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

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

Dear Committee Members,

On behalf of **CareCo**, I am pleased to submit for your review the *Transcript-Cited GenAI Payment Model for Care Coordination*. This proposed Physician-Focused Payment Model is designed to align reimbursement with the most upstream and reliable source of clinical truth: the patient conversation itself.

For decades, Medicare reimbursement and quality reporting have depended on claims data, a downstream proxy that is disconnected from the patient's voice and vulnerable to waste, fraud, and abuse. With advances in transcription and generative AI, it is now possible to anchor documentation — and therefore payment — directly in the words of patients, whether captured in a phone call, video visit, text exchange, or in-person encounter.

The proposed model reimburses providers when GenAI-supported documentation is:

- **Cited back to a transcript**, ensuring verifiable fidelity;
- Used to **update care plans**, report quality measures, or capture risk adjustment conditions; and
- **Reviewed and approved by the provider or clinical staff member**, maintaining clinical accountability.

This model represents a structural shift from a trust-based system to a **proof-based system**. It strengthens Medicare integrity by eliminating fraud potential, reduces provider burden, and delivers better data to CMS while improving safety, equity, and patient-centeredness.

We respectfully submit this proposal for your consideration and look forward to engaging with PTAC during the review process.

Sincerely,

Mendel Erlenwein
CEO & Founder, CareCo

Cover Page

Proposal Title: Transcript-Cited GenAI Payment Model for Care Coordination
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Abstract

Proposal Title: Transcript-Cited GenAI Payment Model for Care Coordination

Submitting Entity: CareCo

Overview

This proposal introduces a Physician-Focused Payment Model (PFPM) that ties reimbursement directly to the most upstream and verifiable source of clinical truth: the patient conversation. For decades, Medicare reimbursement has relied on downstream claims data, which is disconnected from the patient's voice, vulnerable to fraud, and insufficient for measuring the value of care coordination.

With advances in transcription and generative artificial intelligence (GenAI), providers can now capture complete transcripts of patient interactions — whether by phone, video, text, or in-person ambient recording — and generate structured documentation such as care plan updates, quality measure reporting, risk adjustment coding, and social determinants of health (SDOH) capture. Crucially, each data point is linked to a verifiable citation in the transcript, ensuring accuracy and auditability.

Key Features of the Model

- Provider Eligibility: Physicians, nurse practitioners, care coordinators, behavioral health providers, and organizations such as ACOs and FQHCs.
- Patient Eligibility: Medicare beneficiaries engaged in longitudinal or preventive care, particularly those with multiple chronic conditions or SDOH needs.
- Care Delivery: All reimbursed documentation is derived from transcripts of patient conversations and reviewed by the provider before submission.
- Payment Model: New add-on CPT/G-codes, PMPM modifiers, or performance bonuses triggered only when documentation includes transcript citations.

Expected Benefits

- Quality: Care plans and reporting directly reflect the patient's words.
- Cost: Reduces waste, fraud, and abuse by making phantom billing impossible.
- Equity: Improves capture of social and behavioral needs often missed in claims data.
- Provider Burden: Reduces administrative work through GenAI support, allowing more time with patients.
- Evaluation: Built-in auditability makes the model straightforward to evaluate against CMS's quality and cost goals.

This model represents a structural shift from a trust-based to a proof-based payment system, delivering better data, stronger integrity, and more patient-centered care.

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Summary of Key Elements:

Provider Eligibility

- Physicians, nurse practitioners, clinical nurse specialists, and other eligible professionals engaged in care coordination.
- Care coordinators, community Health Workers, behavioral health providers, and social workers functioning under physician supervision.
- Organizations such as Accountable Care Organizations (ACOs), Federally Qualified Health Centers (FQHCs), multi-specialty groups, and primary care practices.

Patient Eligibility

- Medicare beneficiaries receiving longitudinal or preventive care, including:
    - Chronic Care Management (CCM)
    - Transitional Care Management (TCM)
    - Annual Wellness Visits (AWV)
    - Behavioral Health Integration (BHI)
    - Advanced Primary Care Model (APCM)

- Particularly applicable to **high-need populations** with multiple chronic conditions, social determinants of health (SDOH) barriers, or high risk of hospital readmission.

Accountable Entity

- The participating provider organization (e.g., ACO, FQHC, or physician group) acts as the accountable entity.
- The entity receives Medicare payments and distributes funds to eligible professionals.
- Physicians retain oversight and accountability for all GenAI-supported documentation.

