Joanne Bayouk Proposal:

Episode Intelligence Authorization and Payment (EIA) Compensation Model

Public Comments

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public regarding the *Episode Intelligence Authorization and Payment (EIA) Compensation Model*. PTAC has received six responses from the following stakeholders:

1. Impact Family Wellness
2. Dr. Tyler Thurman
3. Anicia Cross-Robinson
4. Refuge Psychotherapy
5. Action for Progress Coalition (A4P)
6. MCG Health
    a. Joanne Bayouk, Correction to the Record

From: Monica McKitterick <Monica@impactfamilywellness.com>
Sent: Tuesday, August 11, 2026 5:43 PM
To: PTAC (OS/ASPE) <PTAC@hhs.gov>
Subject: Public Comment: Episode Intelligence Authorization and Payment (EIA) Model

Designated Federal Officer and Members of PTAC,

I am writing in support of the evaluation of the Episode Intelligence Authorization and Payment (EIA) Compensation Model submitted by Joanne Bayouk.

I am a Family Nurse Practitioner and the owner and CEO of Impact Family Wellness, a Direct Primary Care practice in Texas. One of the reasons we chose the DPC model was to remove unnecessary insurance interference and administrative burden from the relationship between the patient and provider.

Prior authorization is a prime example of that burden. What should be a clinical decision often becomes phone calls, portals, documentation requests, resubmissions, appeals, and hours of staff time. The true cost is not just financial. It is time taken away from caring for patients, along with delays in patients receiving the care their provider has already determined they need.

That is what I find compelling about the EIA model. Moving toward an evidence-based episode of care rather than repeatedly authorizing and adjudicating individual services has the potential to reduce unnecessary administrative work while maintaining clinical accountability.

My primary recommendation is that implementation remain simple for clinicians. Any model designed to reduce administrative burden must actually remove work from practices, not replace one set of administrative requirements with another. This is especially important for small and independent practices.

As a DPC practice owner, I have seen firsthand what happens when unnecessary administrative barriers are removed: providers have more time, patients have better access, and clinical decisions can focus on what the patient needs.

I believe this model deserves serious evaluation by PTAC.

Thank you for the opportunity to provide public comment.

Respectfully,



Monica McKitterick, APRN, FNP-C
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Learn more about me

Letter of Support

Episode Intelligence Authorization (EIA) Framework | Open for public comment at HHS PTAC through Tuesday, September 1, 2026

Date

August 18, 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
200 Independence Avenue SW, Washington, DC 20201 | Submitted by email to PTAC@HHS.gov

Re: Written statement on the Episode Intelligence Authorization and Payment (EIA) Compensation Model, open for public comment through September 1, 2026

Dear Designated Federal Officer,

I am a hospitalist physician licensed in North Carolina with 12 years in practice. I am writing in my personal capacity as an individual clinician. I am not writing on behalf of, and do not speak for, any employer, hospital, health system, group practice or other organization, and no organization has reviewed, authorized or endorsed this letter.

What I See in My Own Practice

On a near-daily basis I will meet a patient whose primary needs are support for their mental health, behavioral health, or dependence on substance. Although I am not able to directly monitor their progress as outpatient, I am able to see first-hand that it is obvious their needs are not met as outpatient. Sometimes they are able to get connected with a provider on the outside who is able to carry our plan forward. Often, they are not. Often, the clinics they are told to call, are full of patients and they are placed on a waitlist. Even if they get an appointment, the clinic is grossly understaffed and the appointment is rushed. When these patients' treatment plans are interrupted, they fall behind, relapse, and they're right back in my hospital, just as helpless as they were to begin with. Without better care, and outpatient resources, this is a vicious cycle that will never improve.

What I Support

I support the Committee's consideration of an approach that authorizes a full course of behavioral health treatment once, in advance, against published specialty society guidelines, rather than requiring separate authorization for each service delivered within that course.

The Limits of This Letter

I want to be precise about what I am and am not saying. I am not an expert in payment policy, actuarial science, medical billing, or insurance administration. I make no representation about the financial design of this proposal, its cost or savings estimates, its technical specifications, or whether it would work as designed. I have not evaluated those things and I do not vouch for them. My support is limited to the clinical problem described above and to the general direction of authorizing a course of care in advance rather than service by service.

This letter is not a financial commitment, a contract, a business arrangement, an endorsement of any product or vendor, or a professional opinion rendered on behalf of any patient or organization. I have no financial interest in the proposal, I hold no stake in it, and I receive nothing in exchange for this letter.

