Royal Australian College of General Practitioners

RACGP

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RACGP recommendations on professional attendances items used in general practice

Items considered

Item No	Item Name - Short
3	Professional Attendance – Level A – Consulting Room
23	Professional Attendance – Level B – Consulting Room
36	Professional Attendance – Level C – Consulting Room
44	Professional Attendance – Level D – Consulting Room
4	Professional Attendance – Level A – Hospital or Home
24	Professional Attendance – Level B – Hospital or Home
37	Professional Attendance – Level C – Hospital or Home
47	Professional Attendance – Level D – Hospital or Home
20	Professional Attendance – Level A – Residential Aged Care Facility
35	Professional Attendance – Level B – Residential Aged Care Facility
43	Professional Attendance – Level C – Residential Aged Care Facility
51	Professional Attendance – Level D – Residential Aged Care Facility
721	Preparation of a GP management plan (GPMP)
723	Development of team care arrangements (TCA)
729	Contribution to multidisciplinary care plan
731	Contribution to or review of care plan prepared by RACF or pre-hospital discharge
732	Review or coordinate review of GPMP or TCA
735	Organise case conference – 15-20 minutes
739	Organise case conference – 20-40 minutes
743	Organise case conference – 40 minutes or more
747	Participate in case conference – 15-20 minutes
750	Participate in case conference – 20-40 minutes
758	Participate in case conference – 40 minutes
701	Health assessment – less than 30 minutes
703	Health assessment – 30-45 minutes
705	Health assessment – 45-60 minutes
707	Heath assessment – 60 minutes or more
900	Domiciliary medication management review
903	Residential medication management review
139	Early intervention services for children with specific disorders

Issues/Themes

The disparity between scheduled fees for care provided by General Practitioners (GPs) and other medical specialists is a major concern

- There is disparity between General Practice and other medical specialist consultation items:
    - consultation items for other medical specialist are not time-tiered – an initial specialist consultation item could take less than 10 minutes and still attract a rebate of $85.55

  - consultation items for other medical specialists are valued much higher than GP consultation items – calculations show that GPs are paid significantly less, even after adjusting for training time. A loading of 18.5% should be applied to GP consultation items to bring them to the level of other medical specialist consultation items (see Appendix 1)
  - other medical specialist home and Residential Aged Care Facility (RACF) visits have set patient rebates and are not calculated using the same formula as general practice patient rebates – other medical specialists are therefore not subject to the same diminishing rebates as GPs.
- Changes should be made to ensure that the value of scheduled fees for general practice services are aligned to other medical specialist scheduled fees. These changes should include:
  - introducing a time-tier for other medical specialist consultation items
  - increasing the scheduled fee for GP consultation items to equitably reflect scheduled fee value for other medical specialist consultations
  - removing the law of diminishing patient rebates from patient visits in settings other than the consultation room.
- Non-vocational registered GP (non-VR) items have a different time-tier scale to vocationally registered GP (VR GP) items – time-tiers should be consistent across all medical professionals using the Medicare Benefit Schedule (MBS).

Consultation items

- The consultation item descriptors do not require significant change.
- The value of patient rebates need to be realigned to other medical specialist rebate values.

Level E consultation

- There is currently no support through the MBS for GPs to spend more than 60 minutes with their patients.
- The RACGP recommends an extension of the time tiered scale to include a Level E attendance.
- The descriptor for a Level E attendance should be the same as the Level D descriptor and apply to attendances for 60 minutes or more.
- The Level E item should only be used ‘where no other appropriate item applies’ (i.e. if another item number is applicable, for example a Mental health plan or health assessment, a Level E should not be used).

Telehealth

- The MBS does not reflect current technology and practice processes – consultation items need to be modernised, recognising e-health services and utilising telehealth services where clinically appropriate.

Practice Nurse recognition

- The MBS should support a team care model that better recognises practice nurse time.
- In the current MBS, nurse time is not recognised unless within the context of a health assessment. This is a result of previous legislation changes which saw nurse immunisation and dressing incentives replaced by the Practice Nurse Incentive Payments (PNIP).
- The RACGP recommends the reintroduction of a practice nurse MBS item number, with a broad range of activities listed under the single item number. This approach would be administratively simple and it would create an obligation to document, while retaining some flexibility in remuneration for practice nurses.
- Recognition of practice nurse time should be in addition to practice nurse time recognised as part of a health assessment and under the PNIP. Practice nurse time recognised under the PNIP is intended to support the practice, while practice nurse time recognised under the proposed practice nurse item is intended to support the GP.
- The practice nurse item should include a broad range of activities including:
    - dressing
    - immunisations
    - point of care testing
    - health coaching
    - care coordination
    - advice on appropriate prevention (as per the current edition of the RACGP *Guidelines for preventive activities in general practice*).

