IDC MarketScape: U.S. Provider Data Management for Payers 2022 Vendor Assessment
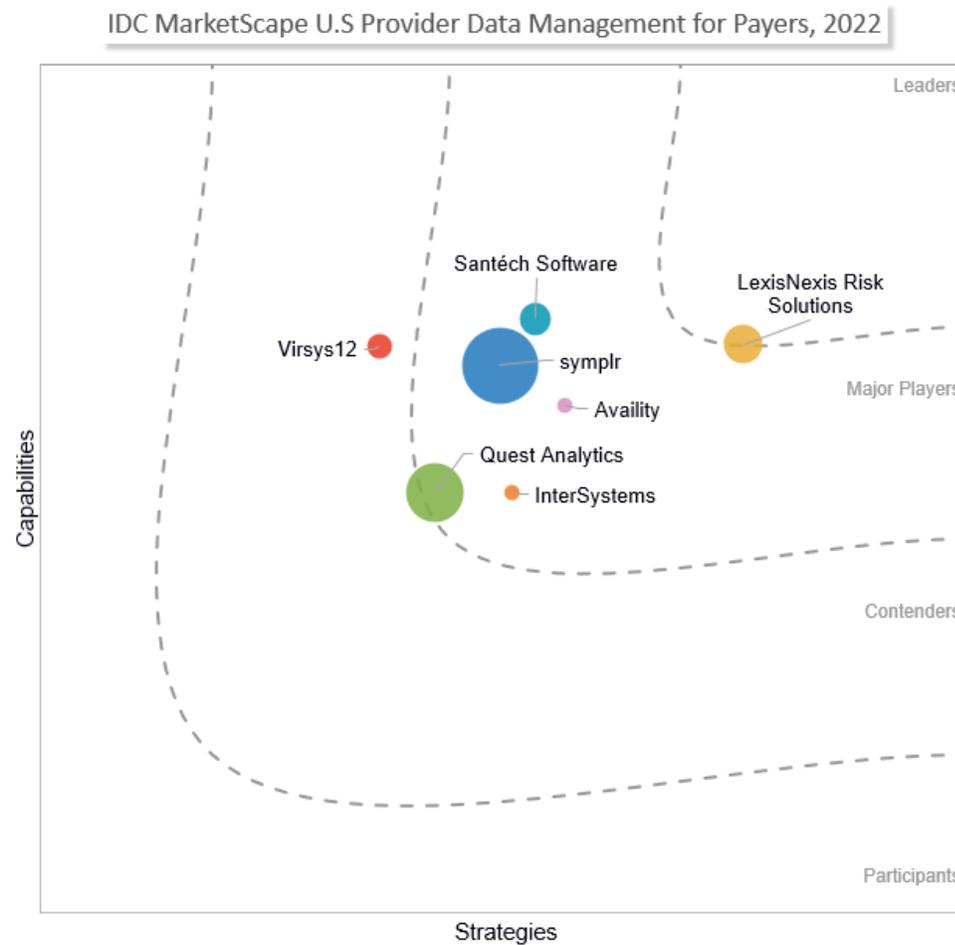
Jeff Rivkin

THIS IDC MARKETSCAPE EXCERPT FEATURES LEXISNEXIS RISK SOLUTIONS

IDC MARKETSCAPE FIGURE

FIGURE 1

IDC MarketScape U.S. Provider Data Management for Payers Vendor Assessment

IDC MarketScape U.S Provider Data Management for Payers, 2022

Source: IDC, 2022

Please see the Appendix for detailed methodology, market definition, and scoring criteria.

IN THIS EXCERPT

The content for this excerpt was taken directly from IDC MarketScape: U.S. Provider Data Management for Payers 2022 Vendor Assessment (Doc # US48815718). All or parts of the following sections are included in this excerpt: IDC Opinion, IDC MarketScape Vendor Inclusion Criteria, Essential Guidance, Vendor Summary Profile, Appendix and Learn More. Also included is Figure 1.

