

PHYSICIAN-FOCUSED PAYMENT MODEL PROPOSAL
Episode Intelligence Authorization and Payment (EIA)
Compensation Model

An Episode-Based Payment Model in Which Authorization and Payment Are a Single Event

REVISED AND RESUBMITTED

*In response to the initial feedback and written questions of the Preliminary Review Team dated
September 23, 2026*

Submitted to the Physician-Focused Payment Model Technical Advisory Committee U.S.
Department of Health and Human Services

Submitting Individual

Joanne Bayouk, MBA, MSN, RN
5702 Ashleigh Walk Dr., Suwanee, GA 30024
847-373-4956 | joannebayouk@gmail.com

Primary Point of Contact

Joanne Bayouk, 5702 Ashleigh Walk Dr., Suwanee, GA 30024, 847-373-4956,
joannebayouk@gmail.com

*Letter of Intent confirmed by PTAC, June 12, 2026. Proposal originally posted for public
comment August 11, 2026. Recommended for Track 1 review September 10, 2026.*

*Patent pending: U.S. Provisional Patent Application No. 64/107,509, filed July 8, 2026. The
author designed this model and holds that pending application. She has no license, no
commercial arrangement and no revenue relating to it.*

Transmittal Letter

To the Physician-Focused Payment Model Technical Advisory Committee:

I am resubmitting the Episode Intelligence Authorization and Payment Compensation Model, revised in response to the initial feedback and written questions of the Preliminary Review Team dated September 23, 2026.

The Review Team raised four principal concerns: the absence of demonstrated cost savings, an amount of risk it measured at 1.2 percent of the episode payment, vulnerability to gaming of the outcome measure, and the absence of an incentive to deliver valuable care. Each is addressed in this revision by enhancing the payment methodology itself rather than by explaining it differently. The amount genuinely at risk on the standard episode moves from \$22.80 to \$224.59, delivery is reconciled against services actually furnished, and outcome measurement is verified independently of the treating practice. The accompanying one-page summary of changes sets out what was altered and why.

I am committed to providing the Committee with the most thorough analysis I can produce, and to continuing that work for as long as it is useful, so that what reaches a test is a payment methodology that succeeds in behavioral health rather than one that merely passes review. Where the evidence does not yet support a claim, this proposal says so, and I would rather bring the Committee an honest account of what is not known than a confident one that does not survive testing.

This proposal requests that the Committee recommend the model for limited-scale testing by the Center for Medicare and Medicaid Innovation under section 1115A of the Social Security Act. The proposed test is in traditional Medicare, for adult beneficiaries with major depressive disorder, with clinician practices as the participating entities, in a defined set of geographic areas as permitted by section 1115A(a)(5).

Section 8 addresses each of the ten criteria the Secretary of Health and Human Services has established for physician-focused payment models at 42 CFR 414.1465. It is written with the Secretary's review in view as well as the Committee's, because the Committee's comments and recommendations, and the Secretary's response to them, are the route by which a model of this kind reaches a test. Medicare has never tested an episode-based payment model for a behavioral health condition, and the submitter believes the beneficiaries who would benefit most from one are the least able to wait for it.

I am grateful for the specificity of the Review Team's feedback. It identified two design problems I would rather have found before a vote than after one.

Respectfully submitted,

Joanne Bayouk, MBA, MSN, RN

Registered nurse. Completing psychiatric mental health nurse practitioner training, December 2026.

Abstract

Medicare pays for behavioral health one service at a time. A clinician is paid for each visit delivered, whatever happens to the patient, and a single twelve-week course of treatment for major depressive disorder generates eighteen separately adjudicated claims. Nothing in that arrangement pays for the patient getting better.

The Episode Intelligence Authorization and Payment Compensation Model prices a defined course of treatment once, against the specialty society's published care pathway, and conditions part of the payment on a recorded change in a validated instrument.

A benchmark is constructed from Medicare fee schedule amounts for the services in the pathway. The target price is the benchmark less a discount factor representing Medicare's share, set at 1.5 percent. Eighty-eight percent of the target price is paid when the episode is authorized. At episode close the payment is reconciled against the services actually delivered, so payment for care not given is returned, and a twelve percent holdback is released on a graduated scale according to the patient's measured improvement. A patient whose condition deteriorates may be re-tiered clinically, but the episode remains priced at the opening band, and escalation beyond the band closes the episode and opens a new one on human review.

The decision logic never issues an automatic denial. It authorizes or routes to a human reviewer, and every positive suicide risk screen routes to a person immediately. The same outcome standard applies whichever qualified practitioner delivers the care, and each service is paid at the rate Medicare already sets for that practitioner.

On the standard twelve-week low-intensity episode in the District of Columbia the benchmark is \$1,900.07, the target price \$1,871.57, and \$224.59 is at risk on the patient's outcome. Tested across all fifty-one jurisdictions, four acuity bands, eleven delivery levels and nine outcome levels, 20,196 combinations in total, the amount Medicare pays never exceeds what fee-for-service would have paid for the care actually delivered.

The model requires no prior authorization to operate and is proposed for testing in traditional Medicare. It requires no separate care team structure, no patient registry and no contracted psychiatric consultant, which is why it can be delivered by the small and solo practices where much behavioral health care is furnished.

Table of Contents

Summary of Key Elements	5
Section 1. The Problem: Paying for Services Instead of a Course of Care	6
Section 2. The Model	7
Section 3. Expected Participants	8
Section 4. Payment Methodology	9
Section 5. Effects on Beneficiaries	12
Section 6. Expected Effect on Spending and Evaluability	14
Section 7. Proposed Test Design and Timeline	18
Section 8. Responses to the Secretary's Ten Criteria	21
Summary of Changes	28
Appendix A. Episode Definition: Major Depressive Disorder	29
Appendix B. Payment Parameter Basis	32
Appendix C. Acuity Index and Cohort Testing	35
Appendix D. Traceability to the Preliminary Review Team's Feedback	37
Appendix E. Household Capacity to Pay	40
Appendix F. Medicare Claims Analysis	42
Appendix G. Regulatory and Filing Record	45
Appendix H. Letters of Support	47

Summary of Key Elements

What is paid for.

A defined twelve-week course of outpatient treatment for major depressive disorder, or sixteen weeks in the medically monitored band, priced from Medicare fee schedule amounts for the services in the specialty pathway.

How it is paid.

Eighty-eight percent of the target price at authorization. Reconciliation at close against services actually delivered. A twelve percent holdback released on a graduated scale according to measured symptom improvement.

What is at risk.

\$224.59 of the standard \$1,900.07 episode, against the \$57.00 that 42 CFR 414.1415(c)(3)(i)(B) and (c)(5) treat as more than nominal for an episode target price, plus the cost of any care exceeding the pathway up to a twenty percent stop-loss.

Who participates.

Clinician practices furnishing outpatient behavioral health care in traditional Medicare. Psychiatrists, psychiatric nurse practitioners, clinical psychologists, licensed clinical social workers, marriage and family therapists and mental health counselors, each paid at the rate Medicare already sets for that practitioner.

What is measured.

The PHQ-9 at episode open, at pathway intervals and at close. Episode completion. The proportion of patients reaching a fifty percent reduction. The rate at which cases route to human review.

What is requested.

Limited-scale testing under section 1115A of the Social Security Act, in defined geographic areas as permitted by section 1115A(a)(5).

Section 1. The Problem: Paying for Services Instead of a Course of Care

Medicare pays for outpatient behavioral health one service at a time. Each visit is billed, adjudicated and paid on its own, and the payment does not depend in any way on whether the patient improves.

A single twelve-week course of treatment for major depressive disorder, following the pathway set out in Appendix A, produces eighteen separately adjudicated claims. In the higher acuity bands it produces as many as thirty-six. Every one of those is an administrative event, and none of them asks whether the treatment is working.

The consequence is not that clinicians are paid badly. It is that the payment system is silent on the only question that matters to the patient.

Medicare already pays for a better model, and it does not arrive

Psychiatric collaborative care management works. Gilbody and colleagues pooled thirty-seven randomized trials covering 12,355 patients and found a standardized mean difference of 0.25 at six months, with United States trials at 0.27 and minimal between-study heterogeneity. Medicare has paid for it since January 2017.

It does not reach patients. Milliman, in an analysis commissioned by the Meadows Mental Health Policy Institute and built on one hundred percent of CMS claims, found that in 2022 collaborative care reached 21,160 distinct patients in Original Medicare, billed by 5,131 distinct providers. That is 56.1 patients per 100,000 population, after five years of rapid relative growth.

The constraint is not the evidence. It is what delivery requires. Collaborative care needs a contracted psychiatric consultant, a dedicated behavioral health care manager, a patient registry and monthly time accounting. That is a practice transformation, and the small and solo practices where much behavioral health care is delivered are not positioned to perform it.

Medicare's own claims show what happens when the requirement is lower. In 2024, Medicare Part B paid for 422,066 services under CPT 99484, general behavioral health integration care management, which requires only that a treating practitioner direct the care. Over the same period it paid for 152,400 services under the three collaborative care codes. The code with the lower delivery requirement generated roughly 2.8 times the services.

These figures are drawn from the CMS Medicare Physician and Other Practitioners by Provider and Service public use file for 2024, which suppresses rows covering fewer than eleven beneficiaries. Counts of distinct providers are therefore not comparable between high-volume and low-volume services and are not used here. Provider counts in this proposal are taken from Milliman, which worked from unsuppressed claims.

What this proposal changes

It prices a course of care rather than a count of services, and it makes part of the payment depend on whether the patient got better. It requires no new team structure, which is why it can be delivered where collaborative care is not.

Section 2. The Model

Opening an episode

An episode opens when a clinician records a diagnosis of major depressive disorder and a baseline PHQ-9. An acuity score is computed from six dimensions already present in the clinical record: risk of harm, functional status, comorbidity, recovery environment, treatment history and engagement. Each is scored from one to five and the composite places the patient in one of four bands. Appendix C sets out the index and its testing.

The decision logic never issues an automatic denial. It authorizes the episode or routes the case to a human reviewer. Every positive suicide risk screen routes to a person immediately rather than to any automated path. Across four thousand simulated episodes, no case received an automatic denial, no case with active risk was placed below the medically monitored band, and no case was routed out of outpatient care on social adversity alone.

The four bands

Band	Benchmark	Target price	At risk on outcome
A1	\$663.12	\$653.17	\$78.38
A2	\$1,900.07	\$1,871.57	\$224.59
A3	\$3,313.95	\$3,264.24	\$391.71
A4	\$3,987.41	\$3,927.60	\$471.31

Amounts shown are for the District of Columbia with a psychiatric nurse practitioner delivering the episode, the reference configuration used throughout this proposal.

Movement between bands

A patient whose condition deteriorates may be re-tiered clinically. The episode remains priced at the band it opened in. Where the patient requires care beyond the scope of that band, the episode closes with reconciliation for the services delivered and a new episode opens at the appropriate level on human review.

The original submission allowed re-tiering to change the episode price. The Review Team identified correctly that this created a payment incentive when a patient failed to improve. The protection against denial is retained. The payment incentive is removed.

Section 3. Expected Participants

The participating entity is the clinician practice. Practices furnishing outpatient behavioral health care to beneficiaries in traditional Medicare would be eligible.

Medicare's 2024 claims show who furnishes this care. Of approximately 2.08 million services billed under CPT 90834, forty-five minute psychotherapy, licensed clinical social workers delivered 983,095 and clinical psychologists 851,700. Licensed professional counselors delivered 97,928, psychiatrists 78,175 and nurse practitioners 45,486.

Psychiatrists furnish under four percent of Medicare psychotherapy. Any episode design that assumes the prescriber delivers the therapy will not match how the care is actually provided. This model therefore prices each service line at the rate Medicare already sets for the practitioner who furnishes it: the full schedule amount for physicians and clinical psychologists, eighty-five percent for nurse practitioners under 42 CFR 414.56(c), and seventy-five percent of the clinical psychologist amount for licensed clinical social workers, marriage and family therapists and mental health counselors under 42 CFR 414.53.

The same outcome standard applies whoever delivers the care. A team without a prescriber cannot open an episode in the medically monitored band.

The model operates within each state's scope of practice as that state has set it. It confers no authority on any practitioner and removes none. Where a state permits a practitioner to furnish a service, this model pays for it at the rate Medicare already sets. Where a state does not, the model changes nothing. Section 1115A(b)(2)(B)(xvii) of the Act contemplates precisely this arrangement, describing models in which a service is furnished by a health professional who has the authority to furnish it under existing State law.

Section 1115A(b)(2)(B) of the Social Security Act enumerates model opportunities the Secretary may select from. Clause (xxii) names models focusing on practices of fifteen or fewer professionals and clause (xxiii) names risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment. Both describe the participants and the payment structure proposed here.

Section 4. Payment Methodology

This section is substantially revised. The structure described here replaces the one in the proposal filed August 11, 2026.

Construction

A benchmark is constructed from Medicare Physician Fee Schedule amounts for the services in the pathway for the band, using the conversion factor of \$33.4009 from the CMS CY 2026 national physician fee schedule relative value file, issued under the CY 2026 Physician Fee Schedule final rule, CMS-1832-F, 90 FR 49266. The target price is the benchmark less a discount factor representing Medicare's share of savings from the episode, set at 1.5 percent. The Center for Medicare and Medicaid Innovation applies the same construction in the Transforming Episode Accountability Model, where 42 CFR 512.540(c) sets a discount factor of 1.5 percent for coronary bypass and major bowel episodes and 2 percent for joint replacement, hip fracture and spinal fusion. This model adopts the lower of those two figures. CMS set the higher discount for the more standardized procedures, and major depressive disorder is a more variable condition than any of them.

