HealthConvos

HEALTH-SYSTEM EXECUTIVE BRIEF

The Health-System Business Case for Patient Education

CMS does not impose one universal "whole-person care mandate." It does something more consequential: across multiple programs, it ties payment, quality performance, and accountability to what happens after the encounter.

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HEALTH-SYSTEM MATRIX

From CMS economics to a defensible patient-support role

Start with the lever that actually applies, then move left to right. A patient-support layer is not the entire intervention.

CMS lever	Organizational exposure or opportunity	What the organization must operationalize	Appropriate patient-support role	Claim boundary
Hospital Readmissions Reduction Program (HRRP)	Medicare inpatient payment can be reduced for excess 30-day readmissions for selected conditions and procedures; the reduction is capped at 3 percent.	A broader readmission strategy spanning discharge preparation, medication management, follow-up, symptom escalation, access, and care coordination.	Provide governed post-discharge answers, reinforce the next step, and show aggregate areas of patient uncertainty.	A patient-support layer alone does not prevent readmissions and should not be credited with a reduction without a designed evaluation.
Hospital Value-Based Purchasing (VBP)	CMS withholds 2 percent of participating hospitals' base operating MS-DRG payments and redistributes the pool according to performance. Patient experience is one component.	Performance or improvement across the applicable measure set, including the patient's experience of communication, medicines, discharge, and care transition.	Extend approved explanations beyond the encounter and help patients prepare for the next conversation with the care team.	A patient-support layer is not an HCAHPS survey intervention and cannot guarantee a score or payment change.
Transforming Episode Accountability Model (TEAM)	Participating hospitals are financially accountable for defined surgical episodes through 30 days after the procedure or hospital discharge, as applicable.	Episode coordination across settings, required primary-care referral, recovery support, and management of quality and spending.	Add pathway-specific education about recovery, medication questions, follow-up, and appropriate escalation.	A patient-support layer does not perform care coordination, clinical monitoring, referrals, or TEAM compliance.
Advanced Primary Care Management (APCM)	Eligible practitioners can bill a monthly Medicare bundle when they furnish the required advanced-primary-care services.	Consent, continuity, comprehensive management, care planning, transition follow-up, communication, gap identification, and performance reporting.	Reinforce care-team education, provide private asynchronous access to governed answers, and reveal aggregate question trends.	A patient-support layer is not independently billable and does not replace any practitioner, care-team, documentation, or reporting requirement.
Medicare Shared Savings Program (MSSP)	ACOs may receive shared-savings payments - and in some tracks share losses - based on spending and quality performance.	Control total cost while meeting the applicable quality standard and coordinating care for the assigned population.	Support understanding and follow-through at one defined transition where unanswered questions may weaken continuity.	A patient-support layer cannot be represented as producing shared savings or total-cost improvement without program-specific evidence.
ACCESS Model	Participating Medicare-enrolled organizations receive recurring payments for qualifying chronic-condition care, with full payment tied to measurable outcomes.	Clinician-guided, coordinated, technology-supported care that measures condition-specific clinical or patient-reported outcomes.	Supply a governed education and patient-understanding layer within an eligible participant's broader chronic-care service.	The layer is not itself an ACCESS participant, reimbursable treatment, or complete chronic-care program.
Medicare Advantage and Part D quality programs	Medication-adherence measures affect plan Star Ratings; the direct economic exposure belongs to health and drug plans and may matter to provider-sponsored plans or risk contracts.	Address the clinical, access, affordability, behavioral, and communication factors influencing medication use.	Privately address governed medication concerns and identify aggregate topics that require better education or care-team attention.	A patient-support layer does not fill prescriptions, remove access barriers, or guarantee adherence or a Star Rating change.

1 CONFIRM THE EXPOSURE

Name the program, population, accountable entity, and performance year that actually apply.

2 CHOOSE ONE TRANSITION

Begin with one bounded moment: discharge, new diagnosis, medication start, or first follow-up.

3 DEFINE THE PROOF

Pair aggregate question trends with the next step independently measured in the health system's own systems.

