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*

Submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)
U.S. Department of Health and Human Services · PTAC@hhs.gov

**Submitting Individual**

**Joanne Bayouk, MBA, MSN, RN, PMHNP-c**
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*

PTAC PROPOSAL SUBMISSION

Episode Intelligence Authorization and Payment (EIA) Compensation Model

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

July 12, 2026

Physician-Focused Payment Model Technical Advisory Committee

c/o U.S. DHHS Assistant Secretary for Planning and Evaluation

Office of Health Policy, 200 Independence Avenue S.W.

Washington, D.C. 20201

PTAC@hhs.gov

Dear Committee Members,

I respectfully submit this full proposal for the Episode Intelligence Authorization and Payment (EIA) Compensation Model, a physician-focused payment model in which the authorized clinical episode and the payment unit are the same event. A Letter of Intent was submitted on June 11, 2026.

I am an individual submitter: a psychiatric mental health nurse practitioner candidate and clinical informaticist with approximately 20 years of cross-sector experience spanning payer operations, pharmacy benefit management, health plans, hospital systems, and revenue cycle management. I am not a trade association, a law firm, or a technology vendor. I am a clinician who built this model because the existing prior authorization system causes patient harm and the payment system that finances it is designed in a way that makes that harm structurally inevitable.

The EIA framework underlying this payment model was filed with CMS on June 9, 2026, under Docket CMS-2026-1255 (CMS-0062-P) and simultaneously registered with the US Copyright Office under Case 1-15181678151. That first registration has since grown to seven U.S. Copyright Office registrations covering the complete framework, and the framework is patent pending: U.S. Provisional Patent Application No. 64/107,509, filed July 8, 2026, sole inventor.

Provider support is anchored by the Georgia Alliance of Community Hospitals, representing more than 90 hospitals statewide, whose signed letter of support accompanies this proposal in Appendix D. Additional letters from state agencies and early CMS ACCESS Model participants are in progress and will be forwarded to the Committee as supplements as they arrive.

I welcome any questions at joannebayouk@gmail.com or 847-373-4956.

Respectfully,

Joanne Bayouk, MBA, MSN, RN, PMHNP-c

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

FULL PROPOSAL

Episode Intelligence Authorization and Payment (EIA) Compensation Model

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

## Abstract

Under current Medicare payment, a clinician is exposed to administrative failure twice for every service delivered: prior authorization before delivery and claims adjudication after it. For behavioral health, these failure points multiply across a single treatment episode, requiring authorizations, renewals, and re-authorizations for services that guidelines treat as a continuous care process. The Episode Intelligence Authorization and Payment (EIA) Compensation Model eliminates both failure points by fusing authorization and payment into one episode-level event.

When a clinical episode is authorized against open specialty-society care pathways, expressed in FHIR and CQL, payment is committed in the same event: 88 percent of an RVU-constructed episode base rate is paid prospectively, a 12 percent holdback is released at episode close against the guideline's own outcome definitions, 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 rather than face denial. In-pathway services carry no claims adjudication and no retrospective denial or recoupment exposure.

The model operates on the FHIR Prior Authorization API infrastructure already required of payers under CMS-0057-F and extended under CMS-0062-P. It is payer-agnostic by design, beginning in Medicare and extending without modification to Medicaid and commercial coverage. The submitter believes the model meets MACRA requirements for an Advanced Alternative Payment Model.

# Table of Contents

## Summary of Key Elements

**Provider Eligibility:** Psychiatrists, psychiatric mental health nurse practitioners, clinical psychologists, clinical social workers, and primary care clinicians treating major depressive disorder; small and solo practices are explicitly eligible. An initial test involves an estimated 200 to 400 eligible clinicians across participating practices.

**Patient Eligibility:** Medicare beneficiaries with moderate-to-severe major depressive disorder (PHQ-9 of 10 or above at episode initiation). Beneficiaries retain full freedom of provider choice and all existing Medicare coverage. The population includes a defined treatment-resistant depression tier, the highest-cost and highest-abrasion segment. Named Phase 2 expansion episodes: opioid use disorder and serious mental illness (Section 3.1).

**Accountable Entity:** The participating group practice or solo practitioner, as the APM Entity, receives the prospective Medicare episode payment and distributes funds to participating clinicians.

**Care Delivery Model:** Episode-based care in which a clinical episode is authorized against open specialty-society care pathways (APA, ASAM, ASCO) expressed in FHIR and CQL. Authorization and payment occur in a single event; care coordination is embedded in the episode pathway.

**Payment Model:** A prospective episode base rate constructed on an RVU basis and stratified by complexity tier; 88 percent is paid at episode authorization and a 12 percent holdback is released at episode close, adjusted by a fidelity multiplier corridor of 0.90 to 1.10. In-pathway services carry no separate claims adjudication.

# Section 1: The Problem

## 1.1 The Double Administrative Failure Point

Under current Medicare fee-for-service payment, every covered service carries two sequential administrative failure points. First, prior authorization must be obtained before service delivery. Second, claims must be adjudicated after delivery. Each point is an independent opportunity for denial, recoupment, and administrative burden. For most medical and surgical care, these two points are separated by a single service event. For behavioral health, they are not.

Behavioral health treatment is continuous. A patient with moderate to severe major depressive disorder requires assessment, medication management, psychotherapy across multiple sessions, care coordination, and response monitoring. Under current Medicare payment, each of these service components requires separate authorization, separate claims submission, and separate adjudication. A single treatment episode generates dozens of administrative transactions, each of which carries denial risk.

The AMA's 2025 Prior Authorization Physician Survey found that 26 percent of physicians reported prior authorization caused a serious adverse event for a patient, 95 percent reported delayed access to necessary care, and 79 percent reported treatment abandonment. Behavioral health carries the heaviest burden of these three outcomes because its treatment episodes are the most authorization-intensive in all of Medicare.

## 1.2 The Criteria Problem

The prior authorization criteria in widest current use, primarily MCG Health and InterQual, were built for a pre-FHIR era of adjudication and were never designed to produce an auditable, machine-readable citation trail. They are licensed under confidential agreements, have no open citation trail, produce no FHIR-native output, and cannot be independently audited against clinical evidence. That is not a failure of payer intent; it is a structural mismatch between legacy criteria licensing and the interoperability CMS now requires. Payers face the same audit exposure clinicians do when a criteria decision cannot be traced to a specific guideline version.

The APA, ASAM, and ASCO publish open clinical guidelines that define medically necessary care by diagnosis and clinical presentation. The EIA model uses these guidelines directly, expressed as FHIR PlanDefinitions and CQL clinical logic rules. Every authorization decision is cited to a specific guideline version, creating an auditable evidentiary record that any party can review.

## 1.3 Why Existing Medicare Payment Cannot Fix This

Fee-for-service payment requires claims adjudication. Episodic add-on codes (such as Psychiatric Collaborative Care Management) exist but do not eliminate per-service authorization or retrospective denial risk. Accountable Care Organizations reduce some total cost pressure but do not address the per-service authorization burden for behavioral health clinicians operating inside ACO arrangements.

