IDC MarketScape

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

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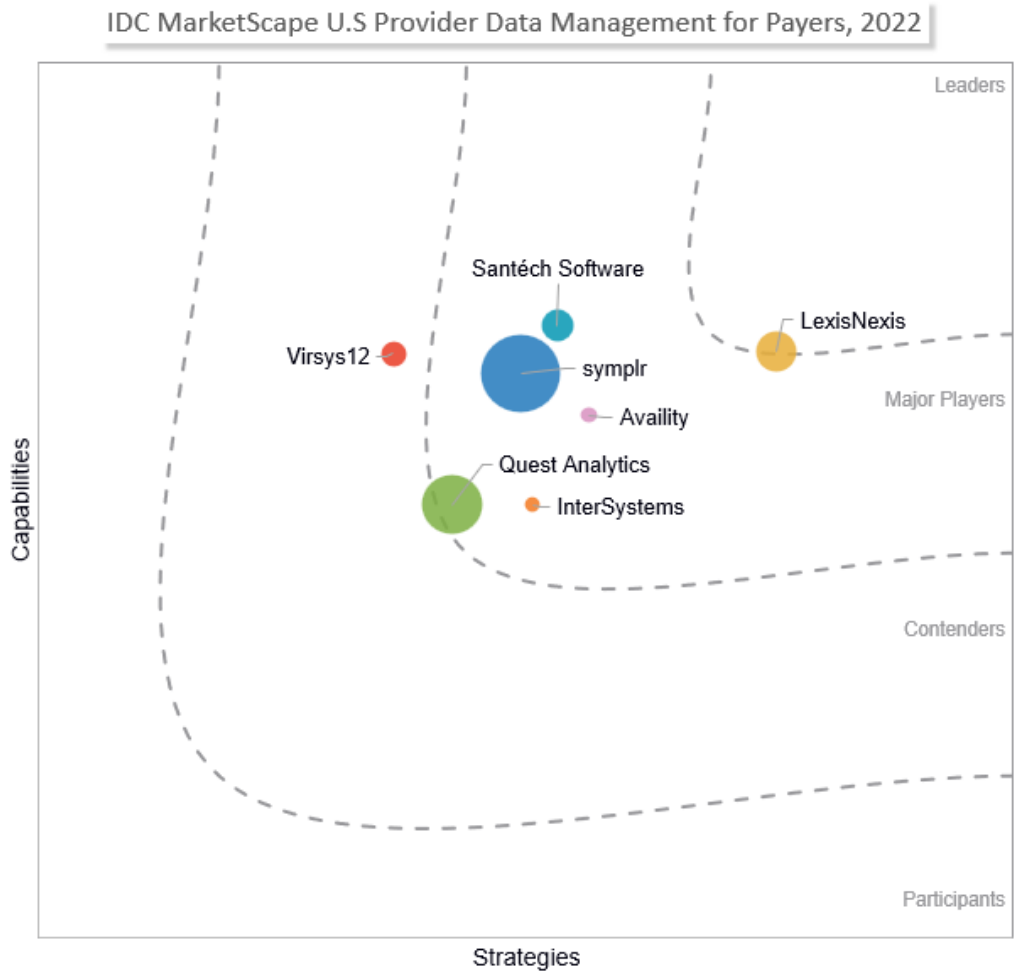
## THIS IDC MARKETSCAPE EXCERPT FEATURES INTERSYSTEMS

## IDC MARKETSCAPE FIGURE

## FIGURE 1

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

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

## IN THIS EXCERPT

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

## IDC OPINION

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

- **Provider data is now its own core application.** Provider data has moved from being a set of tangential reference data used to validate claims to become a core administrative asset that is being used for competitive advantage.
- **Provider data management has a crowded, dynamic field of vendors, and few do everything well.** Vendors are being challenged by start-up and established companies that are creatively offering services, lightweight search, and modular approaches to function. Many "major players" were identified, each with its own value proposition. Traditional players are being challenged by an expanding problem set, and newer vendors are just beginning to appreciate the complexity of this space.
- **Provider data is a consumer differentiator.** Consumers now want to search for providers not only by their location or network affiliation but also by increasingly more granular criteria including newly defined specialty types (e.g., adolescent-oriented psychiatrists, autism-inspired art therapists, naturopaths, and wellness specialties).
- **Provider data is a social differentiator.** Recently, providers of "social determinants of health" like food banks, job placement, and government agencies are relevant to payers as "providers" as well.
- **Network adequacy is equivalently important to directory accuracy, but vendors are slow to adopt this function.** Legislatively, an adequate, diverse, and broad network is desired by consumers and required by ACA and state regulations.
- **Data stewardship remains a problem.** Consumers expect payers to make available quality provider data. Unfortunately, providers do not always supply this information to the payer. The

