2026

Prior Authorization & Interoperability Readiness Benchmark (PAIR)

Market Readiness, Workflow Reliability, and Operational Maturity Across the ePA Ecosystem

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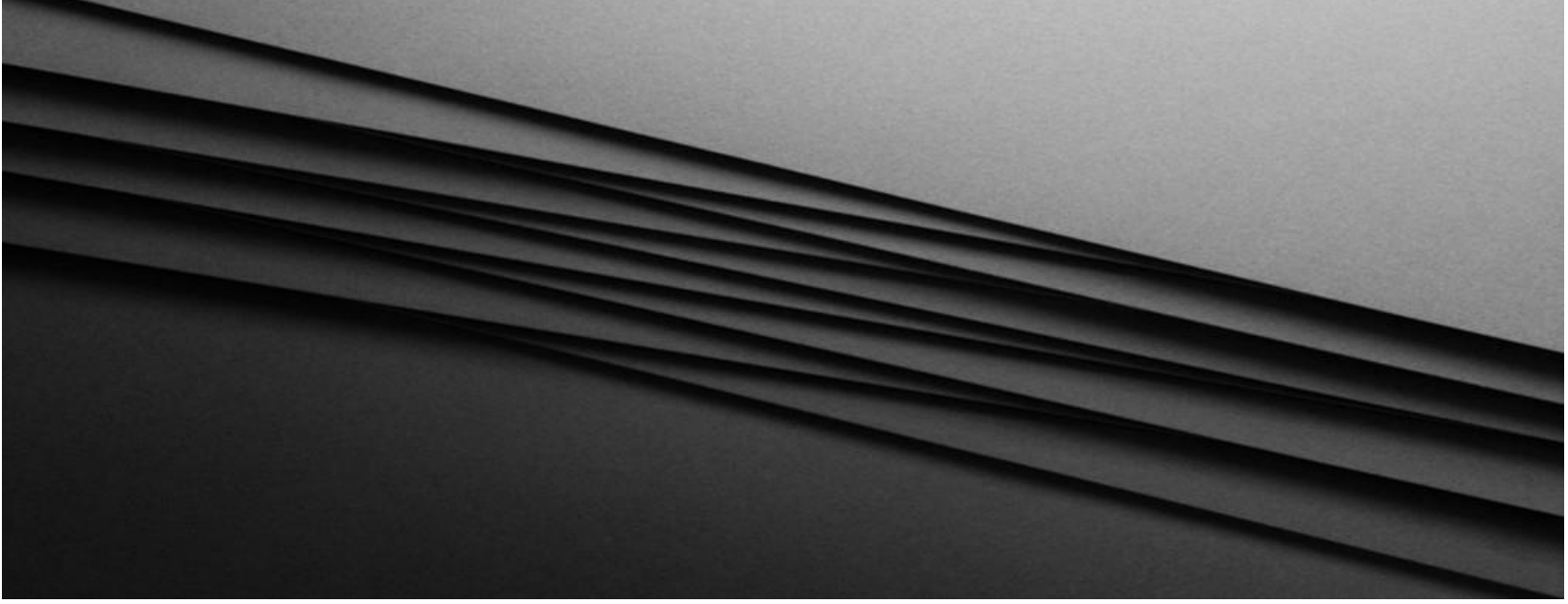


01

EXECUTIVE OVERVIEW

1.1 The Operational Reality Behind the HIMSS Agenda

As HIMSS26 approaches, payer-provider technology leaders are facing a convergence of policy deadlines and operational fragility that is not always reflected in mainstream conference narratives. HIMSS's published topic taxonomy spans broad themes such as cybersecurity, interoperability, and public policy.

What the agenda can underweight because it is less demo able and less glamorous than AI, is the hard operational truth: prior authorization modernization and interoperability success will be decided by workflow reliability, API production readiness, and governance accountability.

The **Black Book PAIR Benchmark** is designed to quantify that readiness in a way executives can use:

- a clear 0–100 readiness score
- five pillar subscores (workflow, interop usability, observability, governance, compliance readiness)
- maturity tiers (Foundational → Leading)
- and a vendor scorecard approach based on respondent-attributed qualitative KPIs (not vendor claims)

1.2 Why This Benchmark Now

Two external milestones define the urgency for a pre-HIMSS26 readiness benchmark:

- CMS Interoperability & Prior Authorization Final Rule (CMS 0057-F): Implementation obligations begin applying in 2026, with major API requirements on the path to 2027.
- ONC HTI-1 Final Rule: USCDI v3 becomes the certification baseline as of January 1, 2026.

These timelines move interoperability and prior authorization modernization from roadmap discussion to production accountability.

> *The market is moving from "planning interoperability" to operationalizing it under deadline pressure.*

1.3 Introduction & Purpose

What PAIR is

HIMSS26 arrives at a uniquely consequential moment for U.S. healthcare operations: prior authorization modernization and interoperability are no longer aspirational programs, they are live execution requirements with measurable impacts on access, revenue cycle performance, provider burden, and payer administrative cost. With HIMSS26 convening March 9–12, 2026, the industry is gathering in the first full quarter after key January 2026 milestones, when many organizations have shifted from planning and procurement into real-world deployment, troubleshooting, and stabilization.

This paper is necessary now because the market is entering a compressed transition window defined by overlapping forces:

- **Regulatory acceleration:** The CMS Interoperability & Prior Authorization Final Rule has provisions that begin applying in 2026, with major API obligations on the path to 2027. At the same time, ONC's HTI 1 changes elevate baseline interoperability expectations (including USCDI v3 as the certification baseline as of January 1, 2026). The practical implication is simple: 2026 is the year organizations must prove they can operationalize change—not just announce readiness.
- **Operational fragility in the transaction stack:** The industry has already seen how disruptions in high concentration administrative infrastructure can ripple across provider cash flow, claims operations, and downstream patient access. As prior auth and interop workflows become more digital and more interconnected, reliability becomes a patient care and financial continuity issue, not only an IT concern.
- **Privacy and governance beyond HIPAA:** The data perimeter has expanded into patient-facing apps, analytics tooling, and consumer health ecosystems where HIPAA assumptions may not apply. As organizations increase connectivity and automate workflows, privacy, consent, and breach-response obligations become increasingly complex—and increasingly consequential.

Despite this urgency, measurement remains fragmented. Existing surveys and industry reports capture pieces of the problem—transaction automation rates, provider burden, technical standards adoption, or point in time readiness snapshots—but they rarely answer the executive question that matters most in 2026.

Not “can we connect?” but “can we run?”

That is the purpose of the **Black Book Prior Authorization & Interoperability Readiness Benchmark** (PAIR Benchmark). It is designed to quantify operational readiness across payers, providers, and enabling vendors using a consistent framework that reflects how modernization succeeds or fails in practice:

- **Workflow operationalization** (including exception handling and manual fallback persistence)
- **Interoperability usability** (data completeness and semantic alignment, not just access)
- **API reliability and observability** (monitoring, runbooks, incident ownership, escalation discipline)
- **Governance and accountability** (clear ownership across IT, UM/RCM, clinical operations, and vendor partners)
- **Compliance readiness** (alignment of timelines, implementation posture, and operational controls)

This paper is relevant now because HIMSS26 will not be won by the most compelling slide about interoperability or the most ambitious “digital prior auth” roadmap. It will be won by organizations that can demonstrate production-grade execution reliable workflows, measurable reduction in rework, accountable governance, and resilient operations under real-world conditions.

1.4 Key Issues Shaping HIMSS26

Beyond vendor announcements and product demonstrations, several practical forces are shaping HIMSS26 conversations. These underreported issues will likely determine organizational success — regardless of which solution presents the most compelling future-state vision.

1 – Transaction stack resilience is becoming a board-level operational risk

The Change Healthcare cyberattack exposed a systemic reality: when a highly concentrated transaction node is disrupted, payment flows and critical operations can stall across the sector.

At the same time, HHS is publicly framing sector resilience expectations through the Health Care & Public Health Cybersecurity Performance Goals (CPGs)—a signal that resilience is being treated as a critical-infrastructure problem, not merely an IT controls checklist.

☐ **Why it gets missed:** it's uncomfortable, cross vendor, and requires admitting single points of failure (clearinghouse dependency, "one rail" routing, untested downtime modes).

2 – "Interoperability" is now a compliance and operations race, not a standards debate

CMS 0057 F and ONC HTI 1 move the industry from aspirational interoperability toward operational accountability, especially when programs must implement provisions starting in 2026 and certification baselines shift.

Why it gets missed: many public forums still talk about interoperability generically, while the actual work is:

- API endpoint reliability
- exception handling
- semantic alignment
- and workflow ownership across IT + RCM/UM + clinical operations

3 – Health data privacy risk is no longer "just HIPAA"

Consumer health data increasingly lives outside HIPAA (apps, patient-facing tools, marketing/analytics SDKs, device ecosystems). The FTC's updated Health Breach Notification

Rule clarifies its applicability to health apps and similar technologies not covered by HIPAA and expands breach-notice expectations.

States are also raising the bar: Washington's My Health My Data Act is explicitly positioned as protecting personal health data outside HIPAA and constraining collection/sharing without consent.

- ☐ **Why it gets missed:** it sits between security, legal, marketing tech, and digital front door, and many provider orgs still assume "HIPAA = privacy."

1.5 Introducing the Black Book PAIR Benchmark

What the PAIR Benchmark measures

The Prior Authorization & Interoperability Readiness (PAIR) Benchmark quantifies operational readiness across payers, providers, and enabling vendors with emphasis on execution, not slogans.

The benchmark is designed to answer five executive questions:

1. **How ready are organizations to operationalize prior authorization modernization under CMS 0057 F?**
2. **Where do workflows still degrade into portal/phone/fax—and why?**
3. **Are APIs production grade (reliable, monitored, governed), or "best effort"?**
4. **Is interoperability usable (complete, semantically aligned), not just available under USCDI baselines?**
5. **What governance and investment behaviors separate top quartile performers?**

Where PAIR fits vs existing industry benchmarks

PAIR is designed to complement, not duplicate, existing reference points:

- **CAQH Index:** tracks health plan/provider adoption of fully electronic transactions and savings opportunity (a key adjacent benchmark on administrative automation).
- **AMA Prior Authorization Physician Survey:** quantifies provider burden and patient impact - crucial context, but not an operational readiness maturity model across payer/provider technical workflows.
- **WEDI CMS 0057 F readiness surveying:** valuable baseline readiness signals on implementation progress and challenges across stakeholders.
- **HL7 Da Vinci PAS + CMS PAS test kit:** the standards backbone and implementation support tools that shape technical readiness expectations.

PAIR's differentiator is that it benchmarks the "last mile of real life" the part of modernization that determines whether a program works on Tuesday at 10:30 a.m., not just whether it looks good in an architecture diagram.

In healthcare, it is relatively easy to say a workflow is "digital" because an API exists, a standard is selected, or a pilot succeeded under controlled conditions. What separates success from disappointment is what happens after the pilot, when volume increases, stakeholders vary, policies change, and edge cases become the rule rather than the exception. The "last mile" is the messy, operational reality where systems must behave predictably despite incomplete information, changing requirements, and downtime. PAIR benchmarks that reality—because that's where time, cost, and patient impact accumulate.

Exception handling: what happens when the happy path breaks

Most modern workflows are designed around an ideal scenario: the request is complete, the data matches, the policy is clear, and the system responds correctly. But day to day operations are dominated by exceptions—cases that fall outside the happy path.

Examples of "exceptions" that happen constantly:

- Clinical documentation is missing, outdated, or not in the expected format.
- The payer's policy-logic changes or differs by product, region, or plan type.
- A code set mapping mismatch causes a rejection even though the clinical intent is clear.
- The request needs additional information, but the workflow doesn't clearly route it to the right person or system.
- A provider's EHR workflow supports one type of authorization well but breaks for another specialty or service line.

When exception handling is weak, the workflow silently degrades into manual work—phone calls, portals, faxes, ad hoc emails—and the organization loses the benefits of modernization. PAIR measures how frequently this degradation occurs, how well it is managed, and whether the organization can keep exceptions from becoming a permanent operating model.

API observability: can you see problems before patients and staff feel them?

Even well-designed APIs will fail sometimes—because of authentication issues, version changes, data quality problems, latency spikes, misconfigurations, or upstream dependencies. The key question is not "do failures ever happen," but how quickly and clearly you detect them, diagnose them, and recover from them.

"Observability" is a plain-language concept: it means you can answer, quickly and confidently:

- **Are our endpoints up?**
- **Are they responding fast enough?**
- **Are errors increasing, and what type of errors are they?**
- **Which partners are affected?**
- **What changed since yesterday?**
- **Who is responsible for fixing it, and what's the playbook?**

Organizations without strong observability often learn about issues from the worst possible source: front-line staff and frustrated patients. By contrast, organizations with strong observability have dashboards, alerts, thresholds, and runbooks that allow them to respond like an airline operations center—before disruption becomes a crisis. PAIR benchmarks this capability because it is one of the strongest predictors of whether digital workflows stay digital.

Operational ownership: who is accountable when the workflow fails?

