Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee on the *Episode Intelligence Authorization and Payment (EIA) Compensation Model (Revised Version)*

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Physician-focused payment model (PFPM) proposals submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in accordance with PTAC's proposal submission instructions are assigned to a Preliminary Review Team (PRT). Each PRT prepares a report of its findings on the proposal for discussion by the full PTAC. The report is not binding on PTAC; PTAC may reach different conclusions from those contained in the report. Each report and related materials are available on the PTAC section of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) website.

A. Proposal Information

1. **Proposal Name:** Episode Intelligence Authorization and Payment (EIA) Compensation Model (Revised Version)
2. **Submitting Organization or Individual:** Joanne Bayouk
3. **Submitter's Abstract:**

   "Medicare pays for behavioral health one service at a time. A clinician is paid for each visit delivered, whatever happens to the patient, and a single twelve-week course of treatment for major depressive disorder generates eighteen separately adjudicated claims. Nothing in that arrangement pays for the patient getting better.

   The Episode Intelligence Authorization and Payment Compensation Model prices a defined course of treatment once, against the specialty society's published care pathway, and conditions part of the payment on a recorded change in a validated instrument.

A benchmark is constructed from Medicare fee schedule amounts for the services in the pathway. The target price is the benchmark less a discount factor representing Medicare's share, set at 1.5 percent. Eighty-eight percent of the target price is paid when the episode is authorized. At episode close the payment is reconciled against the services actually delivered, so payment for care not given is returned, and a twelve percent holdback is released on a graduated scale according to the patient's measured improvement. A patient whose condition deteriorates may be re-tiered clinically, but the episode remains priced at the opening band, and escalation beyond the band closes the episode and opens a new one on human review.

The decision logic never issues an automatic denial. It authorizes or routes to a human reviewer, and every positive suicide risk screen routes to a person immediately. The same outcome standard applies whichever qualified practitioner delivers the care, and each service is paid at the rate Medicare already sets for that practitioner.

On the standard twelve-week low-intensity episode in the District of Columbia the benchmark is $1,900.07, the target price $1,871.57, and $224.59 is at risk on the patient's outcome. Tested across all fifty-one jurisdictions, four acuity bands, eleven delivery levels and nine outcome levels, 20,196 combinations in total, the amount Medicare pays never exceeds what fee-for service would have paid for the care actually delivered.

The model requires no prior authorization to operate and is proposed for testing in traditional Medicare. It requires no separate care team structure, no patient registry and no contracted psychiatric consultant, which is why it can be delivered by the small and solo practices where much behavioral health care is furnished."

B. Summary of the PRT Review

The Bayouk proposal was submitted to PTAC and found to have met the Committee's administrative requirements on September 28, 2026. This proposal is a revised version of an earlier proposal with the same title from the same submitter, which was submitted to PTAC and found to have met the Committee's administrative requirements on July 22, 2026. The PRT conducted its review of the revised version of the proposal between September 28, 2026, and October 30, 2026.

The submitter and PRT agreed that the proposal would be considered on Track 1, meaning that the proposal includes most or all of the information that PTAC believes is essential for proposals to address in order to be evaluated against each of the 10 criteria established by the Secretary of Health and Human Services (HHS) for PFPM proposals. As a Track 1 proposal, PTAC will vote on the extent to which the proposal meets each of the Secretary's 10 criteria and vote on an overall recommendation to the Secretary regarding the proposal.

The PRT evaluated the proposal and voted on the extent to which the proposal met each criterion. PRT ratings categories for each criterion were: does not meet, meets, or meets

and deserves priority consideration. The PRT's ratings of the proposal against each criterion are summarized in the table below.

