IDC MarketScape

IDC MarketScape: U.S. Provider Data Management 2018 Vendor Assessment

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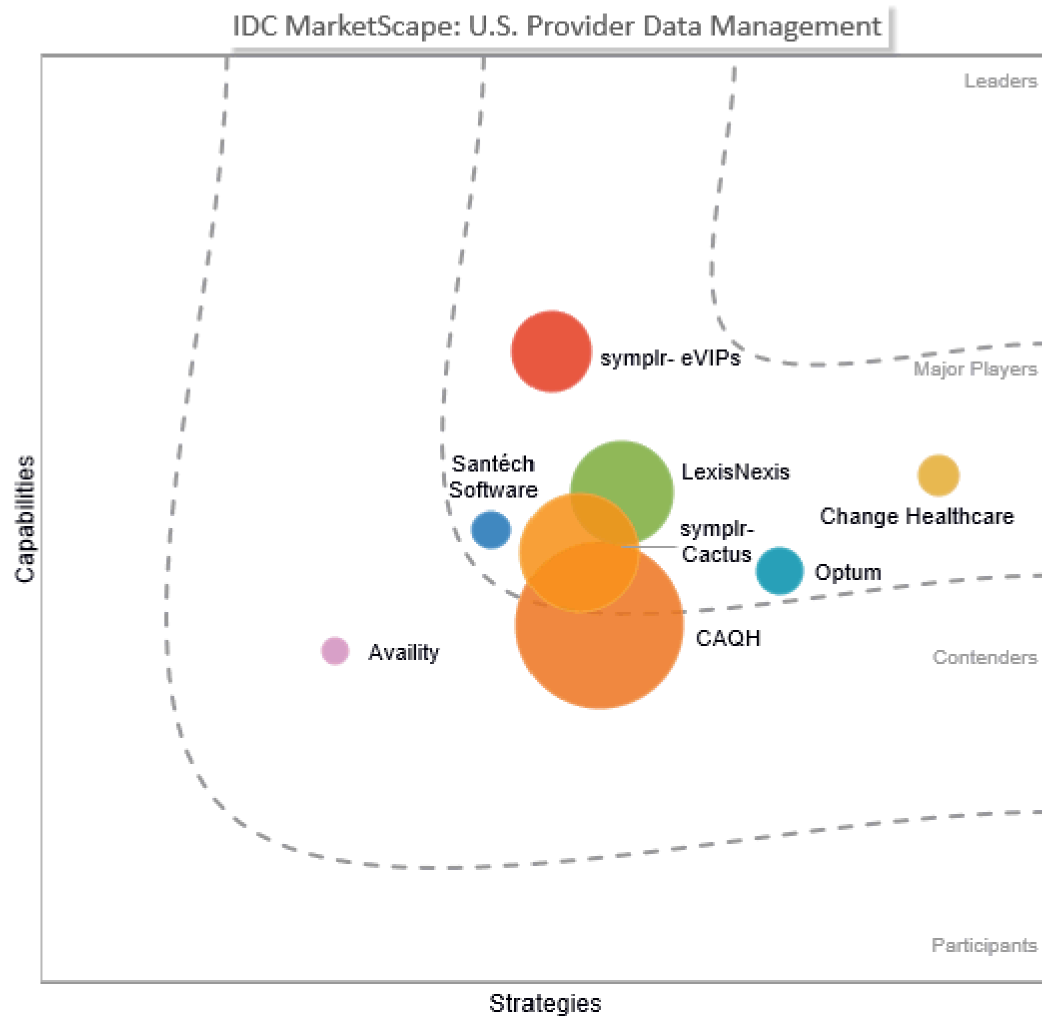
IDC MARKETSCAPE FIGURE

FIGURE 1

IDC MarketScape U.S. Provider Data Management Vendor Assessment



Source: IDC, 2018

December 2018, IDC #US44514018

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

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.
- **Provider data management has a crowded, dynamic field of vendors, and nobody does everything well.** Vendors are being challenged by start-up and established companies that are creatively offering services, lightweight search, and modular approaches to function. Therefore, no outstanding "leaders" were derived from this analysis. Instead, 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).
- **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.
- **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, 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.
- **Provider data management is back-office plumbing and is hard to justify enhancement, funding-wise.** 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.

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-premise 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 a majority 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 sunsetting of IBM Emptoris (estimated at over 250 installations) for contract management, 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 the following criteria:

- Enable provider outreach and enrollment. (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, 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.

- Include reference systems such as provider data in the commitment to revamping next-generation administrative systems. Address provider data and the corresponding vendors that support the desired business capabilities comprehensively, considering all applications in a "suite" approach, however vendor diverse. Since no vendor today provides all functions, and the space is growing, consider best of breed.
- Establish (buy or build) an independent flexible system of record for provider data. Use master data management principles.
- Use an independent canonical data mart approach for downstream access that allows separation of data concerns. Collect universally and comprehensively and then enable data access downstream via canonical marts or directly from the (potentially vendor based) system of record.
- 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.

VENDOR SUMMARY PROFILES

This section briefly 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
- CAQH
- Change Healthcare
- LexisNexis
- Optum
- Santéch Software
- symplr

Availity

According to IDC analysis and buyer perception, Availity is positioned in the Contenders category in the IDC MarketScape for provider data management for payers software in the U.S. market for 2018.

