PETERSON HEALTH TECHNOLOGY INSTITUTE

# Payment for Clinical AI

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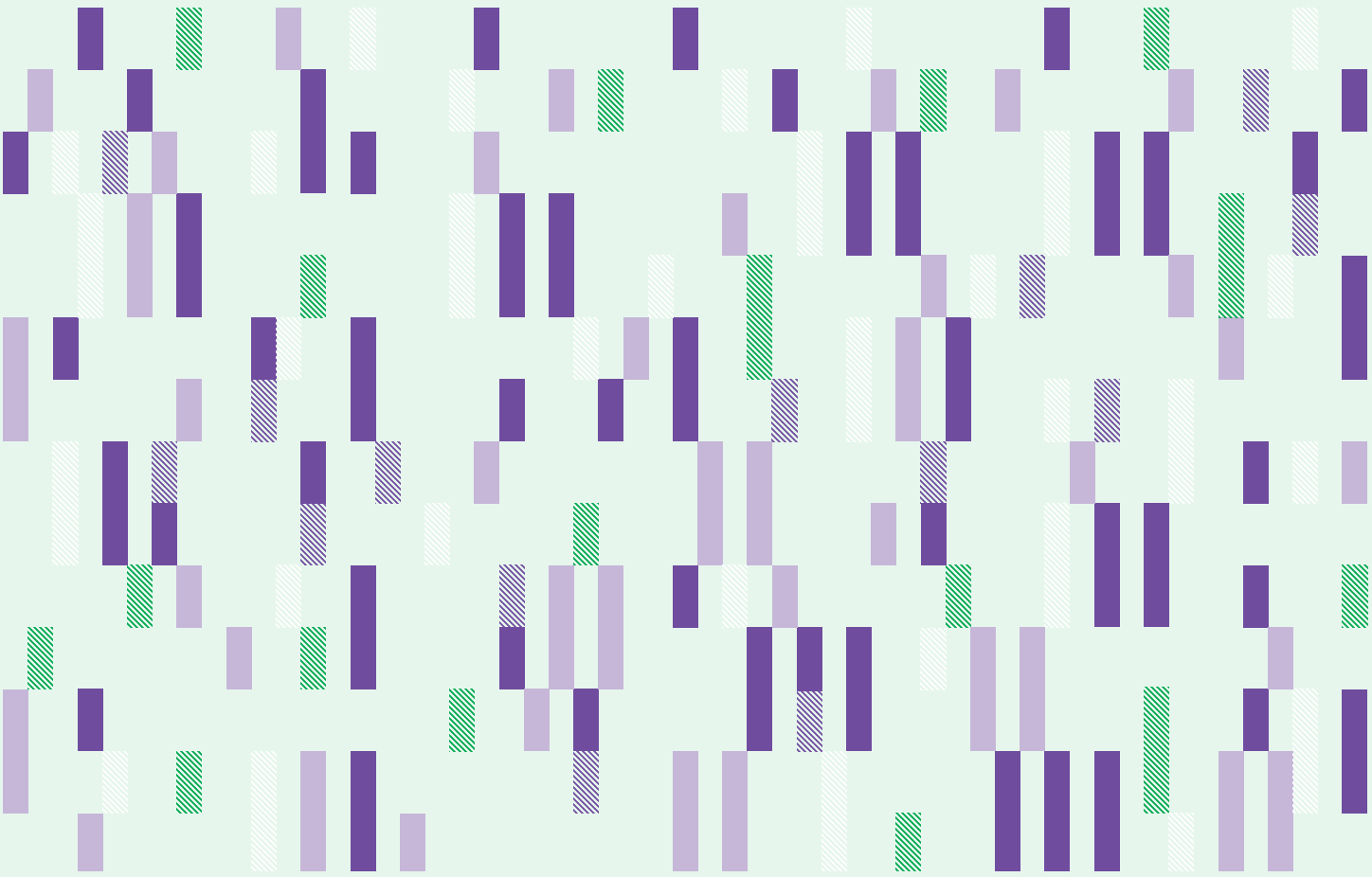

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# Executive Summary

Clinical applications of AI are advancing rapidly and present an opportunity to expand access, improve patient outcomes, increase the efficiency of care delivery, and lower the cost of care. Yet the limitations of today's payment models are hampering the adoption of high-value clinical AI and increasing costs where adoption occurs.