One of the most common reasons "digital transformation" stalls is that ownership is unclear. Prior authorization and interoperability sit at the intersection of:

- IT/integration teams
- revenue cycle or utilization management operations
- clinical documentation workflows
- compliance and policy
- vendor partners and intermediaries

When something breaks, these groups can easily point at each other. The result is slow resolution, recurring incidents, and a culture of workaround. PAIR benchmarks whether an organization has clear operational ownership, meaning:

- a named accountable leader (not "a committee")

- defined escalation paths
- an incident response process that is practiced, not improvised
- and cross-functional agreements about what "good" looks like (service levels, response times, responsibilities)

This matters to the average reader because a workflow doesn't fail in theory—it fails in a specific place at a specific time, and someone must own the recovery.

End-to-End Workflow Reliability: Does the whole process complete successfully?

Healthcare workflows rarely fail because of one system. They fail because they cross too many systems and too many handoffs. Prior authorization and interoperability are end-to-end processes involving:

- the clinician ordering care
- documentation capture
- EHR workflow and integration
- payer rules and decisioning
- status updates and patient communication
- and downstream billing and claims steps

A program can look "successful" if one link in the chain works say, an API returns a response. But if the status isn't visible to the right people, if follow up tasks don't route correctly, if exceptions cause rework, or if downtime forces manual processing, the end-to-end outcome is still poor. PAIR benchmarks reliability at the level that matters: the percentage of cases that move from start to finish without rework, delays, or manual detours.

Why this "last mile" focus is the difference between progress and noise

PAIR's differentiator is that it treats modernization as a **production operating model**, not a project. In a production operating model:

- Exceptions are expected and managed.
- Failures are detected early through observability.
- Ownership is clear when something breaks.
- Reliability is measured across the entire workflow, not a single interface.

That "last mile" is where patients experience delays, staff experience burnout, and organizations experience avoidable cost and revenue leakage. By benchmarking these real-world capabilities—not just standards adoption or implementation intent, PAIR provides a clearer picture of readiness in 2026 than traditional "are you compliant?" surveys.

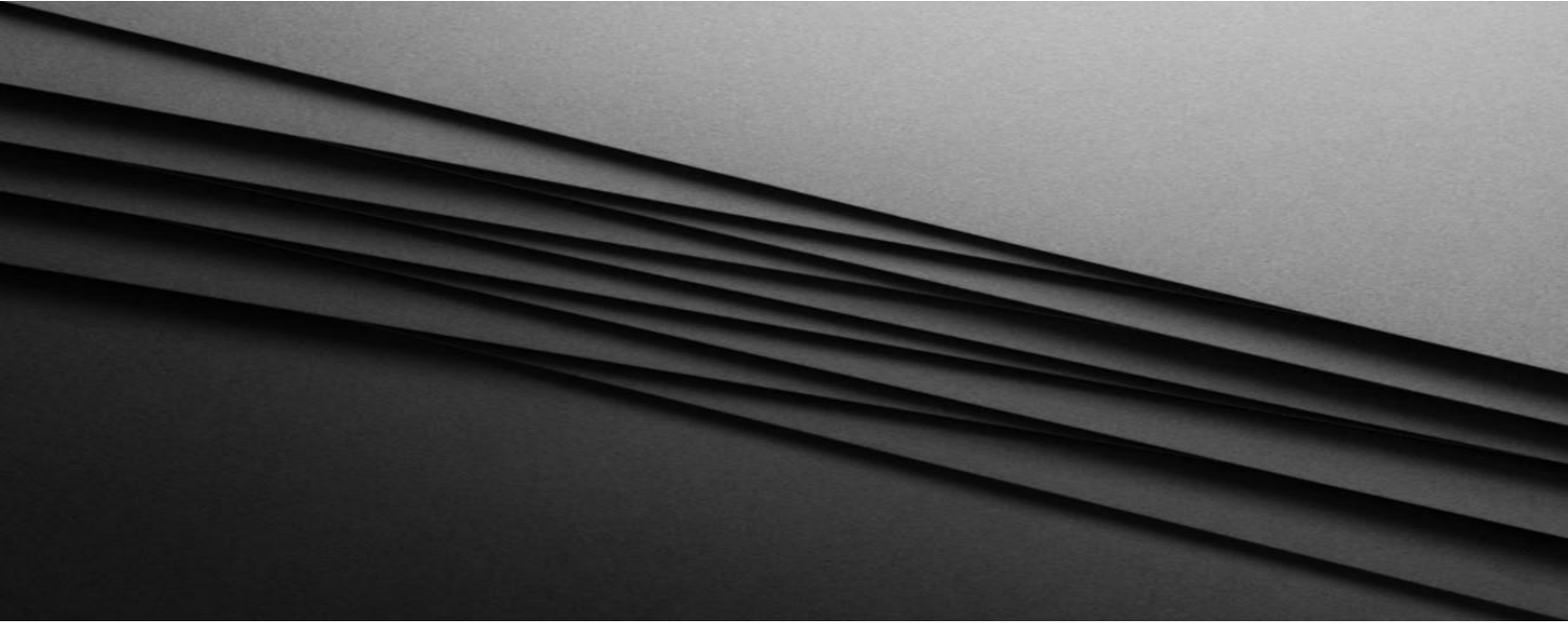
1.6 Key Findings At-a-Glance

The 2026 PAIR Benchmark indicates that the market is in a transitional mid-maturity phase: measurable progress is visible, but production-grade reliability remains uneven across organizations and workflow domains.

Several themes consistently differentiate higher-performing organizations from the rest of the market:

1. **Manual fallback remains persistent.**
   - Even where digital prior authorization pathways exist, exception volume continues to push 30–40% of cases into manual handling in many environments. The bottleneck is not standards adoption alone, but documentation readiness, policy variability, and structured exception management.
2. **API connectivity does not equal operational readiness.**
   - Many organizations report endpoint availability but lack SLO-grade monitoring, defined runbooks, or clear incident ownership. Without observability discipline, digital workflows degrade silently until operational pain becomes visible to staff and patients.
3. **Interoperability is increasingly judged by usability and completeness.**
   - Data exchange alone is insufficient. Semantic alignment gaps, documentation inconsistencies, and incomplete payloads continue to drive rework and delay even when APIs are technically implemented.
4. **Governance maturity is the primary differentiator of top-quartile performance.**
   - Organizations that demonstrate clear RACI ownership, escalation pathways, and recurring operational review cycles outperform peers across reliability and workflow completion metrics.
5. **The "last mile" determines real-world success.**
   - Standards adoption and modernization roadmaps are necessary but insufficient. The decisive gains heading into HIMSS26 will come from production-level execution: disciplined exception handling, proactive monitoring, accountable ownership, and end-to-end workflow reliability.

Taken together, the findings suggest that the strategic conversation at HIMSS26 should shift from "*Can we connect*?" to "*Can we run reliably at scale under real-world conditions*?"



02

STUDY DESIGN & PAIR FRAMEWORK

2.1 Multi-Stakeholder Research Design

This benchmark was designed to answer a simple, practical question: how ready is the healthcare market to run prior authorization modernization and interoperability workflows at scale, under real operating conditions—right now? To do that, Black Book fielded a cross sectional online benchmark survey using a multi stakeholder sample that reflects how these workflows function in reality: they span payers, providers, and enabling vendors, and they require coordination across operations, IT/integration, and clinical documentation.

Rather than surveying only one stakeholder group, the PAIR Benchmark intentionally captures the handoffs and points of friction across the full ecosystem from payer UM operations and IT integration teams, to provider revenue cycle and interoperability leaders, to the vendors responsible for implementation and workflow enablement. This approach supports comparative segment analysis (payer vs provider vs vendor) while also enabling deeper cuts by role, seniority, organization characteristics, and technology footprint.

2.2 Study Design & Respondents

Cross sectional, Online Benchmark survey (Multi Stakeholder)

A cross sectional design provides a time stamped snapshot of readiness at a specific moment (pre HIMSS), which is essential when organizations are moving quickly from planning into production deployments. It is ideal for generating comparative benchmarks and identifying market-wide maturity gaps.

Respondents

- Payer leaders: utilization management (UM) / prior auth operations + IT/integration leadership
- Provider leaders: revenue cycle (RCM) / prior auth operations + integration/interoperability leadership + clinical informatics contributors
- Enabling vendors: product/clinical strategy and implementation/service leaders (those responsible for real-world deployment outcomes)

This respondent mix emphasizes decision-makers and operators, not just observers—people who can credibly report on workflow realities such as exception handling, API reliability, and operational ownership.

Respondent Sourcing

To maximize breadth and minimize channel bias, respondents were sourced through two primary pathways:

- Partner Panels (60%): curated healthcare leadership panels used to reach qualified payer, provider, and vendor respondents efficiently and at scale.
- Online Survey Tools (40%): fielded through online survey distribution tools, including Qualtrics, to broaden reach and diversify respondent acquisition channels.

Respondent acquisition mix (n=200)

Partner panels:	120 (60%)
Online tools*: **incl. Qualtrics*	80 (40%)

Outputs

The study generates:

- PAIR Benchmark Score (0–100)
- Five pillar subscores (20 points each)
- Maturity tiers (Foundational → Leading)
- Segment cut tables (payer/provider/vendor and sub-cuts)
- Qualitative themes coded from open-text responses (strengths, gaps, failure modes)

Respondent Pool Overview

Block A — Study Snapshot

Attribute	Value
Study type	Cross-sectional online benchmark survey
Wave	Pre HIMSS26
Total participants	n = 200
Stakeholders	Providers, payers, enabling vendors
Sourcing mix	60% partner panels, 40% online tools (incl. Qualtrics)
Primary outputs	PAIR Score (0–100), pillar subscores, maturity tiers, segment cuts, qualitative themes

Block B — Segment Mix (n=200)

Segment	n	%
Providers	100	50%
Payers	70	35%
Vendors / Intermediaries	30	15%
Total	**200**	**100%**

☐ **Narrative note:** This mix reflects the fact that operational readiness is co-produced across the ecosystem. Providers experience the workflow at the point of care and revenue cycle. Payers govern policy interpretation and UM operations. Vendors influence integration quality, reliability, and workflow usability.

Role and Functional Representation (Primary function; n=200)

Block C — Role Mix (by segment)

Providers (n=100)

Primary function	n	% of providers
IT / CIO org (infrastructure, apps)	30	30%
Integration / interoperability leadership	25	25%
Revenue cycle / prior auth operations	25	25%
Clinical informatics / CMIO org	20	20%

☐ **Why this matters:** Provider readiness is not only an IT issue. It is a workflow issue spanning documentation capture, operational routing, and exception management—hence the deliberate inclusion of RCM/PA operators and clinical informatics.

Payers (n=70)

Primary function	n	% of payers
Utilization management / prior auth operations	30	43%
IT / integration / interoperability	25	36%
Provider relations / network ops	10	14%
Compliance / policy	5	7%

☐ **Why this matters:** PA modernization fails when UM operations and IT integration teams are not aligned. This payer mix is intentionally balanced to capture both operational realities (UM) and technical readiness (integration).

Vendors / Intermediaries (n=30)

Primary function	n	% of vendors
Product / clinical strategy	12	40%

Primary function	n	% of vendors
Implementation / services / customer success	10	33%
Sales / BD / partnerships	8	27%

☐ **Why this matters:** Implementation leaders see what breaks in production. Product leaders influence roadmap, standards support, and usability. Commercial leaders provide signal on market demand and adoption barriers.

Seniority Profile (n=200)

Block D — Seniority Mix

Level	n	%
C suite / EVP / SVP	22	11%
VP / AVP	40	20%
Director	78	39%
Manager / Lead / Principal IC	60	30%
Total	**200**	**100%**

☐ **Interpretation:** The sample is intentionally operator-heavy (Director + Manager/Lead = 69%), reflecting the benchmark's focus on last-mile execution. Executive representation remains sufficient to reflect governance, investment priorities, and strategic accountability.

Geography (U.S.; n=200)

Block E — Regional Distribution

Region	n	%
Northeast	38	19%
Midwest	44	22%
South	70	35%
West	48	24%
Total	**200**	**100%**

☐ **Interpretation:** The distribution supports credible national signal while enabling directional regional cuts where sample size permits.

Technology and Business Context Cuts

Block F — Provider EHR Footprint (Providers only; n=100)

EHR footprint	n	% of providers
Epic	45	45%
Oracle Cerner	18	18%
MEDITECH	12	12%
Other / mixed	25	25%
Total	**100**	**100%**

☐ **Why this matters:** EHR footprint materially affects interoperability workflow design, integration patterns, and operational tooling. This cut enables meaningful comparisons across dominant EHR environments without overstating causality.

Block G — Payer Lines of Business (Payers only; multi select; n=70)

Line of business	n	% of payers
Medicare Advantage	35	50%
Medicaid MCO	38	54%
Commercial	40	57%

☐ **Note:** Multi-select; totals exceed 100% because many payer organizations operate multiple lines of business.

☐ **Why this matters:** Readiness, policy variability, and operational workflows can differ by line of business. This cut enables analysis of whether readiness gaps cluster in specific program contexts.

Fielding and analytical notes

- **Sampling approach:** multi-channel sourcing (partner panels + online tools) to diversify acquisition and reduce single-channel bias.
- **Data structure:** segment-level reporting with functional and seniority cuts; vendor naming contingent on minimum n thresholds if vendor scorecards are published.
- **Qualitative analysis:** open-text responses coded into standardized themes (e.g., exception handling failure modes, observability gaps, documentation evidence issues, ownership/RACI breakdowns).
- **Reporting discipline:** where subgroup sizes are small, results are reported as directional and/or rolled into broader categories to avoid overinterpretation.

