Congress of the United States

Washington, DC 20515

July 31, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Abe Sutton
Deputy Administrator and Director of CMMI
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Administrator Oz and Director Sutton:

We write regarding a new initiative within the Center for Medicare and Medicaid Innovation (CMMI) to test the expansion of pre-treatment approvals, more commonly known as prior authorization, in Traditional Medicare. We are concerned that this effort could erode the quality of coverage provided by Traditional Medicare and result in the delay and denial of necessary health care. We urge the administration to immediately halt any efforts to implement this model.

On June 27, 2025, the Centers for Medicare & Medicaid Services (CMS) released plans for CMMI to institute the Wasteful and Inappropriate Service Reduction (WISeR) model beginning January 1, 2026.[1] According to CMS's announcement, this model will require Traditional Medicare providers in several states to obtain approval from for-profit companies prior to administering certain health services.[2] This proposed expansion of prior authorization follows independent studies from the U.S. Department of Health and Human Services Office of the Inspector General and the Medicare Payment Advisory Commission that reveal the high overturn rates of inappropriate denials of authorization and the burden this places on patients and providers.[3] Now, as CMS continues to oversee enforcement of new rules restricting prior authorization under the Medicare Advantage program and hosts press conferences touting commitments from insurance companies to rein in these practices, it proposes to expand prior authorization in Traditional Medicare.[4] While strong guardrails are important to prevent fraudulent claims and the wasteful delivery of unnecessary medical services, prior authorization, which imposes an overly steep burden on patients and providers, is a poor tool for achieving these objectives.

Since its inception, Traditional Medicare has provided high-quality coverage to enrollees, offering peace of mind to patients that they can see any doctor of their choice and that very few services will be subject to prior

[1] "CMS Launches New Model to Target Wasteful, Inappropriate Services in Original Medicare," Centers for Medicare & Medicaid Services, (June 27, 2025), https://www.cms.gov/newsroom/press-releases/cms-launches-new-model-target-wasteful-inappropriate-services-original-medicare.

[2] The model will be tested in the following select states: New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington.

[3] "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," U.S. Department of Health and Human Services Office of Inspector General, (April 27, 2022), https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/; "Report to Congress: Medicare and the Health Care Delivery System," Medicare Payment Advisory Commission, (June 2024), https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf, at 69-70.

[4] "HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System," U.S. Department of Health and Human Services, (June 23, 2025), https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html.

authorization. As a result, Traditional Medicare enjoys strong patient satisfaction and is supported by 81 percent of Americans.[5]

In contrast, Medicare Advantage, the private, for-profit alternative to Traditional Medicare, has narrow provider networks and a strict prior authorization protocol that requires virtually all of their enrollees to obtain pre-approval for services like inpatient hospital stays, skilled nursing facility stays, and chemotherapy.[6] Though only a small share of prior authorization denials were appealed to Medicare Advantage for-profit insurers, more than 80 percent of appeals were partially or fully overturned in 2023.[7] That is substantially higher than the less than one-third of appeals overturned in Traditional Medicare in 2022.[8] This suggests for-profit insurers in Medicare Advantage overutilize prior authorization as a means to restrict care and increase their profit. The substantial administrative burden of seeking prior authorization and appealing denials is reportedly resulting in high physician burnout and several health systems withdrawing from Medicare Advantage contracts.[9]

In the proposed model, CMMI plans to pay private companies processing prior authorizations "based on a share of averted expenditures."[10] In other words, under this payment structure, companies will be paid more if they deny more prior authorization requests, thus incentivizing restrictions of necessary care. In a 2024 survey of doctors, over 90 percent reported that prior authorization caused delays in treatment, and one-third reported that these delays resulted in a serious adverse event for the patient.[11] Incentivizing further care denials endangers patients and is an inappropriate basis for payment.

