December 23, 2025

Abe Sutton, J.D.
Deputy Administrator and Director, Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services (CMS)
200 Independence Avenue, SW
Washington, DC 20201

Dear Director Sutton,

Thank you for meeting with representatives from the Surgical Coalition on August 14, 2025, to discuss the Center for Medicare & Medicaid Innovation (CMMI) Wasteful and Inappropriate Service Reduction (WISeR) Model. We write to follow up on that conversation and highlight several areas where greater clarity, transparency, and accountability are needed as the WISeR model gets underway on January 1, 2026. Many of these issues have not yet been addressed or were addressed only briefly in the WISeR Provider and Supplier Operational Guide (the Operational Guide).[1] We also offer suggestions for how CMMI might approach both initial implementation and ongoing oversight of the model.

In summary, we offer comments on the following areas where we believe additional clarity on various processes would support the model's success:

- Communication from participants to providers
- Ongoing transparency and feedback to providers
- Transparent criteria and algorithms
- Non-affirmations
- Audit process and monitoring
- Reporting of performance metrics, outcomes, and provider/supplier and beneficiary experience
- Prior authorization of facility-based services
- Third party evaluation
- Participant payment incentives

We also recommend refinements to the model in the following areas:

- Gold carding
- Implementation of an annual fee-based structure
- 6-month soft launch

[1] WISeR provider and supplier guide. Accessed December 16, 2025. https://www.cms.gov/files/document/wiser-provider-supplier-guide.pdf.

- Process for removing items from the prior authorization list

Key Areas Requiring Additional Clarity to Ensure Successful Model Implementation

Since our meeting, CMMI has released information about the six WISeR Model participants. We ask that further information in these areas to be published in an updated version of the Operational Guide:

Communication from participants to providers

- Education: We ask that the selected participants distribute targeted and accessible educational information to providers on the model and how they are implementing their specific solution that is being tested in the affected jurisdictions as soon as possible. While the WISeR website and the December 4 Provider Office Hour offer helpful, high-level information, those resources are not substitutes for detailed, direct outreach from the entities that will actually be issuing determinations. We ask that CMMI require each participant company to distribute to the providers in their states a code-by-code breakdown of applicable items and services, pathways to coverage determination, the specific feedback process they will be using in the model, appeal rights, and other operational requirements. We ask that particular attention be paid to education related to how providers can incorporate model requirements into their workflows.

- Ongoing transparency and feedback to providers: In addition to pre-implementation education, participants should be required to issue routine and meaningful feedback about participants' performance to the providers subject to the model with a frequency that is informative and useful. We request that the feedback reports include, but not be limited to, participant response times (related to both standard and expedited reviews); information regarding the background and qualifications of "human clinician" reviewers with "relevant clinical expertise;" non-affirmation rates; the rate at which preliminary non-affirmation determinations are overturned by the relevant clinical expert; appeal rates; overturn rates on appeal; and resubmission data. CMS must also specify the frequency (e.g., quarterly) and format (e.g., webinars, written reports) of such feedback. We request that CMMI clarify the types of feedback participants will be required to make publicly available. We believe this high-level and timely feedback will contribute to the model's success and help our providers be good partners in the model's success.

Transparent Criteria and Algorithms

We request additional information regarding the criteria, algorithms and methodologies participants will use to make determinations under both the prior authorization process and the pre-payment medical review process. The WISeR website and Operational Guide do not describe these approaches in any detail.

We want to be sure that we are communicating correctly to our physician members in the selected states that what is included in the section on "required documentation" in the Operational Guide(i.e., the list of general documentation check boxes for each targeted procedure) is all they need to know to begin submitting requests to the participants on January 2, 2026. We are confused by the following language, which seems to allow for participant discretion:

> *To meet coverage criteria, the patient's medical record must contain documentation that fully supports the medical necessity for services,* ***such as*** *[emphasis added] the documentation requirements listed in the appropriate section below.*[2]

We are concerned that the Model affords participants excessive discretion to deviate from the listed coverage criteria, particularly in the initial implementation period. This level of flexibility could result in inconsistent determinations driven by individual judgment rather than uniform standards, undermining predictability and patient safety. While clearly and comprehensively written criteria could, over time, support appropriate and consistent decision-making, we do not support allowing deviations from the listed coverage criteria at the outset of the Model.

