

IDC MarketScape: U.S. Provider Data Management for Payers 2025–2026 Vendor Assessment

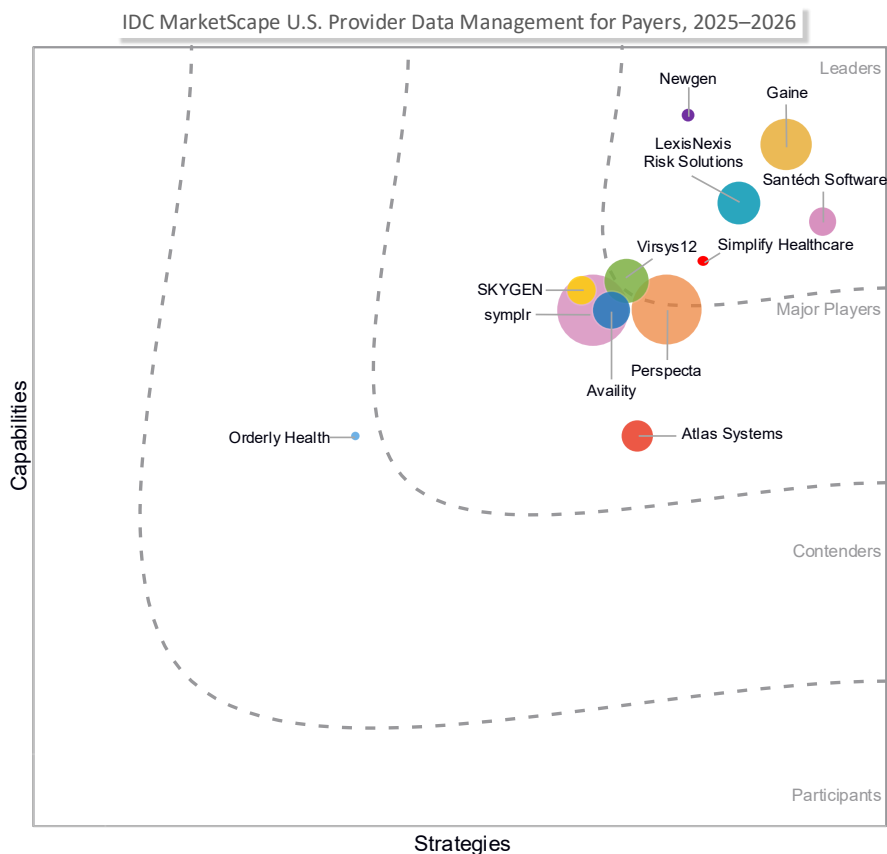
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THIS EXCERPT FEATURES LEXISNEXIS AS A LEADER

IDC MARKETSCAPE FIGURE

FIGURE 1

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



Source: IDC, 2025

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

ABOUT THIS EXCERPT

The content for this excerpt was taken directly from IDC MarketScape: U.S. Provider Data Management for Payers 2025–2026 Vendor Assessment (Doc # US52986825).

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 established provider data management (PDM) vendors that are found in payers that use the PDM software to establish a "core provider system of record of 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 increased scrutiny of provider data quality by regulatory bodies, the potential development of a "national provider directory," the evolution of provider/payer interoperability, 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 the 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 CMS mandates around interoperability and the various state mandates around directory accuracy 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.

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 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. Telehealth has complicated the network adequacy framework.
- **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 it 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 or mandated initiatives for funding. Even though provider data is changing all of the time, the back office is hard-pressed to get dollars.

For more information, refer to the Detailed Research Findings heading in the Appendix section.

IDC MARKETSCOPE VENDOR INCLUSION CRITERIA

This research includes analysis of 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 on the 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. Vendors that offer supportive functions were also given consideration in the evaluation.

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, application programming interface (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 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 12 vendors: Atlas Systems, Availity, Gaine, LexisNexis Risk Solutions, Newgen Software Technologies, Perspecta, Orderly Health, Santéch Software, Simplify Healthcare, SKYGEN USA, symplr Software LLC, and Virsys12. Other vendors did not meet the inclusion criteria, highlighted in the "Vendors to Watch" section, are HealthEdge, InterSystems, Sagility, Smart Communications, and Virtusa.