Care Delivery Model

- Patient interactions (phone, video, text, or in-person) are **transcribed in full**.
- GenAI generates structured outputs (care plan updates, quality metrics, risk adjustment documentation, SDOH capture).
- Each output must include a **verifiable citation to the transcript**.
- Providers review and approve before submission to the EHR.
- Documentation becomes audit-ready, reducing fraud and ensuring accuracy.

Payment Model

- Introduces new **add-on CPT/G-codes** or **PMPM modifiers** for transcript-cited documentation events.
- Example reimbursement triggers:
    - Care plan updates tied to transcript citations.
    - Quality measure reporting with transcript evidence.
    - Risk adjustment/HCC documentation verified by transcript.
- Optional performance-based bonus for improved care gap closure and risk adjustment accuracy.
- Payment is contingent on **citation to the patient conversation**, making the model resistant to waste, fraud, and abuse.

1. Problem Statement

The Current Paradigm: Claims-Based ROI

For decades, CMS and other payers have relied on **claims data** as the primary measure of quality, utilization, and return on investment in healthcare. While this was once the only feasible option, claims data is:

- **Downstream**: It is generated long after the patient interaction, shaped by coding and billing rules rather than clinical nuance.
- **Fragmented**: Claims are divorced from the patient's voice, often omitting social determinants of health (SDOH), functional status, and behavioral context.
- **Distorted by incentives**: Providers code and document in ways that maximize reimbursement, not necessarily in ways that reflect clinical truth.
- **Susceptible to fraud and waste**: Billing systems reward time spent and volume of codes, creating perverse incentives for over-documentation, copy-paste behaviors, and even phantom services.

In effect, claims serve as a **blunt instrument**, insufficient for capturing the richness of care coordination and the complexity of patient needs. They are at best a **proxy** for clinical reality — and at worst, a barrier to innovation and accurate measurement.

The Gap: Disconnect Between Patient Conversations and Documentation

At the heart of care delivery is the **conversation between patient and provider.** This is where:

- New symptoms are revealed.
- Barriers to adherence are discussed.
- Social and behavioral needs come to light.
- Shared decision-making occurs.

Yet under current reimbursement and documentation systems, this foundational conversation is reduced to:

- A set of billing codes.
- A physician note often typed hours later, influenced by memory and administrative burden.
- A claim submitted weeks after the fact.

By the time CMS or any payer evaluates quality or outcomes, the data is **five steps removed** from the original source of truth:

Patient → Provider → EMR Note → Coder → Claim.

This distance not only reduces accuracy but also enables **waste, fraud, and abuse**. Providers can bill for time without demonstrating impact, and coders can inflate documentation without verifiable patient input.

A New Possibility: Going Upstream with GenAI

For the first time, modern transcription and GenAI technologies make it possible to anchor documentation **directly in patient conversations.** Whether through:

- **Phone calls** with a care coordinator,
- **Video visits** with a physician,
- **Secure text messaging**, or
- **Ambient in-person recording** of an exam room encounter,

We now have the ability to:

1. **Transcribe** the entire patient interaction.
2. **Generate structured documentation** (care plan updates, quality reporting, risk adjustment, SDOH capture).
3. **Cite every data element back to the transcript**, including exact time stamps or quoted excerpts.

This approach represents the **most upstream, accurate, and fraud-proof source of truth** available to the healthcare system.

Why Transcript-Citation is a Breakthrough

1. Data Fidelity:

Transcript-based documentation reflects what the patient actually said, not what was inferred or coded later. This ensures quality reporting, risk adjustment, and care planning are grounded in reality.

2. Auditability and Fraud Prevention:

Every reimbursed data point must have a verifiable link to the transcript. If the patient never said it, it cannot be documented. This makes phantom billing, over-coding, or "note bloat" impossible. Unlike current models, this system does not rely on trust — it creates **proof.**

3. Reduced Burden:
GenAI reduces the cognitive load on providers by surfacing structured documentation from conversations automatically, while still requiring provider review and sign-off.

4. Policy Value:
This model provides CMS and CMMI with **higher-quality, real-time data** to inform payment reform, replacing lagging claims proxies with direct patient-sourced insights.