Availity was launched in Jacksonville, Florida as a joint venture between Florida Blue (formerly Blue Cross and Blue Shield of Florida) and Humana in 2001. In 2006, Availity combined with The Health Information Network, a wholly owned subsidiary of Health Care Service Corporation (HCSC), which operates Blue Cross and Blue Shield plans in Illinois, New Mexico, Oklahoma, Montana, and Texas. In 2010, Availity acquired RealMed, a provider of revenue cycle management services. In 2014, Availity

acquired RevPoint Healthcare Technologies to help providers increase patient collections at the beginning of the revenue cycle process. In 2015, Availity launched Revenue Program Management, an automated solution to risk adjustment, and Provider Data Management, which addresses inaccuracies in health plan provider directories.

Products

Availity Provider Data Management is a combination of back-end technology and provider engagement tools that engage providers to manage their existing business profiles on a continual basis. For health plans, they manage the current health plan profile (golden record) for every specific provider business, and when profiles change or are validated as current, they compare and provide specific actionable updates to each health plan. In other words, Availity PDM is a set of core services to allow provider organizations to update their information and provide a mechanism for health plans to consume results effectively by indicating how the data matches to a health plan's existing provider information. Service elements of PDM include:

- **Provider Information Maintenance** — This is a portal-based service where a user manages (add, change, and delete) information regarding the identification of a healthcare provider.
- **Proactive Maintenance** — This is a portal-based service designed to enhance provider utilization of the portal by leveraging available data to find and present data anomalies to the user for review and or correction.
- **Provider Directory Verification Workflow** — This is a portal-based service targeting key provider data elements contained in provider directories as a subset of the full, provider data management set of data elements. The service is designed to request and receive provider directory information (updates or confirmation all information is correct) that the payer may use toward compliance with state and federal mandates or regulations.
- **Provider Data Transaction** — This enables electronic data exchange of all changes or validations by users in a format mutually agreed between Availity and a payer. Availity will return to the payer either a confirmation that the provider's existing demographic information is correct or the provider's updated demographic information with actionable tags based on the payer's current provider record.
- **Delegated Provider Service** — This enables the acceptance of "delegated provider" roster files from the payer or delegated providers.

Add-ons include:

- **Availity Provider Enrollment/Onboarding** is a separate set of core services designed to assist the building and maintenance of providers into a health plan network. Service elements of this include:
  - **Provider Onboarding** — This is a portal-based data collection service where a user inputs information regarding the initial identification of a healthcare provider. This input is directed by business rules that link required data elements and attribution. The result is a clean data exchange to a health plan.
  - **Request for Participation/Letter of Interest ("LOI**") — This is a portal-based data collection service where a user inputs information regarding the request to join a specific payer.
- **Availity Credentialing Application and CVO services** is a set of functionalities that allows providers to leverage their managed profile from PDM and enter relevant credentialing information in a method that allows for health plan adherence to regulatory guidelines. Service elements of this include:

- **Credentialing Application —** Providers can enter application data and access and view their application status through the Provider Engagement Portal.
- **CVO services —** In addition, there are CVO services available, or the output of the application can be sent to the health plan or CVO vendor of choice. The advantage to the service to the health plan is a more complete and accurate application that can reduce turnaround time. It also reduces provider abrasion and receipt of invalid data.

Availity also offers a comprehensive set of clearinghouse functionality for financial, administrative, clinical, and other health plans to provider communications.

Strengths

Availity's roots in this area come from the company's scalable clearinghouse that allowed direct engagement and from its portal that allowed self-service functionality to get data to/from providers directly. Since providers and payers use their clearinghouse and log on to their portal frequently to provide functions like authorizations, it is reasonable to assume that this vehicle is better than most for getting providers to keep their information current. Availity also has strong claims validation support of its provider system of truth as it evaluates claims for provider data that might be inconsistent. In addition, it has a road map that indicates an aggressive commitment to an entire platform supporting the entire provider data management life cycle including contracting and reimbursement.

Challenges

With few customers (but those are big players with a large provider quantity, covering approximately 70% of the covered lives in the United States), it is hard to ascertain Availity's true comprehensive system of truth capability as defined in this analysis. It executes minimal external data cleansing activities, do not have published APIs, nor does it emphasize other interfaces, even delegated provider processes. Availity currently has no network adequacy functionality nor cost/quality provider insights, although those are on their road map.

Consider Availity When

Buyers should consider Availity when payers are interested in scalable provider engagement driven through a self-serve portal (perhaps with Availity's own or another existing system of truth) and want to engage providers directly to obtain demographics. Availity is a fit when a payer has a limited budget for internal or extensive cleansing and wants to push the data entry/validation functions out to the provider community.

CAQH

According to IDC analysis and buyer perception, CAQH is positioned in the Contenders category in the IDC MarketScape for provider data management for payers software in the U.S. market for 2018.

CAQH, a nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration. CAQH has three divisions: CAQHCORE that establishes national operating rules for electronic business transactions, CAQHExplorations that does industry research, and CAQHSolutions that makes utilities (products) for sale to the industry.

