

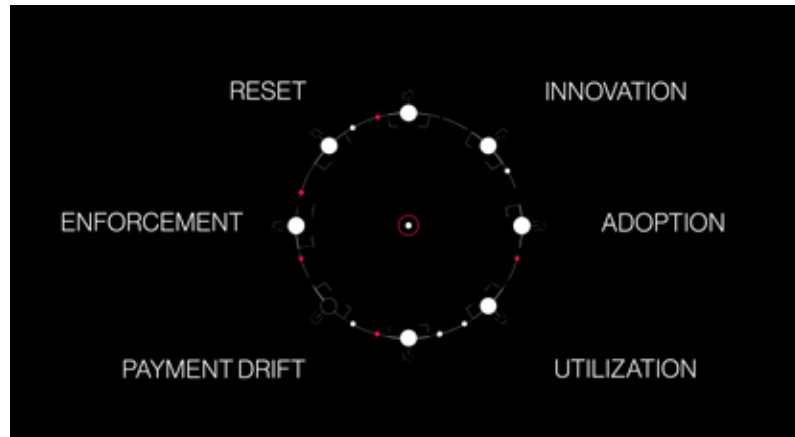


# SAYING THE QUIET PART OUT LOUD: YOU WILL GET WHAT YOU PAY FOR.

**Technology scales. Payment decides what survives.**

## EXECUTIVE SUMMARY

Clinical AI's real-world impact is determined not only by clinical performance, but by the payment systems through which it is monetized and sustained. This paper examines a recurring pattern in healthcare innovation: new technologies scale faster than the reimbursement and governance frameworks intended to manage them. Using historical and contemporary examples, it highlights how payment misalignment shapes utilization, cost, and trust, and why these dynamics are especially consequential as clinical AI adoption accelerates. It concludes by outlining a practical approach for improving early visibility into payment behavior as innovation scales.



## INTRODUCTION

Recent attention from the Department of Health and Human Services, including its Request for Information on artificial intelligence in clinical care, reflects the speed at which AI is moving from theory into practice. As that conversation unfolds, it is worth examining a less visible but equally consequential dimension of adoption: the payment systems. These systems will undoubtedly determine how clinical technologies are deployed, scaled, and sustained once they enter routine care.

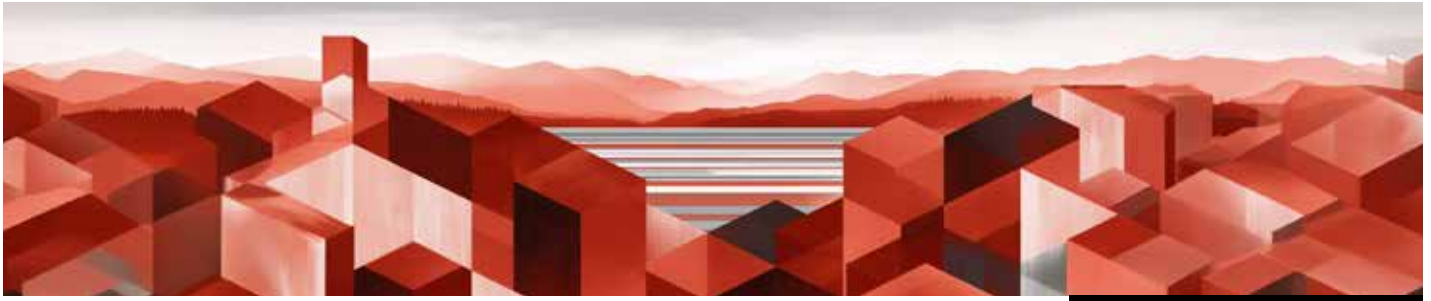
Why? Simply put, clinical AI does not live in a vacuum. It is monetized, operationalized, and sustained through payment systems that shape how—and how much—it is used. As new technologies enter clinical workflows, they do so within existing reimbursement frameworks that were often designed for an earlier era of care delivery. When innovation advances faster than those frameworks adapt, predictable patterns emerge: utilization expands, costs escalate, and accountability becomes diffuse. These dynamics are not unique to AI. They have appeared before, across multiple waves of healthcare innovation, and they offer important lessons for the present moment.

This paper explores those patterns to illuminate a recurring structural challenge that arises when clinical innovation outpaces the payment and fiduciary systems that govern its use.



AI does not live in a vacuum.





What gets paid for gets repeated.

