November 24, 2026

Physician-Focused Payment Model Technical Advisory Committee

c/o PTAC Staff

PTAC@hhs.gov

Re: Episode Intelligence Authorization and Payment Compensation Model (EIA); written response to initial Preliminary Review Team report

Dear PTAC Staff and Members of the Preliminary Review Team,

My thanks to Dr. Botsford, Dr. Bhansali, and Dr. Pulluru for the October 30 report. The report identifies strengths under all ten criteria, including that the “withhold” contrasts with FFS, which pays for services regardless of outcome, and psychiatric collaborative care management (CoCM) codes, which pay for cumulative time and a staffing structure regardless of outcome. This is "contrasted with CoCM, which requires a specific care team structure." The comments in the committee’s report are serious responses that I will herein clarify back to the committee before my Dec 8 appearance before you.

I write to respond to each finding as an interim step as I will attend the December 8 deliberation in person to be available to answer the Committee's questions with adequate time for discussion if requested. In offering the additional clarifications around the EIA model provides a pre-curser to the committee before you have time to review the aforementioned patent I have filed on November 20, 2026, with the US Patent and Trademark Office. My application for a process patent on the EIA model is being combined with another model that adapts the EIA functionality as a critical aspect to the national need for a totally re-engineered health provider and delivery system refocused on access to care, physician patient re-engagement, curative care and outcomes driven with RCM efficiency with collective reductions in total cost of care however, to be clear about EIA, I am not proposing to change the existing model at the point of service. With a single exception noted below, every critical finding in the report is a consequence of one omission: the proposal did not describe how the framework operates accordingly, and while the report does note the provisional and pending patents application in three places, the miss by the committee was that the omission in the proposal was the cause of the findings rather than a feature of the design.

CRITERION 1. SCOPE

> *"Participation in the proposed model appears to be limited to providers who purchase/adopt/implement this single proprietary framework/tool/software."*

Participation is not conditioned on purchasing, licensing, or adopting any product of mine although I have submitted a patent application to protect my idea and design precedent. The EIA model specifies what must be recorded and transmitted. It does not specify what product performs the recording. Any system meeting that specification qualifies.

> *"It is unclear what this authorization is referring to since Original Medicare does not require prior authorization of services."*

The observation is correct. Prior authorization denotes the episode-opening event that triggers the prospective payment. It is not a coverage gate, and the EIA model creates no prior authorization requirement as to Original Medicare.

CRITERION 2. QUALITY AND COST

> *"The submitter points out that published estimates of score reduction under the current standard of care already are between 40.5 and 70 percent. It is unclear what the care delivery changes are under the proposed model that would improve on clinical outcomes that already occur."*

Those published reductions are reported among patients who complete a course of treatment. The EIA model measures across every episode that opens. Those are different denominators, and the difference is the problem in outpatient behavioral health. A figure computed on finishers does not describe what happens to the whole population therefore has limited if any actual value to providers.

No routine comparison exists in any case. Under fee-for-service, clinicians are not required to administer a PHQ-9 at open and at close, and no payment turns on whether it happens.

The release is graduated, not a single bar: full release at a 50 percent reduction, nothing below 25 percent, and proportional between.

The care delivery changes the report asks for is episode completion. Under fee-for-service, a patient who disengages at week four generates four paid claims, and no party bears a loss. Under the EIA model that episode releases nothing. Retention becomes the occurrence that pays the provider, and retention, rather than response rate among completers, is the ignored gap in this population that EIA addresses.

> *"It is unclear what 're-tiered' means if the patient remains within the same episode."*

Re-tiering is a clinical reassignment of acuity within an open episode. The episode remains priced at the opening band, the practice bears the cost of the additional care up to the 20 percent stop-loss, and no new payment is generated.