IDC OPINION

This IDC study represents the vendor assessment model called IDC MarketScape. This research is a quantitative and qualitative assessment of the characteristics that explain a vendor's current and future success. This study assesses the capability and business strategy of many of the most prominent provider data management (PDM) vendors found in payers that use that software to establish a "core provider system of record or truth" for the payer enterprise. This evaluation is based on a comprehensive framework and a set of parameters expected to be most conducive to success in providing provider data management software today and in the future. A significant and unique component of this evaluation is the inclusion of buyers' perception of both the key characteristics and capabilities of these vendors. Interest in reengineering and automating payers' "provider back office" is stimulated by the evolutionary change of value-based reimbursement provider contracts, the availability of enterprise workflow software, lightweight cloud models of operations proven by cooperatives and start-up health plans, and enhanced document management capabilities. A summary of findings of this study include:

- **Provider data is now its own core application.** Provider data has moved from being a set of tangential reference data used to validate claims to become a core administrative asset that is being used for competitive advantage.

- **Provider data management has a crowded, dynamic field of vendors, and few do everything well.** Vendors are being challenged by start-up and established companies that are creatively offering services, lightweight search, and modular approaches to function. Many "major players" were identified, each with its own value proposition. Traditional players are being challenged by an expanding problem set, and newer vendors are just beginning to appreciate the complexity of this space.

- **Provider data is a consumer differentiator.** Consumers now want to search for providers not only by their location or network affiliation but also by increasingly more granular criteria including newly defined specialty types (e.g., adolescent-oriented psychiatrists, autism-inspired art therapists, naturopaths, and wellness specialties).

- **Provider data is a social differentiator.** Recently, providers of "social determinants of health" like food banks, job placement, and government agencies are relevant to payers as "providers" as well.

- **Network adequacy is equivalently important to directory accuracy, but vendors are slow to adopt this function.** Legislatively, an adequate, diverse, and broad network is desired by consumers and required by ACA and state regulations.

- **Data stewardship remains a problem.** Consumers expect payers to make available quality provider data. Unfortunately, providers do not always supply this information to the payer. The

lack of a true "data steward" in this space is an ongoing problem, which drives the "data cleansing" function to have high weight when evaluating vendors.

- **Provider data management pricing will be more competitive, flexible, and on demand.** Models of pricing that meld the "own the software" legacy mindset with the "buy as you need" incremental functionality will evolve.

- **Provider data management has significant scope and breadth and is enlarging.** Up and coming requirements include tracking value-based provider and community affiliations and truly embedding the contract-to-claims loop into the provider management ecosystem.

- **Provider data management is back-office plumbing and is hard to justify enhancement, fundingwise.** In the race for funding dollars in a cost-squeezed payer industry, back-office operational improvements rarely get high priority, competing against flashier or mandated initiatives for funding. Even though provider data is changing all of the time, with vendor stats indicating 33,000 weekly address changes, the back office is hard-pressed to get dollars.

For more information, please refer to the Detailed Research Findings section.

IDC MARKETSCAPE VENDOR INCLUSION CRITERIA

This research includes analysis of seven software providers that offer both on-premises and cloud-based provider data management solutions to payers for their purpose of contracting with providers. IDC believes that the vendors in this study generate most of the revenue in this market.

The increasing depth and breadth of the data that consumers require from their provider directories, the explosion of new provider types under wellness or specialty care themes, the maturation of value-based reimbursement, and the strategic payer advantage of establishing narrow networks cause a rethink of the provider data management software market. Vendors were polled and were included based on meeting the majority of following criteria:

- Enable provider outreach and enrollment. (The vendors should have the ability to find, vet, and enroll providers to a health plan for future contracting.)
- Establish the provider "source of truth" for demographics for a payer enterprise.
- Cleanse provider data. (Match with external data sources, identify duplicate or deceased providers, validate various demographics and specialties, and identify sanctions against providers.)
- Maintain provider directories. (Upload new [valid] data, extract print and web and electronic directories in various formats, and support audits when external organizations challenge the completeness, accuracy, and adequacy of the network and directory.)
- Configure and interface to provide provider data inside and outside the payer organization.
- Maintain provider data via mass update, self-service portals, sanctions monitoring, and integration with hospital systems.
- Define and prove network adequacy to customers, regulators, and other parties.

There are a variety of vendors around the broader "provider relationship management" space. The focus of this research is around the core administrative system that provides a "source of provider truth" for the enterprise. Therefore, this scope specifically excludes contract management, product assignment, credentialing, fee schedule management, network modeling, contact management, provider relations, provider quality management, contract monitoring, and visits management.

