July 16, 2025

Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: WISeR Model in Medicare Fee-for-Service

Dear Administrator Oz,

On behalf of the twenty-three undersigned organizations representing physicians involved in the delivery of surgical care to Medicare beneficiaries, we write to express our deep concern to the Wasteful and Inappropriate Service Reduction (WISeR) Model in the Medicare Fee-for-Service (FFS) program. While we share the Centers for Medicare & Medicaid Services' (CMS) commitment to ensuring Medicare beneficiaries receive items and services that are reasonable and necessary, we firmly believe that this six-year prior authorization demonstration project will jeopardize patient access to care, create more administrative burdens for physicians, offer perverse payment incentives for third-party vendors, and represent a substantial reversal of progress toward this Administration's goal of prioritizing patients over paperwork.

Expansion of Prior Authorization in Medicare FFS

The WISeR Model would dramatically increase the volume of items and services subject to prior authorization, which has historically not been utilized in Medicare FFS. There is no general authority for prior authorization in Medicare FFS, as evidenced by the enactment of 42 U.S.C. § 1395m(a)(15) to allow for prior authorization in the program only for durable medical equipment, prosthetics, orthotics, and supplies. In further recognition of the Agency's limited authority to implement prior authorization in Medicare FFS, the hospital outpatient department (OPD) prior authorization policy was executed in 2020, not under a general FFS prior authorization authority, but rather under a statute that CMS cited to enact measures to address "overutilization."[1]

CMS' announcement of the WISeR Model is also concerning given that it directly contradicts the Administration's recent endorsement of AHIP's set of reforms, which includes efforts to limit the scope of claims subject to prior authorization, provide simple explanations and easy-to-access assistance for prior authorization determinations, and guarantee that prior authorization denials based on medical necessity for clinical factors will be reviewed by a qualified clinician.[2] These efforts, to which several major health insurers have committed, are broadly intended to *reduce* the volume of items and services to which prior authorization applies. In contrast, the Agency is signaling through WISeR its intention to substantially expand prior authorization via the Medicare FFS program. Given that the CMS Innovation Center exists to pilot delivery system reforms with the intent of broader adoption, the implications of this model's implementation are significant. Expanding prior authorization under the guise of innovation risks exacerbating existing barriers to care, rather than advancing meaningful reform.

[1] 42 U.S.C. § 1395l(t)(2)(F) states "the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services"
[2] Health Plans Take Action to Simplify Prior Authorization. AHIP. June 23, 2025. https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization.

Model Impact on Physicians and Patients

Although the Agency characterizes the WISeR Model as "voluntary," in practice, physicians within the model's jurisdiction will be forced to choose between submitting a prior authorization request for items and services included in WISeR or go through a post-service/pre-payment review process. Physicians that proceed with the prior authorization route must either submit a request directly to a participating vendor or to their Medicare Administrative Contractor. Should a physician elect not to submit a request for an included item or service, their claim will be subject to medical review to determine if the delivered item or service met Medicare rules prior to payment. CMS also indicates that payment to physicians for included items and services will not change under the model (i.e., physicians will not receive any additional funds for complying with model requirements despite the greater amount of time and resources they are expected to devote to achieve compliance); however, participating vendors will be compensated based on a share of averted expenditures that can be directly attributed to their prior authorization review processes.