> *"This ability for the clinician to close an episode partway through and open a new episode... could serve as an exit strategy."*

The proposal states that feature of the existing model make this practice visible and unprofitable. The report correctly notes that it does not say how. Those features are part of the framework and were not before the Preliminary Review Team.

"CMS will incur costs identifying and reconciling actual services delivered versus services expected in each episode."

This finding assumes reconciliation is reconstructed by the program after the fact. It is not. Reconciliation is produced sequentially and reconciled at episode close as part of closing the episode. The report credits this at Criterion 4, where it notes that "reconciliation is included for undelivered services within the episode." The administrative burden priced here does not arise in the form described. The EIA model does not compensate for undelivered services or for less than properly reconciled closing of the episode.

CRITERION 3. PAYMENT METHODOLOGY

"The burden is on CMS to recoup payment already made for undelivered services."

Addressed above. Reconciliation is produced at close.

"Many providers already meet the outcome requirement needed to earn the holdback payment without necessarily providing better care."

Addressed above under Criterion 2.

"The PHQ-9 assessment... would be administered by the paid clinician who has a financial stake... it is unclear when or how administration of the random sample of episodes would work, when or how those results would be compared with clinicians' scoring, and what actions would be taken and by whom if discrepancies are observed."

The sampling, scoring, comparison, and consequence design are specified. They are part of the framework and were not before the Preliminary Review Team.

I would note that the report credits the first half of this control at Criterion 6: "The PHQ-9 administration is a structured event with a time stamp, date, and identity of administrator for each administration, allowing it to be evaluable." That record is the foundation that independent assessment within the guideline's precedent is measured by.

"It is unclear what would prevent the clinician from closing episodes at lower bands before completion and opening new episodes at higher bands to optimize provider payments."

Addressed above under Criterion 2. The guidelines are part of the EIA framework.

"It is unclear what happens with the 12 percent holdback amount for uncompleted episodes and whether the provider receives or forfeits that payment amount."

The holdback is a function of measured change between a baseline and a closing PHQ-9. Where there is no closing measurement, there is no function to evaluate, and nothing is released. The amount is forfeited, not paid, and it does not carry forward to a successor episode. As the provider may feel a pinch as certain individuals may respond while other individuals do not, there is no implied right to compensation by the provider if the results are less than conclusive however the historical evidence is that paying providers without expectation of outcome has not produced the outcomes patients need.

Responsibility for expected outcomes should be shared with the provider who is being compensated for delivering positive outcomes with guardrails and offramps where compliance and participation by the patient is required.

CRITERION 4. VALUE OVER VOLUME

> *"The payment methodology is structured such that providers are effectively paid FFS amounts for the same volume of services already delivered under FFS."*

The twelve percent is not paid for volume. It is paid for measured change, and it is forfeited where no measurement occurs, including where the patient disengages. A practice that delivers every service on the pathway and produces no measured outcome is paid less than fee-for-service would have paid. A practice that must deliver care beyond the pathway absorbs that cost to the 20 percent stop-loss, which the report credits at Criterion 3. Neither of those is how fee-for-service behaves.

> *"The proposal specifies there is an 'equity guard' but does not explain what it would do."*

The equity guard is specified however was referenced but not before the Preliminary Review Team with adequate information as to be able to opine.

CRITERION 5. FLEXIBILITY

> *"Clinicians can also close the original episode and open a new episode... an option which may be more financially beneficial to the clinician. This process may interrupt a patient's care."*

The premise is that closing and reopening is financially advantageous. It is not, for the reasons stated under Criterion 2, and the continuity concern that follows from the premise does not arise. EIA effectively reduces or eliminates unearned compensation to clinicians and incentivizes clinicians to encourage patients to complete their course of care.

CRITERION 6. ABILITY TO BE EVALUATED

> *"An untested, proprietary tool may introduce unknown biases during model implementation that would be difficult to control and account for in an evaluation."*

This conclusion follows from the premise that participation runs through a proprietary tool. The premise is incorrect, and the conclusion does not survive it.

