

MBS Review Advisory
Committee

**Review of
MBS-referred
chronic condition
management
services**

***Draft
Report***

October 2026

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Summary

Medicare Benefits Schedule (MBS) items for referred chronic condition management (CCM) services were introduced on 1 July 2004 for individual services and 1 May 2007 for group services. Since their introduction, an ageing and growing population with longer life expectancy has increased the impact of chronic conditions and caused more demand for services to support those living with chronic conditions. Over time, patients, providers and stakeholders have raised several concerns regarding the MBS items, including the service caps per patient per year, exclusion of some health professionals, the fee structure and a need for a longer initial CCM assessment service.

Following a review of the items in 2019, the MBS Review Taskforce's report on primary care called for further research to determine whether the items were adequately supporting the management of chronic conditions. In October 2024, the CCM Working Group – a subgroup of the MBS Review Advisory Committee (MRAC) – was established to advise the MRAC on the review. The review questions were:

1. What should the calendar year limit be for individual chronic condition management services?
2. Should the existing individual chronic condition management service 'floor' of 20 minutes be increased? If so, what is an appropriate 'floor' and should this vary (for example, longer initial consult or time-tiering)?
3. Should the existing condition-specific restriction on group services be expanded beyond type 2 diabetes? If so, which conditions would benefit from group services, and which of the existing eligible individual health provider services are appropriate for group settings?
4. Should the list of eligible individual health providers be expanded? If so, which health professions should be added?

The review was informed by an umbrella review of existing evidence, as well as department-commissioned quantitative and qualitative research. Targeted consultation feedback also informed the recommendations.

Individual services

It was clear from the evidence that a cap of 5 individual CCM services per calendar year was insufficient for most patients' needs. Patients who can only participate in a low number of services rarely experience meaningful improvements in their condition, leaving them dissatisfied with their treatment. The current cap is especially difficult for people with a complex chronic condition or several conditions (called multimorbidity) who need care from multiple CCM health professions, as they must split the 5 services between professions or prioritise one type of treatment over others. Considering the research findings and what would likely be implementable by Government, the CCM Working Group considered that the cap should be increased to 12 sessions per patient per year, with a corresponding increase from 10 to 17 sessions per patient per year for Aboriginal and Torres Strait Islander patients. This is an improvement on what is currently available, especially if used with group services.

The research also showed that most eligible professions typically provide an individual CCM health session lasting between 40 and 60 minutes, while initial consultations typically last up to 60 minutes. Both of these exceed the current MBS item 'floor' of 20 minutes, and the discrepancy between the current 'floor' and typical session lengths generally results in a gap fee that is either paid by patients or absorbed by providers.

Similarly, the research and clinical practice support time-tiering separated into 20-, 40- and 60-minute tiers, which would cover initial and subsequent consultations.

Group services

MBS CCM group services are currently only available for people who have been diagnosed with type 2 diabetes. Noting that group services have the potential to improve access to evidence-based care for people living with other chronic conditions, the CCM Working Group considered that access should be expanded to chronic conditions beyond type 2 diabetes.

Currently, only exercise physiologists, dietitians and diabetes educators are eligible to render MBS group CCM services. There is a lack of evidence supporting the use of group therapy for all referred CCM health professions, but the strongest available evidence supports its use by Aboriginal and Torres Strait Islander health workers and practitioners, accredited mental health social workers, chiropractors, occupational therapists, osteopaths, physiotherapists, psychologists and speech pathologists (in addition to the 3 professions that can already render group CCM services).

Comparative models (such as that used by the Department of Veterans' Affairs) and findings from the umbrella review and qualitative research suggest that the current cap of 8 group sessions per patient per year is insufficient, with 12 sessions per year being a pragmatic minimum. When combined with the recommended increase to the cap for the number of individual services, the total number of MBS-referred CCM services available to patients each year (24 for non-First Nations patients and 29 for First Nations patients) will be more in line with the typical midpoint number required for many of the chronic conditions considered in this review.

Evidence suggests that some eligible health professions require a longer baseline assessment than the minimum of 45 minutes for the current MBS assessment item. Replacing the existing 45-minute service with time-tiered assessment items of at least 40 minutes and at least 60 minutes (with proportional MBS benefits) would be more appropriate.

Evidence also suggests that it is generally impractical to undertake an assessment of an individual patient's progress within the final group session, given the time constraints and the competing clinical demands of delivering care to the group. This assessment is required to measure a patient's clinical outcomes, functional improvement and goal attainment, which the referred health professional must report back to the referring medical practitioner. It also allows the health professional to educate the patient and support them with self-managing their condition. It would therefore be appropriate to introduce post-group assessment items, time-tiered at 40 minutes and 60 minutes (with proportional MBS fees), that would be delivered as an individual service.

The current MBS items for group services only allow dietitians to provide telehealth assessments and group services. However, the CCM Working Group considered that allowing all eligible professions access to telehealth group services (via both phone and video) could overcome access barriers and allow sessions to occur even when an appropriately sized physical room is not available. It would also align with recommendations from a previous MRAC [post-implementation review of MBS telehealth items](#).

Recommendations

Based on the umbrella review, quantitative and qualitative research, and [targeted consultation feedback](#), the CCM Working Group developed the following recommendations.

1. Increase the limit of individual MBS-referred CCM services from 5 to 12 per patient per calendar year, with a corresponding increase from 10 to 17 services for Aboriginal and Torres Strait Islander patients.
2. Replace the 'at least 20 minutes' individual MBS-referred CCM service items with time-tiered individual MBS-referred CCM service items of at least 20 minutes, at least 40 minutes and at least 60 minutes that have proportional per-minute benefits.
3. Expand eligibility for MBS group services (beyond type 2 diabetes) to patients 'with one or more medical conditions that have been (or are likely to be) present for at least 6 months or are terminal'.
4. Expand eligibility to provide MBS group services (beyond exercise physiologists, dietitians and diabetes educators) to Aboriginal and Torres Strait Islander health workers and practitioners, accredited mental health social workers, chiropractors, occupational therapists, osteopaths, physiotherapists, psychologists and speech pathologists.
5. Allow MBS group services to be provided by telehealth, including phone and video.
6. Increase the number of MBS group services per patient per calendar year from 8 to 12.
7. Create time-tiered MBS group suitability assessment services of at least 40 minutes and at least 60 minutes, to replace the existing 45-minute service, with proportional MBS benefits.
8. Create time-tiered MBS post-group assessment items of at least 40 minutes and at least 60 minutes, with proportional MBS benefits, to be provided individually on completion of referred group service treatment.
9. Apply an assessment framework to assess health provider expansion to provide individual CCM services.

Implementation of these recommendations will substantially expand current arrangements for MBS-referred CCM services, which have remained unchanged since their introduction around 22 years ago. Evidence shows that they are no longer appropriate to support an ageing Australian population that is living longer with chronic conditions and placing a higher demand on CCM services. The CCM Working Group advised that costs will be controlled by several factors, including:

- having general practitioners as the 'gatekeepers' to CCM services
- workforce capacity
- the time needed to shift to group service models of care
- the variation in uptake of services.

Implementation of these recommendations is subject to Government consideration through a Budget process.

Acronyms

CCM	Chronic condition management
GP	General practitioner
GPCCMP	GP chronic condition management plan
MBS	Medicare Benefits Schedule
MRAC	MBS Review Advisory Committee

Introduction

Individual referred chronic condition management (CCM) services were introduced to the Medicare Benefits Schedule (MBS) on 1 July 2004, while CCM group services were introduced on 1 May 2007. As part of the MBS Review Taskforce (Taskforce) work, the Allied Health Reference Group was established to review these MBS items. The aim was to ensure that the items aligned with contemporary clinical evidence and practice and were improving health outcomes for patients.

The reference group's final report included several recommended amendments to the CCM MBS items. The [Taskforce findings](#) supported some of the recommendations but did not endorse their implementation. Instead, the Taskforce requested further research and analysis on whether the CCM MBS items were adequately supporting management of chronic conditions in eligible patients.

In May 2024, the then Department of Health and Aged Care proposed that the MBS Review Advisory Committee (MRAC) perform the additional review of the CCM MBS items. This work was to draw on the unresolved Taskforce recommendations but not be limited by them. In October 2024, the CCM Working Group was established as a subgroup of the MRAC to advise on the review.

Review scope

The following 4 review questions, formulated based on policy advocacy and outstanding recommendations from the Taskforce, were endorsed by the MRAC to address the issues requiring independent clinical and consumer input:

1. What should the calendar year limit be for individual chronic condition management services?
2. Should the existing individual chronic condition management service 'floor' of 20 minutes be increased? If so, what is an appropriate 'floor' and should this vary (for example, longer initial consult or time-tiering)?
3. Should the existing condition-specific restriction on group services be expanded beyond type 2 diabetes? If so, which conditions would benefit from group services, and which of the existing eligible individual health provider services are appropriate for group settings?
4. Should the list of eligible individual health providers be expanded? If so, which health professions should be added?

Mental health conditions can also be considered as chronic conditions. Because people with a mental health treatment plan can access MBS-subsidised mental health support through the Australian Government's [Better Access initiative](#), this review focuses on chronic conditions not related to mental health.

