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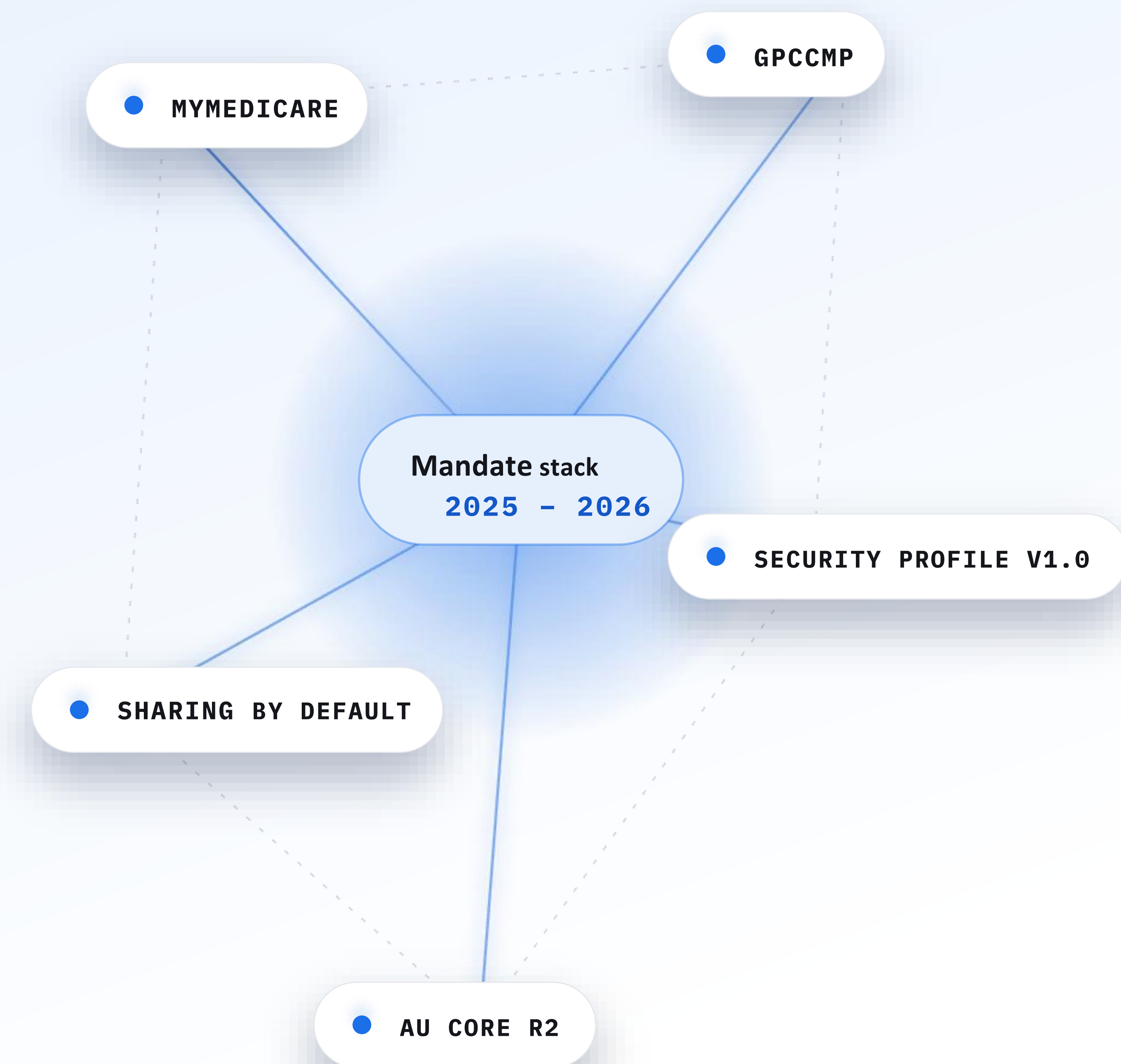
KASTHUNT CONSULTING · HEALTHCARE AI   BRIEF NO. 001 — 2026   THOUGHT LEADERSHIP

AUSTRALIA · PRIMARY CARE · DIGITAL HEALTH

Australia's Digital Health Mandates

2025 – 2026

What changed, what is coming, and what the next twelve months demand of multi-site clinic operators.



PUBLISHED · MAY 2026

Prepared for CEOs and COOs of clinic groups operating one to fifty sites.

THE MANDATE STACK RESHAPING MULTI-SITE PRIMARY CARE

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IN THIS BRIEF

Contents & Scope

Between 1 July 2025 and 1 July 2026, two structurally different mandates have reshaped what it means to operate a compliant, billable, and competitive multi-site clinic clinic group in Australia.

This brief explains what changed, why it changed, where the operational risk sits, and and what AI-enabled solutions can realistically do to absorb the new burden.

WRITTEN FOR

CEOs and COOs of Australian clinic groups operating between one and fifty sites multi-disciplinary general practice, allied health, specialist outpatients, and groups with a residential aged care service line.

THE JOURNEY · EIGHT SECTIONS

01 The strategic context p.04

02 1 July 2025 mandate p.06

03 1 July 2026 mandate p.12

04 The wider landscape p.17

05 Where groups get tripped up p.20

06 How AI can realistically help p.21

07 Recommendations & roadmap p.24

08 The bottom line p.26

APPENDICES A–D **Glossary** · Key dates & milestones · Track-by-track checklist · Sources & references p.28

TWO DATES THAT MATTER

1 July 2025 · 1 July 2026

1 JULY 2025 MyMedicare & GPCCMP commenced.

1 JULY 2026 Sharing by Default commences.

00 · OPENING

Executive summary

Australia's healthcare system is in the middle of its most significant regulatory and digital digital transformation in a decade. Between 1 July 2025 and 1 July 2026, two structurally structurally different mandates have reshaped what it means to operate a compliant, billable, and competitive multi-site clinic group in this country.

The first — the **MyMedicare and GPCCMP** reforms that commenced on 1 July 2025 — restructured the way chronic care is funded and the way patients are attributed to practices. practices. The second — the **Sharing by Default** mandate that commences on 1 July 2026 2026 under the Health Legislation Amendment (Modernising My Health Record—Sharing Sharing by Default) Act 2025 — restructures the way clinical data flows into the national national health record and the way Medicare benefits are tied to digital compliance.

Both mandates carry material financial consequences. Both demand operational changes changes that cannot be solved with a software update alone. And both have a structural structural blind spot for groups operating across multiple sites: patient attribution, vendor vendor accountability, and compliance visibility do not scale linearly with the number of of clinics under one banner.

TWO MANDATES, TWELVE MONTHS APART

1 JULY 2025 — LIVE

MyMedicare + GPCCMP

Funding restructured.

01 **Patient registration model live.**
Voluntary MyMedicare program operating since Oct 2023; ~10% of patients enrolled.

02 **Old 721/723 retired.**
GP Management Plan and Team Care Arrangement items ceased on 30 June 2025.

