Strengthening MyMedicare Updates

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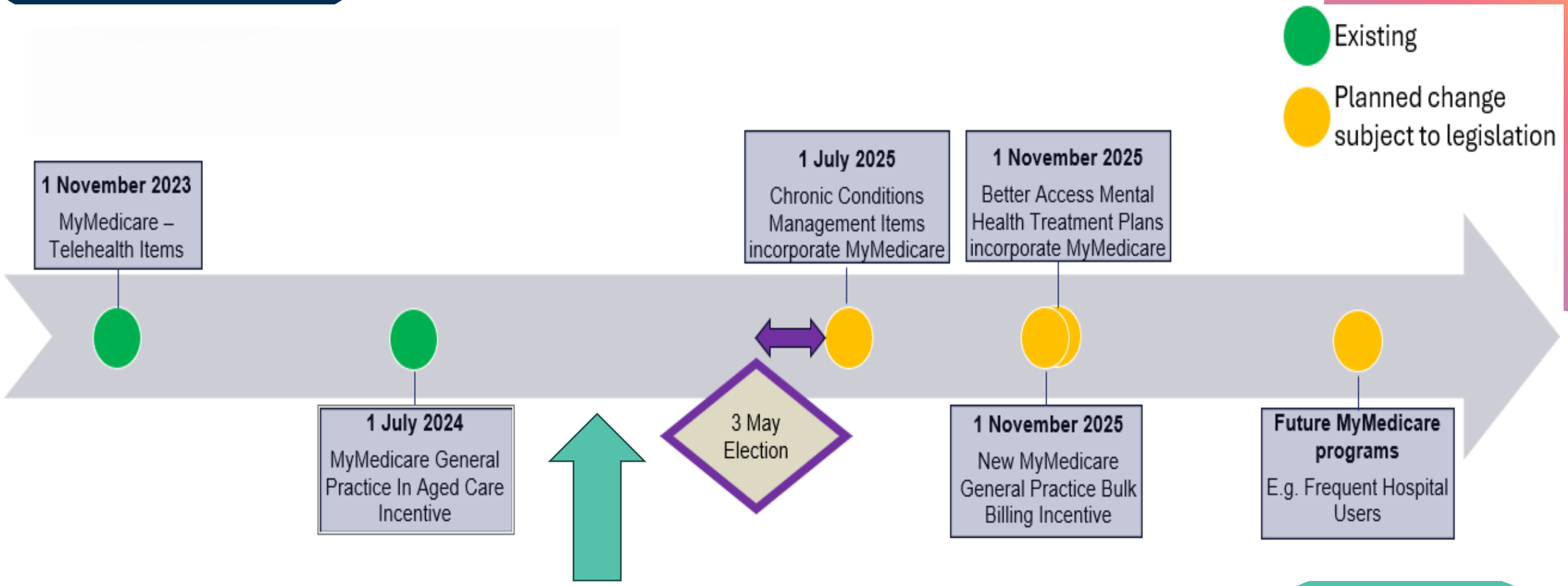
Australian Government
Eastern Melbourne PHN is primarily funded by the Australian Government through the Department of Health and Aged Care

- General update on MyMedicare programs coming in 2025
- General Practice in Aged Care Incentive QI Toolkit
- General Practice in Aged Care incentive Coordination Toolkit
- Chronic Condition Management Activation Series