LexisNexis Risk Solutions

According to IDC analysis and buyer perception, LexisNexis Risk Solutions (healthcare business) is positioned in the Leaders category in this 2025–2026 IDC MarketScape for U.S. provider data management for payers.

Product: Provider Data Management Suite

LexisNexis Risk Solutions (LexisNexis Risk), part of RELX and 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 a suite of solutions for *provider insights*. LexisNexis Risk started providing provider data management solutions to payers in 2006. Over the past 11 years, LexisNexis Risk has acquired seven companies as part of an ongoing strategic growth initiative.

In the overall healthcare market, LexisNexis Risk states that it serves a wide range of payers, providers, retail pharmacy, life sciences, and healthcare IT customers, including:

- More than 50% of U.S. health systems
- Over 250 hospitals, health systems, and IDNs
- Prominent life sciences organizations
- Established pharmacy retailers and PBMs
- 70% of U.S. federal and local government agencies

The value to payers in the provider data management suite of products is driven by correct, current, and comprehensive data collection available.

Products are:

- LexisNexis Provider Data MasterFile (PDMF)
- LexisNexis ProviderPoint
- LexisNexis Provider Data Enhancements (PDE)
- LexisNexis Provider Data Validation
- LexisNexis Provider Integrity Scan
- LexisNexis MarketView

Product: LexisNexis Provider Data MasterFile (MasterFile)

It is a centralized referential database that improves and evolves daily *by ingesting, verifying, and integrating* incoming data including proprietary data collection and outreach findings. This solution can be delivered through a batch file or a web interface.

LexisNexis Risk acquires healthcare provider data from over 2,000 different sources to populate and verify the many fields in MasterFile. MasterFile contains comprehensive information on over 12 million U.S. healthcare practitioners and over 800,000 organizations, including 1.3 million physicians with active locations, 4.7 million registered nurses and licensed practical nurses, 7,000 acute care hospitals, 320,000 medical group practices, and full representation of other types of physicians and organizations.

It utilizes public sources (state and federal) and private sources (license agreements and partnerships), as well as manufactures its own data (web search, phone calls, emails, and analytics) to compile "golden" records payers can count on for reliability and completeness.

LexisNexis Risk uses a nontraditional approach to MDM. Whereas many MDM implementations create a "golden record" in a static database, its approach differs in that it maintains the original source material and leverages proprietary linking technology. When a golden record is needed, it is built dynamically by linking

technology. Using this dynamic approach, LexisNexis Risk easily adjusts to new inputs, assesses the quality of inputs, and determines which inputs provide the greatest quality golden record possible.

Address standardization is accomplished according to USPS address guidelines utilizing the SAP America USPS CASS Certified product. Basic correction of addresses occurs in this process, including correcting street address, city, state, and zip to USPS standardization. Undeliverable and invalid addresses are identified in this process as well; often those addresses are replaced with valid USPS addresses in the correction and augmentation steps of the cleansing process that LexisNexis Risk offers. To further strengthen its determination of active and inactive locations, LexisNexis Risk has developed proprietary confidence scores that are updated weekly based on all updated/refreshed data, including claims activity.

NPPES information is included in all provider data solution offerings. The NPPES data is sourced as frequently as available, and cross-walked to provider profiles.

LexisNexis Risk sources data from *SAM in the form of the OIG exclusion list*.

Its *outreach (for provider data validation, not provider contact for potential payer enrollment)* strategy targets high-risk or low-confidence records, using a combination of intelligent change detection, web research, and direct provider contact. Proactive outreach is triggered by smart signals from continuous monitoring of thousands of data sources, client transactions, and profile change indicators.

LexisNexis Risk does not host or create *directories nor does it extract to create a directory*, but it does support payers with accuracy. A given payer directory is sent to LexisNexis Risk, cleansed and augmented, and then returned to the given payer for their upload to their directory database. This can be done via batch and API options. LexisNexis Risk can also monitor the customer's network and proactively alert when a directory element needs to be updated.

Provider Data MasterFile includes Drug Enforcement Administration licenses, de-identified medical claims, and data validation through multiple outreach channels.