THE EXECUTIVE VIEW

The one-page decision matrix on page 2 separates the applicable CMS economics from the supporting role a governed patient-conversation system can responsibly play.

CMS Payments are Shifting to Outcomes

A diagnosis is not an outcome. An encounter completed is not a next step taken. A prescription written is not a medication taken. For health systems, the space between the clinical plan and the patient's next step is no longer peripheral. It is increasingly where financial performance, quality performance, patient experience, and continuity of care meet. CMS does not impose one universal requirement called "whole-person care" on every provider. The policy landscape is more specific - and more important - than that. CMS uses several different levers:

- Direct payment for advanced primary care and care-management services
- Payment reductions associated with excess readmissions
- Hospital value-based purchasing tied partly to patient experience and care transitions
- Mandatory episode accountability extending beyond the procedure or hospital stay
- Shared-savings models that reward quality and lower total cost of care
- Outcome-aligned payment for technology-supported chronic care
- Quality measures that make medication adherence and follow-through financially visible

The programs differ. The direction does not.

CMS states the direction plainly. Its value-based programs are intended to move payment toward quality rather than quantity. Its Innovation Center strategic direction continues value-based payment and care-delivery models and calls for moving Medicare and Medicaid beneficiaries into accountable-care arrangements in which providers assume responsibility for outcomes and cost.

CMS says its value-based programs are intended to move payment toward quality rather than quantity, while its Innovation Center strategy continues the move toward accountable care. CMS headquarters, Woodlawn, Maryland. Photograph: Carol M. Highsmith / Library of Congress. "Life in the Community": John Ahearn and Rigoberto Torres.

CMS is not simply issuing instructions and waiting for providers to comply. It is increasingly making money available to organizations that can operationalize coordinated, continuous, whole-person care - and putting existing revenue at risk

when performance falls short. That money moves in several distinct ways. Some of these programs apply specifically to inpatient hospital care. Others reach outpatient procedures, emergency-department follow-up, primary care, chronic-condition management, health plans, or risk-bearing organizations. The matrix below gives health-system leaders a practical way to separate the applicable CMS economics from the role a patient-education layer can responsibly play.

Build the case from the CMS lever

The CMS program name is not enough. Before connecting patient follow-through to revenue, a health-system team should be able to answer six questions:

1. Which lever applies? Name the CMS program or payer contract and the current performance year.
2. Who holds the exposure or opportunity? It may be the hospital, practitioner, ACO, health plan, or another risk-bearing entity.
3. Which patients and encounters are included? Inpatient stays, outpatient procedures, emergency care, primary care, chronic-condition services, and covered populations are not interchangeable.
4. How does money move? Distinguish direct payment for a qualifying service from withheld revenue, penalties, episode reconciliation, shared savings or losses, and quality-linked plan economics.
5. What must the organization operationalize? Identify the human, clinical, documentation, coordination, and reporting work the program actually requires.
6. What can a patient-support layer credibly strengthen? Define the bounded role, the independently measured next step, and the claims that remain outside the evidence.

Start with the CMS lever. Then identify where governed patient understanding can support the larger operating model.

Follow-through has become part of the economic model

Health systems have always cared whether patients understood their instructions, filled their prescriptions, returned for follow-up, and recovered without an avoidable complication. The difference now is that these events increasingly affect more than clinical goodwill. They can influence:

- Medicare payment adjustments
- Eligibility for shared savings
- Performance under episode-based payment models
- Patient-experience scores and public comparison data
- Total cost of care under accountable arrangements
- Contract performance with Medicare Advantage and other payers
- The ability to retain an appropriate, continuous relationship with the patient

No patient-education intervention produces those outcomes by itself. Follow-through is shaped by clinical complexity, cost, transportation, access, trust, caregiver support, health literacy, housing, nutrition, work, and many other factors. But understanding is one of the modifiable conditions around the next step. A patient who does not understand why follow-up matters, fears a medication, cannot interpret a symptom, or does not know which question to ask is less prepared to participate in the plan. A health system that cannot see where uncertainty is concentrated is less prepared to improve the support surrounding that plan.

