2017 Price Controls Review – Consultation on NDIS pricing arrangements discussion paper

Introduction

Community Mental Health Australia (CMHA) is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. CMHA provides a unified voice for approximately 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

CMHA promotes the recovery of people living with a mental health condition so that they are contributing citizens and included in all of the economic and social aspects of their community. The organisation presents a united and representative voice for the community managed mental health sector who work every day on mental health issues and have the expertise through a specialised workforce, including a peer workforce and lived experience.

CMHA would like to thank the National Disability Insurance Agency (NDIA) for the opportunity to make a submission to the 2017 Price Controls Review. At the outset, we wish to note that the timeframe for making a submission to this important consultation was extremely short and has not allowed the level of consultation CMHA would have been able to make with the state and territories and their members. While we recognise the time constraints that the NDIA are operating under, this consultation should have been widely notified and communicated to the disability sector and time allowed for vital input from consumers, carers, service providers and representative organisations.

CMHA remains committed to the NDIS and the benefits that it can bring to the lives of people living with a mental health issues. However, it is vital to ensure that the recovery focus of community managed mental health services — which has come to inform the overall approach that is taken to addressing mental illness — is not lost. We also do not want to create a situation where some people receive a high level of support and others do not. People living with a mental health condition must have their psychosocial needs met regardless of whether they are eligible for the NDIS or not.

CMHA's submission to this Discussion Paper will provide input in line with the questions posed in the Discussion paper.

CMHA made a submission to the Productivity Commission NDIS Costs Issues Paper[1] and will reiterate comments made to that inquiry, particularly in relation to scheme costs and market readiness, as the comments are directly relevant to NDIS pricing.

An overall comment – which was also made in relation to the Productivity Commission NDIS Costs inquiry – is that a key issue is in the actual implementation of the scheme where the focus is becoming about signing people up within a defined timeframe and the cost of services rather than the quality of support that is being provided to people. The aim of the NDIS was to deliver a better system of care than people living with a mental illness have received before and that they don't have reduced care. If the

[1] Community Mental Health Australia, NDIS Costs – Productivity Commission Issues Paper, http://www.pc.gov.au/__data/assets/pdf_file/0019/215038/sub0011-ndis-costs.pdf

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focus purely becomes about signing as many people up as quickly as possible and preventing cost-overruns, then the intent of what the NDIS was actually meant to deliver starts to become lost.

As per the Productivity Commission's paper, we would again express the concern that the commentary in the NDIA Discussion Paper is focused on having lower prices with limited reference to quality. The Price Controls Review Discussion paper in the section 'Rationale for improving price controls' discusses price controls being required as providers may be incentivised to excessive prices participants which may happen due to not looking for alternatives and not receiving the full benefits of changing lower cost providers. This makes no consideration of consumers receiving services that are of a high quality and not just cheaper. Further, the same section states that there may be resistance to changing providers and therefore limited competition as strong relationships have been established with one provider. Again, trust and building relationships is vital in mental health in providing a service to a consumer. These are both aspects that are seen as positives in mental health, not barriers, and ignoring these facts will impact on how mental health services are priced in the NDIS structure.

Questions for the 2017 price review

Price limits for attendant care and related individual supports

It is encouraging to see the Discussion Paper acknowledge that the NDIA has received feedback from providers that the provision of attendant care is not homogenous and that there are differing levels of quality and design across services. Also that the NDIA are considering options for setting price limits about what is considered the efficient price. This is an issue that CMHA has consistently raised as central to the operation of mental health within the NDIS.

A central issue for mental health being a part of the NDIS has been mental health not fitting into the pricing structures of the NDIS, therefore a mismatch between benchmark costs and actual costs of packages for people living with a mental illness in a disability structured market will be an issue. There is an impact of the NDIS pricing structure and its relationship to qualified mental health staffing, with a seeming misunderstanding between what constitutes psychosocial disability support and what constitutes psychosocial rehabilitation. The skills and knowledge required are different with the NDIS pricing structure able to fund disability support, while being unclear about its reach into more complex supports. Therefore, retaining a highly qualified mental health workforce for the NDIS is a concern. This is particularly difficult in remote communities including Aboriginal mental health workers.

