Transcript-Cited GenAI Payment Model for Care Coordination Environmental Scan

February 17, 2026

I. Overview

The purpose of this environmental scan is to provide members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) with background information and context for the proposed physician-focused payment model (PFPM) *Transcript-Cited GenAI Payment Model for Care Coordination*. This proposal was submitted by Mendel Erlenwein, CEO & Founder of CareCo, and was determined to have met the administrative requirements on December 18, 2025.

The scan focuses on three topics:

1. Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
2. Medicare Payment Policy Related to Reimbursement Based on AI-Generated Documentation versus Claims-Based Reimbursement
3. Results from Proposed or Similar Models that Use Technologies to Transcribe Patient-Provider Interactions and Anchor Documentation to Transcripts

Appendix A provides the guiding research questions used to conduct this scan. Appendix B includes an Annotated Bibliography. Appendix C provides references.

II. Information on the Submitter

CareCo is a Software-as-a-Service (SaaS) company based in Kingston, Pennsylvania, that provides tools for care coordination teams. The company provides an artificial intelligence (AI)-based copilot that aims to reduce administrative burden and burnout, increase efficiency, and increase providers' time with patients. The copilot automates routine tasks, including documentation and follow-up planning. Using ambient listening tools, CareCo transcribes conversations through telephone, video, Short Message Service (SMS), and in-person care. The platform documents interactions between providers and patients using transcripts and citation tracking, leverages provider-patient conversations and documentation to develop conversation guides for providers, and allows providers to copy and paste information into their electronic health record (EHR) systems. The platform is Health Insurance Portability and Accountability Act (HIPAA)-compliant and available for provider practices and payers. According to the company's website, CareCo has supported over 500 health care professionals and saved more than 12.6 years and $8.2 million.[1]

III. Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools

Clinical documentation includes the process of recording a patient's medical information—including symptoms, exams, diagnoses, treatments, medications, and care plans—in the EHR. Health care professionals, such as primary care providers (PCPs), surgeons, nurses, physical therapists, and psychologists, manually record patient medical information into the EHR by typing the information into a computer during patient visits or after hours. However, clinicians may enter information into a

patient's EHR using other methods, such as dictating the information, using templates with pre-defined options, or leveraging human scribes to record the information.[2]

Documentation serves multiple functions, including promoting the quality, safety, and continuity of patient care; aiding in informed decision-making for patient care; supporting communication between providers; facilitating coding and billing activities; and recording information for audit.[3] Given that multiple clinicians may be involved in managing a patient's care, it is important for clinicians to ensure that a patient's notes are complete and current. Despite the benefits of clinical documentation, clinical documentation activities are often time-consuming for providers, contributing to administrative burden and potentially impacting documentation quality. Poor documentation can lead to claim denials and negatively impact patient care, such as increasing the risk of medical errors and threats to patient safety.

AI is technology that leverages computers to process data and perform tasks that require human-like intelligence. Generative AI (GenAI) is a type of AI that creates new content by learning patterns from multiple datasets. Use of AI scribes—a generative AI tool that uses ambient listening to record, transcribe, and summarize patient-clinician conversations into clinical notes and integrate the information into the EHR for billing—can automate the clinical documentation process. AI scribes have advanced in recent years from offering basic speech-to-text functions to more complex functions that generate information, such as clinical notes, discharge summaries, treatment summaries, and referral letters.[4]

To generate medical notes for a patient-clinician interaction, AI scribes use automatic speech recognition (ASR) to record and convert spoken words into written text, and natural language processing (NLP) to analyze and interpret text to organize the information into a clinical note.[5] New AI tools are integrated in the EHR and can populate orders, diagnosis codes, and billing codes based on the information in the transcripts.[6,7] These tools often use machine learning (ML) to learn from and identify patterns in data to make decisions and predictions—improving accuracy over time—without being programmed for each individual task.

Recent AI scribes capture and convert audio recorded conversations into structured, billable clinical documentation, structured notes, orders, referral letters, discharge summaries, and patient instructions (e.g., summarizing key takeaways and medications using plain language); draw from transcripts and notes to answer physicians' questions in real time; and generate coding suggestions, referral letters, and after-visit summaries.[8,9] Some tools also convert conversations into review chart histories to identify potential diagnoses and risk factors and suggest medication orders and International Classification of Diseases (ICD)-10 codes after a patient's visit.[10] AI scribes are also commonly called autoscribes; virtual medical scribes; digital scribes; virtual scribes; ambient AI scribes; AI documentation assistants; and digital, virtual, or smart clinical assistants.[11]

Given recent advancements in AI, there is growing attention on the use of AI tools in clinical settings. In 2025, the U.S. Department of Health and Human Services (HHS) released an AI Strategy to increase the adoption of AI in clinical care.[12] HHS' goals include addressing health conditions using AI-enabled tools and promoting the use of AI tools to support clinical decision-making and early warning. Building on HHS' Strategy, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) recently released a Request for Information (RFI) to gather the public's feedback on strategies to enhance the adoption and use of AI in health care.[13]

Automating certain aspects of clinical documentation using AI scribes aims to mitigate some of the challenges associated with current documentation practices in health care (described in detail in the next section). Despite the potential benefits of using AI scribes, the adoption and implementation of such tools can introduce a new set of challenges that must be considered.

Provider and Patient Challenges and Opportunities with Clinical Documentation Practices

Manual clinical documentation practices are associated with challenges for both providers and patients. Providers face substantial administrative burden with documentation. Documentation burden can lead to time constraints and working after hours, issues with documentation quality, and challenges with effectively communicating with other providers. Poor documentation can also have negative impacts on patient care, including increasing the risk of medical errors and threats to patient safety. Inaccurate or incomplete documentation can also increase the risk of claim denials, impacting both providers and patients.

Administrative Burden. Clinical documentation places substantial administrative burden on providers. Documentation activities are often influenced by the way EHR systems are set up and function.[14] Some EHRs can make entering data, using template notes, and navigating copy and paste errors challenging for providers.[15] These challenges can increase the amount of time and effort providers devote to documenting patient medical information, contribute to cognitive load, and potentially lead to reduced direct patient care.[16] Documentation burden is also associated with greater provider job dissatisfaction, job attrition, and burnout.[17,18]

By automating clinical documentation activities, AI scribes can help address high administrative burden and burnout among clinicians by reducing the need for manual charting.[19] Generating structured clinical notes using AI scribes can reduce administrative burden for providers, including the time providers spend on documentation and the cognitive load associated with documentation.[20,21,22] One study estimated that an AI scribe saved clinicians of a large health care organization nearly 15,800 hours of documentation time over the course of one year.[23,24] Time saved on documentation by using AI scribes may be greatest among providers who most frequently use the technology compared with providers who less frequently use the technology.[25] After 30 days of using an AI scribe, clinicians have reported improvement in their ability to add patients to the clinic schedule, if urgently needed, and improvement in their ability to create notes that patients can understand.[26]

This reduction in time spent on documentation can reduce provider burnout.[27] One study found a reduction in burnout from 51.9 percent to 38.8 percent after 30 days of using an AI scribe.[28] Another study found that 82 percent of physicians reported that using AI scribes had a positive impact on their work satisfaction.[29] However, it is important to note that reductions in clinician burnout associated with the use of AI scribes may not be entirely due to reductions in time spent documenting information in the EHR. Even if clinicians use AI scribes to support documentation, they will still need the EHR to review patient information, place orders, and communicate with other clinicians.

