PLATFORM WHITE PAPER · PAYER-SIDE AI PRIOR AUTHORIZATION

HIP One

Health Intelligence Platform

Coverage policy assessment. Not care allocation. Built on the legal floor. Proven in federal Medicare production.

GOVERNING PRINCIPLE · COVERAGE POLICY ASSESSMENT, NOT CARE ALLOCATION

UM organizations determine coverage — whether a requested service is covered under the applicable benefit design, NCD, LCD, or payer policy, given the documentation submitted. They do not determine care. The decision about whether a patient needs a specific treatment is a clinical judgment made by a licensed physician. These are not the same function, and conflating them is how large payers have found themselves defending AI systems in federal court.

Federal law is unambiguous: any adverse coverage determination on clinical grounds must be reviewed and signed by a physician holding an active license in the relevant specialty before it is issued. No AI system satisfies that requirement. HIP One enforces this architecturally — the system has no technical pathway to issue a clinical coverage denial without physician sign-off. This is not a policy choice. It is the legal floor, built into the code.

Executive Summary

Health plans today manage multiple lines of business — each with its own coverage rules, regulatory timelines, audit requirements, and financial stakes — through a patchwork of point vendors. One platform for PA, a different one for UM, a third for payment integrity, a fourth for risk adjustment. Every vendor means another integration, another audit trail to reconcile, another gap where coverage assessments made in one system are invisible to every other.

HIP One changes that equation. Genzeon's Health Intelligence Platform runs prior authorization, utilization management, medical review, payment integrity, risk adjustment, and quality measurement on a single agent substrate — Aether One. Every module shares the same agents, the same audit ledger, and the same per-criterion citation architecture. One integration. One audit trail. One team.

This is not positioning. It is architecture — and it has been running in production under federal Medicare oversight since January 1, 2026, when Genzeon went live as the CMS WISeR Participant for New Jersey.

12,609	100%	42%	<3 min

PA Cases · Q1 2026 · CMS WISeR MAC JL	3-Day TAT Compliance · CMS SLA · Q1 2026	Clinician Productivity Gain · Production	Median Decision Latency · Production

70%+ Affirmation Rate · WISeR NJ · May 2026	**85%** Provider Portal Adoption Rate	**309** Pre-Payment Claims Reviewed · Q1 2026	**12** U.S. Patents Filed and Pending on the Architecture

The Coverage / Care Distinction

This distinction is not semantics. It is the legal and architectural foundation on which the entire category stands — and where several large payers have already encountered serious regulatory and legal exposure.

What AI Does — Coverage Policy Assessment	What AI Must Not Do — Care Allocation
Reads coverage policy criteria (NCD, LCD, payer benefit design)	Determines whether a patient needs a specific treatment
Reads submitted clinical documentation	Issues an adverse clinical coverage determination without physician review
Maps documentation to each criterion independently	Substitutes for the clinical judgment of a licensed physician
Flags gaps and surfaces evidence per criterion	**These functions belong exclusively to a licensed physician of the same specialty. Federal law, not vendor policy.**
Produces a structured, per-criterion analysis with citations	
Presents that analysis to a licensed physician for review and determination	

Administrative Non-Affirmations: A Distinct and Configurable Category

A separate category of non-affirmations is purely administrative — duplicate requests, frequency-limit conflicts, incorrect billing units, enrollment gaps, coverage exclusions. These are administrative coverage issues, not clinical determinations. The legal requirements that apply to clinical adverse determinations do not apply here.

HIP One publicly documents and enforces this architectural separation. Clinical non-affirmations always route to a licensed physician — this is not configurable, and the system has no technical pathway to bypass it. Administrative non-affirmations flow through a configurable pathway: payers can elect human-in-the-loop administrative review or automated determination based on their own operational model and risk tolerance. This flexibility lets each payer configure the administrative workflow to match their internal processes without touching the clinical determination architecture.

