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The WISeR Model at Six Months

AI-Enabled Prior Authorization in Traditional Medicare — Evidence, Efficacy, and Downstream Effects

Prepared June 28, 2026 · Reasoning structure: deductive (design → prediction) + inductive (record → pattern) · Three-pass discipline applied

Bottom line up front

WISeR is the largest expansion of prior authorization (PA) in the history of Traditional Medicare, and the first CMMI model in which the only participants are technology vendors paid on a contingent share of the spending their reviews avert.[1] That payment design — not the use of AI as such — is the analytic crux.[2]

On CMS's own terms the early efficacy case is unproven and confounded: the single largest "saving" CMS can point to (skin substitutes) is attributable to a *separate* nationwide payment change effective the same day, not to WISeR review.[3]

On access, the early field record — a 16-hospital Washington dataset, multi-state physician reporting, and vendor admissions of a rushed build — shows real, if not-yet-quantified-at-scale, harm: authorization timelines stretching from ~2 weeks to 4–8 weeks, and CMS turnaround standards routinely missed.[4] A GAO determination (May 12, 2026) found WISeR is a "rule," triggering an active Congressional Review Act repeal effort.[5]

"Which states are next" has no published answer. CMMI's director has stated there are *currently no changes* to the service list and no announced geographic expansion; any specific next-state list would be speculation.[6]

[1] Ctrs. for Medicare & Medicaid Servs., Wasteful and Inappropriate Service Reduction (WISeR) Model, https://www.cms.gov/priorities/innovation/innovation-models/wiser (last visited June 28, 2026). Model authority: § 1115A of the Social Security Act (CMMI).

[2] Cong. Rsch. Serv., IF13133, Overview of the Medicare Wasteful and Inappropriate Service Reduction (WISeR) Model (May 12, 2026), https://www.congress.gov/crs-product/IF13133.

[3] KFF, Examining the Potential Impact of Medicare's New WISeR Model (Feb. 10, 2026), https://www.kff.org/medicare/examining-the-potential-impact-of-medicares-new-wiser-model/.

[4] Healthcare Dive, Medicare AI prior authorization pilot delaying care in Washington: report (Apr. 24, 2026), https://www.healthcaredive.com/news/medicare-ai-prior-authorization-pilot-care-delays-washington-senator-maria-cantwell/818348/; Off. of Sen. Maria Cantwell, WISeR Snapshot Report (Apr. 2026).

[5] Medicare Policy Initiative, Georgetown CHIR, CMS's WISeR Model Faces Potential Repeal Following GAO Determination (June 2026), https://medicare.chir.georgetown.edu/cmss-wiser-model-faces-potential-repeal-following-gao-determination/.

[6] KFF Health News, Medicare's AI Push Snarls Patients and Doctors in Errors and Delays (June 24, 2026), https://kffhealthnews.org/medicare/medicare-ai-prior-authorization-wiser-delays-errors/; reprinted CBS News & Phila. Inquirer (June 24, 2026).

1. The model, stated plainly

WISeR (Wasteful and Inappropriate Service Reduction) is a six-year CMMI demonstration running January 1, 2026 through December 31, 2031 in six states — New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington — spanning four MAC jurisdictions.[7] It applies only to Original (fee-for-service) Medicare; Medicare Advantage and Railroad Medicare beneficiaries are unaffected.[8]

It introduces PA (or, if a provider declines PA, post-service pre-payment medical review) for roughly 13 selected Part B services that CMS deems low-value or fraud-prone — among them skin and tissue substitutes, epidural steroid injections, percutaneous vertebral augmentation (kyphoplasty), nerve-stimulator implants, knee arthroscopy for osteoarthritis, incontinence-control devices, and impotence treatments.[9] Coverage and payment rules do not change; determinations are made against existing NCDs/LCDs.[10]

1.1 The four design features that matter

1. **Vendor-only participants.** Six technology firms each cover a state/MAC region: Cohere Health (TX), Genzeon, Humata Health (OK), Innovaccer, Virtix Health, and Zyter. This is the first CMMI model in which providers are not participants at all.[11]
2. **Contingent-fee compensation.** Participants receive a percentage of the expenditures their reviews avert — i.e., a share tied to denied/averted spend — adjusted by performance measures including provider-experience surveys and determination accuracy.[12]
3. **AI-first, human-confirmed.** AI/ML generates the initial recommendation; a licensed clinician must review every non-affirmation (denial) before issuance. The adequacy of that human layer is the central governance question.[13]
4. **“Voluntary” but functionally mandatory.** Providers may skip PA, but any unauthorized claim for a selected service is automatically routed to pre-payment review — so there is no true opt-out, only a choice of when the review occurs.[14]

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[7] CMS, WISeR Model, supra note 1.