03 **New items 965/967.**
Single consolidated GPCCMP item at $156.55 (GP) and $125.30 (PMP).

1 JULY 2026 — IMMINENT

Sharing by Default

Data flow restructured.

01 **Pathology + imaging auto-upload.**
Reports flow to My Health Record by default; patients can opt out, providers cannot.

02 **Penalties up to $82,500/offence.**
Civil penalties under s 41A; 250 penalty units × $330.

03 **Medicare benefit clawback.**
Non-compliant providers lose the MBS payment for the test or scan as a Commonwealth debt.

STRATEGIC INFLUENCE
Australia's Digital Health Transformation

2025 + 2026	2025 + 2026	2025 + 2026	2025 + 2026
Revenue Impact	Compliance Impact	Technology Impact	Operational Impact

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SECTION 01 · THE STRATEGIC CONTEXT

Why these reforms exist

1.1 The structural problem the Australian government set out to solve

Before October 2023, Australia stood out among OECD countries for one striking reason: it had no formal mechanism to link a patient to a primary care provider. A patient could see one GP for a chronic condition, another for a prescription, and a third for a referral, with no system in place to coordinate care, share information, or hold any single provider accountable for continuity.

This created four cascading problems each of which the new mandates were designed to address.

The government's response outlined in Australia's Primary Health Care 10-Year Plan (2022–2032) was not a single intervention but a layered reform strategy that connects funding, registration, data flow, and accountability into one ecosystem. Each mandate reinforces the others.

THE FOUR STRUCTURAL PROBLEMS

01 No patient registration system

Australia was an OECD outlier. **76.9%** of Australians reported a usual GP in 2023, but care fragmented freely across practices with no informational continuity.

02 Chronic disease pressure

An ageing population and rising rates of complex chronic conditions were colliding with a primary care system not engineered for multidisciplinary coordination.

03 Fee-for-service breaks coordination

The MBS rewards transactional volume, not continuity. Integrated care for complex patients is structurally disadvantaged by the funding model.

04 Old system gamed

721/723 plans were billed, filed, and forgotten. The billing event existed; the care relationship often did not. Government was paying for coordination it could not verify.

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SECTION 01 · STRATEGIC CONTEXT

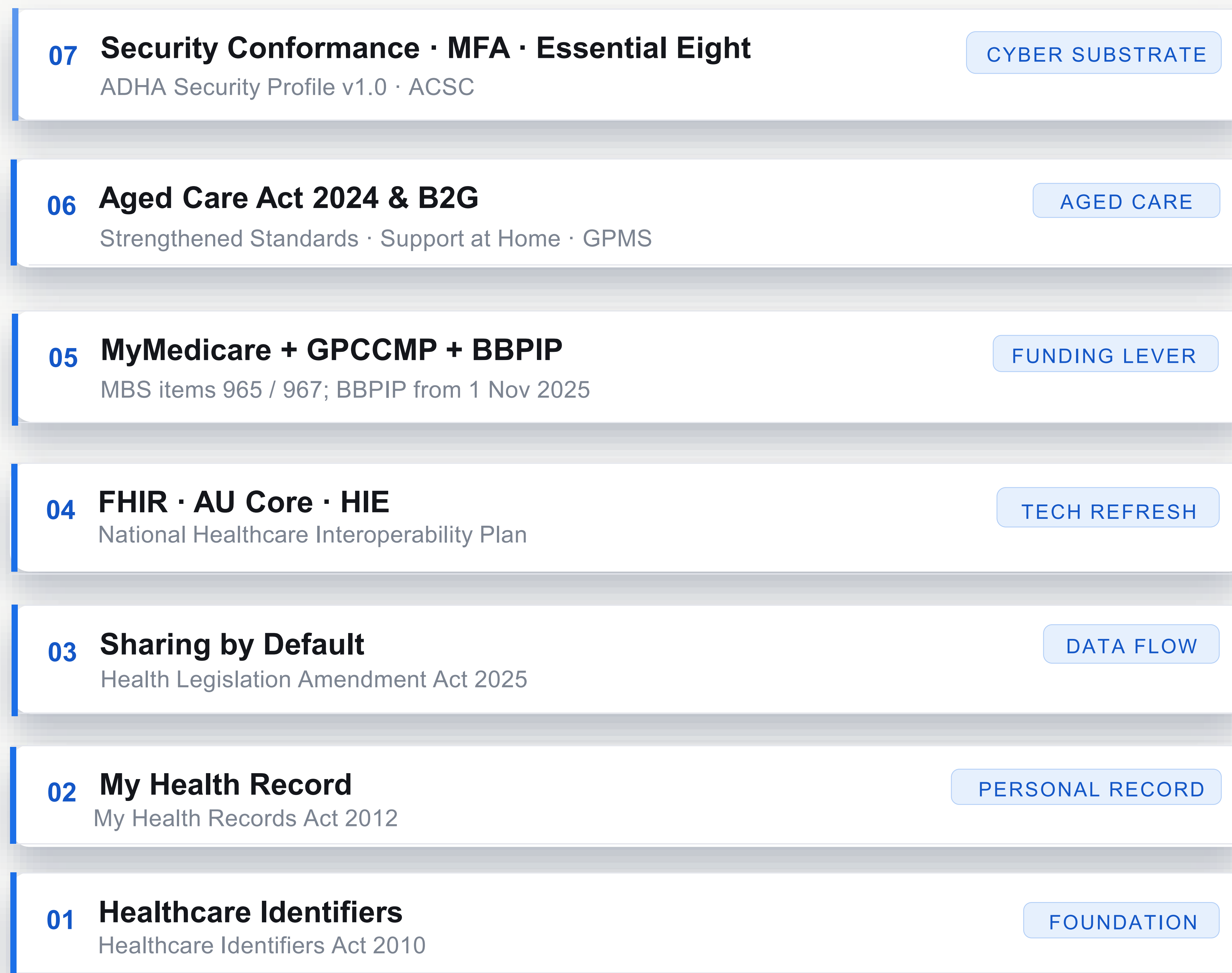
1.2 The government's response — a layered reform strategy

Understanding the seven-layer reform stack is essential, because each layer reinforces and is dependent on the layer below it. The stack reads bottom-up.

As of 2026, more than **24 million Australians** have a My Health Record built on this identifier infrastructure. Most **(99%)** GPs and pharmacies use it, but only about **half** of pathology reports and **one in five** diagnostic imaging reports were being shared to it as of 2024 the problem the 1 July 2026 mandate exists to solve.

ARCHITECTURE

AUSTRALIA'S DIGITAL HEALTH REFORM STACK



SECTION 02 · THE 1 JULY 2025 MANDATE

MyMedicare and GPCCMP

2.1 What changed on 1 July 2025

On 1 July 2025, the Medicare Benefits Schedule chronic disease management framework was fundamentally restructured. The old items used by GPs to claim for chronic condition planning 721 (GP Management Plan), 723 (Team Care Arrangement), and 732 (review) were retired. They were replaced by a single, consolidated framework built around two new items: **965 (preparation)** and **967 (review)**, each attracting a fee of **$156.55** for GPs and **$125.30** for prescribed medical practitioners.