Documentation Completeness and Quality. Documentation burden can lead to poor documentation quality.[30] When reviewing medical information, providers face issues such as note bloat—where the information in the EHR contains irrelevant or redundant information, potentially due to the duplication of text from previous notes—and these issues can further contribute to documentation burden and cognitive load for providers.[31,32] Evidence suggests that over 50 percent of clinical text is duplicated from

previous content written about a patient.[33] Insufficient or inaccurate documentation and issues such as note bloat not only contribute to burden but can also hinder communication between providers.[34,35]

Further, issues in clinical documentation can lead to claim denials, where an insurer refuses to pay for a certain medical service or treatment. Incomplete or ambiguous clinical documentation, such as lack of specificity in a diagnosis or treatment, impacts coding accuracy and can lead to claim denials or delayed payments.[36] For health care organizations, claim denials can negatively impact revenue, operational efficiency, and administrative load, as each denial must be reviewed, corrected, and resubmitted.[37]

Some research indicates that AI scribes can also improve documentation completeness and quality.[38] In some cases, AI scribes can also improve the accuracy of clinical notes and support billing activities.[39] Use of AI tools may improve documentation completeness and quality.[40] For example, AI technologies that convert patient-clinician conversations into structured clinical notes have the potential to improve the consistency and completeness of clinical notes over time by iteratively learning and adapting to a patient's case and evolving needs with each visit.[41]

Challenges Related to Adopting and Implementing AI Technologies to Support Clinical Documentation

Different technological, implementation, economic, and payment challenges can arise when adopting and implementing AI technologies to automate the clinical documentation process.

Technological Challenges. Technological challenges can arise in the various tasks that AI scribes perform, such as collecting quality audio recordings of conversations between patients and clinicians and generating accurate clinical summaries based on the audio recorded conversations.[42] Given the potential for errors and inconsistencies in the outputs of AI scribes, physicians must spend time reviewing and editing the content for accuracy.

Audio Quality and Completeness. Generating quality transcriptions of conversations between clinicians and patients relies on the recording of high-quality audio. However, the quality of audio can be negatively impacted by noisy environments and issues with microphone placement during a patient visit.[43] Additionally, clinicians often include information that was not stated out loud in medical notes from observing and physically examining a patient. This information may not be captured verbally in an audio recording of the conversation and therefore not included in the transcription.[44] Clinicians may choose to vocalize their thoughts and observations during a patient visit to ensure that the information is captured in the transcription. However, there may be situations where clinicians do not want to vocalize some of this information in front of a patient.

Errors and Inconsistencies. To automatically extract and summarize patient-clinician conversations, AI scribes rely on ML algorithms that are trained using past medical transcripts of conversations and their associated structured notes. The structured summaries generated by AI scribes are vulnerable to errors and inconsistences. A systematic review on the performance of AI-based speech recognition to support clinical documentation found high variability in the accuracy and error rates in automated clinical summaries.[45] Variation in accuracy can depend on the length and complexity of conversations, where accuracy may be lower in longer conversations and in conversations with multiple speakers compared with shorter conversations and conversations with fewer speakers.[46] Additional evidence indicated that accuracy may be lower in cases with greater clinical complexity.[47]

In addition to challenges related to the accuracy of transcriptions, AI scribes are vulnerable to omissions—where important information is not included in summaries—and hallucinations—where

false or fabricated information that is not based on existing data is included in summaries.[48] Physicians have reported additional errors in AI-generated clinical summaries, including errors related to misgendering patients, providing inappropriate diagnoses, and including mistakes in important aspects of the patient visit.[49]

Physician Verification. Outputs of AI scribes must be reviewed, edited, and verified by providers to confirm accuracy and completeness, and ultimately ensure safety, as providers are responsible for the accuracy of patients' health records.[50,51] Although some research shows that AI scribes reduce clinician documentation time and increase completeness of clinical notes, other research shows insignificant change in documentation time from using AI scribes and even increased documentation time due to the need for clinicians to review and correct AI-generated content.[52]

Implementation Challenges. Implementation challenges can arise when adopting AI scribes, such as achieving provider buy-in, navigating clinician and patient privacy concerns, overcoming the up-front and ongoing costs associated with adopting and using the technology, and navigating changes in coding intensity from using AI scribes.

Provider Buy-in. Provider buy-in is often needed to achieve effective uptake of AI tools. Although many providers understand the benefits of the tools, some providers remain cautious as they perceive the tools as disruptive. Although the percentage has decreased over time, one in four physicians reported that their concerns about AI exceeded their enthusiasm about using the technology in 2024.[53] Several factors can impact clinician buy-in, including:

- Dissatisfaction with the high error rates in AI-generated transcripts;[54]
- Resistance to adopting AI scribes if clinicians believe reviewing, correcting errors, and verifying AI-generated summaries requires more time than writing the summaries themselves;[55]
- Concern with the language use and style of AI-generated clinical notes, with limitations in the extent to which clinicians can customize the tools based on their preferences;[56,57]
- Concern that they may be asked to see more patients if the use of an AI scribe was mandated;[58] and
- Challenges due to a lack of integration of AI scribes in the EHR.[59]

Clinician and Patient Privacy Concerns. There are also clinician and patient privacy concerns with using AI tools in clinical settings. AI scribes capture audio of conversations between patients and clinicians and train on the collected information. Audio recording these conversations raises data security risks, requires encryption and compliance, and may require obtaining patient consent to be audio recorded.[60,61] Patient privacy concerns may arise when training the models, which rely on sensitive patient information.[62] Clinicians may also be reluctant to audio record patient visits due to potential liability concerns.[63] Additional research is needed to understand how patients perceive the use of AI scribes in clinical settings, as the majority of research has focused on understanding clinicians' perspectives of the tools.[64]

Economic and Payment Issues. There are different economic and payment-related considerations when adopting and implementing AI scribes. There are up-front and ongoing costs associated with adopting and using the technology, potential for reduced costs due to efficiencies at the practice-level, improved patient care and outcomes, and increased costs due to greater coding intensity or utilization.