Currently the NDIS sets the basic rate for support work at $43.58 per hour. Rob Woolley, General Manager of Just Better Care has been quote as describing this as "a bargain basement rate for what is expected to be a platinum quality service."[2] The discrepancy in NDIS rates and what organisations have previously been paying support workers and other staff, puts significant pressure on organisations and places at risk the required number of workers available to provide services at NDIS rates and the Government's commitment that nobody would be worse off under the NDIS.

[2] Norman Hermant, 'We have grave concerns': There could be trouble ahead for the NDIS if the ACT's problems go national, Updated 6 Jan 2017 http://www.abc.net.au/news/2017-01-03/ndis-there-could-be-trouble-ahead-after-problems-in-act/8157662

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Community-managed mental health organisations within the community-managed mental health sector prioritise community-based rehabilitation to support individuals to recover, and through this the sector has developed a workforce that is appropriately qualified and skilled to deliver these services and a culture that reflects the appropriate standards. In Victoria for example, 90 per cent of the community mental health sector holds a diploma or higher qualification.

However, the hourly rates included in the NDIS pricing structure demonstrate a lack acknowledgement and understanding about the level of skills and expertise that are required to provide disability support to individuals with serious mental illness.

It is widely accepted that people with high and complex needs cost more to support, and that this requires that higher complexity be factored into the NDIA price guide. A recent article in the ACTCOSS publication "NDIS transition – Where have we landed?" of their journal *Update*, notes that "A one size fits all approach is at odds with the other pricing structures in the NDIS."[3]. This article also makes the point that a requirement for support staff on weekends and public holidays will result in additional costs. While the NDIS recognises complexity of support and differentiation in cost of service provision due to penalty rates in some of its pricing, it only provides a "maximum payment for short term accommodation in a centre or group residence set at a single rate per person per 24-hour period. This is an inclusive, all expenses price for a 24-hour period with no additional loading permitted. While this amount may be adequate for a range of lower needs participants, it is often not sufficient for those requiring higher support or levels of supervision to stay safe, particularly during higher wage periods."[4]

The implications of the current pricing for community-managed mental health services are potentially:

- The exclusion of participants with higher needs that require higher levels of staff support from these services, and the withdrawal of service providers.
- The loss of existing skilled and qualified staff and a de-skilling of the workforce. In time providers may well opt to hire the lower-skilled staff they can afford to be able to offer NDIS services. This will impact on recovery-focused psychosocial rehabilitation supports which will develop into generalist disability supports.
- Service providers may choose to only provide low-priced supports if the NDIS participant also purchases higher-priced supports from them, effectively aiming to some degree offset losses on support with profits on another. This limits choice and control and undermines the objectives of the NDIS.

In relation to the assumptions applied to estimating the efficient cost of the provision for attendant care, the following comments in relation to mental health apply:

- Base hourly rate:
    - the assumed qualification levels will be higher for some mental health workers

[3] Marymead, The Disability Trust, Hartley Lifecare, Duo, and Carers ACT, Challenges of converting the NDIS category of 'short term accommodation' to meet need, ACTCOSS Update Journal, Issue 77, Spring 2016, p. 11, https://actcoss.org.au/publications/quarterly-journal-update/update-issue-77-spring-2016-ndis-transition-where-have-we

[4] Ibid.

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- employees were more commonly employed on a permanent basis however NDIS is leading to increased casualization of the workforce
- the 24/7 nature of many mental health services is not accounted for in the categorisation of rates

- Non-client facing time:
  - Doesn't account for outreach which may be classified as time not directly with a client
  - Training and development is a significant part of furthering the qualifications of the community-managed mental health workforce and should be included, as is noted as a consideration by the NDIA
  - Travel time, particularly for outreach and services in regional, rural and remote areas needs to be included.
  - The cost of transition processes to the NDIS is causing significant administrative costs so the assumption should not be theses costs have now reduced, given many services in mental health are still transitioning over the next years to the NDIS.

