Black Book
Research Insights

AI-DRIVEN RCM MANAGED SERVICES CLAIMS OPTIMIZATION DENIAL PREVENTION, AND REVENUE PROTECTION

2026

Black Book Market Research LLC Insights
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ABOUT THIS REPORT

Black Book™ conducts an annual evaluation of healthcare software and service providers across 18 key performance indicators (KPIs) of operational excellence, based entirely on verified end-user satisfaction data. The evaluation process is independent and designed to be free from vendor influence. Survey responses are validated and audited for completeness and respondent authenticity while maintaining the anonymity of participating organizations.

This 2026 Publication Edition refreshes the market context for AI-driven revenue cycle management (RCM) managed services, while preserving the most recent completed Black Book benchmark scoring dataset.

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EXECUTIVE SUMMARY

AI-driven denial prevention, claims integrity, and revenue protection have become core operating priorities for provider revenue cycle leaders. The 2026 environment is defined by sustained denial pressure, regulatory requirements for faster and more transparent prior authorization, and heightened expectations for business continuity across clearinghouse-dependent workflows.

- Denials remain elevated: Black Book Research benchmarking indicates that a substantial share of provider organizations continue to report denial rates at or above the 10% threshold, with preventable denials concentrated in eligibility/coverage, authorization, clinical documentation, and coding-driven edits.
- Prior authorization modernization becomes enforceable: Black Book Research expects accelerated adoption of electronic prior authorization workflows and payer-facing automation as federal requirements and contractual SLA expectations converge in 2026–2027.
- Business continuity is now an RCM KPI: Black Book Research notes that sector-wide clearinghouse and cyber disruption events have elevated resilience expectations, including contingency routing, manual fallback playbooks, and time-to-recover commitments embedded in vendor governance.
- Buyer expectations are shifting: Black Book Research finds that AI model transparency, auditability, and governance are increasingly evaluated alongside traditional RCM outcomes (clean claim rates, appeal success, and cash acceleration).

This report includes

1. a refreshed 2026 market narrative,
2. the 2026 benchmark Top 20 vendor performance results,
3. a normalized, apples-to-apples managed-services peer comparison that highlights vendors commonly evaluated by healthcare organizations for RCM operational outsourcing, and
4. a full KPI scorecard appendix for the benchmarked vendors.

KEY TAKEAWAYS FROM THE RESPONDENT DATASET

Across the 2,193 verified respondents, category leadership is increasingly defined by time-to-first-value and the ability to sustain change, not by model performance in isolation. Buyers consistently describe the early phases of autonomy programs as a race to stabilize real workflows, queue ergonomics, exception handling, and adoption discipline, and to prove measurable touch reduction quickly enough to maintain executive and frontline support. Vendors perceived as leading are those that convert automation into dependable standard work and provide the enablement necessary to keep performance improving after go-live, rather than stalling once initial configuration is complete.

The dataset also reinforces that the most common blockers to scaling autonomy are foundational. Interoperability, data observability, and governance repeatedly emerge as the gating factors that determine whether organizations move from narrow pilots into enterprise-scale autonomy. Satisfaction outcomes align tightly with this reality: buyer sentiment correlates more strongly with implementation quality and service recovery performance than with feature breadth, because reliability and support responsiveness determine whether teams trust automation enough to expand it.

ORGANIZATION TYPE OF SURVEY PARTICIPANTS (PRIMARY EMPLOYER)

Organization type (primary employer)	n	% of total
Health systems / IDNs (multi-hospital)	221	10.1%
Hospitals (standalone community + academic medical centers)	418	19.1%
Physician organizations & groups (multi-specialty, ACOs, MSOs, IPAs)	338	15.4%
Payers / health plans (commercial, Medicare Advantage, Medicaid)	410	18.7%
Ambulatory organizations (ASC, urgent care, specialty clinics)	205	9.3%
Diagnostics (labs, imaging, pathology, radiology groups)	126	5.7%
Long-term & post-acute (SNF, home health, hospice, rehab)	65	3.0%
Other healthcare entities (FQHCs, behavioral health networks, DME, RCM service orgs)	99	4.5%
Unclassified / not reported primary employer	311	14.2%
Total	**2,193**	**100.0%**

Network connectivity remains a consistent differentiator in denial prevention and payment workflows, where payer reach and real-time eligibility and claim-status coverage materially reduce follow-up labor. Finally, several underreported signals, especially integration burden, quality of service recovery, and the year-two optimization experience, tend to predict renewal intent and switching behavior earlier and more reliably than headline overall satisfaction measures.

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2026 MARKET UPDATE

Operational, regulatory, and technology factors are converging to increase both the volume and the complexity of claims interventions required to protect net revenue. AI-enabled managed services are being adopted to reduce manual rework, prioritize high-risk claims, and industrialize appeals and recovery workflows.

DENIALS AND ADMINISTRATIVE REWORK

Providers continue to report rising denials, increasing claim errors, and staffing constraints. Black Book Research fieldwork and respondent commentary indicate that a majority of provider organizations are experiencing increased edit intensity and claim error rates year over year, alongside persistent understaffing in billing, coding, and A/R operations. Across Black Book Research benchmarking, denials and rework are most often concentrated in eligibility/coverage verification, authorization compliance, documentation specificity, and coding-driven edits.

Black Book Research also finds a growing gap between interest and operational deployment: most respondents report strong belief that AI-enabled workflow intelligence can improve clean-claim performance, yet adoption remains uneven across departments. Among early adopters, Black Book Research polling indicates measurable reductions in denials and higher resubmission success when AI is paired with managed operational execution and disciplined governance.

PRIOR AUTHORIZATION AND INTEROPERABILITY MANDATES

Federal prior authorization modernization and interoperability requirements are increasing expectations for timeliness, transparency, and data exchange across impacted payers. Black Book Research expects accelerated operational adoption in 2026, with broader API-enabled automation requirements maturing into 2027.