Residential Aged Care, Home and Hospital visits

- The formula for calculating MBS rebates for patient visits reflects the ‘law of diminishing returns’.
- There is considerable financial disincentive for GPs to leave their surgery to attend a patient’s home, hospital or RACF.
- The current formula used to calculate patient rebates for patient visits results in patients receiving different rebates on different days depending on the number of patients a GP has seen that day. This means that GPs cannot realistically raise a private bill for a patient in a RACF if they see more than one patient due to the administrative barriers created.
- The formula for calculating the patient rebate for patient visits should be amended to separate the ‘initiation fee’ from the patient rebate. This would ensure that patients are always billed at a consistent rate, and GPs receive an additional initiation payment for conducting the visit.
- GPs visiting RACFs are currently paid an incentive depending on the number of visits in a year. This incentive will be removed when the PIP is redesigned, resulting in GPs will missing out on up to $5,000 a year. This factor should be considered when looking at the patient rebates for this setting.

Chronic Disease Management items

- Chronic Disease Management (CDM) items should be simplified, and reflect patient complexity.
- Many CDM item descriptors are overly prescriptive and focus on the process rather than the quality of the service (e.g. for General Practice Management Plans (GPMP))
- The GPMP should incorporate a holistic view of a patient – currently it does not encourage practitioners to incorporate all patient medical concerns. As a result, practitioners may opt to complete the management plan for the primary concern only. CDM item descriptors should be reworded to encourage all of a patient's comorbidities to be documented.
- The Department of Veteran Affair's Coordinated Veterans' Care (CVC) program descriptors better reflect best practice in CDM. MBS CDM item descriptors should be amended where relevant to reflect CVC program descriptors.
- To better respond to patient complexity, the MBS should reflect RACGP's proposed risk stratification tiers for CDM as outlined in the RACGP *Vision for general practice and a sustainable health care system* (the Vision). This will align the management of CDM with the RACGP's Patient Centred Medical Home (outlined in more detail in Appendix 2).
- The number and complexity of mandatory requirements for CDM items often differ in description depending on whether a GP is referring to MBS Online or the legislation. There are over 30 mandatory requirements for GPMPs and Team Care Arrangements that should be abolished.

Allied Health and other medical specialist reporting

- The MBS should encourage best practice reporting between members of the multidisciplinary team.
- Allied health professionals and other medical specialists should follow up a patients visit by reporting back to a patient's GP.

Case Conference items

- The current case conference items are very useful in residential care but very difficult to utilise in community care.
- The descriptor requirement for the presence of 'at least two other members, each of whom provides a different kind or care or service to the patient' makes it difficult to use in the community.
- A new item should be developed to support case consultations conducted in the community between a GP, the patient, and the patient's family/carers.

Health assessment items

- The frequency and requirements differ significantly between different health assessments and should be standardised. For example, the health assessment for people aged 75 years and older may be claimed once every 12 months, but the health assessment for patients at risk of diabetes can only be claimed once every three years.
- The available evidence is more supportive of the value of follow up care, than the health assessments themselves.

75+ in the home

- The MBS should support a health assessment in the home for people aged 75 years or older. – the health assessment would ensure the safety and quality of life for older patients. The aim is to identify services needed and to assist these patients to remain in their own home.
- Health assessments for people aged 75 years or older should remain yearly, with the option of a timed assessment at the practice or an untimed assessment in the home. The home assessment would have an increased rebate to reflect increased complexity. The decision to conduct the assessment in the home or the practice should be at the discretion of the GP and the patient.

Comprehensive medical assessment

- The Comprehensive Medical Assessment (CMA) should be reinstated.
- Previously, patients aged over 75 who had a health assessment within the last 12 months were not eligible for a CMA. The CMA should not be dependent on the last health assessment and should be given to all patients on their admission to a RACF, as a patient's move to a RACF represents a significant change in circumstances and therefore a new assessment is warranted.
- A practice nurse or health professional should be able to contribute to the CMA (as previously existed) but the item should not be billed until the GP has visited the residential care patient and completed the CMA.

