as well as an early intervention pathway for children. Changes will be guided by good legislation and good plans for implementation – developed in partnership with people with disability and the disability community.

Together with government, the NDIA will take the time to carefully considered all recommendations of the NDIS Review including the development of legislation, NDIS process reform – all the way through to implementation.

2.1.2 The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (DRC) was established in April 2019 in response to community concern about widespread reports of violence against, and the neglect, abuse and exploitation of people with disability.

The final report was tabled on 29 September 2023. The report consists of 12 volumes outlining 222 recommendations. It contains recommendations on how to improve laws, policies, structures, and practices to create a more inclusive and just society. A Government taskforce has been established to consider the recommendations, with the NDIA represented within this group.

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2.1.1 Pricing Reform

In the financial year 2024–25, the Australian Government has allocated $5.3 million to the Independent Health and Aged Care Pricing Authority (IHACPA), to work with Department of Social Services (DSS) and the National Disability Insurance Agency (NDIA), to undertake the initial work to reform the National Disability Insurance Scheme (NDIS) pricing arrangements.

The primary objective of this initiative is to enhance the efficiency and effectiveness of NDIS pricing structures. The initial work expected to conduct a comprehensive review of current NDIS pricing mechanisms, as well as develop a new pricing data strategy.

2.2 Annual Pricing Review decision making framework

The NDIA conducts regular, thorough assessments of its pricing framework and market dynamics through the Annual Pricing Review (APR), which integrates insights from the evolving Australian economic landscape, labour market statistics, and sector-specific conditions. This process is reinforced by stakeholder consultations and analyses of impacts from legislative changes, and market movements, ensuring data-driven and relevant pricing strategies for NDIS-related supports.

Figure 1: APR Conceptual Framework



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2.3 Terms of Reference for the Annual Pricing Review

The APR acknowledges the comprehensive insights from the Independent NDIS Review and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (DRC). While these reviews offer extensive recommendations for systemic reform, this APR focusses specifically on non-structural adjustments to the current price settings. It aims to implement immediate, impactful improvements with the existing framework of pricing established in the NDIS Pricing Strategy 2019, ensuring ongoing supply of support and continuity of access to services for NDIS participants, while broader structural reforms are considered for future implementation by the Australian Government.

The APR will examine, through engagement with participants, providers and community and government stakeholders and targeted research, whether the Scheme's existing price control framework (pricing arrangements and price limits) continue to be appropriate or if modification is required.

The APR will have an increased focus on participants, with a dedicated consultation paper to gather participants' perspectives. This participant engagement will ensure that the APR is inclusive of the voices of both providers and participants.

In particular, the APR will review the pricing arrangement and price limits:

a) that apply to supports delivered by disability support worker (DSW) by updating the *NDIS Cost Model for Disability Support Workers*;

b) for therapy supports to ensure participants receive value for money, while providers strive to improve quality of service and increase efficiency, with a particular emphasis on pricing benchmarks;

c) for support coordination to promote service quality and value for money, with a focus on participants experiences when utilising support coordinators to oversee their supports;

d) in relation to the NDIS Cancellation policy, which changed from two days to seven days in line with the Social, Community, Home Care and Disability Services (SCHADS) Award. The analysis will examine the impact on participants choice and control.

2.4 Consultation overview

The 2023-24 APR consultation commenced on 25th January 2024 and concluded on 10 March 2024 for providers and 17 March 2024 for participants. This year's consultation featured the publication of two key documents: a Provider Consultation Paper and a Participant Consultation Paper. These papers invited a wide range of stakeholders, including providers, participants, community members, and government entities, to contribute their perspectives and expertise. The robust response, especially from participants via the Form.io survey, underscores the community's active participation and the effectiveness of using varied submission

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formats to accommodate diverse needs. A total of 912 submissions were recorded, a significant increase from the previous APR's 304 submissions.

Submissions were categorised as follows:

- **Providers:** Contributed 353 submissions, offering insights and feedback from a service delivery perspective.
- **Participants**: Contributed 559 submissions, broken down as:
    - 546 submissions received through the Form.io platform
    - 11 submissions were made through traditional paper forms.
    - 2 submissions were presented in an easy read format.

A summary of submissions to the Consultation Paper can be found in Appendix A and throughout the report.

2.4.1 Consultations with other government insurance and funding schemes

The NDIA collaborated with 16 Commonwealth and State Schemes to obtain their therapy pricing. Responses from 13 schemes were received. Schemes that assisted with information were:

- Catastrophic Injuries Support (CIS) Scheme,
- ComCare,
- Department of Veterans' Affairs (DVA),
- Home and Community Care Program for Younger People (HACC-PYP),
- Lifetime Support Scheme (LSS),
- Motor Accidents Insurance Board (MAIB),
- Medicare Benefit Scheme (MBS),
- National Injury Insurance Scheme Queensland (NIISQ),
- Return To Work SA (RTWSA),
- State Insurance Regulatory Authority (SIRA),
- Victorian Transport Accident Commission (TAC),
- WorkSafe VIC, and
- WorkCover WA.

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2.5 Pricing Arrangement Reference Group

The work of the APR was overseen by the NDIA's Pricing Arrangement Reference Group, which provides advice, through the Chief Executive Officer of the NDIA, to the NDIA Board on price control arrangements for the NDIS. This is to ensure price regulation activities and decisions are coordinated to support the best possible outcomes for NDIS participants during the transition to a competitive marketplace. The current members of the Pricing Arrangement Reference Group are:

- **Flavio Menezes** is a leading economist in market design, auction theory, competition, regulation, and incentives. He is a Professor of Economics and the Director of the Australian Centre of Business and Economics at the University of Queensland. He is also the Chair of the Queensland Competition Authority. As a highly regarded expert, he is sought after for his economic counsel by various private and public organisations.
- **Matthew Clarke** works as an Associate Director at Marsden Jacob specialising in price regulation, cost recovery and funding. He has a proven track record of conducting complex pricing reviews for state, territory, and federal government agencies across sectors.
- **Felicity McNeil PSM** has a track record of managing complex healthcare budgets including such as the Pharmaceutical Benefits Scheme (PBS) and other subsidy national programs, both within the Health and Finance portfolios., which she has since channelled into her volunteer work helping patient and clinical groups to participate in government processes.
- **Deborah Cope** brings over 35 years of experience in analysing, reforming, and implementing social, economic, and environmental policies across all levels of government. She was a member of the New South Wales (NSW) Independent Pricing and Regulatory Tribunal (IPART), and the Principal of PIRAC Economics.
- **Jim Cox, PSM** is Deputy Chair of the Australian Energy Regulator. He contributes advice from his experience in price regulation, economics, and social policy issues.

2.6 Pricing Interdepartmental Committee

The Pricing Interdepartmental Committee was established in November 2022 to discuss strategic matters related to pricing in the NDIS and its wider implications within the current economic environment. This forum allows the NDIA to proactively work with key Australian Public Service stakeholders with broader Government considerations to NDIS pricing-related matters.

The committee consists of representatives from Department of Social Services, Department of Finance, NDIS Quality and Safeguards Commission (NDIS Commission) and the Commonwealth Treasury.

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3. Domestic economic conditions and the care economy

3.1 Pricing regulation in the current economic environment

Australian economic conditions can impact the efficiency and sustainability of the market for disability goods and services and therefore influence whether the NDIS price control framework continues to be appropriate or if modification is required.

The NDIS is part of the care and support economy[2] and the broader Healthcare and Social Assistance (HCSA) sector[3]. Economic trends in these sectors could potentially affect the efficiency and sustainability of the disability market. The NDIS both impacts, and is impacted by, the care and support economy and the HCSA sector, particularly the care and support economy as the NDIS comprises a greater proportion of this sector relative to the HCSA sector. However, given the diversity of the care and support economy and the HCSA sector, it is important to exercise caution when drawing comparisons between trends in the HCSA sector and the specific trends within the NDIS workforce.

Data on economic conditions suggest strong demand for health and disability services, a tight labour market for health and disability related workers, as well as higher costs given high general inflation and wage inflation.

Businesses in the care and support economy are reporting strong confidence in the outlook for their industry. Despite the slowing in Australian economic growth, the HCSA sector is resilient due to the 'non-discretionary' nature of the services provided (generally necessities) and continued demand from population growth and an ageing population. The HCSA is also heavily reliant on funding from the public sector and the NDIS is a major and fast-growing item of government expenditure.

High inflationary environment can increase cost pressures on providers delivering supports to NDIS participants such that these providers may then be under pressure to raise prices for their services. The HCSA sector had significant inflation and wage growth in the year to December 2023, above the all-industries' growth rates, suggesting strong upward pressure on input costs and wages. One of the reasons

[2] This comprises the paid provision of disability support services, early childhood education and care, veterans' care, and aged care. Department of the Prime Minister and Cabinet. (2023). *Draft National Strategy for the Care and Support Economy.* https://www.pmc.gov.au/resources/draft-national-strategy-care-and-support-economy/summary

[3] The Health Care and Social Assistance sector includes organisations mainly engaged in providing human health care and social assistance such as hospitals, General Practitioners and specialists, allied health, diagnostics, aged and other residential care, child care and disability care.

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for wage inflation in the sector has been increases in Award wages, such as a 15% increase in minimum wages for direct care employees working in aged care.

Jobs and Skills Australia considers many NDIS-related occupations to be in "shortage". This includes aged and disabled carers, personal care and special care workers, physiotherapists, speech professionals and audiologists, occupational therapists, and psychologists. Some of these occupations have vacancy numbers that are high compared with their total occupational employment levels (i.e., speech professionals and audiologists, occupational therapists, and physiotherapists).

3.2 NDIS supports

Disability Support Workers (DSWs) are an essential part of the NDIS, bridging the gap between healthcare services and daily living assistance for individuals with disabilities. DSWs provide personalised support that enhances the independence of NDIS participants.

Therapy supports, including early childhood interventions, are also an essential part of the NDIS by playing an important role in assisting participants to achieve their personal goals. These supports are delivered by a diverse range of professionals, such as Occupational Therapists (OT), Speech Pathologists (SP), Physiotherapists, Psychologists, and many others.

3.3 Economic outlook

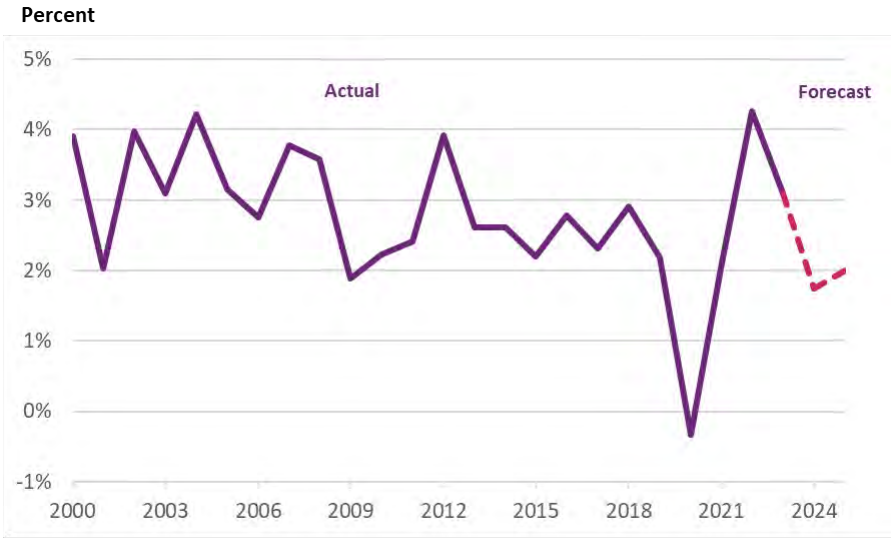
Economic growth, as measured by real Gross Domestic Product (GDP), has been slowing from above average rates, given lower household consumption from high inflation and increased interest rates[4]. The Commonwealth Treasury projects real GDP growth to be 1.75% for 2023–24 before rising in the following year[5]. See Figure 2 for historical and forecast GDP growth outlook.

[4] Commonwealth Treasury. (2024). *Budget 2024-25: Budget Strategy and Outlook Budget Paper No. 1*. https://budget.gov.au/content/bp1/download/bp1_2024-25.pdf

[5] ibid

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Figure 2: Australian Real GDP Growth from 2000 to Forecasted 2024



Businesses in the care and support economy are reporting positive business confidence in the outlook for their industry[6]. According to the Roy Morgan Business Confidence survey in April 2024, general business confidence is still below the neutral level and the average tracked since December 2010 but the community services industry's confidence is positive[7]. The HCSA sector is resilient to slowdowns in Australian economic activity due to the 'non-discretionary' nature of the services provided (generally necessities) and continued demand from population growth and an ageing population. The HCSA is also heavily reliant on funding from the public sector.

3.4 Inflation

High inflation has had widespread impacts across the economy over the past three years. High inflationary environment can increase cost pressures on providers delivering supports to NDIS participants, such as energy, logistics, increased interest rates and property costs. These providers may then be under pressure to raise prices for their services.

Moreover, headline inflation, as measured by the Consumer Price Index (CPI) (changes in the price of a fixed basket of goods and services that are representative of items bought by households), was 3.6% in the year to March 2024, above the

[6] Roy Morgan. (2024). *Roy Morgan Business Confidence improves marginally in April – up 1.3pts to 99.3 before next week's pre-election Federal Budget.* https://www.roymorgan.com/findings/roy-morgan-business-confidence-april-2024

[7] ibid

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Reserve Bank of Australia (RBA) target of 2% to 3% [8]. The RBA predicts inflation to fall to be within the target range by December 2025, given easing supply constraints and a slowing of domestic activity from high interest rates[9].

Inflation in the health industry ('Health CPI[10]') has run above the economy wide (all-industries) rate for most of the past decade, suggesting relatively strong cost pressures in the HCSA sector[11]. Between December 2021 and June 2023, all industries CPI outpaced Health CPI given significant inflationary pressures across the economy, but Health CPI has returned to being higher than the all-industries CPI (see Figure 3) [12].

Figure 3: All Industries CPI and Health Specific CPI Growth from 2016 to 2023



Source: ABS Consumer Price Index

[8] Australian Bureau of Statistics. (2024). *Consumer Price Index, Australia March Quarter 2024: 6401.0 Consumer Price Index, Australia, TABLES 1 and 2. CPI: All Groups, Index Numbers and Percentage Changes and TABLE 7. CPI: Group, Sub-group and Expenditure Class, Weighted Average of Eight Capital Cities, Original.* https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release

[9] Reserve Bank of Australia. (2024). *Statement on Monetary Policy – May 2024.* https://www.rba.gov.au/publications/smp/2024/may/

[10] The health industry includes the health care and social assistance sector.

[11] Australian Bureau of Statistics. (2024). *Consumer Price Index, Australia March Quarter 2024: 6401.0 Consumer Price Index, Australia, TABLES 1 and 2. CPI: All Groups, Index Numbers and Percentage Changes and TABLE 7. CPI: Group, Sub-group and Expenditure Class, Weighted Average of Eight Capital Cities, Original*. https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release

[12] ibid

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3.5 Labour market conditions

The labour market has been strong relative to historical averages. The seasonally adjusted unemployment rate in March 2024 was 3.8%, lower than the ten-year historical average of 5.3%[13]. About 336,900 additional people became employed over the year to March 2024 (seasonally adjusted, 2.4% year-on-year growth)[14]. The labour market is still forecast to remain strong relative to historical averages over the coming years as economic conditions relax. The unemployment rate is expected to rise to 4% in the June quarter 2024 and then is forecasted to peak at 4.5% in the June quarter 2025[15].

The HCSA sector is the largest employing sector in the economy and employment in the sector is growing quickly. The sector had 2.23 million workers in February 2024, equating to 15.6% of total Australian employment[16]. The sector has grown at a higher average rate over the past ten years compared to all other sectors (see Figure 4)[17]. In the year to February 2024, the number of new entrants was 112,940 persons (about 5% of the total HCSA workforce)[18].

[13] Australian Bureau of Statistics. (2024). *Labour Force, Australia March 2024: Unemployment rate, Australia, August 1966 to March 2024, seasonally adjusted*. https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/mar-2024

[14] Australian Bureau of Statistics. (2024). *Labour Force, Australia March 2024: 6202.0 Labour Force, Australia Table 1. Labour force status by Sex, Australia - Seasonally adjusted* https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/mar-2024

[15] Commonwealth Treasury. (2024). *Budget 2024-25: Budget Strategy and Outlook Budget Paper No. 1*. https://budget.gov.au/content/bp1/download/bp1_2024-25.pdf

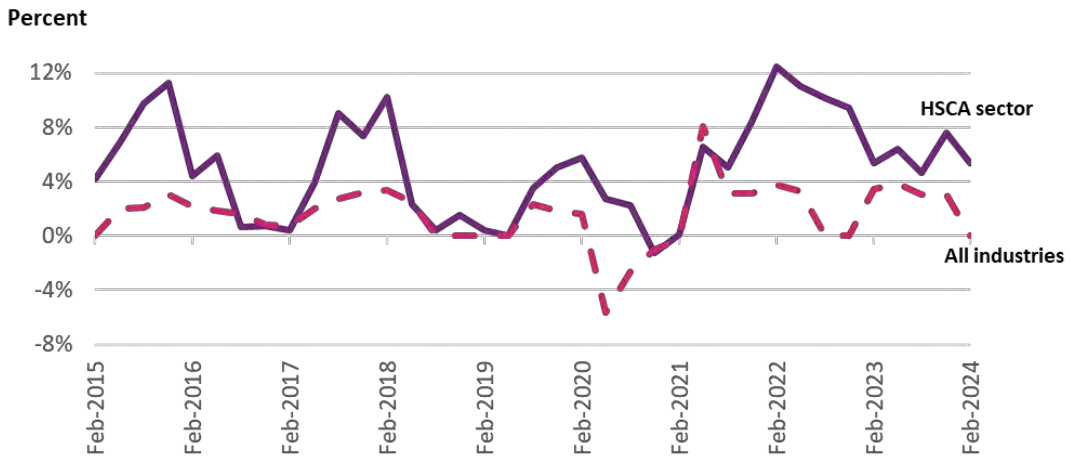
[16] Australian Bureau of Statistics. (2024). *Labour Force, Australia, Detailed February 2024, seasonally adjusted*. https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia-detailed/latest-release#about-this-release

[17] ibid

[18] ibid

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Figure 4: Employment Growth in All Industries and HCSA Sector from 2015 to 2024



Source: ABS Labour Force, Australia, Detailed

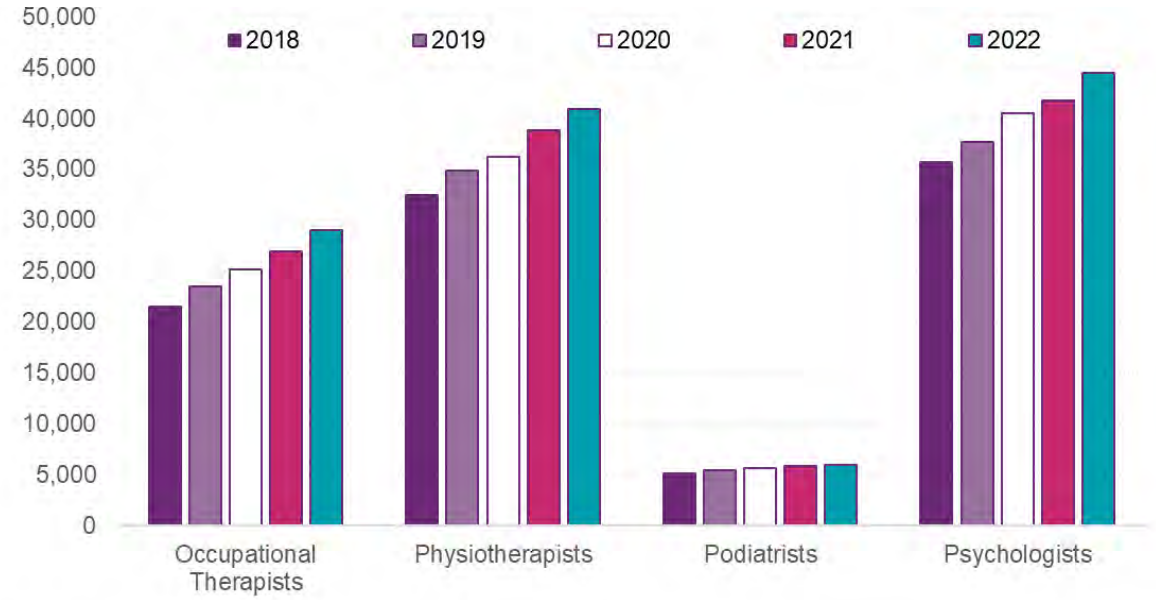
It is estimated that total DSW employment is currently about 300,000 persons. As published in the NDIS Review in December 2023, there were an estimated 280,000 DSWs as of 2021-22, representing about 14% of total HCSA employment.

There are about 170,000 therapists in Australia[19]. The most recent data from the Australian Health Practitioners Registration Agency (AHPRA), shows an increase in registered therapists from 2018 to 2022, with Psychologists, Physiotherapists, Occupational Therapists, and Podiatrists collectively growing by 27% (see Figure 5). Specifically, Psychologists saw a 24.3% increase, and Physiotherapists increased by 25.9%, reflecting a growing workforce responding to heightened healthcare demands, including from NDIS participants.

[19] Australian Government. (2023). *Employment Projections*. https://labourmarketinsights.gov.au/our-research/employment-projections/

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Figure 5: Number of Registered Therapists from 2018 to 2022



Source: Department of Health and Aged Care

Jobs and Skills Australia considers many NDIS-related occupations (relevant for the broader HCSA too) to be in shortage - aged and disabled carers, personal care and special care workers, physiotherapists, speech professionals and audiologists, occupational therapists, and psychologists[20], supported by record high numbers of vacant positions in NDIS-related occupations. There were 13,000 vacant positions in March 2024 for these NDIS-related occupations (see Figure 6)[21]. The occupations with the highest number of vacancies were aged and disabled carers, nursing support and personal care workers and occupational therapists[22]. Figure 7 shows the comparison between job vacancies and total employees for each occupation in the NDIS-related occupations. The occupations with the highest proportion of vacancies relative to their total occupational employment levels are speech professionals and audiologists, occupational therapists, and physiotherapists.

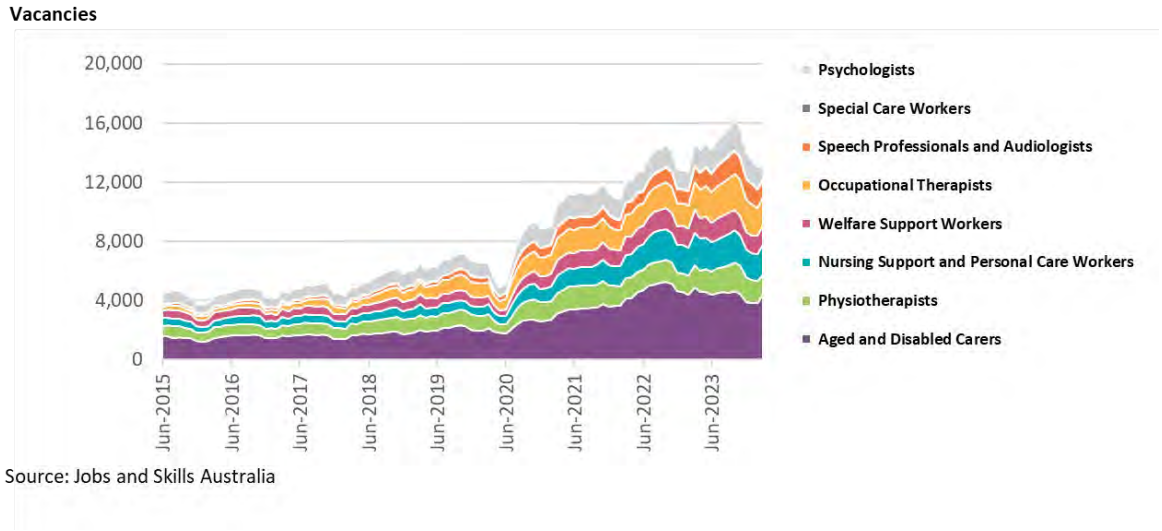
[20] Jobs and Skills Australia. (2024). *Jobs and Skills Atlas*. https://www.jobsandskills.gov.au/jobs-and-skills-atlas-dashboard?nav=state&region=aus&tab=state-occupations; an occupation is in shortage when employers are unable to fill or have considerable difficulty filling vacancies for an occupation or cannot meet significant specialised skill needs within that occupation, at current levels of remuneration and conditions of employment and in reasonably accessible locations.

[21] *Nowcast of Employment by Region and Occupation*. https://www.jobsandskills.gov.au/data/nero/nero-dashboard

[22] ibid

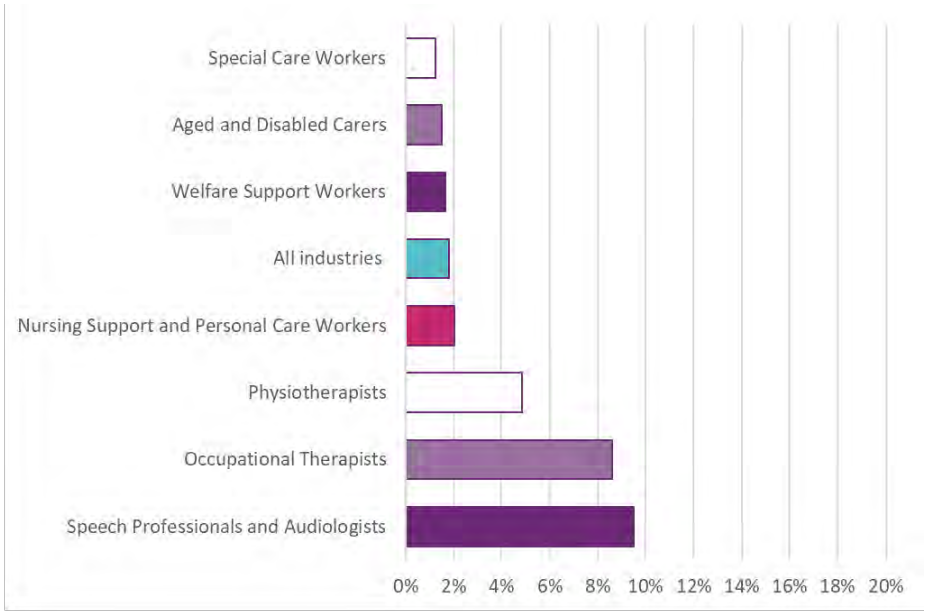
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Figure 6: Job Vacancies in NDIS-related Occupations from 2015 to 2023



Source: Jobs and Skills Australia

Figure 7: Job Vacancies compared to Total Occupational Employment at November 2023[23]



Source: Jobs and Skills Australia; ABS Labour Force, Australia, Detailed

[23] Note psychologists have not been included as the employment data available also includes psychotherapists.

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Data from Jobs and Skills Australia in December 2023 indicates that there may have been an improvement in matching community and personal service workers to vacancies, in line with a softening of tight labour market conditions. Over the quarter, fill rates (percentage of advertised vacancies filled by occupation) for vacant positions, applicants per vacancy, qualified applicants per vacancy[24], and suitable applicants per vacancy improved[25], particularly in regional areas[26]. This trend is the same for all occupations[27].

Continued net immigration could alleviate some of the current labour supply pressures in the care and support economy workforce, as could growth in the education and training for these occupations. Overseas-born workers comprise a large and growing proportion of the care and support workforce in Australia (40%)[28]. Migration levels have recovered strongly since 2020-21 (COVID-19 related border closures), although levels are forecast to reduce significantly due to migration reforms[29]. Those studying health-related subjects (all students studying at higher education institutions) increased by 4.2% per annum on average between 2012 and 2022[30].

The disability workforce is expected to increase significantly to support the forecast growth in the NDIS and the HCSA sector. The Australian Government projects employment in the HCSA sector to grow by 257,300 people (or 12.1%) over the five years to May 2028, the fastest growth of all 19 Australian and New Zealand

[24] Qualified applicants are the applicants who are assessed by employers as meeting the required qualification criteria of an advertised vacancy.

[25] Suitable applicants are those who are deemed by employers to be suitable for the job advertised.

[26] Jobs and Skills Australia. (2024). *Skills Shortage Quarterly Report - December 2023*. https://www.jobsandskills.gov.au/publications/skills-shortage-quarterly-december-2023

[27] ibid

[28] Jobs and Skills Australia. (2021). *Care Workforce Labour Market Study Report Summary*. https://www.jobsandskills.gov.au/sites/default/files/2023-11/care_workforce_labour_market_study_-_report_summary.pdf

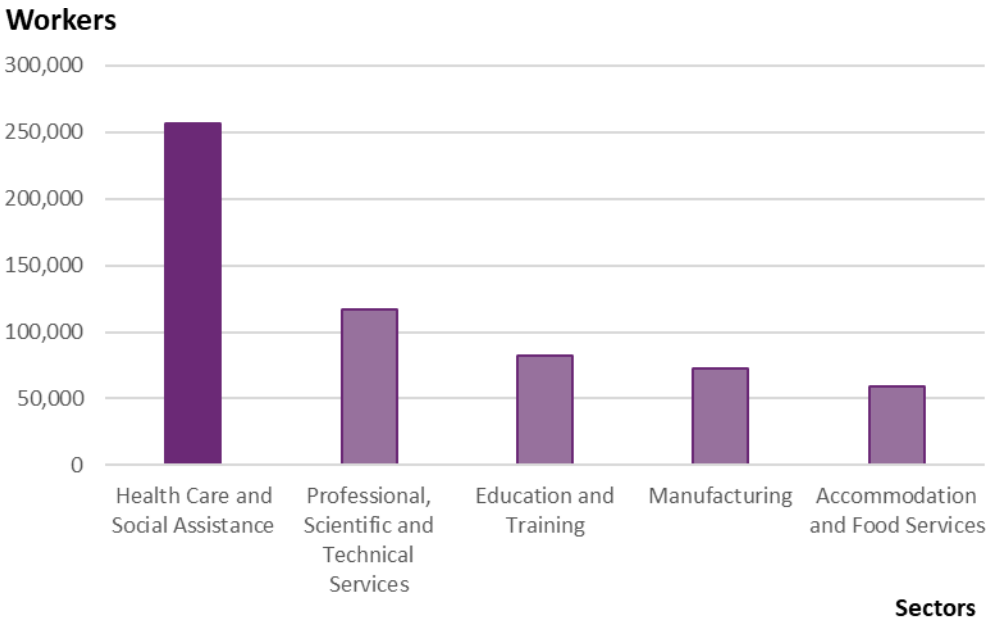
[29] Australian Bureau of Statistics. (2023). *National, state and territory population June 2023*. https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release; Commonwealth Treasury. (2024). *Budget 2024-25: Budget Strategy and Outlook Budget Paper No. 1*. https://budget.gov.au/content/bp1/download/bp1_2024-25.pdf; Commonwealth Treasury. (2023). *Mid-Year Economic and Fiscal Outlook 2023–24*. https://budget.gov.au/content/myefo/download/myefo2023per centE2per cent80per cent9324.pdf; Crowe, D. (2023, December 11). Australia's migrant intake blew out to 510,000. Students are central to the plan to halve that. *Sydney Morning Herald.* https://www.smh.com.au/politics/federal/australia-s-migrant-intake-blew-out-to-510-000-students-are-central-to-the-plan-to-halve-that-20231210-p5eqcg.html

[30] Department of Education. (2024) *Student Data*. https://www.education.gov.au/higher-education-statistics/student-data

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Standard Industrial Classification (ANZSIC) industries[31] and more than double the next closest sector in the economy (Professional, scientific, and technical services) (Figure 8). Employment growth for aged and disabled carers is expected to be 42,600 people between May 2023 and May 2028, equating to a total growth rate of 14.3%[32]. Employment projections show a 17.2% growth for therapy professionals by 2028 (see Table 1).

Figure 8: Projected Employment Growth for Five Largest Sectors from May 2023 to May 2028



Source: Jobs and Skill Australia

[31] Australian Government. (2023). *Employment Projections*. https://labourmarketinsights.gov.au/our-research/employment-projections/

[32] Australian Government. (2023b). *Employment Projections*. https://www.jobsandskills.gov.au/data/employment-projections

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Table 1: Employment Numbers and Projected Employment Growth for Therapy Sector

Occupation Code	Occupation	Employment Level – May 2023 ('000)	Projected employment level – May 2028 ('000)	Projected employment growth – five years to May 2028	Projected employment growth – five years to May 2028 (%)
2527	Audiologists and Speech Pathologists/Therapists	15,100	17,600	2,500	16.6%
2522	Complementary Health Therapists	8,400	9,800	1,400	17.0%
2721	Counsellors	29,700	34,200	4,500	15.1%
2511	Nutrition Professionals	8,200	9,500	1,200	15.1%
2524	Occupational Therapists	26,000	30,400	4,400	16.9%
2525	Physiotherapists	37,300	43,900	6,500	17.5%
2526	Podiatrists	5,900	7,000	1,000	17.6%
2723	Psychologists	41,800	48,600	6,800	16.3%

Source: Job and Skills Australia[33]

3.6 Wage growth

The rate of wage growth in the economy has been increasing since June 2020. Wage growth (as measured by the all-industries' Wage Price Index excluding bonuses) rose to 4.1% in the year to March 2024[34]. The Commonwealth Treasury projects wage growth to be 4% in 2023-24 before decreasing in the following two years[35].

[33] Australian Government. (2023). *Employment Projections*. https://labourmarketinsights.gov.au/our-research/employment-projections/

[34] Australian Bureau of Statistics. (2024). *Wage Price Index, Australia March 2024, All Industries Excluding Bonuses Original*. https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/wage-price-index-australia/mar-2024

[35] Commonwealth Treasury. (2024). *Budget 2024-25: Budget Strategy and Outlook Budget Paper No. 1*. https://budget.gov.au/content/bp1/download/bp1_2024-25.pdf

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The HCSA sector had significant wage growth of 5.3% in the year to March 2024, above the all-industries' growth rate, suggesting strong upward pressure on wages for care and support sector workers (see Figure 9)[36].

One of the reasons for wage inflation in the sector has been increases in Award wages, such as a 15% increase in minimum wages for direct care employees working in aged care[37] (Social, Community, Home Care and Disability Services (SCHADS) Industry Award, Aged Care Award, and Nurses Award) from 1 July 2023, an increase in the national minimum award wages of 5.75% from 1 July 2023, and an increase in the minimum wage from 1 July 2023[38].

The transferability of skills and qualifications across the care and support economy and the HCSA sector means that NDIS providers need to compete for workers with aged care, health care and childcare services. This competition is influenced by various factors such as relative wages.

Figure 9: All Industries and HCSA Sector Wage Price Index from 2015 to Forecasted 2027



Source: ABS National Accounts, Commonwealth Treasury

[36] Australian Bureau of Statistics. (2024). *Wage Price Index, Australia March 2024, Excluding Bonuses Original*. https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/wage-price-index-australia/latest-release#industry-wage-growth

[37] Also the most senior food services employees.

[38] Fair Work Commission. (2023). *15% wage increase for aged care sector*. https://www.fairwork.gov.au/newsroom/news/awr-2023#:~:text=Awards%20are%20legal%20documents%20that%20outline%20the%20minimum,period%20starting%20on%20or%20after%201%20July%202023

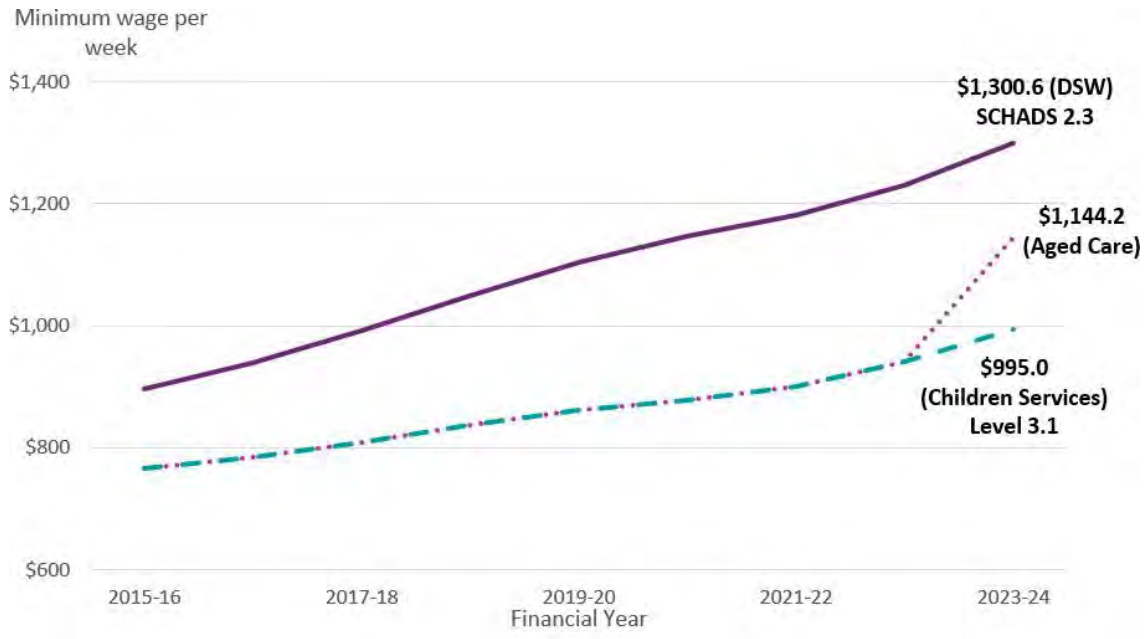
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3.7 Disability support worker wage

The Award wage system is one of the determinants of wages for disability support workers (DSWs), and thus the cost of many related NDIS supports. Many DSWs delivering NDIS supports are paid under Schedule B of the SCHADS Award.

Minimum weekly payments for DSWs continue to be above the comparable industries in the care and support economy when considering a similar type of worker (Figure 10). Note, it is considered reasonable to match a DSW with the Aged Care Award Level 4 worker. The NDIA does acknowledge some supports delivered to NDIS participants could be delivered by other types of workers classified across other types of aged care employees, such as level 3 or level 5. This matching is based on the type of work generally performed by this type of worker (personal care tasks by a "personal care worker grade 3") and personal care support provided require working under limited supervision. Further the Aged Care Award level 4 worker can require a qualification at Certificate 3 or higher, while the SCHADS Award Level 2 worker requires a Certificate 4 or higher.

Figure 10: Weekly Minimum Wage for SCHADS Award, Aged Care Award, Children Services Award for Comparable Workers



Source: Fair Work Ombudsman

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Table 2 displays a comparison of wage data from major job platforms as of February 2024, demonstrating that DSWs earn, on average, higher hourly wages compared to aged care and children services workers.

Table 2: Relative Advertised Wages of Disability, Aged Care and Children Services Workers as at February 2024 (Australian Average Wages, dollars per hour)

Occupation	Employed	Seek	Indeed	PayScale
Disability support worker	280,000 (2021-22)	$35 - $40	$36.79	$29.37
Aged care worker	195,000 (2020)	$20 - $30	$33.69	$24.83
Children services worker	216,000 (2021)	$25 - $30	$31.29	$24.47

Source: NDIS Review, Department of Education, Committee for Economic Development of Australia (CEDA). Estimates exclude nurses and allied health professionals. Wages from Seek, Indeed and PayScale

3.8 Aged Care Award wage changes

On 15 March 2024, the Fair Work Commission (FWC) made the decision for further adjust wages for direct care and indirect care employees in the aged care sector of between 18.2% to 28.5%, inclusive of the interim 15% increase already awarded from 1 July 2023[39]. It is still too early to determine the impacts of this decision on wage increases for aged care workers, which brings aged care workers roughly on par with disability workers, but this warrants ongoing monitoring. The NDIA's DSW Cost Model uses the SCHADS Award, social and community services employee, Level 2, pay point 3 as the basis of setting the standard disability support worker. The 2022-23 Annual Pricing Review considered this to be appropriately matched with the Aged Care Award Level 4 worker.

In the proposed amendments to the Aged Care Award classifications and definitions found in Schedule I (page 68) of the draft determination and award mark-up, the current "Aged care employee – direct care – level 4" will translate into the proposed classification of "Aged care employee – direct care – level 3 - Qualified".[40]

This matching is based on the type of work generally performed by this type of worker, personal care tasks and personal care support requiring working under limited supervision. Further, the proposed *Aged Care Award* "Aged care employee – direct care – level 3 – Qualified" requires a Certificate III in Individual Support

[39] Fair Work Commission. (2024). Summary of Decision 15 March 2024: Work value case – Aged care industry – Stage 3. https://www.fwc.gov.au/documents/decision-summaries/2024fwcfb150-summary.pdf

[40] Draft determination and award mark-up - Aged Care Award 2010 (fwc.gov.au)

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(Ageing) or equivalent, while the SCHADS Award Level 2 worker requires a certificate 4 or higher.

The NDIA does acknowledge some supports delivered to NDIS participants could be delivered by other types of workers classified across other Schedules or Awards. For instance, the proposed new classifications for aged care employee – direct care - level 2 or level 4.

Comparison of these Award worker minimum wages shows the wage difference between comparable workers continues to narrow between the disability and aged care sector. From 1 July 2023, the weekly pay rate for the full and part time SCHADS Award Level 2, pay point 3 was $1,300.60 ($34.23 per hour).[41] The equivalent to the full and part time *Aged Care Award* "Aged care employee – direct care – level 4" from 1 July 2023 was $1,144.20 ($30.11 per hour).[42]

The proposed increase to the full and part time *Aged Care Award* "Aged care employee – direct care – level 3 – Qualified" is expected to raise the minimum wage for this worker to $1223.90 ($32.21 per hour), a proposed pay increase of 23% from prior to these Aged Care reform, inclusive of the previous 15% interim increase.[43] This would equate to a difference of $76.7 (approximately $2.02 per hour), with the SCHADS Level 2.3 worker wage rate to being 6.7% higher.

Overall, the NDIA acknowledges that adjustments to Aged Care worker wages and other reforms being undertaken in aged care. However, given the pay of disability support workers still considered being competitive, on balance the NDIA expects the impact of these changes to the cost of similarly skilled workers to be limited in the short run. Moreover, these changes may impact workforce availability across the broader care sector, so the NDIA should continue to monitor these reforms as suggested in 2022-23 APR.

[41] *Social, Community, Homecare And Disability Services Industry Award 2010* pay guide effective 1 July 2023 found at Pay guides - Fair Work Ombudsman.

[42] *Aged Care Award 2010* pay guide effective 1 July 2023 found at Pay guides - Fair Work Ombudsman.

[43] Draft determination and award mark-up - Aged Care Award 2010 (fwc.gov.au)

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4. Disability Support Worker related supports

Disability Support Workers (DSWs) are an essential part of Australia's care and support workforce, bridging the gap between healthcare services and daily living assistance for individuals with disabilities. DSWs represent the sector's diversity, working across various settings, from private homes to community-based programs, providing personalised support that enhances the independence of NDIS participants.

