Joanne Bayouk Proposal:

Episode Intelligence Authorization and Payment (EIA) Compensation Model

(Revised Version)

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* (Revised Version). PTAC has received five responses from the following stakeholders:

1. Tyler Thurman, DO
2. Hillside, Inc.
3. Kelly Alline Evans, RN, BSN, MBA
4. NHMH – No Health without Mental Health; International Society for Psychiatric Mental Health Nurses; and Legal Action Center
5. Skyland Trail

From: Tyler Thurman
To: PTAC (OS/ASPE)
Subject: Public Comment, Episode Intelligence Authorization and Payment (EIA) Compensation Model, Revised Version
Date: Tuesday, October 6, 2026 9:33:02 AM

Letter of Support
Episode Intelligence Authorization and Payment (EIA) Compensation Model, Revised Version
Open for public comment at HHS PTAC through Monday, October 26, 2026

Date: October 6, 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 revised Episode Intelligence Authorization and Payment (EIA) Compensation Model, further to my statement of August 18, 2026

Dear Designated Federal Officer,

I submitted a written statement to the Committee on August 18, 2026 in support of the Episode Intelligence Authorization and Payment (EIA) Compensation Model. I have reviewed the revised proposal now before the Committee, and I am writing to address two elements of the revision specifically.

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 care for patients whose primary needs relate to mental health, behavioral health, or dependence on a substance. I am not in a position to monitor their progress after discharge, but it is evident that those needs are frequently not met in the outpatient setting.

Some patients connect with an outside provider who carries our treatment plan forward. Many do not. The clinics they are directed to call are at capacity and they are placed on a waitlist. Where an appointment is obtained, the clinic is often substantially understaffed and the visit is rushed.

When a treatment plan is interrupted in this way, patients fall behind, they relapse, and they return to my hospital in no better condition than when they left it.

Why the Revision Matters to the Point I Raised

The failure I described in August occurs at a specific moment: the transition out of the hospital. The patient leaves with a plan, and the plan does not survive the handoff.

Two provisions of the revised proposal address that directly, and I want the Committee to understand why they matter from the admitting side.

First, the revision authorizes a course of treatment once, in advance, against clinical guidelines published by the relevant specialty societies, and the authorization follows the patient across levels of care rather than restarting at each transition. The transition is where my patients are lost. An authorization that survives it addresses the failure I actually observe, rather than a different one.

Second, the revision does not permit evidence of failure at a lower level of care to be required as a condition of access. This is the provision I would most want preserved. The patients who return to me are, in my experience, frequently those whose outpatient treatment was interrupted rather than those who declined care. A requirement to document failure before authorizing an appropriate level of care would, in those cases, require the relapse that the treatment was meant to prevent. I have watched that happen, and it is avoidable.

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, and I make no representation about the financial or actuarial design of this model. I am describing what the present authorization arrangement does to the patients I admit and identifying the two provisions of the revision that correspond to what I see.

Respectfully submitted,

Tyler Thurman, DO
Hospitalist
Licensed in North Carolina

HILLSIDE®
Compassion • Connection • Community

October 19, 2026

Designated Federal Officer
Physician-Focused Payment Model Technical Advisory Committee
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: Public comment on the Episode Intelligence Authorization and Payment Compensation Model

Dear Members of the Committee:

Hillside, Inc. is a nonprofit providing psychiatric residential treatment, day treatment, virtual intensive outpatient, and intensive in-home treatment to children and teens in Atlanta, Georgia. We treat approximately 800 patients each year across our service array. We contract with the major commercial payers and Medicaid managed care organizations.

Prior authorization and continued stay authorization create a significant administrative burden. The number of people employed in utilization management, admissions, billing, and collections has increased in the past few years due to workload. Peer reviews pull psychiatrists, nurse practitioners, and therapists away from direct care and are costly for the organization and patient care as well.