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

- **Provider data management pricing will be more competitive, flexible, and on demand.** Models of pricing that meld the "own the software" legacy mindset with the "buy as you need" incremental functionality will evolve.
- **Provider data management has significant scope and breadth and is enlarging.** Up and coming requirements include tracking value-based provider and community affiliations and truly embedding the contract-to-claims loop into the provider management ecosystem.
- **Provider data management is back-office plumbing and is hard to justify enhancement, fundingwise.** In the race for funding dollars in a cost-squeezed payer industry, back-office operational improvements rarely get high priority, competing against flashier or mandated initiatives for funding. Even though provider data is changing all of the time, with vendor stats indicating 33,000 weekly address changes, the back office is hard-pressed to get dollars.

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

## IDC MARKETSCAPE VENDOR INCLUSION CRITERIA

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

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

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

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

## ADVICE FOR TECHNOLOGY BUYERS

When purchasing provider data management software, consider these recommendations:

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

## VENDOR SUMMARY PROFILES

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

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

### InterSystems

According to IDC analysis and buyer perception, InterSystems is positioned in the Major Players category in this IDC MarketScape for provider data management for payers software in the U.S. market for 2022.

#### *Product: HealthShare Provider Directory*

InterSystems, a global player in information technology platforms for health, finance, and government applications, founded in 1978, and serving payers since 2005, is privately held and offers HealthShare as one of its product suites. InterSystems has been providing interoperability solutions for decades internationally for many industries. Its ability to atomize, aggregate, deduplicate, and normalize data clearly is and has been its focus.

HealthShare is a suite of connected health solutions, and Provider Directory is a standalone purchasable unit that has been in the suite since 2019. It alternatively can be used within HealthShare as a directory FHIR resource and to maintain a provider registry for notifications. For example, a HealthShare buyer could purchase the following individual products:

- **HealthShare Unified Care Record with FHIR Gateway.** Provides an aggregated, deduplicated, and harmonized view of a member's care record
- **HealthShare Health Insight.** An analytics product, dependent upon HealthShare Unified Care Record, used for dashboards, data quality, as well as to aggregate and clean data to use with other analytics solutions
- **HealthShare Patient Index.** An enterprise master patient index (EMPI) solution that provides an automated and easily integrated solution for creating a "single source of truth" for patient identity and demographic information
- **HealthShare CMS Solution Pack.** A turnkey solution for CMS-9115-F Interoperability and Patient Access Final Rule
- **HealthShare Personal Community.** A member self-management and engagement solution dependent on Unified Care Record
- **HealthShare Care Community.** A solution for care givers, patients, and their families to improve communication, care transitions, and care coordination outside of the hospital setting
- **InterSystems IRIS for Health.** An innovation and development platform to develop applications internally and used as the base of the HealthShare and other suites
- **HealthShare Provider Directory.** A master data management (MDM) solution for provider data to support member attribution and alerting (optional, standalone)

HealthShare Provider Directory, introduced in 2019-2020, on premises or hosted, focuses on master data management. Its data model and its understanding of the interoperability between payers and providers is its strength. Its core solution centers on the following key functionalities: data ingestion; data preparation and cleaning/normalizing; parsing data into the data model; matching and linking based on customizable rules; operational data management, such as validating matches, running queries, and updating records; and sharing and exporting data in multiple formats including FHIR.

HealthShare Provider Directory also offers a provider identity matching engine that combines deterministic matching, probabilistic algorithms, and defined rules to create, manage, and maintain the complex relationships that define the healthcare landscape, such as organization hierarchies, network participation, and multiple practice locations for provider information. Its Provider Directory is built on the HealthShare platform that includes interoperability tools combined with a push service that maintains a directory FHIR repository and can supply master data management records' updates to downstream systems with accurate, up-to-date, reliable information.

InterSystems offers an on-premises or cloud solution in a "per provider" pricing model.

For data ingestion, HealthShare uses a suite of tools to enable interoperability among and onboarding of healthcare systems. Key tools in the ingestion process are:

- Out-of-the-box adapters for working with healthcare standard formats, custom formats, and standard protocols with prebuilt mappings for common healthcare standards
- Intuitive visual data mapping and process orchestration tools

HealthShare processes inbound records as data events, allowing rules-based action triggers based on transactions flowing through the system. As data is ingested, it is also made available in a relational data model for operational reporting and analysis.