4.1 DSW Cost Model

The NDIA uses the Disability Support Worker Cost Model (DSW Cost Model) to estimate the cost that a reasonably efficient provider would incur in delivering a billable hour of support. Its primary aim is to ensure that pricing reflects the cost-of-service delivery.

4.1.1 Parameters of the DSW Cost Model

In 2022, the NDIA simplified the DSW Cost Model. The simplification was prompted by a recognition that the model's specificity could inadvertently encourage rigid adherence to its parameters as de facto targets, potentially restricting innovation, and adaptability of providers. By consolidating the cost categories into direct worker employment costs, operational overheads, and corporate overheads, the NDIA aimed to reflect the nuanced ways providers manage their resources. The current parameters of the cost model are outlined below:

- **Base salary and shift loadings:** The cost model is based on permanent worker costs. These are linked to *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award) wage levels 2.3, 2.4/3.1, 3.2 and 4.4.
- **Direct on-costs:** Includes Superannuation entitlements (currently 11%, 11.5% from 1 July 2024), Annual Leave entitlements (20 days), Personal Leave entitlements including domestic and family violence leave (10.3 days), Long Service Leave entitlements (4.3 days), and Employee Allowances.
- **Operational overheads**: Covers supervision, quality and safeguarding, training, and workforce rostering costs, alongside provisions for utilisation rates and the mix of permanent versus casual staff and the extent to which overtime is utilised.
- **Corporate overheads**: Accounts for essential business functions such as accounting, human resources, information technology, legal, and marketing.

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- **Margin**: Which represents the return that the provider makes because of the provision of working capital to the business.
- **Temporary loading:** Acknowledges additional costs arising from COVID and SCHADS Award adjustments, introduced on 1 July 2022.

The DSW Cost Model is driven by the relevant SCHADS Award wage movements, operates on a multiplicative basis where operational and corporate overheads, as well as profit margins, are determined as a percentage of the direct costs, including wages and on-costs. Any changes in the wage rates directly affects the entire model's cost structures. Moreover, temporary adjustments, applied as a percentage of all costs at the end of calculations, recognise additional variables like COVID-19 impacts and SCHADS Award updates.

In setting NDIS price limits for DSW related supports, the model is an important approximation, considered alongside market dynamics, award conditions, and regulatory requirements such as minimum wages and superannuation contributions.

4.1.2 Applicable industrial award

The national award for DSWs is the SCHADS Award. The NDIA recognises that some DSWs are classified as Home Care Employees and others are classified as Social and Community Services Employees under the SCHADS Award, and some DSWs are employed under Enterprise Bargaining Agreements (EBAs). However, these EBAs must leave the worker no worse off than they would be under the applicable industry Award. The NDIA therefore considers the conditions set out in the SCHADS Award to be the appropriate foundation of the DSW Cost Model.

The NDIA recognises that providers can employ DSWs with different skill levels and levels of experience to meet the different needs of participants. The Cost Model therefore has different sets of cost assumptions for four types of workers (DSW Level 1, DSW Level 2, DSW Level 3 and DSW Level 4). This does not mean these are the only types of workers who can deliver NDIS supports through DSW-related supports.

4.1.3 DSW price limit growth

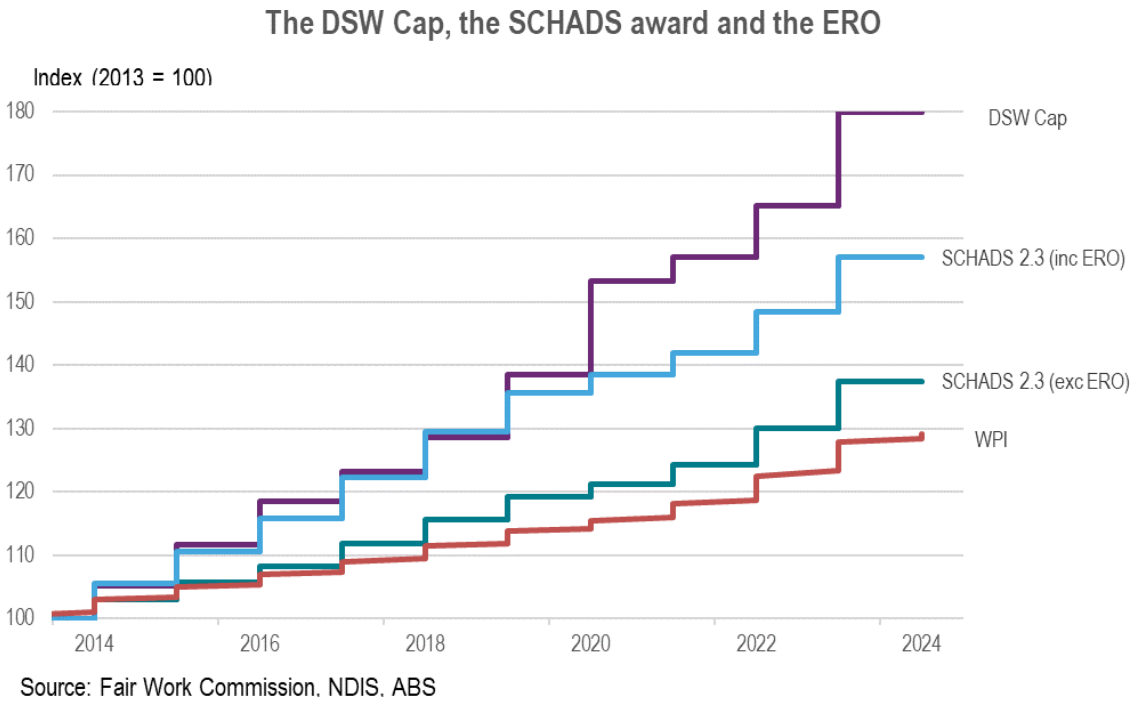
Standard DSW-related supports in the Cost Model use the SCHADS Award, at Schedule B, level 2.3. Level 2.3 has seen, on average, an annual increase of 6.1% since 2013, outpacing the Wage Price Index (WPI) by over 2% (see Figure 11). These rises, mandated by the FWC through the Award system, account for approximately 80% of the increase in NDIS DSW price limits.

The Equal Remuneration Order (ERO), issued by the FWC in 2012, has significantly influenced the SCHADS Award growth. The ERO addressed gender-based pay disparities in community service roles, mandating special pay rises in addition to the regular annual increases through the Award System until 2020. As a result, the SCHADS Award's minimum pay rate for level 2.3 is now 23% higher than it would

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have been without the ERO. With the ERO fully phased in, future growth in the SCHADS Award is likely to align with national minimum wage determinations.

Figure 11: NDIS DSW Price Limit Compared to SCHADS Award and ERO Growth Since 2013



4.2 Scheme statistics

In the six-months to December 31, 2023, a total of 283,406 participants, which represents 44% of the 646,449 active participants as of December 31, 2023, received DSW-related supports through their plans. This is an increase from the previous period (July to December 2022), with the number of participants rising by 12%. Active providers also saw growth, with a 21% increase from 101,459 to 122,857.

Payments on DSW-related supports during this period reached $13 billion, accounting for 64% of all NDIS payments, which totalled $20.4 billion. This is a 27% increase in DSW-related support payments compared to the same period in the previous year, indicating growing market for DSW-related supports and services. Table 3, Table 4, Table 5 and Figure 12 further illustrate this growth.

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Table 3: DSW-Related Supports Scheme Statistics – All Providers

Statistics	July – December 2022	July – December 2023	Percentage Change
Number of NDIS participants	253,558	283,406	+12%
Number of active providers	101,459	122,857	+21%
Amount claimed by active providers of DSW-related supports ($ billion)	$10.3	$13.0	+27%
Average amount claimed by all active providers of DSW-related supports	$101,324	$106,180	+5%

Table 4: DSW-Related Supports Scheme Statistics – Registered Providers

Statistics	July – December 2022	July – December 2023	Percentage Change
Number of active registered providers of DSW-related supports	9,286	8,697	-6%
Amount claimed by registered providers of DSW-related supports ($ billion)	$7.9	$9.4	+19%
Average amount claimed by registered providers of DSW-related supports ($ million)	$0.9	$1.1	+27%

Table 5: DSW-Related Supports Scheme Statistics – Unregistered Providers

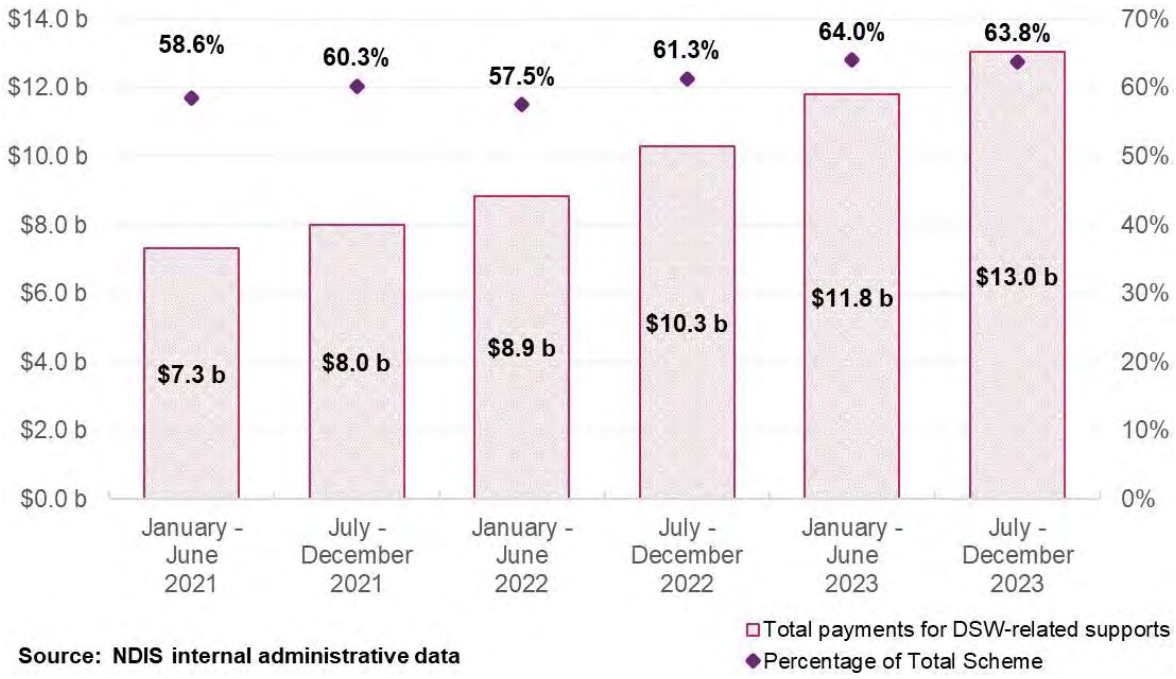
Statistics	July – December 2022	July – December 2023	Percentage Change
Number of active unregistered providers of DSW-related supports	92,490	114,777	+24%
Amount claimed by unregistered providers of DSW-related supports ($ billion)	$2.3	$3.6	+54%
Average amount claimed by unregistered providers of DSW-related supports	$25,340	$31,348	+24%

Source: NDIS internal administrative data

Note: The totals for registered and unregistered DSW-related providers don't match the overall active provider count due to two factors: 1) Some providers offer both registered and unregistered supports within the same period, 2) A small fraction of providers with unspecified registration status are included in the total count but not detailed in the table.

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Figure 12: NDIS Expenditure on DSW-related Supports since January 2021 Relative to Total NDIS Expenditure



Source: NDIS internal administrative data

Over the past three years, providers offering DSW-related supports have shown a diversified approach to generating revenue, often billing for services across multiple registration groups within the NDIS. Specifically, DSW-related supports have accounted for approximately 77% of the total NDIS payments received by registered providers and about 83% for unregistered providers. In 2023, the primary sources of payments for registered providers delivering DSW-related supports concentrated in three areas:

1. Daily Activities (56% of payments)
2. Social Community and Civic Participation (22% of payments)
3. Capacity Building Daily Activity (10% of payments)

4.2.1 Temporary Transformation Payment (TTP)

The TTP for many DSW-related supports was introduced on 1 July 2019 to assist registered NDIS providers with transitioning their businesses into the NDIS. Transitional price levels represented the price necessary to attract new providers to enter the market or to reduce exits from the market. They represented the price required to attract economic resources to expand supply. Transitional price levels were above sustainable price levels at the time, and those price limits were adopted where a significant expansion of supply was required.

In line with the NDIS Pricing Strategy, the base price limits for supports delivered by disability support workers have, since 1 July 2019, been set in line with the estimated efficient costs of delivery at the time of updates. The TTP loading has been used to

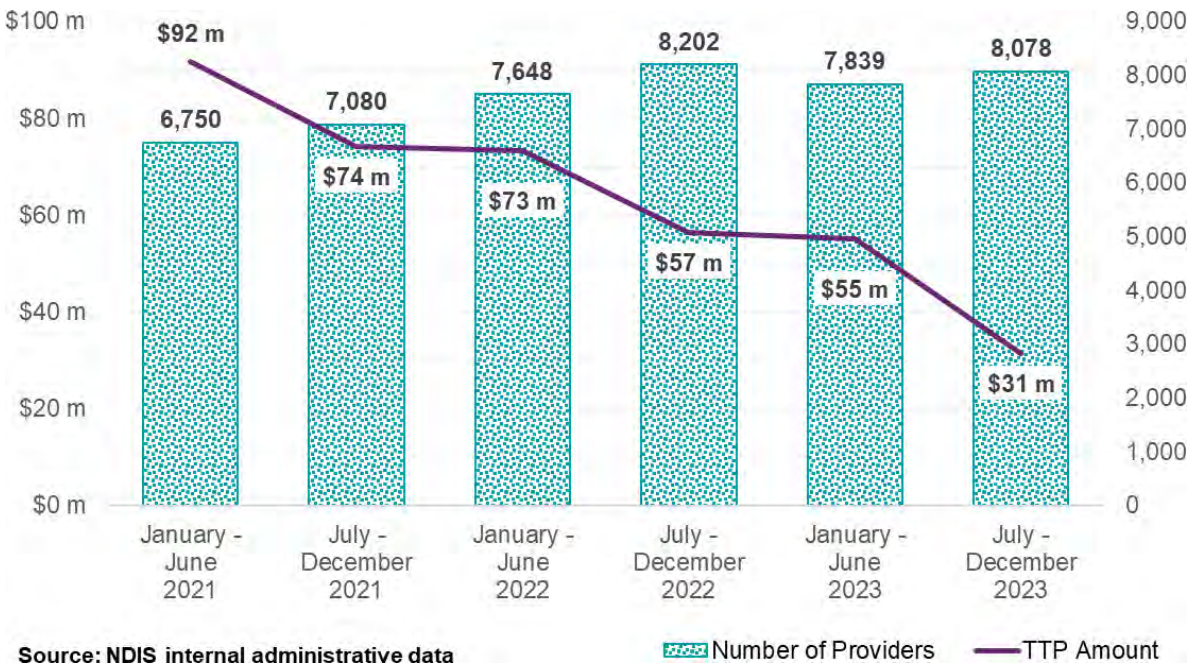
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adjust these efficient prices to transitional levels. The level of the loading was initially set at an amount equal to the difference between the estimated efficient cost of delivery and the estimated average cost of delivery. It was always intended that this amount would decrease over time as providers became more efficient.

Given there are more than 150 different lines of supports related to TTP, more information on the specific price limits for the TTP loadings can be found in the Pricing Arrangements and Price Limits published on the NDIS website.

Figure 13 displays the number of providers claiming TTP items has been relatively steady between the half-years starting January to June 2022 and ending July to December 2023. In addition, it shows that additional amount from the TTP loading has been reducing, driven by the 1.5% rate reduction deployed at the beginning of each financial year. The TTP loading is due to be phased out on 1 July 2024.

Figure 13: Expenditure on Temporary Transformation Payment (TTP) supports and provider numbers for DSW-related supports, January 2021 to December 2023



Source: NDIS internal administrative data

4.2.2 Participants

In the six months to 31 December 2023, a total of 283,406 participants accessed DSW-related supports. The most common DSW-related supports accessed by participants are for:

- **Access Community Social and Recreational Activities Standard:** utilised by 179,356 participants, with 77,568 providers claiming $2.2 billion in payments.

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- **Assistance with Self-Care Activities Standard:** utilised by 123,248 participants, with 73,555 providers claiming $2.7 billion in payments.
- **Group Activities Standard:** Utilised by 38,617 participants, with 8,773 providers claiming $204.9 million.
- **Activity Based Transport:** utilised by 141,551 participants, with 30,664 providers claiming $175.7 million in payments.
- **Capacity Building and Training:** utilised by 54,834 participants, with 24,223 providers claiming $168.8 million in payments.
- **Provider Travel:** utilised by 123,248 participants, with 37,139 providers claiming $113.6 million in payments.

Further detail is found in Table 6.

The average payments per participant between 1 January 2020 and 31 December 2023 have increased from $52,300 in 2020 to $62,700 in 2023, a 6.2% increase per annum. Specifically, average payments are nine times higher for participants in Supported Independent Living (SIL) than those not in SIL ($405,400 versus $43,700 respectively, in the year to 31 December 2023). Average payments are also higher for adults compared with children ($71,400 for participants not in SIL aged 25 to 64 versus $20,100 for those aged 0 to 14 years, in the year to 31 December 2023), by a factor of almost 4 times.

Table 6: Top 10 largest DSW-related supports, July to December 2023

Support Delivered	Total payments ($ million)	Number of Participants	Number of Providers
Assistance in Supported Independent Living Standard	$3,861	33,198	4,559
Assistance With Self-Care Activities Standard	$2,740	123,248	73,555
Access Community Social and Recreational Activities Standard	$2,239	179,356	77,568
Access Community Social and Rec Activities Standard – TTP	$761	68,867	4,585
Short Term Accommodation (STA) And Assistance	$537	37,365	14,438
Assistance in Supported Independent Living High Intensity	$509	4,918	1,122
Assistance With Self-Care Activities Standard – TTP	$496	29,660	3,935
Group Activities Standard – TTP	$370	35,066	1,653
Assistance With Self-Care Activities High Intensity	$294	6,092	4,692

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Source: NDIS internal administrative data

4.2.3 Providers

In the six months to 31 December 2023 the number of active registered providers of DSW-related supports decreased by 6%, from 9,286 to 8,697. The amount claimed by these registered providers rose by 19% to $9.4 billion, and the average amount claimed per registered provider grew by 27%, from $850,843 to $1,081,264.

On the other hand, active unregistered providers of DSW-related supports increased by 24%, from 92,490 to 114,777, with the amount claimed by these providers experiencing a significant 54% increase, from $2.3 billion to $3.6 billion. Consequently, the average amount claimed by unregistered providers also rose by 24%, from $25,340 to $31,348.

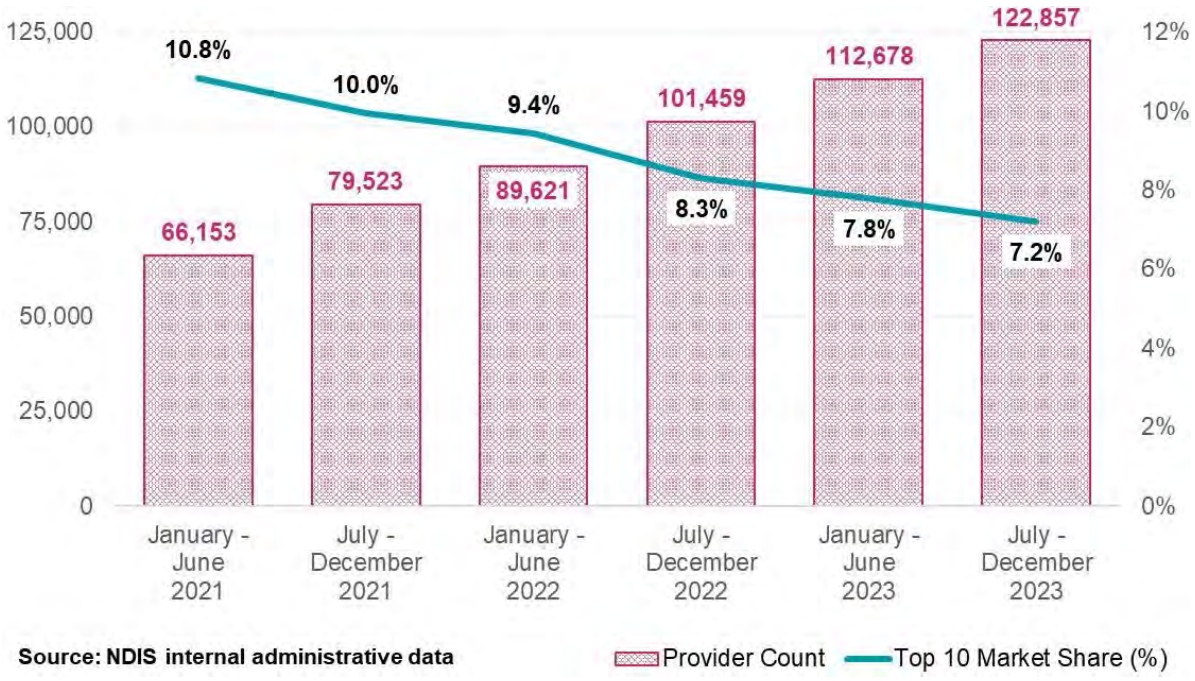
In the same six-month period to December 2023, 283,406 providers submitted claims for DSW-related services. Among these, the supports most frequently claimed included Access Community Social and Recreational Activities Standard by 77,568 providers, Assistance With Self-Care Activities Standard by 73,555 providers, followed by Provider Travel (37,139), Activity Based Transport (30,664), Capacity Building and Training (24,223), STA And Assistance (14,438), and Group Activities Standard (8,773).

Providers market share

Figure 14 shows that between January 2021 and December 2023, the market share attributed to the top 10 providers, in terms of DSW-related support payments, has seen a decrease from 10.8% to 7.2%. Over this period, it is also observed the number of unregistered providers continues to grow and therefore there is a corresponding decrease in market share among registered providers (from 80% to 72%).

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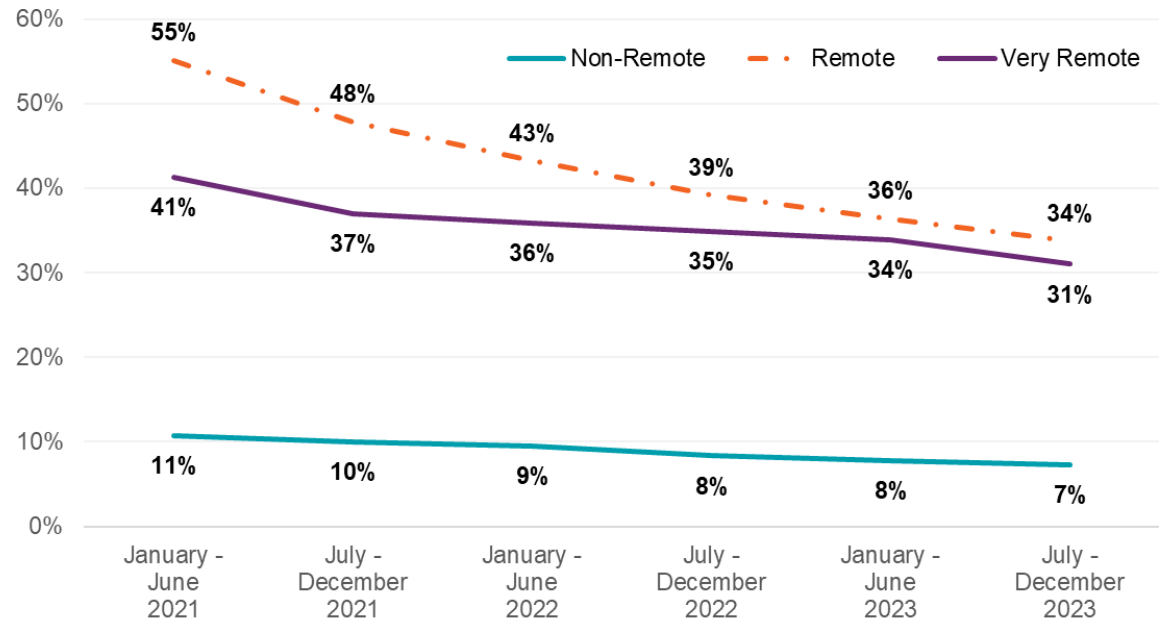
Figure 14: Top 10 Providers' Market Share Against Overall Provider Growth on DSW-related Supports, January 2021 to December 2023



Source: NDIS internal administrative data

Further analyses demonstrates that the share of top ten providers by payment amounts received across very remote, remote, and non-remote areas all have a steady downward trend (Figure 15).

Figure 15: Top 10 Providers' Market Share by Remoteness for DSW-related Supports, January 2021 to December 2023



Source: NDIS internal administrative data

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Providers distribution by geographic areas

Table 7 shows in the second half of 2023, there was a continued decrease in the number of registered providers in non-remote areas, contrasted with Table 8 showing the growth of unregistered providers across all geographic areas. When comparing the half-year ending December 2022 with the half-year ending December 2023, the number of active registered providers of DSW-related supports decreased by 6%, from 9,286 to 8,697. In contrast, the amount claimed by the registered providers rose by 19% to $9.4 billion, and the average amount claimed increased by 27%, from $850,843 to $1,081,264.

On the other hand, the active unregistered providers of DSW-related supports increased by 24%, from 92,490 to 114,777 providers, with the amount claimed by these providers increasing by 54%, from $2.3 billion to $3.6 billion. Consequently, the average amount claimed by unregistered providers rose a comparable percentage of 24% (from $25,340 to $31,348).

Table 7: Registered Providers by Remoteness for DSW-related Supports, January 2021 to December 2023

Remoteness	January – June 2021	July – December 2021	January – June 2022	July – December 2022	January – June 2023	July – December 2023
Non-Remote	7,686	8,406	8,745	9,196	8,807	8,612
Remote	369	416	430	420	380	388
Very Remote	206	241	224	233	227	236
Total for Registered	**7,748**	**8,474**	**8,814**	**9,286**	**8,893**	**8,697**

Table 8: Unregistered Providers by Remoteness for DSW-related Supports, January 2021 to December 2023

Remoteness	January – June 2021	July – December 2021	January – June 2022	July – December 2022	January – June 2023	July – December 2023
Non-Remote	58,047	70,522	80,125	91,417	103,028	113,419
Remote	679	864	1,020	1,093	1,199	1,374
Very Remote	379	438	473	530	582	622
Total for Unregistered	**58,770**	**71,391**	**81,152**	**92,490**	**104,263**	**114,777**

Source: NDIS internal administrative data

Note: The totals for registered and unregistered DSW-related providers do not match the overall provider count due to providers offering multiple support types under different registration statuses, a small proportion of providers with indeterminate registration status not detailed in the table, and the unavailability of participant location data at the time of transactions which affects the determination of provider remoteness.

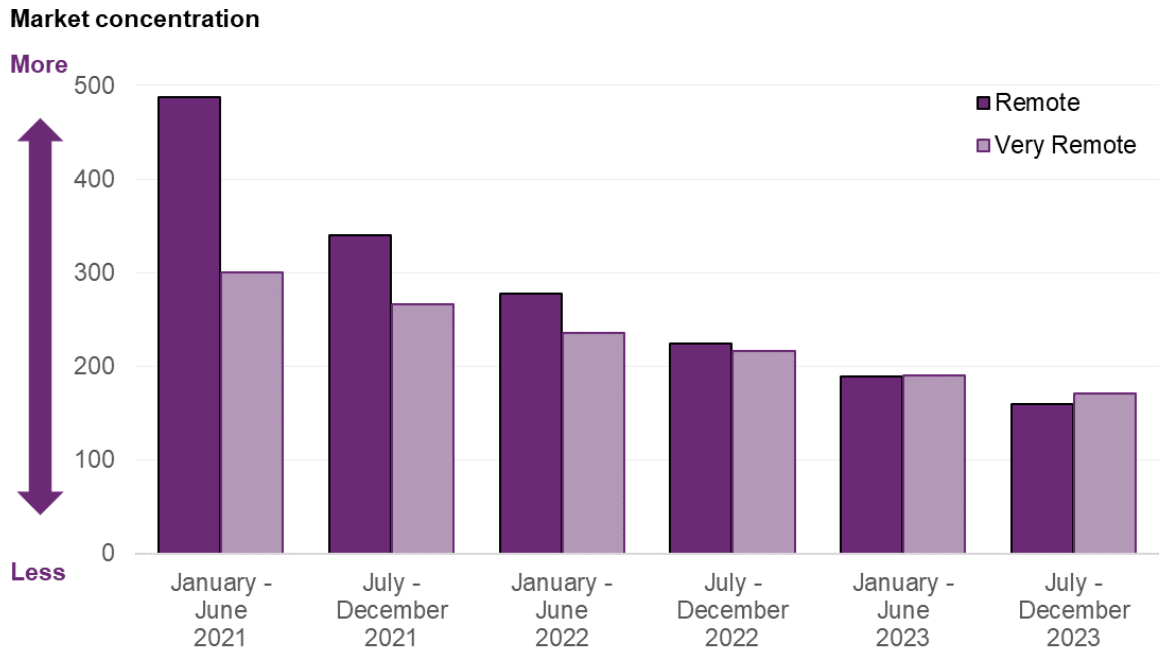
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Herfindahl-Hirschman Index

The Herfindahl-Hirschman Index (HHI) is a metric that assesses the level of concentration in a market by examining the market share among businesses. A higher HHI points to a market with less competition, whereas a HHI under 1,500 signals a competitive marketplace. A HHI which is low, potentially indicates a healthy market where no single provider can disproportionately influence market conditions.

Over the period from January 2021 to December 2023, the HHI for DSW supports across varying degrees of remoteness has been on a downward trajectory, revealing a decrease in concentration. As shown in Figure 16, the HHI has dropped from nearly 500 for very remote areas and about 300 for remote areas to below 200 for providers in both remote and very remote areas by the end of December 2023. This suggests a significant decrease in market concentration over the past three years, in line with the observed decrease in market share held by the top ten providers.

Figure 16: Herfindahl-Hirschman Index by Remoteness for DSW-related Supports, January 2021 to December 2023



Source: NDIS internal administrative data

Note: Adjustments were made to HHI as the overall size of the Australian market and providers' financial statements are unknown at the time of the analysis. Therefore, the NDIA assumed that the size of the market is equal to the total amount of payments made to providers for DSW-related supports.

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Providers claiming below the price limit

Approximately 36% of DSW-related supports were claimed below the price limit. Table 9 provides a detailed comparison of pricing below the limit for both registered and unregistered providers. Over the past three years, there has been a decrease in the percentage of DSW support claims below the price limit for both registered and unregistered provider. The period to December 2023 observed a significant shift in this pattern, especially amongst unregistered providers. The overall pricing behaviour of providers in relation to price limits has demonstrated a consistent trend, noting a decrease in the proportion of claims by registered providers from 82% in the period from July to December 2021 to 68% in the same period in 2023.

Table 9: Claiming Patterns at Price Limit Analysis for DSW-related Supports January 2021 to December 2023

Claiming patterns – At price limit	January – June 2021	July – December 2021	January – June 2022	July – December 2022	January – June 2023	July – December 2023
Registered	68%	66%	71%	71%	73%	69%
Unregistered	37%	38%	51%	47%	56%	50%
All Providers	63%	61%	67%	65%	68%	63%

Source: NDIS internal administrative data

Note: All Providers above are inclusive of providers with the unknown registration status at the time of the transaction.

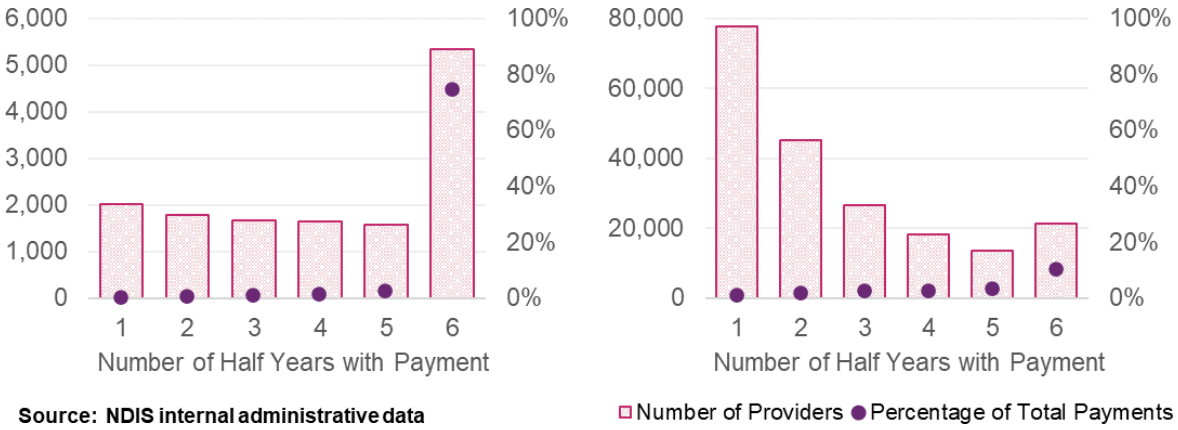
4.3 Business dynamism of registered providers

This section looks at the dynamics of the DSW market among registered providers, given registered providers account for 72% of the total value of payments in the six months leading to December 2023. Business dynamism, characterised by the entry and exit of businesses, as well as the capacity of service providers to adapt to changing market conditions. This dynamism serves as an important indicator of the market's health.

Figure 17 shows the number of registered and unregistered DSW providers with payments between January 2021 and December 2023 respectively, split by the number of half-year periods in which each provider received a payment. As seen in this figure, 5,335 out of 14,016 (38%) registered providers have received payments in all six half-years between January 2021 and December 2023. These providers account for almost 75% of total DSW support payments across the three-year period. In contrast, only 11% of unregistered providers received payments in the six half-years, implying that registered providers exhibit greater continuity of activity.

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Figure 17: Provider Continuity by Registration Status and Percentage of Total Payments. Registered Providers (Left) and Unregistered Providers (Right), January 2021 to December 2023



Source: NDIS internal administrative data

Despite a slight decrease in the number of registered DSW-related support providers, they still accounted for a significant 72% of total DSW payments in the latter half of 2023. The following section will focus specifically on registered providers.

In the six months to 31 December 2023, 1,202 registered DSW providers stopped claiming payments for DSW services. Among these providers, 78% continued to receive payments for other types of support within the same timeframe. It's also notable that 73% of these inactive DSW providers had historically received less than $10,000 per half-year in payments for the last three years.

Figure 18 presents a breakdown of registered providers based on the number of participants they serve and the percentage of their claimed services. This figure highlights a trend towards registered providers serving more participants from the first half of 2021 to the second half of 2023. In particular, the proportion of providers supporting 11 or more participants increased from 37% to 44% among registered DSW providers over this period, indicating a shift towards providers catering to a larger number of participants.

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Figure 18: Registered Providers of DSW-related Supports and Number of Participants that Claimed, January 2021 to December 2023

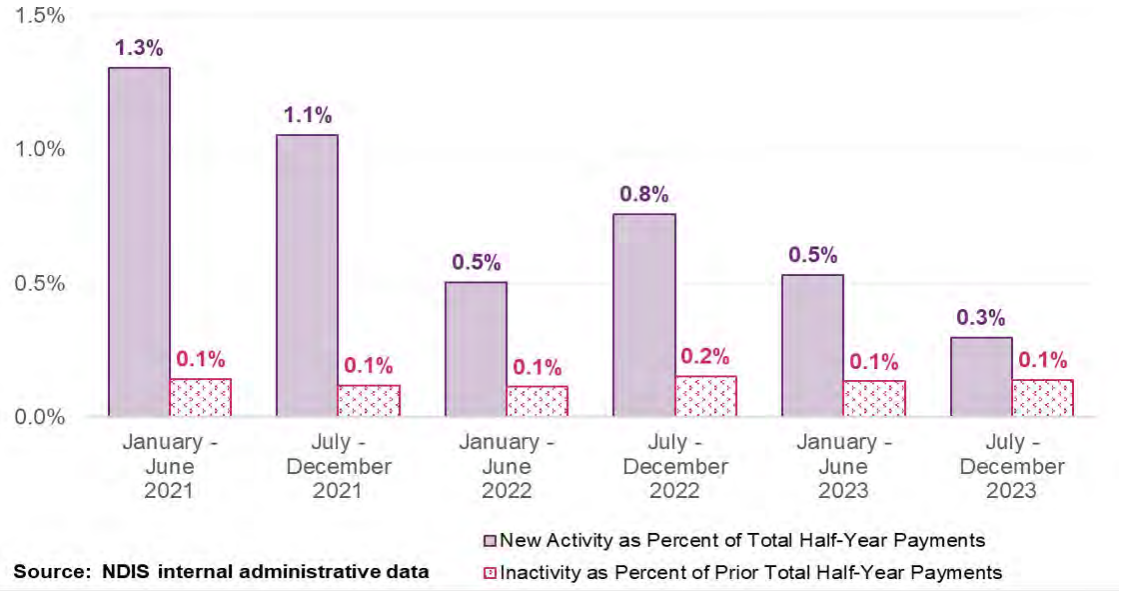


An analysis of payment activity for registered providers from January 2021 to December 2023 shows an evolving provider market. 'New Activity' within a half-year period is identified when providers who were inactive in the previous half-year begin to receive payments. Conversely, 'Inactivity' is noted when providers that received payments in one half-year do not in the subsequent one. These fluctuations are measured as a percentage of the total payments made within that half-year, or the previous one, in the case of inactivity. While the NDIA recognises that this methodology may not perfectly capture market exits, it serves as the best available proxy.

Figure 19 shows that inactive registered providers account for 0.2% or less of the total payments in any half-year period. In comparison, newly active registered providers account for 0.3% to 1.3% of total payments for the corresponding timeframe, with a notable decline in 2023.

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Figure 19: DSW-related Registered Provider Activity Movements, January 2021 to December 2023



Further analysis indicates that 87% of inactive registered providers received less than $5,000 in DSW related payments in the half-year prior to becoming inactive. In contrast, active registered providers received on average $999,749 of payments in each half-year period, highlighting the substantial difference in activity between providers that are on the verge of become inactive and those that remain active.

4.4 The Ability Roundtable Benchmarking Survey

The Ability Roundtable has provided the Agency with workforce and financial data from 55 organisations, of which 54 disclosed that they were registered with the Australian Charities and Not-For-Profits Commission (ACNC), for analysis of key metrics. The sample represents organisations with a combined revenue of over $6.0 billion for the 2022-23 financial year, of which NDIS revenue represented $4 billion, and with a workforce exceeding 55,000 personnel. Collectively, these organisations delivered services to over 65,000 unique NDIS participants. More information on this survey and its results are available on The Ability Roundtable's website.

The analysis of the survey results provided by Ability Roundtable reveals several key insights into the financial performance and workforce dynamics of registered NDIS providers across Australia. For the analysis, the organisations were grouped into one of five bands, with organisations increasing in size from Band 1 to Band 5.

Larger organisations appeared to benefit from economies of scale and lower operating expense ratios, with Band 5 organisations' operational expenses equating to 19% of their total revenue compared with Band 3 organisations' 30% of their total revenue. The largest organisations also appeared to have lower permanent staff turnover and are more likely to pay above Award rates (Table 10). Note,

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approximately 50% of participating organisations pay their staff under Enterprise Bargaining Agreements (EBAs).

Table 10: Turnover Percentage of Permanent Casual Workers, as well as Percentage of Organisations that Pay DSW Staff Above the Award Rate

Band Number	Permanent Staff Turnover	Casual Staff Turnover	Percentage paying above Award
Band 1	26%	32%	60%
Band 2	22%	49%	45%
Band 3	23%	32%	55%
Band 4	21%	43%	27%
Band 5	16%	34%	74%
Average	21%	38%	50%

Source: NDIA analysis

The organisations showed general increases in non-current assets alongside increases in non-current liabilities. It is difficult to determine why there was an increase from data alone. This may come from a range of reasons, such as the increasing value of non-current assets. However, it was seen that of those surveyed, only Band 1 (organisations with the smallest revenue size) and Band 5 (organisations with the largest revenue size) reported increases in total equity levels in 2022-23.

In 2022-23, Ability Roundtable's submission to the APR suggested 36% of sampled organisations recorded a profit. This is a 4.4 percentage points increase from 2021-22. Of all sampled organisations, the data showed the median profitability result to be -2.1% in 2022-23, 0.5 percentage points higher than the result in 2021-22. Of the sampled organisations that made a loss, the data shows a median loss of -5.9% in 2021-22 and -4.9% in 2022-23.

4.5 Disability Services Financial Benchmark Report

StewartBrown conducts a Disability Services Financial Benchmark Report that provides an overview of the financial performance of the disability services sector in Australia. It is based on the results of the 51 participating organisations for the 12 months to 30 June 2023. This report can be found on StewartBrown's website.

The sample represents a combined revenue of $2.5 billion for 2022-23, delivering services to over 26,500 NDIS participants. This survey extends beyond DSW supports, also including Allied Health (Therapy) and Support Coordination supports.

The analysis of the survey results suggests that in 2022-23, 45% of sampled organisations recorded a profit, an increase from 43% in FY21-22. The sample, of those providers who recorded an operating deficit of $0.91m for 2021-22 per provider to an average operating deficit of $1.26m per provider for 2022-23.

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The survey also delved into the operating result at the service level, where for the sample, four out of the six services covered were operating at a loss. Supports with an operating profit were Supported Independent Living (SIL) (3.1%) and Daily Living non-SIL (2.2%) supports, whereas operating at a loss were Social, Community Participation (-0.3%), Supported Employment (-4.1%), Allied Health (-4.6%) and Support Coordination (-10%).

4.6 Australian Charities and Not for Profit Commission (ACNC)

Charities and not-for-profit (NFP) organisations represent a significant segment of the provider market delivering supports to NDIS participants. All entities classified as charities or NFPs are legally required to disclose their annual financial statements. This financial data is made available by the ACNC.

To assess the financial health of charitable and not-for-profit NDIS providers, the Agency undertook an analysis of the financial data from 100 such organisations that have claimed a NDIS payment for at least six months in each of the last four fiscal years[44]. These organisations generated around $2 billion in total revenue in 2022-23, of which around 50 percent of this was generated by claiming for NDIS services.

To conduct the analysis, the 100 organisations were separated into four bands based on their total revenue collected in 2021-22 (the middle year of the data collected[45]). Band 1 consists of the 25 organisations with the lowest total revenue base, with Band 2 consisting of the next 25 smallest organisations by revenue, and so on.

It is acknowledged that assessing the financial health of charitable and not-for-profit NDIS providers is challenging. Financial reports do not distinguish between NDIS and non-NDIS activities. This complicates analysis as many organisations serve a wide array of sectors, not solely NDIS participants. The distinct financial characteristics of not-for profit organisations also hinder comparisons and inferences with for-profit organisations' financial health. For example, for-profit organisations typically do not use volunteer staff to fulfill operational demands and have different tax obligations.