PRT Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR§414.1465)	PRT Rating	Unanimous or Majority Conclusion
1. Scope (High Priority)	Does Not Meet Criterion	Majority
2. Quality and Cost (High Priority)	Does Not Meet Criterion	Unanimous
3. Payment Methodology (High Priority)	Does Not Meet Criterion	Unanimous
4. Value over Volume	Does Not Meet Criterion	Unanimous
5. Flexibility	Does Not Meet Criterion	Majority
6. Ability to Be Evaluated	Does Not Meet Criterion	Unanimous
7. Integration and Care Coordination	Meets Criterion	Majority
8. Patient Choice	Does Not Meet Criterion	Unanimous
9. Patient Safety	Does Not Meet Criterion	Majority
10. Health Information Technology	Does Not Meet Criterion	Majority

Note: These ratings are based only on the PRT's review of the proposal and are not binding on the full PTAC. All Committee members will independently vote on each of the Secretary's 10 criteria at the public meeting during which the proposal is deliberated. Committee members also will conduct an overall vote on the proposal: recommend full proposal, recommend components, or not recommended.

C. Information Reviewed by the PRT

1. Proposal and Additional Information Provided by the Submitter

The PRT reviewed the Bayouk proposal, including information from an environmental scan and analysis of Medicare claims data. In addition, five public comment letters regarding the proposal were received.

Proposal Summary

The submitter proposes a model where payment is provided for a complete 12-to-16-week episode of outpatient services for treatment of major depressive disorder (MDD), rather than paying for each individual service. The proposed model involves placing patients into one of four bands based on a composite acuity score from the Level of Care Utilization System (LOCUS)[1]: 1) brief and maintenance, 12 weeks; 2) low intensity, 12 weeks; 3) high intensity, 12 weeks; and 4) medically monitored, nonresidential, 16 weeks. Each band has a corresponding defined pathway of services to be delivered.

Targeted beneficiaries are those with MDD. Eligible providers include clinician practices providing outpatient behavioral health care, psychiatrists, psychiatric nurse

[1] The LOCUS is an instrument from the American Association for Community Psychiatry (AACP) and includes six dimensions (risk of harm, functional status, comorbidity, recovery environment, treatment and recovery history, and engagement).

practitioners, clinical psychologists, licensed clinical social workers, marriage and family therapists, and mental health counselors.

Medicare will provide a prospective payment (88 percent of total episode payment) to clinicians for an MDD episode with a 12 percent withhold of total episode payment that the provider can earn back or lose based on the patient's clinical outcome. The holdback is released on a graduated scale based on improvement between baseline and episode close in a patient's score on the Patient Health Questionnaire-9 (PHQ-9). Providers earn back the full 12 percent withhold if the patient has at least a 50 percent reduction in PHQ-9 score; providers earn back 0 percent (i.e., lose the full withhold) if the patient has less than a 25 percent reduction in PHQ-9 score. Providers for whom the patient has between a 25 and 50 percent reduction in PHQ-9 scores earn back a proportion of the 12 percent withhold.

Episode payments are based on benchmarks constructed using the Medicare Physician Fee Schedule for the individual services in the pathway, minus a discount factor of 1.5 percent that would be the Medicare program's share of savings. At episode close, a reconciliation occurs involving comparison of services within the treatment pathway to those services actually delivered. If the provider did not deliver all pathway services, the provider would refund Medicare for those undelivered episode services. When patients require more care than the planned pathway, they may be clinically re-tiered, and the practice will pay the additional costs up to a stop-loss of 20 percent of the episode benchmark payment amount. Patients whose condition escalates may be placed in a different band, which will close the original episode (with reconciliation) and open a new episode at the new band.

The proposed model details key evaluation metrics, including change in PHQ-9 score at start to episode close, proportion of patients attaining a 50 percent reduction in PHQ-9 score, episode completion, rate at which cases route to human review, 30-day psychiatric readmission, and net Medicare expenditure per completed episode against a matched-comparison group.

The submitter proposes that the Committee recommend the proposed model for limited-scale testing by the Centers for Medicare & Medicaid Services (CMS) Innovation Center and requests two waivers: 1) waiver of Medicare Parts A and B payment requirements in order to make the episode payment and perform reconciliation; and 2) waiver of sections 1813 and 1833(a) of the Social Security Act in order to reconcile payments so beneficiary cost-sharing for services received is not altered. The submitter does not seek to alter beneficiary cost-sharing.

2. Literature Review and Environmental Scan

ASPE, through its contractor, conducted a targeted environmental scan of peer-reviewed and non-peer-reviewed publications. The search may not be comprehensive and was limited to documents that met predetermined parameters, generally including a 10-year look-back period, a primary focus on United States-based literature and documents, and relevancy to the proposal.