MyMedicare Timeline



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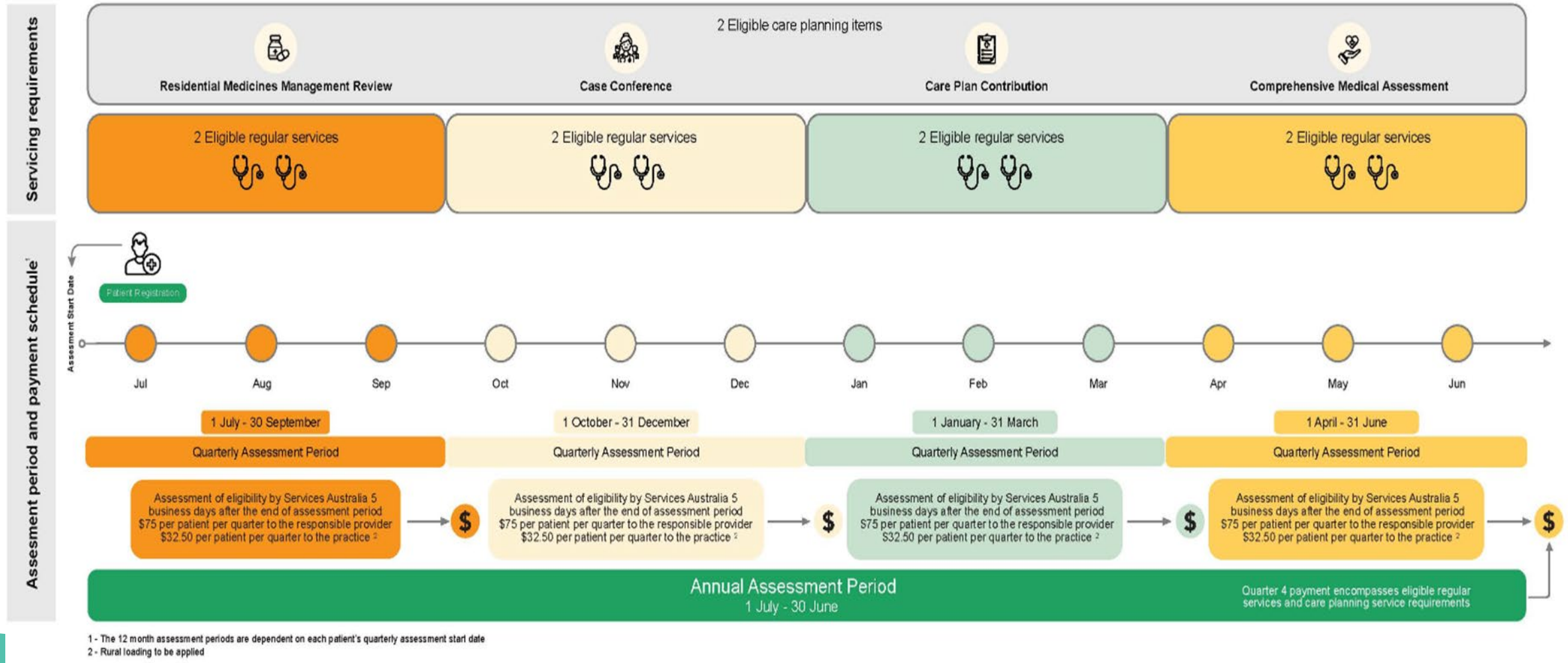
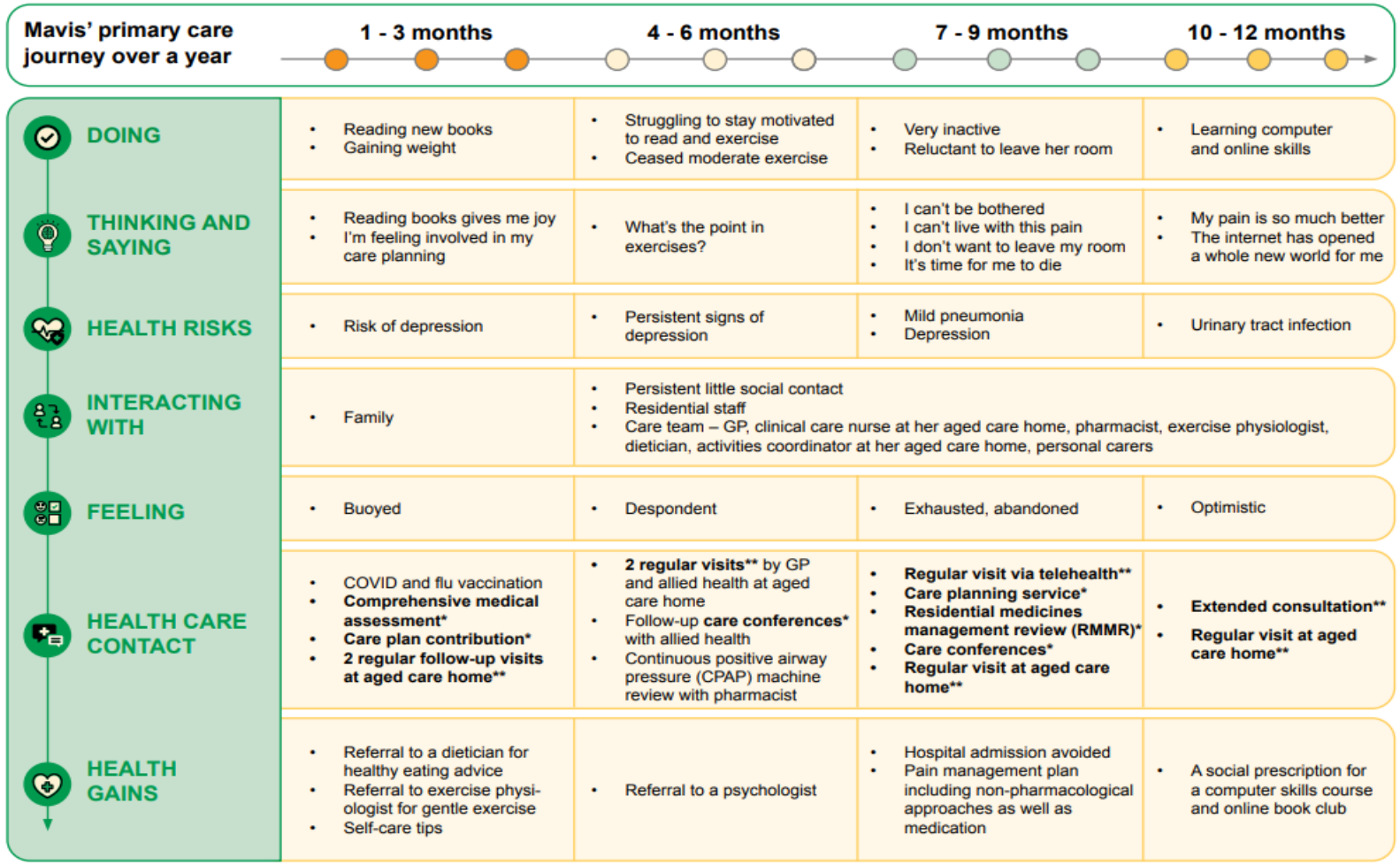
General Practice in Aged Care Incentive (GPACI) Payment Structure



