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Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary of Planning and Evaluation, Office of Health Policy
200 Independence Avenue S. W.
Washington, D.C. 20201
PTAC@hhs.gov

Letter of Intent: Joanne Bayouk; Episode Intelligence Authorization (EIA) Compensation Model, an episode-based payment model in which authorization and payment are a single event

Dear Committee Members,

I write as an individual submitter to express intent to submit a proposed Physician-Focused Payment Model for PTAC review on August 10, 2026.

Expected Participants

Patients: Medicare beneficiaries with moderate to severe major depressive disorder would constitute the initial episode population, with a defined expansion path to substance use disorder and additional behavioral health episode types anchored in ASAM and APA guidelines. The initial test is sized at approximately 5,000 episodes over 12 months within one payer arrangement.

Clinicians and providers: psychiatrists, psychiatric mental health nurse practitioners, clinical psychologists, clinical social workers, and primary care clinicians practicing in collaborative care or behavioral health integration arrangements. An initial test of the proposed scale would involve an estimated 200 to 400 eligible clinicians across participating practices. All participant types are eligible professionals under section 1848(k)(3)(B) of the Social Security Act and would play the core role in implementing the payment methodology.

Goals of the Payment Model

Under current payment, a clinician is exposed to administrative failure twice for the same service: prior authorization before delivery and claims adjudication after it. In the American Medical Association's 2025 Prior Authorization Physician Survey (released May 2026), 26 percent of physicians reported that prior authorization caused a serious adverse event for a patient in their care, 95 percent reported delayed access to necessary care, and 79 percent reported treatment abandonment. Behavioral health carries the heaviest burden, requiring authorizations, renewals, and re-authorizations across a single treatment episode. The model's goals are to: (1) eliminate both administrative failure points for in-pathway care by fusing authorization and payment into one episode-level event; (2) improve clinical outcomes through guideline-fidelity incentives for measurement-based care; (3) reduce administrative spending, a portion of the more than \$20 billion automation opportunity documented in the 2025 CAQH Index; and (4) deliver structural payment parity for behavioral health by placing it on the identical episode architecture as medical and surgical care.

Model Overview

The model is an episode-based payment in which the authorized episode is the payment unit. When an episode is authorized against open specialty-society care pathways (APA, ASAM) expressed in

FHIR and CQL, payment is committed in the same event: 88 percent of an RYU-constructed episode base rate is paid prospectively, a 12 percent holdback is released against the guideline's own outcome definitions at episode close, and a fidelity multiplier of 0.90 to 1.10 adjusts payment based on pathway adherence captured passively from FHIR clinical data. Patients who deviate from the expected course re-tier to a higher-complexity episode with a new base rate rather than facing denial. In-pathway services require no claims adjudication and carry no retrospective denial or recoupment exposure. The model operates on the FHIR prior authorization API infrastructure already required of payers under the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F). The model is payer-agnostic by design: Medicare is the initial payer as required for a physician-focused payment model, and the architecture extends without modification to Medicaid (including alignment with the CMS Innovation in Behavioral Health Model) and to commercial coverage, where the same episode definitions, guideline pathways, and payment formula apply. The submitter believes the model would be likely to meet MACRA requirements for an Advanced Alternative Payment Model: participants bear more than nominal financial risk through the outcome holdback and fidelity corridor (79 to 110 percent of base), certified EHR technology use is inherent to the FHIR-based design, and payment is tied to quality measures comparable to those used in MIPS through guideline-defined outcomes.

Implementation Strategy

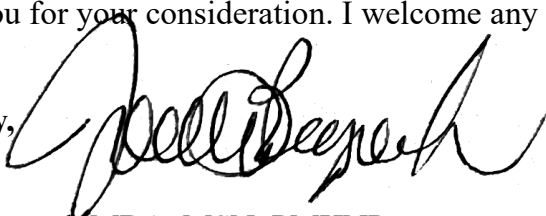
The submitter is a psychiatric mental health nurse practitioner candidate and clinical product strategist with approximately 20 years of cross-sector experience spanning payer operations, pharmacy benefit management, health plans, hospital systems, and revenue cycle management. The Episode Intelligence Authorization framework underlying this payment model was filed with CMS on June 9, 2026 (Docket CMS-2026-1255). The submitter is an individual, not a provider organization; discussions are underway with clinical technology platforms and federal delivery partners, and recruitment of provider organizations committed to implementing the model is in progress. Committed provider organizations will be identified in the full proposal.

Timeline

Proposal submission: August 10, 2026, for review at the Committee's December 8-9, 2026, public meeting. Earliest implementation readiness: participating provider organizations could be ready to implement within 12 months of model approval, reflecting episode pathway configuration on existing FHIR infrastructure, with a target readiness date of January 2028.

Thank you for your consideration. I welcome any questions at the contact information above.

Sincerely,



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