Payment for healthcare professional services in the United States remains predominantly fee-for-service, incentivizing volume of visits and procedures.[1] Because the majority of today's payments are based on clinician time and activities, they create a disincentive for healthcare organizations to invest in tools that could transform care delivery by reducing visit volume, procedures, or other billable work. Moreover, current payment models provide few mechanisms to reimburse services delivered by AI, leaving limited pathways for technology developers or operators to be paid directly.

In May 2026, PHTI convened senior leaders from health systems, health plans, technology developers, investment firms, academia, and federal agencies to discuss payment that supports the adoption of high-value clinical AI. The workshop centered on current and future payment models for assistive and autonomous AI, focusing on hypertension management to illustrate how care delivery and payment could evolve as AI takes on a greater role in clinical care delivery. The workshop was held under the Chatham House Rule to encourage candid dialogue.

Participants gathered to explore the following questions:

- Which existing payment options can be adapted for increasingly autonomous AI delivery models?
- Where do payment options fall short and where are incentives misaligned?
- How should future payment options be designed to support high-value clinical AI adoption?

**The following takeaways emerged from the discussion:**

1 Applying today's payment options to clinical AI will both inflate costs under fee-for-service and insufficiently incentivize adoption under pay-for-performance and capitation models.

2 Payment models for AI should be deflationary,[1] outcome-based, and adaptive to evidence and an evolving clinician role.

3 Autonomous clinical AI requires new payment models, not incremental modifications to existing ones.

### What Is Clinical AI?

AI-enabled technology that supports the screening, diagnosis, treatment, or management of health conditions. This includes:

- **Assistive tools** that support clinician decision making (e.g., recommending medication adjustments for clinician review)
- **Autonomous tools** that perform clinical tasks with minimal clinical involvement (e.g., managing routine prescription refills)

[1] "Deflationary" in this context is defined as reducing the long-term total cost of care for a defined population, while maintaining or improving outcomes.

# The Opportunity: Realizing the Potential of Clinical AI

Clinical AI is unlike other health technologies because it can perform tasks that have historically required human labor or expertise.

Early evidence demonstrates that clinical applications of AI-based technologies can support the screening, diagnosis, treatment, and management of health conditions. This includes identifying patterns that are not recognized by human review,[2,3] detecting patient deterioration early,[4] diagnosing illness,[5,6] reducing risk of clinical escalations,[7] and avoiding downstream hospitalizations.[8] In hypertension, for example, randomized control trials show that assistive AI improves adherence to hypertension guidelines[9] and supports reductions in blood pressure;[10] a single-arm pilot found that participants in an autonomous AI coaching program experienced a meaningful reduction in blood pressure after 24 weeks.[11]

Real-world evidence for both assistive and autonomous AI remains limited, given how new they are. Building this evidence base and realizing the potential of AI requires an enabling environment in which organizations can afford to deploy, generate evidence for, evaluate, and ultimately scale high-value solutions. However, today's payment models were designed for human-delivered services supported by technology—not for technologies that can increasingly perform clinical work independently.

### Clinical AI Innovation for Hypertension Care

Innovation in hypertension care is growing as more organizations are leveraging AI to automate care delivery.

Cadence, a chronic disease management company, works within primary care practices to support hypertension medication management using remote monitoring devices, an assistive AI platform, and a remote prescribing team to treat more patients and adjust medications faster. In June 2026, Cadence announced that they had raised $100 million to automate chronic care with AI.[14]

Mass General Brigham—a not-for-profit integrated health system in Massachusetts—developed a remote hypertension management program that uses home blood pressure measurements, algorithm-driven care pathways, and nonlicensed patient navigators with oversight from pharmacists to help patients reach blood pressure goals.[15] While the program outcomes showed the promise of algorithmic-driven care and highlighted opportunity for greater automation, scaling the program was challenging for several reasons, including the investment required and the lack of a sustainable reimbursement model.