Costs of Adoption. There are substantial costs associated with adopting and scaling AI scribes in health care settings. Many AI scribes require up-front set-up costs to purchase or license the tools and integrate the tools within existing workflows and EHRs.[65] Setting up these tools can be expensive and time-consuming for health care organizations, as organizations commonly have to upgrade their software and infrastructure, train clinicians to use the tools, and monitor the effectiveness of the tools.[66,67] Fragmented existing EHRs can hinder the integration of AI-generated content in the EHR, leading to additional barriers to adoption.[68]

In addition to up-front costs, many AI scribes require ongoing subscription costs that may be customized to the organization adopting the tools. The American Association of Family Physicians estimated that AI scribes cost between $150 to $200 per month.[69] Additionally, some AI scribes include recurring per-user fees. Subscription costs can be $600 or more per clinician per month, in addition to the initial set-up fee.[70]

Reductions in Costs Due to Efficiencies at the Practice Level. Currently, research evidence is mixed regarding the cost effectiveness of implementing AI scribes in clinical settings. Although the up-front and ongoing costs of the tools can be substantial, AI scribes may reduce costs by streamlining administrative processes (e.g., billing, claims processing) and supporting providers with the diagnosis and treatment of health conditions.[71]

Additional factors can influence the cost effectiveness of AI scribes. For example, the use of AI scribes to transcribe patient-clinician conversations may be less expensive than manual transcription in some but not all clinical settings depending on factors such as the complexity of cases.[72] Although AI scribes have the potential to reduce costs and increase workflow efficiencies for providers, additional research is needed to understand the value of implementing AI scribes in clinical settings.

Improved Patient Care and Outcomes. Automating clinical documentation using AI scribes can positively impact patient care and outcomes. Inadequate, missing, or incorrect patient information; errors or outdated information in patient data; missing or incorrect information in referrals; and patient information documented in the wrong place or fragmented across multiple locations can be associated with adverse events, such as medical errors and threats to patient safety.[73,74,75,76] Claim denials also can negatively impact patients, decreasing their trust in the health care system and contributing to financial strain.[77]

By automating documentation, AI scribes can increase providers' time focused on patients during patient visits, improving the coordination and quality of the visits and increasing patient satisfaction.[78,79,80,81] For example, patients of physicians who use AI scribes have reported that their doctor spent less time looking at a computer and more time speaking to the patient during medical visits.[82] One study showed that 56 percent of patients reported that AI scribes had a positive impact on the quality of their visit, and 92 percent of patients reported feeling comfortable or neutral about AI being used during their visit.[83] Clinicians have also reported that AI scribes have a positive impact on their communication with patients and job satisfaction.[84,85] One study showed that 84 percent of physicians reported feeling that AI scribes positively impacted their interactions with patients during visits.[86]

The majority of research studies on AI scribes are based on relatively small-scale and short-term studies or on specific health care settings. Although evidence generally supports the use of AI scribes in clinical

settings, additional research is needed to understand potential challenges and opportunities of using the technologies across different settings and specialties.[87,88]

Costs Due to Greater Coding Intensity or Utilization. Evidence indicates that the use of AI scribes may increase revenue for payers and/or providers by increasing physician work relative value units (wRVUs), documented diagnoses per encounter, documented Hierarchical Condition Category (HCC) diagnoses per encounter, and the number of billed high-level Evaluation and Management (E/M) visits.[89] Greater wRVUs, diagnoses, and risk scores associated with use of AI scribes may not necessarily reflect upcoding—a fraudulent billing practice where providers document more severe illnesses or more complex procedures than actually occurred. Instead, greater wRVUs, diagnoses, and risk scores associated with the use of AI scribes may reflect a more complete capture of previously missed details before the use of AI scribes.[90] More complete documentation from the use of AI scribes could promote earlier treatment and lead to better patient outcomes and potentially lower long-term costs in value-based arrangements.[91]

Despite the potential benefits of more complete documentation practices associated with using AI scribes, more complete documentation practices could have financial impacts on patients and providers. For example, regulators will likely apply adjusted risk score formulas in response to increases in coding intensity and subsequent risk-adjusted capitation payments to Medicare Advantage (MA) plans. Until adjustments to increased coding intensity are made, taxpayers will cover the potential increase in payments to MA plans, and employers and workers will likely face higher premiums in commercial fee-for-service (FFS) markets.[92] Conducting random audits that compare audio to approved clinical notes and increasing transparency about AI-generated content can ensure that unjustified upcoding practices are not occurring.[93]

Providers' share in the revenue generated from more complete documentation produced by AI scribes will depend on how the providers are paid by health plans. In Medicare FFS, revenue from richer documentation—including higher-level E/M codes and more billable services—is shared directly with clinicians and health systems.[94] In MA, revenue from richer documentation increases MA plans' risk-adjusted capitation payments—through increased member risk scores—and providers may benefit from this increased revenue only if their contracts with the MA plans share the revenue.[95]

AI-enabled services have the potential to decrease health care costs by reducing the time needed to diagnosis diseases, replacing invasive diagnostic tests, and allowing less specialized physicians to make diagnoses. However, cost reductions associated with the use of AI-enabled services may be offset if the AI-enabled services also increase use.[96] For example, under FFS payment arrangements, increased use of AI, enhanced documentation and coding from using AI tools, and increased provider capacity for billable services due to using AI could lead to increased health care spending.[97] There is also risk of continually increased prices for AI tools and services and incentivizing overutilization if Medicare selects generous payment methods to meet AI technology companies' increased prices for their products.[98] Importantly, however, increasing providers' capacity for more direct patient care could have a positive impact on value by increasing access to and quality of care.[99]

IV. Medicare Payment Policy Related to Reimbursement Based on AI-Generated Documentation versus Claims-Based Reimbursement

The relative magnitude of the potential costs and benefits of using AI scribes (described above) may depend on the payment policies implemented. Medicare FFS payment policy relies on claims-based

reimbursement, where providers receive payment after a claim detailing that the care has been submitted to the payer.

Potential Issues with Medicare FFS Claims-Based Reimbursement Practices

There are several potential issues associated with current claims-based reimbursement practices under Medicare FFS. Claims-based reimbursement practices are vulnerable to waste, fraud, and abuse. In addition, the lack of key information about a patient in claims data can impact payment for providers and health plans.