1 - The 12 month assessment periods are dependent on each patient's quarterly assessment start date
2 - Rural loading to be applied

General Practice in Aged Care Incentive (GPACI)

Mavis' 12-month journey



Mavis' primary care journey over a year	1 - 3 months	4 - 6 months	7 - 9 months	10 - 12 months
DOING	• Reading new books • Gaining weight	• Struggling to stay motivated to read and exercise • Ceased moderate exercise	• Very inactive • Reluctant to leave her room	• Learning computer and online skills
THINKING AND SAYING	• Reading books gives me joy • I'm feeling involved in my care planning	• What's the point in exercises?	• I can't be bothered • I can't live with this pain • I don't want to leave my room • It's time for me to die	• My pain is so much better • The internet has opened a whole new world for me
HEALTH RISKS	• Risk of depression	• Persistent signs of depression	• Mild pneumonia • Depression	• Urinary tract infection
INTERACTING WITH	• Family	• Persistent little social contact • Residential staff • Care team – GP, clinical care nurse at her aged care home, pharmacist, exercise physiologist, dietician, activities coordinator at her aged care home, personal carers		
FEELING	• Buoyed	• Despondent	• Exhausted, abandoned	• Optimistic
HEALTH CARE CONTACT	• COVID and flu vaccination • **Comprehensive medical assessment*** • **Care plan contribution*** • **2 regular follow-up visits at aged care home****	• **2 regular visits**** by GP and allied health at aged care home • Follow-up **care conferences*** with allied health • Continuous positive airway pressure (CPAP) machine review with pharmacist	• **Regular visit via telehealth**** • **Care planning service*** • **Residential medicines management review (RMMR)*** • **Care conferences*** • **Regular visit at aged care home****	• **Extended consultation**** • **Regular visit at aged care home****
HEALTH GAINS	• Referral to a dietician for healthy eating advice • Referral to exercise physiologist for gentle exercise • Self-care tips	• Referral to a psychologist	• Hospital admission avoided • Pain management plan including non-pharmacological approaches as well as medication	• A social prescription for a computer skills course and online book club

