
Medicare Benefits Schedule Review Taskforce

Taskforce Findings: General Practice and Primary Care Clinical Committee Report

This document outlines the Taskforce’s recommendations in response to the report from the General Practice and Primary Care Clinical Committee (GPPCCC).

The Taskforce endorsed 16 recommendations from the Final Report from the GPPCCC and submitted them to the Minister for Health for Government consideration.

Number of items reviewed	171
Number of recommendations made	23

The recommendations are intended to encourage best practice, improve patient care and safety, and ensure that MBS services provide value for the patient and the healthcare system through deleting obsolete or low clinical value items; consolidating or splitting items to address potential misuse; modernising item descriptors to reflect best practice; and providing clinical guidance for appropriate item use through explanatory notes.

List of General Practice Recommendations

Phase 1

Below are recommendations from the GPPCCC Phase 1.

Recommendation 3 – Develop a non-adversarial system for resolving complaints about consumers’ out-of-pocket healthcare costs and disagreements about clinicians’ charges

This recommendation proposes encouraging consumers to build on their health literacy and take greater ownership of their own healthcare.

Recommendation 4 – Support PHNs in educating people about and encouraging the use of case conferencing where appropriate – both prior to and at the point of hospital discharge, as well as in the community – to ensure that care is integrated across all domains

This recommendation proposes provisioning access to best-practice health services through case conferencing (organising and coordinating, or participating in, a meeting or discussion to discuss a

patient's multidisciplinary care needs and ensuring these needs are met through a planned and coordinated approach).

Note: The Allied Health Reference Group (AHRG) addressed case conferencing as part of AHRG Recommendation 8, which proposed case conferencing for children with a potential Autism Spectrum Disorder (ASD), Complex Neurodevelopmental Disorder (CND) or disabilities diagnosis.

Recommendation 5 – Support the efforts of PHNs to develop HealthPathways clinical guidelines in collaboration with LHNs/LHDs, other local clinicians, and consumers

The GPPCCC supports the efforts of PHNs to develop HealthPathways clinical guidelines in collaboration with LHNs/LHDs, other local clinicians, and consumers. HealthPathways are web-based and provide detailed recommendations for the evidence-based management of a wide range of common conditions, taking into account local resources and offering links to local clinicians, both public and private. HealthPathways are evolving to integrate with decision-support tools and electronic requesting/referring mechanisms.

Recommendation 8 – Delete item 173

This recommendation proposes deleting item 173, which does not require the clinician to be appropriately credentialed to provide acupuncture services, while keeping items 193, 195, 197 and 199.

Recommendation 9 – Revise item 193-199 descriptors

This recommendation proposes revising item descriptors for acupuncture services items to specify the credentialing required includes all Medical Practitioners (rather than specifying GPs only), and clarify the service duration refers to the period of time during which the clinician is physically present with the individual patient (and not the 'needle time').

Phase Two

Below are recommendations from the GPPCCC Phase 2.

Recommendation 1 – Move to a person-centred primary care model supporting general practitioner (GP) stewardship and team based care.

This recommendation proposes promoting equitable access to high quality person-centered health care by maximizing patient outcomes, enhancing patient experience, minimizing cost and optimizing the experience of health providers.

Recommendation 2 – Introduce a new fee for practices to enrol a patient.

This recommendation proposes the adoption of a voluntary patient enrollment model that encourages practices to build continuity of care into their business models, ensuring support for longitudinal care and population health, as well as acute, episodic care. The Taskforce supports the implementation of a voluntary patient enrolment model.

Recommendation 3 – Introduce flexible access to primary care services for enrolled patients.

This recommendation proposes mutual obligations on the GP and the practice for enrolled patients should, at a minimum, include:

- a. non-face-to-face access to enrolled patients, and
- b. some after hours or emergency services for enrolled patients.

Recommendation 4 – Implement a comprehensive package of longitudinal care for enrolled patients with chronic health conditions that promotes effective use of primary care chronic disease management items

The following suite of recommendations focus on increasing high value primary care, enhancing multidisciplinary care planning and coordination activities, and supporting increased patient activation.

These recommends propose a range of enhancements to MBS supported chronic disease management items, and are designed as a package of care for patients with chronic health conditions; the sub-recommendations below are not intended to be considered in isolation.

4.1. Combine GP Management Plans (GPMPs) and Team Care Arrangements (TCAs), and strengthen GPMPs

This recommendation proposes reducing administrative burden and low value care by:

- a. deleting items 723 and 729,
- b. not changing item 731 (in the context of Residential Aged Care Facilities (RACF)), and
- c. changing the item descriptor, schedule fee and explanatory note for item 721 to state that the patient is attending a practice where they are enrolled.

4.2. Link allied health chronic disease management items to the creation of a GPMP

This recommendation proposes enabling the simplification of Chronic Disease Management items by changing descriptors for items 10950-10970 and 81100-81125 to:

- a. remove references to TCAs, and
- b. make clear that allied health services will be linked to the creation of a GPMP.

4.3. Equalise rebates for GPMP preparation and review to encourage longitudinal patient care

This recommendation proposes improving access to longitudinal care for patients with chronic disease and ensuring proper use of chronic disease management items by:

- a. changing the descriptor, explanatory note and schedule fee for item 732 to state that the patient is attending a practice where they are enrolled and that this item is only available for 3 months after the creation of a 721 and then on a schedule of every three months after that (max 3 claims in the first year and 4 in subsequent years), and
- b. ensuring the schedule fee for items 732 and 721 are of equal value, supporting an increase to funding for general practice, including chronic disease management.