The CMS-0057-F final rule (January 2024) and CMS-0062-P proposed rule (April 2026, Docket CMS-2026-1255) mandate FHIR Prior Authorization APIs but do not supply the clinical criteria

content that flows through those APIs. The pipes are now legally required. What flows through them remains proprietary. The EIA model supplies open, society-anchored clinical content that makes those pipes work as Congress intended.

### 1.4 Distinction from the CMS ACCESS Model

In July 2026, the CMS Innovation Center launched the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model, a ten-year voluntary model that pays Outcome-Aligned Payments for technology-supported chronic condition management, including a behavioral health track covering depression and anxiety. ACCESS and EIA address different points in the same patient's care and are structurally complementary, not competing.

ACCESS pays a recurring, condition-level payment for ongoing management, structured around patient engagement technology and outcome thresholds measured over time. It does not authorize care, does not touch the prior authorization process, and does not resolve the per-service denial and adjudication cycle described in Section 1.1. A beneficiary can be attributed under ACCESS and still face prior authorization for the psychotherapy, medication management, and higher-acuity services that make up the treatment itself. EIA operates at exactly that point: the authorization event for a defined clinical episode, fusing the authorization decision with the payment commitment and eliminating the per-service denial cycle at its source. A practice could reasonably participate in both, with no duplication of payment for the same service.

The two models share an important signal for the Committee's evaluation: CMS's own Innovation Center has independently concluded that technology-enabled, instrument-anchored, outcome-based payment for depression and anxiety is feasible and worth testing at national scale. ACCESS validates the direction; EIA addresses the specific administrative failure point, prior authorization, that ACCESS was not designed to solve. Section 4.6 develops this precedent relationship in detail.

## Section 2: The Model

### 2.1 Model Overview

The EIA Compensation Model is an episode-based payment model in which the authorized episode is the payment unit. Authorization and payment occur in the same event. When a clinician submits an episode authorization request through the FHIR Prior Authorization API infrastructure required under CMS-0057-F, the authorization response contains not only clinical approval but the prospective payment commitment for the approved episode.

### 2.2 Episode Definition

A clinical episode is defined by: (1) a triggering diagnosis with a specified severity threshold, (2) an authorized care pathway drawn from the relevant society guideline, (3) a defined episode duration, (4) re-tiering criteria for patients whose clinical course changes, and (5) episode-close outcome definitions against which the holdback is measured.

The initial episode type is major depressive disorder (MDD), moderate to severe, in Medicare beneficiaries. The episode pathway is drawn from the APA Practice Guideline for the Treatment of Patients with Major Depressive Disorder, expressed as a FHIR PlanDefinition. Episode duration is 16 weeks for the initial authorization, with re-authorization available for continuation-phase care based on documented clinical response.

A complete episode definition for MDD is provided in Appendix A.

### 2.3 How the Model Resolves the Problem

By authorizing at the episode level rather than the service level, the model eliminates the dozens of per-service authorization transactions that a single MDD treatment episode currently requires. The clinician submits one FHIR-based episode authorization request. The payer responds with one approval and one prospective payment commitment. In-pathway services during the episode carry no additional authorization burden and no claims adjudication.

The model does not eliminate clinical accountability. The 12 percent holdback and the fidelity multiplier create financial incentives for guideline adherence and outcome achievement. Patients who improve as expected close their episodes and trigger holdback release. Patients who do not improve re-tier to a higher-complexity episode with a new base rate, rather than facing denial of continued care.

At its core, the model relocates authorization authority: the clinician, not the payer, initiates and holds the episode authorization, and the relocation is credible because everything that backs it is verifiable by anyone. The pathway belongs to the specialty society, not to either party. The severity instrument is validated and administered in the open. The audit trail is generated automatically by the care itself. Under current payment, oversight is exercised as payer discretion before care is delivered, through criteria the clinician often cannot see. Under this model, oversight is evidence produced by delivering the care, against criteria everyone can read. Authority moves to the clinician; accountability becomes stronger, not weaker, because it becomes inspectable.

### 2.4 Payer-Agnostic Architecture

The model begins in Medicare because PTAC requires a physician-focused Medicare payment model. The architecture extends without modification to Medicaid, including the CMS Innovation in Behavioral Health Model, and to commercial coverage. The same FHIR episode definitions, the same APA-anchored criteria, and the same payment formula apply across payers. A clinician practicing under EIA does not manage different criteria sets for different payer populations.

## Section 3: Expected Participants

### 3.1 Eligible Beneficiaries

Medicare beneficiaries with moderate to severe major depressive disorder, defined by a PHQ-9 score of 10 or above at episode initiation, constitute the initial episode population. The initial test is sized at approximately 5,000 episodes over 12 months within one payer arrangement. An

expansion path to substance use disorder, anxiety disorders, and additional behavioral health episode types anchored in ASAM and APA guidelines is defined but not included in the initial test scale. The population explicitly includes the treatment-resistant depression tier: beneficiaries whose depression has not responded to two or more adequate antidepressant trials. This tier represents roughly one third of the treated MDD population, carries roughly twice the per-patient cost, accounts for nearly half of the total cost burden of medication-treated depression, and generates the most contested prior authorizations in behavioral health, including transcranial magnetic stimulation and esketamine. The complexity-tier structure in Section 4.1 prices this tier directly, with no change to the measurement instrument.

Beneficiaries in the model retain full freedom of choice of provider and continuity of all existing Medicare coverage. The model adds prospective payment and eliminates per-service authorization. It does not restrict beneficiary access to any covered service.

**Expansion episodes (Phase 2).** The model launches deliberately narrow: one diagnosis, one instrument, one episode type, so that the evaluation design in Section 6 can attribute results cleanly. Two expansion episodes are named now, so the Committee can see a specified path rather than a promise.

Opioid use disorder is the first expansion episode: level-of-care authorization for residential and intensive outpatient treatment is the single most contested prior-authorization category in behavioral health, Medicare has covered opioid treatment programs since 2020, and retention in medication treatment is a hard, validated outcome measure. Serious mental illness (schizophrenia and bipolar disorder) is the second: it carries the highest per-beneficiary behavioral-health spend in Medicare, with authorization abrasion concentrated in inpatient continued-stay review and long-acting injectable antipsychotics, measured on 30-day readmission. Each expansion episode reuses the same architecture without modification: a society-guideline pathway expressed in FHIR and CQL, a severity instrument at initiation, complexity tiers, and an outcome holdback released against instrument-based measures.

## 3.2 Eligible Clinicians and Practices

Eligible participants include psychiatrists, psychiatric mental health nurse practitioners, clinical psychologists, clinical social workers, and primary care clinicians practicing in collaborative care or behavioral health integration arrangements. All participant types are eligible professionals under section 1848(k)(3)(B) of the Social Security Act. For solo and small practices, day-one episode payment removes the accounts-receivable float and per-service authorization labor that currently make behavioral-health participation financially marginal.