Operational requirements generally emphasize faster decision turnaround for expedited versus standard requests, clearer documentation of denial rationales, and increased reporting transparency for prior authorization activity. For provider revenue cycle teams, these requirements make upstream authorization discipline and documentation quality materially more consequential to net revenue protection.

For RCM leaders, these policies raise the importance of: (a) tighter linkage between authorization, clinical documentation, and claims submission; (b) rapid root-cause analysis of authorization-related denials; and (c) audit trails that support payer challenge resolution.

BUSINESS CONTINUITY AND CLEARINGHOUSE DEPENDENCIES

Recent sector-wide clearinghouse and cyber disruption events have demonstrated that claims-routing concentration risk can quickly become a liquidity event for providers. Black Book Research polling indicates that most hospitals experiencing a major claims-routing disruption report immediate cash flow impacts and significant operational friction when attempting to switch routing partners on short notice. As a result, contingency routing, manual fallback playbooks, and time-to-recover commitments are increasingly embedded in managed services governance and contracting.

Contingency planning, alternate routing, and outage playbooks are now standard diligence items in managed services selection and contracting.

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2027 OUTLOOK:
SECTOR GROWTH, CLIENT DEMAND, AND VENDOR REQUIREMENTS

As denial pressure, payer automation, and staffing constraints continue into 2026, Black Book Research observes that the AI-driven RCM managed services sector is accelerating beyond "denials management" toward end-to-end revenue protection operating models. The 2027 outlook below summarizes demand drivers, buyer segments, and the capability expectations that are becoming standard in enterprise RFPs, based on Black Book Research benchmarking and industry-source synthesis.

GROWTH SIGNALS AND DEMAND DRIVERS

Black Book Research outlook: Growth is being driven by persistent denial pressure, expanding payer policy complexity, and executive mandates to stabilize cash while reducing administrative burden. Demand is strongest for vendors that combine AI-enabled workflow intelligence with accountable managed operations (not software alone).

- Black Book Research projects that provider spending on AI-driven RCM managed services (denial prevention, claims optimization, and related recovery operations) will increase at a high double-digit pace through 2027 as organizations expand from pilot programs to enterprise-scale operating models.
- Across Black Book Research buyer interviews and survey work, the most common investment triggers are: (1) denial rates trending above internal tolerance bands, (2) payer mix shifts toward products with higher edit intensity, (3) staffing volatility in billing and A/R teams, and (4) leadership mandates for measurable ROI within 2–3 quarters.
- Black Book Research also observes a shift in sourcing strategy: many health systems are moving from point-solution procurement to outcomes-based managed services contracts that embed KPIs, shared governance, and performance guarantees.

Black Book Research directional benchmarks (planning ranges): among surveyed providers, initial denial rates frequently cluster in the high single digits to low teens, with meaningful variance by specialty, payer mix, and front-end authorization discipline.

- Black Book Research notes that preventable denials are most often linked to eligibility/coverage verification, authorization timing, documentation specificity, coding accuracy, and avoidable payer edits—creating a durable ROI case for upstream prevention and rapid appeals.
- Black Book Research estimates that the fully loaded administrative effort tied to denial rework remains a top-5 non-clinical cost driver for many provider organizations, particularly where manual work queues and fragmented payer rule management persist.
- Black Book Research finds that the addressable market is widening as buyers seek integrated services that connect prior authorization, medical necessity documentation, clean-claim optimization, denial intelligence, and appeal execution into one accountable operating model.

Taken together, these factors are widening the addressable market for managed services that combine advanced analytics, AI-enabled work queues, and experienced RCM operations teams.

CLIENT TYPES ADOPTING AI-DRIVEN RCM MANAGED SERVICES

Adoption is no longer limited to large IDNs. In 2026–2027, managed services demand is broadening across provider types, often starting with denial prevention and expanding into adjacent integrity and recovery functions.

EXPECTED DEMAND INCREASES IN 2026–2027 (BLACK BOOK RESEARCH)

Based on Black Book Research fieldwork and directional benchmarking, expected demand for AI-driven RCM managed services is rising in 2026–2027 as organizations move from denial-recovery "back-end" programs to upstream prevention. Black Book Research projects:

- **2026:** a majority of mid-to-large providers will expand denial prevention and claims integrity programs beyond a single department or service line;
- **2027:** more buyers will require contractual commitments for automation coverage, continuity planning, and auditable AI decision support.
- **2026:** 35%–55% of surveyed providers expect to increase spend on outsourced/managed denial prevention and claims optimization services;
- **2027:** 45%–70% expect further increases, with the steepest growth among organizations facing staffing constraints or aggressive payer edit intensity;
- **2026–2027:** 25%–40% expect to consolidate vendors (fewer partners, broader scope) under outcomes-based contracts.

TYPICAL BUYERS OF AI-DRIVEN RCM MANAGED SERVICES

Black Book Research segments the most common buyers into the following categories (often with distinct use cases and procurement drivers):

- **Large IDNs and academic medical centers —** enterprise denial prevention, complex payer mix, and cross-facility standardization.
- **Community health systems and multi-hospital networks —** rapid cash stabilization, staffing supplementation, and payer-rule operationalization.
- **Specialty physician groups (e.g., radiology, anesthesia, emergency medicine) —** high edit volume, authorization sensitivity, and fast-cycle A/R.
- **Ambulatory surgery centers and high-throughput outpatient providers —** clean-claim optimization and authorization discipline.
- **Rural and critical access hospitals —** scalable expertise, remote operations, and simplified governance with predictable monthly fees.
- **Safety-net and public providers —** denials prevention tied to eligibility/coverage workflows and complex program requirements.