Settlement

The amount earned for an episode is the fee schedule value of the services actually delivered, capped at the benchmark, multiplied by one minus the discount factor, multiplied by an outcome factor.

Eighty-eight percent of the full-delivery target price is paid when the episode is authorized. At close the account is settled. Where delivery fell short of the pathway, the difference is returned. Where the patient required more than the pathway, the excess is the practice's cost up to a stoploss of twenty percent of the benchmark, above which Medicare funds the care so that it is not left unfunded. Twenty percent is the figure 42 CFR 512.550(e)(1) uses to cap downside for Track 3 participants in the Transforming Episode Accountability Model, where it limits repayment rather than excess cost; the percentage is adopted, the construct is not identical.

Risk adjustment

The Transforming Episode Accountability Model risk adjusts its reconciliation target price at 42 CFR 512.545(a) on hierarchical condition category count, age bracket, beneficiary economic status keyed to low-income subsidy eligibility, full Medicaid eligibility and area deprivation, and hospital bed size and safety net status. This model adopts that model's discount factor and stoploss but not its risk adjustment, and the submitter states that rather than leaving it to be found. What the model does instead is stratify at entry: the acuity index sets the episode price from six dimensions, which is case-mix adjustment at pricing rather than beneficiary-level adjustment at reconciliation. The outcome condition is also partly self-adjusting, because the threshold is a fifty percent reduction from the patient's own baseline rather than an absolute score, so a patient entering at a PHQ-9 of twenty-two and one entering at twelve face the same proportional standard.

The risk that creates. Comorbidity burden, age and beneficiary economic status are not reflected in the price. The third is the one that matters: if beneficiaries who are dually eligible, who receive

the low-income subsidy, or who live in areas of high deprivation improve less for reasons unrelated to the care delivered, a practice serving them earns less under an outcome-conditioned holdback, and the small and safety-net practices this model exists to reach are disproportionately those practices.

It is correctable without new data collection. Every service in the pathway is an encounter Medicare already counts for risk adjustment: CPT 90791, 90792, 90832, 90834, 90837, 90853, 96127, 99213, 99214, 99484, 99492 and 99493 all appear on the CMS Medicare Risk Adjustment Model CPT/HCPCS Filtering Included List for calendar year 2026. Because the conditions in scope are DSM-5-TR diagnoses recorded on those encounters, the diagnostic and economic data needed for a factor analogous to 42 CFR 512.545(a)(3) is already in the claim and eligibility record. The submitter proposes that the test prespecify stratified analysis of holdback release rates by dual eligibility, low-income subsidy status and area deprivation, and that CMS apply such a factor if those rates differ, set on measured data rather than proposed in advance on none.

How the target price is built. This model constructs the target price from the fee schedule amounts Medicare would have paid for the services in the pathway rather than forecasting it from historical episode spending. Cher and colleagues, examining Bundled Payments for Care Improvement Advanced, found that target prices built from historical spending do not account for regression to the mean and that hospitals are likelier to join when offered higher targets, exposing Medicare to losses. A constructed target price cannot be set too high relative to fee-for-service, because it is built from what fee-for-service would have paid.

The outcome factor

Twelve percent of the target price is held back and is forfeitable. It releases on a graduated scale: nothing below a twenty-five percent reduction in the PHQ-9 from the recorded baseline, in full at fifty percent or more, and proportionally between.

The filed proposal multiplied the holdback by a fidelity factor of 0.90 to 1.10, so a clinician received between 98.8 and 101.2 percent of the episode amount whatever the outcome. The Review Team is correct that this does not represent substantial risk. On the standard episode it placed \$22.80 at risk. Under the structure described here it places \$224.59 at risk.

For reference, 42 CFR 414.1415(c)(3)(i)(B) sets the nominal amount standard for an Advanced Alternative Payment Model at 3 percent of expected expenditures, and (c)(5) defines expected expenditures for episode payment models as the episode target price. The floor used throughout this proposal is 3 percent of the benchmark rather than of the target price, which is \$57.00 on the standard episode and a slightly higher bar than the regulation sets. Advanced APM qualification would be a separate determination by CMS and is not claimed here; the standard is cited because it is the threshold Medicare applies elsewhere in the program.

The fidelity multiplier is retired. Adherence to the pathway becomes a condition of release rather than a separate adjustment. Forfeited amounts are retained by Medicare and are not redistributed.

Measurement integrity

The Review Team was not persuaded by the argument in the filed proposal at Section 4.7, because that argument relied on retrospective review and the Team was unsure CMS has a system in place to perform such detection. That argument is withdrawn rather than restated.

The concern is well founded and the literature supports it. Pigott and colleagues, reanalyzing the STAR*D data set with fidelity to its protocol, found that the investigators reported outcomes using an unblinded clinic-administered measure rather than the protocol-stipulated blinded instrument, and that the cumulative remission rate so reported was approximately twice the rate the protocol instrument produced.

Two design features respond to this. Release is graduated rather than triggered at a single threshold, which removes the discontinuity that would make manipulation at the margin valuable. And a randomly selected share of episodes receives an outcome assessment administered independently of the treating practice, against which each practice's release rate is compared.

What the parameters produce

The range on the standard episode. Full delivery with the outcome met earns \$1,871.57 against \$1,900.07 of care delivered, and Medicare pays \$28.50 less than fee-for-service. At the other end, needs 30 percent more than pathway, Medicare pays \$408.51 less. Every tested combination falls between those, and in none of them does Medicare pay more.

Appendix B sets out all four scenarios in a table and gives every parameter with its source and the reasoning for its value.

Section 5. Effects on Beneficiaries

What the benefits owe

Traditional Medicare Part B carries twenty percent coinsurance with no annual out-of-pocket maximum. On the standard episode a beneficiary owes \$380.01 where the Part B deductible has been met and \$606.41 where it has not, using the 2026 annual deductible of \$283 published by CMS on November 14, 2025.

Most beneficiaries in traditional Medicare hold supplemental coverage and would not bear that amount directly. CMS made this point in the Episode Payment Models final rule when declining requests to waive copayments, noting that employer-sponsored coverage, Medicaid and Medigap together covered most beneficiaries. That reasoning applies here and no general cost-sharing waiver is sought.

For beneficiaries without supplemental coverage the amount is real, and that is the population this proposal draws attention to rather than seeks to exempt. Modelling built for this proposal from HUD Fair Market Rents for fiscal year 2027, the USDA Thrifty Food Plan, MEPS out-of-pocket spending and 2026 federal tax parameters finds that at \$30,000 of annual household income, 300 of 408 combinations of jurisdiction and household size leave nothing at all after housing, food, out-of-pocket health care and taxes. Appendix E sets out the method and its limitations, of which the most important is that the budget omits transportation, other necessities, and the value of in-kind benefits, so it is not a precise estimate in either direction.

Cost-sharing is collected as care is delivered, exactly as it is today. What the model does request, following the approach CMS took at CMS-5519-F, is that settlement between CMS and the participant not alter beneficiary cost-sharing for the underlying services. That request appears at Section 7.1.

Unintended consequences

The proposal filed in August did not discuss how this model could harm beneficiaries. It should have, and this revision does.

Undertreatment. A prospective payment creates a financial reason to deliver less care. Three features respond. Payment is conditioned on a recorded change in a validated instrument, so reducing care below what produces improvement reduces payment. Reconciliation means that delivering fewer services reduces payment directly. And the decision logic never denies; it authorizes or routes to a person.

On whether fewer services in this condition constitutes undertreatment, the evidence is relevant. Gilbody found that a greater number of case management sessions was not associated with improved outcomes, and that adding a specific psychotherapy to medication management produced no significant improvement. Grypma and colleagues compared real-world delivery of an adapted collaborative care program against the trial arm at the same site and found fourteen treatment contacts against the trial's twenty, a difference significant at $P < .001$, with six-month outcomes statistically indistinguishable.

Patient selection. A fixed episode payment creates a reason to prefer patients likely to improve. The acuity logic carries an equity guard: social adversity alone cannot move a patient out of the outpatient bands, and exit requires a clinical threshold independent of the recovery environment.

Upcoding at entry. Because the outcome target is computed from the baseline the clinician records, recording a patient as more severely ill raises the improvement that must be shown before payment is released.

Re-tiering during an episode. Addressed in Section 2. The episode remains priced at the opening band, so there is no payment gain from moving a patient up.

Section 6. Expected Effect on Spending and Evaluability

The applicable standard

The Review Team wrote that the Center for Medicare and Medicaid Innovation would not be able to test a payment model likely to increase spending. The statutory standard is more specific.

Section 1115A(b)(3)(A) of the Social Security Act provides that the Secretary shall not require, as a condition for testing a model, that its design ensure the model is budget neutral initially. Section 1115A(b)(3)(B) then requires the Secretary to terminate or modify a model unless, after testing has begun, it is expected to improve the quality of care without increasing spending, to reduce spending without reducing the quality of care, or both. The same three conditions govern expansion at section 1115A(c)(1).

This proposal is written to the first of those conditions.

Why payment cannot exceed fee-for-service

Three features bound it. The benchmark is constructed from the fee schedule amounts Medicare would have paid for the same services. A discount factor removes 1.5 percent of that before any payment is made. And reconciliation returns payment for services not delivered.

Section 1115A(c)(5) of the implementing regulation at 42 CFR 414.1415 makes the same point from the other direction: expected expenditures under a model should not exceed the Part A and Part B expenditures a participant would be expected to incur without it. An episode priced from the fee schedule for a defined service set satisfies that by construction rather than by estimate.

This was tested exhaustively rather than argued. Across fifty-one jurisdictions, four acuity bands, eleven delivery levels from zero to twice the pathway, and nine outcome levels, 20,196 combinations in total, the amount Medicare pays never exceeded what fee-for-service would have paid for the care actually delivered.

How this differs from the opioid treatment program bundle

The Review Team cited the Office of Inspector General's finding that Medicare could have saved \$301.5 million of \$564.6 million on bundled payments for opioid use disorder treatment. In that audit, report A-09-23-03002 of October 2025, 89 of 100 sampled episodes were overpaid, and payments totaling \$21,216 corresponded to \$9,901 of services actually delivered.

Three features produced that result and this model shares none of them. A single service triggered the full weekly payment under 42 CFR 410.67(d)(3); here payment is reconciled against delivery. The rate assumed a service combination rarely furnished, with individual and group psychotherapy accounting for about 56 percent of the nondrug component while seldom being provided, and 49 of 100 sampled episodes consisting of medication and dispensing alone; here the service set is the specialty pathway and adherence is captured from structured clinical data. And CMS monitored billing but did not review which services were provided; here delivery is observable at episode close.

The Inspector General recommended in A-09-23-03002 that payment reflect the services actually furnished. This revision implements that recommendation at the episode level.

What the test would measure

Three things that cannot be established from the literature. First, the proportion of patients reaching a fifty percent reduction under this model in this population, against published estimates ranging from 40.5 to 70 percent. Second, whether episode completion rises relative to a matched comparison group. Third, total cost of care including inpatient medical utilization, measured over a window long enough to observe the effect the literature locates in years three and four.

A fourth question is whether delivery reconciliation works as intended. The Office of Inspector General has twice found Medicare paying for defined service sets that were not fully furnished: in the opioid treatment program bundles described above, and in remote patient monitoring, where about 43 percent of enrollees who received the service did not receive all three of its components and Medicare lacked information about who ordered it, report OEI-02-23-00260 of September 2024. In this model both are observable, because delivery is reconciled and every instrument administration carries a time stamp and the identity of the administrator.

Rebasing

Amounts in this proposal are constructed from the CY 2026 Physician Fee Schedule. The CY 2027 proposed rule projects a lower conversion factor, principally because the one-year increase provided by Public Law 119-21 for CY 2026 does not continue. The benchmark is a function of the fee schedule rather than a fixed sum, so it rebases with the schedule, and the relationship between the benchmark, the target price and what fee-for-service would have paid is unaffected by the level of the conversion factor.

Where savings would come from

The Review Team found that the filed proposal did not demonstrate cost savings. The submitter sets out three channels, ordered by how certain each is, and is explicit about which are arithmetic and which are not. None is actuarially certified.

First, the discount factor and reconciliation. A 1.5 percent discount is removed from the target price before any payment is made, producing \$28.50 on every completed standard episode, and reconciliation returns payment for services not delivered. Across 20,196 tested combinations of jurisdiction, acuity band, delivery level and outcome, payment never exceeds what fee-for-service would have paid for the same care. This channel is arithmetic. It does not depend on any clinical effect and it does not require the Committee to accept a forecast.

Second, administrative. One standard course of treatment generates eighteen separately adjudicated claims, which the model replaces with one payment event and one reconciliation. No dollar figure is attached, because the cost of adjudicating a Medicare claim is CMS's figure and not the submitter's.

Third, and the largest, medical spending associated with untreated mental illness. Figueroa and colleagues, analyzing 2015 claims for 4,358,975 fee-for-service Medicare beneficiaries, found that 4.2 percent of Medicare spending went to mental health services and a further 8.5 percent to additional medical spending associated with mental illness, 12.7 percent in total. Beneficiaries with serious mental illness incurred \$4,768 more in medical services for physical conditions than

beneficiaries with no known mental illness, a 37 percent increase. Two of every three dollars Medicare spends in connection with mental illness go to something other than treating it.

The Committee should hold that finding to exactly what it is. It is observational, it uses 2015 data, and it establishes the size of the target rather than demonstrating that better upstream treatment reduces it. It is offered as the magnitude of the opportunity, not as a savings estimate.