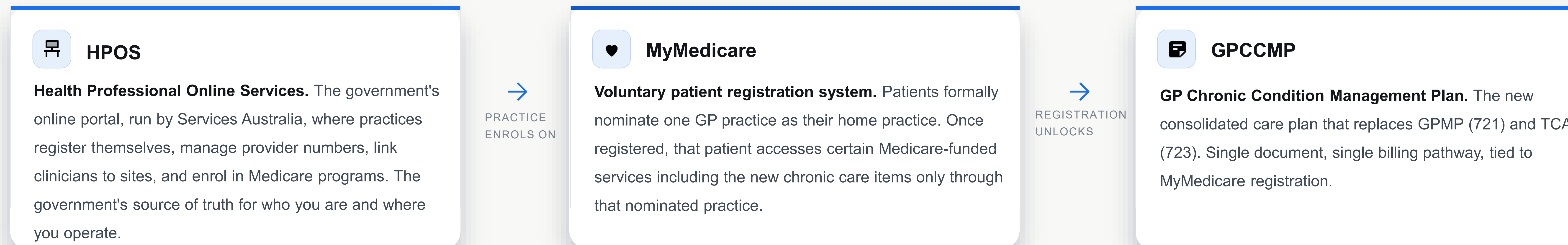
$156.55 New item 965 / 967 fee (GPs). Single consolidated plan.

~10% Of patients registered under MyMedicare since Oct 2023 ~2.6 million Australians.

30 Jun 2027 Deadline for pre-1 July 2025 GPMP/TCA plans to transition to GPCCMP.

But the structural change was bigger than the billing code change. **The new items can only be claimed for patients who are formally registered with the practice under the MyMedicare voluntary patient registration program.** This is the first time in Australian primary care history that access to a Medicare item has been tied to a formal patient–practice registration relationship.

2.2 Understanding the key terms



COMPARATIVE ANALYSIS

2.3 Old vs new — a side-by-side comparison

The structural shift is captured in ten operational dimensions. The change is not merely cosmetic; the rules of access, billing, and portability have all moved.

CHRONIC CARE FRAMEWORK, PRE VS POST 1 JULY 2025

DIMENSION	OLD MODEL · per 1 July 2025	NEW MODEL · from 1 July 2025
Item numbers	721 (GPMP prep), 723 (TCA prep), 732 (review)	**965 (prep), 967 (review)**
Structure	Two separate plans - distinct items with different purposes	Single consolidated plan covering both
Who can bill	Only the GP who prepared the plan	Any GP or PMP at the registered practice
Patient eligibility	Any patient with a chronic condition - no registration required	Patient must be **MyMedicare-registered** at your practice
Fee	721 ≈ $164.35, 723 ≈ $130.25 (separate claims, ceased rates)	965 prep / 967 review = **$156.55** (GPs); **$125.30** (PMPs)
Review cycle	3–12 months, billed separately per item	Consolidated review under 967, same practice
Allied health referral	Up to 5 visits under TCA (item 723)	Up to 5 visits, referral pathway preserved
Admin burden	High - two plans, two sets of documentation, two billing events	Reduced - one plan, one billing pathway
Portability	Patient could access plan at any practice	Plan tied to MyMedicare-registered practice
Transition	N/A	Existing 721/723 plans valid until **30 June 2027**

Source: Department of Health, Disability and Ageing; Services Australia MBS billing rules for GP chronic condition management plans.

Two dimensions deserve special attention from a multi-site operator's vantage point: **who can bill** and **portability** . The former unlocks within-practice flexibility (any GP at the registered site). The latter creates an entirely new operational risk if a patient walks into the "wrong" site under your banner.

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2.4 The patient journey — old vs new

This is where the strategic implications of the new model become operational reality. We follow one patient through both regimes.

R PERSONA · RAJ · 58 · TYPE 2 DIABETES + HYPERTENSION

WHERE ATTRIBUTION BREAKS AT CLINIC B

PRE-1 JULY 2025 · OLD MODEL

Step 01
First visit, any clinic
Raj walks into Clinic B. No prior registration needed.

Step 02
Two separate plans
GP creates 721 (GPMP) + 723 (TCA). Two claims, two documents.

Step 03
Allied health
Up to 5 Medicare-subsidised allied health visits, any provider.

Step 04
Review
3–12 months later. Could be at any GP, any clinic.

Step 05
Patient moves
New clinic picks up where the old one left off. No re-registration.

POST 1 JULY 2025 · NEW MODEL

Step 01
Register first
Raj nominates Clinic A via Medicare online / Express Plus app.

Step 02
Clinic A enrolled
Site must be MyMedicare-enrolled on HPOS; every GP linked.

Step 03
One plan, bill 965
Single GPCCMP document. GP bills MBS 965 for preparation.

Step 04
Allied health
Up to 5 Medicare-subsidised visits, unchanged.

Step 05
Review, bill 967
Raj returns to Clinic A. GP bills MBS 967.

WHERE IT BREAKS
Raj walks into Clinic B

Raj is travelling, Clinic A has a long wait, or he prefers Clinic B's GP that day. Clinic B checks: Raj is MyMedicare-registered at Clinic A, not Clinic B. **Clinic B cannot bill MBS 967 for Raj. Full stop.** Clinic B can still provide care but cannot claim the chronic care item. Raj either pays out of pocket or Clinic B absorbs the gap.

THE IMPLICATION FOR MULTI-SITE OPERATORS

> **For a CEO or COO of a multi-site group, patient attribution is now a revenue integrity issue, a care continuity issue, and an operational design issue - all at once.**
>
> — KASTHUNT CONSULTING · STRATEGIC BRIEF, MAY 2026

2.5 What this means for a 10-site or 50-site group

If all your sites are registered as separate MyMedicare entities on HPOS, you have the attribution problem at scale. A patient registered at Site 3 cannot be billed for GPCCMP items at Site 7.

If your group has explored network-level MyMedicare registration where sites operate under a shared organisational structure there may be more flexibility, but this depends on your legal and operational structure and how Services Australia has classified your sites.

2.6 Why the government accepted this trade-off

The friction is not an oversight. The government considered it, accepted it, and built solutions around it in three layers:

LAYER 1 · VOLUNTARY BY DESIGN

Patients still access MBS-funded primary care at any practice. The restriction on GPCCMP items is intentional the mechanism that creates accountability.

LAYER 2 · LOW UPTAKE RECOGNISED

Only ~10% of patients have signed up since Oct 2023. A 2025 National Consumer Sentiment Survey found just one in three Medicare cardholders had even heard of MyMedicare.

LAYER 3 · INCENTIVES DRIVE UPTAKE

Rather than mandate patient registration, the government makes it financially attractive for practices to drive it see incentive stack overleaf.

The incentive stack BBPIP (1 Nov 2025), longer telehealth, blended payments for complex chronic patients, uncapped aged care incentive, mental health and early childhood cohorts to follow is the lever the government is pulling to convert practice behaviour into patient enrolment.