Also, while the WISeR Model request for applications (RFA) required applicants to explain their planned artificial intelligence (AI) algorithms, none of this information is currently available to providers or patients. To what extent do (and can) these algorithms go beyond the criteria included in the Operational Guide? To what extent do they account for unique cases that might not fit the listed criteria, but still represent appropriate care? We want to be confident that we are educating our members appropriately for their state and participant company assigned. We would appreciate additional specifics added to the Operational Guide as soon as possible to answer this question.

We understand that some methodologies may be proprietary; however, basic transparency about the inputs, evaluation metrics, and decision factors is essential to ensure that determinations appropriately account for patient-specific factors such as complexity, comorbidities, and physician judgment. Without this, patients and providers are left with opaque "black box" decisions that are difficult to challenge or appeal because they will not be aware of the information that is still needed by the participant.

We urge CMMI to establish clear parameters for participants' use of AI in prior authorization, including requirements for explainability and sufficient detail to support appeals.

[2] WISeR provider and supplier guide, page 10. Accessed December 16, 2025. https://www.cms.gov/files/document/wiser-provider-supplier-guide.pdf.

Non-affirmations

The WISeR Model frequently asked questions (FAQ)[3], as well as the Operational Guide, states that any prior authorization non-affirmation must be reviewed by a human clinician with relevant clinical expertise before being finalized. We request additional parameters around this requirement, including that non-affirmations be reviewed by a clinician who is licensed and board-certified within the same specialty as the submitting provider and that participants make information about these reviewers and their qualifications available to the public. We also urge CMS to apply these requirements to both prior authorization non-affirmations and as pre-payment medical review denials.

We also request more detail about what information will be included in a non-affirmation or denial notice. At minimum, participants should be required to provide:

- the specific Medicare coverage policy applied,
- the clinical basis for the denial, and
- confirmation that patient-specific factors were meaningfully considered.

Medically necessary but non-standard services may otherwise be inappropriately delayed or denied simply because they fall outside algorithmic norms or use different terminology versus what the algorithm was trained and validated on.

Audit process and monitoring

The WISeR FAQ and RFA indicate that:

- The Centers for Medicare & Medicaid Services (CMS) will audit participants to ensure their determinations align with Medicare coverage criteria, and that audit results will affect participants' quality scores and payment adjustments;
- CMS may conduct annual audits, as well as targeted or ad-hoc audits as needed; and
- Participants with high inaccuracy rates may be terminated.

We appreciate that CMMI has addressed audits and monitoring, but request clarification on audit timing and frequency, criteria for initiating ad-hoc audits, what constitutes an "inaccurate" determination, how the results will be scored and weighted, and how audit results will be shared. Timely and appropriate audits, as well as timely public reporting of audit findings, are essential to ensuring accountability and protecting both patients and physicians.

Reporting of performance metrics, outcomes, and provider/supplier and beneficiary experience

CMS will oversee WISeR participants through audits, process metrics, stakeholder feedback, and monitoring of downstream clinical outcomes. CMS will audit determinations for consistency with Medicare coverage criteria, with results affecting quality scores, payment adjustments, and

[3] WISeR Model Frequently Asked Questions, available at: WISeR Model Frequently Asked Questions | CMS

potential termination for persistently inaccurate performance. Process quality will be assessed using participant and administrative data, including prior authorization volume and timeliness, affirmation and appeal patterns, and documentation adequacy. CMS will also field, or require participants to field, surveys of providers, suppliers, and beneficiaries to assess clarity, ease, and timeliness of WISeR processes. Given the diversity of services included, CMS will evaluate clinical quality using broader downstream indicators such as use of alternative services, adverse events, hospitalizations, emergency department utilization, and mortality.

We appreciate CMMI including information on ways that audit results can be used to monitor and improve participants' performance. We request greater clarity and transparency on implementation, including how specific audit outcomes will translate into payment adjustments, what constitutes a "high rate of inaccuracy" for purposes of termination, how process metrics will be measured and whether the results will be shared publicly, how provider/supplier/beneficiary surveys will be administered to avoid bias, and what downstream quality and safety measures CMS will use in its assessments. The broad framework is helpful, but substantial operational details remain unaddressed.

We strongly urge CMS to require that WISeR participants employ a uniform, standardized questionnaire (developed by CMMI, not the participants themselves) to adequately assess the experiences of each of the following groups: providers, suppliers, and beneficiaries. This will ensure the collection of consistent, objective data across participants and allow for comparability of data across participants. Regarding the evaluation of downstream clinical outcomes, it is also critical that CMS work with relevant clinical stakeholders through a transparent, publicly-informed process, to identify appropriate, evidence-based metrics.