The best long-term evidence that treatment moves that spending runs through the same channel and is not statistically significant, and the submitter states that rather than resting on it. Unutzer and colleagues followed patients from the IMPACT collaborative care trial for four years and reported mean total healthcare costs of \$29,422 for intervention patients against \$32,785 for usual care. The difference of \$3,363 carries a confidence interval from negative \$9,282 to positive \$2,557; the authors state the cost differences are not significant at $p < .05$ and report instead a bootstrap probability of 87 percent. Of that difference \$2,578 was inpatient medical cost, and the effect appeared in years three and four. So the mechanism is medical hospitalization rather than behavioral health spending, the magnitude is uncertain, and the timing is slow enough that a short evaluation window would miss it.

The submitter has read the Innovation Center's own synthesis of its episode payment models, which states that to date model evaluations have not found net savings to Medicare, and that in the Bundled Payments for Care Improvement models and the Comprehensive Care for Joint Replacement model there were no significant net savings after reconciliation payments to participants were taken into account. That synthesis also gives the cause and the remedies. The cause: if target prices are set too high, participants earn more than anticipated in reconciliation and the model does not save. The remedies it names include incorporating downside risk sooner and improving target pricing.

This design answers both directly, and that is the substance of the submitter's response to the Review Team's first finding. The target price is not forecast from historical episode spending, which is the step at which a target price can be set too high. It is constructed from the fee schedule amounts Medicare would have paid for the services in the pathway, less the discount, so it cannot exceed what fee-for-service would have paid for the same care. The discount is also removed before any payment is made rather than recovered at reconciliation, and forfeited holdback is retained by Medicare rather than redistributed to participants, so the saving does not depend on a reconciliation that later gives it back. And downside risk is present from the first episode rather than phased in, because reconciliation returns payment for services not delivered. The Innovation Center notes that its target prices already include a Medicare discount set by CMS in order to achieve net savings; this model applies the same instrument to a condition the portfolio has never covered.

What follows is the reason to test rather than to model further. The submitter is not asking the Committee to accept a projection. The first channel is arithmetic and is already established. The third is unproven and is the whole question. This design measures it rather than estimating it, because every episode carries a recorded baseline, a recorded outcome and a settlement reconciled against services actually furnished, and net expenditure per completed episode against a matched comparison group is a primary measure from the first performance year. A model that must estimate its own savings asks for trust. This one produces the number.

Evaluability

The primary outcome is the change in PHQ-9 from episode open to close and the proportion of patients reaching a fifty percent reduction. Secondary measures are episode completion, the rate at which cases route to human review, thirty-day psychiatric readmission, and net Medicare expenditure per completed episode against a matched comparison group.

Where the data comes from. Outcome and adherence measures come from the FHIR resources participating practices transmit as a condition of participation, each instrument administration carrying the score, the date and the identity of the administrator. Expenditure and readmission measures come from Medicare claims, which CMS holds already. Measurement validity comes from the independently administered subsample described at Section 4. No separate collection instrument and no chart abstraction is required of participants.

Over what period. Outcome and completion measures are available per episode within the twelve to sixteen weeks of the episode itself, so the primary outcome can be read in the first performance year. Total cost of care cannot. The only long-term evidence in this literature locates the cost effect in years three and four, so an evaluation window shorter than that would not detect one and should not be read as evidence that none exists. The submitter states this rather than letting a short window produce a null result that is then attributed to the model.

How it is stratified. Results should be reported stratified by dual eligibility, low-income subsidy status and area deprivation, for the reason given at Section 4: if release rates differ on those characteristics, a risk adjustment factor is needed, and the test is what would show it.

One condition, one instrument and one threshold make the evaluation tractable. Published estimates of the proportion of patients reaching a fifty percent reduction span 40.5 percent, in the STAR*D reanalysis against the blinded Hamilton scale at the first antidepressant trial, to 68 and 70 percent, in the trial and real-world arms of an adapted collaborative care program measured on the PHQ-9. The rate under this model in this population is not known, and establishing it is one of the things a test would determine. The submitter proposes no target figure for it, because a target proposed in advance of the evidence would be an assertion rather than a goal.

Section 7. Proposed Test Design and Timeline

7.1 What is requested

This proposal requests that the Committee recommend the model for limited-scale testing by the Center for Medicare and Medicaid Innovation under section 1115A of the Social Security Act.

The proposed test is in traditional Medicare, for adult beneficiaries with major depressive disorder, with clinician practices as the participating entities, in a defined set of geographic areas as permitted by section 1115A(a)(5), which allows the Secretary to limit testing of a model to certain geographic areas.

Two waivers are requested. First, waiver of Part A and Part B payment requirements to the extent necessary to make the episode payment and to settle reconciliation amounts. Second, following the approach CMS took in the Episode Payment Models final rule at CMS-5519-F, waiver of sections 1813 and 1833(a) of the Act to the extent they would otherwise apply to reconciliation payments or repayments, so that settlement between CMS and the participant does not alter beneficiary cost-sharing for the underlying services. No change to beneficiary cost-sharing for covered services is sought.

7.2 Scale

The scale of the test follows from two things: the precision the primary outcome requires, and how many practices furnish this care in the geography proposed.

Precision. The primary outcome is the proportion of patients reaching a fifty percent reduction on the PHQ-9. Published estimates place that proportion between 40.5 and 70 percent depending on instrument, intervention and blinding, and narrowing it is one purpose of the test. Estimating a single proportion to within three percentage points at ninety-five percent confidence requires approximately 1,100 completed episodes. To within two points it requires approximately 2,400.

Supply. In 2024, 35,840 distinct rendering providers billed a psychotherapy or psychiatric evaluation code in Medicare fee-for-service, and Medicare paid for 1,004,330 psychiatric diagnostic evaluations under CPT 90791 and 90792. A diagnostic evaluation is the event that opens a course of treatment in this pathway and is therefore the closest available proxy for treatment initiation. These figures come from the CMS Medicare Physician and Other Practitioners by Provider and Service public use file for 2024.

A test region anchored on Georgia, where the Georgia Alliance of Community Hospitals has provided a letter of support, would draw on the following supply.

State	Providers furnishing this care	Billing evaluations	Evaluations in 2024
Georgia	687	426	20,268
Tennessee	579	367	23,876
South Carolina	455	289	11,510
Alabama	254	149	7,828
Region total	1,975	1,231	63,482

Participation. Across the region, evaluating providers furnish an average of 51.6 diagnostic evaluations a year. At participation rates a voluntary model might plausibly achieve:

- Five percent of evaluating providers: 62 practices, approximately 3,200 evaluations a year.
- Ten percent: 123 practices, approximately 6,300 evaluations a year.
- Fifteen percent: 185 practices, approximately 9,500 evaluations a year.

A region of this size therefore supports the precision the primary outcome requires at modest participation. Ten to fifteen percent of evaluating providers, between 123 and 185 practices, is proposed as the target.

What is not established. Three things, and each is stated rather than estimated. First, the share of these evaluations that are for major depressive disorder is unknown. The public use file is organized by procedure code and carries no diagnosis, and establishing that share requires beneficiary-level diagnostic data not available in a public file. Second, the file suppresses rows covering fewer than eleven beneficiaries, so every provider count above is a floor rather than a total, and the effect falls hardest on the smallest practices, which are the ones this model is designed to reach. Third, uptake in a voluntary model cannot be predicted from supply. The figures above describe the opportunity, not the enrollment.

The final scale is a matter for CMS. What this analysis establishes is that a geographically limited test anchored on Georgia has sufficient supply to answer the primary question.

7.3 Participant recruitment

The Georgia Alliance of Community Hospitals, representing more than ninety hospitals, provided a signed letter of support on July 9, 2026, which appears at Appendix H. Recruitment would proceed through Georgia psychiatric and psychiatric advanced practice nursing networks, including the United Advanced Practice Registered Nurses of Georgia, alongside the hospital affiliated behavioral health service lines the Alliance represents.

Medicare's own claims indicate where the participants are. In 2024, licensed clinical social workers and clinical psychologists together furnished the substantial majority of Medicare psychotherapy services, with psychiatrists furnishing under four percent. A recruitment strategy aimed only at psychiatry would not reach the practices that deliver this care.

Letters of support received after submission would be forwarded to the Committee as supplements during the review period.

Relationship to the Innovation in Behavioral Health Model. The filed proposal referred to the Cohort 2 award states of the CMS Innovation in Behavioral Health Model as an expansion pathway, anticipating awards in September 2026. That reference is withdrawn. As of the Innovation Center's model page last modified June 10, 2026, the IBH Model is active with three state participants, Michigan, New York and South Carolina, operating from 2025 through 2032 under section 1115A authority. No second cohort is described.

One of those three states, South Carolina, falls inside the region proposed above, and model overlap is a recognized design problem in this portfolio. The Innovation Center's own review of its episode payment models identifies overlap, alongside target price setting and beneficiary

attribution, as a recurring lesson across model evaluations. Two features make the overlap manageable here. The IBH Model is state-based and organized around Medicaid agencies, reaching Medicare beneficiaries principally through dual eligibility, while this model pays Medicare fee-for-service episodes directly. And the two operate on different objects: IBH pays practices to become a point of entry and to integrate physical and behavioral care, while this model prices the course of treatment that follows.

The submitter proposes that beneficiaries attributed to an IBH participating practice be excluded from episode attribution for the duration of the overlap, with precedence resolved in favor of the earlier model. If CMS prefers a cleaner separation, the region can be constituted without South Carolina. Georgia, Tennessee and Alabama alone contain at least 942 providers billing psychiatric diagnostic evaluations and 51,972 such evaluations in 2024, which at ten to fifteen percent participation yields between 94 and 141 practices and between approximately 5,200 and 7,800 evaluations a year. That is above the volume the primary outcome requires. The test does not depend on South Carolina.

7.4 Submitter qualifications

The submitter is a registered nurse completing psychiatric mental health nurse practitioner training in December 2026, with approximately twenty years of cross-sector experience spanning payer operations, pharmacy benefit management, health plans, hospital systems and revenue cycle management. She designed this model and holds a pending United States patent application on it. She has no license, no commercial arrangement and no revenue relating to it. Seven applications covering the underlying framework have been filed with the United States Copyright Office, with case numbers assigned at submission and certificates not yet issued. They are listed with their filing dates at Appendix G.

The reference implementation described in this proposal was built by the submitter and runs locally on synthetic data, meaning computer-generated patient records with no real patients and no protected health information. Every figure in this proposal is generated from it rather than transcribed.

7.5 Timeline

A five-year test period is proposed, consistent with the duration of comparable Innovation Center episode payment models, with a pre-implementation period for participant onboarding, baseline data provision and connectivity testing before the first performance year opens.

Beyond that, the submitter does not propose a calendar. A model test period runs against the Innovation Center's model development sequence and, where the model is implemented through rulemaking, against the rulemaking calendar. Both are matters for CMS, and a timeline proposed in the abstract by a submitter would be speculative. What the submitter can commit to is readiness: the payment methodology, the outcome definition, the data specification and the evaluation design are complete as submitted, and none of them awaits further development work before a test could be designed.

Section 8. Responses to the Secretary's Ten Criteria

Criterion 1. Scope

The proposal filed in August described a benefit that exists only in Medicare Advantage. That was a limitation of the description rather than of the design, and this revision corrects it. The mechanism is episode pricing with an outcome condition and reconciliation, none of which requires prior authorization, and all of which operate identically in traditional Medicare.

This model would add a new option to CMS's alternative payment models. The Innovation Center's disease-specific and episode-based models are built around procedures and around chronic medical conditions: joint replacement, hip fracture, spinal fusion, coronary bypass and major bowel procedures in the surgical bundles, and oncology, kidney disease, end stage renal disease, diabetes prevention, dementia care and maternal health elsewhere in that category. None of them prices a course of outpatient treatment for a psychiatric condition, which is what this proposal does.

The Innovation Center does pay for behavioral health outcomes elsewhere, and the submitter distinguishes this model from that work rather than claiming an empty field. The Innovation Center has announced the Advancing Chronic Care with Effective, Scalable Solutions model, which tests an outcome-aligned payment approach in Original Medicare and which includes depression and anxiety among its initial clinical tracks, with substance use disorder to follow. That model pays for the ongoing management of a chronic condition through recurring payments reconciled against outcomes over a care period. This model prices a discrete course of treatment once, against a published pathway, and settles it against services actually delivered. The two operate on different objects and different time structures: continuing management in one, a bounded episode in the other. They are complementary rather than duplicative, and practices already participating in that model would be a natural first cohort for this one.

The submitter also notes what the Committee's own record shows. The proposals and letters of intent PTAC has published since 2016 span oncology, radiation oncology, cardiology, nephrology and end stage renal disease, ophthalmology, urology, gastroenterology, wound care, emergency and acute care, primary care, post-acute and skilled nursing care, and palliative care. None is a behavioral health payment model. This appears to be the first submitted to the Committee, which is the reason the submitter persisted through a revision rather than withdrawing.

It also includes entities whose opportunities to participate in alternative payment models have been limited, and the Review Team observed as much in its own summary. And it corresponds to opportunities Congress enumerated at section 1115A(b)(2)(B), at clauses (xvii), (xxii), (xxiii) and (xxvii), the last of which names exploring ways to avoid unnecessary hospitalizations or emergency department visits for mental and behavioral health services, such as for treating depression.

Criterion 2. Quality and Cost

On quality. Medicare today pays the same amount whether a patient with depression gets better or does not. Under this model it does not. Twelve percent of the episode price is conditioned on a

recorded change in a validated instrument, which no current Medicare behavioral health payment requires, and seven quality measures are specified at Section 6.

