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IN FOCUS

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Overview of the Medicare Wasteful and Inappropriate Service Reduction (WISeR) Model

On June 22, 2025, the Centers for Medicare & Medicaid Services (CMS) announced a new prior authorization (PA) initiative in traditional Medicare, the Wasteful and Inappropriate Service Reduction (WISeR) model, which is to be tested in six states from January 1, 2026 to December 31, 2031. WISeR is one of the largest expansions of PA in the history of traditional Medicare. This CRS In Focus describes the WISeR model, provides background information on the current state of PA in Medicare, and addresses areas of congressional interest.

Overview of Medicare

Medicare is a federal program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act to provide health insurance to individuals aged 65 and older, and it was expanded to include permanently disabled individuals under the age of 65 and certain other individuals. As of August 2025, there were 69 million Medicare beneficiaries.

Medicare has four parts. Parts A and B comprise original fee-for-service Medicare. Together, Parts A and B encompass *original* or *traditional* Medicare. Part C (Medicare Advantage, or MA) provides a private plan alternative for Parts A and B. Part D is an optional outpatient prescription drug benefit offered through private organizations, either as a stand-alone benefit or integrated with an MA plan.

Prior Authorization in Medicare

PA is one of several utilization management strategies health insurers use to manage service use and costs. PA requires health providers to submit a request to a health insurer for coverage approval, and to receive a decision, before services are rendered. PA also may be referred to as *prior approval*, *precertification*, *pre-claim review*, or *preauthorization*.

Traditional Medicare

In traditional Medicare, PA historically has been limited to a narrow set of services or items with high rates of improper payments, including certain cosmetic surgery procedures, non-emergent ambulance transport, durable medical equipment, home health services, and inpatient rehabilitation facility admissions. CRS calculated that in FY2023, traditional Medicare's existing PA programs reviewed 3.1 million claims, representing less than 1% of the 1.2 billion total Part A and B claims.

PA Practices in Medicare Advantage and Part D

PA and other utilization management strategies are used more commonly by MA and Part D plans than by traditional Medicare. KFF reported in 2024 that "nearly all Medicare Advantage enrollees (99%) are in plans that require prior authorization for some services, which is generally not used in traditional Medicare." KFF found there were 1.8 PA determinations per MA beneficiary in 2023, compared with 0.01 per beneficiary in traditional Medicare. A 2024 study found MA plans required PA for about 18% of Part B clinical services. There have been reports of inappropriate denials and delays in care with PA in MA. In response to these concerns, in 2025 several large health insurers have pledged to reduce the number of services subject to PA.

Many MA plans already use the PA processes that are to be used in WISeR. A recent survey by the National Association of Insurance Commissioners found that in 2025 70% of health insurers are implementing artificial intelligence to conduct PA or plan to do so within three years. Part D drug plans commonly employ PA on some drugs as part of drug utilization management programs.

WISeR Model

The WISeR model is being implemented under CMS's Centers for Medicare & Medicaid Innovation Center (CMMI) authority. CMMI was established by Section 3021 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), "to test innovative payment and service delivery models to reduce program expenditures" under Medicare and other CMS programs while "preserving or enhancing the quality of care" provided to beneficiaries. In WISeR, CMS is using the Innovation Center authority to waive statutory limits on PA in Medicare.

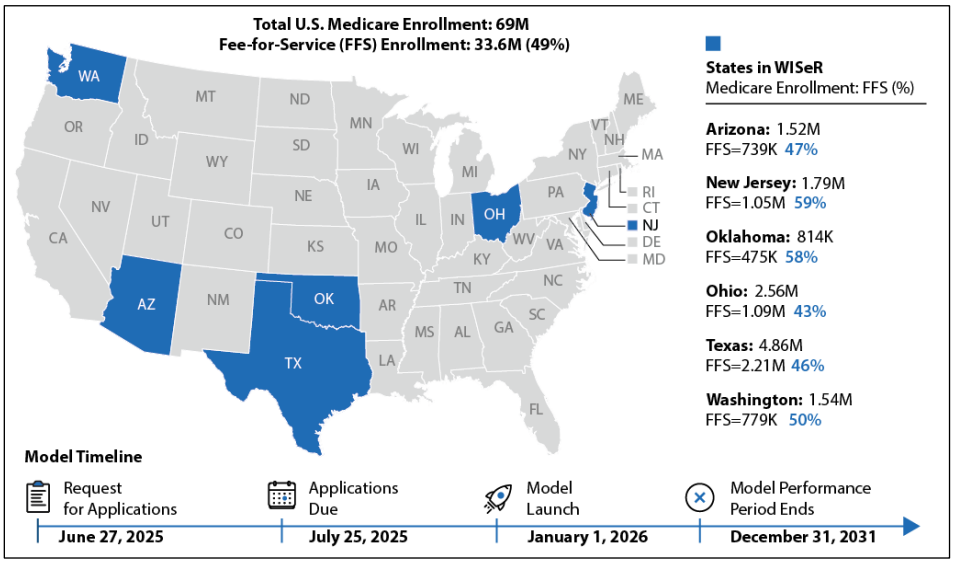
WISeR's goal is to leverage artificial intelligence and machine learning, along with human clinical review, to conduct PA "to ensure timely and appropriate Medicare payment for selected services." CMS states that WISeR can apply artificial intelligence technologies that MA plans are already using to streamline PAs and reduce unnecessary care.

