American Hospital Association™
Advancing Health in America

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October 23, 2025

Abe Sutton, JD
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Medicare Program; Implementation of Prior Authorization for Select Services for the Wasteful and Inappropriate Services Reduction (WISeR) Model; (CMS–5056–N)

Dear Deputy Administrator Sutton:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, as well our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — the American Hospital Association (AHA) writes to share our members' perspectives regarding the Centers for Medicare & Medicaid Services' (CMS') Wasteful and Inappropriate Services Reduction (WISeR) model. Given the delay in our in-person meeting due to the government shutdown, and given the impending start date of Jan. 1, we wanted to expeditiously share our recommendations for placing some guardrails on this important model to ensure that it achieves its goal of eliminating waste, fraud and abuse without creating inappropriate barriers to patient care or administrative burden for providers.

The WISeR model seeks to utilize technology-enabled prior authorization to decrease certain services that may have little to no clinical benefit for some patients and historically have had a higher risk of waste, fraud and abuse. Using selected vendors, CMS intends to reduce inappropriate utilization of applicable medical services to lower spending in Original Medicare while also easing provider administrative burden. The model would be conducted in six states: Arizona, New Jersey, Ohio, Oklahoma, Texas and Washington.

We commend CMS for its efforts to combat waste, fraud and abuse in the health care system, and we recognize that the WISeR model can be a useful tool to help ensure patient care is based on well-established evidence of efficacy and safety. However, prior authorization requirements, if not properly administered, can create dangerous

delays in care and substantial provider administrative waste.[1] As a result of the difficulties that our members have had with improperly administered prior authorization programs, we offer the following suggestions to improve the model.

Vendor Payment Methodology

We have substantial concerns regarding the participating vendor payment structure, which incentivizes denials at the expense of physician medical judgment. CMS has indicated that participating vendors will be compensated by receiving 10-20% of the savings associated with care denials. Such a structure creates a perverse incentive to deny care that otherwise may be appropriate, as vendors may increase their profits by denying care. Although we appreciate that CMS plans to regularly audit participating vendors to ensure that they are not denying necessary care, these audits may only address the most egregious inappropriate denials, thereby leaving coverage determinations "in the margins" vulnerable to denial rather than the informed medical judgment of the practitioner treating the patient. This problematic compensation model was utilized by MultiPlan, as detailed in a New York Times investigation and addressed in the ongoing federal antitrust lawsuit.[2,3] Rather than create the inherent bias of tying compensation to denying patient access to recommended treatment, we recommend that CMS utilize a flat fee compensation structure for selected vendors. Such reform will ensure that WISeR vendors do not have a financial motivation to create obstacles to Medicare beneficiaries' timely access to necessary treatment.

Appeal Rights

To ensure appropriate patient access to treatment, CMS should enable patients to appeal prior authorization denials issued by participating vendors. Currently, Medicare Advantage (MA) beneficiaries are entitled to appeal all adverse organization determinations, including prior authorization denials.[4] Conversely, under the proposed WISeR structure, a non-affirmed prior authorization decision can only be resubmitted or reconsidered via peer-to-peer consultation with the vendor.

Although we appreciate the inclusion of a peer-to-peer review of denied authorizations, we believe that Original Medicare beneficiaries are entitled to the same rights as their MA counterparts and should have the ability to proactively and completely appeal adverse organization determinations made on prior authorization requests. Preventing patients from having the ability to appeal denials to CMS in advance of care jeopardizes their ability to receive timely and appropriate care, as improper denials would have significantly diminished avenues for being corrected. This is particularly troubling when

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[1] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[2] https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills-takeaways.html
[3] https://www.justice.gov/atr/media/1394631/dl
[4] https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims

dealing with AI-based denials, which have been shown to often target financial gain over medical appropriateness when rendering decisions.

We recommend that CMS require participating vendors to have timely and sufficient appeals processes in place that allow patients to have their denials reviewed by a physician with appropriate expertise in the relevant field of medicine on which the request is based.

Guardrails on Artificial Intelligence

The WISeR model plans to leverage artificial intelligence (AI) and machine learning technologies to determine Medicare coverage. Although we recognize the efficiencies that these technologies may offer the health care system, their use in determining coverage criteria and supporting medical necessity determinations requires substantial oversight and appropriate guardrails. The use of AI and other automated technologies in medical decision-making, without appropriate controls, may ignore patient-specific care details in favor of algorithm output.

We appreciate CMS indicating that vendors will be required to have appropriately trained medical professionals review and make final decisions; although experience has shown that health plans often over-rely on the AI recommendations, and medical review, if it occurs, is often little more than a check-the-box exercise.[5] To ensure that AI is used to supplement, rather than replace, the independent medical judgment of an appropriately trained medical professional, CMS needs to implement additional guardrails to specifically track physician involvement in prior authorization determinations, including but not limited to, tracking the time spent reviewing each AI-proposed denial, the number of AI recommendations that the vendor physician(s) overturned, and the service-specific qualifications of the clinician reviewer.

Adequate Vendor Oversight

In the Federal Register notice, CMS indicated an interest in the WISeR demonstration using the same vendors and AI technologies as MA organizations. Specifically, the notice mentioned exploring "findings from MA plans regarding the use of enhanced technologies to examine how to efficiently, accurately, and appropriately ensure select services are provided and paid for based on clinical and evidence-based guidelines."[6]

We have significant concerns with using vendors used by MA plans — the very same prior authorization plans that the Department of Health and Human Services (HHS) Office of the Inspector General has repeatedly found to inappropriately interfere with

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[5] https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims
[6] https://www.federalregister.gov/documents/2025/07/01/2025-12195/medicare-program-implementation-of-prior-authorization-for-select-services-for-the-wasteful-and

patient access to necessary care — as a model for how to implement such a program.[7,8] The troubling history of MA plans' inability to properly apply CMS coverage criteria highlights the crucial need for CMS to issue strong controls on the specific technologies used by plans, including requiring public transparency into the algorithms used and disclosure of the exact coverage rule and corresponding clinical information relied upon in issuing a denial to providers and patients.