The current Medicare FFS billing system incentivizes a greater volume of services. Paying for the quantity of services can increase the potential for waste, fraud, and abuse. Examples of waste, fraud, and abuse include upcoding—a practice where a provider knowingly bills for higher-level procedures or visits than were used—and phantom billing—a practice where a provider bills for services, procedures, or supplies that were never provided to the patient. Although improper payments may include overpayment or underpayment due to mistakes or omissions, improper payments can also be a result of waste, fraud, and abuse. Evidence indicates that 7.7 percent of payments under Medicare FFS in 2024 were improper payments.[100] Improper payments totaled $54.3 billion across Medicare FFS, MA, and Medicare Prescription Drug in 2024.[101]

The lack of certain patient characteristics and needs, including health-related social needs (HRSNs), in claims data can impact payment for providers and health plans. The Centers for Medicare & Medicaid Services (CMS) adjusts performance and payments using the CMS-HCC risk adjustment model. This model uses ICD-10-CM codes from claims to assign risk scores to patients, with greater reimbursement for more risk. However, the CMS-HCC risk adjustment model can miss important clinical and social factors when estimating costs of care for patients, potentially leading to inadequate performance and payment adjustments for clinicians and health plans that care for patients with certain risk factors and needs.[102]

Existing Billing Codes for Use of AI-Enabled Services and Procedures

The percentage of physicians who reported using AI increased from 38 percent in 2023 to nearly 66 percent in 2024.[103] Recent efforts have focused on incorporating the use of AI-supported devices and services in billing codes. In 2022, the American Medical Association introduced Appendix S in the Current Procedural Terminology (CPT) codebook[104] that includes a taxonomy for AI's role in medical procedures and services. The taxonomy provides structure for creating CPT codes that reflect AI-driven services relative to the services delivered by clinicians. The taxonomy categorizes the use of AI into three classes:

- Assistive, which, under clinician oversight, supports clinicians by detecting relevant data without conducting data analysis or generating summaries;
- Augmentative, which, under clinician oversight, analyzes and quantifies data to provide clinically relevant suggestions; and
- Autonomous, which interprets data and generates clinically relevant conclusions without clinician involvement.

The CPT 2026 code set includes 288 new codes, many of which reflect codes for digital health services (e.g., remote patient monitoring) and medical services that involve AI, such as coronary atherosclerotic

plaque assessment to assess the severity of coronary disease and multispectral imaging for burn wounds as a non-invasive way to assess burn healing.[105]

The U.S. Food and Drug Administration has approved over 1,350 AI-enabled medical devices that support clinicians with diagnosing and treating patients.[106] Medicare reimburses clinicians for using some of these devices. For example, Medicare reimburses use of HeartFlow Analysis, a non-invasive test that creates a personalized three-dimensional model of an individual's coronary arteries to diagnose and treat coronary artery disease.[107]

CMS payment for AI-enabled services leverages existing rules for reimbursing new technologies. Reimbursement for AI-enabled services uses one of three payment methods:

- Bundle the new technology with an existing service without including an initial payment adjustment but adjusting the service price over time;
- Bundle the new technology with an existing service and include an add-on payment for the technology; or
- Pay for the new technology as a separate service.[108]

There are several potential approaches to reimburse AI-enabled services under Alternative Payment Models (APMs). The first approach includes bundling the AI-supported service with an existing FFS payment (described previously).[109] A second approach might be to include the AI-supported services within larger bundles of services, such as in existing Accountable Care Organization (ACO) and episode-based payment models. A third approach—which could be used in combination with the second approach—is to use Outcome-Aligned Payments (OAPs), where the payment is based on achieving specific outcomes that are influenced by the use of AI-enabled services.[110] CMS' new Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model will test the OAP approach to provide a payment option for supporting AI-enabled care. Additional work is needed to understand effective approaches for reimbursing AI-enabled services and incentivizing AI's use in clinical settings.

V. Results from Proposed or Similar Models that Use Technologies to Transcribe Patient-Provider Interactions and Anchor Documentation to Transcripts

Two new CMS payment models—the ACCESS Model and the Wasteful and Inappropriate Service Reduction (WISeR) Model—have started or will start in 2026. Evaluation results on the effectiveness of using AI technologies to transcribe patient-clinician interactions are not yet available. However, the ACCESS and WISeR Models will focus on the use of AI-supported technologies to support patient care and coding, respectively. In addition, MA and commercial payers are currently using AI-based technologies to support different documentation, coding, and billing activities.

Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model

CMS' ACCESS Model is a new, 10-year, nationwide voluntary model that will begin on July 5, 2026.[111,112] The model aims to expand access to technology-supported care services—such as wearable devices, applications that promote lifestyle changes, and AI-assisted care delivery support—that prevent and manage certain chronic conditions (hypertension, dyslipidemia, obesity, prediabetes, diabetes, chronic kidney disease, atherosclerotic cardiovascular disease, and chronic musculoskeletal pain) and two behavioral conditions (depression and anxiety). Participants (Medicare Part B-enrolled providers and suppliers) will receive payments for providing technology-supported care, such as lifestyle and

behavioral support, therapy, patient education, and medication management. Care can be provided in person, virtually, or asynchronously. Technology-enabled care provided by participating ACCESS organizations is intended to supplement the patient's traditional care. Primary care providers and other referring clinicians can refer beneficiaries to organizations participating in the model to receive these additional technology-supported care services. The referring providers will then receive electronic updates on the patients. These referring clinicians may also bill a new co-management payment code for reviewing patient updates and other care coordination actions to incentivize coordination between ACCESS participants and the referring providers. ACCESS participants will receive OAPs based on achieving quality measures and outcome targets.

Wasteful and Inappropriate Service Reduction (WISeR) Model

CMS' WISeR Model is a new, six-year voluntary model that aims to reduce fraud, waste, and abuse by disincentivizing use of medically unnecessary care and promoting timely and appropriate Medicare payment for certain items and services.[113] WISeR does not change Medicare coverage or payment policy. The model aims to ensure that payment complies with documentation, coverage, and coding rules. As participants, technology companies will support the use of AI and ML technologies to facilitate the review of medical necessity and streamline prior authorization decisions for certain items and services to limit inappropriate utilization, reduce Medicare spending, and reduce provider administrative burden. The model began on January 1, 2026.

Medicare Advantage and Commercial Payers

The role of AI scribes is generally focused on creating efficiencies and reducing burnout among health care providers. However, given the roles of AI scribes in automating clinical documentation, coding, and billing activities, AI scribes and their outputs play important roles for payers, including MA plans and commercial payers. Some AI tools are used to streamline and increase the transparency of the prior authorization process by assessing medical necessity against a patient's health records and the health plan's guidelines. AI tools are also used to match medical summaries with payer criteria.[114]

MA plans and commercial payers use AI scribes to support clinical documentation and the claims process. For example, one payer supports the use of an AI scribe to record conversations between patients and clinicians, flag errors in clinical notes, and generate structured clinical summaries within existing workflows.[115] The payer uses an AI-powered tool to exchange patient visit information, claims data, and payment data between providers and payers in real time. Within the EHR, this tool gives providers transparency on how payers will process a claim before the claim is submitted, allowing providers to describe what is versus is not covered to patients and how much patients will owe before they receive care, as well as decreasing the likelihood of claim denials.[116] Since its launch in 2025, the AI tool has shown a 43 percent reduction in providers' time spent on notetaking.[117]

Use of AI scribes for clinical documentation may have financial implications for both health care organizations and payers, as accurate documentation can help avoid financial penalties and audit failures. For example, in MA, health plans use AI tools to support the risk adjustment process. CMS provides MA organizations with monthly payments based on members' risk scores, where members' risk scores are computed using diagnosis codes submitted by providers. AI tools can identify potential errors and inconsistencies in codes to prevent incorrect risk scores, and payers may choose to share these errors with providers to avoid future errors.