ADVICE FOR TECHNOLOGY BUYERS

When purchasing provider data management software, consider these recommendations:

- Take an inventory of the number of possible data sources or origination points of provider reference data within your organization. Consider all the departmental/external responsibilities.
- Take an inventory of the number of provider data "targets" or systems that need provider data. The typical payer may have more than a dozen provider targets. While normal, if not addressed comprehensively, there is a potential risk with duplicative ETL or overlapping SOA services executing.
- Establish (buy or build) an independent flexible system of record for provider data. Use master data management principles.
- Consider plug-and-play application architecture for the system of record/data mart.
- Isolate workflow, document management, and other business capability applications from structured and unstructured data whenever possible.
- Consider point solution, best-of-breed API, or microservices-oriented applications as the requirements are changing rapidly.
- Educate providers as to the downstream value of having their data correct and incent them both negatively and positively to comply and communicate. Continue/implement the "carrot and stick" approach to partnering with your providers to enable quality provider data.
- Recognize that payer data is probably very "dirty" and plan to spend significant time "cleaning" during the conversion.

VENDOR SUMMARY PROFILES

This section explains IDC's key observations resulting in a vendor's position in the IDC MarketScape. While every vendor is evaluated against each of the criteria outlined in the Appendix, the description here provides a summary of each vendor's strengths and challenges.

IDC's assessment includes seven vendors: Availity, InterSystems, LexisNexis Risk Solutions, Quest Analytics, Santéch Software, symplr, and Virsys12. Other vendors did not meet the inclusion criteria and they will be highlighted in an upcoming document featuring the vendors to watch for provider data management in 2022. Those vendors are NTT DATA, Ribbon Health, Salesforce, SKYGEN, and Simplify Healthcare.

LexisNexis Risk Solutions

According to IDC analysis and buyer perception, LexisNexis Risk Solutions (healthcare business) is positioned in the Leaders category in this IDC MarketScape for provider data management for payers software in the U.S. market for 2022.

Product: Provider Data Intelligence Suite

LexisNexis Risk Solutions (LN Risk), part of RELX, a global provider of information and analytics for professional and business customers across industries, uses its vast data resources, big data technology, analytics, linking, and industry-specific expertise to provide an end-to-end solution for a suite of provider truth. Its acquisitions of Enclarity and Health Market Science (HMS) a few years ago reinforced a commitment to provider data. LN Risk maintains information using 3,000 disparate

sources including 450 routine feeds from state license boards and 64 contributions from health plans. It claims, "more data in and more data out than anybody." As a subsidiary of RELX, LN Risk can leverage over 84 billion public records and 6PB of data to power a comprehensive, consolidated, and sophisticated provider data engine:

- On more than 11 million U.S. healthcare practitioners and 1.3 million organizations
- Using intelligence from 2.2 billion claims annually
- Verifies prescriber data for 7.5 million prescriptions daily
- Using 3 million auditing and outreach calls annually

Simply, LN Risk understands information at the individual level and drives value at the aggregate level, which is the cornerstone of the "provider data is an asset" data factory strategy being adopted by payers of scale.

The LN Risk Provider Data Intelligence Suite (PDIS) blends thousands of data sources, advanced analytics, technology, data science, and deep healthcare expertise to deliver correct, current, and comprehensive healthcare practitioner and organization data. Its solutions deliver precise healthcare provider data through:

- Continuously updated source data
- Data mining and intelligent analytics
- Verification directly from providers
- Claim analytics
- Data accuracy assessments and KPIs
- Linking algorithms tuned specifically to healthcare providers
- Standardized data elements
- A consortium of provider information pulled from across the industry

Its suite contains seven products. These products are complementary and are often bought together. The products are:

- **Provider Data MasterFile** is a subscription service to access slices of 11.5 million practitioners and 1.3 million organizations.
- **ProviderPoint** is a proactive cleansing of a client file of providers. It includes keying, verification (identification of good/bad client information), correction, and augmentation.
- **Provider Data Enhancements** matches, links, de-dupes, and augments provider records with the most current information available from the LexisNexis Master Provider Referential Database. This is a two-way data exchange service that allows healthcare organizations the ability to get direct feedback on their data while supplementing their provider records with LN Risk's augmentation and additional records.
- **Provider Data Validation** is a web-based, real-time provider information search service.
- **Verify HCP** is a provider data cleansing leveraging ProviderPoint (aforementioned), a hosted, crowd-sourced, real-time data management and analysis solution that optimizes data insights and attestation for payers, including a portal for confirmation, correction, and roster management.
- **Provider Integrity Scan** identifies potentially fraudulent providers and businesses enrolled or attempting to enroll in health-related programs.