Prior authorization of facility-based services

During the WISeR Office Hours, CMMI staff clarified that when services are furnished in a facility setting (i.e., hospital outpatient department or ambulatory surgical center), only the facility claim is subject to prior authorization. Any related professional claims are treated as associated claims and will only be paid *if* the prior authorization request for the facility claim is approved. The Operational Guide further states that "Depending on the timing of claim submission for any associated items and services, claims may be automatically denied or denied on a post-payment basis" if the primary service is non-affirmed during prior authorization or denied during claims process.[4]

This framework raises several significant concerns as it is potentially setting up a scenario whereby the claim for a professional service could be denied not because the service fails to meet Medicare coverage criteria, but solely because the facility where the service was performed failed to go through the prior authorization or pre-payment review process in a timely manner or

[4] WISeR provider and supplier guide, page 25. Accessed December 16, 2025. https://www.cms.gov/files/document/wiser-provider-supplier-guide.pdf.

did not provide the proper documentation. For example, if a provider does not opt for prior authorization, it would trigger pre-payment review, under which the facility would have 45 days to submit their required documentation. However, it is not clear what would happen if the physician submitted the professional claim, prior to the facility submitting the required documentation. Would CMS deny the claim up front? Hold the claim for that 45-day period? Or would CMS pay the physician claim and then claw it back if the required documentation is not submitted on time or the prepayment review results in a claim denial?

We are concerned that this fragmented structure introduces the unacceptable risk that physicians may be subject to delayed payments or even claw backs on their professional services post-payment. Additional clarity is needed regarding how these processes will operate when both facility and professional claims are involved and what safeguards CMMI will implement to ensure that physicians are not unfairly burdened or penalized due to administrative errors or omissions by the facility, which they do not control.

Third party evaluation

We strongly urge CMMI to engage an independent, external evaluator for the WISeR Model. The Department of Health and Human Services (HHS) and CMMI have previously used third-party evaluators for complex demonstrations, and doing so here would enhance transparency and credibility, particularly given the potential for participant involvement in collecting or analyzing feedback. We further encourage CMMI to make the Model's evaluation framework publicly available and to commit to releasing preliminary evaluation findings no later than six months after the conclusion of the first performance period.

We also encourage CMMI to consider a structure similar to Medicare Carrier Advisory Committees (CACs) to facilitate communication among MACs/participants, clinicians, and other stakeholders.

Participant payment incentives

The WISeR Model FAQ states that participants are incentivized to make an accurate determination at the time of the first request. It also states that the aim is to drive toward "auto-approvals" of requests whenever possible. However, the underlying methodology for how participants are compensated creates the opposite incentive. Participants are paid more if they deny more care. CMMI notes that audits, claw backs, quality score reductions, and potential termination from the model will prevent inappropriate denials. Yet, CMMI has not provided sufficient detail on how inappropriate denials will be identified, how claw backs will be executed, how quality scores will be adjusted, and what thresholds will trigger termination.

Even with strong safeguards, appeals remain burdensome for providers and can delay care and disproportionately harm smaller practices. Moreover, even with the safeguards that CMMI is deploying in this model, the shared-savings methodology creates incentives to deny higher-cost services and disincentivizes robust provider education, since improved provider accuracy may

reduce participant payments. We therefore urge CMMI to consider replacing the shared-savings structure with a fee-based payment model in the future to avoid these inappropriate incentives and ensure that participant financial motivations align with accurate, timely determinations.

Suggested Refinements to Support Successful Model Implementation

Gold carding

The WISeR materials describe a future "gold carding" process for providers and suppliers with a demonstrated record of compliance. CMMI indicates that a provider/supplier would be exempt from prior authorization if they achieve a prior authorization provisional affirmation threshold of 90 percent during a periodic assessment, thereby demonstrating a sufficient understanding of the requirements for submitting an accurate claim.

Currently, there is little information on the gold-carding process. As CMMI develops additional operational details for the WISeR Model, we request a clear and transparent pathway for a gold carding process that meaningfully reduces administrative burden for consistently high-performing providers. A gold carding option is consistent with CMS' broader prior authorization reform efforts and would help ensure that WISeR does not impose unnecessary delays in patient care. We are disappointed that a gold card program will not be available until mid-2026 and ask that CMMI use the first half of 2026 as the look-back period for determining gold card status to prevent any further delays in implementation.