3. Data Analyses

ASPE, through its contractor, provided background information on the potential scope of and impact to the Medicare population of the proposed model. The analysis examined Medicare 2024 fee-for-service (FFS) claims data to assess the total number and cost of outpatient claims for MDD, the average number and cost of outpatient claims for MDD per beneficiary, and the average number and cost of outpatient claims per month for MDD per beneficiary during 2024. Additionally, the analysis identified the number of providers (e.g., psychiatrists, clinical psychologists, nurse practitioners) who billed for MDD as the primary diagnosis during 2024.

4. Public Comments

Five public comment letters were received for this proposal, from two mental health treatment facilities, a hospitalist, a registered nurse, and a joint letter from three nonprofit organizations advocating for mental health.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope (High Priority)

Aim to either directly address an issue in payment policy that broadens and expands the CMS Alternative Payment Model (APM) portfolio or include APM entities whose opportunities to participate in APMs have been limited.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposed model targets behavioral health practitioners as APM entities, a group where participation in APMs has been limited.

Weaknesses:

- The proposed model relies on the Episode Intelligence Authorization and Payment (EIA) framework but does not describe what the EIA framework is or how it operates. Participation in the proposed model appears to be limited to providers who purchase/adopt/implement this single proprietary framework/tool/software. Additionally, the proposal indicates that the initial prospective episode payment occurs "at authorization," but it is unclear what this authorization is referring to since Original Medicare does not require prior authorization of services.

Summary of Rating:

A majority of the PRT members find that the proposed PFPM does not meet the criterion. While it may be valuable to examine models in the behavioral health space, the PRT is concerned that this model describes a potentially proprietary tool or framework, for which the submitter has a patent pending, and does not provide details behind how the EIA

framework would operate or how behavioral health practitioners could participate in the proposed model without it.

Criterion 2. Quality and Cost (High Priority)

Anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposed model ties quality to payment through a 12 percent withhold of the total episode payment, allowing providers to earn back the 12 percent on a graduated scale based on improvement in PHQ-9 assessment score (no earnback for PHQ-9 scores reduced less than 25 percent through full earnback for at least a 50 percent reduction in PHQ-9 scores).
- The proposed model specifies quality and cost measures (change in PHQ-9 score at start to episode close, proportion of patients attaining a 50 percent reduction in PHQ-9 scores, episode completion, rate with which cases route to human review, 30-day psychiatric readmission, and net Medicare expenditure per completed episode against a matched comparison group).

Weaknesses:

- It is unclear what mechanisms under this proposed model would impact care delivery, and in what way, to improve the quality of patient care. For example, the proposal identifies a quality target of 50 percent reduction in the PHQ-9 score. However, the submitter points out that published estimates of score reduction under the current standard of care already are between 40.5 and 70 percent. It is unclear what the care delivery changes are under the proposed model that would improve on clinical outcomes that already occur for patients under the current, usual standard of care.
- The PRT is concerned that a clinician's ability to shift patients mid-course into new bands, pathways, and episodes may be used by practices to avoid financial losses. The proposal states that patients may be re-tiered clinically if their condition worsens, but the episode would remain priced at the original band amount. It is unclear what "re-tiered" means if the patient remains within the same episode. The proposal also states that if the patient requires care beyond the scope of the band, the original episode would be closed, reconciliation would occur for services not delivered in that episode, and a new episode at a higher band would be opened. This ability for the clinician to close an episode partway through and open a new episode with different services and a higher payment amount could serve as an exit strategy for clinicians to absorbing costs for needed patient services that exceed the episode payment (i.e., that would be the practice's responsibility as part of the episode's 20 percent stop-loss amount). Similarly, prematurely closing an episode and opening a new episode could prevent forfeiture of the holdback payment if patients do not sufficiently improve within the original episode.

- CMS will incur costs identifying and reconciling actual services delivered versus services expected in each episode. If a sizable proportion of patients do not complete all services in the pathway of the full 12-to-16-week episode, CMS may be at risk for substantial recoupment costs.