The 2026 Regulatory Context

Five regulatory events in 2026 reshape what it means to have a compliant PA and UM infrastructure. HIP One was built to operate across all five simultaneously.

Live	**CMS WISeR · Jan 1, 2026**	First federal validation of commercial AI-assisted coverage policy assessment for Medicare PA. Genzeon is the CMS WISeR Participant for New Jersey (MAC JL), with full Q1 2026 production data publicly reportable under federal SLA standards.
Active	**CMS-0057-F · Mar 31, 2026**	Public PA-metrics reporting now active. Payers publish denial rates, turnaround times, and appeal-overturn rates in machine-readable form. HIP One is CMS-0057-F compliant in production.
9 Months	**FHIR PA API · Jan 1, 2027**	All payers must expose FHIR-compliant PA APIs. HIP One was designed with this deadline as a foundational requirement — not a retrofit. Clients will be compliant without a platform migration.
17 Months	**Pharmacy ePA · Oct 1, 2027**	Drug PA under NCPDP SCRIPT at sub-second response. A distinct architecture from medical PA. Genzeon's PA-RX patent specification covers this pathway; pharmacy PA product launch planned for 2027.
Ongoing	**State AI Laws · 2025–2026**	Multiple states have codified the standards validated under WISeR: physician review of every adverse clinical coverage determination, per-criterion citation, no automated clinical denial. HIP One satisfies these structurally, not through policy documentation.

WHY THIS MOMENT IS DIFFERENT

Before 2026, vendor performance claims were largely self-reported and unverifiable. CMS WISeR changed that: production metrics are now publicly reportable under federal SLA standards. CMS-0057-F changed that further: payer-level denial rates, turnaround times, and appeal-overturn rates are now mandated public data. A vendor decision made today is made knowing that performance will be visible. The era of unverifiable efficiency claims is over.

HIP One Platform

One Integration. Seven Workflows.

Every HIP One module runs on Aether One, the same underlying agent framework. This is not a marketing claim about data sharing — it is an architectural fact with measurable consequences. When all modules share the same agents and audit ledger, the coverage assessment made in PA is visible to the UM agent, the payment integrity agent, and the risk adjustment agent without any data pipeline, reconciliation job, or manual transfer. There is no gap. There is no reconciliation.

1	**Prior Authorization**	AI-assisted coverage policy assessment against NCD/LCD/payer policy at the per-criterion level. Agents read coverage criteria, read submitted clinical documentation, and map one against the other — criterion by criterion — producing a structured analysis for physician review. Auto-affirmation when all criteria are met; physician routing on every non-affirmation. Sub-3-minute median latency in CMS production. 85% provider portal adoption.
2	**Utilization Management**	Concurrent and retrospective UM for inpatient, outpatient, and post-acute settings. InterQual and MCG clinical criteria supported. Daily inpatient review, observation management, and discharge planning in the same workflow. Same per-criterion citation architecture as PA — every UM analysis is as auditable as every PA analysis.
3	**Medical Review & Clinical Decision Support**	Licensed clinician review integrated into the same workflow — not bolted on after AI processing. The agent prepares a structured, per-criterion analysis so the reviewing physician can apply clinical judgment efficiently and with confidence. Peer-to-peer review handling, clinical escalation routing, and structured rationale generation on every non-affirmation. 42% clinician productivity gain in CMS production: physicians spend their time on judgment, not document organization.
4	**Medicare STAR Ratings & HEDIS**	Quality measure tracking on the same data substrate driving PA and UM. C15 (PA timeliness), C09 (appeals), and care gap measures update in real time as coverage assessments are made — no separate reporting feed, no end-of-year reconciliation.
5	**Payment Integrity**	Pre- and post-payment claim review on the same agent substrate as PA. Duplicate detection, frequency-limit enforcement, billing unit validation, unbundling analysis — all backed by per-criterion citation. 309 pre-payment claims reviewed in Q1 2026 alongside 12,609 PA cases. Administrative determinations in this category flow through a separate routing pathway from clinical coverage assessments.
6	**Risk Adjustment (HCC)**	HCC coding support and risk adjustment documentation review on the same longitudinal record driving PA and UM. Risk signals surfacing during authorization — comorbidities in submissions, diagnosis codes on PA requests — are captured for risk adjustment without a separate data workflow.
7	**Medical Record Digitization**	Unstructured document ingestion and structuring — the input substrate for all other modules. PDF, EHR export, fax, portal upload, esMD submission. All formats converted to structured, citation-ready data before any agent maps documentation to coverage criteria.