Products

CAQH ProView, invented in 2002, eases the burden of provider data collection, maintenance, and distribution. CAQHSolutions provider data management solutions started with a heavy credentialing

focus but has evolved to address industry-level challenges. They are used by more than 1.4 million providers to self-report their professional information to over 900 participating organizations nationwide.

Additional solutions include:

- **DirectAssure** – This product, invented in 2016, serves as an event trigger to remind and outreach to providers to update their directory data. This improves provider directory quality by enabling providers to easily review and update their self-reported professional data for use in health plan directories. This product is unique as it takes into consideration the provider's motivation to log on.
- **VeriFide –** This, invented in 2017, is a primary source verification (PSV) solution that improves the quality, speed, and integrity of provider data provided to plans while reducing the overlapping, non-differentiating business processes associated with credentialing. CAQH is also an NCQA-certified CVO (not in scope of this analysis).
- **SanctionsTrack –** This product collects over 500 sources of multistate information of healthcare provider licensure disciplinary actions and integrates with CAQH ProView to enable a single workflow with other provider data captured. (Available to purchase separately from CAQH ProView)
- **EnrollHub –** This, invented in 2013, product reduces paper checks with one-stop provider enrollment with multiple health plans for electronic payments and electronic remittance advice. By entering the payment (routing number, etc.) data once, this product can communicate this information to multiple payers (available to purchase separately from CAQH ProView).

In addition to its provider data management solutions, CAQH offers COB Smart, which uses coverage information provided weekly by more than 30 health plans to identify which members have other coverage before a claim is paid. Payers are then able to avoid unnecessary payments and recovery costs.

Strengths

CAQH is uniquely positioned to see industry needs and deliver solutions at a competitive price as its board is interested in nonprofit industry progress with a shared mission, not stockholder returns. 50–60% of the industry is already using a portion of its portfolio, in part, because much of the data comes directly from providers (the horse's mouth). This means interpretation need not occur and health plans are able to accelerate accuracy increases to their provider data. CAQH has built beyond its strong credentialing roots and is used to acting as a third-party data source of self-reported provider data to payers who may also be supplementing their own provider data management solutions with CAQH data feeds when they were the de facto source of such information. Over the past couple of years, this nonprofit consortium has responded to the industry with new products and has a dedicated board of payers willing to be their test bed.

Challenges

CAQH has not yet embraced end-to-end provider data management (provider, contract, core for reimbursement). However, they do have a road map indicating development of cleansing, handling delegated providers and workflows, increased interface work, and opening an architecture for enhanced communications with providers.

Consider CAQH When

Buyers may consider CAQH when payers have a workflow system in place, are on a budget with limited scope, have previous experience with CAQH, and/or are doing credentialing and need supplemental data for validation and specific functions.

Change Healthcare

According to IDC analysis and buyer perception, Change Healthcare is positioned in the Major Players category in the IDC MarketScape for provider data management for payers software in the U.S. market for 2018.

Change Healthcare is a merger of two companies, Change Healthcare Holdings, Inc. and McKesson Technologies. On March 2, 2017, McKesson Technology Inc. (MTI), of which McKesson Health Solutions was a division, merged with Change Healthcare Holdings, Inc. (CHC), Change Healthcare, as the company is now called, combines substantially all CHC's business and the majority of MTI. McKesson owns approximately 70% of Change Healthcare, with the remaining equity ownership held by CHC stockholders, including Blackstone and Hellman & Friedman. The new company is jointly governed by McKesson and CHC stockholders.

Products

Provider Manager is an enterprise provider data source of truth designed to be integrated with a payer's core administrative systems to ensure accurate representation of provider networks. The flexible data model makes extensive use of date cycles to represent temporal nature of the various attributes and relationships, thereby enabling retrospective and prospective reporting and analysis. Rules-based assignment of contract and network affiliations and reimbursement arrangements enable the scaling of strategic initiatives like narrow and tiered networks. The platform includes components for efficiently moving data in and out of Provider Manager, including bulk updates, batch extracts to downstream systems, and real-time bidirectional communication using a Tibco-based service-oriented framework. User workflow is managed through "ActivityPacks" that guide the user through various enrollment and maintenance processes using a web-based user interface. ActivityPacks are configurable to allow nontechnical users to modify screens, workflows, and business rules to address unique customer needs.

Add-on products include:

- Contract Manager automates the contract creation and negotiation process and serves as a repository for provider contract documents and codified contract information.
- Reimbursement Manager is utilized by payers to manage rate schedules, model contracts, and price claims. It is integrated with Contract Manager to optimize provider contracts.
- ClaimsXten is an industry leading claims editing and payment policy management solution. The contract terms in Contract Manager are typically enforced during the claims' adjudication process using ClaimsXten rules, and provider data from Provider Manager is used to enforce payment policies in a more targeted fashion.
- HealthQx is a value-based payments analytics platform designed for health plans that want to foster deep clinical and cost analysis through episodic claim grouping and network analysis.
- Payment Integrity Services is a contingency-based audit and recovery service. These services utilize contracts that can be stored in Contract Manager to find payment recovery opportunities.