Provider Data MasterFile Add-Ons

Additional characteristics about providers and organizations can be added on, including federal and state sanctions, American Board of Medical Specialties certifications, Controlled Substance Registrations, medical schools, practitioner to organization affiliations, organization to organization affiliations, hospital profile attributes, Medicare and Medicaid numbers, e-prescriber IDs, and telehealth availability flags.

Product: LexisNexis ProviderPoint

It leverages the (aforementioned) proprietary MasterFile database to *cleanse* provider data to keep provider information accurate and up to date while significantly reducing operating costs. Further:

- A more complete picture of current provider demographic information with thorough record validation and proactive monitoring of data
- Notification of critical issues with providers or contracts, allowing immediate action
- Time-saving workflow allowing users to automate updates and take proactive steps to keep provider data accurate
- Improved compliance with industry benchmarks

Payer's data sets are compared with the MasterFile database to identify verifications, replace inaccuracies, de-duplicate data sets, and augment incomplete provider records.

ProviderPoint is configurable to meet payer-specific business rules, include pass-through values to ease consumption, and offer accuracy ratings at the data element level to empower payers to set thresholds in line with their level of comfort.

Along with providing a cleansed data set, ProviderPoint includes a "stoplight report" and customizable integration codes to support payers through the process of loading updates back into their source system. ProviderPoint results can be delivered through batch or API to best suit the payer's needs.

Product: LexisNexis Provider Data Enhancement

It matches, links, de-dupes, and augments provider records with the most current information available from the (aforementioned) Provider Data MasterFile. Provider Data Enhancement is a two-way *data exchange service* that allows healthcare organizations to get direct feedback on their data while supplementing their provider records with augmentation and additional records from LexisNexis Risk.

Product: LexisNexis Provider Data Validation

It is a *web-based, real-time provider information search* service that leverages the most current, comprehensive, and accurate provider data. Because the Provider Data Validation product pulls from the (aforementioned) MasterFile data set, payers can easily consolidate their processes of searching multiple websites and improve speed and accuracy of their workforce. The Provider Data Validation product quickly consolidates common lookup needs from key systemic acquisition sources like state and federal license and sanction boards, authoritative sources like NPPES and DEA, as well as proprietary source data like claims data and provider outreach results.

LexisNexis Risk offers payers a comprehensive data set including remit information, directory and utilization management information, credentialing, and PCP information.

Product: LexisNexis Provider Integrity Scan

It is specifically designed to help payers *identify the potential for fraud before it happens*. This product is useful for payers during the preenrollment or credentialing of a provider but can also be used in ongoing maintenance of a provider record. Provider Integrity Scan helps payers by *verifying licensing and credential information*. It gives visibility into provider risk by monitoring bankruptcies, liens, judgments, deceased status, OIG/GSA exclusions, felony convictions, state of licensures, status, and retirements. This product supports the requirements of the Affordable Care Act, which states that only legitimate providers and suppliers can be enrolled in Medicare, Medicaid, and CHIP (Children's Health Insurance Program), and that only legitimate claims are paid. It also supports compliance with CMS-6028 because it includes identity verification.

Product: LexisNexis MarketView

It delivers de-identified medical *claims-based* intelligence to life sciences, providers, pharmacies, healthcare IT, and payer organizations across the United States. By *combining the provider referential database, de-identified claims data, and proprietary analytics, along with a visualization tool*, MarketView delivers insights into areas including referral patterns, physician alignment strategies, the quality of clinically integrated networks, patient volumes, and reimbursement insights. As a result, customers can focus on outreach efforts on high-value targets, recognize physician splitting across facilities, and grow service lines and market share. MarketView leverages more than one billion provider claims, and it reveals key details through dynamic dashboards. While payers have plenty of data on their own providers and members, they often lack data points for markets where they do not provide coverage. They need an accurate picture of what happens — insights on how practitioners render care, where their patients go, and what those patients cost other payers.