Appendix A: Research Questions

The environmental scan involved a targeted search of information from existing peer-reviewed and non-peer-reviewed publications to address the research questions provided in Table A.1. Sources reviewed included major medical and health services research journals, grey literature, and websites of professional associations/societies and CMS that include relevant evaluation reports and program documentation.

Table A.1. Research Questions

Research Questions
Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
1. What challenges do providers face with current clinical documentation practices? 2. What issues in current clinical documentation practices can negatively impact patient care? 3. What are the potential challenges and opportunities of adopting and implementing technologies to transcribe patient-provider interactions, generate structured documentation, and integrate the documentation into the electronic health record (EHR) for billing? 4. What existing tools support the transcription of patient-provider interactions, generate structured documentation, and integrate the documentation into the EHR for billing? 5. Are GenAI transcription service tools readily available to most providers? What are the estimated costs of using the tools?
Medicare Payment Policy Related to Reimbursement Based on AI-Generated Documentation versus Claims-Based Reimbursement
6. What are the current Medicare FFS reimbursement guidelines for longitudinal and preventive care services? 7. What are potential issues with current claims-based reimbursement practices? 8. What are potential issues with current coding and billing practices? 9. Are there billing codes for the use of AI-enabled services and procedures? If so, in what ways are those codes used?
Results from Proposed or Similar Models that Use Technologies to Transcribe Patient-Provider Interactions and Anchor Documentation to Transcripts
10. What existing Alternative Payment Models (APMs) have used technology to transcribe patient-provider interactions and/or support clinical documentation practices? Have the models been implemented or evaluated? 11. How have Medicare Advantage plans and commercial payers used technology to transcribe patient-provider interactions and/or support clinical documentation?

Appendix B. Annotated Bibliography

Anderson, JP, Couture, SJ, Louis, JF, Wiltz, J, Sheingold, S, Smith, SR. Opportunities for technology-enabled care: economic and payment issues. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2025.

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools; Medicare Payment Policy Related to Reimbursement Based on AI-Generated Documentation versus Claims-Based Reimbursement
Type of Source: Issue Brief
Objective: To discuss the opportunities to integrate technology into the health care system and assess payment policy issues that hinder widespread adoption and implementation.
Main Findings: Technology-enabled care (TEC) has the potential to improve patient-provider interactions, continuity of care, care coordination, and interoperability by introducing new opportunities for data collection and sharing between providers and patients. Evidence shows that TEC can effectively support interventions for chronic conditions such as cardiometabolic diseases, musculoskeletal conditions, and mental health. However, as technologies become more widespread, the health care industry should consider how these technologies impact cost and expenditures, as well as the payment policy lag in accounting for these technologies. Value-based care models could be one pathway to test the integration of TEC and determine best practices for adoption in the health care system.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Strong; this issue brief discusses how Medicare currently reimburses TEC and explains that a separate payment code could be created for the Medicare Physician Fee Schedule to account for TEC use.
Methods: N/A

Biswas, A, Talukdar, W. Intelligent clinical documentation: harnessing generative AI for patient-centric clinical note generation. *ArXiv*. 2024;9(5). doi:10.38124/ijisrt/ijisrt24may1483

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To discuss the potential for generative artificial intelligence (AI) to relieve some of the burden associated with clinical documentation while maintaining patient confidentiality, address model biases, and describe the need for responsible deployment of generative AI in health care settings.
Main Findings: The generative AI models produced highly accurate and comprehensive documentation based on the scenarios processed. The models accurately transcribed patient-clinician interactions and generated notes in the common SOAP (Subjective, Objective, Assessment, Plan) and BIRP (Behavior, Intervention, Response, Plan) formats. Generative AI models still have drawbacks, including the need to continue the models' training on diverse and comprehensive datasets encompassing a wide range of medical conditions and the lack of transparency into models' decision-making processes. Additionally, the models must be checked for compliance with health care regulations, including those related to patient privacy, data protection, and medical record-keeping.
Strengths/Limitations: This study may have limited generalizability given that findings are based on a single case study.

Generalizability to the Medicare Population: Moderate; this study examined the application of generative AI without considering regulations specific to the Medicare population. However, findings may be relevant to many patient populations.
Methods: Using a simulated health care scenario, a case study assessed the use of AI technologies to streamline the clinical documentation process. The scenario followed current practice guidelines of data collection and considered ethical considerations to maintain patient confidentiality.

Braaf S, Manias E, Riley R. The role of documents and documentation in communication failure across the perioperative pathway. A literature review. *Int J Nurs Stud*. 2011;48(8):1024-38. doi:10.1016/j.ijnurstu.2011.05.009

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To determine the role of documentation across the perioperative pathway and assess how documentation contributes to communication failures between health care professionals.
Main Findings: Five major themes related to documentation were identified: design of documentation, quality of documentation, accuracy of documentation, functions of documentation, and documents that coordinate verbal communication. Documents can be designed to assist providers in capturing accurate information, but the expectation of high-quality documentation can fall on the provider to ensure completeness and accuracy. It is incumbent on health care professionals to recognize that the function of a document may be to communicate essential clinical information across the perioperative pathway to a broad audience.
Strengths/Limitations: This literature review was designed to capture a multidisciplinary perspective, which expanded the number of articles included and provided a comprehensive analysis of studies focused on documentation.
Generalizability to the Medicare Population: Moderate; although this article did not focus on the Medicare population, better documentation processes can improve health outcomes across many patient populations.
Methods: A literature review of past research pulled from electronic databases was conducted. Content analysis was used to determine patterns across the articles included in the review and distill those patterns into major themes for discussion.

