2017 NDIS Price Controls Review

MHCC ACT response to the NDIA Discussion Paper

28 April 2017

mental health
community coalition ACT

Peak Body in the ACT for the Community Mental Health Sector

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About Mental Health Community Coalition ACT Inc.

The Mental Health Community Coalition of the ACT (MHCC ACT), established in 2004 as a peak agency, provides vital advocacy, representational and capacity building roles for the community-managed mental health sector in the ACT. This sector covers the range of non-government organisations that offer recovery, early intervention, prevention, health promotion and community support services for people with a mental illness.

The MHCC ACT vision is to be the voice for quality mental health services shaped by lived experience. Our purpose is to foster the capacity of ACT community managed mental health services to support people to live a meaningful and dignified life.

Our strategic goals are:

- To support providers deliver quality, sustainable, recovery-oriented services
- To represent our members and provide advice that is valued and respected
- To showcase the role of community managed services in supporting peoples' recovery
- To ensure MHCC ACT is well governed, ethical and has good employment practices.

Executive summary

MHCC ACT values the opportunity to provide a response to the NDIA discussion paper on '2017 Price Controls Review'.

Our response is written entirely from the perspective of the provision of services that support people with mental illness and psychosocial disability (PSD). It is informed by a direct survey of our stakeholders in which we asked the questions posed in the NDIA paper. It is also informed by the experience gained in the ACT as the only whole of jurisdiction NDIS Trial site, and the information we have consolidated in responding to the other reviews of the workings of the NDIS currently underway. As such, we also direct you to the publicly available submissions MHCC ACT made to the:

- Joint Standing Committee on the NDIS Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition (27 February 2017)
- Productivity Commission report into NDIS Costs (24 March 2017)
- Senate Standing Committees on Community Affairs Inquiry into the Delivery of outcomes under the National Disability Strategy 2010-2020 to build inclusive and accessible communities (28 April 2017)
- Australian National Audit Office Audit into Decision-making controls for sustainability — National Disability Insurance Scheme access (forthcoming)

For the NDIA to open up discussion around the assumptions underlying the way prices are set and to raise the possibility that prices need to rise, fills our stakeholders with hope. Concerns about the artificially low levels of prices available under the NDIS have been raised from before the trial began in the ACT. It has been exceedingly difficult to achieve any understanding of the validity of these concerns.

The community-managed sector has managed to operate with minimal funding for decades. It is known for its relatively low wages and limited career structures. Indeed, one of its biggest

difficulties has been in attracting and retaining well-qualified and experienced staff. The Fair Work Commission Equal Remuneration Order (2012) illustrates that this is not a fantasy. Yet the introduction of the NDIS is effectively putting downward pressure on wages once again, through setting very low prices that translate into generally lower wages and an increasingly casualised workforce across the sector.

Our key recommendations arising from the NDIA discussion paper are as follows:

- Redesign the price review process - a three week turnaround is not an adequate amount of time to provide meaningful input into such an important process
- Strongly promote the price review process – a media release, headlines in the NDIS e-newsletter and highlighted on the front of the website as a minimum
- Urgently review and revise the modelling underlying the NDIS pricing of supports for people with PSD. Recognise that for support to be effective the model needs to informed by expertise and understanding of:
    - the specificities and complexity of supporting people with PSD
    - the episodic nature of PSD
    - the importance of both individual and group based supports
    - the need for a relatively stable, well qualified and experienced workforce
    - the particular risk management strategies that are important for effective PSD supports
    - the significant cost shifting to the community sector resulting from the NDIS – for example, the increased administrative burden (particularly when the NDIA itself is not functioning efficiently or effectively yet)
    - the cost of compliance with the broader legal framework governing organisations operating in this sector.

- The NDIS does not replace the health system – a whole of government approach is required to ensure that all people with mental illness and PSD can access a full range of effective services, regardless of whether they are a NDIS participant or not.

If the NDIS continues without these sorts of changes, indications from the experience in the ACT at least, are that the scheme will not deliver on its objectives. If the NDIS is allowed to fail to deliver effective support to people with PSD it is likely to impose a much bigger human and economic cost to Australia than would be the case if the scheme were adequately structured and funded in the first place..

