Enterprise Buyer Journey for Health Plans

Introduction

The purpose of this Enterprise Buyer Journey document is to help Payspan develop a marketing strategy and key messages for the health plan market and for the specific buyers within health plans with whom we primarily interact. The document is split into two sections. Part 1 provides an overview of the health plan as an enterprise persona, and Part II includes personas for four specific buyers that we approach in our campaigns and outreach.

Part I – Enterprise Buyer Journey for Health Plans

- Target Markets
- Vendor Selection Process
- Decision-Making Influencers
- Content Preferences
- Pain Points/Challenges
- Primary Goals/Key Messages
- Recommendations for Payspan 2018

Part II – Buyer Personas for Member Engagement, Quality, Provider Relations & Operations

Each persona includes:

- Demographics (age, gender ratio, titles)
- Personality Traits
- Persona Summary (characterization)
- Career Path
- Job Description
- Authority
- Decision-making on scale of 1-5
- Goals
- Challenges
- Common Objections
- Key messages
- Elevator pitch

Part I – Enterprise Buyer Journey for Health Plans

Target Markets

Primary Target - Regionals

Our primary focus is on winning the business of regional health plans with 50,000 to 1 million members with growing markets in Medicare and Medicaid populations. Regional plans have slim staffs that are challenged with maintaining ongoing state regulations and audits while trying to improve quality care and outcomes for an increasing population of sick members from the public sector markets. They continually struggle with not having enough internal resources to comply with regulatory requirements while ensuring quality care for members.

Large Plans

We also have won business with some of the largest health plans in the U.S. Like regional plans, large health plans are challenged with maintaining ongoing regulations, but across multiple states instead of one, while taking care of an increasing volume of sick members. However, they may have enough internal resources to comply with regulatory requirements and ensure quality care for members, but they may also need assistance from outside vendors.

Vendor Selection Process

Health plans tend to be collaborative, relying on teams, committees and group decision-making rather than one person. Payspan will speak with multiple people who are impacted by our solution. At some point, a vendor manager or procurement specialist will become involved. Their level of involvement depends on the health plan and often the size of the health plan. There is often an RFI/RFP process, which varies per plan.

Our four buyer personas are all VP-level or above and their reputations can be made or broken by the success of the vendors they select. A vendor that fails to produce results and ROI could keep them from advancing in the organization. In some cases, they could even be forced out of the organization for a poor choice. Therefore, their standards and expectations will be challenging to meet during the sales process.

A major source of information for health plans seeking vendors is to get information from other health plans by setting up meetings with them through association memberships or conference attendance. They may also turn to preferred vendor lists, also provided through association memberships.

Below are summaries of how the selection process generally unfolds at regionals, nationals and a Blues plan.

Regionals

Typically, regional health plans form committees and assign a staff member, or an independent consultant, to be responsible for finding vendors to meet a need. As regionals have less resources, they may rely heavily on the advice of consultants they are speaking with regularly and frequently obtain references from them, which is why it is good to get in with consultants and to have a consultant

outreach list. At some point the health plan will have to bring in procurement, but they tend to do the initial research on their own through committees and networking.

Nationals

Large plans adhere religiously to their bureaucratic processes, so even if Payspan gets in good with a VP, the VP will have to comply with the Procurement process. Procurement always manages the contracts; however, the Procurement departments of large plans know little about vendors or how to identify the best ones. Influencers and decision-makers must be involved with recommending the best vendors and influencing Procurement. It is easiest to get in the door with large plans through connections and introductions since they are such big, vast organizations.

Some Plans Have Vendor Managers

A former Payspan employee described the vendor management function at a Blues plan where he worked previously. When targeting a health plan, it may make sense to find out if the plan has an official vendor management department.

Description

A Vendor Management department plays a larger role in the vendor selection process than Procurement. Unlike Procurement departments for large health plans, vendor managers play an active role in seeking out, vetting and recommending relevant vendors, and they are considered influencers in the decision-making process.

Vendor managers act as gatekeepers for vendors. Part of their role is to actively evaluate vendors on an ongoing basis in between selection processes so they are knowledgeable when the time comes to seek a new vendor. If a vendor initiates an interaction with a VP, the VP may opt to send them directly to the vendor manager to be vetted before talking with them.