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The incentive stack - the government's solution to drive uptake

BBPIP

+12.5% incentive on every dollar of MBS benefit from eligible services. Live 1 November 2025. To participate, practices must be registered for MyMedicare.

Telehealth

From 1 Nov 2025, **triple bulk billing incentive** for longer telehealth consultations expanded to all Medicare-eligible patients registered through MyMedicare.

Blended pay

From 2024–25, MyMedicare practices can access new **blended funding payments** for complex, chronic patients who frequently attend hospitals. Rolling out over three years.

Aged care

General Practice in Aged Care Incentive has **no cap** on the number of patients a GP can visit, unlike the previous $10,000/year limit.

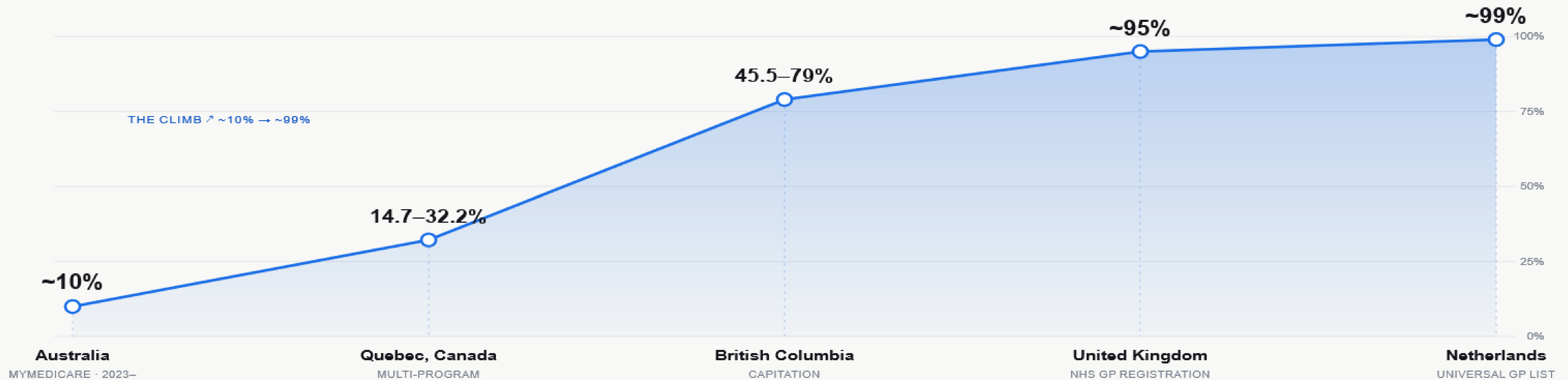
Next cohorts

Mental health and early childhood expected to be incentivised through MyMedicare in 2025 and beyond.

INTERNATIONAL COMPARISON · PATIENT REGISTRATION COVERAGE ACROSS OECD COUNTRIES

Australia is an outlier on patient registration

Share of population formally registered or attributed to a primary care provider visualised as an ascent. Australia & Quebec figures from voluntary programs; UK / NL via mandatory or near-universal GP registration.



Sources: UNSW 2025 analysis; Consumers Health Forum NCSS 2025; OECD comparative studies on primary care registration models.

Sharing by Default

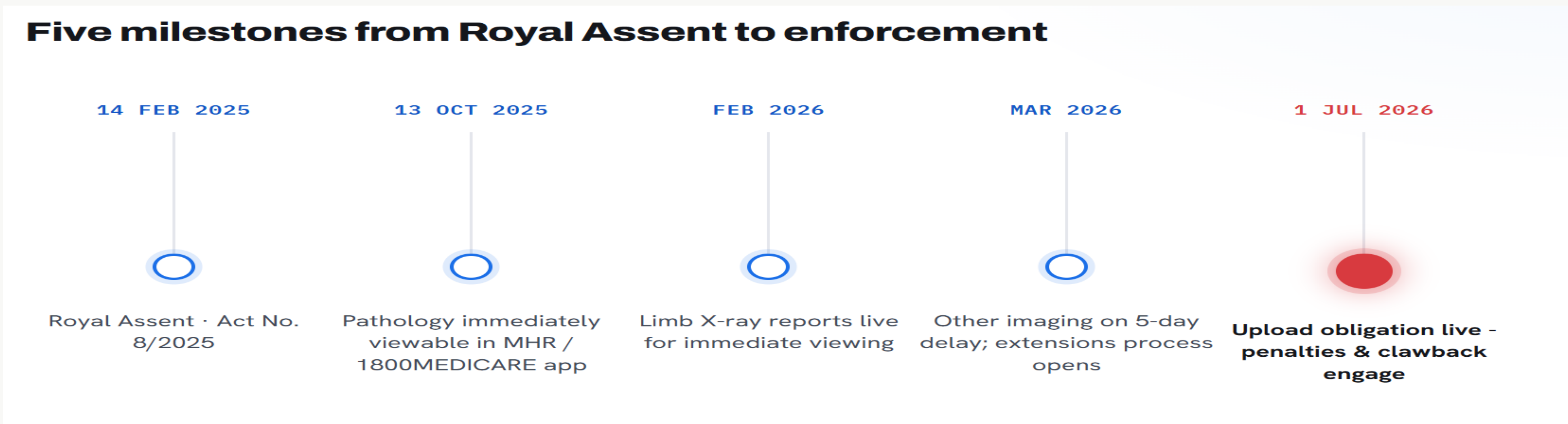
3.1 What the mandate does in plain terms

From 1 July 2026, if a patient has a pathology test or diagnostic imaging scan done, the lab or radiology provider must automatically upload the report to the patient's My Health Record. No additional patient request is needed. If they do not upload, the provider loses their Medicare payment for that test. Patients can opt out, but the default is now: results go in automatically.

This is the **Health Legislation Amendment (Modernising My Health Record—Sharing by Default) Act 2025** — Act No. 8 of 2025, which received Royal Assent on 14 February 2025. The accompanying My Health Record (Share by Default) Rules 2025 (F2025L01569) and the companion Health Insurance (Share by Default) Rules 2025 sit underneath the Act.

3.2 The phased rollout

The reform did not arrive all at once. It is being delivered in staged phases, with the upload obligation as the final commencement.



Source: Australian Digital Health Agency · Department of Health, Disability and Ageing rollout schedule (current as at May 2026).

3.3 The enforcement framework - what the penalties actually look like

This is not a framework with aspirational guidelines and no teeth. The Act introduces three tiers of civil penalty for non-compliance, plus a Medicare clawback mechanism that flows directly to the provider.

PENALTY ARCHITECTURE · CIVIL PENALTIES & MEDICARE CLAWBACK

$82,500

TIER 01 · PER OFFENCE

Failure to register under section 41A of the My Health Records Act. The most serious civil penalty in the framework.

250 penalty units × $330

$9,900

TIER 02 · PER INSTANCE

Failure to upload required information per the Share by Default Rules.