The WISeR Model runs counter to the Administration's stated commitment to reducing unnecessarily burdensome federal regulations and requirements in order to foster innovation in the private sector. The vast majority of physicians who render and bill for items and services under FFS are committed to program integrity and consistently comply with Medicare coverage requirements. Rather than relying on vendors to implement a complex and administratively burdensome model, the Agency should engage directly with the physician community to design targeted safeguards that protect the program without compromising access to care. CMS already maintains appropriately tailored programs to combat waste, fraud, and abuse, including recovery auditing and the Targeted Probe and Educate program.[3,4] These and other outreach and education efforts could be easily enhanced if CMS has concerns about the provision of particular services, ensuring that there are no undue burdens placed on compliant physicians and no unnecessary delays in the accessibility and delivery of medically-necessary care. If CMS proceeds with the WISeR model, it must, at a minimum, incorporate a gold-carding program or other approach to exempt FFS-compliant physicians. Although the model's Request for Applications indicates that CMS is considering such an approach, failing to include a policy or exemption process from the outset will penalize the physician community at large for the behaviors of a few individuals. Additionally, barriers to care have potential to negatively impact patients' health. Ensuring the quality and safety of patient care should be at the forefront of all CMS models, and if WISeR is implemented, the Agency must incorporate a methodology to evaluate its alignment with the care pathway and impact on patients' outcomes and experience.

Transparency, Accountability, and Oversight Mechanisms

CMS has failed to formally institute meaningful eligibility or accountability standards for vendors participating in the WISeR Model. Decision criteria to be used by participating vendors—including algorithms, scoring models, and evidence-based guidelines—remain a "black box," leaving stakeholders with little to no insight into how prior authorization determinations will be made. This again runs counter to the recent announcement by the Administration that several major health insurers have pledged to enhance transparency around their prior authorization processes. If CMS moves forward with the WISeR Model, it must stringently enforce guardrails to ensure that participating vendors operate with clinical and programmatic integrity and should conduct mandatory audits on a regular basis to monitor participating vendors' performance.

As previously noted, participating vendors will be financially rewarded based on the effectiveness of their technology solutions for reducing Medicare FFS spending. Specifically, payment amounts for

[3] Medicare Fee for Service Recovery Audit Program. Centers for Medicare & Medicaid Services. Updated June 2, 2026. Accessed July 8, 2025. https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medicare-fee-service-recovery-audit-program.
[4] Targeted Probe and Educate. Centers for Medicare & Medicaid Services. Updated September 10, 2024. Accessed July 8, 2025. https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/targeted-probe-and-educate-tpe.

participating vendors will be based in part on the volume of prior authorization requests processed and the number of non-affirmations made that are not successfully appealed. Models that monetarily incentivize coverage/claims denials undermine the integrity of the Medicare program, as such arrangements not only erode trust between physicians and insurers but also risk delaying or denying beneficiaries' access to the treatment they need.

For these reasons, we strongly urge CMS to reconsider implementation of the WISeR Model in the Medicare FFS program. This model fundamentally contradicts CMS' stated policy objectives to standardize, streamline, and limit the scope of prior authorization. Rather than introducing extralegal new prior authorization requirements via opaque third-party decision-making tools, we recommend that the Agency focus on solutions that support access to medically-necessary items and services while *reducing*—not *increasing*—administrative burdens and other barriers to the delivery of timely, high-quality patient care.

Sincerely,

American College of Surgeons

American Academy of Facial Plastic and Reconstructive Surgery

American Academy of Ophthalmology

American Academy of Otolaryngology – Head and Neck Surgery

American Association of Neurological Surgeons

American Association of Orthopaedic Surgeons

American College of Obstetricians and Gynecologists

American Orthopaedic Foot & Ankle Society

American Society for Surgery of the Hand Professional Organization

American Society of Anesthesiology

American Society of Cataract and Refractive Surgery

American Society of Colon & Rectal Surgeons

American Society of Metabolic and Bariatric Surgery

American Society of Plastic Surgeons

American Society of Retina Specialists

American Urogynecologic Society

American Urological Association

Congress of Neurological Surgeons

Society for Vascular Surgery

Society of American Gastrointestinal and Endoscopic Surgeons

Society of Gynecologic Oncology

The American Society of Breast Surgeons

The Society of Thoracic Surgeons

cc: Stephanie Carlton
Deputy Administrator and Chief of Staff
Centers for Medicare & Medicaid Services

Chris Klomp
Deputy Administrator and Director
Center for Medicare

Abe Sutton
Deputy Administrator and Director
Center for Medicare & Medicaid Innovation