A relevant consideration in looking at the NDIS pricing structure and pay for the workforce, is the Social, Community, Home Care and Disability Services Industry (SCHADS) Equal Remuneration Order (ERO) – the 2012 decision by Fair Work Australia for equal remuneration in the social and community services industry - and the Governments acceptance of the argument that community sector work attracted low wages due to it traditionally being 'women's work' and had therefore supported redress through the ERO. It could be argued the NDIS is another avenue to under-value the 'helping' skills required to support people with disabilities to live well in the community and may well result in similar calls for 'redress' on the same platform.

Simplification of 'shared care' price controls

As noted in the Discussion Paper, shared care covers supports including group-based activities, centre based care, respite and supported independent living (SIL) packages, all of which are relevant to mental health. The Discussion Paper states that the NDIA have observed that providers are, amongst other issues, not efficiently matching care ratios to service offerings, and that they have concerns around restricted choice, price controls being ineffective, and providing value for money. In relation to mental health this again doesn't recognise that there will be varying levels of complexity and that some activities, such as group and centre-based care, will be impacted by how much and what can therefore be provided.

The NDIA need to consider that under block funding arrangements, shared care arrangements for a range of consumers, including more complex consumers, could be effectively 'subsidised' to account for variances in need, complexity and what people wanted to access. This is not possible under the NDIS model.

The Discussion Paper proposes two options for restructuring the price controls for group based care – Option 1 merge community based and centre based care price controls; and option 2 introduction of price matrices for shared care. CMHA would suggest that exploring option 2 might be the best path as it is likely to be able to better deal with different levels of complexity rather than through merging the two

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price controls. CMHA would urge the NDIA to undertake some in-depth and first-hand experience from consumers and providers on both options to determine what will best address the issues that are currently impacting this type of care.

Other updates to price controls, rules and guidance

In relation to the options for updating the 2017 price guide:

- Community participation supports – Along with clearer rules around the provision of transport, the NDIA will need to consider the impact of the federal Court ruling regarding funding arrangements for transport under the NDIS.
- Short-term accommodation- This should consider levels of complexity including the options noted to consider whether price controls should be split by levels of need and whether or how providers can claim for additional supports above the base level.

Price banding

As addressed earlier in 'Price limits for attendant care and related individual supports', CMHA would reiterate the point made that a central issue is mental health not fitting into the pricing structures of the NDIS. There is an impact of the NDIS pricing structure and its relationship to qualified mental health staffing, the skills and knowledge required are different with the NDIS pricing structure able to fund disability support, and therefore, retaining a highly qualified mental health workforce able to provide effective recovery-oriented approaches under the NDIS is a concern. The issues raised in the 'Scheme Costs' section are relevant in terms of the community-managed mental health sector not only being prepared, but supported to make the transition.

The withdrawal of block-funding impacts on pricing and service provision. In the *Power to Persuade* blog Simon Viereck, Executive Officer, Mental Health Community Coalition ACT is quoted as stating this will "result in little capacity in community-managed organisations to support people with psychosocial disability to engage with and access the NDIS. This puts the responsibility back on the NDIA and Local Area Coordinators to take up this engagement work. It is unclear what this means for the many people with psychosocial disability who are expected to access the NDIS, but are not yet engaged."[5]

Simon Viereck also makes the point that the NDIS 'market' is not a market. He notes that within the scheme, prices are fixed, supports are strictly defined, administrative burdens have increased, and there is a significant information gap. His description of the 'market' is as a one-sided affair. That is: "To the extent it is a market, this is reflected in service closures, workers leaving, business mergers, and less choice and control. Unless service providers are given the freedom to decide which services they want to offer, to price those services, and to test whether they can sell their product in the market at the price they ask, the NDIS won't produce efficient market-based outcomes and won't work for provider organisations".[6]

[5] Transition to change: Lessons from the act NDIS trial, Power to Persuade Blog, July 13, 2016, http://www.powertopersuade.org.au/blog/transition-to-change-reflections-on-the-act-ndis-trial/12/7/2016

[6] Ibid.