CMS is creating a portfolio of incentives - not a single mandate

“CMS mandates whole-person care” is tempting shorthand, but health-system buyers will immediately ask which program, which population, which measure, and which payment consequence applies. The defensible statement is this:

> **CMS is aligning a growing portfolio of payment programs, quality measures, and care-delivery requirements around continuity, coordination, patient experience, chronic-condition management, and measurable outcomes beyond the encounter.**

The following programs show how that alignment works.

Readmissions can reduce hospital payment

The Hospital Readmissions Reduction Program reduces payments to hospitals with excess 30-day unplanned readmissions for selected conditions and procedures. The payment reduction is capped at 3 percent. This is the most direct hospital-level example of follow-through becoming a financial issue. The program does not tell a hospital to deploy a particular patient-education tool. It holds the hospital financially accountable for a result occurring after the patient leaves. Readmissions are not caused simply by inadequate instructions. Some are unavoidable. Others reflect clinical severity or circumstances no communication program can solve. But the policy makes one principle unmistakable: the economic boundary of the hospitalization extends beyond the discharge door. For a health-system team, the relevant question is not whether education “prevents readmissions” in the abstract. It is narrower and more useful: Where does avoidable uncertainty contribute to a medication mistake, an unmanaged symptom, a missed appointment, or a delayed call for help? That is a place where better post-encounter support may contribute to a broader readmission-reduction strategy - provided its effect is evaluated rather than assumed.

Patient understanding affects value-based hospital payment

Under the Hospital Value-Based Purchasing Program, participating hospitals have 2 percent of their base operating Medicare severity diagnosis-related group payments placed into the value-based incentive pool. A hospital can earn back more than, equal to, or less than that reduction based on performance. The FY 2026 Person and Community Engagement domain is based on HCAHPS dimensions that include:

- Care transition
- Communication about medicines
- Discharge information
- Communication with nurses and doctors
- Overall hospital rating

CMS describes the care-transition dimension as whether patients strongly agreed that they understood their care when they left the hospital. Discharge information reflects whether patients reported receiving information about what to do during recovery at home. Communication about medicines includes whether staff explained what a medicine was for and possible side effects. These dimensions appear in the FY 2026 Hospital VBP data and CMS’s explanation of how quality links to payment. HCAHPS is a retrospective survey, not a measure of whether a specific digital experience caused an outcome. But it reveals what CMS considers economically relevant: understanding at transition, medication communication, discharge preparation, and the patient’s experience of care. The operational implication is broader than raising a survey score. When patients leave with unanswered questions, the problem may surface later in experience data, calls, complaints, avoidable utilization, or a weakened relationship with the system.

Mandatory episode accountability now extends 30 days beyond surgery

The Transforming Episode Accountability Model, or TEAM, began January 1, 2026. It is mandatory for selected acute care hospitals in designated geographic areas and runs through 2030. TEAM covers five surgical episode categories:

- Lower-extremity joint replacement
- Surgical hip and femur fracture treatment
- Spinal fusion
- Coronary artery bypass graft
- Major bowel procedures

Participating hospitals are responsible for coordinating an episode from an included surgery through 30 days after the procedure or hospital discharge, as applicable. CMS says participants must refer patients to primary care services to support continuity and long-term outcomes. TEAM turns a familiar operational challenge into formal episode accountability. Recovery happens across settings: the hospital, post-acute care, primary care, specialists, the patient's home, and the patient's family. The hospital cannot control every event in that chain, but it is expected to coordinate it. That creates a practical need for patient support that remains available after the encounter and can reinforce:

- What to expect during recovery
- Why the next appointment matters
- Which concerns belong with the care team
- How medication questions should be escalated
- What barriers or uncertainties commonly interrupt the pathway

The patient-conversation system provides a governed educational layer within a larger transition strategy; the health system retains responsibility for TEAM-required care coordination and compliance.