How large the improvement will be is not known, and establishing it is what a test is for. What is established now is firmer: every episode carries a baseline and a closing score, and payment moves with them. In a condition where objective monitoring runs at a small fraction of visits, a model that cannot pay in full without a recorded outcome changes what gets measured before it changes what gets paid.

On cost. The proposal is written to the first of the three conditions at section 1115A(b)(3)(B), improving quality without increasing spending. No Innovation Center episode payment model has yet produced net savings, and the submitter does not claim this one will. The Innovation Center's own synthesis says why: target prices forecast from historical spending can be set too high, and participants earn back in reconciliation what the model was meant to save.

This model is built differently, and that can be checked today. The benchmark is not forecast. It is constructed from the fee schedule amounts Medicare would have paid for the same services, so it cannot be set above them. The discount comes off before payment rather than at reconciliation, and forfeited holdback stays with Medicare. Across 20,196 tested combinations, payment never exceeds what fee-for-service would have paid.

Criterion 3. Payment Methodology

The Review Team found that a clinician received between 98.8 and 101.2 percent of the episode amount whatever the outcome, which is not substantial risk. That finding is accepted and the design changed. The holdback is now earned or forfeited rather than multiplied, moving the amount genuinely at risk on the standard episode from \$22.80 to \$224.59, against the \$57.00 that 42 CFR 414.1415(c)(3)(i)(B) and (c)(5) treat as more than nominal for an episode payment model. The standard is met at a ratio of 3.94 in all 204 combinations of band and jurisdiction.

The measurement integrity concern is answered structurally rather than by detection, because the submitter agrees that retrospective review is not a sufficient answer and withdraws that argument. Three changes replace it. Release is graduated between twenty-five and fifty percent improvement, so no single point of measured change carries the whole holdback. A randomly selected share of episodes receives an outcome assessment administered independently of the treating practice, and each practice's release rate is compared against that subsample. And the episode is priced at the band it opened in regardless of later re-tiering, which removes an incentive the Review Team correctly identified and which the submitter quantified at \$1,074.55 on the standard episode.

Downside is bounded. A patient requiring more than the pathway is the practice's cost up to a stop-loss of twenty percent of the benchmark, above which Medicare funds the care. Whether the model qualifies as an Advanced Alternative Payment Model is a determination for CMS and is not claimed here.

Why this cannot be tested under current payment methodologies. Three features of the design have no mechanism in existing Medicare payment. There is no code and no mechanism by which Medicare conditions any portion of a payment on a recorded change in a validated clinical

instrument; fee-for-service pays for each service delivered whatever the result, and the collaborative care codes pay for cumulative time and a staffing structure rather than for an outcome. There is no mechanism to hold back a defined share of payment at the start of a course of treatment and release it at the end on measured improvement. And there is no mechanism to settle a prospectively paid amount against the services actually furnished across an episode, because Medicare adjudicates each claim on its own and has no episode to reconcile against. Testing the model therefore requires the waiver authority at section 1115A(d)(1), and the specific waivers requested are set out at Section 7.

The design may create another way to take advantage of the payment rules, and the submitter raises it rather than waiting to be asked. Because clinical escalation closes an episode and opens a new one, a practice could in principle close and reopen episodes to collect repeated prospective payments. Three features make that visible and unprofitable. Every episode carries a stable identifier and every closure carries a recorded closure type, so a close-and-reopen cycle is a pattern in the data rather than an invisible event. A reopening within a defined window links to the prior episode record rather than creating a fresh payment event. And because settlement is against services actually delivered, a short episode earns short-episode payment, so churn generates administrative traces without generating revenue. The reopen window is a parameter a test would calibrate.

Criterion 4. Value over Volume

The Review Team observed that because eighty-eight percent is paid prospectively and additional visits generate no additional revenue, the design may incentivize fewer services. Under delivery reconciliation, delivering fewer services reduces payment proportionally, so the incentive identified no longer exists.

What the model rewards, stated positively. Twelve percent of the target price releases on a graduated scale keyed to the change in a validated instrument, so the return to better outcomes is continuous rather than a single threshold to clear. Documented care coordination is a further condition of that release. Nothing in the design pays more for more visits, and the evidence summarized in Section 5 indicates that volume is a weak proxy for quality in this condition.

Criterion 5. Flexibility

The response filed in August rested on two things this revision removes. It argued that flexibility came from re-tiering a patient to a higher-complexity episode with a new base rate, which no longer changes payment, and that no incremental technology investment was required because CMS-0057-F already mandates the infrastructure, which is true only in Medicare Advantage. Both arguments are withdrawn and replaced.

Clinical judgment inside the episode. The pathway determines whether an episode opens and what it is priced at. It does not dictate how the clinician practices: sequence, modality, session length, spacing and the decision to change medication or approach all remain the clinician's. Fee-for-service offers less latitude, not more, because there every element of care must map to a separately billable and separately documented code before it is paid at all.

Freedom in both directions. Because payment reconciles against services actually delivered, a clinician who reaches the outcome in eight sessions rather than eleven is neither penalized nor

rewarded for padding, and the evidence in Section 5 is that neither additional case management sessions nor an added psychotherapy has been shown to improve outcomes in this condition. Where a patient needs more than the pathway, the practice bears that cost only to twenty percent of the benchmark, above which Medicare funds it, so clinical judgment can exceed the pathway without financial exposure overriding it.

Team configuration. The model prices eight care team configurations, from a single prescriber delivering the whole episode, to a prescriber working with a psychologist or a licensed therapist, to psychologist-only and therapist-only teams in the bands where a prescriber is not required. Each service is paid at the rate Medicare already sets for the practitioner who furnishes it. Collaborative care management, by contrast, requires one specific team structure and cannot be delivered without it.

Practice scale. Participation requires no patient registry, no contracted psychiatric consultant, no separate care management platform and no monthly time accounting. What it requires is transmission of a defined set of FHIR resources already present in certified electronic health record technology. The model is designed for the small practices section 1115A(b)(2)(B)(xxii) contemplates.

Criterion 6. Ability to Be Evaluated

The evaluable goals, set out in full at Section 6. For quality: the proportion of patients reaching a fifty percent reduction in the PHQ-9 from the recorded baseline, which is the primary outcome; episode completion; and the rate at which cases route to human review. For cost: net Medicare expenditure per completed episode against a matched comparison group, and thirty-day psychiatric readmission. Each is computed from data the model already generates, so evaluation requires no separate collection instrument and no chart abstraction.

The PHQ-9 is administered at episode open to establish the baseline against which the outcome condition is computed, at intervals during the episode consistent with the pathway, and at close. Each administration is a discrete time-stamped structured data element carrying the score, the date and the identity of the administrator.

That is substantially more structured than ordinary practice. Hawkins reported a quality improvement initiative in an outpatient psychiatry clinic in which the rate of objective symptom monitoring using a rating scale was 5.1 percent before intervention, rising to 51.3 percent after. That study covered a single clinic and 230 patients in an uncontrolled before-and-after design and is offered as an illustration rather than a national rate.

Criterion 7. Integration and Care Coordination

Care management is furnished inside the episode and is billable as CPT 99484 when a prescriber directs it and HCPCS G0323 when a therapist furnishes it. The division of responsibility between prescriber, psychologist and licensed therapist is specified by the care team configuration and is priced accordingly.

The Review Team observed that the filed proposal asserted care coordination occurs without explaining how it happens or how it would be measured. That is correct and this revision specifies both.

What is required. Two contacts are required in every episode and a third where the care team includes more than one practitioner. A notification to the patient's primary care clinician when the episode opens, stating that behavioral health treatment has begun, the condition being treated and the recorded baseline. A notification at episode close, stating the outcome and any medication changes. And where a prescriber and a therapist both participate, at least one documented communication between them during the episode.

Why primary care specifically. This is not a procedural courtesy. The only demonstrated cost mechanism in this literature runs through medical rather than behavioral health utilization: of the four-year cost difference Unutzer and colleagues reported, \$2,578 of \$3,363 was inpatient medical. The clinician managing a patient's medical comorbidity is the primary care clinician, and a behavioral health episode that never reaches them cannot operate through that mechanism. The Transforming Episode Accountability Model requires the same thing at 42 CFR 512.564(a), which obliges participants to include a referral to a supplier of primary care services in discharge planning, with non-compliance subject to remedial action under 42 CFR 512.592.

How it is captured. Each contact is a FHIR Communication resource carrying the sender, the recipient, the date and the episode identifier. Team composition is carried in a FHIR Care Team resource, which establishes whether the third requirement applies to a given episode. No separate reporting is required, because the resources are created in the course of the communication itself.

How it is measured. Three measures, all computable from the same resources. The proportion of episodes with a documented primary care notification at open. The proportion with one at close. And, among episodes whose care team includes both a prescriber and a therapist, the proportion with at least one documented communication between them.

Consequence. Documented care coordination is a condition of holdback release rather than a separately billed service. A practice that treats the patient well and never tells the primary care clinician has not completed the episode as defined.

Criterion 8. Patient Choice

On the health of the population served. The unit of account in this model is a course of treatment carried to a recorded outcome, not a series of visits, so a practice is measured on how its patients finish rather than on how many it saw. Because every episode carries a baseline and a closing score, a participating practice can see its own completion and improvement rates across its whole panel, which fee-for-service billing does not show it.

On the needs and preferences of individual patients. The model places no restriction on a beneficiary's choice of practitioner and grants no authority to steer. Enrollment in an episode does not lock a beneficiary to a practice. A beneficiary may leave at any point, and the episode then closes and settles on the services actually delivered, so leaving costs the beneficiary nothing and costs the practice only what it did not furnish.

Cost-sharing is stated rather than omitted. Under Part B coinsurance a beneficiary owes \$380.01 on the standard episode where the 2026 annual deductible of \$283 has been met, and \$606.41 where it has not. It is collected per service as care is delivered, exactly as it is today. No change

to beneficiary liability is proposed and no cost-sharing waiver is requested, following the approach the Innovation Center took in the Episode Payment Models final rule.

The submitter draws the Committee's attention to Appendix E, which establishes what that amount means for the households this model is meant to reach: at \$30,000 of annual household income, 300 of 408 combinations of jurisdiction and household size have nothing left after housing, food, out-of-pocket health care and taxes. That is a finding about Medicare cost-sharing generally rather than about this model, and it is offered as evidence rather than as a request.

Criterion 9. Patient Safety

Addressed in Section 5 under unintended consequences. Four protections govern the decision logic. It never issues an automatic denial; it authorizes or routes to a human reviewer. Every positive suicide risk screen routes to a person immediately. Evidence of failure at a lower intensity of treatment is never required as a condition of access, so the model cannot be operated as step therapy. And access is not restricted by age, cognitive level or diagnosis. The equity guard is a fifth, preventing social adversity alone from moving a patient out of outpatient care. Across four thousand simulated episodes those invariants held without exception.

Beneficiary appeal rights are untouched. Nothing in this model waives or narrows any statutory right of appeal. Where a decision can go against a beneficiary, at episode open, on the acuity band assigned, or on a contested closure, the ordinary appeal chain applies in full. Inside an authorized episode there are fewer adverse determinations to appeal because there are fewer adverse determinations made, which is a reduction in the events that generate appeals rather than a reduction in due process.

These are constraints rather than commitments. In the submitter's reference implementation they are fixed in the decision logic itself and are outside the layer a deploying organization may configure, which can set severity bands, comparators and citations only. An organization operating the model cannot configure away the protections the model exists to enforce, and a configuration that attempts it stops the service rather than silently substituting a default. The submitter proposes that CMS make the same four protections a condition of participation.

Criterion 10. Health Information Technology

The Review Team is correct that CMS-0057-F and the CMS-0062-P proposed rule reach Medicare Advantage organizations, Medicaid and CHIP programs and marketplace issuers, and do not reach Medicare fee-for-service.

What traditional Medicare lacks is a mandate, not a capability. The FHIR resources this model relies on for pathway adherence and outcome capture exist independently of the prior authorization API requirement and are present in certified electronic health record technology. In a limited-scale test, participating practices would transmit through FHIR as a condition of participation, which is how Innovation Center models routinely establish their data requirements.

This model encourages the use of health information technology to inform care, which is what the criterion at 42 CFR 414.1465(b)(3)(i) asks of it. The instrument score and the patient's position in the pathway are returned to the treating clinician inside the workflow they are already in, through published HL7 interoperability standards, rather than in a separate portal requiring a

separate login. Because every episode carries a recorded baseline and a closing score, a practice can also see completion and improvement across its own panel, which claims data does not show it today. Both are uses of health information technology to inform care rather than to report on it after the fact.

A working version has already been built using synthetic data rather than specified. It holds no protected health information, generates every figure in this proposal, and would be available to CMS for inspection on the terms at Appendix G. A participating practice would need an integration with its existing certified electronic health record, not a new system.

SUMMARY OF CHANGES

Episode Intelligence Authorization and Payment (EIA) Compensation Model, revised and resubmitted. Submitted by Joanne Bayouk, MBA, MSN, RN.

This revision responds to the Review Team's feedback by enhancing the payment rules and clarifying how the model would work.

This proposal is revised in response to the initial feedback and written questions of the Preliminary Review Team dated September 23, 2026. The Team's four principal concerns were the absence of demonstrated cost savings, an amount of risk measured at 1.2 percent, vulnerability to gaming of the outcome measure, and the absence of an incentive to deliver valuable care. Each is addressed by enhancing the payment methodology itself rather than by explaining it differently. Appendix D maps every finding and question to the page that answers it.

