RACGP response:

Consultation for Modernising gap-only billing and the 90-Day Pay Doctor via Cheque (PDVC) scheme

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RACGP

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1. Executive Summary

The Royal Australian College of General Practitioners (RACGP) has consistently advocated for the complete retirement of the outdated Pay Doctor via Cheque (PDVC) scheme since 2022 due to its negative impacts on patient access and general practice viability. This paper has been prepared in response to the Australian Government's public consultation on modernising gap-only billing and phasing out the 90-day PDVC scheme.

The RACGP supports replacing cheque-based Medicare payments with digital claiming and supports gap-only billing in principle as a mechanism to reduce upfront patient costs.

However, the proposed model retains the central structural flaw of the PDVC scheme - a reimbursement delay of up to 90 days - which is financially unviable for general practices and will limit provider participation. The RACGP has undertaken a Regulatory Burden Measurement (RBM) for the PDVC Scheme in its proposed form, with the indicative burden being approximately $3.9 million per year.

Without legislative reform to enable providers to be the legal payees under a gap-only model, the proposed arrangements will not achieve their intended objectives.

2. RACGP recommendations

The RACGP's preferred outcome is reform that enables real-time or near real-time Electronic Funds Transfer (EFT) reimbursement to providers, consistent with bulk billing arrangements, or at minimum a substantially reduced reimbursement timeframe (e.g., within 30 days).

To support the successful transition to a viable gap-only billing model, as recommended by the RACGP recommends the following changes:

- Amend Sections 20 and 20A of the *Health Insurance Act 1973 (Cth)* (the Act) to enable providers to be the legal payees of Medicare rebates for privately billed services under a gap-only model, allowing real-time or near-real-time EFT reimbursement comparable to bulk-billing arrangements.
- Create a new billing class under the Act to define and support gap-only arrangements.
- Align claim processing for privately billed services with real-time or near real-time payment standards or alternatively establish a substantially reduced reimbursement timeframe (e.g. within 30 days) to ensure gap-only billing is financially viable for providers.
- Ensure compliance with modern digital infrastructure standards.

Further recommendations from the RACGP include:

- Provide clear implementation guidance and adequate transition timeframes ahead of any reforms, including support for practices to communicate changes to patients.
- Monitor provider uptake, patient access impacts, and unintended consequences of the model on an ongoing basis, including within general practice settings.

Without these changes, the model is unlikely to achieve its intended objectives and the RACGP cannot support the model in its current form.

3. Background and general feedback

3.1 Overview of the government's proposal

In December 2025, DoHDA released a consultation paper proposing the replacement of the PDVC scheme with a new 'gap-only billing' model. The reform includes the removal of cheque-based Medicare payments and introduces EFT claiming by providers on behalf of patients.

However, under this model, the Medicare benefit would still be paid up to 90 days after the claim is submitted, replicating the existing PDVC delay. The new arrangement would only apply to Medicare Benefits Schedule (MBS) services with a schedule fee above the $697 threshold. The patient would pay the 'gap' component at the time of service, while the provider would be reimbursed the rebate amount via EFT after 90 days.

This legal framework precludes the provider from receiving direct, immediate payment in a way that is comparable to bulk billing. The RACGP has undertaken a RBM which models the administrative burden for the reconciliation process for each affected transaction. The calculated GP share cost for the PDVC in its proposed form is $3.9 million per year.

While the move to digital claiming is welcome, RACGP considers the continuation of the 90-day payment delay to be a critical failure of the proposed model.

3.2 Findings from the 2025 Impact Analysis

The DoHDA's 2025 *Impact Analysis* offers important context about the scale and structure of the PDVC scheme. It confirms that although PDVC usage represents a relatively small proportion of all Medicare claims, it plays a significant role for certain patient groups – particularly those holding concession cards – and for services with high up-front costs, such as procedures.

PDVC system usage and cost

According to the Impact Analysis, approximately 1.3 million PDVC claims are submitted annually, with Medicare rebates totalling $186 million. Despite efforts to modernise claiming processes, the system still issues around 870,000 cheques each year. This represents a significant administrative and operational cost for government and providers.