- **MarketView** delivers insights into areas including out-of-network referral patterns, physician alignment strategies, the quality of clinically integrated networks, patient volumes, and reimbursement insights. This provides payers with data points for markets where they don't provide coverage (yet).

It also offers:

- **PDIS Advisory Services** provides best practice guidance and provider data insights to help payers optimize the consumption of their PDIS solution(s). This includes supporting payers in pilots, implementations, and production.
- **Audits** is for reviewing a provider or an organization record to meet the need for an internal audit/investigation, questioning a discrepancy in data that requires additional research. This is white glove service that is performed by a team of LN Risk auditors who manually verify and investigate the data.

Strengths

LexisNexis Risk Solutions' commitment to cleansed, quality provider data is outstanding and evident. Its presence in dozens of payers, including the 90% of all commercial payers including 30 BCBSA plans, shows its scalability and range.

Accordingly, the LN Risk's understanding of the master data management life cycle, operational job tracking and submission, and hands-off operations is inherent for a company that works data for a living.

In addition, it is unique in offering personal data about a provider to get a more accurate demographic profile. As "What is a provider?" continues to broaden to include social workers, pharmacists, and DME providers of all types and as payers, providers, pharmacies, and life sciences companies merge and align, the breadth and depth of LN Risk data will continue to increase its value to payers.

Challenges

As a "big data" healthcare horizontal company in a payer vertical world looking for industry-specific solutions (although the company has an extensive API architecture allowing for seamless integration into existing workflow applications), LN Risk doesn't bundle or package its solutions in a "payer process intuitive" manner, making it hard to do head-to-head comparisons of feature and function.

Notably, LN Risk does not have a network adequacy solution, but it does partner with mapping and scheduling vendors to support payer needs. Nor does it have an ability to do network analysis natively. It has broader network management capabilities on its road map and does have geolocation data in its database, but no native mapping applications upon that data. Payers have been quoted as using the LN Risk data for this function but writing or purchasing other applications to exploit that geolocation data.

Finally, functions such as "integration with other vendors" and features like "easy user interfaces," "workflow," and other "complete solution" operational components are not emphasized in its marketing materials nor packaging of SKU. This perhaps keeps LN Risk off provider data management short lists where it might belong. LN Risk markets and packages products from a "data management" perspective like "identifying, augmenting, validating, affiliating, deduplicating, and cleansing provider data" when payers might be looking for current operational processes/solutions syntax and semantic.

Similarly, LN Risk also does not have companion products in the narrow payer ecosystem such as claims processing, care management, contract management, or enrollment engines that leave the company perceived as a "data specialty vendor" with its subject matter expertise suspect to some payers that might prefer to see explicit vast SME knowledge about healthcare and provider use cases. This may change as LN Risk recently hired strategy executive leadership from Cognizant-TriZetto and Anthem, which will most likely present more intuitive marketing, pain point recognition, and vertical packaging soon. LN Risk's new offering for "PDIS advisory services" seems to concentrate on this by focusing on payer pain points with consulting services.

Consider LexisNexis Risk Solutions When

Buyers may consider LexisNexis Risk Solutions when extremely serious about provider data quality and completeness at scale, have their own workflow infrastructure, and are willing to give up control of some/all processes of validation to an outside vendor because the LN Risk solution is so source comprehensive.

As atypical (non-NPI) providers enter the payer spectrum through the expansion of provider types (home health, holistic, deeper specialties, social determinants, etc.), horizontal big data services like LexisNexis Risk Solutions become more relevant and attractive to payers.

This is indeed an impressive set of pure provider data management functionality; its approach to volume, quality, completeness, coverage, and mandate compliance is notable.

APPENDIX

Reading an IDC MarketScape Graph

For the purposes of this analysis, IDC divided potential key measures for success into two primary categories: capabilities and strategies.

Positioning on the y-axis reflects the vendor's current capabilities and menu of services and how well aligned the vendor is to customer needs. The capabilities category focuses on the capabilities of the company and product today, here and now. Under this category, IDC analysts will look at how well a vendor is building/delivering capabilities that enable it to execute its chosen strategy in the market.

Positioning on the x-axis, or strategies axis, indicates how well the vendor's future strategy aligns with what customers will require in three to five years. The strategies category focuses on high-level decisions and underlying assumptions about offerings, customer segments, and business and go-to-market plans for the next three to five years.