PAYMENT METHODOLOGY

- 1. The holdback is forfeitable and releases on a ramp.** The submitted design multiplied a 12 percent holdback by a fidelity factor of 0.90 to 1.10, so a clinician received between 98.8 and 101.2 percent of the episode amount whatever the patient's outcome. The Team is correct that this is not substantial risk. The holdback is now earned or forfeited, placing \$224.59 of the standard District of Columbia episode at risk rather than \$22.80, against the \$57.00 that 42 CFR 414.1415(c)(3)(i)(B) and (c)(5) treat as more than nominal. Release ramps between 25 and 50 percent symptom improvement, because a single release point would put the whole holdback on one percentage point of measured change.
- 2. The fidelity multiplier is retired.** It adjusted the same holdback a second time, was described inconsistently as both a 79 to 110 and a 90 to 110 percent corridor, and in the submitter's own actuarial exhibit its expected value raised payment above base rather than placing payment at risk. Pathway adherence is now a condition of release.
- 3. Reconciliation and recoupment are added, and a 1.5 percent discount factor is applied.** The submitted proposal stated that in pathway services carried no recoupment exposure. That is reversed. The entity earns the fee schedule value of services actually delivered, capped at the benchmark, and payment for services not delivered is returned. Following the Transforming Episode Accountability Model, the target price is the benchmark less the discount, producing \$28.50 of savings per standard episode before any clinical effect. Across 20,196 tested combinations of jurisdiction, acuity band, delivery level and outcome, and payment never exceeds what fee-for-service would have paid for the care delivered. This responds to the Team's citation of OIG report A-09-23-03002, which recommended that payment reflect services actually furnished.
- 4. Re-tiering no longer increases payment, and a 20 percent stop-loss limits excess cost.** Re-tiering was intended as protection against denial and the Team correctly identified that it also created a payment incentive when a patient did not improve. It remains permitted clinically and the episode remains priced at the opening band; escalation beyond the band closes the episode with reconciliation and opens a new one on human review. Because the entity is capped at the benchmark, a patient requiring more than the pathway is the entity's cost, limited consistent with that model's Track 3.
- 5. Outcome measurement is verified independently.** The argument at Section 4.7 relied on retrospective review and is withdrawn rather than restated. A randomly selected share of episodes now receives an outcome assessment administered independently of the treating practice, and each practice's release rate is compared against that subsample.

SCOPE AND FRAMING

- 6. The test population is traditional Medicare and the request is for limited-scale testing.** The submitted proposal described a benefit that exists only in Medicare Advantage and contained no explicit request. The mechanism is episode pricing with an outcome condition and reconciliation, none of which requires prior authorization. The participating entity is the clinician practice and Medicare Advantage becomes an extension. The request is for limited-scale testing of one condition measured by one instrument.
- 7. Beneficiary effects and unintended consequences are stated directly.** The submitted proposal discussed neither. Under Part B coinsurance a beneficiary owes \$380.01 on the standard episode where the annual deductible has been met and \$606.41 where it has not. Sections on undertreatment, patient selection, upcoding at entry and mid-episode re-tiering are added.

FURTHER CHANGES ON THE SUBMITTER'S OWN REVIEW

Care coordination is specified and measured: notification to primary care at episode open and close, a documented prescriber-to-therapist communication where both are on the team, each captured as a FHIR Communication resource, three measures computed from them, and documented coordination made a condition of holdback release rather than a billed service. A test design is added and sized from Medicare claims, against a primary outcome requiring roughly 1,100 completed episodes, with the limits of that analysis stated rather than estimated. The Flexibility criterion is rewritten, because the argument in the submitted proposal rested on re-tiering changing the price and on the Medicare Advantage technology mandate, both now removed. And the reference to Innovation in Behavioral Health Model Cohort 2 award states is withdrawn, with overlap with that model addressed directly.

WHAT DID NOT CHANGE

The clinical pathway and its basis in published specialty society guidance; the acuity structure; the principle that the same outcome standard applies whichever qualified practitioner delivers the care; and four protections on the decision logic, which never issues an automatic denial, routes every positive suicide risk screen to a human reviewer immediately, never requires evidence of failure at a lower intensity as a condition of access, and does not restrict access by age, cognitive level or diagnosis.

Every figure here is generated from the submitter's reference implementation rather than transcribed, and the payment parameters are final.

APPENDIX A. EPISODE DEFINITION: MAJOR DEPRESSIVE DISORDER

Episode Intelligence Authorization and Payment Compensation Model. Prepared by Joanne Bayouk, MBA, MSN, RN, September 2026. Amounts are District of Columbia, psychiatric nurse practitioner delivering the episode, the reference configuration used throughout the proposal.

What opens an episode

Three things, all of which must be present and all of which are already recorded in ordinary practice:

A recorded diagnosis of major depressive disorder.

A baseline PHQ-9 administered and recorded at or before the opening encounter. The baseline score is the denominator for the outcome condition and is fixed at open.

An acuity composite computed from the six dimensions set out at Appendix C, which places the episode in one of four bands.

What does not open an episode

The episode is defined for major depressive disorder treated in an outpatient setting. A patient whose presentation falls outside that is referred to the appropriate level of care rather than enrolled. Specifically: a bipolar spectrum diagnosis, a psychotic disorder, a substance use disorder requiring its own level of care, and active suicidality requiring a level of care above the medically monitored non-residential band.

A positive suicide risk screen at any point routes to a human reviewer immediately and never to an automated path. The decision logic never issues an automatic denial; it authorizes the episode or routes the case to a person.

Table A1. The four bands

Band	Acuity composite	Length	Claim lines	Benchmark
A1 Brief and maintenance	6 to 9	12 weeks	9	\$663.12
A2 Low intensity	10 to 16	12 weeks	18	\$1,900.07
A3 High intensity	17 to 19	12 weeks	28	\$3,313.95
A4 Medically monitored, nonresidential	20 to 22	16 weeks	36	\$3,987.41

Each band carries the level of care shown in the Level of Care Utilization System: A1 is Level 1, Recovery Maintenance and Health Management; A2 is Level 2, Low Intensity Community Based Services; A3 is Level 3, High Intensity Community Based Services; A4 is Level 4, Medically Monitored Non-Residential Services.

Table A2. The service pathway in each band

A1. Brief and maintenance. 12 weeks, 9 claim lines, benchmark \$663.12.

Service	Units
90791 Psychiatric diagnostic evaluation	1
90832 Psychotherapy, 30 minutes	4
99213 Office or outpatient visit, established patient, low complexity	2
96127 Brief emotional or behavioral assessment	2
Total claim lines	9

A2. Low intensity. 12 weeks, 18 claim lines, benchmark \$1,900.07.

Service	Units
90792 Psychiatric diagnostic evaluation with medical services	1

90834 Psychotherapy, 45 minutes	11
99214 Office or outpatient visit, established patient, moderate complexity	4
96127 Brief emotional or behavioral assessment	2
Total claim lines	18

A3. High intensity. 12 weeks, 28 claim lines, benchmark \$3,313.95.

Service	Units
90792 Psychiatric diagnostic evaluation with medical services	1
90837 Psychotherapy, 60 minutes	14
99214 Office or outpatient visit, established patient, moderate complexity	6
99484 General behavioral health integration care management	3
96127 Brief emotional or behavioral assessment	4
Total claim lines	28

A4. Medically monitored, non-residential. 16 weeks, 36 claim lines, benchmark \$3,987.41.

Service	Units
90792 Psychiatric diagnostic evaluation with medical services	1
90837 Psychotherapy, 60 minutes	16
99214 Office or outpatient visit, established patient, moderate complexity	8
G0560 Safety planning interventions	1
99484 General behavioral health integration care management	4
96127 Brief emotional or behavioral assessment	6
Total claim lines	36

The pathway sets the required elements of a course of treatment. It does not set modality, site of service or staffing mix, and it is not a utilization ceiling. A patient who needs more than the pathway receives more; the difference is the practice's cost up to the stop-loss described at Section 4. A patient who needs less generates less payment, because the entity earns the fee schedule value of services actually delivered, capped at the benchmark.

What closes an episode

Completion of the pathway, with a closing PHQ-9 recorded.

Clinical escalation beyond the scope of the band, which closes the episode with reconciliation for services delivered and opens a new episode at the appropriate level on human review.

Patient withdrawal or loss to follow-up, which closes the episode with reconciliation. Payment for services not delivered is returned.

In every case the episode settles against services actually furnished. This is the feature the Preliminary Review Team found absent from the filed proposal, and it is the feature the Office of Inspector General recommended in report A-09-23-03002 after finding that the opioid treatment program bundle paid \$301.5 million of \$564.6 million for services that were not delivered.

The outcome condition

The model measures improvement by comparing the patient's PHQ-9 score at the start and end of treatment. Twelve percent of the target price is held back and is forfeitable. It releases on a graduated scale: nothing below a twenty-five percent reduction, in full at fifty percent or more, and proportionally between. A randomly selected share of episodes receives an outcome assessment administered independently of the treating practice, and each practice's release rate is compared against that subsample.

The PHQ-9 is administered at open, at pathway intervals and at close, each as a time-stamped structured element rather than free text. Hawkins and colleagues reported objective symptom monitoring at 5.1

percent of visits in an outpatient psychiatry clinic before intervention, which is the practice this condition is written against.

A worked case

One case from the reference implementation, on synthetic data. Acuity scores of risk 1, function 4, comorbidity 3, environment 5, history 3 and engagement 2 give a composite of 18, placing the episode in band A3 at Level 3, High Intensity Community Based Services.

Service	Units	Allowed
90792 Psychiatric diagnostic evaluation with medical services	1	\$197.22
90837 Psychotherapy, 60 minutes	14	\$2,147.00
99214 Office or outpatient visit, established patient, moderate complexity	6	\$786.37
99484 General behavioral health integration care management	9	\$488.68
96127 Brief emotional or behavioral assessment	4	\$20.47
Total	34	\$3,639.73

This case carries Z codes Z59.41 and Z91.120, recorded social conditions. They are captured because they bear on the recovery environment dimension and on the support the patient needs. They do not move the patient out of outpatient care: the equity guard described at Appendix C prevents social adversity alone from doing so.

APPENDIX B. PAYMENT PARAMETER BASIS

Episode Intelligence Authorization and Payment. Every parameter, its source, and why it takes the value it does.

Parameters settled 2026-09-23. Figures generated from the reference implementation on 2026-09-25.

The Preliminary Review Team should be able to see where each number came from without asking. Each entry below gives the value, the source, and the reasoning. Amounts are for the standard twelve-week low-intensity episode in the District of Columbia delivered by a psychiatric nurse practitioner, which is the reference configuration throughout this proposal.

Amount at risk on outcome

Value. 12 percent of the episode target price, earned or forfeited

Source. 42 CFR 414.1415(c)(3)(i)(B) and (c)(5), verified at eCFR September 23, 2026

Why this value. The regulation sets the Advanced APM nominal amount standard at 3 percent of expected expenditures and defines expected expenditures for episode payment models as the episode target price. Twelve percent places \$224.59 of the standard District of Columbia episode at risk against a \$57.00 floor. Because the withhold is 12 percent of a target price set at 98.5 percent of the benchmark and the floor is 3 percent of that same benchmark, the amount at risk is 3.94 times the floor in every case, a ratio that is constant by construction. Verified across 204 jurisdiction and band combinations. Twelve percent is also the figure in the filed proposal, so only its behavior changes. Advanced APM qualification is a determination for CMS and is not claimed.

Release schedule

Value. Graduated release between 25 and 50 percent symptom improvement

Source. Grypma L, Haverkamp R, Little S, Unutzer J. Gen Hosp Psychiatry. 2006;28(2):101-107; Pigott HE, Kim T, Xu C, Kirsch I, Amsterdam J. BMJ Open 2023;13:e063095

Why this value. Fifty percent symptom reduction is the published response threshold. Grypma reported it reached by 68 percent of a trial arm and 70 percent of a real-world cohort on the PHQ-9. Pigott, reanalyzing STAR*D against the blinded Hamilton scale, reported 40.5 percent at the first antidepressant trial. The true rate under this model is unknown and spans that range, so release ramps rather than triggering at a point. A single threshold would also place the entire holdback on one percentage point of measured change, which is inside the measurement error of the instrument.

Fidelity multiplier

Value. Retired. Pathway adherence is a condition of release rather than a multiplier

Source. PTAC Preliminary Review Team initial feedback, September 23, 2026; EIA Compensation Model Pro Forma Actuarial ROI Analysis, June 2026

Why this value. The Review Team noted the corridor is described as 79 to 110 percent in Section 4.5 and 90 to 110 percent elsewhere. The submitter's own actuarial exhibit lists the expected fidelity bonus as a program cost of \$59.31 per episode, two percent above base, meaning the multiplier raised payment rather than placing payment at risk.

Destination of forfeited amounts

Value. Retained by Medicare, not recycled to a bonus pool

Source. Decision of September 23, 2026

Why this value. If forfeited amounts are redistributed to other participants, Medicare realizes no saving and the Review Team's finding on spending survives the revision intact.

Discount factor

Value. 1.5 percent of the benchmark

Source. CMS, Transforming Episode Accountability Model Preliminary Target Price Fact Sheet

Why this value. TEAM constructs its target price as benchmark times trend times (1 minus a CMS discount factor), described as Medicare's portion of savings from the episode, set at 1.5 percent for coronary bypass and major bowel and 2 percent for lower extremity joint replacement, surgical hip femur fracture and spinal fusion. The lower figure is used here because CMS states in its own synthesis of episode payment model evaluations that where available data carries substantial variability it is harder to set an accurate prospective price, contrasting elective joint surgery as far less variable. Major depressive disorder is a more variable condition than the procedures priced at 2 percent. One and a half percent produces \$28.50 of saving on the standard episode before any clinical effect.