PARTICIPANT AND RESPONDENT PROFILE TABLE

(BLACK BOOK RESEARCH SURVEY FIELDWORK: SEPT 2025–FEB 2026)

The table below summarizes the participant profile segmentation framework used in this study period. Respondent counts (n) are maintained in the Black Book Research dataset and may be provided upon request or inserted in client-specific editions.

Buyer segment	Organization type	Typical size	Primary use cases	Respondent role(s)	Region	Respondent count (n)
Large IDNs / AMCs	Health system	10+ hospitals / $3B+ net patient revenue	Enterprise denial prevention; claims optimization; appeals ops	VP/Director Revenue Cycle; Denials Mgmt lead	National	Not disclosed
Community systems	Health system	2–9 hospitals / $500M–$3B NPR	Cash acceleration; staffing augmentation; payer edit governance	CFO/Revenue Integrity; Patient Financial Services	National	Not disclosed
Specialty physician groups	Physician services	50–500+ providers	Authorization discipline; coding/documentation; fast-cycle A/R	Revenue Cycle Manager; Billing Ops lead	National	Not disclosed
Ambulatory/outpatient	ASC / outpatient networks	Multi-site	Clean-claim optimization; eligibility; auth workflows	Practice Administrator; RCM Director	National	Not disclosed
Rural / critical access	Hospital	1–2 hospitals	Remote RCM ops; denials prevention; simplified governance	CFO; Revenue Cycle Director	National	Not disclosed

- Large health systems and academic medical centers: enterprise denial analytics, payer-specific rules management, complex case mix, and appeals industrialization.
- Community hospitals and rural providers: outsourcing to offset staffing gaps, stabilize cash flow, and reduce dependence on scarce coding/denials specialists.
- Multi-specialty and large physician groups: automation to increase first-pass yield, reduce billing office burden, and handle payer policy volatility.
- High-denial specialties (e.g., radiology, surgery, cardiology, orthopedics, oncology): prior authorization-linked denials, documentation completeness, and medical necessity defense.
- Post-acute, behavioral health, and home-based care: eligibility/authorization complexity, fragmented payer rules, and patient-responsibility collections pressure.

Financial leaders remain focused on net revenue protection. In a Black Book Research revenue cycle poll, 70% of respondents cited increasing revenue as their highest priority, followed by reducing operating costs.

WHAT CLIENTS WILL DEMAND FROM VENDORS IN 2027

Buyer requirements are shifting from point improvements in denials to broader operational assurance. The following demands are increasingly common as the federal prior authorization rule becomes operationally enforceable and as cyber resilience is treated as an RCM control requirement.

- Prior authorization and claims convergence: tight linkage between authorization, clinical documentation, and claim submission, including payer-specific evidence requirements and audit trails.
- Interoperability readiness: demonstrated ability to consume payer APIs and automate data exchange workflows that support timeliness and transparency requirements under federal prior authorization rules.
- Model governance and auditability: explainable AI outputs, reproducible decision logs, and human-in-the-loop controls aligned to AI risk management practices.
- Operational playbooks, not just software: staffed denial prevention/appeals operations with defined escalation paths, payer engagement routines, and continuous improvement governance.
- Business continuity as a contractual control: alternate routing options, clearinghouse failover planning, and tested outage procedures.
- Security and privacy posture: HIPAA-aligned safeguards, supply-chain risk management, and rapid incident response transparency for any PHI exposure.
- Outcome proof and commercial clarity: baseline-to-target performance reporting, ROI attribution logic, and transparent fee structures (including contingency terms where applicable).

TRENDS TO WATCH THROUGH 2027

- Generative AI–assisted appeals and correspondence: broader use of LLM-supported drafting and summarization, paired with strict human review and source traceability to prevent compliance risk.
- Real-time payer rule maintenance: shift from annual payer "rules updates" to continuous monitoring and rapid deployment of edits, supported by analytics and managed services.
- Denials-to-underpayments convergence: vendors increasingly bundle denials prevention with underpayment detection and contract variance recovery to protect net revenue end-to-end.
- RCM resiliency engineering: providers will formalize downtime playbooks, dual-path clearinghouse connectivity, and treasury-driven liquidity monitoring after 2024's disruption experience.

Black Book Research observes that planning ranges commonly referenced in 2027 RFPs include: 1–3 percentage-point improvement targets in first-pass yield for selected payers, 15–30% reductions in manual touches for targeted claim types, and accelerated appeal cycle times for high-value denials. Actual outcomes vary materially by baseline performance, payer mix, documentation quality, and the extent of workflow change.

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METHODOLOGY AND SCORING

BENCHMARK DATA SOURCE

Black Book's Annual Revenue Cycle Management User Survey received 1,342 total survey submissions in Q3 2025-Q1 2026 for this market segment. After validation and eligibility screening, 1,037 responses met inclusion criteria and were used in the benchmark scoring dataset. Vendors are evaluated across 18 KPIs on a 0–10 satisfaction scale, and composite scores represent the equal-weight mean performance across KPIs (K1–K18).

2025 SURVEY RESPONDENT ROLES

Respondent identification	Total submissions
Chief Financial Officer (CFO) – Strategic financial oversight	30
Vice President of Revenue Cycle – Oversees all revenue cycle functions	41
Director of Revenue Cycle – Manages billing, collections, and denial prevention	110
Revenue Integrity Manager – Ensures compliance, coding accuracy, and claim optimization	28
Denial Management Supervisor – Specializes in claim adjudication and appeal processes	112
Patient Financial Services Manager – Handles claim submissions and revenue recovery	89
Billing and Collections Manager – Manages reimbursements and follow-ups	210
HIM (Health Information Management) Director – Oversees coding and documentation compliance	107
Practice Administrator – Manages overall revenue cycle and business functions	254
Director of Revenue Cycle (Physician Group/Medical Practice) – Handles denials, coding, and claims	44
Medical Billing Manager – Directly involved in claims submission and denials	229
Credentialing and Contracting Manager – Ensures proper payer credentialing, reducing denials	31
Other: Additional revenue cycle leadership roles or consultants	57
TOTAL	**1,342**

RAW SCORE SCALE

Scores are reported on a 0–10 scale (0 = deal-breaking dissatisfaction; 10 = exceeds all expectations).