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The Mental Health Council of Tasmania (MHCT) identified that a member organisation was struggling to remain viable within the fee rates of the NDIS:

> The fee rates determined by the NDIS to be paid for PHaMs services by NDIS participants are insufficient to cover delivery costs, especially for consumers who need mentoring, coordinating and family support services as opposed to more intensive services. Funding is often sufficient only to cover staff salaries at a comparatively junior level (CSW 3 and below). This makes it difficult for the sector to retain staff with degree qualifications who are required to effectively deliver programs for consumers with complex needs. The amounts set out in the NDIS Price Guide are not enough to fund complex case coordination or skilled staff particularly once expenses such as developing individual case plans and group programs, travelling time, making and following up referrals and so on have been removed.

The MHCT have also identified the following concerns of members:

- That with the potential loss of 30% of their client base their viability may be compromised. For service providers who are juggling clients with packages and clients without packages there is also a moral and financial dilemma. To survive, providers need to take the NDIS clients attached to higher value packages but this means that other individuals are at risk of delayed or no access to supports.
- With regards to pricing, line item costings aren't viable for the mental health sector. Current pricing is based on the general disability sector at SCHADS level 2 which is effectively the lowest common denominator. One Tasmanian service provider is experiencing a loss of about 50% an hour on any given line item. To be viable, service providers feel that it will create a market where clients are 'cherry picked' based on higher priced line items. A new pricing catalogue is needed, based on the service costs as related to providing psychosocial rather than just disability supports.

A high risk of seeing significant market failure across the sector is an issue that has been raised by all state and territories. The NDIS may potentially be faced with an exponentially growing level of disability while at the same time community-based rehabilitation services are experiencing loss of funding, loss of qualified mental health staff and the capacity to provide services commensurate with need. The potential loss of existing skilled and qualified staff and a de-skilling of the workforce means that that organisations are unable to offer services to people with NDIS Plans as well as those without.

As per comments raised throughout this submission, the current questions and suggestions proposed by the NDIA with regards to price banding still don't seem to allow for different levels of complexity. Two components are outlined – a benchmark price reflecting efficient costs of providing reasonable and necessary levels of care; and a price cap above the benchmark price that has an upper bound on what can be changed. A consistent issue that has been raised by the sector is what is classified or considered as necessary and reasonable by the NDIA may be very different to what a consumer, carer or provider thinks is reasonable and necessary. The transport ruling by the Federal Court would also seem to indicate this.

The report *Making it happen: Complex disability (with complex support needs)* states that in determining what is necessary and reasonable supports in central as there are many factors for people with complex disability and not addressing these factors will mean that needs can't be met. It notes that there must be greater understanding about cost drivers for complex disability and issues such as co-morbidity. This

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is particularly relevant for people living with a mental illness. Complexity also affects service intensity, duration, staffing, training and supervision. The NDIS must make allowances for the cost of supporting people with more complex disability, which could be used to increase support when it is needed, as will be the case for people with complex mental illness.[7]

The Discussion paper states that one of the purposes of the changes would be to create greater flexibility in plans allowing participants to purchase the full quantity of supports that are included in their plan at the benchmark price or a lower quantity of higher quality supports at a higher price. As with much of the language being used, this is concerning as it seems to be suggesting a person can get more of a lower quality or less of a higher quality, but that if you want higher quality you have to accept less services or care. Consumers should have the ability to negotiate and have choice, but lessening quality to fit within a price band or a consumers package of care again does nothing to guarantee that people will receive quality supports.

The Discussion paper notes that the NDIA must consider a number of issues for using different price bands for different supports including competition being sufficiently strong, that it may not be appropriate for critical supports that would then place people at risk; and there will be regional variations. CMHA agrees with each of theses points and would urge the NDIA to incorporate these areas in developing price bands, if that occurs. Price bands can have the benefit of allowing for quality care and complexity, however, this should not mean people receive less supports if they require higher quality or complex care.

[7] Fitzgerald, Dr J, (2017) Making it happen: Complex Disability (with Complex Support Needs): Engagement, Reasonable and Necessary Supports, and Cost Drivers. NDIS Implementation taskforce Participants with Complex Needs Sub-Working Group, 4 April 2017

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