In developing a gold card program, CMMI should consider currently existing gold carding programs. According to the National Association of Insurance Commissioners (NAIC), 23 jurisdictions have provisions relating to gold carding, many of whom include prior authorization exemptions for providers with an approval rate above 90 percent and exemptions for certain procedures or services.[5]

Additionally, as noted above, some physician services will not be subject to prior authorization if furnished in a facility as they will be considered associated claims. We request additional information on how associated claims will be considered when determining a physician's gold carding status.

Delay of denials

Given the limited time for provider education and the scheduled January 1, 2026, launch, we strongly urge CMMI to delay the issuance of denials during the first six months of the program to allow both participants and providers time to operationalize model requirements without being subject to downside risk. Several CMS models have incorporated an initial testing or "soft launch" phase to allow participants to establish their operational processes and give providers

[5] NAIC fall meeting materials available at: Materials - Regulatory Framework (B) Task Force

time to integrate new requirements into their workflows. A similar approach for WISeR would reduce early disruptions to patient care and improve program integrity.

We also recommend that CMMI consider using this initial phase as an on-ramp to a potential gold carding pathway by allowing providers who demonstrate high affirmation rates during the testing period to qualify for reduced prior authorization burden going forward.

Maintaining consistency with updates to national/local coverage determinations (NCDs/LCDs) and changes in Medicare policy

We appreciate CMMI's intent for WISeR determinations to align with updates to NCDs, LCDs, and forthcoming rulemaking, including policies finalized in the CY 2026 Medicare Physician Fee Schedule. To ensure consistent and accurate determinations, we request additional clarity on how these policy updates will be operationalized. Specifically, we ask CMMI to outline how frequently WISeR participants must update their review tools or algorithms to reflect new or revised Medicare coverage criteria, how these updates will be validated, and what monitoring mechanisms will be used to ensure timely adoption across participants. Maintaining real-time consistency with Medicare policy is essential to safeguarding beneficiary access and ensuring fair, accurate determinations.

In addition to the timeliness of adoption, we urge CMMI to address how participants will be required to educate affected providers about coverage changes and any resulting impacts on the prior authorization process, particularly when updates to an NCD or LCD are significant enough to necessitate changes to prior authorization checklists or documentation requirements. Providers may need adequate notice and transition time to update their own internal workflows once participants implement process changes. Clear expectations for provider education and reasonable implementation timelines are essential to maintaining real-time consistency with Medicare policy, safeguarding beneficiary access, and ensuring fair and accurate determinations.

Services subject to review

We appreciate CMMI's decision to remove deep brain stimulation for Parkinson's disease from the initial list of WISeR services in response to physician feedback. CMS appropriately recognized the procedure's clinical complexity and its frequent inpatient setting. This demonstrates the value of ongoing engagement with providers as the model evolves.

As WISeR is implemented, we urge CMMI to establish a clear, data-driven pathway for removing services from the program when providers consistently demonstrate strong performance and low denial risk. Such a mechanism would reduce unnecessary administrative burden, allow the model to focus oversight where it is most needed, and reinforce high-quality clinical practice.

We thank you for your consideration of these recommendations and hope to continue working with you to ensure the WISeR demonstration achieves its dual aims of using advanced

technology to improve the prior authorization process for physicians while also protecting the integrity of the Medicare program by reducing waste, fraud and abuse.

Sincerely,

American College of Surgeons

American Academy of Facial Plastic and Reconstructive Surgery

American Academy of Ophthalmology

American Association of Neurological Surgeons

American Association of Orthopaedic Surgeons

American Society for Metabolic and Bariatric Surgery

American Society for Surgery of the Hand Professional Organization

American Society of Anesthesiologists

American Society of Cataract and Refractive Surgery

American Society of Colon & Rectal Surgeons

American Urological Association

Congress of Neurological Surgeons

Society for Vascular Surgery

Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)

Society of Gynecologic Oncology

The American Society of Breast Surgeons

CC: Chris Klomp
Deputy Administrator and Director
Center for Medicare

Gary Bacher
Chief Strategy Officer
Center for Medicare and Medicaid Innovation

Kate Blackwell
Division Director
CMS Innovation Center

Alexandra Chong
Deputy Division Director
CMS Innovation Center