> *"PHQ-9 score data would need to be available for a comparison group using intervals similar to the proposed model's episodes."*

This is a fair evaluation design question. The cost measures the proposal specifies, net Medicare expenditure per completed episode against a matched comparison group, does not require instrument data on the comparison side however an “outcome measure” does, and constructing that comparison is properly a matter for CMS and its evaluator. What the EIA model supplies is a structured, timestamped, attributed measurement at open and close on every episode in the intervention arm, which the report credits in the same section.

CRITERION 7. INTEGRATION AND CARE COORDINATION

This is the one criterion the Preliminary Review Team found the model meets. The report notes two weaknesses under it, and both are answerable now.

> *"The proposal specifies that documented care coordination is a condition of episode payment holdback release but does not describe how this would work. In multiple areas in the proposal, the holdback payment is stated as being conditioned only upon a specified reduction in PHQ-9 score."*

I accept that comment in the report. The release condition should be stated once then stated the same way everywhere it appears. The inconsistency is in the drafting and not in the model.

Regarding the level of collaboration, the report describes the model accurately. Notification at open and close is a low bar, and primary care is neither included in the model nor paid under it. That is a design choice rather than an omission, and I accept that the initial proposal did not make the case for it however again, I did not want to initially overwhelm the committee with every detail but to bring the committee attention to EIA and to commence a collaboration towards meeting the needs of our provider networks while meeting the societal needs of the patient.

CRITERION 8. PATIENT CHOICE

> *"It is unclear whether the patient has visibility into the episode determination and payment mechanisms, or how shared decision-making is part of the model."*

The acuity band sets the price and the expected pathway. It does not restrict what care the patient may receive. The report restates that beneficiaries "retain full access to all Medicare-covered services" with no change to cost-sharing. The sequence, modality, intensity, and medication decisions remain the clinician's and the patient's, which the report credits at Criterion 5. The shared decision-making detail should have been set out explicitly, and I accept the comment in the report.

> *"The proposed model requires providers to use the 'EIA framework' with no alternatives to its use, thus limiting patients to providers with this proprietary framework/tool/software."*

Addressed under Criterion 1. Beneficiary access is not narrowed to any vendor's installed base, nor does it require a specific product to manage the process.

CRITERION 9. PATIENT SAFETY

> *"The proposal does not describe what the decision logic is, where it comes from, or how it is implemented... The proposal also does not offer details about the 'equity guard.'"*

Both are specified and included as part of the EIA framework but were not before the Preliminary Review Team. I note that the report sets out all four protections at this criterion and disputes none of them.

> *"There is no crisis plan or pathway."*

There is. Every positive risk screen route to a person immediately, which the report credits in the same section, and escalation beyond the band closes the episode and opens a new one upon human review. The decision logic that governs both is included but not described, for the reason given below.

> *"There is no monitoring of patients beyond the PHQ-9 assessment administered by the clinician who is being paid based on the PHQ-9 score."*

Addressed under Criterion 3.

CRITERION 10. HEALTH INFORMATION TECHNOLOGY

> *"It is not clear whether these are the only required FHIR resources, whether the required FHIR resources already are part of practices' existing EHRs, or whether new resources or modifications to existing EHRs would be required."*

The full set is specified, together with what a small or solo practice must have in order to participate. The concern about small and solo practices is one I share and is the population who can realize significantly greater net compensation as a result of EIA while patients receive superior care and guidance under care as positive conclusive outcomes are the mutually desired objective. The patient is adequately treated, and the clinician is adequately compensated.

> *"No substantive information is provided about the EIA framework... whether the framework involves any technology that is proprietary or incurs a cost, whether other technology could substitute for the EIA framework, or what level of effort, resources, and costs would be required."*

That information exists and partially addressed in the next section.

ON WHAT THIS PROPOSAL IS, AND WHAT IT IS NOT

A word about why this came to the Committee in this form.