An initial test of the proposed scale would involve an estimated 200 to 400 eligible clinicians across participating practices. Recruitment is anchored by the Georgia Alliance of Community Hospitals, representing more than 90 Georgia hospitals, whose signed letter of support appears in Appendix D, and proceeds through Georgia psychiatric APRN professional networks and clinical technology platform partners.

### 3.3 Practice Infrastructure Requirements

Participating practices must have electronic health record systems capable of generating FHIR-based prior authorization requests, as already required under CMS-0057-F for practices billing Medicare Advantage or Medicaid managed care. Certified EHR technology use is inherent to the FHIR-based design. No additional technology investment beyond existing CMS-0057-F compliance infrastructure is required.

## Section 4: Payment Methodology

### 4.1 Episode Base Rate Construction

The episode base rate is constructed on an RVU basis, summing the relative value units of the services included in the standard APA-defined MDD treatment pathway for the episode duration. The base rate reflects the expected resource cost of guideline-adherent care, not historical average cost, which in behavioral health is significantly suppressed by authorization denials and treatment abandonment.

The base rate is stratified by episode complexity tier. Tier 1 is initial MDD episode without comorbid SUD or significant medical complexity. Tier 2 adds comorbid SUD (ASAM Level 1 or 2) or one or more high-complexity medical comorbidities. Tier 3 is reserved for MDD with psychotic features, treatment resistance, or acute safety risk requiring intensive outpatient or partial hospitalization level services.

### 4.2 Payment Structure

The fidelity multiplier corridor of 0.90 to 1.10, applied to the holdback portion (12 percent of base rate), creates meaningful financial risk that is proportionate to the payment amount and tied directly to clinical guideline performance. Participants bear more than nominal financial risk through this corridor, supporting MACRA Advanced APM qualification.

**Provider economics compared with current payment.** Under fee-for-service, the same Tier 1 pathway is billed as roughly twenty separate claims across ninety days: each claim individually submitted, individually adjudicated, and individually exposed to denial, downcoding, and rework, with payment arriving thirty to ninety days after each service. The 2025 AMA prior-authorization survey documents what surrounds that revenue: roughly thirteen hours of physician and staff time per week consumed by authorization work, and widespread treatment abandonment while approvals are pending. Whatever a practice loses to denials and write-offs under that system is simply gone; nothing the clinician does clinically can earn it back.

Under this model the same services produce one payment event. Eighty-eight percent of the episode rate arrives at authorization, before the first visit, converting a rolling ninety-day accounts-receivable cycle into day-one cash flow; for solo and small practices, the segment most absent from behavioral-health networks, this is frequently the difference between participation being viable or not. The twelve percent that the current system takes as unrecoverable administrative loss becomes an earnable outcome payment, released at episode close for doing what the clinician already intends to do: deliver guideline-adherent care and measure the result. Even the model's floor case, full fidelity at the 0.90 multiplier, pays 98.8

percent of the full episode rate; a practice's net under fee-for-service is typically below that once billing and collection costs and denial write-offs are subtracted, and it arrives months later after some twenty separate adjudications. The comparison is not between more money and less money for the same work; it is between revenue a practice must chase and revenue that is settled before care begins, with the upside tied to outcomes rather than to paperwork.

## 4.3 No Claims Adjudication for In-Pathway Services

Services delivered within an authorized episode pathway carry no claims adjudication requirement. The episode authorization serves as the prospective claims approval for all in-pathway services. This eliminates the retrospective denial and recoupment exposure that currently creates the second administrative failure point.

Services outside the authorized pathway, or services after episode close without re-authorization, remain subject to standard Medicare claims adjudication. This boundary is clearly defined in the FHIR episode definition and communicated to participants at enrollment.

## 4.4 Payment Flow

Medicare makes the prospective episode payment to the participating practice as the episode entity. The practice is responsible for distributing payment to all clinicians delivering in-pathway services. This mirrors existing group practice payment arrangements and requires no new payment infrastructure. The holdback is released to the practice at episode close upon submission of the episode outcome documentation.

## 4.5 Advanced APM Qualification

The submitter believes the EIA Compensation Model meets MACRA requirements for an Advanced Alternative Payment Model based on: (1) certified EHR technology use inherent to the FHIR-based design, (2) more than nominal financial risk through the outcome holdback and fidelity corridor covering 79 to 110 percent of base rate, and (3) quality measures tied to guideline-defined outcomes that are comparable to measures used in MIPS. PTAC's assessment of Advanced APM qualification is respectfully requested. The risk level is calibrated deliberately. Solo and small behavioral-health practices cannot absorb capitation-style downside, and a model that demands it would select for exactly the large organizations that already have APM options. Accountability in this model is carried by the authorization gate, the re-tiering criteria, and the fidelity multiplier rather than by revenue withholding: a clinician who departs from the pathway loses the episode mechanism itself, which is a stronger control than a marginal holdback.

## 4.6 Precedent and Justification: Built From Mechanisms Medicare Operates Today

Each element of this payment methodology is already in production somewhere in Medicare. The Committee is not asked to approve new payment machinery; it is asked to approve joining proven mechanisms at a new point in the care process (authorization) for a population they have never reached (behavioral health).

**Episode-based prospective payment - operating today:** Episode-based prospective payment is how BPCI Advanced has paid for episodes since 2018, and the mandatory TEAM model brings episode payment to hundreds of hospitals beginning January 2026. EIA extends the same episode unit to behavioral health, where no episode model exists.

**Fee-schedule-anchored rates - operating today:** The episode base rate is constructed by RVU summation from the Medicare Physician Fee Schedule (Section 4.1 and Appendix B) - standard actuarial practice. Every rate is auditable against the fee schedule rather than newly invented.

**Outcome holdbacks - operating today:** Quality withholds are routine Medicare and Medicaid machinery: state Medicaid managed-care quality withholds, quality-gated shared savings in MSSP, and Star Ratings bonus payments in Medicare Advantage. EIA's 12 percent holdback releases at episode close against pre-published, instrument-based measures (PHQ-9 response and remission) rather than plan-level composites - narrower and more transparent than the withholds already in operation.

**Payment tied to measurement-based care - operating today:** Medicare already conditions behavioral-health payment on measurement-based care in the psychiatric Collaborative Care Model codes, which require a registry and validated rating scales as a condition of billing. EIA applies the same instruments at episode scale.

**Reduced per-service adjudication - operating today:** Medicare pays without per-service adjudication wherever capitation operates (Medicare Advantage, PACE). EIA is deliberately narrower: adjudication-free payment applies only inside a clinically authorized episode pathway, with the authorization itself serving as the control that capitation lacks.

**Prospective clinical review - operating today:** Pre-service coverage determination is what prior authorization already does across Medicare Advantage and, since January 2026, in the WISeR Model. EIA keeps the determination but makes it transparent, episode-level, and binding - eliminating the duplicate downstream adjudication of a decision that has already been made.