Why Existing Medicare Policy Cannot Solve This

Current payment methodologies — including chronic care management (CCM), transitional care management (TCM), and even value-based models — all ultimately tie reimbursement back to **time, codes, or claims.**

- Time-based reimbursement rewards length of interaction, not quality of insights.
- Code-based reimbursement rewards quantity of documentation, not accuracy.
- Claims-based measurement delays evaluation by months, while errors and fraud accumulate.

There is no mechanism today that allows reimbursement **only when documentation is verifiably grounded in patient conversation transcripts.**

Thus, without a new payment model, CMS will miss the opportunity to capitalize on the most transformative advance in care documentation in decades.

The Opportunity

The proposed Transcript-Cited GenAI Payment Model addresses this systemic problem by:

- **Shifting reimbursement upstream** to the point of patient interaction.
- **Eliminating fraud and abuse** by requiring transcript citations for every reimbursed output.
- **Improving patient outcomes** by ensuring care plans reflect patient voice and context.
- **Reducing administrative burden** while increasing provider trust in AI-generated documentation.

This is not just an incremental improvement; it is a **structural shift** in how Medicare measures, reimburses, and evaluates care coordination.

2. Proposed Care Delivery Model

2.1 Overview

The proposed Transcript-Cited GenAI Payment Model integrates **patient conversations** into the very foundation of care documentation and reimbursement. It is designed to work across care settings, provider types, and communication modalities, ensuring flexibility and inclusivity for diverse practice environments.

At its core, the model ensures that all reimbursed documentation is:

1. **Generated during or immediately following patient interactions.**
2. **Derived from complete, auditable transcripts of those interactions.**
3. **Cited back to the transcript, with time-stamps or direct quotations.**
4. **Reviewed and approved by the provider** prior to submission into the EHR or billing system.

2.2 Patient Interaction Modalities

The model supports care coordination across **multiple modalities**, recognizing that modern Medicare beneficiaries engage with care teams in diverse ways:

- **Phone calls** – e.g., Chronic Care Management check-ins.
- **Video visits** – e.g., telehealth primary care or behavioral health.
- **Secure text or messaging** – e.g., asynchronous patient updates or education.
- **In-person ambient recordings** – e.g., Annual Wellness Visits, follow-ups, or specialty care encounters.

Each interaction type produces a **verbatim transcript** that becomes the source of truth for all downstream documentation.

2.3 Workflow

The workflow is standardized to ensure reproducibility and auditability:

1. **Capture**
    - Patient-provider (or patient-coordinator) conversation is transcribed in real time using HIPAA-compliant tools.

2. **Processing with GenAI**

    - GenAI analyzes the transcript and generates structured outputs such as:

        - Care plan updates (new goals, barriers, interventions).
        - Quality measure documentation (e.g., PHQ-9 score, fall risk screening).
        - Risk adjustment insights (e.g., HCC coding candidates).
        - Social determinants of health (e.g., housing, food insecurity).
        - Patient education/adherence confirmation.

3. **Citation Linking**

    - Every output includes an embedded **citation** linking back to the transcript, with either:

        - Direct quotations, or
        - Time-stamped markers within the transcript.

4. **Provider Review**

    - A physician or care coordinator reviews the GenAI-generated draft, validates accuracy, and approves it for entry into the EHR.

5. **Documentation Export**

    - Final, approved documentation is pushed into the EHR in structured formats (e.g., HL7, FHIR).
    - The transcript and citations are stored in an **audit-ready record** accessible to CMS.

6. **Reimbursement Trigger**

    - Reimbursement is tied only to **documentation events with verified transcript citations.**
    - Examples: a care plan updated with cited transcript evidence, or a quality measure reported based on patient dialogue.

2.4 Example Scenarios

Example 1: Care Plan Update

- **Interaction**: Patient calls coordinator and reports difficulty affording medications.
- **Transcript Excerpt**: "I haven't picked up my blood pressure pills this month because the co-pay is too high."

- **GenAI Output**:
    - New barrier: Medication affordability.
    - Intervention: Apply for medication assistance program.
- **Citation**: Linked to transcript line and timestamp.
- **Reimbursement**: Coordinator/physician receives payment for a transcript-cited care plan update.

Example 2: Quality Measure Reporting

- **Interaction**: Annual Wellness Visit, ambiently transcribed.
- **Transcript Excerpt**: Patient responds to PHQ-9 depression screening.
- **GenAI Output**:
    - PHQ-9 score = 12 (moderate depression).
    - Documented for CMS quality measure reporting.
- **Citation**: Links each scored response to the transcript.
- **Reimbursement**: Payment for validated quality metric documentation.