Bundy H, Gerhart J, Baek S, et al. Can the administrative loads of physicians be alleviated by AI-facilitated clinical documentation? *J Gen Intern Med*. 2024;39(15):2995-3000. doi:10.1007/s11606-024-08870-z

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To assess how well DAX Copilot (DAXC), a generative clinical voice technology facilitated by artificial intelligence (AI), relieves clinical documentation burden for physicians.
Main Findings: Three broad themes were identified across 12 semi-structured interviews: (1) the potential or realized benefits of DAXC; (2) the encounters that AI technology is suitable for; and (3) the concerns of physicians about AI-facilitated clinical documentation. Within these themes, physicians varied in their opinions of DAXC. While some physicians thought the tool allowed them to be more personable and attentive to their patients, other physicians thought the tool could increase the number of patients physicians would be required to see. Additionally, while some physicians reported that DAXC accurately captured the patient visit, other physicians

caught significant errors and did not feel comfortable supplanting their own documentation processes with the software in its current iteration.
Strengths/Limitations: This study was conducted at a health system considered an early adopter of DAXC. Since time of publishing, the tool has likely undergone further development, and opinions on its use may have changed.
Generalizability to the Medicare Population: Moderate; although this study does not focus on a specific patient population, findings are relevant to many patient populations.
Methods: Twelve semi-structured interviews were conducted with physician users of DAXC. Interview transcripts were analyzed, coded, and reconciled to identify major themes from the interviews.

Dai T, Kvedar JC, Polsky D. Policy brief: ambient AI scribes and the coding arms race. *npj Digit Med*. 2025;8(1):780. doi:10.1038/s41746-025-02272-z

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Policy Brief
Objective: To examine the implications of using ambient artificial intelligence (AI) scribes in the context of fee-for-service (FFS) and Medicare Advantage (MA) payment models.
Main Findings: Ambient scribes carry the risk of amplifying, mitigating, or reconfiguring the distortion of clinical priorities and documentation that payment systems currently influence. These tools can facilitate a more complete capture of diagnoses in MA and support higher-level Evaluation and Management coding in FFS. More complete documentation in MA can result in increased risk-adjusted capitation payments for MA plans. These increased payments can lead to a temporary upside for early adopters of the tools, before recalibration and offsets are applied. Late adopters of the tools may have to practice under a lower baseline set without their data included. The authors suggested several policy guardrails, including having physicians and health systems actively review and audit diagnoses and billing codes, implementing transparent disclosure about the use of AI-drafted content, and considering health system contract and pricing discipline.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Strong; this policy brief focused on the use of ambient AI scribes within FFS and MA payment models.
Methods: N/A

Ghatnekar, S, Faletsky, A, Nambudiri, VE. Digital scribe utility and barriers to implementation in clinical practice: a scoping review. *Health Technol*. 2021;11:803-809. doi:10.1007/s12553-021-00568-0

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To discuss potential benefits and barriers related to the use of digital scribes in clinical practices.
Main Findings: One benefit of using digital scribes is relieving documentation burden for clinicians. Another benefit of using digital scribes is improving patient-provider relationships and interactions, as providers can actively engage with patients and remain present while the digital scribe captures the details of clinical documentation. There are also barriers to using this technology. Training physicians to use digital scribes can be time-intensive, and the technology itself must be trained to work across different patient populations. There are also privacy and legal concerns regarding the use of digital scribes to accurately capture clinical encounters. The

authors suggested solutions to mitigate the potential risks of digital scribes, including performing quality checks, conducting future research on training the tools for novel clinical encounters, and testing the tools' ability to improve efficiencies in the clinical documentation and billing process.
Strengths/Limitations: This study was conducted in the early stages of the availability of this technology, limiting the number of studies available for review.
Generalizability to the Medicare Population: Moderate; although this study does not focus on a specific patient population, findings are relevant to many patient populations.
Methods: A literature review was conducted. To identify relevant research articles, key words included "digital scribe," "e-scribe," and "voice-to-text transcription." A snowball method was also used to identify relevant publications.

Johnston KJ, Bynum JP, Maddox KE. The need to incorporate additional patient information into risk adjustment for Medicare beneficiaries. *JAMA*. 2020;323(10):925-926. doi:10.1001/jama.2019.22370

Subtopic: Medicare Payment Policy Related to Reimbursement Based on AI-Generated Documentation versus Claims-Based Reimbursement
Type of Source: Journal Article
Objective: To discuss key factors that are not included in the Centers for Medicare & Medicaid Services Hierarchical Condition Category (CMS-HCC) risk adjustment system.
Main Findings: The CMS-HCC risk adjustment model focuses on specific patient factors to predict future health care costs. The authors suggested that certain factors associated with increased Medicare costs and less favorable clinical outcomes have been left out of the model. The authors proposed potential solutions to improve risk adjustment, including adding International Classification of Diseases (ICD)-10 diagnostic codes for dementia and depression to the CMS-HCC model, using claims-based frailty measures as proxies for information on activities of daily living, and using Z-codes to include measures of poverty, low education, social isolation, housing issues, and abuse and neglect. These solutions could improve the current model and lead to more accurate reimbursement for clinicians who serve Medicare beneficiaries.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Strong; this article focuses on additional risk factors to consider in Medicare reimbursement policy.
Methods: N/A

Khullar D, Bond AM, Qian Y, O'Donnell E, Gans DN, Casalino LP. Physician practice leaders' perceptions of Medicare's Merit-based Incentive Payment System (MIPS). *J Gen Intern Med*. 2021;36(12):3752-8. doi:10.1007/s11606-021-06758-w

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To assess how physician leaders view the Merit-based Incentive Payment System (MIPS) and its approach to measuring performance across four domains: quality, costs, practice improvement, and promoting interoperability.
Main Findings: Six themes emerged from physician interviews: (1) MIPS is a continuation of prior value-based payment programs; (2) the measures are more relevant for primary care than general surgery or subspecialists; (3) there are mixed perceptions on whether MIPS improves patient care; (4) there is substantial administrative burden associated with programmatic changes; (5) incentives are small relative to the effort needed to participate; and (6) there is a need for external support for MIPS participation. These findings suggest that policymakers should consider finding a way to mitigate the challenges experienced by practices, including

encouraging more meaningful participation by adding specialty-specific measures and peer comparisons within specialties. Additionally, policymakers should consider finding ways to limit the administrative burden of data entry and improving financial and technical support for practices to navigate changes to the MIPS program.
Strengths/Limitations: Findings from this study may not be generalizable to other practices due to the composition of the participants. Participating providers did not represent all medical specialties across the Centers for Medicare & Medicaid Services.
Generalizability to the Medicare Population: Strong; this study examined Medicare providers' perceptions of MIPS measures.
Methods: This qualitative study included semi-structured interviews with physician practice leaders. The protocol was developed based on findings from a literature review, subject matter expert review, and pilot testing. Themes from the interviews were identified through a framework analysis. Discrepancies were reconciled through discussions among the authors.