Citation Architecture: Per-Criterion, by Design

Citation architecture is the most important technical differentiator in the AI PA market in 2026 — and the least transparently disclosed. Most vendors describe their systems as producing 'auditable' decisions. Few disclose whether that evidence is bound at the document level, the determination level, or the criterion level.

Document-Level Citation	Identifies which source documents were relevant. A reviewer can see that clinical notes were considered — but cannot see which criterion was or was not met, or which passage was cited for each criterion. Weakest form for audit defense.
Per-Determination Citation	Produces evidence for the overall determination. A reviewer can see the general clinical rationale but cannot reconstruct which criterion was evaluated against which evidence independently. Adequate for many commercial contexts; insufficient for CMS WISeR and most state AI law requirements.
Per-Criterion Citation HIP One	Each coverage policy criterion is evaluated independently. Each criterion produces its own evidence citation chain — the specific passage from submitted documentation that supports or fails to support that criterion, bound to the criterion text, the source document, and the evaluation agent. An auditor can reconstruct exactly which criterion was at issue and what the evidence showed. This is the standard CMS validated under WISeR. HIP One delivers it on 100% of assessments — not by sampling, not on request.

Physician Review: Enforced Architecturally

Every non-affirmation on clinical grounds routes through Agent 871 to a licensed clinical reviewer. There is no configuration, no override, no exception. The system has no technical pathway to issue a clinical adverse determination without physician sign-off. The PA8-Core patent specification documents the dual-gate architecture that makes this enforceable at the code level — not the policy level.

The 42% clinician productivity gain measured in CMS production reflects the value of this architecture precisely: the physician's time is spent on judgment, not on reading and organizing unstructured documentation. The agent does the analytical preparation. The physician makes the determination.

Patent Stack: 12 Patents on the Architecture

HIP One's architecture is protected by a patent stack of filed and pending applications covering every critical technical element. The public patent record is verifiable; buyers should ask every vendor for their filing inventory.

Patent	Coverage	What It Protects
PA8-Core	**Agent Architecture**	Core multi-agent orchestration framework for coverage policy assessment.
PA8-Deploy	**Multi-Stakeholder Deployment**	Architecture for deploying across multiple payer and provider contexts.
PA1	**Document Processing**	Unstructured document ingestion, extraction, and structuring.

Patent	Coverage	What It Protects
PA2	**Criteria Decomposition**	Per-criterion decomposition of NCD/LCD/payer policy and independent evidence binding.
PA-GATE	**Pre-Screening**	Administrative and eligibility pre-screening before clinical agent engagement.
PA-LLM	**PHI Security**	PHI-safe large language model integration for clinical document processing.
PA-RX	**Pharmacy Benefit (filed)**	Pharmacy ePA architecture for sub-second response — addressing CMS-0062-P October 2027 deadline.
PA-OAP	**Outcome Attestation (filed)**	Outcome attestation and post-determination audit trail architecture.
PA16	**Ambient Integration (filed)**	Integration architecture for ambient clinical AI (Dragon Copilot) into the PA workflow.
PA-CTX	**Context Management (filed)**	Multi-turn clinical context management across concurrent assessments.
PA-MKT	**Marketplace Distribution (filed)**	Architecture for marketplace-distributed PA agents (Microsoft, AWS, GCP, Salesforce).
PA-META	**Meta-Builder Substrate (pending)**	Institutional knowledge corpus, seven-layer taxonomic scaffold, and Builder abstraction structurally invariant to human-or-AI Builder identity.

