

Medicare's AI prior authorization pilot was rushed and full of problems, new documents reveal

Documents released as part of a lawsuit shows how initial hiccups led to delays in care delivery

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The rollout of a Medicare program that uses artificial intelligence to approve or deny care was hasty and error-ridden, according to more than a thousand pages of recently released documents and data.

The pilot program, called the Wasteful and Inappropriate Service Reduction model, or WISeR, launched in January and requires health care providers to seek approvals before they can provide certain procedures and products, like skin substitutes and epidural injections for pain management.

The experiment operates in New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington and will run until 2031.

Among other issues, the documents obtained by the Electronic Frontier Foundation through a Freedom of Information Act lawsuit show that one WISeR vendor warned the Centers for Medicare and Medicaid Services that it was unrealistic to expect a working product by the time the federal agency wanted to launch the program.

During the early months of the rollout, both the company, called Innovaccer, and its Medicare contracting partner reported issues that matched complaints coming from providers. The poorly implemented technology resulted in canceled and postponed surgeries and “patients calling our offices crying in pain because their procedures are being delayed while awaiting approvals or guidance,” providers said.

“I have had to watch 3 patients cry at bedside for not hearing back on their prior auth for kyphoplasty/vertebral augmentation [sic]

procedure,” wrote one Ohio-based provider in a feedback survey. “These patients are in deep pain. So many offices of my physicians are not hearing back from Innovaccer and [...] there is no way to get a hold of a human to talk to on Innovacer [sic]. What a disgrace to the human race in America. This is Third World.”

WISeR is a key piece of the Trump administration’s push for affordability and cutting waste in health care. Officials have positioned WISeR as a way to use technology to easily “expedite and improve the review process” for certain procedures that are prone to fraud, waste, and abuse. The approval process, meant to be completed in three days or fewer, is intended to “decreas[e] costs and eas[e] administrative burden on providers and suppliers,” even though these procedures previously did not require approvals.

Earlier this summer, the Senate unsuccessfully attempted to end WISeR after the Government Accountability Office found that CMS did not follow proper procedure in setting up the Medicare experiment. The federal watchdog’s finding came amid complaints that the pilot was harming people in Washington state.

Congresswoman Suzan DelBene (D-Wash.), who led a House effort to stop WISeR, told STAT in a statement that “the more that American seniors learn about WISeR, the more they are outraged that the Trump administration is allowing tech companies to profit by delaying and denying necessary care.” While the new information answers many questions, she said, it also begs new ones, and she pledged to hold the administration accountable. “It’s incredibly frustrating how reticent HHS has been in sharing information about this hastily put together AI experiment,” she said.

CMS has acknowledged some issues with the program. The agency has put Virtix, the technology vendor in Washington state, on a corrective action plan after an audit revealed that the company was not complying with the three-day turnaround time for approvals. Since then, the issue has been corrected, said CMS, with the turnaround time going from five days near the start of the program to 1.7 days for prior authorization and just over three days for the pre-payment review process, according to KUOW, Seattle’s National Public Radio station. Virtix’s audit and

corrective action plan are not publicly available and CMS did not specify whether other vendors have also received corrective action.

CMS told STAT that further data on turnaround times and preliminary quality data for all WISeR vendors will be shared in a forthcoming report on the first six months of the program. The agency added that it “closely monitors the implementation of all models, including system performance and denial patterns, and is actively addressing issues as they arise.”

Payment structure

Leading health policy experts have questioned if paying WISeR vendors based on a share of the spending averted incentivizes vendors to deny care. In the past, CMS staff have defended the program’s payment structure by saying the payments are subject to a “quality adjustment” that incentivizes the vendors to get the decision right the first time, and adhere to timelines.

But agency documents show that the penalty for not achieving full quality marks is small in comparison to the possible payments. The WISeR payment formula awards the tech vendor 25% of the value or estimated average value of a denied claim, less a “discount” meant to adjust for historical practices that have resulted in savings that aren’t attributable to the new program. That amount is then adjusted by the quality score.

A vendor scoring between 60% and 85% on quality measures only gets penalized by 5% on the payment, and any score below 60% still receives 90% of the payment. Vendors aren’t paid for any denials that are eventually overturned by an appeal. Still, many people don’t appeal — for example, an HHS OIG investigation of a separate Medicare Advantage program found that 82% of patients did not appeal their denials.

Rushed implementation

The WISeR program was announced last summer, vendors for each of the six states announced in November, and it went live in January. The American Hospital Association, which represents health care providers, and at least one vendor asked CMS to delay implementation, according to the recently released documents.

Innovaccer, the vendor for Ohio's WISeR program, warned in a Dec. 12 letter to CMS that given the agency's "decision not to delay the model start date," the company would go live in January without full functionality. It decided that auto-approving all requests would be the only way to both go live and not create a huge backlog of requests.

Though Innovaccer initially thought it would take 45-60 days to stand up its tools, the estimated go-live dates slipped from early March to late March to the end of April. The reports included in the FOIA document release stop in early April before the tools were tested and released. Innovaccer declined to say when its tools went into operation, but confirmed to STAT that they are currently "fully live."

"We have worked closely with all of our partners to refine and improve the program since its launch and we will continue to do so with the spirit of putting patients first," the company said in a statement to STAT.

Technical incompetence

More than two months after WISeR's launch, a Medicare administration contractor, Noridian, realized that one of the vendors did not know the difference between Medicare Part A and Part B. It traced back ongoing provider complaints about claims being incorrectly categorized to Zyter, the company administering WISeR for Arizona. "Zyter acknowledged that access to its portal was limited to 'outpatient' requests due to a misunderstanding that outpatient hospital services equate exclusively to Part B," Noridian wrote, adding that it provided Zyter guidance as to the distinction between the two.

In the same March report, Noridian reported that Zyter's portal was not configured to handle requests from ambulatory surgical centers, and that it had warned Zyter that simply dismissing requests coded for ASCs "could result in provider abrasion and potential compliance concerns." "We are fully functional across Medicare Part A and Part B claims and fulfill requests from all providers, including ASCs," said Zyter CEO Sundar Subramanian in an emailed statement.

Over a month into the program, Noridian realized that Virtix, the vendor for Washington, had not been notifying health care providers when it made a decision on a request because it thought Noridian was handling that based on the WISeR user guide. But Noridian hadn't received any

instructions from Medicare saying that it was the responsibility of the Medicare contractor, so neither company was doing it.

Difficulties with portals resulted in reverting to fax

Despite ambitions of using AI to make the review process quick and easy, providers complained about how non-functional vendors' portals were and ended up reverting to paper.

“It appears that all documentation has to be faxed, the portal cannot be used to submit the documentation. I have been told that there is a way to submit via the portal, but the customer service representatives have not been able to provide instructions on how to proceed,” wrote a provider from Kettering Health Network in Ohio.

“Our whole team is unable to log in to Zyter,” wrote a commenter at a webinar. “The system is not accepting the NPI for Tucson Medical Center, we are unable to get a clear answer on how to fix this.”

All of the technical hiccups have created greater costs for the Medicare program. According to an email between Medicare staffers, the Medicare contractor for Texas, New Jersey, and Oklahoma alerted CMS that it was going to need more funding than originally planned.

The organization, which handles Medicare billing, had assumed that it would be involved only in the initial WISeR launch and then transition into a support role, but the three vendors it was responsible for “continue to need a large amount of support after the model has been in place for over two months,” wrote Amy Drake, a Medicare contracting representative, and the additional support the vendors need “is not decreasing and is above what was originally proposed.”