Selection Process

Vendor managers create vendor matrixes that list vendors and rank them according to factors such as these:

- Number of current customers
- Years in the business
- Strengths and weaknesses
- Brand name recognition
- Price
- Application & programming support
- Stability
- Product documentation

Vendor managers identify the top three vendors, coordinate sales presentations/demos and manage the RFI/RFP process. Of course, VPs are the decision-makers and can make recommendations, but each vendor must go through the vetting process.

Decision Making Influencers

Summary

Key ways health plans learn about vendors they may be interested in:

- Memberships in health plan associations to get references and learn from other health plans
- Information gathered at key industry events
- Referrals from other health plans
- Data-driven content that presents product overviews and results
- Provider input
- Third-party resources like Gartner

When looking for vendors or meeting with them, health plan leaders are most impressed by:

- Experience with other health plans
- A reference from another health plan on the vendor's performance
- Accreditations
- Research and thought leadership exposure (e.g., participation in scientific studies, a recognizable reputation)

Key Influencer - Health Plan Associations

Both regional and large health plans leverage memberships in health plan associations, where they network with leaders of other health plans to exchange information, obtain advice or receive recommendations. Each health plan association is dramatically different and provides services for health plans that can be accessed via their websites.

Examples of services include:

- Access to preferred vendor lists and preferred vendor programs
- Conferences, workshops, forums and webinars where health plan executives and mid-level managers can hear from their colleagues at other health plans to get ideas for solutions and to learn about vendors that may be a good fit for their needs
- Small working groups of representatives from just a few health plans that get together regularly to exchange ideas
- Networking opportunities
- Introductions and face-to-face time with potential vendors
- Association communications like newsletters
- Invitations to be speakers at events

Popular Associations

- America's Health Plans of America (AHIP)
- Medicaid Health Plans of America (MHPA)
- Blues Association
- Health Plan Alliance of America (HPA)
- Alliance of Community Health Plans (ACAP)
- Workgroup for Electronic Data Interchange (WEDI)

Benefits for Payspan

- Association member email lists to be used for outreach and email blasts
- Access to invitation-only events
- Newsletters that can be used by vendors to promote services
- Opportunities to sponsor events, network, present, organize work groups, forums and webinars, get in front of health plans face-to-face
- Get to the front of the line when health plans start looking for a vendor

Content Preferences

Payspan's targeted VP-level buyers are educated and informed and already aware of trends and pain points affecting their role. They are further along the funnel and don't need to be educated about their problems and challenges.

They are at the stage where they need to learn about solutions. They are more interested in a case study or data-driven product-focused white paper that shows how the product works in detail and the results it has gotten with other clients.

Since developing that type of content is a challenge for Payspan right now, the support staff may be a better target for content about trends and pain points. They may be more likely to download that content to educate themselves and then orchestrate a meeting with their boss to meet the vendor.

Health plan leaders like to see hard numbers, results and data. Here are examples of the types of content that may interest them:

- Executive summaries of important policy issues or research topics
- Published research articles that contain strong data (leaders may read a theoretical article, but it would have to be really compelling for them to read it without data)
- Product white papers that outline solutions and provide impressive numerical results and ROI
- White papers on new information, findings and insights generated from rigorous analysis of existing data
- Scientific research studies
- Case studies of positive experiences with clients, other health plans with results
- Testimonials of what works (results): "We have demonstrated xyz for our clients by implementing programs…"

Common Objections/Concerns

Worried about:	How we address:
1) Lack of experience – HPs don't want to be the guinea pig 2) Lack of results and proof – vendor results can make or break VP careers 3) Long implementation cycles, complexity and risk – don't have the time to manage complicated vendor implementations 4) Integration issues with existing platforms – need seamless integrations so internal resources can be free to maintain audits 5) Accreditations, compliance 6) Cost-effective, ROI	1) Payspan has built the largest healthcare epayment network connecting 750+ health plans with 1.3 million provider payees and 1+ million consumers. 2) Payspan moves $90 billion in healthcare payments for 330 million claims and manages $400 million in credit card transactions annually. 3) Payspan can work with your team to speed through implementations. We have built an accelerator program with major claims adjudication platforms like QNXT to help get you up and running quickly. 4) Payspan's solutions don't integrate with other platforms. 5) Payspan's solutions are compliant with PCI, HIPAA and CAQH. 6) Payspan has achieved a 99% EFT adoption rate among providers for our largest health plans. Payspan's 100% paperless guarantee helps health plans reduce and/or eliminate paper, mailing and postage costs.