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2026 BENCHMARK RESULTS (TOP 20)

The table below summarizes the composite benchmark rankings based on 18 KPI mean scores from the 2026 survey dataset.

Rank	Vendor	Composite (Mean)
1	IKS Health	9.42
2	Ensemble Health Partners	9.19
3	Synergen Health	8.71
4	R1 RCM	8.60
5	CorroHealth	8.34
6	Optum (Optum360 / Change Healthcare)	8.18
7	Omega Healthcare	7.94
8	Access Healthcare	7.79
9	Firstsource	7.63
10	Coronis Health (incl. MiraMed Global Services)	7.36
11	AGS Health	7.03
12	GeBBS Healthcare Solutions	6.89
13	Zotec Partners	6.78
14	Conifer Health Solutions	6.73
15	Infinx	6.58
16	Aspirion	6.30
17	Parallon	6.02
18	Sagility	5.72
19	Invensis	5.34
20	EXL	5.05

See Appendix B for the full KPI-by-KPI scorecard for each benchmarked vendor.

2026 COMPETITOR SET

The benchmarked vendor universe may include adjacent solution categories (e.g., payments networks, utilization management, pure-play analytics/AI consultancies, or eligibility/credit data services). For readers specifically evaluating outsourced RCM managed service partners, Black Book Research identified a normalized subset of vendors that healthcare organizations most commonly include for RCM operational outsourcing, claims optimization, denial prevention, and revenue protection engagements. Black Book Research independently determines all benchmark participants, scoring methodology, and analytical groupings. Vendors do not select peer groups.

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APPENDIX

APPENDIX A:
KPI DEFINITIONS (K1-K18)

The 18 KPIs below are qualitative measures of client experience and operational excellence. In addition to understanding the definitions, clients can use the evaluation guidance to translate each KPI into diligence questions, evidence requests, and ongoing governance scorecards.

Practical recommendation: define a baseline for each KPI-aligned outcome metric prior to go-live (e.g., denial rate by payer and category, first-pass yield, appeal turnaround, days in A/R), then require monthly reporting and quarterly business reviews (QBRs) that reconcile vendor-reported impact to the client's system-of-record.

K1 DENIAL PREVENTION AND CLAIM OPTIMIZATION PERFORMANCE

Measures the vendor's ability to prevent avoidable denials before submission and improve claim accuracy through AI-enabled edits, workflow intervention, and managed-services execution.

- **Metrics to track:** Preventable denial rate (%), initial rejection rate, first-pass yield/clean claim rate, denial dollars avoided, and denial rate by payer and denial reason code.
- **How to evaluate:** Require a baseline (pre-go-live) and a 60–120 day pilot or phased rollout by payer/service line; verify improvement with a control cohort and consistent denial taxonomy.
- **Evidence to request:** Monthly denial analytics with root-cause categories, examples of pre-bill interventions, edit library governance (who updates, how often), and sample work-queue logic.
- **Contract checkpoints:** Document reporting cadence, time-to-update payer edits, and performance accountability for targeted denial categories (with clear inclusions/exclusions).
- **Red flags:** Vague denial definitions, limited payer-specific insight, or heavy reliance on retrospective appeal work without measurable upstream prevention.

K2 AI-DRIVEN REVENUE PROTECTION AND CASH-FLOW STABILITY

Assesses the extent to which the vendor protects net revenue and improves cash predictability by prioritizing high-risk claims, accelerating resolution, and reducing leakage.

- **Metrics to track:** Net collection rate, days in A/R, cash acceleration (days), write-off rate, appeal recovery yield, and underpayment/variance recovery where in scope.
- **How to evaluate:** Ask the vendor to model expected cash impact using your historical payer mix; validate through a staged go-live and track cash trend vs. seasonality and volume changes.
- **Evidence to request:** Case studies with before/after performance, the attribution method for "AI impact," and examples of executive dashboards used in client governance.
- **Contract checkpoints:** Define how revenue outcomes are measured, what baseline data is required, and how disputes are handled (e.g., payer policy changes, service-line shifts).
- **Red flags:** ROI claims that are not traceable to source data, or outcome reporting that cannot be reconciled to the client's GL/RCM system-of-record.

K3 REDUCTION OF ADMINISTRATIVE BURDEN AND MANUAL REWORK

Evaluates how effectively the vendor reduces staff workload through automation, intelligent routing, and standardized operating procedures.

- **Metrics to track:** Touches per claim, manual work-queue volume, rework rate, appeal cycle time, staff hours per 1,000 claims, and backlog aging by work type.
- **How to evaluate:** Observe workflow in production (or a sandbox) to confirm which tasks are automated vs. shifted to vendor staff; validate with time-and-motion sampling.
- **Evidence to request:** A process map of "before vs. after," queue definitions, automation coverage by claim type, and examples of exception handling and escalation paths.
- **Contract checkpoints:** Include service-level expectations for backlog limits, response times for escalations, and a clear RACI for client vs. vendor responsibilities.
- **Red flags:** Automation described only at a high level, or a model that primarily relies on adding labor rather than eliminating avoidable work.

K4 ACCURACY AND EFFECTIVENESS OF AI-DRIVEN CLAIM ADJUSTMENTS

Measures the correctness and financial impact of AI-supported edits, coding guidance, and claim adjustments, including the prevention of downstream audit risk.

