

## **Parliament of Australia**

### **Joint Standing Committee on the National Disability Insurance Scheme**

#### ***Inquiry into market readiness for provision of services under the NDIS***

Supplementary submission in light of the NDIS  
Independent Pricing Review

Occupational Therapy Australia (OTA)

May 2018

## Introduction

Occupational Therapy Australia (OTA) thanks the Committee for its invitation to make this supplementary submission to the inquiry into market readiness for provision of services under the National Disability Insurance Scheme (NDIS), made in light of the recommendations arising from the Independent Pricing Review of the scheme, conducted by McKinsey and Co.

It is the view of OTA that the Independent Pricing Review was largely a waste of taxpayers' money. There was no meaningful consultation with NDIS service providers. Despite five of the 25 recommendations being highly relevant to allied health providers, none of the major allied health professions were approached for input. It transpires that there was no concerted data collection and no modelling to inform proposed reforms.

It is our view that the NDIA hurriedly accepted these reforms recommended by McKinsey, without genuine consultation with the stakeholders who could advise on the impact of such reforms on the sector and service provision. Consequently, allied health professionals were angered by not only the process undertaken, but the decisions that were made. As a result, the NDIA was ultimately obliged to defer the introduction of several of the key recommendations, most notably the introduction of differentiated pricing for therapy supports delivered by a qualified therapist. McKinsey had proposed a tiered fee structure for therapy services and the categorisation of participants into these tiers according to the "complexity" of their disability.

It is dismayed that despite our repeated requests for meaningful consultation, the NDIA has once again ignored provider associations until that point in time where its failure to consult has resulted in a clear and present threat to the very viability of the scheme.

## OTA's response to the Independent Pricing Review

Upon learning of McKinsey and Co.'s recommendations, OTA immediately conducted two surveys of its membership. Both attracted phenomenal responses. The first survey comprised mainly open-ended questions about the proposed changes to pricing and attracted 683 responses.

The second survey attracted 626 responses. Among its key findings:

- More than 75% said they would be less likely to provide services to NDIS participants if a tiered pricing structure was introduced;
- 48% of those who responded 'less likely' said they would not remain a registered provider if a tiered pricing structure was introduced; and
- 55% said the majority of participants they support receive less than adequate therapy support funding to achieve their goals.

In light of this feedback from its membership, the CEO of OTA, Ms Rachel Norris, wrote to the NDIA's CEO, Mr Rob De Luca on 21 March. The substance of that correspondence, as it pertains to tiered pricing, remains the view of OTA and, as such, is reproduced below.

The most concerning recommendation is the introduction of a three tiered fee structure whereby service providers will be paid according to the complexity of the case. The [McKinsey] report states that the fees for physical therapy will vary from \$110 to \$190. The proposed fee structure was never the subject of meaningful consultation with key stakeholders, most notably the service providers most directly affected by it. This is most regrettable. And despite our repeated calls for the NDIA to engage with the allied health

professions, the Agency appears to have endorsed McKinsey's recommendations without seeking input from service providers.

It is no exaggeration to say that the new fee structure, if introduced, will threaten not just the market readiness but the very viability of the NDIS. A recent survey conducted by OTA had around 700 responses on this issue – a phenomenal response. Similar surveys have been conducted by other allied health professional associations and I am advised that they too are attracting phenomenal responses. This feedback has been almost entirely negative in tone.

It is fair to say that hundreds of service providers are poised to cancel their NDIA registration.

Among OTA members' most serious concerns are:

### **Recommendation 17 – Tiered Fee Structure**

- **The question of who will determine the complexity of a case**

It is widely accepted that not all Local Area Coordinators and Planners have an adequate understanding of disability, as evidenced by the development of plans that do not adequately reflect a participant's needs. We frequently observe differences in the quality of plans being dependent on the advocacy skills of the participant and their informal supports. Moreover, the complexity levels have not been explained in detail and our fear is that they will not take into account behavioural, cognitive and mental disorders, nor socio-economic circumstances that can contribute to the complexity of a client.

- **The risk of level 1 and 2 funded participants receiving low quality support**

It is anticipated that businesses will employ experienced therapists to enable them to provide support to the most complex participants. This will leave less experienced therapists to provide support to level 1 and 2 funded participants. This is problematic, as many NGOs and private practices cannot afford to fund the required supervision structures under the new funding arrangements.

- **Misleading comparisons with other schemes**

The McKinsey report fails to note that the Department of Veterans' Affairs (DVA) pays fees that have not increased in real terms for ten years. Indeed, those occupational therapists who continue to undertake DVA work do so at a loss and only out of loyalty to longstanding clients.

