



Charles N. Kahn III
President and CEO

September 3, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS Innovation Center Model on Wasteful and Inappropriate Service Reduction (WISeR)

Dear Dr. Oz:

On behalf of the Federation of American Hospitals (FAH), we are writing to express concerns about the Wasteful and Inappropriate Service Reduction (WISeR) Model. The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. The FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

We commend the Centers for Medicare & Medicaid Services (CMS) for its continued commitment to safeguarding the fiscal integrity of the Medicare program. Efforts to eliminate fraud, waste, and abuse are important and necessary. However, we are deeply troubled by both the substance and process of the WISeR Model and urge CMS to reconsider its approach. As currently structured, we are concerned the WISeR Model would threaten patients' access to medically necessary services, imposes excessive burdens on providers, lacks transparency, and incentivizes contractors to deny appropriate services to Medicare beneficiaries.

As outlined in more detail below, we do not believe the WISeR Model is the best approach for trying to address perceived over-utilization of Medicare services and we urge CMS not to move forward. However, if CMS moves forward, we recommend that CMS:

- Delay this "mandatory" model and offer stakeholders a full opportunity for notice and comment rulemaking prior to final program design and implementation;
- Provide at least 6 months after guidance and program processes are released before implementation to ensure providers, MACs and WISeR vendors have time for education and to make operational and system changes;

- Remove the financial incentives to deny care by basing WISeR vendor payment on the level of denied services; and
- Use the WISeR technology-enabled applications to identify and correct excessive Medicare Advantage plan prior authorization denials and inconsistencies.

The WISeR Model and the Risks of Expanding Prior Authorization in Traditional Medicare

As outlined in CMS' June 2025 Request for Applications (RFA), the WISeR Model seeks to reduce unnecessary spending in Traditional Medicare by implementing prior authorization and prepayment review for a select group of outpatient procedures. CMS plans to contract with technology companies that will use artificial intelligence (AI), machine learning, and clinician reviewers to assess requests for services such as skin and tissue substitutes, nerve stimulators, and arthroscopic knee surgeries. The model will initially apply in six states: Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington.

Selected vendors will be compensated for reducing volume and spending on the targeted services. Contractors will receive a share of the savings from services deemed medically unnecessary or non-covered. Providers in participating regions will be required to either obtain prior authorization for targeted services or undergo automatic prepayment review.

While CMS frames WISeR as a demonstration of technology-enabled innovation, we respectfully submit that this model is neither novel nor well suited for Traditional Medicare. Rather, our concern is that the WISeR Model risks replicating some of the worst aspects of Medicare Advantage (MA) utilization management practices within Traditional Medicare—a program that has largely shielded beneficiaries from burdensome and opaque prior authorization requirements.

Traditional Medicare has ensured the ability of beneficiaries to access timely, medically necessary care without the obstacles of the additional administrative costs to providers routinely encountered in MA and the commercial insurance setting. The introduction of prior authorization into this environment represents a significant departure from historical program design.

The FAH and other stakeholders have documented the widespread harm caused by aggressive prior authorization practices in MA. These include inappropriate denials of medically necessary services, care delays, provider burnout, and excessive administrative costs. According to the Office of Inspector General (OIG), MA plans routinely deny services that would have been covered under Traditional Medicare. A 2022 OIG report found that 13% of denied prior authorizations met Medicare coverage rules, and 18% of payment denials were for services that should have been paid. Additionally, appealing MA plan denials is administratively burdensome and costly – requiring teams of clinical, utilization management, and financial staff to spend hours on each case. Further, in another 2018 report on prior authorization abuses, the OIG found that MA plans often overturned 75 percent of their own initial denials during 2014-2016.

