Congress of the United States

Washington, DC 20515

August 7, 2025

The Honorable Dr. Memet Oz
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave, SW
Washington, DC 20201

Dear Administrator Oz,

We write to share our concerns regarding the Centers for Medicare and Medicaid Services' (CMS) expanded implementation of prior authorization practices into Traditional Medicare via the Center for Medicare and Medicaid Innovation's (CMMI's) Wasteful and Inappropriate Service Reduction (WISeR) Model.

The use of prior authorization in Medicare Advantage shows us that, in practice, WISeR will likely limit beneficiaries' access to care, increase burden on our already overburdened health care work force, and create perverse incentives to put profit over patients.

On June 27, 2025, CMS announced its intention to use WISeR, which contracts with private companies to implement artificial intelligence (AI) to automate prior authorization. The model will run for six performance years, starting on January 1, 2026, until December 31, 2031. Newly impacted health care services that will soon be subjected to prior authorization include, but are not limited to, skin and tissue substitutes, electrical nerve stimulator implants, and knee arthroscopy for knee osteoarthritis. The model will only apply to providers and patients in New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington.[1]

Traditional Medicare has rarely required prior authorization. This is vastly different in Medicare Advantage, in which beneficiaries are regularly subjected to prior authorization, as documented by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) and CMS.[2] While prior authorization is often described as a cost-containment strategy, in practice it increases provider burden, takes time away from patients, limits patients' access to life-saving care, and creates unnecessary administrative burden. Many patients choose Traditional Medicare because they know their care will be determined by their doctors and not by insurance companies.

The use of prior authorization has steadily increased, with Medicare Advantage insurers making roughly 50 million prior authorization determinations in 2023.[3] A 2018 HHS OIG report found that 75% of denied prior authorization requests were overturned upon appeal, suggesting inappropriate initial denials were widespread.[4] A 2022 HHS OIG report further revealed that MA plans frequently violated Medicare coverage rules in their use of prior authorization. HHS OIG has investigated plans and their contractors because prior authorization can be profit-seeking.[5]

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[1] https://www.aamc.org/advocacy-policy/washington-highlights/cmmi-releases-new-prior-authorization-model-medicare
[2] https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/
[3] https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/
[4] https://oig.hhs.gov/reports/all/2018/medicare-advantage-appeal-outcomes-and-audit-findings-raise-concerns-about-service-and-payment-denials/
[5] https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/

The Trump Administration publicly recognized the harm of prior authorization. On June 23, 2025, Trump Administration officials publicly touted a pledge by the health insurance industry to curtail prior authorization abuses.[6] And yet, not a week after these statements, CMS put forward a new proposal to increase the utilization of prior authorization in a type of health coverage that had seldom used the tactic before, replacing doctor's medical knowledge with an algorithm designed to maximize care denial in order to increase profits.

It is also troubling that the WISeR model is expected to contract with entities including Medicare Advantage plans– the very entities that have abused prior authorization for Medicare patients enrolled in private plans – to run these demonstrations. The model is described as voluntary, but it is only voluntary for the model participants. Medicare providers in WISeR model states will be required to either submit a prior authorization claim or be subject to review prior to payment, making this an involuntary burden on providers and Medicare beneficiaries.

Prior authorization has long been abused, and it is bad for patients and providers. The American Medical Association notes, "Among America's physicians, more than nine in 10 surveyed say that prior authorization has a negative impact on patient clinical outcomes." We urge you to put patients and providers first by cancelling the WISeR model and exploring other ways to limit fraud, waste, and abuse in the Medicare program.

Following this announcement, we request you answer the following questions by September 1, 2025.

- What criteria were used to select the six states for this model?
- What services will be subject to prior authorization in each state? Will the model operate on a statewide basis for all services and in all states or will there be variation among states (and if so please describe)?
- How will entities performing prior authorization be selected? What qualifications will be required to ensure that reviewers have appropriate expertise?
- How will patients and providers be educated about the new prior authorization requirements and appeals rights?
- What review of the contracted entities' algorithms will occur to ensure that inappropriate denials of medically necessary care do not occur?
- What performance metrics will be required for entities performing prior authorization? How quickly must entities issue decisions? Will there be sanctions for participants that to not render decisions timely? Will prior authorization denials count as benefit denials that allow patients to access appeal rights?
- Has CMS studied how prior authorization in Traditional Medicare may increase rates of physician burden and burnout?
- CMS has indicated that model participants will be compensated based on a share of "averted expenditures." This approach appears to reward participants based on the volume or cost of care they prevent from being delivered or paid, yet past experience from Medicare Advantage and other markets shows that this incentive has often led to inappropriate denials.
    - What protections or thresholds will CMS impose to ensure that denials are evidence-based, not volume-driven?

Sincerely,

[6] https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html

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