A number of occupational therapists have advised that whilst the TAC rate is lower than the NDIS rate, the TAC allows therapists to charge their usual market rates if they are higher than TAC rates.

- **Administrative burden**

The NDIS processes and systems place a considerable unpaid administrative burden on service providers that other schemes do not. These include having three invoicing processes – portal, plan-managed or self-managed – time spent liaising with finance to stay abreast of service bookings, and constant changes in processes with associated down time in training staff – both clinical and administrative.

- The report describes level 1 support as ‘the delivery of therapy for a single physical condition’, while level 3 support is described as ‘the delivery of therapy to participants with extreme presentations’. Therapy should not simply be based on a condition, but rather goal attainment and minimising functional impairment. A provider may well provide exactly the same type of therapy to a participant who has a mild intellectual disability (ID) as one with a complex physical impairment. In addition, the creation of separate pricing structures for physical and psychological therapy represents a fundamental misunderstanding of the nature of disability, as it neglects the fact that many people have both a physical and psychological impairment.
- It may be assumed from the tiered pricing recommendation that providers can ‘treat’ a number of participants at the same time. Working as an occupational therapist requires one-on-one service delivery, generally in the client’s home or places where they undertake key activities. Occupational therapy services are generally not clinic based.
- Many occupational therapists provide physical therapy and psychological therapy to clients during the same therapy session, however the report separates these two categories.
- Overall it is accepted that participants with lower levels of complexity require less funding for therapy and may achieve their goals in a shorter amount of time than other participants. However, while the overall funding required to achieve their goals may be lower, this does not mean that providers should receive a lower pay rate. The tiered payment system equates to a significant pay cut for providers, circa 40%, however it should be recognised that the costs of running a business do not change in relation to the complexity of clients.
- It is unclear if these changes will lead to greater pressure on paediatricians to diagnose young children to provide evidence of complexity, rather than focus on early intervention and goal achievement.

Ms Norris’ letter to Mr De Luca also addressed other recommendations of the McKinsey report which pertain to therapy provision. However, these observations were subsequently updated and refined following a meeting of Allied Health Professions Australia (AHPA) on Wednesday 18 April at which a board member of the NDIA, Mr Martin Laverty, was present and representatives of McKinsey and Co. later gave a presentation.

In light of these deliberations, OTA prepared arguments for and against the McKinsey report’s other recommendations. These were incorporated into AHPA’s response to the McKinsey report, a submission largely ignored by the NDIA which proceeded to endorse the 1 July 2018 start date for many of the recommendations. This fact notwithstanding, the observations below remain the strong view of OTA.

#### **Recommendation 18 – Therapy Assistants**

- OTA does not support the introduction of differentiated pricing for therapy assistants. We do not accept the apparent assumption that a level 1 therapy assistant works at a similar level to an attendant carer or personal support worker.

- The report's recommendation pertaining to the use of therapy assistants fails to acknowledge the clinical necessity for high quality supervision of assistants by fully qualified occupational therapists, particularly as a participant's functionality changes.
- The report does not provide a clear definition of 'therapy assistant'. Further clarification is required as to the recommended qualifications of therapy assistants and this should be applied consistently within a national framework. OTA believes that these qualifications should be either a certificate 3 or 4 or a competency based Recognition of Prior Learning.
- It is reported that attendant care agencies are already delineating between personal care and therapy based support. It is recommended that an agency be required to provide evidence of their staff being supervised by a professional who has developed the therapy program, and that the participant receives regular reviews from a professional to enable the agency to invoice at the tier 2 rate.
- Concerns have been raised that participants will receive inadequate funding which will result in organisations employing therapy assistants at the lower rate, although allowing them to complete what is considered level 2 work. We also received consistent feedback that the level 1 rate is still inadequate to cover costs.
- Core supports (attendant carers or personal support workers) have an entirely different purpose compared with Capacity Building supports (therapy assistants). All supports, whether core or capacity building, should be based on capacity building. If "the activities performed by this type of therapy assistant are comparable to those performed by a disability support worker", the assistant should be referred to and paid the same as a disability support worker.
- The NDIA needs to provide further information as to where students and allied health assistants will sit within the NDIS Quality and Safeguarding Framework.