Provider Data Management — Optional Services

LexisNexis Risk offers the following services to complement provider data management:

- **Advisory services:** The advisory services team provides best practice guidance and provider data insights to help clients optimize the consumption of their provider data management solutions. This includes supporting clients in pilots, implementations, and production.
- **Verification services:** LexisNexis Risk offers verification services as BPAAS as an additional service available with Provider Data Management. If a payer needs to

review a provider or organization record to meet the need for an internal audit/investigation or questioning a discrepancy in data that requires additional research, LexisNexis Risk can offer verification research on specific attributes/provider/organizations with turnaround times and prioritization. This is a white glove service that is performed by a team of LexisNexis data researchers who manually verify and investigate the data.

In addition to its suite of provider data management solutions, LexisNexis Risk Solutions empowers payer organizations across a variety of *other* business imperatives, including member engagement, care coordination, identity verification to protect digital assets and health data, and market insights to drive growth:

- **Whole person insights.** Enhance member engagement and care delivery with member information to understand the healthcare journey.
- **Identity verification.** Protect member and provider data and improve user experience with dynamic identify verification and authentication solutions that keep systems and data secure.
- **Population health.** Address gaps to improve care coordination, promote positive interactions, and advance health equity initiatives with demographic and social insights on a population.
- **Healthcare market data and insights.** Drive market expansion, enhance customer acquisition and retention, and optimize provider networks and facilities by leveraging extensive data resources.

The LexisNexis Risk suite of solutions offers payers the ability to buy products individually, or in concert with one another, along with a set of professional services to meet payers where they are either during implementation or in operations.

Strengths

- Simply, LexisNexis 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. LexisNexis Risk Solutions' commitment to cleansed, quality provider data is strong and evident.
- The provider data is used in over 3.7 billion transactions per year to validate prescriber compliance with the nation's established retail and mail order pharmacy chains.
- The provider data management data sourcing includes 2.2 billion medical claims annually and thousands of data sources received and applied on different frequencies. It processes over 300 million prescription transactions monthly and uses feedback from those transactions to verify accuracy of provider data.

- Its platform is multi-payer. That is, once a provider's information is updated (by it), his/her information goes to multiple payers.
- Its payer output files to claims systems are customized to ensure consumption, and it offers batch and API interfaces to its products, which have been integrated into a number of customer claims applications, including TriZetto.
- Its business model includes a call center that performs manual outreaches for provider data accuracy validation.
- LexisNexis Risk can support payers in mock audit activities upon request. Within this function, payers can specify a population they wish to audit or perform outreach upon for validation.
- OIG sanctions, GSA/EPLS/SAM sanctions, and CMS Medicare enrollment are all included in solutions.
- It is unique in this market to offer 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 LexisNexis Risk data will continue to increase its value to payers. As typical (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 become more relevant and attractive to payers.
- As its provider data solutions are fully hosted by LexisNexis Risk, payers may not need any full-time employees to maintain or support the data. Once business integration rules are configured for the consumption of the LexisNexis Risk data, customers should be able to automate the processing of the resulting output data into the payer organization.

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 integration into existing workflow applications), LexisNexis 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. 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 LexisNexis Risk off some provider data management short lists where it might belong. LexisNexis 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 semantics.

To clarify, LexisNexis Risk also does not have companion products in the narrow payer ecosystem such as claims processing, care management, contract management, or enrollment engines. This isolation leaves the company perceived as a "data specialty vendor" with its subject matter expertise suspect to some payers. Some payers might prefer to see explicit, vast SME knowledge about health insurance and provider management-based use cases.

That being said, to implement or integrate their data environment into a payer, a payer must do it themselves, contract with one of their partners, or their LexisNexis Risk Advisory Services. For example:

- LexisNexis' interpretation of "outreach" is to contact providers for provider data validation, not provider contact for potential payer enrollment. They do not have a marketing application to generate providers for participation in a payer's network, nor do they interface directly with marketing communications applications.
- LexisNexis does not support a new provider enrollment web application, welcome kits, or templates.
- LexisNexis does not have a direct provider-based attestation portal. It believes in its multisource verification effort that minimizes the effort and abrasion to providers and includes targeted outreach when necessary to gather information directly from providers.
- LexisNexis Risk does not have a credentialing application. It can support pre-fill of provider elements into credentialing systems.
- LexisNexis only offers advisory services to support payers in estimating the impact analysis of adding or deleting a provider to a network.
- LexisNexis Risk does not have a document management application.
- LexisNexis Risk does not have a contract management platform. It can pre-populate provider elements into other contract management systems and do validation and can offer batch and API interfaces to its products, which have been integrated with a number of customer systems.
- LexisNexis Risk does not perform directory printing or extracts, nor host directories.
- LexisNexis Risk does not offer provider ratings on the market. However, it is a supplier of attributes to other companies that create provider ratings.

