NDIS Review May 2023

The role of pricing and payment approaches in improving participant outcomes and scheme sustainability.

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About Assistive Technology Suppliers Australia (ATSA)

ATSA is a national organisation representing assistive technology (AT) providers, including manufacturers, importers, distributors, retailers, tradespeople, allied health workers and technicians.

Our 160 members comprise businesses and not-for-profit organisations range from small family-owned concerns to multinational organisations throughout Australia. It is estimated that, excluding AT for communication and sensory disabilities, approximately 80% of the AT in Australia passes through ATSA members.

ATSA is a registered not-for-profit charity with the ACNC and requires members adhere to a comprehensive Code of Practice on the provision, sales and servicing of AT, ensuring end users are ethically and fairly catered for. We are also a member of the Australian Ethical Health Alliance.

ATSA's Response

General Comments:

ATSA's submission is directed towards the pricing and payments for Assistive Technology (AT)[1].

We believe there are two key areas of change that will significantly improve the management of NDIS costs for AT.

The first is accountability. This means AT must be prescribed correctly and must start with a thorough assessment prior to an AT provider being engaged in trials and appointments. A thorough assessment includes: identification of purpose and goals, identification of all stakeholders to be involved, a physical assessment of the individual who is being prescribed equipment, an environmental, transport and community assessment, selection of most appropriate AT Provider(s) for trial phase, determination if AT is to be hired for short trial, purchased and/or loaned.

There needs to be a clear process in regard to who is accountable for which services during the procurement process. At present, there is at times, an unrealistic reliance on AT provider staff to offer up what they think should be prescribed. This could be a reflection of the number of inexperienced prescribers in some areas. Additional support through an NDIS Community of Practice and AT Mentors may help to support these new prescribers.

ATSA is currently working on scoping educational opportunities for prescribers and suppliers and building an online menu of existing courses and information links for use by AT providers, allied health professionals and participants to assist the educational process.

[1] "Assistive technology is an umbrella term covering the systems and services related to the delivery of assistive products and services" - Reference: Key Facts- Assistive technology (who.int)

The second is minimising wastage of AT. As an example, people with neurological conditions may need to replace their AT more frequently as their condition deteriorates and needs change over shorter periods of time. Such AT could be returned to providers who would undertake a quality and safety check of the device and re-allocate it for trials, hire or sale to another family.

ATSA recommends the NDIA initiate a data collection process to assess the size of AT wastage within the Scheme to inform the best solution.

ATSA has begun scoping a project outline for members to be able to collect AT no longer required by the participant and then determine if it should be recycled or reissued based on condition and product life cycle. Some AT providers already have this in place.

In recent times, there has been much media coverage in regard to AT providers "price gouging." To apply such comments to the industry as a whole is incorrect and paints AT providers, the vast majority of whom are doing the right thing, in a very bad light. ATSA members themselves have been complaining about online platforms who sell their products at over inflated prices. Some members have withdrawn their products from those platforms and others have made formal complaints and had their products withdrawn by the platform.

We have been in discussion with the Department of Social Services and Minister Shorten's office on this matter. Organisations who price gouge give the industry a bad name and members do not want this behaviour in our sector. ATSA members rely on the ACCC to investigate any participant or other provider complaints into price gouging. We have also been advised to provide this information to the NDIS Quality and Safeguards Commission.

ATSA has a Code of Conduct signed by members as part of our onboarding process. It includes a Code of Practice, Gifts Policy, Statement of Ethics, Commissions and Rebates guidelines and a Privacy Policy. We request that if any of our members are identified over charging, the NDIS Commission for Quality and Safeguards seek permission to advise ATSA so we can work with that provider to change their practice. Should this not succeed, ATSA may remove them from our membership.

Concern around the NDIS Review process

ATSA was disappointed to learn that while the NDIS Review is intended to be a consultation, it appears certain decisions have already been made in regard to the 'preferred provider' approach. In a recent meeting with Tristian Delroy, Adviser to the NDIS Review Secretariat in the Department of the Prime Minister and Cabinet and his colleagues, COTA Victoria and ARATA representatives were advised the Department of Social Services is promoting evidence-based AT and supports. We understand this includes co-designing an expert AT advisory panel and establishing preferred providers to access Assistive Technology equipment and additional reports.