- **Metrics to track:** Coding/charge accuracy indicators (where applicable), edit acceptance vs. override rates, DRG/APC impact (if relevant), and post-payment recoupment or audit findings tied to adjusted claims.
- **How to evaluate:** Conduct joint sampling (vendor + client compliance/HIM) on adjusted claims; test high-risk service lines and confirm documentation support for each adjustment.
- **Evidence to request:** Examples showing the rationale and source data for an adjustment, QA procedures, and how the vendor manages payer-specific billing/coding nuances.
- **Contract checkpoints:** Define approval workflows (who signs off on adjustments), audit support obligations, and how the vendor remediates systemic errors.
- **Red flags:** High-volume adjustments without clear documentation linkage, weak QA controls, or limited involvement of certified coding/compliance expertise.

K5 RELIABILITY OF AI IN PREDICTING DENIALS AND PRIORITIZING WORK

Assesses the performance and stability of predictive models and prioritization logic used to identify high-risk claims and guide staff actions.

- **Metrics to track:** Predictive performance (precision, recall, lift), false-positive burden (unnecessary touches), model drift indicators, and hit-rate by payer/denial category.
- **How to evaluate:** Require a transparent validation approach: historical back-testing on your data, performance by payer and denial class, and ongoing monitoring for drift.
- **Evidence to request:** Model documentation (features used, refresh cadence), sample "reason codes" or explanations presented to users, and the monitoring dashboard used by the vendor.
- **Contract checkpoints:** Specify performance reporting expectations and the remediation process when models degrade (re-training, rule tuning, workflow changes).
- **Red flags:** Black-box scoring with no measurable performance reporting, or a model that performs well only in aggregate but fails on key payers or service lines.

K6 SYSTEM COMPLIANCE WITH EVOLVING PAYER RULES

Evaluates how quickly and accurately the vendor adapts to payer policy changes, billing rule updates, and documentation requirements that drive denials.

- **Metrics to track:** Time to implement payer policy changes, denial spikes after policy updates, rule coverage across top payers, and recurrence of "known" denial reasons.
- **How to evaluate:** Ask for examples of recent payer updates and how they were operationalized; validate with a payer-change log and post-change denial trend monitoring.
- **Evidence to request:** Payer rule governance artifacts (bulletins monitored, update workflow, testing steps), plus samples of payer-specific documentation checklists.
- **Contract checkpoints:** Define update SLAs for high-volume payers and a formal change-control process, including communication to client stakeholders.
- **Red flags:** Reactive updates only after denial spikes, unclear ownership for payer rule monitoring, or limited payer-specific expertise.

K7 TRANSPARENCY AND EXPLAINABILITY OF AI OUTPUTS

Measures the clarity of AI recommendations and whether users can understand, trust, and audit the logic behind claim interventions.

- **Metrics to track:** User override rates, "reason provided" completeness, time-to-resolution for disputed recommendations, and audit success for AI-influenced decisions.
- **How to evaluate:** During demos, require the vendor to trace an intervention from source data → AI rationale → user action → outcome; test with real claim examples where possible.
- **Evidence to request:** Explanation formats (reason codes, contributing factors), audit logs, and examples of governance review for model decisions and exceptions.
- **Contract checkpoints:** Include requirements for traceability and reporting access (client ownership of reports/exports) and define how AI-driven decisions are documented for audits.
- **Red flags:** "Proprietary" logic that cannot be explained to auditors, or workflows that encourage blind acceptance without appropriate human review.

K8 FLEXIBILITY AND ADAPTABILITY TO CLIENT WORKFLOWS

Assesses how well the vendor can align to the client's operating model, specialties, payer mix, and technology environment without excessive customization cost or delay.

- **Metrics to track:** Time to onboard a new payer or service line, configuration turnaround time, number of client-requested workflow changes delivered per quarter, and user satisfaction by department.
- **How to evaluate:** Review configurability in workflow demos; test the process for adding a new payer rule, changing queues, or adapting to a new clinical documentation requirement.
- **Evidence to request:** Configuration options, documented playbooks for different care settings, and examples of how the vendor handled a mid-contract scope change.
- **Contract checkpoints:** Define change-control governance and pricing rules for configuration vs. custom development, plus clear timelines for delivery.
- **Red flags:** Rigid "one-size-fits-all" workflows or frequent dependence on custom development for routine client needs.

K9 EASE OF INTEGRATION WITH EXISTING RCM AND CLINICAL SYSTEMS

Measures interoperability with the client's EHR, PM/billing, clearinghouse, document management, and analytics stack, including data quality and timeliness.

- **Metrics to track:** Integration time-to-live, data latency, interface error rates, reconciliation accuracy between systems-of-record, and completeness of required data elements.
- **How to evaluate:** Confirm supported standards (e.g., X12, HL7, FHIR where applicable) and validate with an interface test plan and reconciliation checks during implementation.
- **Evidence to request:** Integration architecture diagrams, data dictionaries, example interface logs, and the vendor's approach to master data management and payer mapping.
- **Contract checkpoints:** Clarify integration responsibilities, ongoing interface monitoring, and fees for interfaces, upgrades, and new connections.
- **Red flags:** Unclear ownership for interface troubleshooting, heavy dependence on manual file transfers, or limited experience with your core EHR/clearinghouse environment.

K10 USABILITY AND LEARNING CURVE FOR CLIENT USERS

Evaluates how intuitive the solution is for revenue cycle staff, and how quickly users can become proficient without heavy ongoing training burden.

- **Metrics to track:** Time to proficiency, training hours per role, user satisfaction, task completion time for common workflows, and help-desk ticket volume by feature.
- **How to evaluate:** Require role-based usability testing (billers, denials staff, managers) and validate the workflow for the top 10 daily tasks in real scenarios.
- **Evidence to request:** Training materials, in-application guidance, user group resources, and examples of how the vendor supports new-hire onboarding.
- **Contract checkpoints:** Include training commitments for go-live and turnover, plus expectations for documentation updates when features change.
- **Red flags:** High dependence on "power users," complex navigation for routine tasks, or frequent workflow workarounds.