Another challenge is that payers often apply medical necessity criteria that are not aligned with level of care we provide and are often unique to each payer. For example, criteria built around acute risk applied to residential treatment. The clients we serve typically have multiple acute hospitalizations which have not adequately met treatment needs. Meeting acute risk criteria while in residential treatment should not be required and can be detrimental to kids and families.

The proposed model would authorize a defined course of treatment once, in advance, against published specialty society care pathways, and make that authorization the payment event. The documentation standard would be fixed when the episode is approved rather than discovered when a denial arrives, and the authorization would follow the patient across levels of care rather than restarting at each step down.

The model itself is not age restricted. The proposal states that its decision logic does not restrict access by age, cognitive level or diagnosis. The proposed first test is in traditional Medicare, for adults with major depressive disorder, which means

the test cohort is adults because of the payment vehicle chosen, not because of anything in the design.

That distinction matters to us. We treat children and adolescents, and the authorization problem in our population is at least as severe as the one described for adults. The authority the proposal relies on, section 1115A of the Social Security Act, extends to Medicaid and the Children's Health Insurance Program as well as to Medicare, so a cohort of children and adolescents is available under the same authority already cited.

We urge the Committee to recommend that children and adolescents be included, or at minimum that the test be designed from the outset so it can extend to them and to residential levels of care, rather than be retrofitted afterwards. What is tested first determines what is extended later, and a model built only around adults will be harder to adapt to young people than one designed with them in view.

Hillside, Inc. supports the Episode Intelligence Authorization and Payment Compensation Model and urges the Committee to recommend it for limited-scale testing by the Center for Medicare and Medicaid Innovation.

This letter constitutes a public comment. It does not represent a financial commitment, a technology contract, or any obligation to participate.

Respectfully submitted,

Emily Acker, MSA
President and CEO
Hillside, Inc.
404-875-4551 / Eacker@hside.org

From: Kelly Evans
To: PTAC (OS/ASPE)
Subject: Public Comment – Episode Intelligence Authorization and Payment (EIA) Compensation Model
Date: Monday, October 19, 2026 8:06:38 PM

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

I am writing as a registered nurse with nearly 40 years of healthcare experience and as a healthcare executive currently responsible for physician services and operations. Throughout my career, I have worked at the bedside, alongside physicians, and in leadership roles responsible for ensuring patients have access to timely, appropriate medical care.

I have witnessed healthcare evolve in extraordinary ways. We have developed remarkable technologies, advanced surgical techniques, and treatments that would have been unimaginable when I began nursing. Yet somehow, we have also created an administrative system in which a physician's clinical judgment can be delayed or overridden by an insurance authorization process.

And the people who ultimately pay the price are patients.

Prior authorization may have originated as a mechanism to manage utilization and control healthcare costs. I recognize that responsible stewardship of healthcare resources is necessary. But when the process delays medically necessary treatment, interrupts continuity of care, or places excessive administrative demands on clinical teams, we must question whether it is accomplishing its intended purpose.

A patient should not have to become sicker while a physician waits for permission to provide medically necessary care.

From an operational perspective, I see the resources consumed by these processes. Nurses, medical assistants, referral coordinators, and administrative staff spend countless hours gathering documentation, submitting requests, tracking responses, and appealing denials. These are hours that could otherwise be spent coordinating treatment, educating patients, and improving access to care.

For physicians, the burden is equally concerning. We ask these highly trained professionals to practice evidence-based medicine, exercise sound clinical judgment, and accept responsibility for patient outcomes. Yet we increasingly require them to justify those decisions through administrative processes that can create unnecessary delays.

There is a fundamental disconnect in that expectation.

I recognize the potential value of innovative payment models, including the proposed Episode Intelligence Authorization and Payment Compensation Model, if they can reduce unnecessary administrative barriers while maintaining appropriate accountability, transparency, and patient protections. However, any approach that changes how care is authorized or reimbursed must be evaluated against what matters most: whether patients receive timely, safe, clinically appropriate care.

I encourage the Committee to prioritize models that reduce repetitive authorization requirements, establish meaningful accountability for delays, respect physician clinical

judgment, and measure the actual impact of these processes on patients and healthcare delivery.

