



MAVERICK'S MINUTE CMMI's New WISer Model

July 2025

CMS is testing a new model that will apply tech-enabled prior authorization for traditional Medicare to reduce low-value care.

Overview

WHAT: The Center for Medicare and Medicaid Innovation (CMMI) announced the launch of the Wasteful and Inappropriate Service Reduction (WISer) Model to reduce unnecessary and potentially harmful care in some traditional Medicare services. The voluntary model will test whether technologies like artificial intelligence (AI) and machine learning can improve prior authorization processes for select services that are at higher risk for fraud, waste, and abuse. CMS will partner with technology companies that already manage prior authorization for commercial plans to initially run the program across six states (AZ, WA, OH, NJ, TX, and OK).

IN BRIEF: According to CMS, up to 25% of U.S. healthcare spending is attributed to waste and MedPAC estimates Medicare spent \$5.8B on low-value services in 2022. In the WISer Model, participants will be compensated with a share of the savings from reducing unnecessary or non-covered services for each selected service, tying payment to outcomes. The model does not impact Medicare Advantage (MA) plans and excludes inpatient-only and emergency services. This initiative comes amid other recent efforts to streamline prior authorization processes across commercial, MA, and Medicaid managed care plans.

WHEN: CMMI announced the model on June 27, 2025. Applications from potential participants are due July 25, 2025. The performance period will last six years, running from January 1, 2026, through December 31, 2031.

Highlights

Reducing Waste and Improving Efficiency

- By introducing technology-enabled prior authorization earlier in the claims process, the model intends to prevent unnecessary procedures, streamline decision-making, and reduce administrative burden for providers through faster, more predictable claims reviews.
- WISer targets 15 Medicare services that are particularly vulnerable to inappropriate use, including skin/tissue substitutes, nerve stimulators, and knee arthroscopy for osteoarthritis. CMS selected these services based on multiple factors:
 - Evidence of fraud, waste, and abuse from sources like HHS OIG, DOJ, and the Medicare's certified health IT program.
 - Classification as low-value care in existing research, citing this *JAMA* [journal article](#).
 - Existing use of prior authorization for the service in MA.
- CMS is considering a "gold carding" exemption process to reduce administrative burden for providers with strong compliance records. Under this approach, entities with at least a 90% affirmation rate during

periodic assessments could be exempt from prior authorization requirements. The exemption could be revoked if future claim reviews indicate noncompliance with Medicare billing rules.

WISeR's Prior Authorization Workflows

- Providers/suppliers can submit prior authorization requests to model participants or through their Medicare Administrative Contractors (MACs), which will forward the request to the model participant (i.e., selected prior authorization vendor). The model participant will then offer either an affirmative recommendation or not – which will then be taken into account by MACs when conducting their medical review.
- If the request is not affirmed, providers/suppliers may submit unlimited resubmissions and may request a peer-to-peer review to inform the new determination.
- A provider or supplier can choose to forgo the WISeR model's prior authorization process; however claims submitted without prior authorization will be subject to pre-payment medical review by the model participant, and model participants will notify the MAC of their final determination.
- If a claim is denied, it will follow the standard Medicare appeals process, which remains unchanged under the model.

Eligible Participants

- CMS is looking for applicants with an understanding of managing prior authorization processes, particularly those with experience with MA plans.
- Applicants should be able to integrate with CMS and MACs and must comply with the CMS Interoperability and Prior Authorization final rule, including use of FHIR APIs and HHS data standards.
- Applicants must also meet federal privacy standards and be able to serve as a HIPAA business associate and comply with HIPAA rules.

Performance-Based Payments

- The model participants (i.e., selected vendors) will be paid based on performance, based on a percentage of savings from non-affirmed requests that do not lead to paid claims and using historical regional claim-level data adjusted for current pricing.
 - CMS is also applying a discount based on historical denial rates to account for savings that would have occurred without the model.
- Payments are delayed up to one year to confirm the decision isn't overturned. This will minimize the need to claw back any payments if an appeal is successful.
- Annual payments will be subject to adjustments based on performance across CMS-defined quality metrics, such as:
 - Timeliness of determinations
 - Accuracy of reviews (affirmation rates)
 - Provider, supplier, and beneficiary experience
 - Compliance with operations and reporting

Maverick's Perspective

The WISeR model marks a significant move in expanding prior authorization into traditional fee-for-service Medicare. It is a clear example of CMMI's new strategy to leverage technology to reduce federal healthcare spending. This is an invitation to the private sector to play a more active role in designing and implementing public health program reforms. WISeR's success will depend on several key factors: ensuring transparency in AI-assisted decisions and reducing – not adding – to provider workflow burden. If not implemented carefully, this could create a massive burden on providers to submit specifically-formatted documentation and could put

revenues at risk with retrospective denials. If done well, WISeR could become a blueprint for the future of prior authorization across public and private payers.