

Medicare Is of Two Minds on Prior Authorization

— CMS is cracking down on it in Medicare Advantage while expanding its use in traditional Medicare

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3

Earlier this year, the Centers for Medicare & Medicaid Services (CMS) [announced an agreement](#) with Medicare Advantage plans to lessen the use of prior authorization, but the agency also said it would conduct a demonstration project looking at [expanding its use](#) in traditional Medicare. In this story, we look at what has happened so far and what experts are watching for in the future.

As the year comes to a close, the Trump administration seems to be going in two different directions when it comes to the use of prior authorization in Medicare.

On the one hand, there is the effort by CMS to crack down on the use of prior authorization among Medicare Advantage plans and other federal and private insurance programs. In June, HHS Secretary Robert F. Kennedy Jr. and CMS Administrator Mehmet Oz, MD, [held a roundtable](#) with industry stakeholders.

The participants included America's Health Insurance Plans, the Blue Cross Blue Shield Association, CareFirst BlueCross BlueShield, Centene Corporation, Cigna, Humana, Kaiser Permanente, and UnitedHealthcare. The participating insurers pledged to, among other things:

- Standardize electronic prior authorization submissions

- Reduce the volume of medical services subject to prior authorization by Jan. 1
- Implement real-time approvals for most requests by 2027
- Ensure medical professionals review all clinical denials

Prior Regulation

That agreement came on top of regulatory changes to prior authorization that were already underway. For example, CMS issued a final rule on interoperability and prior authorization in January 2023, and more regulations later that year as part of the Medicare Advantage and Part D final rule, explained Neil Patil, MPP, policy director at the Medicare Policy Initiative at Georgetown University's Center on Health Insurance Reform. "Those two rules put a lot of new requirements on plans," including streamlining the use of electronic prior authorization requests rather than requiring providers to submit requests via phone or fax, Patil said in a phone interview.

In addition, "by law, Medicare Advantage plans have to cover traditional Medicare services," he said. "A lot of plans were using prior authorization as kind of a way to deny some of the care that beneficiaries are legally entitled to ... so CMS put out some new rules saying, 'You have to follow traditional Medicare laws, regulations, National Coverage Determinations, and Local Coverage Determinations. You can't just unilaterally deny something that would have been covered under traditional Medicare.'"

But even as CMS is scrutinizing prior authorization in Medicare Advantage, it is also expanding its use -- if only a little -- in traditional Medicare. In June, [CMS announced](#) a new demonstration project in traditional Medicare: the Wasteful and Inappropriate Service Reduction (WISeR) Model. Under the model, "CMS will partner with companies specializing in enhanced technologies to test ways to provide an improved and expedited prior authorization process" under traditional Medicare, the agency [said in a press](#)

[release](#), adding that the model will help "patients and providers avoid unnecessary or inappropriate care and [will safeguard] federal taxpayer dollars."

The WISeR Model will test new technologies including artificial intelligence (AI) to see whether they can expedite the prior authorization processes for certain items and services "that have been identified as particularly vulnerable to fraud, waste, and abuse, or inappropriate use," the press release noted. "These items and services include, but are not limited to, [skin and tissue substitutes](#), electrical nerve stimulator implants, and knee arthroscopy for knee osteoarthritis." Emergency services and inpatient-only services are exempt from the model, which will initially be tested in six states: New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington.

Although the model is "voluntary" for providers, "providers and suppliers in the assigned regions will have the choice of submitting prior authorization requests for selected items and services or their claim will be subject to pre-payment medical review," the agency noted, so either way the claims for the affected services will be reviewed.

Pushback From Congress

The model came in for some immediate pushback on Capitol Hill. "It's baffling how in one breath the administration is trying to take a victory lap on insurers streamlining prior authorization in Medicare Advantage, and in the other instituting the same delay tactics in traditional Medicare," Rep. Suzan DelBene (D-Wash.), whose state is one of those included in the model, said in an email to *MedPage Today* shortly after WISeR was announced. DelBene is the chief sponsor of [H.R. 5940](#), which would prohibit WISeR's implementation. The bill has 32 co-sponsors, all Democrats. A [Senate companion bill](#) introduced by Sen. Patty Murray (D-Wash.) has 17 co-sponsors, also all Democrats.

This is not actually the first time that prior authorization has been used in traditional Medicare, according to Marsha Simon, PhD, adjunct professor of health policy at George Washington University in Washington. Prior authorization has worked well there when it comes to the [purchase of electric scooters](#) and the [use of ambulances](#) to transport patients to routine dialysis appointments; both of those items had been involved in allegations of fraud or overuse, she said.

"It's not prior authorization that's the problem; it's the vendors who are conflicted," said Simon. She was referring to the information technology (IT) vendors that CMS has contracted with to implement the WISeR Model. Under the model, the vendors are paid a share of the savings generated by the claims that they deny.

And that's not their only conflict, according to Patil. With two of the vendors, "we've done some digging into them and they have financial and strategic investors tied to Medicare Advantage plans; that's where we're concerned about potential indirect conflict-of-interest concerns," he said. "They could potentially try to make traditional Medicare less popular" by denying lots of claims. In addition, "a few vendors ... do have existing relationships with Medicare Advantage plans.... I think this does raise some concerns about the measures CMS has taken to ensure the WISeR Model isn't inadvertently endorsing Medicare Advantage markets."

Little Word to Providers

Meanwhile, WISeR is slated to launch on Jan. 1, but doctors in the affected states have heard very little from the vendors about how the program will work. For example, in Washington State, Virtix Health has been assigned as the IT contractor, said Bindu Nayak, MD, vice president of the Washington State Medical Association. But "there really hasn't been any information from Virtix Health to the healthcare providers," she said in a phone interview. "I did look at their website and ... I noticed they have job listings for physicians to be

the ones who will review the claims to be denied ... so they are still setting up shop."

"With traditional Medicare, prior authorizations are not a big part of the picture," said Nayak, an endocrinologist in Wenatchee, Washington. "I certainly am concerned about Medicare recipients who may find that it is hard to handle [denied] claims; they are a vulnerable group, so to make things harder for them to navigate ... is not fair to the patients."

Asked about the level of communication between vendors and providers, a CMS spokesperson said in an email that "CMS is actively working with WISeR participants and CMS Medicare Administrative Contractors (MACs) on readiness. WISeR participants, MACs, and CMS have been conducting education and outreach to providers in selected states and will continue to do so as the model begins. CMS will continue to work with providers and participants to ensure any issues are rapidly identified and resolved."

Prior authorization's benefits should not be overlooked, according to Michael Lutz, managing director at the consulting firm Avalere Health. "I tend to believe there is a role for prior authorization when it's done correctly, when it's executed efficiently based on clinical guidelines and well-documented approaches to delivery of care," he said in a phone interview. "So it does not surprise me when, in a world where we need to be focused on controlling costs and increasing quality, that folks like Medicare are looking to see what prior authorization can bring to the market."

"If we get rid of prior authorization completely, we lose a lot of the benefits of managed care," but it needs to be implemented efficiently and in a way that doesn't interfere with physicians' workflow, he said. "What I do see across the board is a desire to use technology ... to make the process better, to make it less disruptive to patients and members of the health plans, and I do think we can get there."

One thing Lutz said he'll be watching is the use of AI in the WISeR Model. "There's a lot of drive to use AI to help comb through the clinical information and be an aid to the final reviewer as they look at these cases," he said. "But there's also a lot of pushback from regulation about how AI can be deployed.... Is regulation going to interrupt the process? Is regulation going to enhance the process of adoption or guide it in certain ways? I think that's the big question."



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