K11 CUSTOMER SUPPORT, TRAINING, AND CHANGE ENABLEMENT

Measures the quality of vendor support, responsiveness to issues, and effectiveness of training and change management throughout the relationship.

- **Metrics to track:** Support response and resolution times, service recovery effectiveness, training satisfaction, and the frequency/severity of recurring issues.
- **How to evaluate:** Ask for support SLAs and escalation paths; speak to reference clients about support responsiveness during high-volume denial spikes or payer changes.
- **Evidence to request:** Support model (tiers, coverage hours), sample ticket metrics, training schedule, and examples of proactive communications about known issues.
- **Contract checkpoints:** Define SLAs, penalty/credit mechanisms (if used), and the cadence of operational check-ins and QBRs.
- **Red flags:** Inconsistent support ownership, long resolution times for high-severity issues, or limited domain expertise in the support team.

K12 PROACTIVENESS AND CONTINUOUS IMPROVEMENT

Assesses whether the vendor actively identifies opportunities, anticipates payer behavior, and drives measurable improvements without waiting for client escalation.

- **Metrics to track:** Number of proactive recommendations implemented, reduction in recurring denial categories, improvement velocity over quarters, and documented CI roadmap execution.
- **How to evaluate:** Review QBR artifacts and improvement backlogs; require examples where the vendor identified an issue, quantified impact, and implemented corrective action.
- **Evidence to request:** Continuous improvement playbooks, payer trend monitoring, operational dashboards, and examples of training updates tied to new denial patterns.
- **Contract checkpoints:** Commit to a defined governance cadence (monthly ops + quarterly exec) and track CI actions to closure with measurable outcomes.
- **Red flags:** A "reporting-only" posture with limited action orientation, or improvements that are not translated into operational changes.

K13 ETHICAL BUSINESS PRACTICES AND TRANSPARENCY

Measures the vendor's integrity in sales, pricing, disclosures, and performance reporting, including clarity on what is AI-driven vs. labor-driven.

- **Metrics to track:** Pricing clarity, variance from contracted terms, frequency of billing disputes, and alignment between promised vs. delivered functionality and staffing.
- **How to evaluate:** Validate what is included in scope, how outcomes are calculated, and what happens when assumptions change; require transparent definitions in the SOW.
- **Evidence to request:** Contract exhibits that define deliverables, reporting logic, governance obligations, and the vendor's policy on subcontractors/offshore staffing (if applicable).
- **Contract checkpoints:** Include clear change-order rules and data access rights so clients can independently validate performance reporting.
- **Red flags:** Opaque fee structures, bundled pricing that obscures accountability, or reluctance to disclose operational delivery details.

K14 CYBERSECURITY AND DATA PROTECTION

Assesses protections for PHI, resilience against cyber threats, and the vendor's operational maturity in security, privacy, and incident response.

- **Metrics to track:** Security incident history, time to notify/contain (if applicable), audit results (SOC 2/HITRUST where available), and third-party risk management coverage.
- **How to evaluate:** Conduct a security review (policies, controls, evidence), review penetration testing summaries, and validate BAA terms and subcontractor controls.
- **Evidence to request:** Security program overview, encryption and access control details, incident response plan, business continuity testing results, and security attestations.
- **Contract checkpoints:** Define breach notification timelines, audit rights, subcontractor requirements, and obligations during a cybersecurity event affecting claims flows.
- **Red flags:** Limited transparency on security posture, weak identity/access controls, or insufficient contingency planning for clearinghouse-dependent workflows.

K15 TRUSTWORTHINESS AND INTEGRITY IN AI-DRIVEN DECISIONING

Measures AI governance maturity: bias controls, human oversight, validation discipline, and safeguards against unsafe automation in claims processes.

- **Metrics to track:** Documented model governance, rates of inappropriate automation overrides, exception volume, and evidence of ongoing monitoring for model drift and bias.
- **How to evaluate:** Ask how models are trained, validated, and monitored; confirm human-in-the-loop checkpoints for high-risk decisions and the ability to override AI safely.
- **Evidence to request:** Model governance policies, testing and monitoring reports, controls for PHI use, and alignment to recognized AI risk management practices.
- **Contract checkpoints:** Require transparency on model updates and clear accountability when AI-driven recommendations contribute to compliance or financial risk.
- **Red flags:** Over-automation without human controls, limited documentation, or vague statements about how the vendor prevents harmful or non-compliant outputs.

K16 REGULATORY COMPLIANCE AGILITY AND AUDIT READINESS

Assesses how well the vendor supports compliance, documentation, and readiness for payer audits, governmental reviews, and changing regulations.

- **Metrics to track:** Audit response turnaround time, success rates in documentation-based appeals, recurrence of compliance-related denials, and quality of audit logs.
- **How to evaluate:** Review the vendor's audit support playbook and sample audit packages; confirm retention policies and the ability to reproduce prior claim decisions.
- **Evidence to request:** Policies for documentation retention and traceability, examples of appeal packages, and proof of regulatory monitoring and update processes.
- **Contract checkpoints:** Define audit support obligations, data retention requirements, and roles in responding to payer disputes or external audits.
- **Red flags:** Inconsistent documentation practices, weak traceability, or limited experience supporting large-scale audits and payer investigations.

K17 OVERALL VALUE AND RETURN ON INVESTMENT

Measures whether the vendor delivers measurable value relative to total cost, including operational savings, improved collections, and reduced risk.

- **Metrics to track:** Total cost of engagement vs. incremental cash/revenue protected, cost per claim processed, avoided labor costs, and realized savings from reduced rework.
- **How to evaluate:** Require an ROI model tied to baseline metrics and validate monthly; ensure benefits are net of internal effort and any incremental technology costs.
- **Evidence to request:** Value realization reporting, assumptions and exclusions, and examples of how the vendor separates true improvement from volume or payer-mix effects.
- **Contract checkpoints:** Align fees to outcomes where appropriate and define how value is measured, audited, and reconciled to the client's financial systems.
- **Red flags:** ROI claims that depend on unrealistic baselines, or "savings" that cannot be reconciled to operational or financial records.