- LexisNexis Risk does not have out-of-the-box dashboards. It uses services contracts and a collaborative approach that takes advantage of standard offerings, and it can develop customized offerings as required.

LexisNexis Risk does not have a network adequacy solution, but it does partner with mapping and scheduling vendors to support payer needs.

LexisNexis Risk does not have the 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 LexisNexis Risk data for this function, but writing or purchasing other applications to exploit that geolocation data.

CAQH data is not a current source of data for LexisNexis Risk. However, matching and integration of customer-supplied CAQH data has and can be done on behalf of any specific customer upon request. Its data solutions may be competitive with CAQH; thus, the CAQH data is not a source for the LexisNexis Risk products.

Matching and integration of customer-supplied NPDB, QXRS, or PECOS data can be done on behalf of any specific customer upon request as a customization, even though NPDB is not a current direct data source for LexisNexis Risk.

LexisNexis Risk does not collect or support a provider's Medicare Opt-Out information.

LexisNexis Risk does not support competitive analysis of payer networks. However, it has products that can support payers in their network growth strategy. The MarketView suite of products can support payers in understanding the key providers in a given demographic area and activity volumes by service.

LexisNexis Risk does not support conversion of existing paper provider files by importing images and indexing data to make the content searchable. It has supported customers in their provider system conversion activities through keying, standardization, de-duplication, and augmentation via a service contract.

Consider LexisNexis Risk Solutions When

LexisNexis Risk Solutions is a good choice for buyers prioritizing comprehensive provider data quality on a scale. Payers with existing workflows who are willing to outsource validation processes and build on the LexisNexis Risk source of truth — using current systems, new development, integration partners, or LexisNexis Risk services — will benefit from its robust data. The solution demonstrates strength in its data volume, quality, completeness, coverage, and compliance with directory mandates.

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.

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

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

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 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
- Service companies evolving products
- Organizations that only collect provider data directly from providers
- Salesforce partners offering deeper data models and functionality than Salesforce
- Provider 360 companies emphasizing the entire "person" that a provider represents
- Services companies using modules flexibly to craft individual solutions in an a la carte way

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 non-health 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.

Focusing on flexible workflow, exhaustive data cleansing, expansion of provider types, provider engagement, network adequacy, data management, value-based contracting, and a comprehensive yet modular product approach is sometimes too much for most vendors to do comprehensively. Many 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 Determinants 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, and 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.

Telehealth complicates this functionality as "time and distance" are irrelevant. However, states have not caught up with the new paradigm and still require some geographic network adequacy.

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 in a timely nor accurate way. 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 and electronic data interchange (EDI) capabilities. These "carrots and sticks" change cash flow via either an increase in pending 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 and reminder capability an industry-unique differentiator in picking a provider system of record 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.

For any vendor, especially one new to this space, to comprehensively address all this scope is daunting. On the other hand, new approaches using rules-based AI 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, in terms of funding, but interoperability and telehealth monies 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/state mandates has spiked interest in both the member-360 and provider-360 data spaces.

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 approach to provider data and those that are willing to have other companies be their source.

LEARN MORE

Related Research

- *IDC Market Glance: Payer, 1Q25* (IDC #US53200825, March 2025)
- *IDC PeerScape: Lessons Learned for Payers in Provider Data Management* (IDC #US48405121, December 2021)

Synopsis

This IDC study provides an evaluation of vendors that provide payer solutions for provider data management. The vendors included in this study are representative vendors in the industry that met the established criteria for market share and potential growth opportunities.

This study also identifies vendors in the provider data management market that did not qualify for this IDC MarketScape but are still identified as "vendors to watch" in this active space.

According to Jeff Rivkin, research director, Payer IT Strategies at IDC Health Insights at IDC, "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 cannot upgrade 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."

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