* Service is an example of the care planning services that could contribute to the yearly requirements under the incentive (2 in total per year)
** Service is an illustration of how the 8 consultations required per year under the incentive can be deployed

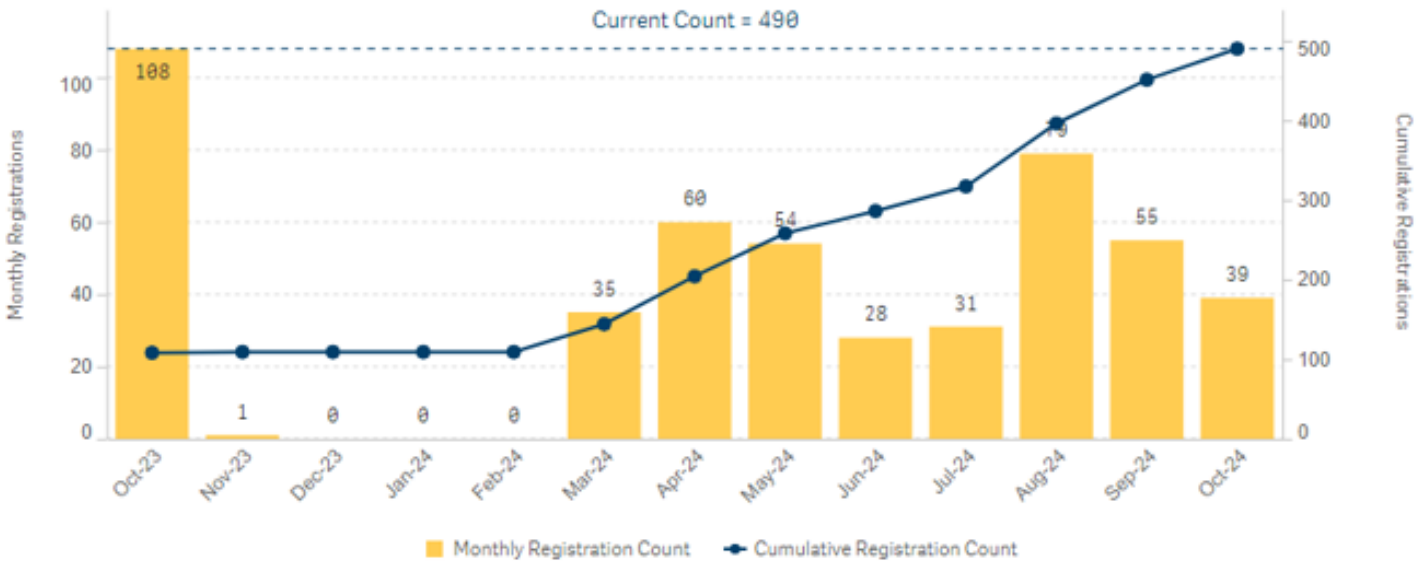
General Practice in Aged Care Incentive

EMPHN Practice Report Page 7

MyMedicare Registrations

Registration Rate: 4% (490 of 11,534 patients)

Percentage of Clinic Active & RACGP Active patients who are registered for MyMedicare. (PHN Top 10% Avg Registration Rate: 4%)



How can you use this information to increase MyMedicare Registrations at your practice?

For example you may focus on percentage registration rate when discussing this with your team.

My Health Record - Shared Health Summary (SHS) Patient Uploads

Provider	This Quarter (0)	Last Quarter (139)
Dr Dolittle	0	17
Indiana Jones	0	16
Desmond Tutu	0	15
Dr Doogie Howser	0	15
Dr Richard Kimble	0	15
Dr Strange	0	15
Dr Who	0	14
Valentino Rossi	0	14

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MBS User Guide

- A resource to support General practices to plan their delivery of care for the GPACI
- Demonstrates the potential use of MBS items related to the GPACI and provides some examples

GPACI MBS User Guide

National MyMedicare PHN Implementation Program

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GPACI RACH Visits - Sample Schedule - RESPONSIBLE PROVIDER + OTHER CARE TEAM MEMBERS