We cannot continue to discuss healthcare efficiency solely in terms of dollars saved while overlooking the human and operational costs of delayed care.

After nearly four decades in healthcare, I remain convinced that the purpose of our work is remarkably simple: to care for people.

Our systems, policies, and payment structures should make that possible, not make it harder.

Thank you for the opportunity to provide public comment and for your consideration of the perspectives of those of us responsible for delivering care every day.

Respectfully,

Kelly Alline Evans, RN, BSN, MBA

Submitted in my individual professional capacity.

No Health without Mental Health
www.nhmh.org • 501(c)(3) organization

October 22, 2026

Designated Federal Officer for PTAC
Physician-Focused Payment Model Technical Advisory Committee
Washington, D.C.

Re: **Episode Intelligence Authorization & Payment Compensation Model Proposal – (EIA)**
Episode of Care for Major Depressive Disorder (MDD) -
Public Comment Submittal

Main Message: We believe the EIA proposed model should be tested for all the reasons discussed below and notwithstanding the concerns, including provider payment distribution, expressed in the final paragraph. At this stage in the shift to value-based care, it is important to see how well this bundled payment for the behavioral condition of major depressive disorder (MDD) might work.

Preface: NHMH – No Health without Mental Health, joined in this comment letter by the undersigned organizations, is a 501©(3) patient advocacy organization engaged since 2007 in health policy reform at the federal level to improve our U.S. healthcare system by simultaneously achieving high quality care while also reducing healthcare cost. Cost growth exists across the entire health system but is especially acute in the Medicare program. NHMH's focused mission has been to advance comprehensive, coordinated, medical-behavioral whole person healthcare that is population-based and accountable for improved patient outcomes and reduced cost of care.

Model Concept: We support the EIA's concept of a behavioral health (BH) episode-based alternative payment model for major depressive disorder and recommend PTAC consider recommending it to CMS as a potential candidate for a CMMI voluntary test pilot.
The EIA proposal appears to present an episode-level intelligence, authorization, measurement and accountability framework for a common behavioral health disorder, major depressive disorder that can apparently be delivered in traditional Medicare and later included in Medicare Advantage's value-based environment.
The EIA concept appears to propose having a common clinical episode architecture that would link payment to financial and performance accountability for whether the patient actually gets better, and making authorization part of the clinical episode itself. Further, as behavioral health advocates, we are pleased the proposal offers an opportunity to develop an integrative, coordinated whole person treatment for a common BH disorder, rather than continuing to treat behavioral illnesses as simply disconnected encounters. The healthcare system has long known how to deliver and pay for an episode of *physical* illness care such as joint replacement, cardiac care, or oncology. Yet to date this has not been the case with behavioral health conditions whose treatment has remained more fragmented. We see this model as moving in the right health policy direction as regards integrative care.

Alignment with CMS Value-Based Strategy: The EIA's episode-based payment approach is consistent with CMS's current value-based care system with priority on establishing population-based

accountability around a defined clinical course of care rather than a count of care services. EIA aligns with CMS's focus to reward providers/systems with additional payment when they perform well and deliver high quality care to Medicare patients while applying CMS's financial and quality standards and measures in the process. We are supportive of the CMS's strategic goal to develop delivery and payment pathways that create a common architecture for behavioral and physical health which can eventually lead to a unified whole person care system. The EIA model appears to have the potential to fit into this category. In future we see the potential for the proposed MDD episode of care being a forerunner for a broader much-needed diabetes plus depression episode model, or a cardiovascular plus depression episode model, ultimately leading to a whole-person total cost of care model.

Element of Clinical 'Intelligence': Our understanding is that the model would use available clinical and patient/family history to develop an appropriate course of care, using intelligence to determine the right treatment pathway which is then authorized as part of the clinical episode itself. With needed providers assembled to provide coordinated treatment, clinical and patient progress measured, and payment following the authorized episode of care, with the amount dependent on the episode's performance results.