**Outcome-tied behavioral-health payment - operating today:** As of July 5, 2026, the CMS Innovation Center ACCESS Model pays Medicare fee-for-service providers on measured behavioral-health outcomes tracked by the PHQ-9 and GAD-7 - the same instruments this model uses at episode close. EIA is complementary to ACCESS, not duplicative of it: ACCESS pays for chronic-care outcomes; EIA supplies the episode-level authorization and payment-integrity infrastructure that outcome-based models depend on but do not themselves provide.

The current industry direction strengthens rather than strains this design: WISeR (2026-2031) commits Medicare to prospective-review technology; the 2026 insurer commitments and the Improving Seniors' Timely Access to Care Act, past 290 House cosponsors as of June 2026 (the Consensus Calendar threshold), commit the industry to faster, disclosed authorization decisions; and the Rural Health Transformation Program and IBH Model commit public funds to care-delivery redesign. This methodology is the payment expression of directions Medicare has already chosen - assembled so that behavioral health finally benefits from them.

### 4.7 Program Integrity: The Instrument Question

The Committee should ask, and this proposal answers directly: the clinician being paid on a PHQ-9 outcome is the same clinician administering the PHQ-9. Three structural controls address this. First, every instrument administration in the model is a timestamped, structured data event on the episode record, not a number typed into a claim: score history, administration dates, and the identity of the administering user are all inspectable, and implausible trajectories (uniform maximal improvement at exactly the holdback threshold, scores clustered at cutoffs) are detectable in the aggregate data CMS already receives. Second, episode initiation requires the same instrument plus guideline criteria evaluated before authorization, so the entry gate and the exit measure discipline each other: a population initiated at inflated severity produces baseline distributions that diverge visibly from epidemiologic norms. Third, the model's evaluation design (Section 6.2) includes independent re-measurement in a sampled subset, and the audit-and-provenance record makes clawback straightforward where fabrication is found. The model does not assume clinicians are honest; it makes dishonesty measurable, which is more than per-service review accomplishes today.

## Section 5: Effects on Beneficiaries

### 5.1 Patient Choice

The model does not restrict beneficiary choice of provider. Medicare beneficiaries retain the right to see any Medicare-participating clinician regardless of model participation. The model applies only to clinicians who elect to participate and to beneficiaries who choose to receive care from a participating practice.

### 5.2 Access to Care

The model directly improves access to behavioral health care by eliminating the authorization delays that currently delay initiation of treatment. The AMA's 2025 survey found that 95 percent of physicians report prior authorization causes delays in necessary care and 79 percent report treatment abandonment. For a Medicare beneficiary with moderate to severe depression, treatment delay is not an administrative inconvenience. Mental health conditions are the leading cause of pregnancy-related death in the United States (CDC, 2024) and a leading driver of functional disability among Medicare beneficiaries. Eliminating the authorization delay eliminates the most common reason treatment episodes begin late or not at all.

### 5.3 Quality and Safety

The fidelity multiplier and outcome holdback create financial incentives for guideline adherence that do not currently exist in fee-for-service payment. A clinician paid for delivering services regardless of whether they follow APA guidelines has no payment-linked incentive for guideline adherence. Under EIA, guideline adherence generates the holdback release and the favorable fidelity multiplier. Deviation from guidelines reduces the multiplier, and persistent deviation triggers clinical re-tiering rather than denial.

### 5.4 Care Coordination

The episode framework requires care coordination as a structural element. The MDD episode pathway includes coordination between the prescribing clinician, the psychotherapist, and the primary care clinician as defined services within the episode. Care coordination is not billed separately under a complex add-on code. It is embedded in the episode authorization and paid as part of the episode base rate.

## Section 6: Expected Savings and Evaluability

### 6.1 Expected Medicare Program Savings

Expected savings derive from four sources.

First, administrative cost reduction. The CAQH 2025 Index found that prior authorization transactions represent a more than $20 billion annual automation opportunity across the healthcare system. A single episode-based authorization replacing an average of 15 to 20 per-service authorizations for a 16-week MDD treatment episode reduces per-episode administrative cost by an estimated 85 to 90 percent on the authorization side. Claims adjudication elimination for in-pathway services produces comparable savings on the back end.

Second, treatment completion rates. The OIG found in 2022 that Medicare Advantage plans denied 13 percent of prior authorization requests that met Medicare coverage rules, and 75 percent of those denials were overturned on appeal (OIG Report OEI-09-19-00260). Denials generate appeals, re-submissions, peer-to-peer reviews, and treatment interruptions. Each interruption in a behavioral health episode increases the probability of relapse, hospitalization, and higher-cost downstream utilization. Eliminating authorization-driven treatment interruptions reduces preventable inpatient psychiatric admissions and emergency department utilization.

Third, guideline-fidelity incentives. The fidelity multiplier incentivizes APA-guideline-adherent care. Guideline-adherent MDD treatment has documented associations with lower rates of treatment resistance, reduced need for higher-intensity services, and improved functional outcomes that reduce long-term Medicare utilization.

Fourth, payer administrative and compliance cost reduction. Every denial that is later overturned on appeal, as documented in OIG Report OEI-09-19-00260, represents duplicated payer cost: the original denial review, the appeal intake, the peer-to-peer review, and the reversal. EIA's prospective, guideline-anchored authorization eliminates that cycle at its source, reducing payer spend on manual review and appeals infrastructure while generating, as a structural byproduct, the MHPAEA parity documentation that federal regulators have found no payer currently produces sufficiently. Participating payers gain lower operating cost and reduced regulatory exposure in the same event.

### 6.2 Evaluation Design

The model is designed for rigorous evaluation from the outset. FHIR clinical data captured passively during episode delivery provides the fidelity measurement infrastructure without

additional data collection burden. Episode-level cost and utilization data, generated as a byproduct of the authorization records, supports the PMPM analyses required for CMS Innovation model evaluations and for SMD 26-003 actuarial certification requirements.

Proposed evaluation metrics include: episode completion rate, holdback release rate, fidelity multiplier distribution, 30-day psychiatric readmission rate, 90-day PHQ-9 score change, per-episode administrative cost versus pre-model baseline, and net Medicare expenditure per completed episode versus matched comparison group. CMS CMMI evaluation infrastructure is anticipated to support formal model evaluation upon PTAC recommendation and Secretary approval.

# Section 7: Implementation Strategy and Timeline

## 7.1 Submitter Qualifications

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) and simultaneously registered with the US Copyright Office (Case 1-15181678151).

## 7.2 Partnership Structure

The Georgia Alliance of Community Hospitals, representing more than 90 hospitals, has provided a signed letter of support (Appendix D) and anchors provider recruitment in the initial state. Recruitment proceeds through Georgia psychiatric and psychiatric-APRN professional networks, alongside clinical technology platform partners. A parallel engagement with the CMS Innovation in Behavioral Health Model is underway for Cohort 2 application alignment.

