



## Unaccountable Care:

# AI-Driven Denials of Care From CMMI Coming for Medicare Patients

## SUMMARY

In 2010, the Affordable Care Act (ACA or Obamacare) created the Center for Medicare and Medicaid Innovation (CMMI) under the Center for Medicare and Medicaid Services (CMS) to design and test new healthcare models intended to improve affordability and quality. Few of those models have proven to be worthwhile, and the agency's flawed process almost always guarantees it will miss the mark. A good example is the Wasteful and Inappropriate Service Reduction (WISeR) model announced by CMMI in June 2025. Under the model, Medicare patients and their physicians will, for the first time, face prior authorization (PA) decisions under Original Medicare rendered by opaque Artificial Intelligence (AI) algorithms. Americans are already frustrated with health insurance denials and bureaucratic barriers to care and WISeR would expand those obstacles to Medicare patients. CMMI's authorizing statute allows the agency to impose major program changes without meaningful public input, including from the patients and providers these models are meant to serve.

Perhaps more concerning is how these models can directly affect whether and how these patients receive care. WISeR introduces new incentives and systems that could delay treatment and services for patients. After 15 years of wasteful spending and care disruption, the wiser approach for Congress is to eliminate CMMI.

## BACKGROUND

Armed with \$10 billion per decade in “mandatory” taxpayer funding, and after more than 15 years of experimentation, CMMI has failed to generate savings or improve care. Instead, it has wasted that money running one-size-fits-all experiments with healthcare that strip patients and providers of choice and control, bypass Congress, and rewrite healthcare policy administratively.

Despite its hefty taxpayer support, CMMI has failed to deliver meaningful savings or durable improvements. Between 2011 and 2020, CMMI lost \$5.4 billion on more than 100 models that seldom met expansion criteria and is headed to lose even more by 2030. A 2021 study of 174 CMMI models found that only four met the statutory criteria to be expanded nationwide. Yet the agency continues launching new models that can significantly affect how care is delivered to Medicare patients, often introducing new administrative barriers that physicians and patients must navigate before treatment can proceed.

## THE PROBLEM

CMMI forces taxpayers to finance costly initiatives that are described as “tests” but often represent disruptive changes in care delivery. As a result, it has quietly evolved into a parallel policymaking body, increasingly reshaping care delivery without meaningful input or review by Congress, providers, patients or the public.

As a result, administrative decisions become de facto policy reforms made unilaterally by an obscure healthcare agency. This forces healthcare providers to rapidly adapt to changing rules which impacts care delivery in real time. For patients, this can mean delays in treatment, changes in recommended care, or uncertainty about whether recommended services will be approved.

Once implemented, these models can significantly alter the clinical and financial environment in which providers operate, making it harder for providers to deliver consistent care and creating confusion for patients navigating an already complex healthcare system.

In effect, taxpayer dollars are routinely squandered on “temporary fixes” that not only fail to produce any return on a steep public investment but also negatively impact healthcare.

## A CLOSER LOOK: THE WISER MODEL

The Wasteful and Inappropriate Service Reduction (WISeR) Model, which will run from January 31, 2026, through December 31, 2031 in six states, is another clear example of CMMI using its demonstration authority to advance novel healthcare policy changes without meaningful provider input.

WISeR has sparked significant controversy due to its implementation with no formal public input, unprecedented implementation of PA through AI algorithms in original Medicare, and embedding utilization controls that created new incentives to reduce or deny services. In practice, this means **government bureaucrats are introducing new hurdles making it harder for patients to access certain treatments.**

**Critics warn** that AI is already increasing denial of care and interfering with decisions about medically necessary individual treatment. Determining a service's "value" based on opaque standards and unreliable, one-size-fits-all judgments that overshadow clinical expertise and patient needs will increase delays and coverage denials and inappropriately limit medically necessary care.

**Even worse, WISeR compounds this risk by financially rewarding private companies that issue more coverage denials.** Under WISeR guidelines, participating vendors are **compensated** for model participation by receiving 10-20 percent of the savings generated through denied services, creating a financial incentive to reduce care even when a provider determines it is clinically appropriate.

In other words, the more care that is denied or avoided, the more vendors stand to benefit financially, which raises serious concerns that cost-cutting could take priority over patient care.

**Despite** widespread provider opposition, CMMI is moving full steam ahead with WISeR, reinforcing concerns about growing government control over healthcare. A December 23, 2025, **letter** signed by 16 prominent associations that represent anesthesiologists, oncologists, ophthalmologists, and a wide variety of surgeons, has warned that the model could increase administrative burdens, delay care, and interfere with physicians' ability to treat their patients effectively.

## THE SOLUTION

CMMI is a wasteful and burdensome agency that increasingly operates beyond its intended scope and makes consequential healthcare decisions without meaningful dialogue from the providers responsible for patient care.

By enabling unelected bureaucrats to dictate how care is evaluated and reimbursed, CMMI undermines patient-provider relationships and erodes accountability.

Policies that create incentives to deny care, rely on opaque algorithms, and add other hurdles will make it harder to deliver healthcare to Medicare patients.

As such, we urge Congress to support the immediate termination of CMMI and reassert its policymaking authority. Repealing CMMI ensures that healthcare policy is shaped in partnership with providers, not through administrative models that quietly reshape healthcare delivery.

Healthcare is complex and consequential, and reforms must be developed through a transparent legislative deliberation that incorporates meaningful stakeholder input, protects patients, and respects the role of elected governing bodies. Restoring congressional control through CMMI elimination is essential to reestablishing accountability and preventing further administrative overreach.