Additionally at the recent 2023 ATSA Melbourne and Perth Expos, representatives from the NDIA also referred to the preferred provider approach for AT citing the established EOI process for continence products as an example.

Based on the above feedback, we have significant concerns and must consider questioning the NDIS Review process and the commitment from the NDIS Review co-chairs "…to genuine engagement with all stakeholders."[2]

If the preferred provider approach is enacted, many small regional and metro AT suppliers will disappear, adversely affecting participants of the NDIS, Aged Care and Department of Veterans Affairs schemes.

Advisory panels often exclude key personnel within AT supplier organisations. These individuals are the experts in this field, are part of the whole cycle of AT (referral to post-delivery) and can provide valuable insight to where we are seeing wastage, reasons for poor outcomes or decision making and other issues.

Noting the value and importance NDIS participants place on AT, we find the development of such a process without prior consultation unacceptable.

[2] About the NDIS Review | NDIS Review

Response to Questions in Consultation Paper

Finding 1: There are opportunities to improve NDIS pricing arrangements over the short-to medium-term.

1.1. Setting of price caps is transparent including greater use of market data and independent price monitoring and/or price setting.

In the current processes, AT providers have no visibility of existing price caps or what they may cover (i.e., whether the item only or delivery fee, fitting fee etc is part of the price). While the NDIS has a 'price range' for AT, AT providers do not know what that is and are therefore not pricing to the cap. They are only informed if a cost they provide falls out of the price range.

ATSA members support a transparent process to set the price cap including the use of market prices. However, in lieu of a 'Price Cap,' it may be more effective to have parameters around a person's disability and what funds they may need to live so the individual has choice as to how they spend their funds within that limit.

Under price capping arrangements, the NDIA would need to accept AT providers will begin to charge for all services which they are currently not doing, including call out fees for each visit, assessment fees, pick up/delivery, services of trials, cleaning and maintenance and other services. This brings us back to value proposition - hence the variance between one provider's pricing and another's.

In regard to the other options listed in Figure 13 of the consultation paper our comments are provided below:

<u>Block funding – lump sum payments</u>
This is not necessarily easily applied to Assistive Technology which is a periodic or one-off service.

<u>Fee-for-service – reimbursement per unit of service</u>
Currently many AT providers do not claim a fee-for-service from the NDIS for all interventions they have with participants, although it could be a useful tool when it comes to clearly separating accountability between different providers working with the same participant/s.

<u>Enrolment (capitation) – period lump sum payments for each enrolled user</u>
This is not necessarily easily applied to Assistive Technology as it is a periodic or one-off service.

<u>Outcome payments – rewards or penalties based on certain metrics</u>
Key to this type of payment structure is clarity on which provider is responsible for each aspect of service to the participant during the AT procurement process. Noting there are AT providers who are smaller businesses supporting local communities, the compliance costs would need to be manageable. In order to address the issue of an incentive to move beyond targets in an outcome payment model, the NDIS could recognise those who do go beyond the targets in some non-financial or financial way. Measuring which providers have "gone beyond" would require a participant feedback process.

Blended payments

The inclusion of a subscription payment for episodic services such as the maintenance of AT, would be cost effective from an administrative perspective and give the participant more control. Additionally, it would reduce wastage as the AT will be in good condition for longer. This combined with a form of outcome payment or fee for service for the required wrap around services could be an effective model. It is important to understand these types of support services require a strong relationship between the AT provider and the participant.

Participants also need to be able to trust that a provider will attend in the event of an emergency or breakdown. Funds need to be available for emergencies and breakdowns. We suggest accountability under this option be enforced through random audits rather than price caps.

Recommendation 1:

ATSA recommends the development of a blended model of payment for AT noting the provision of AT has two components, the product and the wrap around services for the participant, their carer/s and family.

