National Rural Health Association

August 21, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Administrator Oz,

The National Rural Health Association (NRHA) appreciates the Centers for Medicare and Medicaid's (CMS) continued dedication to the health of rural communities. NRHA respectfully submits its concerns regarding the recently announced Wasteful and Inappropriate Services Reduction (WISER) Model. NRHA agrees with CMS' commitment to protecting Medicare beneficiaries and taxpayer resources, but we urge the agency to consider and address the implications this model may have on rural providers and the communities that they serve.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals (CAHs), doctors, nurses, and patients. We provide leadership on rural health issues through advocacy, communications, education, and research.

NRHA is calling attention to several impacts the WISER Model may bring to rural communities in the following areas:

- Prior Authorization: Longstanding Challenges for Rural Providers and Patients
- WISER Incentive Structure Risks Repeating RAC-Era Harms
- Caution Toward Aligning with Medicare Advantage

I. Prior Authorization: Longstanding Challenges for Rural Providers and Patients

The WISER Model introduces technology-enabled prior authorization and prepayment review for select services under Medicare Fee-for-Service (FFS) across several states. This demonstration is mandatory for all Medicare FFS-enrolled providers and suppliers furnishing the selected services in affected regions. In practice, NRHA is concerned that this model will add administrative layers for already strained rural health systems. In rural communities, where staffing shortages, broadband limitations, and administrative constraints pose challenges for providers, the burden of navigating complex and often inconsistent prior authorization systems can disrupt workflows, divert resources from patient care, and delay necessary services. These delays directly affect rural beneficiary outcomes.

The model allows for prior authorization requests to be submitted either directly to the WISER vendor or through the provider's Medicare Administrative Contractor (MAC). Claims submitted without prior authorization will be automatically routed to pre-payment medical review. Providers may resubmit prior authorization requests an unlimited number of times and request peer-to-peer clinical review. However, these options may not mitigate the burden for small rural practices that are already stretched thin and do not have the bandwidth to chase down the same request multiple times.

While the WISER Model is being tested in a limited number of states and for particular services, the requirements placed on providers are nevertheless mandatory. There is no opt-out process as any

claim for a covered service that is not preceded by a prior authorization request will be flagged for pre-payment medical review. Such practice introduces new administrative steps for rural providers. The services targeted by WISER are already subject to National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) which have undergone rigorous evidence reviews and, in some cases, Food and Drug Administration (FDA) clearance. Adding a separate layer of prior authorization to services that CMS has already deemed medically necessary risks duplication, confusion, and inconsistency in coverage standards. CMS's decision to forgo the notice-and-comment rulemaking process by classifying WISER as a voluntary model further limits public input on policy design that will, in practice, significantly affect rural provider operations in selected states.

II. Concerns Regarding WISER Incentive Structure

Another troubling aspect of the WISER Model is its payment structure for participating vendors, who will be compensated based on a percentage of "averted" Medicare spending, effectively rewarding the denial of services. This process models the flawed incentives that characterized the Recovery Audit Contractor (RAC) program in the early 2010s, during which hospitals, including many rural facilities, spent a significant amount of time and money appealing denials issued by contractors.

WISER's combination of technology-driven review and performance-based payment risks recreating a similar system, where the emphasis shifts from appropriate utilization to cost avoidance. Without robust guardrails and a transparent, clinician-led review processes, the model may disproportionately affect low-volume providers who lack the infrastructure to navigate automated decision-making systems or appeal denials effectively.

CMS notes in the model frequently asked questions document that all denials will be reviewed by a human clinician and cannot be performed solely by technology. Additionally, CMS notes that it will audit vendors to ensure decisions are consistent with Medicare coverage criteria, vendors must assume the cost of processing prior authorization requests, and beneficiaries retain their rights to appeal any denied requests.[1] NRHA asks that CMS vigorously enforce these protections to safeguard rural beneficiaries' access to care.

III. Caution Toward Aligning with Medicare Advantage

WISER arrives amid CMS's recent work to reform prior authorization across Medicare Advantage (MA), including new rules to streamline prior authorization processes and reduce unnecessary care delays. However, NRHA is worried that WISER may signal CMS's intent to align utilization management strategies, like prior authorization, and administrative oversight across both MA and FFS. By introducing technology-enabled prior authorization into the FFS environment, CMS appears to be moving toward a more uniform framework in which providers are subject to similar utilization management controls regardless of a beneficiary's enrollment in MA or FFS. The WISER Model is set to run for three years in select states, but NRHA has major concerns should CMS decide to expand these policies beyond the end of the model.

Greater consistency across FFS and MA processes may seem like a reasonable objective, yet NRHA believes that such alignment poses significant challenges for rural providers. Many rural hospitals and clinics already struggle under the weight of MA prior authorization requirements, which frequently delay care, require significant staff time and resources, and result in confusion for beneficiaries. Rural hospitals often do not have the staff or capacity to handle the mounting burden of prior authorization requirements. Extending similar processes into Medicare FFS risks doubling

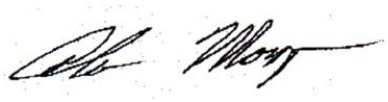
[1] https://www.cms.gov/priorities/innovation/files/document/wiser-model-frequently-asked-questions

the administrative burden for rural facilities that are already operating with limited resources. Rather than leveling the playing field, this shift could deepen existing disparities by subjecting rural providers to further complex, time-consuming prior authorization systems without the infrastructure to absorb them.

If CMS intends to harmonize MA and FFS oversight, it must do so with an explicit understanding of the disproportionate impact on rural health care delivery and ensure any changes are accompanied by safeguards and support mechanisms tailored to the needs of underserved communities.

NRHA appreciates your consideration of our rural health priorities. We look forward to working together to improve rural health and health outcomes across the country. **We would welcome a meeting with your team to discuss these priorities further.** Please contact NRHA's Government Affairs and Policy Director Alexa McKinley Abel (amckinley@ruralhealth.us) with any additional questions or to discuss further.

Sincerely,



Alan Morgan
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National Rural Health Association