K18 CONFIDENCE, PARTNERSHIP SUSTAINABILITY, AND LONG-TERM FIT

Captures the client's overall confidence that the vendor can sustain performance, scale with growth, and remain a trusted partner over multiple years.

- **Metrics to track:** Executive sponsor engagement, staff turnover on the account, roadmap delivery reliability, and client retention/referenceability.
- **How to evaluate:** Assess vendor stability (delivery capacity, leadership continuity), validate the roadmap with committed deliverables, and speak with long-tenured clients.
- **Evidence to request:** Governance structure, staffing model and attrition controls, roadmap artifacts, and examples of how issues were resolved during high-stress events.
- **Contract checkpoints:** Include clear renewal/exit terms, data portability requirements, and transition support obligations if services are moved in-house or to another partner.
- **Red flags:** High turnover, weak executive governance, or limited transparency on how the vendor sustains delivery capacity at scale.

APPENDIX B.
FULL SCORECARD (TOP 20)

The tables below present KPI scores by vendor. Composite is the equal-weight average of the 18 KPIs (K1–K18) and corresponds to the benchmark "Mean" score.

Table B1. KPI Scores (K1 to K9) – Top 20

Vendor	K1	K2	K3	K4	K5	K6	K7	K8	K9
IKS Health	9.91	9.69	9.92	9.81	9.66	9.63	9.55	9.17	9.28
Ensemble Health Partners	8.98	8.81	9.57	9.22	9.33	8.89	9.11	9.34	9.70
Synergen Health	8.84	9.15	8.18	8.37	8.99	8.82	9.64	8.41	8.09
R1 RCM	9.01	8.21	8.45	9.06	8.65	9.16	8.35	7.88	8.27
CorroHealth	8.14	9.44	7.86	7.99	7.96	7.59	9.21	8.19	9.10
Optum (Optum360 / Change Healthcare)	8.33	7.89	7.43	9.63	8.38	8.24	8.38	7.65	7.27
Omega Healthcare	7.95	7.83	7.19	7.85	7.88	8.72	7.79	7.96	7.85
Access Healthcare	7.54	7.69	7.92	7.71	7.34	7.91	7.51	8.05	7.56
Firstsource	7.71	7.89	7.18	7.16	7.80	7.72	7.71	7.74	7.38
Coronis Health (incl. MiraMed Global Services)	7.64	7.12	7.05	7.59	7.34	7.67	7.59	7.39	7.12
AGS Health	7.07	6.65	7.17	7.25	7.43	6.42	6.57	6.72	7.23
GeBBS Healthcare Solutions	5.77	7.08	7.70	6.51	7.65	8.03	7.28	6.10	7.05
Zotec Partners	7.52	6.99	6.06	6.83	6.53	7.06	6.49	6.73	6.94
Conifer Health Solutions	5.75	5.93	6.85	7.05	7.83	6.36	7.26	6.45	6.85
Infinx	7.40	7.02	6.12	6.49	7.10	6.41	6.81	6.93	6.33
Aspirion	6.77	5.76	6.67	6.27	5.92	6.43	6.34	6.06	6.29
Parallon	6.09	5.77	5.92	5.82	5.78	6.29	6.11	5.75	6.30
Sagility	6.02	5.37	5.77	5.51	5.50	5.96	5.86	5.86	6.03
Invensis	5.02	4.95	5.78	5.65	5.59	5.59	5.37	5.06	5.40
EXL	5.21	4.94	4.96	5.20	4.61	4.63	4.87	5.05	5.23

Table B2. KPI Scores (K10 to K18) and Composite – Top 20

Vendor	K10	K11	K12	K13	K14	K15	K16	K17	K18	Composite (avg)
IKS Health	9.23	9.44	9.20	9.35	9.07	9.14	9.00	9.31	9.25	9.42
Ensemble Health Partners	9.43	9.09	9.20	9.09	8.95	9.30	8.93	9.59	8.88	9.19
Synergen Health	8.06	8.96	8.91	9.45	8.13	8.60	8.25	8.60	9.31	8.71
R1 RCM	8.74	8.83	9.36	9.11	8.37	7.18	8.35	8.68	9.06	8.60
CorroHealth	8.02	7.61	7.95	7.98	8.82	8.05	8.24	8.76	9.16	8.34
Optum (Optum360 / Change Healthcare)	8.47	9.15	8.17	6.89	8.17	8.67	8.46	7.16	8.84	8.18
Omega Healthcare	7.45	8.26	8.12	8.13	7.54	8.35	7.37	8.06	8.62	7.94
Access Healthcare	8.43	7.61	7.77	8.17	7.45	7.96	8.34	7.32	7.95	7.79
Firstsource	7.70	7.72	7.37	8.27	7.78	7.20	7.85	7.28	7.89	7.63
Coronis Health (incl. MiraMed Global Services)	6.89	7.26	7.72	7.49	6.98	7.48	7.55	7.11	7.47	7.36
AGS Health	5.78	7.23	8.40	7.25	5.45	7.38	7.28	6.94	8.31	7.03
GeBBS Healthcare Solutions	6.08	5.34	7.48	7.46	5.65	7.37	5.87	7.27	8.32	6.89
Zotec Partners	7.07	6.35	6.65	6.60	6.54	7.38	6.91	6.32	7.09	6.78
Conifer Health Solutions	7.40	7.04	6.64	6.77	7.25	6.76	5.09	7.03	6.79	6.73
Infinx	6.64	5.52	6.30	6.57	6.22	7.23	6.16	6.50	6.70	6.58
Aspirion	6.13	6.31	6.50	6.82	5.83	7.01	5.58	6.21	6.47	6.30
Parallon	6.10	6.27	6.21	5.70	5.79	6.25	6.20	5.98	6.03	6.02
Sagility	5.58	5.81	5.47	5.69	5.53	5.61	5.78	5.29	6.31	5.72
Invensis	5.13	5.71	5.32	5.08	5.26	5.52	5.17	5.08	5.46	5.34
EXL	5.64	5.42	5.06	5.11	4.77	5.11	5.02	5.23	4.83	5.05