Chronic Condition Management Working Group

The CCM Working Group comprises a mix of MRAC members, allied health and Aboriginal and Torres Strait Islander primary health care professionals, medical practitioners and consumers. The CCM Working Group members are outlined in Table 1.

Table 1 Chronic Condition Management Working Group members

Name	Specialty/role
Associate Professor Beverley Rowbotham (Chair)	Pathology
Dr Jason Agostino	General practice/epidemiology/Indigenous health
Ms Jan Donovan	Consumer representative
Ms Jade Hansen	Aboriginal and Torres Strait Islander health practitioner
Mr Ray Kelly	Exercise physiology
Ms Alison Marcus	Consumer representative
Dr Sue Masel	Rural general practice
Professor Hylton Menz	Podiatry
Dr Andrea Mosler	Sports and exercise physiotherapist
Mr Brady Schulz	Dietitian, sports dietitian, exercise physiology
Ms Robyn Stephen	Paediatric speech pathology
Ms Helen Whait	Occupational therapy
Ms Anita Hobson-Powell (contribution ceased May 2026)	Chief Allied Health Officer, Department of Health, Disability and Ageing
Associate Professor Andrew Singer	Principal Medical Adviser, Department of Health, Disability and Ageing

The CCM Working Group met on 7 occasions: 20 November 2024, 4 February 2025, 2 April 2025, 8 May 2025, 20 November 2025, 22 April 2026 and 5 August 2026.

Background

Chronic conditions are long-term health conditions that usually progress gradually, can affect quality of life and independence, and need ongoing medical attention. People with complex needs may require care from a team of health professionals (a multidisciplinary team).

There are many types of chronic conditions, including:

- arthritis
- asthma
- back pain
- cancer
- cardiovascular disease
- chronic obstructive pulmonary disease
- diabetes
- mental health conditions.

Chronic conditions are common. According to Australian Bureau of Statistics data from 2022, at least 1 in 2 Australians (12.6 million) were living with at least one chronic condition, with the most common being mental and behavioural conditions (26.1%), back problems (15.7%) and arthritis (14.5%). Around 5.3% of Australians were living with diabetes.¹ At least 4.9 million Australians were living with 2 or more chronic conditions (multimorbidity).²

Chronic conditions in Australia

Over time, Australia has experienced a health transition from acute conditions (those that last for a short time) to more chronic conditions. This shift has many contributors, including improved infectious disease control measures, advancements in medicine and an ageing population that is living longer. According to the Australian Institute of Health and Welfare:³

- from 2003 to 2023, the rate of fatal burden (years of life lost to dying early) fell by 27%, but the rate of non-fatal burden (years of healthy life lost from living with illness and injury) increased by 6.3%
- in 2023, 91% of non-fatal burden and 78% of fatal burden were related to chronic conditions
- from 2003 to 2023, there was an increase in both the number of years lived with disability due to chronic conditions and the years of life lost due to chronic conditions

¹ ABS (Australian Bureau of Statistics) (2023) [Health condition prevalence](#), ABS, accessed August 2024.

² AIHW (Australian Institute of Health and Welfare) (2024) [Chronic conditions](#), AIHW, accessed August 2024.

³ AIHW (Australian Institute of Health and Welfare) (2024) [The ongoing challenge of chronic conditions in Australia](#), AIHW, accessed July 2026.

- the proportion of the Australian population living with more than one chronic condition (multimorbidity) has increased at a greater rate than the proportion living with one chronic condition.

This means that, although Australians are living longer, they are increasingly spending more years living with chronic conditions. The increased impact of chronic conditions has led to higher demand for services to care for and support those living with chronic conditions.

Chronic condition management services in Australia

People living with chronic conditions in Australia have access to several services to help manage their condition, including through:

- general practice
- allied health
- Aboriginal and Torres Strait Islander primary health care
- specialist care
- community health services
- mental health services
- home and community care
- hospital outpatient clinics.

The Australian Government subsidises the cost of some of these services for eligible people, including through Government-funded schemes (such as [My Aged Care](#) and the [National Disability Insurance Scheme](#) [NDIS]) and Medicare-funded health services (including the [Better Access initiative](#)).

Although other models of care have been, and are currently being, piloted to support people living with chronic conditions (for example, Health Care Homes, My Medicare, Medicare Mental Health Centres), the MBS is the only primary care funding stream that is universally accessible across Australia.

Chronic condition management in the Medicare Benefits Schedule

The MBS CCM framework is a group of MBS-funded services that support the ongoing management of people living with chronic or terminal conditions in primary care. This collection of MBS items helps general practitioners (GPs), allied health professionals and other providers deliver coordinated, multidisciplinary care. The framework includes:

- GP CCM plans (GPCCMPs)
- allied health services (individual and group)
- Aboriginal and Torres Strait Islander primary health care professional services
- multidisciplinary case conferences.

For CCM MBS items, chronic conditions are defined as one or more medical conditions that have been (or are likely to be) present for at least 6 months, including terminal conditions.

GP chronic condition management plan

A GPCCMP is a personalised care plan that a GP develops with a patient to support the long-term management of a chronic condition or terminal condition. A GPCCMP is designed to help coordinate care, set health goals and ensure the patient receives the services they need.

If deemed clinically appropriate, a GPCCMP enables patients to access MBS-subsidised eligible referred health services to help manage their condition.

Referred individual and group chronic condition management

People who are referred to health services as part of their GPCCMP are eligible for a certain number of MBS-subsidised individual and group services per calendar year. The specific health services must be recommended in the GPCCMP, based on the person's condition, goals and clinical needs.

Currently, the number of referred MBS-subsidised health services a person can access per calendar year under a GPCCMP are:

- up to 5 individual services (up to 10 for Aboriginal and Torres Strait Islander people)
- up to 8 group services, and one assessment of suitability for group services.

The health professionals who are eligible to provide individual services under a GPCCMP (subject to accreditation and credentialing requirements) are:

- Aboriginal and Torres Strait Islander health workers and practitioners
- audiologists
- chiropractors
- diabetes educators
- dietitians
- exercise physiologists
- mental health nurses
- mental health social workers
- occupational therapists
- osteopaths
- physiotherapists
- podiatrists
- psychologists
- speech pathologists.

Access to CCM group services through the MBS is only available for patients with type 2 diabetes. CCM group services can only be provided by 3 types of health professionals: exercise physiologists, dietitians and diabetes educators.

The MBS items for CCM services comprise MBS item groups [M3](#) – Allied Health and Aboriginal and Torres Strait Islander Health and Wellbeing Services, [M9](#) – Allied Health Group Services and [M18](#) – Allied Health and Other Primary Health Care Telehealth Services.

Multidisciplinary case conference chronic condition management

For patients with more complex care needs, the MBS includes items that support multidisciplinary case conferences. These are structured collaborations between a GP and at least 2 other care providers to discuss the patient's care, agree on treatment goals and coordinate ongoing management. This supports a multidisciplinary team approach in CCM.

The case conference items were not considered as part of this review.

Concerns regarding Medicare Benefits Schedule chronic condition management services

The cap of 5 services and the minimum consultation lengths for the CCM MBS items have remained unchanged since 2004 (approximately 22 years), when the items were introduced.

Since their introduction, patients and providers have raised several concerns regarding the CCM MBS items, including the:

- service caps per patient per calendar year (5 for non–First Nations people and 10 for First Nations people), which are likely insufficient for many patients, especially those with more than one chronic condition; MBS data (2023) show that more than one-third of eligible patients reach the annual cap of 5 services per year
- exclusion of some health professionals
- requirement that at least 2 other providers collaborate with the GP (this requirement was removed on 1 July 2025)
- inability for specialists to initiate CCM service referrals
- fee structure
- need for a longer initial assessment for CCM services.

Stakeholders have also raised several issues around the MBS items for group services, including:

- limiting eligibility to patients with type 2 diabetes when there is evidence that other chronic conditions can also benefit from group intervention (for example, respiratory conditions, musculoskeletal conditions, cardiovascular disease, pain, cancer)
- the financial viability of the items, as there is an attendance threshold required for group sessions to be financially viable over an individual session
- logistical challenges, such as some patients not attending booked sessions (meaning the minimum number requirement for group sessions is not met) and a lack of space in health practices to conduct group sessions.

In its review, the Allied Health Reference Group recommended amendments to the MBS CCM items to address many of these issues.

The case for change

The MBS CCM items were introduced around 22 years ago. During those 2 decades, Australia's health has transitioned from acute conditions to more chronic conditions, putting more strain on CCM services. The Australian Government developed a framework and introduced and updated several national policies and strategies to address the growing impact of chronic conditions. However, the MBS CCM items have remained unchanged, and there is evidence that they are no longer appropriate to support the millions of Australians living with chronic conditions.

