

**Initial Feedback¹ by the Preliminary Review Team (PRT) of the
Physician-Focused Payment Model Technical Advisory Committee (PTAC)
on the
Episode Intelligence Authorization and Payment (EIA) Compensation Model
Proposal
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Summary of Initial Feedback

The proposal aims to improve delivery of behavioral health services by bundling services in a predefined episode with a single up-front prior authorization for the entire episode. The majority of the episode payment (88%) would be made prospectively at the start of the episode with a 12% holdback to be paid at the end of the episode based on performance (with a yield of 10.9% to 13.2% of the total episode payment). Behavioral health practitioners represent a group where participation in Alternative Payment Models (APMs) has been limited. The Preliminary Review Team (PRT) found that the submitted model has significant limitations in terms of the criteria specified by the Secretary. Specifically, the PRT has concerns about the ability of the proposed model to produce cost savings (Criterion 2: Quality and Cost), the amount of meaningful risk involved (1.2% of total payment), and that the model design may be vulnerable to gaming because release of the withhold payment is based on PHQ-9 performance determined directly by the provider who receives payment (Criterion 3: Payment Methodology). Additionally, the proposal does not address how clinicians would be adequately incentivized to provide valuable care (Criterion 4: Value over Volume).

¹ **Disclaimer Regarding Initial Feedback:**

- Initial feedback is preliminary feedback from a Preliminary Review Team (PRT) subcommittee of the PTAC and does not represent the consensus or position of the full PTAC.
- Initial feedback is not binding on the full Committee. PTAC may reach different conclusions from that communicated from the PRT as initial feedback.
- Provision of initial feedback will not limit the PRT or PTAC from identifying additional weaknesses in a submitted proposal after the feedback is provided.
- Revising a proposal to respond to the initial feedback from a PRT does not guarantee a favorable recommendation from the full PTAC to the Secretary of Health and Human Services (HHS).

Evaluation of Proposal Against Select Criteria

CRITERION 2. QUALITY AND COST (High Priority Criterion). 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.

A 2025 Office of the Inspector General (OIG) report performed an audit on Medicare's only existing behavioral health episode payment—the opioid treatment program bundles—and reported that the bundled payments resulted in over \$300 million in overpayments. The proposal does not explain how this model would be different and produce savings for Medicare. Furthermore, the proposal does not describe a process for reconciliation and recoupment for episode overpayment when patients drop out and do not complete their entire treatment regimen under the 16-week MDD episode. The CMS Innovation Center would not be able to test a new payment model that would be likely to increase spending.

Additionally, the psychiatric collaborative care management (CoCM) approach, which currently exists within Medicare fee-for-service (FFS), reimburses providers for cumulative time spent delivering CoCM services per month. The proposal does not explain why this model would improve quality beyond the CoCM approach that Medicare already has in place.

CRITERION 3. PAYMENT METHODOLOGY (High Priority Criterion). Pay APM Entities with a payment methodology 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.

The proposed model would provide a prospective payment of 88% to clinicians for a 16-week MDD episode with a 12% withhold of total episode payment that the provider can earn back at episode close with a fidelity multiplier of 0.90 to 1.10 based on clinical guideline performance. This means that providers would receive a minimum of 98.8% of total episode payment regardless of performance (and up to 101.2% of the episode rate), which does not represent substantial risk to the provider and would be unlikely to change provider behavior. The PRT notes a discrepancy: the fidelity corridor is described as covering 79 to 110 percent of the base rate in Section 4.5 whereas the rest of the proposal mentions a fidelity corridor of 90 to 110 percent. Regardless, the PRT has concerns that the amount of substantial risk to the provider would be negligible and unlikely to change provider behavior.