Recruitment targets psychiatry and psychiatric APRN practices in Georgia as the initial state, expanding to IBH Cohort 2 award states following the September 2026 awards. Letters of support received after submission will be forwarded to the Committee as supplements throughout the review period.

## 7.3 Timeline

# Section 8: Responses to the Secretary's 10 PTAC Criteria

The following section addresses each of the 10 regulatory criteria for physician-focused payment models established by the Secretary at 42 CFR 414.1465.

### Criterion 1: Scope

The EIA Compensation Model directly addresses a structural gap in the CMS APM portfolio: no existing physician-focused payment model fuses authorization and payment into a single episode-level event for behavioral health. The model broadens the APM portfolio by creating a

new episode architecture applicable to any behavioral health condition with a defined society-guideline care pathway.

The model includes APM Entities, specifically participating group practices and solo practitioners, whose current opportunities in existing APMs do not address the per-service authorization burden that is unique to behavioral health practice. Existing episode payment models (such as oncology care and joint replacement bundles) do not include behavioral health conditions. The EIA model fills this gap.

The model also aligns with CMS Innovation in Behavioral Health Model requirements, the AHEAD total cost of care framework for participating states, and the SMD 26-003 actuarial certification requirements for Section 1115 demonstrations. It is designed to extend across Medicare, Medicaid, and commercial payers without modification. Section 1.4 addresses the scope relationship with the CMS ACCESS Model: complementary layers, with no duplication of payment.

### Criterion 2: Quality and Cost

Quality improvement is achieved through three mechanisms. First, guideline-fidelity incentives: the fidelity multiplier ties payment directly to APA-defined care pathway adherence, creating a financial incentive for evidence-based practice that does not exist in current fee-for-service payment. Second, treatment completion: eliminating authorization-driven treatment interruptions increases episode completion rates and reduces relapse-driven rehospitalization. Third, outcome measurement: the holdback release is conditioned on documented achievement of APA guideline outcome definitions, embedding outcome accountability into the payment event.

Cost reduction is achieved through: (1) elimination of 85 to 90 percent of per-service authorization transactions for a standard MDD episode, (2) elimination of claims adjudication for in-pathway services, (3) reduction in authorization-driven treatment abandonment and the higher-cost downstream utilization it generates, and (4) reduction in appeals, peer-to-peer reviews, and administrative overhead currently financed by both payers and clinicians. The CAQH 2025 Index documents more than $20 billion in annual prior authorization administrative costs across the healthcare system. Behavioral health disproportionately carries this burden. Participating payers benefit directly as well: reduced manual review volume, reduced appeals and peer-to-peer overhead, and a documented parity compliance record that lowers regulatory and litigation exposure under MHPAEA.

### Criterion 3: Payment Methodology

The payment methodology is described in detail in Section 4. The model uses a prospective episode base rate constructed on an RVU basis, with an 88 percent prospective payment and a 12 percent outcome holdback released at episode close. A fidelity multiplier of 0.90 to 1.10 adjusts the holdback based on pathway adherence.

The methodology is sufficiently developed for PTAC evaluation. Base rate construction methodology using RVU summation of APA-pathway services is standard actuarial practice. The fidelity multiplier corridor creates more than nominal financial risk. The outcome holdback is

conditioned on clinically meaningful, guideline-defined outcome definitions, not on administrative metrics.

The entity receiving Medicare payment is the participating group practice or solo practitioner as the APM Entity. Funds are distributed to individual clinicians delivering in-pathway services according to practice-level compensation arrangements.

### Criterion 4: Value over Volume

The EIA model fundamentally restructures the volume incentive in behavioral health payment. Under fee-for-service, a clinician is paid for each service delivered, creating a volume incentive independent of outcome. Under EIA, the clinician is paid for episode authorization and episode outcome achievement. Services delivered within the episode carry no additional payment. The incentive shifts from service volume to episode completion and outcome quality.

The fidelity multiplier specifically rewards pathway adherence, meaning the clinician is rewarded for delivering the right services in the right sequence, not for maximizing service count. The holdback structure creates a direct financial stake in patient outcomes that does not exist in current fee-for-service behavioral health payment.

### Criterion 5: Flexibility

The model accommodates practice variation through the episode re-tiering mechanism. Patients who present with greater clinical complexity are re-tiered to a higher-complexity episode with a new base rate, rather than being excluded from the model or subjected to per-service denials. This creates flexibility for clinicians treating heterogeneous patient populations without creating incentives to avoid high-complexity patients.

Small practices and solo practitioners are specifically included as eligible participants. The FHIR-based infrastructure required to participate is already mandated under CMS-0057-F for practices billing Medicare Advantage or Medicaid managed care. No incremental technology investment is required for compliant practices. The model is designed for practices at every scale.

### Criterion 6: Ability to Be Evaluated

The model generates its own evaluation data infrastructure as a byproduct of operation. FHIR episode authorization records contain the episode type, tier, pathway, duration, and outcome documentation for every episode. This data is captured passively from existing clinical workflows and requires no additional reporting burden.

Evaluation metrics are clearly defined (see Section 6.2) and are measurable using existing Medicare claims data combined with FHIR episode records. A matched comparison group of Medicare beneficiaries with MDD treated outside the model provides the counterfactual for net savings and quality comparisons. The model is evaluable under standard CMMI rapid-cycle evaluation methods.

### Criterion 7: Integration and Care Coordination

Care coordination is embedded in the episode pathway, not billed separately. The APA-defined MDD episode pathway includes specific care coordination services between the prescribing clinician, the psychotherapist, and the primary care clinician as defined in-pathway services. These services are authorized and paid as part of the episode base rate.

The model aligns with the CMS Innovation in Behavioral Health Model, which positions behavioral health practices as the integration point for physical and behavioral care. EIA episode pathways are designed to work within IBH Model infrastructure. The model also integrates with primary care collaborative care arrangements through the pathway definition for complex episodes.

### Criterion 8: Patient Choice

Beneficiaries retain full freedom of choice of provider and full access to all Medicare-covered services. Model participation is voluntary for both clinicians and beneficiaries. A beneficiary who prefers care from a non-participating clinician retains all existing Medicare coverage without modification. A beneficiary who chooses a participating clinician receives the same clinical care under the same society guidelines, with the administrative burden of authorization and claims adjudication removed from the care process.

### Criterion 9: Patient Safety

The model enhances patient safety by eliminating authorization-driven treatment delays and interruptions that currently cause adverse events. The AMA's 2025 survey documented that 26 percent of physicians report prior authorization caused a serious adverse event for a patient. For behavioral health, where treatment continuity is directly linked to suicide risk, the authorization delay is not a minor inconvenience. It is a safety event.

The re-tiering mechanism further enhances safety by ensuring that patients whose clinical course deteriorates receive a higher-complexity episode authorization, rather than denial of continued care. Clinical deterioration triggers a more intensive episode with a higher base rate, not an authorization barrier.