Other GP / Prescribed medical practitioner / Nurse practitioner/ Practice Nurse/ Aboriginal &/or Torres Strait Islander Health Practitioner

Quarter 1	Quarter 2	Quarter 3	Quarter 4
Contribution or review of Multidisciplinary Care Plan MBS 731 suggested to be co-claimed with: MBS 232 - Contribution to or review of Multidisciplinary Care Plan	**Comprehensive Management Assessment** MBS 703-707 OR MBS 224-227 Comprehensive Management Plan (CMA) - Health Assessment item ***Item choice depend on length of assessment and type of practitioner***	**Residential Medication Management Review** MBS 903 OR MBS249 ***Item choice depends on practitioner type***	**Case Conference** MBS 235-240 OR MBS 735-758 Multidisciplinary Care Conference ***Item choice depend on length of conference and type of practitioner***

Across the 12-month period must provide 2 of the above Eligible Care Planning Items

These can be claimed at any point across the 12-months. Claiming MBS 731 early in the cycle (Q1) enables other MBS items and referrals. MBS 731 can be co-claimed with other items.

Quarter 1	Quarter 2	Quarter 3	Quarter 4
2x Eligible Regular Services 1x Responsible Provider + 1x Alternative Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215 OR Non-urgent after-hours item **OR** MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner on a patient who has a Care Plan	2x Eligible Regular Services 1x Responsible Provider + 1x Alternative Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215 OR Non-urgent after-hours item **OR** MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner on a patient who has a Care Plan	2x Eligible Regular Services 1x Responsible Provider + 1x Alternative Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215 OR Non-urgent after-hours item **OR** MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner on a patient who has a Care Plan	2x Eligible Regular Services 1x Responsible Provider + 1x Alternative Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215 OR Non-urgent after-hours item **OR** MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner on a patient who has a Care Plan

NOTE: Completing 2 Regular Visits with your patient per quarter triggers the incentive payment to both the Responsible Practitioner and the Practice. Payments will not be triggered if the two visits are not completed within the quarter in two separate calendar months. Triple bulk billing applies with eligible patients.
Also note, the **RESPONSIBLE PROVIDER must complete 4 of the eligible regular services** 1 per quarter across the 12-months, another GP or Nurse Practitioner can provide the other regular visits. **MBS731 MUST** have been billed before the follow up items can be completed by a Practice Nurse or Aboriginal &/or Torres Strait Islander Health Practitioner.