Summary of Rating:

The PRT unanimously finds that the proposed PFPM does not meet the criterion. The proposed model ties quality to payment through a 12 percent withhold and allows providers to earn back the withhold on a graduated scale. It also includes quality and cost metrics. However, the PRT is unclear how the care delivered to patients with MDD under the proposed model would be better care (higher quality) than the current standard of care that patients already receive. Additionally, the ability for clinicians to close episodes partway through and open new more costly episodes creates the opportunity for practices to avoid potential payment losses that are part of the provider's risk and incentive to improve quality of care under an episode-based model.

Criterion 3. Payment Methodology (High Priority)

Pay APM entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare, and other payers, if applicable, pay APM entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposed model implements a 12 percent withhold to be earned back based on quality (reduction in PHQ-9 score). This outcome-based payment contrasts with FFS, which pays for services regardless of outcome, and psychiatric collaborative care management (CoCM) codes, which pay for cumulative time and a staffing structure regardless of outcome.
- Clinicians are responsible for providing and paying for patient care beyond the episode pathway of care if necessary, up to a stop-loss of 20 percent of the episode benchmark price.

Weaknesses:

- The model proposes to provide clinicians with an upfront payment of 88 percent of the FFS amounts for a pre-defined set of expected services over a 12-to-16-week timeframe, rather than paying the same FFS amounts at the time of individual service delivery. Clinicians effectively would receive FFS payments for expected individual services but obtain a large advance payment for those services three to four months in advance of delivery. Reconciliation ensures that providers receive standard FFS payment for individual services actually delivered, but the burden is on CMS to recoup payment already made for undelivered services.

- Published studies cited in the proposal indicate that the current standard of care already yields a 40.5 to 70 percent decrease in the post-treatment PHQ-9 score from baseline. The proposed model sets the target at 50 percent reduction for release of the full 12 percent withhold payment. It is unclear how this payment methodology will promote improvements in care and quality beyond what already exists, given that many providers already meet the outcome requirement needed to earn the holdback payment without necessarily providing better care.
- The PHQ-9 assessment, upon which release of the 12 percent holdback payment is based, would be administered by the paid clinician who has a financial stake in a certain change in the PHQ-9 score. The proposal mentions that a random sample of episodes would be independently scored, but it is unclear when or how administration of the random sample of episodes would work, when or how those results would be compared with clinicians' scoring, and what actions would be taken and by whom if discrepancies are observed.
- If a patient does not improve sufficiently during the episode, the clinician can close the current episode partway through (with reconciliation) and open a new higher acuity episode with a higher level of payment. It is unclear what would prevent the clinician from closing episodes at lower bands before completion and opening new episodes at higher bands to optimize provider payments. The proposal specifies that when a patient requires more treatment than the set of services on the pathway, the patient can be re-tiered clinically and would remain within the original episode, and the practice would bear the cost of the additional treatment in the episode up to 20 percent above the benchmark cost for the episode (stop-loss). However, the proposal also indicates that if a patient's condition escalates, the current episode could be closed, and a new episode opened with an increased level of services and higher payment. With this option, there is no clear incentive for clinicians to absorb the 20 percent excess costs for additional services under the original episode rather than simply close the original episode midstream and escalate the patient to a higher episode with higher payment. Although the proposal states that there are features of the proposed model to make this practice of closing and opening new episodes both visible and unprofitable, it is unclear how these features would work, who would monitor them, or what actions would be taken when they occur.
- When patients do not complete the full course of treatment or are moved by the clinician to a new higher-band episode, the onus is placed on CMS to recover portions of the prospective payment that already was made to providers. It is unclear what happens with the 12 percent holdback amount for uncompleted episodes, and whether the provider receives or forfeits that payment amount. It also is unclear how this payment methodology promotes improvements in care delivery beyond the current standard of care.