The experience in the ACT is too often easily dismissed due to the small size of the jurisdiction, the fact that it is essentially one city, and that its population is relatively well educated and affluent. These same characteristics of the ACT would suggest that implementing the NDIS in the ACT should be easier than in most other parts of Australia. If NDIS implementation is proving problematic in the ACT – too often leaving people worse off, opening up service gaps, proven services disappearing – then it might serve as a warning to the rest of Australia where the challenges of implementation will be greater.

In the ACT we are seeing a reduction in quality services and an increase in sector fragmentation and competition following the introduction of the NDIS. There is no longer a sense of supporting the community as a whole but rather (and reasonably so) organisational survival.

Downward pressure on prices, and subsequently wages, drives outcomes that are not in the best interests of service users. It can only lead to:

- The commodification of services, and corresponding lowering of quality
- Ethical decisions to withdraw services rather than provide them at low quality
- Less qualified and experienced workforce unable to deliver the full range of recovery oriented services required to support people with PSD to stay in their communities
    - especially those people with the most complex needs
- Higher demand on tertiary more expensive health services, especially hospitals.

- Over time, a sector that is not robust, diverse and innovative – leaving consumers and carers with little choice and control over their lives.

There has been a distinct lack of a partnership approach in building the NDIS pricing framework, and other related areas of the NDIS. If consumers, carers and providers had been recognised from the start as holding years of valuable expertise, experience and knowledge around the provision of these services, many costly mistakes could well have been avoided. Instead, this group has largely been viewed with suspicion, as being driven by narrow self-interest. As a result an 'us and them' attitude has prevailed.

What has been created by the way the NDIS has been implemented is not an efficient market place. Prices are fixed (artificially low), services are defined by a third party, access is managed, change is managed, and the scheme is being driven almost wholly by entry number targets. The way these variables interact is producing many detrimental market distortions.

Simon Viereck
Executive Officer
Mental Health Community Coalition ACT

28 April 2017

Introduction

This submission focusses entirely on the provision of supports to people with PSD through the NDIS.

The content of this submission is informed by:

- Consultations regarding the above-mentioned recent NDIS related submissions
- Understanding of the experience of service providers during the NDIS Trial in the ACT, and subsequent national rollout
- Specific answers to the NDIA discussion paper questions provided by four of our stakeholder service providers.

Although four is a small number of organisations, their responses are entirely consistent with the feedback we have been receiving since the beginning of the NDIS experience in the ACT.

NDIA discussion paper - answers

Approach to setting price limits for attendant care

1. How do you decide what price to charge participants?

Organisations providing services to NDIS agency managed participants are guided by the NDIA prices. In some cases this has resulted in them deciding to discontinue providing this service to agency managed NDIA participants as it is not sustainable to do so.

'(Service Provider name) has chosen to offer 24/7 Supported group homes through NDIS as they are funded to a level that allows for future sustainability, however they do not allow for training and or back end organisational supports'

2. Comments on current price limits?

The widespread view – informed by deep experience – is that the current price limits are not sufficient to recover costs, let alone earn any profit. They do not allow for high quality recovery focused services and to respond effectively to participants with high psychosocial needs and the episodic nature of severe and persistent mental illness. All organisations reported as having to withdraw some services; and as being left with less capacity to respond to the episodic nature of mental illness and PSD.

All four of the organisations surveyed reported being financially worse off since the introduction of the NDIS:

> *With the NDIS there has been a massive, unprecedented cost shift from Government to the community sector. At the current pricing levels it is unsustainable.*

Service providers have told us the following:

> *"In many cases the pricing for plans is so restrictive that it makes the opportunity to provide a flexible and quality service to participants unsustainable. We have had to start employing a lesser skilled workforce to cater for the shift to lower wages which the NDIS demands by its pricing structure, and have very limited capacity for supervision and training of staff. We are concerned this will have an impact on the quality of service we provide."*

> *'The pricing limits set by NDIS have not considered the costs associated with supporting people with a mental illness and associated PSD. Staff in this field require a minimum Cert IV qualification which sits beyond the SCHDS level 2 award.'*

Current price limits are negatively affecting the ability of organisations to compete in the NDIS market:

> *'We are also finding that some providers are choosing not to register so they do not have to comply with the NDIS pricing structure and can charge what they determine the services are worth. This limits our ability to find good providers for some of the services we need, for instance there are almost no registered psychologists in*

Canberra, which makes it impossible to use these services when someone needs it when they have an agency managed plan.'