Kinnunen UM, Kivekäs E, Palojoki S, Saranto K. Register-based research of adverse events revealing incomplete records threatening patient safety. *Digital Personalized Health and Medicine. Proceedings of MIE 2020*. 2020. doi:10.3233/SHTI200265

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To identify clinical documentation errors that can lead to patient safety risks.
Main Findings: Although adverse events due to issues with patient data management and documentation were relatively unusual, 18 reports showed that poor patient data management and documentation led to serious harm for patients. The authors concluded that more accurate information on adverse events should be documented and that organizations should plan and implement standardized documentation platforms and care processes to mitigate risks associated with poor documentation.
Strengths/Limitations: This study examined safety incident reports from the largest hospital district in Finland, promoting broad generalizability to the Finnish population.
Generalizability to the Medicare Population: Weak; this study was based in Finland and does not focus on a specific patient population.
Methods: Document review of incident reports from health and social care districts in Finland was conducted. Descriptive analysis of the data was conducted using Statistical Package for the Social Sciences (SPSS).

Kunze KN, Bepple J, Bedi A, Ramkumar PN, Pean CA. Commercial products using generative artificial intelligence include ambient scribes, automated documentation and scheduling, revenue cycle management, patient engagement and education, and prior authorization platforms. *Arthroscopy*. 2025;41(11):4950-4955. doi:10.1016/j.arthro.2025.05.021

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools; Results from Proposed or Similar Models that Use Technologies to Transcribe Patient-Provider Interactions and Anchor Documentation to Transcripts
Type of Source: Journal Article
Objective: To provide an overview of the current large language model (LLM) products available to providers, which can assist with the administrative burden of modern health care.
Main Findings: There are five categories of artificial intelligence (AI) products currently available to providers: documentation tools, ambient scribes, patient engagement assistants, resource optimization, and operational efficiency platforms. Limitations to widespread adoption of

current products in clinical settings include a lack of clear regulatory frameworks; uncertainty regarding the propagation of existing biases related to race, sex, socioeconomic status, and geographic disparities; inconsistent interoperability with electronic health records (EHRs); and physician and stakeholder buy-in due to insufficient output transparency. That is, AI models often do not show their reasoning for decision-making to physicians. Future use cases of AI tools for clinical care (e.g., surgical decision-making, diagnostic decisions) may come with risks. Developers of these technologies will need to overcome current concerns and limitations of AI by collaborating with physicians, regulators, and patients. These collaborations will help ensure that the next generation of AI tools are trusted, responsible, and effective.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; although this study does not focus on a specific patient population, findings are relevant to many patient populations.
Methods: N/A

Leung TI, Coristine AJ, Benis A. AI scribes in health care: balancing transformative potential with responsible integration. *JMIR Med Inform*. 2025;13(1):e80898. doi:10.2196/80898

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To provide an overview of opportunities and challenges of using ambient artificial intelligence (AI) scribes to support clinical documentation.
Main Findings: AI scribes, particularly those that use large language models, automate clinical note generation. These technologies can help improve documentation quality, improve interactions between clinicians and patients, reduce clinician burnout and cognitive task load, and promote clinician well-being. However, there are concerns with the accuracy of notes generated by AI scribes, as research findings indicate that AI-supported notes can include errors, omissions, and/or hallucinations. There are also security and privacy-related considerations with using AI scribes in health care settings.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; although the article was not focused specifically on the use of AI scribes for the Medicare population, opportunities and challenges associated with using AI scribes are applicable to many populations.
Methods: A review of the literature on AI scribes was conducted.

Moy AJ, Schwartz JM, Chen R, Sadri S, Lucas E, Cato KD, Rossetti SC. Measurement of clinical documentation burden among physicians and nurses using electronic health records: a scoping review. *JAMIA*. 2021;28(5):998-1008. doi:10.1093/jamia/ocaa325

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To review the literature on measurement approaches for documentation burden among physicians and nurses.
Main Findings: Thirty-five studies met the inclusion criteria. Clinician time and effort emerged as the primary constructs measured for documentation burden. Seven constructs emerged related to effort: electronic health record (EHR) usage and workload; clinical documentation/review; EHR work after hours and remotely; administrative tasks; cognitively cumbersome work; fragmentation of workflow; and patient interaction. Four constructs emerged related to time: average time; proportion of time; timeliness of completion; and activity rate. There is a lack of

standard and validated measures for clinician documentation burden. Fewer than half of the studies that met the inclusion criteria assessed the impact of EHRs on clinicians and/or patients, and only 40 percent of the studies noted clinician burnout. Additional research and consensus are needed on the best approaches to measure clinician documentation burden.
Strengths/Limitations: The authors noted a lack of maturity in research on the topic, which may have reduced the extent to which the scoping review captured all available research.
Generalizability to the Medicare Population: Moderate; although this article was not focused specifically on clinicians who care for the Medicare population, findings are applicable to many populations.
Methods: A scoping review on measures of documentation burden was conducted.

Ng JJW, Wang E, Zhou X, et al. Evaluating the performance of artificial intelligence-based speech recognition for clinical documentation: a systematic review. *BMC Med Inform Decis Mak*. 2025;25(236). doi:10.1186/s12911-025-03061-0

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To assess the performance of automatic speech recognition (ASR) and natural language processing (NLP) technologies to support clinical documentation.
Main Findings: Twenty-nine studies met the inclusion criteria. Reported word error rates ranged broadly. The lowest word error rates were found in controlled dictation settings, while the highest word error rates were found in conversational or multi-speaker settings. Findings were mixed regarding the usefulness of these technologies. For example, some studies showed reductions in documentation time and improvements in note completeness, while other studies showed increases in clinician burden, persistent errors, and inconsistent findings on cost effectiveness. Technologies that generate clinical summaries require clinicians to review the automated summaries for accuracy to ensure safety.
Strengths/Limitations: The review could not assess the long-term impacts of these technologies on efficiency or patient care. Most of the studies included in the systematic review were short-term evaluations, had small sample sizes, or were conducted in controlled settings.
Generalizability to the Medicare Population: Moderate; although this article was not focused specifically on the use of ASR and NLP among clinicians who care for the Medicare population, findings are applicable to many populations.
Methods: A systematic review on the performance of ASR and NLP to support clinical documentation was conducted.

Olakotan O, Samuriwo R, Ismaila H, Atiku S. Usability challenges in electronic health records: impact on documentation burden and clinical workflow: a scoping review. *J Eval Clin Prac*. 2025;31(4):e70189. doi:10.1111/jep.70189

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To identify electronic health record (EHR) usability issues that influence clinical documentation burden and workflow disruptions.
Main Findings: Twenty-eight studies met the inclusion criteria. Clinicians reported substantial workflow disruptions due to poorly designed EHRs. These workflow disruptions can lead to task-switching, excessive screen navigation, and fragmented information in EHRs. Further, these disruptions were commonly associated with workarounds. For example, clinicians might

duplicate documentation or use external tools. However, doing so may increase the risk of errors and lengthen the time needed to complete documentation activities. Findings highlight the need for improved EHR design.
Strengths/Limitations: The review may not have captured issues that can further impact documentation burden and workflow disruptions, such as clinician resistance to change. Additionally, findings may not be generalizable to low-resource health care settings as the majority of studies included in the scoping review were conducted in high-resource settings.
Generalizability to the Medicare Population: Moderate; although this article was not focused specifically on clinical documentation burden among clinicians who care for the Medicare population, findings are applicable to many populations.
Methods: A scoping review on documentation burden and workflow disruptions associated with EHR usability issues was conducted.