The MBS CCM items do not align with patient and provider needs

The service number caps, minimum consultation lengths and group therapy restrictions for the CCM MBS items do not allow patients and providers to receive and provide the care needed. Research and MBS data show that:

- more than one-third of patients reach the annual cap of 5 individual services per year, forcing them to either forgo further treatment or pay high-out-of-pocket costs
- providers find it difficult to provide adequate care within such a limited number of sessions, and patients are left dissatisfied and do not achieve their desired outcomes
- low-dose individual services have limited value in improving conditions
- longer individual sessions are needed to allow providers to build trust, gather patient history and educate and treat patients, and to allow patients more time to explain the support they require
- people living in remote and very remote communities face barriers to accessing CCM services, which may include limited service availability and workforce challenges
- group therapy is effective for more chronic conditions than just type 2 diabetes, and for more health professions than just exercise physiologists, dietitians and diabetes educators
- the current requirement that group CCM services be performed in person (except for dietetic services) may be restricting uptake.

Importantly, patients and providers support increasing the cap on services and the minimum consultation lengths, as well as expanding group therapy eligibility.

Recent policy and strategy changes support amending the MBS CCM items

The Australian Government is making efforts to address the growing impact of chronic conditions:

- The [National Strategic Framework for Chronic Conditions](#) (first published in 2017 and recently updated in 2026) provides a high-level, evidence-based approach to addressing the challenges associated with chronic conditions in Australia.
- The [Strengthening Medicare Taskforce Report](#) (2022) outlines a plan to improve access to affordable, high-quality primary care by investing in multidisciplinary teams, expanding bulk-billing incentives, supporting digital health and modernising Medicare. These reforms aim to ensure people with chronic conditions receive timely, coordinated care.

- The [Primary Health Care 10 Year Plan 2022–2032](#) focuses on improving access, equity and integration of care, particularly for people living with chronic conditions and those in rural and remote areas. The plan also highlights the importance of localised, person-centred care that is responsive to community needs.
- Australian state and territory governments committed to the [National Agreement on Closing the Gap](#) in 2020. The 4 priority reforms and 17 socioeconomic targets aim to enable Aboriginal and Torres Strait Islander peoples and governments to work together to overcome inequality experienced by Aboriginal and Torres Strait Islander peoples.

These efforts provide a basis for amending the MBS CCM items, which currently do not align with the aims of the framework or subsequent policy and strategy changes.

Aligning expansion, evidence and outcomes

This review was informed by a 2024 department-commissioned umbrella review⁴ that investigated the effectiveness of CCM group interventions for adults with certain chronic conditions. The department also commissioned the Sax Institute and Quantum Market Research to undertake supporting research to further inform recommendations.

- The Sax Institute performed a rapid literature review of systematic reviews and meta-analyses from peer-reviewed databases ($n = 166$), as well as literature identified by stakeholders ($n = 429$), that focused on individual CCM services.
- Quantum Market Research performed qualitative research of peak body ($n = 30$), provider ($n = 30$) and patient ($n = 33$) views on both individual and group referred CCM health services.

Table 2 lists the chronic conditions that were considered in the umbrella review and in the research by the Sax Institute and Quantum Market Research. More information on the research methods can be found in [Appendix A](#).

⁴ Dennis S, Kwok W, Alison J, Hassett L, Nisbet G, Refshauge K, Sherrington C and Williams A (2024) '[How effective are allied health group interventions for the management of adults with long-term conditions? An umbrella review of systematic reviews and its applicability to the Australian primary health system](#)', *BMC Primary Care*, 25:325, doi:10.1186/s12875-024-02570-7.

Table 2 Chronic conditions considered in the research informing the review

Umbrella review	Sax Institute literature review	Quantum Market Research qualitative research
• Cancer • Cardiovascular disease (hypertension, coronary heart disease, heart failure) • Chronic kidney disease • Chronic respiratory disease (chronic obstructive pulmonary disease [COPD], bronchiectasis, asthma) • Chronic stroke • Diabetes (types 1 and 2) • Musculoskeletal conditions (osteoarthritis, back pain, high risk of falls)	• Cardiovascular disease (hypertension, coronary heart disease, heart failure) • Chronic respiratory disease (COPD, bronchiectasis, asthma) • Diabetes (types 1 and 2) • Musculoskeletal conditions (osteoarthritis, back pain) • Parkinson's disease • Stroke (post/sub-acute and chronic)	• Cancer • Cardiovascular disease (hypertension, coronary heart disease, heart failure) • Chronic kidney disease • Chronic pain • Chronic respiratory disease (COPD, bronchiectasis, asthma) • Diabetes (types 1 and 2) • Gastrointestinal disorders (inflammatory bowel disease, Crohn's disease, ulcerative colitis, coeliac) • Musculoskeletal conditions (osteoarthritis, osteoporosis) • Neurological conditions (Parkinson's disease, epilepsy, stroke) • Obesity • Paediatric conditions (stuttering, childhood apraxia of speech)

The department attempted to commission research specific to the Aboriginal and Torres Strait Islander population to support the review, but it was unsuccessful due to research capacity constraints. However, Aboriginal and Torres Strait Islander peak bodies did contribute to the research.

A limitation of the research was the lack of studies addressing the management of people with multimorbidity. The CCM Working Group suggested that, if available, research on multimorbidity should be considered as part of any post-implementation review.

The CCM Working Group agreed that a cost–benefit analysis was not possible with the current available evidence.

Individual services

The CCM Working Group noted from MBS data that, in 2023, around 2.6 million people attended an individual CCM service, of which 63% were aged over 60. Almost 80% of all individual services were for physiotherapy and podiatry. Patients under 10 years of age

mostly used speech pathology services, with occupational therapy and audiology being other common services for this cohort.

Although speech pathology and occupational therapy were highly used in the younger population, these services and psychology were the most underused of the CCM services.

Number of individual services per calendar year

The CCM Working Group noted from MBS data that, in 2023, the highest proportion of patients attended the maximum of 5 individual CCM services (35%) (Figure 1), and the difference between the number of patients attending 5 services and those attending fewer than 5 services appeared to be increasing over time (Figure 2). Females were more likely than males to use all 5 available services available through the MBS.

Figure 1 Proportion of patients accessing MBS chronic condition management services, 2020 to 2023

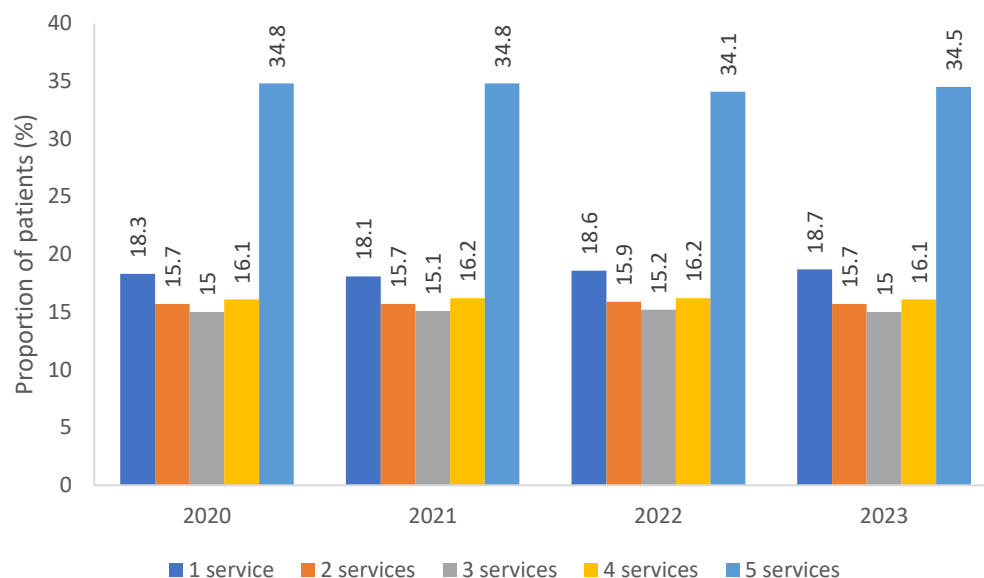
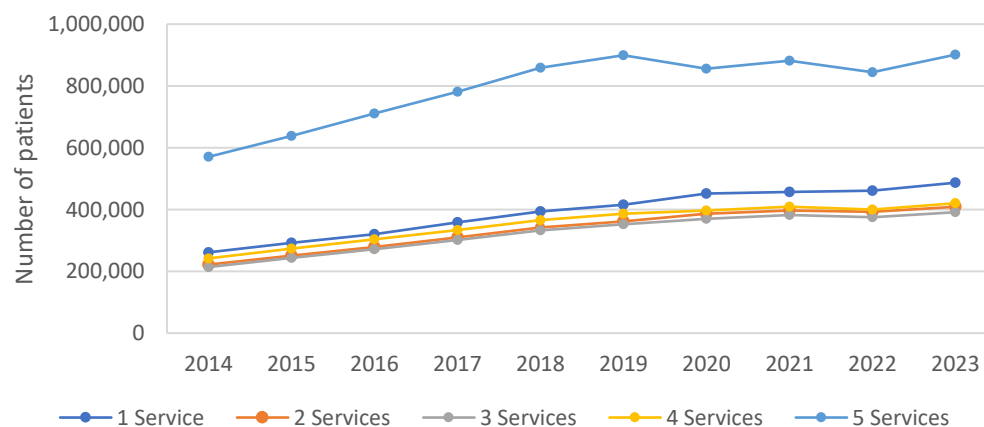


Figure 2 Number of patients accessing MBS chronic condition management services, 2014 to 2023



When considering the number of accessed CCM services by Modified Monash (MM) classification, people in remote and very remote communities (MM 6 and MM 7) were more likely to only use one of the available services, while people in MM 1 to MM 5 locations were more likely to access all 5 services. This may be due to service availability

and workforce challenges in rural and remote locations, compounded by a higher male distribution in those communities.