Health assessment for vulnerable children

- Children and young people in out-of-home care, of parents with significant mental health issues or of parents who undertake intravenous drug use, have poorer health status than the typical Australian child – the MBS should support a health assessment for these children.
- The health assessment for vulnerable children should be added as categories under existing MBS health assessment items (items 701, 703, 705, 707).
- Each child who enters out-of-home care should be eligible for an annual health assessment.
- The child should also be eligible for:
    - an annual health assessment in the year following their 'discharge' from out-of-home care to identify any transitional issues
    - an (additional) health assessment should they move a substantial distance from the location where the last health assessment was done
    - an annual health assessment, until they turn 18, should they be in out-of-home care on their 15th birthday - to address the transitional issues that occur for older children leaving care.

Medication reviews

- Medication reviews are beneficial for patients. To ensure that patients continue to have access to medication reviews, the cap of 20 medication reviews per calendar month per pharmacist should be removed.
- Although the cap on medicine reviews occurs under the Community Pharmacy Agreement (CPA), it has significant flow-over effects for patient medication reviews under the MBS.
- Given the flow over effects onto the MBS, it should be recommended that changes are made to the CPA to remove the cap on home medicine reviews.
- Med-checks within the CPA should be discontinued and the funding reinvested into home medicine reviews.

Principles

- Disparities between scheduled fees for GP and other medical specialist consultations should be addressed.
- Consultations lasting more than 60 minutes should be supported.
- Consultative medicine should be modernised.
- Practice nurse time should be recognised.
- The formula for patient visits (home, RACF, institution and hospital) should be amended to separate the ‘initiation fee’ from the patient rebate.
- CDM item numbers should reflect patient complexity, as per the tiers set out in the RACGP’s Vision.
- CDM descriptors could be improved by including the Care Plan checklist from the CVC program descriptors.
- CDM descriptors should encourage efficient reporting processes between multidisciplinary team and GPs.
- An item to allow case conferencing in the community between the GP, patient and family/carers should be supported.
- A health assessment in the home for patients aged 75 years or older should be developed.
- The CMA should be reinstated (previously item 712).
- Health assessment categories should be broadened to support vulnerable children.

Recommendations

The recommendation table below addresses the broad changes that need to be made to the MBS as it currently stands in order for the RACGP's recommendations to be achieved.

#	Item/ Explanatory note	Change / Requirement	Purpose	Rebate value
1	Items 3 – 51	**Address disparities between other medical specialist and GP consultation scheduled fees** Calculations show that scheduled fees for GP items are consistently undervalued when compared to scheduled fees for other medical specialist consultations, even after adjusting for years in training. A loading of at least 18.5% should be applied to all GP consultation scheduled fees to bring them to the level of specialist consultation items. *See Appendix 1 for calculations*	To address disparities between other medical specialist and GP consultation scheduled fees by applying an equitable loading payment to GP consultation items	+18.5%
2	Items - 104, 105, 6007, 106, 3005, 3010, 110,116,2801, 2806, 385, 386, 109	**Address disparities between other medical specialist and GP consultation items** Under the current MBS, items for other medical specialist consultations are not time-tiered. They are instead split into initial and subsequent attendance. For simplicity and consistency, other medical specialist consultation items should also be time-tiered to align with GP consultation items.	To address disparities between other medical specialist and GP consultation scheduled fees by amending other medical specialist items to reflect a time-tiered scale.	

#	Item/ Explanatory note	Change / Requirement	Purpose	Rebate value
3	Items 52, 53, 54, 57	**Difference in time tiers between VR and Non-VR consultations** Items 52, 53, 54 and 57 reflect non-VR consultation items. The time tiers for these items differs from that of VR items. There is no clear rationale for a difference in time tiers. For simplicity and consistency non-VR consultations times should be amended to reflect VR time-tiers.	Increase simplicity and consistency within the MBS	
4	New item – Level E professional attendance at **consulting rooms.**	**Extend consultation items time tiered scale to include a Level E attendance** A new item be developed for a Level E consultation **at consulting rooms**. Level E descriptor should be the same as the Level D descriptor but reflect a consultation lasting for at least 60 minutes. The Level E descriptor should note that 'Where other appropriate item numbers are available (eg Mental health plan, health assessment) these should be charged – a Level E item should be only used 'where no other appropriate item applies''	To support consultations lasting more than 60 minutes	$163.185 (based on Level D ($105.55) + % equivalent increase from Level C to Level D (31%) + 18.5% loading)
5	New item – Level E professional attendance at **hospital, institution or home**	**Extend consultation items time tiered scale to include a Level E attendance** A new item be developed for a Level E consultation **at a hospital, institution or home**. Recommendations for item descriptor as above.	To support consultations lasting more than 60 minutes	Proposed: Level E as above (The proposed initiation fee item can also be claimed with this item)