Competitive Landscape

Six vendors are operating in the payer-side AI prior authorization market in 2026. All are serious platforms. Four are CMS WISeR Participants. The grid below reflects publicly available information reviewed through May 13, 2026, applied against seven criteria that matter for 2026 procurement decisions.

ANALYTICAL DISCLOSURE

Genzeon Platforms is the publisher of this analysis and one of the six vendors evaluated (★). Vendor assessments reflect our reading of public materials and are subject to correction. This analysis should be paired with the Gartner 2026 iPA Market Guide (ID G00803711) and the Everest Group Healthcare Payer Intelligent Operations PEAK Matrix 2026.

Vendor	CMS Production	WISeR Participant	CMS-0057-F Disclosed	Per-Criterion Citation	Coverage Breadth ≥4 wf	Physician Review (Arch.)	Published Patent Stack
Anterior	✓	—	—	~	~	~	—
Cohere Health	✓	✓	✓	~	✓	~	—
Genzeon HIP One ★	✓	✓	✓	✓	✓	✓	✓
Humata Health	✓	✓	~	~	—	~	—
Innovaccer	✓	✓	—	~	✓	~	—
Optum + Change Healthcare	✓	~	~	~	✓	~	~

✓ **Publicly verifiable** ~ Partial or not disclosed at granular level — No public evidence as of May 2026 ★ Publisher of this analysis

Note on Physician Review (Arch.) criterion: federal law requires physician sign-off on any adverse clinical coverage determination regardless of vendor. The criterion evaluates whether this is enforced architecturally or through configuration policy. Last reviewed May 13, 2026.

Where This Analysis May Be Wrong

Every vendor analysis has blind spots. The credibility of this framework depends on naming them explicitly.

- Anterior's payer-self-service rule configuration depth may be more important than this analysis credits.

Most payers want to own their policies, not delegate them. Anterior's customer-uploadable policy-to-decision-tree conversion meets payer operations where they actually live. This capability may outweigh criteria like patent depth or federal program participation for certain buyer profiles.

- Cohere's auto-affirmation rate at scale may matter more than architectural elegance.

12 million annual PA requests with a claimed 90% auto-approval rate is a real outcome. If the physician-review commitment holds in practice at that scale, scale becomes its own validation. Buyers with volume as their primary constraint should weight this accordingly.

- We do not have access to other vendors' internal production data.

Vertically integrated platforms like Optum are less measurable from the outside than marketplace-distributed products. Actual at-scale performance inside UHG is plausibly stronger than externally visible signals suggest.

- Virtix Health and Zyter are not profiled here.

Two of the six CMS WISeR Participants — Virtix Health LLC (Washington, MAC JF Noridian) and Zyter Inc. (Arizona, MAC JF Noridian) — are not included in this analysis due to limited pre-WISeR public market presence. Both hold the same WISeR Participant credential as the vendors profiled above and deserve direct evaluation from any payer scoping the WISeR cohort comprehensively.

- Genzeon's brand recognition outside CMS regulatory contexts is lower than several competitors — though that is beginning to shift.

The company was named to MedTech Breakthrough 2026 (AI-Powered Healthcare Innovation Award, recognized for HIP One and the CMS WISeR New Jersey deployment), the Bronze Stevie® at the 2026 American Business Awards (AI in Healthcare Achievement), and most recently a Product Challenger in the 2026 ISG Provider Lens™ report in two categories — Healthcare AI Strategy and Advisory Services, and Healthcare AI Development and Delivery Services. This analysis reflects our own positioning bias; buyers should weight the Genzeon profile accordingly and pair it with independent analyst sources.