Quantitative research findings

Although based on limited evidence, the rapid review revealed that single, low-dose episodic care rarely produced meaningful clinical improvements.⁵ In comparison, higher-dose or more-intensive interventions sometimes produced greater short-term improvements, although there appeared to be a threshold beyond which returns diminished. The evidence also suggested that multiple sessions delivered by a multidisciplinary team was the normal model (and required) for chronic conditions. However, funding and out-of-pocket costs affect achievable dose and equity.

The typical number of sessions varied across condition groups (Table 3), but for all of them, the number of sessions far exceeded the current MBS cap of 5 sessions per calendar year. The CCM Working Group noted that these numbers were for the total treatment course (and not the number of services per year), and included services provided by single health professionals as well as multidisciplinary teams. Overall, the researchers concluded that the current cap of 5 sessions per calendar year is a barrier to access, particularly when shared across all CCM health professions.

Table 3 Typical midpoint number of CCM sessions for different condition groups

Condition group	Typical midpoint number of sessions
Parkinson's disease	53 (ongoing episodic therapy; repeated review and progression common)
Chronic respiratory disease (chronic obstructive pulmonary disease, bronchiectasis, asthma)	31
Stroke (post/sub-acute and chronic)	29 (multi-session rehabilitation; often intensive blocks then review)
Musculoskeletal conditions (osteoarthritis, osteoporosis)	18–19
Cardiovascular disease (hypertension, coronary heart disease, heart failure)	18 (limited evidence base)
Diabetes (types 1 and 2)	14

Suggested changes arising from the evidence included:

- increasing the session cap, possibly specific to each condition (although this is out of scope for this review), to allow for multidisciplinary care tailored to the individual patient
- reviewing patient progress at an appropriate point during a course of treatment to support decisions about access to further sessions.

The included studies were designed to focus on a single primary disease – none addressed the management of people with multimorbidity. However, it is highly likely that some patients included in the studies were living with more than one chronic condition.

⁵ A consultation 'dose' is defined as the number of individual consultations and/or the length of consultation.

The researchers suggested that flexibility around service numbers is needed for complex multimorbid cases.

Qualitative research findings

The findings from the qualitative research showed that peak bodies, providers and patients all support increasing the number of individual sessions available each calendar year. Feedback noted that patient needs evolve and that they often require access to more than one health professional for treatment (especially patients with a complex chronic condition or multimorbidity), which quickly reduces the number of reimbursable sessions. Under the current system:

- some patients need to split their available sessions across different health professions or prioritise one type of treatment over others
- some patients may neglect seeking treatment for less-severe conditions
- short-term care is prioritised over preventative care
- continuity of care may be hindered.

Some patients are left dissatisfied with their treatment and do not achieve their desired outcomes, and some providers experience challenges in providing adequate care to patients.

Specific suggestions for improvement included:

- increasing the cap to 10–12 sessions per year
- allowing 5–10 sessions per health professional type per year
- removing the cap and allowing GP and referred health professionals to determine the appropriate number of services, possibly by risk stratification (although this is out of scope for this review)
- moving to condition-specific plans, with the number of services determined based on available evidence (although this is out of scope for this review).

Length of individual services

Quantitative research findings

The research found that the common midpoint session length was 40 to 44 minutes, with a broader range being 35 to 54 minutes across the condition groups. The most effective interventions used 45- to 55-minute consultations. Short sessions of less than 20 minutes were rarely sufficient as standalone models.

Longer initial consultations were also often clinically justified. They allow time to establish a baseline assessment, which enables accurate review of patient progress over time.

Based on the findings, the suggested changes included:

- reviewing consultation lengths to align MBS item descriptors with standard clinical practice (45- to 60-minute sessions)
- considering differential rebates for longer initial assessments.

Qualitative research findings

Participants in the qualitative research supported increasing the length of sessions beyond 20 minutes, with most providers identifying 40 to 60 minutes as a typical session length. Longer sessions allow providers time to build trust and rapport, gather all the necessary history, and educate and treat patients. Participants also supported increasing

the initial consultation length to allow patients more time to feel comfortable with a provider and explain the support they require.

The current discrepancy between the 20-minute floor and typical session lengths results in a gap fee that either increases financial burden for patients or is absorbed by providers, affecting financial viability. As well as addressing these issues, increasing the session length could reduce provider burnout and improve quality of care for patients.

Participants also supported time-tiering (20-, 40- and 60-minute sessions) as it would offer flexibility to provide patients with the most optimal treatment. However, they believed that decisions on time-tiering should be made collaboratively with GPs and referred CCM health professionals, rather than applying a blanket approach for specific professions.

Eligible conditions

The CCM Working Group noted that there is no list of eligible chronic conditions for MBS Group M3 services (allied health and Aboriginal and Torres Strait Islander health and wellbeing services). It is a matter of clinical judgement for a GP to determine whether their patient is eligible for MBS CCM services based on the definition of a chronic condition from the [Health Insurance \(General Medical Services Table\) Regulations 2021](#).

Group services

The CCM Working Group noted from MBS data that, in 2023, almost 12,000 patients attended a group CCM service. People aged 50 and over made up the largest proportion of group therapy patients, with the highest uptake being in those aged 70 to 79.

Uptake of group services

The CCM Working Group noted that uptake of MBS-listed group items for type 2 diabetes has been low, with approximately 57,000 claims compared to the type 2 diabetes population of approximately 1.3 million. The possible reasons for this include:

- MBS items for type 2 diabetes have low MBS schedule fees compared to other MBS-subsidised services, and there is a large difference in the schedule fees for individual and group services
- GPs are unaware of the MBS group items
- patients do not want to participate in group interventions
- in rural areas, it may be difficult to meet the threshold of at least 2 patients to undertake group sessions (in 2023, 73.6% of group therapy patients were in metropolitan areas)
- dietitians and diabetes educators may not have access to a room large enough for group sessions.

Most group services are provided by exercise physiologists. These providers often have access to large spaces that can accommodate group sessions.

The CCM Working Group noted that the Department of Veterans' Affairs limits its funding of group sessions to certain health professions, and practitioners must first confirm that the patient is eligible for treatment. Primary Health Networks also commission group therapy according to regional need. State and territory health departments offer a range of inpatient, outpatient and community group programs, but due to these services often being provided for free, they have long waitlists (3 to 6 months). Group therapy performed in the private sector either incurs out-of-pocket costs or is funded by private health insurers.

Umbrella review findings

The 2024 umbrella review concluded that:

- there is strong support for the effectiveness of group interventions for cardiovascular diseases, chronic obstructive pulmonary disease, chronic pain (including osteoarthritis and low back pain), people at risk of falls and diabetes
- group therapy interventions improve outcomes including functional capacity, hospitalisations and, in some instances, mortality
- there is evidence for the value of group interventions for the following health professionals: physiotherapists, exercise physiologists, occupational therapists, osteopaths and chiropractors
- the length and frequency of effective group therapy interventions are specific to each condition, but the most effective are those lasting between 45 and 60 minutes per session, 2 to 3 times per week for 12 weeks.

Qualitative research findings

The findings from the qualitative research on group health services showed that:

- there is potential for group services to provide support and skills to patients so that they can better self-manage conditions
- patients and providers support the expansion of group services, noting benefits relating to education, socialisation and peer support
- there is potential for further expansion of group services for dietitians, diabetes educators, speech pathologists, exercise physiologists and social workers

Aboriginal and Torres Strait Islander health workers and practitioners highlighted the potential for group services to include broader health education as part of yarning circles.

Some health professionals raised concerns about financial feasibility because of the high costs related to running group services.

Some patients expressed hesitancy towards group services because they value their privacy or are fearful of sharing information about their condition with others. Some also feared that the quality of care would be lower than with individual services.

Bulk billing and out-of-pocket costs

The CCM Working Group recognised that out-of-pocket costs for referred CCM health services are a major barrier to both uptake and ongoing care.

According to MBS data from 2023, females accessing CCM health services had a lower bulk-billing rate and higher average patient contribution than did men accessing the services (Figure 3 and Figure 4). These findings align with data from the Australian Bureau of Statistics. There is increasing research on gender bias and disparities within the healthcare system, and this shows that women are less likely than men to receive appropriate treatment and more likely to experience delayed diagnosis. More research is needed to understand the out-of-pocket cost disparity between genders.