2.3 How the PAIR Benchmark Works

This section explains in everyday language what the PAIR Benchmark produces, what each part means, and how scoring works. The goal is to make the benchmark understandable to someone who doesn't live in interoperability acronyms or prior authorization operations every day.

Headline Outputs

1) PAIR Benchmark Score (0–100)

What it is:

A single, easy-to-interpret score that summarizes an organization's overall readiness to operate modern prior authorization and interoperability workflows reliably.

What it tells you:

- A **higher score** indicates the organization is more likely to run these workflows successfully in real-world conditions (high volume, changing policies, missing data, partner variability, downtime scenarios).
- A **lower score** indicates readiness gaps that typically show up as delays, rework, manual fallback (fax/phone/portal), and unstable integration performance.

What it does *not* claim:

It does not claim an organization is "fully compliant" or "risk-free." It's an operational readiness benchmark—meaning it reflects preparedness and maturity, not perfection.

2) Maturity Tier

What it is:

A simplified classification that converts the 0–100 score into one of five tiers. Tiers are helpful for publication because they allow benchmarking without over-emphasizing small differences (e.g., a score of 61 vs 63).

How to read the tiers:

1. Foundational

- Organizations in this tier are typically in early-stage readiness.
- Work is often fragmented or still largely manual.

- Policies and workflows may not be standardized.
- Monitoring and escalation may be informal.
- Digital processes frequently fall back to manual work when exceptions occur.

☐ **Translation:** "We're getting started, but we're not reliably running at scale yet."

2. Developing

Organizations are actively building capabilities but still experience frequent breakdowns.

- Pilots or partial implementations exist.
- Some teams have processes, but they aren't consistent across service lines or partners.
- Exceptions are handled, but often through workarounds.

☐ **Translation:** "We have progress, but it doesn't run consistently everywhere."

3. Operational

Organizations can run core workflows at meaningful volume with stable performance.

- Standard workflows exist and are repeatable.
- Exceptions are managed with defined steps.
- Monitoring exists, and there is clearer ownership for incidents.

☐ **Translation:** "This works most of the time in production, and we can manage the failures."

4. Advanced

Organizations demonstrate strong operational discipline and measurable performance.

- Robust exception handling reduces rework.
- APIs and workflows are monitored with mature alerts and runbooks.
- Governance and accountability are clearly defined and practiced.

☐ **Translation:** "We operate like a well-run service, not a one-time project."

5. Leading

Organizations perform consistently at scale and continuously improve.

- Performance is measured and optimized (cycle time, rework, reliability).
- Downtime readiness is tested.
- Cross-functional ownership is strong, and improvements are built into operating rhythm.

☐ **Translation:** "We're ahead of the market and can adapt quickly without chaos."

☐ **Note:** The tier thresholds (what score range maps to which tier) are published as part of the benchmark methodology so readers understand how tiering is assigned.

2.4 The Five Pillars

The PAIR Benchmark score is built from five pillars, each worth 20 points. This structure prevents one strong area (like having a standard selected) from masking weakness in another (like poor exception handling or unclear ownership).

Pillar 1 — Compliance Readiness (20 points)

What it measures:

Whether the organization understands the relevant requirements and has a realistic implementation plan aligned to policy and operational reality.

In plain English:

This pillar answers:
"*Do you know what's required, have you planned for it, and are your policies and operations aligned to execute*?"

Examples of what's evaluated:

- Awareness of key requirements and timelines
- Presence of a credible plan (not just intention)
- Alignment between policy interpretation and operational execution
- Readiness to document and demonstrate compliance-related processes

☐ **Why it matters:** Compliance requirements create the "deadline pressure," but compliance alone doesn't guarantee operational success. This pillar is necessary, but not sufficient—which is why the other four pillars exist.

Pillar 2 — Workflow Operationalization (20 points)

What it measures:

How well prior authorization workflows actually run day-to-day, including digital adoption and how quickly requests move through the process.

In plain English:

This pillar answers: "Is the work truly operational—or does it still break down into manual work and delays?"

Examples of what's evaluated:

- Adoption of ePA workflows (where appropriate)
- Turnaround-time controls (how cycle time is managed and improved)
- Exception-handling maturity (how often the happy path breaks and how it is handled)
- Reduction of manual fallback paths (fax/phone/portal)

☐ **Why it matters:** Modernization fails when "digital" workflows still require heavy manual work to complete. This pillar measures whether modernization is producing real operational improvement.

Pillar 3 — Interoperability Usability (20 points)

What it measures:

Not just whether data can be exchanged, but whether it is complete, understandable, and usable for clinical and administrative purposes (like authorizations).

In plain English:

This pillar answers: "When data shows up, is it the right data, in usable form, at the right time?"

Examples of what's evaluated:

- Completeness of exchanged data (do you get what you need?)
- Semantic friction (mapping issues, code mismatches, inconsistent meaning)
- Evidence availability (can you retrieve the clinical documentation needed to support decisions?)
- Consistency across partners and service lines

☐ **Why it matters:** Interoperability that is "technically connected" but not usable still creates delay and rework—because humans must interpret, chase, or correct what systems didn't deliver cleanly.

2.5 Results Summary: PAIR Benchmark

The PAIR Benchmark results show a market that is moving, but not yet consistently operating prior authorization and interoperability workflows at scale. Progress is real, especially among payers and enabling vendors. but the data also confirms a persistent "last mile gap" driven by documentation quality, policy variability, exception handling, and production-grade operational discipline.

PAIR Benchmark Score (0–100)

Overall	Providers	Payers	Vendors / Intermediaries
58	54	62	67

What this means for decision-makers:

- The ecosystem is moderately prepared, but performance is uneven across stakeholders.
- Providers score lowest, reflecting higher exposure to workflow complexity at the point of care and revenue cycle.
- Vendors score highest, which is common in benchmarks where product capability may outpace real-world operationalization inside payer/provider environments.

Maturity Tier Distribution (Overall)

Foundational	Developing	Operational	Advanced	Leading
8%	44%	28%	16%	4%

What this means for decision-makers:

- **52%** of organizations fall into **Foundational** or **Developing**, indicating meaningful gaps in consistency, scalability, and reliability.
- Only **20%** reach Advanced or Leading, suggesting that true operational excellence—measured, repeatable performance with strong governance and resilience—is still limited to a minority of the market.

Operational Signals That Define the Current Readiness Gap

- **Only ~20%** report **SLO-grade API monitoring and runbooks,** meaning most organizations are still operating without mature observability and disciplined incident response.

- **Provider-side manual fallback remains in the ~35–40% band**, confirming that "digital" workflows still degrade into portal, phone, and fax at significant volume.

What this means for decision-makers:	Organizations should assume that modernization outcomes will be constrained unless they invest in the operational layer—monitoring, exception handling, and ownership—rather than focusing solely on tools, integrations, or standards selection..

Top Barriers to Readiness

Top Blockers (Respondents selected 3)

Blocker	% of respondents
Missing/unclear clinical documentation	52%
Policy variability / requirements drift	47%
Exception-handling rework	41%
Endpoint reliability / downtime	38%
Semantic mapping burden	35%

☐ **Interpretation for the average reader:** These blockers show that delays and administrative friction are driven less by the absence of technology and more by operational breakdowns incomplete evidence, changing rules, rework loops, unstable production behavior, and inconsistent meaning across data elements.

2.6 Core Findings & Decision Guidance

Finding Theme A: Workflow Reliability Drives Modernization

Prior authorization performance is being constrained by the same pattern across payer and provider settings: the happy path works, but the exceptions dominate. Manual fallback rates in the ~35–40% range on the provider side are a direct signal that exceptions, missing documentation, and variability in requirements continue to force work out of digital channels.

What this means operationally:

- The primary bottlenecks are not "standards adoption." They are evidence readiness, policy interpretation consistency, and repeatable exception handling.
- When exceptions are not managed systematically, organizations experience rework, longer cycle times, staff burnout, and higher administrative cost.

Decisions leaders can make now:

- Prioritize documentation and evidence capture as a workflow product, not an afterthought (structured requirements, checklists, and role-based prompts).
- Treat exception handling as a designed workflow with defined routing and resolution steps—not an improvised manual workaround.
- Assign ownership for "end-to-end completion" rather than ownership for a single system step.

Finding Theme B: Reliability & Observability Differentiate Readiness

API reliability and observability are the hidden readiness differentiators.

Only about one in five organizations report SLO-grade monitoring and runbooks. This is a clear signal that many organizations cannot reliably detect, diagnose, and recover from API and workflow issues before those issues show up as delays and backlogs.

What this means operationally:

- API uptime alone is not readiness. Readiness requires knowing: error rates, latency, failure modes, partner impacts, and time-to-recovery.
- Without observability, organizations often learn about failures through operational pain—queues, denials, staff escalation, patient complaints—rather than through proactive monitoring.

Decisions leaders can make now:

- Establish a minimum production standard: dashboards + alert thresholds + runbooks + named incident ownership.
- Require vendor and partner integrations to support operational telemetry (error codes, tracing, and clear escalation paths).
- Track reliability as a business metric (volume completed end-to-end without rework), not just a technical metric.

Finding Theme C: Usable Interoperability Matters More Than Access

Interoperability maturity is being tested not by whether data can be exchanged, but by whether it is **usable and complete** when it arrives. The continued significance of semantic mapping burden (35%) and documentation gaps (52%) shows that "data availability" does not equate to "operational utility."

What this means operationally:

- Even when endpoints exist, workflows slow down if humans must interpret inconsistent meaning, hunt for missing evidence, or manually reconcile mismatched data elements.
- The operational cost of interoperability failures often appears downstream—in exception handling loops, manual work, and cycle-time inflation.

Decisions leaders can make now:

- Invest in reducing semantic friction where it most impacts throughput (common code sets, terminology services, mapping governance).
- Define "usable interoperability" in measurable terms (completeness thresholds, error-rate tolerances, and evidence availability standards).
- Align clinical documentation workflows with administrative requirements to reduce avoidable pend/denial cycles.

Finding Theme D: Governance Is the Force Multiplier

The distribution of maturity tiers—where only 20% reach Advanced or Leading—signals that operational excellence is largely determined by how organizations govern execution, not only by what they buy.

What this means operationally:

- Governance is the mechanism that turns intent into reliability: RACI clarity, escalation maturity, and cross-functional accountability prevent recurring failures from becoming "normal."

- Without governance discipline, organizations accumulate workarounds, and "digital transformation" becomes a patchwork of manual exceptions.

Decisions leaders can make now:

- Establish a clear RACI for prior authorization and interoperability operations, including who is accountable when workflows fail.
- Implement a regular operating cadence: incident review, root-cause accountability, and performance improvement cycles.
- Treat vendor performance governance as an operational requirement: escalation pathways, response expectations, and post-incident learning.

Bottom Line for Leaders Heading Into HIMSS26

The PAIR Benchmark results indicate that the market is in a mid-maturity phase: progress is visible, but operational reliability is not yet the norm. The most decisive near-term gains will come from focusing on the operational layer—documentation readiness, exception handling discipline, API observability, and governance clarity—rather than assuming that standards adoption or new tooling alone will close the readiness gap.

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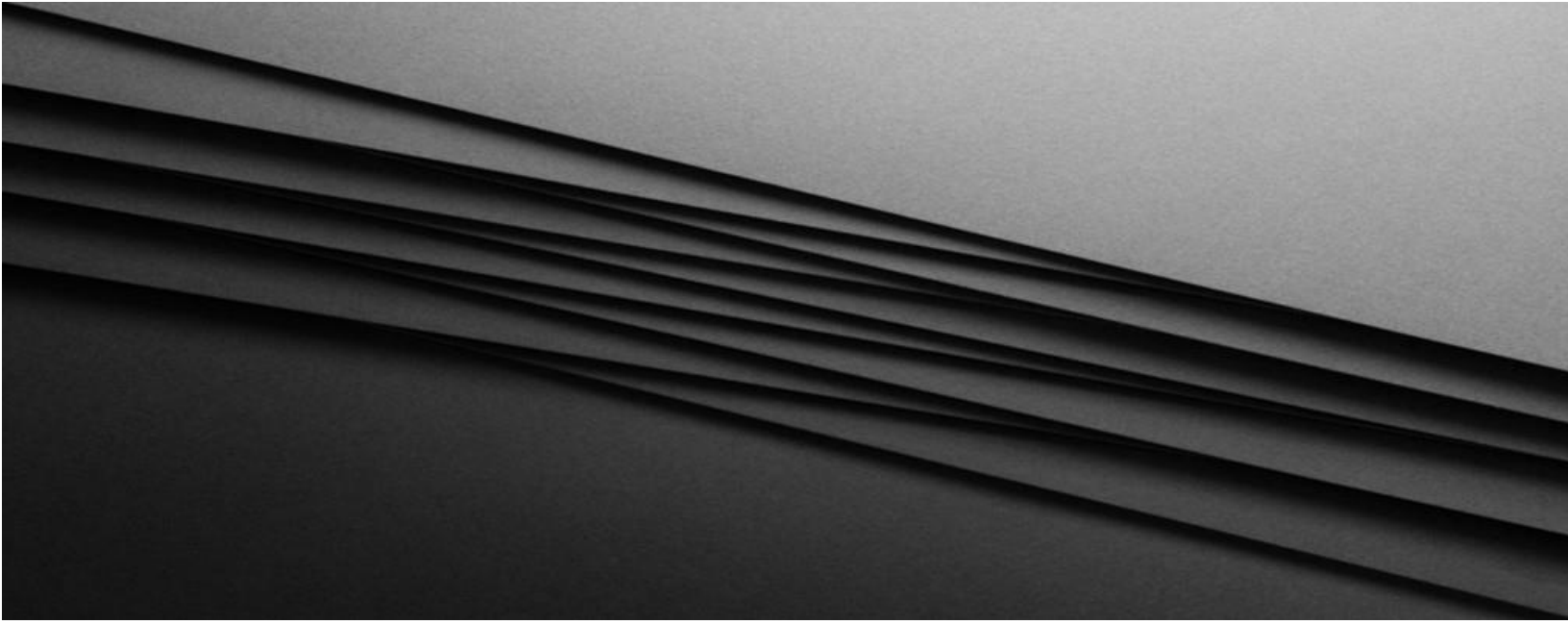


03

MARKET FINDINGS & ECOSYSTEM ANALYSIS

3.1 Vendor Evaluation: Qualitative KPI Scorecards (Respondent Attributed)

Modern prior authorization and interoperability programs rarely fail because a vendor lacks features on paper. They fail in the last mile of execution—when workflows hit real-world volume, partners behave inconsistently, policies shift, documentation is incomplete, or an interface degrades and no one can diagnose it quickly. For that reason, Black Book's vendor evaluation is designed to measure what matters most to buyers and operators in 2026: operational performance as experienced by users.