Pain Points

Challenges to Success

1. Low star ratings & HEDIS scores
2. Low member satisfaction scores, member attrition, lack of member engagement
3. Lack of provider participation in value-based care reimbursement
4. Lack of provider engagement in electronic adoption of epayments
5. High operational costs from inefficiencies and paper communications
6. Loss of revenue and cash flow, MLR challenges

How We Solve their Challenges

1. Payspan boosts your star ratings and HEDIS scores by leveraging the largest healthcare epayments network as a foundation to securely transport clinical and financial information about members that drives member engagement and value-based care reimbursement. Our Premiums/Member Engagement Solution gives your members what they want – digital payment options that lead to positive payment experiences and higher member satisfaction scores. Our Quality Incentive Communications System (QICS) reduces provider barriers to value-based care by making it easy and affordable for providers to participate in closing care gaps and applying quality measures, resulting in better health outcomes and higher star ratings and HEDIS scores.
2. Our Premiums/Member Engagement Solution drives member satisfaction and retention by offering flexible, convenient payment options, a seamless payment experience and a portal where members can access their payment information in one place.
3. Our QICS solution addresses the most common provider objection to value-based care – the overhead costs of applying complex value contracts. The system translates clinical data into simplified, actionable care gap alerts, guidance on quality measures and incentive reports and enables health plans to communicate the messages electronically over Payspan's secure network via attachments.
4. Payspan's Core Payer Network leverages provider engagement best practices to enroll providers in the network and set them up to begin receiving electronic payments to their banks or a virtual card.
5. Payspan's 100% paperless guarantee helps health plans reduce and/or eliminate paper, mailing and postage costs.
6. Payspan's solutions together or apart boost star ratings, HEDIS and member satisfaction scores, reduce costs, and drive revenue.

Primary Goals & Key Messages

Goals

1. Boost star ratings, HEDIS and member engagement scores
2. Improve member engagement
3. Build loyalty & retain members
4. Reduce costs by improving quality care
5. Contain operational costs and drive revenue

How We Help

1. Payspan boosts your star ratings and HEDIS scores by leveraging the largest healthcare epayments network as a foundation to securely transport clinical and financial information that drives member engagement and value-based care reimbursement.
2. Our Premiums/Member Engagement Solution improves member engagement by offering your members the flexible, mobile-optimized digital payment options that they have come to expect with a purchasing experience.
3. We help you build brand loyalty by keeping your health plan current with the latest payment trends. Our Premiums/Member Engagement Solution delivers positive, satisfying payment experiences that attract and retain members in an increasingly competitive marketplace.
4. Payspan leverages our secure healthcare epayments network connecting 750 health plans with 1.3 million provider payees to enable you to exchange quality information electronically with your providers to close care gaps and improve health outcomes.
5. Payspan's epayment solutions reduce costs and drive revenue by driving provider adoption of electronic payments, provider engagement with value-based care and member engagement through positive payment experiences.

Recommendations for Payspan in 2018

Content

Case Studies

- Identify 3 clients that are happy with Payspan and have good results to share
- Develop case studies that could be used in email campaigns and posted online
- Add Case Studies section to website after at least three have been completed

Product-Focused Value Content

- **White Paper** - Support Core with white paper that details provider best practices as a differentiator and how we are transitioning clients to 100% paperless
- **Video** – Overview of Payspan solutions

Collateral

- Revise Payspan Solutions overview brochure based on Persona research
- Core slick

Email Campaigns

- Develop email lists for each persona and begin targeted email campaigns
- Add personas to Hubspot
- Enable the sales team to leverage key personas through Hubspot with one-to-one target prospecting tools that provide insight into the health plans they are targeting and the individuals inside those organizations
- Develop a consultant sales list to include in campaigns.
- Develop separate campaigns to consultants, or slant message of existing campaigns to consultants

Associations

At this time Payspan does not have the resources to fully participate in association memberships, but that may change as the company grows. Memberships require a lot of time to participate in the events, presentations and thought leadership events. However, there may be limited ways Payspan can leverage the benefits of associations:

- Some associations may offer limited membership options, such as the opportunity to do a webinar or attend a networking event.
- It may be worth considering offering one sales person interested in developing themselves as a thought leader to become a member of an association and commit to making time to participate with the support of Marketing (presentations, emails, collateral, etc.)
- With associations that do not offer vendor memberships, Payspan can offer to sponsor events at a key meeting (lunch, happy hour), and volunteer to participate in panels or present at key meetings.