Exhibit 1

**EVOLUTION OF A HYPERTENSION MANAGEMENT CARE MODEL**

| | No AI | Assistive AI | Autonomous AI |
|---|---|---|---|
| **Level of AI Autonomy** | Patient manually tracks blood pressure and brings readings to visits. Clinician reviews data and makes medication titration and treatment decisions at visits. | AI continuously monitors blood pressure between visits and drafts titration recommendations. Clinician reviews and approves treatment changes. | AI continuously analyzes blood pressure and delivers medication titrations to the patient with minimal clinician involvement. |
| **Clinician Role** | Clinician performs all cognitive work | AI performs some cognitive work; clinician reviews and makes decisions | AI performs most cognitive work; clinicians may oversee models and provide input |
| **Care Delivery** | Episodic | Continuous monitoring; episodic decisions | Continuous |
| **Potential for Scale** | **Constrained;** scale impacted by clinician capacity | **Limited;** requires clinician review and approval for decisions | **High;** enables population-level health management |

The workshop focused on hypertension management as an illustrative use case. Hypertension management programs have validated outcome measures, established and effective treatments, and a path toward autonomous care delivery (**Exhibit 1**), yet fewer than one in four U.S. adults with hypertension have their blood pressure under control.[12] Market readiness for AI solutions for hypertension management is increasing with device innovation[13] and the development of innovative AI solutions (see Clinical AI Innovation for Hypertension Care box).[14,15]

The payment challenges related to hypertension apply broadly across clinical AI. While payment is not the only barrier to adoption that clinical AI faces (e.g., regulatory frameworks, professional licensure, and medical liability must also evolve), without addressing payment, broad adoption will lag.