Equally concerning is CMMI's solicitation of applications from companies, including Medicare Advantage plans, that use artificial intelligence (AI) to make medical necessity determinations. For-profit insurers who use AI to review prior authorization requests refuse to disclose the methodology, protocols, or code used in their AI tools.[12] Independent research and legal filings further suggest that the use of AI in prior authorization likely increases delays and denials of needed care and erodes the quality of care patients receive. This was highlighted in a recent class action lawsuit against UnitedHealth, which alleges that the company relied on a flawed algorithm developed by its subsidiary, NaviHealth, to make coverage decisions that caused lasting and irreparable harm to Medicare Advantage enrollees.[13] Under CMMI's specifications, UnitedHealth is nevertheless eligible to participate in this model.

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[5] Ashley Kirzinger, Marley Presiado, Isabelle Valdes, and Mollyann Brodie, "KFF Health Tracking Poll March 2023: Public Doesn't Want Politicians To Upend Popular Programs," KFF, (March 30, 2023), https://www.kff.org/medicaid/poll-finding/kff-health-tracking-poll-march-2023-public-doesnt-want-politicians-to-upend-popular-programs/.

[6] Jeannie Fuglesten Biniek, Nolan Sroczynski, Meredith Freed, and Tricia Neuman, "Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023," KFF, (January 28, 2025), https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/.

[7] *Id.*

[8] *Id.*

[9] Tanya Albert Henry, "Exhausted by prior auth, many patients abandon care: AMA Survey," American Medical Association, (July 18, 2024), https://www.ama-assn.org/practice-management/prior-authorization/exhausted-prior-auth-many-patients-abandon-care-ama-survey; Jakob Emerson, "Hospitals are dropping Medicare Advantage plans left and right," Becker's Hospital Review, (September 27, 2023), https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right/.

[10] "Medicare Program; Implementation of Prior Authorization for Select Services for the Wasteful and Inappropriate Services Reduction (WISeR) Model," Notice by the Centers for Medicare & Medicaid Services, posted in the Federal Register, (July 1, 2025), https://www.federalregister.gov/documents/2025/07/01/2025-12195/medicare-program-implementation-of-prior-authorization-for-select-services-for-the-wasteful-and.

[11] Tanya Albert Henry, "Exhausted by prior auth, many patients abandon care: AMA Survey," American Medical Association, (July 18, 2024), https://www.ama-assn.org/practice-management/prior-authorization/exhausted-prior-auth-many-patients-abandon-care-ama-survey.

[12] Casey Ross and Bob Herman, "UnitedHealth pushed employees to follow an algorithm to cut off Medicare patients' rehab care," STAT, (November 14, 2023), https://www.statnews.com/2023/11/14/unitedhealth-algorithm-medicare-advantage-investigation/.

We understand that CMMI has intentionally selected health care services that are reported to have limited clinical value and may be vulnerable to abuse in the Medicare program, and we support efforts to ensure Medicare remains a good steward of taxpayer dollars. However, the expansion of AI-fueled prior authorization will not improve program integrity in Traditional Medicare. Giving private for-profit actors a veto over care provided to seniors and people with disabilities in Traditional Medicare, even as a pilot program, opens the door to further erosion of our Medicare system. We therefore strongly urge you to immediately halt the proposed WISeR model and instead consider steps to address the well-documented waste, fraud, and abuse in the Medicare Advantage program.[14]

Sincerely,

Alexandria Ocasio-Cortez
Member of Congress

Lloyd Doggett
Member of Congress

Jan Schakowsky
Member of Congress

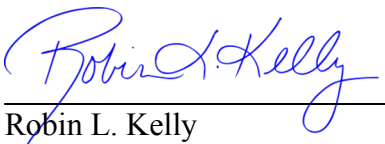
Debbie Dingell
Member of Congress

Yvette D. Clarke
Member of Congress

Marc A. Veasey
Member of Congress

[13] Bob Herman, "Class action suit over UnitedHealth's AI care denials nears key moment," STAT, (February 7, 2025), https://www.statnews.com/2025/02/07/unitedhealth-class-action-lawsuit-ai-care-denials-nears-key-decision/; Melody Schreiber, "New AI tool counters health insurance denials decided by automated algorithms," The Guardian, (January 25, 2025), https://www.theguardian.com/us-news/2025/jan/25/health-insurers-ai.