Strengths

Some large clients have been with Change Healthcare for provider data management for more than a decade, as their first automation. As a mature player in this market, Change Healthcare has taken significant time and effort over the past years to both optimize the individual features of its modular Provider Network Management suite and integrate the pieces around network, contract, and reimbursement management. Although these pieces each came from different roots, Change Healthcare has built not only a comprehensive ecosystem for a system of demographic and network truth but also an operational suite to cover contracts and reimbursement. Its wide-ranging operational understanding of the use of provider data throughout the enterprise is shown by its architecture that features "activity packs" that allow clients to pick and choose functionality and an "activity designer" to manage business rules. Its interfaces to TIBCO ESB (for all its products), extensive interfacing with Cognizant's FACETS, and its extensively detailed road map show that it understands its market and what payers are looking for on the ground for the complexities around provider data management both now and in the future.

Challenges

Change Healthcare has a comprehensive product approach. It is parsed nicely into products (and activity packs), but it can be a lot to comprehend. Change Healthcare's lack of self-service capability and on-premise focus may discourage those who wish to farm out some of the operational aspects of provider data management to others. In addition, Change Healthcare does not have a network adequacy capability, and its approach to cleansing assumes that other third-party vendors will need to participate. Finally, its open API/microservices architecture is on its road map, a bit behind the competition.

Consider Change Healthcare When

IT buyers may consider Change Healthcare when serious about establishing a comprehensive provider management ecosystem in-house, when one wants to work with a proven mature vendor that has a commitment to the entire problem of provider data management, and when a larger scope covering contract management and (standard- and value-based) reimbursement is to be considered.

LexisNexis

According to IDC analysis and buyer perception, LexisNexis is positioned in the Major Players category in the IDC MarketScape for provider data management for payers software in the U.S. market for 2018.

Products

Provider Data Intelligence Suite

LexisNexis uses its vast data resources, big data technology, analytics, linking, and industry-specific expertise to provide an end-to-end solution for a system of truth. Its acquisitions of the Enclarity and Health Market Science (HMS) companies a few years ago reinforced a commitment to provider data, and today it is one of the two companies in the United States that aggregates provider data from every state. It maintains information on more than 8.5 million U.S. healthcare practitioners and reviews 1.64 billion claims annually.

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

- **Provider Data MasterFile** is a subscription service to access slices of provider data, used by payers considering network expansion, analyzing network adequacy, and understanding and contacting nonparticipating providers.
- **Provider Data Enhancements** (including ProviderPoint) is an API- or batch-based service to take in a payer set of data, cleanse (deduplicate, verify, correct, augment) the data using proprietary algorithms to maintain data currency, and return the data cleaned with flagged records to activate, inactivate, or investigate. This can be done and be cleaned multiple times per day and/or on a periodic basis. In addition, changes can be "pushed" in between processing cycles.
- **Provider Data Validation** is a web-based, real-time provider information search service. It provides healthcare entities with an efficient means to research new providers, healthcare organizations, and affiliations to help claim/service operations or to assist with credentialing and provider data maintenance.
- **Verify HCP** is a bundled product that combines the Provider Data Enhancements (aforementioned) and claims analytics and multichannel outreach, including a portal for confirmation, correction, and roster management.
- **Provider Integrity Scan** is a pre- and post-enrollment product that uses both healthcare professional and personal characteristics, such as criminal history, bankruptcies, liens, and judgements, to screen providers (this is especially important when dealing with both typical and atypical Medicaid providers) for fraud, waste, and abuse; licensing; and credentials. Notably, this product is used to comply with CMS mandates that Medicare, Medicaid, and CHIP providers be screened for the risk of committing FWA before being allowed to enroll in federal programs.

Add-ons include:

- MarketView delivers insights into areas including referral patterns, physician alignment strategies, the quality of clinically integrated networks, patient volumes, and reimbursement insights. Historically, this product was not available to the Payer market, but recent data rights expansion has enabled LexisNexis to introduce this product to Payers.
- Email Append is an email service designed to offer reliable, verified physician business email addresses.
- Verified Secure Fax Append is a service designed to offer reliable, verified physician HIPAA secure fax numbers.

Strengths

LexisNexis commitment to cleansed, quality provider data is outstanding and evident. Its presence in dozens of payers, including the vast majority of the top 10, shows its scalability and range. Its data points are drawn from over 3,000 verified sources of provider data including 400 routine feeds from state license boards, and it leverages 1.6 billion claims a year (60% of all claims) to ensure recency of (billed and rendering, TIN, and NPI) provider data. Accordingly, its understanding of the MDM 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.

Challenges

As a "big data" horizontal company in a payer vertical world looking for industry-specific solutions (although the company has an extensive API architecture), LexisNexis 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. Functions such as integration with other vendors and features like easy user interfaces, workflow, and other "complete solution" operational components are not emphasized. This perhaps keeps LexisNexis off provider data management short lists where it might belong. LexisNexis markets and packages products as "nouns" when the payers are looking for operational processes/solutions "action verbs." It also does not have companion products in the payer ecosystem such as claims, care, or enrollment engines that leave the company perceived as a data island with its subject matter expertise suspect to some whose payers would prefer to see explicit vast SME knowledge about healthcare and provider use cases.