The PAIR Benchmark's vendor scorecards are therefore built on respondent-attributed qualitative KPIs. In practical terms, this means vendors are evaluated based on how payers, providers, and implementation teams report outcomes and operational realities not based on marketing claims, demo impressions, or self-reported capability statements.

This approach produces two benefits for the average decision-maker:

1. It translates complex technical and operational experiences into a clear, comparable scorecard aligned to measurable readiness outcomes.
2. It reduces noise and "feature theater" by focusing on workflow impact, reliability, and delivery performance as experienced in production.

How the vendor scorecards are reported

Respondent attributed ratings (not vendor self-claims)

Every KPI is scored based on what respondents—people responsible for implementation or daily operations—report about performance in the field. This ensures results reflect the operational "truth on the ground."

Reporting guardrails (to ensure results are fair and publishable)

To keep the evaluation credible, Black Book applies three guardrails:

1. **Minimum sample thresholds before naming vendors**
   - Vendors are only named when there is sufficient respondent volume to support stable reporting:
     - n ≥ 20 overall, or
     - n ≥ 10 within a specific segment (payer or provider) when reporting segment-specific findings.

   If a vendor does not meet the threshold, results are reported at the category level or included in "other," avoiding misleading conclusions from small samples.

2. **Tiering rather than forced ranking**
   - Instead of publishing "#1 through #10" lists, which often exaggerate minor differences, vendors are grouped into performance tiers such as:
     - Leader
     - Strong Performer
     - Competitive
     - Developing

   Tiering is more decision-useful for most buyers because it highlights meaningful performance bands rather than making small score differences appear decisive.
3. **Separate reporting when payer and provider experiences diverge**
   - A vendor can be strong in payer environments but less effective in provider workflows, or vice versa. When results show a meaningful split, Black Book reports ratings separately for:
     - payer respondents, and
     - provider respondents.

This prevents apples-to-oranges comparisons and gives buyers clarity about fit for their operating context.

What the KPIs measure (and why they matter)

Each KPI uses a 1–5 anchored rubric so the ratings are consistent across respondents and vendors. Scores are then normalized to a 0–100 scale for comparability and summarized into domain scores.

Below is the KPI framework and the operational story it captures.

KPI Domain 1: Workflow Impact

This domain measures whether the vendor measurably improves day-to-day operations.

In the PAIR Benchmark results, provider-side manual fallback remains in the ~35–40% band, and exception-handling rework is a top blocker. Vendor evaluation therefore begins with the question operators care about most: does the tool reduce real work, or simply shift it around?

Workflow Impact KPIs

1. **Reduction in manual fallback**
   - Measures whether the vendor reduces reliance on portal/phone/fax by keeping cases in digital channels—even when exceptions occur.
2. **Turnaround-time improvement**

- Measures whether workflows move faster and more predictably, particularly in routine prior auth processes where delays compound quickly.

3. **Exception-handling quality**
   - Measures how well the product/workflow handles edge cases without forcing staff into ad hoc workarounds.
4. **Documentation/evidence capture support**
   - Measures whether the vendor helps capture and package the right clinical evidence the first time, reducing pend/denial cycles caused by missing or unclear documentation.

Why this domain matters:

If a vendor cannot reduce manual fallback, shorten cycle times, or handle exceptions at scale, it will not materially move the organization up maturity tiers even if its interoperability features are strong.

KPI Domain 2: Interoperability Execution

This domain measures whether interoperability is usable, not merely "connected."

The PAIR Benchmark identifies semantic mapping burden and documentation gaps as persistent readiness constraints. Interoperability execution KPIs focus on whether vendors reduce these friction points, particularly where prior authorization workflows depend on timely, consistent evidence exchange.

Interop Execution KPIs

1. **PAS/FHIR implementation maturity (where applicable)**
   - Assesses how effectively the vendor supports standards-aligned workflows for prior authorization, including depth of implementation and stability in real use.
2. **Semantic mapping burden reduction**
   - Measures whether the vendor reduces the effort and variability associated with mapping codes and terminology so exchanged data retains consistent meaning.
3. **Interoperability usability**
   - Measures whether exchanged data is complete and operationally useful for clinical and administrative decision-making—rather than requiring human reconciliation.

Why this domain matters:

A system that can "send data" but not provide usable evidence still produces delays and rework. Interop execution is scored through the lens of operational usability.

KPI Domain 3: Reliability & Observability

This domain measures whether the vendor's solution behaves like a production-grade service.

The PAIR Benchmark shows only ~20% report SLO-grade monitoring and runbooks—indicating a market-wide observability gap. Vendor readiness therefore requires more than features; it requires production discipline: reliability, telemetry, and recovery.

Reliability & Observability KPIs

1. **Production reliability**
   - Measures availability, latency stability, and error behavior under normal load and peak conditions.
2. **Observability/runbooks maturity**
   - Measures the quality of dashboards, alerting, diagnostic visibility, and operational playbooks—so teams can detect and resolve issues quickly.
3. **Continuity/downtime support**
   - Measures whether the vendor supports realistic downtime modes, fallback workflows, and recovery steps that keep operations running through disruption.

Why this domain matters:

In modern payer-provider operations, downtime isn't just inconvenient—it can cause backlogs, care delays, and revenue disruption. Vendors that cannot support observability and continuity will typically suppress readiness even when workflows look strong in a demo.

KPI Domain 4: Delivery & Support

This domain measures whether value is achieved quickly and sustained over time.

Even strong products fail when implementations stall, change management is weak, support is slow, or root-cause analysis is superficial. This domain captures the operational reality of "getting to production and staying stable."

Delivery & Support KPIs

1. **Speed-to-value**
   - Measures how quickly organizations achieve a meaningful production use case after contracting and kickoff.
2. **Implementation quality**
   - Measures project discipline, resource adequacy, stakeholder alignment support, and change enablement.

3. **Support responsiveness / RCA quality**
   - Measures ticket responsiveness, escalation effectiveness, and the quality of root-cause analysis when failures occur.
4. **Roadmap credibility**
   - Measures whether the vendor delivers on commitments, communicates transparently, and evolves capabilities in line with operational needs.

Why this domain matters:

A vendor can score well in features but still underperform in the field if implementation and support are weak. Buyers need confidence not only in the product—but in the vendor's ability to deliver outcomes.

Open-text qualitative analysis (coded themes)

Numbers alone rarely capture what leaders need to know. For that reason, the scorecards include two open-text questions:

- "**What does this vendor do best?**"
- "**Where do they fall short?**"

Responses are coded into standardized themes (e.g., exception handling gaps, documentation workflow issues, mapping pain, reliability concerns, implementation variability, support quality). The result is a set of publishable visuals such as:

- **Top strengths heatmap (what users consistently praise)**
- **Top gaps heatmap (where organizations experience friction and risk)**

☐ **Why this matters:** Open-text coding provides context for why a vendor lands in a specific tier and highlights "watch-outs" that often don't show up in simple satisfaction ratings.

What decision-makers can do with these scorecards:

The vendor scorecards are designed to support practical decisions such as:

- **Vendor shortlisting:** quickly identify which vendors are credible at your maturity tier and operating context.
- **Risk assessment:** spot where a vendor may require stronger internal governance or supplemental tooling (e.g., observability).

- **Implementation planning:** anticipate common failure modes and design mitigation plans before go-live.
- **Performance management:** set expectations with vendors around reliability, response times, evidence capture, and exception handling.

In summary, Black Book's vendor evaluation aligns vendor performance with what actually moves readiness: **reducing manual work, improving turnaround, stabilizing workflows, and operating reliably at scale**—as reported by the people who live with these systems every day.

3.2 Notable Market Participants (Non-Exhibitors)

The following organizations are not listed as HIMSS26 exhibitors but are frequently encountered in real-world prior authorization workflows and are included here for ecosystem context.

Carelon Medical Benefits Management

Carelon MBM is a major payer-side presence in specialty authorization workflows and is frequently encountered by providers through plan-driven pathways. It is important for balance because many ePA friction points originate in policy requirements, evidence expectations, and operational routing on the payer side. In PAIR terms, the relevance is turnaround controls, exception patterns, and documentation completeness expectations.

Cohere Health

Cohere Health is commonly referenced in payer-focused prior authorization modernization initiatives centered on administrative efficiency and workflow optimization. It is useful for balance because it represents an approach that emphasizes improving decision workflows and reducing unnecessary operational burden. Under PAIR, the most relevant angles are exception-handling quality, evidence capture support, and measurable reduction in rework touches.

eviCore (Evernorth)

eviCore is widely encountered by providers through specialty and diagnostic authorization pathways used by many plans. It is important for balance because it represents a large share of real-world specialty PA experience where documentation requirements and policy variability often generate rework loops. Under PAIR, the focus is status transparency, exception routing, and operational consistency across service lines.

Evolent (including NIA/RadMD pathways)

Evolent is a common presence in specialty benefit management and prior authorization pathways, often experienced through provider-facing portals and plan-administered workflows. It matters for balance because it reflects how specialty authorization processes can revert to manual steps when interoperability is incomplete or evidence requirements are unclear. In PAIR terms, the relevance is exception loop handling, status visibility, and operational workload.

TurningPoint Healthcare Solutions

TurningPoint is frequently referenced in specialty benefit management contexts where authorization decisions depend on complex evidence requirements and clinical review. It is valuable for balance because it reflects high-variance operational realities that can drive delays even when electronic submission exists. Under PAIR, the focus is exception-handling

discipline, evidence readiness, and turnaround-time controls at scale.

3.3 Vendor Ecosystem Callouts For HIMSS26 Attendees

Black Book Q1 2026 planning guide aligned to the PAIR Benchmark (vendor agnostic; not a ranking)

Prior authorization and interoperability modernization are increasingly judged by what happens in production—when documentation is incomplete, policies vary by plan and product, endpoints degrade, and workflows must still complete without reverting to portal/phone/fax. This section profiles exhibitors that PAIR Benchmark respondents most commonly identified as priority stops for demonstrations and product explanations ahead of HIMSS26.

These profiles are organized around the PAIR Benchmark's "last mile" focus areas:

- exception handling
- API observability
- operational ownership
- end to end workflow reliability

The PAIR demo script (use this at every booth)

Ask each exhibitor to show, in a short, concrete demo:

1. **End to end "happy path"**
   - Request initiation → evidence capture → submission → decision/response → status posting back into the workflow.
2. **Exception path**
   - Missing evidence, policy mismatch, endpoint error, or status ambiguity—what happens next and who acts.
3. **Operational telemetry**
   - What is monitored (errors, latency, drop offs), how alerts trigger, and how runbooks are executed.
4. **Ownership model**
   - Who is accountable across payer/provider/vendor boundaries when the workflow breaks and how escalation works.