The problem I am describing is structural, and it is not confined to Medicare. Nothing in fee-for-service pays for a patient getting better in fact providers are compensated for extended periods of treatment where curative care typically results in a reduction in compensation so where is the financial motivation by the clinician to facilitate curative outcomes. Authorization in this country is built as an adversarial gate rather than a clinical one. That is true in Medicare, it is true in Medicaid, it is true in commercial coverage, and it is true whichever licensed discipline delivers the care. This is a systemic failure in how care is paid for. Action that addresses a holistic corrective pathway that can be implemented today is required.

The reengineered framework for a fully integrated health deliver system with results driven compensation incentives referenced within the EIA proposal is payer and provider agnostic by design. It does not depend on a line of business, a benefit structure, or a practitioner type. What the Committee received and responded to was a glimpse of the Medicare instantiation of a single area of need that is forever caught inside a failed RCM infrastructure that continually spends money without expectation of positive results nor with accountability for substandard treatment protocols.

I would ask the Committee to view EIA as a fresh perspective on a massive problem rather than a Medicare variant. Nothing in the design is specific to any specific line of business. It does not depend on Medicare's benefit structure, and it does not change if the payer is Medicaid, a commercial plan, or an employer sponsored plan. Medicare is where EIA could be tested because that is where this Committee can act and because traditional Medicare is an ideal proving ground. The Committee does not need to step outside its specific mission or objective criteria set however I am suggesting this committee is another entry point for advancing the EIA design consistent with the mandate so set forth by the Secretary.

I did not come alone as clinicians and the organizations that carry these types of patients have put their name on the public record in support of the ideas set forth in the initial proposal again, with only limited visibility to the details: two psychiatric treatment organizations, a state advanced practice nursing association, direct primary care practices, individual licensed clinicians, and a coalition letter signed by former Congressman Patrick J. Kennedy. Two of those filers asked the Committee to go further than I did and recommend implementation rather than a pilot. They are not describing a theoretical problem. They are describing what their practices absorb today, and they are the reason I am aggressively promoting EIA as a corrective aspect to a specific framework leading to an expanded adoption of corrective measures that structurally enhance quality of care and outcomes at a significantly reduced cost on everyone. Of course, this accountable care for compensation approach rewards the clinicians who keep patients in care and help them get better, which is what our neighbors in distress need. Enhancing expectations and accountability are milestones to positive outcomes.

The report interpreted the proposal as a constraint that narrows who may participate however and contrary, is the opposite as will become more evident as we move the ball forward.

The framework is not missing. It exists and is documented in full. Its operating detail was not placed in the proposal until the aforementioned patent application was duly filed and recorded as operating detail of an unfiled invention or process does not belong in a public federal record. The EIA framework includes details not included in the proposal, therefore, were not before the Preliminary Review Team. The safeguards against closing and reopening episodes, the sampling and comparison design for independent PHQ-9 assessment, the equity guard, the decision logic, and the full FHIR resource set are contained in the patent application.

I would welcome the opportunity to walk the full Committee through the framework in a tabletop session, working sample episodes from open to close, and to continue the discussion as a whole group on how to move this forward. The framework is in place. What remains is finding the avenue to continue this work with a larger group, so that we get this right for the country. I respectfully ask that the Committee treat December 8 as a continuation of its deliberation rather than its conclusion, so that the full Committee can consider the framework before it reaches a final recommendation the Secretary.

ATTENDANCE ON DECEMBER 8

I will attend the December 8, 2026, meeting in person to be available to answer any questions the Committee has for me. I am not requesting time for an opening statement other than a public reading of the preceding response to your report and posting to your website however in the event your committee would prefer an opening statement, and will notify me immediately, I will be glad to do so.

I am grateful to the Committee and to the Preliminary Review Team for the time already given, and to the organizations and clinicians who filed public comments.

Respectfully,

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