Advanced primary care payment requires continuity, transitions, and whole-person context

Beginning in 2025, CMS created monthly Advanced Primary Care Management services. These bundled services combine elements of chronic care management, principal care management, transitional care management, and communication technology-based services. The requirements are unusually instructive because they show what CMS now considers part of advanced primary care. Depending on what is appropriate for the patient, the billing practitioner must provide capabilities that include:

- 24/7 access and continuity of care
- Comprehensive care management
- Assessment of medical and psychosocial needs
- Medication reconciliation, management, and self-management support
- A patient-centered comprehensive care plan
- Coordination across care settings and providers
- Follow-up after emergency-department visits and facility discharge
- Communication with the patient or caregiver within seven days of discharge, as clinically indicated
- Coordination with home- and community-based services

- Documentation of psychosocial strengths, functional deficits, goals, preferences, and desired outcomes
- Secure and asynchronous communication options
- Population-level identification of gaps in care
- Performance measurement involving quality and total cost of care

That is whole-person care expressed as an operating model rather than a slogan. The monthly APCM payment creates an opportunity for eligible practitioners who meet all requirements. It also creates an important boundary for the patient-conversation system: a software layer does not independently furnish or bill the complete service. The patient-conversation system can support education, prepare patients for conversations, surface aggregate areas of uncertainty, and extend access to approved information. The billing organization remains responsible for consent, clinical work, care planning, communication, documentation, and every CMS requirement.

Accountable care makes coordination and total cost inseparable

The Medicare Shared Savings Program includes 511 ACOs serving approximately 12.6 million assigned beneficiaries in 2026. ACOs can share in savings when they deliver high-quality care while spending Medicare dollars more wisely. The opportunity is not theoretical. In performance year 2024, CMS reconciled 476 ACOs. Seventy-five percent earned shared savings, producing $4.1 billion in performance payments while Medicare saved $2.5 billion relative to benchmarks. CMS reports these results in its Performance Year 2024 financial and quality data. Quality is not optional to the economics. For performance year 2026, ACOs must report the APP Plus measure set and meet a quality performance standard to qualify for the maximum sharing rate available under their track. CMS's 2026 resources include measures for:

- Hospital-wide 30-day all-cause unplanned readmissions
- All-cause unplanned admissions for patients with multiple chronic conditions
- Patient experience through CAHPS

The logic of accountable care is simple even when the methodology is complex: fragmented care becomes expensive, and better coordination creates the possibility of sharing in avoided cost. Patient understanding is not the only variable, but it is part of the coordination environment. If patients do not know what comes next, if caregivers are unprepared, or if recurring questions never reach the organization in usable form, care can remain fragmented even when the formal plan is sound.

CMS is beginning to pay directly for technology-supported chronic-care outcomes

The ACCESS Model may be the clearest signal of where CMS wants chronic care to go. ACCESS began July 5, 2026, as a voluntary, 10-year Innovation Center model. It creates Outcome-Aligned Payments for technology-supported care in Original Medicare. The initial clinical tracks include:

- Hypertension, dyslipidemia, obesity, and prediabetes
- Diabetes, chronic kidney disease, and cardiovascular disease
- Chronic musculoskeletal pain
- Depression and anxiety

Participating organizations receive recurring payments for managing qualifying conditions, with full payment tied to the share of patients who meet measurable clinical or patient-reported outcomes. CMS identifies examples such as improvement in blood pressure, HbA1c, weight, pain, mood, and function. ACCESS is voluntary and applies to participating organizations; it is not a universal health-system mandate. Still, its payment logic is strategically important. CMS is no longer treating technology-supported chronic care merely as a collection of reimbursable activities. It is testing

payment tied to measurable improvement. For health systems, that raises the standard for digital engagement. “We made content available” is not an outcome. The useful questions become:

- Did patients engage with the support?
- Did it help them understand the plan?
- Did it reveal barriers soon enough to act?
- Did the care team know where questions were concentrated?
- Did the larger intervention improve an outcome that matters?

The patient-conversation system is not currently presented as an ACCESS participant or an independently reimbursable treatment. Its relevance is as a patient-understanding and governed-content layer that can complement an outcomes-oriented chronic-care strategy.