Use by vulnerable patients

The analysis shows that 37% of PDVC claims involve concession card holders, highlighting the scheme's importance for vulnerable patients. While the proposed model maintains a reduced upfront cost for patients, it places the financial risk on providers, who must wait up to 90 days for reimbursement. This delay threatens the viability of practices that care for high-need populations, potentially forcing them to charge full private fees upfront or withdraw from the model – ultimately reducing access for those who need support most.

Provider participation

The same analysis highlights that fewer than 20% of providers participate in the PDVC scheme, with just 2.5% of all Medicare patients accessing it. This low level of participation is consistent with contemporary general practice experience. A *newsGP* poll conducted between 19–26 January 2026 (n=720) found that only 4% of respondents reported ever using the PDVC cheque system, while 80% reported that they do not use it and 15% were unsure.

Estimated administrative efficiencies

The government estimates that replacing cheques with EFT will generate administrative savings of $3.7 million per year for providers, and $8 million for patients. The RACGP supports these efficiency gains, but notes they depend on provider uptake – which is unlikely unless payment timelines are shortened.

3.3 Implications for general practice

General practices rely on predictable, timely payments to manage payroll, rent, consumables, and operating costs. They typically operate on tight cash flows and cannot fund services for extended period while awaiting Medicare rebates. Bulk billing claims are typically reimbursed within 1–3 business days via Health Professional Online Services (HPOS). A model that introduces a 90-day delay, even in digital form, significantly alters the risk profile for practices – especially when claiming for services with a schedule fee above $697.

GPs working in rural or remote settings, or with advanced procedural interests, delayed reimbursement presents a significant financial burden, especially when servicing vulnerable or concession-card-holding patients.

Such a delay could:

- discourage practices/ providers from participating
- lead to practices charging full up-front private fees instead
- erode the viability of mixed billing
- reduce access for low-income and rural patients

- increase patient diversion to public hospitals or specialist outpatient services, shifting care from cost-effective primary care settings to higher-cost state and federally funded hospital systems.

This cost transfer risk is likely to increase overall health expenditure. Primary care is widely recognised as the most cost-effective setting for many procedural and diagnostic services. Where delayed reimbursement renders these services unviable in general practice, the resulting shift to hospital-based care is likely to increase costs to both Commonwealth and state governments.

If the government's policy objective is to preserve incentives for bulk billing through differential payment timing, the RACGP notes that a 90-day delay is commercially unworkable for most general practices. A materially shorter reimbursement period - such as 30 days - may represent a pragmatic balance between maintaining bulk billing incentives and ensuring that gap-only billing remains a viable affordability mechanism in situations where universal bulk billing is not sustainable.

3.4 Legislative reform to address barriers to real-time EFT

Medicare's technical systems can process real-time EFT payments, as is already done for bulk billing. The barrier to enabling this under gap-only billing is the *Health Insurance Act 1973*In the absence of bulk billing, there is no mechanism for the provider to become the legal recipient of the rebate in a private billing context.

While the rebate legally belongs to the patient and is assigned to the provider under bulk billing arrangements, no such mechanism currently exists for gap-only services.

4. RACGP consultation question responses

The following section provides formal responses from the RACGP to the specific consultation questions and should be read in conjunction with the comments above.

4.1 To what extent are gap-only billing arrangements for high-cost services necessary to support patients who cannot afford the full fee at the time of service?

Gap-only billing can play an important role in improving affordability for patients who face significant out-of-pocket costs, especially for services with high Medicare fees. These arrangements help reduce upfront costs, providing a deferred payment structure where patients only pay the 'gap' between the full fee and the Medicare patient rebate.

However, the viability of these arrangements is dependent on provider participation – which in turn is reliant on timely reimbursement. Under the proposed model, the 90-day delay remains a substantial deterrent

According to DoHDA's 2025 *Impact Analysis*, 37% of PDVC claims are made by concession card holders, showing that the current model is heavily relied upon by vulnerable Australians. If these patients are unable to access a viable alternative, affordability and access to timely care will suffer.