Part II – Buyer Personas for Member Engagement, Quality, Provider Relations & Operations

Member Engagement Persona

Age: 30s-50s

Gender Ratio: 50/50

Titles:
VP/GM Consumer Engagement
VP/GM Payment Innovations
VP/GM Consumer or Member Solutions
Chief Innovation Officer

Personality Traits: Highly driven, plugged in, cutting edge, can be cynical and pessimistic toward vendors

Persona Summary: This persona is well-educated, digitally savvy, and plugged into social media platforms and apps. As the person responsible for coming up with ways to get members to be more engaged with their health, he/she is typically health conscious and fit. They are under a lot of pressure to drive business through member attraction and retention.

Career Path: He/she is likely to have been recruited to work in member engagement from technology or started out in digital application development. Or he/she may have worked their way up from claims operations. They know the details of how things work and like to make people aware that they know more than them about their realm, e.g., they like to point out when they think that sales people are not considering how the solution impacts regulations.

Job Description: Their main responsibility is to create services that drive value for members, loyalty and member retention. Increasingly, their position is transitioning from operational to consumer marketing, and this is a new challenge for them. Because healthcare tends to make changes slowly, health plans are behind other consumer-driven industries. It is the job of this persona to find ways to catch up to other industries and be competitive.

They are always focusing on coming up with and improving existing member engagement tools – 90% oriented toward health engagement, and 10% toward the payment experience. They constantly monitor member digital activity with both health/wellness and payment activity. They use the data to gauge whether members are having positive or negative experiences and to improve or alter existing services.

This persona must decide how to market to members and how much to spend. They are always evaluating the cost to acquire and sustain customers vs. the dollar value of a customer's lifetime value. Payspan knows a major Medicare Advantage regional plan that is spending in the area of $10.50 per member/per month for Medicare Advantage. These funds are designed to market to members for retention and make them aware of plan benefits.

Sometimes, the member engagement persona leads subsidiary businesses within health plans focused on member functions, such as provider networks, wellness, cost estimates, and health management. Some develop services in-house and others rely on vendors or a combination of both.

Authority:

The member engagement persona is the final decision-maker and the person who signs the contract.

Decision-making on a scale of 1-5:

5

Primary Goals:

- Drive innovative ideas to build stock in the organization and get promoted
- Improve member engagement
- Boost star ratings and HEDIS scores
- Attract new members
- Build loyalty & retain members
- Drive revenue based on member satisfaction

Secondary Goals:

- Provide seamless experience via health portal
- Create a positive payment experience
- Keep members engaged and connected to plan (notifications, info about payments, communications)
- Provide mobile-optimized experience
- Keep members informed about incentives

Challenges:

- Pressure by the C-suite, who are influenced by analysts saying health plans are behind the curve, to bring forward ideas and solutions that help the health plan be perceived as a progressive company current with other consumer-driven businesses. They want to distinguish themselves by coming up with cutting edge solutions that attract new members, drive retention and position themselves for the next promotion.
- Loss of member satisfaction that results in lower star ratings, reduced revenue and limited ability to attract new members
- Unmet consumer expectations regarding digital payment options that result in customers leaving, payments are the number one determinate of member satisfaction

- Consumer demand for transparency of costs. Members that need more extensive healthcare services seek help from health plans in understanding and sorting through their payment responsibility.
- Lack of analytical tools to understand individual members. They have ideas for campaigns-of-one for members but lack the tools for data analysis to take actions that produce results.
- Loss of revenue due to long payment collection periods
- Lack of cash flow to advance business
- Cost per member of lower ratings
- Increase in customer acquisition cost

Common Objections:

- Don't like to make decisions during open enrollment

Plans that Buy Premiums

Working on defining this.