'Pricing is grossly inadequate for some service types and the criteria sited is flawed and does not reflect all criteria to be considered'

'We have had programs such as PHaMs and PIR transition to the NDIS so have had contractual obligations and a sense of responsibility those participants into the NDIS and to provide services to them. We also want to support people with severe mental illness because we have the skills, experience and qualified staff to do so. Given that so many MH services are being or have been defunded to make way for the NDIS we have wanted to endeavour to make the most of this 'reform'. ... We are not only concerned pricing will have an impact on the quality of service we provide, but whether we can continue to be an NDIS provider in the PSD space.'

3. Do you charge a different price for agency-managed, self-managed or non-NDIS participants?

Organisations in the ACT are responding to the prices set by the NDIS in an economically rational way. Under the NDIS Framework, however, organisations do not have the opportunity to price differentiate in the way posed by this question. Once they are a registered provider with the NDIS then they are bound by NDIS prices for all their services to NDIS participants. One organisation explained it in this way:

'*When the funding for supports under a participant's plan is agency managed, only registered providers of supports can provide those supports (subsection 33(6) of the NDIS Act). Accordingly, a person or organisation seeking to deliver supports or services to participants whose funding is managed by the NDIA must apply to be a registered provider of supports. Registered providers are required to follow the NDIS Price Guide for charging services.*

There is no restriction on who may provide supports under a 'plan managed' plan or a self-managed plan. These participants are able to exercise choice about the selection of their providers. It is only when funding for a participant's supports is managed by the Agency that the supports must be provided by a registered provider of supports. It is not hard to see that self or plan managed NDIS Plans have advantages over agency managed plans.

For example, when participants are self or plan managed, psychologists can charge what they are accustomed to in their private practice and invoice directly without further ado. The participants are able to claim the full amount back from the Scheme. Registered psychologists, on the other hand, have to follow the NDIA price guide and, to be paid, they have to navigate the time consuming NDIS portal (with all its many faults, failings and delays). What incentive is there to register then? Why would such providers do that when they can restrict themselves to self or plan managed participants?

The disincentive to register goes for many other providers of services. Gardening is particularly difficult to obtain for agency managed plans – they can't get anything or there is a prohibitive waiting time. Gardening businesses are not interested in being paid $42.05/hr as dictated by the NDIS Price Guide – their services are generally quote based but an estimated equivalent would be a minimum of $60/hr.

Just Better Care (JBC) which has delivered a quality support services is another case in point. JBC has de-registered itself as of this month. JBC is a good service provider that has now exited all their clients who are agency managed and will only provide services to people with plan or self-managed plans – no longer restricted to what they consider unsustainable pricing restrictions imposed on registered providers they are charging a rate that they do consider sustainable as well as competitive in a less restricted market place. Other agencies are also contemplating exiting the registration process.

This of course sets up a kind of two tiered system and an inherent injustice - the haves and the have-nots. Those whose plans are agency managed are disadvantaged and excluded from using unregistered providers in an unrestricted and unconstrained marketplace. This will continue to create a distortion in the market and it is a very concerning trend. Even the language reveals this double standard. The category for "financial intermediary" (plan management) is called "Improved Life Choices" (Support Category 14). People whose plans are self or plan managed have all the advantages of "improved life choices".

But the "poor relations" who are agency managed have to accept what is available in a still very underdeveloped market. It is a restricted market place for the have-nots. The process of choice between being agency managed or plan/self-managed would seem a bit arbitrary and include elements of luck or previous experience with a suitably supportive agency. Effectively those who are agency managed have been deemed (or have deemed themselves) as incapable of self-managing. Those that can navigate the system and have the education to do

this, or the contacts within the system or the initiative to make these contacts, can take advantage of the supports offered by an agency and are likely to have much better outcomes in their plan implementation.'