Example 3: Risk Adjustment (HCC Capture)

- **Interaction**: Telehealth follow-up for diabetes.
- **Transcript Excerpt**: Patient mentions worsening neuropathy symptoms.
- **GenAI Output**:
    - Suggests ICD-10-CM code for diabetic polyneuropathy.
- **Citation**: Highlights patient's statement as coding source.
- **Provider Review**: Physician approves diagnosis update.
- **Reimbursement**: Payment tied to validated risk adjustment capture.

2.5 Eligible Participants

- **Patients**:

    - Medicare beneficiaries with chronic conditions, post-hospital needs, behavioral health needs, or preventive care needs.
    - Particularly beneficial for high-need populations where care coordination has the greatest ROI.

- **Providers**:
    - Physicians (primary and specialty).
    - Nurse practitioners, clinical nurse specialists.
    - Care coordinators, social workers, behavioral health providers.
    - Organizations such as ACOs, FQHCs, and group practices engaged in care coordination.

2.6 Barriers Overcome

- **Documentation Burden**: GenAI reduces time spent charting.
- **Data Fidelity**: Documentation is more accurate because it's anchored in conversation.
- **Equity Gaps**: Captures social and behavioral insights often missed in claims.
- **Fraud Potential**: Eliminates fabricated documentation by requiring transcript citations.

2.7 Why This Model Improves Care Delivery

- **Patient-Centered**: Focuses on the patient's actual words, not billing abstractions.
- **Timely**: Insights are generated during or immediately after care, not months later via claims review.
- **Scalable**: Works across communication modalities, provider types, and practice settings.
- **Future-Proof**: Accommodates emerging AI tools while requiring safeguards (citations, provider oversight).

3. Proposed Payment Model

3.1 Overview

The proposed **Transcript-Cited GenAI Payment Model** introduces a **new reimbursement category** for documentation that is verifiably grounded in patient conversations. Unlike current payment models that reimburse for *time, volume, or claims*, this model reimburses providers **only when GenAI-supported outputs are traceable to transcript citations**.

This ensures that CMS pays for **value-creating documentation events** rather than for administrative work or billing artifacts.

3.2 Payment Mechanisms

We propose three complementary reimbursement pathways. CMS may choose to test one or combine them:

1. Per-Event Add-On Codes

- A new **G-code or CPT add-on** reimburses providers when transcript-cited documentation is generated and approved.

- **Examples:**

    - $10 for a quality metric documented (e.g., PHQ-9 score).
    - $20 for a care plan update (new goal, barrier, intervention).
    - $35 for validated HCC or SDOH documentation.

- **Trigger:** Reimbursement is only released if the documentation includes verifiable transcript citations.

2. PMPM Modifier

- Practices engaged in longitudinal care coordination (e.g., CCM, TCM, Behavioral Health Integration) receive an **enhanced PMPM payment** if they use certified GenAI systems that meet transcript-citation standards.
- Example: CCM base payment + $15 PMPM for transcript-cited documentation.

3. Performance Bonus Uplift

- Practices that adopt transcript-grounded GenAI may receive a **bonus percentage of shared savings** if care gap closure, quality reporting, or risk adjustment accuracy improves.
- This incentivizes both adoption and outcomes.

3.3 Payment Flow

1. **Provider conducts patient conversation** (phone, video, text, or in-person).
2. **GenAI generates draft documentation**, each output linked to transcript citations.
3. **Provider reviews and approves** the documentation.
4. **EHR records the output** with embedded citations and audit log.
5. **Billing system submits add-on code or PMPM modifier** to CMS.
6. **CMS reimburses the provider entity** (practice, ACO, FQHC).
7. **Funds distributed** to physicians, NPs, and care coordinators per organizational policy.

3.4 Why This Model Cannot Be Tested Under Current Payment Systems

- **Existing CCM/TCM models**: Reimburse based on *time spent*, which is subjective and gameable.
- **Quality reporting incentives**: Often rely on self-attestation or manual EHR entries, without transcript validation.
- **HCC risk adjustment**: Driven by coding behaviors and chart reviews, not patient conversations.
- **Fraud detection**: Currently retrospective and claims-based, not prospective and conversation-grounded.