Quiroz JC, Laranjo L, Kocaballi AB, et al. Challenges of developing a digital scribe to reduce clinical documentation burden. *npj Digit Med*. 2019;2:114. doi:10.1038/s41746-019-0190-1

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To provide an overview of the challenges associated with developing automated speech-based documentation in health care settings.
Main Findings: Challenges with developing digital scribes include capturing high-quality audio recordings of conversations between patients and clinicians; converting the audio to transcripts using speech recognition; structuring and extracting medical concepts from the conversations; and generating medical summaries of the conversations. Another challenge is obtaining sufficient clinical data for artificial intelligence and machine learning algorithms given privacy issues of sharing clinical data.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; although this article was not focused specifically on digital scribes used by clinicians who care for the Medicare population, findings are applicable to many populations.
Methods: This perspective paper reviewed and summarized the literature on challenges related to developing digital scribes.

Rawat PK. Clinical editors impact on claims processing. *IJCNIS*. 2022;14(2):724-740.

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To provide background information on the role of clinical editors in medical record review and claims processing.
Main Findings: Clinical editors support documentation and claims processing activities. They review medical records to assess compliance with coding standards (e.g., determine whether the information may lead to the denial of a claim) and support the process of linking clinical documentation to administrative requirements. Clinical editors collaborate with coders to ensure accuracy of diagnosis and procedure codes for reimbursement and compliance. Additionally, clinical editors educate coders and clinicians on documentation practices and changes in payer or coding regulations.
Strengths/Limitations: N/A

Generalizability to the Medicare Population: Moderate; although this article was not focused specifically on clinical editors who support providers who care for the Medicare population, findings are applicable to many populations.
Methods: N/A

Steinkamp J, Kantrowitz JJ, Airan-Javia S. Prevalence and sources of duplicate information in the electronic medical record. *JAMA Netw Open*. 2022;5(9):e2233348. doi:10.1001/jamanetworkopen.2022.33348

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To determine the prevalence of duplicated text in clinical notes.
Main Findings: Approximately 50 percent of the text in a patient's record was duplicated from prior text written about the patient. Approximately 54 percent of the duplicated text was written by the same author, while nearly 46 percent of the duplicated text was written by a different author. The percentage of duplicated text in patient records has increased over time. Patient records with more notes had more duplicated text.
Strengths/Limitations: The methods used to assess duplicated text could not capture summarized or paraphrased text. Thus, the study likely underestimated the prevalence of text duplication. The study was conducted within a large academic health system with many trainees and a single electronic health record (EHR). Results may not be generalizable to other types of settings.
Generalizability to the Medicare Population: Moderate; although this study did not focus specifically on duplicated notes for the Medicare population, findings are applicable to many populations.
Methods: A retrospective, cross-sectional analysis was conducted on inpatient and outpatient clinical note length and duplication rates. Duplication from the same author and from different authors was quantified.

Tierney AA, Gayre G, Hoberman B, et al. Ambient artificial intelligence scribes: learnings after 1 year and over 2.5 million uses. *NEJM Catal Innov Care Deliv*. 2025;6(5):CAT-25. doi:10.1056/CAT.25.0040

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools
Type of Source: Journal Article
Objective: To summarize lessons learned, including sustainability and effectiveness of implementing ambient artificial intelligence (AI) scribes that leverage generative AI one year following adoption.
Main Findings: Providers' use of AI scribes increased over time, particularly among high users. Clinicians who used AI scribes more often showed the greatest reductions in time spent on notetaking compared with clinicians who used AI scribes less frequently. Physician characteristics, including age and years since graduation, were unrelated to the adoption of AI scribes. Most physicians reported positive experiences with using AI scribes. Many patients also reported positive perceptions of the impact of AI scribes on the quality of their visits.
Strengths/Limitations: The evaluation was conducted within a large integrated health system. Findings may not be generalizable to other types of health care settings. Additionally, the evaluation did not assess the extent to which physicians edited the automated notes.
Generalizability to the Medicare Population: Strong; this evaluation focused specifically on the use of AI scribes within a large health system that serves Medicare beneficiaries.
Methods: N/A

U.S. Government Accountability Office. Improper payments: information on agencies' fiscal year 2024 estimates. GAO-25-107753. March 11, 2025. https://www.gao.gov/assets/gao-25-107753.pdf

Subtopic: Medicare Payment Policy Related to Reimbursement Based on AI-Generated Documentation versus Claims-Based Reimbursement
Type of Source: Report
Objective: To quantify improper payments across federal agencies.
Main Findings: In 2024, improper payments totaled approximately $162 billion across federal agencies. Nearly 84 percent of these improper payments ($135 billion) reflected overpayments. Medicare and Medicaid are among the programs that reported the largest percentage of government-wide improper payments in 2024.
Strengths/Limitations: The estimate of improper payments in 2024 reflected only a subset of federal programs.
Generalizability to the Medicare Population: Strong; the report quantified the number of improper payments for the Medicare program.
Methods: The Government Accountability Office compiled improper payment estimates from the Office of Management and Budget's PaymentAccuracy.gov website.

Zink A, Chernew ME, Neprash HT. How should Medicare pay for artificial intelligence? *JAMA Intern Med*. 2024;184(8):863-4. doi:10.1001/jamainternmed.2024.1648

Subtopic: Problems in Care Delivery and Payment Related to Enhancing Care Coordination Using GenAI Tools; Medicare Payment Policy Related to Reimbursement Based on AI-Generated Documentation versus Claims-Based Reimbursement
Type of Source: Journal Article
Objective: To describe payment structures and pricing for artificial intelligence (AI)-enabled clinical services.
Main Findings: AI-enabled clinical services have the potential to reduce health care spending and improve patient outcomes. The Centers for Medicare & Medicaid Services' (CMS') payment approaches for AI-enabled services are currently based on existing rules for reimbursing new technologies. These approaches include bundling new technologies with existing services without adjusting the service price over time; bundling new technologies with existing services with add-on payments for the technologies; and paying for the technologies as separately payable services. Regarding the pricing of AI technologies, AI companies will likely charge clinicians what the market will bear. Regarding reimbursement approaches for AI-enabled services, the authors recommended bundling AI services with complementary services and using reference pricing when setting separate fees or transitional add-on payments for AI services.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Strong; this article discussed current CMS payment approaches and opportunities for AI-enabled services.
Methods: N/A

Appendix C. References

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