Delivery reconciliation

Value. Earned equals delivered fee schedule value capped at the benchmark, times one minus the discount factor, times the outcome factor

Source. CMS Innovation Center, Bundled Payments key concepts; HHS Office of Inspector General, A-09-23-03002, October 2025

Why this value. CMS defines both retrospective and prospective bundled payments as reconciling against a target price with providers achieving losses or savings relative to it. The Inspector General found Medicare could have saved \$301.5 million of \$564.6 million on opioid treatment program bundles, with 89 of 100 sampled episodes overpaid, because a single service triggered a full weekly payment and the rate assumed a service combination rarely delivered. The Inspector General recommended that payment reflect services actually furnished.

Stop-loss on excess cost

Value. 20 percent of the benchmark

Source. CMS, Transforming Episode Accountability Model Participation Tracks Fact Sheet

Why this value. TEAM Track 3 applies a 20 percent stop-loss and stop-gain. Without a limit an entity absorbs the full band gap, \$1,413.88 moving from A2 to A3. With the limit it absorbs \$380.01.

Meaning of the stop-loss

Value. Medicare funds cost above the cap, so care beyond the pathway remains funded

Source. Decision of September 23, 2026

Why this value. The alternative reading, that the entity simply owes no more, leaves care above the cap unfunded, which is a patient safety problem rather than a financing one. Under this reading Medicare still saves at least 22 percent of the benchmark in every case where delivery exceeds the pathway.

Mid-episode re-tiering

Value. Permitted clinically; the episode remains priced at the opening band. Escalation beyond the band closes the episode with reconciliation and opens a new one on human review

Source. Decision of September 23, 2026

Why this value. Pricing at the opening band leaves a zero incentive to re-tier. Permitting payment to move while holding the outcome target to the original baseline would have left an incentive of \$1,074.55 on the standard episode, and \$940.08 moving from A1 to A2 where the clinical justification is weakest. Holding the price at the opening band is also what creates expenditure risk under 42 CFR 414.1415(c)(1).

Prospective share

Value. 88 percent of the target price, paid at authorization

Source. Unchanged from the proposal filed August 11, 2026

Why this value. Retained so that the change to the holdback reads as a correction rather than a redesign of the whole payment.

Conversion factor

Value. CY 2026 conversion factor, \$33.4009

Source. CMS CY 2026 national physician fee schedule relative value file (PPRRVU2026), issued under CMS-1832-F, 90 FR 49266

Why this value. Most participants in a single-condition model will not attain Qualifying APM Participant status, which requires 50 percent of Medicare Part B payments or 35 percent of Medicare patients through the entity. Pricing at the qualifying factor of \$33.5675 would assume a status most participants would not hold.

WHAT THE PARAMETERS PRODUCE

Band	Benchmark	Target price	Medicare saving	At authorization	At risk on outcome	3 percent floor
A1	\$663.12	\$653.17	\$9.95	\$574.79	\$78.38	\$19.89
A2	\$1,900.07	\$1,871.57	\$28.50	\$1,646.98	\$224.59	\$57.00
A3	\$3,313.95	\$3,264.24	\$49.71	\$2,872.53	\$391.71	\$99.42
A4	\$3,987.41	\$3,927.60	\$59.81	\$3,456.29	\$471.31	\$119.62

Every band exceeds the 3 percent reference threshold, and by the same margin. Because the withhold is 12 percent of a target price set at 98.5 percent of benchmark, and the threshold is 3 percent of that same benchmark, the ratio is 3.94 in every case by construction. Verified across all fifty-one jurisdictions and all four bands, 204 combinations.

WHAT MEDICARE PAYS, STANDARD EPISODE

Scenario	Value delivered	Entity earns	Settle-up	Medicare against fee-for service
Full pathway, outcome met	\$1,900.07	\$1,871.57	+\$224.59	\$-28.50
Full pathway, no improvement	\$1,900.07	\$1,646.98	+\$0.00	\$-253.09
Half delivered, outcome met	\$950.04	\$935.78	\$-711.20	\$-14.26
Drops out at week two	\$342.01	\$296.46	\$-1,350.52	\$-45.55
Needs 30 percent more than pathway	\$2,470.09	\$1,871.57	+\$224.59	\$-408.51

The final column is negative in every row. Tested exhaustively across fifty-one jurisdictions, four bands, eleven delivery levels from zero to twice the pathway and nine outcome levels, 20,196 combinations in total, payment never exceeds what fee-for-service would have paid for the care delivered.

Advanced Alternative Payment Model qualification is a determination for CMS and is not claimed here. The nominal amount standard at 42 CFR 414.1415 is cited because it is the threshold Medicare applies elsewhere in the program.

Joanne Bayouk, MBA, MSN, RN.

What the parameters produce

Four scenarios on the standard low-intensity episode, District of Columbia, psychiatric nurse practitioner delivering the episode. Negative amounts in the final column are savings to Medicare against what fee-for-service would have paid for the same care.

Scenario	Value delivered	Practice earns	Medicare against FFS
Full pathway, outcome met	\$1,900.07	\$1,871.57	\$-28.50
Full pathway, no improvement	\$1,900.07	\$1,646.98	\$-253.09
Half delivered, outcome met	\$950.04	\$935.78	\$-14.26
Drops out at week two	\$342.01	\$296.46	\$-45.55
Needs 30 percent more than pathway	\$2,470.09	\$1,871.57	\$-408.51

APPENDIX C. ACUITY INDEX AND COHORT TESTING

Episode Intelligence Authorization and Payment Compensation Model. Prepared by Joanne Bayouk, MBA, MSN, RN, September 2026.

Provenance

The index is not original to this proposal and is not presented as such. Its six dimensions are the evaluation parameters of the Level of Care Utilization System, the adult level of care instrument published by the American Association for Community Psychiatry: risk of harm; functional status; medical, addictive and psychiatric co-morbidity; recovery environment, combining stress and support; treatment and recovery history; and engagement and recovery status. That instrument defines six levels of care. The four bands in this model correspond to its levels one through four. Levels five and six are medically monitored and medically managed residential care, which fall outside the outpatient scope of this episode and are referred rather than enrolled. What this proposal adds is the mapping from a composite score to an episode price, and that mapping is the submitter's.

The Level of Care Utilization System is copyrighted by the American Association for Community Psychiatry. The submitter has used its published structure for the acuity construct and attributes it here rather than presenting a renamed equivalent as original. If CMS tested this model, the submitter would expect participating practices to hold whatever license the Association requires for clinical use of the instrument, and would raise that with the Association in advance of a test. An alternative construct could be substituted if the Association preferred, at the cost of losing comparability with an instrument already in wide use.

Using a published level of care instrument rather than a new one is deliberate. A payment model that requires clinicians to learn a new assessment has added burden before it has delivered anything, and a model whose acuity construct cannot be compared to anything already in use cannot be evaluated against existing practice.

Table C1. The six dimensions

Dimension	What it captures
Risk of harm	Danger to self or others, including suicidal and homicidal ideation, and the patient's capacity to manage it.
Functional status	Ability to fulfil roles at work, at home and in relationships, and to manage activities of daily living.
Comorbidity	Co-occurring medical, psychiatric and substance use conditions and the burden they place on treatment.
Recovery environment	The stress the environment places on the patient and the support it provides, scored together.
Treatment and recovery history	Response to prior treatment, including prior remission and prior relapse.
Engagement	The patient's understanding of the condition and willingness to take part in treatment.

Each dimension is scored from one to five from elements already present in the clinical record. The composite is their sum, so it ranges from six to thirty.

Table C2. Composite to band

Band	Composite	Level of care	Benchmark
A1 Brief and maintenance	6 to 9	Level 1	\$663.12
A2 Low intensity	10 to 16	Level 2	\$1,900.07
A3 High intensity	17 to 19	Level 3	\$3,313.95

A4 Medically monitored, nonresidential	20 to 22	Level 4	\$3,987.41
--	----------	---------	------------

Benchmarks are District of Columbia with a psychiatric nurse practitioner delivering the episode. A composite above twenty-two indicates a level of care above the medically monitored non-residential band and does not open an episode in this model; the case is referred.

Cohort testing

The index was run across 4,000 simulated episodes on synthetic data. The purpose was not to estimate how patients distribute in practice, which synthetic data cannot establish, but to test whether the invariants the model depends on hold under load.

Table C3. Band distribution across the simulated cohort

Band	Episodes	Share	Median benchmark
A1	44	1.1 percent	\$663.12
A2	2,034	50.9 percent	\$2,062.97
A3	1,167	29.2 percent	\$3,476.84
A4	733	18.3 percent	\$4,204.60
A5+	22	0.6 percent	referred out
Total	4,000	100.0 percent	

The 22 cases at A5 and above, 0.6 percent, scored beyond the medically monitored non-residential band. They are referred to a higher level of care rather than enrolled, and they are shown here because a model that silently absorbed them would be understating who it cannot serve.

Invariants tested

Four properties were checked on every simulated episode, and all four held without exception:

No case received an automatic denial. Every case was either authorized or routed to a human reviewer.

No case with active risk of harm was placed below the medically monitored band.

No case was moved out of outpatient care on social adversity alone. The equity guard fired 30 times across the cohort, meaning that in 30 cases a recorded social condition would otherwise have contributed to moving the patient to a higher band and was prevented from doing so on its own.

Every determination carried the version of the clinical criteria that produced it, so any decision in the cohort is reproducible after the fact.

What this testing does not establish

Four limitations, stated rather than estimated around.

1. The cohort is synthetic. It contains no protected health information and no real patients. It demonstrates that the logic behaves as specified; it does not demonstrate that the index classifies real patients correctly.
2. The band distribution above reflects how the synthetic cohort was generated and should not be read as a prediction of case mix in a test. Case mix is one of the things a test would measure.
3. The composite to band mapping has not been validated against treatment outcomes. The Level of Care Utilization System has its own published reliability literature; the mapping from its parameters to these four price bands does not, and establishing it is properly part of a test rather than a claim made in advance of one.
4. The index is not a diagnostic instrument and does not determine whether a patient has major depressive disorder. It operates after diagnosis to determine intensity.

The submitter proposes that reliability of the index in practice, including agreement between the recorded composite and an independent assessment, be a measured outcome of the test rather than an assumption of it.

APPENDIX D. TRACEABILITY TO THE PRELIMINARY REVIEW TEAM’S FEEDBACK

Episode Intelligence Authorization and Payment Compensation Model, revised and resubmitted. Every finding and every written question from the Preliminary Review Team of September 23, 2026, in the Team’s own words, with the response and the page of the revised proposal where it is answered.

F items are findings from the Initial Feedback document. Q items are the written questions. N items were not raised by the Review Team and are changes the submitter made on its own review. The Status column says how the submitter responded, not how far the drafting has progressed. Page references are to the main body of the revised proposal.

ID	Criterion	What the Preliminary Review Team said	How the revision answers it	Where it is answered	Status
F1	C1	Prior authorization for outpatient behavioral health applies only to Medicare Advantage, not to Medicare fee-for-service. CMS0057-F and CMS-0062-P apply only to MA. The proposal does not address how the model would be implemented or differ between the two populations.	The mechanism is episode pricing with an outcome condition and reconciliation, none of which requires prior authorization. Traditional Medicare becomes the test population with the clinician practice as the participating entity; Medicare Advantage becomes an extension.	Abstract, p.3; Section 1, p.6; Section 3, p.8; Criterion 1, p.21	Design changed
Q1	C1	How would the proposed model work in traditional Medicare where prior authorization is typically not required?	One standard course generates eighteen separately adjudicated claims, between nine and thirty-six depending on band. The model replaces those with one payment event carrying an outcome condition. Fee-for-service pays per service regardless of improvement; this pays for a course and releases part only on improvement.	Section 1, p.6; Criterion 1, p.21; Appendix A	Answered
N1	C1	Not raised by the Review Team. Added by the submitter.	The model corresponds to opportunities Congress enumerated at section 1115A(b)(2)(B), clauses (xvii), (xxii), (xxiii) and (xxvii). Section 1115A(a)(5) permits limiting a test geographically, which is what is requested.	Section 7, p.18; Criterion 1, p.21	Submitter added
F2	C2	A 2025 OIG report found the opioid treatment program bundles produced over \$300 million in overpayments. The proposal does not explain how this model would be different and produce savings.	OIG A-09-23-03002 found \$301.5 million of \$564.6 million, 89 of 100 sampled episodes overpaid. Three features caused it: one service triggered the full weekly bundle, the rate assumed a service mix rarely delivered, and delivery was never reviewed. The revision shares none of the three and implements the Inspector General’s own recommendation.	Section 4, p.9; Section 6, p.14; Criterion 2, p.21	Answered
F3	C2	The proposal does not describe a process for reconciliation and recoupment for episode overpayment when patients drop out and do not complete the episode.	Delivery reconciliation added. The entity earns the fee schedule value of services actually delivered capped at the benchmark; payment for services not delivered is returned. This reverses a statement in the filed abstract, and the summary of changes gives the reason rather than leaving the reversal silent.	Section 4, p.9; Appendix B	Design changed
F4	C2	The CMS Innovation Center would not be able to test a new payment model that would be likely to increase spending.	Section 1115A(b)(3)(A) provides that budget neutrality is not required as a condition for testing. Section 1115A(b)(3)(B) sets the standard as expected, after testing begins, to improve quality without increasing spending, reduce spending without reducing quality, or both. The proposal is written to the first. Payment cannot exceed fee-for-service for the care delivered, tested across 20,196 combinations with no exception, and a 1.5 percent discount factor produces \$28.50 of saving on every completed standard episode.	Section 6, p.14; Criterion 2, p.21; Appendix B	Answered
F5	C2	The proposal does not explain why this model would improve quality beyond the collaborative care management approach Medicare already has in place.	Collaborative care works and the revision says so, citing Gilbody 2006. The difficulty is reach: Milliman, on 100 percent of CMS claims, found 56.1 patients per 100,000 in Original Medicare in 2022 after six years of payment. In 2024 Medicare paid for 422,066 services under 99484 against 152,400 under the collaborative care codes. The lower-requirement code generates 2.8 times the services.	Criterion 2, p.21; Appendix F	Answered
Q2	C2	How will the proposed model improve quality and result in better care?	Payment is conditioned on a recorded change in a validated instrument, which no current Medicare behavioral health payment does. Seven quality measures are specified, and the submitter states plainly that the size of the effect is what the test is for.	Section 6, p.14; Criterion 2, p.21	Answered
Q3	C2	How do the payment approach and re-tiering hold providers accountable for improving quality?	Twelve percent of the target price is forfeitable on a recorded outcome, released on a ramp. Re-tiering no longer changes the episode price, so it cannot be used to avoid the outcome condition.	Section 4, p.9; Criterion 2, p.21	Answered