Summary of Rating:

The PRT unanimously finds that the proposed PFPM does not meet the criterion. It is unclear how the proposed payment methodology would promote improvements in the

delivery of patient care beyond what already exists with Medicare FFS. Although the holdback payment does represent provider risk, published studies show that many patients already obtain a 50 percent decrease on PHQ-9 scores from baseline to episode close, which is the model's proposed benchmark. Although the proposal does attempt to address the risk of provider gaming, the PHQ-9 scoring is still performed by the paid clinician whose 12 percent withheld payment relies upon a certain change in the score. It is unclear how an episode-based payment methodology that allows clinicians to close in-progress episodes and open new higher acuity and higher payment episodes would promote improvements in patient care. The payment methodology also puts the burden on CMS to retrospectively calculate and collect portions of prospective payment amounts made when patients do not complete the full course of treatment under the episode.

Criterion 4. Value over Volume

Provide incentives to practitioners to deliver high-quality health care.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The submitter proposes an episode-based model that pays for a clinically derived episode of care rather than individual services; reconciliation is included for undelivered services within the episode.

Weaknesses:

- The payment methodology is structured such that providers are effectively paid FFS amounts for the same volume of services already delivered under FFS. Providers are paid lower amounts for delivery of fewer services under the proposed model (through episode reconciliation) and higher amounts for delivery of more services (FFS payment amounts for a pre-defined set of services).
- Providers may choose to avoid patients with difficult-to-treat depression due to the potential to lose the full 12 percent holdback payment when a patient improves less than the 50 percent reduction in PHQ-9 score that is required for release of the full holdback amount. The proposal specifies there is an "equity guard" but does not explain what it would do.

Summary of Rating:

The PRT unanimously finds that the proposed PFPM does not meet the criterion. Although defining an episode of care and bundling payments may lead to increased value since payment would be based on the episode rather than individual services, the proposed payment methodology effectively operates like an FFS model. Episode amounts are based on the sum of the FFS payment amounts for the individual services in the episode, with the vast majority paid in advance of service delivery, and CMS must recoup payment from providers for services not rendered under the episode when it closes early. The PRT also is concerned that because the holdback payment amount is based on change in PHQ-9 score

between baseline and episode closure, providers may be motivated to avoid those patients with cases of depression that are least likely to show the necessary improvement on the instrument.

Criterion 5. Flexibility

Provide the flexibility needed for practitioners to deliver high-quality health care.

PRT Qualitative Rating: Meets Criterion

Strengths:

- Within a given episode, the clinician can determine the sequence of care, number and length of sessions, modality, and the decision to change approach or medication.
- The proposal provides episode pricing for eight care team configurations (e.g., single prescriber; prescriber and psychologist or licensed therapist; psychologist only; therapist only) and is contrasted with CoCM, which requires a specific care team structure.

Weaknesses:

- The PRT is concerned about the flexibility of the proposed model to treat patients with varying levels of acuity. Initial assignment to treatment band is based on a baseline acuity score. If a patient requires a differing level of care over time (higher or lower), the patient can be re-tiered clinically within the episode, and the provider is responsible for up to 20 percent of the episode's benchmark payment for the additional care. However, clinicians can also close the original episode and open a new episode with requirements for a new set of services—an option which may be more financially beneficial to the clinician. This process may interrupt a patient's care rather than yield a continuous seamless course of treatment for the patient as the acuity of their condition fluctuates.

Summary of Rating:

A majority of the PRT members find that the proposed PFPM does not meet the criterion. The clinician can determine care delivery approaches, such as sequence of care and modality, and the proposed model does not require a specific care team structure. However, the model may not provide the flexibility needed to treat behavioral health patients of varying acuity if patients can be frequently moved into different bands and episodes of care.

Criterion 6. Ability to Be Evaluated

Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposed model provides key evaluation metrics: proportion of patients reaching a 50 percent reduction in PHQ-9 score from baseline, episode completion, rate at which cases are routed to human review, net Medicare expenditure per completed episode against a matched comparison group, and 30-day psychiatric readmission rate.
- The proposal states that the PHQ-9 administration is a structured event with a time stamp, date, and identity of administrator for each administration, allowing it to be evaluable.

Weaknesses:

- The PRT is concerned about the ability to test the effectiveness of the proposed episode-based payment methodology. Although the PHQ-9 is a widely used depression screening tool, PHQ-9 score data would need to be available for a comparison group using intervals similar to the proposed model's episodes in order to assess the model's impact on quality improvements. Additionally, it is unclear whether the effectiveness of the proposed episode payment methodology could be unambiguously assessed given its implementation through the EIA framework, which is undescribed. An untested, proprietary tool may introduce unknown biases during model implementation that would be difficult to control and account for in an evaluation.

