Submission to the QPC Inquiry into the NDIS market in Queensland

Rural Lifestyle Options Australia – Response to Provider Short form Issues paper

11/08/2020

***As a provider, how well prepared were you for the introduction of the NDIS*?**

RLOA was fairly well prepared, we had designed a service agreement and understood the financial change that would accompany the transition. We had the pricing and NDIS provider portal sorted out early on, and were prepared with our software systems for the change.

***What were the greatest barriers to transitioning to the NDIS*?**

Inconsistent messages and information from NDIS and the LACs contracted to NDIS. This made transitioning difficult for participants as they received differing information, they also were being 'warned' by LACs/NDIS staff that they did not have to share their plans with RLOA which made it difficult to know what funding they had available in what category.

Communicating with NDIS was (is) extremely difficult, having only generic phone numbers or email addresses to contact wasted a lot of time and resources, often to get no definitive answer.

Funding the overheads and administration side of the business without direct support in those areas.

Changing from consistent payment in advance, to service based payment in arrears was a challenge for administration and systems.

Transitioning to delivering services that are in constant change has also been a challenge.

What are the key changes that your organisation has made to operate in the NDIS market?

Systems changes with greater need for software that can work across the organisation and "talk" to each other. Greater automation with billing for individual line items in the NDIS. Higher demands on the CRM for audit and record keeping.

Staffing changes, with a greater need for more staff in office based positions due to the advent of Support Coordination, Plan Management, need for NDIS Intake staff, higher administrative demands, greater need for HR and recruiting staff, more staff needed to support rostering, and service delivery, due to the constant state of change and need for new Service agreements due to expiries and Reviews.

The entire organisation has been restructured several times since NDIS began. Many positions need to have income potential attached to them in order to be sustainable.

Policy and Procedure have all had to be completely redeveloped.

RLOA is unrecognisable when compared to the pre NDIS organisation.

What barriers remain for the scheme to achieve its potential in Queensland? How can these be addressed.

NDIS has identified and attempted to correct many issues that have been consistent across providers.

One barrier that consistently causes issues is not having one direct contact to deal with at NDIS. It would be extremely beneficial to providers if they could have a direct "case manager" to contact who could then find answers on the providers behalf. RLOA has emails from several years ago that have never been answered, and when trying to follow up by phone we are constantly retold to send emails to those same addresses. Provider payments being the most problematic area, but SIL approvals also a previous issue.

RLOA has a large amount of income outstanding due to non-payment caused by gaps in plans, taking on emergency respite and never getting paid, and SIL supports commencing, with the payment then commencing at a later date. Many emails and phone calls regarding these issues have never been addressed or responded to, and result in circular correspondence.

Remaining liquid under these circumstances becomes a barrier to continuing support.

Some support types are not financially viable also, though the TTP has been helpful in this regard.

SUPPLY OF SERVICES AND SUPPORTS

What are the most important factors that affect your decision to supply into the NDIS market?

- Profitability of a support type.
- Distance and ability to recoup transport costs
- Ability to deliver the support, based on complexity, and service delivery parameters.

Is market information sufficient to inform your decision-making about services/supports to offer and your service locations?

More information about gaps in delivery for unmet needs by areas would be useful. Knowing what unspent funds by region might assist in targeted marketing.

What developments in the choices by participants – about when, how and who provides supports – have been the most difficult to accommodate or meet? Why?

As a SIL provider, filling gaps in houses in regional areas when a participant is rated 1:2 or 1:3 is very difficult. Often RLOA have to just absorb the cost of under tenanted houses.

Having SIL tenants able to give 30 days notice and leave, can be problematic. It takes a lot of hours of work to set up and run a SIL arrangement, so when participants leave without proper consultation or mediation being required, that causes a strain on the organisation.

Some pressure areas are: replacing the house mate, loss of income with no reduction in expenses, staff having to be utilised in other areas or laid off, and often it is the organisation that holds the lease on the house and will have to continue to pay it. Perhaps SILs should be like residential tenancies and for set terms?