[8] Noridian (JF MAC), WISeR Model — Arizona and Washington Providers and Suppliers (Mar. 11, 2026), https://med.noridianmedicare.com/web/jfb/cert-reviews/pre-claim/wiser-model (service list; review process; turnaround standards).

[9] Noridian (JF), WISeR Model, supra note 8.

[10] CMS, WISeR Model, supra note 1.

[11] Medscape, Medicare’s New WISeR Spending Model: 5 Things to Know (Dec. 23, 2025), https://www.medscape.com/viewarticle/5-things-doctors-know-about-medicares-wasteful-and-2025a1001041 (vendor list; $134–$185B waste estimate).

[12] CMS, WISeR Model, supra note 1.

[13] InsightHealth, Medicare’s WISeR Model: AI-Powered Prior Authorization and What It Means for Practices (Apr. 6, 2026), https://www.insighthealth.ai/blog/medicares-wiser-model-prior-authorization (AHA “check-the-box” human-review critique; insolvency context).

[14] Forvis Mazars, CMS WISeR Model: What Providers Need to Know by January 2026 (Dec. 10, 2025), https://www.forvismazars.us/forsights/2025/12/cms-wiser-model-what-providers-need-to-know-by-january-2026 (“voluntary” but functionally mandatory; review pathways).

> **Why this is squarely a 5Q two-tier-accountability case**
>
> WISeR imports the Medicare Advantage utilization-management apparatus — AI gatekeeping with a contingent-fee intermediary — into Traditional Medicare, for a population (older, disabled, disproportionately rural and safety-net) that has never had to navigate PA and is least resourced to manage appeals. The deterministic coverage criteria (NCD/LCD) are unchanged, but a probabilistic AI triage layer is inserted ahead of them. The accountability gap opens precisely at that seam: the criteria are public and auditable; the model's denial rates, error rates, and the depth of "human review" are not.[15]

2. The critique, framed through the CMS lens

To evaluate efficacy fairly, the model is first stated as its sponsors would state it, then pressure-tested from *within* that frame rather than from outside it.

2.1 CMS's theory of change (steelmanned)

CMS's premises are coherent on their face:

- Fee-for-service pays for volume, which can incentivize low-value or unnecessary care; PA is one of the few utilization levers available in Traditional Medicare, where PA is nearly absent (roughly 0.01 determinations per beneficiary vs. ~1.8 in MA).[16]
- Specific targeted services show genuine waste signals: HHS-OIG flagged a ~700% two-year surge in skin-substitute spending; MedPAC has flagged kyphoplasty as overused.[17]
- The fiscal stakes are real: the Hospital Insurance trust fund faces insolvency in the early-to-mid 2030s, and waste/fraud estimates in the $134–$185B/year range make even fractional recovery material.[18]
- Process safeguards exist on paper: clinician review of every denial, 1–3 day turnaround standards, unlimited resubmission, peer-to-peer review, a planned "gold-card" exemption at high affirmation rates, and financial penalties on vendors for denials overturned on appeal.[19]

2.2 Where the CMS frame strains under its own logic

Three internal tensions surface without ever leaving CMS's own premises:

Tension 1 — the incentive contradicts the stated goal. CMS says vendors are incentivized to "get the determination right," not to deny. But the fee is a percentage of averted spend. A neutral-accuracy incentive and a share-of-denials

[15] CRS, IF13133, supra note 2.
[16] CRS, IF13133, supra note 2.
[17] HHS Off. of Inspector Gen. warning (Sept. 2025) re: ~700% two-year growth in skin-substitute spending, as reported in KFF Health News (June 24, 2026).
[18] InsightHealth, WISeR Model, supra note 13.
[19] CRS, IF13133, supra note 2.

incentive are not the same object; the performance adjustments (provider-experience surveys, accuracy metrics) are second-order corrections layered on a first-order denial incentive. Bipartisan critics, the AHA, and a House appropriations letter all identified this as a "perverse incentive."[20]