1.2. Differentiating price caps to reflect additional costs in delivering services to participants with complex needs and in regional areas.

AT suppliers do not currently have visibility of the price caps and therefore do not price within the price cap.

ATSA supports differentiating price caps to reflect the additional costs of providing AT to people with complex needs and those in regional areas. These costs include costs of modifications to the AT (e.g., staff time, parts); potentially multiple trials to find the right AT and required adjustments to the AT, additional staff time working with the participant and allied health professional. Transparency between government and providers is important in the price cap process.

We would support differentiating price caps to reflect additional costs for participants in regional areas. The areas of additional costs to AT providers in regional areas are shipping costs for the AT products and travel expenses, noting they have larger areas to cover. Distances of 400 plus kilometres in one trip are not unusual for regional providers. Many regional providers also offer mobile showrooms and similar services in order to take their products to other rural and remote areas. They also provide AT training to allied health professionals.

Price caps only work on products themselves and are not applicable to services linked to the product. E.g., a price cap on a manual chair with tilt may be $10,000 (without seating) but the provider should be able to charge assessment and trial costs involved in that solution. This may include 2 x visits, 1 x one week trial and 1 x pre order visit. Hence the quotation may equal $12,000 but the item itself is only $10,000.

Alternatively, will the NDIA allow provisions in participant plans to claim the costs as they occur regardless if the product is purchased from that provider?

Recommendation 2:

Noting ATSA suppliers do not have visibility of the existing price caps, ATSA supports differentiating price caps to reflect the additional costs of providing AT to people with complex needs and those in regional areas. We recommend that a blended model is required for the provision of AT which includes products and services. For wrap around services and emergency repairs subscription payments may be more appropriate. Such payments also give participants more choice and control.

1.3. Implementing 'preferred provider' panel arrangements - where providers agree to supply supports at an agreed price and on agreed terms as an alternative to price caps.

ATSA does not support a preferred provider panel arrangement. As noted above, the NDIA have advised such an arrangement could be modelled on the current Preferred Continence Product Provider model. AT cannot be compared to continence products as the business model for each is different:

- The supply model for the provision of AT is a service+product delivery and set up model, while for continence products it is a consumer product delivery model. Each piece of AT requires a new fitting for the participant unlike continence products.

- Continence products are a regular repeat business where AT is not.

- Much of the content in this consultation paper is focussed on increasing competition. The preferred provider approach is the exact opposite of competition and is instead an oligopoly. This will negatively impact customer choice and damage the supply market.

- Based on the providers listed on the Continence Foundation website, we have estimated that 35% are dedicated to continence only products. 65% of providers are therefore not relying on one product type and the risk to them of not being on the preferred provider list is low. The risk to our AT members of not being on a preferred provider list will be significantly higher given the only product type offered is AT.

- AT providers work with the participant and allied health practitioners by providing AT trials across a large range of mid-cost and complex AT (generally, at no additional cost). The trials may be held in the showroom, at the participants residence, a facility or in the community. In the case of continence products, trials by providers are not required due to the consumable nature of the products.

- All continence products can be purchased online, delivered to the end-user and used without the need for any further intervention or support by the provider. For mid-range

and complex AT, providers deliver the AT product, provide information to the participant, allied health professional or AT mentor and carers/family on the safe use of the device e.g., all terrain mobility device for farming areas, tilt and lift and so on. They also support the participant and allied health professional by setting the product up for the individual requirements/needs of the NDIS participant such as adjusting the wheel placement on a wheelchair. Modifications based on a script are also undertaken by AT providers. The supply of AT is significantly more complex than for continence products.

- Additionally, the range of products under AT is significantly broader and more varied than for continence product providers. As noted above, a large proportion of AT products are not suitable to be posted/delivered and "dropped" at an address as in. the case of continence products.

In the absence of competition and the creation of an oligopoly, how are existing continence preferred providers monitored and how would quality and standard of service be monitored for "preferred" AT providers?