This PFPM creates a **new reimbursement class** where the *only path to payment* is through **documented, verifiable patient interactions.**

3.5 Physician Role

Physicians and other clinicians remain **central** to this model:

- They oversee GenAI outputs.
- They validate transcript-linked documentation.
- They approve entries into the EHR and submission for reimbursement.

This ensures that while GenAI reduces burden, **clinical accountability stays with the provider.**

3.6 Risk Adjustment and Financial Risk

- Payments can be **risk-adjusted by patient complexity**, ensuring fairness across high- and low-acuity populations.
- Providers are **not penalized** for AI adoption but are rewarded for validated, patient-grounded documentation.
- Practices can opt into **two-sided risk models** where improved documentation fidelity increases accuracy of benchmarks and shared savings allocations.

3.7 Diagram: Payment Flow

Patient Conversation → Transcript Capture → GenAI Documentation w/ Citations → Provider Review & Approval → EHR Integration → Add-On Code/PMPM Modifier → CMS Payment → Provider Distribution

3.8 Summary

This proposed payment model:

- **Aligns incentives** with accurate, patient-centered documentation.
- **Differs fundamentally** from existing models by tying payment to transcript verification.
- **Eliminates fraud risk**, since outputs cannot be reimbursed without a transcript anchor.
- **Supports flexibility** in how payments are structured (per-event, PMPM, or bonus-based).

Excellent. Let's now build out **Section 4: Beneficiary Impact**. PTAC wants to see how a proposed model *directly benefits patients* — choice, quality, safety, access, equity. This is where we show why your transcript-cited model matters for Medicare beneficiaries themselves.

4. Beneficiary Impact

4.1 Improved Accuracy of Care Plans

Today, many care plan updates are incomplete or inaccurate because they depend on retrospective chart review or provider recall. With transcript-cited documentation:

- Updates are drawn directly from the patient's words.
- Interventions reflect lived experience (e.g., "I can't afford my medications" → documented as a barrier).
- Care plans become more personalized, improving adherence and outcomes.

Impact on patients: Care feels more responsive, tailored, and reflective of what they actually said.

4.2 Better Capture of Social and Behavioral Needs

Traditional claims and EHR notes often omit **social determinants of health (SDOH)**, caregiver context, and behavioral insights. Transcript-cited GenAI captures these details in real time.

- Example: Patient mentions difficulty getting to the pharmacy → transcript generates a transportation barrier entry.
- Example: Caregiver expresses stress → documented as caregiver support need.

Impact on patients: More comprehensive support for non-clinical needs that drive health outcomes.

4.3 Reduction of Waste, Fraud, and Abuse → More Resources for Patients

Because every reimbursed documentation event must be transcript-cited:

- Fraudulent billing and over-documentation are structurally eliminated.
- CMS resources are better targeted to **actual patient needs** instead of wasteful spending.

Impact on patients: Trust that Medicare dollars are being used to improve care, not wasted on gaming or fraud.

4.4 Enhanced Patient Safety and Trust

Transcript-grounded documentation reduces errors caused by miscommunication, incomplete notes, or assumptions.

- If a patient denies chest pain during a call, the transcript ensures this is documented exactly.
- If a patient confirms medication adherence, the transcript verifies this rather than leaving it undocumented.

Impact on patients: Greater safety through reduction of documentation drift and misinterpretation.

4.5 Patient Choice and Engagement

This model works across all care modalities: phone, video, text, or in-person. Beneficiaries are not required to change how they access care — their conversations, however they occur, are captured and honored.

- Patients can continue to choose their preferred method of communication.
- Patients gain confidence that their words are not lost but recorded and tied directly to their medical record.

Impact on patients: Increased confidence, empowerment, and participation in care planning.

4.6 Equity and Access

Transcript-cited documentation helps surface **disparities** in care delivery and outcomes:

- Language barriers, financial strain, and access issues are more likely to be captured in transcripts than in claims.
- Populations historically underrepresented in claims data (e.g., rural, minority, or low-income patients) will have their voices reflected in the data.

Impact on patients: A fairer, more equitable system that values patient-reported needs and experiences.

4.7 Reduced Administrative Burden → More Time with Patients

By automating documentation through transcript analysis, providers spend less time typing and coding. That time is redirected toward patient interaction.

- Less screen time.
- More eye contact and active listening.

Impact on patients: A more human care experience, where clinicians focus on them rather than paperwork.