Regarding curation of data, HealthShare ensures the consistency of data in several ways:

- Message validation
- Matching records across data sources, which can match deterministically or probabilistically using matching algorithms (Matching rules and linkage models can be customized, and customers can tune weightings and thresholds.)
- Normalizing various formats into a single comprehensive data model and applying code system mappings to normalize codes to a chosen target code system
- Role-based access for data stewards who maintain the directory

## Strengths

InterSystems is extremely experienced in health data and its management. Its preexisting adapters for mapping standard data formats that facilitate data onboard show its commitment to (international) standards, and it serves on standards bodies (DaVinci, DEQM, Carin, INTEROPen, FHIR, HL7, and IHE). Tangentially, it is notable that EPIC relies on InterSystems development technology for its EHR software and expertise in infusing data into the EHR workflow. It also serves as the engine for 12 state health information exchanges (HIE) and the eHealth Exchange. The eHealth Exchange is active in all 50 states, is the oldest and largest national health information network in the United States, and is the principal network that connects federal agencies and nonfederal organizations, including over 75% of U.S. hospitals and tens of thousands of clinics, to share patient records to better treat patients and coordinate care. This shows its expertise in scalable bidirectional data exchange and an understanding of standards, certifications, and state regulation.

## Challenges

InterSystems does not support campaigns for recruiting, onboarding, search (although it has REST and FHIR API implementation guides), outreach, attestation, self-service, CAQH/SAM/PECOS/LexisNexis validations, network adequacy, provider ratings, or sanctions, but these are on its road map and the data model is extensible.

InterSystems' focus is on cleansing and identity so that the company's core HealthShare applications and external interfaces have good provider data to execute with, including adherence to DaVinci methodology. InterSystems has an expertise in claims, enrollment, clinical, and SDoH data integration. Its slant on its provider data focus shows that lineage.

## Consider InterSystems When

Consider InterSystems when you want a very health-oriented, international, experienced, data-centric, professional software vendor that understands the importance of clean data, governance, and the role of provider data integration in the interoperable health ecosystem. Its experience in HIE, payers,

providers, finance, and government show its dedication to data engines providing accurate data as the commerce for better health.

## Reading an IDC MarketScape Graph

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

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

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

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

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

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

## IDC MarketScape Methodology

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

## Market Definition

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

## Detailed Research Findings

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

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

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

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

### *Provider Data Is Now Solidly Its Own Core Application*

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

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

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

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

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

Unfortunately, focusing on flexible workflow, exhaustive data cleansing, expansion of provider types, provider engagement, network adequacy, value-based contracting, and a comprehensive yet modular product approach is too much for most vendors to do comprehensively at this time. Many "major players" were identified, each with its own value proposition. Traditional players are being challenged by an expanding problem set, and newer vendors are just beginning to appreciate the complexity of this space.

## *Provider Data Is a Consumer Differentiator*

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

## Provider Data Is a Social Differentiator

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

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

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

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

## Data Stewardship Remains a Problem

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

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

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

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

## *Provider Data Management Has Significant Scope and Breadth and Is Enlarging*

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

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

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

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

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

## *Other Findings*

Other findings of this research include:

- Payers rarely "rip and replace" their core claims system, and now they also rarely replace their core provider system in toto. However, changing requirements around expanded/niche directories, network adequacy, narrow networks, expansion of provider types, payer/provider systems integration, regulatory requirements, telemedicine, plan design, and value-based provider reimbursement cause major rethink and payers struggle to incrementally improve.
- Clients generally have a positive outlook on the capabilities of their vendors, particularly in supporting technical requirements, domain expertise, and support for the baseline demographic capture and workflow requirements of most payer organizations.
- Demographic capture and workflow requirements are now only a portion of the fundamentals in establishing a core for the provider information management ecosystem. Scalability, data model flexibility, and a vendor's entire suite of products are more relevant in this space than simple demographic seamlessness.
- A divide now exists between payers using their own internal master data management (MDM) approach to provider data and those that are willing to have other companies be their source.

## LEARN MORE

## Related Research

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

## Synopsis

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

According to Jeff Rivkin, research director, Payer IT Strategies at IDC Health Insights, "Provider data management systems of record are being evolved by payers that want to automate workflow, solidify data, and enable flexibility in their back office to reduce operational costs. As payers attempt to respond to governmental mandates and competitive pressures, the ability to maintain, control, and evolve provider networks fast and effectively is a competitive advantage. Those payers that can't may not survive the onslaught of value-based reimbursement, expanding provider types, and the increased consumer and regulatory demand for directory accuracy and network adequacy."

## About IDC

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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