## INCENTIVES SHAPE HOW INNOVATION SCALES

Healthcare innovation is often discussed in terms of clinical promise: better detection, earlier intervention, improved outcomes. Less attention is paid to the economic substrate that determines how innovation is deployed in practice. Payment systems do more than reimburse care. They define incentives, establish boundaries, and implicitly answer questions about duration, intensity, and appropriateness.

When a new technology fits cleanly into existing payment models, adoption tends to be orderly. When it does not—when it expands duration, automates labor, or blurs the line between episodic and continuous care—payment systems tend to lag. During that lag, utilization is shaped less by clinical clarity than by economic possibility.

In everyday terms, this dynamic is often summarized by a familiar phrase: you get what you pay for. In healthcare, and everyday life, that saying is typically understood to mean that higher-priced services reflect greater quality or complexity. But at a system level, it also points to something more basic. Payment structures do not merely reflect clinical practice. They influence what is repeated, what is scaled, and what becomes routine.

This is not a theoretical concern, nor is it unique to AI. Similar dynamics have emerged in prior waves of clinical innovation, particularly when new technologies expanded capability faster than reimbursement frameworks adapted to govern their use.

## A PRIOR PATTERN: FROM HOLTER MONITORING TO CONTINUOUS TELEMETRY

In the early 2000s, ambulatory cardiac monitoring underwent a meaningful technological shift. Traditional Holter monitors recorded heart rhythms for 24 to 48 hours, after which data were reviewed and interpreted. These devices were well understood clinically and administratively, with established billing conventions and clear expectations around duration and use.

Newer technologies extended that model. Mobile cardiac telemetry made it possible to monitor patients continuously for weeks, transmitting data in near real time and allowing for automated detection of arrhythmias. Clinically, this represented a genuine advance: certain intermittent conditions that might be missed during short monitoring windows could now be detected with greater reliability.

Administratively, however, these capabilities strained existing payment frameworks. Billing rules had been written for discrete episodes of care, such as short-duration Holter monitoring and patient-triggered event recorders, not for extended or continuous surveillance. As a result, mobile cardiac telemetry did not fit cleanly within existing coverage and billing categories in its early years. Guidance on when extended monitoring was appropriate, how long it should persist, how it should be reimbursed, and when lower-cost alternatives should be used developed slowly, even as adoption accelerated.





Duration expanded. Governance lagged.

Real-world consequences of this lag became visible over time. In 2015, BioTelemetry and its CardioNet subsidiary agreed to pay \$6.4 million to resolve allegations that they had improperly billed Medicare for mobile cardiac telemetry services that were not medically necessary, notably when less expensive event monitoring would have sufficed. This settlement, tied to practices predating 2012, came more than a decade after these technologies first entered widespread use. Additional enforcement actions followed in subsequent years, including settlements in 2022 and 2023 totaling nearly \$60M related to improper billing practices, inappropriate service levels, and other violations across multiple forms of remote cardiac monitoring.

Each of these resolutions followed years or even a decade after the technologies were in broad use and after the initial billing practices became common. The pattern is not one of immediate or arbitrary correction, but of delay, adaptation, and eventual enforcement. This is evidence of an adjustment process in which the mismatch between innovation and payment rules persists long enough to affect cost and deployment at scale.

The lesson is not that the technology was misguided or inherently problematic. Rather, it is that billing systems, once out of sync with clinical capability and reimbursement frameworks, can unintentionally reward volume and duration in ways that are difficult to unwind and that take many years to address through policy clarification and enforcement. Behind the payment recommendations made.

## A CONTEMPORARY ECHO: REMOTE PATIENT MONITORING

A similar dynamic can be observed more recently in remote patient monitoring (RPM). Advances in sensors, connectivity, and analytics have made it possible to track physiologic data continuously outside traditional care settings. RPM holds clear promise, particularly for managing chronic disease and supporting patients with complex needs.

As with cardiac telemetry, adoption accelerated quickly, especially during and after the COVID-19 pandemic. Payment models evolved rapidly to support this expansion, often through recurring monthly reimbursement tied to device use and data transmission. In many cases, those models placed few explicit limits on duration or clear criteria for ongoing necessity.



Correction followed years later.



Unlike earlier episodes of innovation, this pattern is still unfolding. Federal oversight bodies have already noted the speed and scale of RPM adoption and raised concerns about whether utilization is consistently aligned with clinical need. In 2023, the HHS Office of Inspector General reported that Medicare spending on RPM services grew from approximately \$15 million in 2019 to more than \$300 million by 2022, driven largely by increased volume rather than changes in reimbursement rates. The report highlighted vulnerabilities related to patient eligibility, monitoring duration, and limited guardrails on ongoing billing.

