MODEL OVERVIEW FACTSHEET

Wasteful and Inappropriate Service Reduction (WISeR) Model

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE AND MEDICAID INNOVATION

Model Overview

Waste in health care can not only harm patients, but it represents up to **25% of health care spending** in the United States. According to the Medicare Payment Advisory Commission, **Medicare spent up to $5.8 billion** in 2022 on unnecessary or inappropriate services with little to no clinical benefit. The Wasteful and Inappropriate Service Reduction Model (WISeR) will harness enhanced technologies like Artificial Intelligence (AI) and Machine Learning (ML) to streamline the review process for certain items and services that are vulnerable to fraud, waste and abuse, helping people with Medicare receive safe and appropriate care and protecting federal taxpayers. The model is voluntary and will run for six performance years from January 1, 2026 to December 31, 2031.

Model Goals

WISeR will aim to:

- Focus health care spending on services that will improve patient well-being
- Apply commercial payer prior authorization processes that may be faster, easier and more accurate
- Increase transparency of existing Medicare coverage policy
- De-incentivize and reduce use of medically unnecessary care

Model Participation

Participants in WISeR will be companies with expertise managing the prior authorization process for other payers using enhanced technology like AI. They will be required to have clinicians with the expertise to conduct medical reviews to validate determinations.

Participants will apply their technology in an assigned state to help medical reviewers assess a set of items and services chosen by CMS that may 1) pose concerns related to patient safety if delivered inappropriately; 2) have existing publicly available coverage criteria; and 3) may involve prior reports of fraud, waste and abuse.

Examples of selected services include:

Skin and tissue substitutes

Electrical nerve stimulators

Knee arthroscopy for knee osteoarthritis

WISeR will exclude inpatient-only services, emergency services, and services that would pose a substantial risk to patients if substantially delayed.

All recommendations for non-payment will be determined by appropriately licensed clinicians who will apply standardized, transparent, and evidence-based procedures to their review.

WISeR Model Website:
CMS.gov/priorities/innovation/innovation-models/wiser

Request for Applications:
CMS.gov/priorities/innovation/files/wiser-model-rfa.pdf

Email:
WISeR@cms.hhs.gov

Medicare Coverage and Payment Policies Remain the Same

WISeR does not change Medicare coverage or payment policy.

Health care coverage for people with Medicare will not change, and they retain the freedom to seek care from their Original Medicare provider or supplier of choice.

Payment to providers and suppliers for covered items and services will not change under the model. WISeR does not apply to people with Medicare Advantage and will have no impact on them.

Model Impact on Providers and Suppliers

Providers and suppliers for people with Original Medicare in selected regions will have the choice of submitting a prior authorization request for the model's selected items and services or go through a post-service/pre-payment medical review.

Those that choose the prior authorization route may either submit the prior authorization request (a) directly to the model participant or (b) to their Medicare Administrative Contractor (MAC) that will forward the request to the model participant.

If they opt not to submit a request for an included service, their claim will be subject to medical review by the model participant to ensure the delivered service met Medicare coverage, coding, and payment criteria prior to payment.

Model Payment Overview

Participants will be rewarded based on the effectiveness of their technology solutions for reducing spending on medically unnecessary or non-covered services. For each selected service, participants will receive a percentage of the reduction in savings that can be attributed to their reduction of wasteful or inappropriate care.

Model Performance Measures

Payment adjustments will be based on participant performance measures across three categories:

Process Quality

- Number of non-affirmations and favorable appeal decisions
- Volume of requests processed

Provider/Supplier and Beneficiary Experience

- Timeliness of response
- Clarity of explanation of request determination

Clinical quality outcomes

- Use of alternative services
- Evidence of ongoing urgent need to address the clinical issue

Model Timeline