Figure 3 Bulk-billing rates for female and male MBS chronic condition management patients, by age group

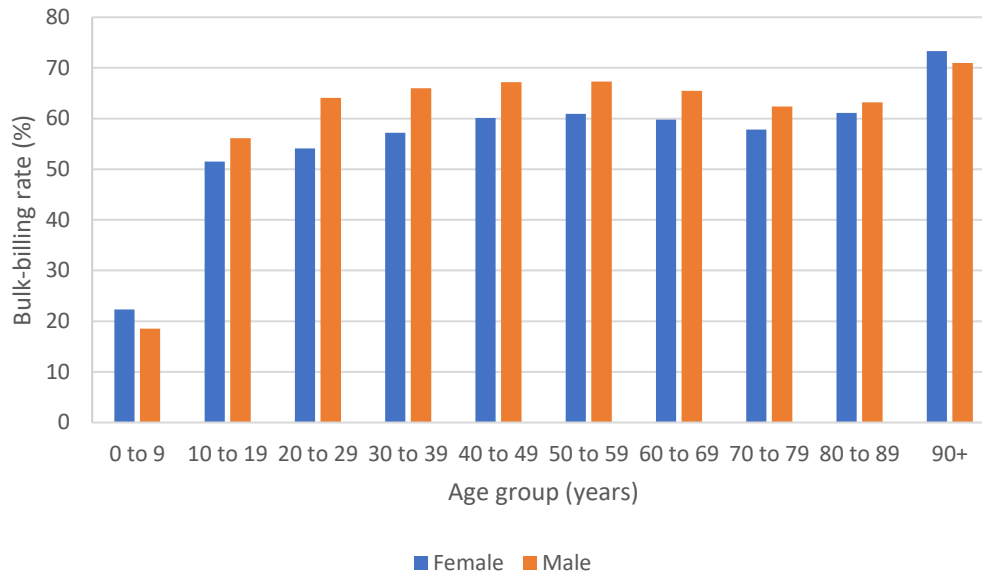
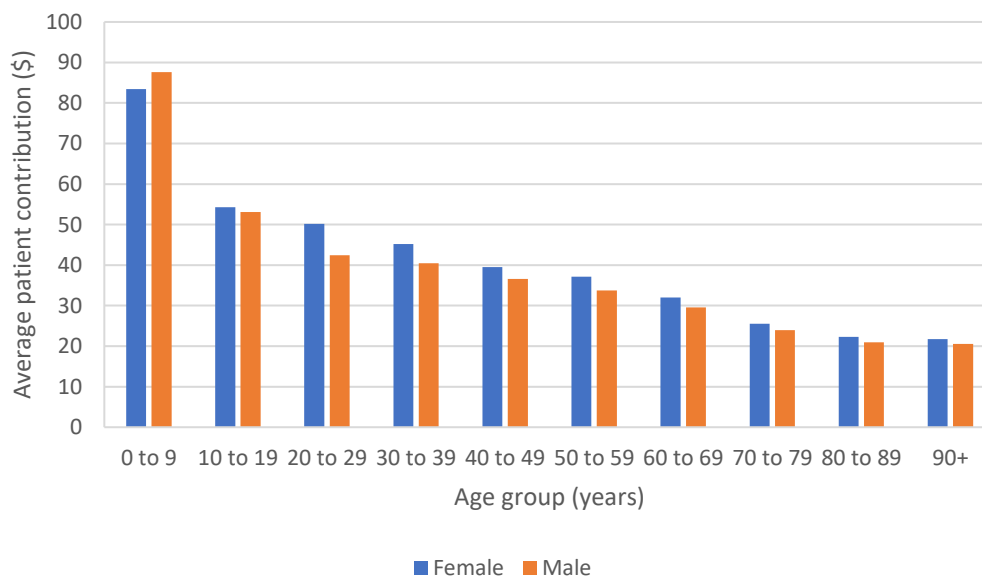


Figure 4 Average patient contributions for female and male MBS chronic condition management patients, by age group



The CCM Working Group noted from MBS data from 2023 that, despite having the highest bulk-billing rates, people in remote and very remote communities have higher out-of-pocket costs than do most people in more metropolitan areas. Additionally, increased age was associated with higher bulk-billing rates and lower average patient contributions.

Consultation and feedback on the recommendations

Consultation with relevant and interested organisations, peak bodies and consumers is considered essential in the formulation of advice to Government on recommended changes to MBS items. The MRAC and its working groups seek feedback on their understanding of the existing model of care and issues of consideration, with particular emphasis on any (yet) unidentified consequences that may result from proposed changes.

All feedback provided through consultation processes is considered.

Targeted consultation feedback

Targeted consultation occurred from 19 February to 19 March 2026. Input was sought from 23 stakeholder groups on draft recommendations that addressed the following review questions:

- Should the existing condition-specific restriction on group services be expanded beyond type 2 diabetes? If so, which conditions would benefit from group services, and which of the existing eligible individual health provider services are appropriate for group settings? (Review question 3)
- Should the list of eligible individual health providers be expanded? If so, which health professions should be added? (Review question 4)

Twenty organisations submitted a response. A summary of stakeholders approached for targeted consultation is in Table 4.

Table 4 Summary of targeted consultation stakeholders

Stakeholders that submitted a response	Stakeholders that declined to participate
• Allied Health Professions Australia • Audiology Australia • Australian Association of Psychologists Inc • Australian Association of Social Workers • Australian Chiropractors Association • Australian College of Mental Health Nurses • Australian Diabetes Educators Association • Australian Medical Association • Australian Physiotherapy Association • Australian Podiatry Association • Australian Psychological Society • Chiropractic Australia • Dietitians Australia • Exercise & Sports Science Australia • Indigenous Allied Health Australia • Occupational Therapy Australia • Osteopathy Australia • Royal Australian College of General Practitioners • Services for Australian Rural and Remote Allied Health • Speech Pathology Australia	• Australian College of Audiology • National Aboriginal Community Controlled Health Organisation • National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners

Stakeholders were broadly supportive of the draft recommendations related to expanding eligibility for MBS group services. Stakeholders recognised the recommendations as a positive step towards improving CCM, and a significant improvement to MBS group services.

Table 5 provides a summary of stakeholder support for the draft recommendations. More detail on stakeholder feedback for each draft recommendation is provided in the following sections.

Table 5 Summary of stakeholder support for the draft recommendations

Draft recommendation	Stakeholder support
3: Expand eligibility for MBS group services (beyond type two diabetes) to patients 'with one or more medical conditions that have been (or are likely to be) present for at least 6 months or are terminal'.	Supported

Draft recommendation	Stakeholder support
4. Expand eligibility to provide MBS group services exercise physiologists, dietitians and diabetes educators) to Aboriginal and Torres Strait Islander health workers and practitioners, osteopaths, physiotherapists and speech pathologists.	Partially supported
5: Allow MBS group services to be provided by telehealth, including phone and video.	Supported
6. Increase the number of MBS group services per patient per calendar year from 8 to 12.	Supported
7. Create a second MBS group suitability assessment service of at least 60 minutes, with a proportional MBS benefit.	Supported
8: Create an MBS 'post-group service assessment' item to be provided individually on completion of referred group service treatment.	Supported
9: Apply an assessment framework to assess health provider expansion to provide individual chronic condition management services.	Partially supported

Draft recommendation 3

All stakeholders supported this draft recommendation.

Evidence supports the effectiveness of group-based interventions for various chronic conditions beyond type 2 diabetes, including musculoskeletal conditions, chronic pain, mental health, stroke recovery and lifestyle-related risks. Group services improve self-management and behaviour change, provide peer support and motivation, improve health literacy and increase system efficiency and cost-effectiveness. Examples of effective group models include [ESCAPE-pain](#) and [GLA:D](#).

Several stakeholders stressed the importance of minimising administrative burden related to group services and ensuring group services complement, rather than replace, individual services.

Draft recommendation 4

Stakeholders supported expanding MBS group service eligibility to Aboriginal and Torres Strait Islander health workers and practitioners, osteopaths, physiotherapists and speech pathologists. However, some stakeholders requested further expansion of the eligible professions. They argued that excluding these professions undermines the multidisciplinary intent of the proposed recommendations, creates inequities of access, and represents inconsistency given their existing participation in providing individual services under CCM.

Specifically, stakeholders requested expanding eligibility to:

- all allied health professions currently eligible to provide individual services under CCM
- chiropractors
- mental health social workers
- nurse practitioners

- occupational therapists
- psychologists
- social workers.

The department noted that psychologists, occupational therapists and accredited mental health social workers – who received the most support for inclusion from stakeholders – can deliver group services through the ‘Better Access to focused psychological therapies’ MBS item group.

The department noted that there is limited evidence on the applicability of chiropractic group services outside of international patient registries for the GLA:D back program. However, the umbrella review found group exercise programs effectively reduce pain intensity and functional limitation associated with chronic low back pain, and that the design of group programs and prescription exercise is in scope for chiropractors.

Draft recommendation 5

Stakeholders strongly supported this draft recommendation to address geographic, mobility, workforce, cost and access barriers to treatment, especially for rural, regional and underserved populations. Although it may not be suitable in all contexts, telehealth is broadly valuable and necessary to improve the continuity and quality of care, and it complements in-person services.

Draft recommendation 6

Stakeholders strongly supported this draft recommendation, noting that it is backed by robust evidence and will ensure better alignment with how group services are delivered in practice. Increasing the number of MBS group services that patients can access:

- supports continuity of care
- improves clinical and sustained outcomes
- reduces fragmented care
- supports the efficient use of the health workforce
- improves access
- reduces reliance on intensive one-on-one services.