Tension 2 — the human-review safeguard is only as strong as its depth. Requiring a clinician to sign every denial is meaningful only if that review is substantive. The AHA has warned that in practice human review of AI recommendations often degrades to a "check-the-box" exercise — the precise failure mode that produced litigation against MA algorithmic-denial tools.[21]

Tension 3 — the administration is scaling PA back everywhere else. CMS/HHS simultaneously pressed commercial and MA plans to reduce PA, while WISeR expands it into the one program that lacked it. Even granting the fraud case, the directional inconsistency undercuts the "modernization, not gatekeeping" framing.[22]

[20] Healthcare IT News, Care delays and denials grow across 6 states using WISeR Model, lawmaker says (Apr. 20, 2026), https://www.healthcareitnews.com/news/care-delays-and-denials-grow-across-6-states-using-wiser-model-lawmaker-says.

[21] InsightHealth, WISeR Model, supra note 13.

[22] KFF Health News, AI Push Snarls Patients, supra note 6.

3. Deductive reasoning: from design to predicted effects

Holding CMS's own stated facts fixed, the model's structure entails a set of predictions *before* any outcome data are consulted. If the premises are true, these consequences follow.

Premise (CMS-stated)	Logical consequence	Predicted signal
Vendor paid a share of averted/denied spend	Expected revenue rises with denial volume/value at the margin; accuracy adjustments dampen but do not invert the gradient	Denial-leaning posture on ambiguous claims
AI generates first-pass; clinician must confirm denials	Throughput pressure pushes confirmation toward the AI recommendation; review depth compresses as volume rises	High concordance between AI flag and final denial; thin documentation of independent reasoning
1–3 day turnaround standard; rushed build (announced June 2025, live Jan 2026)	Capacity lag at go-live; portals and staffing trail demand	Standards missed; backlogs; manual MAC routing
No true opt-out (skip PA → pre-pay review)	Administrative load lands on providers regardless of pathway	Rising per-claim admin time; staffing strain
Population new to PA; appeals rights formally preserved	Appeals uptake limited by literacy/resource gaps despite formal availability	Delays/abandonment concentrate among under-resourced patients/providers

The deductive verdict is conditional but pointed: if the design is as described, then access friction and a denial-leaning equilibrium are not aberrations of a bad rollout — they are the model operating as specified. This is the claim most resistant to a "growing pains" defense, because it does not depend on the early data at all.

4. Inductive reasoning: from the early record to patterns

The first six months supply a limited but converging evidentiary record. Inductively, the question is whether independent observations point the same direction — and how far one may generalize from them.

4.1 The strongest dataset: Washington (16 hospitals)

Sen. Cantwell's April 2026 snapshot, drawing on Washington State Hospital Association survey data from 16 hospitals, found procedure completion taking two to four times longer post-WISeR — services previously authorized in ~2 weeks now taking 4–8 weeks.[23] The University of Washington system reported average response times of 15–20 days against CMS's 1–3 day standard, with roughly 100

[23] Cantwell/WSHA Snapshot Report, supra note 4.

patients queued for epidural steroid injections. More than 18,600 Washington residents received these now-PA-gated services in 2024.[24]

4.2 Corroborating, multi-source signals

- Cross-state field reporting (KFF Health News / CBS / Inquirer, June 2026): clinicians in Oklahoma, New Jersey, and elsewhere describe confusion, errors, and delays; one NJ rehabilitation physician reported a patient who deteriorated to costlier hospital care while awaiting authorization — a cost-shift, not a saving.[25]
- Operational breakdowns (trade and investigative reporting): Ohio's vendor portal reportedly non-functional until recently; Arizona peer-to-peer reviews requiring 1+ hour by phone with week-long scheduling delays; Washington timelines stretching well past standard.[26]
- Vendor admissions: Humata Health's CEO described an "aggressive rollout" from notification to go-live; multiple vendors were still adding product features into spring 2026 — consistent with the deduced capacity-lag prediction.[27]
- Turnaround degradation generalized: industry reporting documents standard PA turnarounds moving from 1–2 days (urgent) / 3–5 days (standard) to 10–15 days across pilot states.[28]

4.3 The disconfirming / complicating evidence (held honestly)

- KFF's structural read: first-year impact is likely modest because the targeted services touch relatively few beneficiaries and a small share of Part B spend.[29]
- Attribution problem: the ~90% spending reduction CMS associates with skin substitutes stems from a separate, nationwide payment-policy change effective Jan 1, 2026 — not from WISeR review. This severs the model's headline savings claim from the model itself.[30]
- CMS's rebuttal: CMMI states it has "no evidence of inappropriate denials" to date, attributes some delay to manual MAC routing during portal stand-up, and commits to corrective action and vendor penalties.[31]

> **Inductive verdict (with its limits stated)**
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> The independent observations converge on delay and administrative strain, and

[24] Cantwell/WSHA Snapshot Report, supra note 4.