[44] To be eligible for the population, a provider must have received a payment for six months, every year for the past four fiscal years from 2019-20 to 2022-23.

[45] 2021-22 was chosen as the base year, as total revenue of organisation moved in such a way that organisations saw movement between bands far more frequently if 2020-21 or 2022-23 were used as base years.

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4.6.1 Summary of results

From 2020-21 to 2022-23, of the organisations sampled, there was almost a doubling in the number of NDIS payments that were made, with a 33% increase in the total amount of NDIS revenue claimed over that period. There has also been an increase in the number of NDIS claims made by each organisation. Only 4% of organisations sampled reported a loss in each of the three financial years. Among the organisations analysed, 65% reported a profit in the 2022-23 financial year, marking an increase from the previous year, where only 60% achieved profitability. This is a decline in terms of profits from the 2020-21 financial year, during which a notable 88% of sampled organisations recorded a profit. The result in 2020-21, however, can be largely explained by the temporary increase in price limits given to NDIS providers and wage supplements and government support during the COVID-19 pandemic.

Table 11 details the profitability of the sampled organisations across the three financial years. The average financial performance across the three financial years was healthy with positive average and median profits across the sample size in each year.

Table 11: Financial performance across 2020-21 to 2022-23

Financial Year	Number that recorded a loss	Number that recorded a profit	Average Profit/Loss	Median Profit/Loss
2020-21	12	88	$1,505,156	$476,943
2021-22	40	60	$565,434	$76,974
2022-23	35	65	$580,586	$76,831

Source: NDIA analysis using ACNC data.

There are other indicators showing the financial health of the NFP industry. Organisations across all revenue bands reported a working capital ratio above the industry benchmark (1.5[46]) and consistently maintained debt ratios below 0.5 (a ratio below 0.5 suggests that organisations hold at least double the amount of assets as it does liabilities). The data also suggests that despite the varying scales of operation, the NFP sector has seen growing levels of average revenue generated per Full Time Employee (FTE) over time (Figure 20).

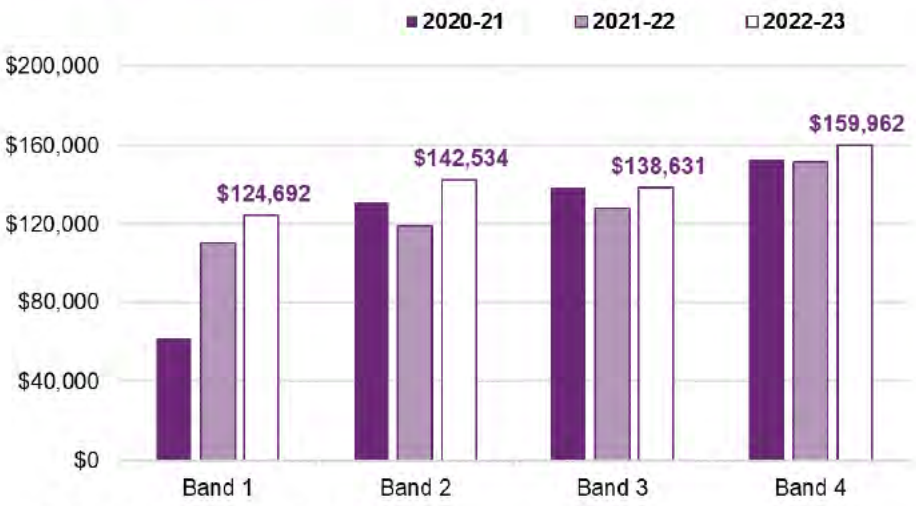
[46] National Disability Services Financial Ratio Tool

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

Figure 20: Average Revenue per FTE Across 2020-21 to 2022-23



Source: NDIA analysis using ACNC

As was seen in the analysis of the Ability Roundtable survey, there were increases in equity for most organisations, with all bands recording improvements. It was found that despite there not being as many profitable organisations in 2022-23 as there were in 2020-21 (the latter being due to additional financial support provided to providers during the pandemic), all bands saw substantial growth in assets over the 2021-22 and 2022-23 (Table 12). This growth was particularly notable among organisations in the Band 4 (top 25 organisations by revenue size), where on average, total equity levels rose by over $4 million over the period.

Table 12: Asset, Liability and Equity Change from 2020-21 to 2022-23

Band Number	Assets	Liabilities	Equity
Band 1	$87,510	$1,367	$86,143
Band 2	$454,496	-$54,670	$509,166
Band 3	$415,590	-$230,466	$646,055
Band 4	$6,966,584	$2,651,625	$4,314,959
Median	$325,819	$44,571	$344,806

Source: NDIA analysis

4.7 Feedback from consultations

A total of 79 provider submissions were received regarding the suitability of the methodology and parameters used in the DSW Cost Model. The majority of feedback received from stakeholders regarding the DSW Cost Model raised concerns about its alignment with the actual costs and complexities faced by the sector in delivering disability support services. It was suggested that the DSW Cost

Page 913 of 1049

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Model may not fully account for the real-world operational and corporate overheads, suggesting a possible underestimation of the financial requirements necessary for service provision.

Concerns raised about the accuracy of assumed overhead costs within the DSW Cost Model are suggested to be a discrepancy between theoretical assumptions and the operational realities experienced by providers. This misalignment extends to the costs associated with ensuring service quality and meeting regulatory compliance, which stakeholders suggest are not sufficiently considered in the current model. The sector called for a revised approach that more accurately reflects the varied and significant needs of service delivery in the disability support sector.

There were also challenges raised regarding workforce management. Particularly in recruiting and retaining skilled personnel for complex care needs and recognising the recent Aged Care Award wage increases, both claimed to have impacts on providers.

See Appendix A for more details on common themes raised in submissions to the 2023-24 APR Consultation Paper.

4.8 Discussion

4.8.1 Acknowledgment of concerns raised on the DSW Cost Model

The NDIA acknowledges the complexities of updating the DSW Cost Model, particularly in ensuring that data are recent, reliable, and representative. The last Financial Benchmarking Survey conducted for the 2021-22 financial year is due for an update to better reflect current economic conditions. Stakeholders have raised several issues with the DSW Cost Model:

- Potential underestimation of corporate overheads and operational costs, such as insurance premiums and regulatory compliance.
- The model lacks differentiation and may not fully account for the services or staff needed by clients with higher or specialised needs.
- Setting parameters at the 25th percentile for 'efficient' levels may not cover current providers' costs adequately.

In response to these critiques, the NDIA has incorporated more comprehensive and representative data sources in the current report, including surveys by Ability Roundtable and StewartBrown. Despite challenges with sample size and representativeness, these efforts aim to better capture the financial experiences of organisations.

The new data provide valuable insights into providers' financial performances from various perspectives, enriching the NDIA's decision-making process. As a market steward, the NDIA actively monitors and tracks the financial health of providers to

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ensure that the diverse and evolving conditions of the NDIS provider market are considered.

Building on the insights from previous surveys, the NDIA has expanded its data analysis this year to include mandated data from not-for-profit organisations, as reported to the ACNC. However, differentiating financials between NDIS-specific activities and broader organisational functions remains complex, particularly given the differing financial structures of for-profit and not-for-profit entities.

The NDIA is committed to continue to collaborate with the sector, providers, and other stakeholders to refine pricing arrangements for Disability Supports. This includes exploring methods to obtain objective information to inform potential approaches.

The NDIA's ongoing pricing work aligns with broader pricing reform initiatives across the Australian Government. This includes the Department of Social Services' 'Pricing and Payments Framework' and the Independent Health and Aged Care Pricing Authority (IHACPA)'s planned work for 2024-25, aimed at reforming NDIS pricing arrangements, reviewing existing pricing approaches, and developing a pricing data strategy.[47]

4.9 Recommendations

Analyses suggest significant variability in the financial performance and growth potential of organisations providing DSW-related supports. Additionally, the labour market for the health and care sector remains tight, which could continue to put upward pressure on the supply of DSWs.

In the financial year 2024–25, the Australian Government has allocated $5.3 million to the Independent Health and Aged Care Pricing Authority (IHACPA), to work with Department of Social Services (DSS) and the National Disability Insurance Agency (NDIA), to undertake the initial work to reform the National Disability Insurance Scheme (NDIS) pricing arrangements. The primary objective of this initiative is to enhance the efficiency and effectiveness of NDIS pricing structures. The initial work is expected to conduct a comprehensive review of current NDIS pricing mechanisms, as well as develop a new pricing data strategy.

On balance, it is considered appropriate to pass on minimum Award wages and national employment standard changes to superannuation at this time. This includes

[47] Commonwealth Treasury. (2024). *Budget 2024-25: Budget Strategy and Outlook Budget Paper No. 2, page 173*. https://budget.gov.au/content/bp2/download/bp2_2024-25.pdf

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employer superannuation contributions, which will rise from 11% to 11.5% from 1 July 2024.[48]

Recommendation 1

The NDIA, subject to any specific recommendation arising from the current Annual Pricing Review, should increase the price limits for supports that are determined by the NDIS Disability Support Worker Cost Model from 1 July 2024 to reflect any changes in the minimum wages specified in the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award) following the Fair Work Commission's Annual Wage Review and any increase in the Superannuation Guarantee Charge.

The temporary loading of 2% was introduced on 1 July 2022 to the DSW Cost Model as a short-term measure to assist providers in managing the increased costs associated with COVID-19 and changes stemming from the SCHADS Award changes. As COVID specific supports continue to wane in other sectors in the economy, it is recommended that this temporary measure ends as scheduled and as recommended in the 2022-23 APR.

Recommendation 2

The NDIA should cease the temporary loading applied to the NDIS Disability Support Worker Cost Model from 1 July 2024.

The NDIA recognises there are supports that are not within the scope of the 2023-24 APR, nor tied to the DSW Cost Model and are neither price limited nor benchmarked. Notably, nursing supports fall into this category, alongside other core and capacity-building supports like personal domestic cleaning and house or yard maintenance.[49]

Given the recent aged care reforms, which include up to a 25% wage increase for aged care workers and potential future adjustments to the Nursing Award, it is crucial that these supports remain in line with their applicable markets. Failing to adjust the price limits, particularly nursing supports, could risk the adequacy of support for NDIS participants. Therefore, it is proposed that the price limits for these supports be increased, following the methodology used in previous years' indexation. It should be noted that capital items are excluded from the APR and is addressed by a separate process.

Recommendation 3

The NDIA, subject to any specific recommendation arising from the current Annual Pricing Review and any future reviews, should increase the price limits

[48] As determined by the Australian Tax Office
[49] This does not include Plan Management supports.

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for nursing and other supports, not covered by Disability Support Worker-related supports or Capital supports, on 1 July 2024 in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses) and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter immediately preceding the indexation date (with an 80/20 weighting). This recommendation does not include Plan Management.

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5. Therapy Supports

5.1 Context

Therapy supports play an important role in assisting participants to achieve their personal goals. Early therapeutic interventions enhance participant outcomes and reduce long-term cost by building capacity and independence. These supports are delivered by a diverse range of professionals, such as Occupational Therapists (OT), Speech Pathologists (SP), Psychologists, Physiotherapists, and many others, including therapy assistants who operate under the supervision of therapists. This ensures a broad and inclusive delivery of therapeutic interventions, that meet the diverse needs of the NDIS participants.

Therapy supports are organised into several registration groups, with the majority of therapy supports delivered under three main categories - Therapeutic Supports for improving functional skills (0128), Early Intervention Supports for Early Childhood for children with developmental delays (0118), and Exercise Physiology & Personal Wellbeing Activities for physical health (0126). There are other additional categories which provide supports for specific needs like behaviour management and hearing services.

Pricing for therapy services under the NDIS varies by service type, delivery method, location, and whether the services are provided to individuals or groups (see Table 13). The Scheme also allows for claiming of non-face-to-face supports, travel and cancellations. This structure supports the delivery of personalised, effective therapy services to NDIS participants, aiming to improve their independence and participation in daily activities. Additional information on the Pricing Arrangements and Price Limits for therapy supports can be found here.

This chapter reviews the pricing arrangements for therapy supports in the NDIS, assessing their alignment to comparable schemes, and with the private therapy support market.

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Table 13: Price Limits for Therapy Supports as at 1 January 2024

Type of Therapist	NSW / VIC / QLD / ACT	SA / WA / TAS / NT	Remote	Very Remote
Art Therapist, Audiologist, Developmental Educator, Dietitian, Music Therapist, Occupational Therapist, Orthoptist, Podiatrist, Rehabilitation Counsellor, Social Worker, Speech Pathologist, and Other Professional	$193.99	$193.99	$271.59	$290.99
Counsellor	$156.16	$156.16	$218.62	$234.24
Exercise Physiologist	$166.99	$166.99	$233.79	$250.49
Physiotherapist	$193.99	$224.62	$314.47	$336.93
Psychologist	$214.41	$234.83	$328.76	$352.25
Therapy Assistant - Level 1	$56.16	$56.16	$78.62	$84.24
Therapy Assistant - Level 2	$86.79	$86.79	$121.51	$130.19

Source: NDIS Pricing Arrangements and Price Limits 2023-24

5.2 Scheme statistics

5.2.1 The number of therapy providers continues to grow

In the six months to 31 December 2023, 379,296 participants, representing 59% of the total 646,449 active participants, as of 31 December 2023, purchased therapy supports through their plans. Table 2 shows that the number of providers delivering therapy supports increased during this period, with 52,736 providers receiving payments, a 14% rise compared to the year before. The total amount claimed by unregistered providers in the six months to 31 December 2023 grew by 60% compared to the same time the previous year. However, most of the total amount claimed for provision of therapy supports is still through registered providers (65%, or $1.3 billion, of therapy supports claimed).

Refer to Table 14, Table 15 and Table 16 for further breakdown of the number of registered and unregistered providers delivering supports to NDIS participants.

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Table 14: Therapy Supports Schemes Statistics – All Providers

Statistics	July – December 2022	July – December 2023	Percentage Change
Total number of NDIS participants	325,319	379,296	+17%
Total number of active providers	46,326	52,736	+14%
Total amount claimed by active providers of Therapy supports	$1.6 billion	$2.1 billion	+28%
Average amount claimed by all active providers of Therapy supports	$35,028	$39,257	+12%

Table 15: Therapy Supports Scheme Statistics – Registered Providers

Statistics	July – December 2022	July – December 2023	Percentage Change
Number of active registered providers of Therapy supports	8,778	7,392	-16%
Total amount claimed by registered providers of Therapy supports	$1.2 billion	$1.3 billion	+15%
Average amount claimed by registered providers of Therapy supports	$132,541	$180,913	+36%

Table 16: Therapy Supports Scheme Statistics – Unregistered Providers

Statistics	July – December 2022	July – December 2023	Percentage Change
Number of active unregistered providers of Therapy supports	38,206	45,961	+20%
Total amount claimed by unregistered providers of Therapy supports	$0.4 billion	$0.7 billion	+60%
Average amount claimed by unregistered providers of Therapy supports	$11,764	$15,651	+33%

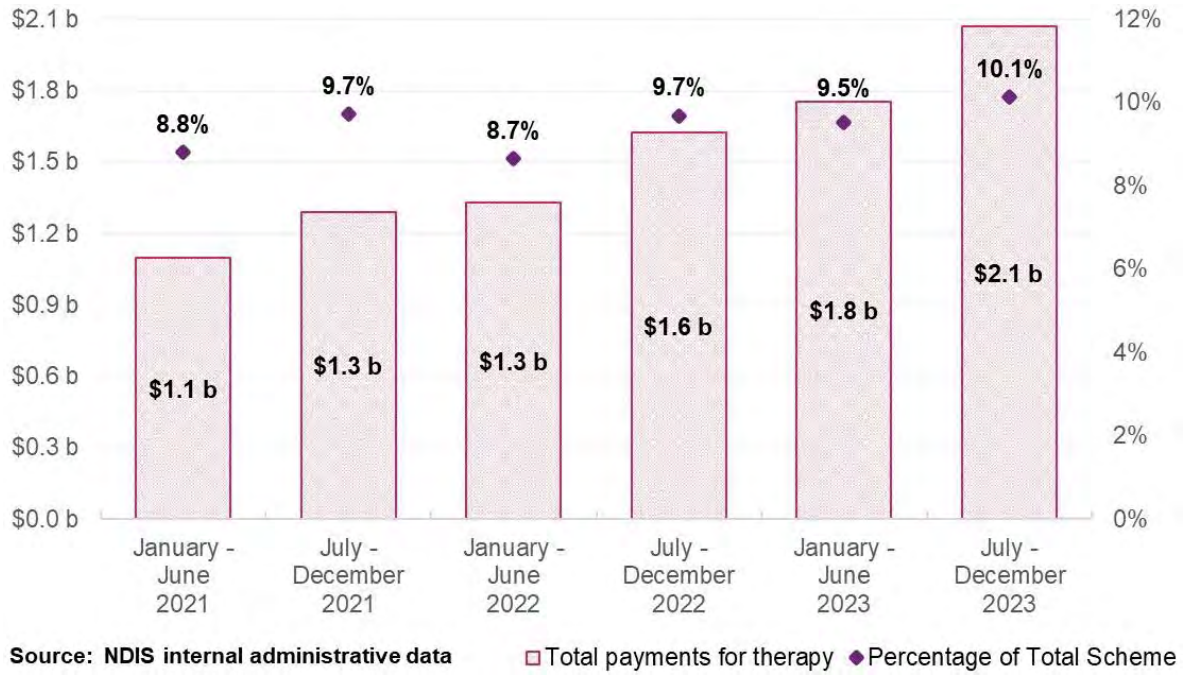
Source: NDIS internal administrative data

Please note a discrepancy in the total number of 'active' therapy providers, attributable to two factors. 1) some providers offer a mix of registered and unregistered supports, leading to their classification in both categories. 2) a small fraction of providers with undetermined registration status contributes to total payment figures but is excluded from detailed tabulation, representing less than 1% of the overall financial transactions.

Figure 21 shows NDIS payments on therapy supports in the six months to December 2023, which amounted to $2.1 billion. This expenditure accounts for just over 10% of the NDIS's total expenditure of $20.4 billion during this six-month period, reflecting a 28% increase from the previous year's spending on therapy supports.

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Figure 21: NDIS Expenditure on Therapy Supports Since January 2021 Relative to Total NDIS Expenditure



Over the last three years payments for therapeutic supports have comprised about 14% of total NDIS payments to registered therapy support providers and about 37% of payments to unregistered therapeutic providers. From January to December 2023, the top three payment support categories for registered providers for therapy supports were:

- Daily Activities (51% of payments)
- Social Community and Civic Participation (22% of payments)
- Capacity Building Daily Activity (13% of payments)

5.2.2 Participants

Participants access a broad range of therapies. In the six months to 31 December 2023, participants claimed therapy supports, predominantly from Occupational Therapists ($441.6 million from 214,271 participants), followed by Early Childhood Professionals ($357.9 million from 93,154 participants), Behavioural Therapists ($287.7 million from 53,064 participants), Physiotherapists ($202.2 million from 95,095 participants) and Speech Pathologists ($198.2 million from 109,829 participants). See Table 17 for more information.

The average payment for a participant receiving therapy supports was $5,458, a 9% increase from the previous period, while the average claim per provider was $39,257, up 12%. This data underlines the significant role of therapy supports in the NDIS, highlighting both the extensive use of these services by participants and the corresponding financial investment by the Scheme.

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Table 17: Scheme Expenditure by Type of Therapy, July to December 2023

Type of Therapist	Total Payments ($ million)	Number of Participants	Number of Providers
Occupational Therapist	$441.6	214,271	8,633
Early Childhood	$357.9	93,154	13,881
Behavioural Therapist	$287.7	53,064	1,454
Physiotherapist	$202.2	95,095	10,134
Speech Pathologist	$198.2	109,829	5,733
Psychologist	$173.9	99,042	12,660
Other Professional	$156.0	101,727	24,139
Exercise Physiologist	$76.9	41,765	4,712
Therapy Assistant	$42.5	40,393	4,045
Counsellor	$27.4	19,966	4,364
Social Worker	$22.9	13,842	2,141
Dietitian	$20.4	23,672	2,053
Travel	$20.1	104,182	11,146
Podiatrist	$10.7	28,251	2,738
Miscellaneous	$9.4	5,135	2,914
Music Therapist	$8.1	5,208	1,039
Art Therapist	$6.9	4,787	1,272
Development Educator	$5.9	3,316	440
Orthoptist	$0.7	1,250	234
Rehabilitation Counsellor	$0.7	724	314
Audiologist	$0.4	840	152
TOTAL	**$2,070.3**	**379,296**	**52,736**

Source: NDIS internal administrative data

Note: The total for both the number of participants and providers represent unique counts with the July to December 2023 period. 'Other Professional' refers to a diverse group of therapy providers offering services such as assessments, recommendations, and group therapies, which may encompass a variety of therapy disciplines not individually listed.

5.2.3 Providers

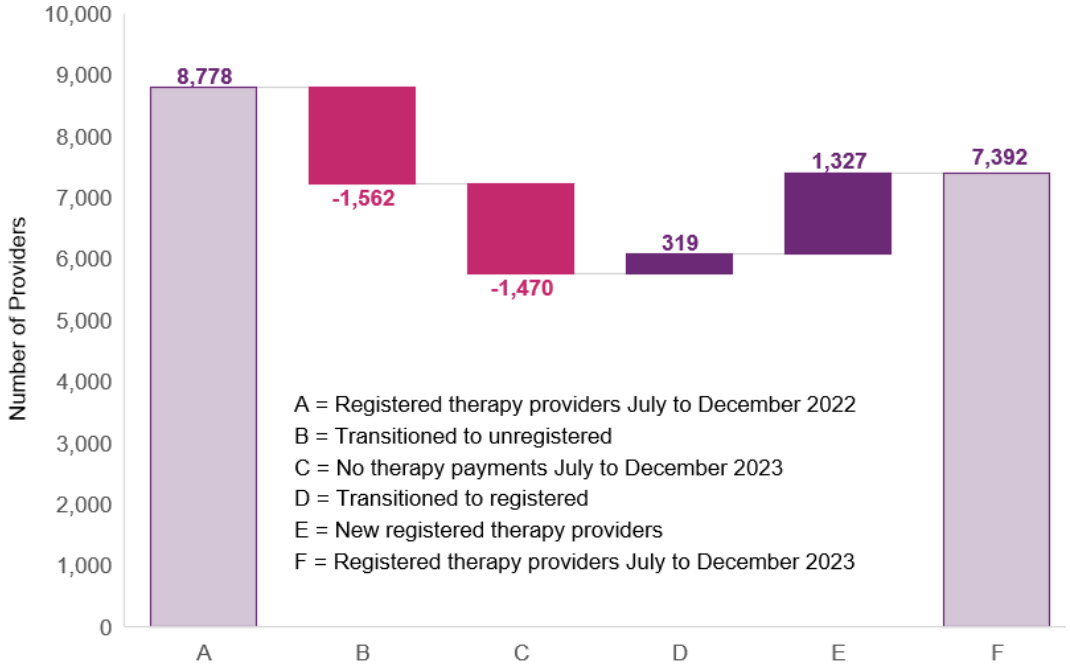
Market growth ensures diverse therapy options for expanding participant demand

In the six months to 31 December 2023, as shown in Table 3, 52,736 providers received payments for therapy supports. Most claims were made by 'Other Professionals' (24,139 providers), Early Childhood Professionals (13,881 providers), Psychologists (12,660 providers), Physiotherapists (10,134 providers) and Occupational Therapists (8,633 providers).

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Registered provider numbers decreased by 16% from 8,778 to 7,392 providers in the six months to 31 Dec 2023. Of the $2.1 billion paid to providers, $1.3 billion was paid to registered providers (Table 15). This is an increase of $174 million from the six months to 31 December 2022. The decline in registered providers, as shown in Figure 22, is attributed to 1,562 providers switching to unregistered status and 1,470 registered providers no longer receiving therapy related payments in the six months to 31 December 2023. In contrast to the decline, 1,327 new providers registered to deliver therapeutic supports in the NDIS in the six months to 31 December 2023 compared to the same period in the previous year.

Figure 22: Registered Therapy Provider Volume Change Between July to December 2022 and July to December 2023

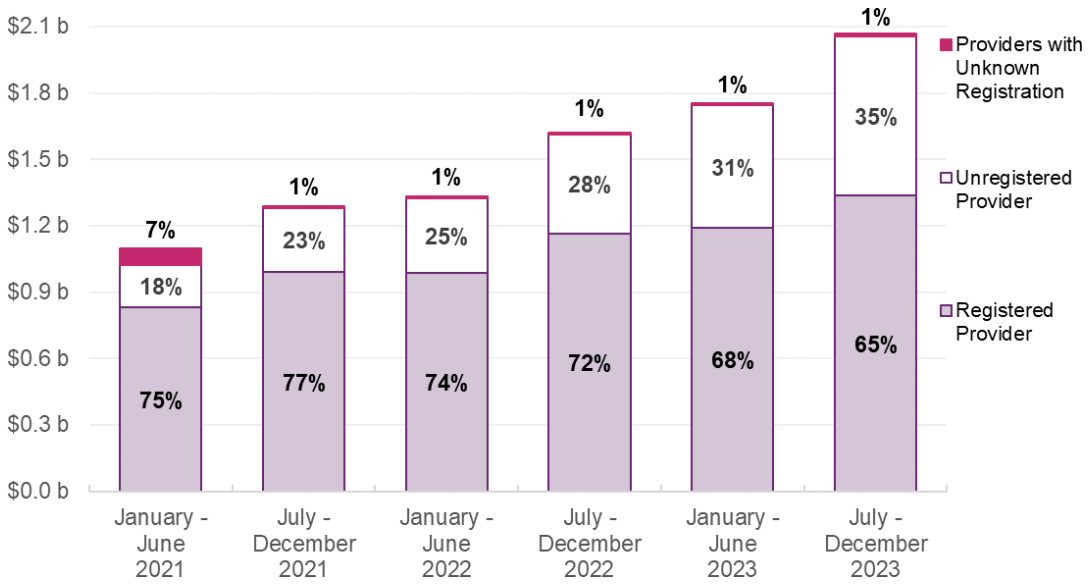


Source: NDIS internal administrative data

Figure 23 shows the distribution of NDIS therapy payments by provider registration status for half-year periods from January 2021 to December 2023. Over this period, therapy payments made to unregistered providers has increased from 18% to 35%. Moreover, payments made to registered providers still accounts for 65% of the totally payment for therapy supports six months to 31 December 2023.

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Figure 23: Total Payments for Therapy Support Items by Provider Registration Status, January 2021 to December 2023

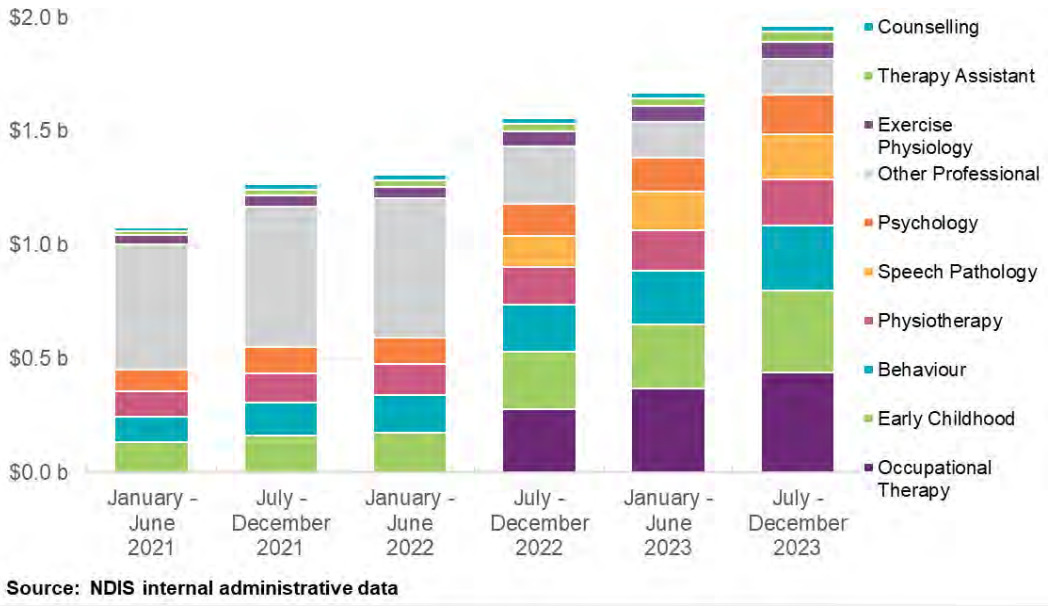


Source: NDIS internal administrative data

In the six months to 31 December 2023, the five leading therapy categories by total NDIS payments, excluding 'Other Professionals', were Occupational Therapists ($441.6 million), Early Childhood Professionals ($357.9 million), Behavioural Therapists ($287.7 million), Physiotherapists ($202.2 million), and Speech Pathologists ($198.2 million). Together, these categories represented $1.5 billion in claims, accounting for approximately 72% of the NDIS's $2.1 billion expenditure during this period as detailed in Figure 24.

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Figure 24: Largest Ten Therapy Types Based on Total NDIS Payments, January 2021 to December 2023



Note: Before July 2022, the NDIS grouped various therapies under 'Other Therapy' support. Post-categorisation changes, expenditure on specific therapies like Occupational Therapy and Speech Pathology were more distinctly tracked.

Top 10 providers sustain market share despite a drop in market share

As detailed in Figure 25 and Figure 26, the market share of the top ten registered therapy providers has seen a modest decline, from 14% to just under 11% from January to December 2023. This shift occurred alongside an expansion of the therapy market, with an overall increase of $174 million in payments to registered providers in the six months to December 2023 compared to the same period in the previous year. Although there has been a notable increase in unregistered providers, this does not necessarily indicate a downturn for registered providers, who are still experiencing substantial business growth. The rising number of unregistered providers suggests a broadening of the market landscape rather than a displacement of the existing registered providers' activities, as the total payments to and number of participants serviced by registered providers continue to grow, demonstrating an expanding and robust NDIS therapy provider market.

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Figure 25: Top 10 Providers' Market Share Against Overall Provider Growth for Therapy Supports, January 2021 to December 2023

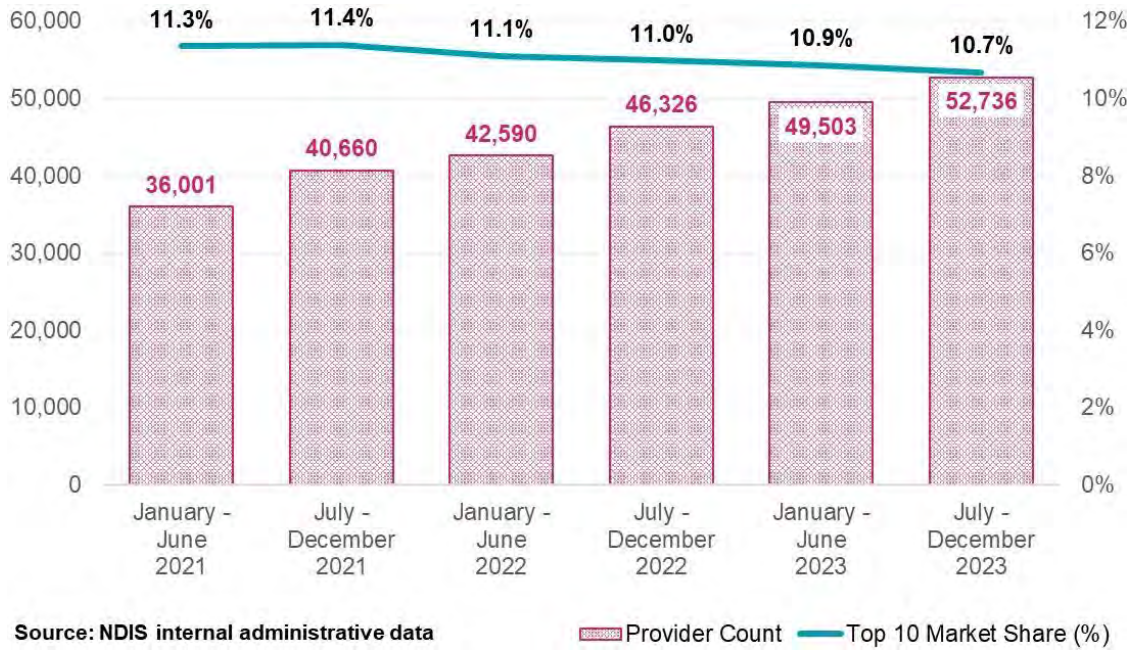
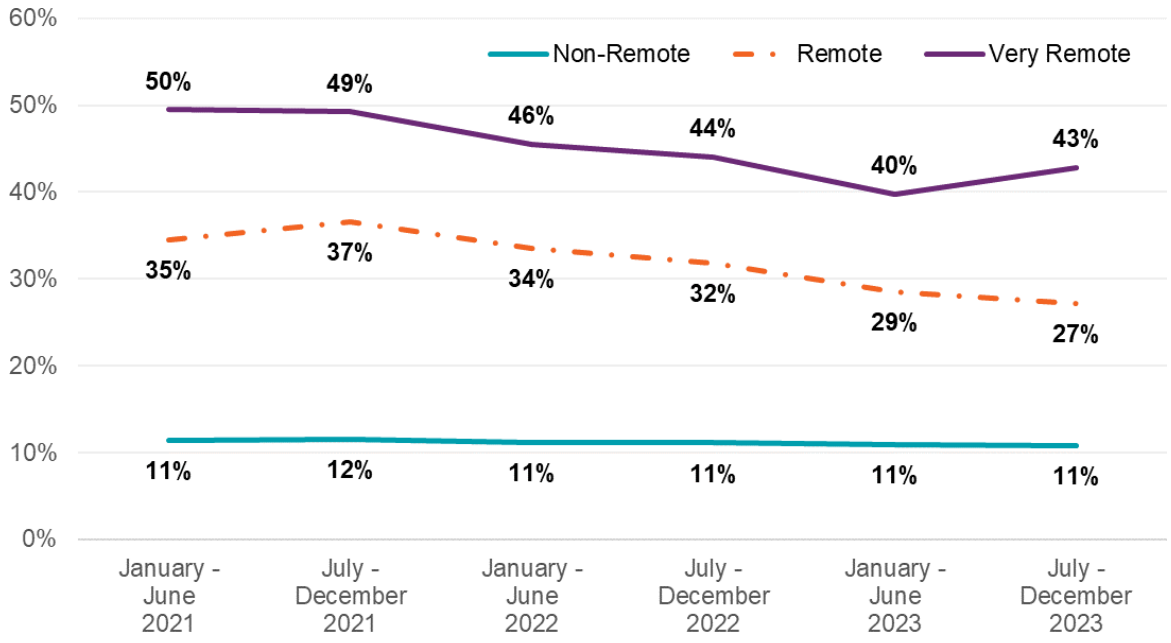


Figure 26: Top 10 Providers' Market Share by Remoteness for Therapy Supports, January 2021 to December 2023



Source: NDIS internal administrative data

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The increase in unregistered providers is common for all areas

Table 18 highlights a decrease in the number of registered therapy support providers in non-remote areas, with a drop from 8,509 providers in the six months to 30 June 2021 to 7,326 in the six months to 31 December 2023. Conversely, unregistered providers have risen in all areas, growing from 27,528 to 45,543 in non-remote areas within the same periods (Table 19). This growth in unregistered providers contributes to the declining market power of the top ten providers which may signal increasing a less concentrated market. This is further explored in the market concentration section with the Herfindahl-Hirschman Index (HHI).

Table 18: Registered Providers by Remoteness for Therapy Supports, January 2021 to December 2023

Remoteness	January – June 2021	July – December 2021	January – June 2022	July – December 2022	January – June 2023	July – December 2023
Non-Remote	8,509	8,695	8,552	8,735	8,252	7,326
Remote	537	553	534	520	522	519
Very Remote	268	288	282	300	298	324
Total for Registered	**8,552**	**8,745**	**8,595**	**8,778**	**8,302**	**7,392**

Table 19: Unregistered Providers by Remoteness for Therapy Supports, January 2021 to December 2023

Remoteness	January – June 2021	July – December 2021	January – June 2022	July – December 2022	January – June 2023	July – December 2023
Non-Remote	27,528	31,964	34,090	37,940	41,938	45,543
Remote	407	511	583	660	775	944
Very Remote	169	209	250	299	346	427
Total for Unregistered	**27,740**	**32,205**	**34,350**	**38,206**	**42,260**	**45,961**

Source: NDIS internal administrative data

Note: The total for registered providers of therapy supports and total for unregistered providers of therapy supports does not align with the total number of therapy support providers. The reasons for this are: 1) One provider can provide multiple supports, being registered for some supports and unregistered for others (different registration groups) in the same period, so they are accounted for in both groups of providers; 2) Providers with unknown registration are captured in total amounts but not presented in this table as they make up a very small percentage of total payments; and 3) Some participant location details at the time of transaction were not available, so provider remoteness could not be determined.

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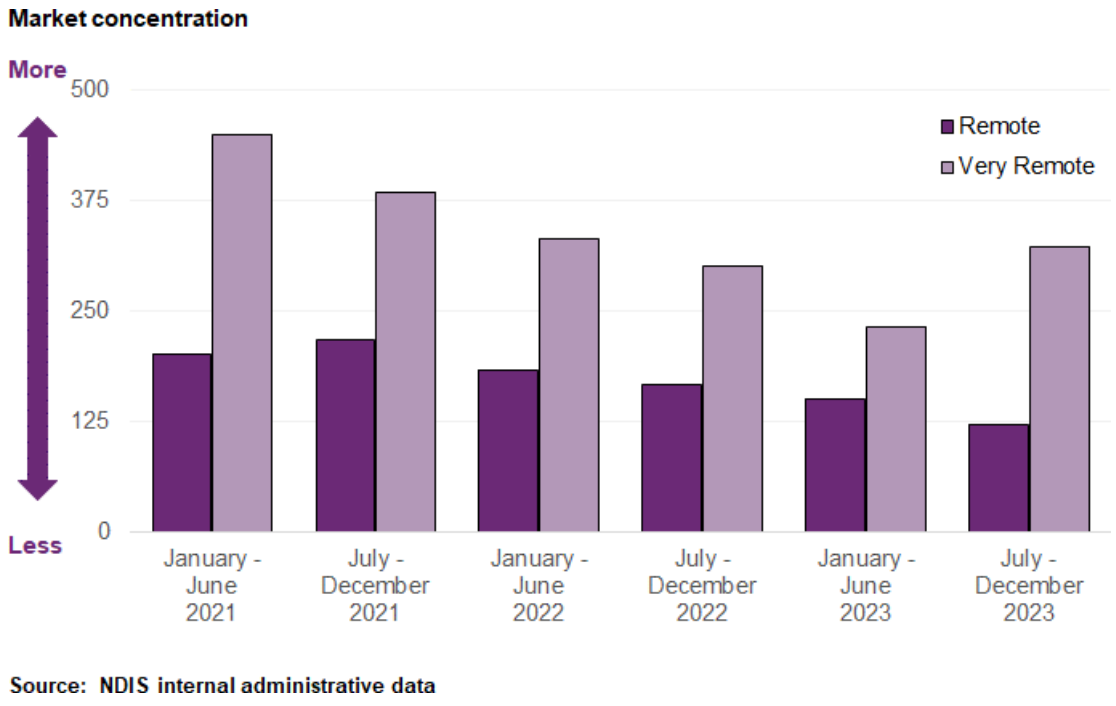
Herfindahl-Hirschman Index - Increasing provider diversity signals less concentration in the therapy market

The Herfindahl-Hirschman Index (HHI) measures market concentration and offers insight into the competitive dynamics of therapy support providers within the NDIS from January 2021 to December 2023. A HHI below 1500 signals a concentrated market, and the observed decrease in the HHI during this timeframe indicates a growing level of concentration. This trend has correlated with the diminishing market share of the top ten providers, which has dropped to just under 11%, and the growth in the market share of unregistered providers, which has almost doubled from 18% to 35%.

Adjustments to the HHI have been made, assuming the total market is equivalent to the sum of payments made to providers for therapy supports, due to the absence of comprehensive financial data for the Australian market and individual providers' financial statements. This approach offers a practical snapshot of the market's competitive environment, as visually represented in Figure 27.

The adjusted HHI index has remained low for non-remote areas between the observation period of six months to June 2021 and six months to December 2023. The perceived lack of concentration of providers has been most pronounced in the very remote areas; however, this situation has improved over the observation period. This is one metric to assist the Agency understand the health of the therapy market, with this trend suggesting an increasing diversity in provider options and potential benefits for NDIS participants in the therapy market.

Figure 27: Herfindahl-Hirschman Index for Therapy Supports, January 2021 to December 2023



Source: NDIS internal administrative data

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Note: Adjustments were made to HHI as the overall size of the Australian market and providers' financial statements are unknown at the time of the analysis. Therefore, the NDIA assumed that the size of the market is equal to the total amount of payments made to providers for DSW-related supports.

Provider claiming analysis – Unregistered providers are more likely to be charging below price limits

Approximately 34% of services are paid under the published price limit, showing a slight decrease over recent periods across all providers. These claiming patterns are shown in Table 20 that distinguish between services priced at the price limit for both provider types. This shows a consistent increase in the proportion of services billed at the price limit across all providers, with registered providers more likely to charge at the limit compared to unregistered ones.

While this trend is common to both registered and unregistered providers, unregistered providers more frequently offer services below the price limit (57% claimed at the price limit compared to registered providers' 70% in the six months to December 2023). Compared to total claims, the share of payment claims by unregistered providers has almost doubled from 18% to 35% from the first half of 2021 to the end of the 2023.

Table 20: Claiming Patterns at Price Limit Analysis for Therapy Supports, January 2021 to December 2023

Claiming patterns – At price limit	January – June 2021	July – December 2021	January – June 2022	July – December 2022	January – June 2023	July – December 2023
Registered	64%	66%	68%	69%	70%	70%
Unregistered	41%	45%	49%	52%	56%	57%
All Providers	**59%**	**61%**	**63%**	**64%**	**65%**	**66%**

Source: NDIS internal administrative data

Note: All Providers above are inclusive of providers with the unknown registration status at the time of the transaction.

5.3 Business dynamism in the NDIS therapy support market

This section assesses the activity and change among providers in the therapy market. Business dynamism is gauged by the frequency of new providers joining and existing ones becoming inactive in the market, which serves as an indicator of the market's overall health, and market competition.