Consider LexisNexis When

Buyers may consider LexisNexis when very, very serious about provider data quality, have their own workflow infrastructure or are willing to give up control or supplement of some processes of validation. As nontraditional (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 become more relevant and attractive.

Optum

According to IDC analysis and buyer perception, Optum is positioned in the Major Players category in the IDC MarketScape for provider data management for payers software in the U.S. market for 2018.

As the information technology and services arm of UnitedHealth Group, Optum offers population health management, pharmacy benefit management, analytics, consulting, and other services to care providers, health plans, government entities, and life sciences companies through its OptumRx, OptumInsight, and OptumHealth. Optum has had a busy year. This year, Optum has:

- Announced the planned acquisition of DaVita Medical Group for $4.9 billion (December 2017) DaVita Medical Group manages and operates medical groups and affiliated physician networks in California, Colorado, Florida, Nevada, New Mexico, and Washington. The deal is anticipated to close by the end of 2018.
- Launched Optum Ventures, with an initial $600 million venture fund focused on investing in start-up and early-stage healthcare technology companies (November 2017).
- Joined forces with Humana, MultiPlan, Quest Diagnostics, and UnitedHealthcare to launch a blockchain pilot program to address the challenges of provider data management (April 2018), called the Synaptic Health Alliance.

Products

- **Intelligent Directory (ID) –** It is the latest evolution of a technical platform where Optum has been supporting since 1999. This is now a greatly enlarged, re-architected, multitenant core component that leverages Optum's MDM engine/framework and system of truth that can be used standalone or in concert with other parts of the Optum suite. The latest evolved version launched in 2016 and serves as the data aggregation, business rules engine, and data repository for provider data.
- **ProviderLookup Online –** It is originally introduced in 1999 and advanced with capabilities, technology, and services over nearly 20 years, and this web and mobile provider search product integrates with the payer's member portal and with environments used by internal operational or call center staff. The Optum ProviderLookup Online's next release leverages the

power of Intelligent Directory as the underlying, accessed data set and offers a mobile-first responsive design.

- **Provider Network Relationship Management (PNRM) –** It is a late 2017-launched Salesforce-enabled workflow product that supports provider enrollment, onboarding (recruiting, credentialing, and contracting), and ongoing provider maintenance functions in an integrated manner.

Add-ons include:

- **Intelligent Directory:**
  - Additional APIs, batch integrations, data extracts
  - Data validation/updating leveraging Optum's provider database including demographic, credential, and sanctions data
  - Federated Storage – document management for the provider application and accompanying documents
- **ProviderLookup Online:**
  - Hospital Quality Data – validation of a National Hospital Quality Database
  - Best Match Search – transparency into provider treatment and prescribing history and ability to "match" consumer profiles and preferences to providers for alignment and fit
- **PNRM:**
  - Contract Lifecycle Management module
  - Provider Portal API – provider "self-service" enrollment portal – originally designed for providers to directly enroll in state programs (This function can be altered, appended, and data exchanged with the workflow engine and the MDM source of truth [Intelligent Directory].)

Strengths

Should the acquisition of Davita Medical Group be approved, UnitedHealth Group will be the largest employer of doctors in the United States, adding to it being one of the largest payers. UnitedHealth's IT arm, Optum, is an established provider of many scalable products and services for payers. It has dozens of customers in this space and shows maturity and depth in both the sales cycle and the operational implementation of other products. Its use of Salesforce as a backbone in this product set guarantees the workflow, security and user interface challenges will be minimal, and its architecture is inspired and extensible. Finally, committing to early R&D study of blockchain in this space shows financial strength in a market where some companies could never afford to invest in such futures.

Challenges

This product has expanded dramatically in the past couple of years and been rearchitected to facilitate the entire provider data management life cycle. While the discrete components are deployed actively to the market and some have been in place for years, this new, larger, rearchitected version has few customers, so it is hard to ascertain payer satisfaction on the current fully integrated suite.

Also, being a part of UnitedHealth Group biases some competitive payers from considering Optum for any strategic back-office software asset. In addition, some organizations may not be looking for the custom-suite approach that Optum espouses and may want to retain more control of isolated best-of-breed components. Optum emphasizes the alignment of workflow and data across the enterprise in a meaningful way. But, while that provides a more tailored solution that integrates and aligns with

internal systems, that means that it is not as easily adopted "out of the box" as some competition. Optum also does not offer a packaged "network adequacy" set of functions, which is increasingly becoming intertwined with the "directory accuracy" function for payers. Last, while Optum offers strong APIs used for integration, Optum does not affiliate with systems integrators nor has any packaged third-party interfaces so customers have less labor implementation options.

Consider Optum When

Buyers may consider Optum when they want a partner to develop a potential end-to-end, flexible, scalable, customized, professional, comprehensive approach to managing provider relationships with an eye to the future when payers and providers have converged.

Santéch Software

According to IDC analysis and buyer perception, Santéch Software is positioned in the Major Players category in the IDC MarketScape for provider data management for payers software in the U.S. market for 2018.

Santéch's provider management platform garnered attention from a growing number of payer/provider organizations as a disruptive solution for managing provider data and networks since its founding in 2008. Santéch is a self-funded, privately held, and employee-owned Delaware corporation with offices in California and New Jersey.