# Key Takeaways and Implications

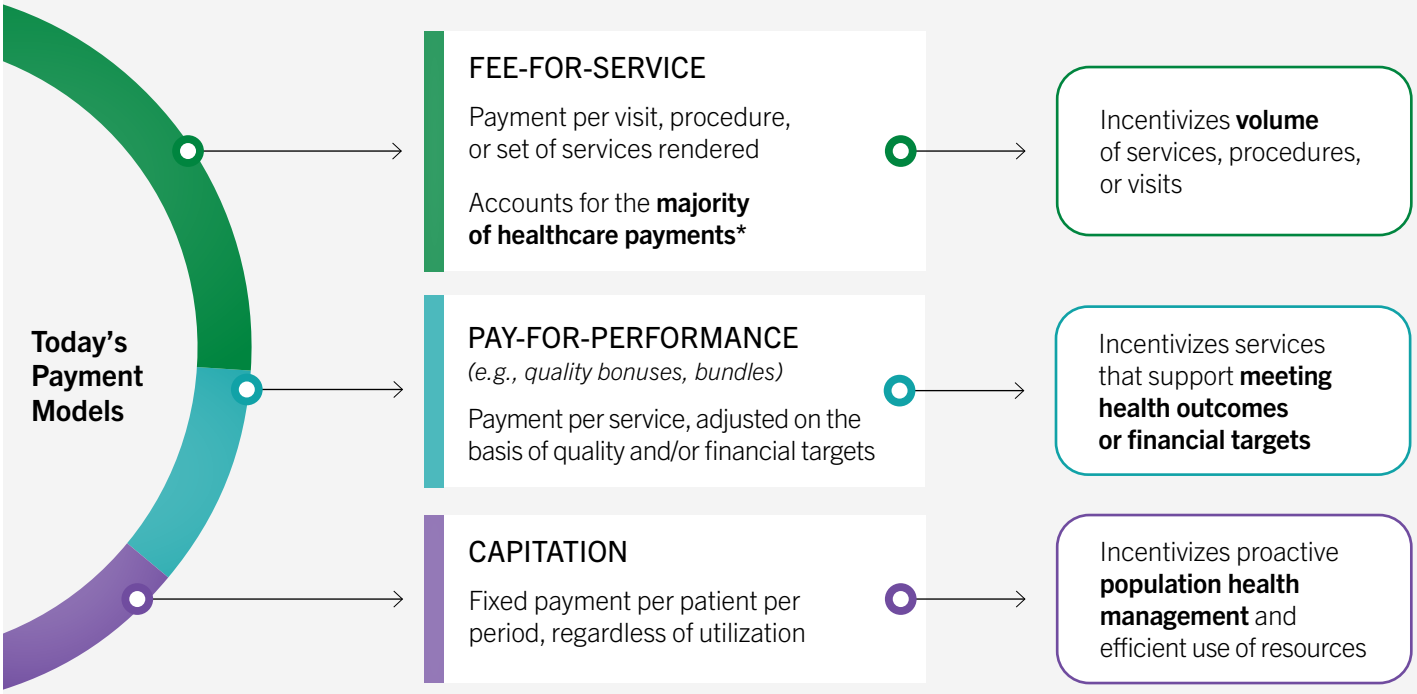
**TAKEAWAY 1**

Applying today's payment options to clinical AI will both inflate costs under fee-for-service and insufficiently incentivize adoption under pay-for-performance and capitation models.

Healthcare payment today is largely structured around three types of payment models—fee-for-service, pay-for-performance, and capitation—each with differing incentives (**Exhibit 2**). However, none were designed for technologies that can independently perform clinical work. As a result, applying today's payment structures to clinical AI creates a structural misalignment.

Exhibit 2

**OVERVIEW OF TODAY'S HEALTHCARE PAYMENT MODELS**




* Health Care Payment Learning & Action Network (LAN), 2020–2021 Alternative Payment Model (APM) Measurement Report.

Exhibit 3

**STRUCTURAL MISMATCH BETWEEN FEE-FOR-SERVICE PAYMENT AND CLINICAL AI**

| Today's Fee-for-Service Payment Inputs | Structural Mismatch With Clinical AI |
|---|---|
| LABOR-BASED PAYMENT | AI decouples clinical output from clinician effort and time. |
| ENCOUNTER-BASED PAYMENT | AI enables continuous, patient-directed longitudinal care. |
| UTILIZATION-BASED ECONOMICS | AI marginal cost approaches token consumption costs at scale. |

## Applying today's fee-for-service payment model risks making clinical AI cost inflationary.

Fee-for-service remains the dominant payment model in the United States today. It was designed to pay for human labor, time, and discrete activities—not for technology. It assumes that delivering more care requires more clinician effort and, thus, more payment.

These assumptions break down in the context of clinical AI (**Exhibit 3**). Clinical AI can generate more clinical output without a proportional increase in clinician labor; deliver clinical value without consuming clinician time; and enable continuous, patient-directed care rather than discrete encounters. At scale, its marginal costs resemble those of software rather than labor, allowing clinical activity to expand without a commensurate increase in cost.[16]

> "I hope we move beyond assistive AI because it just ends up dropping more work on clinicians. It is tough to manage remote data and recommendations between visits, especially when the extra time could be used for a higher-impact (and billable) patient visit."
>
> —Clinician, on Assistive AI

Under fee-for-service, reimbursement increases with the volume of billable services, rather than the value created. AI will enable healthcare organizations to deliver more services and generate more billable work at unprecedented scale. Layering this onto the existing fee-for-service payment chassis would allow reimbursement to grow far faster than the true cost of delivering that care.

The misalignment becomes more pronounced along the continuum from assistive to autonomous AI (**Exhibit 4**):

**Today's fee-for-service models can partially accommodate assistive clinical AI.** For example, existing supervisory billing codes could be modified to allow clinicians to bill for encounters involving oversight of AI-generated clinical recommendations. However, workshop participants noted that this approach ultimately runs into the same access and time constraints as traditional care because a licensed clinician must remain involved. Moreover, if AI reduces the amount of time clinicians spend per encounter without a proportional decline in reimbursement rates, providers can see more patients with less effort while receiving the same payment per service, driving up aggregate spending.