The fidelity multiplier creates financial incentives for guideline-adherent care, which is by definition the care that clinical evidence supports as safe and effective. Guideline adherence is not enforced retrospectively through denials. It is incentivized prospectively through the payment formula.

### Criterion 10: Health Information Technology

The model is built entirely on the FHIR Prior Authorization API infrastructure already mandated under CMS-0057-F (2024) and extended under CMS-0062-P (Docket CMS-2026-1255, 2026). Certified EHR technology use is inherent to the design. The episode authorization request is a standard FHIR transaction. The pathway adherence fidelity measurement is captured passively from existing FHIR clinical data. No proprietary technology platform is required.

The EIA framework, filed with CMS on June 9, 2026, under Docket CMS-2026-1255 and registered with the US Copyright Office under Case 1-15181678151, is an open standard. Any EHR vendor, any clinical technology platform, and any payer operating FHIR infrastructure can

implement EIA episode definitions without licensing fees or proprietary access. This open architecture ensures that the model can scale across the Medicare program without technology access barriers.

# Appendix A: EIA Episode Definition: Major Depressive Disorder

This appendix provides the complete episode definition for the initial episode type, following the five-part structure in Section 2.2.

### A.1 Triggering Diagnosis and Severity Threshold

The episode is triggered by a clinician-documented diagnosis of major depressive disorder, moderate to severe: ICD-10-CM F32.1 or F32.2 (single episode, moderate or severe without psychotic features) or F33.1 or F33.2 (recurrent, moderate or severe without psychotic features), confirmed against DSM-5-TR criteria. The severity threshold is a PHQ-9 score of 10 or greater at baseline, documented in the record. Presentations outside this definition route to different pathways rather than being denied: MDD with psychotic features (F32.3/F33.3), bipolar spectrum diagnoses, and active suicidality requiring a higher level of care trigger referral to the appropriate level-of-care pathway under Module 5 rather than entry into this episode.

### A.2 Authorized Care Pathway

The pathway is drawn from the APA Practice Guideline for the Treatment of Patients with Major Depressive Disorder and expressed as a FHIR R4 PlanDefinition with CQL logic. In-pathway services - none of which require claim-by-claim adjudication once the episode is authorized (Section 4.3) - are: initial psychiatric diagnostic evaluation; pharmacotherapy initiation and titration following the guideline's sequencing logic, with medication management visits; evidence-based psychotherapy (cognitive behavioral therapy, interpersonal psychotherapy, or behavioral activation) delivered individually or in groups; measurement-based care, with the PHQ-9 administered at baseline and at each clinical contact; and care coordination with the beneficiary's primary care clinician. The step logic of the guideline is transparent to the treating clinician before any service is delivered, including where the patient sits in the antidepressant sequencing rules.

### A.3 Episode Duration

The initial authorization covers 16 weeks, corresponding to the acute treatment phase. Re-authorization for continuation-phase care (up to an additional six months) is available on documented clinical response, without re-initiating the full authorization process; the episode record carries forward under Module 5.

### A.4 Re-Tiering Criteria

The episode re-tiers - rather than terminating or requiring a new authorization fight - when the clinical course changes. Escalation triggers include: less than 50 percent PHQ-9 improvement by week 8 despite documented adherence; emergence of psychotic features or safety concerns requiring a higher level of care; and treatment resistance, defined as two adequate antidepressant trials without response, which routes the patient to the treatment-resistant

depression tier where augmentation strategies within the guideline become in-pathway. De-escalation to a maintenance tier occurs on sustained remission. All tier changes are recorded as episode events with the triggering data attached, preserving the audit chain.

### A.5 Episode-Close Outcome Definitions

At episode close, the holdback described in Appendix B is measured against: clinical response (50 percent or greater reduction in PHQ-9 from baseline) or remission (PHQ-9 below 5); measurement fidelity (PHQ-9 completion at the required cadence); engagement (proportion of scheduled visits attended); and safety (absence of unmanaged deterioration events). These are the same outcome definitions the beneficiary sees in plain language under Module 7, so the patient, the clinician, and the payer close the episode against one shared record.

## Appendix B: Payment Architecture Detail

The episode base rate for a Tier 1 MDD episode is constructed by summing the Medicare Physician Fee Schedule RVUs for: (1) one comprehensive psychiatric evaluation (CPT 90792), (2) four medication management visits at 30 minutes (CPT 90833 plus E/M), (3) eight weekly and four biweekly psychotherapy sessions (CPT 90837), and (4) four PHQ-9 monitoring encounters (CPT 99213 with G8431). The total RVU sum is multiplied by the current Medicare conversion factor to produce the episode base rate in dollars. The actuarial model in Appendix F applies the final CY 2026 conversion factors ($33.5675 qualifying APM; $33.4009 nonqualifying, per the final rule issued October 31, 2025) and produces a base-case episode rate of $2,965.69; the example below uses $2,966.

The 12 percent holdback is withheld from the prospective payment and released at episode close. The fidelity multiplier is applied to the holdback amount only, creating a risk corridor of plus or minus 10 percent of the holdback (approximately 1.2 percent of the total episode base rate) based on pathway adherence. This structure produces meaningful but proportionate financial risk for participating clinicians.

Example: A Tier 1 MDD episode with a base rate of $2,966 results in a prospective payment of $2,610 (88 percent) at episode authorization. At episode close with documented 50 percent PHQ-9 reduction and full fidelity, the $356 holdback (12 percent) is released with a 1.10 fidelity multiplier, yielding a total holdback release of $392. Total episode payment: $3,002. If fidelity criteria are partially met, the multiplier may be 1.00, yielding total payment of $2,966. If fidelity criteria are substantially not met, the multiplier may be 0.90, yielding total payment of $2,930, which is 98.8 percent of the full episode rate. For comparison, the same episode under current fee-for-service: approximately twenty claims submitted across ninety days, payment on each arriving thirty to ninety days after the service, every claim individually exposed to denial and rework, and per-episode administrative friction that the actuarial model in Appendix F prices at roughly $126 to $229 across the provider and payer systems. Under this model: one authorization, one prospective payment of $2,610 on day one, one outcome-based release at close, and zero in-pathway claims.

# Appendix C: Regulatory and Filing Record

### C.1 U.S. Copyright Office Registrations (seven cases)

Case 1-15181678151 - filed June 9, 2026. EIA Three-Layer Clinical Governance Framework: the Module 1 clinical appropriateness gate anchored in APA, ASAM, and ASCO open society guidelines, expressed as FHIR R4 PlanDefinitions with CQL logic.

Case 1-15182783101 - filed June 11, 2026. EIA Compensation Model and two other unpublished works: the episode-based payment model fusing prior authorization and payment into a single episode-level event - the model proposed here.

Case 1-15185778731 - filed June 15, 2026. CPIG, Module 2 full product specification and CQL logic: Medicare Secondary Payer payer-order validation using 42 CFR Part 411 precondition logic.