Medication adherence is visible in Medicare quality measurement

For Medicare Advantage and Part D organizations, the 2026 Star Ratings include a diabetes medication-adherence measure. CMS defines adherence as the percentage of eligible members whose prescription claims cover at least 80 percent of the treatment period. The measure appears in the 2026 Part C and D Star Ratings Technical Notes. This measure applies directly to health and drug plans, not universally to hospital reimbursement. But many health systems operate Medicare Advantage plans, participate in risk contracts, or work closely with payers whose economics are affected by adherence. The measure also demonstrates a larger policy point: writing the prescription is not the endpoint CMS measures. Continued access to and use of the medication matter. Medication nonadherence can reflect affordability, side effects, regimen complexity, access, mistrust, misunderstanding, or competing life demands. The patient-conversation system cannot solve all of those barriers. It can provide a private place for patients to explore governed answers, hear relatable experiences, and recognize when a concern should return to the care team.

The unanswered question is often emotional

In a defined test cohort, 246 participants submitted 832 questions during the seven-day period ending September 1, 2026. The patient-conversation system classified each question by its primary intent. The cross-module distribution was:

- 45 percent emotional
- 16 percent diagnosis
- 11 percent family
- 10 percent disclosure
- 8 percent prognosis
- 7 percent diet
- 3 percent other

Two figures describe different scopes, and both are current. The 45 percent above is the blended distribution across all modules. Within the diabetes module specifically, 155 patients used the experience and 58 percent of them asked emotion-focused questions. The modules differ substantially. The herpes experience concentrated around disclosure and finding the right words rather than around emotion. Because of that spread, the blended figure describes no single patient population, and the condition-specific figure is the more useful number for a health system evaluating one service line. The herpes module observation should remain qualitative until its denominator and category percentages are reported. These findings describe what a 246-participant test cohort asked within the available modules during a defined period. They are not estimates of prevalence among all patients. That finding matters because emotional concerns can interrupt action even

when the clinical instruction is clear. The American Diabetes Association's 2026 Standards of Care state that psychosocial well-being is foundational to diabetes management, recommend screening for diabetes distress during transitions and when self-management problems arise, and report that diabetes distress can negatively affect medication-taking and other self-care behaviors. A national study using National Cancer Institute HINTS data also found that people avoid care even when they believe they should seek it; among the reasons patients described were fear, embarrassment, and guilt (Taber, Leyva, and Persoskie, 2015). The implication is not that patient education should diagnose or treat emotional disorders. It is that a follow-through strategy cannot assume every barrier is informational. Patients may first need privacy, recognition, and a nonjudgmental way to name what they are worried about before they are ready to take the next practical step.

Financial value extends beyond direct reimbursement

Health-system evaluations often begin with the question, “Which billing code pays for this?” That is too narrow for a capability intended to support continuity. The patient-conversation system is not itself a billable APCM, transitional-care, community-health-integration, or other clinical service. Its value to a health system spans several economic categories.

Protect revenue already placed at risk

Readmission penalties, value-based purchasing, episode accountability, shared savings, and risk contracts place existing revenue or potential performance payments at risk. A patient-support layer can contribute to the broader operational work needed to perform under those arrangements.

Support reimbursable human care-management work

CMS pays for qualifying care-management services because continuity, communication, and coordination require work. Governed patient education can reinforce that work between human interactions, but it does not replace the required practitioner or care-team activity.

Reduce avoidable friction in the patient journey

When uncertainty delays a prescription, appointment, or call for help, the system can lose continuity and the patient can return with a more difficult problem. Not every delay is avoidable. The opportunity is to identify and address the portion connected to unanswered questions and insufficient understanding.

Strengthen the patient relationship

Patient experience affects public reporting, reputation, loyalty, and - in some CMS programs - payment. A useful post-encounter channel demonstrates that the organization remains present after the visit, procedure, emergency encounter, or hospital stay has ended.

Learn where education is failing

Page views and video completions show consumption. They do not show what patients still need. The patient-conversation system processes a patient’s question without retaining the submitted words, identifies non-identifying intent, and reports aggregate patterns. A health system can learn that questions are concentrating around medication, cost, symptoms, caregiving, follow-up, or another topic without creating a patient-level marketing profile. Those patterns can guide new reviewed content and improvements to the surrounding care pathway.