#	Item/ Explanatory note	Change / Requirement	Purpose	Rebate value
6	New item – Level E professional attendance at **RACF**	**Extend consultation items time tiered scale to include a Level E attendance** A new item be developed for a Level E consultation at a **Residential Aged Care Facility**. Recommendations for item descriptor as above.	To support consultations lasting more than 60 minutes	Proposed: Level E as above (The proposed initiation fee item can also be claimed with this item)
7	Explanatory notes A5	**Extend consultation items time tiered scale to include a Level E attendance** Explanatory note A5 will need to be amended to reflect the addition of a Level E attendance	To support consultations lasting more than 60 minutes	
8	New item – practice nurse	**Recognise practice nurse time** An item number recognising practice nurse time should be developed. This item should include a broad range of activities including, but not limited to; dressing, immunisations, point of care testing, health coaching, care coordination and advise on appropriate prevention (as per RACGP *Guidelines for preventive activities in general practice*).	To support multidisciplinary team care and recognise practice nurse time	
9	New item – visit initiation fee	**Formula for calculating the patient rebate for patient visits should be amended to separate the 'initiation fee' from the patient rebate** A new item be developed to reflect a 'visit initiation fee' that can be charged once per visit, for attendances outside of consultation rooms.	This change will allow patients to receive a consistent rebate that does not change depending on the number of patients seen by the GP that day.	

#	Item/ Explanatory note	Change / Requirement	Purpose	Rebate value
10	Items 721, 723, 729, 731, 732	**CDM items should be simplified and reflect patient complexity** CDM items be amended and expanded to reflect patient complexity. Rebates for CDM patients should be based on proposed RACGP risk stratification. *See Appendix 2 for chronic disease management tiers*	To align with best practice CDM	From lowest to highest complexity: CDM A: $80 CDM B: $112 CDM C: $400
11	Explanatory note A36	**CDM should incorporate a holistic view of a patient** Explanatory note A36 notes requirements for CDM items. This explanatory note should be amended to include a statement that requires GPs to complete document all of a patient's comorbidities in a GPMP or TCA.	To support documentation of all of a patient's conditions in their GPMP	
12	Explanatory note A36	**Changes to CDM descriptors should be made to reflect CVC descriptors more closely** Explanatory note A36 notes requirements for CDM items. This explanatory note should be amended to include the CVC checklist. Insert: *The GPMP should contain at least the following information:*	To align with best practice in CDM	

#	Item/ Explanatory note	Change / Requirement	Purpose	Rebate value

		• *a description of all chronic and other health conditions, including:*
		  ○ *current care guide*
		  ○ *targets*
		  ○ *red flags*
		  ○ *background information*
		  ○ *current management*
		  ○ *most recent results*
		• *medications list including dose, frequency and known adherence*
		• *allergies and adverse reactions*
		• *self management goals and strategies*
		• *any family and/or carer contact details*
		• *significant medical events and results*
		• *other treatment providers and their contact details*
		• *referrals planned and reasons for referral*
		• *devices being used.*
		
		The explanatory note should also include the CVC guidelines for a patient friendly version		

14	New item – Community case conference	**Support community case conferences** A new item for case conferences be developed to allow case conferences to be conducted in the community. This service would be for a patient who lives in the community but has a number of chronic and complex problems and arrangements that need to be made with the patient and family member/s or carer/carers in regard to the patient's health and future care needs.	To allow case conferences to be conducted in the community setting	