Early enforcement activity suggests these concerns are not merely theoretical. The Department of Justice has announced multiple False Claims Act cases involving RPM and related remote monitoring services, including allegations that providers billed for monitoring that did not occur, enrolled patients without meaningful clinical justification, or continued billing long after any plausible monitoring value had been exhausted. While these cases represent only a fraction of overall RPM utilization, they mirror the early stages of prior innovation cycles, where misuse becomes visible before policy correction is fully developed.

What distinguishes RPM at this stage is not necessarily the presence of widespread fraud, but the absence of mature policy (e.g., stop-rules). Once patients are enrolled, monthly billing can continue with limited friction, even as clinical value plateaus. This persistence reflects the same structural conditions seen in earlier technologies: rapid innovation, permissive payment pathways, and delayed governance.

As a result, RPM today occupies an intermediate state. It has moved beyond novelty, but has not yet reached equilibrium. Oversight is increasing, evidence is accumulating, and policy responses are beginning to take shape. Yet the core alignment challenge remains unresolved.

## WHY THIS MATTERS FOR CLINICAL AI

Against this backdrop, clinical AI simply represents a further step along the same innovation trajectory, but with important differences of both degree and speed. Unlike earlier technologies, AI can scale decision support, pattern recognition, and workflow automation across entire populations with minimal marginal cost. It can operate continuously, invisibly, and at speeds that far exceed human review.

These characteristics magnify the importance of payment design. AI systems are improving rapidly, often through iterative model updates that occur far faster than traditional clinical technologies evolve. At the same time, adoption is occurring at unprecedented pace, with AI tools being embedded into existing workflows rather than introduced as discrete, optional services. Together, these dynamics compress the time between innovation, deployment, and financial impact.

When AI-enabled services are reimbursed without clear boundaries—when attribution is opaque, duration is undefined, or incentives reward deployment rather than value—the risk is not simply higher spending. It is a loss of clarity around responsibility and accountability. Compared to prior innovation cycles, there is little reason to expect that faster growth and faster adoption will result in fewer payment errors or fewer misalignments. If anything, they reduce the time available for correction.

This risk spans public and private systems alike. While federal health programs operate within defined statutory and regulatory scopes, the majority of Americans receive coverage through employer-sponsored plans governed by fiduciary standards that were not designed with continuously learning, continuously operating clinical technologies in mind. Innovation does not respect these jurisdictional lines, even when oversight frameworks must.



## RECOGNIZING THE PATTERN

The history of cardiac telemetry and the current experience with remote monitoring, along with a host of other examples, suggest a common pattern:

- Clinical innovation expands capability and scale
- Payment systems adapt incrementally
- Utilization grows faster than governance
- Correction arrives later, often after cost and complexity have already increased and public/patient confidence are already eroding

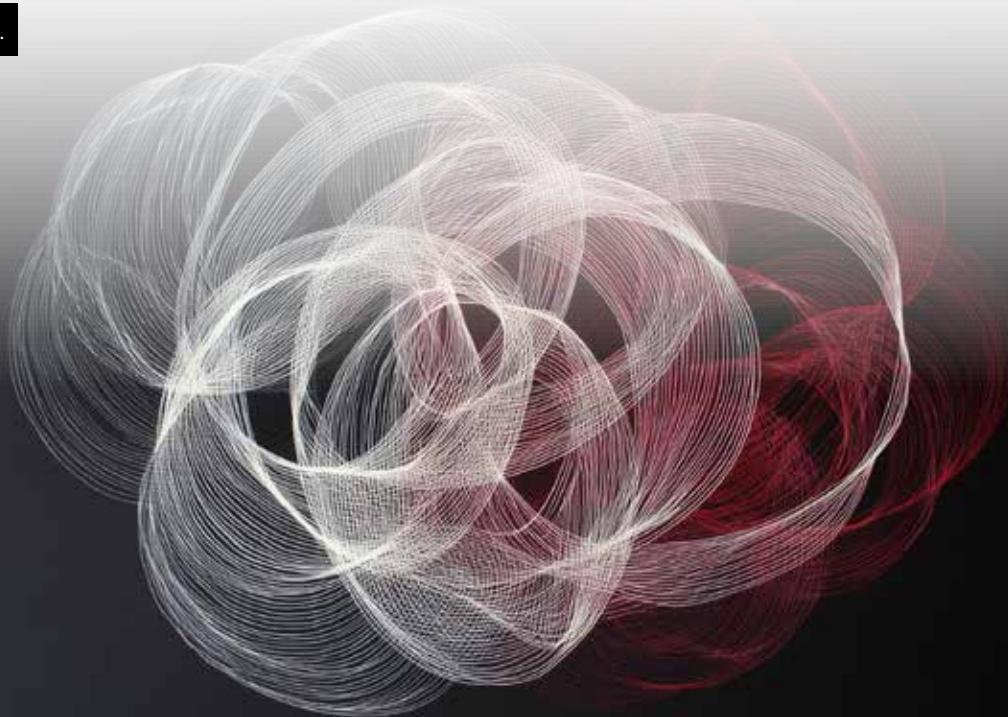
AI intensifies each step in that sequence. Recognizing the pattern early does not require opposing innovation or predicting misuse. It requires acknowledging that payment systems are not neutral backdrops. They are active participants in how technology is used, sustained, and justified. Understanding that reality is a prerequisite for thoughtful policy, responsible deployment, and durable trust in the next generation of AI clinical tools.