The difference in these two models is also highlighted by the use of guidelines for the provision of certain types of AT on the NDIS website for use by Government, professionals and providers of AT. We could find no similar NDIS guidelines for the providers of continence products. Additionally, there are guidelines from the World Health Organisation for some AT such as the Wheelchair Guidelines, 5 June 2023 -Wheelchair provision guidelines (who.int)), however again we could not find any similar guidelines for continence products. This further highlights the level of complexity for AT as opposed to the more consumable continence products.

The following table shows the role of the provider during key processes for the supply of AT and compares this to role of the provider for continence products. The differences between the two supply models explains how the continence model is a consumable product model while the AT model is a combined service and product model. The concept that only a few providers should be promoted by the NDIS to participants is impractical as those few providers cannot possibly meet the increased demand for service as well as product across the country.

Service level activity	AT provider involvement	Continence provider involvement
Selection of product in discussion with participant	YES	YES
Fit – product is prepared and fitted to each person	YES. Higher level AT is modified by providers based on a script provided to the provider by an allied health professional.	NO. Catheters are the only AT requiring fitting and this is done initially by a medical or Continence Clinical Nurse specialist.
Follow up by provider on the product sold to the participant	YES - for mid-range and higher-level AT.	NO.

There are a number of questions associated with a preferred provider model which must be considered:

- We understand the number of providers listed as preferred providers will be limited to a small proportion of the total number of providers across the country. What process and criteria will be used to decide which providers will be on the list and which will be excluded? If multiple providers meet all the necessary criteria, it would not be equitable nor in the public interest to exclude any of them from the NDIS provider list.
- Could a regional provider who supports people across multiple LGAs including remote areas be excluded and a provider with a wide geographic coverage be included? If so, why? Who would supply the emergency back-up services to regional participants currently offered by local providers?
- Why are providers described as being “preferred” – this language indicates all other providers who not on the list offer a lower quality of service or a higher price and is not accurate nor appropriate.
- ATSA members currently rely on the NDIS listing as a key way for participants to find their businesses. Would they still be listed on the NDIS website?
- What analysis has been/will be undertaken to understand the loss of income to these businesses and jobs in local metro and regional areas and the impact on these local economies?
- The level of innovation is significantly higher in the AT product area than for continence products. As an example, in the case of paediatric AT, innovation has resulted in

manual and power paediatric wheelchairs being adjustable for growth spurts making the same device last longer for each child participant. This type of innovation is expected to be constrained under a preferred provider model as the number of suppliers competing for business decreases. What will replace the value of competition in creating innovation in the AT sector?

- How does the process of having a preferred provider align with Section 5.5 p14 of the Commonwealth Procurement Rules (CPRs) 13 June 2023 aimed at SME protection. The NDIA indicated an EOI process could be used to select preferred AT providers, in this case, what protection is there for SMEs? This use of an EOI could be seen as a work around for the NDIA to avoid having to comply with the CPRs.

- How would the selection process work when comparing providers who have higher than average costs based on their regional/rural or metro location?

- Noting the proposed changes for the GEAT model under the Aged Care Reforms, and the preferred provider model under the NDIS, the outcome from these proposals is expected to be a widespread downsizing and loss of small and possibly medium sized AT providers across metro and regional areas. What response is being planned to address this issue and is this a cross-government response?

Impact on Thin Markets

To be sustainable, regional AT providers need to sell a volume of simple AT in addition to more complex AT. The preferred provider model is expected to reduce the number of AT providers in thin markets as those providers determined to be "preferred" are expected to control a large proportion of the simple AT market as a result of their elevated profile. Reduced numbers of thin market suppliers in turn, impact the number of trials and support service for participants in these areas. The following example demonstrates the value and importance of having providers within reach of local communities:

> *A bed was delivered to a client in a regional area but not supplied by the local AT supplier. On a Friday afternoon before a public holiday weekend the bed handset stopped working. The client is quadriplegic and for medical reasons, is required to lie flat at night, with the adjustable bed used to assist with repositioning him through the night. This client only had his power wheelchair to spend the weekend in if he wasn't able to be assisted to bed. The local supplier was advised of the situation and attended the site with spare handsets – none of which were compatible with the bed supplied. The local supplier then removed the person's bed and put in a loan bed. Had the bed been supplied locally, the supplier would have had the right parts in stock to make the necessary repair.*

Under a preferred provider model, it is unlikely there would be an AT provider close enough by to resolve situations such as the one in this example.

