Design Envelope ID: E46CA5A7-C775-43E-B6AF-80B2BBDCCB06

ABRIDGE

Abridge AI Inc.
30 S 15th St Ste 1550
PMB 41901
Philadelphia, PA 19102
govtaffairs@abridge.com

Physician-Focused Payment Model Technical Advisory Committee
Office of Health Policy
Assistant Secretary of Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Sent electronically to PTAC@HHS.gov

SUBJECT: PTAC Proposal Submission — Transcript-Cited GenAI Payment Model for Care Coordination

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee:

Abridge appreciates the opportunity to submit comments in response to the proposed model under consideration titled, "Transcript-Cited GenAI Payment Model for Care Coordination" by the U.S. Department of Health and Human Services' (HHS) Physician-Focused Payment Model Technical Advisory Committee (PTAC).

We look forward to continued engagement with the PTAC and the Administration on designing thoughtful approaches to unleash data to improve management of chronic conditions, empower patients, and reduce administrative burdens. Our comments below reflect our shared goals to improve value-based care and empower patients through the effective and responsible adoption of technology in healthcare. The observations offered herein are intended to support PTAC's independent evaluation of

the proposal under the Secretary's statutory criteria, rather than to propose modifications to the model itself.

Abridge Background

Abridge was founded in 2018 by physicians to improve clinical documentation efficiencies while enabling clinicians to focus on what matters most—their patients. With the patient's consent, Abridge's AI technology captures conversations via a secure smartphone application or laptop/desktop with web recording to document conversations with clinicians. The clinical note is presented in real-time, allowing the clinician to review and edit the resulting note as needed. Once the clinician reviews and submits the notes, they are directly integrated into the patient's electronic health record (EHR).

Abridge also recently announced a collaboration with a payer-provider to provide real-time, in-appointment support for clinicians navigating the prior authorization process. The technology identifies the information needed to support prior authorization requests, assembles evidence to support those requests, pinpoints where missing criteria must be addressed, and completes notation of clinical visit documentation all while the patient is still in the room. The result: improved efficiency, more complete and timely submissions, clearer context for coverage review, enhanced patient experiences, and reduced administrative burden for payers.

Abridge's solution supports a critical evolution of the patient-clinician relationship by improving clinician well-being, reducing administrative burdens, and more fully reflecting the care patients receive from clinicians. Through partnerships with more than 200 health systems, Abridge is currently used by tens of thousands of clinicians, across a wide range of specialties and care settings, who report enhanced clinician satisfaction, reductions in note-writing efforts and volume of after-work hours spent, as well as decreased turnaround time to respond to patient inquiries.

AI as a Critical Solution in Medicare

When deployed appropriately, generative AI can improve the way clinicians are reimbursed for providing high quality care. Generative AI's true value in this context lies in its unique ability to transform unstructured patient-clinician conversations into

high-fidelity, actionable, and auditable transcript-grounded documentation. This new data stream creates legibility around the qualitative and contextual dimensions of care that are often invisible in traditional claims data, offering a richer and more accurate reflection of patient complexity and needs.

That is why Abridge supports the consideration of initiatives – like the Transcript-Cited GenAI Payment Model for Care Coordination – that could improve efficiency and incentivize the use of innovative technologies. From Abridge's perspective, the proposal does not merely contemplate payment for documentation, but more holistically validates clinical insight derived directly from patient-clinician interactions, including information relevant to care coordination, quality measurement, and accurate reflection of patient complexity, which PTAC may view as distinct from traditional claims-based reimbursement approaches.

Abridge also acknowledges HHS' broader efforts to test other outcomes-based payment models by utilizing innovative technologies, such as the Centers for Medicare & Medicaid Services' (CMS) Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model. The CMS ACCESS Model will test outcomes-aligned results associated with the use of new technologies in the treatment of chronic conditions.

Taken together, the ACCESS Model and the proposed Transcript-Cited GenAI Payment Model for Care Coordination reflect an important shift toward upstream, patient-centered data to support value-based care.

Proposal Feedback

As PTAC considers the proposed model, Abridge respectfully offers several observations that we believe may be relevant to the model's long-term success, scalability, and alignment with beneficiary and clinician needs. These observations are offered in reference to the Secretary's statutory evaluation criteria—including value over volume, flexibility, quality and cost, payment methodology, scope, ability to be evaluated, integration and care coordination, patient choice, patient safety, and health information technology to assist PTAC in its independent assessment of the proposal.

First, Abridge strongly encourages PTAC to prioritize capability- and standards-based requirements rather than vendor-specific implementations. Defining

transcript-grounded documentation, clinician review, auditability, and interoperability in functional terms will promote competition, innovation, and broad adoption across diverse practice settings, while avoiding unintended vendor lock-in.

Second, while transcript-cited documentation meaningfully improves data fidelity, Abridge believes it is important that any associated payment mechanisms remain clearly linked to patient-centered outcomes—such as care gap closure, improved adherence, reduced avoidable utilization, and enhanced care coordination—rather than documentation volume alone. Documentation should serve as a pathway to better care, not an end in itself. Notably, transcript-grounded data may enable new forms of quality measurement that claims data cannot support, such as whether barriers were identified, whether those barriers were addressed, and whether appropriate follow-up occurred.

For example, a patient with uncontrolled Type 2 diabetes may have a complex conversation with their primary care physician about their inability to afford a new prescription or their struggle with housing or food insecurity, which directly impacts medication adherence. While traditional claims data may only reflect that the prescription was not filled, a transcript-grounded note captures the specific social determinants of health barriers discussed, allowing the payment model to recognize the complexity of the patient's condition and the clinician's effort in providing care coordination, even when immediate clinical outcomes remain challenging. This shift from simple billing codes to auditable, contextualized documentation is essential for accurately measuring high-quality, whole-person care.

Third, Abridge supports the model's emphasis on clinician oversight and underscores the importance of maintaining human-in-the-loop review as a foundational safeguard. Ensuring that clinicians retain final authority over AI-generated outputs will be essential to maintaining trust, particularly as ambient and asynchronous technologies become more widely adopted.

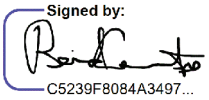
Finally, appropriate quality thresholds, oversight processes, and operational safeguards will remain essential to ensure accuracy and reliability across varied clinical environments. PTAC may also wish to consider how transcript-cited outputs could support consistent evaluation across participating and non-participating providers,

including the use of comparison groups to assess impacts on quality, utilization, and administrative burden.

Taken together, the proposal appears to touch on each of the Secretary's statutory criteria, and careful attention to standards, safeguards, interoperability, and outcome linkage may be especially important as PTAC conducts its independent assessment. Abridge appreciates PTAC's role in rigorously assessing whether emerging technologies can be responsibly incorporated into payment policy in ways that advance value-based care while protecting beneficiaries and clinicians alike.

We appreciate your consideration of our comments and welcome any future opportunities to work with PTAC and the HHS to advance solutions to deploy ambient listening and other AI tools for the betterment of healthcare delivery.

Sincerely,

Signed by:

C5239F8084A3497...

Reid Conant, MD, FACEP
Sr. Physician Executive