[14] For example, *see* "The Medicare Advantage program: Status report," Medicare Payment Advisory Commission (MedPAC), (March 2025), https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf, at 323; George Joseph, "Revealed: UnitedHealth secretly paid nursing homes to reduce hospital transfers," The Guardian, (May 21, 2025), https://www.theguardian.com/us-news/2025/may/21/unitedhealth-nursing-homes-payments-hospital-transfers; "Medicare Advantage: Questionable Use of Health Risk Assessments Continues to Drive up Payments to Plans by Billions," U.S. Department of Health and Human Services Office of Inspector General, (October 2024), https://oig.hhs.gov/documents/evaluation/10028/OEI-03-23-00380.pdf; Tara Bannow, "Study shows how UnitedHealth uses coding to rake in extra cash from Medicare Advantage," STAT, (April 7, 2025), https://www.statnews.com/2025/04/07/medicare-advantage-study-risk-adjustment-coding-unitedhealth/; Reed Abelson and Margot Sanger-Katz, "'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions," The New York Times, (October 8, 2022), https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html; *United States ex rel. Swoben v. Secure Horizons, et al*., 09-5013, filed in U.S. District Court, Central District of California, (2009), Note: This case was dismissed by a federal judge, who provided the DOJ the opportunity to amend and refile their complaint. DOJ declined to refile the case; *United States of America ex rel. Benjamin Poehling v. UnitedHealth Group, Inc., et. al,* 16-08697, filed in U.S. District Court, Central District of California, (2017), Note: This case is ongoing.



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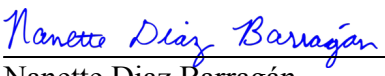
Member of Congress



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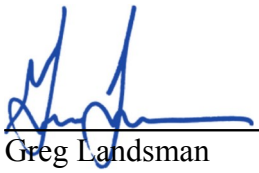

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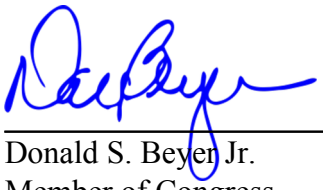

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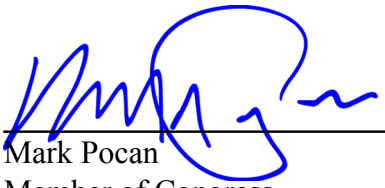

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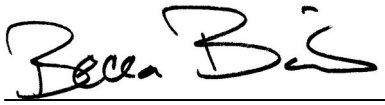

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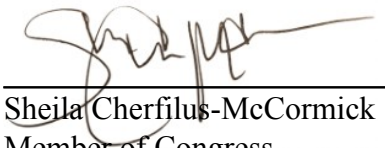

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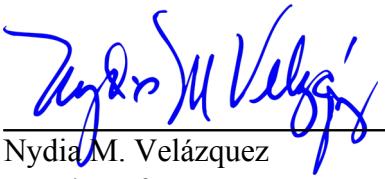

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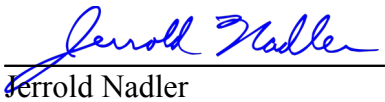

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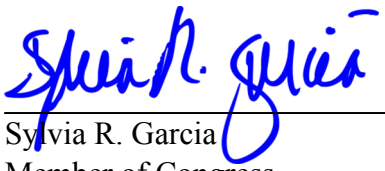

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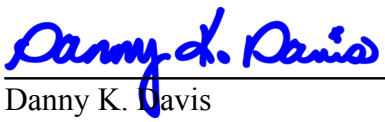

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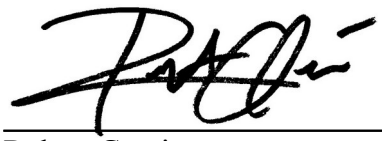

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