30 penalty units × $330

$3,300

TIER 03 · PER INSTANCE

Failure to keep records of exceptions for the 2-year retention period.

10 penalty units × $330

DIRECT REVENUE IMPACT

Medicare clawback

If a report is not uploaded and no valid exception applies, the Commonwealth can recover the Medicare benefit paid for that service as a debt owed by the provider. The patient's Medicare entitlement is unaffected. The recovery comes from the provider. As Health Minister Mark Butler put it at Victorian Healthcare Week: pathology and diagnostic imaging companies that do not upload **"will not get a Medicare benefit for that test or scan."**

The penalty unit value is currently $330, under section 4AA of the Crimes Act 1914, in effect from 7 November 2024 through 30 June 2026. The next indexation occurs 1 July 2026 — meaning these penalty values will rise immediately after the mandate commences.

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3.4 The compliance checklist - every mandate, every owner

This is the master compliance table for any multi-site clinic group operating in Australia in 2026.

● HIGH ● MEDIUM ● LOW

12 MANDATES, DEADLINES, PENALTIES, OWNERS

#	MANDATE & WHAT IT MEANS	APPLIES TO	DEADLINE	SEVERITY	ACTION OWNER
01	**Sharing by Default — pathology** Labs auto-upload pathology to MHR	Pathology providers	1 Jul 2026	● HIGH	Lab operator
02	**Sharing by Default — imaging** Radiology auto-uploads imaging	Imaging providers	1 Jul 2026	● HIGH	Imaging operator
03	**MyMedicare practice registration** Every site registered on HPOS, program enrolled	All GP practices	Live · ongoing	● MED	Practice manager
04	**GPCCMP new chronic care items** 965 / 967 — patient must be MyMedicare-registered	GP practices · chronic patients	Live 1 Jul 2025	● HIGH	GP + billing team
05	**MHR software conformance** CIS/PMS on ADHA Register of Conformity	All MHR-connected practices	Ongoing	● MED	Software vendor
06	**Security Conformance Profile v1.0** MFA, encryption, pen testing, hardening	All MHR-connected systems	Live Sept 2024	● HIGH	IT lead + vendors
07	**Healthcare Identifiers** HPI-O, HPI-I, IHI maintained correctly	All providers	Ongoing	● MED	Practice manager
08	**Patient opt-out + exception records** Inform patients, manage opt-outs, keep records 2 years	All referring practices	1 Jul 2026	● HIGH	Clinical governance

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MASTER COMPLIANCE CHECKLIST · CONTINUED

3.4 The compliance checklist — every mandate, every owner

This is the master compliance table for any multi-site clinic group operating in Australia in 2026.

● HIGH ● MEDIUM ● LOW

#	MANDATE & WHAT IT MEANS	APPLIES TO	DEADLINE	SEVERITY	ACTION OWNER
09	**Electronic prescribing** Conformant eScript platform	All prescribing providers	eP-default trial 2026	● MED	Prescribers +vendor
10	**Aged Care Act 2024** New quality standards, 24/7 RN reporting, registered categories	Groups with RACF service lines	Live 1 Nov 2025	● HIGH	Clinical + ops
11	**NASH PKI certificate** Required for MHR, eScripts, secure messaging	All sites	Ongoing	● MED	IT lead
12	**AU Core FHIR R2 / AU eRequesting** Not mandated, but HIE integration assumes FHIR	All software buyers	Practical: 2027–28	● LOW	COO / CTO

READING THE TABLE

Severity dots: ● **high** · ● **medium** · ● **low**. Twelve mandates converge on the same multi-site operating model — a single conformance audit cycle can surface all of them at once.

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3.5 Vendor vs provider responsibility split

For CEO / COO accountability purposes, it is critical to distinguish what your software vendors owe you from what your clinic group owes the regulator. Written attestation is the only acceptable evidence in an audit verbal assurance does not count.

SOFTWARE VENDOR VS CLINIC GROUP RESPONSIBILITIES

OWED TO YOU

Software vendor responsibilities

- ✓ Software conformance —Security Profile v1.0, MHR upload, eP, FHIR APIs
- ✓ ADHA conformance assessment completed and current
- ✓ Declaration on Register of Conformity — written, dated, verifiable
- ✓ Ongoing security updates with documented patch cadence
- ✓ MFA enforcement for privileged users, regardless of VPN status
- ✓ Vendor-side breach notification within contracted SLA

OWED BY YOU

Clinic group responsibilities

- ✓ Organisation registration — HPI-O, NASH PKI current
- ✓ Organisation Register accuracy in HPOS at every site
- ✓ Accreditation against National General Practice Accreditation Scheme
- ✓ Clinician credentialing — HPI-I tracking, AHPRA status, site linkage
- ✓ Patient identification & consent workflow at every touchpoint
- ✓ Opt-out & exception record-keeping retained 2 years
- ✓ MyMedicare patient registration drive and reporting
- ✓ MBS billing integrity against new GPCCMP rules

If a software vendor cannot attest in writing to the Security Conformance Profile v1.0 by 30 June 2026, that is a procurement signal — not a technicality. The right escalation is a replacement RFP, not a renegotiated SLA.

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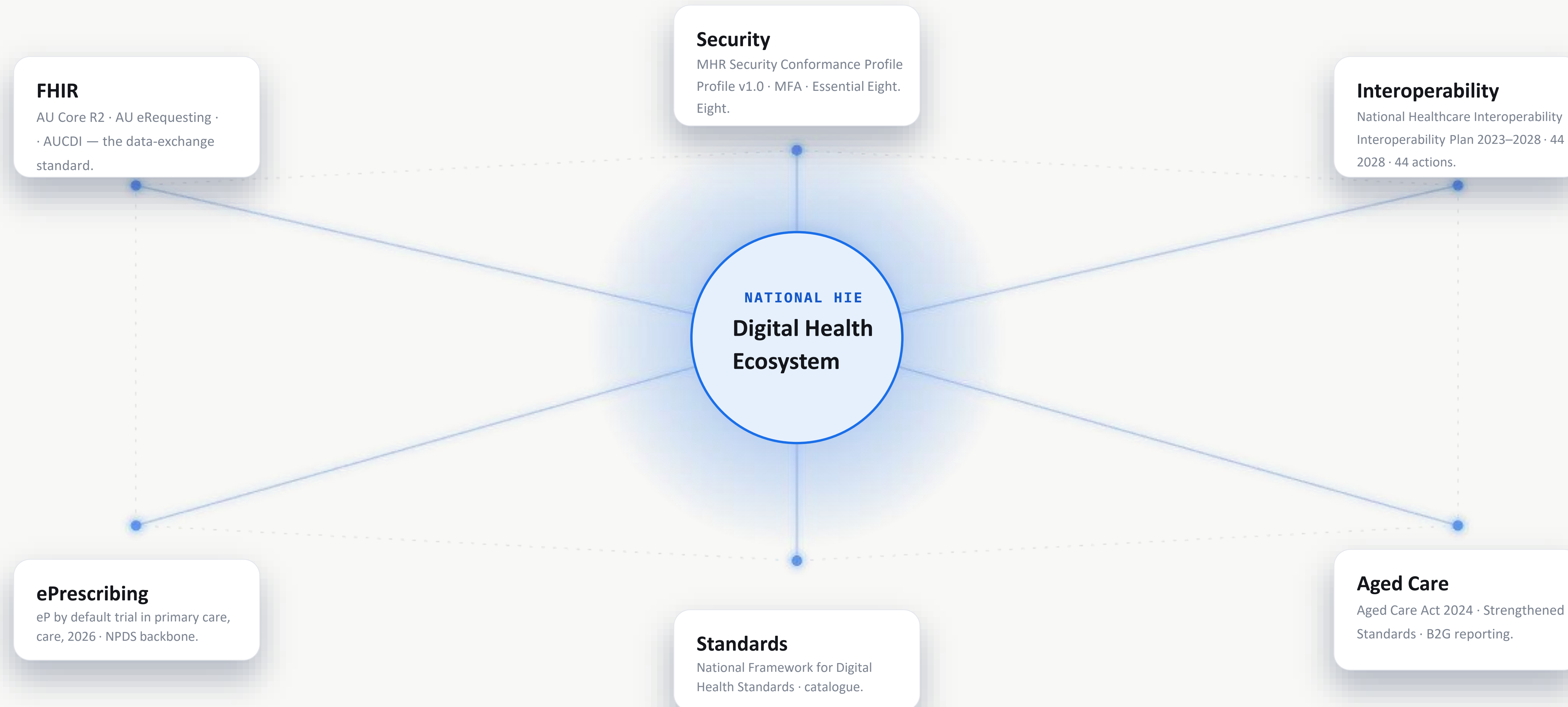
SECTION 04 · BEYOND THE TWO HEADLINES