The focus on choice and control and making that choice early (during the assessment) for each AT item should underpin the supply of AT.

Recommendation 3:

The preferred provider model does not work when services and products are offered together to meet the needs of participants. Additionally, mid-range and complex AT is not a product which can be ordered and delivered with no further intervention or follow up from a supplier. Early research indicates the implementation of a preferred provider model will result in a combination of SME AT suppliers either downsizing or closing their businesses across the country, the impact on the supply of AT will be significant. The results of our research and analysis to quantify the number of businesses by region across Australia, will be available by the end of August 2023. The impact on the supply of the wrap around services is expected to be devasting for participants in metro areas but particularly for those living in thin market areas.

ATSA recommends the NDIA not proceed with this model.

Finding 2: The fee-for-service payment approach rewards NDIS providers for the volume of supports they deliver, rather than for supporting participants to achieve outcomes.

2.1. Opportunities to use other payment approaches in the NDIS along with complementary measures (such as improved market monitoring)

Supply of AT registered with the TGA as a Class 1 medical device is done on a service+product basis. Our members have published the prices for base models of AT products and have added various messages such as “prices from” next to the base prices on their websites to inform participants that any additional features/modifications will incur additional charges. Unfortunately, many participants still expected the final modified product to cost the same as the base price. This is an issue for both the AT provider who has made the scripted modifications and the participant who accepted the inclusion of the base price in their plan. Our members now work with participants and allied health professionals to understand what modifications or adjustments may be required for a participant and then provide the quote based on the agreed expected final product.

A fee for service model may actually ‘add costs’ to a NDIS plan, rather than averaging across all sales.

ATSA’s members providing low complex AT, do not always charge a fee for service except for the delivery fee. AT providers charge a fee for services when working with the participant and allied health professional in regard to the script for the AT. These “free” services go unrecorded and unrecognised except by the participant. It would be helpful to have these recognised in any rating system as going above and beyond the required service provision.

In order for participants to achieve the outcomes they want, the initial assessment is critical in the supply of AT. This reduces the amount of re-work and increases the level of confidence by the participant in the process. Clarity on who is accountable for what activity during this process is essential.

Additionally, many AT providers do not charge separately for emergency call outs where the participant may be stranded. The following are two examples of when an AT provider supported a participant in an emergency situation but did not charge for their time. This level of support is very common amongst AT providers.

Example 1
Customer emergency – manual chair (agency managed) participant lives in care facility. The AT provider was called and turned up to find emergency was flat tyre and just needed a tyre pumped up. The AT provider fixed the tyre but felt this was neglect from the care facility whose staff could easily have inflated the tyre and should have basic equipment like tyre pumps on site.

Example 2
A long-term client needed a replacement tyre and had no support or money to fix it. The AT provider provided replacement for free.

Recommendation 4:
The provision of AT cannot be viewed in the same way as the purchase of a consumable product and any alternate payment process needs to recognise the provision of wrap around services and emergency call outs as well as the relationship required between the participant and supplier for the provision of these services.

The payment process can be a useful tool to support accountability during the assessment and provision of AT processes. Payments are made to the appropriate provider based on their role in this process being completed. ATSA would be willing to work with the NDIA and allied health professionals to clarify the areas of accountability.

2.2. What approaches could be considered for different types of supports, including daily living supports, therapy supports and others?

The supports required by participants for the provision of AT include:

- Triaging for need
- Assessment (often a therapist)
- Provider assisting therapist in assessment by providing information on AT options and functionality.
- Trial phase
- Delivery phase
- Post delivery refit/s (reviews for suitability and adjustments)
- Servicing (maintenance of AT).
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For the triaging, assisting therapists and post-delivery refits services, it is difficult to use an outcomes-based model as these services are about helping the participant in determining what outcomes are possible. We suggest an expense claim model could be the least administratively costly approach.