[25] KFF Health News, AI Push Snarls Patients, supra note 6.

[26] RemoteScouts, WISeR Model, AI Prior Authorization & Claim Denials 2026 (May 13, 2026), https://remotescouts.com/blog/cms-wiser-model-healthcare-claim-denials/ (state-by-state operational reports: WA, OH, AZ).

[27] KFF Health News, AI Push Snarls Patients, supra note 6.

[28] Healio, Updates on prior authorization: What's changed and will it make a difference? (June 23, 2026), https://www.healio.com/news/primary-care/20260623/ (turnaround-time degradation across pilot states).

[29] KFF, Examining the Potential Impact, supra note 3.

[30] KFF, Examining the Potential Impact, supra note 3.

[31] KFF Health News, AI Push Snarls Patients, supra note 6.

> they match the deductive predictions — raising confidence that the early harms reflect design, not merely immaturity. But the generalization is bounded: the strongest dataset is single-state and advocacy-released; denial-rate and overturn-rate data are not yet published by CMS; and rollout immaturity is a genuine confound that only later quarters can separate from inherent design effect. The honest present position is **corroborated concern, not settled proof of net harm.**

5. Efficacy assessment: is it working on its own terms?

Efficacy splits into two questions CMS itself separates — does it save money, and does it preserve access/quality.

Savings: unproven and confounded. The most-cited reduction is attributable to a parallel payment change, not WISeR; CMS has not published model-attributable net savings (gross averted spend minus administrative cost, appeals cost, and downstream cost-shifting such as the NJ hospital-escalation example). Until that ledger exists, the savings claim is unfalsifiable in the precise sense — asserted but not yet measurable against a counterfactual.[32]

Access/quality: early indicators negative. The delay data, the missed-standard rates, and the documented care-deferral and cost-escalation cases all cut against the "streamline efficiency / improve accuracy" objective. CMS's monitoring plan does commit to tracking adverse events, hospitalizations, and mortality — but those longer-horizon outcomes are not yet reported.[33]

Net read: at six months, WISeR has not demonstrated efficacy on either axis, while generating measurable access friction. That is a failing-to-neutral interim grade, with the caveat that a demonstration is designed to surface exactly this and adjust.

6. Downstream effects: people, institutions, society

6.1 People (beneficiaries)

- Delay-mediated harm: prolonged pain, repeated rescheduling, and deterioration while awaiting authorization — concentrated in pain-management and mobility-adjacent services.[34]
- Geographic and equity gradient: rural beneficiaries (e.g., an Oklahoma patient contemplating crossing into Kansas to avoid the process) and those with the least capacity to appeal absorb the friction disproportionately — the structural-determinant pattern.[35]
- A public-health second-order effect worth flagging: WSHA warns that delays to non-opioid pain treatments (epidural steroid injections) may push some patients toward opioids during the wait — a substitution that runs directly counter to federal harm-reduction goals.[36]

[32] KFF, Examining the Potential Impact, supra note 3.

[33] Federal Budget IQ, WISeR Medicare Decision Technology Kicks Off (July 21, 2025), https://federalbudgetiq.com/insights/wiser-medicare-decision-technology-kicks-off/ (CMS monitoring metrics; Project 2025 lineage; payment structure).

[34] Cantwell/WSHA Snapshot Report, supra note 4.

[35] KFF Health News, AI Push Snarls Patients, supra note 6.

[36] Cantwell/WSHA Snapshot Report, supra note 4.