The wider mandate landscape

The 1 July 2025 and 1 July 2026 mandates are the headline items, but a multi-site clinic group cannot operate in 2026 without awareness of the other regulatory and infrastructure changes happening in parallel.



SECTION 04 · THE WIDER MANDATE LANDSCAPE · 4.1 – 4.3

Security, FHIR & electronic prescribing

The 1 July 2025 and 1 July 2026 mandates are the headline items, but a multi-site clinic group cannot operate in 2026 without awareness of the other regulatory and infrastructure changes happening in parallel.

4.1

MHR Connecting Systems — Security Conformance Profile v1.0

Published by the Australian Digital Health Agency in September 2024, this profile applies to all Clinical Information Systems and Contracted Service Providers including HIPS that use one or more My Health Record B2B web services. It mandates multi-factor authentication for privileged users (regardless of VPN), penetration and vulnerability testing, hardened configurations, encryption controls, and incident management.

HIPS v9.0 - released 7 July 2025 is the first HIPS version aligned to the new profile; new installations after that date must use v9.0. Conformance is applied to **software** , not organisations, but as a buyer of that software, clinic groups are exposed if their vendors do not comply.

4.2

FHIR adoption — no mandate yet, but the procurement floor is rising fast

There is no Australian regulation mandating FHIR R4 in primary care, specialist or allied health practices today. What exists is rapid de facto standardisation:

- **Sparked AU FHIR Accelerator** (CSIRO + ADHA + Department of Health + HL7 Australia), 2023–2025.
- **AU Core FHIR IG R1** approved Jan 2025; R2 published after Aug–Sept 2025 ballot. AUCDI R1 released 2024.
- **AU eRequesting Release 1.0** - Australia's first end-to-end FHIR-based national clinical service specification, replacing paper / fax orders.
- **ADHA Health Information Gateway** - Deloitte contract; technical go-live July 2025; FHIR-native; part of the National HIE build-out.

FHIR is not mandatory yet but every state EMR procurement, PHN integration, hospital discharge feed and HIE pilot from 2025 onwards assumes FHIR.

4.3

Electronic prescribing — eP by default trial in 2026

The 2023–24 Budget plan to mandate electronic prescribing of high-risk and high-cost drugs has been superseded by the Electronic prescribing by default model. Per the Department of Health: **"Electronic prescribing by default will initially be trialled in primary care in 2026 where existing electronic prescribing clinical systems are already in use."** Paper prescriptions remain available as an exception. NPDS supports nearly 300 million prescriptions annually via Fred IT Group's eRx Script Exchange.

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4.4

National Framework for Digital Health Standards — consultative, not yet mandatory

ADHA released a draft National Framework for Digital Health Standards for consultation, open **10 November 2025 to 31 January 2026** . Once final, the Framework will sit alongside the National Digital Health Standards Catalogue (first published June 2024), the Council for Connected Care, and the Standards Advisory Group.

The Framework does not introduce new mandates beyond the existing reforms but it signals where future mandates will be drawn from. Operators should monitor the post-consultation outputs in Q2 2026.

4.5

National Healthcare Interoperability Plan 2023–2028

44 actions across five priority areas: identity, standards, information sharing, innovation, and measuring benefits. ADHA Chief Digital Officer Peter O'Halloran told the Medical Software Industry Association Summit on 1 November 2024 that the interoperability plan is **"now running close to one year ahead of time."**

COMPLETED ACTIONS

- Healthcare Identifiers Roadmap
- Standards catalogue & guiding principles
- Conformance Framework
- Procurement guidance
- GP & aged care interoperability work
- Digital health maturity assessments

MEDIUM-TERM (2025–26 → 2027–28)

- FHIR-enabled My Health Record (MHR on FHIR)
- Health Information Exchange build-out
- Provider Connect Australia maturity
- National Health Services Directory expansion
- AU Core R2 / AU eRequesting baseline adoption

ADHA CEO Amanda Cattermole PSM, on the release of the National Digital Health Strategy Action and Impact Report 2023–2025, noted that 47% of Agency-led initiatives are complete and 53% are underway. For multi-site operators, the practical read-out is that the regulatory and infrastructure runway is shortening, not extending. Plans that assumed 2028 deadlines should be re-baselined.

OPERATOR TRANSLATION

Three separate work streams - security profile, FHIR readiness, eP by default converge on the same procurement decisions in 2026. A single conformance audit cycle can surface all of them; running them as separate workstreams creates duplicate vendor conversations and missed deadlines.

SECTION 05 · FAILURE MODES

Where multi-site groups get tripped up

After tracking the full landscape, five recurring failure modes emerge in multi-site clinic operations. Each is avoidable. None is theoretical.

01

Conflating MHR conformance with security profile conformance

The Security Conformance Profile v1.0 is **additional** , on top of clinical conformance, and applies to ALL existing connectors not only new installations.

02

Assuming Sharing by Default does not apply because you do not run a lab

Referring providers have an obligation to manage patient opt-outs, communicate the regime, and record exceptions for two years. The mandate touches every referring practice, not only labs.

03

Letting MyMedicare registration drift across sites

Patients registered at the wrong site lose access to GPCCMP items at the site they are actually attending. Drift compounds quarter over quarter without active reconciliation.