Where the patient-conversation system fits - and where it does not

The patient-conversation system provides a conversational patient-education experience built from a finite library of governed video responses. Responses are delivered by generative video presenters using scripts shaped from real patient conversations. The presenter is synthetic, preserving the anonymity of the people whose experiences inform the stories while allowing patients to follow recognizable human journeys. Generative video does not mean generative medical advice. Nothing is improvised when a patient asks a question. Every script and finished clip is reviewed for medical accuracy and governance before release. At runtime, AI identifies intent and selects a relevant clip from the finite approved library; it does not compose a patient-facing medical answer. Because no response is generated live, the presenter cannot hallucinate or introduce an uncleared medical claim. A patient can enter through a QR code, webpage, embed, privacy-appropriate email or SMS link, or another approved channel. The patient asks a question in their own words. Identifying material is screened, and the submitted words are processed but not stored. The organization receives aggregate intent trends rather than stored patient submissions or patient-level marketing profiles.

A clear division of responsibility

The patient-conversation system provides	The health system provides
Private access through approved distribution channels	Patient identification, outreach, consent, and access under the organization's policies
Anonymous generative video presenters and relatable patient journeys	Clinical and regulatory expertise used to review and approve scripts and finished clips
Intent recognition and selection from a finite approved response library	Diagnosis, treatment decisions, clinical assessment, symptom triage, and emergency care
Screening of submitted words for identifying material, without storing the submission	The legal medical record, patient-specific documentation, and longitudinal follow-up
Aggregate reporting on question intent and unmet educational needs	Measurement of clinical, operational, quality, and financial outcomes in the health system's own systems
Technology, hosting, approved-content delivery, and experience management	Care management, navigation, referrals, escalation, billing, and CMS or payer-program compliance

This division makes the patient-conversation system potentially useful for:

- New chronic diagnoses
- Medication initiation
- Defined post-encounter pathways
- Preparation for procedures
- Recovery after procedures
- Caregiver education
- Recurring questions surrounding follow-up
- Patient-experience initiatives where privacy is essential

Within a larger care-delivery strategy, the patient-conversation system provides one governed layer for extending approved patient education and revealing aggregate areas of uncertainty. The health system retains responsibility for care delivery, compliance, and outcomes.

Begin with one patient transition

The strongest implementation does not begin with “all patients” or “all of diabetes.” It begins with one bounded point where the organization already sees loss of momentum. Examples include:

- The first 30 days after a defined inpatient stay or outpatient procedure
- The first days after an emergency-department visit
- The first weeks after a new diabetes diagnosis
- The period between a prescription and the first refill
- Preparation for a primary-care follow-up
- A caregiver’s first month after a dementia diagnosis

For that transition, establish four layers of measurement.

1. Reach and use

- How many eligible patients received access?
- Which distribution channels produced engagement?
- Which questions or character journeys were explored?
- Where did patients leave the experience?

2. Understanding and experience

- Did patients report greater clarity or confidence?
- Were they better prepared for the next conversation?
- Did the experience address common concerns in understandable language?
- Did it support accessibility and language needs?

3. Operational follow-through

Measured by the health system in its own clinical systems, this may include:

- Completed follow-up contacts or visits
- Medication initiation or refill activity
- Successful primary-care connection
- Fewer avoidable clarification calls
- Appropriate escalation to clinical resources
- Completion of a defined next step

4. Financial and quality relevance

Select measures appropriate to the applicable contract or CMS program:

- Readmission performance
- HCAHPS care-transition, medicine-communication, or discharge-information results
- TEAM episode performance
- ACO utilization, quality, and total cost
- Medicare Advantage adherence measures

- Performance under a chronic-care or risk contract

Because the patient-conversation system is designed not to identify individual users, patient-level attribution should not be invented. Evaluation can use privacy-preserving methods such as phased deployment, location- or pathway-level comparison, aggregate trend analysis, and independently measured downstream outcomes in the health system’s own systems.