Respectfully,

Tyler Brett Thurman

_____

Tyler Thurman, DO
Internal Medicine / Hospital Medicine
Charlotte, North Carolina
Signing in a personal capacity

Date Signed

August 18, 2026

SONA BAILE LLC
2330 Scenic Hwy • Snellville, GA 30078
P: (404) 876-0876 • E: AnnaJCar@sona-baile.com • W: sonabaile.com

Date: August 21, 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, 200 Independence Avenue SW, Washington, DC 20201

Re: Written statement on the Episode Intelligence Authorization and Payment (EIA) Compensation Model, open for public comment through September 1, 2026

Dear Designated Federal Officer,

I am a Family/Psychiatric Nurse Practitioner licensed in Georgia, with over 20 years in practice. I am writing in my personal capacity as an individual clinician. I am not writing on behalf of, and do not speak for, any employer, hospital, health system, group practice, or other organization, and no organization has reviewed, authorized, or endorsed this letter.

What I See in My Own Practice

In my practice, I regularly care for patients managing both medical and behavioral health or substance use disorders. I have observed that interruptions, delays, or the absence of timely outpatient behavioral health treatment often result in my patients experiencing a worsening of their symptoms, deterioration of their overall health, and increased challenges in managing coexisting medical conditions. Too often, I see patients who reach my care after opportunities for early intervention were missed, leading to preventable clinical complications and, in some cases, emergency department visits or hospitalizations. These disruptions in care negatively impact patients' safety, functioning, and quality of life.

What I Support

I support the Committee's consideration of an approach that authorizes a full course of behavioral health treatment once, in advance, against published specialty society guidelines, rather than requiring separate authorization for each service delivered within that course.

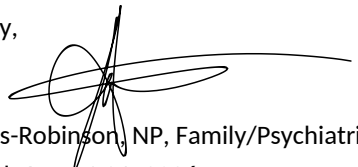
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This letter is not a financial commitment, a contract, a business arrangement, an endorsement of any product or vendor, or a professional opinion rendered on behalf of any patient or organization. I have no financial interest in the proposal; I hold no stake in it, and I receive nothing in exchange for this letter.

Respectfully,

Signature:



Anicia Cross-Robinson, NP, Family/Psychiatric Nurse Practitioner, Snellville, Georgia, signing in a personal capacity

Date Signed: August 21, 2026

Refuge Psychotherapy
Watkinsville, Georgia

August 26, 2026

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
U.S. Department of Health and Human Services
Submitted via PTAC@HHS.gov

RE: Letter of Support — Episode Intelligence Authorization and Payment (EIA) Compensation Model, submitted by Joanne Bayouk, MBA, MSN, RN, PMHNP-c

Dear Members of the Committee,

I am writing to express my strong support for the Episode Intelligence Authorization and Payment (EIA) Compensation Model, submitted to PTAC by Joanne Bayouk, MBA, MSN, RN, PMHNP-c. I offer this letter both as the owner of Refuge Psychotherapy, a private psychotherapy practice in Watkinsville, Georgia, and as a psychiatric-mental health nurse practitioner faculty member with more than twenty years of experience in psychiatric nursing across crisis stabilization, community mental health, and primary care settings.

In practice, I have seen firsthand how the fragmentation between clinical care, authorization, and reimbursement processes creates real barriers to timely, coordinated treatment. Behavioral health care, in particular, suffers when authorization decisions are made in isolation from the broader episode of care a patient is experiencing. Prior authorization delays, disconnected documentation requirements, and misaligned reimbursement incentives add administrative burden that falls on both clinicians and patients, often at the exact moments when continuity of care matters most.

The EIA Compensation Model's episode-based approach directly addresses this problem. By aligning clinical care, authorization, and payment around a single episode of care rather than a series of disconnected transactions, the model has the potential to reduce administrative burden, improve coordination among providers, and support the broader shift toward value-based care that our health care system urgently needs. From the perspective of an independent practice owner, a framework that reduces fragmentation between authorization and reimbursement would meaningfully improve both the quality of care I could offer patients and the sustainability of practices like mine.

I have also had the privilege of watching Ms. Bayouk develop this proposal through her work in Brenau University's PMHNP program. Her grasp of the operational realities clinicians face, combined with her ability to translate those realities into a workable federal payment model, speaks to the caliber of leadership advanced practice nurses are bringing to health policy. I believe this proposal deserves the Committee's serious consideration.