**Autonomous AI relies on different inputs than those used to calculate fee-for-service payment today.** Autonomous AI does not depend on clinician time as the primary driver of value and can deliver care continuously, at scale, and at low marginal cost. Applying fee-for-service payment without rethinking these inputs risks significantly increasing volume and total costs. Creating new billing codes for autonomous AI would likely amplify current fee-for-service billing incentives without a link to outcomes and a low price.

Exhibit 4

**STRUCTURAL FEE-FOR-SERVICE PAYMENT MISMATCH INCREASES WITH LEVEL OF AUTONOMY**

Example: Hypertension Care Model

| Level of AI Autonomy | No AI | Assistive AI | Autonomous AI |
|---|---|---|---|
| | Patient manually tracks blood pressure and a clinician reviews the data to create a titration plan at each visit. | AI continuously monitors blood pressure and drafts titration recommendations, which a clinician must approve before action. | AI continuously analyzes blood pressure and delivers medication titrations to the patient with minimal clinician involvement. |
| **Labor-Based Payment** | Clinician work drives care; payment maps to time spent with and complexity of patient | AI may compress clinician effort and time | Minimal clinician work involved; oversight only |
| **Encounter-Based Payment** | Care is mostly episodic, visit-focused | AI performs activity between encounters | AI monitoring and titration replaces encounters |
| **Utilization-Based Payment** | Volume limited by clinician capacity | AI may enable increased volume of activity per clinician and increase costs | AI-created potential for cost inflation with near-zero marginal costs and unlimited potential for scale |
| **Overall Fit with FFS Payment Model** | ● GOOD | ◐ PARTIAL | ○ POOR |

## Performance-based and capitated models are better aligned than fee-for-service payment but lack design features required to drive adoption.

Performance-based and capitated models are better suited to AI than fee-for-service because they shift incentives away from volume and toward value and outcomes. However, as designed today, these payment models do not create sufficient incentives to drive adoption at scale.

While these models may reward AI-enabled improvements in outcomes or efficiency, they present other challenges. For example:

- **Significant workflow redesign:** Successfully deploying clinical AI requires significant clinical workflow redesign and change management investment that extends well beyond the direct cost of the tools. This includes defining new roles and responsibilities (e.g., model orchestration and oversight), establishing when AI can act independently, and developing new clinical workflows. Implementing these changes will require retraining staff, investing in new governance and infrastructure, and dedicating organizational time and support to shift to new models of care.
- **Misaligned payer incentives:** Most provider organizations contract with multiple payers, all with different payment structures, incentives, and coverage rules. This makes it impractical to redesign care delivery for a subset of their patients covered by performance-based or capitated arrangements.
- **Attributing cost savings:** As care shifts away from discrete visits toward more continuous monitoring and AI-to-patient interactions, outcomes will increasingly result from many interventions over time. This makes it difficult to attribute cost savings or improvements to a specific AI solution. Today, financial incentives for managing spend accrue to the entity accountable for a patient's total cost of care (e.g., health system participating in an accountable care organization [ACO], primary care practice). Isolating the contribution of condition-specific tools in this setting is difficult, weakening the business case for adoption and creating contractual complexity that increases implementation costs and creates vendor lock-in.
- **High upfront investment and licensing costs:** Health systems and other organizations must absorb substantial upfront implementation and licensing costs for AI deployment before realizing any returns. Returns from technology adoption are often delayed, uncertain, and shared across multiple stakeholders who often did not bear the costs.

Current adoption trends reflect barriers to innovation. Even in capitated and full-risk settings, where incentives are most aligned, adoption of new technologies has been slower than expected. A national survey of 276 ACO-contracting organizations found only one-third had adopted digital health technology for a high-priority, pervasive chronic condition, and those that did used it to complement rather than replace traditional care.[17,18] Without deliberate payment redesigns, clinical AI is likely to face many of the same barriers to adoption.