To further assess the market dynamics, the NDIA reviewed the payment activities of registered providers over a three-year period from January 2021 to December 2023. 'New activity' is characterised by providers receiving payments in the half-year who

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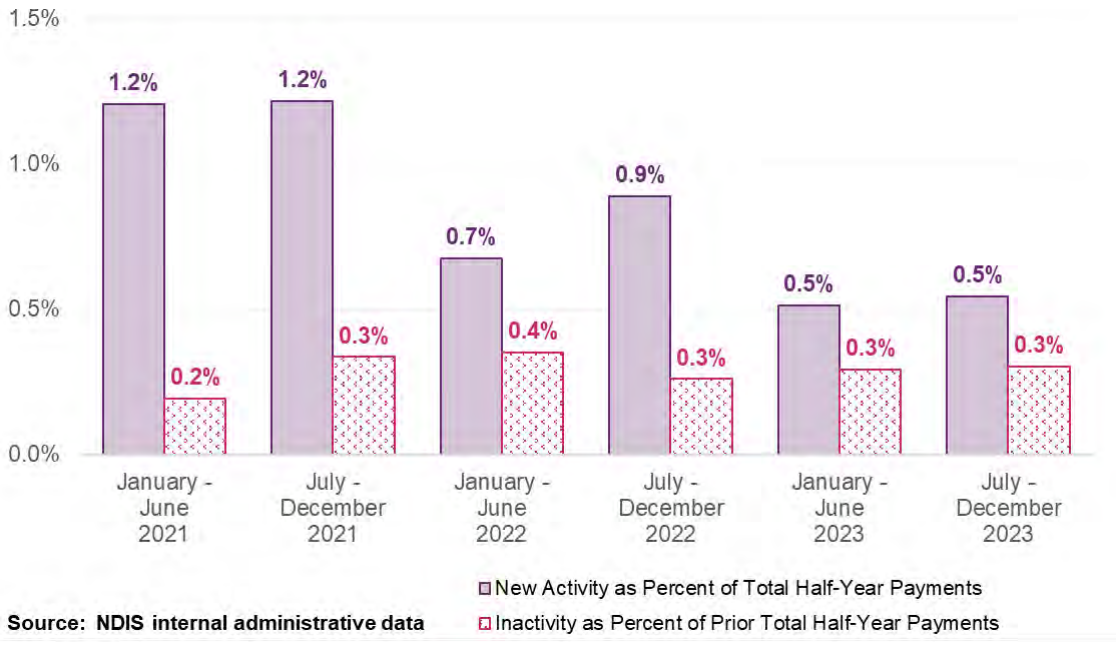
did not receive payments in the preceding half-year. Conversely, 'inactivity' refers to providers not receiving payments in a half-year after having received payments in the previous one. Each provider's activity is quantified as a percentage of the total payments within that half-year for new activity, of the prior half-year for inactivity. The NDIA recognises that this method does not perfectly measure market exits but provides the best estimation with the data available.

Despite a decrease in the number of registered therapy providers, they still accounted for 65% of total payments in the six months to 31 December 2023. This, in conjunction with the HHI findings, suggests that while the market is contracting in registered provider numbers, it continues to remain an important part of the therapy market.

Among registered therapy providers, 1,086 providers became inactive during this period; however, just under 840 providers of this group remained financially active by receiving payments for other services. Further analysis shows that 78% of these inactive therapy support providers had consistently received payments under $10,000 every six months, indicating that smaller providers could have contributed to the NDIS therapy market's fluctuation.

Figure 28 displays the change in registered provider activity between January 2021 to December 2023. Over the past three years, inactive registered providers in each half-year contributed to less than 0.4% of total payments. In contrast, registered providers with new activity in a half-year have contributed between 0.5% and 1.2% of total payments for that same period. The trend in the chart shows new providers receiving a smaller portion of total therapy support payments in 2023.

Figure 28: Registered Therapy Provider Activity Movements, January 2021 to December 2023



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Additional analysis reveals that inactive registered providers had relatively smaller claims averaging $3,129 in each half-year before becoming inactive, of which 88% received less than $5,000. This contrasts sharply with active registered providers, who claimed an average of $139,542 each half-year. This difference in payments underscores the extent of market diversification and the relative financial weight of new versus established providers.

Figure 29 offers a more granular look at the number of participants supported by registered providers, showing a trend towards a larger client base in the period between January to June 2021 and July to December 2023. Despite a reduction in the number of registered therapy support providers over this period, the number of providers servicing more than 20 participants increased, with these providers receiving 96.2% of payments in July to December 2023.

Figure 29: Registered Providers of Therapy Supports and Number of Participants that Claimed, January 2021 to December 2023

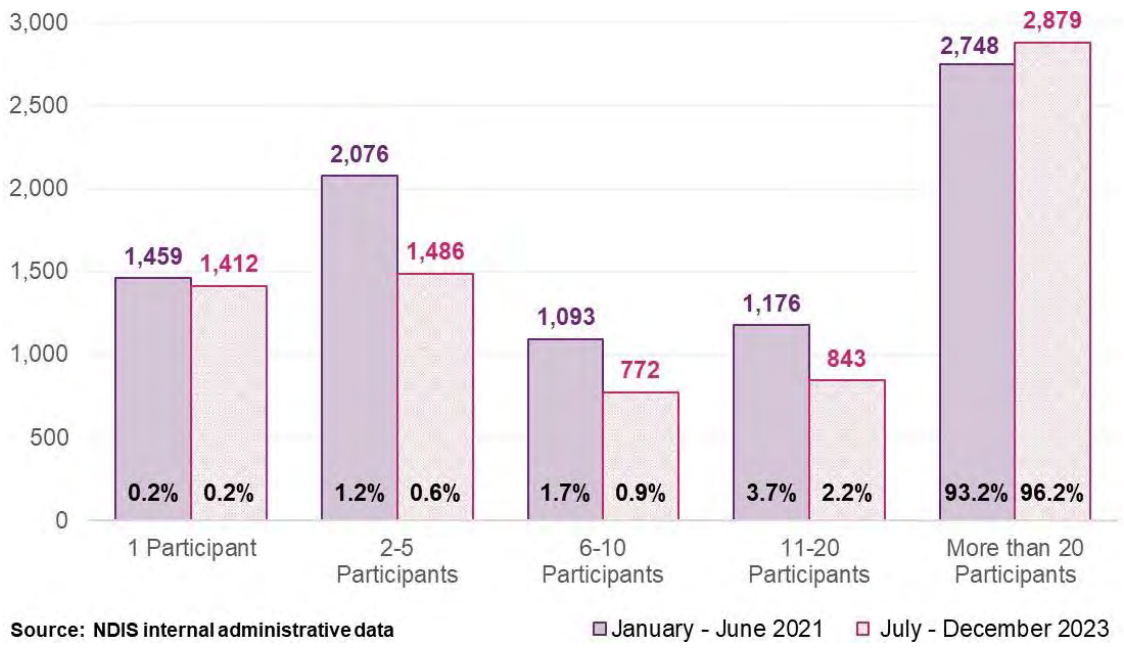


Figure 30 shows the number of registered therapy providers receiving payments from January 2021 to December 2023. Notably, 6,342 (48%) of 13,239 registered providers consistently received payments in all six half-year periods, which made up 94% of total payments. This data points to a common operating model adopted by large, registered providers which serves more participants.

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Figure 30: Provider Continuity by Registration Status and Percentage of Total Payments. Registered Providers (Left) and Unregistered Providers (Right), January 2021 to December 2023



5.4 Comparable government and funding schemes

The NDIA compared therapy price limits and arrangements across other comparable government schemes and funding. Overall, the analysis shows that NDIS price limits are broadly in line with other comparable schemes for most types of therapies.

The NDIA collaborated with 16 Commonwealth and State Schemes to obtain their therapy pricing. Responses from 13 schemes were received. For a complete overview of participating schemes, see section 2.4 Consultation overview.

To calculate the effective hourly price limit, the NDIA sought information about the regulated length of therapy sessions (for example, the NDIS price limits for therapy are per hour). For comparability, the NDIA generally used standard or subsequent consultations where possible, noting that many schemes have differentiated items and/or pricing for initial consultations and standard/extended consultations.

The NDIA were able to calculate the effective hourly price where the length of a session was provided (for example, price per 20 minutes) or as an average session time, based on the observed length of sessions. In some cases, the length of a session was based on a minimum or maximum length (for example, price for at least 20 minutes). In these situations, some assumptions were made by the NDIA to calculate an hourly price, based on available information. If the length of a session (or an approximation) was not provided, the NDIA were unable to calculate the effective hourly price, and not able to directly compare prices, so these were excluded from the analysis.

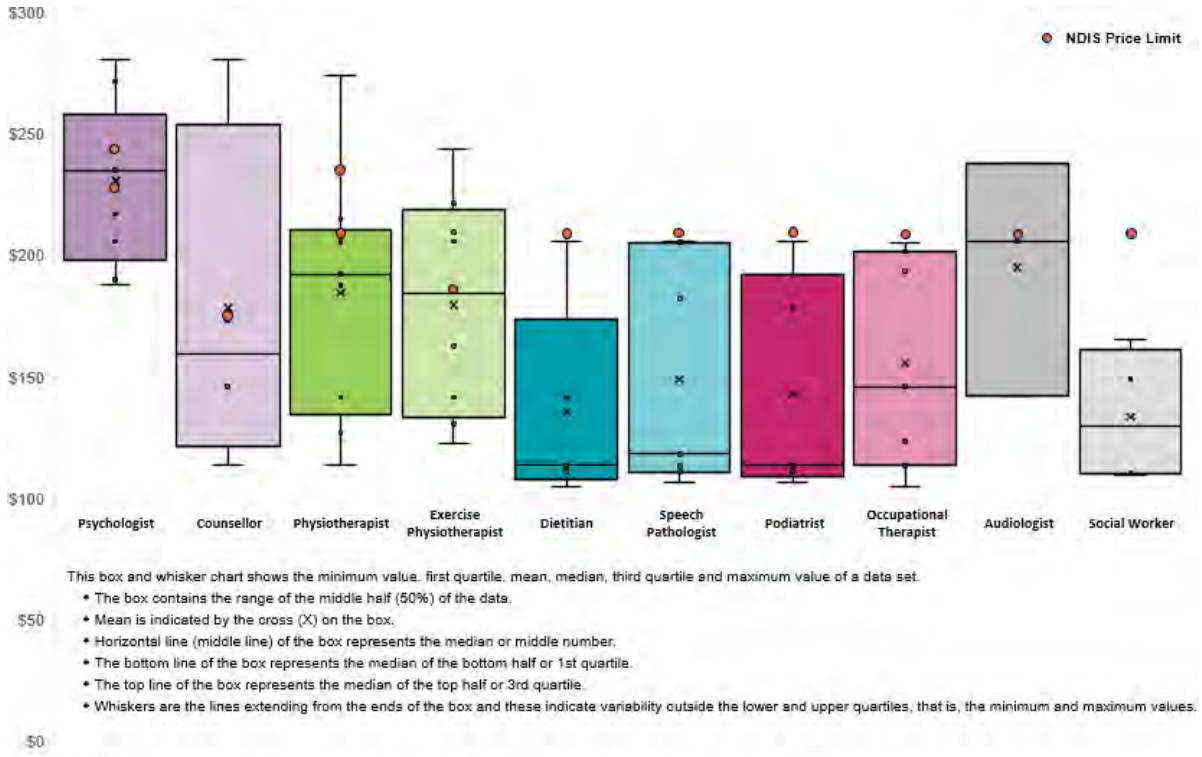
As Figure 31 shows, the current NDIS price limits (shown as orange dots) are broadly within the range of the effective hourly rates paid by other schemes for the most common therapy supports, after considering duration of service. Information received indicates that over the past year, most schemes have increased prices for

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the therapy supports that they provide. Price changes vary by scheme and therapy support, but typically fall between 2% and 8%. This appears to have put NDIS into the middle range for some therapies, such as Audiologists, Counsellors, Exercise Physiologists and Psychologists, acknowledging ranges can be quite broad once scheme prices are turned into a comparable hourly price.

The main Medicare Benefits Schedule (MBS) items for allied health have a scheduled fee of $68.55 per 20 minutes session. This equates to an effective hourly rate of $205.65 which is higher than the NDIS hourly price limit. The Commonwealth funding (MBS benefit) for the hour is 85% ($174.80), but co-payments are common in the MBS and the scheduled fee is a better estimate of the total cost of the support.

Figure 31: Comparison of NDIS price limits to other government schemes



Source: NDIS calculations of comparable prices of other government funding schemes

Note: NDIS price limits are shown by orange dots. For some therapy supports, the NDIS has two different price limits. One price limit is for the eastern states (NSW, VIC, QLD, ACT) and the other is for all other states (WA, SA, TAS, NT).

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5.5 Private billing rates

This section analyses a data set of 1,791 private billing rates for several NDIS-related weekday in-room therapy services. The private billing dataset was compiled by the NDIA by scanning provider websites across Australia. Prices for weekend, initial consultations and telehealth consultations were excluded from the dataset, as well as some outliers[50].

The sample has been derived from the private billing analysis conducted in the 2021-22 Annual Pricing Review (4,014 in-scope observations). The NDIA tried to replicate the same sample during the 2022-23 Annual Pricing Review (2,857 in-scope observations). For reference to last year's analysis, 1,167 observations dropped out of the last years sample of 2,857.

For greater representation in certain segments of the sample, observations were expanded in certain states (NSW, SA, NT and ACT) to ensure there were enough observations for significant results. This led to over 200 provider websites randomly sampled for relevant pricing, with many not having available or comparable pricing. In total, this provided a sample size of 1,791 observations for the 2023-24 period. The sample size is still considered sufficient for the purpose of pricing benchmarking. In the absence of a requirement to publish pricing or a database of comparable, time-based therapeutic sessions, these hinder the long-term viability of this sampling method. The NDIA intends to consider measures to improve this process in coming years.

The private billing rates were converted to effective hourly rates based on the length of consultation, for more direct comparison to the applicable NDIS price limit. About 30% of the sample included billing rates from non-metropolitan areas (considered as Modified Monash Model (MMM) areas 4 to 7).

In the analysed sample of therapy services, the most frequently represented therapists were Physiotherapists, making up 20.5% of the dataset, followed by Psychologists at 15.4%, Clinical Psychologists at 10.1%, and Dietitians at 8.9%. For most therapy types, the dataset includes at least 80 observations, with the exceptions being Art Therapists (26 observations), Music Therapists (39 observations), and Social Workers (45 observations).

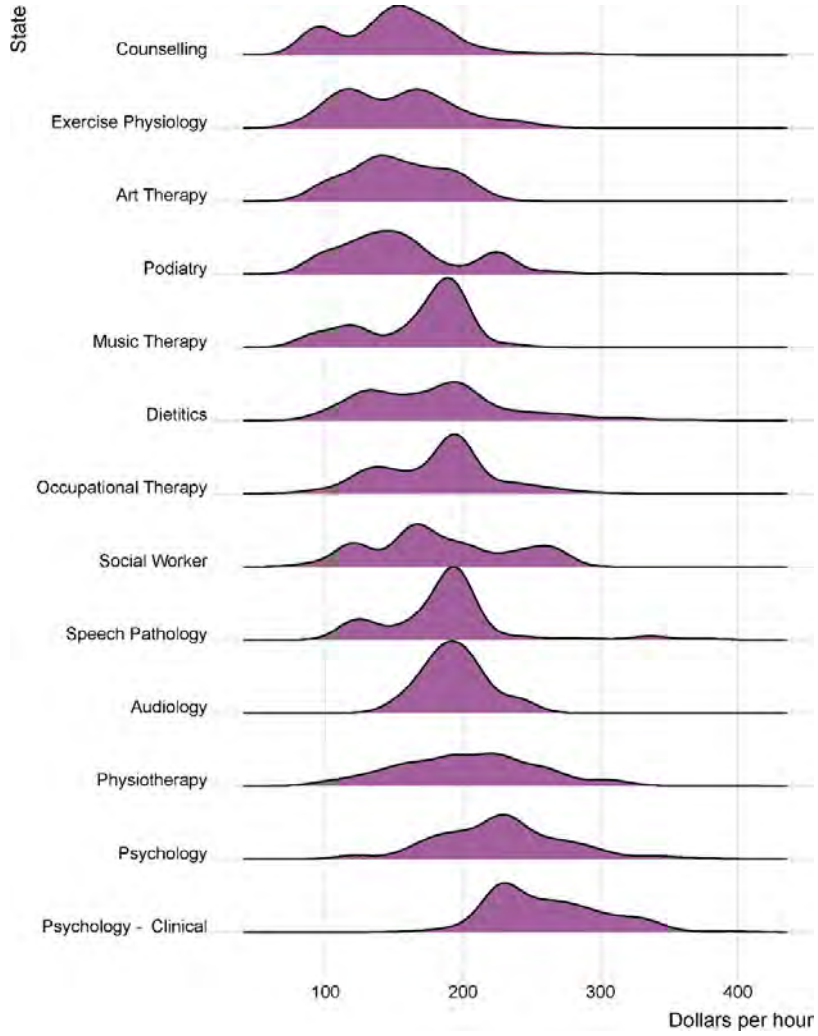
The diversity and overlap in pricing across different therapy types are illustrated in Figure 32, showing the range and commonalities in billing rates among the various services. There appears to be some multi-modal distributions for several types of

[50] The study excluded outliers where the value of hourly rate was either greater than Quartile 3 +1.5*Interquartile or was smaller than Quartile 1 – 1.5*Interquartile.

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therapies, where there is a cluster of prices in the sample around different price points.

Figure 32: Distribution of Private Billing Rates by Therapy Types



The distribution of sample observations geographically leaned more towards VIC, 34% of the sample, and QLD, with 27%, indicating an underrepresentation of therapists from NSW, which accounted for only 20%, compared to its share of the NDIS market (31% of total NDIS therapy claims in the six months to December 2023). The NT was the only state or territory with fewer than 30 observations (12).

Figure 33 shows the distribution of private billing rates across different states and territories, revealing substantial overlap and variance. From the analysis, certain states, and territories, including the NT and TAS, exhibited a variety of trends in pricing distribution.

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Figure 33: Distribution of Private Billing Rates by State and Territory

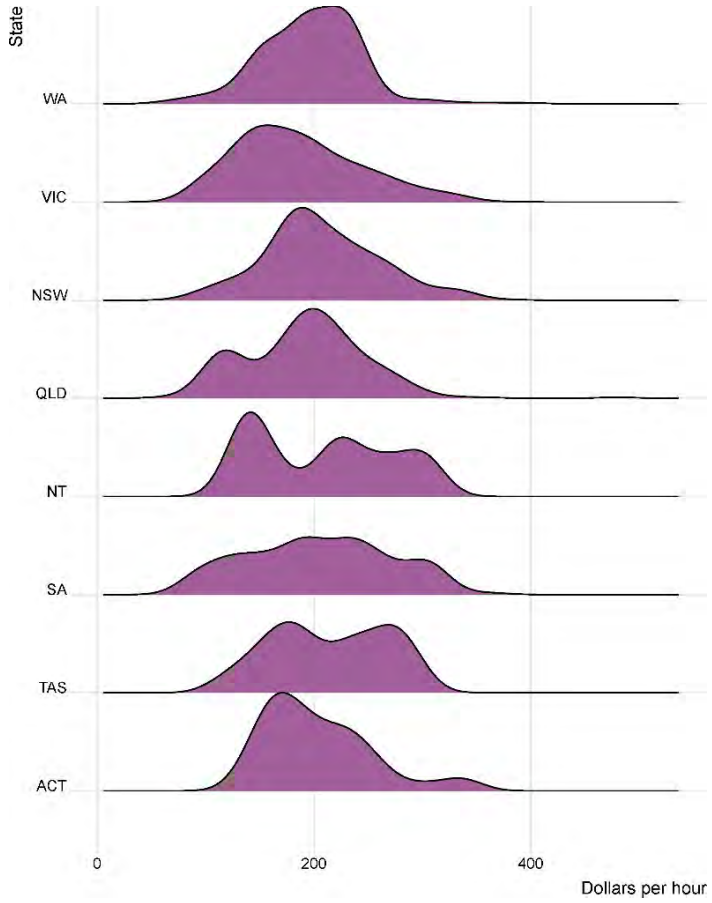


Table 21 shows an overview of the distribution statistics for the private billing rates sampled. On average, the effective hourly rate for therapists providing in-room services on weekdays was $195.6, with a median rate closely following at $194. The data set revealed a wide range of billing rates, from a minimum of $85 to a maximum of $396.

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Table 21: Summary Statistics of Private Billing Rate Sample, by Therapy Type

Type of Therapy	Count	Mean	Standard Deviation	Min	25th percentile	Median	75th percentile	Max	NDIS price limit
Art Therapy	26	$154.5	$30.6	$100.0	$135.0	$147.5	$178.8	$216.0	$193.99
Audiology	86	$194.5	$21.7	$156.7	$180.0	$190.0	$210.0	$240.0	$193.99
Counselling	161	$153.1	$41.2	$85.0	$120.0	$150.0	$179.5	$305.5	$156.16
Dietetics	165	$175.3	$51.2	$92.5	$132.0	$170.0	$200.0	$320.0	$193.99
Exercise Physiology	115	$154.1	$39.2	$93.3	$120.0	$159.0	$180.0	$265.3	$166.99
Music Therapy	39	$166.0	$36.7	$90.4	$120.0	$180.8	$194.0	$233.3	$193.99
Occupational Therapy	128	$181.0	$38.4	$93.3	$150.0	$194.0	$194.0	$291.0	$193.99
Physiotherapy	364	$202.7	$50.2	$90.0	$165.0	$200.0	$240.0	$324.0	$193.99*/ $224.62**
Podiatry	86	$157.9	$46.8	$90.0	$120.0	$150.0	$180.0	$315.0	$193.99
Psychology	281	$228.6	$45.7	$120.0	$196.5	$228.0	$254.2	$380.0	$214.41*/ $234.83**
Psychology - Clinical	179	$260.3	$39.6	$165.3	$230.0	$255.0	$284.4	$396.0	$214.41*/ $234.83**
Social Worker	47	$184.8	$48.0	$90.0	$160.0	$180.0	$218.2	$270.0	$193.99
Speech Pathology	113	$192.7	$65.6	$95.0	$163.3	$193.3	$194.0	$380.0	$193.99
Total	**1,791**	**$195.6**	**$56.0**	**$85.0**	**$158.0**	**$194.0**	**$230.0**	**$396.0**	**Varies**

Note: * VIC, NSW, QLD, ACT. ** WA, SA, TAS, NT

Figure 34 and Figure 35 compare the average private billing rates for various therapy types to the current NDIS price limits. The findings indicate:

The average billing rates for clinical psychology and psychology in all states and territories exceed the NDIS price limits.

Therapies such as Speech Pathology, Audiology, Occupational Therapy, Dietetics, Social Work, Exercise Physiology, and Counselling have billing rates that are 90% or more of their NDIS price limits.

Conversely, Art Therapy (78.7%), Podiatry (81.4%), and Music Therapy (85.6%) show average billing rates that fall significantly below their NDIS price limits.

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Figure 34: Average Private Billing Rate Compared to the NDIS Price Limit (Dollar Value)

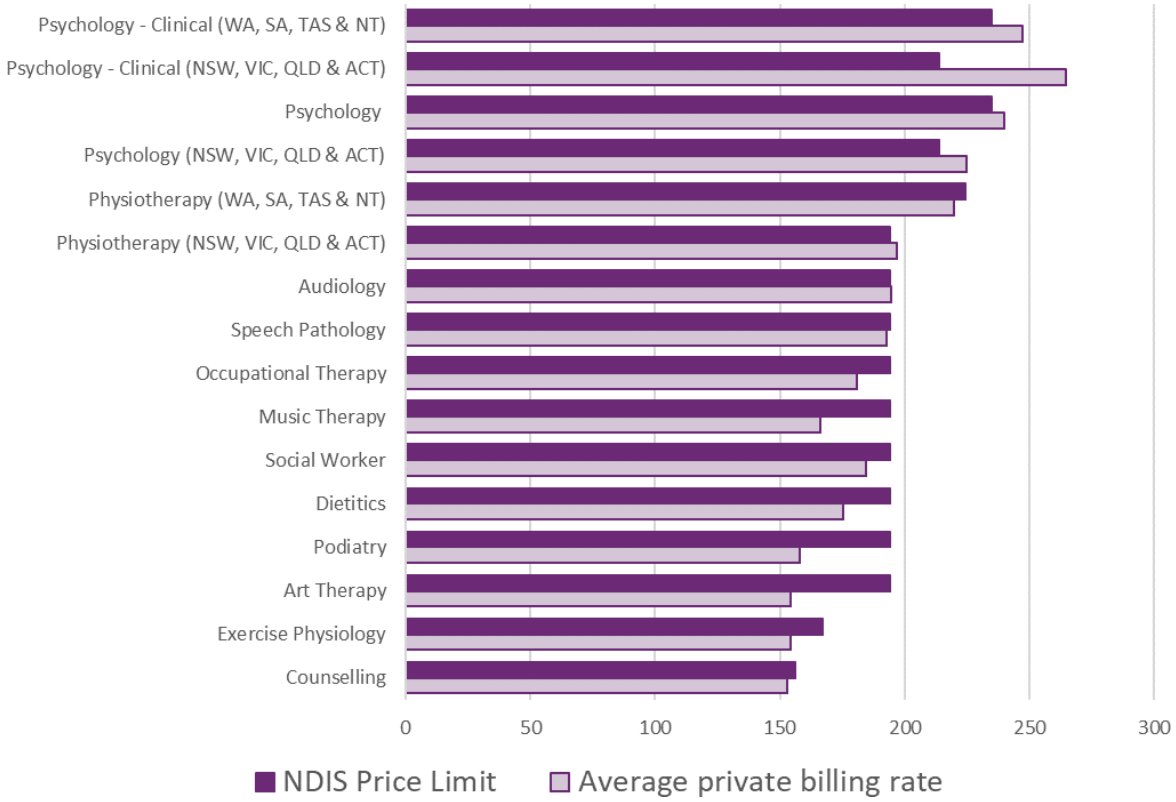
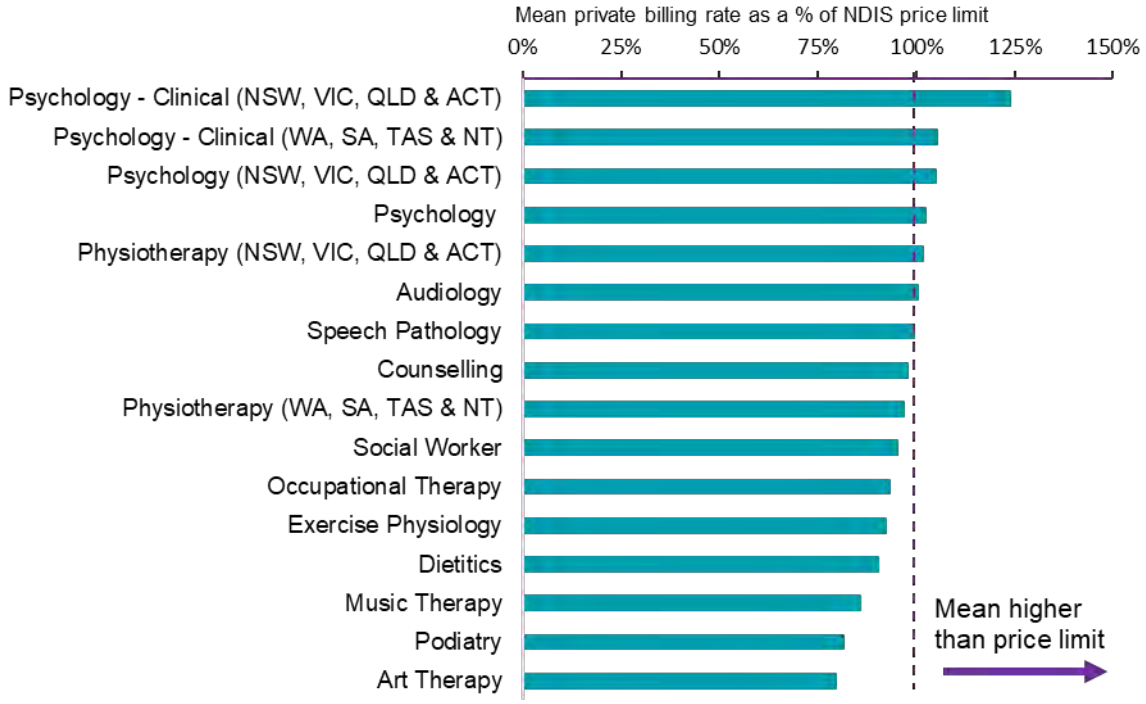


Figure 35: Average Private Billing Rate as a percentage of NDIS price limit



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5.6 Mean, Median and 75th percentile billing rates

Comparing the NDIS price limits with the mean, median, and 75th percentile billing rates for therapy types reveals important insights into the alignment between NDIS price limits and market-driven billing practices.

5.6.1 Psychology

The relevant NDIS price limits for Psychologists are set at $214.41 for VIC, NSW, QLD, and ACT (state grouping 1), and $234.83 for WA, SA, TAS, and NT (state grouping 2).

The statistical analysis shows that Psychologists have an average billing rate of $228.6, and Clinical Psychologists have a higher mean rate of $260.3. These amounts for this sample exceed the NDIS hourly price limits for Psychology supports, for both different state and territory groupings.

The median billings rates for Psychologists and Clinical Psychologists were at $228.0 and $255.0, respectively, which exceed the NDIS hourly price limits for Psychology supports, for most state and territory groupings.

The 75th percentile billing rates for psychologists and clinical psychologists are $254.2 and $284.4 respectively, indicating that a significant portion of billed appointments exceed the NDIS price limits.

This upper quartile of billing rates suggests that the private billing rates are frequently higher than the NDIS price limits. The benchmarking results indicate that the market rates for Psychology services, at the mean, medians and 75th percentile are now higher than the NDIS price limits.

5.6.2 Other therapy types

The following section discusses Audiology, Physiotherapy and Speech Pathology (selected due to sample being the next closest to the NDIS price limits). Note, $193.99 is the NDIS price limit for Audiology (national), Speech Pathology (national) and Physiotherapy (VIC, NSW, QLD, and ACT – state grouping 1). It is $224.62 for Physiotherapy in WA, SA, TAS, and NT (state grouping 2)

The means of private billing rates for Audiologists, Physiotherapy, and Speech Pathologists are $194.5, $202.7, and $192.7, respectively. For Physiotherapy, it has means of $197.0 and $220.9 for state groupings 1 and 2, respectively.

This is compared to the median billing rates for Audiology, Physiotherapy and Speech Pathology of $190.0, $200.0 and $193.3, respectively. For Physiotherapy, when considering the state groupings, the medians are $194.0 and $224.6 for state groupings 1 and 2, respectively.

At the 75th percentile, observed rates within the private market for these supports is $210.0 for Audiology, $240.0 for Physiotherapy, and $194.0 for Speech Pathology,

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suggesting the top 25th percentile of market rates are above NDIS price limits for Audiology and Physiotherapy.

The NDIS hourly price limits appear broadly in line with these measures, suggesting a general compatibility with the current private billing rates, particularly with mean and median rates aligning with the applicable NDIS price limits.

5.7 Regressions

Regression analyses were undertaken to understand the relationship between therapy types, geographic regions, and billing rates, and to determine how these variables influence the price variability within the private therapy market. Table 22 details the results of the regression analysis. The dependent variable in all model regression models is the hourly private billing rate in dollars.

The analysis explores the similarities between some of the therapy groups. A series of Tukey's range tests[51] were undertaken to group therapy types with similar means of private billing rates. The test found that Audiology, Dietetics, Occupational Therapy, Physiotherapy, Speech Pathology, and Social Work share comparable billing averages (Group 1); while Art Therapy, Counselling, Exercise Physiology, Music Therapy, and Podiatry share similar means. Group 3 comprises of both Psychology and Clinical Psychology, which are distinct but are considered together for analytical simplicity. These grouping forms the basis of Model 3, which will be explained further below.

Table 22: Statistical Models of Private Billing Rates

Variable	(1)	(2)	(3)
Constant	180.6***	178.1***	192.5***
Art Therapy	-25.5**	-23.3**	
Audiology	13.1*	20.4*	
Counselling	-30.6**	-32.7**	
Dietetics	-0.7	-2.9	
Exercise Physiology	-29.5***	-27.6***	
Music Therapy	-14.8**	-20.1**	
Physiotherapy	23.8***	20.4***	
Podiatry	-22.7***	-21.5***	

[51] A Tukey range test is a statistical tool used to compare the means of different groups to determine if they are significantly different from each other, while accounting for the fact that multiple comparisons are being made.

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Variable	(1)	(2)	(3)
Psychology	47.1***	47.6***	
Psychology – Clinical	90.1***	78.3***	
Social Work	5.1	4.7	
Speech Pathology	23.2***	22.4***	
Counselling, Exercise Physiology, Art & Music Therapy & Podiatry			-40.2***
All Psychology			46.7***
Regional		-11.4***	-12.57***
NSW		23.2***	22.9***
QLD		2.8	0.2
SA		12.3**	11.5**
WA		0.2	-0.4
Tas		2.4**	3.5**
ACT		22.6**	19.1**
NT		53.7**	52.1**
Adjusted R2	0.321	0.352	0.315
F Statistic	70.76	51.2	92.01
Observations	1,791	1,791	1,791

(* = p <0.05, ** = p < 0.01, *** = p<0.001)

Note: The baseline (Constant) for Model 1 is Occupational Therapy. The baseline in Model 2 is Occupational Therapy in Metropolitan Victoria and in Model 3 it is Group 1 therapies (Audiology, Dietetics, Occupational Therapy, Physiotherapy, Speech Pathology, and Social Work) in Metropolitan Victoria.

Regression results of three specifications are presented in this section. The modelling begins with each therapy type as variables, (Model 1). The base (or omitted) variable is Occupational Therapy, meaning the constant coefficient reflects the mean Occupational Therapy private billing fee. The coefficients attached to each therapy type reflects the fee relative to Occupational Therapy (for example, the coefficient attached to Art Therapy is -25.5 and hence the average billing rate for Art Therapy is $155.1 (180.6 minus 25.5).

Model 2 builds upon Model 1 by including state/territory and regional indicators, with Occupational Therapy, Metropolitan and Victoria being the base variables that reflect the coefficient on the constant term. Model 3 keeps the geographical indicators but replaces the individual therapy variables with the groupings found using the Tukey difference in means tests discussed previously.

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Model 2 is preferred over Models 1 and 3 for its slightly higher explanatory power, with an adjusted R-squared[52] of 0.352, indicating it explains 35.2% of the variations in private billing rates. The results suggest that the average hourly rate of $178 for Occupational Therapists in Metropolitan Victoria (Model 2), with Audiologists, Psychologists, Physiotherapists and Speech Pathologists appear to have exceeded the applicable NDIS price limits (statistically significant at 0.05 level).

A deep dive into the regression results revealed a meaningful statistical difference between both Clinical and Non-Clinical Psychology nation-wide. The results showed significant statistically difference consistent across applicable states and above its price limits. This adds significance to the previously discussed means, medians and 75th percentiles comparisons between the different types of therapies.

The NDIA acknowledges that there are many uncaptured variables that would assist a greater explanation of private billing rates. This, however, is difficult to obtain through website scrapping alone.

5.8 Consultation feedback

The APR received 178 provider submissions, feedback from 13 professional bodies, one union, and 142 participants on therapy support services. A predominant theme was the suggested increase in the costs of delivering therapy support services, cited by approximately 87% of providers. These cost increases spanned across wages (including adjustments to meet Allied Health Awards and professional development), business expenses such as rent, utilities, office supplies, and insurance, as well as recruitment and retention challenges. The Ability Roundtable, incorporating an Allied Health Cost Model by Deloitte Access Economics, suggested a large difference, with a 12.9% variance between projected costs and the current NDIS Price Limit for major allied health disciplines. Professional bodies advocated for a price limit increase reflective of cumulative indexation since 2019 and suggested automatic indexation from 2025, claiming thin margins on which many small-scale therapy support businesses operate.

Regarding the provision of therapy and early childhood supports to both NDIS and non-NDIS participants, most providers catered to a mix of clients, with the proportion of NDIS participants ranging from 25% to nearly 100%. Despite the varied client base, appointment durations were often standardised, tailored to client needs rather than funding source, although complexities associated with NDIS participants sometimes necessitated longer sessions. Pricing approach varied, with most providers charging at the NDIS price limit, yet some reported differences in charges between NDIS and non-NDIS clients, attributed to the complexity of NDIS

[52] R-squared is a statistical measure that represents the proportion of the variance for a dependent variable that is explained by an independent variable or variables in a regression model.

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participants or additional administrative burdens. Unique costs associated with early childhood supports for NDIS participants were identified, including the need for team-based approaches, specialised skills, and extended appointments, which highlighted the complexity and intensity of services required. Professional bodies echoed these sentiments, emphasising the need for specialised training and resources, particularly for providers catering to young children with disabilities.

See Appendix A for more details on common themes raised in submissions to the 2023-24 APR Consultation Paper.

5.9 Discussion

The Australian therapy market encompasses a wide array of services provided by allied health professionals, who are typically university-educated with specialised expertise in preventing, diagnosing, and treating various conditions and illnesses. While the NDIS forms an important part of this landscape, allied health services extend beyond NDIS funding. These services are also accessed through various other arrangements, including Medicare subsidies, private health insurance, where it is common for out-of-pocket payments to be made by the consumer, other government schemes, and the Department of Veterans Affairs (DVA).

In the 2022-23 financial year, 39% or approximately 10,389,000 individuals accessed allied health services[53]. For comparison, 379,296 participants, representing 59% of the total 646,449 Scheme participants in the six months to 31 December 2023, accessed allied health supports using NDIS funding.

The NDIS therapy provider market has continued to demonstrate strong growth (14% growth for the six-month comparison to 31 December 2023 to same period the previous year), with a notable trend away from registered providers to a diversified unregistered provider market. The proxies the NDIA has used as an overview for market health and competition include the HHI, provider entry, periods of activity and inactivity and share of total NDIS therapy payments has suggested the market continues to mature and continues to meet increasing demand in most areas.

The NDIS therapy market operates in a manner that closely aligns with the characteristics of a deregulated, or private market, more so than other NDIS sub-markets. Despite its market-like behaviour, the NDIS therapy market includes regulatory mechanisms, specifically price limits, to assist participants to receive value for money. These price limits are closely linked to the dynamics of the private market, ensuring that NDIS pricing remains competitive and reflective of current service costs.

[53] Australian Institute of Health and Welfare (2022), *Australia's health 2022: in brief,* catalogue number AUS 241. Australia's health series number 18, AIHW, Australian Government.

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Accordingly, other government schemes and the private billing market serve as suitable comparators to assess the appropriateness of the NDIS price limits. Feedback from consultations and discussions with various government funding schemes has indicated that, despite the relative smallness of users of the NDIS therapy market, it could act as a 'price setter.' Evidence of this may be seen in private billing rates, where the median and 75th percentile rates pricing for certain therapies align closely with the corresponding NDIS price limits.

Although benchmarking NDIS price limits against other comparable government funding schemes may introduce certain inaccuracies, it remains an important process. This ensures that government funding mechanisms do not inadvertently compete against each other for therapy professionals. Key factors to consider when comparing NDIS to other schemes include:

- **Risk assessment and pricing models:** Some schemes often base pricing on risk assessments and pooled resources, which does not always reflect the costs of individualised support required by individuals, such as NDIS participants compared to the general population.
- **Contractual and volume discounts:** Prices in other government schemes may be influenced by contractual agreements or volume discounts that are not applicable in the context of the NDIS service delivery that can lead to lower benchmarks.

The 2023-24 APR analysis of other schemes showed that while some have increased their pricing or funding levels, NDIS price limits remain consistent with the majority of therapies provided across these schemes. It is important to note, that there is significant variation in therapy pricing and funding levels among different schemes. Additionally, certain therapies such as Audiology, Art Therapy, and Music Therapy, which are covered by the NDIS, are not typically funded by other insurance schemes, including private health.

The analysis of private billing rates offers a comprehensive view of the diverse range of therapy supports available to NDIS participants, reflecting market-driven costs influenced by direct service delivery, provider expertise and current demand. By gathering a broad dataset of private billing rates from provider websites and adjusting them to effective hourly rates, the NDIA ensures a fair comparison across different therapies and geographic areas. This standardisation is important for assessing whether NDIS price limits align with market rates, thereby maintaining fairness and relevance within the private therapy sector.

The analysis indicates that NDIS price limits generally match or exceed the rates for most therapies nationwide. However, regression analysis highlights statistically significant variances among therapies, which could correspond to differences among therapy professionals such as in qualifications, skills, and experience.

Examining the statistically significant differences and general market pricing metrics, including the mean, median, and 75th percentiles, showed that rates for

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Psychologists often met or exceeded the NDIS price limits. Additionally, when compared with other government schemes, the NDIS price limits for Psychologists are not at the higher end of the spectrum. This information together suggests there is stronger evidence supporting adjustment to NDIS price limits for Psychologists compared to other types of therapists.

5.10 Recommendations

After reviewing the current price limits for Psychologists against private billing rates and other comparable government schemes, it is apparent that the current limits generally sit below the prevailing market rates. The mean billing rate for psychologists is $228.6, with clinical psychologists at a higher rate of $260.3, both exceeding the NDIS hourly limits. The difference is further highlighted at the 75th percentile billing rates, where a significant portion of billed services are charged at higher rates, than current price limits. This gap between market rates and the current NDIS price limits suggests that the NDIA should increase the hourly price limits, with the proposal being to use an indexation methodology of 80/20 split between the Australian Bureau of Statistics (ABS) Wage Price Index (WPI) and ABS Consumer Price Index (CPI).

Recommendation 4

The NDIA should increase the price limits for supports delivered by a Psychologist on 1 July 2024 in line with the weighted movement over the previous twelve months in the ABS Wage Price Index (Australia, total hourly rates of pay excluding bonuses) and the ABS Consumer Price Index (All Groups, weighted average of eight capital cities) over the 12 months to the March Quarter immediately preceding the indexation date (with an 80/20 weighting).

Specifically, this should be for support line items: ‘Assessment Recommendation Therapy or Training – Psychologist (15_054_0128_1_3), ‘Early Childhood Supports – Psychologist (15_001_0118_1_3)’, and ‘Specialist Behaviour Intervention Support (11_022_0110_7_3)’.

Review of the alignment of the NDIS price limits for other therapists against the private billing rates and other comparable schemes suggests a general compatibility between NDIS price limits and prevailing market rates. In general, for most therapists, mean and median billing rates closely mirror the NDIS hourly price limits, which are set at $193.99 in most regions, suggesting that the current price limits adequately reflect market norms. Even when considering some therapists which means, medians and 75th percentile billing rates exceed NDIS price limits, the frequency of such instances does not indicate a systemic pricing concern that hinders participants from accessing these services relative to other clientele.

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Recommendation 5

The NDIA should not make any further structural adjustments to the pricing arrangements for therapy supports at this time and should not index the price limits for all other therapy-related supports on 1 July 2024.

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DISCLOSURE LOG

6. Support Coordination

6.1 Context

Support coordination, funded by the NDIS, is important for supporting participants to utilise their NDIS plans and achieve their goals. Support coordinators assist participants by connecting them to NDIS funded and mainstream supports, tailoring services and supports to individual participant wishes and plan budgets. They are also instrumental in enhancing participants' abilities to understand and navigate the NDIS, empowering them to make informed decisions. This includes monitoring plan budgets and the effectiveness of supports, ensuring they align with participants' needs, preferences, and goals.