5

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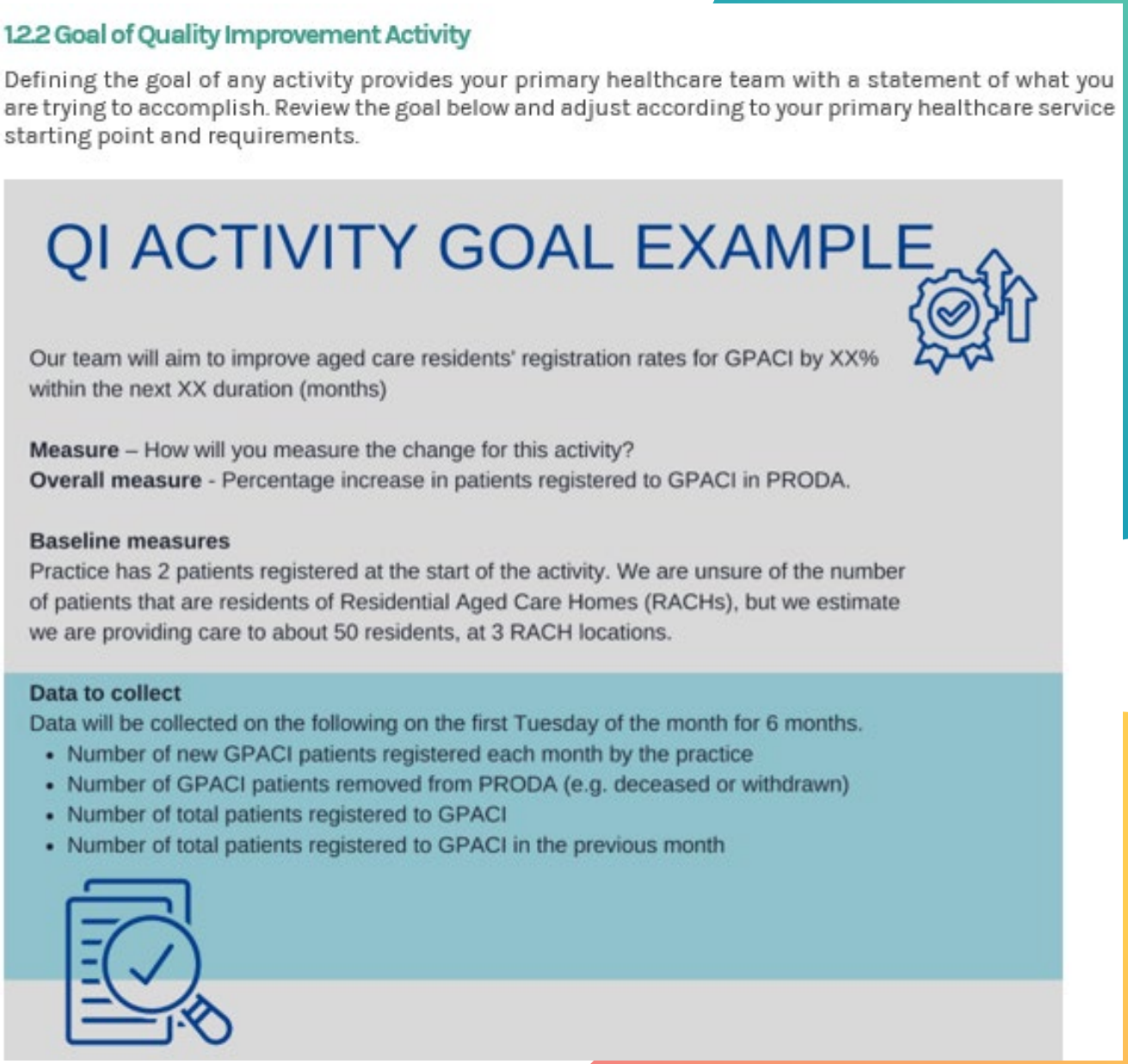
GPACI User Guide

GPACI QI Toolkit

The toolkit outlines key steps for MyMedicare registration, care planning, coordination with multidisciplinary teams, and accessing incentive payments.

You can utilise the toolkit to streamline workflows, access resources and implement continuous QI activities, ultimately fostering a patient centred approach in aged care settings.



1.2.2 Goal of Quality Improvement Activity

Defining the goal of any activity provides your primary healthcare team with a statement of what you are trying to accomplish. Review the goal below and adjust according to your primary healthcare service starting point and requirements.

QI ACTIVITY GOAL EXAMPLE

Our team will aim to improve aged care residents' registration rates for GPACI by XX% within the next XX duration (months)

Measure – How will you measure the change for this activity?
Overall measure - Percentage increase in patients registered to GPACI in PRODA.

Baseline measures
Practice has 2 patients registered at the start of the activity. We are unsure of the number of patients that are residents of Residential Aged Care Homes (RACHs), but we estimate we are providing care to about 50 residents, at 3 RACH locations.

Data to collect
Data will be collected on the following on the first Tuesday of the month for 6 months.

- Number of new GPACI patients registered each month by the practice
- Number of GPACI patients removed from PRODA (e.g. deceased or withdrawn)
- Number of total patients registered to GPACI
- Number of total patients registered to GPACI in the previous month

GPACI-QI-Toolkit

Primary Care – RACH Coordination Toolkit

- Provides tools and tips for improving coordination between Residential Aged Care Homes (RACHs) and General Practices.
- Includes templates such as:
  - Orientation information for General Practitioners
  - Primary Care and RACH Collaboration Checklist and Action Plan

The Partnership Continuum

The partnership continuum can help RACHs and care providers to reflect on the **level of engagement** among the care team. This can also be considered as a measure of the 'health' or **maturity of the partnership**.