The strategic question for health systems

The question is not whether a digital conversation can replace the clinician, navigator, pharmacist, or care manager. It cannot. The question is whether the health system will leave the patient alone in the period when understanding is most likely to break down - and when CMS increasingly holds providers and payers accountable for what follows. The encounter may be over. The episode, care plan, recovery, chronic condition, patient experience, and financial accountability are not. The patient-conversation system gives health systems a private, governed way to remain present: answering approved questions, helping patients follow relatable journeys, learning where uncertainty is concentrated, and directing patients toward an appropriate next step. That is not the entire solution to whole-person care. It is a practical way to strengthen one of its weakest points: the conversation after the encounter ends.

Frequently asked questions

Does CMS mandate whole-person care?

Not through one universal rule applying identically to every provider. CMS advances whole-person care through specific payment programs, quality measures, billing requirements, and Innovation Center models. The applicable obligation depends on the provider, patient population, payment arrangement, and program.

Can the patient-conversation system reduce readmissions?

The patient-conversation system can support patient understanding within a larger readmission-reduction strategy, but it should not be claimed to reduce readmissions without a properly designed evaluation. Readmissions have many clinical, social, operational, and economic causes.

Is the patient-conversation system independently reimbursable by Medicare?

The patient-conversation system is not presented as an independently reimbursable Medicare service. It may support education surrounding qualifying care-management or value-based-care programs, but the responsible provider must furnish and document every required service.

How does the patient-conversation system support whole-person care?

It gives patients a private place to explore approved education around emotional, practical, behavioral, and clinical concerns. Aggregate intent trends can help organizations see where unmet needs are concentrated. It does not replace clinical assessment, social services, care navigation, or a comprehensive care plan.

Are the patient-conversation system's responses generated live?

No. Generative video technology creates anonymous presenters for reviewed scripts based on real patient conversations. During the patient experience, AI identifies the question's intent and selects from a finite library of approved clips. It does not improvise or compose a new medical answer, so a patient-facing response cannot hallucinate an uncleared claim.

What CMS programs are most relevant to the business case?

Depending on the organization, relevant programs may include the Hospital Readmissions Reduction Program, Hospital Value-Based Purchasing, TEAM, Advanced Primary Care Management services, the Medicare Shared Savings Program, the ACCESS Model, and Medicare Advantage or Part D quality programs.

What should a health system measure first?

Start with a single patient transition and measure access, engagement, expressed question intent, patient understanding, and an independently tracked next step. Connect financial measures only to the CMS program or payer contract that actually applies.

Primary research and policy sources

1. Advanced Primary Care Management Services
2. CY 2025 Medicare Physician Fee Schedule Final Rule
3. Hospital Readmissions Reduction Program
4. Hospital Value-Based Purchasing Program
5. FY 2026 Hospital VBP Person and Community Engagement data
6. HCAHPS: Patients' Perspectives of Care Survey
7. TEAM Model
8. Medicare Shared Savings Program
9. PY 2026 Shared Savings Program quality performance standard
10. 2026 Shared Savings Program Fast Facts
11. Performance Year 2024 Shared Savings Program financial and quality results
12. ACCESS Model
13. ACCESS Model payment amounts and performance targets
14. 2026 Medicare Part C and D Star Ratings Technical Notes
15. CMS National Quality Strategy
16. 2026 Medicare ACO participation highlights
17. American Diabetes Association: Facilitating Positive Health Behaviors and Well-being to Improve Health Outcomes. Standards of Care in Diabetes - 2026
18. Why do people avoid medical care? A qualitative study using national data
19. CMS Value-Based Programs
20. CMS Innovation Center Strategic Direction
21. CMS headquarters photograph: Carol M. Highsmith Archive, Library of Congress

About HealthConvos

HealthConvos extends approved patient education beyond the encounter with private, governed video conversations. Anonymous generative video presenters deliver reviewed scripts shaped from real patient conversations, so the people behind the stories are not exposed. Every script and finished clip is reviewed before release. During the experience, AI identifies intent and selects from a finite approved library; it does not improvise or compose a live medical answer. The organization receives aggregate intent trends, not stored patient submissions.

BEGIN WITH ONE PATIENT TRANSITION

Identify one moment where understanding breaks down, then talk with us about where governed patient conversations fit.