The size of the individual vendor markers in the IDC MarketScape represents the market share of each individual vendor within the specific market segment being assessed. Critical to a successful vendor selection is the articulation of the priorities and strategy of the purchasing organization.

Recognize that a vendor's market share as represented in this document is a snapshot in time and may not reflect its near-term growth or consider its experience and success with related legacy products. A vendor's market share should be considered when evaluating the relative risk of a relationship with a vendor. For example, if a vendor's product has been active in the market for 10 years and has fewer than 20 clients further, due diligence is required.

The IDC MarketScape is a valuable representation by a neutral third party of a vendor's current capabilities and future strategy. The IDC MarketScape should not be used in a vacuum but rather be one of several inputs to short listing vendors.

IDC MarketScape Methodology

IDC MarketScape criteria selection, weightings, and vendor scores represent well-researched IDC judgment about the market and specific vendors. IDC analysts tailor the range of standard characteristics by which vendors are measured through structured discussions, surveys, and interviews with market leaders, participants, and end users. Market weightings are based on user interviews, buyer surveys, and the input of IDC experts in each market. IDC analysts base individual vendor scores, and ultimately vendor positions on the IDC MarketScape, on detailed surveys and interviews with the vendors, publicly available information, and end-user experiences in an effort to provide an accurate and consistent assessment of each vendor's characteristics, behavior, and capability.

Market Definition

Provider data management in the payers' back office involves creating a "system of truth" for provider data in a payer organization. Concerns include demographic data capture, facilitating provider relations, enabling network formulation, establishing a provider relationship, credentialing, contracting, and directory publication as well as enabling the rest of the organization to refer to the system of truth for reference.

Detailed Research Findings

Interest in reengineering and automating payers' "provider back office" is stimulated by the increased scrutiny for clean provider data as mandated by governments, evolutionary change of value-based reimbursement provider contracts, the availability of enterprise workflow software, lightweight cloud models of operations proven by cooperatives and start-up health plans, and enhanced document management capabilities.

There is a lot of manual paper-based workflow existing today in the payers' back office concerning provider relations, network formulation, establishing a provider relationship, credentialing, contracting, and directory publication. Similarly, there are a lot of spreadsheets and emails around the communication of the state of the networks inside the organization and external to the providers' back office. While not flashy to invest in, this manual workflow paradigm has moved past annoying to affecting competitiveness for payers. Without an ability to flexibly design networks to support creative products, payers lose consumer attraction. These manual and piecemeal "systems" are being looked at for enhancement or replacement to automate and digitally store provider materials in an incremental fashion.

Exposure resulting from the 2021 CMS mandates around interoperability has added to the plethora of risks that payers have had due to poor provider data. Historically, payers have fought against claims errors, provider overpayment, missed risk adjustment revenue, other compliance risk and penalties, and member dissatisfaction due to poor provider data quality. The transition from volume-based care to value-based health is maturing, and healthcare organizations are now concurrently struggling to scale programs to manage providers in risk/value-based contracting. Value-based health requires new strategies, skills, processes, data, and technology. Provider data management systems are historically unfamiliar with the strategies to manage the variable relationships inherent in bundles, shared savings, and pay-for-performance paradigms.

Provider data management is challenging, particularly in a health insurance industry facing shrinking margins, new market pressures, unification with health systems, and continuing regulatory concerns. Payers have a few years of automated provider data management under their belt, and several practices have emerged to assist organizations scale the provider relations' back office. Functions addressed include recruiting, onboarding, creating a cleansed "system of truth," facilitating provider relations, enabling network formulation, credentialing, contracting, and directory publication as well as enabling the rest of the organization to refer to the system of truth for reference. The sections that follow provide the findings of this study.

Provider Data Is Now Solidly Its Own Core Application

Internally, for payers, gone are the days where limited provider information could be maintained inside core administration/claim adjudication engines and extracted and passed around the payer enterprise for various operations. As payers consolidate and/or rethink their provider data comprehensively, they are using a holistic approach to their provider data architecture and its accompanying applications, normally called "provider data management." Provider data has moved from being a set of tangential reference data used to validate claims to become a core administrative asset with real competitive advantage differentiation.