The use of prior authorization as a blunt cost-containment tool in MA has harmed both patients and providers. Extending these practices to Traditional Medicare will only exacerbate these harms. Moreover, the reliance on AI systems to support these determinations raises concerns about bias, lack of transparency, and limited ability to account for clinical nuance—issues that have not yet been fully addressed through regulation or industry standards. Notably the WISeR proposal seems to conflict with CMS' recent announcement with national health insurers and the joint effort to reduce the overall volume of prior authorization requirements in the MA program.

WISeR's proposal to base contractor payment on the volume of care denied adds another troubling dimension. This structure could create a financial incentive to deny legitimate claims, prioritizing cost savings over patient care. Without stringent oversight and meaningful appeals processes, patients and providers may be left with little recourse.

While the FAH strongly supports efforts to ensure program integrity, we urge CMS to abandon this flawed program. This Model will add significant administrative burden and costs to providers and patients, provides incentives for WISeR vendors to deny care to Medicare beneficiaries in order to increase their own revenue, and relies on AI-based technology that may lead to biases in care with little transparency.

WISeR Implementation Process is Rushed and Lacks Transparency

CMS' approach to developing and announcing the WISeR Model has lacked the transparency and stakeholder engagement that such a significant policy change warrants. The release of the RFA and fact sheets occurred without prior notice or opportunity for public comment. Despite fundamentally altering access to services for beneficiaries in six states, CMS has proceeded without engaging stakeholders, including hospitals, clinicians, and patient advocates.

Additionally, the proposed January 1, 2026 implementation date is far too soon. Hospitals, physicians, the Medicare Administrative Contractors (MACs), and new WISeR prior authorization firms will need time to update systems, train staff, and develop workflows to comply with prior authorization requirements. If this program moves forward, CMS will need to issue guidance and education to all parties with plenty of time to implement the new processes to ensure that patient care is not delayed and compromised. Hospitals, physicians, and health systems in affected states will be forced to make hasty operational changes, potentially resulting in service delays and billing disruptions. To date, CMS has offered no clear guidance to support provider readiness. **The FAH urges CMS to delay the start of the program and to provide at least 6 months after guidance and program processes are released before implementation.**

Furthermore, while CMS refers to WISeR as a *voluntary* demonstration, it imposes mandatory requirements on every provider and supplier furnishing selected services in the target regions. If the provider declines to file a PA request prior to the patient receiving the service, they will still face an automatic pre-payment review, which delays or denies payment until additional paperwork is supplied. In practice, the model therefore imposes a mandatory layer of administrative burden on every claim in the selected states. In effect, this is a mandatory model implemented without giving the public an opportunity to comment. Section 1395hh of the Social Security Act calls for notice-and-comment rulemaking whenever CMS changes a substantive condition of payment. By introducing the WISeR Model through a single Federal Register notice, the Agency appears to have bypassed that process. The FAH is concerned that stakeholders were not given the opportunity to review and comment as the statute envisions. The administrative burdens of the WISeR model should not be put on patients and providers without clear, proven benefits for patients and the health system as a whole.

The lack of clarity regarding the model's appeals process, data sharing protocols, oversight mechanisms, and AI vendor transparency further heightens our concerns. CMS has not provided sufficient detail about how providers will be treated, how beneficiary outcomes will be measured, or how performance failures by contractors will be remedied. **Again, the FAH urges CMS to delay the program and use the notice and comment rulemaking** to address all of these issues and concerns through rulemaking prior to the implementation of any new model.

Misaligned Financial Incentives and Risk of Care Denials

CMS' decision to pay WISeR contractors based on a share of the savings they generate from denied claims is deeply problematic. This model risks incentivizing prior auth and payment denials for the sake of profit, rather than focusing on appropriateness of necessary care and patient safety. Such arrangements are at odds with CMS' broader commitment to patient-centered care and program integrity.