Participants often choose flexible supports now also, which can be difficult to staff, as staff no longer have set rosters but have to be more able to work across supports and on different days. It can be difficult to give participants the stability they also want in having a consistent worker, when the support days and times constantly change.

There are also unethical behaviours being created by the competitive environment. Providers poaching staff and participants by encouraging participants to utilise their "choice and control", when in some cases these vulnerable people are being manipulated.

Self managed funding, and the ability to choose nonregistered providers when Plan Managed also can cause questionable choices and encourage unethical behaviours.

What differences arise from self-managed plans compared to plan- or agency managed plans?

Self managed plans are more open to incorrect use of funding.

Plan managed plans, often the participant can be seen using non-registered providers, sometimes someone they know becomes their support worker/cleaner/gardener etc and bills them, individuals charge the same prices as large providers despite much smaller operating costs, participants try to claim for non NDIS related items.

Which types of providers or services/supports are in short supply?

Some Allied Health services in regional areas are difficult to secure. SDA houses.

RLOA is taking on new participants consistently, some remote areas are difficult to service.

What are the key barriers to increasing your capacity to deliver services in the NDIS market in Qld?

- The time it takes to get SIL packages through, and the timing issues when no clear start date is given in advance it makes setting up a house very difficult.
- Participants requesting short shifts for DA or CP, is often hard to deliver.
- Staffing the growth with qualified experienced support workers.
- Participants expecting to be able to start immediately, when we actually have to recruit and roster which may take up to a month.

Does the NDIS market reward efficient/effective providers? Are those operators thriving at the expense of less efficient/effective providers.

There becomes a fine balance between ability to deliver quality supports and ability to be financially viable. Providers that can find that line are the ones that are successful in NDIS.

How does your organisational form influence your delivery strategy and competitiveness in the NDIS market.

As a NFP our strategy is to grow whilst remaining sustainable. I feel that this influences our delivery strategy by making us more quality focussed, and trying to gain competitive edge by reputation.

Do you provide other services to persons with disability outside of NDIS? Are there economies of scope where providing other services gives you a cost advantage?

RLOA is a provider under NQIIS however the scope is not great enough to provide cost advantage at this stage.

What are the key barriers to entering the NDIS market for those who operate outside of NDIS, such as aged care and health services?

Finding participants and understanding the registration, regulation and claiming processes are the key barriers.

NDIS participants do not seem to be captured by advertising/websites/social media etc. LACs and SCs have great control over where they take their business.

What are the key sources of uncertainty for your organisation? How easily are you able to secure capital for investment in your NDIS operations?

Portability of participant funds causes uncertainty. RLOA has access to capital.

CONCENTRATION

Are there any structural regulatory or other impediments that act as a barrier to entering an local NDIS market?

Not for individuals but significant barriers for start up Providers.

What are the key barriers to expanding your services to other locations, or to regional and remote areas?

Finding participants, generally you can only break into a new area if you have a staff member with existing contacts in that area. Advertising, Social media, website, doing 'stalls', and having a shop front in the area we have found to have little effect on participant enquiries.

THIN MARKETS

Which services and supports have demand greater than supply? What are the key barriers to meeting those demands?

Allied health services can be difficult to obtain properly qualified and experience professionals in the disability space.

SIL and STA have demand but barriers to obtaining funding and start up is expensive for providers.

Are there critical services where a lack of availability affects the demand for related services?

Yes, obtaining OT services affects the ability to progress SILs.

From your perspective, what barriers do participants face in finding providers and utilising their plans?

Participants generally still rely on recommendations from their SC or LAC. They are not really actively seeking providers themselves. So certain bias can exist.

Participants not clearly understanding how they can use their funding also presents barriers, for example they could use underspent Core for "respite" STA, but they are not aware of this, or feel they have to "save" their funding.

REGULATION ISSUES IN THE NDIS MARKET.

Are the registered/unregistered provider requirements effective and efficient? If not why not?

Allowing unregistered providers to deliver supports makes somewhat of a mockery of the strict controls and audits placed on the registered providers. Especially when the only requirement is that they go through a plan manager, who has no control over the quality of those services.