#### **Recommendation 19 – Travel Policy**

- Although there is agreement amongst OTA members that the travel cap should be removed, there is still significant concern that funding just 20 minutes of travel to an appointment will fall well below what is required for many participants. In rural areas, the 45 minutes' allowance will also not reflect true travel time. Additionally, it has been noted that travel should be listed as a separate item to therapy supports.
- Participants will be disadvantaged based on where they live. Therapists may well choose to provide supports to participants who live within the 20 minute radius, thus providing less choice and control for participants. Many therapists have indicated that they will cease providing support to participants who require more than 20 minutes' travel.
- Travel should be paid in a time-based manner and on an individual basis (i.e. if it takes 50 minutes to travel one way, the provider gets paid 50 minutes one way). OTA notes that Victoria's Transport Accident Commission pays an hourly rate of \$130 for travel.
- The audit process could include checking that providers have encouraged the participant to engage with a provider in their geographical location and that practice-based intervention has been provided where possible.

- There needs to be payment for first and last visits. Occupational therapists often undertake assessment re skills of daily living and visit people in the early morning. (There is little point in undertaking a showering assessment at 11am when the participant has completed this task a few hours earlier. Occupational therapists want to assess clients as they go about their usual routine.) In regional areas the occupational therapist might travel 1-2 hours to undertake such an assessment and this would be their first visit of the day. Similarly, many occupational therapists plan their schedule in such a way as to visit their most distant client first and then work their way back towards their home base. Proposed arrangements mean the most significant and expensive part of their daily travel is not reimbursed.

#### **Recommendation 20 – Cancellation Policy**

- Vulnerable participants could end up with an entire plan being used just for cancellations, with no remaining funds for services. There needs to be a system in place whereby if participants are charged a set number of cancellations by all providers within a period of time (i.e. five in three months), this is automatically reported to the NDIA. Participants in this situation should then be referred to a social support service to address barriers to access.
- It needs to be recognised that unlimited invoicing of cancellations would place the scheme at financial risk. OTA recommends placing a limit on the number of cancellations that can be claimed – either a percentage of overall funded support hours or a specified number of cancellations. A specified number of cancellations would be simpler to calculate and acknowledges that cancellations do negatively impact business, regardless of whether the participant has access to 5 or 50 hours of funding.
- Given that “no shows” have the same financial impact on an organisation as cancellations, these should be treated in the same way.

#### **Recommendation 21 – Report Writing**

- Not all reports fit under the category of “NDIA requested” – this definition will not accurately capture all the report writing required of an occupational therapist. This recommendation may result in the NDIA imposing firm restrictions on reports that it requests. For example, participants may request that an occupational therapist provide a report to support a plan review, a change of circumstances or an appeal.
- Participants with complex needs often require reports for transitioning between services, accessing mainstream supports, transitioning to new community settings (school, respite etc.), or to help develop written recommendations for key stakeholders (educators, therapy assistants, extended family members). Members have raised concerns that the NDIS may limit approval for these.
- Increased clarity is therefore required. Report writing needs to cover plan review reports, Assistive Technology/Home Modifications applications, and third party requests that are integral to a participant’s goal attainment.
- Currently, when the NDIA contacts an occupational therapist and asks for further advice and/or an independent assessment to support a case at the Administrative Appeals Tribunal there is remuneration available. It would seem reasonable, therefore, that other requests for further information or an independent report for the participant should also be remunerated.

- OTA believes consideration should be given to a flat rate reporting fee as per the current TAC fee schedule.
- There are reports of providers taking many hours to write a plan review report. This is unnecessary and costly. The NDIA needs to provide clear guidelines as to what a report should include, under basic headings such as: Participant Goals, Therapy Outcomes, Barriers impacting Goal Attainment, Future Recommendations.

## **Solutions**

### **Improved planning and quality of plans**

OTA receives frequent feedback that the quality of a participant's plan is highly dependent on the skill of the Planner and the advocacy of the participant and their support network. We believe that the employment of Planners who have a solid understanding of the benefits of including allied health services in the participant's plan will have positive long term economic benefits for the scheme. Short term investment in capacity building supports will often reduce the need for long term core supports over a person's lifetime. In the medium to long term, this commitment to getting plans right in the first instance will save the scheme hundreds of millions of dollars.

OTA has consistently offered to play a proactive role in the training of Planners, and these offers have gone unacknowledged by the NDIA.

### **Use of Allied Health Assistants**

OTA believes that informed use of qualified AHAs will reduce the long term costs of the scheme. The NDIA needs to introduce clear guidelines around the utilisation of AHAs with regard to qualifications and the need for close supervision by an allied health professional. AHAs need to be paid at a significantly higher rate than a personal support worker, and there should be a clear delineation between the role of an AHA working with a participant to build capacity as compared to a personal support worker who is funded under core supports.