Key Messages:

- Payspan's Premium Payments solution was designed to make the most important aspect of the customer experience with your organization – the payments experience – a positive one. This way, you don't have to worry about increasing customer acquisition costs due to members leaving because of negative payment experiences.
- Our solution helps you boost your star ratings and HEDIS scores by offering your members the flexible, mobile-optimized digital payment options that they have come to expect with a purchasing experience.
- Keeping your health plan current with the latest payment trends enables you to deliver positive, satisfying experiences that attract and retain members in an increasingly competitive marketplace.
- We are always thinking about the future and being able to help you grow with the latest trends. Our approach leverages the payments function to build a gateway to brand loyalty and lasting relationships with your customers based on positive experiences that go beyond premium payments.
- Our developing solution enables you to use the premium payments function to communicate about other financial information, such as EOBs or incentives, or even guidance to help members take better care of themselves. Your members will log on to access this information in one place, including a record of their invoices and transactions.
- Our Premium Payments Solution is the foundation from which we offer simplified, satisfying payment experiences. Our solution makes it easy for your members to pay via a choice of flexible multilingual phone and online options.
    - For your members with complex homes, we offer an easy-to-use tool for updating dependents that automatically adjusts premium rates.

    - Payspan integrates lockbox (paper check processing) into a consolidated electronic file process that incorporates online and IVR payments.
- Our mobile-optimized, single-sign-on payment portal is branded to your organization, making it possible for your members to enjoy a seamless payment experience.
- Making it easy for your members to pay, track payments and understand their payment responsibility leads to greater member engagement, satisfaction and brand loyalty. As a result, your health plan develops a reputation for delivering positive experiences.
- Payspan's multiple payment options and convenience drives revenue for your organization by increasing your collections and reducing the time it takes to collect payments. By improving your collections, you support your cash flow, allowing your health plan to meet its business goals.

Elevator Pitch:
(for email or in person at an event)

Subject line: Delight members with positive payment experiences

Today's technologically-savvy consumers want digital payment options and interactions, but health plans have fallen behind the digital payment trend.

Nowadays, the payment experience can be a deciding factor of whether a consumer chooses to buy your services. Payspan's Premium Payments solution was designed to help your organization stay ahead of the curve.

Our approach was designed to do what few other solutions in the market can do – make the most important aspect of the customer experience with your organization– the payments experience – a positive one.

We offer the kind of flexible, mobile-optimized digital payment options your members have come to expect during the purchasing process, including multilingual phone and online options.

Our approach is to leverage Premium Payments as the foundation to deliver positive payment experiences that attract and retain members, enabling you to boost you star ratings and HEDIS and member satisfaction scores.

Would you like to like to learn more? Maybe we could schedule a quick call for me to share a little more detail. Here's my card, etc.

Quality Persona

Age: 30s-50s

Gender Ratio: 60% women/40% men overall
Chief Medical Officers (CMOs) are mostly male

Titles: CMO, Medicare or Medicaid Programs, or Government Programs
VP, Clinical Innovation or Analytics or Integration
VP, Clinical Strategy or Risk Adjustment
VP, Performance Management or Value-based Programs
VP, Center of Excellence/Star Programs
VP, Risk Adjustment, Government Operations, Commercial Risk or Quality

Personality Traits: Dedicated, mission-driven, idealistic

Persona Summary: People within this persona are driven to positively impact the health insurance business and be a part of helping to improve the overall healthcare system. They are highly educated, experienced, knowledgeable and passionate about what they do. They believe they are helping people by improving their healthcare. Though he/she is the Chief Medical Officer or a VP reporting to the CMO, they are not just working for the money; they are driven to make a difference. They believe in what they are doing. Many started out in care delivery as clinicians, nurses, physicians or other supporting roles and moved to health insurance on a mission to fix problems and make improvements.

Most of these people are VPs who are over particular areas that have to do with improving care delivery and they report to the CMO, who is over everything. The CMO is usually a male in their 50s-60s, can be arrogant or have a superior attitude (they are the smartest guy in the room and know it) and hard to impress. Whether a CMO or VP, they are all knowledgeable about both their own as well as their colleagues' areas of expertise.

Career Path: Quality people have been in the healthcare business for years, many on the care side as clinicians, but some may have come from prestigious consulting firms or previously been government employees managing care in the public sector.

Job Description: No matter what VP title these people have, they must continually evaluate the health plan's performance against star ratings and Hedis scores and come up with strategies to effectively manage its members with the greatest clinical needs who generate the highest healthcare costs. As part of those efforts, their primary responsibility is to develop and manage quality programs to ensure that health plans can earn their incentive bonuses from CMS. They are held accountable by the health plan for earning those dollars.