Exhibitor quick scan (by PAIR relevance)

Functional category	Exhibitor	Booth	Primary PAIR focus
ePA / prior authorization workflow networks	Surescripts	1139	Workflow operationalization; exception loops; status transparency
ePA / medication access & PA	CoverMyMeds	1422	Evidence capture; cycle-time improvement; manual fallback reduction
Payer–provider administrative connectivity	Availity	MP11554	Workflow standardization; exception routing; operational ownership
Provider EHR "system of work"	Epic	12713	In workflow initiation; documentation readiness; exception routing
Enterprise EHR + ecosystem integration	Oracle Health and Life Sciences	4022	Cross domain workflow reliability; governance; operational consistency
Integration / interoperability platform	InterSystems	222	Orchestration; reliability engineering; monitoring and recovery
API management (healthcare context)	Google (Google Cloud)	3507	API observability; SLO discipline; production reliability
Integration accelerators (healthcare context)	Salesforce (MuleSoft)	2522	Prebuilt integration assets; production supportability; speed-to-value
Decision logic / workflow governance	Trisotech	10018 31	Policy logic traceability; governed change; exception governance
RCM adjacency	Waystar	4622	Rework reduction; denial prevention; operational controls
National exchange / trusted network	eHealth Exchange	MP11552	Evidence availability; governance; escalation pathways
Standards and implementation ecosystem	HL7 (Interop+Smart Pavilion)	12517	Implementation realism; usability expectations; testing learnings
Prior auth burden reduction IGs	HL7 Da Vinci Project	12620	CRD/DTR/PAS workflow lessons; what "good" looks like in practice

3.4 Detailed Exhibitor Profiles Aligned To Pair Benchmark Focus

ePA Workflow Networks & Execution Platforms

Surescripts — Booth 1139

Why attendees prioritize this booth: Teams looking to reduce manual fallback and stabilize authorization workflows want to see how ePA performs under real-world conditions—especially when documentation is incomplete or requirements vary by payer.

PAIR focus alignment

- **Workflow operationalization:** keeping requests in digital channels end-to-end
- **Exception handling:** how "missing evidence" and "request for information" loops close
- **Reliability:** status accuracy and predictability under volume
- **What to request in a demo:**
  - A full PA transaction showing request initiation, evidence packaging, submission, payer response, and status posted back into workflow queues
- **A missing documentation scenario:** how prompts, task routing, and resubmission work
- **A status reconciliation scenario:** resolving ambiguous or conflicting statuses and reducing status-chasing
- **Questions that matter:**
  - What are the most common exception categories in production, and what is automated vs. manual for each?
  - How is escalation handled when the break is upstream (payer endpoint) vs. downstream (provider workflow) vs. network-mediated?
  - What operational dashboards exist for error rates, latency, and drop-offs by payer or transaction type?
- **KPIs to capture (qualitative):**
  - Reduction in manual fallback
  - Exception-handling quality (loop closure without rework)
  - Production reliability (status transparency, error behavior)

CoverMyMeds — Booth 1422

Why attendees prioritize this booth:	Medication PA is a high-friction workflow. Attendees seek demonstrations of how evidence capture, rule variability, and multi-step loops can be managed without adding clinician burden.

PAIR focus alignment

- **Evidence capture support:** getting the right package submitted the first time
- **Turnaround improvement:** cycle-time controls and fewer rework loops
- **Exception handling:** predictable routing when the request is incomplete or pended
- **What to request in a demo:**
  - A medication PA workflow starting at prescribing, showing what is auto-captured vs. what requires human action
  - A "pend for more information" loop showing task routing and resubmission without duplicative work
  - A policy variability scenario (same therapy request, different payer requirements) showing workflow adaptation
- **Questions that matter:**
  - How do you reduce documentation gaps without pushing more work onto clinicians?
  - Where do semantic mismatches (med lists, diagnoses, labs) most commonly break the process, and how is that mitigated?
  - What signals detect a failing payer pathway early enough to avoid operational disruption?
- **KPIs to capture (qualitative):**
  - Documentation/evidence capture support
  - Turnaround-time improvement
  - Exception-handling quality and rework reduction

Availity — Booth MP11554

Why attendees prioritize this booth: Organizations want to standardize payer-provider administrative workflows and reduce operational overhead from multiple portals and varying requirements.

PAIR focus alignment

- **Workflow operationalization:** consistent intake, routing, and status tracking across payers
- **Governance & ownership:** clarity of who acts at each point in the workflow
- **Exception handling:** standardized workqueues and escalation models

- **What to request in a demo:**
  - **A day-in-the-life view:** intake → status tracking → exception workqueue → resolution with role-based views (RCM/ops vs IT/integration)
  - **A reporting view:** where manual work leaks in and which payer pathways are most fragile
  - **An escalation workflow:** triage and resolution across payer-provider boundaries
- **Questions that matter:**
  - Can you show how responsibilities are assigned during failures (provider ops vs payer ops vs IT vs vendor support)?
  - What exception categories can be automatically routed, and what remains manual triage?
  - What operational telemetry detects breakdowns early (drop-offs, aging, repeated touches)?
- **KPIs to capture (qualitative):**
  - Reduction in manual fallback
  - Support responsiveness and incident RCA quality
  - Implementation quality (fit with existing workflows and systems)

DrFirst — Booth 3243

Why attendees prioritize this booth	Many provider organizations evaluate ePA as part of broader medication workflow efficiency and want to see how authorizations are handled without shifting work into portals and phone calls.

PAIR focus alignment

- **Workflow operationalization:** keeping authorization work inside the medication workflow
- **Exception handling:** task routing when additional info is required
- **Usability:** reducing operational burden for clinicians and support teams
- **What to request in a demo:**
  - A medication workflow showing where ePA decisions and status updates appear and who acts next
  - A missing-information scenario with role-based routing and resubmission
  - A visibility view showing where requests stall and how bottlenecks are identified
- **Questions that matter:**
  - What are the top reasons requests stall, and what automation exists to prevent repeated touches?
  - How is status surfaced to the right role at the right time without duplicative checking?
  - What is the escalation path when partner pathways fail or responses are inconsistent?
- **KPIs to capture (qualitative):**

- Reduction in manual fallback
- Exception-handling quality (tasking and loop closure)
- Support responsiveness / RCA quality

Optum — Booth 3224

Why attendees prioritize this booth:	Attendees often seek payer/provider perspectives on authorization operations, clinical criteria, and interoperability pathways that reduce ambiguity and accelerate completion.

PAIR focus alignment

- **Evidence readiness:** consistency of documentation requirements and decision transparency
- **Workflow reliability:** reducing rework loops driven by policy variability and incomplete submissions
- **Operational ownership:** clear escalation and performance management practices
- **What to request in a demo:**
  - A workflow example showing how evidence requirements are surfaced early and packaged consistently
  - A status transparency scenario showing how updates are communicated to operational teams
  - A performance view showing how recurring exceptions and delays are identified and reduced
- **Questions that matter:**
  - What are the most common reasons requests are pended or delayed, and how are those addressed operationally?
  - How are decision pathways explained to reduce back-and-forth and disputes?
  - What governance exists for policy/criteria changes to prevent workflow instability?
- **KPIs to capture (qualitative):**
  - Documentation/evidence capture support
  - Exception-handling quality and rework reduction
  - Roadmap credibility and change discipline

MCG Health — Booth 6232

Why attendees prioritize this booth:	Payer and provider teams look for practical demonstrations of how evidence-based guidance supports consistent authorization decisions and reduces variability-driven rework.

PAIR focus alignment

- **Evidence readiness:** clarifying documentation requirements to reduce incomplete submissions
- **Usability:** operational transparency for why a case is approved, pended, or denied
- **Governance:** controlled change when criteria and policies evolve
- **What to request in a demo:**
  - An example of authorization criteria applied to a real request and how evidence requirements are operationalized
  - An exception scenario showing what happens when evidence is missing or ambiguous
  - A change-management scenario showing how updates to criteria are communicated and governed
- **Questions that matter:**
  - How do you reduce "missing/unclear documentation" as a primary delay driver?
  - How do operational teams see what is required next and avoid repeated touches?
  - How do you prevent policy/criteria changes from destabilizing production workflows?
- **KPIs to capture (qualitative):**
  - Documentation/evidence capture support
  - Interoperability usability (evidence completeness and clarity)
  - Roadmap credibility and change discipline

3.5 EHR Workflow Engines Where Prior Auth Begins And Ends

Epic — Booth 12713

Why attendees prioritize this booth:	Provider organizations often view prior authorization as an "in-workflow" problem and want to see how authorizations begin, route, and resolve inside the EHR without parallel work.

PAIR focus alignment

- **Workflow operationalization:** initiating and tracking PA within clinical workflows
- **Evidence readiness:** capturing and packaging documentation reliably
- **Continuity:** queueing and recovery during external downtime
- **What to request in a demo:**
  - An authorization initiated from an order/referral, showing evidence prompts and task routing
  - An exception case: missing documentation or conflicting data—role-based task assignment and rework prevention
  - A downtime scenario: what happens if an external endpoint is unavailable and how cases are reprocessed
- **Questions that matter:**
  - Where do "incomplete packages" typically originate, and what controls reduce them?
  - How is authorization status surfaced to clinicians and RCM teams without duplicative checking?
  - How is operational ownership supported across IT, RCM, and clinical operations?
- **KPIs to capture (qualitative):**
  - Documentation/evidence capture support
  - Exception-handling quality (tasking and rework reduction)
  - Continuity/downtime support

Oracle Health and Life Sciences — Booth 4022

Why attendees prioritize this booth:	Organizations with complex, multi-domain operations look for enterprise approaches that connect clinical, operational, and financial workflows so prior authorization does not remain a silo.

PAIR focus alignment

- **End-to-end workflow reliability:** multi-system and multi-team handoffs
- **Governance:** policy alignment and controlled change over time
- **Observability:** workflow-stage reporting, not just interfaces
- **What to request in a demo:**
  - A cross-domain PA workflow showing handoffs between clinical and financial operations with accountability signals
  - A policy change scenario: changes surfaced, versioned, and operationalized without breaking production
  - A performance dashboard view: throughput, aging, exception categories, and drop-offs
- **Questions that matter:**
  - How is cross-functional accountability enforced when workflows break?
  - What is the restart strategy when a workflow fails midstream?
  - How are recurring exceptions translated into process improvement?
- **KPIs to capture (qualitative):**
  - Governance & ownership clarity
  - Speed-to-value for operational outcomes
  - Observability maturity (workflow-level)

3.6 Integration, Interoperability, And The Reliability Layer

InterSystems — Booth 222

Why attendees prioritize this booth:	Interoperability platforms are evaluated when organizations can connect systems but cannot keep workflows stable under volume and variability.

PAIR focus alignment

- **Reliability & observability:** tracing, monitoring, and recovery patterns
- **Exception handling:** routing and isolation of failures
- Operational ownership: runbooks and cross-team incident discipline
- **What to request in a demo:**
  - Transaction-level traceability across systems and partners (what operators see during incidents)
  - A failure scenario: malformed data or endpoint downtime—detection, isolation, retry logic, resolution
  - A runbook workflow: alert → triage → resolution → root-cause analysis
- **Questions that matter:**
  - How do you support idempotency, deduplication, and retry patterns that reduce rework and manual fallback?
  - What monitoring is built-in vs. required via separate tooling?
  - How do clients establish ownership and escalation paths across teams?
- **KPIs to capture (qualitative):**
  - Production reliability
  - Observability/runbooks maturity
  - Continuity/downtime support

Firely — Booth 5144

Why attendees prioritize this booth:	Teams implementing FHIR-based prior authorization need practical guidance and infrastructure support for production-grade execution.

PAIR focus alignment

- **Interoperability usability:** data completeness and consistent meaning in exchanged artifacts
- **Reliability:** performance and stability of FHIR-based services underload
- **Implementation realism:** testability and operational support
- **What to request in a demo:**
  - A FHIR-based prior auth workflow showing validation, error handling, and performance considerations
  - A semantic mismatch scenario and how it is detected and corrected
  - An operability view: logs/metrics/traces and how teams troubleshoot
- **Questions that matter:**
  - How do you validate conformance and reduce variability in real partner integrations?
  - How do you prevent semantic friction from becoming manual rework?
  - What operational patterns support stable production behavior?
- **KPIs to capture (qualitative):**
  - Interoperability usability (complete + operationally usable data)
  - Production reliability
  - Implementation quality (testability and operability)

1upHealth — Booth 5253

Why attendees prioritize this booth:	Organizations pursuing API-first ePA want clarity on execution readiness and real-world deployment experience.

PAIR focus alignment

- **Workflow operationalization:** turning standards-based APIs into operational throughput
- **Observability:** visibility into drop-offs, errors, and partner variability
- **Ownership:** escalation paths and operational support
- **What to request in a demo:**
  - Partner onboarding and testing workflow (how integrations go from pilot to production)
  - Failure handling: incomplete payloads, timeouts, and retries
  - Operational dashboards that show where requests break and why
- **Questions that matter:**
  - Which failure modes are most common in production and how are they mitigated?
  - How do you separate data quality issues from endpoint issues operationally?
  - What is the escalation workflow when partner pathways degrade?
- **KPIs to capture (qualitative):**
  - Production reliability
  - Observability maturity
  - Speed-to-value and implementation quality

eHealth Exchange — Booth MP11552

Why attendees prioritize this booth:	Evidence availability is a major driver of authorization delays. Teams seek demonstrations of how documentation is located, retrieved, and packaged reliably.

PAIR focus alignment

- **Interoperability usability:** evidence availability, completeness, and usefulness
- **Governance:** trusted exchange operations and escalation
- **Workflow reliability:** reducing delays caused by missing or late documentation
- **What to request in a demo:**
  - Evidence retrieval workflow: discovery, packaging, and delivery for administrative use
  - Missing evidence scenario: handling incomplete/unavailable records within required time windows
  - Escalation and dispute handling: investigation and resolution of retrieval failures
- **Questions that matter:**
  - Does retrieval reduce rework or increase review burden due to unstructured/duplicative data?
  - What are the common failure points in evidence retrieval, and what mitigations exist?
  - How are responsibilities defined across participating organizations?
- **KPIs to capture (qualitative):**
  - Evidence availability and usability
  - Support responsiveness and RCA quality
  - Governance and escalation clarity

Trisotech — Booth 10018-31

Why attendees prioritize this booth:	Organizations that see prior authorization as a policy and governance problem seek tools for decision traceability and controlled change.