Targeted States and Services

WISeR is to be implemented in Arizona, New Jersey, Oklahoma, Ohio, Texas, and Washington, as shown in **Figure 1**. CMS selected these states so that each could be compared with non-model states within the same Medicare claims processing region, allowing for more reliable evaluation of the model's effects.

Figure 1. States Selected for WISeR & Model Timeline

Model is to Cover Six States with 6.4 million Medicare Beneficiaries



Source: Medicare enrollment statistics are taken from the Centers for Medicare & Medicaid Services' (CMS's) Medicare Monthly Enrollment dataset for August 2025. Wasteful and Inappropriate Service Reduction (WISeR) model details are summarized from CMS's WISeR website.

CMS states that the services targeted by WISeR are "low-value" or "vulnerable to fraud, waste, and abuse." In this model, CMS defines *low-value care* as having "limited clinical evidence of effectiveness, not aligned with an individual's specific health condition or needs, or could lead to complications and further unneeded services." The services selected for PA are nerve stimulation, destruction of nerve tissue, steroid injections for pain, bone cement injections for compression fractures of vertebrae, cervical fusion, knee arthroscopy for osteoarthritis, incontinence control devices, impotence treatments, decompression of the spine for spinal stenosis, and skin substitutes. In selecting these services, CMS stated that they are non-emergent, subject to PA by other payers (including many MA plans), and have publicly available Medicare coverage requirements. However, there are different ways of measuring potentially avoidable health services, and some patients and providers may disagree with CMS's classification of some the selected services as "low value."

Health providers are to submit PA requests to CMS contractors. The contractors are to use technologies such as artificial intelligence to review the service and either preapprove or deny it. A human clinician must review every denial decision. After a denial, providers may resubmit the request and participate in peer review with the contractors. If the provider disagrees with a denial of a claim, the provider can appeal it through the regular Medicare appeals process. CMS is to pay the PA contractors a percentage of the dollar value of the denied requests after all resubmissions have been adjudicated. Providers and beneficiaries cannot opt out of WISeR. However, if a provider does not want to go through PA, the provider can skip it and may submit claims after providing the medical service, but the claims will be subject to detailed medical and documentation review by Medicare's claims processors. The model includes beneficiary protections like time limits on PA decisions and financial penalties on the PA companies for denials that are overturned on appeal.

WISeR Model Resources

For specific model guidance and sources, see CMS's WISeR website, specifically the FAQ, provider and supplier operational guide, request for applications, and slides from a July 2025 office hour.

Potential Impacts

Under WISeR, health providers may see more PA denials, increased time responding to PA requests, and potential revenue losses from services that are denied or that they choose not to furnish. Medicare beneficiaries may experience delays or barriers to accessing the selected services. By reducing the use of low-value or unnecessary care, CMS states that WISeR would decrease Medicare spending and potentially reduce patient safety risks. This decreased spending could modestly decrease Part B beneficiary premiums and the federal deficit.

Congressional Response

PA and other utilization management techniques can prevent unnecessary health spending but also can limit access to needed health care. Congress may hear from constituents, such as health providers, medical suppliers, and beneficiary advocates, who have concerns that PA or the WISeR model could limit beneficiaries' access to care. Some Members of Congress have sent letters to CMS raising concerns and seeking additional information about the model (for example, in August and September). In the House, legislation has been introduced that would prohibit implementation of the WISeR model, and the House Appropriations Committee adopted an amendment to the FY2026 Labor-Health & Human Services-Education appropriation bill that would prohibit funding for WISeR if enacted. The model may face litigation from health providers or beneficiaries who face denials or oppose being included in WISeR without their consent.

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