RLOA is a registered provider, as an NFP we welcome the compliance and practice standards set by the NDIS Q&S Commission and regulation in place. Audits assist us to know that we are delivering a quality service.

What resources are required to comply with NDIS price and quality regulations?

Significant investment in systems, software, and personnel is required to meet and maintain the standards required.

What impact do differences in the requirements for registered and unregistered providers have on your sector of the NDIS and on the level and quality of supports for participants?

In some cases a significant impact on quality of service, unregistered providers can be close to the participant in ways that present significant conflict of interest, for example family members. Unregistered providers may not have the necessary insurances/qualifications/licences. This can also open the way for unethical behaviour with funding/invoicing, as they may be charged for services that were not actually rendered.

What impact does regulation have on innovation?

Regulation causes expensive and time consuming compliance, which can mean that innovation becomes a secondary concern.

REGULATION OF PRICES

Is price regulation effectively and efficiently achieving its objectives? If not, why not? Is the framework for setting prices robust, transparent, and accountable?

I don't believe so. It appears that almost all providers simply charge the highest price in the price guide that they can. It does not matter if they are big, small or a sole trader everyone charges the same price.

This is possibly a reflection that prices are not yet high enough for the market to self-regulate, however I believe it is more that this has become the norm, and as participants accept the prices in the price guide as 'the price' then that will not change.

Larger providers have significant overhead, administration, supervision, training and audit burdens to fund from the price, whilst unregistered sole traders do not, yet they both use the same price. The TTP has assisted with this somewhat, but it is being phased out.

If the NDIS provided separate support for registered providers to manage their expenses not directly related to support (as DS used to) then the price to participants could come down.

Allied Health suppliers and unregistered providers also tend to charge the maximum price in the Price guide, even though their price for non NDIS clients might be different and substantially lower in some cases.

What influence does price regulation have on the supply, types and quality of services/supports you offer?

The organisation has done extensive analysis of profitability and unit cost of the various support service types and focusses on providing and expanding those that can make positive contribution. Services identified as running at a loss have been discontinued.

REGULATION OF QUALITY

Is quality regulation effectively and efficiently achieving its objectives?

The framework is robust and extensive for registered providers. The complaints process and audits provide good accountability.

How do the quality standards affect your pricing and cost structure? What elements of quality require the most resources? Are practice standard and compliance methods proportional to the risks they seek to control?

Quality Standards do not affect our pricing except in as far charging the TTP to try to account for some of the transitional costs.

The most resources are dedicated to compliance checking, record keeping and constant supervision.

Yes they are proportional for an industry dealing with highly vulnerable participants.

How might the quality of provider services, and the management of risks to participants be better regulated?

Regulated Self assessments to be implemented by providers.

All providers to be audited, smaller or mini audits could be instigated around risk management/ quality of care for non-register providers/sole traders.

Reporting in participant goals should be added to the plan review process.

BEHAVIOUR SUPPORT PLANS AND RESTRICTIVE PRACTICES

What arrangements are required to ensure that the interface between the Qld Government policy framework for restrictive practices and the requirements of the NDIS Commission achieve their purpose and are efficient?

There are strict reporting requirements in place for the use of RPs, as long as the Commission monitors this then the purpose should be met. The process for authorising RPs can be lengthy, locating registered practitioners in regional areas or willing to travel is not always easy.

We are currently reporting to The Quality and Safeguards Commission on all use of restrictive practices.

FOR EMPLOYERS

How has NDIS changed the type of workers you need? What developments in the labour market have affected your ability to find and retain the workers you need? Key challenges in attracting staff?

We need workers willing to do shorter shifts and/or multiple participants in a day. They need to work across regions or arrangements in most cases and be flexible with their rosters, as things change more regularly.

The level of skill needed has increased as there is less ability to train staff on the job, as there is no funding for that. Workforce development and training expenses must be absorbed by the organisation.

The market for obtaining workers is more competitive and workers are more transient. Turnover has increased significantly.