6.2 Institutions (providers, hospitals, MACs, CMMI)

- Provider economics: new submission queues, peer-to-peer labor, and appeals work land on already-thin staff; some physicians report considering dropping specific procedures — a quiet access contraction that never appears as a "denial."[37]
- Safety-net and rural facilities (the 5Q market) are least able to add PA infrastructure; the model rewards documentation sophistication (clean PARs, gold-card eligibility) that well-resourced systems acquire fastest — widening the capability gap.[38]
- Institutional precedent: WISeR is positioned as a "roadmap for incorporating private-sector innovations into CMS operations." If it normalizes contingent-fee AI intermediaries in FFS Medicare, the template, not the pilot, is the lasting effect.[39]

6.3 Society (system-level)

- Privatization-by-architecture concern: critics across both chambers frame WISeR as a "Trojan horse" that grafts the MA utilization-management model onto Traditional Medicare; the lineage traces to Project 2025's call to use AI for waste/fraud detection.[40]
- AI-governance precedent: WISeR is a live test of whether "human-in-the-loop" plus appeal rights is sufficient governance for algorithmic determinations affecting entitlements — the exact accountability question now contested in courts and Congress over MA AI-denial tools.[41]
- Trust externality: importing PA into a program seniors paid into and never had to "negotiate" with risks a diffuse erosion of confidence in Traditional Medicare that outlasts any line-item saving.[42]

[37] RemoteScouts, WISeR Claim Denials 2026, supra note 26.
[38] InsightHealth, WISeR Model, supra note 13.
[39] CMS, WISeR Model, supra note 1.
[40] Federal Budget IQ, WISeR Kicks Off, supra note 33.
[41] KFF, Examining the Potential Impact, supra note 3.
[42] Healthcare IT News, Care delays and denials grow, supra note 20.

7. Which states are next?

> **Honest answer: no state has been officially named.**
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> CMMI Director Abe Sutton has stated there are "currently no changes" contemplated to the WISeR service list, while adding that CMS "continues to assess whether any changes are warranted." No geographic-expansion list has been published. Any specific next-state claim circulating publicly is inference, not policy.[43]

What can be said responsibly is structural — the model's own documents reserve the right to add participants, states, or services if early results support it, and to consider national expansion after the pilot. Three distinct expansion vectors exist, and they are not equally likely in the near term:[44]

Vector	What it would look like	Near-term likelihood
Service-line expansion (within the 6 states)	Add codes to the existing PA list — plausibly reaching DMEPOS/CRT-adjacent items given the legacy Power Mobility Device PA demonstration infrastructure	Low–moderate; Sutton says no current change
Geographic expansion (new states)	Extend within the four involved MAC jurisdictions (Novitas, CGS, Noridian) or to an adjacent MAC region; CMS retains discretion to add participants	Low near-term given active repeal effort and poor early press
National scale-up (post-pilot)	Roll the model out across FFS Medicare after the demonstration window	Contingent on multi-year results; years away if at all

Forward-looking note for 5Q's market: CRT and standard DMEPOS are *not* currently in WISeR's 13 services (incontinence-control devices are the closest DMEPOS-adjacent item). But the pre-existing DMEPOS PA demonstration for power mobility devices means the rails for a CRT/DMEPOS service-line expansion already exist — a contingency worth tracking, not a present fact.[45]

8. Legal and repeal trajectory

On May 12, 2026, the GAO determined that WISeR meets the Administrative Procedure Act definition of a "rule" — because it imposes new PA requirements on Traditional Medicare providers in the pilot states — meaning it should have been submitted to Congress and is subject to the Congressional Review Act.[46] On May 20, Sen. Wyden (Senate) and Reps. DelBene and Landsman (House) introduced

[43] KFF Health News, AI Push Snarls Patients, supra note 6.
[44] Federal Budget IQ, WISeR Kicks Off, supra note 33.
[45] Noridian (JF), WISeR Model, supra note 8.
[46] Georgetown CHIR, Potential Repeal, supra note 5.

joint resolutions of disapproval; the CRA gives a 60-day window for expedited, filibuster-immune consideration, with a possible floor vote around July 11, 2026.[47]

Realistic read on outcome: the resolutions carry numerous Democratic co-sponsors but no announced Republican support; the standalone repeal bills (Seniors Deserve SMARTER Care Act, H.R. 5940 / S. 3480) stalled, and a 2025 House appropriations rider to defund the model did not survive into law. Even if a CRA resolution cleared both chambers, it would face a near-certain presidential veto from the administration sponsoring the model, and an override needs two-thirds. The likeliest near-term path is therefore continued operation under intensifying oversight pressure, with CMS making operational fixes (portals, turnaround, possibly accelerated gold-carding) rather than rescission.[48]

[47]Off. of U.S. Sen. Ron Wyden, Senate Finance Comm., Wyden, Senate Democrats Take Action to Roll Back Trump AI Care Denial Experiment on Seniors (May 20, 2026), https://www.finance.senate.gov/ranking-members-news/wyden-senate-democrats-take-action-to-roll-back-trump-ai-care-denial-experiment-on-seniors.