BLACK BOOK TIERING TABLE (FROM APPENDIX B COMPOSITES)

Black Book tier	Composite band	Vendors (rank • composite)
Leaders	≥ 8.77	1 IKS Health • 9.42; 2 Ensemble Health Partners • 9.19
Strong	7.92–8.76	3 Synergen Health • 8.71; 4 R1 RCM • 8.60; 5 CorroHealth • 8.34; 6 Optum (Optum360 / Change Healthcare) • 8.18; 7 Omega Healthcare • 7.94
Needs Improvement	6.77–7.91	8 Access Healthcare • 7.79; 9 Firstsource • 7.63; 10 Coronis Health (incl. MiraMed Global Services) • 7.36; 11 AGS Health • 7.03; 12 GeBBS Healthcare Solutions • 6.89; 13 Zotec Partners • 6.78
At Risk	< 6.77	14 Conifer Health Solutions • 6.73; 15 Infinx • 6.58; 16 Aspirion • 6.30; 17 Parallon • 6.02; 18 Sagility • 5.72; 19 Invensis • 5.34; 20 EXL • 5.05

KPI TOP AWARD SUMMARY (K1–K18 WINNERS)

KPI	KPI title	Top rated vendor	Top score
K1	Denial prevention and claim optimization performance	IKS Health	9.91
K2	AI-driven revenue protection and cash-flow stability	IKS Health	9.69
K3	Reduction of administrative burden and manual rework	IKS Health	9.92
K4	Accuracy and effectiveness of AI-driven claim adjustments	IKS Health	9.81
K5	Reliability of AI in predicting denials and prioritizing work	IKS Health	9.66
K6	System compliance with evolving payer rules	IKS Health	9.63
K7	Transparency and explainability of AI outputs	Synergen Health	9.64
K8	Flexibility and adaptability to client workflows	Ensemble Health Partners	9.34
K9	Ease of integration with existing RCM and clinical systems	Ensemble Health Partners	9.70
K10	Usability and learning curve for client users	Ensemble Health Partners	9.43
K11	Customer support, training, and change enablement	IKS Health	9.44
K12	Proactiveness and continuous improvement	R1 RCM	9.36
K13	Ethical business practices and transparency	Synergen Health	9.45
K14	Cybersecurity and data protection	IKS Health	9.07
K15	Trustworthiness and integrity in AI-driven decisioning	Ensemble Health Partners	9.30
K16	Regulatory compliance agility and audit readiness	IKS Health	9.00
K17	Overall value and return on investment	Ensemble Health Partners	9.59
K18	Confidence, partnership sustainability, and long-term fit	Synergen Health	9.31

KPI wins count:

- IKS Health = 9 (K1–K6, K11, K14, K16);
- Ensemble Health Partners = 5 (K8–K10, K15, K17);
- Synergen Health = 3 (K7, K13, K18); R1 RCM = 1 (K12).

ABOUT BLACK BOOK MARKET RESEARCH

Black Book Research LLC is an independent healthcare technology and services research firm that publishes qualitative market intelligence based on verified end-user experience. Black Book benchmarking is designed to support vendor selection, contracting, and ongoing performance management by providing KPI-level satisfaction scoring that reflects real-world client outcomes.

INDEPENDENCE AND VENDOR NEUTRALITY

Black Book surveys and publications are designed to be free from vendor influence. Black Book's published methodology describes audited data collection processes that validate respondent authenticity while maintaining participating organizations' anonymity.

- No financial ties to vendors covered: Black Book states that it does not hold fiscal interest in surveyed vendors and does not solicit vendor participation, review, or inclusion fees for rankings.
- Client voice–driven evaluation: Black Book reports are grounded in verified client ballots across 18 performance areas of operational excellence.

RESEARCH METHODOLOGY AND DATA INTEGRITY

Black Book collects client ballots by vendor and function, then audits and segments the results by factors such as client size, geography, and category. The published methodology emphasizes multi-review audit practices and minimum sample-size thresholds for ranked categories.

- 18 KPI scoring framework: Clients score vendors across 18 qualitative KPIs of operational excellence using a 1–10 satisfaction scale.
- Audit and validation: The methodology describes internal and external review steps to verify completeness, accuracy, and validity of responses while preserving client anonymity.
- Statistical confidence safeguards: Black Book publishes minimum unique-client thresholds for ranked categories (e.g., minimum unique-client ballots for top rankings; broader categories requiring larger samples).
- Longitudinal dataset: Black Book reports that more than 2.9 million healthcare IT users have participated in annual satisfaction polls over time.

HOW TO USE THIS BENCHMARKING IN PROCUREMENT AND VENDOR GOVERNANCE

Black Book qualitative KPIs are most effective when used as a structured companion to your organization's quantitative revenue cycle metrics (e.g., first-pass yield, denial rate, overturn rate, days in A/R, and net collection rate). Recommended use cases include:

- RFP scoring: map KPIs to your evaluation committee (finance, compliance, IT security, HIM/coding, patient access) and require evidence for each KPI during demonstrations.
- Contracting: translate the KPIs into service-level reporting requirements (monthly scorecards, root-cause analytics, change-control SLAs, and downtime/BCP testing).
- Operating governance: use KPI-aligned quarterly business reviews (QBRs) to track trend improvements and enforce corrective action plans when performance regresses.

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