Provider Data Management Has a Crowded, Dynamic Field of Vendors, and a Few Do Everything Well

Vendors are being challenged by start-up and established companies that are creatively offering services, lightweight search, and modular approaches to function. These competitive approaches shown by some vendors in this study include:

- Services models using national data as a service
- Start-up and established companies, inspired by HealthCare.gov, establishing national databases of healthcare providers
- Players of more than 20 years revamping their portfolios architecturally and in response to market pressures
- Big data companies showing the value of serious data cleansing
- Network adequacy companies broadening their footprint to encompass provider data management
- Service companies evolving products
- Salesforce partners offering deeper data models and functionality than Salesforce
- Provider 360 companies emphasizing the entire "person"

As payers consolidate and providers coalesce, and as affiliations become more complicated to ascertain and verify, services become more attractive, especially to newer entities (ACOs, external nonhealth industry disrupters) that desire a lightweight operational footprint. Like the evolution of centralized consumer credit bureaus, national provider databases with embedded validation are challenging CAQH, NPPES, PECOS, and other established reference sources. HIE, cross-state mergers, HealthCare.gov, and other national drivers now exist where previously plan-specific local directories prevailed. Other established companies are integrating their provider, contract, and reimbursement packages into suites in response to the value-based trend.

Unfortunately, focusing on flexible workflow, exhaustive data cleansing, expansion of provider types, provider engagement, network adequacy, value-based contracting, and a comprehensive yet modular

product approach is too much for most vendors to do comprehensively at this time. Many "major players" were identified, each with its own value proposition. Traditional players are being challenged by an expanding problem set, and newer vendors are just beginning to appreciate the complexity of this space.

Provider Data Is a Consumer Differentiator

More than the internal systems backbone for provider network definition and demographic capture, detailed provider data is essential for provider directories, which consumers perceive as a market differentiator. Consumers now want to search for providers not only by their location or network affiliation but also by increasingly more granular criteria including newly defined specialty types (e.g., adolescent-oriented psychiatrists, autism-inspired art therapists, naturopaths, and wellness specialties). The ability for a member to understand and easily consume the provider service options within the network via searchable directories is paramount. The payer's response to broadening the concept of "What is a provider and how can I find them?" greatly determines how a payer is perceived in the consumer's mind.

Provider Data Is a Social Differentiator

Recently, providers of "social determinants of health" like food banks, job placement, and government agencies are relevant to payers as "providers" as well. While not having an NPI, these "providers" affect health and supply services and are just as relevant to a "care plan" than any medical provider. The provider data management solution that allows for nontraditional providers indeed has a leg up.

Network Adequacy Is Equivalently Important to Directory Accuracy, But Vendors Are Beginning to Adopt This Function

Legislatively, an adequate, diverse, and broad network is desired by consumers and required by ACA and state regulations. "Network adequacy" refers to a health plan's ability to deliver benefits promised by providing reasonable access to enough in-network primary care and specialty physicians, as well as all healthcare services included under the terms of the contract. The Center for Medicare and Medicaid Services (CMS) and some states have addressed this issue by enacting laws and regulations to try to ensure that despite this vague definition, provider networks are of adequate, reasonable, and enough size.

Some vendors studied have not caught the connection that they have the data to do the network adequacy reporting desired by payers (with a little geographic and attribution enhancement), but do not feature it in either their current offerings or road maps. Puzzling.

Data Stewardship Remains a Problem

Consumers expect payers to make available quality provider data. Unfortunately, providers do not always supply this information to the payer. Challenges concerning provider-supplied data quality are noteworthy in the industry, uniquely spawning a cottage industry of "data cleansing" services, vendors, and websites. Payers are resorting to cash flow "carrots and sticks" to get providers to keep their data current as their data changes. Data updates include providers that move, change professional or financial affiliations, change office hours, segregate specialties by office location, and adopt standard HIPAA transactions such as electronic funds transfer (EFT) and electronic data interchange (EDI) capabilities. These "carrots and sticks" change cash flow via either an increase in pended claims or a reduction/increase in reimbursement, and it usually gets provider attention. Payers are slowly

implementing these methods depending on local norms (payer market share and number of dominant providers) and the evolution of the payer/provider collaboration culture.

The lack of direct data stewardship (the payers are semi-responsible for data that is owned and should be maintained by providers, but providers deal with multiple payers, so the process is inconvenient for them) makes a data cleansing capability an industry-unique differentiator in picking a provider system of record system for payers.