[48]Fierce Healthcare, House and Senate Democrats move to overturn CMS' WISeR AI prior auth pilot (May 20, 2026), https://www.fiercehealthcare.com/regulatory/legislators-introduce-resolution-seek-congressional-disapproval-cms-wiser-ai-prior-auth.

9. Confidence map, limitations, and what would change the assessment

Per the three-pass standard, every material claim above is graded; the grade travels with the claim.

Claim	Confidence	Basis
Model design facts (states, vendors, 13 services, §1115A authority, contingent-fee structure)	HIGH	CMS primary docs + CRS
GAO "rule" determination; CRA resolutions filed; veto math	HIGH	GAO + Senate/House primary
Early access friction (WA 2–4× delays; missed turnaround standards)	HIGH (existence) / MED (scale)	Cantwell/WSHA single-state dataset
Savings attribution problem (skin-substitute 90% from separate policy)	HIGH	KFF analysis
Delays are design-driven, not merely rollout immaturity	MED	Deductive + converging field reports; confounded
Opioid-substitution downstream effect	MED	WSHA-flagged, not yet quantified
Net savings / net harm verdict	LOW	No CMS-attributable ledger; outcomes lag
Which states/services are next; expansion timing	FLAG	No official source; inference only
Vendor denial/overturn rates	FLAG	Not yet published by CMS

9.1 Limitations

- The richest outcome data are single-state and released by a model opponent; CMS has not published model-attributable denial, overturn, or savings figures. Treat magnitudes as directional.
- Six months conflates rollout immaturity with inherent design effect; the two can only be separated with later-quarter data and a stabilized-portal baseline.
- Longer-horizon clinical outcomes (adverse events, hospitalizations, mortality) that CMS committed to monitor are not yet available — the most important efficacy evidence does not exist yet.

9.2 What would change this assessment

- Toward CMS: publication of model-attributable net savings with a credible counterfactual; denial/overturn rates comparable to or below MA benchmarks; turnaround standards met after portal stabilization; gold-carding meaningfully reducing burden.

- Against CMS: a multi-state dataset replicating Washington's delay pattern; documented adverse clinical outcomes attributable to delay; evidence that human review concords with AI at near-100% (the "rubber-stamp" signal); rising appeal-overturn rates indicating systematic over-denial.
- On trajectory: a CRA vote outcome and any veto; any CMS notice expanding services or geography (which would also reset the "which states next" FLAG to a sourced answer).

Drafting note: This is a capability and analysis working paper. It contains no client work product, makes no representation of filed comments or engagements, and states confidence and source for each material claim. Authorities are cited in footnotes for verification and refinement to full Bluebook form.

Section Update — Enforcement Arrives: The Virtix Corrective Action and the Multi-Front Challenge to WISeR

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How to use this supplement. This section updates "The WISeR Model at Six Months" with developments verified against primary sources through July 2, 2026. It is drafted to slot in as a new closing section (recommended placement: after the six-month findings, before the confidence map), with the confidence map replaced by the revised version in §6 below. Version the combined paper as v1.1.

1. What Happened

In late June 2026, CMS ordered Virtix Health — the WISeR model participant for Washington State — to submit a Corrective Action Plan (CAP) after finding the company out of compliance with the model's required 72-hour turnaround time for prior authorization and pre-payment determinations. Per CMS statements reported by KUOW, the finding followed an audit across five domains: clinical determinations, communications, portal functionality, customer service, and timeliness. The CAP must document root causes, specific operational and process improvements, implementation timelines, and mechanisms for ongoing monitoring and quality assurance. CMS will hold biweekly performance-review meetings with Virtix going forward.

A material discrepancy: Virtix told Healthcare Dive it "hasn't received a corrective action plan," while CMS and Rep. Suzan DelBene's office confirmed the order. Whatever the resolution, an agency and its AI contractor publicly disagreeing about whether an enforcement action exists is itself a governance finding — a failure of the accountability communication channel that ISO/IEC 42001 Clause 7.4 (communication) and Clause 9 (performance evaluation) are designed to prevent.

