# NDIS 2025-26 Annual Pricing Review Consultations

**Prepared by Cerebral Palsy Alliance**

**For the National Disability Insurance Agency**

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# Submission to the 2025–26 NDIS Annual Pricing Review – Therapy Supports

Cerebral Palsy Alliance (CPA) welcomes the opportunity to contribute to the 2025–26 Annual Pricing Review (APR), with a specific focus on therapy supports. As a member of Alliance20, we fully support the broader response they have provided as well.

CPA is Australia's leading organisation supporting people with cerebral palsy (CP), a lifelong and highly complex physical disability. We deliver multidisciplinary therapy, early diagnosis, assistive technology–informed interventions and community-based services across metropolitan, regional and rural settings in NSW and ACT. Founded in 1945, CPA employs more than 225 allied health professionals in a staff cohort of over 2500.

CPA primarily employs therapists as permanent employees (full-time and part-time), reflecting our commitment to clinical governance, supervision and workforce development. NDIS therapy sessions are most commonly delivered as 60-minute sessions, though duration varies depending on participant need, setting and whether sessions are joint or delivered in natural environments. A significant proportion of therapist time is spent on non-face-to-face activities required for safe and effective therapy delivery, including documentation, coordination and supervision.

Cerebral palsy is one of the highest-funded conditions in the NDIS, with almost 18,000 participants receiving average plan budgets of approximately $144,000. Supporting this cohort requires specialised, multidisciplinary, and frequently community-based therapy, delivered by clinicians with advanced capability and supported by strong clinical governance.

However, CPA's experience, supported by NDIA analysis and independent benchmarking, indicates that current NDIS therapy pricing is materially misaligned with the cost and complexity of delivering safe, evidence-based therapy for people with CP. This submission outlines why uniform pricing is no longer fit for purpose and why differentiated therapy pricing is now required to protect participant outcomes and market sustainability.

## The current therapy pricing model is not sustainable

Independent benchmarking and market analysis show that the registered therapy market is under severe and worsening financial pressure. Ability Roundtable data (from Their

Quality Quandary White Paper) indicates median losses for registered therapy providers have deteriorated from approximately –5.5% in 2023–24 to –13.4% in 2024–25, with losses projected to reach –24.6% in 2025–26 following recent APR decisions. Even top-quartile providers are forecast to operate at significant deficits.

These outcomes are not the result of inefficiency. Therapy price limits have been effectively frozen for six consecutive years while consumer prices have increased by approximately 23% and wages by around 19%. During the same period, regulatory, workforce and clinical governance obligations have increased.

Bottom-up cost modelling undertaken with Deloitte Access Economics demonstrates that the fully loaded cost of delivering therapy now exceeds NDIS price limits by at least 15% across occupational therapy and speech pathology, and by approximately 22% for physiotherapy following recent price reductions.

For providers delivering complex, disability-specific therapy, these cost gaps are structural rather than transitional. Without reform, the consequence is predictable: withdrawal of registered providers from complex work, contraction of multidisciplinary models, and loss of clinical capability from the system.

## Complexity of therapy for people with cerebral palsy

Therapy for people with CP is fundamentally different from standardised, clinic-based allied health delivered in other sectors.

Effective CP therapy requires sustained, interdisciplinary intervention addressing mobility, posture, communication, swallowing, assistive technology, and participation in daily life. Therapy is frequently delivered in homes, schools, early learning settings, hospitals and community environments to ensure strategies are safe, functional and transferable.

This work involves significant non-face-to-face clinical activity, including collaborative planning, documentation, supervision, coordination with health and education systems, and training of families and frontline support workers. For participants with dysphagia or complex postural needs, clinicians must observe and intervene in real-world environments to meet safety and quality standards.

In practice, current funding structures frequently interrupt this model of care. Short funding periods, rapid exhaustion of therapy budgets and rigid plan boundaries limit continuity of therapy and lead to delays or cancellations of clinically indicated services.

Reviews and appeals have become increasingly common as families and providers seek to maintain access to essential therapy, adding further disruption and uncertainty.

Families are often left confused by changing plan structures and funding rules, and in some cases absorb out-of-pocket costs to maintain therapy continuity for their child. These impacts are most acute for participants with complex needs, where interruptions to therapy can have immediate functional and safety consequences.

At the provider level, therapy services experience increased administrative burden associated with navigating funding constraints, repeated plan reviews, and inconsistent advice from plan managers. Plan manager rejections or retrospective payment disputes can result in unpaid invoices and growing debtors, shifting financial risk onto providers and further eroding sustainability. All of this activity consumes clinical and administrative time that is not recognised or funded under current pricing arrangements.

Current pricing assumes therapy can be delivered as a discrete, billable hour, with minimal allowance for these realities. This assumption does not reflect the operational environment in which CP therapy is delivered and contributes directly to service fragmentation and poorer outcomes.

## Natural environment therapy and the impact of travel pricing

The APR recognises that therapy delivered in natural environments is best practice, particularly for children and participants with complex needs. However, recent changes to travel pricing *directly* undermine this objective.

Ability Roundtable analysis shows that registered providers deliver approximately half of all therapy in natural settings, yet travel represents a relatively small share of total revenue (around 12%). Providers are not over-claiming travel; rather, travel is already under-recovered and limits productivity.