Organisations in the ACT have in the main been committed to finding ways to make the NDIS work despite the significant challenges involved in doing so – including by cross subsidizing from other areas of operation. Increasing, however, organisations are contemplating changing their model of service provision in the interests of business sustainability.

There is the well-publicised case in the ACT of the service provider, 'Just Better Care', which is deregistering from the NDIS as they change their model to cater just for self-managed NDIS participants. This decision was driven from both a values and a business viability perspective – they had lost $200,000 in the previous year providing NDIS services. The General Manager of Just Better Care in the ACT, Rob Woolley, described NDIS prices as "*a bargain basement rate for what is expected to be a platinum quality service*" (Canberra Times, Norman Hermant, 6 January 2017).

4. Comments on the approach to setting price limits based on the efficient cost of provision?

The widespread view on this matter is that when it comes to PSD in particular, the approach is not well informed and reflects a lack of understanding of what is involved in delivering effective support to people with PSD.

Greater understanding of the market, including reliable data, is required before setting prices for attendant care. Current NDIS prices makes it difficult to attract staff to sector, and is causing significant disruption and service gaps in the sector. Costings (and therefore prices) must be soundly based on all factors, including client load mix and SCHADS award minimum compliance for rostering.

To quote one provider:

"this approach is not applicable to support people with mental illness - their needs are complex and staff require higher skill sets. The assumptions also do not factor in organisational quality systems that are essential to ensure effective and efficient services."

5. What changes are you likely to make in the provision of attendant care according to the following price limit scenarios?

a. **Unchanged:** serious assessment of whether to remain as an NDIS service provider; or at the very least a more stringent assessment of whether it was viable to accept individual packages.

b. **Increased:** this would be very dependent on the level of increase. If it was a truly sustainable pricing model then organisations are likely to increase the quality and service offerings. One provider noted that prices would need to be able to sustain as an absolute mimimum employment at the SCHDS Level 3.3.

c. **Decreased:** Most organisations would stop providing services, or seriously contemplate doing so.

6. Specific concerns around access to sufficient labour to offer attendant care? If so how is this impacting costs and how is your organisation responding?

All organisations have labour force concerns resulting from the NDIS pricing framework. These can be summarised as the difficulty in attracting and retaining suitably qualified staff to effectively provide the level of support that people with PSD require. These concerns were classed as 'serious' when it came to the workforce being suitably qualified. The following quote from a service provider is illustrative:

In our work with people with a PSD, regular contact with Support Workers (SW) is critical. We have SW's report in to us and be able to discuss their interactions with participants. We are currently paying for all SW's to come to a regular team meeting for reflection and discussion to share ideas and experiences. This sort of supervision is essential in the mental health area, and knowing when and how to interact with participants who are unwell can be challenging and confusing for a staff member who does not have prior experience of working in this area. This is not affordable under the NDIS model but feel it is a critical part of our service. We will

have to consider whether we can sustain this massive cost shift to the community sector from block funded models that allowed for appropriate wages to the skilled workforce required, and for appropriate levels of administration, supervision and training associated with the work.

Some other specific comments received are:

We found ourselves in permanent recruitment mode – so now we are reviewing our service offerings

The pricing structure of the NDIS and the difficulties inherent in the shift from block funding are making it increasingly difficult to retain staff, attract and pay for good skills and provide appropriate supervision

Challenges with recruiting to a low paid position: staff who apply have no or limited experience in the field or no or limited skill set.

Level of skills/qualifications required for different client categories and whether we can find these staff at the prices proposed.

Price does not take into account those clients who have complex care requirements and the skills/qualifications required to deliver these services - which may require a trained nurse..