In the case of a trial of AT an outcomes approach would be that the trial was completed, not that it was or wasn't successful as the point of the trial is to determine which AT the best solution. Having a trial not work out informs the selection process. The costs AT providers

need to recover in a trial are staff time, insurance on the AT used in the trial, delivery and collection. The delivery phase also includes the set-up of the AT in the participants' home, training in how to use the AT and watching the participant use the AT in their local environment to make sure it is correctly set up for that person & appropriate for where they will be using the AT.

The costs for post-delivery refit/s will vary based on whether the AT has to be returned to the provider's centre or can be adjusted in the showroom or participant's home. Costs may include parts, technician time, travel and delivery costs.

A subscription approach may be more effective for software upgrades (communication devices) and for servicing (maintenance of AT) so the participant and AT provider can plan and have a transparent and known cost/income from these activities. The variable cost would be any additional parts not covered by warranty. The same would apply to regular 6 monthly refit/reviews to ensure AT will be fit for purpose for the life span of product to reduce waste from participants needing to obtain a new product because the one they have isn't fitting/working.

Funding for ongoing care is important as it impacts the longevity of the product.

E.g., A school aged participant who uses a power wheelchair for independence and mobility needs is a high end user. A subscription approach to service and maintenance would allow the AT provider, clinician and participant's parents to set up regular preventative maintenance appointment each school holidays – this would be considered reasonable and necessary under the NDIA guidelines. Inclusive in the subscription would be access to funds for replacement, repair of consumable items enhancing longevity but also reducing the likelihood of emergency repairs.

Recommendation 5:

ATSA recommends an expense claim approach for the following wrap around services

- *trialling funding for ongoing care as this would have a positive impact on longevity of product*
- *6 monthly refit/reviews to ensure AT will be fit for purpose for the life span of product.*

We also recommend the use of a subscription approach for the following services; servicing, (maintenance and repairs), emergency call outs and software upgrades for communication and similar AT devices.

Finding 3: A lack of Transparency around prices, volume, quality and outcomes is restricting the effectiveness of NDIS service delivery

3.1. Market monitoring through collection of transaction data supported by near real-time payment systems

ATSA members support the use of market monitoring by the NDIS provided it can be managed by various sized businesses including sole practitioners and family organisations.

The question of whether this should also apply to non-registered providers needs to be considered. Additionally, providers should have visibility of reports where the data they provide is used, provided the report does not contain competitive information. Transparency needs to be two-way.

3.2 Requirements for providers to disclose their prices through an online marketplace similar to the My Aged Care website

The ability for an AT provider to provide a price for AT depends on the AT product being purchased or trialled. For higher level AT, providers need to see the participant who goes through the scripting + testing/trial process before the provider is able to provide a quote on the scripted product. As noted previously in this response in 2.1, our members have tried using various messages next to the base prices on their websites such as "from" or "excluding adjustments for the individual" or "base model, extras additional cost", however, participants still expected the final product to be at the base price and say the base price is what is in their plan. The cost of modifications may also differ by provider due to their location (regional, metro) and other factors, so just using base model pricing as a comparison does not give the participant a true quote for the AT.

As part of their responsibility to ensure the type of AT is safe for the participant within their local environment, many AT providers have been reluctant to create a process where participants can buy AT without first having a conversation with the provider on the AT selected.

Some AT takes up to 18 months to finalise - such as a modified vehicle – the cost of supply of materials for modifications is not always stable. This means the price of this type of AT needs to be updated frequently to reflect the instability of prices for external parts and metal supply chains.

Note: The feedback we have received is the My Aged Care website is difficult and "clunky" to use.

3.3. Measuring and reporting on provider performance e.g., star rating system

ATSA members would support a process which measures and informs participants about the quality supports provided by AT providers.