Group services would also benefit from a time-tiered structure to tailor shorter sessions for frailer participants.

Draft recommendation 7

Stakeholders strongly supported this draft recommendation. The tiered structure allows providers to respond to patient complexity with longer comprehensive evaluations, and it will improve the matching of patients with suitable groups.

One stakeholder raised concerns about upcoding.

Another stakeholder noted that gender-based and cultural considerations, such as avoidance relationships, should be considered for Aboriginal and Torres Strait Islander people. The department considered that this could be addressed through a comprehensive suitability assessment to ensure patients are matched with suitable groups.

Draft recommendation 8

Stakeholders fully supported this draft recommendation. Post-group service assessment allows for the measuring of clinical outcomes, functional improvement and goal attainment, and provides time for patients to consolidate key learnings and assess individual outcomes that may not be fully explored within a group setting. This new item would improve patient and multidisciplinary care through increased quality reporting to the referring GP. It would also support decision-making regarding the patient's need for further treatment.

Draft recommendation 9

Most stakeholders supported this recommendation. Several stakeholders misunderstood the intent of the recommendation, which the department later clarified.

One stakeholder was concerned that the framework privileged larger, metropolitan-based health professions and disadvantaged smaller, rural, emerging or culturally specific health professions. They considered that, if implemented, the framework must explicitly prioritise patient access, equity, cultural safety, rural workforce impact and Closing the Gap outcomes. The department acknowledged these concerns and amended the framework accordingly.

Other stakeholders requested that only regulated and appropriately qualified health and allied health professions be considered, and that the framework include a defined minimum qualification standard.

Recommendations

Based on the umbrella review, quantitative and qualitative research, and [targeted consultation feedback](#), the CCM Working Group developed the following recommendations to address the review questions. Rationale for each recommendation is provided in the subsequent section.

The CCM Working Group acknowledges that implementation of these recommendations will substantially expand current arrangements for MBS-referred CCM services. However, the CCM MBS items have remained unchanged since their introduction around 22 years ago. During that time, Australia's population has aged and is living longer with chronic conditions, placing a higher demand on CCM services. It is clear from the research evidence that the CCM MBS items are no longer appropriate, resulting in patients either paying high out-of-pocket costs for treatment or not receiving the full treatment they need.

The CCM Working Group advises that costs of the MBS item amendments will be controlled by several factors, including:

- having GPs as the 'gatekeepers' to CCM services
- workforce capacity
- the time needed to shift to group service models of care
- the variation in uptake of services.

Review question 1: What should the calendar year limit be for individual chronic condition management services?

- **Recommendation 1:** Increase the limit of individual MBS-referred CCM services from 5 to 12 per patient per calendar year, with a corresponding increase from 10 to 17 services for Aboriginal and Torres Strait Islander patients.

Review question 2: Should the existing individual chronic condition management service 'floor' of 20 minutes be increased? If so, what is an appropriate 'floor' and should this vary (for example, longer initial consult or time-tiering)?

- **Recommendation 2:** Replace the 'at least 20 minutes' individual MBS-referred CCM service items with time-tiered individual MBS-referred CCM service items of at least 20 minutes, at least 40 minutes and at least 60 minutes that have proportional per-minute benefits.

Review question 3: Should the existing condition-specific restriction on group services be expanded beyond type 2 diabetes? If so, which conditions would benefit from group services, and which of the existing eligible individual health provider services are appropriate for group settings?

- **Recommendation 3:** Expand eligibility for MBS group services (beyond type 2 diabetes) to patients 'with one or more medical conditions that have been (or are likely to be) present for at least 6 months or are terminal'.
- **Recommendation 4:** Expand eligibility to provide MBS group services (beyond exercise physiologists, dietitians and diabetes educators) to Aboriginal and Torres Strait Islander health workers and practitioners, accredited mental health social workers, chiropractors, occupational therapists, osteopaths, physiotherapists, psychologists and speech pathologists.

- **Recommendation 5:** Allow MBS group services to be provided by telehealth, including phone and video.
- **Recommendation 6:** Increase the number of MBS group services per patient per calendar year from 8 to 12.
- **Recommendation 7:** Create time-tiered MBS group suitability assessment services of at least 40 minutes and at least 60 minutes, to replace the existing 45-minute service, with proportional MBS benefits.
- **Recommendation 8:** Create time-tiered MBS post-group assessment items of at least 40 minutes and at least 60 minutes, with proportional MBS benefits, to be provided individually on completion of referred group service treatment.

Review question 4: Should the list of eligible individual health providers be expanded? If so, which health professions should be added?

- **Recommendation 9:** Apply an assessment framework to assess health provider expansion to provide individual CCM services.

Rationale for the recommendations

Recommendation 1

Based on the findings from the quantitative and qualitative research, the CCM Working Group considered the MBS cap of 5 individual CCM sessions (10 for Aboriginal and Torres Strait Islander people) per calendar year to be insufficient. It is especially insufficient for patients with a complex chronic condition or multimorbidity requiring treatment from multiple CCM health professions, who must split the 5 services between professions or prioritise one type of treatment over others.

Considering the research findings and what would likely be implementable by Government, the CCM Working Group considered that the cap should be increased to 12 individual sessions per calendar year (17 sessions for Aboriginal and Torres Strait Islander people). Members acknowledged that, although this increase is an improvement on what is currently available, it is still inadequate (as shown in the research), especially for people living with a complex chronic condition or multimorbidity who require treatment from multiple health professions. More research is especially needed regarding people with multimorbidity to determine an adequate number of individual CCM services. However, the CCM Working Group noted that, with the recommended cap increase for group services (as part of recommendation 6), patients will have access to up to 24 CCM services per calendar year (or 29 for Aboriginal and Torres Strait Islander people). This brings the total number of MBS-referred CCM sessions available to patients each year more in line with the typical midpoint number of services required for many of the chronic conditions included in this review, as identified in the research (see Table 3).

The decision on how the MBS CCM services are used (that is, which eligible health professionals are used and how many services are required from each) should remain with the GP in collaboration with the patient and other treating practitioners, based on evidence and patient preference and priorities. This helps ensure the patient is engaged with their treatment.

In making this recommendation, the CCM Working Group noted that, although outside of the remit of the department, the way patients, GPs and referred health professionals track the number of eligible sessions remaining must be improved. Patients in particular find this very difficult under the current system, leading to lost trust and disengagement.

The CCM Working Group considered adding the requirement for a review of patient progress after a certain number of sessions before they can access the remaining

sessions, to ensure appropriate use. However, members noted that this review should be at the discretion of the GP rather than mandated. [MBS item 967](#) (for a GP to review a GPCCMP) is available for a review if required.

Recommendation 2

Based on the research findings, the CCM Working Group agreed that the single 20-minute floor for individual services should be changed, and that a time-tiered structure was the most appropriate way to cater for various primary healthcare professionals who deliver individual MBS-referred CCM services. The CCM Working Group agreed that the time-tiered structure should have 20-, 40- and 60-minute time tiers, as this would be appropriate for most eligible health professions (noting that some professions, such as podiatry, find a 20-minute session sufficient).

The CCM Working Group also recommended that a proportional fee/benefit increase should be assigned to the 40- and 60-minute time tier items, equivalent to the current 20-minute tier fee/benefit in terms of dollars per minute. Noting that provider satisfaction was a part of the Quadruple Aim framework,⁶ members considered that matching the dollars per minute could lead to better care provision and decrease provider burnout.

The CCM Working Group considered that it would be sufficient for providers and patients to select one of the time tiers for the initial consultation, removing the need to create a separate item.

Recommendation 3

The CCM Working Group noted from the research and targeted consultation that group services have the potential to improve access to evidence-based care for people living with chronic conditions other than type 2 diabetes, and that expanding condition eligibility will address existing barriers to delivery and uptake of group services.

Therefore, the CCM Working Group recommended adopting the approach used for individual MBS CCM and Aboriginal and Torres Strait Islander health and wellbeing services – that is, patients are eligible for group services if they have one or more medical conditions that have been, or are likely to be, present for at least 6 months or are terminal. The CCM Working Group considered this approach more appropriate than developing a list of chronic conditions, as a list:

- may imply some conditions are more important than others, which may be difficult to justify
- would likely result in ongoing lobbying by advocates for conditions that are not listed
- would prohibit conditions that do not have diagnostic titles but that might still benefit from group services from accessing them.

Recommendation 4

The CCM Working Group did not consider it appropriate to broaden access to the CCM MBS group items to all health professions that are eligible to provide individual referred CCM services. There was a lack of evidence supporting the use of group therapy for all health professions, and not all professions would regard group therapy as valuable or even possible (financially and/or logistically). The CCM Working Group also acknowledged that broadening access to group services would not address workforce

⁶ The Quadruple Aim framework is a strategy aimed to support the delivery of high-value health care. It includes improving patient and provider experience, improving the health of the population, and reducing healthcare costs.

shortages, as it would likely only lead to some shift from individual services to group services.

The strongest available evidence and support (including from the umbrella review, quantitative research and targeted consultation) is for the use of group therapy by the following professions:

- Aboriginal and Torres Strait Islander health workers and practitioners
- accredited mental health social workers
- chiropractors
- occupational therapists
- osteopaths
- physiotherapists
- psychologists
- speech pathologists.