To be effective in their roles, support coordinators need an in-depth understanding of the service offerings within a participant's local market, identifying providers who can meet their needs and preferences. This often involves sourcing alternative providers to ensure continuity of support.

Registration is not mandatory for support coordinators. However, registered support coordination providers in groups: 0106: Assistance in coordinating or managing life stages, transitions, or supports, and 0132: Specialised Support Coordination must adhere to the NDIS Practice Standards. These standards cover participant rights, provider governance, and conflict of interest management.

The NDIS has an established pricing framework to cater to varying levels of support coordination, from basic Support Connection to Specialist Support Coordination for participants with higher support needs. This framework aims to provide a balanced pricing model, facilitating quality support for participants. The three levels – support connection (level 1), coordination of supports (level 2), and Specialist Support Coordination (level 3) – reflect the spectrum of assistance participants might require, each with designated price limits (Table 23). Additional information on the Price Limits and Pricing Arrangements for support coordination can be found on the NDIS website.

This chapter reviews the appropriateness of the current pricing arrangements for Support Coordination.

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Table 23: NDIS Price Limits for Support Coordination Supports

Item Number	Item Name and Notes	Unit	Non-Remote	Remote	Very Remote
07_001_0106_8_3	Support Coordination Level 1: Support Connection	Hour	$74.63	$104.48	$111.95
07_002_0106_8_3	Support Coordination Level 2: Coordination of Supports	Hour	$100.14	$140.19	$150.21
07_004_0132_8_3	Support Coordination Level 3: Specialist Support Coordination	Hour	$190.54	$266.75	$285.80

6.2 The NDIS Review

The final report from the Independent NDIS Review addressed foundational aspects of the current support system, making recommendations on the need to introduce a new navigation function. It acknowledges the essential role of support coordination in aiding participants to manage and implement their NDIS plans effectively but also suggests inconsistencies in its delivery and effectiveness.

Due to the proposed reforms recommended by the NDIS Review, developing a support coordination specific cost model at this point of time involves significant risk of having an outdated pricing model while the sector is undergoing significant evolution. On balance, it is not recommended for the NDIA to develop a specific cost model for Level 2: Coordination of Supports and Level 3: Specialist Support Coordination (Recommendation 9 from the 2022-23 Annual Pricing Review) now. A stable and predictable pricing framework over the transition period is important to allow participants and providers to plan with greater certainty and minimise disruption.

6.3 Scheme Statistics

Table 24 and Figure 36 show that in the six-month period to December 2023, 8,823 unique providers delivered support coordination to 245,696 participants, which accounts for 38% of all active participants in the Scheme. This activity represents $531 million in payments, or 3% of the total scheme spend. This is an 18% increase from the same period in the previous year, which saw $451 million in payments.

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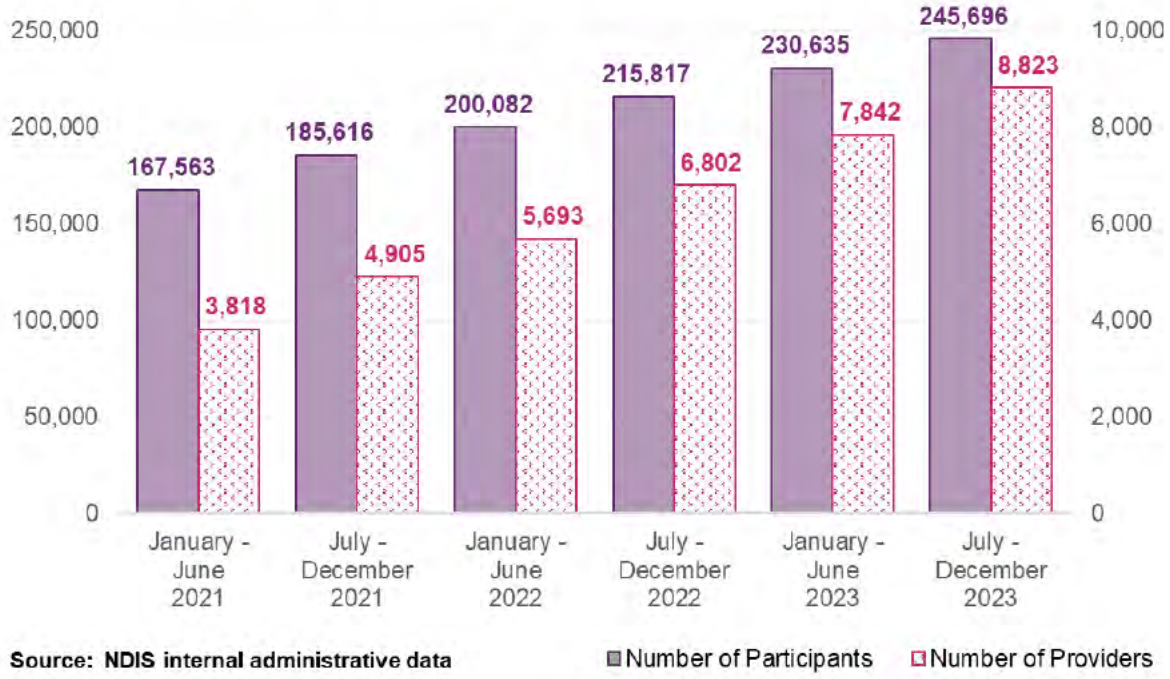
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DISCLOSURE LOG

Table 24: Summary of Changes in Support Coordination Participants, Total Providers and Total Claims

Statistics	July – December 2022	July – December 2023	Percentage Change
Total number of NDIS participants	215,817	245,696	+14%
Total number of active providers	6,802	8,823	+30%
Total amount claimed	$451 million	$531 million	+18%

Figure 36: Number of Participants and Providers Claiming Support Coordination Supports, January 2021 to December 2023



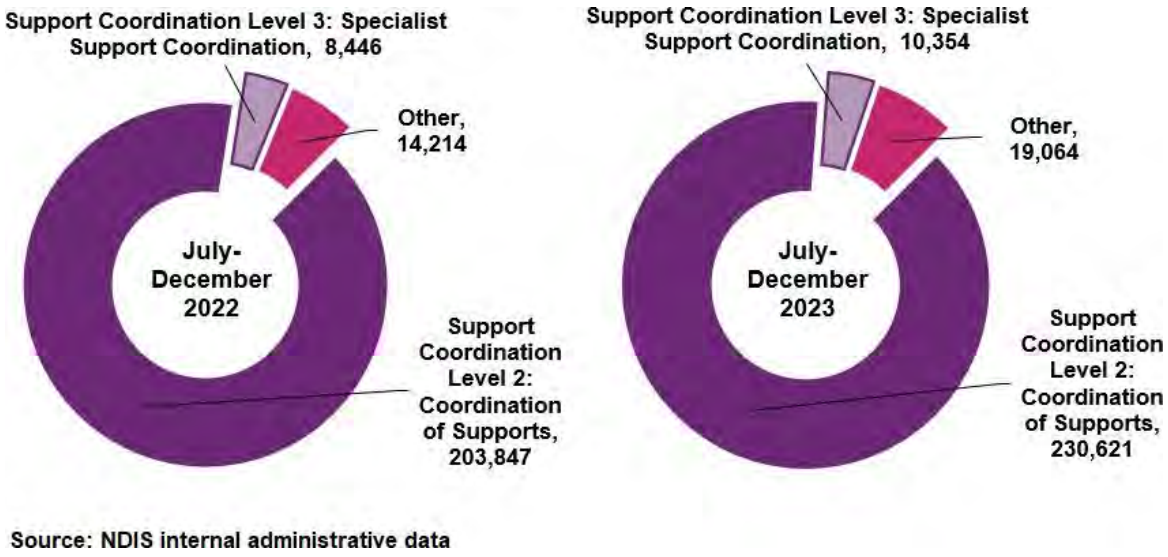
Source: NDIS internal administrative data

6.4 Participants

From July to December 2023, 230,621 participants used Level 2: Coordination of Supports. There were 10,354 participants who used Level 3: Specialist Support Coordination and 19,064 participants who used other support coordination supports (Level 1: Support Connection and Psychosocial Recovery Coach supports). Figure 37 illustrates the distribution of participants using different levels of support coordination compared to the previous year.

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Figure 37: Participants Using Different Levels of Support Coordination Supports



Source: NDIS internal administrative data

6.5 Providers

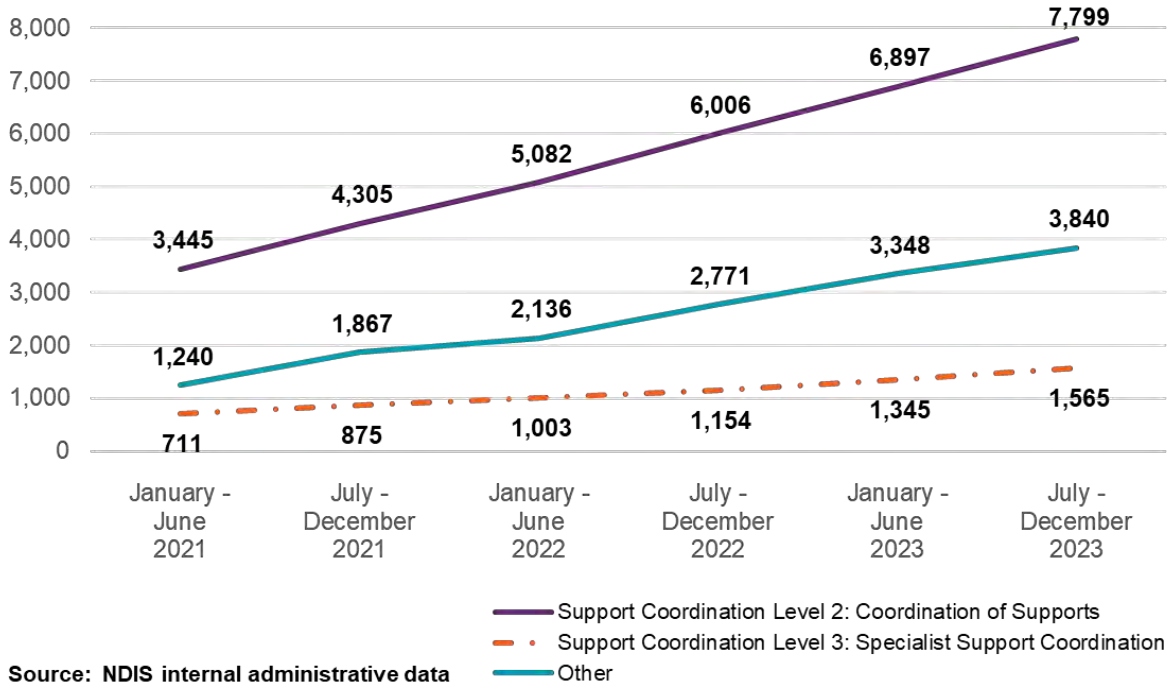
6.5.1 The number of providers continues to grow, especially unregistered providers

Figure 38 examines the growth of NDIS support coordination service providers between January 2021 and December 2023, showing differences in how fast different levels are expanding. The provider landscape has seen considerable growth, with the number of unique providers delivering Level 2 Support Coordination increasing from 3,445 to 7,799 over the period, an average six-month growth rate of 18%. The proportion of registered to unregistered providers has decreased from 79% to 42%, although registered providers still accounted for 82% of the total claims for these services in the six months to December 2023.

Notably, the number of providers for Level 2: Coordination of Supports has tripled over the observation period, showing a much faster growth rate compared to providers of Level 3: Specialist Support Coordination and other support coordination supports, which have grown at a slower pace.

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Figure 38: Number of Providers by Support Coordination Level, January 2021 to December 2023



Source: NDIS internal administrative data

6.5.2 The increasing number of unregistered providers has led to changes in market share

From January 2021 to December 2023, the market dynamics in the support coordination sector changed considerably. The period saw a 50% increase in the number of registered providers, alongside a four times increase in unregistered providers. During this time, the market share of unregistered providers grew from 75% to nearly 18%.

Concurrently, the market share held by the top ten providers diminished from 11% to 7% (Figure 39), a trend observed consistently across different geographical settings; non-remote, remote and very remote areas (shown in Figure 40, Table 25 and Table 26). This decrease in concentration among the largest providers highlights the changing dynamics across the sector.

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Figure 39: Changes in Top Ten Provider Market Share Compared to Growth in Support Coordination Providers, January 2021 to December 2023

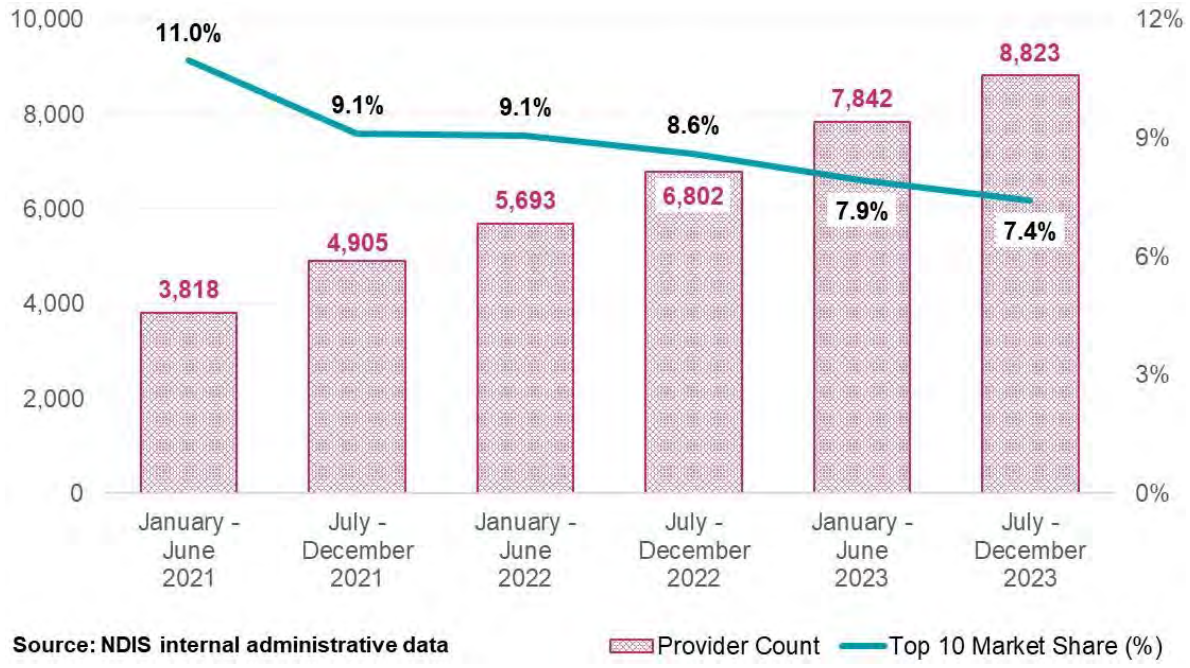
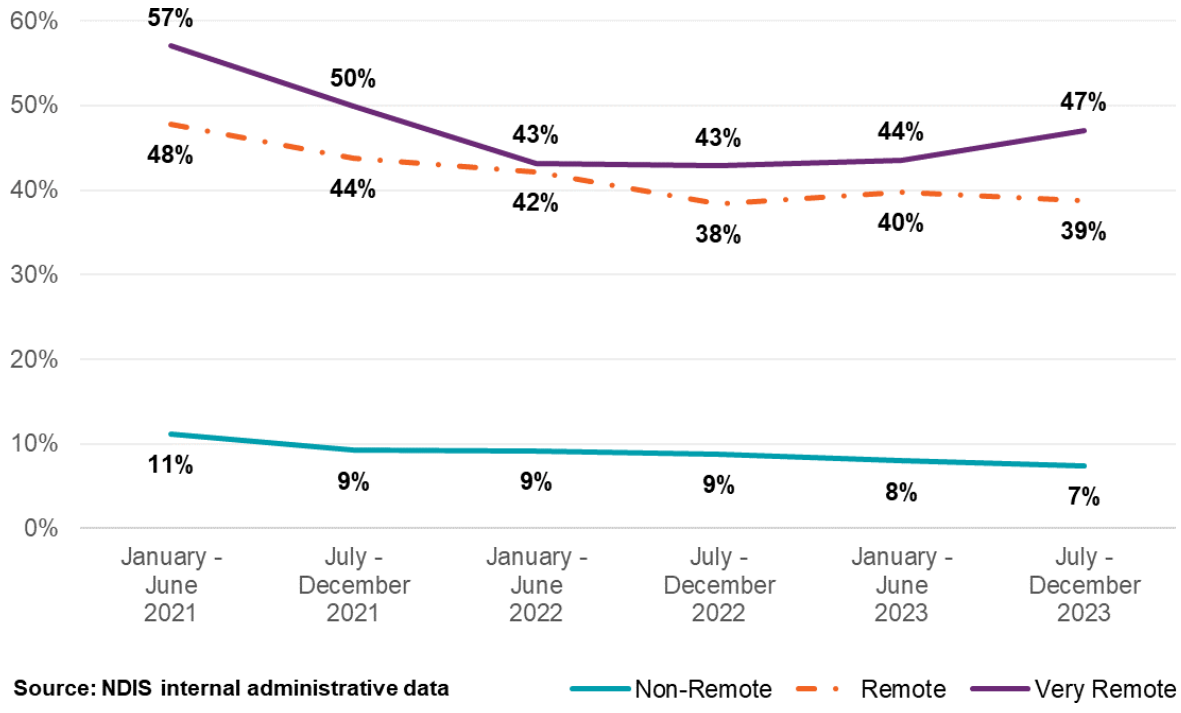


Figure 40: Top Ten Provider Market Share by Remoteness for Support Coordination Supports, January 2021 to December 2023



Note: the chart shows market share for both registered and unregistered providers.

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Table 25: Registered Providers by Remoteness for Support Coordination Supports, January 2021 to December 2023

Remoteness	January – June 2021	July – December 2021	January – June 2022	July – December 2022	January – June 2023	July – December 2023
Non- remote	2,444	2,787	3,026	3,294	3,469	3,647
Remote	280	299	299	308	324	362
Very remote	168	182	175	187	199	212
Total for registered	**2,467**	**2,810**	**3,044**	**3,332**	**3,503**	**3,686**

Table 26: Unregistered Providers by Remoteness for Support Coordination Supports, January 2021 to December 2023

Remoteness	January – June 2021	July – December 2021	January – June 2022	July – December 2022	January – June 2023	July – December 2023
Non- remote	1,437	2,147	2,712	3,472	4,366	5,242
Remote	36	71	85	121	160	197
Very remote	23	35	47	69	80	98
Total for unregistered	**1,455**	**2,174**	**2,739**	**3,518**	**4,420**	**5,300**

Source: NDIS internal administrative data

Please note a discrepancy in the total number of 'active' therapy providers, attributable to two factors: firstly, some providers offer a mix of registered and unregistered supports, leading to their classification in both categories. Secondly, a small fraction of providers with undetermined registration status contributes to total payment figures but is excluded from detailed tabulation, representing less than 1% of the overall financial transactions.

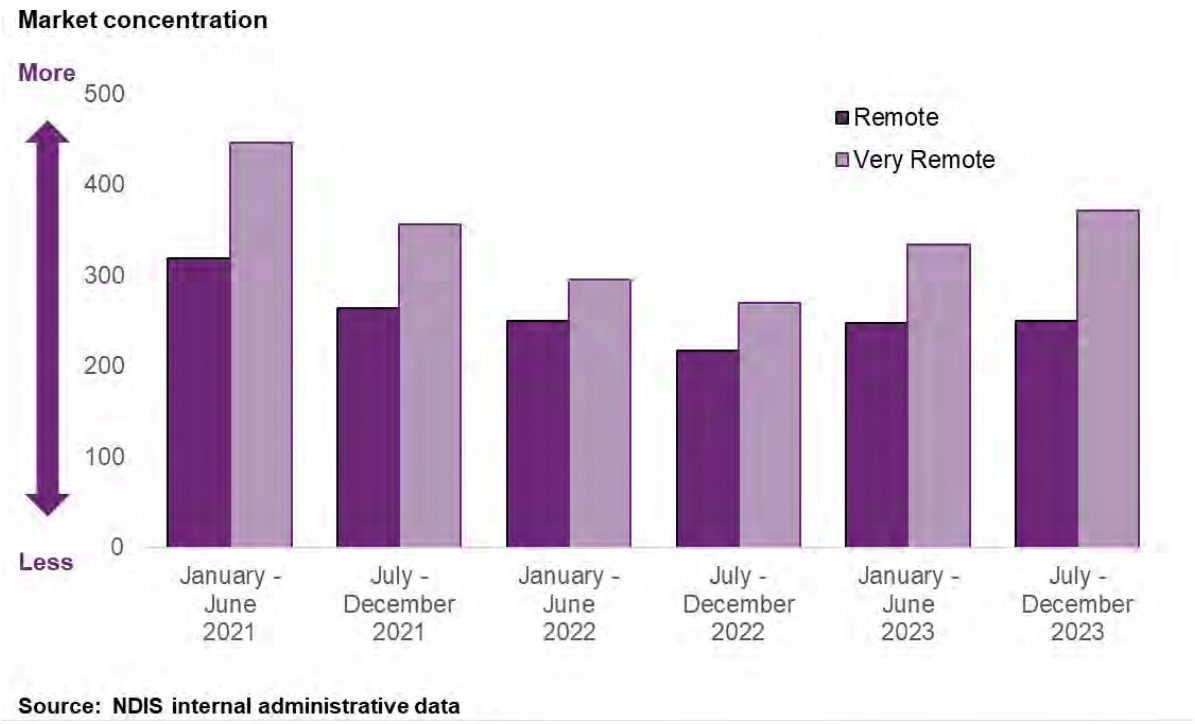
6.5.3 Market share reduction of leading providers shows signs of a less concentrated market

There are a number of indicators which can be used to assess whether there is healthy competition in a market. While no single measure is a perfect indicator of the level of competition, the Herfindahl-Hirschman Index (HHI) measures market concentration and offers some insight into the health of the support coordination sector. A HHI under 1,500 indicates a market with many competitors and a lack of dominance by any single provider, which typically results in more choices. Conversely, a rise in the HHI indicates a rise in market concentration, suggesting less competition among providers.

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In the period from January 2021 to December 2023, the adjusted HHI for support coordination in metro areas has been low and is currently at 16, indicating a less concentrated market. This is contrasted by a much higher adjusted HHI in the remote (250) and very remote areas (371) which is consistent with a prior expectation (Figure 41). Moreover, the adjusted HHI for very remote areas has been decreasing until six months to December 2022. Since then, the adjusted HHI for very remote areas has increased again but not back to the levels from two to three years ago.

Figure 41: Herfindahl-Hirschman Index for Support Coordination Supports, January 2021 to December 2023



6.5.4 The unregistered support coordination market appears to be structured differently

Submissions to the APR from registered support coordinators and peak bodies suggest differences in cost structures between registered and unregistered providers. It is claimed that registered providers face additional financial imposts stemming from the registration process and ongoing compliance obligations, expenses not shared by their unregistered counterparts. This difference in operational costs potentially influences pricing strategies, where registered providers may price their services at or near the NDIS price limit to offset costs associated with regulatory compliance.

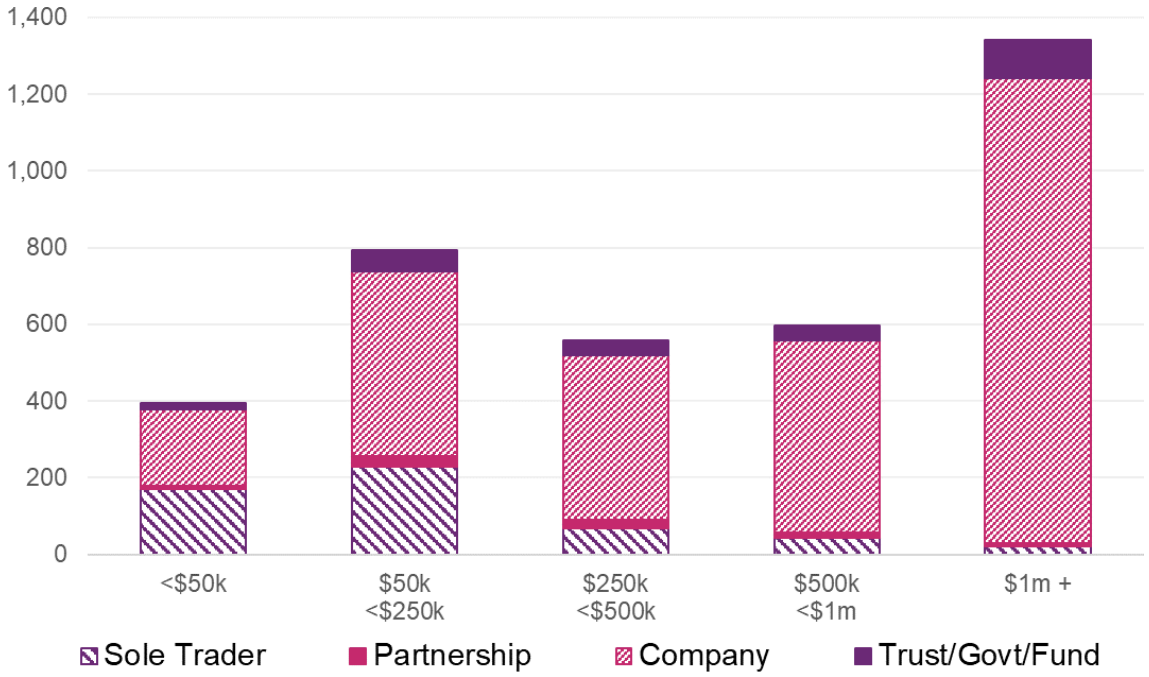
Figure 42 and Figure 43 show the distribution of support coordination providers by registration and entity type for the six months to December 31, 2023. Figure 42 shows that registered providers are mostly companies providing significant NDIS

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supports, while Figure 43 shows that unregistered providers are mostly sole traders especially those with lower turnover.

Registered providers claimed 82% of the support coordination payments made to all providers. This demonstrates that registered providers, although representing a smaller proportion of the total providers count (5,300 unregistered providers to 3,686 registered providers), are responsible for the majority of payments in terms of service delivery.

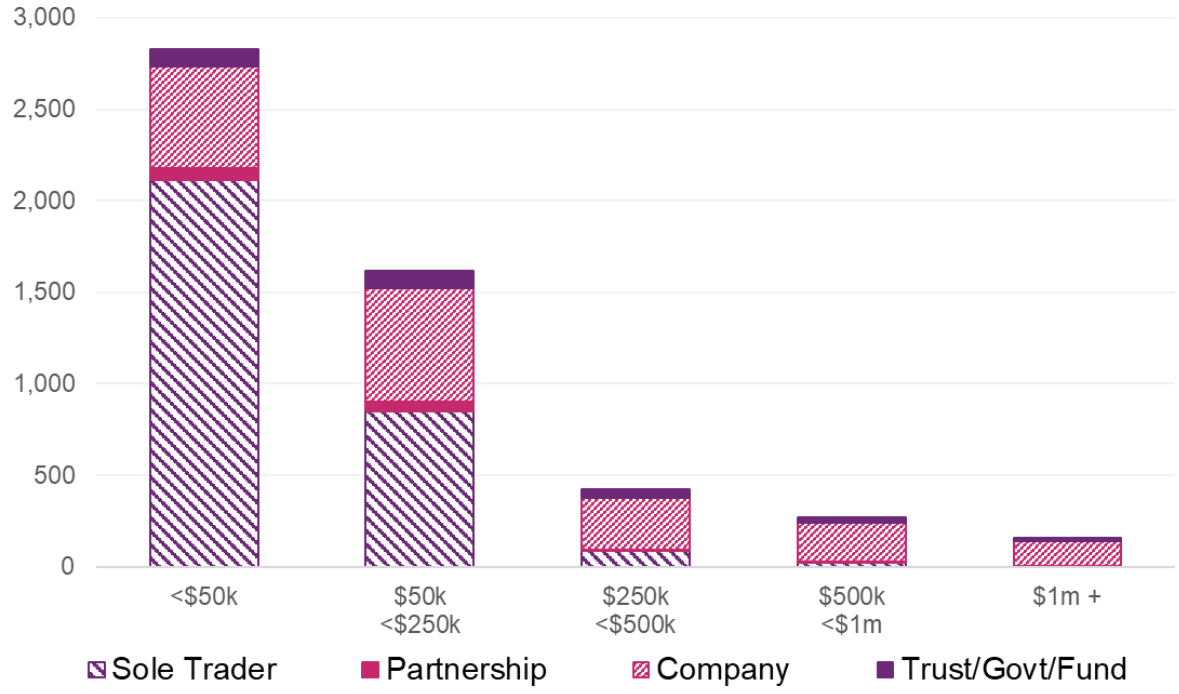
Figure 42: Registered Providers of Support Coordination Supports by Entity Type and Total Payments, July to December 2023



Source: NDIS internal administrative data

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Figure 43: Unregistered Providers of Support Coordination Supports by Entity Type and Total Payments, July to December 2023



Source: NDIS internal administrative data

These above figures highlight a contrast in the type of markets across unregistered and registered support coordinators. That is the make-up of markets, payment wise, the unregistered support coordinator market seems to be dominated by smaller sole traders, compared to the registered support coordinator market that is predominantly larger companies.

Table 27 shows that approximately 13% of support coordination services were delivered at rates below the NDIS price limits. This trend has been driven by activities of unregistered providers, who are more likely to claim below the price limits. Unregistered providers have seen their share of total transactions increase from 2% in the six-month period from January to June 2021 to 12% in the six-month period from July to December 2023, underscoring their growing presence and competitive pricing strategies within the NDIS market.

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Table 27: Claiming Patterns at Price Limit Analysis for Support Coordination Supports, January 2021 to December 2023

Claiming patterns – At price limit	January – June 2021	July – December 2021	January – June 2022	July – December 2022	January – June 2023	July – December 2023
Registered	91%	93%	93%	92%	90%	89%
Unregistered	66%	72%	75%	74%	74%	72%
All Providers	**91%**	**92%**	**92%**	**91%**	**89%**	**87%**

Source: NDIS internal administrative data

Note: All Providers above are inclusive of providers with the unknown registration status at the time of the transaction.

6.6 Business dynamism in the NDIS support coordination market

This section examines the vitality and changes within the market for support coordination of registered providers. The analysis in this section focuses on registered providers as it reflects the majority of the payments (82% in the six months leading to December 2023)[54]. Business dynamism refers to the rate at which new providers enter the market and existing providers exit. This is one of many indicators of the market's health, competitiveness, and its capacity to innovate and meet participants needs.

6.6.1 Comparison of provider payments for "new" activity and inactivity

To further assess the market dynamics, the NDIA reviewed the payment activities of registered providers over a three-year period from January 2021 to December 2023. 'New activity' is characterised by providers receiving payments in the half-year who did not receive payments in the preceding half-year. Conversely, 'inactivity' refers to providers not receiving payments in a half-year after having received payments in the previous one. Each provider's activity is quantified as a percentage of the total payments within that half-year for new activity, of the prior half-year for inactivity. The NDIA recognises that this method does not perfectly measure market exits but provides the best estimation with the data available.

The data indicate that over the three years, providers who became inactive in any half-year accounted for 0.4% to 0.6% of the total payments. On the other hand,

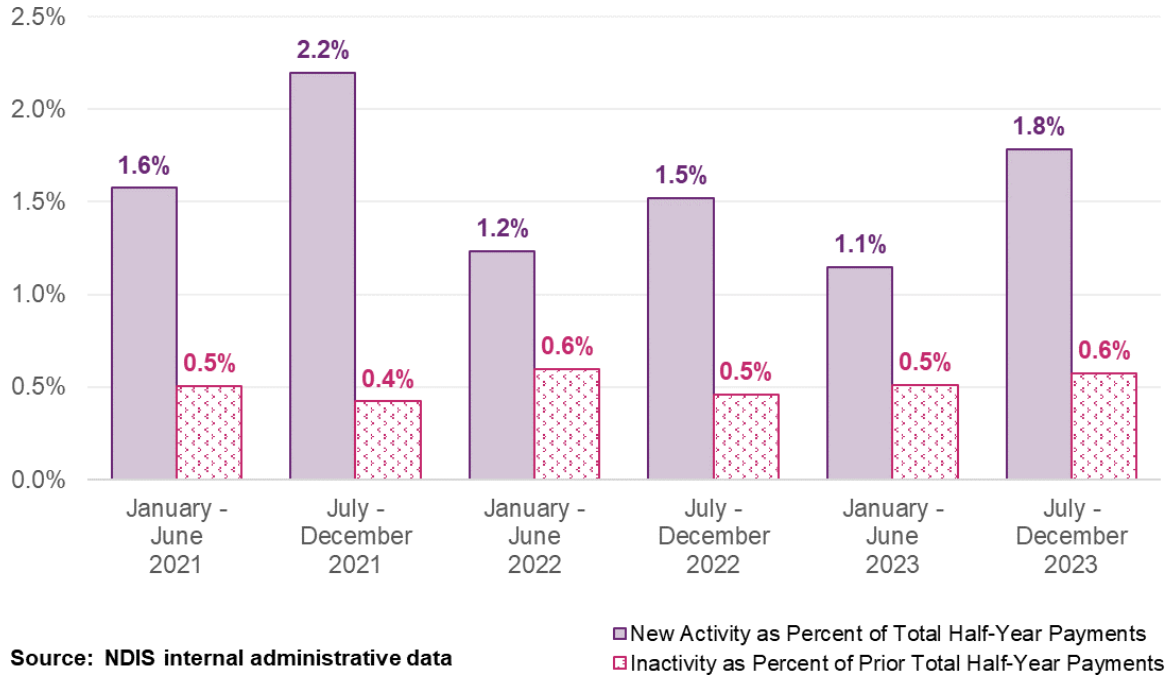
[54] Data analysis of registered provider payment activity by the NDIA includes payments made against Agency managed plans, which are attributed to registered providers, and payments for plan management services. Providers with an unclear status at the time of transaction or those providing an invalid ABN have been excluded from this analysis.

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providers with new activity in any half-year contributed to 1.1% to 2.2% of the total payments.

Figure 44 displays the change in registered provider activity between January 2021 to December 2023. Payments made to "new" active providers are consistently higher than payments made to providers in the six-month period before they became inactive.

Figure 44: Registered Support Coordination Provider Activity Movements, January 2021 to December 2023



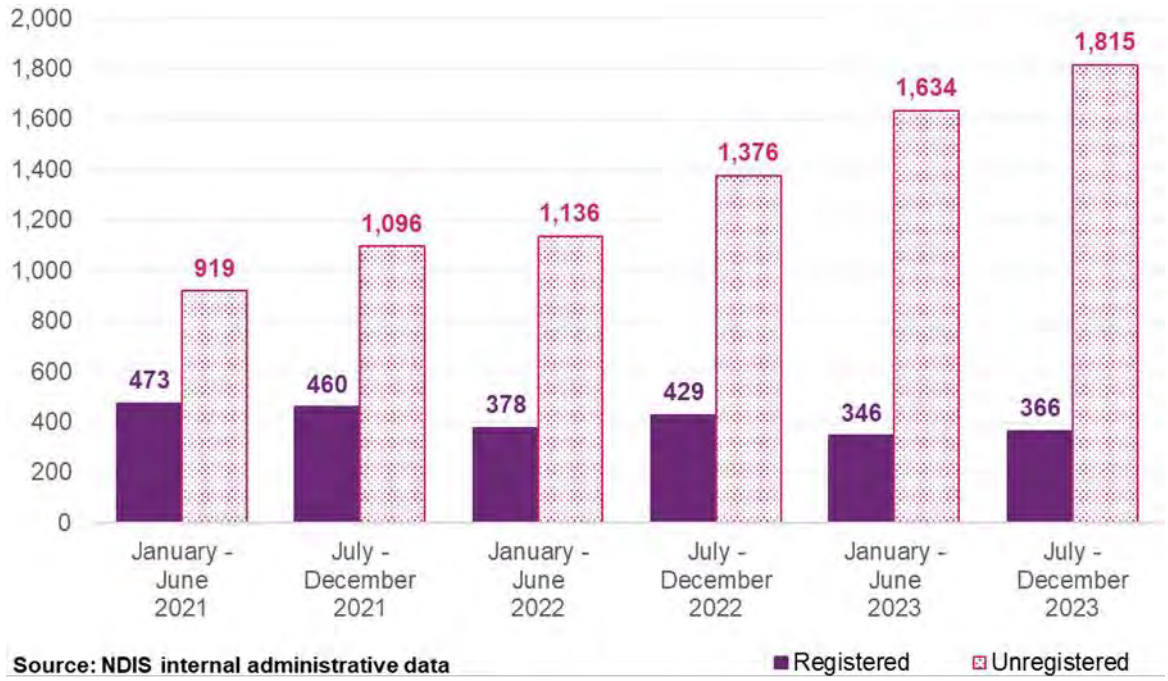
Source: NDIS internal administrative data

6.6.2 The number of providers continues to grow, driven by unregistered providers

Figure 45 illustrates a comparison of new support coordination provider volumes by registration type from January to July 2021 to July to December 2023. It shows a consistent trend where the growth of new unregistered providers outpaces that of registered ones throughout the observed period.

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Figure 45: New Support Coordination Provider Counts, January 2021 to December 2023

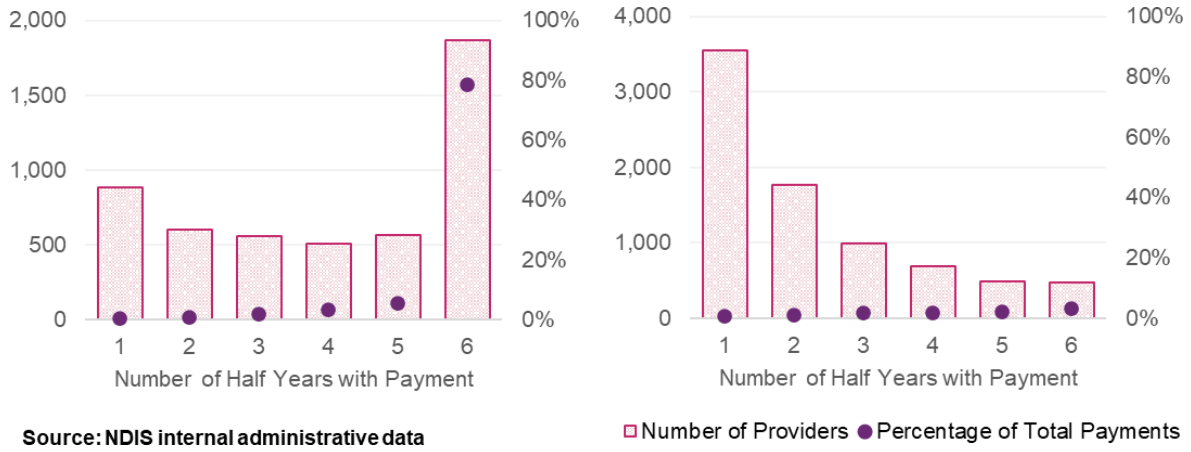


6.6.3 Registered providers show more payment stability than unregistered providers

Assessing the stability of support coordination providers, there is a pronounced distinction between the registered and unregistered provider market. Figure 46 shows the number of half years with payments, with providers split up by registration status. It also shows the percentage of total support coordination payments for each grouping as a portion of total registered and unregistered payments combined. This figure shows that approximately 38% of registered providers have consistently been active across the last six half-year periods, receiving 78.3% of total payments in the six months to December 2023, indicating a high degree of payment stability. Conversely, only about 6% of unregistered providers have maintained the same level of payment activity, accounting for 3.3% of total payments.

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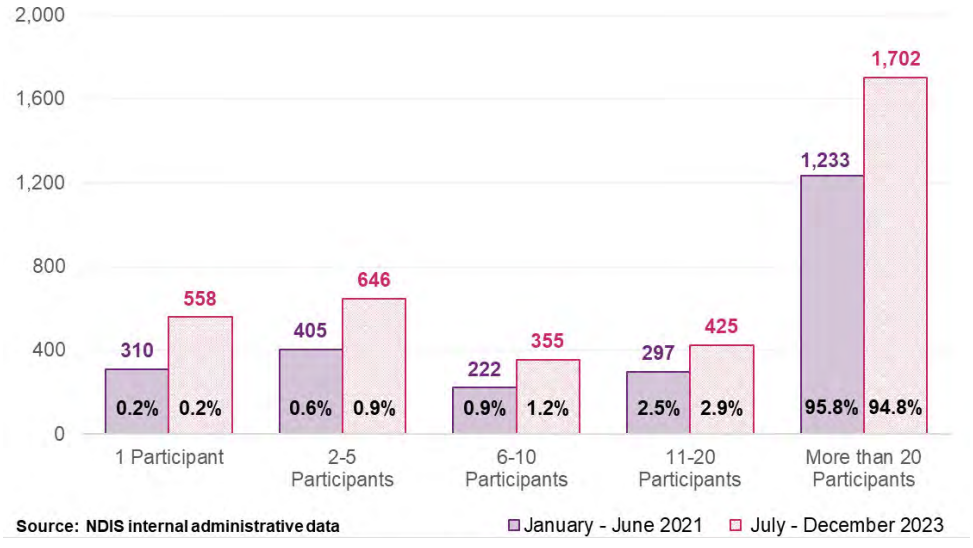
Figure 46: Provider Continuity by Registration Status and Percentage of Total Payments. Registered Providers (Left) and Unregistered Providers (Right), January 2021 to December 2023



6.6.4 Providers with uninterrupted payment history support more participants

A distribution analysis (Figure 47) categorises providers by the number of participants they support, and the proportion of services claimed. Over the timeframe from January 2021 to December 2023, segmented into six-month intervals, the profile of registered providers has remained consistent, suggesting a stability in the scale at which providers operate. In the six months leading to December 2023, 15% (558) of active registered providers were supporting a single participant. Meanwhile, 46% (1,702) of active registered providers were servicing more than 20 participants, contributing to 95% of the total payments to registered support coordination providers within this period.

Figure 47: Registered Providers of Support Coordination Supports and Number of Participants Claimed from, January 2021 to December 2023



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6.6.5 Providers who become inactive typically claimed less and supported fewer participants

Inactive registered support coordination providers received an average of $6,438 in payments during the half-year before ceasing activity. A majority (78%) of these providers claimed less than $5,000 in the same timeframe. Conversely, active registered providers averaged $137,842 in payments per half-year, indicating that inactive providers were claiming for lower amounts on average relative to new and existing registered providers. The payments data also suggests a variance in participant distribution between providers who continued to be active and those who became inactive. Active registered providers over the last three years serviced an average of 74 participants, while inactive registered providers serviced an average of 6 participants during the half-year period before becoming inactive.

6.7 Disability Intermediaries Australia Benchmarking Survey

Disability Intermediaries Australia (DIA) submitted a benchmarking survey to the Annual Pricing Review (APR), gathering data from 1,386 intermediary service providers, including both Plan Managers and Support Coordination providers, categorised as registered and unregistered. Among these, 865 submissions were from support coordination providers, with 91% identified as for-profit organisations and the remainder as not-for-profit. It was a noted a 24% increase in smaller providers participating in the survey compared to the previous year.