PAIR focus alignment

- **Governance & ownership:** traceability, accountability, controlled rule change
- **Exception governance:** systematic routing and categorization of non-happy-path cases
- **Operational reliability:** reducing brittle automation caused by uncontrolled drift
- **What to request in a demo:**
  - Policy-to-production lifecycle: model → review → approval → deployment → monitoring
  - Policy change scenario: versioning, impact analysis, rollback/containment capability
  - Traceability: explainability and auditability when outcomes are disputed
- **Questions that matter:**
  - Who approves and owns logic changes, and how is drift prevented?
  - Can exceptions be categorized and routed using decision logic rather than manual triage?
  - How is operational accountability supported across business and technical teams?
- **KPIs to capture (qualitative):**
  - Exception-handling quality
  - Implementation quality (governed operationalization)
  - Roadmap credibility and change discipline

3.7 Standards And Implementation Ecosystem

HL7 (Interop+Smart Pavilion) — Booth 12517

Why attendees prioritize this booth:	Standards guidance helps teams distinguish between standards compliance and operational usability.

PAIR focus alignment

- **Interop usability:** completeness and meaningful exchange
- **Implementation realism:** common pitfalls, testing, and operational learnings
- **Governance:** best practices for operationalizing standards
- **What to do at the booth:**
  - Ask implementers what breaks in production (missing data, semantic mismatches, workflow integration gaps)
  - Gather practical testing approaches that predict usability and reliability outcomes

HL7 Da Vinci Project — Booth 12620

Why attendees prioritize this booth:	Attendees evaluating "PAS-ready" claims use Da Vinci as a reality check on operationalization—especially exception handling and evidence assembly.

PAIR focus alignment

- **Workflow operationalization:** burden-reduction workflows (CRD/DTR/PAS)
- **Exception handling:** what fails and why in real implementations
- **Usability:** evidence capture, data completeness, semantic friction
- **What to do at the booth:**
  - Ask where implementations struggle most operationally and what patterns help most
  - Ask what success metrics matter beyond implementation (drop-offs, manual fallback, rework)

3.8 API Management And Operational Telemetry

Google (Google Cloud) — Booth 3507

Why attendees prioritize this booth:	Organizations treating payer-provider connectivity as production APIs seek demonstrations of monitoring, reliability engineering, and operational controls.

PAIR focus alignment

- **Observability & resilience:** telemetry, alerts, SLO discipline, incident response
- **Production reliability:** consistent latency and error behavior
- **Governance:** access control, auditing, operational accountability
- **What to request in a demo:**
  - Monitoring view: error-rate, latency, top failing endpoints, partner segmentation, alert thresholds
  - Incident workflow: degradation response and operational escalation
  - Developer onboarding: how integrations are tested and certified safely
- **Questions that matter:**
  - Can you map SLOs and runbooks to payer-provider workflow outcomes, not just API uptime?
  - How are retries, throttling, and graceful degradation handled to avoid manual fallback cascades?
  - Who is paged and how is accountability structured during incidents?
- **KPIs to capture (qualitative):**
  - Observability/runbooks maturity
  - Production reliability
  - Continuity/downtime support

Salesforce (MuleSoft) — Booth 2522

Why attendees prioritize this booth:	Integration accelerators are evaluated to shorten implementation time and reduce integration rework across multiple partners and workflows.

PAIR focus alignment

- **Speed-to-value:** prebuilt templates and repeatable implementation patterns
- **Reliability & observability:** production supportability of integrated flows
- **Interop execution:** reducing rework through standard patterns and governance
- **What to request in a demo:**
  - A healthcare integration pattern including error handling, retries, and idempotency
  - Monitoring scenario: detection, triage, and resolution of broken flows
  - A clarity walkthrough: what is prebuilt vs. what requires customization
- **Questions that matter:**
  - What operational controls are standard in your production deployment methodology?
  - How do you support telemetry and incident response across multiple systems and stakeholders?
  - How do you reduce semantic mapping burden and integration rework in practice?
- **KPIs to capture (qualitative):**
  - Speed-to-value
  - Implementation quality
  - Support responsiveness / RCA quality
  - Production reliability and observability maturity

3.9 Cloud Infrastructure And Operational Resilience

Amazon Web Services (AWS) — Booth 4957

Why attendees prioritize this booth:	Many ePA and interoperability workflows run on cloud infrastructure, making operational resilience and observability design a readiness differentiator.

PAIR focus alignment

- **Observability & resilience:** monitoring, logging/metrics discipline, incident workflows
- **Continuity:** resilience patterns and recovery practices for critical workflows
- **Governance:** operational controls and accountability models
- **What to request in a demo:**
  - Patterns for monitoring critical workflow APIs (errors, latency, backlogs) and operational alerting
  - Resilience patterns for dependency failures and recovery without data duplication
  - Incident workflow examples: response, escalation, and post-incident improvement
- **Questions that matter:**
  - How do teams prevent silent failures that push work back to manual channels?
  - What resilience patterns reduce downtime impact in multi-party workflows?
  - How do you operationalize accountability across teams using shared dashboards and runbooks?
- **KPIs to capture (qualitative):**
  - Observability/runbooks maturity
  - Continuity/downtime support
  - Production reliability

Microsoft — Booth 2812

Why attendees prioritize this booth:	Organizations modernizing payer/provider workflows often rely on Microsoft infrastructure and platforms for secure integration and operations at scale.

PAIR focus alignment

- **Observability & resilience:** operational telemetry and incident response discipline
- **Governance:** access controls, auditing, and operational accountability
- **Reliability:** stable production operations for workflow services
- **What to request in a demo:**
  - Operational monitoring examples tied to business outcomes (drop-offs, aging, repeated touches)
  - Incident management and recovery workflows
  - Governance patterns for multi-team accountability and change control
- **Questions that matter:**
  - What operational standards are recommended to keep workflows stable at scale?
  - How do you detect issues early enough to avoid backlog-driven manual work?
  - How do you structure escalation and accountability across IT and operations?
- KPIs to capture (qualitative):
  - Observability maturity
  - Governance & ownership clarity
  - Continuity/downtime support

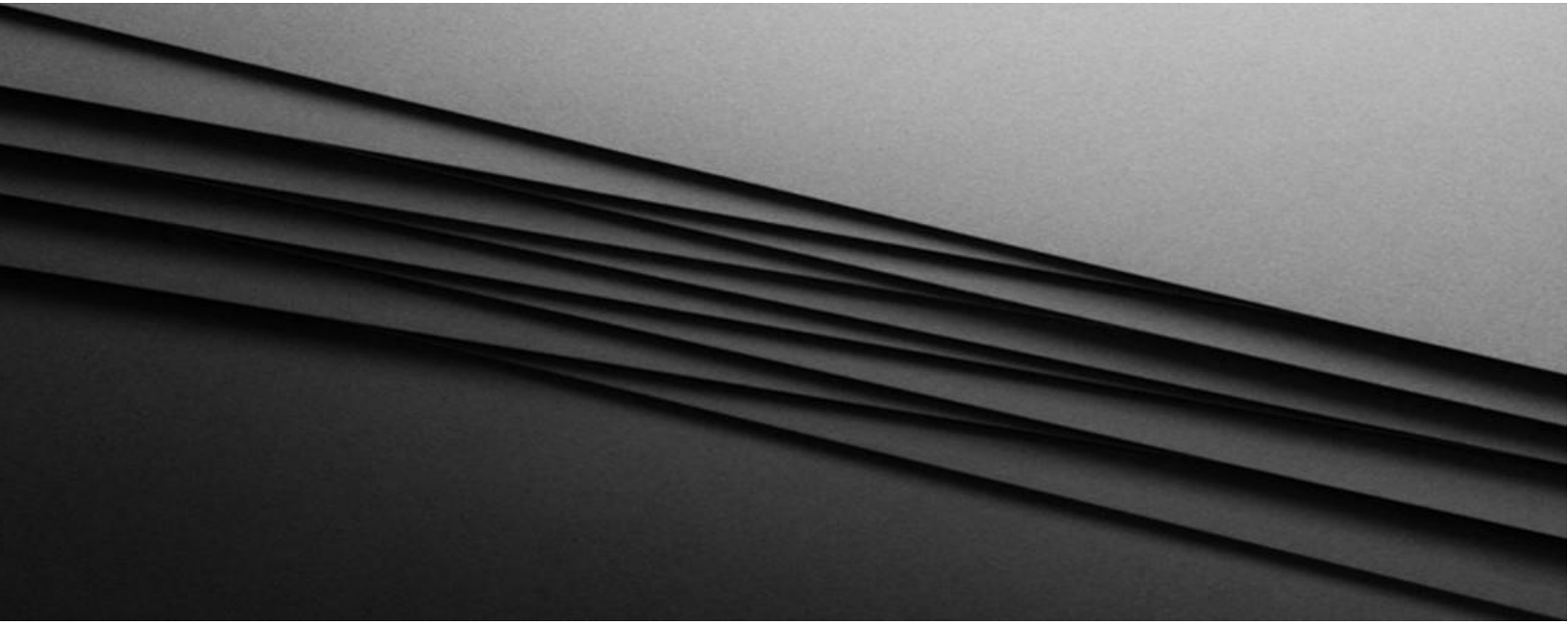
3.10 Revenue Cycle Adjacency

Waystar — Booth 4622

Why attendees prioritize this booth:	Authorization failures often show up downstream as denials, rework, and delayed cash. Teams seek demonstrations that connect pre-service authorization operations to measurable RCM outcomes.

PAIR focus alignment

- **Workflow impact:** reducing administrative touches and rework
- **Operational controls:** identifying high-friction pathways and preventing leakage
- **Reliability:** measuring and improving end-to-end completion outcomes
- **What to request in a demo:**
  - Denial prevention view tied to authorization and documentation completeness
  - Rework reduction: where repeated touches occur and how they are eliminated
  - Reporting: isolating the highest-friction pathways by payer, service line, or facility
- **Questions that matter:**
  - What signals predict authorization-related denials early enough to intervene?
  - Where does manual fallback still occur, and what controls reduce it?
  - How do you quantify operational cost of rework and measure improvement?
- **KPIs to capture (qualitative):**
  - Reduction in manual fallback and rework
  - Turnaround-time improvement controls
  - Support responsiveness and RCA quality



04

HIMSS26 FIELD GUIDE

4.1 What To Listen For On The Show Floor (5 Proof Points)

Use this as a quick screening tool in vendor demos and peer conversations. If you don't hear a clear answer, that's a signal.

1) **Exception handling**

- ❑ Show the "missing evidence" path end-to-end (not just the happy path)
- ❑ Show what happens when payer policy requirements change mid-cycle
- ❑ Show how exceptions are routed (workqueues, tasking, escalation)
- ❑ Show how the loop closes without duplicative re-keying or fax/phone fallback

Ask: *"What happens when evidence is missing or rules change mid-cycle—who does what, and how quickly?"*

2) **Production operations**

- ❑ Show live/realistic dashboards for error-rate, latency, and drop-offs
- ❑ Show alert thresholds and escalation triggers (who gets notified, when)
- ❑ Show incident response workflow (triage → fix → RCA)
- ❑ Show how performance is tracked over time (trend lines, top failing pathways)

Ask: *"What dashboards exist for error-rate, latency, and escalation—and how are they used day-to-day?"*

3) **Ownership and accountability**

- ❑ Identify a named incident owner ("incident commander") by role
- ❑ Show the escalation path across IT, RCM/UM, clinical ops, and vendors
- ❑ Show how cross-organizational issues are resolved (not just logged)
- ❑ Show governance cadence (weekly reviews, RCA cadence, change control)

Ask: *"Who is the incident commander—IT, RCM/UM, clinical ops, or vendor-managed—and what's the escalation path?"*

4) **Semantic reality (mapping and meaning)**

- ❑ Show how mapping burden is reduced in labs/LOINC, meds, diagnoses/problems
- ❑ Show how mismatches are detected and corrected (not discovered by users)

- ❑ Show how data completeness is measured (what "usable" means operationally)
- ❑ Show how evidence is packaged so it's administratively usable, not just transmitted

Ask: *"How are you reducing mapping burden and semantic mismatches in the data domains that cause rework?"*

5) **Continuity and downtime readiness**

- ❑ Describe downtime mode (what keeps running, what queues, what fails over)
- ❑ Show how queued work is recovered and reconciled after restoration
- ❑ Provide testing frequency (tabletop, failover, workflow drills)
- ❑ Show who owns downtime execution and communication

Ask: *"What's your downtime mode, and how often is it tested in realistic scenarios?"*

4.2 90-Day Action Plan: What to do before and after HIMSS26

A practical one-quarter plan to improve readiness quickly. Use as an internal roadmap.