These professions will complement those that are currently eligible to render MBS group CCM services, namely exercise physiologists, dietitians and diabetes educators.

The CCM Working Group acknowledged that there was a lack of eligible health professionals in rural and remote communities, and access to appropriate health care was poor in these communities.

Recommendation 5

The CCM Working Group noted that the current MBS items require that group CCM services be performed in person (except for dietetic services). The umbrella review did not make a conclusion on the use of telehealth for CCM group therapy. However, members considered that allowing access to group services via telehealth could help overcome access barriers, especially for people living in rural and remote locations, and could facilitate uptake of group services when access to an appropriately sized room is not possible. This was supported by targeted consultation feedback. Allowing telehealth for all group services would also align with the principles and recommendations of the MRAC post-implementation [review of MBS telehealth items](#). However, it is important that the MBS criteria define telehealth requirements to ensure the services provided are of a high quality. Members noted that competency standards have been updated since the COVID-19 pandemic to ensure health professionals can provide effective therapy virtually.

When considering whether to restrict to video sessions only (that is, no phone calls), the CCM Working Group acknowledged that some CCM group therapy (such as those involving exercise programs) would be difficult to deliver using phone calls alone. However, the CCM Working Group recalled that feedback received during the MRAC post-implementation [review of MBS telehealth items](#) highlighted the importance of not limiting the telehealth modality, as this would restrict access for some of the most disadvantaged and at-need populations who do not have sufficient hardware, bandwidth or digital literacy to engage in video sessions (including older populations and patients living in rural or remote areas). Therefore, the CCM Working Group considered it appropriate to leave the choice of modality to the provider and patient.

Recommendation 6

The CCM Working Group noted that comparative models, such as that used by the Department of Veterans' Affairs, have a limit of 12 group sessions per patient per calendar year. Based on this, as well as the findings from the umbrella review and

qualitative research, the CCM Working Group considered that the cap for the number of group services per patient per year should be increased from 8 to 12.

The CCM Working Group considered this to be the pragmatic minimum number of group services that, when combined with the increase to the number of individual services (as part of recommendation 1), brings the total number of available MBS-referred CCM sessions more in line with the typical midpoint number of sessions required for many of the chronic conditions considered in this review, as identified in the research (see Table 3).

Recommendation 7

The CCM Working Group noted from the umbrella review that a key feature of group therapy is that the patient undergoes a suitable baseline assessment, and that the group service is delivered in accordance with the assessment. The CCM Working Group considered that the current 45-minute (minimum) assessment item for group services was suitable for some providers and patients, but it acknowledged that some health professions (such as occupational therapy) require a longer assessment. Therefore, the CCM Working Group recommended replacing the existing 45-minute assessment item with time-tiered MBS items of at least 40 minutes and at least 60 minutes, with proportional MBS fees.

Recommendation 8

The CCM Working Group acknowledged that it was challenging to assess a patient's progress during the final group session. It therefore considered it appropriate to create post-group service assessment items, time-tiered at 40 minutes and 60 minutes (with proportional MBS fees), that would be delivered as individual services. This would:

- allow the patient and health professional to provide feedback on the group sessions
- enable the health professional to educate the patient and empower them to self-manage at home
- support robust assessment of outcomes for the report back to the referring medical practitioner.

The CCM Working Group considered that 40 minutes should be the lowest time tier because 20 minutes is not long enough to have a valuable feedback session with the patient.

Recommendation 9

The CCM Working Group considered that an assessment framework should be developed to provide clarity for health professions submitting requests to render services under a GPCCMP. The framework would also provide consistency for the department and Government when considering the merit of these requests.

The framework (see [Appendix B](#)) was developed by the department using the MRAC review request application template and PICO (population, intervention, comparator, outcome) methodology, focusing on matters relevant to chronic conditions. It was then refined based on [targeted consultation feedback](#).

Regarding Vascular Interventional Radiology Working Group recommendation 13

The CCM Working Group noted that, as part of MRAC's [recent review of vascular interventional radiology \(VIR\) services](#) (February 2026), the VIR Working Group emphasised the importance of pre-surgery exercises for patients undergoing vascular

procedures. However, the VIR Working Group considered the cap of 5 MBS-referred CCM services was insufficient to cover the full exercise program, so referred this matter to the CCM Working Group. The CCM Working Group agreed that its recommended changes to MBS-referred CCM services covered the referred matter from the VIR Working Group.

Limitations and opportunities for further review

This review did not consider people living with multimorbidity. The CCM Working Group acknowledged that, although a significant improvement, the recommended service cap increases would still not cover the full treatment course for many people living with one chronic condition, let alone those living with multimorbidity. This means that, even with the recommended changes from this review, people living with more than one chronic condition (or with a complex chronic condition) will still have very high out-of-pocket costs to access treatment. More research is especially needed to understand the management requirements and, therefore, fair caps on service numbers for multimorbidity, which would be informative for a post-implementation review of the recommended changes. This research would also help inform work on developing a tailored number of sessions for each chronic condition.

To support the recommended service cap increases, the CCM Working Group advised that the way the number of eligible sessions are tracked must be improved. Any new system should be user-friendly and accessible by different CCM service providers. The CCM Working Group acknowledged that this is outside of the remit of the Department of Health, Disability and Ageing, but emphasised that it should be considered when planning implementation of the recommendations.

The CCM Working Group also advised that a future review of MBS-referred CCM services should consider how to support multidisciplinary models of person-centred care (such as group sessions delivered by a multidisciplinary team of health professionals). This includes reviewing the health professions eligible to provide MBS group services, to ensure that all health professionals involved in delivering group services are reimbursed appropriately and that patients are not left with high out-of-pocket costs.

Although reviewing and providing recommendations for each separate profession was out of scope for this review, the CCM Working Group acknowledged that the way some CCM services are delivered does not align with the current structure for the MBS M3 item group, and this affects uptake of services. For example, adults accessing occupational therapy must be assessed in their homes rather than at a clinic, and they often require much longer assessment and follow-up sessions than other CCM services, resulting in high out-of-pocket costs. The CCM Working Group advised that different CCM service requirements should be considered as part of a future review.

Appendix A Methods for the quantitative and qualitative research

Quantitative research

The quantitative research was a rapid evidence check review of peer-reviewed and grey literature, performed by the Sax Institute. The aim was to answer the question:

Is there a relationship between allied health consultation dose and health-related outcomes for people experiencing one or more chronic conditions? Does this differ by profession or health condition?

An initial search of literature identified more than 300 systematic reviews and meta-analyses eligible for inclusion (at full-text screening). To manage the delivery of findings, the research was split into 2 phases.

Specific stakeholders were also invited to provide literature for consideration, with those meeting the eligibility requirements being included in the review.

Phase 1

Phase 1 (108 peer-reviewed papers in total) focused on:

- stroke (post/sub-acute and chronic) ($n = 75$ papers)
- Parkinson's disease ($n = 26$)
- diabetes (types 1 and 2) ($n = 7$).

Most reviews reported on either exercise-based or multimodal interventions, with a small number focusing on other intervention types (such as psychological or communication-focused programs).

Physiotherapists and occupational therapists were the most frequently specified health professionals, often working within multidisciplinary teams that included other professions such as speech pathologists, psychologists, nurses, social workers, diabetes educators, dietitians and exercise physiologists.

Phase 2

Phase 2 (58 papers) focused on:

- cardiovascular disease (hypertension, coronary heart disease, heart failure) ($n = 2$)
- musculoskeletal conditions (osteoarthritis, back pain) ($n = 52$)
- chronic respiratory disease (chronic obstructive pulmonary disease, bronchiectasis, asthma) ($n = 4$).

Interventions were primarily exercise based, although many reviews also examined programs incorporating lifestyle education, psychological or behavioural therapies, as well as a wide variety of modalities (such as manual therapy, electrotherapy, biofeedback and virtual reality-based rehabilitation).

Physiotherapists were the most frequently specified health professionals, followed by chiropractors, osteopaths, occupational therapists, psychologists, dietitians, exercise physiologists and podiatrists, often working in multidisciplinary teams.

Qualitative research

The aims of the qualitative research were to:

- assess whether current MBS CCM services are adequately supporting patients with chronic conditions
- explore whether individual and group MBS CCM services could be improved to better support eligible patients.

The qualitative research approach included 3 stages of consultation with eligible peak bodies, providers and patients.

Stage 1

Stage 1 involved online in-depth interviews with representatives from peak bodies (individual or paired) ($n = 30$). The objective was to gather insights regarding:

- the number of individual services
- the minimum length of services
- the purpose and requirements of longer initial consultations
- the applicability of group therapy to specific professions
- relevant models of care
- barriers to service delivery.