Thank you for your time and attention to this proposal. Please do not hesitate to contact me if I can provide any additional information.

Sincerely,

Kim Leverett

Kim Leverett, PhD, PMHCNS-BC, FNP-BC
Owner, Refuge Psychotherapy
Watkinsville, Georgia

September 1, 2026

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

RE: **Action For Progress Letter of Support for the Episode Intelligence Authorization (EIA) Framework Proposal**

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

On behalf of Action for Progress (A4P) – a coalition composed of providers, patient organizations, employers, health plans, and innovators dedicated to transforming the behavioral health system through a bold, coordinated strategy grounded in data and driven by broad-based, collective action – I am writing to express strong support for the Episode Intelligence Authorization (EIA) framework proposal submitted to PTAC by Joanne Bayouck, MBA, RN, PMNPN-c, in partnership with the Georgia Alliance of Community Hospitals.

Before discussing the details of the EIA proposal, we believe it's important for PTAC to understand the larger context of the recommendation, e.g., the incidence of Major Depressive Disorder (MDD) and Treatment-Resistant Depression (TRD) among seniors as well as the significant cost impact of these conditions on the Medicare program. In comparison to medical/surgical and various other medical specialty services, there have been few legislative amendments to Medicare mental health and addiction treatment benefits since 1965 and the program struggles to attract the participation of behavioral health clinicians because of low reimbursement rates stemming, in part, from skewed valuations for mental health care.

Major Depressive Disorder & Medicare: Incidence Rates & Symptomology

According to a study published in the *American Journal of Geriatric* Psychiatry, "major depressive disorder (MDD) affects 5.4% of the older adult population in the United States annually, leading to impaired quality of life and decreased functioning."[1] Additionally, as

[1] Benson, Carmela, et.al,, "An Evaluation of the Clinical and Economic Burden Among Older Adult Medicare-Covered Beneficiaries With Treatment-Resistant Depression," *The American Journal of Geriatric Psychiatry*, March 2020, https://www.ajgponline.org/article/S1064-7481(19)30547-0/fulltext.

many as 18.4% of adults 65+ experience depressive symptoms.[2] "Despite its high prevalence and burden, depression often goes unrecognized in the older adult population because symptoms may present differently than in younger patients. For some older adults, sadness is not their main symptom. Instead, depression may be characterized by tiredness, trouble sleeping, irritability, confusion, and poor attention, or less obvious symptoms. In addition, depression in older adults may be more persistent than depression earlier in life."[3]

Additionally, the study states, "comorbid medical and neuropsychiatric conditions like dementia, normal cognitive decline, and substance abuse can complicate the clinical management of MDD in older adult patients. MDD may itself contribute to poor health behaviors (e.g., excessive smoking, alcohol intake) and a higher rate of obesity, which may lead to an increased risk of comorbidities such as cardiovascular disease, diabetes, and certain types of cancer. The necessity of concomitant medications to treat comorbid illnesses also raises the likelihood of drug interactions. Such interactions and the increased physiologic fragility of older adult patients result in a greater frequency of adverse events related to their treatments. Further, the contributions of these cooccurring conditions to poor adherence can result in treatment failure. **Together, these factors contribute to a poor prognosis for MDD, resulting in lower remission rates. In one study, 71% of older adult patients did not achieve remission even after 6 months of care in specialty or integrated care centers"** (emphasis added).[4]

Importantly, it takes skill to diagnose major depressive disorder in older adult patients. There are, however, **fewer than 1,400 board-certified geriatric psychiatrists** actively in practicing in the United States, creating a severe shortage for millions of older adults.[5] While geriatric psychiatry fellowship spots are available, only a portion of these are filled annually. Total enrollment generally hovers between **55 and 60 fellows** total across the country in any given year because many positions remain unfilled.[6]

Cost Impact of MDD & Treatment Resistant MDD on Medicare

In evaluating the EIA proposal, the PTAC should note that Medicare is already allocating substantial resources to treating patients with MDD and its treatment resistant variant. However, that spending is purchasing subpar clinical outcomes at an extraordinary cost.