Halving the price charged for travel is projected to be one of the largest contributors to the forecast deterioration in provider viability. The likely outcome is a forced shift back to clinic-based services, reduced access in regional and outer-metropolitan areas, and poorer outcomes for participants whose needs cannot be addressed effectively in clinics.

For people with CP, therapy delivered at home, school or in the community is not optional. It is often the only safe and effective way to deliver intervention, particularly for mealtime

management, mobility, communication and assistive technology use. Funding structures that constrain where therapy can occur compound the service disruptions already caused by short funding periods and frequent plan changes.

**External funding is currently required to sustain viable NDIS service delivery in regional, rural and remote markets**

CPA continues to experience high demand for NDIS therapy services for people with complex disability in regional and rural areas, however the current NDIS funding and pricing framework does not cover the true costs of delivering these services. This is further compounded when the reduction in the travel hourly rate for travel, and the rigidity of the Modified Monash Model As a result, service continuity has only been possible through supplementary external funding. Without this additional funding, CPA would risk service reduction or withdrawal, resulting in clients being stranded without crucial therapy services.

Providing therapy services in smaller regional or rural areas is supported through outreach services, given staffing shortages particularly those with expertise in complex CP. One example is our Upper Hunter outreach program that supports 52 participants across Muswellbrook, Singleton and surrounding regions, where access to specialised allied health services is extremely limited. Outreach services involve significant unrecoverable costs under existing NDIS pricing — including travel, venue hire and clinician downtime. CPA have sought to continue providing this service due to external funding from local donors - almost $30,000 has been required in FY26 alone. The key pricing implication here is that NDIS price limits do not adequately account for the structural cost disadvantages of regional outreach models, despite these models being essential to participant access and outcomes.

## Market distortion and loss of quality capability

The APR and broader market data indicate a clear bifurcation in the therapy market. Unregistered, low-overhead providers have grown rapidly, while registered providers have declined in number, despite continuing to deliver the majority of therapy by value.

Registered providers carry the full cost of clinical governance, safeguarding, supervision, workforce development and compliance with NDIS Practice Standards. These requirements are not optional and are central to quality and safety, particularly for participants with complex physical disability.

The current pricing framework unintentionally favours lower-complexity, high-volume service models and disadvantages organisations that invest in multidisciplinary capability, early-career training and evidence-based practice. Over time, this erodes the system's ability to support participants with the highest needs and undermines the NDIS's stewardship objectives. Combined with increasing administrative and funding friction, this accelerates the exit of quality providers from complex therapy work.

**Supporting graduates.**

CPA is committed to developing and sustaining a skilled therapy workforce by supporting early career clinicians to meet the complex needs of NDIS participants. However, this workforce development obligation carries significant unfunded costs under current NDIS pricing arrangements. Graduates require approximately six months of structured training, supervision and clinical experience before they are able to manage a full caseload and achieve productivity comparable to an experienced therapist.

During this period, the productivity-related revenue gap alone is estimated at $58,000 per graduate when compared to an established team member. This figure excludes additional costs associated with clinical supervision, educator time, and the development and delivery of structured training programs. CPA typically recruits 10 graduate clinicians at the commencement of each year, meaning the cumulative impact of this unfunded productivity loss is material and is fully absorbed by the organisation. In addition, CPA works closely with universities across NSW and the ACT to support up to 75 student placements annually, which incurs further unavoidable costs associated with placement planning, supervision, and competency assessment.

These workforce development costs are essential to maintaining service quality and future workforce supply, yet they are not recognised or recoverable within existing NDIS price limits. This places additional pressure on provider sustainability, particularly for services supporting participants with complex needs.

## The case for differentiated therapy pricing

CPA supports the NDIA's stated intention to move toward more differentiated pricing and considers therapy supports an urgent priority for reform.

Differentiation should recognise participant complexity (particularly lifelong, high-complexity conditions such as CP), provider capability and quality, and service delivery context, including natural-environment therapy and regional provision.

A small number of clear therapy pricing tiers (for example, low, moderate and high complexity) would allow pricing to better reflect real cost drivers without creating excessive administrative burden. For known lifelong conditions such as CP, classification should be stable and not require repeated justification.

CPA also supports the establishment of an early intervention therapy tier, reflecting the intensity and family-centred nature of early CP intervention and reducing reliance on repeated plan reviews and appeals to maintain access.

## Conclusion

The evidence is clear and consistent: current NDIS therapy pricing does not reflect the cost, complexity or service-delivery realities of providing high-quality therapy for people with cerebral palsy.

Uniform price limits, short funding horizons and increasing administrative friction are disrupting therapy continuity, increasing burden on families and providers, and undermining the sustainability of quality therapy services.

For the people and families we support the changes such as S33 to funding periods, have led to much consternation around how inadequate or poorly structured funding interrupts clinically appropriate therapy. Specifically, we are seeing the following themes, leading CPA to raise the points it has in this submission -

1. short funding periods
2. early exhaustion of therapy budgets
3. forced pauses in therapy
4. increased reliance on reviews and appeals
5. families absorbing costs to maintain continuity

Therapy pricing fails to account for the true cost of delivery under NDIS conditions. We really want to do better by the clients we serve.

CPA strongly supports the introduction of differentiated therapy pricing, improved recognition of natural-environment delivery, and funding structures that support continuity, workforce sustainability and best-practice multidisciplinary care. CPA is willing to work with the NDIA to pilot and refine these approaches for complex disability cohorts such as CP.  CPA welcomes further discussion and stands ready to provide additional data, costing insights and implementation support as required.