4.8 Summary

For Medicare beneficiaries, this PFPM:

- Ensures care plans and quality measures **truly reflect their voice**.
- Addresses **clinical, social, and behavioral needs** often missed today.
- Protects them from harm caused by **fraudulent or fabricated documentation**.
- Enhances **trust, safety, and equity** in care delivery.
- Reduces provider burden, translating to **more meaningful patient-clinician interaction**.

Perfect — now let's write **Section 5: Safeguards and Fraud Prevention.** This is a crucial part because PTAC, CMS, and CMMI care deeply about how any new payment model avoids gaming and protects taxpayer dollars.

5. Safeguards and Fraud Prevention

5.1 The Problem with Current Models

Current payment structures are vulnerable because reimbursement is tied to:

- **Time spent** (e.g., CCM minutes logged) — which can be inflated.
- **Volume of codes** submitted — which incentivizes over-coding.
- **Claims attestations** — which often lack verifiable grounding in patient reality.

This structure creates opportunities for:

- **Phantom billing** (billing for services never provided).
- **Copy-paste abuse** (recycling old notes).
- **Exaggerated documentation** (to maximize reimbursement).

5.2 Transcript-Citation as a Structural Safeguard

The proposed model eliminates these risks by **requiring transcript citations** for every reimbursed documentation event.

- **No transcript = no reimbursement.**
- Every data point (care plan update, quality metric, risk adjustment) must link to a **time-stamped transcript excerpt**.
- Providers cannot fabricate or exaggerate documentation because each entry is verifiable against the patient's words.

This creates a **proof-based reimbursement system** rather than a trust-based system.

5.3 Auditability

The model is inherently audit-ready:

- CMS or other oversight bodies can **replay transcripts** or review text logs to confirm accuracy.
- Documentation outputs include embedded citation metadata (e.g., "line 45 of transcript, timestamp 10:12").
- Audits become faster and more objective because each documentation event can be verified at the source.

5.4 Provider Oversight (Human-in-the-Loop)

While GenAI generates structured outputs, providers remain the **final checkpoint**:

- Physicians or care coordinators must review and approve all outputs before they enter the EHR or are eligible for reimbursement.

- This prevents errors in interpretation and ensures clinical responsibility remains with the provider.

5.5 Privacy and Security

Safeguards for patient data include:

- **HIPAA-compliant transcription and storage.**
- **Role-based access controls** so only authorized individuals can review transcripts.
- **Audit logs** of who accessed transcript data and when.
- De-identification protocols for research or quality improvement use.

5.6 Elimination of Waste, Fraud, and Abuse

This model prevents fraud in ways current models cannot:

- **No billing for time** that cannot be verified.
- **No coding without transcript evidence.**
- **No falsified documentation**, since CMS can always request transcript validation.

> In short, this PFPM makes it **impossible to bill Medicare without verifiable proof** of what the patient actually said.

5.7 Summary

The Transcript-Cited GenAI Payment Model is **structurally ungameable**:

- Citations tie reimbursement directly to patient conversations.
- Providers cannot bill for what was never said.
- CMS gains a transparent, auditable system.
- Patients gain protection from fraudulent or inaccurate records.

This approach moves Medicare from a **trust-based** system (vulnerable to abuse) to a **proof-based** system (anchored in verifiable conversations).

6. Expected Medicare Savings and Evaluation

6.1 Sources of Savings

1. Fraud, Waste, and Abuse Reduction

- Today, Medicare spends billions annually combating improper payments, phantom billing, and fraudulent claims.
- Because this model requires **transcript citations for every reimbursed event**, fabrication is impossible.
- Savings accrue through:
    - Elimination of phantom time-logging in CCM/TCM.
    - Prevention of up-coded or exaggerated diagnoses without transcript proof.
    - Reduction in manual audit and oversight costs, since verification is built-in.

Estimated Impact: Even a 10% reduction in improper payments (>$30B annually in Medicare FFS) would generate billions in savings.

2. Improved Risk Adjustment Accuracy

- Current HCC/Risk Adjustment relies on chart review and coding behaviors, which are inconsistent and prone to error.
- Transcript-grounded documentation ensures diagnoses are **anchored to patient conversations**, leading to more accurate risk scoring.
- Accurate risk scores align payments with true patient complexity, reducing both overpayment (up-coding) and underpayment (missed conditions).

3. Care Gap Closure and Downstream Cost Avoidance

- Transcript-cited GenAI captures social needs, barriers, and adherence issues in real time.
- Addressing these early reduces costly downstream utilization (ER visits, hospitalizations).
- Example: Capturing "I haven't filled my insulin" → triggers intervention → avoids preventable admission.