Progressively moving towards an integrated partnership is encouraged. Tools contained in this resource have been designed to support better integration and collaboration among the care team. GPs and RACHs are encouraged to use tools including the orientation toolkit (appendix 1) and the collaboration action plan (appendix 2) to improve coordination of care elements including visiting arrangements, immunisation processes and areas of clinical governance.

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Chronic Conditions Management (CCM) – change activities

To help your practice prepare for the transition to CCM with small, manageable changes EMPHN invites your practice to participate in our CCM activation series.

Two activities have been released so far, with the third coming soon.

A CCM QI Toolkit is under development and is planned to be released in July 2025 after the changes have come into effect.

Chronic disease management - EMPHN

Activity 1 – New year CCM resolutions

As the new year rolls around, many of your existing patients with chronic disease management plans will be due for a new chronic disease management plan and team care arrangements. Patients and practices often time chronic disease management plans with the start of the calendar year, when allied health items available through team care renew (items 10950 to 10970 and 81100 to 81125).

The following activities focus firstly on strengthening patient-practice relationships by registering Chronic Disease Management Patients for MyMedicare, and routine scheduling of patients for Chronic Disease Management Reviews.

There are a range of ideas outlined below for you to use to tailor and modify to develop your own plan for change at your practice. We suggest you document your plan for each Activity Idea below using a Plan-Do-Study-Act Template. Ensure responsibility for each activity is allocated to a member of your practice team with a timeline for completion.

- **1. Register all returning Chronic Disease Management Patients for MyMedicare with your practice prior to, or at their next Chronic Disease Management appointment**
- **2. Review and strengthen your process for booking review appointments for any patient you put onto a Chronic Conditions Management Plan, or with an existing Chronic Disease Management Plan**
- **3. Review and strengthen communication for why review appointments are important to attend for your practice team and patients (including if there are out of pocket costs for the patient)**
- **4. Review and strengthen your process to manage missed or cancelled patient review appointments**

Activity 2 – Planning with your practice team

This activity aims to raise awareness among your practice team of MyMedicare, Chronic Conditions Management changes, and support your team to explore their roles in both MyMedicare and Chronic Conditions Management. By exploring and defining these roles, your practice team can work collaboratively to prepare for change and develop processes, systems and skills needed to succeed. This process will help ease your team through change and provide a shared document that can help your team to identify and discuss anything that isn't quite working as planned, explore changes and update the document to keep everyone on the same page. This approach will allow your team to adapt and improve and empower each team member in their own role.

There are a range of ideas outlined below for you to use to tailor and modify to develop your own plan for change at your practice. We suggest you document your plan for each Activity Idea below using a Plan-Do-Study-Act Template. Ensure responsibility for each activity is allocated to a member of your practice team with a timeline for completion.

- **1. Your practice team has a better understanding of MyMedicare (Voluntary Patient Registration)**
- **2. Your practice team has a better understanding of the proposed Chronic Conditions Management changes**
- **3. Your practice team roles in MyMedicare and Chronic Conditions Management are well defined, and each team member has a clear role and responsibilities**

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What's coming November 2025?

Bulk billing incentive changes

GPs will be able to claim the bulk billing incentive items when they bulk bill **any** Medicare-eligible patient.

Bulk Billing Practice Incentive Payment (PIP)

Practices participating in the Program will receive an additional 12.5% loading split between the GP and the practice.

Better Access Initiative changes

A planned linkage between MyMedicare and the Better Access Mental Health Program.

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Resources

EMPHN

- MyMedicare
- GPACI
- GPACI User Guide
- GPACI-QI-Toolkit
- Chronic disease management - EMPHN

MyMedicare

- https://www.health.gov.au/our-work/mymedicare
- MyMedicare Program Guidelines

GPACI

- General Practice in Aged Care Incentive
- General Practice in Aged Care Incentive Guidelines
- General Practice in Aged Care Incentive - patient journeys

Resources

CCM Changes	➢ Upcoming changes to MBS Chronic Disease Management Arrangements
Bulk Billing Changes	➢ Upcoming Changes to Bulk Billing Incentives in General Practice
Better Access Changes	➢ Item 80110 | Medicare Benefits Schedule – see explanatory note ‘Better Access redesign from 1 November 2025’
Services Australia	➢ MyMedicare - eLearning - Health Professional Education Resources

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