### **Cancellation policy**

The recommendation that enables providers to bill 90% of the fee for unlimited short notice cancellations places the scheme at considerable risk. There is a risk that scheme funds could be absorbed by cancellations, and even more concerning is the fact that participants who are not engaging with the funded supports are less likely to achieve their goals. OTA recommends that cancellations be capped and that after a certain number, the NDIA or their community partner contact the participant and the provider to undertake an assessment of the barriers that are resulting in frequent cancellations.

### **Report writing**

There has been widespread confusion about what, if any, reports can be billed for. It is concerning to hear that some organisations are leaving two to three hours of funding to enable them to write a plan review report for the participant. The NDIA should provide clear guidelines to providers that dictate what information is required in a plan review report. Schemes such as the TAC pay providers a flat rate reporting fee. The introduction of a similar fee for the NDIS would be a simple initiative to manage the costs of reports.

## Conclusion

Given the significant challenges that providers experience when dealing with the NDIA, the reluctance of many occupational therapists to commence or continue working with the Agency is entirely understandable. The introduction of lower rates of pay and the stress of supporting participants who have undergone assessment to place them in a funding tier will only worsen this situation.

At a time when the NDIS needs more service providers, the proposed reforms, and in particular a tiered fee structure, will in fact drive existing providers away in droves.

Another likely consequence is that participants deemed less complex, and therefore who pay the lowest rate, will experience increasing difficulty accessing quality service providers.

It is precisely because OTA recognises the great potential of the NDIS to improve the lives of people with disability that we are so critical of reforms that threaten its very existence.

The Committee's attention is drawn to Appendix A of this submission which outlines why the proposed tiered fee structure in particular threatens the viability of the scheme from an occupational therapist's perspective.

OTA thanks the Committee for the opportunity to make this supplementary submission.



## Appendix A. Summary of Occupational Therapy Australia's review of OT expenses conducted in January 2016 (and why the proposed tiered fee structure fails to cover these expenses)

In January 2016, in the context of a submission to the Victorian Government regarding the state's Transport Accident Commission fee schedule, Occupational Therapy Australia reviewed the actual costs of running an occupational therapy (OT) practice. Results confirmed the hourly fee that practices of varying sizes must be paid in order to cover expenses and make a modest (10%) profit.

The key findings of the review were:

- Most OT businesses bill between 60 and 70% of their time, due to the nature and complexity of their work. There is a considerable amount of non-billable time that OTs need to absorb in their fee structure. Across the board, OTs often find themselves playing the role of de facto case manager. However, time spent corresponding with GPs, calming distressed relatives and carers, waiting to speak by telephone with agencies, etc is not billed.

	Single Person Practice	Three Person Practice	Five Person Practice
Annual turnover required to make a 10% profit	\$182,338.08	\$513,680.91	\$845,023.74
Number of worked versus billable hours	1786 vs 1250	5358 vs 3751	8930 vs 6251
Hourly rate required to make 10% profit	\$146 p/hr	\$137 p/hr	\$135 p/hr

- A single person practice needed to make \$182,338.08 in order to cover expenses and make a 10% profit.
- A three provider practice needed to make \$513,680.91 in order to cover expenses and make a 10% profit.
- A five provider practice needed to make \$845,023.74 in order to cover expenses and make a 10% profit.
- Assuming all OTs working in these practices work a 47 week year (four weeks annual leave and one week sick leave are deducted), and assuming a 38 hour week, that leaves:
  - The single person practice working 1786 hours (but only billing 1250);
  - The three person practice working 5358 hours (but only billing 3751); and
  - The five person practice working 8930 hours (but only billing 6251).

It follows therefore that the single person practice needs to bill at a rate of \$146 per hour in order to make a 10% profit.

A three person practice needs to bill at a rate of \$137 per hour to make a 10% profit.

A five person practice needs to bill at a rate of \$135 per hour to make a profit.

It should also be noted that the business costs identified in January 2016 will have increased over the past two years so these are extremely conservative figures.

The proposed three tiered fee structure for the NDIS means that working with Level 1 clients, for whom the fee payable is \$110 - \$120, would be completely unsustainable for OT practices.

Working with Level 2 clients, for whom the fee payable is \$140 - \$150, would be too financially precarious to be viable.

Working with Level 3 clients would be sustainable.

It is not unreasonable to assume that a substantial number of OTs will walk away from NDIS work because they are unable to perform it in a financially sustainable manner. Those that continue to provide support to NDIS participants will only be able to afford to work with Level 3, i.e. the most complex, cases.