The experience of our members under MA has demonstrated that financial incentives tied to denials result in delayed care, prolonged hospital stays, and avoidable harm. When contractors are compensated based on how much care they prevent, the line between necessary and unnecessary services becomes dangerously blurred. When Medicare recovery audit contractors (RACs) were first utilized in the early 2000's with unchecked incentives to deny payment because they received a portion of the “savings” recouped from providers, the RACs were overly aggressive, as expected. Ultimately, the RACs were scaled back, monitored, and their incentive payments were limited by several checks and balances to minimize overly aggressive denials. **If CMS moves forward, we recommend that CMS implement penalties, limits on incentives and other constraints to minimize overly aggressive denials of care and payment.**

Moreover, the reliance on AI-based determinations—even with clinician oversight—raises profound concerns about fairness and accountability. AI systems are only as good as the data and assumptions behind them. Without full transparency into these algorithms, it is impossible to ensure that decisions are free of bias, accurate across diverse populations, or aligned with evidence-based practice. The stakes are too high to proceed without robust validation, testing, and accountability. CMS has not provided information on how these concerns will be addressed – even though these concerns have become increasingly problematic with vocal opposition and concern being raised across the healthcare and policy community. Further, any denials issued by the contractor must include clinical documentation outlining the rationale and the algorithm's criteria for the denial with specifics related to the individual patient's case. Denial communications with generic verbiage will not allow providers to adequately address the patient's appeal opportunities nor will they help to educate and prevent future denials.

Better Solutions: Targeted Oversight of Outliers

CMS already has effective tools to address aberrant billing and reduce waste in Traditional Medicare. The agency can use post-payment review, focused audits, and data analytics to identify providers with unusually high utilization of specific services. By targeting outliers, CMS can root out fraud and abuse without imposing burdensome preauthorization requirements on all providers and patients.

This selective, data-driven approach respects the expertise of front-line clinicians, preserves patient access to timely care, and aligns with the principles of value-based care. It also avoids the costly and disruptive administrative layering that WISeR introduces.

We urge CMS to redirect its efforts toward refining these existing oversight mechanisms. Rather than subject millions of Medicare beneficiaries in the selected states to delays and denials, CMS should focus on strengthening its ability to detect and address problematic behavior through targeted, evidence-based interventions. If CMS moves forward, we urge CMS to exclude WISeR services that receive prior authorization from CMS' existing program integrity programs such as reviews by RACs, QIOs, Targeted Probe and Educate program, etc.

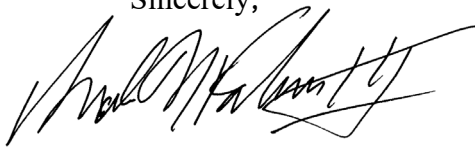
Focus on Opportunities to Address Needed Improvements in MA

With the recent announcement from health plans and CMS to address excessive prior authorization in MA, we urge CMS to re-focus this effort on MA. These tools which are often used today by MA plans to deny care, could be re-tooled to identify and prevent excessive denials and inconsistencies in prior authorization use. As we noted earlier in this letter, a 2018 OIG report on MA prior authorization abuses found that MA plans overturned 75 percent of their own initial denials during 2014-2016. While patients ultimately received care and providers were finally paid, their initial “error” rate in prior authorization decisions was approximately 75 percent. We recommend that CMS re-evaluate the WISeR model and consider retooling to address the problems with abusive prior authorization in Medicare Advantage.

The FAH is committed to supporting CMS' mission to safeguard Medicare while ensuring access to high-quality, patient-centered care. However, the WISeR Model, as currently designed, represents a step in the wrong direction. It prioritizes denial-based cost savings over clinical judgment, imposes unjustified burdens on providers and patients, and lacks the transparency and stakeholder engagement.

We respectfully urge CMS to reconsider its approach and engage with providers, patients, and other stakeholders to design a more thoughtful approach. The FAH appreciates the opportunity to share our concerns. If you have any questions, please contact me or Don May at 202-624-1500 or email at DMay@fah.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Abe Sutton', written over a white background.

cc: Abe Sutton, Deputy Administrator and Director, Center for Medicare and Medicaid Innovation