#	Item/ Explanatory note	Change / Requirement	Purpose	Rebate value
		This would allow the patient to remain living in his/her own home and avoid the need to move to residential care.		
17	New item – health assessment in the home for patients aged 75 years or older	**Develop item for a health assessment in the home for patients aged 75 years or older** A new item should be developed to support a health assessment in the home for patients aged 75 years or older. This item will be an untimed health assessment, separate from the current timed health assessment items.	To support patients 75 years and older to remain safely in their homes.	Proposed: $295.17
18	New item – Comprehensive Medical Assessment and Plan	**Reinstate the Comprehensive Medical Assessment and Plan** A new item should be developed to reinstate the comprehensive medical assessment for residents of RACFs. The comprehensive medical assessment and plan should reflect the descriptor of the discontinued item 712. The Comprehensive Medical Assessment and Plan should: • Allow a practice nurse to contribute to the assessment • Not be dependent on when the last health assessment (701-707) was conducted, and should be undertaken for all patients on their admission to a residential aged care facility and repeated when significant health changes occur	To support patients in residential care.	Proposed: $268.80

#	Item/ Explanatory note	Change / Requirement	Purpose	Rebate value
19	Amend explanatory note A25	**Broaden health assessment items to include categories that support vulnerable children** Health assessment items be broadened to support an annual health assessment for children in out-of-home care, children who have a parent(s) with significant mental health issues and children with parents who undertake intravenous drug use. For children in out-of-home care, the item should reflect that the child should also be entitled to: • an annual health assessment in the year following their 'discharge' from out-of-home care to identify any transitional issues. • an (additional) health assessment in the event that they move a substantial distance from the location where the last health assessment was done. • an annual health assessment until they turn 18 in the event they are in out-of-home care on their 15th birthday - to address the transitional issues that occur for older children leaving care.	To address the specific health needs of vulnerable children.	

RACGP

Appendix 1 - General practice MBS loading
Explanatory note

1. Background

While there has been much discussion among the general practice profession that general practitioner (GP) patient rebates are undervalued when compared to other medical specialists, there is no quantified or established figure.

The purpose of the calculations described in this paper is to demonstrate that there are disparities in MBS scheduled fees for consultation items for GPs and other medical specialists that remain even after the scheduled fee is adjusted for training time. In identifying the gap in rebates, a range of issues are considered, including:

- minimum training time to achieved fellowship in a medical speciality
- time/complexity tiered consultation items compared to single consultation items
- initial consultation items compared to follow-up consultation items.

2. Calculations and findings

Calculations analysing the difference in scheduled fees for services provided by other medical specialists and GPs showed that the disparities remain even after adjusting for training time.

The RACGP has used the calculation to recommend a loading be applied to GP consultation items for the purpose of aligning scheduled fees to the level of the equivalent specialist service.

The calculations outlined in this document were completed for all medical specialist consultation items (ie specialist, consultant physician, neurosurgery, palliative medicine, ophthalmology, public health and psychiatry). Calculations show that, after adjusting for training time, 'specialist' items (MBS items 104/105) are valued at 18.5% higher than general practice items. With the exception of public health, all other medical specialist consultation items were valued even higher. The average difference in fees, after adjusting for training time, across other medical specialists was 43.26%.

Applying the average difference in scheduled fees as a loading (43.26%) would value the GP items higher than the 'specialist' 104/105 items. The RACGP's intention is not to advocate for GP services to be valued at a higher rate than other medical specialists, but rather to ensure GPs services are valued at a fair and comparative level. For this reason, the RACGP considered 'specialist' 104/105 items as the baseline for the loading calculation.

Calculating the average GP and 'specialist' consultation items

A challenge in comparing GP and other medical specialist items is the difference in item structure. While other medical specialists have 2 consultation items for initial attendance and follow-up, there are 4 tiers of consultation items for GPs.

In order to establish a homogeneous value for GP consultation items, the mean value of GP consultation was identified by calculating a weighted value based on billing frequency and value of the item (see table 1 below).

Based on billing frequency, a single figure was calculated to represent an average GP consultation fee and items 104 and105.

Table 1: Average GP consultation item value

Item	MBS scheduled fee	Billing frequency 2015/16	% of total billing	Weighted fee
Level A	$16.95	3,195,479	2.88%	$0.49
Level B	$37.05	90,265,729	81.34%	$30.14
Level C	$71.71	16,080,002	14.50%	$10.40
Level D	$105.55	1,430,482	1.29%	$1.36
Total	-	110,971,692	-	-
Average	**$42.39**	-	-	-

Table 2: Average item 104 and 105 consultation item value

Item	MBS scheduled fee	Billing frequency 2015/16	% of total billing	Weighted fee
104	$85.55	5,106,666	43.34%	$37.07
105	$43.00	6,677,185	56.66%	$24.36
Total	-	11,783,851	-	-
Average	**$61.43**	-	-	-

Calculating the variance in scheduled fee after adjusting for minimum training time

The difference in years of training is often used to justify the difference in Medical Benefits Schedule (MBS) for services provided by GPs compared to patient rebates for services provided by other medical specialists.