2. Governance Analysis: The CAP as a Retrofitted Management System

Read against the NIST AI RMF, the corrective action documents a deployer-ecosystem failure across three functions:

- **GOVERN 3.2 (third-party risk).** CMS's oversight of its technology participants relied on complaint-driven detection. Six months of provider and beneficiary reports — not proactive monitoring thresholds — surfaced the failure.
- **MEASURE 2.x (performance metrics).** The 72-hour standard existed on paper from launch (CMS FAQ, January 2026), but no published mechanism tied measurement to consequence until the CAP. Metrics without enforcement triggers are aspiration, not measurement.
- **MANAGE 4.1–4.2 (post-deployment monitoring and response).** The biweekly CMS–Virtix meetings and the CAP's required monitoring mechanisms are a retrofit of what ISO/IEC 42001 Clause 8 operational controls and Clause 10 (improvement) would have required as a condition of go-live.

Root cause (5-Whys). Turnaround failure → review capacity misaligned to volume → cost structure optimized for denial economics rather than throughput → contingent-fee compensation (participants are paid a share of averted expenditures; CRS IF13133 confirms payment as a percentage of the dollar value of denied requests after resubmissions are adjudicated) → no independent governance layer separating the financial incentive from the determination pipeline. The timeliness violation is the symptom; the compensation architecture is the condition.

This is the two-tier accountability gap in operation: the model imposes hard, enforceable clocks and documentation burdens on providers — disproportionately straining small practices, critical access hospitals,

and DMEPOS/CRT suppliers — while the AI participant's own obligations were, until this CAP, governed by soft commitments in an FAQ.

3. Legal Posture: Three Concurrent Fronts

3.1 Congressional Review Act

On May 12, 2026, GAO concluded (B-337994) that the WISeR Model Notice is a "rule" under the APA definition adopted by the CRA, because it prescribes new requirements for Original Medicare providers and substantially affects the rights and obligations of non-agency parties — providers and beneficiaries. No CRA exception applied. Because CMS never submitted the Notice to Congress as 5 U.S.C. § 801 requires, the determination opened a 60-day expedited-consideration window; joint resolutions of disapproval are pending in both chambers (Sen. Wyden; Reps. DelBene and Landsman), with a filibuster-immune Senate vote possible by approximately July 11, 2026. Analyst consensus: passage is plausible, but a presidential veto of the administration's own model is likely; WISeR should be treated as operative through at least FY2027 for planning purposes.

3.2 Appropriations

The House Appropriations Committee adopted a bipartisan amendment (Frankel–Harris) barring the use of federal funds on WISeR. The rider faces low odds of surviving Senate negotiation, and the earliest it could bind is October 1, 2026. It matters less as a repeal vehicle than as evidence of bipartisan discomfort — Rep. Harris is a physician Republican.

3.3 Litigation and Transparency

The Electronic Frontier Foundation filed a FOIA action against CMS in March 2026 seeking information on the AI tools used by model participants, and APA-based litigation reportedly targets WISeR's AI outputs, due-process deficiencies, and the structural conflict in participant compensation. The procedural-validity template here echoes *Azar v. Allina Health Services*, 587 U.S. 566 (2019), where the Supreme Court held CMS must use notice-and-comment procedures for changes to "substantive legal standards" under Medicare Act § 1395hh. [Citation verified July 2, 2026: Azar v. Allina Health Services, 587 U.S. 566, 139 S. Ct. 1804 (2019) — case, holding, and parallel citation confirmed against the Supreme Court's opinion and secondary reporting. The application of Allina's notice-and-comment reasoning to the WISeR Model Notice remains an analytical inference, not a holding — FLAG retained in the confidence map.] GAO's B-337994 reasoning and 5 U.S.C. §§ 801, 804 were verified directly.

4. Program Timeline Additions (verified)

- **April 2026:** CMS delayed two services — deep brain stimulation (essential tremor/Parkinson's) and percutaneous image-guided lumbar decompression — citing operational readiness.
- **May 12, 2026:** GAO CRA determination (B-337994).
- **May 20, 2026:** Joint resolutions of disapproval introduced in both chambers.
- **June 2026:** 60+ House members (Pocan letter) request wind-down by December 31, 2026; 31 House Democrats separately demand six-month data on turnaround lag, dismissal reasons, and submission-to-payment timelines; Virtix CAP ordered; House Appropriations rider adopted.
- **July 6, 2026 (scheduled):** Gold-carding exemption launches in Washington — providers achieving a 90% affirmation rate on a minimum of 10 requests during the assessment period are exempted from review; quarterly rollout to the other five states to follow.