4.2 Does the impact analysis accurately reflect the impact of gap-only billing, including the saving in administrative time estimated in section 4.3?

The *Impact Analysis* provides helpful insights into the scope and cost of the PDVC scheme, as well as projected savings.

However, the analysis fails to account for critical issues:

- Provider type is not disaggregated, meaning impacts on GPs are not distinguished from those on non-GP specialists or allied health professionals.
- Assumptions about uptake are optimistic. The analysis assumes current usage rates will continue or expand under the new model, despite retaining the 90-day payment delay.
- Financial impact on practices is under-analysed. Practices must absorb the cost of delayed reimbursement – a significant burden for small or rural clinics.

The potential savings will only materialise if providers adopt the model, which is unlikely under the proposed design.

4.3 Gap-only billing is proposed for services with an MBS fee over $697. What is the effect of this threshold? How can fee inflation and bulk billing rates be protected?

The $697 threshold is intended to restrict the model to high-cost services where affordability barriers are most pronounced. In theory, this helps prevent fee inflation and preserves high bulk billing rates for low- and mid-cost services.

However, the threshold may inadvertently exclude common services in general practice that still impose significant costs on patients — such as long consultations (e.g. items 36, 44 and 123).

If the threshold is lowered in future iterations, the RACGP recommends the following protections:

- Ensuring MBS indexation is aligned with practice cost increases.
- Publishing transparent out-of-pocket cost data to monitor inflation.
- Implementing appropriate safeguards to monitor unreasonably high out-of-pocket expenses.
    - Encouraging continued bulk billing for concessional patients where feasible for practices.
- The threshold should be regularly reviewed with input from primary care stakeholders to ensure it supports patient access without incentivising inflation.

4.4 What is the effect of the 90-day delay? What alternatives could mitigate this?

The 90-day payment delay is the single greatest flaw in the proposed model. For general practices, which rely on consistent cash flow, this delay presents a severe risk to financial sustainability. It disincentivises participation and reduces access to affordable services for patients.

A 90-day delay materially increases working capital exposure and, in effect, requires practices to absorb financing costs that would not be acceptable in other small business sectors.

With interest rates and commercial lending costs elevated compared to when the PDVC scheme was originally designed, the opportunity cost of delayed reimbursement is significantly greater in the current economic environment.

Key risks include:

- providers refusing to use the scheme altogether
- practices asking patients to pay full fees upfront
- administrative complexity in reconciling delayed claims
- reduced access in rural or under-resourced communities
- patients being diverted to public hospitals or alternative care settings due to affordability barriers when services cannot be offered viably under the delayed payment model.

The preferred solution is enabling real-time or near-real-time EFT to providers - as currently occurs under bulk billing arrangements.

However, this requires legislative change. Under the *Health Insurance Act 1973 (Cth)*:

- section 20 assigns Medicare rebates to the patient
- section 20A allows assignment of a patient's Medicare rebate to a provider as full payment for a bulk billed service.

Thus, Services Australia cannot lawfully process EFT payment to the provider under the proposed model. The RACGP strongly recommends amending these sections to facilitate modern reimbursement methods.

4.4.1 How will the removal of cheques from the Child Dental Benefits Scheme (CDBS) affect patients?

The CDBS is not relevant to general practice therefore no response has been provided.

4.5 Do you foresee any unintended consequences of the proposed gap-only billing arrangements?

Yes. Several risks are likely if the current proposal proceeds without modification:

- Low provider uptake due to unviable 90-day delay.
- Increased upfront charges for patients as practices reject these arrangements.
- Withdrawal from gap-only billing in rural or underfunded practices.
- Potential widening of the digital divide if software and access issues are not addressed.

If implemented without reform, the model may worsen equity outcomes rather than improve them.

4.6 Other feedback

The RACGP supports:

- the abolition of cheques
- the transition to digital systems
- a move toward more equitable billing models.

However, the proposal must be operationally viable.