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[2] Villarroel, Maria, et al,"NCHS Data Brief No. 379: Symptoms of Depression Among Adults: United States, 2019," September 2020, https://www.cdc.gov/nchs/products/databriefs/db379.htm
[3] Benson, Carmela, et.al,, "An Evaluation of the Clinical and Economic Burden Among Older Adult Medicare-Covered Beneficiaries With Treatment-Resistant Depression," *The American Journal of Geriatric Psychiatry*, March 2020, https://www.ajgponline.org/article/S1064-7481(19)30547-0/fulltext.
[4] Ibid.
[5] Volle, Dax, et al., "The September 2025 Special Report: Geriatric Psychiatry," *Psychiatric Times,* October 2025, https://www.psychiatrictimes.com/view/geriatric-psychiatry-september-special-report-recap
[6] Brewster K, et al., "Improving Geriatric Psychiatry Fellowship Recruitment in Underserved Areas of New York State" *The American Journal of Geriatric Psychiatry*, 32, S108-S109

Specifically, patients with treatment-resistant depression (TRD) cost Medicare an average of about $46,000 per beneficiary annually, which is roughly 21% to 46% higher than costs for patients with general major depressive disorder (MDD) whose symptoms respond to standard treatment.[7]

The majority of high spending for TRD patients comes from frequent inpatient hospitalizations, longer hospital stays, and expensive prescription drug regimens.[8] TRD beneficiaries experience roughly 46% more inpatient admissions, more emergency department visits, and significantly higher numbers of outpatient clinical services compared to non-TRD depressed patients.[9] Standard MDD treatment costs vary by the number of medication steps or lines required, ranging from roughly $14,000 to over $21,000 annually for baseline or responsive management paths before reaching severe treatment resistance.[10] **As noted in the proposal, the EIA prospective payment approach works with existing prior authorization processes to constrain these costs while improving care coordination and efficiency.**

In addition, the direct medical costs referenced above do not account for the tremendous caregiver burden, acceleration of disability, increase in required social services, and reduced work capacity (e.g. early retirement, cutting back hours and diminished ability to help family) that depression causes in the elderly population.[11]

EIA Proposal Consistent with Action for Progress Principles

Under the EIA proposal, when a clinical episode of MDD is authorized against a clinical care pathway published by relevant specialty societies such as the American Psychiatric Association (APA) or the American Society of Addiction Medicine (ASAM), a prospective payment is committed in the same event. Specifically, 88% of an RVU-constructed episode rate is paid prospectively while 12% is held back to be released at episode close to assure fidelity against the guideline's outcome definitions. The model operates on a FHIR Prior Authorization API infrastructure already required of payers as well as the Office of the National Coordinator (ONC) via health information technology certification standards.

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[7] Anastasia, Gliadkovskaya, "Patients with treatment-resistant depression are costing Medicare big," *Fierce Healthcare*, June 1, 2026, https://www.fiercehealthcare.com/finance/patients-treatment-resistant-depression-cost-medicare-more-those-managed-symptoms.

[8] Ibid.

[9] Zhadanava, M, et al., "Economic Burden of Treatment-Resistant Depression in Privately Insured U.S. Patients with Physical Conditions," *Journal of Managed Care & Specialty Pharmacy,* 2020. https://www.analysisgroup.com/Insights/publishing/economic-burden-of-treatment-resistant-depression-in-privately-insured-u.s.-patients-with-physical-conditions/.

[10] Arnaud, Alix, et al., "The Increasing Economic Burden with Additional Steps of Pharmacotherapy in Major Depressive Disorder," *PharmacoEconomics*, 2021, https://pmc.ncbi.nlm.nih.gov/articles/PMC8166719/#Sec14.

[11] Langa, Kenneth et al., "Extent and Cost of Informal Caregiving for Older Americans With Symptoms of Depression" *The American Journal of Psychiatry*, 2004. https://doi.org/10.1176/appi.ajp.161.5.857

In turn, via group practices or solo practices, the prospective payment purchases a bundle of essential services including initial assessment, ongoing medication management, multiple psychotherapy sessions and response monitoring. The model also explicitly finances care coordination consistent with the APA Collaborative Care guidelines facilitating integrated services with primary care physicians as needed.

A4P supports the EIA model for an array of reasons. First, EIA is broadly consistent with our Payment Pillar, which details advance payment structures that support the delivery of high-quality, cost-effective care that reduce overall costs but are not widely adopted. We are also working to drive consensus on definition and measurement of quality and outcomes in the behavioral health therapeutic space and, again, the EIA model is fully aligned with our ongoing efforts. Prospective payment episodes are not widely adopted in the BH sector, and this Medicare model would lead the way for broader multi-payor alignment.