Twelve Questions Every Payer Should Ask Every AI PA Vendor

The standard is evidence — a sample audit artifact, a production metric reported under regulatory oversight, a public patent filing. Descriptions of capabilities do not substitute for evidence of capabilities.

#	Question	What to look for
1	**Are you deployed in production today?**	Name the customers, regulatory programs, or commercial contexts. Pilots and roadmap commitments do not count.
2	**Are you a CMS WISeR Participant?**	Six participants are publicly named. Ask which state and MAC. 'WISeR-positioned' and 'WISeR Participant' are not the same thing.
3	**Does your system ever issue a clinical coverage denial without licensed physician review?**	Federal law requires physician review of any adverse coverage determination on clinical grounds. Ask whether this is enforced architecturally or through configuration policy. Ask separately how administrative non-affirmations (enrollment gaps, duplicates, frequency limits) are routed and whether that pathway is configurable.
4	**Is citation per-criterion, per-determination, or document-level?**	Show a sample audit artifact from a production case. Per-criterion citation — each coverage policy criterion independently supported — is the standard CMS validated under WISeR.
5	**Are workflows on a shared agent substrate?**	'Integrated platform' can mean common branding over separately-built products, or genuine substrate sharing. Ask at the data-model level.
6	**How many patents have you filed on the architecture?**	Public filing record only. Vendors positioning on AI without IP backing have shorter-horizon competitive moats.
7	**What is your CMS-0057-F deployment status?**	In production at a named payer, in build, or on roadmap? If in production, name the payer.
8	**Do you support pharmacy benefit PA at sub-second response?**	CMS-0062-P's October 2027 deadline requires a distinct architecture from medical PA. Most PA vendors do not have a pharmacy ePA product.
9	**What does the audit trail look like at the determination level?**	Tamper-evident? Cryptographically signed? Reconstructable to the exact rule pack version in effect at the moment of each determination?
10	**What independent third-party validations exist?**	Gartner, Everest Group, NelsonHall, KLAS, Black Book — with specific category and date.
11	**Can modules be deployed individually or only as a full platform?**	Modular procurement matches modular budgets. Ask what a phased adoption looks like technically.
12	**What is the three-year total cost of ownership?**	Including integration, customization, training, and ongoing tuning. The headline subscription number is not the TCO.

Sources & Methodology

Primary Sources

CMS Innovation Center WISeR Model overview at cms.gov/priorities/innovation/innovation-models/wiser. CMS-0057-F Final Rule (effective January 1, 2026; FHIR API compliance January 1, 2027). CMS-0062-P Proposed Rule (published April 14, 2026; pharmacy ePA October 1, 2027 deadline). Novitas Solutions MAC JL provider portal.

Industry Analyst Sources

Gartner Market Guide for Intelligent Prior Authorization (February 12, 2026, ID G00803711). Everest Group Healthcare Payer Intelligent Operations PEAK Matrix Assessment 2026. NelsonHall NEAT Evaluation 2026. Black Book Research RCM rankings.

Independent Research

Peterson Health Technology Institute, April 2026 report on administrative AI cost claims and efficiency outcomes. KFF (Kaiser Family Foundation), Total Medicare Beneficiaries state indicator — used for Medicare FFS population thresholds.

Genzeon Production Data

CMS WISeR Q1 2026 metrics reported under federal SLA standards: 12,609 PA cases, 309 pre-payment claims reviewed, 100% three-day TAT compliance, 90% cases assessed within one business day since April 2026, sub-three-minute median decision latency, 42% clinician productivity gain, 70%+ affirmation rate (May 2026), 85% provider portal adoption. Documented at genzeon.one/wiser.

Vendor Materials

All competitor assessments reflect publicly available materials reviewed through May 13, 2026. Vendors are invited to submit corrections via genzeon.one. This is not legal, financial, regulatory, or procurement advice.

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