The benchmarking survey highlights concerns regarding static NDIS price limits since July 1, 2020, which have reportedly led some providers to cease operations or deregister, primarily affecting Level 2 and Level 3 support coordination. Despite these challenges, the broader data presented in the report indicates a substantial and continuous growth in the support coordination market. From 2021 to 2023, the number of providers significantly increased from 2,637 to 8,823.

Regarding employment conditions, most staff, including those interacting directly with participants and their supervisors, are reported to be compensated according to the SCHADS Award, covering 92% and 91% of the workforce, respectively. The survey reported a 10% increase in losses and a 24% decrease in profits from the previous year among providers. It documented mean operational overhead costs per hour at $19.34 for Level 1, $38.17 for Level 2, and $90.70 for Level 3 support coordination. This is suggested to 37.2%, 55.3% and 93.3% for Support Coordination Level 1, Level 2, and Level 3, respectively (operational overheads divided by cumulative cost per hour before operational overheads).

The survey also reported other additional employment-related expenses include a 17.5% annual leave loading, accrual of 76 hours of personal leave annually, and an increase in the superannuation guarantee from 10.5% to 11% for the 2023-24 financial year. The survey indicated that the diversity in organisational structures

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among service providers does not correspond to significant differences in cost structures.

6.8 Provider Consultation Feedback

The NDIA received 55 submissions from providers responding to the consultation questions regarding support coordination. Approximately 75% of submissions indicated significant changes in service delivery costs over the past year. Submissions highlight a discrepancy between rising operational expenses—such as audit costs, wages, rent, and fuel—and the static NDIS price limits for support coordination. Providers emphasise the financial strain from increased audit expenses and operational costs without corresponding price adjustments.

Concerns over sustainability and the viability of services underscore the discussions, with fears that the quality and diversity of support coordination services may dwindle, potentially undermining the NDIS' goal of ensuring participant choice and control. Additionally, providers report a marked increase in the effort required to navigate NDIA regulatory processes. This, coupled with funding inadequacies and workforce instability, including high turnover and the added stress of billable Key Performance Indicators (KPIs), compounds the operational difficulties facing the sector.

6.9 Participant Consultation Feedback

Feedback from NDIS participants on their experiences with support coordination services reveals a wide spectrum of satisfaction. According to responses to the APR online form, 63% of participants expressed satisfaction, appreciating their coordinators for effectively connecting them with suitable providers and enhancing their access to necessary services. These participants valued the coordinators' ability to navigate the complexities of NDIS services. However, 22% of participants reported dissatisfaction, attributing their discontent to the high costs, frequent changes in coordinators, and a lack of responsiveness, which sometimes led them to consider changing providers.

6.10 Discussion

This chapter has explored the growth and evolving landscape of the support coordination market from July to December 2023, marked by a significant increase in both the number of providers and participants utilising support coordination services. Notably, the market has seen a substantial rise in unregistered providers, growing from 2,637 to 8,823 over the past three years. Despite this influx of new entrants, registered providers still accounted for 82% of total claims, highlighting their important role in the ecosystem even as the number of registered providers has declined.

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The market is undergoing a transformation towards less concentration, evidenced by unregistered providers gaining a greater market share and the top ten providers experiencing a reduction. This shift is further supported by data from the HHI, indicating a decrease in market concentration.

Provider submissions and participant feedback underscore the rising costs of service delivery and the challenges in maintaining service quality under the current financial model. Such feedback highlights the complex interplay between cost management and service quality, particularly for Level 2: Coordination of Supports and Level 3: Specialist Support Coordination. These levels are crucial for detailed planning, case management, and crisis resolution, requiring providers to possess extensive knowledge and the ability to integrate supports across various sectors.

6.11 Recommendations

It is considered reasonable that support coordination supports currently determined by the Disability Support Worker (DSW) Cost Model, continue to be done so, including any applicable changes that occurs for DSW supports.

Recommendation 6

The NDIA should index the price limits for Level 1: Support Connection services and Psychosocial Recovery Coaches services in line with the indexation of supports determined by the Disability Support Worker Cost Model in recommendation 1 on 1 July 2024.

Analyses in the chapter highlights that whilst the market for support coordination continues to evolve, there is no evidence to suggest that supply is not meeting demand. In light of significant upcoming reforms recommended by the NDIS Review, which aim to enhance service integration and improve participant outcomes, there is a strong rationale to mitigate potential market disruptions during this transformative period. Any changes to pricing at this point of time would be up for further changes until the reforms in the intermediary sector settle. On balance, it is not recommended to change the price limits of Level 2 and Level 3 support coordinators to ease undue disruption.

Recommendation 7

In alignment with strategic outcomes from the NDIS Review and recognising the current period of significant reform, it is recommended that the NDIA maintain existing price limits for Level 2: Coordination of Supports and Level 3: Specialist Support Coordination.

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7. Short Notice Cancellation Policy

7.1 Context

The NDIS short-notice cancellation policy intends to allow providers to recover costs faced from participant cancellations where costs are incurred within a reasonable timeframe. The existing policy, while designed to ensure providers meet their legal obligations to workers without financial detriment, may not fully reflect the varied and fluid operational landscapes in which these services are delivered.

In July 2022, the NDIA updated its short notice cancellation policy from 2 days to 7 days, for applicable NDIS supports, in line with the *Social, Community, Homecare and Disability Services Industry Award 2010* (SCHADS Award). The policy allows service providers to claim up to 100% of the agreed fee for a scheduled appointment if it is cancelled on short notice. Short notice is defined in two main scenarios: if the participant does not show up within a reasonable time for the scheduled support, or if the participant cancels with less than 7 days' notice. Furthermore, for supports intended for a group, if a participant cancels and cannot be replaced, the provider may bill for the cancelled attendance at the agreed rate.

Providers can claim for these cancellations directly from the participant's plan, provided several conditions are met. These include:

- the support item being eligible for short notice cancellation claims as per the NDIS Pricing Arrangements and Price Limits,
- the charges comply with these pricing arrangements and limits,
- there is a pre-existing agreement with the participant allowing for such claims; and
- the provider was unable to find alternative billable work for the staff involved.

Claims for short notice cancellations must be submitted using the 'cancellation' option in the NDIS Myplace portal, using the same support item used for the actual service delivery.

7.1.1 The short notice cancellation policy aligns with the SCHADS Award

The NDIS short-notice cancellation policy aims to balance the costs incurred by service providers with value for money for participants. It recognises the financial and operational impacts of cancellations on providers, ensuring they can recover costs when services are cancelled without sufficient notice. The policy encourages participants to give timely cancellation notice, allowing for providers to effectively manage their resources.

Additionally, the policy aims to safeguard participants' flexible needs by setting clear expectations around cancellations. By establishing a fair and transparent framework, it fosters a cooperative relationship between participants and providers. It also

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includes provisions for monitoring and addressing frequent cancellations, emphasising the provider's duty of care.

FWC updated the client cancellation requirements for workers under the SCHADS Award starting 1 July 2022. Clause 25.5(f)(v-vi) requires employers to handle client cancellations within seven days of the scheduled date, applying only to employees covered by the SCHADS Award. Employers can either reassign employees to other tasks or cancel the shift entirely.

When a client cancels, employers must compensate employees for the scheduled hours or arrange make-up time, provided the employee was notified at least 12 hours before their shift. Make-up time should be arranged within six weeks of the cancellation, in consultation with the employee, potentially involving work in other business areas. This provision is designed to be flexible for both employers and employees, ensuring fair compensation while adjusting work schedules.

In practice, providers often rearrange worker shifts under the SCHADS Award, even with less than seven days' notice. This flexibility helps reduce the financial consequences of client-initiated cancellations. However, there can still be additional costs for make-up shifts, especially if the shift changes from daytime to evening/weekend work, potentially leading to financial loss.

The current NDIS short-notice cancellation policy also applies to supports not delivered by DSWs under the SCHADS Award, even though they do not have the same legislative requirements.

No legislative requirements exist for similar sectors under the *Aged Care Award* 2010 and *Children Services Award* 2010. For therapy providers, the *Health Professionals and Support Services Award* 2020 doesn't include requirements for client cancellations. This serves as the minimum award for many types of therapists delivering NDIS supports.

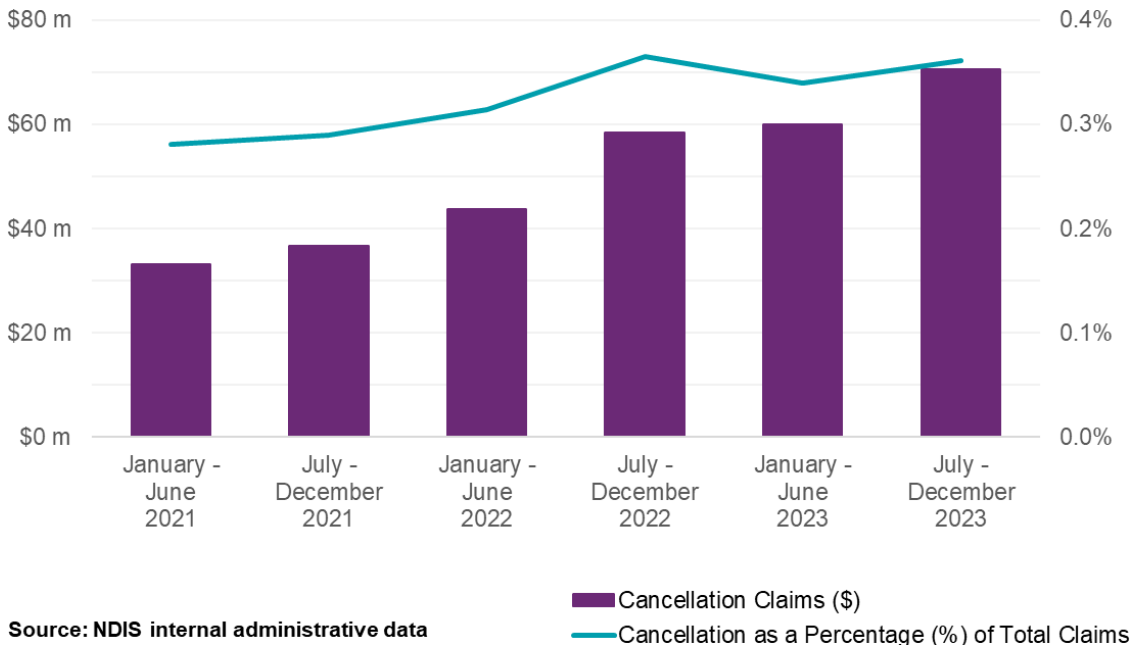
7.2 Scheme Statistics

7.2.1 The number of short notice cancellations claims has grown

Since the revision of the NDIS short notice cancellation policy from July 2022, there has been significant increase in the number of claims and corresponding Scheme expenditure associated with short notice cancellations. From the financial year 2020-21 to 2022-23, Scheme expenditure has nearly doubled (97%), from around $60 million to just under $120 million. Figure 48 shows this increase on a half yearly basis, comparing the total expenditure on cancellation claims against the overall expenditure for all supports delivered by registered providers.

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Figure 48: Scheme Expenditure of Cancellation Claims Compared to Total Scheme Expenditure from July 2020 to December 2023



Source: NDIS internal administrative data

The NDIA also analysed Scheme data by Modified Monash Model areas (MMM) that revealed no significant difference in cancellation rates between metropolitan and remote/very remote locations. This finding suggests that geographical factors may not be major determinant of cancellations, and thus does not warrant a policy consideration focussed on location.

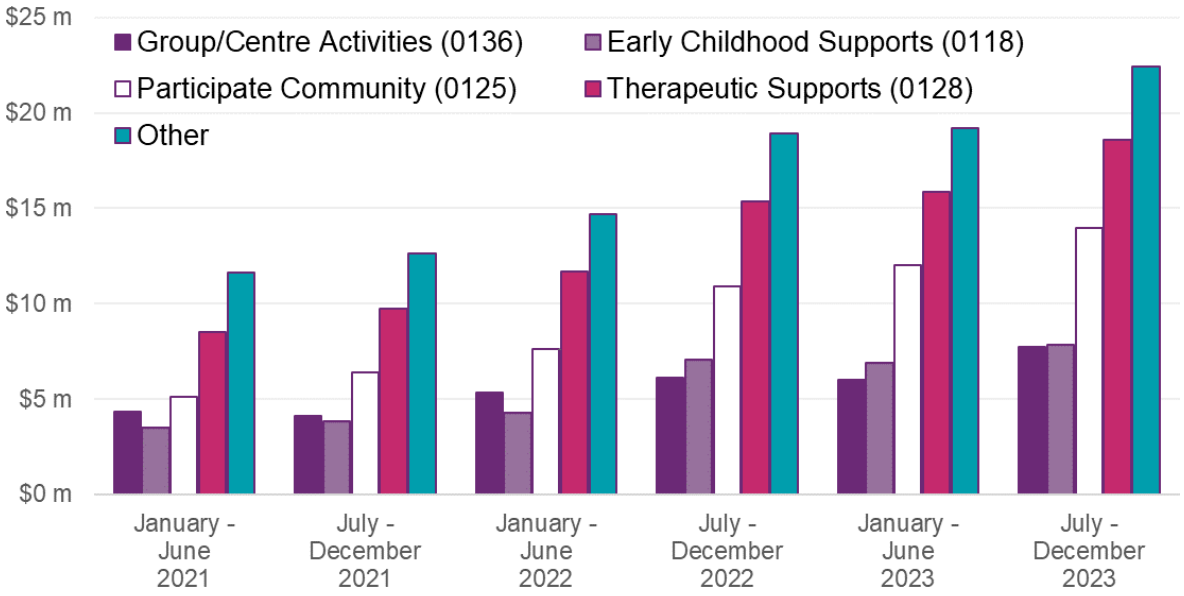
Therapeutic supports account for more than one third of all cancellation claims

Figure 49 breaks down the cancellation claims by the top 4 registration groups, with '0128: Therapeutic Supports' and '0118: Early Childhood Supports' together accounting for 37% of the total in the six-months to December 2023. These two registration groups, generally with workers not covered by the SCHADS Award, contrast with other registration groups such as '0136: Group and Centre Based Activities' and '0125: Participant in the Community, Social and Civic Activities'. The latter comprises 31% of cancellation claims and have workers under the SCHADS Award requirements.

Other supports spread across fifteen other registration groups represent 32% of claims, indicating cancellations are common across various NDIS services. Frequency of cancellation claims of other registration groups are also rising over the observed period at a less rapid rate.

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Figure 49: Trend in Cancellation Claims by Top 4 Registration Groups from July 2020 to December 2023



Source: NDIS internal administrative data

7.3 Consultation Feedback

7.3.1 The lack of unity in cancellation policies

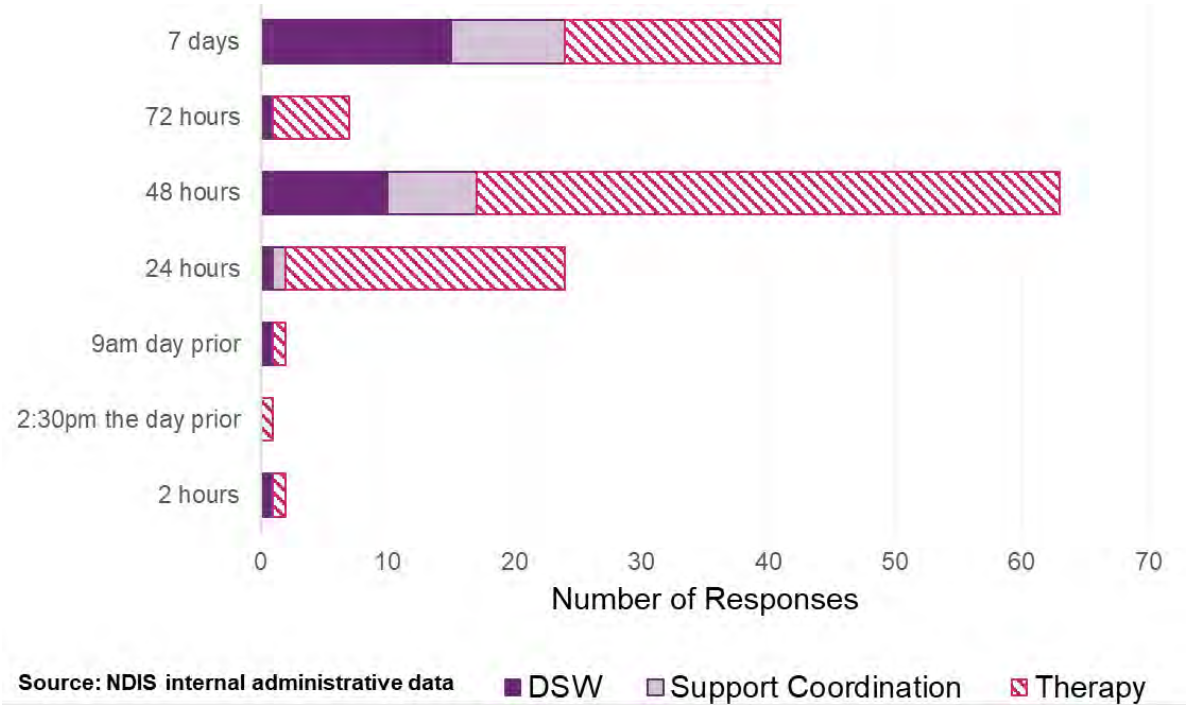
Since the NDIA revised the short notice cancellation policy, participants and stakeholders have shared feedback through ministerial correspondence and the public APR consultation. They emphasised the wide variety of cancellation policies used by NDIS providers. Participants highlighted varying levels of understanding regarding these policies, with some discovering the provider's rules after being charged for the cancelled appointment. According to participant consultation responses, 78% of participants knew their provider had a cancellation policy, and 45% noted different rules applied to different services. This diversity illustrates the complexity of the marketplace.

Among providers who responded to the consultation, the majority delivering DSW supports (52%) and support coordination (53%) followed the seven-day cancellation policy. In contrast, 76% of therapy providers reported following a policy of less than 48 hours (Figure 50). One provider explained:

"We follow a seven-day policy for DSW services, but therapy services are cancelled within 48 hours due to their nature."

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Figure 50: Provider Submission Responses to Short Notice Cancellation Policies



One provider noted the difference in how cancellation policies are applied between NDIS and non-NDIS participants. This is discussed further in section 4 of this chapter.

"This is different to non-NDIS participants and I will explain why. We are unable to charge for cancellations under HCP, workcover or DVA so don't charge those clients. Our private clients we can charge up to 100% of the appointment cost if they fail to attend or cancel late notice if there is not a reasonable explanation for the failure to attend."

7.3.2 Discrepancies and confusion

Providers noted discrepancies in the interpretation of cancellation policies, leading to confusion and frustration among participants. One provider shared:

"Clients often don't realise the financial impact their late cancellation has on our operations."

The lack of understanding often results from insufficient education on cancellation fees and participant awareness of the policy's effects. Strictness in policy enforcement further contributes to the perception of unfairness. Some participants claimed they were charged for cancellations even when emergencies occurred, causing dissatisfaction, and leading to calls for more empathetic practices.

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7.3.3 Mitigation strategies

Providers have highlighted various strategies to minimise the impact of short notice cancellations on NDIS participants. These include flexible appointment rescheduling, sliding scale fees, and telehealth services. One provider explained:

"As an alternative to a short notice cancellation, we offer telehealth appointments, or offer non-face to face services (if required) such as resource development or report writing. If these strategies are accepted, the cancellation charge is not applied…. We support Participants to achieve attendance at their appointments by providing SMS and/or phone call and/or email reminders, and implement various appointment scheduling strategies (for example, scheduling consistent times to reduce change)."

Another provider suggested sending appointment reminders 48 hours before to allow participants to adjust their schedules or cancel with enough notice:

"We send reminder text messages, we work with scheduling to ensure we are able to provide flexible appointment times that suit the participant needs."

These strategies reflect a shift toward flexible service models designed to maintain continuity and adapt to participant's evolving needs.

7.3.4 Flexibility and tailored engagement

Providers emphasised the importance of tailoring engagement with participants to prevent cancellations. For instance, a psychology provider emphasised the need for effective communication with care managers or house managers in cases of frequent cancellations to understand underlying issues:

"We tailor our approach to each individual participant based on their living or travelling circumstances. In instances of frequent cancellations, we typically engage in communication with the care manager or house manager to address the situation effectively."

Similarly, an Occupational Therapy provider highlighted the role of reminders and personalised communication through text, phone, or email:

"We have multiple reminders automated on software via email and SMS.

A peak body highlighted the most common approaches for their members:

"Telehealth is the most mentioned alternative to short notice cancellations; other alternatives include home exercise programs. Some respondents also mention using the time allocated for cancelled appointments for billable non –face-to-face supports such as administrative tasks or report writing, assistive technology trials, liaison with care team, updating a home program, etc."

These personalised approaches help identify and overcome barriers to attendance, keeping services flexible and participant centred.

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7.3.5 Understanding reasons for cancellations

Short notice cancellations occur for various reasons, including logistical challenges and sudden illness. Participant feedback revealed frustration with some notice periods, as many find it unreasonable to predict their availability seven days in advance. One participant shared:

"For Physiotherapy, it is 7 working days or full price is charged. (Honestly, how do you know 7 days out if you are going to be sick?"

Participants often cancel appointments due to unpredictable factors like illness, hospitalisations, or caring for sick children, calling for policies that balance predictability with fairness. They expressed the need for more empathetic practices, particularly for emergencies. Some providers understood this and showed flexibility:

"My solo provider doesn't charge for cancellations due to sickness or emergencies even if I let her know that morning. She requires 48 hrs notice for cancellation if it's due to change of plan or something I know about beforehand."

7.3.6 Technology and scheduling systems

Providers noted that integrating technology into scheduling systems plays a crucial role in minimising cancellations. Automated reminders via email or SMS help participants stay informed about appointments. A therapy provider emphasised:

“we send reminder text messages and use flexible scheduling to accommodate participant needs”

Technology also helps coordinate mobile appointments:

“For mobile appointments, I privately SMS all clients if not meeting at homes to arrange locations. This minimizes no shows, but not short notice cancellations.”

Beyond reminders, some providers employ technology to delve into the reasons for frequent cancellations, engaging directly with participants to understand the underlying barriers. They offer solutions like telehealth or non-face-to-face supports, including administrative tasks and report writing.

7.3.7 Participant experiences with cancellation policies vary depending on their service provider

Navigating cancellation policies presents challenges for participants due to the wide variation in provider requirements. Notice periods can range from as little as 24 hours to as long as two months, creating confusion for those relying on multiple services. One participant explained:

"Can be anywhere from 2 weeks to 24 hrs and has to be in writing which is not good for some."

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This inconsistency makes it difficult for those managing complex situations, who may need to cancel due to sudden illness or emergencies. Participants often find themselves penalised for cancelling on short notice.

Rules also differ depending on the reason for cancellation. Planned absences like holidays or medical appointments and unplanned absences like illness are treated with distinct rules, which many consider arbitrary or unfair. One participant noted:

"Different rules for planned reasons to miss a session (eg holiday, medical appointment, etc) versus if I am sick (which has a much shorter notice period)."

Discrepancies between participant and provider cancellations exacerbate the confusion. One participant expressed concern:

" With current services, if I cancel the service less than 48 hours before the support worker is due, I pay the full amount, but if they cancel or don't show up, that is supposed to be ok."

Some participants feel unable to seek clarification or negotiate their terms of support, citing a lack of transparency and flexibility from providers. One participant said:

"Eight hours for OT and psychologist. The OT only requires 24 hours for private patients and has not responded to my email enquiry questioning the reason for the difference for participants."

Participants believe that short notice cancellation policies should account for their circumstances, ensuring they're not penalised unfairly. Improving communication and transparency would help alleviate confusion and frustration.

7.4 Discussion

Analyses on NDIA-related short-notice cancellation claims does have its limitations. While some insights can be observed from NDIS cancellation claim data, there are limitations that prevent a comprehensive deep dive. These are:

- **Notice period:** The NDIA system does not currently capture the advanced notice period provided by a participant for cancellation claims (i.e., one day before or 5 days before).
- **Limited reasons:** The NDIA system prompts providers to select a cancellation reason from a list though this is not an exhaustive list of potential reasons. However, a significant portion of cancellations claims (70%) are classified as "Not Defined" or "Other". This lack of specificity makes it difficult to understand the true driver behind most cancellation claims in the NDIS.
- **No free-text field:** The system does not offer a free-text field for providers to explain cancellation reasons beyond the predefined options.

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Due to the lack of current NDIS administrative data for analysis, it is more reasonable to consider analysis of the marketplace and current practices for this policy.

7.4.1 Market analysis and efficiencies

This section examines cancellation policies across various government schemes in Australia, focusing on their similarities and differences with the NDIS.

Aged Care: A mature market with different practices

The most comparable sector for DSW supports is Aged Care, specifically the Home Care Package program within Aged Care. Home Care providers must be registered with the Australian Aged Care Quality and Safety Commission[55] and can charge additional fees beyond hourly rates, such as care management and package management fees[56].

Thus, providers delivering this program have more flexibility in setting prices, allowing them to potentially absorb some costs associated with cancellations. This is reflected in a sampling of Home Care Package providers cancellation policies, acknowledging this sample is not representative of the entire aged care sector. From a sample of 50 randomly selected Home Care Package providers that listed clear cancellation policies, 96% (48 providers) did not charge for cancellations if given more than 2 business days' notice (Table 28). Most providers charged the full fee if the cancellation was within the notice period.

Table 28: Review of 50 Aged Care Providers Delivering Home Care Package Supports Cancellation Notice Periods

Required Notice to avoid cancellation charges	24 Hours or Day Prior	2 business days or less	More than 2 business days
Number of providers with this policy	41	7	2
Percentage of providers	82%	14%	4%

Other Government Funding Schemes

Table 29 compares cancellation policies against other government schemes, such as Medicare and Department of Veterans Affairs (DVA). Many other Government Schemes offer limited or no ability for providers to claim for cancellations. While

[55] Homepage | Aged Care Quality and Safety Commission

[56] Provider Guidance - Home Services Pricing and Agreements | Aged Care Quality and Safety Commission

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some, like Medicare allow participant charges for non-attendance, this approach may not be feasible for NDIS participants due to the NDIS required to cover the reasonable and necessary support needs of participants and considering reasonable costs associated with service delivery.

However, it is important to note that unlike the NDIS, these schemes generally do not prohibit providers from charging cancellation fees directly to participants.

Table 29: Comparison of Other Comparable Government Funding Schemes and their Cancellation Policies

Scheme	Cancellations
Medicare	Not covered
DVA	Not covered
Transport Accident Commission (TAC)	Not covered unless fee schedule has specific items
ComCare	Not covered (except for Medical Practitioners)
Return To Work South Australia (RTWSA)	Not covered (except for Medical Practitioners)
Victims of Crime Assistance Tribunal (VOCAT)	Not covered for no-shows by clients
Worksafe Vic	Not covered (except for Medical Practitioners)
WorkCover Qld	Not covered (except for Medical Practitioners)

As part of the APR's Therapy Analysis, the NDIA received responses from 13 Commonwealth and State Schemes on their therapy pricing and arrangements such as cancellation policies. From these Scheme responses, only 2 of the 13 responses mentioned they allow for cancellation claims for some of their therapy supports. For further information on the schemes that participated, please refer to the Therapy Chapter of this report.

Market Cancellation Data through Website Scrapping

Following consultation feedback that suggested there was a segment of participants that were not be aware of their provider's cancellation policy, the NDIA conducted a website analysis of 300 NDIS providers who claimed for a cancellation in Financial Year 2022-23. These providers were randomly selected from 1,700 NDIS providers who made over $10,000 worth of claims for short-notice cancellation in 2022-23. Noting, the NDIA does not mandate providers to publicly display their cancellation policies.

Findings from this sample of providers suggested a potential lack of transparency:

- Only 16% of providers had a clear cancellation policy directly accessible on their website. This means 84% had no explicit mention of their cancellation policy.

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- 12% offered downloadable terms and conditions, where only some included a clear cancellation clause.

Among the 49 providers with published policies:

- 80% did not claim up to the 7-day notice period, the majority of whom offered a 48-hour notice period.
- 16% had a 7-day cancellation policy.
- 4% differentiated policies between private clients and NDIS participants.

These findings suggest from the sample with published cancellation policies, there are many providers who offer a shorter notice period (48 hours) than the maximum allowable 7-day period. This supports a market that could potentially sustain a shorter notice period than the current NDIS short notice cancellation policy.

From this exercise, the NDIA consider there is a need for potential improved transparency regarding cancellation policies within the NDIS system. There is evidence from submissions to the APR that participants are only made aware of a provider's cancellation policy after the fact. There is a need for clear cancellation policy that is not only balancing the needs of participants and costs of providers, but that is also communicated between both parties.

Use of Diverse Models and Technology

The NDIA operates in a diverse environment with a huge range of providers in terms of size, support coverage, access to technology, and levels of efficiency. This diversity has a clear impact on the application of cancellation policies and the management of scheduling and rostering systems.

Mitigation strategies

APR consultation respondents suggested mitigation strategies like reminder messages, telehealth options, and reallocating staff to other work or training. There is general support amongst providers of the efficacy of reminders (via SMS, phone, etc.) in reducing no-shows, although no single method consistently outperforms others. These approaches could limit the need to claim for cancellations, with providers using innovative practices to maximise support time.

Understanding reasons for cancellations

Non-attendance reasons vary from transport issues and childcare needs to opportunity costs like time and money. Lead time between bookings is a good predictor of no-shows, and prior history often indicates future cancellations. However, situations like sudden illness may necessitate a more flexible cancellation policy to accommodate participants' diverse and unpredictable needs.

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7.5 Recommendations

The NDIA operates within a diverse landscape of providers varying in size, support coverage, technological access, and efficiency. This diversity significantly influences cancellation policy applications, scheduling, and rostering systems.

In therapeutic and nursing supports, a worker may assist multiple participants per shift, meaning that the cancellation of one appointment won't usually lead to a cancelled shift. However, for longer-duration supports like Supported Independent Living (SIL), the rostered shift might align more closely with scheduled support.

The NDIA acknowledges that providers have the right to recoup costs from cancellations affecting their operations, but emphasises the need for fairness to participants, providers, and taxpayers. While the current cancellation policy applies to all NDIS supports, it deviates from the original intent of the SCHADS Award (which covers the cost of a support worker's shift) and differs from the private therapy market (typically operating with 24 to 48-hour notice periods).

Consultations with stakeholders, including service providers, participants, and peak bodies, revealed a clear demand for a short-notice cancellation policy adaptable enough to reflect the realities of service delivery while ensuring participants continue to receive the supports they need.

The NDIA recognises that there is a need to strike a balance in its short-notice cancellation policy to allow providers sufficient ability to recover costs while incentivising them to work with participants to reduce the number of short-notice cancellations. Participants, in turn, must be given reasonable period to provide notice, considering unforeseen circumstances like illness, urgent appointments, or changes in personal circumstances, to minimise using NDIS funds on services they do not receive.

Providers delivering DSW-related supports can incur costs if they cannot redeploy employees to other work or set up make-up shifts for the staff, as these employees are generally covered by the SCHADS Award. This requirement is unique to the care sector for workers under the SCHADS Award.

The NDIA believes that NDIS providers should generally be able to reschedule staff according to the SCHADS Award to minimise claims for cancellations from NDIS participants, though this might not be feasible in all situations (e.g. SIL supports). Providers who reschedule or find alternative work for their employees should not claim short-notice cancellation fees from the affected participant, as alternative arrangements have been made for the worker.

On balance, the NDIA recognises the diversity of operational contexts in which providers operate, which includes potential costs that could be faced by providers to meet legislative requirements to their workers in instances beyond their control. It is important that the cancellation policy incentivises providers to minimise the cost of cancellations, while also signalling to participants that they should provide as much

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notice as possible when cancelling their services and supports. This recognition forms the basis for the recommendations aimed at refining the NDIS cancellation policy to better align with Service Delivery.

Recommendation 8

The NDIA should retain the existing 7-day short notice cancellation policy for applicable supports determined by or derived from the Disability Support Worker Cost Model from 1 July 2024. Providers of Disability Support Worker supports must continue to make reasonable effort to find alternative billable work for the staff involved.

Non-DSW related supports (non-SCHADS related), such as therapy services, lack a standardised legislative or Award requirement for client cancellations. This is the case for other comparable care and support services such as Aged Care and Children's Services. There are also limited cancellation policies in other Government funding schemes.

Through consultation and research conducted, there is a case that the maximum of 7-day policy may not be necessary for non-DSW supports. There appears to be a greater usage of a 2-day cancellation policy in the sector, particularly among therapy providers, which supports a potential for a shorter cancellation policy. 76% of provider respondents delivering therapy supports to NDIS participants suggest they already have a short-notice cancellation policy of 48 hours or less. This is also supported by the website data analysis conducted by the NDIA, acknowledging the limited sample that had available data for analysis. The NDIA believes there to be mechanisms and methods already being utilised by the sector to assist participants limiting cancellations, which could make the reduction in notice period feasible.

Recommendation 9

The NDIA should adjust the 7-day short-notice cancellation policy for non-Disability Support Worker-related supports to two clear business days from 1 July 2024.

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

8. Feedback from the Participant Consultation Paper

8.1 Context

The 2023-24 APR has an increased focus on participants to ensure that it includes the voices of both providers and participants. For the first time, the NDIA published a dedicated consultation paper to gather participants' perspectives and sought participant feedback via an online form.

During the 2022-23 APR consultation process, the NDIA received 12 submissions from participants and their representatives. To improve the options available for participant engagement, the NDIA undertook a broader consultation campaign for the 2023-24 APR. This approach recognises that the NDIA puts participants at the centre of everything we do and that many of the ideas about how to make the NDIS better have come from the disability community.

The consultation questions asked participants about:

- How much they know about the current price limits.
- Their experiences in finding the best price for supports and services within these limits.
- How the price limits affect the quality of supports they receive.

The NDIA received 559 responses to the participant consultation questions, with most providing feedback through the online form.

This chapter summaries the feedback received from participants throughout the APR consultation process.

8.2 Overview of participant responses

The NDIA invited any participants, family members of participants, carers, and participant advocacy groups with an interest in NDIS pricing arrangements and price limits to make a submission to the APR. Consultation took place between 25 January and 17 March 2024. The participant consultation paper included a Plain English paper,[57] an accessible easy-read paper,[58] and an online form. The NDIA received 546 responses to the online form, 11 responses to the Plain English paper and 2

[57] Plain English presents information in a way that helps others to understand the message the first time they read or hear it.

[58] Easy Read combines text with layout and imagery to simplify and explain information.

Page 977 of 1049

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responses to the easy-read paper. The selection of respondents was not randomised and participants could choose which questions they responded to.

The NDIA promoted the participant consultation options through several channels including:

- NDIA website
- NDIA news update
- NDIS social media
- NDIS newsletter
- Participant First newsletter.[59]

There are over 640,000 NDIS participants across the Scheme. The number of participants who responded to the survey represents less than 1% of all participants. Despite this, the responses provide important insights into participant experiences with pricing.

Table 30 shows the proportion of participants who responded to the consultation questions and how they choose to manage their NDIS funding. It includes a comparison to Agency data on how total Scheme participants manage their funding. Over 85% of participants who responded were self-managed or plan-managed, and a small number were Agency-managed participants. 8% of respondents were mixed-managed and 2% reported that they were not sure how they manage their NDIS funding.

[59] Participant First offers an opportunity for participants, families, carers and people within the disability community to share their views about the best ways to improve the NDIS through completing surveys, joining focus groups or taking part in interviews.

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Table 30: APR Online Form Participant Respondents and How They Manage Their Funding

Ways to manage funding	Description	Percentage of online form respondents	Percentage of NDIS participants
Plan-managed	The NDIA provides funding in the participant's plan to pay for a Plan Manager who pays providers, helps keep track of funds and takes care of financial reporting for the participant.	52%	62%
Self-managed	The NDIA provides the participant with funding so they can access the supports that will best help them pursue their goals.	34%	29%
Agency-managed	The NDIA pays providers on the participant's behalf.	4%	9%
Mixed-managed	The participant can choose a combination of the three options above. For example, they may choose to self-manage one part of the plan and have the rest managed by the NDIA.	8%	Not available

Source: Participant responses to APR online form; NDIS, NDIS Quarterly report to disability ministers 31 December 2023, p 49.

Note: 2% of respondents reported that they were not sure how they manage their NDIS funding.

8.3 Participant awareness and perception of prices

8.3.1 Participants were asked about their awareness of prices

The NDIA is responsible for empowering participants to exercise choice and control. A key component of empowerment for participants is having access to information and tools to make an informed decision about the services they use, including the prices for those services. For this reason, the NDIA asked participants about their awareness of prices.

A high proportion of participants who responded to the online form reported that they are aware of prices and how to access information about NDIS price limits:

- 94% of participants reported that they know the price they pay for NDIS services and supports.
- 90% reported that they are familiar with the NDIS Pricing Arrangements and Price Limits (PAPL). This document assists participants and disability support

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providers in understanding how price controls for supports and services work in the NDIS.

8.3.2 Participants were asked if they pay the same price as a person who is not an NDIS participant

The NDIA asked participants whether they pay the same prices for their services and supports as people who are not NDIS participants. Around 26% of participants reported that they pay the same price as non-NDIS participants, while 41% reported that they do not, and around 33% were not sure.

Participants who said that they do not pay the same price, were then asked to provide examples of the different prices their provider charges.

Most participants who reported that they do not pay the same price as non-NDIS participants provided examples of the prices they pay being higher:

"I go to the OT, on a sign it states $95 first consultation, $90 thereafter. I am charged $193.99 because I am on NDIS."

"If I tell a cleaning provider that it is NDIS they charge me about 40% more supposedly for administration. If I pay direct and claim reimbursement it is about 40% cheaper per hour."

"At a previous Physiotherapy clinic I was paying $105 for a 45 minute appointment, when they found out I was self-managed with NDIS for physiotherapy their price went to the full $193.99 and they stated they needed extra time to write notes and it was more complex to treat someone on the NDIS - yet for 6 months prior they had been treating me for the same issue."

A relatively small number of participants provided examples of the prices they pay being lower than non-NDIS participants:

"Services are cheaper if I am using NDIS. As a result, my provider is thinking of no longer treating NDIS clients."

"I pay less than someone who is privately charged for similar supports."

8.3.3 Feedback on whether prices are reasonable was mixed

The NDIA often receives feedback from participants through Ministerial Correspondence and other channels about concerns about pricing. To better understand participant views on and experiences with pricing, participants were asked whether they consider prices are reasonable. Participants were then asked to explain why they chose this answer.

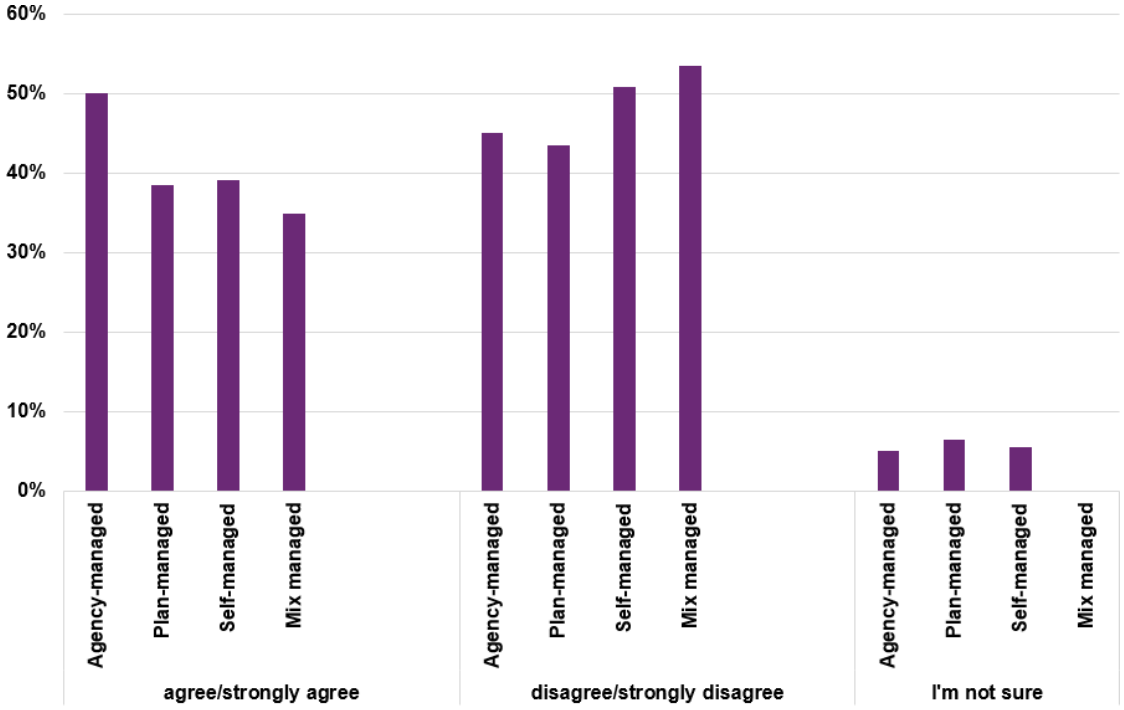
Participant views varied considerably on whether the prices they pay for their services and supports are reasonable. About 42% of respondents reported that they

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agree or strongly agree that prices are reasonable, while 51% reported that they disagree or strongly disagree and 7% were not sure.

Figure 51 shows that agency-managed participants were slightly more likely to agree that prices are reasonable, while mixed-managed and self-managed participants were slightly more likely to disagree that prices are reasonable. Overall, there was relatively little difference in perceptions of reasonableness across the different types of funding management for participants.

Figure 51: Summary of Online Form Participant Responses on Whether Their Prices are Reasonable



Source: NDIA analysis of submissions

Participants who agree that prices are reasonable often stated that they are able to shop around and negotiate prices. For example:

"I live in a very rural town. I pay the best prices I can for the services I need. I pay below the NDIS price caps but only because I plan manage my funding."

"I am charged much less than the NDIS price guide and the same rate as non-participants."

"I am self-managed so set a reasonable rate that is below the maximum rate."

"I am self-managed, have the capacity to shop around, negotiate and choose not to support providers who overcharge or use the NDIS price guide to set their prices."

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Participants who disagree that prices are reasonable often reported that they have different views about the reasonableness of prices, depending on the specific service or support. For example:

"Some prices are reasonable and others aren't."

"I think the maximum price for some services is far to generous. For example to employ a support worker day time weekday to help me access community and social activities can cost about $65 per hour. I think $65 is far too much for unskilled work to drive me to an event, wait and drive me home afterwards."

Many participants also reported that they consider extra charges for travel or administrative activities to be unnecessary or too expensive:

"The price would be reasonable if travel and paperwork were included, not charged separately."

