Linda Kohlhagen
Executive Director
Rehabilitation Aged and Community Services
Email: Linda.Kohlhagen@act.gov.au

Dear Linda

## RACS Client Management for NDIS funded services

Thank you for the opportunity to comment on the draft policy and operational guidelines for "RACS Client Management for NDIS funded services". Thank you also for speaking with community stakeholders about the imminent changes and how Rehabilitation Aged and Community Services (RACS) plans to manage the transition to a fee-for-service model.

Prior to the meeting on 29 May 2019, Health Care Consumers' Association (HCCA) was concerned that some consumers would go without the services they needed while the administrative process to arrange appropriate funding was completed. We were reassured by your presentation where you stated:

- RACS and NDIA are in agreement that we will coordinate to ensure no clients will fall between Health vs NDIA funding responsibilities, and
- RACS will ensure clients do not fail to receive services due to funding responsibility uncertainty.

Based on feedback from consumers and carers with experience in accessing the NDIS we do not believe that the transition period will see the end of administrative difficulties. This belief guides the feedback we provide.

Yours sincerely

Kathryn Dwan
Manager, Policy & Research

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# RACS Client Management for NDIS funded services

Submitted 4 June 2019

Contact: Darlene Cox

Executive Director, HCCA
02 6230 7800

## Comments on operational guideline

There appears to be potentially five types of RACS' clients, not including those who **refuse** to provide documentation.

1) NDIS funded clients whose plan **covers** the requested services
2) NDIS funded clients whose plan **does not cover** the requested services, but are **potentially eligible**
3) Clients who are **not NDIS participants** currently, but who are **potentially eligible** for NDIS services
4) NDIS funded clients whose plan **does not cover** the requested services, because they are **ineligible**
5) Publicly funded clients

Presumably guidelines are needed to cover all these types of clients. If so, it might be worth covering client types 1, 2 and 3 under one set of guidelines where the NDIS pays for the services. Client types 4 and 5 would presumably be funded by Canberra Health Services and therefore be covered under separate guidelines. Our comments assume that the current draft guidelines **only** cover client types 1, 2 and 3, and those people who refuse to provide documentation when requested.

#### Guideline statement

We understand that RACS is developing a transition plan that will cover all those who have already used RACS' services. However, we believe that consumers will continue to find that their service plan does not reflect their current needs on occasions. Therefore, we would like to see the policy and operational guidelines reflect RACS' commitment to ensuring that services are provided, while funding responsibility uncertainties are resolved. Such a commitment could become one of the key objectives.

#### Key Objectives

We suggest simplifying the existing objective and adding another.

1) Ensure NDIS funding is claimed for all eligible clients, where possible.
2) Ensure uncertainty around funding responsibility does **not** prevent clients from receiving services they need.

### Section 1 – Identifying supports

We suggest that the Section I explains how the same service provided by RACS may be associated with a health issue or considered to arise from an individual's disability. In turn, this determines whether it should be funded by the national Disability Insurance Scheme (NDIS) or Canberra Health Services. It would be good to include the criteria that RACS uses to determine this. This may just be the link to the "Principles to determine the responsibilities of the NDIS and other service systems".

The current list of services is missing "Vocational Assessment and Rehabilitation Service".

## Section 2 – Client intake

We found it difficult to understand the interplay of service provision and administration in the current draft guidelines. We suggest including the suggested text (or similar) to clarify the interplay and to emphasise that "clients will not fail to receive services due to funding responsibility uncertainty".

Two parallel processes commence upon intake.

- The **Service Process** establishes what services the client needs and includes a risk assessment to ensure that delays in providing the service do not disadvantage the client.
- The **Administrative Process** establishes who will fund the service. The Administrative Process may draw upon the risk assessment conducted as part of the Service Process.

## Section 3 – Triaging of referral

This section is quite complex and seems to contain a lot of repetition. We have some broad suggestions for simplifying it.

Most importantly, we suggest separating the Service Process from the Administrative Process.

### Service Process

The Service Process would remain quite simple and would essentially take place at the first appointment.

1. Needs assessment
2. Risk assessment

It also needs to specify how carer health and wellbeing is taken into consideration when conducting the Risk Assessment.

### Administrative Process

The Administrative Process would take place immediately after the Service Process and be a clear series of "If-Then" statements. We have attempted this below, but do not necessarily understand all the steps. What we offer is by way of example.

Client **is** NDIS participant and their plan **covers** the requested services

1. Record NDIS participant number
2. Establish that the client's current plan **covers** the services
3. Provide service and **bill NDIS**

Client **is** an NDIS participant, but the requested services are **not covered** under their current plan

1. Record NDIS participant number
2. Establish that the client's current plan does **not cover** the services
3. Establish that client is **likely** to be eligible
4. If **low-med** risk, then direct client to request change to plan
    - 4.1.1. If plan **changed**, then provide service and **bill NDIS**
    - 4.1.2. If plan **not changed**, then …
5. If **high risk**, then escalate to management AND direct client to request change to plan

<u>Client is **not** an NDIS participant, but they are identified as **likely** to meet NDIS eligibility criteria</u>

1. Note that the client is **not** an NDIS participant
2. Establish that client is **likely** to be eligible
3. If **low-med** risk, direct client to apply to NDIS
   3.1. If **accepted** into NDIS and plan **covers** services, then provide service and **bill NDIS**
   3.2. If **accepted** into NDIS and plan does **not cover** services, then …
   3.3. If **not accepted** into NDIS, then …
4. If **high risk**, escalate to management AND direct client to apply to NDIS

For simplicity, I have not tried to incorporate the carer into this series of If-Then statements. If you choose to adopt this way of presenting the flow of events, the title of the section will need to change to something like "Referral through to service provision and billing".

It may also be worth introducing a new section that addresses what happens when a client does not provide adequate documentation.

### Section 4 – Process prior to commencement

This section introduces the notion of a service agreement and needs to be explained more fully.

The first sentence of paragraph 2 states that

> "clients will need to attend and have a service agreement completed prior to commencing care."

However, it is not clear what they are attending or where it might be. Is this in addition to the initial appointment to establish service needs? If so, they should take place at the same location and be scheduled consecutively.

### Section 5 – Standard management

We note that RACS is aware this section lacks clarity around timing. The key issue here is allowing enough time for the client to receive a new plan from the NDIS.

HCCA believes it is not enough for an administrative officer to identify the end of the client's NDIS plan. They need to alert the client and service providers. Ideally, the guidelines will state when the RACS service provider will prepare a report of ongoing service needs.

### Section 6 – Change of circumstances

A change in circumstances that leads to a change in care, will probably involve administrative processes. This section should spell this out those processes more clearly. It should also define what is meant by a change in circumstances. Are you referring solely to change in client function? Does it matter whether the change in circumstances is an improvement or a deterioration?

Once again, HCCA would like to see reflected in the section, the objective of ensuring that uncertainty around funding responsibility does not prevent clients from receiving services they need.

### Section 7 – Escalation process

The escalation process appears to apply only when the risk assessment deems the client to be at high risk. However, escalation presumably is also required when clients do not provide the required documentation. Escalation is included in our suggested If-Then statements. If you do not choose to take that path, you need to specify in this section when escalation would occur.

## Comments on communicating the changes

As was discussed at the information forum, HCCA would like to see some public community forums held around Canberra. HCCA would be happy to host such a forum, meaning we would arrange a suitable time and location, and promote the session to consumers. I believe other community organisations would be similarly willing to assist in this way. We also support calls for the information to be shared in a variety of media.