7. Not aanswered – not relevant in the ACT

Assumptions for estimating prices for attendant care

8. Are the assumptions provided, sufficient for estimating the efficient cost of providing attendant care?

Many of the assumptions are flawed and reflect a lack of understanding of the complexity of working with people with psycho social disability. This is in keeping with the answers to the previous questions. A more detailed response to this question is provided in table format at **Attachment A**

9. Further comments in this regard?

The overwhelming feeling is that the NDIA should undertake a comprehensive of the modelling approach underpinning prices when it comes to PSD. As will be clear from other answers in this submission, without substantial change, the services are in danger of disappearing or being of low quality and less effective than needed.

If this were allowed to happen, then the human and economic costs to Australia are likely to be much higher than getting the costing of PSD supports under the NDIS right in the first place.

Simplification of shared care price controls

10. Should the structure of price controls be changed? Do you have suggested changes?

It was agreed that the current price controls for group based care should be restructured to simplify the controls and better align them with the nature of the supports provided; and that any changes are probably best staged in a clearly articulated (and documented) process, and with adequate lead time to prepare for the change.

There were mixed reactions to the proposed options. The essence of the feedback is captured on the following quotes:

'I've never understood why centre based group support is less - when there are more overheads to having a 'centre''

'Basing support on complexity of need should be favoured'

'We would still emphasise that the prices for all groups do not reflect the needs of people with PSD and as a result we are seeing less and less opportunity for participants to access specialist and tailored group activity to suit their needs. (an example is the Hearing Voices groups - these require specialised facilitation and expertise but current pricing does not reflect this in the model.)'

11. Comments on how a change to the structure of price controls around shared care would change the services you provide or your business processes?

This question was too open-ended to attract specific answers. But Organisations will readily note the number of services that were valued and proven effective that they can no longer offer under NDIS prices. The example in the previous question about the Hearing Voices groups in the ACT is a pertinent example.

Other updates to price controls, rules and guidance

12. Comments regarding the proposed changes to rules and controls?

Community transport: Need much more investment into community transport. This is a major problem area and has a huge shortage. Observations made include:

'Being allowed to use the Core budget to help cover our transport costs have helped. Shifting the cost of transport to service providers has been unsustainable and unacceptable. Where PSD services are concerned transport is vital. Participants with complex PSD are most challenged in overcoming isolation and without provision of transport can't engage'

'The NDIS process in ACT for providing support for transport differs from that in NSW. It seems NSW participants now need to use the NDIS participant portal to access transport funds and additionally we have heard that participants may need to open a second account for the purposes of receiving transport funds from NDIS.'

'Suggest that funding is provided where the person is accessing an approved community transport provider'

Therapy services and transport: Answers were mixed on this issue but it was noted to retain flexibility in whatever changes are made.

Short term accommodation: Yes was answered to all questions. A suggestion was made to also review the ratio of staff to client mix.

Cancellation policies: There was for clarification of, and making them the same across the two types of care identified. It was also noted that is essential to have cancellation policies.

Price Banding

13. What do you think would be advantages and disadvantages of using a price banding approach?

Feedback on this question is as follows:

'the current benchmarking does not reflect the higher need of clients with a mental illness, and as a result there has been a reduction of services. The bench marking appears to be targeted towards the traditional thought of a physical disability not the episodic nature of mental illness.

'price banding allows for reasonable fluctuations in situations'

14. Do you think price banding would lead to better outcomes for participants?

The feedback on this was limited – a lot depends on how it would be implemented and whether the prices are realistic.

'It is very difficult to quantify the quality of service simply based on the higher pricing.'

'More flexibility depending on client's immediate situation'