Q4	C2	How is the episode approach better able to improve quality and reduce cost than collaborative care management, which reimburses cumulative time each month?	Same answer as F5. The comparison is reach, not efficacy, and the revision concedes efficacy explicitly rather than claiming an advantage the evidence does not support.	Criterion 2, p.21; Appendix F	Answered
Q5	C2	What are the specific quality metrics that will be used to measure improved care?	Seven measures, now labelled as quality measures and specified with numerator, denominator and source: outcome attainment, response, instrument completeness, pathway adherence, care coordination at open and	Section 6, p.14; Criterion 6, p.24	Answered

			at close, and prescriber-to-therapist communication.		
Q6	C2	How does this model achieve cost savings for Medicare?	By construction rather than by prediction. The discount factor and delivery reconciliation make the saving arithmetic rather than forecast. The submitter states that no CMS episode model has yet produced net savings and does not claim this one will.	Section 6, p.14; Criterion 2, p.21	Answered
Q7	C2	How would the episode approach for Medicare fee-for-service, which does not require prior authorization, result in cost savings?	The discount factor and reconciliation operate identically without prior authorization. Administrative saving in fee-for-service comes from collapsing eighteen adjudication events into one.	Section 6, p.14; Criterion 2, p.21	Answered
Q8	C2	How are tiers assigned and can patients be re-tiered mi episode?	Tiers are assigned by the acuity index, six dimensions scored from the record. Re-tiering is permitted clinically and the episode remains priced at the opening band. Escalation beyond the band closes the episode with reconciliation and opens a new one on human review.	Section 2, p.7; Appendix A; Appendix C	Answered
Q9	C2	What safeguards protect against undertreatment and patient selection?	Payment conditioned on recorded improvement; no automatic denial; immediate human routing on any positive suicide screen; an equity guard preventing social adversity alone from moving a patient out of outpatient bands; 4,000 simulated episodes holding those invariants.	Section 5, p.12; Criterion 9, p.25	Answered
F6	C3	Providers would receive a minimum of 98.8 percent and up to 101.2 percent of the episode payment regardless of performance, which does not represent substantial risk and is unlikely to change provider behavior.	The holdback becomes forfeitable rather than multiplied, moving the amount at risk from \$22.80 to \$224.59 on the standard episode against the \$57.00 that 42 CFR 414.1415(c)(3)(i)(B) and (c)(5) treat as more than nominal. The standard is met at a ratio of 3.94 in all 204 band and jurisdiction combinations.	Section 4, p.9; Criterion 3, p.22; Appendix B	Design changed
F7	C3	The fidelity corridor is described as 79 to 110 percent in Section 4.5 and 90 to 110 percent elsewhere.	The multiplier is retired, which resolves the inconsistency. The correction is stated in the summary of changes rather than left silent.	Section 4, p.9; Summary of Changes	Design changed
F8	C3	The model could be vulnerable to gaming because release of the withhold is contingent on a PHQ-9 administered and recorded by the paid clinician. The Review Team read Section 4.7 and remained concerned about retrospective review, and was unsure CMS has a system to perform that detection.	The detection argument is withdrawn rather than restated. Two structural changes replace it: graduated release removes the threshold discontinuity that made a single point worth gaming, and a randomly selected share of episodes receives an outcome assessment administered independently of the treating practice.	Section 4, p.9; Criterion 3, p.22	Argument withdrawn
F9	C3	If the patient's score is not reduced the provider can re-tier the patient, providing higher prospective payments. This potential gaming issue is not mentioned in the proposal.	Acknowledged as designed protection that also created an incentive. The episode is now priced at the opening band regardless of re-tiering, removing an incentive quantified at \$1,074.55 on the standard episode and \$940.08 from A1 to A2.	Section 2, p.7; Section 4, p.9	Design changed
F10	C4	88 percent is paid before services are rendered and regardless of value. Additional services generate no additional revenue, potentially incentivizing fewer services. Only 1.2 percent is at risk.	The incentive is removed rather than argued against: under delivery reconciliation, delivering fewer services reduces payment proportionally, so the finding no longer has a mechanism to operate through. On whether fewer services means undertreatment, Gilbody found more sessions did not improve outcomes and Grypma found 14 contacts against 20 with indistinguishable results.	Section 4, p.9; Criterion 4, p.23	Design changed

Q10	C6	How do the use and frequency of the PHQ-9 assessments compare with how the assessments are used in general practice?	Administered at open, at pathway intervals and at close, each a time-stamped structured element. Hawkins 2023 reported objective monitoring at 5.1 percent in an outpatient psychiatry clinic before intervention. Grypma supplies the comparator inside structured programs.	Section 6, p.14; Criterion 6, p.24	Answered
F11	C7	The proposal states care coordination is part of the episode but does not explain how it would occur or how it would be measured.	Both are now specified. Two contacts are required in every episode, a notification to primary care at open and at close, and a third where a prescriber and a therapist both participate. Each is captured as a FHIR Communication resource with team composition in Care Team, and three measures compute from those resources. Documented coordination is a condition of holdback release rather than a separately billed service.	Section 2, p.7; Criterion 7, p.24	Design changed
F12	C9	The proposal does not discuss how the model could lead to unintended consequences for beneficiaries, including clinicians providing fewer services than needed and provider cherry-picking of patients.	A direct section is added covering undertreatment, patient selection, upcoding at entry and mid-episode re-tiering, each with the mechanism that addresses it.	Section 5, p.12; Criterion 9, p.25	Design changed
F13	C10	The FHIR Prior Authorization API rules apply only to Medicare Advantage. The proposal does not describe how health IT or measurement of pathway adherence would be handled for the Medicare fee-for-service population.	What traditional Medicare lacks is a mandate, not a capability. The FHIR resources exist independently and are present in certified EHR technology. Participating practices transmit through FHIR as a condition of participation, as Innovation Center models routinely require.	Criterion 10, p.26	Answered
N2	C5	No comment from the Review Team. Still scored by the Secretary's criteria.	Reviewed and rewritten. The flexibility argument in the filed proposal rested on re-tiering changing the episode price and on the Medicare Advantage technology mandate, both of which this revision removes. The argument is rebuilt on what survives: the pathway sets required elements and not modality, site or staffing mix, and the model operates within each state's scope of practice as that state has set it.	Section 3, p.8; Criterion 5, p.23	Submitter added
N3	C8	No comment from the Review Team. Still scored by the Secretary's criteria.	Beneficiary cost-sharing is now stated rather than omitted: \$380.01 on the standard episode where the 2026 Part B deductible is met, \$606.41 where it is not. Cost-sharing is collected per service as it is today, following the Innovation Center's treatment in the Episode Payment Models final rule, and no cost-sharing waiver is requested.	Section 5, p.12; Criterion 8, p.25; Appendix E	Submitter added
N4	C3	Not raised by the Review Team. Added by the submitter.	The discount factor is set at 1.5 percent, the lower of the two values CMS uses in the Transforming Episode Accountability Model. CMS reserved the higher 2 percent for its more standardized procedures, and major depressive disorder is more variable than any of them. The stop-loss is set at 20 percent of the benchmark, matching that model's Track 3.	Section 4, p.9; Appendix B	Submitter added
N5	C6	Not raised by the Review Team. Added by the submitter.	A test design is added, sized from Medicare claims rather than asserted. The primary outcome requires roughly 1,100 completed episodes; the proposed region contains at least 1,231 providers billing psychiatric diagnostic evaluations and 63,482 such evaluations in 2024. Three limits are stated rather than estimated, including that cells under eleven beneficiaries are suppressed, so every provider count is a floor.	Section 7, p.18; Appendix F	Submitter added
N6	C1	Not raised by the Review Team. Added by the submitter.	The filed proposal named the Innovation in Behavioral Health Model Cohort 2 award states as an expansion pathway. That reference is withdrawn: the CMS model page as last modified June 10, 2026 shows three participants and no second cohort. One of the three, South Carolina, is in the proposed region, so model overlap is addressed directly and the region is shown to work without it.	Section 7.3, p.19	Reference withdrawn

13 findings and 10 written questions from the Review Team, all answered, and 6 changes the submitter made on its own review. The design was changed rather than defended on 10 of them. No finding is left unaddressed and no question is left unanswered.

Joanne Bayouk, MBA, MSN, RN.

APPENDIX E. HOUSEHOLD CAPACITY TO PAY

Episode Intelligence Authorization and Payment Compensation Model. Prepared by Joanne Bayouk, MBA, MSN, RN, September 2026.

Why this appendix exists

Under Part B coinsurance a beneficiary owes \$380.01 on the standard episode where the annual deductible has been met and \$606.41 where it has not. The proposal does not seek to waive that. It states it, and this appendix establishes what that amount means for the households the model is intended to reach.

The question is not whether \$380 is a large number in the abstract. The key question is whether a household has \$380 left after paying essential bills.

Method

A basic-needs budget was constructed for every combination of the fifty states and the District of Columbia with household sizes of one through eight, 408 combinations in all. Each budget sums four components, each from a named federal source:

Component	Source
Housing	HUD Fair Market Rents FY2027 (FY27_FMRs.xlsx; FR doc 2026-17891; 91 FR 56156)
Food	Official USDA Thrifty Food Plan: U.S. Average, July 2026
Out-of-pocket health care	AHRQ Medical Expenditure Panel Survey, household component, 2023 published tables
Federal tax and payroll	IRS Rev. Proc. 2025-32; SSA wage base determination, 90 FR 49047
State income tax	Tax Foundation, State Individual Income Tax Rates and Brackets, 2026, by Janelle Fritts and Katherine Loughead, as of January 1, 2026
Poverty benchmark	Annual Update of the HHS Poverty Guidelines

Household residual is annual income less the sum of those components. A household whose residual is at or below zero has nothing available for an episode of behavioral health treatment, whatever its nominal income.

Table E1. Households with nothing left, by income

Annual household income	Combinations at or below zero	Share	Median residual
\$30,000	300 of 408	73.5 percent	-\$8,782
\$45,000	144 of 408	35.3 percent	\$5,564
\$60,000	26 of 408	6.4 percent	\$18,483
\$90,000	0 of 408	0.0 percent	\$41,209
\$120,000	0 of 408	0.0 percent	\$64,114

At \$30,000 of annual household income, 300 of 408 combinations leave nothing at all, and the median household in the grid is \$8,782 short of its basic-needs budget before any medical care is purchased. The cliff does not clear until roughly \$90,000, at which point no combination in the grid is below zero.

Table E2. Where the shortfall is deepest

Jurisdiction	Household size	Residual at \$60,000
Hawaii	Household of 8	-\$24,644

Hawaii	Household of 7	-\$19,372
California	Household of 8	-\$14,865

At \$60,000, 26 combinations remain below zero and they concentrate in the highest-rent jurisdictions at the largest household sizes. This is a housing cost effect more than an income effect.

Limitations

Five, and the first is the one the main body points to.

1. The budget omits transportation, child care, and other necessities, because no figure for them could be verified from a federal source at state level. It also omits the value of in-kind benefits such as SNAP, housing assistance and Medicaid, which offset costs for some of these households. The two omissions run in opposite directions and are not netted.
2. Because the budget omits necessities, the residual it produces is too large, and a residual that is too large makes a household look more able to pay than it is. Every figure in this appendix is therefore an upper bound on capacity to pay, not a central estimate.
3. There is no state-level federal food cost series. The USDA Thrifty Food Plan publishes three geographies: the contiguous forty-eight states with the District of Columbia, Alaska, and Hawaii. Food cost therefore does not vary across the contiguous states in this model, which understates variation between them.
4. No federal source publishes state-level out-of-pocket health spending. The figure used is a national per person amount from the Medical Expenditure Panel Survey applied uniformly, which understates variation and is the weakest component in the budget.
5. The 408 combinations are a grid of jurisdictions by household size. It is a count of scenarios, not a count of families, and it is not weighted by how many Medicare beneficiaries actually live in each cell. It establishes that the affordability problem is widespread across the grid; it does not estimate how many beneficiaries are affected.

What follows from it

Three things, all of which appear in the main body.

Cost-sharing is stated in the proposal rather than omitted, at both the deductible-met and deductible-unmet amounts.

Cost-sharing is collected per service as care is delivered, exactly as it is today. No change to beneficiary liability is proposed and no cost-sharing waiver is requested, following the approach the Innovation Center took in the Episode Payment Models final rule.

Beneficiary abandonment of a course of treatment for cost reasons is a measured outcome of the test rather than an assumption. An episode that closes early settles on services actually delivered, so the model records the event rather than absorbing it.