Products

I-Network

Santéch's I-Network is a product that:

- Orchestrates provider onboarding, credentialing, product assignment, network tiering, and fee schedule management activities
- Generates automated feeds for claims systems and provider directories
- Validates addresses with USPS, NPPES, and NPI validation
- Has built-in workflow and enotifications
- Has built-in data Import and extract programs to map and ingest rosters
- Has online self-service capability

The add-on products are as follows:

- **I-Network Productivity Suite** is a SaaS-based tool to simplify and automate the provider outreach for provider directory update and attestations and provider recredentialing and new provider enrollment.
- **I-Net Xchange** runs a set of algorithms to establish the unique identity and relationship of the provider and seamlessly relays data between the I-Network and I-Enroll platforms for the identified provider.

Companion Product- I-Enroll It is credentialing and data sharing for and from hospitals and other providers. I-Enroll and I-Enroll.com are used by hospitals, group practices, and small/solo practitioners to manage credentialing data and documents for providers as their system of record. It provides them the capability to manage the provider data life cycle from recruitment, credentialing, participation (for both delegated and nondelegated entities), and contract management.

Strengths

I-Network has a comprehensive data model, seamless flexible workflow, and an end to end, configurable solution that emphasizes strong data integration (consumption, extraction), fast implementation, and an emphasis on best practices for processes. Its recently announced Plexis partnership and its Cognizant FACETS interface show an understanding of the "claims" internals that provider data management efforts want. Of note, evolving dental and medical networks seem to gravitate to Santéch to be their system of record.

Challenges

With a small revenue, employee base, and limited implementation partnerships, Santéch may have problem scaling to win/support many more clients simultaneously. It currently does not have the breadth of third-party data cleansing validations of its competition, and its network adequacy functionality is in its infancy, although both are on its product road map to address. It also does not have companion products in contract or reimbursement management, staying focused on the provider data management demographic scope.

Consider Santéch Software When

Buyers may consider Santéch Software when they want to transform a set of legacy provider network management and demographic capture processes burdened by organizational inertia with a comprehensive creative set of workflows around a flexible source of truth with a small, flexible company with a dedication to customer service.

symplr

According to IDC analysis and buyer perception, symplr has positioned both of its products in the Major Players category in the IDC MarketScape for provider data management for payers software in the U.S. market for 2018.

symplr is a multidimensional organization, covering vendor/general credentialing services, provider management (through the Cactus and eVIPs platforms), outsourced payor enrollment services for providers, as well as visitor management and compliance. In the provider data management space, Cactus was acquired by symplr in May 2016 and Vistar Technologies was acquired by symplr in May 2017. In October 2018, Clearlake Capital Group LP said that it agreed to buy symplr from Pamlico Capital and The CapStreet Group. symplr offers two products in the provider data management space.

Products

eVIPs

It is originally created in 1997 by Vistar Technologies and, based on SOA, the eVIPs solution serves as a central provider data repository for credentialing, contracting, network management, compliance, integration, quality analysis, data access, and reporting. The eVIPs system was designed to support all aspects of provider data management. Features include:

- A single ERD design to serve as the enterprise data repository for all provider data and activity (source of truth)
- Configurable workflows that are triggered automatically based on many different conditions including new records loading and data changes (Workflows also trigger automated actions and alert users to act.)

- Dashboard reporting that drives productivity and workflows (In addition to standard queries and dashboard reporting options, eVIPs interfaces with Crystal Reports and SQL Server Reporting Services [SSRS].)

eVIPs add-on products include:

- **eApply** – a self-service online application supporting practitioners, groups, and facilities
- **eStatus** – an external demographics, images, credentialing, contracting, payer enrollment files-in-process search tool
- **eSearch** – an internal demographics, images, credentialing, contracting, payer enrollment files-in-process search tool
- **Contract Management** – Enables contract generation and cycle management for provider, facility, plans, organizations, or vendor
- **Dynamic Import Utility** – an internal tool allowing clients to import data from external sources such as delegates, CVOs, and CAQH
- **VIP Directory** – a patient, provider, and internal customer service search tool with integrated mapping feature
- **Integration with ABMS Direct Connect Select (DCS), StrikeIron (Address Validation), and DocuSign(eSign)**

Cactus Provider Management Software for Payers, Hospitals, and Health Systems

For 30+ years, and as more provider-owned health plans emerge, the Cactus Provider Management Platform continues to be significantly relevant in the symplr discussion. Despite lacking some of the eVIPs network management functionality, Cactus provides automated credentialing, privileging, payor enrollment, OPPE/FPPE reporting, quality improvement, and risk management that offers cloud-based access for payers, hospitals, group practices, and health systems.