Second, the model's reliance on open specialty-society clinical care pathways to assure quality MDD treatment for both measurement and future incentive payments is foundational to A4P endorsement. We note that the U.S. Department of Health and Human Services, health insurance plans, mental health and addiction treatment providers and patient advocacy organizations all very recently signed a National Behavioral Health Quality and Best Practices Pledge, which unites leaders across the behavioral health ecosystem around a shared commitment to evidence-based, high-quality, patient-centered care. The heart of that pledge is implementation of clinical care pathways (CCPs) grounded in decades of evidence from across medicine. By establishing standardized, evidence-based clinical guidance for behavioral health's highest-priority conditions, CCPs bring the structure, accountability, and measurability that the field urgently needs. The CCPs address such common conditions as: depression and mood disorders, substance use and addiction disorders, anxiety disorders and OCD, trauma-related conditions, psychotic disorders, bipolar and related disorders, attention disorders, and eating disorders.

Additionally, the removal of a burdensome and timely step for pre-authorization by implementing ONC FHIR Prior Authorization API infrastructure would be a monumental advancement for BH providers.

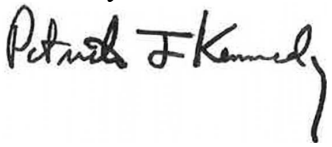
The EIA proposal and the general movement in the behavioral health field toward clinical quality measures point in the same policy direction and seek the same goals: standardization of care and fidelity to clinical care guidelines with the objective of reducing costs and improving the quality of mental health care. In addition, the proposed EIA prospective payment reimbursement rate holds out the prospect of attracting mental health professionals to participate in the Medicare program.

Finally, since BH providers were largely excluded from HITECH Act incentives, a large portion of BH data sits outside mature FHIR and USCDI standards. We recommend the

PTAC and CMMI support this model for implementation with the provision of additional infrastructure support for those providers not currently operating with modern FHIR data exchange capabilities. This support will prove pivotal to the success of this model.

Action for Progress is clear that the current status quo producing poor results at an unacceptable cost does not serve our society. Within the Medicare program, there is a need to confront the fact that behavioral health conditions are a major driver of escalating health care costs. It is time to initiate persistent, bold experimentation to find models that work for all relevant stakeholders and, most importantly, patients and their families. Please reach out to Action for Progress Policy Advisor Katherine Hodgdon (khodgdon@healthsperien.com) with any questions.

Sincerely,



Patrick J. Kennedy
Former US Congressman (RI)
Partner, Healthsperien

701 Fifth Avenue
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USA

Tel 206 389 5300
Fax 206 464 7813

mcg.com

To: Physician-Focused Payment Model Technical Advisory Committee (PTAC), U.S. Department of Health and Human Services

Cc: Joanne Bayouk

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

MCG Health (also known as "MCG") is writing regarding inaccurate and potentially misleading references to MCG in the Episode Intelligence Authorization and Payment (EIA) proposal submitted by Joanne Bayouk for PTAC's consideration.

On page 6, Section 1.2, the proposal identifies "MCG Health and InterQual" and states that these criteria platforms:

- Were built for a pre-FHIR era and were never designed to produce an auditable, machine-readable citation trail;
- Have no open citation trail;
- Produce no FHIR-native output; and
- Cannot be independently audited against clinical evidence.

These statements do not accurately reflect MCG's current solutions, capabilities, or implementation options. MCG provides evidence-based, clinical decision-support guidelines and has developed HL7® FHIR®-enabled capabilities, transparency tools, citation and rationale functionality, versioning, reporting, and other structured clinical workflow solutions. In fact, MCG has been a Principal Member of the HL7 Da Vinci Project since 2019, and as part of that group we helped develop the implementation guides (IGs) cited in the 2024 CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).

The EIA proposal also appears to conflate proprietary licensing with a lack of transparency or auditability. MCG's clinical content is protected intellectual property and is made available under license. Licensed users receive complete evidence citations, rationales, versioning, and transparency information. We also offer 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.

In addition, MCG's products do not independently approve, deny, authorize, or adjudicate claims. Those determinations remain the responsibility of the applicable

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payer or authorized entity licensing our solutions. MCG provides clinical guidance and decision-support resources.

We are providing this notice so that PTAC and HHS have an accurate understanding of MCG's role and capabilities as they review the proposal. We would be pleased to provide additional information or documentation regarding MCG care guidelines, HL7® FHIR® capabilities, transparency solutions, and decision-support functionality.

Thank you for your attention to this matter.

Sincerely,

Donna Baker-Miller
Vice President, Government Affairs
MCG Health

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 unauditable, 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.