"$200/hour (near enough) for allied health services + travel on top seems excessive."

"Providers charge ridiculous amounts of money. Everything is charged, even note writing 15 minutes after every therapy."

8.4 How participants manage their funding and engage with providers on pricing

8.4.1 Many participants choose to self-manage or plan-manage to have more flexibility and control

The NDIA asked participants how they manage their NDIS funding for core supports and therapy supports and why they chose to manage their funding this way. Over 85% of participants who responded to the online form plan-manage or self-manage their NDIS funding. A key theme from participants who self-manage or plan-manage their NDIS funding is that they state they have choice and flexibility to negotiate reasonable prices from providers that meet their needs. At least 20 participants reported that they prefer to have the flexibility to use unregistered providers.

Comments from participants who self-manage include:

"Full control over who I employ or hire, much better value for money, ability to negotiate rates and conditions."

"Because I can stretch my funding further in core supports by still paying a fair price, but I'm not governed by a "price guide". My support workers are privately hired by me."

Comments from participants who plan-manage include:

"To ensure that I have choice and control over providers but have the insurance that all my invoices are paid on time and I have guidance around my budget."

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"I can determine who I want and the price paid is fair and reasonable with some guidance from the plan manager."

Around a third of participants who are agency-managed suggested convenience as a reason for choosing to manage their funding this way and four participants noted they prefer using registered providers. Three participants said that they agency-manage their funding because they would have difficulty with the other options.

8.4.2 Only 23% of participants say they discuss and agree on prices with their provider

Price regulation is in place for NDIS services and supports to ensure that participants get value for money in the supports that they receive. The NDIA sets price limits, which are the maximum prices that registered providers can charge NDIS participants for specific supports. Participants and providers can negotiate lower prices.

To understand whether providers give participants accurate information about the role of the price limits and the scope for negotiating prices, participants were asked how their provider sets prices for their services and supports:

- 38% said their provider tells them the NDIA decides what prices they have to charge.
- 30% said their provider has a price list with fixed prices to pay if buying services from them.
- 23% said they discuss the price with their provider and agree on the price they will pay.
- 9% were not sure.

Based on participant responses, it appears that participants are sometimes given incorrect information about the purpose of the price limits the NDIA sets. While providers are **not** required to charge at the price limits set by the NDIA, it appears that more than a third of participants have been told this is the case.

Participants who discuss and agree on prices with their provider were much more likely to agree or strongly agree that prices are reasonable (71%). Participants who said their provider tells them the NDIA decides what prices they have to charge were much less likely to agree or strongly agree that prices are reasonable (20%).

The NDIA also asked participants how their provider tells them about price changes and policy changes for their services and supports. The most common reported method for communicating these changes was email, followed by letter, plan manager, SMS/text message and in-person.

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8.5 Information and education for participants about the NDIS market

As discussed above, a key component of empowerment for participants is having access to information and tools to make more informed decisions about the services they use. The NDIA considers there is benefit in improving the tools available to participants to ensure they have access to accurate information about their rights as consumers.

Several participants described how they benefit from shopping around to find providers that best meet their needs and negotiating prices and service conditions that work for them. However, not all participants have been able to do this. Participants reported that some providers are not willing to negotiate and, in some cases, provide them with incorrect information about the role of the price limits. For example:

"All supports and services I come across that deal with mainly NDIS participants charge the maximum rate and they say that is the price that NDIS say they HAVE TO CHARGE, they don't get that is the maximum rate and that NDIS really want them to charge less. A friend tried to negotiate with the same provider that I use and she told me that she thought it was rude of the participant to devalue her time."

"Many support workers charge the top rate listed in the pricing arrangement and think that is what NDIS says they should be paid. Many of them don't understand that it is a suggestion/ maximum price one can charge and they DO NOT allow negotiations."

"As a self-managing participant I am supposed to be able to negotiate with providers. I am never given this opportunity. I am charged the highest amount possible. The idea of negotiation, particularly in areas where service providers are limited to a few, is just not realistic. Providers know there is an upper limit to what they can pay and they charge accordingly."

Providers are allowed to charge up to the price limits. However, when providers do so, the NDIA considers that they should clearly communicate to participants that charging at the price limit is a business decision, not a requirement imposed by the NDIA. The PAPL states that "providers should not indicate in any way to participants that the prices that they charge are set by the NDIA".[60] Similarly, the PAPL notes that "the NDIA does not set the prices that providers charge".[61] When providers give incorrect information to participants about the role of the price limits, this may

[60] NDIS Pricing Arrangements and Price Limits 2023-24, p 10.

[61] NDIS, Explaining the NDIS Pricing Arrangements and Price Limits (PAPL), p 1.

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mislead participants and discourage them from attempting to negotiate prices for their services and supports in future.

For this reason, the NDIA considers it is important that participants are well equipped with accessible information about the price limits and their rights to negotiate with providers. A targeted capacity-building education campaign for both participants and providers about these rights, with relevant information published on the NDIS website in an accessible format could help to achieve this. Ultimately, timely and reliable information sharing will empower participants to make informed decisions and ease information asymmetries.

Multiple cross-agency initiatives have been established to improve outcomes for participants and to ensure that providers are doing the right thing:

- The Fraud Fusion Taskforce started in November 2022. It is a partnership between the NDIA, Services Australia and 14 other government agencies including the NDIS Quality and Safeguards Commission, the Australian Federal Police and the Australian Criminal Intelligence Commission. The Taskforce aims to improve how government agencies work together to quickly detect, resolve and prevent fraud, while reducing the impacts of fraud on NDIS participants.[62]
- The NDIS Provider and Worker Registration Taskforce will provide expert advice to Government on the best approach to overhaul the current registration system for providers, while maintaining choice and control for participants - as recommended by the NDIS Review.[63]
- The Fair Price Taskforce to crackdown on unfair price hikes for NDIS participants is now operational. The ACCC will chair the taskforce, together with the NDIS Quality and Safeguards Commission and the National Disability Insurance Agency. The NDIS Commission will tackle illegal overcharging of NDIS participants. The ACCC will focus on investigating and clamping down on misleading conduct, unfair contract terms and anti-competitive agreements that might impact NDIS participants, while supporting the taskforce's work.[64]

Learnings from the participant consultation will be shared with the relevant taskforces to ensure that providers are giving correct information to participants about their rights and the role of the NDIS price limits.

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[62] NDIS, Fraud Fusion Taskforce, accessed 3 April 2024.

[63] NDIS, New Taskforce to help improve NDIS registration, accessed 3 April 2024.

[64] Ministers for the Department of Social Services, Cracking down on overcharging of NDIS participants, 24 March 2024.

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8.6 How the NDIA has considered participant feedback throughout the APR

The NDIA has considered feedback from both participants and providers when making recommendations about the NDIS's price control framework. Other chapters in this report include summaries of feedback received from participants and providers, and explain how we have considered this feedback when making recommendations. Two key areas that participants were consulted on include:

- Support coordination - The NDIA asked participants about their experiences with support coordination, including their level of satisfaction with their support coordinator. Participant responses to these questions are discussed in Chapter 6.
- Cancellation policies - To better understand participant experiences with provider cancellation policies, the NDIA asked participants about their awareness of cancellation policies, as well as how these policies vary across their services supports. Chapter 7 discusses participant feedback on these issues in more detail and recommendations resulting from that feedback.

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9. Appendix A - Feedback from the Provider Consultation Paper

9.1 Overview

The 2023-24 APR consultation commenced on 25 January 2024. Provider submissions closed AEST 11:59pm on 10 March 2024 and participant submissions closed AEST 11:59pm on 17 March 2024. The Provider and Participant Consultation Papers included a series of guiding questions.

A total of 912 submissions were received in response to the consultation papers. Of these, 559 submissions were in response to the Participant Consultation. Participant submissions are discussed in detail in Chapter 8.

The remaining 353 submissions were in response to the Provider Consultation Paper and were received from a range of stakeholders:

- 259 from a range of provider organisations
- 60 from employees/workers
- 15 from professional associations
- 13 from provider peak bodies
- 3 from advocacy groups
- 2 from workers unions
- 1 from an educational institution

9.2 Market environment and influences: changing economic conditions, business risks and vacancies

9.2.1 Adapting to changing economic conditions

The Provider Consultation Paper sought to understand the segment of the care and support sector provider organisations operate in. It also undertook to inform the NDIA's understanding of the impact of recent economic conditions (e.g. inflation and rising interest rates) on providers, the primary business risks faced by them and how these risks are being managed, as well as vacancy rates (as a proportion of total planned workforce).

Providers

A total of 217 provider submissions responded to the questions about economic conditions, business risks and staff vacancies.

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Almost all providers reported increases in costs. Providers highlighted general increases in wage costs in a highly competitive labour market, as well increases in insurances, rent, travel costs, utilities, and other operating expenses. Several providers attributed these increasing costs to reduced profit margins, and expressed concern about their ongoing financial viability as NDIS providers. Many providers noted that the NDIS price limits have not increased for a number of years.

Providers reported a range of approaches to adapting their businesses in response to these changing economic conditions, including:

- increasing prices to the NDIS price limit for NDIS participants
- increasing prices for non-NDIS clients
- adapting billing practices e.g. charging NDIS participants for services previously not charged for, such as preparation and travel
- adapting the services they deliver e.g. limiting the geographic area(s) in which they operate, reducing the frequency and types of supports delivered, providing services differently (e.g. use of tele-health), through to ceasing to provide select services altogether
- pursuing efficiencies from organisational restructures or increasing expectations of billable hours (i.e. increased utilisation rates)
- reducing investment, by deferring capital expenditure
- absorbing cost increases e.g. through salary freezes
- operating at a loss and/or cross subsidising losses through other revenue streams.

One provider stated that:

"Inflation and rising interest rates have impacted my business by a 20% rise, and I have had to respond by increasing my client intake, working before and after school and longer than 10 hours days, since increasing the rate for therapy has NOT been an option."

Provider peak bodies

Provider peak bodies raised similar themes about challenging economic conditions where costs have increased, and profitability is reduced. Respondents noted that these challenges are likely to impact the quality of services offered by providers, with less investment in staff training and other quality-enhancing initiatives. It was also noted that many businesses are operating at a loss, which may lead to market exits.

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Professional bodies

Professional bodies also reported rising costs and financial pressures. It was noted that some providers who previously charged below the NDIS price limits, are now increasing their prices up to the price limits. Professional bodies reported instances where providers are considering moving to self-managed participants so they can charge above the price limits to cover their costs. A professional body reported that many providers are conscious of the impact of a challenging economic environment on participants and have sought to minimise any price increases by bearing the cost themselves.

9.2.2 Primary business risks

Providers

Financial sustainability was identified as the primary business risk by 64% of provider responses. This was raised when responding to questions about changing economic conditions.

Providers also raised challenges with staff recruitment and retention as a key business risk. Providers reported a shortage of practitioners, increasing wage costs and challenges with retaining staff due to competition from other sectors, as well as staff leaving to become unregistered sole-trader providers:

"The biggest risk to my business is that I will be unable to sustain a workforce to support NDIS participants due to the rise in expenses namely practitioner wages (including superannuation increases) and the cost to recruit quality candidates, whilst also holding onto quality employees."

Providers also raised a wide range of other themes, including risks arising from the amount of time spent on NDIS administrative tasks, registration costs and uncertainty about ongoing reforms to the NDIS.

Provider peak bodies

Peak bodies raised concerns about the costs of NDIS registration and noted that some members report considering de-registering.

Professional bodies

Similarly, professional bodies also stated the administrative burden of NDIS registration as a business risk, as well as financial sustainability and uncertainty about broader changes within the NDIS. Professional burnout and delays in receiving payment for services relating to assistive technology were also raised as business risks.

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9.2.3 Staff Vacancies

Providers

Many provider submissions indicated they currently have vacancies. Reported vacancy rates varied considerably, ranging from less than 5% to more than 50%.

High staff turnover was reported in many submissions, as well as broader challenges with recruitment and retention. Several providers reported an operating environment where staff leave to become independent/sole-trader providers or take up work in other sectors where they may receive higher wages. A number of providers reported increasing costs associated with salaries and wages to retain staff, or additional costs associated with recruitment (e.g. advertising and recruitment agency costs). For example:

"We have experienced a significant staffing shortage over the past 18 months. Our workforce operating across disability support and community aged care support has reduced from 70 staff to 50 staff over this time. Like many other industries the disability and aged care sector has been hit hard by staffing shortages, the impact of this has been harder still in rural areas where there is a smaller population to draw from and a lack of transport and housing to attract people from out of the area."

Professional bodies

Professional bodies reported a wide range of vacancies among their members, ranging from no vacancies to up to 80%. It was also noted that in some cases, even though their members have vacancies, they have ceased recruiting due to difficulties with finding staff.

9.3 Disability Support Worker (DSW) Cost Model

The Provider Consultation Paper sought stakeholder views on the DSW Cost Model assumptions about organisational overheads and operating costs. Providers were also asked about impacts of the 15% wage increase under the Aged Care Award that took effect from 30 June 2023. A total of 79 provider submissions, five provider peak bodies and one union organisation responded to questions about the DSW Cost Model.

9.3.1 Alignment of Disability Support Worker Cost Model assumptions with provider's corporate and operational overheads.

Providers

Almost all provider submissions to the DSW questions noted that the assumptions in the DSW Cost Model do not reflect their actual costs. Only 2 of the 79 submissions from providers indicated that the model's assumptions align with their costs.

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Provider submissions raised concerns about financial viability under the model's costings, suggesting it does not reflect actual costs and requires providers to absorb cost increases.

"The cost model does not fully account for the complete cost of a billable hour of support, considering base pay, shift loadings, leave entitlements, salary on costs, employee allowances, operational overheads (including supervision costs, utilisation costs, and workers' compensation costs), corporate overheads, and margin."

Many providers reported that their operational and corporate overheads are generally higher than the percentage assumed in the DSW Cost Model. Key reported differences include:

- worker's compensation rates and insurances
- costs associated with utilisation rates, a casualised workforce and in some cases, a reliance on agency staff
- general operational overhead percentages exceeding levels assumed in the DSW Cost Model
- quality and safeguarding activities, including registration and audit costs.

"The one size fits all approach does not recognise the different living environments, diversity, and complexity of supports across participants in the scheme. The price limit is the same for a sole trader delivering in-home support as it is to for a shared 24/7 living arrangement irrespective of the number of people and their needs, and the complexity of support."

Provider peak bodies

Ability Roundtable provided its Financial and Workforce Benchmarking analysis, which was undertaken in conjunction with 63 DSW registered NDIS providers. A mix of for-profit and not-for-profit providers participated, from both metropolitan and regional areas.

For the organisations included in the benchmarking analysis:

- average profitability was reported at -2.1%.
- over 60% of respondents reported three years of consecutive losses since the 2021-22 financial year (data showed a median loss of 5.9% in 2021-22 and 4.9% in 2022-23).
- there is a 10.9% variance between the DSW Cost Model and actual reported costs to deliver support.

"there is a growing gap between the NDIA DSW Cost Model assumptions and the actual cost of service provision".

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Other peak bodies reiterated that the DSW Cost model does not align with operational and organisational overheads, calling for increases in core supports delivered by DSW.

"Cost model does not take into account the funding nature with donations or reserves, complexity of services provided, provider organisation size or quality and safeguarding requirements."

Unions

The Australian Services Union stated there needs to be clearer rules regarding pay and classifications, portable entitlements to paid and other types of leave and sufficient paid time in rosters for training. Similarly, the Health Services Union highlighted a lack of clarity in the current model for how the NDIS price limits for work performed before and after a sleepover.

9.3.2 Range of SCHADS Award classifications under which staff are employed and distribution of permanent full time, part time and casual employment

The Provider Consultation Paper asked about the range of SCHADS Award classifications under which provider organisations employ DSWs and how they are distributed across permanent full-time, permanent part-time and casual employment.

Providers reported a wide range of SCHADS Award classifications from Level 1 to Level 8. For example:

"We have SCHADS employees from level 2 through to level 6, with one manager at level 8."

"In our organisation DSW are generally paid at level 2.4 or Level 3. Service coordinators at level 4.2."

The proportion of reported DSWs employed casually ranged from 12% to 100%. About half of provider submissions reported that 70% or more of their DSW workforce is employed casually. Several providers responded that DSWs prefer to work casually, as they get paid more and have more flexibility, even if it is at the cost of paid leave.

Several responses highlighted the need for the cost model to reflect the actual costs related to shift work, leave loading and public holidays.

"Reasons cited for [DSWs preferencing casual employment conditions]: pursuit of higher salaries, more flexibility. This also comes with additional cost overheads associated with re-rostering required for a more transient workforce. The assumptions of the DSW cost model are based on a permanent worker in a highly casualised workforce."

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9.3.3 Impacts of the Aged Care Award 15% wage increase from June 2023 on recruitment and retention of Disability Support Workers

Providers

Provider submissions reported mixed impacts from the 15% increase to the Aged Care award, with some providers describing no tangible impact and others experiencing significant workforce challenges.[65] Many providers reported general challenges with finding suitable workers with the right skills and experience. Other providers reported that the Aged Care Award increase has put upward pressure on wages, with many of these providers reporting paying above-award wages to attract DSWs. It was reported that the upward pressure on wages contributes to existing workforce challenges with high turnover rates and associated recruitment costs, as well as competition from staff becoming independent DSWs.

"The increased wage and subsequent increased appeal of the Aged Care sector has made it even more difficult to attract employees to the Disability sector. There are greater opportunities for them to gain Permanent F/T employment in the Aged Care sector."

"Competitiveness in wages has notably increased since the 15% wage increase in Aged Care in July 2023."

9.4 Therapy Supports

The Provider Consultation Paper asked several questions about providing therapy supports, including changes in the costs of delivering services and questions about the differences between providing therapy supports to NDIS and non-NDIS clients.

There were 178 provider submissions received relating to therapy supports, 13 from professional bodies, one from a union and a small number from provider peak bodies. Through the APR online form and Participant consultation paper, 142 participants also provided feedback on therapy supports.

9.4.1 Changes in the costs of delivering services

The Provider Consultation Paper asked providers about significant changes in the costs of delivering Therapy support services.

[65] In March 2024, it was announced that aged care workers will receive a further increase of between 18.2% and 28.5%, inclusive of the 15% already ordered, depending on their skill and qualification level.

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Providers

About 87% of provider submissions reported increases in the costs of delivering therapy supports and services. Providers noted increases in wage costs (including increasing staff wages, keeping up with Allied Health awards and professional development costs) and costs associated with recruitment and retention. Providers also reported increases in business expenses such as rent, utilities, office supplies, insurance, workers compensation premiums and travel expenses.

Provider peak bodies

Ability Roundtable responded to the consultation questions on therapy supports and included an updated Allied Health Cost Model for NDIS-funded services from Deloitte Access Economics. The model estimates the respective services costs of 13 large therapy providers.[66] The model indicates that the current NDIS price limits are lower than the actual and projected costs of delivering therapy supports:

- There is a 12.9% difference between the projected fully loaded cost to deliver an hour of therapy supports and the current NDIA Price Limit for the 2024-25 financial year for the four major allied health disciplines.
- For Psychology Services, there is a 16.6% difference between the fully loaded cost to deliver an hour of Psychology supports, when compared to the current NDIA Price Limit for the 2024- 25 financial year.

Professional bodies

Allied Health Professionals Australia submitted that the price limits for therapy should be raised to reflect cumulative indexation since 1 July 2019 and suggested that from 2025, price limits for therapy supports should be automatically indexed.

Allied Health Professions Australia described rising business costs (e.g. wage market rates, rent and utilities, supplies, fuel, consumables and equipment, travel, insurance and other operational expenses).

"Our members' therapy support businesses tend to operate at a small scale, and they therefore have limited infrastructure and resources and operate on thin margins. There is little possibility of further 'efficiencies' within small and solo practices, without compromising on the amount or quality of service."

[66] These participating provider organisations represent an equivalent of 18% revenue across the therapy supports market.

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Similarly, Australian Physiotherapy Association noted that its members find themselves struggling to balance the need to support their staff in a context of rising cost of living by increasing wages while trying to keep their own costs under control.

9.4.2 NDIS providers offering support for early childhood supports and to non-NDIS clients – prices, appointment durations and fee-setting considerations

The Provider Consultation Paper asked providers if they offer therapy supports/early childhood supports to non-NDIS participants. Providers were asked about the proportion of NDIS participants and non-NDIS participants they service, the typical duration of appointments, and if there are variations in prices. Providers were also asked how they determine the hourly rate charged for NDIS participants and what factors they consider when setting different rates.

Providers

The majority of provider submissions responding to this topic reported providing therapy support services to NDIS clients and other segments of the care and support economy (such as private clients or other insurance schemes). The proportion of NDIS participants serviced by these participants ranged from 25% to almost 100%, with more than half of these providers having a client base that was 70% or more NDIS participants.[67]

Appointment durations reported by providers were in many cases the same for NDIS participants as non-NDIS clients. Many providers explain that appointment durations are tailored to the needs of a client, regardless of whether they are an NDIS participant or not. Other providers reported differences in appointment duration due to the complexity or reporting requirements for NDIS participants, and a small number of providers indicated that they billed NDIS participants for this non-face-to-face time.

"Our appointment length is determined in accordance with the principles of evidence-based practice, considering a client's needs/goals, family commitments and research evidence as to the intensity and frequency of intervention. Therefore, there is no distinction in appointment duration based on whether a client is an NDIS participant or private client."

"30 or 60 minutes non-NDIS. 60 minutes for NDIS clients who are usually more complex with multiple co-morbidities and increased liaison time with involved parties including other therapists, SC, equipment suppliers, builders etc."

[67] Noting that some providers support only NDIS participants.

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Provider submissions outlined a range of pricing practices. Most providers reported charging NDIS participants at the price limit, while a small number reported charging below the price limit.

Many of these providers charge non-NDIS participants the same fees as NDIS participants. Other providers reported a price difference between NDIS participants and non-NDIS clients, with some charging more for NDIS participants and some charging less. Reasons for charging different prices varied widely. For example, some providers reported:

- NDIS participant complexity or additional administrative costs associated with providing services to NDIS participants as a reason for charging NDIS participants more.
- The lack of change in NDIS therapy support price limits over the last five years as a reason for charging non-NDIS clients more than NDIS participants.

Professional bodies

Feedback from professional bodies relating to differences in appointment durations was mixed. For example, the Australian Psychological Society stated the median duration of psychological appointments for its members is 60 minutes for both NDIS participants and non-NDIS clients.

The Australian Orthotic Prosthetic Association noted that while some considerations for fee-setting are the same, there are also NDIS-specific aspects:

"The main difference is the report writing component for NDIS participants which is significantly more time burdensome and almost triple what is required by most non-NDIS clients."

9.4.3 Unique costs in providing early childhood supports for NDIS participants

The Provider Consultation Paper asked providers about unique costs of providing early childhood supports for NDIS participants.

Providers

Providers outlined a range of unique costs of providing early childhood supports, with 85 (or 33%) of provider submissions responding to this question. Most providers describe this group of NDIS participants as more complex, compared to other early childhood clients who are not eligible for supports under the NDIS.

When describing early childhood supports for NDIS participants as more intensive and requiring more time, the following additional activities and costs were noted:

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- collaboration and liaison as part of team-based approaches, with an appointed 'Key Worker'[68]
- delivering supports in natural environments, such as at home or in school settings, which requires travel that can exceeds established caps
- specialist skills and professional development needs, often resulting in a need to pay higher salaries
- mandatory reporting obligations, such as writing reports related to funding allocation decisions, risk assessments, reporting to the NDIS Safeguards Commission and making Child Safe notifications.

Professional bodies

Professional bodies noted similar costs of providing early childhood supports for NDIS participants. For example, the Australian Physiotherapy Association described liaison and communication with the care network, support to the family, the expertise and complexity required, extended appointments, the service environment and administrative load.

Dietitians Australia also noted other unique considerations when providing early childhood supports, such as the requirement for specialised training materials and resources, and tools designed specifically for young children with disability:

"Many children with disability (…) require specialised nutrition and dietetic support. The progression can be significantly prolonged (…) with some requiring lifelong assistance. This necessitates a flexible and long-term funding approach, acknowledging complex feeding needs [of each individual child]."

9.5 Support Coordination

The Provider Consultation Paper asked support coordinators if there have been significant changes to the costs of delivering services over the past 12 months.

About 55 (or 21%) of providers made submissions relating to support coordination, as did a small number from provider peak bodies and professional bodies.

[68] Under the eight principles of best-practice early childhood intervention, a family works together with professionals to form a team around the child, communicating and sharing information, knowledge and skills. One main person, called a key worker, works with the family. NDIS, Early Childhood Approach – a guide for professionals, p 4.

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Providers

Most support coordination providers reported increases in the costs of delivering services. Common themes from those submissions include that operating costs have increased (such as wages and salaries, rent, fuel and insurance), while NDIS price limits for support coordination have been held constant for several years.

Many providers noted that they face difficulties in attracting and retaining suitable staff, reporting that there is pressure to increase wages to keep up with the rising cost of living and to remain competitive with comparable positions in similar industries. Several providers described doing work that is often unbilled but necessary, which they consider is not sufficiently accounted for in the current price limits for support coordination, including:

- activities related to onboarding new clients for support coordination (contacting the NDIA, accessing portals, understanding the client's needs, executing service agreements and doing risk assessments).
- activities associated with transitioning to the new PACE portal.
- administrative activities when a participant dies.

Other providers noted that because the price limits have not kept pace with rising costs, their financial sustainability is under pressure.

Provider peak bodies

Peak bodies raised concerns about the current price limits constraining the quality of support coordination services and noted that the price limits have not increased in recent years. Peak bodies also raised concerns about the price limits not sufficiently accounting for the amount of non-face to face time support coordinators incur.

Unions

The Health Services Union noted that the NDIS Review has recommended phasing out support coordination and introducing navigators. Until navigators are introduced, the Health Services Union suggests that transitional increases to support coordination price limits are critical to ensure support coordinator wages keep up with inflation and increased costs.

9.6 Cancellation Policies

The Provider Consultation Paper asked several questions about provider cancellation policies, including:

- What is your cancellation policy for NDIS participants? Is it different for non-NDIS clients? If so, why?

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- How often do you face short-notice cancellations or no shows and on average and how frequently do you claim for these instances monthly? What approach does your organisation take when a participant has an unusually high frequency of cancellations?
- What service offering does your business have as an alternative to short notice cancellations?

Of the 353 provider submissions received, 121 (or 34%) responded to questions relating to cancellation policies, frequency of short-notice cancellations and alternative service offerings aimed at reducing cancellations.

9.6.1 Provider variances in cancellation policies for NDIS participants and non-NDIS clients

Providers

Most provider submissions reported that they have no differences in their cancellation policies for NDIS and non-NDIS clients, with a small number of providers reporting that their cancellation policy is different.

The majority of therapy support providers described adopting a 2-day cancellation, policy rather than the 7-day policy. Providers noted that 48-hours is an industry standard across the Allied Health sectors, and that they do not want to lose clients by adopting a different policy. In general, there was wide variation in reported cancellation policies, with the most commonly cited cancellation policies being 2-hours, 24-hour or 72-hours.

"Our cancellation policy has a notification period of 48 hours and charges 90% of fee for NDIS participants. It is not different for non-NDIS participants, except in exceptional circumstances (family emergencies eg, hospitalisation, natural disasters, extreme weather events, significant financial hardship)."

Provider peak bodies

Provider peak bodies reported favouring retention of the current 7-day cancellation policy arrangements. Peak bodies noted that under the current SCHADS Award, payment to employees is required for cancellations within 7 days. Peak bodies noted that providers try to find alternative work for the employee, but often this work is administrative and unbillable because existing billable services are usually already rostered to other employees.

Professional bodies

Provider professional bodies described the diversity of cancellation policies across the sector. A large peak body reported that a third of their members adopt a 24-hour

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or 48-hour cancellation policy. About 15% of their members stated they do not have a cancellation policy, as cancellations are very infrequent.

Unions

Submissions from Union organisations representing the DSW workforce suggested the 7-day cancellation policy helps ensure retention of the workforce and assists to increase participants' choice of workers.

9.6.2 Frequency and average of short-notice cancellations and monthly claim averages

Providers

There was considerable variation in reported frequencies of short notice cancellations and monthly claim averages. It was noted that seasonal weather impacts the frequency of cancellations (e.g. the winter flu season brings a higher rate of cancellations).

Provider peak bodies

The Australian Psychological Society noted that cancellations by NDIS participants were relatively infrequent, with two-thirds of members reporting that they occurred in less than 10% of scheduled appointments. A further 29% noted that they occurred occasionally, between 10–30% of scheduled appointments.
Other provider peak bodies also noted that short notice cancellations are relatively infrequent, with some reporting less than 10% frequency.

9.6.3 Provider approaches for unusually high frequency of cancellations and alternative service offerings to reduce cancellations

Providers

Most providers reported that they try to provide participants with a range of alternative service offerings when they need to cancel their appointment, such as telehealth, arranging a home visit or re-booking the appointment. Several providers also describe sending SMS text messages and appointment calendar reminders to participants the day before an appointment to help reduce the frequency of cancellations. In addition, most provider submissions acknowledged that the unique needs of each client need to be considered when determining a suitable alternative.

"Alternatives MUST relate to the best practice for that family and child…switch to telehealth. In the early years, children getting sick is a regular reason for cancellations. Telehealth may not be an option…We offer other non-client facing activities in the same timeslot, development of program materials, complete upcoming service summaries and reports for funding reviews, create supporting

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therapy resources for the school or home or use the time to collaborate with other team members, teachers etc."

Professional bodies

Provider professional bodies stated their members offer telehealth services, phone services, or other non-face-to-face services as an alternative to charging a cancellation fee. These alternatives include using the cancelled appointment time to develop resources (e.g. visual aids and materials), write reports, reach out to the family to offer support, liaise with stakeholders and arrange meetings.

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Annual Pricing Review 2023-24

Matters for Discussion

Chair: Kee Hiaujoo, Branch Manager, Economics and Pricing

1. Purpose

1.1. To seek feedback from the Pricing Arrangements Reference Group (PARG) on the Annual Pricing Review (APR) 2023-24 Provider (Attachment A) and Participant (Attachment B) Consultation papers and the research plan (Attachment C).

2. Recommendations

2.1. That PARG **DISCUSS** the draft APR 2023-24 consultation papers and Research Plan.

3. Context and update since the approval of the 2023-24 APR Terms of Reference

3.1. The NDIA Board approved the APR Terms of Reference (ToR) on 24 October 2023 with a minor revision to note the increased focus on participants. Following approval, the Economics and Pricing Branch actively engaged with internal stakeholders across the NDIA to enhance our understanding and approach towards developing the consultation papers and related questions.

3.2. The final NDIS Review report was submitted to the Disability Reform Ministers on 3 November 2023. It is anticipated that the final report will be publicly available following the December 2023 National Cabinet meeting. The Australian Government will consider the recommendations from the Review.

3.3. The Royal Commission released its final report on 29 September 2023. The report made 222 recommendations for reform. The Australian Government is reviewing these recommendations and has established a Commonwealth Disability Royal Commission taskforce to guide the Governments response.

4. Proposed 2023-24 APR Provider Consultation Paper

4.1. The 2023-24 APR Provider Consultation Paper are designed to understand how organisations and providers in the care and support sector are adapting to recent economic conditions, identify primary business risks, and gauge the impact of the NDIS price arrangements and price limits on their operations. Additionally, it aims to explore the costs associated with governance and compliance within the NDIS, as well as unique challenges and cost factors for therapy and early childhood support providers.

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5. Proposed 2023-24 APR Participant Consultation Paper

5.1. In the 2022-23 APR, only 12 of the 304 submissions came from NDIS Participants, highlighting the need for more direct engagement for the 2023-24 APR. For the first time, the Economics and Pricing Branch directly consulted with the Participant Advocate Branch in developing a Participant Consultation Paper.

5.2. The 2023-24 APR Participant Consultation Paper has been tested with the NDIS Participant Reference Group to get feedback from NDIS participants. The aim is to gauge feedback from NDIS participants of the impacts of current pricing arrangements, and whether they are satisfied with the prices they are paying for supports.

5.3. The consultation questions are designed to capture the experiences of NDIS participants when accessing NDIS funded supports. These include experiences with DSW supports, therapy supports, support coordination, plan management, and the impact of cancellations and provider travel policies.

6. APR 2023-24 research plan

6.1. The APR research plan has been developed to support the APR through empirical research. The plan includes an analysis of Scheme statistics, a historical review of NDIS price limits, domestic benchmarking with Commonwealth, state and territory insurance schemes, and an examination of domestic economic conditions such as economic growth, government expenditure on the NDIS, labour market conditions and inflation.

7. Key dates

Date	Activity
October – November 2023	Feedback sought from agency stakeholders: Market Innovation and Employment, Market Intervention and Commissioning, Childrens Taskforce, Home & Living Innovation and Provider Engagement and the Participant Advocacy Branches
14 November 2023	Feedback on the Participant Consultation Paper and engagement process(es) sought from the Participant Advocacy Group
December 2023	Release of 2023-24 APR Terms of Reference and Consultation Paper
11.59pm Sunday 4 February 2024	Closing date for submissions to the 2023-24 APR public consultation
June 2024	Announce results of the 2023-24 APR Release the 2024-25 NDIS Pricing Arrangements and Price Limits Release the 2024-25 price limits (after the Fair Work Commission's Annual Minimum Wage Decision expected in early to mid-June 2024)
1 July 2024	Implementation of the 2024-25 pricing arrangements

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Attachments

Attachment A:	2023-24 Annual Pricing Review Provider Consultation paper
Attachment B:	2023-24 Annual Pricing Review Participant Consultation paper
Attachment C:	2023-24 Annual Pricing Review Research Plan

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2023-24 Annual Pricing Review

Provider Consultation Paper

December 2023

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Acknowledgement

The NDIA acknowledges the Aboriginal and Torres Strait Islander people of this nation and the Traditional Custodians of the lands across which our Agency conducts our business. We pay our respects to the custodians of the land on which we work as well as their ancestors and Elders, past, present and emerging.

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Terms that we use

Acronym	Meaning
ABS	Australian Bureau of Statistics
APR	Annual Pricing Review
CPI	Consumer Price Index
DSW	Disability Support Worker
FWC	Fair Work Commission
NDIA or Agency	National Disability Insurance Agency
NDIS or Scheme	National Disability Insurance Scheme
NDIS Commission	National Disability Insurance Scheme Quality and Safeguards Commission
SCHADS Award	*Social, Community, Home Care and Disability Services Industry Award 2010*
SIL	Supported Independent Living
WPI	Wage Price Index

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Contents

2023-24 Annual Pricing Review Provider Consultation Paper 1

Acknowledgement 2

Contents 3

1. Purpose of this Consultation Paper 4
2. Your feedback is important 5
3. A snapshot of the National Disability Insurance Scheme 7
4. Scope of the 2023-24 Annual Pricing Review 8
5. Contextual Factors 9
   - 5.1.1 The NDIS Review 9
   - 5.1.2 The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (DRC) 9
6. Market environment and influences 9
   - 6.1.1 The Australian Economy 9
   - 6.1.2 Providers and the growing market 10
7. Disability Support Worker related supports 11
8. Therapy Supports 13
9. Support Coordination supports 14
10. Plan Management supports 15
11. Cancellations 16
12. Conclusion 17

National Disability Insurance Agency 19

DRAFT

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1. Purpose of this Consultation Paper

The National Disability Insurance Agency (NDIA or Agency) administers the National Disability Insurance Scheme (NDIS or Scheme), which was established to:

- support people with disability to pursue their goals.
- help them to realise their full potential.
- assist them to participate in and contribute to society.
- empower them to exercise choice and control over their lives and futures.

Every NDIS participant has an individual plan that lists their goals, desired outcomes, the supports they will use and the funding they have received.

Providers are one of the main contact points for NDIS participants. Providers are an important part of the NDIS, delivering supports and services that help participants pursue their goals.

The NDIA continually monitors and reviews its price control framework and other market settings to determine whether they are still appropriate. This Annual Pricing Review (APR) is an important part of that monitoring and review process.

As market steward, the NDIA has a role in creating an efficient and sustainable marketplace through a diverse and competitive range of suppliers, who can meet the structural changes created by a consumer-driven market.

As market steward the NDIA has responsibility for:

- empowering people supported by the NDIS to exercise choice and control.
- maintaining and expanding the supply of high-quality disability supports.
- driving efficiency and innovation in the market for those supports.
- supporting the transition of the NDIS over the longer term to a more. deregulated outcomes-based approach.

As part of its administration of the Scheme and its role as market steward for the developing markets for disability goods and services, the NDIA regulates the commercial relationships between providers and participants, including through price regulation. The price control arrangements apply to all supports purchased by Agency-managed and plan-managed participants. They do not apply to self-managed participants.

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The current Pricing Arrangements and Price Limits are set in accordance with the NDIS Pricing Strategy,[1] The key principles underlying the pricing arrangements are to:

- provide value for money for participants.
- deliver fair and consistent participant outcomes.
- support sustainable NDIS market growth.
- promote the delivery of high-quality innovative supports.

The pricing arrangements and price limits aim to maintain and increase market supply, and help markets grow to a more mature state in the future, while recognising the need for financial sustainability.

2. Your feedback is important

The 2023-24 Annual Pricing Review (APR) began in October 2023 and will deliver recommendations to the National Disability Insurance Agency (NDIA or Agency) Board. Implementation of changes will occur from 1 July 2024 after the Minimum Wage Decision is released by the Fair Work Commission (FWC) in June 2024.

This Consultation Paper will assist you to prepare a submission to the APR. There are guiding questions listed in this paper – you can choose to comment on all or just some of these guiding questions. Please clearly specify which topic and question is being answered in your submission. This will help us to accurately attribute your feedback.

We encourage submission from everyone, including advocacy groups, carers, employees, government agencies, professional bodies, providers, provider peak bodies, researchers as well as workers unions.

The guiding questions are thematically aligned with the scope of this APR and are specifically related to individual supports and areas.

The NDIA is aware that similar guiding questions have been asked in the past. You are not obligated to reiterate what you have said previously as this feedback will again be taken into consideration.

1 NDIA. (2019). NDIS Pricing Strategy

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The NDIA is seeking feedback on changes that have occurred since the last APR only. High level findings from the 2022-23 APR are summarised in this paper.

Any information that you consider to be of a confidential nature should be clearly marked or identified as confidential. The NDIA will not disclose confidential information to third parties without first providing you notice of its intention to do so, such as where it is compelled to do so by law.

Submission on this Consultation Paper can be lodged via email to apr@ndis.gov.au and close at 11:59pm AEST <insert exact date once we have final release date > February 2024.

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3. A snapshot of the National Disability Insurance Scheme

The NDIS has been in operation for ten years. As of 30 September 2023, the Scheme has grown to include 631,529 participants[2], an increase of 14% from twelve months earlier. During the September quarter, 23,803 participants entered the Scheme.

Total payments increased by 23% from $8.2 billion in September 2022 quarter to $10.1 billion in September 2023 quarter.

The average payment for the 12 months ending 30 September for all participants has increased from $56,400 in 2022 to $61,800 in 2023 (an increase of 9.6%). The median payment per participant has increased by 2.8% over the same period.

It is also observed that average payments are almost nine times higher for participants in Supported Independent Living (SIL) than those not in SIL over the 12 months to 30 September 2023.

Average payments are almost four times higher for adults compared with children. Over the past four years, the proportion of participants under 15 years of age has increased from 40% to 43% and the proportion of participants of SIL in the Scheme has decreased from 6.2% to 5.1%.

[2]All figures in this section are from NDIA. (2023). *NDIS Report to disability ministers for Q4 of Y10 Full Report, 30 June 2023*

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4. Scope of the 2023-24 Annual Pricing Review

The APR will examine, through engagement with participants, providers and community and government stakeholders and targeted research, whether the Scheme's existing price control framework (pricing arrangements and price limits) continue to be appropriate or if modification is required.

In particular, the APR will review the pricing arrangements and price limits:

a) that apply to supports delivered by disability support worker (DSW) by updating the *NDIS Cost Model for Disability Support Workers;*
b) for therapy supports to ensure participants receive value for money, while providers strive to improve quality of services and increase efficiency, with a particular emphasis on pricing benchmarks;
c) for plan management to encourage innovation, improve quality of service and ensure value for money;
d) for support coordination to promote service quality and value for money, with a focus on participants experiences when utilising support coordinators to oversee their supports;
e) in relation to the NDIS cancellation policy, which changed from two days to seven days in line with the Social, Community, Home Care and Disability Services (SCHADS) Award. The analysis will examine the impact on participants choice and control;

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5. Contextual Factors

The scope of the (previous) 2022-23 APR last year reflected work underway the NDIS Review and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

5.1.1 The NDIS Review

The Minister for the NDIS and Government Services, the Hon Bill Shorten MP, announced the NDIS Review in October 2022. Information on the review can be found here. The final report was delivered to Disability Reform Ministers in November 2023. It is not publicly available at the time of publication of this consultation paper.

5.1.2 The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (DRC)

The final report of the DRC was released on 29 September 2023 with 222 recommendations for reform. The full report can be found on the Royal Commission's website here. A Commonwealth Disability Royal Commission Taskforce has been established to coordinate the Australian Government's response to the Royal Commission, setting priorities, providing advice, and bringing together all affected portfolios in a unified effort.

6. Market environment and influences

6.1.1 The Australian Economy

The Australian economy has continued to experience above average price increases in essential goods and services, including housing, groceries, utilities, and petrol. The Consumer Price Index (CPI) increased by 5.4% in the twelve months to September 2023. Annual services inflation marked its most significant increase since 2001 in June 2023, easing for the first time in two years in September 2023. Services inflation is influenced by increasing business costs, such as insurance premiums, rents and cost of labour, noting other 'service-related' industries have contributed to its elevated levels such as holiday travel and financial services.

Amid inflationary pressure, the economy experienced declining domestic demand and slower global growth. The Australian unemployment rate was 3.7% in October

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2023[3]. The Gross Domestic Product (GDP) grew by 3.4% in 2022-23, surpassing the 10-year pre-pandemic average growth rate of 2.6%.[4]. The Australian Bureau of Statistics (ABS) attributes this growth to a demand resurgence post the COVID-19 lockdowns.

The Wage Price Index (WPI) measures the extent of wage growth in the Australian labour market. The seasonally adjusted WPI increased by 4.0% year-on-year to the September 2023 quarter, with the largest contributing industry being the health care and social assistance sector, where its WPI grew by 3.1% over the same period.[5].

The Commonwealth Treasury projects real GDP growth for 2023-24 to be 1.5%, a rate that falls below the preceding 10-year average of 2.3% per annum[6]. This forecasted slowdown in growth is attributable to a range of challenging economic dynamics, including high inflation, a trend of increasing interest rates, a decline in domestic demand, and a slowdown in global economic expansion. The Treasury also forecasts a slight increase in the unemployment rate, reaching 4.25% by June 2024, which, despite the increase, remains low by historical standards. The inflation rate is expected to stabilise in 2023-24 and align with the Reserve Bank of Australia's (RBA) target of 2 to 3 per cent by 2024-25[7]. Concurrently, the Treasury projects an increase in wages, with the WPI anticipated to reach 4.0% by June 2024, and a resurgence in real growth in wages to be positive starting in early 2024[8].