They are under a lot of pressure, carrying the weight of many responsibilities, depending on their piece of the pie. They are expected to deliver quickly and not necessarily just with their own resources. They must navigate the entire organization, tapping other resources to achieve their goals. Typically, they have a lot of power to make decisions. They set the budget and determine where the money will be spent.

Other responsibilities that may fall under these VPs:

- Create member engagement programs that:
  - Encourage members to improve their health, whether they are at risk for an illness or already have a chronic condition
  - Help members with chronic conditions comply with their doctor's treatment regimen and meet disease-specific clinical performance indicators
  - Drive participation in wellness programs to help members lose weight, reduce their health risk, eat better and exercise
  - Help members schedule and fulfill doctor visits
- Per member per month costs
- Metrics
- Accreditation and quality improvement
- Provider contracts and networks

Authority:

The quality persona is the final decision-maker and the person who signs the contract.

Decision-making on a scale of 1-5:

5

Primary Goals:

- Reduce medical costs while improving quality care
- Generate revenue by earning CMS incentives
- Boost star ratings and HEDIS scores
- Engage providers in quality-based care
- Improve member health through member engagement

Secondary Goals:

- Engage public sector populations that can be difficult to reach without feet on the street
- Identify, engage and enroll outliers and highest risk members as quickly as possible
- Improve quality cost-effectively for sickest Medicare/Medicaid members

Challenges:

- Trying to effect behavior change in providers and members
- Getting members to engage in healthy behaviors, including regular doctor visits, care gap closures, preventive health activities, weight management and chronic disease management

- Engaging all-size providers, from IPAs to small rural practices in value-based care
    - Engaging providers with a small volume of members who have little incentive to participate
    - Engaging providers with slim resources who do not believe the incentives are worth the effort
    - Standing out from the pack. Providers are constantly approached with offers from health plans for new tools to use when they don't have the time or money to train new people and set up systems.
- Lack of clinical data from providers that plans need to ensure they are not charged a fee for risk adjustment. They also need the data to show the value-contracts are improving care and health outcomes; providers who will not help since there is not anything in it for them.
    - Why would providers want to go out of their way managing paperwork, making copies, faxing, and engaging in phone calls to provide this information? It's a huge pain point for providers. Providers will get multiple requests for the same data from multiple departments in the same plan. This is why QICS' access to multiple health plans is such a strong selling point for Payspan.
    - Having to pay third parties to visit provider practices to collect this data and other confusing processes that result in convoluted data that is hard to analyze and process.
- Making sure providers are not overloaded with too much information and are managed efficiently so they can focus on delivering care to members. It's a tough balancing act to determine the right information that is usable to them.
- Increasing star ratings and HEDIS scores to generate more cash flow for the health plan, enabling it to build its brand and market to new members all year.,

Common Objections:

- May believe vendors focused in the value-based care space are more qualified than Payspan

Plans that Buy Quality

Public sector health plans – Medicare Advantage and Medicaid

Key Messages:

- Payspan has designed a quality incentive communications solution that addresses one of your most obstinate challenges – how to get your providers to engage in value-based care reimbursement so your organization can boost star ratings and drive revenue.
- Our Quality Incentive Communications System (QICS) makes it easy and convenient for your providers to participate by:
    - Eliminating the need for providers to manually enroll and follow up on each health plan's website