## REIMBURSEMENT SIGNALS DETERMINE WHICH AI SURVIVES

Clinical AI is often discussed as if adoption is driven primarily by performance. In practice, however, durability is determined by reimbursement. Payment systems do not merely support innovation. They select it. In fact, in our largely Fee-for-Service paradigm, you will absolutely get what you pay for ... and, conversely, you won't get what you don't pay for.

AI tools that align cleanly with existing reimbursement structures tend to persist, even when their clinical value is incremental. Tools that create friction, ambiguity, or unpriced effort struggle to survive, regardless of promise. Over time, this dynamic shapes the market more powerfully than evidence alone.

The cycle repeats.





Payment selects innovation.

This selection effect has consequences. When reimbursement rewards volume, duration, or automation without clearly tying payment to clinical necessity or outcome, AI systems are incentivized to scale in those dimensions. When reimbursement is episodic, unclear, or disconnected from downstream financial impact, AI adoption follows suit.

The result is not a neutral marketplace of ideas. It is an environment in which payment logic quietly determines which forms of intelligence are operationalized, which are refined, and which disappear. In that sense,

reimbursement systems function as a de facto product roadmap for clinical AI .

This reality does not imply intent or malfeasance. It reflects the simple fact that technologies which cannot be sustained economically do not persist, while those that can are iterated, embedded, and normalized. Over time, payment signals shape not only adoption, but also design choices, deployment strategies, and clinical workflows.

As you can clearly see, in a fee-for-service environment, “you get what you pay for” takes on a different and more literal meaning. It does

not simply describe a relationship between price and quality. It describes a system-level reality: whatever activities are reimbursed, repeatable, and scalable are the ones that persist. Over time, payment signals determine not only which technologies survive, but how they are designed, deployed, and normalized in clinical practice.

Recognizing this dynamic is essential. Without it, discussions of clinical AI risk treating economics as an implementation detail, rather than as a primary driver of real-world behavior.



## TRUST IN CLINICAL AI IS UNDERMINED BY POST-CARE FINANCIAL HARM

Public trust in clinical AI is often framed as a function of transparency, explainability, and bias. While these factors matter, trust is also shaped by something more immediate and personal: the financial experience that follows care.

When patients, employers, or plan sponsors encounter unexpected or disproportionate costs after AI-influenced clinical decisions, confidence erodes. This erosion occurs even when the underlying clinical decision was reasonable. Financial harm, or even perceived harm, retroactively reframes the technology that preceded it.

This dynamic is not new. In prior waves of innovation, clinical tools that were initially welcomed (e.g., Proton Beam Therapy & Genetic Testing) became sources of skepticism once their economic consequences became visible. The technology itself did not change. The trust environment did.

Clinical AI faces the same risk. If AI-enabled services contribute to cost escalation without clear justification, attribution, or accountability, skepticism will not be limited to billing practices. It will extend to the tools themselves.



Over time, AI may come to be seen not as an aid to care, but as a driver of financial complexity and burden.

This risk is particularly salient in employer-sponsored coverage, where fiduciary responsibility intersects with limited visibility into the mechanisms that shape claims experience (e.g., generation, submission, processing, adjudications). When accountability for outcomes and accountability for costs are misaligned, trust fractures along those seams.