5. Beneficiary and Supplier Impact

Washington State Hospital Association survey data (April 2026) shows Medicare patients waiting two to four times longer for WISeR-covered services, with procedures that previously took two weeks stretching to eight. Reported cases include an 88-year-old caregiver whose epidural steroid injection took from early February to late April through a denial-and-appeal loop, during which he progressed from a cane to a walker. From a RESNA ATP/SMS lens, the mechanism is familiar from Medicaid CRT prior authorization: the delay pathway (submission → denial → documentation churn → peer-to-peer → appeal) does functional harm during the wait — deconditioning, isolation, caregiver strain — that no eventual approval remediates. The WISeR service list already touches DMEPOS adjacency (incontinence control devices, skin substitutes); any expansion toward CRT codes would replicate this pathology inside Original Medicare, the payer of last resort for the populations least able to self-fund or appeal.

6. Revised Confidence Map (replaces v1.0 map)

Finding	Confidence	Basis / What would change it
CMS ordered Virtix to submit a CAP for 72-hour turnaround non-compliance; five audit domains; biweekly oversight meetings.	**HIGH**	KUOW reporting of CMS announcement; DelBene office confirmation. Direct CMS letter not yet public.
Virtix disputes receipt of the CAP.	**HIGH**	Healthcare Dive, on-record Virtix statement.
WISeR is a CRA "rule"; 60-day window from May 12; filibuster-immune Senate vote possible ~July 11.	**HIGH**	GAO B-337994 read directly; Georgetown Medicare Policy Initiative timeline.
Contingent-fee structure (share of averted expenditures / % of denied-request value).	**HIGH**	CRS IF13133; CMS FAQ; KUOW.
All six participants have failed CMS standards to comparable degrees.	**LOW**	Advocacy-source claim (HEALTH CARE un-covered); only WA enforcement is confirmed. Would rise with CMS audit data or the DelBene data response.
Repeal outcome: veto likely; WISeR operative through FY2027.	**MED**	Analyst projection (MedCity/Georgetown); inherently predictive.
Applicability of Allina notice-and-comment reasoning to WISeR litigation.	**FLAG**	Real authority; application is analogical and unverified against filed complaints. Verify before external use.

7. What This Means

For CMS: the CAP converts WISeR from a policy controversy into an auditable governance record. Every biweekly meeting, every CAP milestone, and the pending Congressional data demands will generate documents that discovery, FOIA, and oversight can reach.

For AI vendors in payment adjudication: the enforcement precedent is that turnaround metrics are now contract-consequential, and that the absence of a functioning AI management system (ISO/IEC 42001) will be reconstructed after the fact — under federal supervision, on the vendor's remediation budget.

For providers and suppliers: gold-carding (from July 6) makes documentation discipline a direct financial asset: a 90% affirmation rate is now an exemption ticket, which rewards exactly the clinical-documentation rigor that under-resourced safety-net deployers struggle to staff — the two-tier gap again, expressed as an exemption criterion.

For 5Q Health: this is the deterministic-to-generative rupture with a docket number attached. Deterministic adjudication rules had appeal pathways and published logic; WISeR's "enhanced technology" layer arrived with neither published model documentation nor operational monitoring, and the accountability apparatus is being assembled retroactively by GAO, Congress, litigants, and a corrective action plan. Governance as infrastructure means building that apparatus before deployment — because six months after launch is when the letters arrive.

Sources (primary and verifying)

- KUOW, "Feds reprimand private company using AI to review WA Medicare claims over delayed processing" (June 2026).
- Healthcare Dive, "Democrats push for more data on Medicare AI prior authorization pilot" (June 2026).
- GAO, B-337994, Applicability of the CRA to the WISeR Model Notice (May 12, 2026); 5 U.S.C. §§ 801, 804.
- CRS In Focus IF13133, Overview of the Medicare WISeR Model (May 2026).
- CMS, WISeR Model page and FAQ (2026); Georgetown CHIR Medicare Policy Initiative (June 2026).

- Seattle Times / Spokesman-Review / Daily Chronicle patient reporting (April–June 2026); WSHA April 2026 survey as reported.
- National Law Review, gold-carding launch analysis (June 2026).

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