Attachment A

Comments on assumptions underlying pricing model

a. Base hourly rate: Assumes use of The Social, Community, Home Care and Disability Services Industry Award 2010 (the Award).- Employees (on average) are paid at level 2 pay point 3.- Managers/supervisors (on average) are paid at level 3 pay point 2.
Responses: 1. Need to escalate base rate to 3.3 and managers to 4+ dependent on numbers and complexity of service 2. You can only attract a low skilled workforce on these wage assumptions. You cannot attract managers or supervisors on a SCHADS 3. It is unheard of to pay them at that level. PSD is a complex area. Support Workers should be paid at SCHADS 3 and managers at SCHADS 5 at least - depending on the services provided (particularly Support Coordination and Capacity Building. 3. Need to factor in where enrolled nurses may be required for complex care situations and where SCHADS workers not suitable.
b. The majority of staff are employed on a full time or permanent part time basis. Where this is not the case, and casual or contracted staff are employed, it is assumed that their rate aligns to these pay points, noting that they are not paid for leave and other costs.
Responses: 1. yes 2. We cannot afford to give Support Workers fulltime positions. The NDIS is creating a casualised workforce and will be unable to retain skilled and qualified staff 3. To be competitive and attract staff in the ACT have to pay higher than SCHADS rates

c. Rates are broken into the following categories:> Monday to Friday (6am-8pm)> Monday to Friday (8pm12am)> Saturday> Sunday> Public Holiday
Responses: 1. Organisations have different EBA's 2. Yes 3. Current pricing entails a disincentive to providing after hours support provision 4. Current SCHADS award does not allow for flexible rostering and ensure that night shifts can required same work as day shifts as many clients require stand up workers at night
d. Zero shift allowance costs (The NDIA is considering whether to include a shift allowance in the hourly rate model to account for additional allowances not covered by the base rate of pay.)
Responses: 1. shift allowance needs to be included in costs as per the award 2. I don't know what zero shift allowance means... 3. Must consider allowances in line with the Award
e. 17.98% of employees achieve a tenure of 10 years, and qualify for long service (assumed value based on the Australian Bureau of Statistics data on service tenures).
Responses: 1. yes 2. Our agency has retained good quality staff, but those staff are leaving due to the NDIS model, ie low wages and no career development in the longer term. 3. Unlikely to achieve tenure of 10 years in one agency.

f. Administrative time (the NDIA is considering expanding on assumptions relating to utilisation and is interested in feedback on how staff and managers are utilised. This might include client facing time, training administration, etc): > Carers spend 95% of paid time with clients> Managers spend 90% of their time with clients, or dealing with client related matters.
Responses: 1. these are not representative - NDIA issues are taking up a lot of manager's time 2. the administrative costs for managers is significant - at least 30 - 35% 3. administrative costs are much more significant than this 4. Due to amount of data and paper work required - a higher level of admin time required. SEE ALSO – Attachment 2 – Case study on unfunded administrative costs
g. Zero allowance for additional travel costs
Responses: 1. There is a cost to travel and this has to come from some where 2. 2 ?? 3. Ridiculous for rural regions in particular to have this assumption
h. Span of control of managers of 1:15 (Standard needs - the assumption for average span of control is that for every 15 staff members, one manager will be employed. This is based on a typical medium sized provider, employing between 40 and 100 staff.).(The NDIA is considering whether the current assumption for the manager span of control is appropriate for the current state of the NDIS. The NDIA welcomes stakeholder views on the appropriate assumption for the manager span of control, particularly how this may vary by the complexity of need.)
Responses:

1. organisations moving to flatter structures to achieve efficiencies
2. PSD manager 1;10
3. This kind of ratio does not work with complex, severe and persistent mental illness. There are much higher supervision and training needs and a support worker level of service dependent on workers with lived experience. The latter have a valued role to play but this role requires adequate support and supervision.
4. Higher level of co-ordination and management required for complex and high level clients who may come from complex households

i. Corporate overhead is equal to 15% of total salary, management and non-client facing expenses (The assumption is that overhead costs are generally low for attendant care as the majority of the operational costs are labour. The following were considered typical overhead costs for a medium sized attendant care service provider: rent; data and IT services; building and equipment maintenance; insurance; and utilities. (The NDIA is of the opinion that corporate overheads will decrease over time as providers become more efficient. The NDIA is considering whether the current assumption is appropriate for the current state of the NDIS and what path of reduction would be appropriate going forward.