    - Simplifying communications about quality as to what care gaps providers should focus on closing, per individual member-patient
    - Providing clarification on cumbersome hard-to-understand value contracts
    - Reducing administrative labor and costs for providers
    - Magnifying the value of financial incentives to the bottom line
- Payspan leverages our secure healthcare epayments network that connects 750 health plans with 1.3 million provider payees to enable the electronic exchange via attachments of quality information between health plans and their providers. Health plans share care gap notifications, guidance on quality measures and incentive reports with providers who, in turn, share proof of care gap closures to receive incentives.
- Providers merely enroll in our network one time, and they have instant access to your organization and multiple other health plans. When they see how easy the process is and how little administrative time and effort is required, participation becomes appealing to them. The financial incentives, which previously might have seemed like "small change", now take on new value to their bottom line.
- With QICS, providers are not faced with having to expend exorbitant resources plowing through dense value contracts, which is a primary barrier to engagement for most practices, from small to large.
- QICS removes the complexity by translating raw data from health plans about their patients into clear, simple, visually appealing notifications about existing care gaps that providers can easily read and act on quickly. Our graphical reports about attained and available incentives help providers track and monitor progress with each patient with a care gap, enabling them to improve care outcomes while boosting their revenue.
- By helping your providers work closely with patients to close care gaps, QICS helps your organization improve quality by engaging members in healthy self-care behaviors that reduce avoidable utilization and unnecessary healthcare costs.
- QICS also helps you distinguish your organization from other health plans who are all knocking on provider doors offering new systems and tools, which providers do not have the time to implement in their practices. Offering a solution that solves your providers' primary challenges will help you stand out from the pack.
- QICS paves the way to eliminating third-party collections of healthcare data and confusing processes that result in convoluted data that is hard to analyze and process.
- QICS helps you generate revenue by providing a gateway to clinical data from providers that demonstrates to CMS how your value contracts are improving care and health outcomes by closing care gaps. By boosting your star ratings, you earn your CMS incentives as well as reduce or eliminate risk adjustment fees.

Elevator Pitch:
(for email or in person at an event)

Subject line: Providers can't say no to this quality solution

More than half of the nation's providers are small practices with 10 or less physicians, who don't have the resources to process the paperwork necessary to engage in value-based care.

Payspan's Quality Incentive Communications System for health plans makes it easy for your providers to engage because it does most of the work for them. We make it so easy and hassle-free that they won't have any more excuses for not participating.

Providers and their staffs don't have to expend exorbitant resources plowing through dense value contracts, and the administrative labor and paperwork are significantly reduced.

Providers merely enroll in our electronic epayments network one time, and they have instant access to your organization and multiple other health plans.

When they see how easy the process is and how little administrative time and effort is required, participation becomes appealing to them. The financial incentives, which previously might have seemed like "small change" now take on new value to their bottom line.

Would you like to like to learn more? Maybe we could schedule a quick call for me to share a little more detail. Here's my card, etc.

Provider Relations Persona

Age: 30s-50s

Gender Ratio: 50/50

Titles: VP, Network Management
VP, Provider Relations

Personality Traits: Advocates, helpers, task-oriented, focused on helping providers

Persona Summary: This persona is focused exclusively on advocating for and helping providers meet their goals. Many have worked as clinicians or nurses in provider settings. As a result, they are more clinically driven and attuned to the issues providers face, and understand provider needs.

Task-oriented, "busy bees," they stay focused on getting things done that help providers. They have little use for health plan bureaucracies or for participating in health plan politics. Their ultimate goal is to positively impact members by giving providers the tools they need to improve health outcomes.

Career Path: Most have backgrounds working in provider offices but have been at the health plan for many years. They left the provider setting because they saw opportunities to impact health on a greater level by helping providers.

Job Description: The provider relations persona is most likely on the overall clinical team – responsible for the provider engagement portion of quality. They may report to the Chief Medical Officer or the head of the quality department, usually a doctor.

Primary Responsibilities

- Manage health plan's provider network
- Communicate about care gaps, quality measures and incentives with providers
- Translate complex data into clear communications that do not overwhelm providers and can be acted on.

Description

It's on the provider relations persona to communicate about the program with providers, including letting them know about care gaps, providing guidance on what quality measures they need to take to close the gaps and providing clear reports about the incentives available to them that show the dollar value. The VP and team are operating the quality program and making sure the checks are being sent, but they are not the one writing the checks.

As a result, it's on the provider relations persona to determine how to distill and serve up enormous amounts of complex clinical data to providers that can be easily understood and acted on.

They may manage a team of nurses and clinicians whose responsibility is to reach out to providers, connect with them, keep them updated on changes in policy, offer support with paperwork and answer questions. The VP must overlook the team activities to make sure that:

- Providers are getting what they need to participate in the quality program
- Care gaps are being closed
- Data is being collected from providers to show care gap closures
- Incentives are being paid
- Providers are getting paid what they were promised

Authority: The provider relations persona is influential but not the final decision maker.