Provider Data Management Pricing Will Be More Competitive, Flexible, and On Demand

Models of pricing that meld the "own the software" legacy mindset with the "buy as you need" incremental functionality will evolve. In this model, company-specific rules and incremental functions are bought as needed instead of suite-oriented pricing. As the line between functions blurs because of integrated clinical and administrative networks, value-based reimbursement, and contract modeling, this modular pricing may be more understandable to consumers and procurement.

Provider Data Management Has Significant Scope and Breadth and Is Enlarging

Standard components of provider data management include a central system of record storing provider demographic and network data and workflow to manage onboarding, recredentialing, contracting, pricing, and directory publication processes in and around the provider portal. These functions can include document management, scanning and searching, forms generation, third-party verification connections, rules engines, and reporting/analytics.

Up-and-coming requirements include tracking value-based provider and community affiliations, active (smart contract) contract monitoring for value-based contracts, smart clauses to provide template-based reuse of active sections of contracts, and truly embedding the contract-to-claims loop into the provider management ecosystem. On the horizon, factor in blockchain as a potential immutable technology as well.

For any vendor, especially one new to the space, to comprehensively address all this scope is daunting. On the other hand, new approaches using rules-based/AI, blockchain, and extendable data models are more easily facilitated by vendors without legacy baggage.

Provider data management is back-office plumbing and is hard to justify enhancement, fundingwise but interoperability and telehealth monies to are being used to sponsor a "provider-360" enterprise data direction by some companies.

In the race for funding dollars in a cost-squeezed payer industry, back-office operational improvements rarely get high priority, competing against flashier initiatives for funding. This cross-department set of requirements requires enterprise coordination to show the executive council the comprehensive need. However, the need for payers to exchange quality data around the CMS mandates has spiked interest in both the member-360 and provider-360 data spaces.

Other Findings

Other findings of this research include:

- Payers rarely "rip and replace" their core claims system, and now they also rarely replace their core provider system in toto. However, changing requirements around expanded/niche directories, network adequacy, narrow networks, expansion of provider types, payer/provider

systems integration, regulatory requirements, telemedicine, plan design, and value-based provider reimbursement cause major rethink and payers struggle to incrementally improve.

- Clients generally have a positive outlook on the capabilities of their vendors, particularly in supporting technical requirements, domain expertise, and support for the baseline demographic capture and workflow requirements of most payer organizations.

- Demographic capture and workflow requirements are now only a portion of the fundamentals in establishing a core for the provider information management ecosystem. Scalability, data model flexibility, and a vendor's entire suite of products are more relevant in this space than simple demographic seamlessness.

- A divide now exists between payers using their own internal master data management (MDM) approach to provider data and those that are willing to have other companies be their source.

Strategies and Capabilities Criteria

Tables 1 and 2 provide key strategy and capability measures, respectively.

TABLE 1

Key Strategy Measures for Success: U.S. Provider Data Management for Payers

Strategies Criteria	Definition	Weight (%)
Portfolio development and growth	Firms poised for growth provide relevant specialized offerings that address specific needs, particularly for industries, geographic markets, or the size of the client. Growth strategy is measured by both the diversity of the planned dimensions of growth and the measure of enthusiasm of client recommendation across company size and functional areas.	10.0
Offering delivery strategy	Plans are in place that support the offering of delivery models that will match customers' shifting preferences for adoption/consumption in the next five years and allow them to successfully capture revenue flow as it shifts among different delivery models (e.g., packaged software versus SaaS).	7.0
Customer strategy	This looks at the increase in number of customers year over year for the past one to three years (how to change to future targets).	12.0
Financial stability	The company's strategy for generating, attracting, and managing capital maximizes its potential for creating market value. The vendor has proportionally allocated the financial resources to deliver a robust offering in the marketplace to the current and emerging market opportunity. Commitment of funding and percentage of total revenue are used to score these criteria, including investment in R&D, marketing, and channel programs.	23.0
Innovation	This looks at creativity in product design.	5.0
R&D strategy	The company's innovation model maximizes its potential to generate market value. The vendor has demonstrated its understanding that to increase the capabilities of its offering, it will need to tap not only its internal development resources but also partner with other companies to bring differentiable and innovative capabilities to the market. Vendor has a clear strategy for both R&D investments and partnering worldwide and in the United States in the next three to five years.	15.0
Growth and profit	This looks at YoY percentage of profit and growth.	8.0
Offering road map	Current development of offerings will be relevant and attractive to customers over the next three to five years. A wide variety of approaches will be employed to ensure increased functional and industry capability, including market-sensing capabilities, offering reinforcements, strategic hiring, and training. To ensure maximum impact, organizations will need to increase their ability to construct offerings that leverage those capabilities and provide precise value to clients. In addition, effective firms must have a solid strategy for uncovering future client requirements.	20.0
Total		100.0