Week 1–2: Assign accountability and define success

- ❑ Appoint a single accountable owner for payer/provider workflow reliability
- ❑ Publish a RACI for PA + interoperability incidents and escalations
- ❑ Define success metrics (manual fallback %, turnaround time bands, rework touches, API error-rate/latency targets)

Week 3–4: Establish minimum viable observability

- ❑ Implement dashboards for availability, latency, and error rates
- ❑ Set alert thresholds and escalation triggers
- ❑ Create runbooks for top failure modes (auth failures, payload errors, endpoint downtime, status mismatches)

Week 5–6: Map and rehearse exceptions

- ❑ Document the top 10 exception types and "next best action" for each
- ❑ Build standardized work queues and routing rules
- ❑ Rehearse escalation for policy drift, missing evidence, and endpoint instability

Week 7–8: Run a "week-in-the-life" PA stress test

- ❑ Test routine and urgent scenarios end-to-end
- ❑ Include worst-case conditions: incomplete evidence, semantic mismatches, endpoint downtime
- ❑ **Measure:** rework touches, aging/backlogs, handoffs, time-to-recovery

Week 9–10: Fix the highest-friction semantic domains

- ❑ Prioritize the domains that create the most rework: problems/diagnoses, meds, labs/LOINC, imaging, coverage fields
- ❑ Establish a mapping governance process (who approves changes, how drift is controlled)
- ❑ Measure completeness and usability, not just transmission

Week 11–12: Tighten privacy and consent governance for the "expanded perimeter"

- ❑ Inventory non-HIPAA health data exposure (patient apps, SDKs, analytics/tracking)
- ❑ Align consent practices and breach response obligations across vendors and partners
- ❑ Confirm incident communications workflows and ownership

4.3 Booth Interview Worksheet

(Pair-Aligned, 1–5 Scale)

The PAIR Booth Interview Worksheet is designed to help HIMSS26 attendees evaluate vendor demonstrations in a consistent, evidence-based way. It translates complex "capability talk" into observable proof points tied directly to the operational realities of prior authorization and interoperability—especially under current regulatory and implementation pressure.

CMS's Interoperability & Prior Authorization Final Rule and ONC's HTI-1 updates have accelerated the shift from planning to production execution. As a result, operational readiness—not just connectivity—has become the decision-critical lens.

Each KPI is scored on a 1–5 scale based on what the exhibitor can demonstrate (or credibly explain with operational artifacts):

- 1 = Not demonstrated / primarily manual
- 3 = Working in production for common scenarios
- 5 = Consistently reliable at scale with measurable outcomes, monitoring, and disciplined recovery

The worksheet aligns with widely accepted reliability and operations practices, including the use of service level objectives (SLOs), observability dashboards, incident runbooks, and continuity planning to maintain stability under real-world conditions.

Exhibitors are scored across four domains:

Workflow Impact

Rate the vendor's ability to reduce manual fallback, improve turnaround-time controls, handle exceptions with clean loop closure (without rework), and support structured documentation and evidence capture.

Interop Execution

Score PAS/FHIR implementation maturity where applicable, the reduction of semantic mapping burden, and whether interoperability outputs are complete and operationally usable.

Reliability & Observability

Evaluate production reliability (availability, latency, error behavior), maturity of observability and runbooks (dashboards, alerts, SLOs, incident workflows), and continuity/downtime support.

Delivery & Support

Assess speed-to-value, implementation quality, support responsiveness and root-cause analysis (RCA) quality, and roadmap credibility.

PAS/FHIR maturity is grounded in the HL7 Da Vinci Prior Authorization Support (PAS) implementation guide, and CMS provides implementation and testing resources—including the PAS test kit—to support consistent adoption. Resource references are included so readers can understand the operational meaning behind terms such as PAS/FHIR maturity, observability, SLOs, runbooks, and continuity planning.

The table on the following page translates the PAIR booth evaluation domains into plain-language criteria, observable demo proof points, and supporting standards references to help attendees assess vendors consistently and objectively.

PAIR Booth Evaluation Domains: Practical Measures, Live Demo Proof Points, and Reference Standards (KPIs 1–14)

Worksheet domain	What it measures in plain language	What to look for in a live demo	Key resources
Workflow Impact (KPIs 1–4)	Whether the solution measurably reduces real work and delays (manual fallback, rework loops, evidence chasing)	Show the end-to-end workflow including exceptions (missing documentation, "pend for more info," policy mismatch). Ask for before/after metrics: manual touches, cycle time, rework rate.	CMS frames streamlining prior auth and improving data exchange as a core goal of CMS-0057-F.
Interop Execution (KPIs 5–7)	Whether interoperability is usable (complete, correctly interpreted, operationally helpful)—not just "connected"	If PAS/FHIR is claimed, ask them to show which PAS workflows are implemented, what profiles/operations are supported, and how they handle semantic mismatches. Ask how they test conformance.	HL7 Da Vinci PAS IG and CMS standards/testing resources.
Reliability & Observability (KPIs 8–10)	Whether the system behaves like a production service: stable performance, early detection of problems, fast recovery, and continuity	Ask to see operational dashboards: error rates, latency, drop-offs, top failing pathways, and alerting. Ask what SLOs are used and what runbooks exist for top incidents.	SLO fundamentals (Google SRE); observability concepts (OpenTelemetry).
Delivery & Support (KPIs 11–14)	Whether value is achieved quickly and sustained: implementation quality, support responsiveness, credible roadmap	Ask for a typical "time-to-first-value" timeline, implementation plan roles, and escalation/RCA process examples. Ask for how incidents are managed and how root cause is documented.	Time-to-value as a standard product metric; incident/RCA best practices as part of disciplined service management.

Why These Resources Matter (And How They Map To Pair Language)

PAS/FHIR implementation maturity (Interop Execution):

When vendors say they support "FHIR-based prior authorization," the most actionable follow-up is whether they align to the HL7 Da Vinci PAS guide and whether they can demonstrate tested conformance. PAS is specifically intended to enable a provider system to request authorization and receive a response along with the necessary supporting clinical information.

Observability, SLOs, and runbooks (Reliability & Observability):

"Observability" means you can see what is happening inside a workflow before the business feels it as delays and backlogs. Modern observability is typically built on telemetry (traces, metrics, logs) and is operationalized using SLOs that define what "good" looks like and runbooks that define what teams do when reality deviates from the target.

Continuity and downtime readiness:

Because payer-provider workflows are increasingly interdependent, downtime planning needs to be explicit and tested. Continuity planning is a mature discipline in federal and critical-infrastructure guidance (including structured contingency planning approaches), and healthcare-specific resilience expectations are increasingly emphasized in sector performance goals.

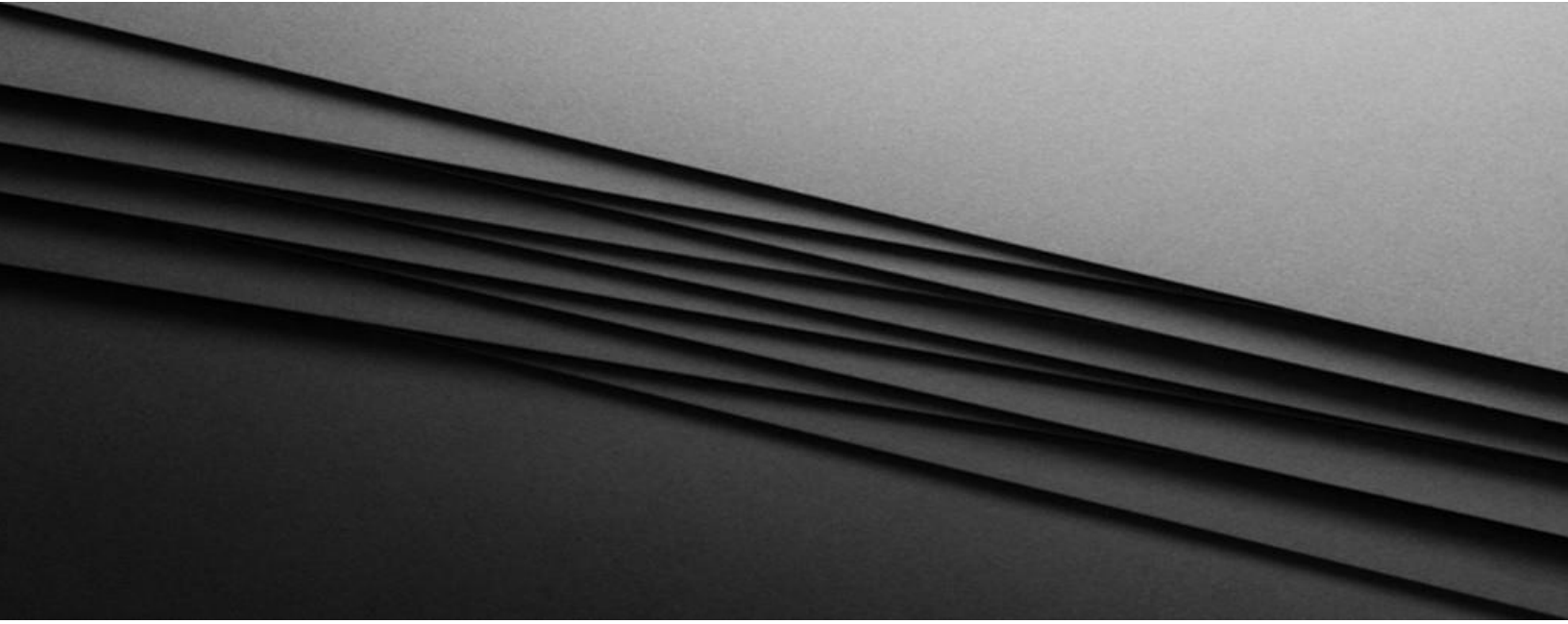
Implementation quality, support responsiveness, and RCA (Delivery & Support):

A solution can be technically sound and still fail to deliver value if it cannot be implemented cleanly, supported under pressure, or improved through disciplined root cause analysis. Time-to-value is a widely used adoption metric, and RCA/incident management practices help prevent recurring failures from becoming normal operations.

How to Evaluate Vendors / Worksheet Usage

Recommended "evidence artifacts" to request at booths

If attendees want to go beyond a demo and capture decision-grade evidence, request at least one artifact per domain: a workflow trace or status timeline (Workflow Impact), a PAS/FHIR conformance/testing statement (Interop Execution), an SLO/dashboard view plus one runbook (Reliability & Observability), and an escalation/RCA example plus time-to-value milestones (Delivery & Support). These artifacts make the 1–5 scoring defensible and comparable across booths.



05

HIMSS26 EXHIBITOR DIRECTORY

5.1 Exhibitor Index (Alphabetical Quick Reference)

The exhibitors below are presented through a PAIR-aligned lens. Vendors are listed alphabetically; inclusion does not constitute endorsement or ranking.

Vendor Name	Booth Number
1upHealth	5253
AiClaim	717-28
Amazon Web Services (AWS)	4957
Availity	MP11554
CoverMyMeds	1422
DrFirst	3243
eHealth Exchange	MP11552
Firely	5144
Google (Google Cloud)	3507
HL7	12517
HL7 Da Vinci Project	12620
InterSystems	222
MCG Health	6232
Microsoft	2812
Optum	3224
Oracle Health and Life Sciences	4022
Salesforce (MuleSoft)	2522
Surescripts	1139
Trisotech	10018-31
Waystar	4622
XCaliber Health	5253

1upHealth — Booth 5253

1upHealth is typically evaluated by teams prioritizing **API-first electronic prior authorization** and payer-provider interoperability execution under real operating conditions. Attendees should ask how partner onboarding is handled, how payload variability is managed, and what happens when requests fail due to incomplete data or endpoint instability. A PAIR-aligned demo should surface production telemetry (drop-offs, error categories) and the escalation path when failures occur. This is a strong stop for organizations building ePA workflows through standards-based APIs rather than portal-led processes.

AiClaim — Booth 717-28

AiClaim is generally sought by revenue cycle and operational leaders focused on reducing authorization-related friction that later manifests as **denials, rework, and delayed cash**. In PAIR terms, the relevance is the "last mile" linkage between pre-service authorization quality and downstream administrative outcomes. Ask to see how the solution identifies missing evidence early, reduces repeated touches, and measures workflow improvement over time. A useful demo will connect operational actions to measurable reductions in rework.

Amazon Web Services (AWS) — Booth 4957

AWS is relevant to PAIR's **Observability & Resilience** pillar as the operational substrate many teams use to host, monitor, and scale workflows and APIs. Attendees should focus on production readiness patterns: logging/metrics, alerting discipline, incident response workflows, and resilience design for business-critical administrative transactions. Ask for practical examples of SLO-driven operations and how teams prevent "silent failures" that push work back to manual channels. This booth is most valuable for leaders treating ePA as a production service that must be engineered for reliability.

Availity — Booth MP11554

Availity is commonly evaluated for payer–provider administrative connectivity where prior authorization workflows coexist with other high-volume transactions. Attendees should ask to see how authorizations are initiated, routed, and tracked across multiple payers without reverting to portal chasing and phone calls. A strong demo includes exception routing (missing evidence, pend requests) and clearly explains who owns escalation across payer, provider, and network dependencies. This is especially relevant for organizations seeking consistent operations across fragmented payer requirements.