Additionally, the model could be vulnerable to gaming because the release of the withhold is contingent on reducing the patient's score on the PHQ-9 assessment by at least 50%. The performance-based assessment is administered and recorded by the paid clinician. The submitter attempts to address these issues in the proposal (Section 4.7) explaining that every PHQ-9 administration is a time-stamped, structured data event where the score, administration dates, and identity of the administrator are all able to be reviewed for potential gaming. Additionally, the same PHQ-9 assessment and guideline criteria

are used at baseline and at end of the episode so any inflation in scores would show deviation from standard norms. However, the PRT remains concerned about the retrospective review of this data and is unsure that CMS has a system in place to perform this data detection. Moreover, if the patient's score is not reduced, then the provider can simply re-tier the patient, which would provide higher prospective payments to the clinician. This potential gaming issue is not mentioned in the proposal.

CRITERION 4. VALUE OVER VOLUME. Provide incentives to practitioners to deliver high-quality health care.

Under the proposed model, providers would receive 88% of the payment before services are rendered and regardless of the value or quality of these services. Additional services or visits would not generate additional revenue, thus potentially incentivizing providers to render fewer services. The only incentive to provide valuable services is the 0.90 to 1.10 multiplier applied to the 12% withhold received at episode completion. However, this represents a maximum of only 1.2% of the total episode payment at risk (e.g., \$36 at risk of the proposal's estimated \$2,996 episode payment). This most likely will not represent substantial risk to providers and consequently will not serve as an incentive to change behavior.

Other Considerations

CRITERION 1. SCOPE (High Priority Criterion). Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

The model proposes to reduce prior authorization approvals by structuring major depressive disorder (MDD) services in a 16-week episode duration where prior authorization would only be required once at the beginning of the episode instead of before each individual service. The PRT notes that the prior authorization process for outpatient behavioral health services is only applicable to the Medicare Advantage (MA) population and not the Medicare FFS population. Similarly, the CMS-0057-F final rule and CMS-0062-P proposed rule that mandate FHIR Prior Authorization APIs, which are proposed as the means for prior authorization approval and measuring clinical pathway adherence, apply only to MA and not to Medicare FFS. The Centers for Medicare & Medicaid Services (CMS) Innovation Center may potentially be interested in models that target MA; however, the proposal does not address how the model would be implemented and/or differ between the Medicare FFS and Medicare Advantage populations. For example, would an outcomes-based payment model such as is proposed still have the potential to improve care under original Medicare in the absence of prior authorization?

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 PFP.

The proposal explains that the pathway and treatment plan for the MDD episode of care includes specific care coordination services that take place between the psychotherapist/clinical psychologist, prescriber, and primary care provider. However, the proposal does not explain how care coordination would occur beyond stating that it is part of the required episode of care. It also does not specify how care coordination would be measured to ensure that care coordination is occurring.

CRITERION 9. PATIENT SAFETY. Aim to maintain or improve standards of patient safety.

The proposal suggests that creating a behavioral health episode of care for a set duration of time, rather than requiring prior authorization approval (applicable to MA only) and retrospective claims adjudication for each individual behavioral health service, should decrease the chances of potential adverse events occurring due to interruptions in care delivery/treatment (e.g., relapses, hospitalizations). Additionally, the proposal indicates that adherence to clinical pathways/guidelines can be assessed throughout the episode of care using the FHIR API infrastructure rather than retrospectively through claims adjudication, ensuring that patients are receiving the proper care for their condition. However, the proposal does not discuss how the model could lead to potential unintended consequences for beneficiaries (e.g., potential for clinicians to provide fewer services than needed, potential provider cherry-picking of patients).

CRITERION 10. HEALTH INFORMATION TECHNOLOGY. Encourage use of health information technology to inform care.

The proposed model states that it would use FHIR Prior Authorization API infrastructure. The proposal indicates that clinical pathway adherence can be measured passively using FHIR clinical data (e.g., FHIR will translate the clinical guidelines into computer logic to evaluate if care received matches against these clinical guidelines).

However, the PRT notes that CMS-0057-F final rule and CMS-0062-P proposed rule that mandate FHIR Prior Authorization APIs apply only to MA and not to Medicare FFS. The proposal does not describe how health IT or measurement of clinical pathway adherence would be handled for the Medicare FFS population.