Estimated Impact: Avoided admissions for chronic patients could generate thousands in savings per beneficiary annually.

4. Provider Efficiency and Burnout Reduction

- Automating documentation reduces administrative overhead.
- Providers can manage larger panels with less fatigue.

- More provider capacity = fewer staffing shortages = better access without increasing costs.

6.2 How CMS Can Evaluate the Model

Evaluation Framework

1. **Comparison Groups**
    - Test group: Practices using transcript-cited GenAI documentation.
    - Control group: Practices relying on standard claims-based documentation.
2. **Key Metrics**
    - **Quality Measures**: % of measures documented with transcript citations; improvement in closure rates.
    - **Fraud Indicators**: Reduction in flagged improper payments and audit discrepancies.
    - **Utilization Outcomes**: Hospitalizations, ED visits, readmissions.
    - **Cost Outcomes**: Per-beneficiary per-month spend compared to baseline.
    - **Provider Burden**: Measured via surveys on time spent charting and burnout rates.
    - **Equity Measures**: Capture of SDOH elements vs. baseline to assess disparity reduction.
3. **Timeline**
    - **Year 1**: Pilot across 50–100 practices, establish baseline metrics.
    - **Year 2**: Scale evaluation, compare outcomes to control sites.
    - **Year 3+**: Assess savings and quality improvements at scale, determine suitability for nationwide expansion.

6.3 Evaluation Advantages of Transcript-Cited Documentation

- **Built-in audit trail**: CMS evaluators don't need new tools — transcript metadata already verifies documentation.
- **Real-time feedback**: Practices can see exactly which outputs CMS considers valid, creating a natural feedback loop.

- **Cross-payer applicability**: Once validated, private payers could adopt similar models, multiplying impact.

6.4 Summary

The Transcript-Cited GenAI Payment Model delivers **twofold Medicare savings**:

1. **Direct savings** through elimination of fraudulent and improper payments.
2. **Indirect savings** through earlier care gap closure, better adherence, and fewer avoidable hospitalizations.

Evaluation is straightforward because **proof is embedded in the model** — every reimbursed output carries a verifiable transcript citation.

> For the first time, CMS would not just measure what was billed — it could measure what was *actually said*.

7. Mapping to the Secretary's 10 Criteria

Criterion 1: Scope

The model directly addresses a **national gap** in Medicare payment policy: the lack of reimbursement tied to patient conversations.

- Applies across **primary care, specialty care, CCM, TCM, behavioral health, and preventive care.**
- Broadens the APM portfolio by enabling participation for providers who rely heavily on **care coordination and patient engagement.**
- Not limited to a single institution or vendor — designed to be **vendor-neutral** and scalable.

Criterion 2: Quality and Cost

- **Quality**: Documentation grounded in patient voice ensures more accurate care plans, quality reporting, and SDOH capture.
- **Cost**: Eliminates improper payments, reduces unnecessary utilization, and lowers administrative overhead.

- Model achieves **better quality at lower cost** by shifting reimbursement upstream.

Criterion 3: Payment Methodology

- Introduces **new add-on CPT/G-codes or PMPM modifiers** tied only to transcript-cited outputs.
- Differentiates from current time- or volume-based models.
- Payments flow from CMS → provider entity → clinicians, ensuring physicians remain central.
- Cannot be tested under current methodologies because **no existing code requires transcript verification.**

Criterion 4: Value over Volume

- Incentives reward **validated, patient-grounded documentation**, not longer encounters or more codes.
- Every reimbursed event must tie to **verifiable patient needs.**
- Encourages higher-value care coordination and discourages unnecessary services.

Criterion 5: Flexibility

- Works across modalities: **phone, video, secure text, or in-person.**
- Applies to diverse providers (physicians, NPs, care coordinators, FQHCs, ACOs).
- Vendor-neutral: any tool can qualify if it meets **transcript-citation standards.**
- Minimizes new operational burden by embedding into existing workflows.

Criterion 6: Ability to Be Evaluated

- Evaluation is straightforward: every output carries a **citation trail**.
- CMS can audit easily: "Did the patient say this?" → transcript confirms.
- Success measurable across: quality metrics, fraud rates, utilization outcomes, provider burden, and SDOH capture.
- Creates a **proof-based, not trust-based** evaluation framework.