Australia's population increased by 2.2% in the year to March 2023[9]. This growth was predominantly driven by migration, with Net Overseas Migration adding 454,400 individuals[10]. A notable percentage of these migrants are of working age, crucial for the care and support sector. Working-age migration could drive economic and employment growth and address the increasing demand in the disability services sector.

6.1.2 Providers and the growing market

[3] ABS. (2023) Labour Force, Australia.

[4] ABS. (2023) Australian National Accounts: National Income, Expenditure and Product.

[5] ABS. (2023) Wage Price Index, Australia.

[6] Commonwealth Treasury (2023) Budget Paper 1

[7] RBA (2023) Inflation Target

[8] Commonwealth Treasury (2023) Budget Paper 1

[9] ABS (2023). National, state and territory population series - March 2023.

[10] ABS (2023). National, state and territory population series - March 2023.

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The provider market continues to grow. As of September 2023, there were 174,275 active providers, with 8,877 providing support to Agency-managed participants and 173,546 providing support to plan-managed participants[11]. There were 13,223 active registered providers as of 30 September 2023, of which 529, or 4%, were active for the first time in the quarter. There were 161,680 unregistered providers, of which 24,122, or 15%, were active for the first time in the quarter.

It should be noted that the sum of the registered and unregistered providers will not reconcile with the total numbers as some ABNs are listed as both registered and unregistered.

Consultation Questions

The APR is seeking the views of stakeholders on the following questions.

1. In which segments of the care and support sector does your organisation provide services?
2. How has your organisation responded to recent economic conditions, like inflation and rising interest rates?
3. What is the primary business risk that your organisation is concerned about? How are you preparing for this challenge?
4. Does your organisation currently have any job vacancies? If so, what is the fulltime equivalent of the vacancies?
5. If your organisation has either renewed its registration or undergone a mid-term audit in the past 12 months, could you specify the financial cost?
6. Has your organisation considered deregistering as a NDIS provider in the past 12 months? If yes, please specify the main reasons.
7. If you are an unregistered provider, have you considered becoming a registered NDIS provider in the past 12 months? Please specify the main reasons why or why not.
8. Are there any direct financial costs to your organisation when implementing changes to the NDIS Price Arrangements and Price Limits each year? If yes, what are they?

7. Disability Support Worker related supports

[11] *NDIS Report to disability ministers for Q4 of Y10 Full Report, 30 June 2023*

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The NDIA utilises the Disability Support Worker Cost Model (Cost Model) to set price limits for supports offered by DSWs. This model calculates the complete cost of an hour's support, factoring in components like base pay, based on the SCHADS Award, entitlements, overheads, and margins.

The NDIA has noted stakeholder feedback on DSW-related supports for the 2022-23 APR, particularly concerning the DSW Cost Model and changes to the SCHADS Award. A recurring theme in the feedback was the request for greater clarity on some assumptions of the DSW Cost Model.

Additional information on the NDIS DSW Cost Model can be found here.

Providers delivering these supports, but not limited to, typically fall under the following registration groups:

- 0104 – High Intensity Daily Personal Activities
- 0107 – Daily Personal Activities
- 0115 – Assistance with Daily Life Tasks in a Group or Shared Living Arrangement
- 0125 – Participation in Community, Social and Civic Activities
- 0133 – Specialised Supported Employment
- 0136 – Group and Centre Based Activities.

In the September quarter of 2023, DSW supports were utilised by 261,483 participants (41% of all active participants). This marks a 12% increase from the same quarter in 2022. Moreover, 101,163 providers offered DSW supports and received payments in this quarter, showing a 23% increase from September 2022. The overall expenditure for these services in the September 2023 quarter reached $6.4 billion (representing 63% of all scheme expenditure), a 28% increase from the $5.0 billion in the September 2022 quarter.

Following the last APR, changes in the SCHADS Award minimum wage, increases to the Superannuation Guarantee and the introduction of the paid family and domestic violence leave were implemented on 1 July 2023.

Consultation questions

The APR is seeking the views of stakeholders on the following questions.

10. Do the assumptions in the NDIS DSW Cost Model align with your organisations overheads and operating costs? If not, can you specify the discrepancies with supporting evidence? The NDIA would like insights into the following areas:

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a. The range of SCHADS Award classifications under which your organisation employ DSWs, along with their respective base pay rates.
b. How are DSWs in your organisation distributed across the following employment conditions; permanent full-time, permanent part-time and casual.

11. Considering the recent 15% wage increase under the Aged Care Award from 30 June 2023, has your organisation experienced any challenges or improvements in attracting and retaining DSWs due to changes in wage competitiveness?

8. Therapy Supports

The NDIA has noted stakeholder feedback on therapy supports in the 2022-23 APR. The feedback particularly emphasised the rising costs of service provision due to the increased wages and workforce management challenges. Moreover, difference in costs between non-NDIS and NDIS participants were highlighted by both participants and stakeholders.

Providers of therapy support, typically fall under the following registration groups:

1. 0128 - Therapeutic Supports
2. 0118 - Early Intervention Supports for Early Childhood
3. 0110 - Specialist Positive Behaviour Support
4. 0126 - Exercise Physiology & Personal Well-being Activities
5. 0135 - Customised Prosthetics
6. 0119 - Specialised Hearing Services
7. 0134 - Hearing Services.

In the September 2023 quarter, 344,574 participants (representing 55% of all active participants) utilised therapy supports. This figure is 18% higher than the corresponding quarter in 2022.

Furthermore, 44,576 providers delivered therapy supports and received payments in the September 2023 quarter, marking a 16% rise from September quarter 2022.

Total expenditure for these services in the September 2023 quarter reached $1.0 billion, which constitutes 10% of all Scheme expenditure. This amount reflects a 28% increase from the $805.7 million spent in the September 2022 quarter.

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Consultation Questions

The APR is seeking the views of stakeholders on the following questions.

12. Has there been significant changes to the costs of delivering your services over the past 12 months? If yes, please provide additional information. The NDIA would like insights into the following areas:
    a. Costs associated with governance, NDIS requested reports, NDIS Compliance and safeguarding.
    b. The change of salary scales for staff members over the past financial year who are involved in delivering therapy and early childhood support services.
13. Do you offer therapy supports/early childhood supports to non-NDIS participants? If so:
    a. What is the proportion of NDIS participants to non-NDIS participants?
    b. What is the typical duration of these appointments compared to an appointment for a NDIS participant?
    c. How much do you charge for these appointments? If you provide various types of therapy, please indicate the amount for each and whether there is a price difference between NDIS and non-NDIS clients? If so, why?
14. What is unique to the cost of providing therapy supports/early childhood supports for NDIS participants?
15. When determining the hourly rate charged for a NDIS participant:
    a. What factors does your organisation consider? For example, report writing, complexity of participants, non-face-to-face preparation time, administration and quality and safeguarding.
    b. Are these considerations different when determining the rate for non-NDIS clients? If so, how?

9. Support Coordination supports

The NDIA has noted the feedback from providers on the 2022-23 APR regarding support coordination pricing, specifically highlighting the need to cover unbillable

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work expenses. As a result, the NDIA is progressing work to develop a support coordinator cost model, as an input to the 2023-24 APR.

In the September 2023 quarter, 223,913 participants (35% of all active participants) utilised support coordination services, marking a 14% increase from the same quarter in 2022.

A total of 7,459 providers delivered support coordination supports and received payments in the September 2023 quarter, a rise of 32% from the previous year.

Total payments for support coordination supports in the September 2023 quarter reached $267.5 million, constituting 3% of the total Scheme expenditure. This reflects a 19% increase from the $225.1 million spent in the September 2022 quarter.

Consultation Questions

The APR is seeking the views of stakeholders on the following questions.

16. Has there been significant changes to the costs of delivering your services over the past 12 months? If yes, what have been the primary increases. Please provide evidence.

10. Plan Management supports

The NDIA has noted the feedback from plan managers for the 2022-23 APR concerning the increased costs associated with attracting and retaining staff. Furthermore, participants highlighted pricing discrepancies between plan managed and self-managed approaches. A frequently raised issue was the need for more explicit guidelines on the role of plan managers.

In the last two years, the distribution of participants' management choices has evolved:

- Self-manage all or part of their plan has decreased from 31% to 29%
- Use a plan manager has increased from 51% to 61%
- Agency-managed plan has decreased from 18% to 10%.

Newer Scheme entrants predominantly prefer using a plan manager for some or most of their supports, in contrast to those who entered the Scheme through transition.

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Expenditure patterns across these management types have also shifted over the same period:

- Self-management has remained between 12%-13%
- Payments managed by a plan manager have increased from 42% to 55%
- Agency-managed payments decreased from 45% to 34%.

For the September 2023 quarter, plan managers received $5.4 billion. Of this, $135 million is attributable to plan management services, while the remaining $5.3 billion is payments made by plan managers to providers on behalf of participants.

The number of plan managers has marginally increased marginally by 1%, from 1,462 in September 2022 to 1,477 in September 2023. Concurrently, the number of participants under plan management supports grew by 22%, increasing from 312,765 to 383,081.

Consultation Questions

The APR is seeking the views of stakeholders on the following questions.

19. Has there been significant changes to the costs of delivering your services over the past 12 months. If yes, what have been the primary increases? Please provide evidence.

11. Cancellations

The NDIA has noted stakeholder feedback received via Ministerial Correspondence and various other channels on the shift in the NDIS cancellation policy, changing the notice period from two days to seven days.

To progress the recommendation in the 2022-23, the NDIA aims to collaborate with the sector to assess the impact of the NDIS cancellation policy. As part of this, the NDIA is actively collecting data and seeking insights from stakeholders.

In July 2022, the NDIA adjusted the short-notice cancellation period to be consistent with updates in the SCHADS Award, which requires employers to compensate workers for shifts cancelled with under seven days' notice. According to the SCHADS Award, when there are changes to rosters (e.g., client cancellations), employers can reschedule worker shifts within the following six weeks. However, the rescheduling must offer the worker at least 12 hours' notice prior to the initial shift, and for any new dates, a minimum of seven days' notice or compensation for the interrupted shift is required.

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Since July 2022, an increase in cancellation claims has been observed. Cancellation claims equate to $35.3 million (0.3% of all Scheme spend) during the September 2023 quarter 2023, compared to $29.3 million (0.4% of all Scheme spend) in the September 2022 quarter.

Consultation Questions

The APR is seeking the views of stakeholders on the following questions

17. What is your cancellation policy (notification period and charges) for NDIS participants? Is it different for non-NDIS clients? If so, why?
18. How often do you face short-notice cancellations or no shows and on average and how frequently do you claim for these instances monthly? What approach does your organisation take when a participant has an unusually high frequency of cancellations?
19. What service offering does your business have as an alternative to short notice cancellations? For example, telehealth, other indirect support such as follow up with mainstream supports.

12. Conclusion

Thank you for taking the time to review the 2023-24 APR Consultation paper.

Your participation in the public consultation is important to us and your feedback supports setting sustainable pricing arrangements that promote choice and control for NDIS participants.

The outcomes from the APR Consultation Paper are intended to be shared with the NDIA Board and published as part of the APR Report by June 2024.

The outcomes of the APR will be announced in June 2024 following the Fair Work Commission's Minimum Wage Decision, which is expected around early to mid-June 2024.

The NDIS Pricing Arrangements and Price Limits will be published in June 2024 to take effect from 1 July 2024.

For more information on the public consultation and how to provide feedback, please visit the NDIS Annual Pricing Review page.

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You can also find more information about this year's Annual Pricing Review by accessing the APR 2023-24 Terms of Reference.

Submissions on this Consultation Paper can be lodged via email to apr@ndis.gov.au and close by 11:59pm AEST Sunday 4 February 2024.

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DISCLOSURE LOG
DOCUMENT 66.2



2023-24 Annual Pricing Review

Participant Consultation Paper

December 2023

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Acknowledgement

The NDIA acknowledges the Aboriginal and Torres Strait Islander people of this nation and the Traditional Custodians of the lands across which our Agency conducts our business. We pay our respects to the custodians of the land on which we work as well as their ancestors and Elders, past, present and emerging.

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DISCLOSURE LOG

Contents

2023-24 Annual Pricing Review 1

Participant Consultation Paper 1

Contents 3

1. What is the purpose of this consultation paper 4
2. Why your feedback is important 4
3. 2023-24 APR topics 5
4. Important dates for the Annual Pricing Review 6
5. How to use this consultation paper 6
6. Consultation questions 7
7. Conclusion 8
8. How to send us your feedback 10

National Disability Insurance Agency 11

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1. What is the purpose of this consultation paper

The role of the National Disability Insurance Agency (NDIA) is to implement the National Disability Insurance Scheme (NDIS), which will support a better life for hundreds of thousands of Australians with a significant and permanent disability and their families and carers. The Scheme helps people with disabilities achieve their goals, participate in society, and have control over their lives.

Providers offer supports and services that NDIS participants need to reach their goals. The NDIA regularly reviews its pricing rules and other market aspects to make sure they are still right. This Annual Pricing Review (APR) is part of that process.

The NDIA, as the market steward, works to create a good and lasting market with a variety of suppliers. The NDIA's goals include giving NDIS participants more choice and control, ensuring a supply of quality supports, encouraging market efficiency and innovation, and smoothly moving the NDIS to a more flexible, outcome-focused system.

2. Why your feedback is important

The NDIA highly values your feedback as a NDIS participant. Your input is essential to us, especially as we review and set our price limits for services and supports. Your first hand experience and insights can help us ensure that our prices limits are fair, realistic and reflect the quality of care you receive.

Your feedback highlights aspects of the supports you receive that we might not see from our perspective. You can tell us how our pricing arrangements impact you and the quality of supports you receive. This will help us to understand if NDIA funded supports are available to you when needed and genuinely beneficial to you when provided.

By sharing your thoughts, you play an important role in shaping the NDIA funded supports you use. Your involvement in this process means that the supports you

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receive are not just provided to you but are created with you. This empowers you and respects your right to have a say in the supports and services you receive.

3. 2023-24 APR topics

The Annual Pricing Review (APR) will look closely at the current pricing arrangements and price limits of disability supports and services in the Scheme. This includes talking to NDIS Participants, service providers, community members and government officials.

Specifically, the scope of the APR this year include:

a) Disability support worker supports;
b) Therapy supports;
c) Plan management;
d) Support coordination;
e) The NDIS cancellation policy;
f) Provider travel when supports are cancelled.

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4. Important dates for the Annual Pricing Review

The important dates for this consultation are:

- The consultation period opens on XX December 2023
- The consultation period closes on XX February 2024
- Outcomes from the 2023-24 Annual Pricing Review will be published in June 2024

Changes from the 2023-24 Annual Pricing Review will be in effect from 1 July 2024.

5. How to use this consultation paper

This paper is here to help you give your thoughts on the APR.

It has some questions to guide you. You can answer all or just some of these questions.

When you respond, please tell us which questions you are answering. This makes sure we understand your feedback correctly.

We welcome responses from NDIS participants, family members of participants, carers, participant advocacy groups, professional bodies and researchers.

The questions in this paper are about specific supports and areas that relate to this year's APR topics which are outlined in Section 3.

If any part of your response is private or confidential, please say so clearly. We will keep the information private and won't share it with others unless we have to by law. You can read the NDIA's privacy policy here.

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DISCLOSURE LOG

6. Consultation questions

The NDIS Pricing Arrangements and Price Limits document is an important tool in managing how supports and services are priced and ensuring that participants receive fair, consistent and equitable access to the services and supports they need.

Through this consultation, the NDIA aims to gather insights on a range of topics, including your awareness and understanding of the current price limits, experience in negotiating supports and services cost within these limits, and the impact of these price limits on your ability to access quality services.

Below are some questions that will guide your feedback.

Consultation Questions:

1. How familiar are you with the NDIS Pricing Arrangements and Price Limits? Do you feel well-informed about these price limits and how they impact your services?
2. How do you manage your NDIS funding for your Disability Support Worker supports? Are you:
    a. Agency-managed
    b. Plan-managed
    c. Self-managed
    d. Unsure
3. Can you tell us why you chose this method?
4. Do you know the prices you pay for your supports? For example, how much an hour of therapy supports costs.
5. Does your provider charge you the same for their services as they charge non-NDIS participants?
    a. Yes
    b. No
    c. Unsure
    d. If you answered yes, can you give examples.

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6. Have you had any experience negotiating prices with service providers within the NDIS price limits?
7. Do you feel that you have enough information to make informed choices about your service providers?
8. How do you usually receive updates about changes in NDIS pricing and provider policies from your support provider?
9. The NDIA does not set the prices that your service providers charge you. Instead, the NDIA sets maximum prices your provider can charge you. Providers and participants should discuss and agree on the final prices you will pay for your services. Which statement best matches how your provider talks to you about their price?
    a. Your provider tells you that the NDIA decides their price.
    b. Your provider shows you a price list and says these are fixed prices to pay if purchasing services from them.
    c. You discuss with your provider and agree on the prices for the services you buy.
10. If you have support coordination funded in your plan, could you describe how you have found the process of working with them? This includes aspects such as the effectiveness of their support to help you understand your NDIS plan, and any challenges or successes you have had with your support coordinator.
11. What is your providers' cancellation policy?

7. Conclusion

Thank you for taking the time to review the 2023-24 APR Participant Consultation Paper.

It is important for us to hear what you think. Your opinions and experiences help us make fair pricing decisions that give NDIS participants choice and control. We will

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share what we learn from the APR with the NDIA Board and include it in the APR report, which we will release by June 2024. The final decisions about pricing will be announced in June 2024, after the Fair Work Commission's decision on the minimum wage around early to mid-June. These new price limits will start from 1 July 2024.

To find out more about this consultation and how to give your feedback please visit the NDIS Annual Pricing Review page. You can also get more details about this year's review in the APR 2023-24 Terms of Reference here.

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8. How to send us your feedback

- You can answer a few or as many questions as you like.
- Please choose questions related to the NDIS supports you receive.
- You can choose to answer just Yes or No, or provide us with more information.
- You can choose to send your feedback to us in one of the following ways:
  - Send an email to the Annual Pricing Review email address apr@ndis.gov.au.
  - Completing the online survey form.

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2023-24 Annual Pricing Review (APR) Research Plan

The Economics and Pricing branch intend to inform the APR through the following research topics. This research plan may change over the course of the APR based on the availability of information and timeframes.

NOTE: There are limitations to the analysis that can be done due to NDIS' transition to PACE.

Introduction

- Scheme statistics
- History of NDIS price limits (i.e., Disability Support Workers)
- International comparison of care spending/international disability schemes
- Consultation submissions/summary

Domestic economic conditions

- Australian economic growth
- Government expenditure on NDIS and other healthcare-related programs
    - Growth in the care sector
- Gross Value Add (GVA) of healthcare and social assistance sector against all industries
- Inflation through:
    - CPI (all industries and health)
    - Real wage growth (all industries and health care and social assistance sector)
- Labour market conditions
- Overseas Migration
- Future supply of occupations

Disability Support Worker (DSW) supports and DSW Cost Model

- Background section on sector
    - Healthcare and Social Assistance sector – employment, growth, GVA
    - Number of DSWs in the sector
    - Wages/prices of workers in the sector
    - Comparison to other sectors and/or other government schemes/programs
- Summary NDIS information (number of participants and providers, payments made for supports)
- Relevant financial information available:
    - StewartBrown survey
    - Ability Roundtable survey
    - Australian Charities and Not-for-Profit Commission data
- Aged Care Award impacts from 1 July 2023
- Business Dynamism (to be investigated and expanded further)
    - Number of registered and unregistered providers
        - Active providers
        - Proportion of market for active against inactive providers
    - Payments made over time
    - Market concentration (Herfindahl-Hirschman Index (HHI))

Therapy supports

- Background section on sector
    - Wages/prices of workers in the sector
    - Workforce linkages, vacancies of certain types of therapists.

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- Summary NDIS information (number of participants and providers, payments made for supports)
- Comparison of price limits and arrangements to other commonwealth and state schemes
- Private billing rate analysis including expansion of sample dataset and regression analysis used
- Business Dynamism (to be investigated and expanded further)
    - Number of registered and unregistered providers
        - Active providers
        - Proportion of market for active against inactive providers
    - Payments made over time
    - Market concentration (Herfindahl-Hirschman Index (HHI))

Support coordination supports

- Summary NDIS information (number of participants and providers, payments made for supports)
- Business Dynamism (to be investigated and expanded further)
    - Number of registered and unregistered providers
        - Active providers
        - Proportion of market for active against inactive providers
    - Payments made over time
    - Market concentration (Herfindahl-Hirschman Index (HHI))

Plan management supports

- Summary NDIS information (number of participants and providers, payments made for these supports)
    - Number and percentage of participants using plan managers, number of plan managers, amount claimed
    - Fee charged by plan managers
- Average funds management ratio (the ratio of the cost of monthly plan management fee to the cost of the supports purchased through the plan manager)
- Business Dynamism (to be investigated and expanded further)
    - Number of registered and unregistered providers
        - Active providers
        - Proportion of market for active against inactive providers
    - Payments made over time
    - Market concentration (Herfindahl-Hirschman Index (HHI))

Cancellations and provider-travel related cancellations (Data capture still being investigated)

- Summary NDIS information (number of participants and providers, payments made for supports)
    - Trend line of cancellation (amount and percentage of plan)
    - Trend line of travel time claimed (amount and percentage of plan)
    - Which supports cancellations were claimed against
    - By remoteness (Modified Monash Model rating)
- Comparison of NDIS cancellation policy against other Government Schemes and private market

DRAFT

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Pricing Arrangement Reference Group (PARG)

Meeting: 6 March 2024

Minutes

Date: Wednesday, 6 March 2024

Time: 3:00pm-5:00pm

Meeting: Microsoft Teams

Members

Chair		
David Gifford	Scheme Actuary	By Teams
Pricing Arrangement Reference Group Members		
Jim s47F - pe	Independent Member	By Teams
Deborah s47F - perso	Independent Member	By Teams
Flavio s47F - personal priva	Independent Member	By Teams
Felicity s47F - personal p	Independent Member	By Teams
Matthew s47F - persona	Independent Member	By Teams
Participating Observer		
Anne s47F - personal p	General Manager, Market Coordinator	By Teams
Kee s47F - personal pr	Branch Manager, Economics and Pricing	By Teams
Mary s47F - personal privac	A/g Director, Economics and Pricing Branch	By Teams
Dominic s47F - person	A/g Director, Economics and Pricing Branch	By Teams
Davor s47F - personal privac	A/g Director, Economics and Pricing Branch	By Teams
Scott s47F - personal p	Assistant Director, Economics and Pricing Branch	By Teams
Secretariat		
Vincent s47F - personal p	A/g Director, Economics and Pricing Branch	By Teams

1.2 Welcome and apologies

- Jim s47F - pe and Anne s47F - personal pr was an apology.

1.3 Previous Meeting's Minutes

- Endorsed by continuing members.

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1.5 Declaration of conflicts of interest

- **Felicity** s47F - personal privac acknowledged a potential conflict of interest arising from her role as voluntary chair of Better Access Australia, a leading health advocate group that also covers disability, while serving as a member of the PARG.
- **Deb** s47F - persona acknowledged a conflict of interest as her sister-in-law is a sole trader for the NDIA, and flagged concerns about perceived impartiality this may give bias towards services they provide.

2.1 Chair Update

- **NDIS Review:** The recently released NDIS Review puts forward substantial recommendations, some potentially changing the scheme's structure and service boundaries with mainstream providers. While not directly affecting this year's pricing review, the broader context must be considered.
- **Media Attention:** The scheme remains under media and government scrutiny, particularly regarding costs and growth projections. The NDIA continues to analyse and advise on these implications.
- **Participant Experience:** The scheme's size and rapid growth make delivering a seamless participant experience a challenge. This remains a core focus for the NDIA despite complexities.
- **Annual Pricing Review:**
    - This year's pricing review will use a 'minimalist' approach. There will not be any fundamental shifts to the structure of pricing reviews ahead of the government's response to the NDIS Review recommendations (including a potential shift in the pricing function). Focus is on the adequacy of core service price limits.
    - The consultation papers for the pricing review were released on 25 January 2024. The submission period has been extended for providers from 3rd to 10th March while participant submission closes on 17th March.
    - PARG requested access to the original submissions (in addition to the final report) to aid understanding of participant and provider perspectives. Concerns about sharing full submissions due to privacy disclosure within consent agreements exist. The Chair supports in principle in sharing the submissions with the PARG.

2.2 Branch Update

- **Current Challenges**: The APR is facing pressure from multiple directions – providers and participants unhappy with decisions and uncertainty around NDIS Review recommendations.
- **Deloitte:** The team is working with Deloitte Access Economics on economic modelling to understand the scheme's growth projections and the impact on pricing. They are assessing supply and demand dynamics and employment effects related to participants and carers. It was suggested to share the findings from the modelling with PARG in upcoming meetings.
- **NDIS Review:** Recommendations from the NDIS Review are being implemented, including DSS taking the lead on developing a new pricing and payment framework. The NDIA will actively collaborate in this process, likely starting after the APR.

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3.1 APR Progress and DSW Cost Model

- **APR Scope:**
  - Due to the pending changes of the NDIS Review, the APR has a narrow Terms of Reference, focussing on disability support worker (DSW) services, therapy supports, support coordination, and short-term cancellations. The Pricing Policy team has received nearly 780 submissions so far (a significant increase over previous years), primarily from participants and providers.
  - The PARG raised concerns that the narrow focus of the current pricing review creates risks while broader policy changes await government implementation. The slow pace of change could worsen existing problems for existing pricing structures relating to service differentiation, regional variations, client mix, and specific service needs to improve outcomes.
- **Therapy:**
  - Initial finding suggests that NDIS Price limits for therapy supports might be at parity or potentially lower than other government-funded schemes – indicating a shift in market dynamics.
  - A concerning 16% reduction in active registered providers has been observed. Further investigation is needed to understand why providers are deregistering and potentially shifting their services away from the scheme. The trend is more apparent than previous years.
- **Support Coordination:**
  - The PARG noted a noticeable increase in the number of active unregistered providers offering support coordination – requiring further investigation on potential causes. This raises concerns about quality and oversight of services delivered.
- **Cancellations:**
  - The PARG discussed how to achieve a fairer NDIS cancellation policy that considers both participant needs and provider sustainability.
  - Participants: The policy come across as inflexible and unreasonable, especially for services related to children where sickness and unexpected events are common.
  - Providers: Some providers have been charging the full rate for up to 7 days and view the policy as essential to prevent losses.
- **DSW Cost Model:**
  - The PARG discussed a few key considerations relating to the DSW Cost Model. The current model likely underestimates true overheads needed to run a DSW business – impacting provider financial sustainability. The pricing structure needs to adequately factor in the higher costs associated with serving participants with complex support needs. The model simplification may have sacrificed necessary detail.
  - The PARG raised whether the current cost model accurately reflects the real costs of providing services. The 25th percentile assumptions and potential under-estimation of figures.

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- The PARG acknowledges that the Cost Model is an approximation, not a perfect reflection of true costs. There is a lack of robust data on the true cost of providing disability supports, leaving pricing recommendations vulnerable to criticism. Providers often argue that overhead costs from the model are underestimated and the PARG signalled that it should be revisited, however, it was noted that the team cannot fully validate or refute these claims due to data limitations.
- The previous surveys used to inform the Cost Model suffered from low response rates and accuracy issues and was discontinued for these reasons. Sector driven financial surveys like Ability Roundtable or Stewart Brown have potential biases in reporting and interpretation and might not fully represent the entire provider landscape. Data from the Australian Charities and Not-for-profit Commission lacks the granularity to isolate NDIS services.
- The PARG discussed mandatory financial reporting could provide valuable insights, while considering how to minimise the reporting burden on providers. Sampling and focussed audits are potential solutions. The PARG suggested additional data requirements to the financials, such as inputs, outputs, and the variation in costs associated with specific cases – helping to improve the model.
- It was stated that it is believed that in other sectors, possibly health care, participants who provide financial information as part of a survey are paid to reflect the time spent extracting and compiling the requested information.

4.1 Actions

#	Meeting	Action	Status
1	20240603	Explore the possibility of sharing a selection of submissions, even if full access is not possible.	Open
2	20240603	The pricing team could consider framing communications positively, highlighting what is being done, while remaining transparent about the challenges they face.	Open
3	20240603	The Chair has supported suggestions to set up a direct discussion between the NDIS Board and PARG.	Open

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MR25/01967 FOI 24/25-2242

DISCLOSURE LOG

DOCUMENT 68

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2023-24 Annual Pricing Review and Disability Support Worker Cost Model

Matters for Discussion

Chair: Kee Hiaujoo, Branch Manager, Economics and Pricing

1. Purpose

1.1. To provide an update on key considerations within the Annual Pricing Review (APR) including concerns raised by stakeholders relating to the Disability Support Worker (DSW) Cost Model.

2. Recommendations

2.1. That PARG notes the APR considerations.

3. Background

3.1. The NDIA Board approved the 2023-24 APR Terms of Reference in October 2023.

3.2. The NDIS Review released their final report in December 2023. One of the recommendations from the Review is to transition the NDIS pricing functions to the Independent Hospital and Aged Care Pricing Authority (IHACPA). This transition is intended to increase transparency and independence of price setting, and to achieve better alignment with the broader care sector.

3.3. Further, the recommendation for the Australian Government to lead a comprehensive review and refinement of the current Pricing and Payments Framework signals an anticipation of substantial structural reforms in the medium to long term.

3.4. The scope of this year's APR's is narrowed, aiming at addressing immediate market needs and ensuring the continuity of supports for participants. It recognises the broader reform initiatives recommended by the NDIS Review and Disability Royal Commission. The APR will focus on DSW supports, therapeutic supports, support coordination and the short-notice cancellation policy.

4. APR Update

4.1. The 2023-24 APR consultation commenced in January 2024. In addition to the provider focussed consultation paper (consistent with consultation papers released to support previous APRs), a participant focussed consultation paper has been released for the first time. As of 4 March 2024, the APR has received 710 submissions, with the majority (508) coming from participants and their representatives.

4.2. **Therapy supports:** Initial analyses indicate the number of active registered providers has decreased (a 16% reduction in the six months to Dec 2023 compared to a year ago), with a greater increase to active unregistered providers delivering therapy supports. Preliminary findings on the comparison of market and other government schemes suggest that NDIS therapy price limits may be on par or lower for certain types of therapies.

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4.3. **Support Coordination:** About 61% of participants responding reported that they are satisfied or very satisfied with the support from support coordinator. Using NDIA payment data, indicative analysis suggests that the number of active providers continues to rise, largely driven by the unregistered providers.

4.4. **Cancellations:** Early insights suggest that providers do not necessarily charge up to the 7-day short-notice cancellation policy, with some opting for a 24 or 48-hour cancellation policy. Around 86% of participants show awareness of their support's cancellation policy, with 49% suggesting they have different cancellation policies across supports.

5. Disability Support Worker Cost Model

5.1. The DSW Cost Model[1] ("Model") estimates the fully loaded cost of a billable hour of support considering six main factors: base pay; direct on-costs; operational overheads; corporate overheads; margin and a temporary loading (currently 1%, set to cease on 1 July 2024).

5.2. Feedback from sector stakeholders suggest the Model's assumptions do not reflect the reality of service delivery, the current economic landscape and there is a greater need for transparency in assumption setting. These concerns include:

5.2.1 Potential underestimation of corporate and operational overheads. Median corporate and operational overheads have increased in recent years, attributed to factors as such insurance premiums and regulatory compliance costs.

5.2.1 Potential model limitations where the Model does not fully account for services or staff required by clients with higher or more specialised needs.

5.2.1 Previously, price limits were set based on the 'efficient' level at the 25th percentile across a range of parameters. The Model was simplified from July 2022, where this assumption is no longer explicit in current publications. Current parameters have considered the 25th percentile of the available data at that time.

5.2.1 Concerns were raised that this assumption is flawed and the parameters in the Model were not adequate to allow providers to recover costs.

6. Financial Data Sources

6.1. The NDIA previously commissioned an annual Financial Benchmarking Survey (Survey) for providers of DSW supports over a 6-year period. Data from the Survey were used to derive parameters to inform the Model. The last Survey was conducted over 2021-22. The parameters in the Model are somewhat dated given the rising costs of living in recent years.

6.2. The NDIA has attempted to work with the sector on sector-run surveys to capture financial information of providers delivering disability supports. This includes the Ability Roundtable survey[2] and more recently, Stewart Brown benchmarking[3].

6.3. However, these surveys do present drawbacks:

6.4. The sample sizes of these surveys are much smaller than the previous NDIA Survey, raising concerns on representativeness. For 2022-23 benchmarking data, 55 providers benchmarked

[1] Pricing arrangements | NDIS.
[2] Ability Roundtable : Service Benchmarking for Excellence in Disability.
[3] Disability Services Survey (stewartbrown.com.au).

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with the Ability Roundtable (11% of NDIS payments). The Stewart Brown June 2023 Survey had 51 participating organisations (with percentage of payments unknown).

- As current surveys are conducted by the sector, there may be a perception of bias within data collection and/or reporting and interpretation of results.

6.5. The Agency is looking into the financial health of organisations through published financial data of not-for-profit organisations (providing NDIS services), as mandated by reporting requirements to the Australian Charities and Not-for-Profit Commission (ACNC).

- Evaluating NDIS providers financial health with ACNC disclosed data is limited by the inability to separate NDIS from non-NDIS activities, coupled with the significant difference between for-profit and not-for profit organisations' financial profiles.

7. Considerations for APR

7.1. The true costs of service delivery incurred by providers and their financial bottom lines continue to be largely unobserved, which hinders the Agency's ability to make informed pricing decisions. In the absence of a comprehensive financial database, the Agency does not have sufficient information as a basis for parameter change, outside minimum wage, or legislative changes, in the near term.

7.2. The Agency recommended in the last APR to explore options with the NDIS Review on mandatory financial reporting from NDIS providers as an input to the Model, similar to the approach used in the aged care sector. Continued work should be undertaken to gather more comprehensive financial information and to refresh the pricing strategy. Some of these considerations could be through collaboration with the Department of Social Services (DSS) on the NDIS Review's recommended Pricing and Payment Framework paper. Any such changes will need to be explored and agreed with IHACPA and potentially DSS as part of the proposed pricing transition.

7.3. To manage expectations and public scrutiny, it is recommended that the Agency have a clear position through the upcoming APR to acknowledge that some assumptions within the Model were the best estimates at the time of the financial benchmarking survey data available. Over the last two years, disability markets continue to show healthy growth and there is no evidence to suggest that supply is not meeting demand. Business entries and exits are an important part of the business dynamism and competition, and there has not been widespread systemic exits observed in the market.

7.4. The APR should also acknowledge that since the Model was simplified in 2022, the assumption of the price limits being set at the 'efficient' level at the 25th percentile is no longer explicit in the current publications. This assumption should be further explored through collaboration with DSS on the upcoming Pricing and Payment Framework paper.

7.5. There has also been heightened criticisms from some sector stakeholders in the pricing approach given price limits for some provider groups (therapy, support coordination and plan management) have not been increased for 4 to 5 years. However benchmarking data (in relation to therapy prices), as well as data relating to market entries and exits (across all these providers) have provided support for the decisions previously made.

8. Risks

8.1. There is a reputational risk to the Agency for not having adequate financial data of providers. This further creates tension with the sector, who have been raising concerns on the costs and profitability of delivering disability supports for NDIS participants.

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8.2. There is a risk of incomplete information leading to inadequate prices, and therefore supply issues and in turn, participant safety risk.

8.3. There is a risk of incomplete information leading to overly adequate prices, leading to sustainability issues.

9. Impact

9.1. The APR process and setting NDIS pricing arrangements and price limits is crucial to ensuring a sustainable provider market to deliver supports to NDIS participants.

10. Next steps

10.1. The draft APR recommendations will be presented at the 9 May 2024 Board meeting.

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Pricing Arrangement Reference Group (PARG)

Meeting: 10 April 2024

Minutes

Date: Wednesday, 10 April 2024

Time: 2:00pm-3:30pm

Meeting: Microsoft Teams

Members

Chair		
Kee s47F - personal pr	Branch Manager, Economics and Pricing	By Teams
Pricing Arrangement Reference Group Members		
Jim s47F - pe	Independent Member	By Teams
Deborah s47F - perso	Independent Member	By Teams
Flavio s47F - personal priva	Independent Member	By Teams
Felicity s47F - personal p	Independent Member	By Teams
Matthew s47F - persona	Independent Member	By Teams
Participating Observer		
Anne s47F - personal p	General Manager, Market Coordinator	By Teams
Mary s47F - personal privac	A/g Director, Economics and Pricing Branch	By Teams
Dominic s47F - person	A/g Director, Economics and Pricing Branch	By Teams
Davor s47F - personal privac	A/g Director, Economics and Pricing Branch	By Teams
Elisha s47F - personal p	Assistant Director, Economics and Pricing Branch	By Teams
Courtney s47F - perso	Assistant Director, Economics and Pricing Branch	By Teams
Scott s47F - personal p	Assistant Director, Economics and Pricing Branch	By Teams
Secretariat		
Vincent s47F - personal p	A/g Director, Economics and Pricing Branch	By Teams
Mike s47F - personal privacy	Assistant Director, Economics and Pricing	By Teams

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1.2 Welcome and apologies

- David Gifford was an apology. Kee s47F - personal priv facilitated the meeting as Chair.

1.3 Previous Meeting's Minutes

- Endorsed by members. Felicity noted that she has had a further discussion with Dave and the mitigation has satisfied the Chair. Deb mentioned we do not have a conflict of interest register with specified mitigation.

1.4 Update on Action Register

- Actions were reviewed.
    - Action 1: Legal team has confirmed we can share a sample of submissions as long as sensitive information would be redacted. Members are unsure there is enough time to digest this and provide feedback given timelines. Members envision having access to all submissions via an online portal for sharing submissions. Kee noted large volume of submissions and that we might not have the capacity to share submissions via online portal currently. Jim suggested Economics and Pricing Branch to select relevant and noteworthy submissions and create a sample for PARG to review. Deb identified a potential risk with providing comment and endorsement of Chapters without fully knowing if the matters raised are reflected in submissions. This should be included in a privacy/confidentiality policy. Kee will take offline to find a solution.
    - Action 2: Pricing team will phrase communications positively, highlighting what is being done, while remaining transparent about the challenges they face in an ongoing manner.
    - Action 3: Idea of setting up a direct discussion between PARG and NDIA board has been presented to the board secretariat and we are awaiting an update.

2.1 Chair Update

- David Gifford was an apology. Kee provided an update. Providers and peak bodies are vocal about price setting and price issues and collaborating to issue joint statements on price pressures. Some comments called for 10% increase in DSW, therapy, and support coordination. They also called for a levy to help with registration and compliance costs. They noted the cost of living rising and NDIS review recommendations.

- Anne Skordis mentioned there have been high profile providers exits. Some providers had shared balance sheets that show decline in financial return over the last 2 years and forecast further deterioration in the next 3-4 years. They requested additional support as a result. Anne's team is providing assistance to those providers who had signal intention to exit.

- Deb noted that we are setting averages across broad categories and activities. There is diversity within these categories and locations, which could lead to different cost structures and therefore providers exiting. More analysis should be undertaken to unpack why costs were high of those providers who exited. Anne agreed and noted that team does look into factors that drove the exit. A question was raised as to whether there are actual exits or just forecasted exits, and Anne confirmed that there are indeed exists happening already.

- Kee mentioned the possibility for pricing to go to IHACPA. If this happens, there will be a different methodology for pricing. If pricing stays with NDIA, there will still be some changes, particularly with DSS' Pricing and Payments Frameworks paper. Jim mentioned that is would be constructive to consider lessons learned and matters for the future to handover if there is a move to IHACPA.

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3.1 APR Branch Discussion – Participant, Economic, and Cancellation Papers

- **Participant**: There was a review of comments made by all members. Felicity suggested to boost context for this chapter, as to why we are doing the participant consultation and why it hasn't been done before. Deb suggested some wording around how the method for asking for participant feedback wasn't adequate and more effective involvement was needed. Flavio noted that we can try to improve the number of participants who engage the consultation even more in the future. Jim questioned how this consultation will influence recommendations. Kee noted that this will be clearer as the chapters are finalised. There were some questions around wording. Matt questioned if the survey is representative of the sector and questioned further information in relations to the type of disability and region of participants will provide more context. Kee stated that in this case, we were advised to not do this for privacy matters but agrees further context and information on participants would be useful. Flavio mentioned that a live document where changes can be made in a live setting through a portal would be useful and time efficient. Economics and Pricing Branch will look into this.
- **Cancellation:** Deb raised questions around the cost component in price, unintended consequences of not giving incentives to providers to minimise cost impacts and what types of incentives providers can investigate for other options other than claiming cancellation. Anne stated that most providers will look to reschedule workers when cancellations occur. In some scenarios, workers can't be reasonable reallocated because of specialised services matched to particular participants. However, Anne agreed that it is best to more clearly communicate that cancellation should be last resort after good practice. Flavio stated we need more analysis needed to support recommendations. An option is to flag those providers that often charge the full cancellation amount with Fraud Fusion team. Kee stated this is something Fraud Fusion does consider.
- **Economic:** Team noted the feedback and will address comments and provide more context. This chapter will be clearer when all other chapters and recommendations are finalised.

4.1 Logistics and next steps

- Final chapters will be circulated by Monday at the latest, even if not fully complete. Kee stated we may not have enough time to discuss remaining chapters on 17/4 meeting but will have to stick with original 90 minute timeframe next week due to member schedules. Jim will not be available on 17/4 but can be free on 19/4 if there is an additional PARG meeting. Kee explained process for PARG and having papers to NDIA board by 23 April. At 17/4 meeting, PARG will determine if additional time or out of session papers are needed. Kee will have more clarity on timeline leading up to 23 April by the 17/4 meeting and will give an update on steps PARG will take between 17-23 April. Recommendations will be signed off at 9 May board meeting. If any additional action/changes/recommendations put forward, PARG may need an additional meeting, Kee will advise after 9 May meeting. Meeting close.

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#	Meeting	Action	Status
1	20240603	Explore the possibility of sharing a selection of submissions, even if full access is not possible.	In Progress
2	20240603	The pricing team could consider framing communications positively, highlighting what is being done, while remaining transparent about the challenges they face.	Ongoing
3	20240603	The Chair has supported suggestions to set up a direct discussion between the NDIS Board and PARG.	In Progress
4	20240410	Economics and Pricing Branch to investigate best method for sharing submission as per action 1	Open
5	20240410	Add a line into the Participant Chapter around why the participant consultation is being done now/why it hasn't been done before	Open
6	20240410	EAP Branch to look into methods for sharing Chapter documents in a live format (ie: Sharepoint) to make review and comment collaboration more efficient	Open
7	20240410	Create Conflict of Interest register with mitigations	Open

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