Sustained trust in clinical AI therefore depends on more than technical performance. It depends on whether the financial consequences of AI-mediated care feel proportionate, intelligible, and fair to those who bear them.

From this perspective, the financial experience that follows AI-influenced care is not incidental. It is the downstream expression of the same incentives that shaped the technology's use in the first place. When the financial consequences of care feel disproportionate or difficult to explain, a patient's (or fiduciary's) trust erodes not at the point of care, but later, when claim costs and premium increases surface.





## WHAT'S AT STAKE?

Taken together, the historical pattern and the current moment suggest a narrow and closing window. AI adoption is undoubtedly accelerating, and payment systems are adapting incrementally as always through changes in billing and coverage. At the same time, fiduciary frameworks, which determine who is responsible for managing cost and appropriateness (oftentimes long after care has been delivered), remain largely unchanged.

Clearly the question is not whether clinical AI will be used (it already is). The question is whether its integration into care will reinforce trust or quietly undermine it through post-care financial experience.

Recognizing how reimbursement shapes which technologies persist, and how post-care financial outcomes shape trust, is a necessary step toward integrating clinical AI responsibly. Innovation will continue to move quickly. Whether it ultimately strengthens or erodes confidence in the healthcare system will depend less on algorithms than on the payment structures that govern their use. Within health systems, “you get what you pay for” is not a statement about quality, but about outcomes.

## FROM RECOGNITION TO PRACTICE: A PRACTICAL PATH FORWARD

The history described in this paper suggests that misalignment between clinical innovation and payment systems is not an anomaly. It is a recurring condition that emerges when new capabilities scale faster than the frameworks designed to govern them. At the same time, payment policy and fiduciary standards evolve slowly by necessity. As such, organizations operating within those systems are exposed to financial and governance risk long before formal corrections take shape.

In the context of clinical AI, this timing is amplified because AI-enabled tools scale rapidly, embed themselves into routine workflows, and influence utilization patterns in ways that are difficult to detect until financial effects are already visible. By the time billing guidance, coverage policy, or enforcement efforts respond, patterns of use may be well established. The challenge, then, is not to eliminate innovation risk, but to observe and manage it earlier in its lifecycle.

One practical response lies at the payment layer, where innovation leaves its clearest operational footprint. Claims data captures how technologies behave once they move from clinical promise into routine use, revealing patterns of duration, intensity, substitution, and cost growth. These signals often emerge well before concerns surface through audits, investigations, or formal policy review. Treating payment behavior as an early indicator rather than a retrospective artifact creates an opportunity to identify misalignment while it is still forming.

This approach does not require new regulation or consensus on AI governance. It requires disciplined payment accuracy and utilization analysis that can distinguish between appropriate adoption driven by patient need and expansion driven primarily by reimbursement incentives. Rather than focusing solely on



individual claim correctness, this perspective examines whether billing patterns remain consistent with reasonable and intended use as technologies scale.

Operationally, this means moving beyond static reviews and episodic audits toward continuous visibility into how emerging technologies are reimbursed over time. For employers, plan sponsors, and payers operating under fiduciary responsibility, this kind of insight supports earlier intervention, more informed engagement with vendors, and defensible decision-making before issues become systemic.

The goal is not to slow innovation or second-guess clinical judgment. It is to preserve trust by ensuring that the financial consequences of innovation remain intelligible, proportionate, and aligned with value. When organizations can observe how new technologies behave economically as they scale, they are better positioned to support responsible adoption rather than react to downstream harm.



Prospective governance, not retrospective correction.

## FROM INSIGHT TO ACTION

As clinical AI continues to move from experimentation to routine use, stakeholders across the healthcare system face a shared challenge: understanding how innovation interacts with payment systems in practice, not just in theory. Doing so requires deliberate attention to the economic signals that accompany adoption, particularly in fee-for-service environments where reimbursement unequivocally shapes behavior.

This moment presents an opportunity for fiduciaries (and others) to shift from retrospective correction to prospective governance. By treating payment behavior as an early signal of innovation risk and value, organizations can engage more constructively with emerging technologies, meet their fiduciary obligations with greater confidence, and sustain trust as clinical AI becomes embedded in care delivery. The question is not whether clinical AI will reshape healthcare economics, but whether those responsible for paying for care are equipped to see and manage that change as it unfolds.



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