CoverMyMeds — Booth 1422

CoverMyMeds is frequently sought for demonstrations of electronic prior authorization (ePA) workflows designed to reduce administrative burden and improve completion rates. Attendees should request proof of "last-mile" performance: how documentation is assembled, how status is surfaced, and how

information-request loops close without duplicative work. PAIR-aligned questions focus on reducing manual fallback, improving turnaround controls, and making exceptions predictable rather than chaotic. This booth is a core stop for medication ePA modernization discussions.

DrFirst — Booth 3243

DrFirst is often visited by organizations evaluating ePA within the broader context of medication management and prescribing workflow efficiency. Attendees should probe how the solution reduces friction when authorizations require follow-up actions and how work stays inside operational workflows rather than shifting into portals and phone escalation. A PAIR-aligned walkthrough should show where requests stall, what triggers next-step tasks, and how issues are escalated and resolved in production. This booth is most relevant for provider-side workflow optimization conversations.

eHealth Exchange — Booth MP11552

eHealth Exchange is relevant when the authorization bottleneck is evidence availability—getting the right records, on time, with the right trust and governance. Attendees should ask how clinical documentation is retrieved, packaged, and delivered in a form that reduces rework rather than increasing review burden. A PAIR-aligned discussion should clarify escalation ownership when evidence is missing, delayed, or disputed. This is a key stop for organizations working to reduce documentation-related pends and manual chasing.

Epic — Booth 12713

Epic is a high-priority stop for provider organizations because prior authorization is often an in-workflow EHR problem, not a standalone tool problem. Attendees should ask to see initiation from an order/referral, evidence prompts, task routing, and status visibility across clinical and revenue-cycle teams. A PAIR-aligned demo must include exception handling (missing documentation, payer requests for more info) and what happens during downtime or endpoint instability. This booth is most useful for leaders trying to eliminate parallel workflows and keep authorization work inside core operations.

Firely — Booth 5144

Firely is a key stop for teams implementing FHIR-based prior authorization and the infrastructure required to operationalize standards-driven workflows at scale. Attendees should validate implementation realism: data modeling, conformance testing, performance, semantic friction handling, and operational supportability. A PAIR-aligned conversation should focus on how problems are detected early and corrected before they become manual rework. This booth fits organizations building durable FHIR foundations for ePA execution.

Google (Google Cloud) — Booth 3507

Google Cloud is relevant to PAIR's API observability and reliability requirements when ePA is delivered through production APIs. Attendees should ask to see dashboards for latency and error rates, alert thresholds, and incident workflows that map to real business outcomes (drop-offs, backlogs, repeated touches). A PAIR-aligned demo includes how SLOs are defined and used and how degradation is handled without triggering manual fallback cascades. This booth is most valuable for teams treating payer-provider connectivity as a reliability-engineering problem.

HL7 — Booth 12517

HL7 provides a neutral anchor for what "good" looks like in standards-aligned implementation, including the practical realities that often break production workflows. Attendees should focus on implementation learnings: where completeness fails, where semantic mismatches occur, and what testing approaches reduce deployment risk. A PAIR-aligned visit helps leaders separate "standards adoption" from "operational usability." This is a high-signal stop for teams validating vendor claims against real implementation constraints.

HL7 Da Vinci Project — Booth 12620

Da Vinci is a critical stop for organizations evaluating FHIR-based prior authorization approaches because it connects standards intent to operational reality. Attendees should ask where implementations most often fail in practice—documentation gaps, exception loops, status ambiguity, and partner variability—and what design patterns reduce rework. A PAIR-aligned conversation should emphasize metrics that matter beyond "we implemented the guide," such as manual fallback reduction and throughput reliability. This booth helps attendees pressure-test "PAS-ready" claims.

InterSystems — Booth 222

InterSystems is commonly evaluated as an interoperability and data platform supporting end-to-end operationalization of payer-provider workflows, including prior authorization. Attendees should request demonstrations that go beyond connectivity to show orchestration, error handling, traceability, and recovery when dependencies fail. Under PAIR, the most valuable proof points are observability (dashboards and incident discipline) and methods to keep workflows digital when exceptions occur. This is a strong booth for enterprise-scale reliability and integration discussions.

MCG Health — Booth 6232

MCG Health is typically sought by payer and provider teams wanting to see how evidence-based guidance and authorization workflows reduce variability and rework. Attendees should focus on how documentation requirements are operationalized, how exceptions are handled, and how decision pathways are made transparent for operational teams. A PAIR-

aligned demo should show what reduces "missing/unclear documentation" as a delay driver and how policy/criteria changes are governed without destabilizing production workflows. This booth is relevant for leaders aiming to tighten evidence readiness and reduce pend/denial loops.

Microsoft — Booth 2812

Microsoft is relevant to PAIR's operational pillars—especially observability, security, and resilience—where payer/provider workflows are delivered through cloud-based services and integrated platforms. Attendees should look for concrete examples of monitoring, incident response, and governance patterns that reduce silent failures and preserve throughput. A PAIR-aligned discussion should focus on operational dashboards, escalation discipline, and continuity strategies rather than generic platform overviews. This booth is most valuable for leaders modernizing the infrastructure layer behind ePA execution.

Oracle Health and Life Sciences — Booth 4022

Oracle Health and Life Sciences is relevant where organizations are connecting clinical and operational workflows so prior authorization does not remain siloed. Attendees should ask for end-to-end demonstrations across teams and systems, including how workflows recover when something breaks midstream. A PAIR-aligned conversation should focus on accountability, reporting across workflow stages (not just transactions), and how policy changes are operationalized without destabilizing throughput. This booth fits enterprises prioritizing cross-domain workflow reliability and governance.

Optum — Booth 3224

Optum is often prioritized for payer/provider conversations about authorization operations, clinical criteria, and interoperability pathways that accelerate completion and reduce ambiguity. Attendees should focus on production execution: evidence packaging, status transparency, and how operational performance is monitored and improved over time. A PAIR-aligned discussion should clarify ownership when workflows break and how recurring issues are surfaced and resolved. This booth is relevant for organizations seeking scalable approaches to decision consistency and operational clarity.

Salesforce (MuleSoft) — Booth 2522

MuleSoft is commonly evaluated for accelerating integration work through reusable assets and reference architectures, which matters when organizations must operationalize multiple payer-provider workflows. Attendees should ask to see healthcare-specific integration patterns with error handling, retries, idempotency, and monitoring—rather than one-time "data moves" demos. A PAIR-aligned discussion focuses on speed-to-value, production supportability, and how incident response and RCA are handled for integrated flows. This booth is valuable for leaders building scalable, repeatable integration operating models.

Surescripts — Booth 1139

Surescripts is frequently identified as a must-see for network-scale enablement supporting benefits and authorization workflows across the ecosystem. Attendees should request demonstrations that include both the happy path and the messy path: missing documentation, payer variability, endpoint errors, and status ambiguity—then evaluate how exceptions are routed and resolved without manual detours. PAIR-aligned questions should probe operational visibility (drop-offs, error patterns), reliability expectations, and escalation ownership across partners. This booth is central for attendees focused on ecosystem connectivity and status reliability.

Trisotech — Booth 10018-31

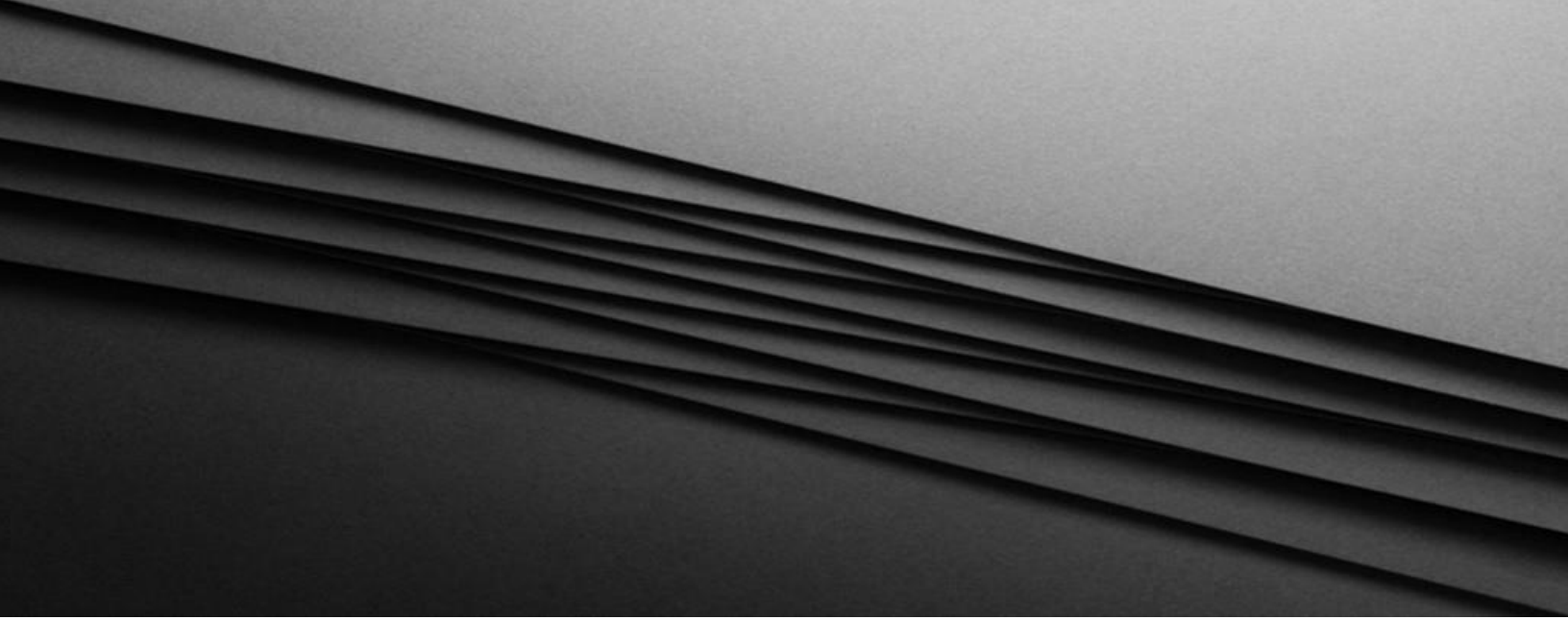
Trisotech is relevant for organizations that recognize prior authorization is also a decision logic and governance problem, not only an integration problem. Attendees should ask to see how policy logic is modeled, versioned, deployed, monitored, and audited—especially when requirements change. A PAIR-aligned demo emphasizes traceability, controlled change, and how exceptions are categorized and routed to reduce manual triage. This booth is useful for leaders building governed automation rather than brittle automation.

Waystar — Booth 4622

Waystar is often prioritized by provider-side leaders who view prior authorization as a driver of denials, rework, and delayed cash rather than an isolated administrative step. Attendees should ask to see how authorization workflow quality connects to downstream outcomes and where repeated touches occur. A PAIR-aligned evaluation focuses on operational controls, reporting that identifies highest-friction pathways, and measurable reduction in rework. This booth is valuable for leaders tying ePA improvements to revenue-cycle performance.

XCaliber Health — Booth 10018-02

XCaliber Health is typically sought by teams exploring how workflow assistance can reduce administrative workload around authorization-related tasks. Attendees should evaluate whether the solution genuinely reduces repeated touches and accelerates completion, especially in exception-heavy scenarios, or simply shifts work to another queue. A PAIR-aligned demo should show when the assistant escalates to humans, how it maintains reliability, and what measurable outcomes it delivers. This booth is relevant for organizations looking to operationalize consistent next-step actions and reduce manual burden.



06

ABOUT BLACK BOOK'S PAIR BENCHMARK

The **Black Book PAIR Readiness Benchmark** is an independent benchmark designed to quantify the operational readiness required to modernize prior authorization and execute payer-provider interoperability reliably at scale. It emphasizes workflow reliability, observability, governance, and usability in addition to compliance awareness—because success in 2026 will depend on operational execution as much as technical standards.

6.1 About Black Book

Black Book is an independent healthcare IT research and benchmarking organization focused on measuring real world performance, user experience, operational impact, and value delivery across the health technology ecosystem. Black Book's benchmark products are designed to help healthcare leaders make high stakes decisions with practical clarity—what works in production, what breaks in the last mile, and which operating models consistently drive better outcomes.

Vendor agnostic benchmarking standard

Black Book's methodology is built on a vendor agnostic standard that prioritizes respondent attributed experience over vendor reported claims. Survey design, sampling approach, scoring logic, and publication formats are structured to support credible comparisons while avoiding "demo bias" and marketing driven narratives. This standard emphasizes operational truth: workflow reliability, exception handling, usability, service performance, and support outcomes as experienced by the people accountable for results.

Black Book maintains a standardized 36 KPI measurement framework applied across healthcare IT categories—enabling consistent comparisons even when products differ in function. The framework currently covers 2,000+ vendors and 20,000+ healthcare IT products and modules, providing a broad ecosystem view while retaining the ability to drill down to product-level realities.

Black Book's mission is to improve user and client usability, total cost performance, and satisfaction across healthcare IT so technology investments translate into practical operational gains. Ultimately, the objective is to help the industry deliver a better healthcare experience by improving patient experience, healthcare consumer access, and consumer satisfaction through more reliable, usable, and accountable technology-enabled workflows.

Contact: Research@BlackBookMarketResearch.com www.blackbookmarketresearch.com
01.800.863.7590