Summary of Rating:

The PRT unanimously finds that the proposed PFPM does not meet the criterion. The PRT is concerned about the ability to create a comparison group that could be used to effectively evaluate the proposed model.

Criterion 7. Integration and Care Coordination

Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The proposal states that the care team configuration chosen by the practice specifies the division of responsibility between the team (held in the Fast Healthcare Interoperability Resources [FHIR] Care Team resource).
- The proposed model requires two contacts for every episode and three contacts when the care team includes more than one practitioner (documented using the FHIR Communication resource). The two required contacts are between the mental health provider and the patient's primary care provider (PCP), with notification when an MDD episode opens and closes. This constitutes a low level of collaboration (e.g., Level 2,

Basic Collaboration at a Distance). The third contact is between the mental health clinicians (prescriber and therapist) who are treating the patient.

- The proposal states how care coordination would be measured: proportion of episodes with a documented primary care notification at both the start and close of an episode and the proportion with at least one documented communication between prescriber and therapist, when applicable.

Weaknesses:

- Although the proposal includes two contacts between the clinician and PCP, this is a very low level of collaboration involving only unidirectional notification from the clinician to the PCP at the beginning and end of a months-long episode of care. There is no close collaboration between the providers regarding the delivery of the patient's mental health care. It is not clear whether anything more than basic information would be transmitted or how the PCP would use this information to support the patient's care. Under CoCM, care is coordinated through regular communication by a team involving both a PCP and behavioral health specialists. The proposed model includes and pays only clinician practices that deliver outpatient behavioral health care. PCPs are not included under the model, and there is no split payment between the mental health clinician and the PCP.
- The proposal specifies that documented care coordination is a condition of episode payment holdback release but does not describe how this would work. In multiple areas in the proposal, the holdback payment is stated as being conditioned only upon a specified reduction in PHQ-9 score.

Summary of Rating:

A majority of the PRT members find that the proposed PFPM meets the criterion. The model includes required contacts among providers for each episode, representing a low level of collaboration (i.e., unidirectional communication from the mental health clinician to the PCP). PCPs are neither included in nor paid under the proposed model. Additionally, there is no specified link between documented occurrence of the required contacts and clinician payment (e.g., of the holdback payment).

Criterion 8. Patient Choice

Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- Beneficiaries can continue to choose their providers and retain full access to all Medicare-covered services, as currently allowed under Medicare FFS.

- The proposal states that the model would involve no changes to beneficiary cost-sharing arrangements that are currently followed under Medicare FFS.

Weaknesses:

- The proposed model involves the clinician setting a months-long treatment pathway and episode price at intake. It is unclear whether the patient has visibility into the episode determination and payment mechanisms, or how shared decision-making is part of the model. The PRT is concerned about the patient's ability to have input into decisions regarding their treatment plan.
- The proposed model requires providers to use the "EIA framework" with no alternatives to its use, thus limiting patients to providers with this proprietary framework/tool/software.

Summary of Rating:

The PRT unanimously finds that the proposed PFPM does not meet the criterion. Although the proposal does draw attention to the unique needs of the behavioral health population, it does not indicate how the proposed model would support those unique needs and patient preferences. It is unclear if the patient would have input regarding the specific treatment or services to be received once a determined pathway of care is established under the episode and the clinician is pre-paid. Under the proposed model, patients also are limited only to those providers who use a single proprietary framework.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposal states that the decision logic includes four protections: 1) it never issues an automatic denial; it authorizes or routes to a human reviewer; 2) every positive suicide risk screen routes to a person immediately; 3) evidence of failure at a lower intensity of treatment is never required as a condition of access (e.g., not a step therapy); and 4) access is not restricted by age, cognitive level, or diagnosis (and there is an equity guard through the acuity logic).

Weaknesses:

- The proposal does not describe what the decision logic is, where it comes from, or how it is implemented in the proposed model. It is unclear if this is related to the EIA framework. The proposal also does not offer details about the "equity guard."
- The PRT is concerned that providing 88 percent of payment up front and placing practices at risk for additional visits (up to a 20 percent stop-loss) may incentivize clinicians to deliver less care than needed, particularly when a patient's condition suddenly escalates. There is no crisis plan or pathway.