Criterion 7: Integration and Care Coordination

- Care plans updated directly from conversations, ensuring **seamless communication across providers.**
- Supports integration between **primary and specialty care** by surfacing accurate, patient-grounded updates.
- Moves the burden of care coordination **from the patient back to the care team.**
- Incentivizes collaboration with social services by capturing SDOH needs.

Criterion 8: Patient Choice

- Patients can engage however they prefer: phone, video, text, or in-person.
- Their **voice is preserved** — no matter the modality.
- Encourages **shared decision-making**, since transcripts capture patient preferences directly.
- Expands equity by surfacing disparities across populations that claims data currently obscures.

Criterion 9: Patient Safety

- Transcript verification reduces errors from misdocumentation.
- Prevents harmful gaps (e.g., missed medication adherence issues).
- Provides auditable proof in disputes, protecting patients from being misrepresented in the record.
- Protects against denial of necessary care by ensuring **patient statements are faithfully represented.**

Criterion 10: Health Information Technology

- Leverages **transcription, GenAI, and EHR integration** to streamline documentation.
- Interoperability supported through structured FHIR/HL7 outputs.
- HIPAA-compliant, privacy-protected transcripts stored securely.
- Encourages provider choice of technology, provided it meets **citation and auditability standards.**

Summary

This proposal **substantially meets all 10 criteria**:

- Broad scope.
- Improved quality at lower cost.
- A novel, auditable payment methodology.
- Aligned with value, not volume.
- Flexible, evaluable, patient-centered, and fraud-resistant.

It represents a **new class of PFPM** — one that ties reimbursement to the most upstream, ungameable source of truth: the patient conversation.

8. Appendices

Appendix A: Sample Transcript → AI Output → Citation Trail

Transcript Excerpt (Phone Call)

Patient: "I haven't picked up my blood pressure pills this month because the co-pay is too high."

Coordinator: "Thank you for letting me know. Let's look at assistance programs."

AI-Generated Draft Documentation

- Care Plan Update: Barrier = Medication affordability.
- Intervention: Apply for medication assistance program.
- Task: Coordinator to send patient assistance application by tomorrow.

Citation Metadata

- Source: Transcript, Timestamp 00:02:31.
- Direct Quote: "I haven't picked up my blood pressure pills this month because the co-pay is too high."

Audit-Ready Output

- Care plan update is reimbursable **only because it is directly tied to transcript evidence.**

Appendix B: Comparison — Claims-Based vs. Transcript-Based Models

Feature	Current Claims-Based Model	Proposed Transcript-Cited Model
Source of Truth	Claims submitted weeks after visit	Transcript of patient conversation
Reimbursement Basis	Time, codes, volume	Documented outputs with citations
Fraud Potential	High – phantom billing, up-coding	Minimal – no transcript = no payment
Data Fidelity	Distorted by billing incentives	Anchored in patient's words
SDOH Capture	Rarely documented	Captured in real time
Auditability	Manual, retrospective, resource-heavy	Built-in, automated, transparent
Provider Burden	High – manual notes & coding	Reduced – AI generates, provider verifies

Appendix C: Sample Payment Flow Diagram

Patient Conversation

↓

Transcript Capture (phone, video, text, or ambient)

↓

GenAI generates draft documentation (care plan, quality metric, HCC, SDOH)

↓

Provider reviews & approves (human-in-the-loop)

↓

EHR integration with citation metadata

↓

Billing system submits add-on code or PMPM modifier

↓

CMS reimburses provider entity (ACO, FQHC, practice)

↓

Funds distributed to physicians, NPs, coordinators

Appendix D: Letters of Support (Placeholder)

Appendix E: Regulatory Alignment

- Statutory Basis: Physician-Focused Payment Model definition (42 CFR § 414.1465).
- Advanced APM Potential: Meets criteria for risk adjustment, quality measurement, and two-sided risk compatibility.

Appendix F: Potential Evaluation Metrics Table

Domain	Metric	Data Source	Expected Outcome
Quality	% care plans updated with transcript citations	EHR metadata	↑ Accuracy
Cost	Improper payment rate	CMS audits	↓ Fraud
Utilization	Hospitalizations/ER visits	Claims + transcripts	↓ Avoidable utilization
Equity	% SDOH needs captured	Transcript analysis	↑ Identification of disparities
Provider Burden	Avg. minutes charting per encounter	Provider survey	↓ Time spent