04

Trusting verbal vendor assurances over Register entries

Written attestation against the ADHA Register of Conformity with the date is the only acceptable evidence in an audit. Reassuring emails from account managers are not.

05

Treating FHIR as a vendor problem

Until a state hospital network or PHN-led care coordination platform requires AU Core APIs as a condition of integration at which point it becomes a procurement problem at speed.

SECTION 06 · WHERE AI PLUGS IN

How AI can realistically help

The core problem AI needs to solve here is not clinical. It is operational and informational. The reforms have created compliance and revenue problems too distributed and too data-heavy to solve with spreadsheets and manual workflows. **Six places AI plugs into the new regime:**

Healthcare AI Operating Model | SIX CAPABILITIES · ONE LAYER

01 DETECT

Patient registration gap detection

Scan PMS visit history to flag patients seen 3+ times in 12 months who are not MyMedicare registered, chronic patients without an active GPCCMP, and patients registered at one site but attending another.

02 OUTREACH

Automated patient registration outreach

Conversational AI on SMS or WhatsApp drafts personalised messages explaining MyMedicare, handles inbound replies, pre-fills registration forms from PMS data, and closes the loop with the practice.

03 TRANSITION

GPCCMP plan transition management

Every 721/723 patient must be transitioned by 30 June 2027. AI prioritises by review date, auto-generates GPCCMP draft documentation for GP review, and triggers recall workflows for patients not seen recently.

04 ATTRIBUTE

Real-time site attribution intelligence

Sits across booking and attendance data to flag when a registered patient books at a non-registered site, prompts reception, and reports registration drift weekly to the COO.

05 DASHBOARD

Compliance & revenue leakage dashboard

A single CEO/COO view of registration coverage, GPCCMP coverage of chronic patients, MBS revenue left on the table, and BBPIP compliance per site maintained in near-real time.

06 SCRIBE

AI Scribe for GPCCMP documentation

Listens to the consultation and auto-generates the GPCCMP plan, mapped to MBS items with care goals, treatment approach, and allied health referral fields. 15–20 minute tasks become 3–5 minute GP sign-offs.

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The six interventions in detail

01 Patient identification & registration gap detection. The cheapest first move because the source data already exists in your PMS. The AI joins the registration table to the appointment table to the problem list. Output: a ranked weekly list of unregistered high-value patients.

02 Automated registration outreach. Conversational AI on SMS or WhatsApp drafts personalised messages, handles inbound replies, pre-fills registration forms from PMS data, and closes the loop with the practice. Small clinical lift; meaningful conversion lift.

03 GPCCMP plan transition management. Every 721/723 patient must be transitioned by 30 June 2027. AI prioritises by review date, auto-generates GPCCMP drafts for GP review, and triggers recall workflows. A 50-site group with 80k active plans is otherwise looking at a manual project.

04 Real-time site attribution intelligence. Sits across booking and attendance data to flag when a registered patient books at a non-registered site, prompts reception, and reports drift weekly to the COO. The single biggest revenue-protection use case in the new framework.

05 Compliance & revenue leakage dashboard. A single CEO/COO view of registration coverage, GPCCMP coverage, MBS revenue left on the table, and BBPIP compliance per site — maintained in near-real time, with site-level outliers surfaced automatically.

06 AI Scribe for GPCCMP documentation. Listens to the consultation and auto-generates the GPCCMP plan, mapped to the correct MBS item with care goals, treatment approach, and allied health referral fields. 15–20 minute tasks become 3–5 minute GP sign-offs.

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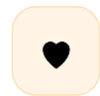
6.1 · THE LIMITS OF AUTOMATION

What AI cannot solve



TRUST PROBLEM

AI cannot fix a patient who actively does not want to register, that is a **trust and communication problem.**

TRAINING PROBLEM

It cannot fix a GP who does not understand the new billing framework - that is a **training problem.**

PROCUREMENT PROBLEM

It cannot fix a PMS vendor who has not integrated with the MyMedicare API - that is a **procurement problem.**

AI works on top of functioning infrastructure and willing participants.

SECTION 07 · A 12-MONTH ROADMAP

Strategic recommendations

A three-stage execution roadmap, oriented to the two mandate dates and the longer-arc procurement decisions that follow. Each action has a benchmark - a measurable signal of completion.

STAGE 01
Stabilise
By end Q2 2026 · next six weeks

01
Appoint a single Digital Health Compliance Lead typically COO or Quality Manager, with quarterly board reporting.

Benchmark · Named lead by end of June 2026.

02
Run a vendor conformance audit. Pull each clinical software vendor's entries from the ADHA Register of Conformity. Demand written attestation against Security Conformance Profile v1.0.

Benchmark · 100% of vendors attested in writing within 30 days, or remediation plan triggered.

03
Verify MFA is on for privileged users at every site regardless of VPN status.

Benchmark · Zero exceptions in IT audit.

04
Confirm every site's HPOS Organisation Register entry is current accreditation date, MyMedicare enrolment, every provider linked.

Benchmark · Zero expired records.

STAGE 02
Operationalise
Before 1 July 2026

05
Run a Sharing by Default tabletop exercise with pathology/imaging suppliers. Map consent/opt-out, exception-recording, and patient communication flows. If you operate a pathology or imaging service line, complete the ADHA Share by Default Scope Interactive Guide.

06
Patient communication script. Train front-of-house and clinicians to explain Sharing by Default. Sensitive categories (BBV, sexual/reproductive health, genetic testing) deserve proactive conversations per ASHM guidance.

07
Cyber insurance and breach response. Confirm incident response plan satisfies the security profile and OAIC APP 11 expectations. Map to ACSC Essential Eight maturity level appropriate to size.

STAGE 03
Procure
Through FY 2026–27

08
Make AU Core R2 and AU eRequesting a contractual requirement in any clinical software renewal. De facto baseline for HIE participation by 2027.

09
Engage with your PHN on Provider Connect Australia, the National Health Services Directory, and the National Digital Health Capability Action Plan.

10
Track the National Framework for Digital Health Standards final release post 31 January 2026 consultation close where the mandate-versus-recommend boundary for the next 3–5 years will be drawn.

7.1 · EXECUTIVE ALERT DASHBOARD

Benchmarks that would change the plan

Four triggers that should prompt an off-cycle escalation to the board or audit committee:

TRIGGER 01 · VENDOR

Vendor cannot attest to Security Profile by 30 June 2026

Escalate to replacement RFP. Do not negotiate further extensions.

TRIGGER 02 · SERVICE LINE

Pathology / imaging line not on MHR Conformance Register by Q1 2026

Activate extension application or partner with a conformant lab.

TRIGGER 03 · CLINICAL

Referring GP records an exception more than 5% of the time

Audit clinical decision-making. Exceptions are meant to be rare, not routine.

TRIGGER 04 · PROCUREMENT

Clinical software vendor signals no AU Core R2 implementation

Factor into renewal negotiations or replacement.