The concept behind the model appears to be that treatment intensity and payment should recognize and respond to the patient's individual clinical situation and the direction of care needed. For instance, a patient's situation might involve any or several of the following: recurrent depression, mild-to-severe depression, different degrees of functional impairment, suicidal risk, psychiatric as well as medical comorbidities, different antidepressant responses, psychotherapy, and/or need for higher levels of intensified care.

Medicare Beneficiaries Benefits: We believe the EIA approach would result in positive benefits for MDD patients in that one, clearly defined accountable entity would 'own' the whole episode of care and provide coordinated inter-disciplinary provider care to address it. This would require those providers who are delivering care, medical and behavioral, to continually be asking themselves: Is the patient actually getting better?
It would also assemble a group of relevant providers into the accountability circle in an organized way to provide coordinated, comprehensive care. For example, in the case of MDD treatment, potentially primary care clinician, psychiatrist, psychologist, nurse practitioner, care manager, emergency department and/or hospital providers, and other medical specialists as appropriate.

Quality Measurement: The EIA approach would consequently need to have clear consensus-based outcomes measures to determine whether or not the patient actually improved. Measures to include:

*depression improvement or remission
*functional improvement
*follow-up after treatment initiation
*patient-reported experience of care
*suicide risk assessment
*acute care utilization
*patient-reported outcomes
*total cost of care accountability

Impact on Chronic Condition: The EIA model would support care for Medicare beneficiaries with major depressive disorder and other *co-occurring* chronic conditions such as diabetes, cardiovascular disease, chronic pain, cancer, substance use disorders. And is aligned with CMS's priority for delivery of accountable whole person care as part of its focus on chronic condition prevention and management.

CMS Claims Data Architecture: CMS currently has an established Medicare Depression episode-based cost measure evaluating Medicare costs for clinicians' management and treatment of depression using Parts A, B and D claims. The EIA model would apparently build on and go beyond this cost measure and expand the episode to also include treatment determination, authorization, payment, and determination whether the episode succeeded.

Cost Savings Potential: With cost growth present across the entire health system, and especially acute in Medicare, we know cost savings must be a priority. There may be significant cost savings associated with the EIA episode-based payment approach for MDD. Rather than CMS paying for separate visits, procedures, and encounters, a population-based total cost-of-care model might more efficiently address patients' multiple, complex chronic conditions and serious illness. The approach aligns well with the American public's desire for care that is efficiently effective and leads to recovery, improvement, functioning, sustained remission, and avoidance of healthcare and medical crises.

Questions Yet To Be Resolved: Areas in the proposal we see requiring further definition and refinement center on: (1) how the bundled payment will be distributed if the providers are not part of the system; this works in an HMO or closed health system that already handles distribution of bundled payments but it is unclear how it would work in rural areas, or for people going to different providers; (2) who is the accountable entity whish 'owns' the episode? For example, is it an ACO, or an integrated behavioral health organization or some other accountable entity? and (3) the episode's duration would have to be considered as major depressive disorder can be a recurrent condition, unlike a hip replacement.

With best regards,

NHMH – No Health without Mental Health
Florence C. Fee, J.D., M.A., Founder and Executive Director

International Society for Psychiatric Mental Health Nurses
Cynthia Handrup, DNP, APRN, PMHCNS-BC, FAAN

Legal Action Center
Paul N. Samuels, J.D., Director and President

From: Beth Finnerty <BFinnerty@skylandtrail.org>
Sent: Monday, October 26, 2026 2:46 PM
To: PTAC (OS/ASPE) <PTAC@hhs.gov>
Subject: Public comment, Episode Intelligence Authorization, and Payment Compensation Model

To: Designated Federal Officer
Physician-Focused Payment Model Technical Advisory Committee:

Skyland Trail, a private non-profit residential psychiatric program located in Atlanta, Georgia, has been serving patients from across the country for over 37 years. We treat adolescents ages 14-17 and adults 18+ diagnosed with a complex combination of psychiatric disorders ranging from major depressive disorder, bipolar disorder, schizophrenia, anxiety, trauma and substance misuse. We serve approximately 500 patients annually across residential, PHP, and IOP programs and do not accept Medicare or Medicaid. However, we do contract with every major managed care organization and as a result, 95% of the patients we admit use insurance. As a result, we are solely responsible for the authorization of treatment for our patients.