Cactus Platform add-on products include:

- **Application Manager** – a self-service provider application
- **Contract Enrollment** – an ability to create and assign contracts and assign in mass to multiple providers
- **License Monitor** – an automated maintenance of accurate medical license records by continuously monitoring license expiration dates
- **Exclusion Screening** – the ability to compare providers with those listed in the OIG, SAM, and state Medicaid database to identify excluded or debarred individuals or entities
- **Committee Manager** – an electronic committee management tool to organize review of candidate profiles, past decisions, post comments and questions to the committee, and committee recommendations
- **Provider Directory** – allows search for providers using any combination of specialty, language, gender, or location
- **Provider Profile** – the ability for providers to monitor and maintain their own records, run reports, and submit comments or requests directly
- **Provider Lookup** – an internal ability for anywhere, anytime access to controlled provider data for your senior staff and committee representatives
- **Pharmacy Lookup** – enabling the ability for pharmacies to quickly and easily verify provider DEA certificates, schedules, and signatures online

- **Integration with CAQH, CVOs like Aperture and CredSimple, and standard XML export and import capabilities**

Strengths

The symplr product portfolios create a provider management software platform covering credentialing, privileging, payer enrollment, event reporting, professional practice reporting, peer review, network management, contracting, recruiting, onboarding, provider relations management, quality management, and systems integration. This means a one-stop shop to meet the traditional provider network management functions for both health plans and health systems.

symplr has a fine market share in this market and shows depth and experience for a clean system of record repository, a serious reporting infrastructure with Crystal and SSRS interface, and a specific interface with CAQH and standard XML import/export and has written custom interfaces to several claims systems including HealthEdge, Facets, QNXT, and Amisys.

It also shows heft as it provides a web services API "Cookbook" that includes a library of common services calls and a complete integration document that explains the eVIPs web services, as well as a full-service API for Cactus.

Challenges

As provider data management and network design/adequacy are increasingly linked functionally, the lack of a capability in this space may cause hesitation by organizations using network design for competitive advantage, although it is in the road map. More importantly, symplr has stated a commitment to creating a consolidated database model and fully modularizing its two products for interchangeable use, both with extensive roots, in its road map. This is a process that will give an opportunity to rearchitect its software, but this may take some time.

Consider symplr When

Buyers may consider symplr when establishing a comprehensive enrollment, credentialing, and/or provider management ecosystem and if one wants to work with a proven mature vendor with an eye for provider and payer.

Vendors to Watch

The following vendors are worth considering for provider data management deployments, but they did not meet our criteria for full analysis. Each of these vendors has shown significant promise and by adding new customers and building out their platforms, they could soon compete with the major players of this market:

- Simplify HealthCare has a new product offering with limited referenceable customers.
- Quest Analytics just merged with BetterDoctor and is formulating strategy.
- Skygen is repackaging its product lines
- Zelis Healthcare recently announced its purchase of Strenuus.

Simplify HealthCare

Simplify Healthcare (formerly The Most Group) started 10 years ago, providing technology consulting services to the health plan industry. With the launch of eBenefitSync three years ago, Simplify Healthcare pivoted to become a software provider, and the growth has been explosive ever since. As

proof, Simplify Healthcare was named in the 37th annual *Inc. 5000* list of the Fastest Growing Private Companies, reflecting its 150% growth.

Simplify Healthcare offers Simplify9, a SaaS platform that enables digital business process transformation with a unique combination of capabilities including a dynamic data storage, workflow management, document generation, user-defined business rules, multiple data views based on need, and easy integration into core systems. Its current products, eBenefitSync, eMedicareSync, eProviderSync, and AP2 are configurations of the Simplify9 platform focused on solving critical pain points for health plans.

eProviderSync is Simplify HealthCare's Provider Life-Cycle Management Solution. It is a patent-pending SaaS-based provider data, provider directory, and provider contract configuration and management solution. It automates the end-to-end provider life cycle, so a Payer can create a single source of truth for providers, leveraging existing sources and repositories. It houses all types of providers and extends the provider models to include the innovative affiliations demanded by Value-Based Purchasing and Contracting.

For payers that have made investments in provider data repositories and need to preserve those investments, eProviderSync can also flexibly work with existing repositories as a wrapper, enabling eProviderSync functionality without supplanting an existing investment. Critically, this union can behave as the single source of truth.

Quest Analytics

In June 2018, Quest Analytics acquired BetterDoctor. Together, the companies will provide a platform that enables health plans to optimize their member experience around providers while complying with federal and state regulations for network adequacy and accuracy.

The combination of Quest Analytics' network decision support tools and BetterDoctor, a primary source–verified provider data management platform, will enable health plans to provide their members with convenient access to an adequate network of doctors and hospitals and an up-to-date, accurate directory of network providers.

"Quest Analytics recognizes that network adequacy and accuracy are inextricably linked," says Ari Tulla, cofounder of Better Doctor and Chief Executive Officer, Quest Analytics. "Together, we will help health plans address two of the biggest issues facing health plans today: accessible networks and accurate provider directories for their members and compliance with federal and state requirements."

The combined company will operate under the Quest Analytics brand.

Skygen USA

Skygen USA helps payers of all sizes and across all lines of business through a portfolio that includes benefits administration, provider data management, and professional services. Skygen USA has clients operating in over 100 markets, serving 35 million member lives on its technology platform and 10 million member lives through its TPA and SaaS solutions.