4.4. Increase patient access to high quality care coordination across physical, mental and social care domains

This recommendation proposes increasing access to care coordination services that encompass bio-psycho-social models of care and supports active patient involvement in their own care planning. Patients with complex health care needs will benefit from greater assistance with care coordination and navigation from a registered nurse, enrolled nurse or Aboriginal health practitioner or Aboriginal health worker.

4.5. Develop advice and support mechanisms to activate and engage patients in their own care planning, including the assessment and support of patient health literacy activities

This recommendation proposes focusing on improving patient experience and increasing patient activation in care planning, allowing patients to be more involved in their own care planning through active goal setting and decision-making, and by receiving self-management support.

4.6. Encourage increased patient participation and rebate attendance of non-medical health professionals at case conferences

This recommendation proposes encouraging access to case conferencing as part of effective chronic disease management, and ensuring that the patients are engaged in their own care planning.

- a. Changing explanatory notes for items 735, 739, 743, 747, and 750 to:
 - (i) Specify that the patient or their nominated representative should usually be invited to attend the case conference, subject to patient agreement;
 - (ii) Require the GP to provide a summary of the conference to the participants and to upload the updated care plan if changed by the case conference to My Health Record, unless patient consent is withdrawn, and where reasonably achievable;

- (iii) Note that case conferences can take place via telephone; and
 - (iv) State that these items are available at the enrolled practice, for patients who are enrolled, or to be performed by the usual GP for patients who are not enrolled.
- b. Creating three new items to rebate attendance at a case conference by non-medical health practitioners, one for 15-20 minutes to align with item 747, and one for 20-40 minutes to align with item 750, and one for >40 minutes to align with item 758.

4.7. Link Medication Management Reviews (MMR) to GPMP and ensure the rebate accurately reflects GP activity

This recommendation proposes enabling better targeted MMRs, ensuring that the rebate accurately reflects the practitioner's effort.

- a. changing the descriptor, explanatory note and schedule fee on items 900 and 903:
- (i) 900 and 903: specify that the patient is attending a practice where they are enrolled and require a copy of the MMR to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.
 - (ii) 900: specify the item must be claimed at the same time or within 12 months of a GPMP (item 721) if the patient is at risk of medication misadventure due to unstable health status, use of high-risk medicines, not meeting therapeutic goals, or issues surrounding adherence.
 - (iii) 903: allow a proxy to request a medication review where they have sought consent from the patient's usual general practitioner, and where the patient is either being discharged or lives in MMM 5, 6, or 7.
- b. substantially reducing the schedule fee for item 900 and make item 903 equal to item 900, noting that any savings should be re-invested into other initiatives to support general practice such as voluntary patient enrolment.

4.8. Increase the schedule fee for home visits for enrolled patients

This recommendation proposes increasing support for home visits for patients who are enrolled within a practice and amending items 24, 37, and 47 to increasing the schedule fee for a home visit for a patient when attended by a GP from the practice where they are enrolled.

Recommendation 5 – Build the evidence base for Health Assessments and ensure that the content of Health Assessments conforms to appropriate clinical practice guidelines

This recommendation proposes that a process be established to gather evidence on the effectiveness and frequency of Health Assessments with a focus on at-risk populations, including using data at a Primary Health Network (PHN) level based on existing groups eligible for Health Assessments, and commissioning studies on the evidence for Health Assessments for new at-risk groups.

Recommendation 6 – Introduce a 6-minute minimum time for a Level B Consultation

This recommendation proposes amending the descriptors for items 23, 5020 and 5023 to state that the consultation length should be a minimum of 6 minutes.

Recommendation 7 – Strengthen the quality of current Health Assessments and expand at-risk groups who are eligible for Health Assessments

This recommendation proposes changing the descriptors and explanatory notes for items 701, 703, 705, 707 and 715 to expand eligibility to new at-risk populations and modify existing populations to better align with clinical and service needs.

Recommendation 8 – Undertake additional research regarding the appropriateness of the current length, content and minimum quality metrics for GP MBS consultation items (Level A-D)

This recommendation proposes research into how GP consultations are currently being managed and how quality of a consultation could be gauged. Additional research, including the time intersect between consultation items can be used to guide appropriate changes to the Level A-D consultation rebate or in VPE

Recommendation 9 – Introduce a new Level E consultation item for consultations of 60 minutes or more by a GP

This recommendation proposes the introduction of an item for consultations lasting at least 60 minutes.

Recommendation 10 – Change the schedule fee for attendances at Residential Aged Care Facilities (RACF) to reflect an initial flag fall rebate, with a stable fee for each consultation at the RACF

This recommendation proposes changes to the schedule fee for items 20, 35, 43, 51, 92, 93, 95 and 96 to reflect an initial flag fall rebate for attendance at a RACF, with a stable fee for each consultation completed at the RACF (irrespective of the number of consultations).

Recommendation 11 – Modernise the terminology currently used in the MBS to describe registered and enrolled nurses and their role to reflect the important role these health professionals play as members of the practice team