Responses:

1. yes
2. I think all service providers are of the opinion that the wage structure imposed does not in any way adequately cover corporate and administrative costs to providers. Even larger agencies with greater economies of scale
3. Corporate overheads will not decrease below 15% due to other changeable operational and business factors in the community services sector such as accreditation compliance

j. Margin allowance is equal to 5% of total costs (before or after tax). (The return that a provider receives is to compensate for deploying funds to run their business (ie, through investment and working capital) and the risk they adopt in doing so. The NDIA is

considering whether this profit margin is an accurate reflection of the risk adopted and capital deployed by a provider in providing the supports.)
Responses: 1. the margin given is at the low end given the risk. the NDIA have succeeded in increasing the level of risk 2. 2 7.5% - due to increasing insurance costs, risk management, etc. 3. This is not an accurate reflection of the risk adopted and capital deployed by us in providing the supports. 4. Wrong margin
k. Additional allowance for providers in some states and territories to give them time to adjust to NDIS funding arrangements. (The NDIA has previously indicated that this transition pricing would be progressively removed over time. The NDIA will consider transition pricing in the context of other changes.)
NA as ACT commenced in July 2015
l. No additional comments.

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Attachment B

Case study

An unfortunately common example of the unfunded costs of trying to work with the NDIA

Communication

- The NDIS arrangements involve layers of complexity that have to be navigated through, making the system a huge administrative burden for providers and participants. Being part of a trial site has meant having to cope with the goal posts regularly changing – with very little communication from the NDIA when this has happened, which often means that we have had to find out about changes or new interpretations of the rules through a process of trial and error.

- Often there are mixed messages from the NDIA about what to do and it is only when we are trying to claim funds that we find out there has been a change in the system. At the moment there is a particularly sparse number of communications coming through from the Agency.

- At the beginning of the trial, staff at the NDIA were more approachable, but as time has progressed it has become harder and harder to have direct contact and help. We had many forums with them earlier in the trial but those have now totally fallen away – closing these useful communication channels.

- There has been huge inconsistency in information provided. The big turnover in staff and/or poor training make it difficult to find 'the truth'. It's not unusual to be told "I don't have the answer to that" without there being any information provided as to where/how to get the answer. It is rare for planners to put anything of substance in writing.

- Planners are no longer able to be contacted directly - every phone call and all correspondence has to go through the Braddon phone number and email – which functions as a bit of a 'black hole'.

- Portal issues can rarely be resolved with one phone call, questions bounce around different sections of the Agency, and in fact NDIA staff often need to ask the Support Coordinator (SC) if they know what is wrong.

- Some participants are becoming so frustrated they have opted to ‘camp out’ at the NDIA until someone sees them in order to get things resolved.

Payment System

- It has been a challenge for us to train staff in the process of billing hours and making sure this covers all our work. The complexity of the system takes staff away from their direct participant support. Previously block funded staff have found this the most challenging.

- The mixed messages coming out from the NDIA and the complexity of the system have often meant that it is only at the crucial stage of claiming funds that the problems or incompatibilities become apparent. This has placed stresses on participants, agencies and service providers alike.

- The portal shut down last year impacted on us significantly. We were unable to have plans approved during the three months it took to sort it out, and during that time we had to carry a number of participants who had not yet entered the scheme but had their ACT Government funding for support cease. We were promised that plans would be back-dated when they did finally get approved, but this did not happen. We couldn’t bill during this period and it has required countless additional admin hours to catch up with billing.

Delays

- Our staff are always having to wait on hold to the NDIA, a standard wait time is 45minutes, but often it goes up to 60 or 90 minutes (even 4 hours has been known to happen!). This time then needs to be charged back to the participant’s package and increases costs, while not providing value for money. This has a particularly significant effect for those on plans with a limited number of Support Coordination hours.

- When being transferred to the local (Braddon) office we are usually cut off or they aren’t available to take the call, resulting in the whole process starting over.

- Emails are not returned within a reasonable time. It is not unusual for it to take 4 weeks to get a reply to an email. Staff now follow up weekly with emails red flagged in order to try to get replies.

- We have submitted several formal complaints to the NDIA over the past year and it has taken sometimes up to 5 months for them to respond (despite our follow up of these complaints). This totally flies in the face of what the NDIS should aspire to in terms of complaint response. The Agency feels like a monolith that is impossible to penetrate!