Long part of Skygen USA's overall suite since 2002, its Provider Data Management Suite was introduced as a separate offering in 2017 and provides:

- **Network prospecting.** This identifies and maintains campaign lists and contacts for recruitment

- **Provider data verification.** This provides web-based tools for medical and dental providers to self-identify both demographic and plan participation information.
- **Credentialing.** This provides online tools for providers to store credentialing information and for payers to purchase completed or verified applications, today focused on dental provider networks, but medical credentialing on the road map.
- **Network rental.** This provides a web portal to allow payers to select and lease provider contracts.
- **Contracting portal.** This provides online tools for payers to finish provider recruitment and obtain electronically signed contracts.

Zelis Healthcare

In 2017, Zelis Healthcare announced the purchase of Strenuus. Strenuus is a provider of healthcare provider network analytics. Strenuus claims to have the largest collector of managed healthcare data in the United States, with its platform, Network360. This platform delivers actionable network intelligence services to payer clients nationwide. Strenuus also powers consumer-facing solutions for leading benefit consultant and healthcare IT companies with a unified provider search using a large network data set that is sourced from thousands of commercial medical, dental, Medicare, Medicaid, and specialty business lines.

"The combination of Zelis and Strenuus further expands our Zelis integrated cost management and payments platform and enables Zelis to provide our payer clients with enhanced support of network access, quality, and cost optimization efforts. This is particularly important as many payers seek to deliver high-performing, cost effective, narrower networks that meet the changing needs of employers and members," said Doug Klinger, CEO of Zelis Healthcare. Zelis Healthcare is backed by Parthenon Capital Partners.

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 less 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 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. The sections that follow provide the findings of this study.

Provider Data Is Now 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.

Provider Data Management Has a Crowded, Dynamic Field of Vendors, and Nobody Does 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

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 any vendor to do comprehensively at this time, and therefore no outstanding "leaders" were derived from this analysis. Instead, 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.

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. "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 nor 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, Funding-Wise

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.

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.

TABLE 1

Key Strategy Measures for Success: U.S. Provider Data Management, 2018

Criteria	Definition	Weight
Adjacent portfolio 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
Cloud-based delivery	Plans are in place for support of offering delivery model(s) 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 growth	This looks at the increase in the number of customers YoY 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. 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
Overall 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
Profit and growth	This looks at profit and growth.	8.0
Specific 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, 2018

TABLE 2

Key Capabilities Measures for Success: U.S. Provider Data Management, 2018

Criteria	Definition	Weight
Customer service delivery	▪ 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. ▪ Company has customer advisory council.	4.0
Functionality or offering	▪ Multichannel outreach and/or CRM capability to be able to reach outbound providers for recruitment ▪ To be able to find a provider either online via subscription and/or receive a population batch ▪ Ability to enter/capture data from providers, administrators, or customer service representatives ▪ Providing templates to enable outreach and enrollment ▪ Onboarding/outreach — provider welcome kit ▪ Cleansing — address, invalid, multiple validation; duplicate matching; and CAQH, LEXIS/NEXIS, NPES, PECOS, SAM, QRXS, NPDB, OIG, NPI, Medicare opt out scrubbing ▪ Directories ▪ External interfaces ▪ Network adequacy ▪ Data maintenance ▪ Security — user level lock on providers/networks; done by users, not IT ▪ Conversion — images and indexing; from other packages ▪ Extensibility ▪ BI ▪ Dashboards ▪ Reporting and analytics	76.0
Portfolio benefits	▪ Internal interfaces — contract management; authorization referral; care management; directory; analytics warehouse; marketing/communications; claims/billing; portals; credentialing; document management and provider education	13.0

TABLE 2

Key Capabilities Measures for Success: U.S. Provider Data Management, 2018

Criteria	Definition	Weight
Range of services	▪ Support to configure and set up software ▪ Development framework — API; SDK for customers/partners; customer/partner support for customization ▪ Ability to support conversion of existing paper contracts by importing images and indexing data to make the content searchable ▪ Demonstrate level and range of support and tools provided by the vendor to support demands of clients; range of services should include the geography, industry, and target market component when appropriate; vendors may be rated on the level of implementation support and tools provided by the vendor ▪ Ability to support BPO/BPAAS models to take over contract management function for a payer	7.0
Total		100.0

Source: IDC, 2018

LEARN MORE

Related Research

- *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)
- *IDC Market Glance: Payer, 4Q17* (IDC #US43315917, 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: Value-Based Reimbursement Demands Payers Execute an Exchanges-Like Level of Effort* (IDC #US41380616, June 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, decrease complexity, and enable flexibility in their back office to reduce operational costs. As payers attempt to respond to governmental and competitive pressures, the ability to maintain, control, and evolve networks fast and effectively is a competitive advantage. Those that can't may not survive the onslaught of value-based reimbursement, expanding provider types, and the increased consumer demand for directory accuracy and network adequacy."

About IDC

International Data Corporation (IDC) is the premier global provider of market intelligence, advisory services, and events for the information technology, telecommunications and consumer technology markets. IDC helps IT professionals, business executives, and the investment community make fact-based decisions on technology purchases and business strategy. More than 1,100 IDC analysts provide global, regional, and local expertise on technology and industry opportunities and trends in over 110 countries worldwide. For 50 years, IDC has provided strategic insights to help our clients achieve their key business objectives. IDC is a subsidiary of IDG, the world's leading technology media, research, and events company.

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