FACTSHEET: PAYMENT INFORMATION

The Health Care Homes model introduces a bundled payment approach to support the health care needs of people with complex and chronic conditions. The approach moves away from traditional fee-for-service arrangements, which can be limiting where more complex and ongoing care is required.

A bundled payment to the practice enables flexibility in how Health Care Home services are delivered. This approach encourages practice level innovation — broadening the use of technology and the roles of the workforce in the services a Health Care Home offers.

Payment arrangements

Health Care Homes register each enrolled patient through the Department of Human Services' Health Professionals Online Services (HPOS) system. Monthly payments are made to the practice on a retrospective periodic basis, which allows for regular patient review and, if appropriate, adjustment of the patient's tier level.

Payment levels

To support participation in Health Care Homes, a one-off grant of $10,000 was paid to general practices and Aboriginal Community Controlled Health Services participating in the Program.

There are three levels of payment linked to each eligible patient's level of complexity and need, with the highest amount paid for the most complex and high-need patients.

As at 1 July 2019, payment levels for the three tiers increased in line with, and at the same time as, MBS indexation. The three payment tiers, in the form of a bundled monthly payment, are linked to each eligible patient's level of complexity and need. The Tier payments from 1 July 2020 are:

Payment Tier	Payment Value
Tier 3 — the highest level of patient complexity	$1,851 per annum
Tier 2 — increasing level of patient complexity	$1,306 per annum
Tier 1 — the lowest level of patient complexity	$609 per annum

Services included

The core principle of the Health Care Homes model is that all primary care services provided by the Health Care Home associated with managing the patient's chronic and complex conditions are funded through the bundled payment. The treating health professional should use their clinical judgement to determine if an episode of care is related to a patient's complex and chronic condition.

Based on clinical advice it is expected that for the vast majority of patients the number of fee-for-service episodes of care, in addition to the bundled payment, will be small. The number of fee-for-service episodes of care will not be capped or restricted, and will be monitored throughout the Program.

Practitioners would access fee-for-service MBS arrangements for care needs that are unrelated to an enrolled patient's chronic conditions. This will also enable patients to visit different practices, for example when travelling.

Generally, it would be expected to see a decline in claiming of most MBS items for enrolled patients. This is especially the case for the chronic disease related MBS items under the following Groups:

- Group A14- Health Assessments
- Group A15- GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans
- Group A18- General Practitioner Attendance Associated With Pip Incentive Payments
- Group A20- GP Mental Health Treatment
- Group M12- Services Provided By A Practice Nurse Or Aboriginal And Torres Strait Islander Health Practitioner On Behalf Of A Medical Practitioner

After hours services

Health Care Homes bundled payments are intended to cover after hours services where they are provided in the practice rooms. After hours services provided outside of the practice rooms can be billed to the MBS.

Bulk billing and patient contributions

Many patients with chronic and complex conditions are bulk billed for primary healthcare services. Health Care Homes are strongly encouraged to continue to bulk bill enrolled patients. However consistent with current approaches in many practices, enrolled patients are able to contribute towards their healthcare costs. The determination and management of patient contributions will be up to each Health Care Home and must be agreed with the patient at the time of enrolment.

Allied health, specialist, diagnostic and imaging services

Funding for services provided by allied health professionals and specialists as well as for diagnostic and imaging services are not included in the bundled payment, and will continue to be funded through the MBS.

Access to MBS funded allied health services that are currently triggered by a GP Management Plan or, where relevant, a Health Assessment for Aboriginal and Torres Strait Islander People or a GP Mental Health Treatment Plan, will be triggered by Health Care Home enrolment. However, these allied health services will continue to be funded through the MBS, and are not part of the bundled payment.