- There is no monitoring of patients beyond the PHQ-9 assessment administered by the clinician who is being paid based on the PHQ-9 score, which can put the patient at risk for over- or under-treatment (e.g., by skewing scores to more severely ill at episode beginning or by skewing scores to less severely ill at episode end in order to show greater improvement at episode end). The proposal mentions that a random number of episodes would undergo an independent outcome assessment but does not provide details on how this would work to guard against PHQ-9 scoring manipulation.

Summary of Rating:

A majority of the PRT members find that the proposed PFPM does not meet the criterion. The proposed model builds in patient safety protections, such as automatic routing to a human reviewer for suicide risk screens. However, the PRT is concerned that the proposed model may incentivize clinicians to deliver less care, particularly for patients in acute crisis. It is also unclear how patient safety is assured when PHQ-9 administration is in the hands of the provider whose payment is based on a certain change in score over the episode.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposed model would use FHIR resources for pathway adherence and outcome capture.

Weaknesses:

- The proposal indicates that participating practices would be required to use FHIR resources integrated within their existing electronic health record (EHR). Although the proposal mentions two FHIR resources (Communication and Care Team), it is not clear whether these are the only required FHIR resources, whether the required FHIR resources already are part of practices' existing EHRs, or whether new resources or modifications to existing EHRs would be required to participate in the proposed model. These requirements may impact the ability for small and solo practices to participate in the model.
- Overall, it is not clear whether providers already have the required technology or whether new technology is required to participate in the proposed model (i.e., the EIA framework). No substantive information is provided about the EIA framework (for which the submitter states that they have a patent pending)—whether the framework involves any technology that is proprietary or incurs a cost, whether other technology could substitute for the EIA framework, or what level of effort, resources, and costs would be required for practices to obtain and implement the EIA framework.

Summary of Rating:

A majority of the PRT members find that the proposed PFPM does not meet the criterion. Although the proposed model requires participating practices to use FHIR resources for pathway adherence and outcome capture, the PRT is concerned about the potential proprietary nature of the EIA framework and what cost, level of effort, and resources may be required to obtain and implement it. The PRT also is concerned whether small or solo practices—a specific type of provider that the proposal identifies as important for delivery of behavioral health services—will have the capability to utilize the FHIR resources specified under the EIA framework.

E. PRT Comments

The PRT recognizes the need for an APM that addresses the delivery of behavioral health services; participation by behavioral health practitioners in APMs has been limited. However, the PRT finds that the proposed model has significant limitations in terms of the criteria specified by the Secretary.

The PRT is concerned about the submitter's patent pending "EIA framework" that underpins this model and which is not described in the proposal—what it encompasses, whether it is proprietary, if it incurs costs and resources to establish, the ability of small and solo practices to use it (and the presumed FHIR resources that must be integrated within the practice's existing EHR), and alternatives to this single proprietary framework that would allow more providers to participate in the proposed model.

It is unclear how the proposed model would improve the quality of care delivered to patients beyond the current usual standard of care. There is a single tool, the PHQ-9, which is tied to release of the holdback payment amount. The threshold for reduction in the PHQ-9 score (between episode open and close) is set at a threshold that many patients already meet or exceed under the current standard of care. The clinician whose holdback payment hinges on the change in PHQ-9 score delivers the assessment instrument to the patient, allowing opportunity to potentially influence the scores. Clinicians also may be motivated to selectively enroll in the proposed model those patients who are easiest to treat and most likely to improve.

Clinicians' ability to close in-progress episodes and open new higher acuity and higher payment episodes may negatively impact costs. By moving a patient to a new episode (with more services and a higher cost), providers could avoid absorbing the cost of additional services under the original episode (the 20 percent stop-loss) or losing the original episode's holdback payment if they are concerned that the patient will not meet the threshold of improvement needed on the closing PHQ-9. Additionally, it would likely be burdensome and costly for CMS to calculate and retrospectively collect previously paid prospective payments when episodes are not completed.