Case 1-15187387921 - filed June 17, 2026. Module 3: Behavioral Health EHB Compliance and Outcomes Layer: MHPAEA NQTL comparative-analysis documentation generated as a structural byproduct of every behavioral health prior authorization.

Case 1-15190064221 - filed June 22, 2026. Group registration, eight works: Module 1 BH/SUD edition; Modules 4-7 complete specifications; the complete seven-module technical architecture (FHIR R4 stack, CARC-to-module routing); peer-reviewed evidence edition; competitive distinctiveness matrix.

Case 1-15195520221 - filed June 29, 2026. EIA: The Complete Compendium - consolidated registration of the full EIA body of work in one volume.

Case 1-15198948341 - filed July 2, 2026. EIA Interactive Prototype Demonstration v0.1: the working interactive demonstration of the full seven-module pipeline, with scripted scenarios, synthetic patients, module-level decision records, and the complete audit-and-provenance chain. Registered prior to any external demonstration.

### C.2 Federal Filings and Engagement

**USPTO:** U.S. Provisional Patent Application No. 64/107,509, filed July 8, 2026; sole inventor Joanne Bayouk; small entity; non-provisional (utility) conversion due by July 8, 2027.

CMS Docket CMS-2026-1255 (CMS-0062-P): The EIA framework standard was filed as a public comment on June 9, 2026, placing the framework in the federal record on the proposed rule that extends FHIR prior authorization API requirements.

PTAC Letter of Intent: submitted June 11, 2026; confirmed by PTAC on June 12, 2026.

CMS-1850-P (CY 2027 OPPS/ASC proposed rule): public comment submitted addressing the HOPD Prior Authorization Program expansion (docket CMS-2026-2344); comment period closes August 31, 2026.

# Appendix D: Letters of Support

Letters of support are provided by organizations that recognize the behavioral-health prior-authorization burden this model addresses and support its evaluation as a physician-focused payment model. A letter of support does not constitute a financial commitment, a contract, or an obligation to participate. Signed letters on organizational letterhead are appended below.

## D.1 Georgia Alliance of Community Hospitals (GACH)

The Georgia Alliance of Community Hospitals, a not-for-profit association representing more than 90 Georgia hospitals and health systems, executed its letter of support on July 9, 2026, on Alliance letterhead and signed by its President. The signed letter is bound into this submission package immediately following this page.

*Additional letters of support will be appended as they are received during the submission window (July 12 to August 10, 2026).*

# 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

# Appendix E: Alignment with the CMS Optimizing Care Delivery Framework (2025)

In July 2025 CMS published Optimizing Care Delivery: A Framework for Improving the Health Care Experience, its five-year strategy to reduce administrative burden and return time to clinicians, organized around seven priorities. Episode Intelligence Authorization advances all seven, on the exact interoperability standards CMS names. The mapping below demonstrates that this model operationalizes CMS's own published strategy.

**Priority 1 (Integrate the voice of the patient and caregiver):** Module 7 writes a plain-language, patient-readable explanation on every authorization, and open, published criteria let patients and caregivers see the basis for a decision rather than a closed rule set.

**Priority 2 (Improve patient safety and reduce burden in care transitions):** Module 5 maintains a persistent episode record so vital information follows the patient across settings, the future state CMS describes, and prevents the step-down denials and continuity gaps that drive readmissions. It uses the same FHIR transitions approach as CMS's PACIO Project.

**Priority 3 (Address well-being and experience for health care workers):** EIA returns clinician hours by removing the guessing, rework, and appeals that opacity creates, and open criteria end the second-guessing of clinical judgment that drives moral injury and attrition.

**Priority 4 (Improve care approval processes to reduce delays):** EIA's core function. Prospective, transparent, episode-level authorization delivers the instantaneous response to prior-authorization requests CMS envisions, with specific denial reasons (Module 4) and public reporting (Module 7) as required by the Interoperability and Prior Authorization Final Rule (CMS-0057-F).

**Priority 5 (Reduce redundant data collection, documentation, and reporting):** EIA generates the clinical record, the MHPAEA parity record, and the CMS and state reporting once, as a structural byproduct of a single authorization, eliminating duplicate documentation and after-the-fact reporting.

**Priority 6 (Leverage technology to accelerate innovation):** EIA is built natively on HL7 FHIR R4, the Da Vinci implementation guides (CRD, DTR, PAS, CDex, PDex), CDS Hooks, and the CMS-0057-F Prior Authorization API, the precise standards CMS names as the path forward.

**Priority 7 (Convene and support public-private partnerships):** EIA is an open, unconflicted standard any payer or EHR can adopt, advanced through the PTAC process and aligned partners, exactly the public-private collaboration CMS says is essential.

*Source: CMS, Optimizing Care Delivery: A Framework for Improving the Health Care Experience, July 2025.*

# Appendix F: Actuarial and ROI Model

The compensation model actuarial and return-on-investment analysis is bound into this submission package as its final exhibit, consistent with PTAC's instruction that appendices may be submitted in PDF format. It details the episode base-rate construction, holdback mechanics,

per-episode economics, and projected Medicare program savings under conservative, base, and favorable adoption scenarios.

For questions about this proposal, contact: Joanne Bayouk, MBA, MSN, RN, PMHNP-c | joannebayouk@gmail.com | 847-373-4956

# Assumptions

Shaded (blue) = input. Scenario columns: Low / Base / High. Sources noted alongside each assumption.