The peak bodies that were approached to participate were:

- Australian Association of Social Workers
- Australian Association of Psychologists Inc
- Australian Podiatry Association
- Australian Chiropractors Association
- Chiropractic Australia
- Dietitians Australia
- Exercise & Sports Science Australia
- Osteopathy Australia
- Occupation Therapy Australia
- Australian Psychological Society
- Australian College of Mental Health Nurses
- Audiology Australia
- Australian Physiotherapy Association
- Speech Pathology Australia
- Australian Diabetes Educators Association
- National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
- Diabetes Australia
- Arthritis Australia
- Painaustralia

- Lung Foundation
- Kidney Health Australia
- National Alliance for Self-Regulating Professions
- Gastroenterological Society of Australia
- Allied Health Professions Australia
- Indigenous Allied Health Australia
- Services for Australian Rural and Remote Allied Health
- Neurological Alliance Australia
- Australian Cardiovascular Alliance
- Australian Primary Health Care Nurses Association
- Royal Australian College of General Practitioners.

Stage 2

Stage 2 involved a 5-day online forum with providers ($n = 30$). The objective was to gather insights regarding:

- the number of individual services
- the minimum length of services
- the purpose and requirements of longer initial consultation
- the applicability of group therapy to specific professions
- relevant models of care
- barriers to service delivery
- patient profile complexity.

The types of providers involved in the research were:

- Aboriginal and Torres Strait Islander health workers
- Aboriginal and Torres Strait Islander health practitioners
- an audiologist
- chiropractors
- a diabetes educator
- dietitians
- exercise physiologists
- a mental health nurse
- occupational therapists
- osteopaths
- podiatrists
- physiotherapists
- psychologists
- social workers
- speech pathologists.

Stage 3

Stage 3 involved a 5-day online forum with patients ($n = 33$). The objective was to gather insights regarding:

- the number of individual services
- the minimum length of services
- the benefit of longer initial consultations
- interest in attending group therapy services
- barriers to service access.

Patients involved in the research were living with the following conditions:

- cancer
- hypertension
- coronary heart disease
- heart failure
- chronic kidney disease
- chronic pain
- chronic obstructive pulmonary disease
- bronchiectasis
- asthma
- diabetes (types 1 and 2)
- inflammatory bowel disease
- Crohn's disease
- ulcerative colitis
- coeliac
- osteoarthritis
- osteoporosis
- Parkinson's disease
- epilepsy
- stroke
- obesity
- stuttering
- childhood apraxia of speech.

Appendix B Framework to assess health provider expansion to provide individual chronic condition management services

Framework element	Relevant details	Purpose and rationale
Problem statement	The applicant to outline the problem statement.	Articulation of the problem statement must focus on patient need. Specifically, what issue or gap are patients facing in the context of MBS-referred chronic condition management (CCM) services that needs to be addressed? Patient input should be sought and highlighted here.
Population	The applicant to provide an estimate of the patient population and outline if there are any patient access, equity or cultural safety issues that should be considered.	The patient population can be estimated from publicly available data on the prevalence of relevant chronic or terminal conditions, and the prevalence of the conditions in the Australian population. This information will assist in understanding the scale of the problem and if there are population specific and cultural matters that should be considered.
Intervention	The applicant to provide information on: • which chronic conditions are treated by the profession? • how does the profession provide treatment for the patient and their condition? • how does the treatment meet the clinical needs of the patient? • clinical efficacy, is there evidence (qualitative or quantitative) to support the intervention? • how the intervention fits the existing referred MBS CCM services?	MBS-referred CCM services are non-specific attendances. Providing information on which chronic conditions the profession routinely treat and manage, as well as the nature of the attendance and intervention, will assist in understanding the proposed solution. Information on the effectiveness of the intervention(s) and/or demonstrating that it is standard practice, will also assist in understanding the proposed solution. Supporting information could be provided in the form of health care guidelines or models of care.

Framework element	Relevant details	Purpose and rationale
		Providing information on how the intervention will complement and/or enhance existing MBS-referred CCM services will assist in understanding compatibility in the context of multidisciplinary care.
Comparator	The applicant to identify: - any existing MBS providers that deliver the same or similar services - any existing MBS services that address the same need.	This should focus on the existing MBS-referred CCM services. Information on whether there are existing MBS services that address the same need will assist in understanding the extent of the problem and the impact of the proposed solution.
Outcome	The applicant to identify the anticipated outcome of expanding MBS allied health CCM services.	Information about the expected outcomes of expanding MBS-referred CCM services must be provided. This should link directly to the issue or gap faced by patients in the problem statement, particularly improved equity of access for patients and Closing the Gap outcomes.
Funding	The applicant to provide information on: - how the services are currently funded - Is any funding provided by the federal or state and territory governments (e.g., Primary Health Care Networks, grant funding agreements, public hospitals or outpatient clinics etc.)? - the anticipated impact of MBS funding - Are there potential changes to how the service will be delivered and funded by expanding MBS-referred CCM services?	Information should be provided that identifies any existing funding sources for the services and if these arrangements allow for equitable access. This will assist in understanding the need for MBS funding to deliver the service and whether it is the most appropriate funding mechanism. Information should also be provided on any possible unintended consequences of MBS funding. For example, cost shifting by state and territory governments and associated workforce transitions.
Workforce	The applicant to provide information on:	For MBS provider eligibility, it is important that providers not only have the appropriate qualifications, but that their profession has processes in place

Framework element	Relevant details	Purpose and rationale
	- the existing qualification requirements of the profession - how the profession is regulated, including registration requirements, continuous professional development and standards of practice - how complaints against the profession are managed - workforce statistics, including the number of providers, the public/private split and geographic distribution.	for professional recognition and ongoing development and training to ensure that the services provided are safe and of high quality. Workforce statistics will assist in understanding the capacity of the profession to meet the needs of patients as well as any potential workforce transitions and rural workforce impacts.
Letters of support	The applicant to provide letters of support from relevant peak professional and advocacy organisations.	Information on the extent to which the applicant has consulted and obtained support from professional and advocacy organisations will demonstrate the level of support for the proposal.
Other	The applicant to provide any other information in support of the request.	This will provide an opportunity for the applicant to add any other information considered relevant to support its request.

Appendix C Medicare Benefits Schedule Continuous Review

The Medicare Benefits Schedule (MBS) is a list of health professional services (items) subsidised by the Australian Government for health consumers. MBS items provide patient benefits for a wide range of health services including consultations, diagnostic tests, therapies and operations.

The MBS Continuous Review builds on the work of the MBS Review Taskforce (the Taskforce). From 2015 to 2020, the Taskforce provided the first extensive, line-by-line review of the MBS since its inception in 1984.

In October 2020, the Australian Government committed to establishing a continuous review framework for the MBS, consistent with recommendations from the Taskforce Final Report.

Established in 2021, the MBS Continuous Review allows for ongoing rigorous and comprehensive reviews of Medicare items and services by experts, on a continuous basis, to ensure that the MBS works for patients and supports health professionals to provide high-quality care.

Medicare Benefits Schedule Review Advisory Committee

The MBS Continuous Review is supported by the MBS Review Advisory Committee (MRAC). The Committee's role is to provide independent clinical, professional and consumer advice to Government on:

1. opportunities to improve patient outcomes in instances where a health technology assessment by the Medical Services Advisory Committee (MSAC) is not appropriate
2. the safety and efficacy of existing MBS items
3. implemented changes to the MBS, to monitor benefits and address unintended consequences.

The MRAC comprises practising clinicians, academics, health system experts and consumer representatives. The current MRAC membership is available on the Department of Health, Disability and Ageing's [MRAC webpage](#).

MBS Continuous Review guiding principles

The following principles guide the deliberations and recommendations of the MBS Continuous Review:

a) The MBS:

- is structured to support coordinated care through the health system by
 - recognising the central role of General Practice in coordinating care
 - facilitating communication through General Practice to enable holistic coordinated care
- is designed to provide sustainable, high-value, evidence-based and appropriate care to the Australian community
 - item descriptors and explanatory notes are designed to ensure clarity, consistency and appropriate use by health professionals
- promotes equity according to patient need
- ensures accountability to the patient and to the Australian community (taxpayer)

- is continuously evaluated and revised to provide high-value health care to the Australian community.
- b) Service providers of the MBS:
- understand the purpose and requirements of the MBS
 - utilise the MBS for evidence-based care
 - ensure patients are informed of the benefits, risks and harms of services, and are engaged through shared decision making
 - utilise decision support tools, Patient Reported Outcome and Experience Measures where available and appropriate.
- c) Consumers of the MBS:
- are encouraged to become partners in their own care to the extent they choose
 - are encouraged to participate in MBS reviews so patient healthcare needs can be prioritised in design and implementation of MBS items.

The MRAC and its working groups recognise that General Practice general practitioners are specialists in their own right. Usage of the term 'General Practice', both within this report and in the MBS itself, does not imply that general practitioners are not specialists.

The MRAC notes that the MBS is one of several available approaches to funding health services. The MRAC and its working groups apply a whole-of-healthcare-system approach to its reviews.

Government consideration

On finalisation of the review, MRAC's recommendations will be provided to Government for consideration through a Budget process. If Government agrees to the implementation of recommendations, it will be communicated through Government announcement. After Government agreement, implementation takes approximately 12 to 18 months to allow for engagement with stakeholders and the passage of legislation.

Information on MBS changes will be made available on [Department of Health, Disability and Ageing websites](#), including [MBS Online](#), and departmental newsletters.