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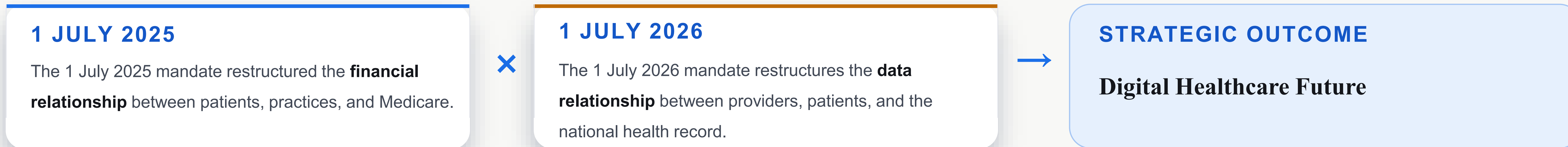
SECTION 08 · CLOSING ARGUMENT

The bottom line



Together, they signal a deeper structural shift: Australia is moving from a fragmented, voluntary, fee-for-service primary care system to an attributed, accountable, digitally-mandated one. For multi-site clinic operators, the next 12 months are not about reacting to two deadlines. They are about building the operational, technical, and governance infrastructure that the next decade of Australian primary care will be built on.

The groups that treat this as a compliance burden will be playing catch-up by 2027. The groups that treat it as a strategic opportunity **investing in patient attribution, vendor accountability, and AI-enabled operational visibility now** will be the ones the system rewards.

CLOSING STATEMENT

"Compliance is the floor. Strategy is the ceiling. The groups building between them will define Australian primary care in 2027."

— KASTHUNT CONSULTING · MAY 2026

APPENDIX A

Glossary of terms

Term	Definition
ADHA	**Australian Digital Health Agency** Federal agency leading digital health policy and infrastructure.
AHPRA	**Aus. Health Practitioner Regulation Agency** National body registering health practitioners.
ASL	**Active Script List** Consumer-accessible list of active electronic prescriptions.
AUCDI	**Aus. Core Data for Interoperability** Core clinical data set defined for FHIR profiles.
AU Core	**Australian Core FHIR IG** National FHIR profile baseline for Australian healthcare.
BBPIP	**Bulk Billing Practice Incentive Program** 12.5% incentive on MBS benefits for fully bulk billing practices.
CDA	**Clinical Document Architecture** HL7 standard for clinical documents (precedes FHIR).
CIS	**Clinical Information System** Software used by clinicians for clinical record-keeping.
FHIR	**Fast Healthcare Interoperability Resources** HL7 standard for healthcare data exchange.
GPCCMP	**GP Chronic Condition Management Plan** New consolidated chronic care plan, replaces 721/723.
GPMP	**GP Management Plan** Old MBS item 721, retired 1 July 2025.
HIE	**Health Information Exchange** National network for sharing health information.
HIPS	**Healthcare Information Provider Service** ADHA software used by some providers to connect to MHR.
HPI-I	**Healthcare Provider Identifier (Individual)** 16-digit identifier for each registered clinician.
HPI-O	**Healthcare Provider Identifier (Organisation)** 16-digit identifier for each healthcare organisation.
HPOS	**Health Professional Online Services** Services Australia portal for practice and provider management.
IHI	**Individual Healthcare Identifier** 16-digit identifier for each individual healthcare recipient.
MBS	**Medicare Benefits Schedule** Federal schedule of Medicare-funded health services.
MHR	**My Health Record** National personal health record system.
NASH	**National Authentication Service for Health** PKI certificate service for secure healthcare transactions.
NPDS	**National Prescription Delivery Service** National backbone for electronic prescription exchange.
OAIC	**Office of the Aus. Information Commissioner** National privacy regulator.
PCA	**Provider Connect Australia** National provider directory and information service.
PHN	**Primary Health Network** Regional health planning and commissioning body.
PMP	**Prescribed Medical Practitioner** Non-VR medical practitioner eligible for certain MBS items.
PMS	**Practice Management System** Software used for clinic operations and billing.
RACF	**Residential Aged Care Facility** Facilities delivering permanent aged care services.
TCA	**Team Care Arrangement** Old MBS item 723, retired 1 July 2025.

APPENDIX B

Key dates & milestones

Date	Milestone
Sept 2024	MHR Connecting Systems — Security Conformance Profile v1.0 published.
Nov 2024	Sharing by Default Bill introduced to Parliament.
1 Nov 2024	ADHA CDO Peter O'Halloran states interoperability plan is "close to one year ahead of time" at MSIA Summit.
Jan 2025	AU Core FHIR IG R1 approved by Sparked Technical Design Group.
14 Feb 2025	**Sharing by Default Act receives Royal Assent** (Act No. 8/2025).
28 Feb 2025	DH-4115:2025 security profile implementation supporting document released.
6 Mar 2025	Healthcare Identifiers (Active Script List Registration) Regulations 2025.
May 2025	Decision to make all pathology results (including genetic) available immediately or within 5 days.
1 July 2025	**MyMedicare GPCCMP MBS reform live;** old 721/723 retired.
7 July 2025	HIPS v9.0 released, aligned to Security Conformance Profile.
Aug–Sept 2025	AU Core FHIR IG R2 ballot.
13 Oct 2025	**Most pathology reports immediately viewable** in MHR / 1800MEDICARE app.
1 Nov 2025	**New Aged Care Act 2024 commences; BBPIP commences.**
10 Nov 2025 – 31 Jan 2026	National Framework for Digital Health Standards consultation.
Nov 2025	National Digital Health Strategy Action and Impact Report 2023–2025 published (47% delivered).
Feb 2026	Limb X-ray reports go live for immediate consumer viewing.
March 2026	Other diagnostic imaging viewable on 5-day delay; extensions process opens.
1 July 2026	**Sharing by Default upload obligation commences;** penalty unit value indexes.
FY 2027–28	Practical de facto deadline for AU Core R2 / AU eRequesting baseline.

APPENDIX C

Track-by-track checklist (selected)

TRACK	OWNER	ACTION
MyMedicare	Practice manager + GP lead	Every site linked in HPOS Organisation Register; every eligible GP linked; MyMedicare program added to Org Site Record.
GPCCMP workflow	Clinical governance	Retire 721/723 templates; configure Best Practice / Medical Director / Bp Premier for items 965 and 967. Pre-1 July 2025 plans transition by 30 June 2027.
MHR connectivity	IT / vendor	Confirm software is on ADHA Register of Conformity for view + upload (shared health summary, event summary, e-referral, ACP).
Cyber conformance	IT + vendors	Written attestation that CIS/PMS conforms to Security Conformance Profile v1.0 — MFA, encryption, patching, backup, pen testing.
Sharing by Default	Path/imaging primary; referring practice secondary	Inform patients; understand opt-out workflow; flag "do not upload" requests; (if needed) extension application.
Healthcare Identifiers	Practice manager	Maintain HPI-O (seed/network), NASH PKI certificate, HPI-I for every clinician, IHI lookup at every patient touchpoint.

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APPENDIX D

Sources & references

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HEALTHCARE AI CONSULTING

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