To address this argument, the average consultation fee was calculated on a “per training year” basis. The average fee per year of training was determined using the averages calculated for both GP and other medical specialist items, divided by the minimum training years required to bill the item.

Note that *minimum training time* was used given the multiple variations in training times between specialties, and even within specialties.

Table 3: Average consultation fee per year of training

Medical Specialist	Minimum years in training[a]	Average consultation fee	Average fee per year of training
General Practitioners[b]	9 years	$42.39	**$4.71**
Specialists 104/105[c]	11 years	$61.43	**$5.58**

Notes to Table 3:

a. All medical practitioners are required to gain a medical degree which requires university education of at least 5 years.
b. GP minimum training time is based on achieving FRACGP. GPs require the completion of at least one post graduate year before satisfactorily completing a minimum 3-year training program.
c. Specialist minimum training time is sourced from the RACS website. Surgeons require the completion of at least one post graduate year before satisfactorily completing a minimum 5-year training program.

Variance between GP and sub-specialist adjusted fees

Formula	((Specialist fee - GP fee) / GP fee) * 100
Calculation	(($5.58 - $4.71) / $4.71) * 100 = **18.5%**

Formula Key:

/ = Divide

* = Multiply

3. Conclusion

Calculations shows that MBS consultation items for other medical (items 104 or 105) are valued at 18.5% higher than GP MBS consultation items (items 3, 23, 36 or 43).

In light of this, the RACGP recommends that a loading of at least 18.5% be applied to general practice consultation items to bring them to a level equivalent to other medical specialist services.

RACGP

Chronic Disease Management Tiers
Explanatory note

1. *Background*

The RACGP proposes that the model of care coordination for chronic disease management outlined in the *RACGP's Vision for general practice and a sustainable healthcare system* be incorporated into the Medicare Benefits Schedule. The proposed model for coordination of care seeks to redesign the chronic disease management (CDM) MBS item numbers – General Practice Management Plans (GPMPs) – to better target services to patients most in need.

The RACGP's proposed model is based on the Department of Veterans' Affairs' (DVA) Coordinated Veterans' Care (CVC) program

2. *Tiers*

The RACGP's proposed model for chronic disease management				
Model	The RACGP proposes a three-tier system for managing patients with chronic disease			
		CDM A	**CDM B**	**CDM C**
	Target population	Patient who has a chronic disease requiring little or no structured care	Patient who has a chronic disease requiring multidisciplinary team care	Patient who has a chronic disease and is at high risk of hospitalisation, or a patient who requires palliative care
	Level of care	As per current GPMP	As per current GPMP	Current GPMP, combined with ongoing intensive care coordination based on Department of Veteran's Affairs Coordinated Veterans' Care program
	GPMP prepared or updated	If clinically indicated (exclusion criteria would apply)	Yes	Yes
	Team care arrangements (TCA)	No	Part of GPMP	Part of GPMP
	Allied health visits	Up to three	Up to five	Five plus five (extra five after additional GP review, if required)
	Patient rebates	Up to $160 annually	Up to $448 annually	Up to $1200 annually

		$80 for preparation of a management plan $80 for mid-cycle review of management plan	$112 for preparation of management plan $112 per quarterly review, up to 3 reviews per year	$400 on preparation of management plan $400 per quarterly review, up to 3 reviews per year
	Model	Current practices for GPMP, with amendments recommended by RACGP	Current practice for GPMP, with amendments recommended by RACGP, incorporating simplified TCA	Modelled on DVA's CVC program
Payment Schedule	Proposed payment schedule across three tiers of CDM items			
		CDM A	**CDM B**	**CDM C**
	MBS rebates for ongoing care provided by GP	Yes	Yes	Yes
	MBS rebate for preparation of GPMP by GP	Yes	Yes	Yes
	Support payments for coordination of care by GP or delegate	No	No	Yes
Roles and responsibilities	**GP's role** • Determination of eligibility for CDM item and suitable tier • Preparation of GPMP • Review of GPMP • Review of allied health service provision and determination of need for additional appointments (CDM C only) **Practice's role** • Employment and support for general practice nurse to undertake coordination and integration activities			