In the case of a star rating system, the criteria for AT providers will differ to an AT mentor or professional given the technical nature of some of the support services offered. ATSA would be interested in working with the NDIS on both the measurement and reporting systems.

Initial thoughts are:

- Participants' experience of the product and support services – who would be the third-party vendor for registered and non-registered providers under the NDIS conducting the survey of participants?
- Compliance – in the NDIS would this refer to retention of registration given the variation in the types of services offered to participants?

- Staffing – this measure should include a mechanism for client feedback on staff. AT providers are very proud of the service their teams offer to clients so the participant feedback would be a good measure.
- Quality Measures – in terms of services provided by our members we would see areas for measurement of quality including the life of the product, regular maintenance provided, information on AT provided to participant/carers/family, AT correctly set up (may also need to apply to the allied health professional for higher AT), trial equipment offered, and follow up conducted.
- The issue of clarity around accountability is important in this process. What happens if the AT that has been scripted by a professional doesn't meet the participant's needs? How will the participant know this responsibility is with the professional and not the AT provider? Conversely if the AT provider doesn't follow the script correctly, how does the participant know this is the AT provider's responsibility and not the professional?
- The NDIA should provide reports by AT product and service type which is harmonised by categories and sub-categories, so each provider uses the correct code which is then allocated to the right category.

How may these approaches potentially be implemented in the scheme without adding administrative and compliance burden?

Please see our comments in 3.1.

Recommendation 6:

Mid-range and complex AT registered with the TGA is a medical device not a consumable product and requires discussion with the participant and/or their prescriber to determine whether the AT is suitable for the participant's environment. Publishing base line pricing for such medical devices has been tried by AT providers and resulted in participants not having the correct amount in their plan for the AT they required. Noting this, ATSA would caution against publishing base line prices.

The NDIA has the information to report on trends, changes and gaps in services and AT & needs the reporting system to share this information.

ATSA members support the use of market monitoring by the NDIS through a participant survey which provides the consolidated information back to participants and providers through a rating system. This will drive continuous improvement.

Finding 4: Removing price caps could place pressure on scheme costs. Instead, the focus should be on foundational market reforms that help align incentives for participants, providers and governments.

4.1. Participants have the information and capability to make informed choices on the value and quality of supports including the help they need to do this.

In regard to the value and quality of the supports participants receive, the results of a 3rd party survey could be provided to participants as part of the star rating or similar process to help them make informed choices.

4.2. Participants' budgets support them to be active consumers in the NDIS market

The NDIS is now starting to capture the data relating to the purchase of AT. By profiling the approved AT and cost against the goals of multiple participants, the NDIS will be able to provide information to participants in regard to what they should expect to pay for AT devices, both modified and unmodified.

4.3. Providers are incentivised to compete on price and quality, and deliver the volume and mix of supports that improve outcomes for participants

A 3rd party survey will demonstrate which providers are providing the best value for money based on quality and price. Providers need to see the results of this survey for their business and the aggregated results across the sector so they can benchmark themselves.

4.4. A range of contestable approaches are used in NDIS sub-markets when they would achieve better outcomes.

In regard to Assistive Technology, we suggest there does not need to be a new approach, however improvements can be made to the existing approach to the supply of AT. The following comments provide solutions to add to the existing processes and procedures to ensure NDIA participants are receiving value for money and they understand what is included in any pricing they obtain. It is also important for the NDIA to include a methodology for participants to provide feedback and that providers receive this information for continuous improvement, innovation and enhanced competition between providers.

<u>Initial purchase of AT</u>

- Where an AT device requires modification for the participants' individual needs, participants should understand and agree to the modifications through a discussion with the provider. The absence of such interventions can lead to health issues for the participant. E.g., *a mother was prescribed and purchased a Roho mattress. The mattress was delivered to the home in a regional area without a discussion between the provider and mother. No appointment to have the mattress correctly inflated by the local provider based on the OT's script had been made prior to the delivery. Her daughter inflated the mattress so her mother could use the mattress. Unfortunately, this was done incorrectly, and the mother ended up being taken to hospital with pressure areas.*

Offering pricing for a base model does not provide the participant with the information they need on the end product; they also need to understand the services that make up the sale for that product. The quote for this work can be compared to quotes from other providers to ensure it is a competitive price.