| Assumption | Low | Base | High | Source / note |
|---|---|---|---|---|
| Plan membership (lives) | 1,000,000 | 1,000,000 | 1,000,000 | *Modeling population; scale as needed* |
| Annual episode initiation rate (eligible moderate MDD in active treatment) | 1.5% | 2.5% | 3.5% | *Assumption: treated MDD prevalence in commercial population approx. 5%; moderate severity subset in active treatment. Verify against plan claims.* |
| Year 1 phase-in (% of eligible episodes enrolled) | 10.0% | 20.0% | 35.0% | *Assumption: pilot ramp* |
| Conversion factor ($/RVU, CY2026 qualifying APM track) | 33.5675 | 33.5675 | 33.5675 | *VERIFIED: CY2026 MPFS Final Rule (released 10/31/2025): QP CF $33.5675; non-QP CF $33.4009.* |
| Electronic PA adoption (industry blend) | 40.0% | 40.0% | 40.0% | *Source: 2025 CAQH Index (Feb 2026): 40% fully electronic medical PA* |
| Provider cost per manual PA ($) | 10.97 | 10.97 | 10.97 | *Source: CAQH Index per-transaction benchmark* |
| Provider cost per electronic PA ($) | 5.79 | 5.79 | 5.79 | *Source: CAQH Index per-transaction benchmark* |
| Payer cost per manual PA ($) | 3.52 | 3.52 | 3.52 | *Source: CAQH Index per-transaction benchmark* |
| Payer cost per electronic PA ($) | 0.05 | 0.05 | 0.05 | *Source: CAQH Index per-transaction benchmark* |
| PA cycles avoided per episode (net of the single EIA authorization) | 2 | 3 | 4 | *Assumption: BH episodes require initial auth plus renewals/re-auths under current practice; EIA requires one* |
| Service claims avoided per episode (replaced by prospective payment) | 18 | 22 | 25 | *Derived from pathway service mix (Episode Pricing section); line-item claims replaced by 2 payment events* |
| Provider cost per claim submitted ($) | 2 | 3 | 4 | *Assumption: provider billing/submission/rework cost per claim* |
| Payer cost per claim adjudicated ($) | 1 | 1.5 | 2 | *Assumption: payer adjudication cost per professional claim* |
| Current claim denial rate on BH professional claims | 8.0% | 10.0% | 12.0% | *Assumption: industry-reported BH denial range; verify against plan data* |
| Provider cost per denial worked/appealed ($) | 35.00 | 44.00 | 60.00 | *Assumption: published per-claim rework estimates; flag for verification* |
| Treatment abandonment reduction under EIA (percentage points) | 2.0% | 5.0% | 8.0% | *Assumption: AMA 2026 survey: 79% of physicians report PA-driven abandonment; EIA removes mid-episode auth friction. Largest model uncertainty.* |
| Downstream 12-month incremental cost of an abandoned episode ($) | 1500 | 2400 | 3500 | *Assumption: incremental medical spend of inadequately treated MDD (ED use, IP risk, comorbidity drag). Literature-informed; conservative.* |
| Expected average fidelity multiplier (F) across panel | 1.02 | 1.02 | 1.03 | *Model design: modest net bonus expectation* |
| Expected average outcome score (O) across panel | 75.0% | 80.0% | 85.0% | *Model design: PHQ-9 response rates under measurement-based care* |
| Platform / governed AI cost per episode ($) | 20 | 15 | 12 | *Assumption: technology cost at scale* |
| Implementation cost amortized per episode, year 1 ($) | 12 | 8 | 6 | *Assumption: build cost spread over year 1 episode volume* |

# Episode Base Rate (B): Bottom-Up RVU Construction

90-day moderate MDD outpatient episode, APA measurement-based care pathway. RVUs are non-facility totals: VERIFY against current MPFS RVU file.

| CPT/HCPCS | Pathway component | Total RVU (non-facility) | Quantity | Allowed per unit | Line total ($) |
|---|---|---|---|---|---|
| 90792 | Psychiatric diagnostic evaluation with medical services | 6.05 | 1 | $203.08 | $203.08 |
| 90837 | Psychotherapy, 60 minutes | 5.00 | 12 | $167.84 | $2,014.05 |
| 99214 | E/M established patient, medication management | 4.06 | 4 | $136.28 | $545.14 |
| 96127 | Brief emotional/behavioral assessment (PHQ-9 cycle) | 0.15 | 6 | $5.04 | $30.21 |
| 99484 | General behavioral health integration care management | 1.72 | 3 | $57.74 | $173.21 |
| | **Episode base rate (B)** | | | | **$2,965.69** |
| | **Claims that would be adjudicated under FFS (sum of quantities)** | | | | **26** |

*Note: B is RVU-priced at launch for adoptability. Over time, episode rates can migrate to guideline-weighted episode intensity weights, as DRG weights decoupled from itemized charges. Teams may allocate internally by wRVU.*

# Per-Episode Economics (payer + provider system view)

Scenario columns: Low / Base / High. All values per episode.

| Component | Low | Base | High |
|---|---|---|---|
| Blended provider cost per PA | $8.90 | $8.90 | $8.90 |
| Blended payer cost per PA | $2.13 | $2.13 | $2.13 |
| PA savings per episode (provider + payer) | $22.06 | $33.09 | $44.12 |
| Claims processing savings per episode | $54.00 | $99.00 | $150.00 |
| Denial/appeal rework avoided per episode | $50.40 | $96.80 | $180.00 |
| **Subtotal: administrative savings per episode** | **$126.46** | **$228.89** | **$374.12** |
| Medical impact: abandonment reduction value per episode | $30.00 | $120.00 | $280.00 |
| **Total gross value per episode** | **$156.46** | **$348.89** | **$654.12** |
| Program cost: expected fidelity bonus over base | $59.31 | $59.31 | $88.97 |
| Program cost: platform / governed AI | $20.00 | $15.00 | $12.00 |
| Program cost: implementation (year 1 amortized) | $12.00 | $8.00 | $6.00 |
| **Subtotal: program cost per episode** | **$91.31** | **$82.31** | **$106.97** |
| **Net value per episode** | **$65.15** | **$266.58** | **$547.15** |
| **Per-episode ROI (gross value / program cost)** | **1.7x** | **4.2x** | **6.1x** |

*Holdback note: the 12% outcome holdback is payment timing, not plan savings; unearned holdback (1-O) x 12% x B accrues to the bonus pool / reinvestment, shown for completeness below.*

| | | | |
|---|---|---|---|
| Unearned holdback retained per episode (memo) | $88.97 | $71.18 | $53.38 |

# Plan-Level ROI: 1M-Member Plan, Year 1, Single Episode Type (Moderate MDD)

Scenario columns: Low / Base / High.

| Line | Low | Base | High |
|---|---|---|---|
| Episodes initiated (membership x initiation rate x phase-in) | 1,500 | 5,000 | 12,250 |
| Episode base rate (B), RVU-constructed | $2,965.69 | $2,965.69 | $2,965.69 |
| Gross value per episode | $156.46 | $348.89 | $654.12 |
| Program cost per episode | $91.31 | $82.31 | $106.97 |
| Net value per episode | $65.15 | $266.58 | $547.15 |
| Annual gross value (plan level) | $234,690 | $1,744,450 | $8,012,970 |
| Annual program cost (plan level) | $136,971 | $411,569 | $1,310,391 |
| **Annual net value (plan level)** | **$97,719** | **$1,332,881** | **$6,702,579** |
| **ROI multiple** | **1.7x** | **4.2x** | **6.1x** |
| PMPM impact (net value / member months) | $0.0081 | $0.1111 | $0.5585 |
| Administrative-only PMPM (excludes medical impact) | $0.0158 | $0.0954 | $0.3819 |
| Provider system: staff hours returned (24 min x PA avoided x episodes) | 1,200 | 6,000 | 19,600 |
| Provider system: day-zero prospective cash committed (88% x B x episodes) | $3,914,709 | $13,049,030 | $31,970,123 |

*Scaling logic: this section prices one episode type at year 1 phase-in. The architecture is condition-agnostic: each added episode type (SUD/ASAM, oncology/ASCO, MSK/AAOS) reuses the same machinery with its own episode pricing. At 15 to 20 episode types and full phase-in, single-condition PMPM figures compound into whole-plan administrative transformation, which is the $21B industry opportunity documented in the 2025 CAQH Index.*

**The clinical and financial story in one line: administrative savings alone carry the ROI above 1.0x in every scenario; every dollar of medical impact from patients who stay in treatment is pure upside. Care forward, cost backward.**