Medicare picks tech vendors to run AI prior authorization pilot in six states

House Democrats seek to prevent Medicare from implementing the WISeR program

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The Centers for Medicare and Medicaid Services has selected the six technology companies that will administer artificial intelligence-powered prior authorization programs for Medicare, STAT has learned.

The pilot, called the Wasteful and Inappropriate Services Reduction (WISeR) model, is a CMS effort to reduce waste and abuse within the taxpayer-funded health insurance program that spent more than $1 trillion in 2024. The new prior authorization program will launch in January and run until 2031 in New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington.

CMS' decision to test the use of AI technology for prior authorizations comes at a time when large private insurers — including UnitedHealthcare and Humana — are facing class action lawsuits and congressional scrutiny over their use of AI for making decisions about care for Medicare Advantage beneficiaries. There is also congressional pushback against the WISeR program; on Friday, a congressional representative from Washington, one of the states where the program will be implemented, is planning to introduce a bill to prevent the Department of Health and Human Services from implementing WISeR.

In Texas, the WISeR model will be administered by Cohere, an AI prior authorization and clinical intelligence company. A Cohere spokesperson told STAT in a statement that it already works with "80% of Texas physicians who treat Medicare patients." In Oklahoma, CMS will work with Humata, a health technology company founded two years ago by

Mayo Clinic radiologist Jeremy Friese out of assets sold by Friese's former employer Olive AI when it shut down in 2023.

In New Jersey, the prior authorization program will be managed by Genzeon, a technology solutions company that announced in August a "sharpened focus" and a "major evolution of its business strategy," saying that it is now "exclusively focused on the health care industry" after splitting off its fashion and retail technology support business under a separate brand in June.

In Arizona, the program will be administered by Zyter, Inc., a tech and AI agent company serving payers. In Ohio, the program will be led by Innovaccer, a health care data and AI company that has to date raised $675 million, the latest round of which was a $275 Series F earlier this year. Washington's program will be led by Virtix Health, a company that, from its website description, seems to have more experience in value-based care and telehealth than in prior authorization.

Genzeon, Innovaccer, and Virtix did not respond to STAT requests for comment. A Zyter spokesperson said the company could not comment at this time.

In an interview, Friese from Humata told STAT that his experience and frustrations with prior authorizations as a radiologist inspired him to get into the business of automating the process. Humata's technology helps payers automate matching medical policies to clinical information about patients "so that our computers can help payers say 'yes,'" he said, describing the WISeR project as a "leapfrog moment" and an "opportunity to transform the process of prior auth decisions to say 'yes' dramatically faster, get more accurate, fast answers so that patients get rapid care."

However, prior to the WISeR program, traditional Medicare has had limited approval requirements compared to Medicare Advantage or commercial health insurance. The program will exclude inpatient-only services, emergency services, and "services that would pose a substantial risk to patients if substantially delayed," according to a CMS factsheet about the initiative.

Instead, WISeR is centered on codes for procedures like skin substitutes and electrical nerve stimulation that have an evidence of low value or fraud or waste. Health policy experts acknowledge this focus could be helpful but have also pointed out that these procedures are a small percentage of Medicare waste and will be adjudicated in black box circumstances under this program. "At the end of the day, what the WISeR project portends is unwise. It takes the bureaucratic, wasteful, and risky processes of permission-seeking that have plagued MA plans for years, and simply imports them into traditional Medicare," Don Berwick, former CMS administrator, wrote in a STAT First Opinion.

A 'textbook perverse incentive'

An enticing aspect for the technology companies involved in the pilot is that under the WISeR model, AI and tech vendors will be paid based on "a share of averted expenditures," according to a notice CMS issued in July.

Health policy consultant David Introcaso said that such a payment structure could create a "textbook perverse incentive."

"The more you deny, the more you get reimbursed," Introcaso told STAT. "I mean, a third grader could see how that's a problem." He also told STAT that the program deviates sharply from past Medicare innovation test programs in that the participants involved are not clinical experts, like clinicians or health systems, but are instead AI and technology companies.

Though such a program could curb unnecessary procedures and save money, its precedent in the privately run Medicare Advantage program suggests that prior authorization slows down medically necessary care. A 2018 study from the HHS Office of Inspector General found that 75% of denials in the Medicare Advantage program were overturned after a single appeal.

Vendors emphasized to STAT how their technology is meant to facilitate access to care. Cohere told STAT in a statement that its technology "auto-approves up to 90% of requests." Friese at Humata told STAT that, "Our technology can only say yes. If the answer is unclear … we have an army

of really wonderful doctors and nurses that review the information and make an ultimate final decision."

Rep. Suzan DelBene (D-Wash.), sponsor of the bill seeking to stop WISeR, told STAT in a statement that, "We know that prior authorization in Medicare Advantage and elsewhere ultimately limits access to care, increases the burden on loved ones and care providers, and leads to worse health outcomes."

"The administration has publicly admitted that prior authorization is harmful, yet it is moving forward with this misguided effort that would make seniors navigate more red tape to get the care they're entitled to," she said.

The bill that seeks to bar HHS from implementing the WISeR program has support from a coalition of Democrats, including Reps. Greg Landsman (D-Ohio), Ami Bera (D-Calif.), Kim Schrier (D-Wash.), Mark Pocan (D-Wisc.), and Rick Larsen (D-Wash.), a spokesperson for Rep. DelBene told STAT.

Groups of Senate Democrats and House Democrats both sent letters to CMS Administrator Mehmet Oz in September, questioning details of the proposed program, such as how the vendors would be selected, how the contractors' algorithms would be reviewed to ensure that medically necessary care wouldn't be denied, and how CMS would ensure that the denials are based on evidence and not based on increasing denials volume to increase payments directed to the vendor.

CMS has previously indicated that the percentage of shared savings paid to the administrating companies will be adjusted according to a variety of quality metrics, including "provider experience" as assessed by a survey, according to the CMS website.

Introcaso told STAT that because the WISeR program did not go through CMS' normal rulemaking process, there are no published estimates of how much money CMS expects to save through the program, as there have been for past pilots. "The entire purpose of demos are to save money — or it's spending neutral — or improve quality, or both, right? And they don't even discuss that," he said. "You have to think that nobody really knows."