Ultimately, today's payment options are insufficient to support increasingly autonomous care delivery (**Exhibit 5**). Workshop participants next discussed what would be required to architect new payment models better suited for clinical AI.

> "Implementing new technology requires significant change management. Even in ACOs, where the incentives are aligned to support technology adoption, we found clinician resistance to changing the way they work."
>
> —Former ACO Executive, on Technology Adoption in Performance-based Contracting

TAKEAWAY 2

## Payment models for AI should be deflationary, outcome-based, and adaptive to evidence and an evolving clinician role.

Payment for AI-enabled care has the potential to function as a deflationary force in healthcare if designed appropriately. That is, by substituting technology for labor-driven activities, clinical AI can reduce the long-term total cost of care per patient in a defined population while maintaining or improving clinical outcomes.

At the same time, AI may expand access and increase overall utilization, putting upward pressure on total spending. Payment models must be structured to ensure that the unit cost of AI-enabled care declines over time, so that the benefits of expanded access translate into lower-cost, scalable care rather than unnecessarily higher spending.

Exhibit 5

**LIMITATIONS OF TODAY'S HEALTHCARE PAYMENT MODELS FOR CLINICAL AI**

| Payment Model | Limitation for AI |
|---|---|
| FEE-FOR-SERVICE | Risks overutilization and inflating costs without necessarily improving outcomes. |
| PAY-FOR-PERFORMANCE *(e.g., quality bonuses, bundles)* | Insufficient incentives for adoption. |
| CAPITATION | Insufficient incentives for adoption; difficult to attribute impact to specific tool. |

**Workshop participants identified three core principles to guide the design of future payment models for AI-enabled care:**

1 **Payment must produce deflationary system-level value.** Payment should only be justified when AI demonstrably improves upon current care, such as better clinical outcomes, reduced total cost of care, or expanded access. Value should be measured against real-world comparators (e.g., what the system would have achieved without AI, at the population level), not idealized benchmarks.

2 **Payment should be tied to results and reward appropriate utilization.** Clinical AI fundamentally changes the relationship between utilization and value. Payment for clinical AI should reflect realized clinical or economic value rather than time, effort, or resource inputs. Because AI can scale interventions across large populations, per-use payment risks overuse unless it is tied to value. Payment design requires explicit safeguards (e.g., withheld-payment mechanisms, price ratcheting) to prevent overutilization and unconstrained spending.

3 **Payment must reward early innovation and adoption, then evolve with evidence, performance, and the changing clinician role.** Payment systems for AI should be more dynamic than those designed for traditional care delivery. Rates should start high enough to stimulate early innovation and adoption, then adjust as utilization scales, marginal costs decline, and real-world evidence accumulates—with regular, longitudinal review. Payment should also recognize and fairly compensate for a rapidly evolving clinician role (e.g., oversight, orchestration, quality assurance, and accountability for AI-generated outputs), incentivizing the shift from individual encounters toward population-level management.

Given the dynamic nature of clinical AI, optimal payment designs must vary by clinical setting and use case, while remaining flexible enough to quickly adjust both coverage and pricing mechanics in the face of rapidly evolving evidence.

TAKEAWAY 3

## Autonomous clinical AI requires new payment models, not incremental modifications to existing ones.

Autonomous clinical AI holds the greatest potential to transform care delivery. Realizing this potential requires new payment models, not just incremental changes to the status quo.

Workshop participants agreed that no single payment model will support AI adoption across all clinical settings and use cases. For example, autonomous AI for the management of hypertension will be different from hospital-based AI tools monitoring the deterioration of patients admitted to the intensive care unit, and different still from self-guided use of autonomous behavioral health support or payment for discrete diagnostics. Each application of AI likely generates different system value, involves different levels of clinician oversight, and impacts patient outcomes over different time horizons.

