

CORRECTION TO THE RECORD

Episode Intelligence Authorization and Payment (EIA) Compensation Model

Date

September 4, 2026

Submitted To

Designated Federal Officer
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
Submitted by email to PTAC@HHS.gov

Re: Correction to Section 1.2 of the EIA proposal, in response to the letter from MCG Health dated September 2, 2026

Dear Designated Federal Officer,

MCG Health has written to the Committee objecting to statements about its products at page 6, Section 1.2 of my proposal. I have reviewed their letter. The passage was written in absolute terms that the record does not support, and I withdraw it. It rested on publicly available information and my professional understanding at the time of filing, and I am correcting it promptly on receiving better information. I am writing to correct the record rather than to defend the passage, and I ask that this correction be entered in the record alongside MCG's letter, so that any reader of that letter sees the correction with it.

WHAT I WROTE

Section 1.2 of the proposal states that prior authorization criteria in widest current use, naming MCG Health and InterQual, were built for a pre-FHIR era, have no open citation trail, produce no FHIR-native output, and cannot be independently audited against clinical evidence.

WHAT IS WITHDRAWN

The passage is written in categorical terms, for example "no" and "cannot," that the record does not support, and each of those absolutes is withdrawn.

On FHIR output. The statement that these criteria produce "no FHIR-native output" is too absolute and is withdrawn. MCG has been a Principal Member of the HL7 Da Vinci Project since 2019 and contributed to the implementation guides that the CMS Interoperability and Prior Authorization Final Rule, CMS-0057-F (89 FR 8758), identifies as recommended implementation guidance for the Prior Authorization API it requires. That participation is verifiable in HL7's published project records, and MCG states that it has developed FHIR-enabled capabilities.

On the citation trail and independent auditability. The statements that these criteria have "no open citation trail" and "cannot be independently audited against clinical evidence" are not supported as written, because they omit the qualifier that does the actual work in my argument. MCG's letter states that "[l]icensed users receive complete evidence citations, rationales, versioning, and transparency information," and that MCG offers "our health plan clients a solution, MCG Transparency, which can be used to show the guideline content used to support decision rationale to both providers and patients." I accept those statements. The distinction I was reaching for concerns who holds the license and who elects to deploy the transparency capability, not whether citations, rationales or versioning exist. My original phrasing did not make that distinction, and it is withdrawn. The corrected statement below makes it.

On the "pre-FHIR era" characterization. That characterization was unnecessary to the point I was making and is withdrawn with the rest of the passage.

On coverage determinations. MCG further notes, correctly, that its products do not approve, deny, authorize or adjudicate. Those determinations rest with the payer or other licensing entity. To the extent my proposal read as attributing coverage determinations to a criteria vendor, I accept MCG's clarification. Nothing in the model depends on such an attribution.

On licensing and transparency. MCG also observes that the passage conflates proprietary licensing with a lack of transparency or auditability. That criticism is fair. Content that is licensed rather than published is not thereby unciteable or unauditale, and the passage is withdrawn on that point as well.

On InterQual. Section 1.2 named InterQual alongside MCG Health. I have not independently verified InterQual's current capabilities, and I make no representation about them. The characterization is withdrawn as to InterQual as well, and the corrected statement below is framed without reference to any particular vendor.

THE CORRECTED STATEMENT

The accurate version of the point I was making, and the version the Committee should substitute for the passage in Section 1.2, is this:

Prior authorization criteria in widest current use are proprietary and made available under license. In the prior authorization transaction, the entity that applies the criteria to a coverage determination is the payer or its delegate, and the criteria vendor does not make that determination. Whether a treating clinician can see the guideline content and decision rationale applied to a particular patient therefore depends on the payer's licensing and deployment elections, including whether it has elected to deploy an available transparency capability. The treating clinician's view of the standard applied to their own patient is the payer's election rather than the clinician's right. Clinical guidelines published by specialty societies, including the American Psychiatric Association, the American Society of Addiction Medicine and the Council of Autism Service Providers, are published to the clinical community and obtainable by the treating clinician directly, without dependence on a payer's licensing election, and their logic can be expressed as FHIR PlanDefinition resources with CQL. The model uses published specialty society guidelines for that reason.

WHAT DOES NOT CHANGE

No element of the proposed payment model changes as a result of this correction. The episode construct, the authorization event, the pricing methodology, the outcome-conditioned holdback, the instruments and the participant definition are all unaffected. The model's use of published specialty society guidelines was never premised on any deficiency in any commercial product; it was premised on those guidelines being obtainable by the treating clinician directly, without dependence on a payer's licensing election. I am therefore not requesting to withdraw and resubmit the proposal, and I do not believe this correction requires it. If the Committee reads it otherwise, I will follow whatever course the Committee prefers.

A NOTE OF THANKS

I am grateful to MCG for writing. A proposal about making clinical criteria auditable should be held to the standard it asks of others, and I would rather correct the record in September than carry the passage into December. I have no dispute with MCG. MCG's letter offers additional documentation, and I have accepted that offer directly; the specific items requested are listed in the annex to this letter, in the interest of a complete record. I authorize the Committee to post this correction to the public record alongside the proposal and alongside MCG's letter.

Respectfully,

Joanne Bayouk, MBA, MSN, RN

Submitter, Episode Intelligence Authorization and Payment Compensation Model

847-373-4956 | joannebayouk@gmail.com

ANNEX. DOCUMENTATION REQUESTED OF MCG HEALTH

MCG's letter offers to provide additional information regarding its care guidelines, HL7 FHIR capabilities, transparency solutions and decision-support functionality. I have asked MCG for the following, and will supplement the record with anything received:

1. Whether MCG guideline content is available to licensees as FHIR artifacts expressing the criteria logic itself, for example PlanDefinition with CQL, or whether FHIR conformance is at the transaction layer through the Da Vinci CRD, DTR and PAS implementation guides.
2. Whether MCG Transparency is included in a standard health plan license or licensed separately, and the extent of client deployment.
3. Whether, and on what terms, a party outside the license, such as a treating clinician, a researcher or a program integrity reviewer, can examine the linkage between a specific guideline recommendation and its cited evidence.

Copy to: Donna Baker-Miller, Vice President, Government Affairs, MCG Health.