Scope

Our members are extremely concerned about the prospect that the WISeR model could be expanded beyond the specific services identified. CMS indicates that the model will target services that "1) pose concerns related to patient safety if delivered inappropriately; 2) have existing publicly available coverage criteria; and 3) may involve prior reports of fraud, waste and abuse," while indicating that CMS may add additional services in future years.[9] Given the enormous disruptions that prior authorization can have on patient access to care and provider administrative burden, we urge the administration to refrain from increasing the number of states or adding new services to the program until after the model has concluded and been subject to a thorough evaluation. Furthermore, if CMS seeks to potentially add services at that time, the agency should limit such considerations exclusively to services that have prior reports of fraud, waste and abuse, and preliminarily engage with hospitals and physicians to better understand potential administrative burdens and impacts on patient care delivery.

Programmatic Evaluation

Although CMS has indicated its goal of testing the use of enhanced technology to decrease certain low-value services, the agency has not specified how the program will be evaluated. To promote transparency and to adequately measure the success of the model, we urge CMS to clearly identify how it will evaluate program success. We recommend that the agency release a quarterly progress report with relevant vendor performance information, including the number of prior authorization approvals, denials, corresponding claim denials and appeals of impacted claims. Additionally, we recommend that CMS ensure that patient and provider experiences with the program are considered when determining programmatic success, with particular attention focused on quality metrics and the program's impact on patient health outcomes and care experience.

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[7] U.S. Department of Health and Human Services Office of Inspector General. "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials," OEI-09-16-00410. September 2018.
[8] U.S. Department of Health and Human Services Office of Inspector General. "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," OEI-09-18-00260. April 2022.
[9] https://www.cms.gov/files/document/wiser-fact-sheet.pdf

Consistency With Prior Authorization Reform Technology

We are concerned that the WISeR model would require the use of technology-enabled prior authorization processes without mandating that participating vendors utilize the standards included in the recent commercial insurer prior authorization pledge. On June 23, HHS announced a comprehensive prior authorization pledge designed to reduce burdens associated with commercial prior authorization programs.[10] One of the central components of the pledge is that all insurers promised to utilize Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interfaces standards in prior authorization, which would ensure that providers can utilize a consistent method of navigating insurer prior authorization requirements using technology that can integrate with provider EHR systems.

The WISeR model fails to incorporate these standards, instead relying on fax machines, postage-based mail, and vendor-specific portals to transmit prior authorization requests. The use of the same antiquated submission platforms that have created administrative burden for years, along with AI-based solutions that do not leverage FHIR transactions, would increase manual processing burdens and require inconsistent workflows for providers, as prior authorizations would have to be handled one way for commercial patients and a completely different way for patients with Original Medicare. Furthermore, the current submission methods fail to leverage the provider's EHR, thereby requiring providers to manually collect and extract all necessary clinical information to submit. Particularly in light of the program's robust documentation requirements, this will add substantial administrative burden on providers. We urge CMS to mandate that vendors participating in WISeR support FHIR-enabled APIs, consistent with the Interoperability and Prior Authorization Final Rule (CMS-0057-F).

Implementation Timeline

The WISeR model is scheduled to begin on Jan. 1, 2026. This timeframe is impractical for providers and jeopardizes the administration's goal of easing provider administrative burden associated with prior authorization. To implement a new workflow, particularly one impacting both clinical and administrative workflows, hospitals must complete numerous essential steps. Although it is difficult to project all necessary changes prior to CMS identifying the specific vendors and programmatic requirements, providers will need to analyze the new technology requirements (including entering into any necessary contracts related to privacy/security requirements), determine how that platform will incorporate into their existing electronic health record and revenue cycle systems, install and test the new platform, educate existing and potentially hire new staff, and update and operationalize new workflows. To properly complete each of these essential processes, hospitals will require more time than the remainder of 2025.

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

Additionally, program vendors will inevitably be engaging in novel processes as they implement WISeR requirements. Although CMS has noted that it is looking to existing prior authorization vendors to serve as participating entities, those systems will inevitably face distinct challenges and nuances in implementing the WISeR model. For example, many prior authorization vendors previously have not employed or managed physician staff to complete claims review, as these functions were typically performed by medical directors of the health plans utilizing their technology solution. Additional time would help to ensure that these vendors can properly decipher medically necessary care from superfluous services. **As a result, we strongly encourage CMS to delay implementation of the WISeR model by at least six months**. Furthermore, upon eventual implementation, we recommend that CMS implement an operations and testing period during which claims will not be denied as a result of the WISeR model processes, and vendors and physicians can test the technologies and identify any unforeseen issues that may impact patient care.

We thank you again for allowing us to offer recommendations for the WISeR model. We believe that the model, with these changes, has the potential to reduce waste, fraud, and abuse while maintaining efficient patient access to care. We look forward to speaking with you and your team further on ways to improve this important demonstration to protect providers and Medicare beneficiaries. Please contact me if you have questions, or feel free to have a member of your team contact Terrence Cunningham, senior director of administrative simplification policy, at tcunningham@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development