If the AT is a Class 1 medical device which does not need to be modified but requires individual adjustment to be safe, then again, this information must be provided to the participant. Not having the right conversation and just selling such products is high risk.
E.g., a gentleman was given a walker which was not adjusted for his height. The gentleman was hunched over the walker and was shuffling rather than walking safety. Once the height adjustment corrected, the gentleman was able to walk around safely. The purchase of such AT without the service and conversation with the participant to ensure it is safe, carries risks for the participant.

Price Gouging

Price gouging can be dealt with through improved monitoring and response to poor behaviour in the provision of AT. For example, prices offered by online platforms need to be monitored by the providers supplying their product to these platforms. Additionally, AT Mentors, planners, professionals, participants and AT providers need a simple reporting pathway to alert the NDIS or appropriate regulator of price gouging. Where online platforms are involved and are not registered with the NDIS as a provider, the control and response to this relies on a process between the NDIS and the ACCC.

- If a registered AT provider, including a registered online platform is found to be price gouging, their registration may be revoked by the NDIS Quality and Safeguards Commission. Enforcement measures could be stronger here.

Client Choice and Control

- It is important that participants are able to provide feedback on whether their goals relating to AT are achieved. We support the use of a 3rd party to conduct a client survey giving participants a chance to report their level of satisfaction to the NDIS. This information needs to be given to AT and other providers in a de-identified way so they can improve their services, product pricing and consumer engagement processes.
- The above gives participants an opportunity to state how many goals were achieved and how this was done, plus how many were not achieved and what were the roadblocks.

Accountability

- Improved transparency on the role of each provider assisting a participant is essential. This can be achieved through a fee for service type structure clarifying the roles of providers working with the same participants.

Waste Management

- The level of AT Waste needs to be recorded and reported to the sector by the NDIA.
- As noted at the start of this submission, ATSA has started on the background work to look at scoping a process across the sector to determine whether AT needs to be recycled or can be reissued based on the state of the device. The recycling process needs to consider plastics, vinyl, metal, batteries and so on as well and the collection from the participant or their family and the delivery to the recycling centre. Financial models for recycling already exist and could be explored to manage the costs for this process.
- In regard to the reissue of AT, our sector has a good relationship with manufacturers so AT providers are able to obtain the training, manuals, spare parts and tools they require to conduct repairs and maintenance to AT. Additionally, ATSA is currently developing an online menu of education and information which will include training on repairs and maintenance of AT to encourage more new technical experts into the AT sector.

Recommendation 7:

Workshops with AT providers, AT Mentors and prescribers should be held to work through who is accountable for which part of the assessment and AT provision process.

Third party survey be held for participants to provide feedback on the outcomes they have achieved and how (which services/ products) helped them achieve these outcomes.

Issues relating to price gouging need to be reported to both the ACCC and the NDIS Quality and Safeguards Commission.

The NDIA should commence a process to record the level of wastage for AT and other goods provided through the NDIS scheme.

The purchase of AT without the service and conversation with the participant to ensure it is safe, carries risks for the participant and may impact the amount of funding in their plan.

4.5. *Governments have clear roles and responsibilities with a coherent and transparent strategy for stewarding the NDIS market – including the approach for the overall market and different sub-markets (e.g., regional and remote markets)*

Recommendation 8:

ATSA suggests a coherent and transparent strategy for stewarding the NDIS market including:

- *Using the data collected by the NDIA from providers to determine market price ranges and forecasting demand for services and products by type.*
- *Clarifying accountability for providers*
- *ATSA supports the establishment of a pricing system to reflect the additional costs of service and product provision to participants living in thin markets.*
- *The focus for a successful NDIS model should be based on value and outcomes*.

Recommendation 9:

The NDIS needs to capture data from participants and providers and provide reports to participants and providers in order to create positive change, increase the service level expectations and create a culture of innovation.