Instead, new payment models for clinical AI must be deliberately designed for specific contexts, addressing key questions across several core dimensions:

- **Pricing Methodology:** How should prices be set and change over time? Healthcare has traditionally priced services according to clinician effort, time, and practice expense. These inputs do not reflect the cost structure of AI-enabled care.
- **Payment Structure:** How should payment be structured (e.g., clawback mechanisms, withheld payments)?
- **Clinician Billing:** How should coding and billing evolve for review and oversight of AI systems? As AI changes the clinician's role, clinicians may spend less time delivering discrete services and more time supervising, validating, escalating, and coordinating care delivered by AI systems.
- **Payment Recipients:** Who is eligible to receive payment for AI-enabled care? Fee-for-service assumes care is delivered and billed by licensed providers. Autonomous AI challenges this model by enabling care delivery with limited clinician involvement and the potential to operate outside of a provider entity. This raises questions about whether and how technology developers or operators could be paid directly.
- **Reporting:** How should performance be measured, demonstrated, and reported without traditional claims-based encounter data?

Payment design inevitably requires tradeoffs. For example, designing a fee-for-service code for AI-enabled care that reduces reimbursement rates to guard against cost inflation could deter AI adoption. Participants noted that in response to lower reimbursement rates, providers will adapt, potentially by shifting toward higher-margin services, avoiding AI-enabled technologies, or limiting deployment to patient panels where it is financially worthwhile.

Future payment will require a combination of models, designed around the guiding principles above, with incentives to drive adoption of increasingly autonomous AI.

The CMS Innovation Center's ACCESS (Advancing Chronic Care with Effective, Scalable Solutions[19]) model is the most concrete step to date toward a payment model that accommodates AI-enabled delivery. The ten-year, outcome-based payment model launched July 2026 with more than 150 participating organizations, focusing on management of cardiometabolic, musculoskeletal, and behavioral health chronic conditions. Major health plans representing 165 million Americans have also pledged to align with an ACCESS-like structure by 2028.[20]

The ACCESS model does not require AI use but its structure accommodates and encourages technology substitution in ways that traditional payment models do not. Because ACCESS rates are relatively low, there is a strong incentive for entrants to leverage highly automated or AI-enabled tools to support patients at a lower cost.

> "I appreciate that the ACCESS model will be in place for the next decade. Capital flees uncertainty. Investors want stability in payment model design."
>
> —Investor, on the ACCESS Model and Future Payment Design

### Applying AI-Payment Principles to ACCESS

- Designed to reduce the total cost of care of select chronic diseases.
- Ties reimbursement to measurable clinical outcomes. Fifty percent of payment is provided upfront, with the remainder withheld pending outcomes achieved.
- Payment provides flexibility in how care is delivered, allowing the use of humans and technology to evolve.

Today, the ACCESS model is not designed to support the participation of traditional provider organizations: ACCESS participants cannot receive payments for their aligned beneficiaries outside of ACCESS model payments. This limits opportunities to layer clinical AI into traditional care delivery. As a result, ACCESS will likely accelerate AI adoption among new market entrants operating outside the traditional delivery system.

While ACCESS is a meaningful advance toward payment models better aligned for AI-enabled clinical care, its outcome-based payment structure will not fit every clinical context. Outcome-based payment requires specific outcomes that are measurable, validated, and directly attributable to an intervention. While chronic disease management (e.g., hypertension) meets these requirements, it is more difficult in primary care. In primary care, patients present with multiple conditions, receive multiple interventions, and visit multiple providers, which makes it difficult to attribute an outcome to an intervention.

The healthcare system must continue developing new payment approaches across more clinical contexts that align incentives and support broad adoption of increasingly autonomous clinical AI.

# Looking Ahead

## Clinical AI presents a once-in-a-generation opportunity to fundamentally redesign how healthcare is delivered.

Unlike previous new technologies, clinical AI has the potential to reshape the underlying economics of care itself by increasingly substituting technology for human labor. If deployed thoughtfully and at scale, this could dramatically expand access to care, improve patient outcomes, and lower healthcare costs over the long term. The decisions we make today on how to pay for AI-enabled clinical care will shape not only the pace of clinical AI adoption, but the impact on our healthcare system for years to come. PHTI is committed to advancing new payment models for technology-enabled care.

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