The submitter draws the Committee's attention to this analysis because a payment model that improves the supply of behavioral health treatment while the beneficiary cannot afford to complete it has not improved access. That is a finding about Medicare cost-sharing generally rather than about this model, and it is offered as evidence rather than as a request.

Figures generated 2026-09-20 from HUD Fair Market Rents for fiscal year 2027 and the other sources named above. Not transcribed.

APPENDIX F. MEDICARE CLAIMS ANALYSIS

Episode Intelligence Authorization and Payment Compensation Model. Prepared by Joanne Bayouk, MBA, MSN, RN, September 2026.

Source and method

All figures in this appendix are computed from the CMS Medicare Physician and Other Practitioners by Provider and Service public use file for data year 2024, file PHY_R26_P05_V10_D24_Prov_Svc.csv. The file was read in full, 9,781,673 rows, and aggregated by HCPCS code, rendering provider and rendering provider state. No figure in this appendix or in the main body is transcribed from a secondary source.

The file reports traditional Medicare fee-for-service only. It does not cover Medicare Advantage, which is the reason the reach figures below understate total behavioral health delivery and the reason they are the right denominator for a model proposed for testing in fee-for-service.

What is counted

A psychiatric diagnostic evaluation, CPT 90791 or 90792, is the event that opens a course of treatment in this pathway and is used throughout as the proxy for treatment initiation. Two provider definitions appear and they are not interchangeable:

Providers billing any psychotherapy or evaluation code means 90791, 90792, 90832, 90834, 90837 and 90853. This is the definition used for the state sizing in Section 7.2 and it yields 35,840 distinct rendering providers nationally. Restricted to individual psychotherapy, excluding group, the same union is 35,536. The difference is stated here so that the two numbers are not read as a discrepancy. **Table F1. National volume, data year 2024**

HCPCS code and description	Providers	Services	Medicare allowed
90791 Psychiatric diagnostic evaluation	11,400	531,318	\$78,293,840
90792 Psychiatric diagnostic evaluation with medical services	8,503	473,012	\$77,164,625
90832 Psychotherapy, 30 minutes	6,210	1,808,431	\$119,273,779
90834 Psychotherapy, 45 minutes	10,253	2,079,419	\$183,072,164
90837 Psychotherapy, 60 minutes	15,804	3,792,555	\$483,255,024
90853 Group psychotherapy	773	225,828	\$5,196,167
96127 Brief emotional or behavioral assessment	9,200	833,787	\$3,726,830
99484 General behavioral health integration care management	1,218	422,066	\$21,124,620
99492 Collaborative care management, initial month	258	22,291	\$3,272,790
99493 Collaborative care management, subsequent month	383	80,997	\$10,047,917
99494 Collaborative care management, each additional 30 minutes	184	49,112	\$2,586,658

Provider counts are distinct rendering NPIs billing that code. They do not sum down the column, because one provider bills several codes. CPT 90791 and 90792 together account for 1,004,330 psychiatric diagnostic evaluations, the figure cited at Section 7.2 as the national proxy for treatment initiation.

The reach of collaborative care

Medicare has paid for collaborative care management since 2017 and for general behavioral health integration since 2018. The Preliminary Review Team asked why an episode model would improve on what Medicare already has. The answer is not that collaborative care fails to work. It is that almost no one bills it.

In 2024 the three collaborative care codes together drew 152,400 services and \$15,907,366 in Medicare payment across the entire country. Against that, the psychotherapy and evaluation codes in Table F1 drew more than eight million services. Service counts are the sound basis for this comparison because they do not depend on how many providers cleared a reporting threshold.

On provider counts this file shows 456 distinct providers billing any collaborative care code against 35,840 billing a psychotherapy or evaluation code. That apparent ratio of 78.6 to one is reported here but should not be used. Suppression of rows covering fewer than eleven beneficiaries does not fall evenly between the two: collaborative care billers are lower volume on average, so proportionally more of them are removed from the file, and the ratio therefore overstates the gap by an amount this file cannot quantify. For a provider comparison between payment mechanisms the proposal uses Milliman, which worked from unsuppressed claims and found 5,131 distinct providers billing collaborative care in Original Medicare in 2022.

The comparison inside the integration codes points the same way. CPT 99484, general behavioral health integration, carries materially lighter requirements than collaborative care: no designated psychiatric consultant and no registry. It drew 422,066 services against 152,400 for the three collaborative care codes combined, or 2.8 times as many, from 1,218 providers.

The pattern is consistent: the lighter the administrative requirement attached to a behavioral health payment, the more it is used. A model that conditions payment on an outcome rather than on a staffing structure and a monthly time log is a test of whether that pattern can be redirected toward results.

Table F2. Who delivers this care

Rendering provider type	Services	Share
Licensed Clinical Social Worker	3,792,242	49.4 percent
Psychologist, Clinical	3,083,864	40.2 percent
Licensed Professional Counselor	325,414	4.2 percent
Psychiatry	245,512	3.2 percent
Nurse Practitioner	135,220	1.8 percent
Marriage and Family Therapist	46,300	0.6 percent
Certified Clinical Nurse Specialist	24,159	0.3 percent
Physician Assistant	5,548	0.1 percent
All individual psychotherapy, all types	7,680,403	100.0 percent

Individual psychotherapy, CPT 90832, 90834 and 90837 combined. The eight largest provider types are shown; remaining types account for the balance. Licensed clinical social workers and clinical psychologists together furnish 89.5 percent of these services. Psychiatry furnishes 3.2 percent. This bears directly on Section 7.3: a recruitment strategy aimed at psychiatry would miss the practices that actually deliver the care, and on Section 3, because the model has to pay the same episode price whichever qualified practitioner delivers it or it cannot reach them.

Table F3. The proposed test region

State	Providers	Billing evaluations	Evaluations in 2024
-------	-----------	---------------------	---------------------

Georgia	687	426	20,268
Tennessee	579	367	23,876
South Carolina	455	289	11,510
Alabama	254	149	7,828
Region total	1,975	1,231	63,482

Evaluating providers in the region furnish an average of 51.6 diagnostic evaluations a year. At ten to fifteen percent participation that is 123 to 185 practices and roughly 6,348 to 9,522 evaluations a year, against the approximately 1,100 completed episodes the primary outcome requires for a three percentage point confidence interval.

Section 7.3 addresses overlap with the CMS Innovation in Behavioral Health Model, one of whose three state participants is South Carolina. Without South Carolina the region holds 1,520 providers, 942 billing evaluations and 51,972 evaluations, which at the same participation rates is 94 to 141 practices and roughly 5,197 to 7,795 evaluations a year. The test does not depend on including South Carolina.

Limitations

Four, each stated rather than estimated around.

1. CMS suppresses rows covering fewer than 11 beneficiaries, so every provider and service count is a floor rather than a total, and the suppression falls hardest on the smallest practices.
2. Tot_Benes is summed across provider rows, so a beneficiary seen by more than one provider is counted more than once. It is an upper bound on patients, not a distinct count.
3. The file is organized by procedure code and carries no diagnosis, so the share of these services furnished for major depressive disorder cannot be determined from it.
4. Allowed amounts are reconstructed as services multiplied by the average Medicare allowed amount per row, which is how the file reports it.

The first of these matters most to this proposal. Suppression of low-volume rows falls hardest on the smallest practices, which are precisely the practices section 1115A(b)(2)(B)(xxii) and (xxiii) contemplate and precisely the ones this model is designed to reach. Every provider count in this appendix is therefore a floor, and the true supply available to a test is larger than the tables show. Provider counts from this file are not used anywhere in this proposal for a comparison of reach between two payment mechanisms

APPENDIX G. REGULATORY AND FILING RECORD

Episode Intelligence Authorization and Payment Compensation Model. Prepared by Joanne Bayouk, MBA, MSN, RN, September 2026.

Disclosure of the submitter's interest

The submitter designed the model this proposal argues for. She is the sole author and claimant of the works listed below and holds a pending United States provisional patent application on the model. She has no license, no commercial arrangement and no revenue relating to it, and no financial relationship with any entity that would participate in a test.

This appendix exists so that the Committee and the public can see the extent of that interest rather than infer it.

Copyright

Seven applications covering the framework have been filed with the United States Copyright Office. The numbers below are eCO case numbers, also called service request numbers, assigned at submission. Registration certificates have not yet issued, which is ordinary Copyright Office processing. The case numbers permit retrieval of the Office record, and frozen deposit copies are retained and available on request.

eCO case number	Filed	What it covers
1-15181678151	June 9, 2026	The founding filing. The episode-based payment model in which authorization and payment are a single episode-level event, together with the clinical appropriateness gate, oncology edition. Referenced as parent by the later filings.
1-15182783101	June 11, 2026	EIA Compensation Model. Group of unpublished works. This is the filing that covers the payment model proposed here.
1-15185778731	June 15, 2026	Payer order validation under 42 CFR Part 411. Full specification.
1-15187387921	June 17, 2026	Parity documentation generated as a byproduct of behavioral health authorization. Full specification.
1-15190064221	June 22, 2026	Group registration of eight works: the clinical appropriateness gate, behavioral health and substance use edition; four further modules; the complete framework architecture; and the evidence edition.
1-15195520221	June 29, 2026	The complete compendium. The whole-work EIA booklet: case for change, concept, competitive analysis, government strategy and the full technical build specification.
1-15198948341	July 2, 2026	Interactive prototype demonstration, version 0.1, unpublished. The seventeen-scenario working demonstration. AI-generated text and code are excluded from the claim; the claimed new matter is the human-authored text and the selection, coordination and arrangement.

The submitter draws attention to the last entry. The prototype filing expressly excludes AI-generated text and code from the claim and claims only the human-authored text and the selection, coordination and arrangement. The separate software reference implementation is machine-assisted work under the submitter's direction and carries a file-by-file authorship manifest recording which files were machine-assisted, maintained for that purpose.

Patent

United States Provisional Patent Application No. 64/107,509 was filed on July 8, 2026. A provisional application establishes a filing date and is not examined and does not issue as a patent; the statutory period for filing a corresponding nonprovisional application runs twelve months from the filing date. No patent has issued and none is claimed to have issued.

The submitter states this because the phrase patent pending appears in earlier materials and should not be read as more than it is.

Procedural record before PTAC

Date	Event
June 12, 2026	Letter of intent confirmed by PTAC.
July 8, 2026	United States Provisional Patent Application No. 64/107,509 filed.
July 9, 2026	Letter of support provided by the Georgia Alliance of Community Hospitals, representing more than ninety hospitals. Reproduced at Appendix H.
August 11, 2026	Proposal filed with PTAC.
September 23, 2026	Preliminary Review Team initial feedback and written questions received.
September 23, 2026	Submitter elected to revise and resubmit, and notified PTAC the same day.

Relationship between the filings and this proposal

The payment model proposed here is covered by the June 11, 2026 filing. The remaining filings cover adjacent specifications, most of which are not part of what this proposal asks CMS to test. Nothing in the intellectual property position restricts CMS in testing the model: the submitter is offering the model for testing and is not proposing to license anything to CMS or to any participant as a condition of the test.

The submitter would make the reference implementation available to CMS for inspection and would participate on the standard terms that govern Innovation Center models, including the rights in data and intellectual property provisions at 42 CFR 512.140, under which CMS may use model data to evaluate and monitor the model and may disseminate de-identified results, and under which material identified as proprietary or confidential is handled as that section provides.

Sourced from the submitter's copyright filing index, corrected version of July 23, 2026. Case numbers and filing dates as recorded there.

APPENDIX H. LETTERS OF SUPPORT

Letter of Support

Episode Intelligence Authorization (EIA) Framework | PTAC Full Proposal Window: July 12 to August 10, 2026



GEORGIA ALLIANCE OF COMMUNITY HOSPITALS

P.O. Box 1572 · Tifton, GA 31793 · (229) 386-8660 · Fax (229) 386-8662 · marcy@gach.org · www.gach.org

Georgia Alliance
118 East 20th Street
Tifton, GA 31794
mveazey@gach.org
229-386-8660

July 9, 2026

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue SW, Washington, DC 20201
PTAC@hhs.gov

Re: Letter of Support for the Episode Intelligence Authorization (EIA) Framework Proposal

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee,

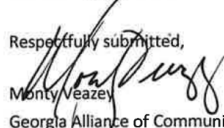
Georgia Alliance of Community Hospitals is a not-for-profit association serving over 90 hospitals and health systems both rural and urban in Georgia. We write in support of the Episode Intelligence Authorization (EIA) framework proposal submitted to PTAC by Joanne Bayouk, MBA, MSN, RN, PMHNP-C.

Behavioral health prior authorization represents one of the most significant administrative and clinical burdens in our organization. Authorization decisions for psychiatric and substance use disorder populations are routinely made against proprietary criteria that were not designed for these populations, resulting in delays, denials, and provider burden that compromise patient care. This problem is systemic, and it is worsening as AI-driven prior authorization models expand without auditable clinical logic.

The Episode Intelligence Authorization framework directly addresses this problem. EIA is a seven-module FHIR R4 clinical decision logic framework that encodes APA and ASAM clinical guidelines as auditable authorization logic, ensuring that every authorization decision for a behavioral health patient traces to a specific clinical criterion and a specific data input. EIA holds five active U.S. Copyright Office registrations and a confirmed Letter of Intent with the CMS Innovation Center as of June 2026.

The Alliance recognizes the problem of behavioral health prior authorization burden and supports the development of a standardized clinical decision logic framework for federal evaluation through the PTAC process. We believe EIA represents a clinically credible, operationally feasible, and federally appropriate solution to a documented and growing problem. We encourage PTAC to give this proposal full consideration.

This letter does not constitute a financial commitment or technology contract of any kind.

Respectfully submitted,

Monty Veazey
Georgia Alliance of Community Hospitals