Source: IDC, 2022

TABLE 2

Key Capability Measures for Success: U.S. Provider Data Management for Payers

Capabilities Criteria	Definition	Weight (%)
Customer service delivery	▪ The company offers training. ▪ Firms must continually refresh and deepen their consultants' skills to keep up with changing issues, approaches, and insights. ▪ Support can happen through organizations other than the company, and relationships exist. ▪ The company has a customer advisory council.	4.0
Offering functionality and capabilities	▪ Multichannel outreach and/or CRM capability is able to reach outbound providers for recruitment. ▪ The company can either find a provider online via subscription and/or receive a population batch. ▪ The company can enter/capture data from providers, administrators, or customer service representatives. ▪ Templates are provided to enable outreach and enrollment. ▪ The company demonstrates required features and functionality required by market demand, including accommodations for external interfaces, network adequacy, data maintenance, security, dashboard reporting, and analytics.	76.0
Portfolio benefits	The company has developed features and functionality to enhance and support the core offering — whether provided in the product itself or via partners — such as internal interfaces — contract management, authorization referrals, care management, a directory, an analytics warehouse, marketing/communications, claims/billing, portals, credentialing, document management, and provider education.	13.0
Range of services	The company offers support to configure and set up software.	1.0
	The company is able to support BPO/BPAAS models to take over provider management function for a payer.	1.0
	The company offers a development framework for API.	1.0
	It has a development framework for SDK for customers/partners.	1.0
	It has a development framework for customer/partner support for customization.	1.0
	The company is able to support conversion of existing paper contracts by importing images and indexing data to make the content searchable.	1.0

TABLE 2

Key Capability Measures for Success: U.S. Provider Data Management for Payers

Capabilities Criteria	Definition	Weight (%)
	The company demonstrates level and range of support and tools provided by the vendor to support demands of clients. The range of services should include the geography, industry, and target market component when appropriate. The vendor may be rated on the level of implementation support and tools it provides.	1.0
Total		100.0

Source: IDC, 2022

LEARN MORE

Related Research

- *IDC PeerScape: Lessons Learned for Payers in Provider Data Management* (IDC #US48405121, December 2021)
- *IDC Market Glance: Payer, 3Q20* (IDC #US46848117, September 2020)
- *IDC PlanScape: Payer Data Platforms for Member-360 and Provider-360 Views* (IDC #US46015320, February 2020)
- *IDC MarketScape: U.S. Contract Management Tools for Payers 2018 Vendor Assessment* (IDC #US43511218, February 2018)
- *IDC PlanScape: Payer/Provider Contract Management 2.0 for Payers* (IDC #US43259117, December 2017)
- *Perspective: For Payers, It's Time to Get a New Claims and Billing Engine – Decoupling and Change Have Atomized Your Legacy System* (IDC #US41552216, July 2016)
- *IDC PlanScape: Directory Accuracy and Network Adequacy – For Payers, the Time Has Come* (IDC #US41242516, May 2016)
- *Vendor Assessment: Provider Data and Network Management Solutions Refactor, Expand, Deepen, and Broaden Markets and Function* (IDC #US40702515, December 2015)
- *Perspective: Why a Comprehensive Provider System of Record Is Fundamental for Payers* (IDC Health Insights #HI259664, October 2015)

Synopsis

This IDC study provides an evaluation of seven vendors that provide payer solutions for provider data management. The vendors we chose include front-runners in the industry that were chosen for their market share and penetration of their potential growth opportunities.

According to Jeff Rivkin, research director, Payer IT Strategies at IDC Health Insights, "Provider data management systems of record are being evolved by payers that want to automate workflow, solidify

data, and enable flexibility in their back office to reduce operational costs. As payers attempt to respond to governmental mandates and competitive pressures, the ability to maintain, control, and evolve provider networks fast and effectively is a competitive advantage. Those payers that can't may not survive the onslaught of value-based reimbursement, expanding provider types, and the increased consumer and regulatory demand for directory accuracy and network adequacy."

About IDC

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Global Headquarters

140 Kendrick Street
Building B
Needham, MA 02494
USA
508.872.8200
Twitter: @IDC
blogs.idc.com
www.idc.com