As a non-profit, Skyland Trail operates with lean teams across its clinical, financial, and administrative functions. When a patient admits with insurance, continued treatment oftentimes requires repeated insurance reviews only days apart, creating a constant cycle of documentation, follow-up, payer communication, and escalation throughout the patient's stay. Skyland has had to hire a team of 4 employees just to manage insurance authorizations. The repeated cycle of requests, reviews, peer-to-peers, denials, appeals, and reversals represents added expense for us. Add to this the impact on physician time: peer-to-peer reviews and appeals pull physicians away from direct patient care, treatment planning, and family discussions. Oftentimes, we are given no consideration in scheduling the time of an appeal and if the provider is not available due to a conflict, the appeal is just denied. In my opinion, if the payer cannot complete a review within a defined timeframe, the existing authorization should remain in effect rather than shifting financial uncertainty to the patient and provider. It is frustrating to say the least and places the burden on a non-profit that is raising philanthropic dollars for financial aid for our patients when coverage runs out.

As an added frustration, payers apply medical necessity criteria built around acute risk, such as active suicidal ideation, to a voluntary, unlocked residential program with an average length of stay of six weeks. The criterion is more applicable to an inpatient psychiatric setting and does not describe the level of care being delivered in this type of setting. Improvement during treatment should not automatically be interpreted as evidence that treatment is no longer necessary; in many cases, improvement demonstrates that the treatment is working and needs time to become sustainable. The clinical question should be whether the patient has completed the treatment necessary for durable improvement, not simply whether the most acute symptoms have

subsided. Denying treatment for a patient has caused much distress for our clinicians and families when patients are deemed safe to be discharged by a payer after a short treatment stay.

Many families travel to Skyland Trail for treatment from out of state. Benefits are always verified in advance. Authorization is required on the day of admission and sometimes the request is denied; sometimes it is approved. Families incur travel, lodging, time away from work, and other expenses when bringing their loved one to Skyland Trail for admission, all in the face of uncertainty about if or how long insurance will cover care. That uncertainty can increase anxiety at a time when the family's attention should be focused on the patient's recovery. In this situation, appeals can take up to two weeks, and families are often unable to afford to pay privately for treatment while they wait for the appeal. Oftentimes they return home without treatment. This is absurd; the cost to families and to Skyland Trail is high.

Authorizing a full course of treatment once, in advance, against published guidelines, with the documentation standard fixed at the point of authorization, would address many of the issues we have outlined above. This would include authorization following a patient from residential to PHP to IOP, without restarting the process. Today a step down is a fresh authorization event and oftentimes this is where people disappear. Authorizations that follow a patient across all levels of care would be ideal! In fact, a more stable authorization model could reduce the cycle of repeated submissions, reviews, denials, appeals, and rework for both the provider and the payer. It would also allow treatment planning to remain focused on clinical milestones instead of the timing of the next insurance review. We should consider emphasizing that continuity of treatment may reduce the likelihood that patients leave care too early and later require another episode of treatment. The goal should be to support a complete and clinically appropriate course of care rather than repeatedly paying for crisis stabilization and return visits

In closing, Skyland Trail strongly supports the physician-focused payment model and urges the Committee to recommend it for implementation rather than for limited-scale testing. Helping patients achieve sustained improvement may reduce future emergency care, rehospitalization, repeated residential treatment, and other higher-cost services. The Committee should consider not only the immediate cost of treatment, but the downstream cost of interrupting treatment before recovery is established.

Sincerely,

Beth Finnerty
President and CEO

Neil Puri, MD
Charles B. West Chief Medical Officer

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