Decision-making on a scale of 1-5: 3

Primary Goals:

- Engage providers with quality program
- Communicate about the program in a way that providers can easily understand and act on
- Communicate the value of incentive dollars to the bottom line
- Identify care gaps from raw data and communicate about them to providers
- Provide clear guidance on quality measures for each care gap

Secondary Goals:

- Identify and outreach to those providers that need the most help and encouragement, who are most likely to not participate

Challenges:

- Nearly 60% of the nation's providers have small practices with 10 or less physicians, and they don't have the resources to keep up the administrative commitment required to participate fully.
- If providers don't understand the program, they will not engage with it. The process needs to be easy and a natural part of their existing work flow.
- Providers can be easily overwhelmed with too much information. In order to engage, they need clear, succinct, easy-to-understand guidance that includes just enough information to act on.
- Provider relations people often have tons of data that they don't know how to process. It's their job to figure out how to make the information digestible for providers and easy to act on to improve health outcomes.
- Providers may see incentives as "small change" and not worth the administrative labor and cost as worth the effort.

- Provider offices with limited internal resources cannot keep up with multiple requests from multiple health plans for documentation and clinical data.
- Providers don't have the time and resources to keep up with ongoing policy changes coming from each health plan. Getting providers to change their processes with each plan every time the policy changes is near impossible.
- While it's easy for providers to sign up to receive electronic payments (and many would prefer that), they don't have the internal resources to manage the ongoing processes of visiting each plan's site to see their payment and remittance information and perform ongoing maintenance tasks.
- Out-of-network providers have no incentive to participate.

Common Objections:

No objections. This group positively receives our program since it is focused on helping providers and facilitating value-based care. If they perceive that the program will positively impact providers by providing them with clear communications and enabling them to engage, they are interested. They have less objections and restrictions. They are less concerned with price, references and the concerns that the other personas may have.

Plans that Buy Quality

Public sector health plans – Medicare Advantage and Medicaid

Key Messages:

- Now there's a way for you to translate complex clinical data into clear, easy-to-understand quality communications with your providers to engage them in your quality program.
- Payspan's Quality Incentive Communications System (QICS) leverages Payspan's secure epayments network to enable you to share these simplified, actionable communications electronically via attachments. Your providers, in turn, share proof of care gap closures to receive their incentive payments over the network. It's that simple.
- You no longer have to worry about how to distill enormous amounts of data into easily digestible, actionable messages that will lead to care cap closures, improved health outcomes and cost savings.
- QICS does all the work for you and your providers by:
    - Processing the raw data from your health plan
    - Generating quick, easy-to-read care gap alerts that include guidance about what quality measures to apply
    - Creating visually appealing incentives reports that show your providers the true dollar value impact to their bottom lines
    - Providing a secure network for your health plan and your providers to exchange sensitive medical information electronically that advances value-based care

- QICS has the power to help you engage those providers who simply cannot afford the time and resources to plow through dense value contracts, which you know is a primary barrier to engagement.
- By providing the information your providers need to close care gaps, QICS enables you to help your organization improve member engagement in healthy self-care behaviors that improve health, reduce avoidable costs and boost star ratings.
- QICS overcomes your providers' primary obstacles to participation. With small practices of 10 or less physicians with limited internal resources comprising 60% of the nation's providers, QICS reduces or eliminates administrative costs from paper processes, mailing and postage.
- Your providers easily enroll in our network one time, and they have instant access to your organization and multiple other health plans, reducing the time it takes to manage each health plan's quality program.
- When your providers see how easy the process is and how little administrative time and effort is required, participation becomes appealing to them. The financial incentives, which previously might have seemed like "small change" now take on new value to their bottom line.
- QICS also helps you distinguish your organization from other health plans who are all knocking on provider doors offering new systems and tools, which providers do not have the time to implement in their practices. Offering a solution that solves your providers' primary challenges will help you stand out from the pack.
- QICS helps you generate revenue by sharing clinical data from providers that demonstrates to CMS how your value contracts are improving care and health outcomes. By boosting your star ratings and HEDIS scores, you earn your CMS incentives and reduce or eliminate risk adjustment fees.

Elevator Pitch:
(for email or in person at an event)

Subject Line: Excite your providers about value-based care

A number of health plans have indicated to Payspan that they have gap closure rates in the 3-5% range, which shows just how much help providers really need to engage in value-based care.

Now there's a solution that solves one of the heaviest burdens on your shoulders – how to create simplified, actionable messaging that gives providers the guidance they need to close care gaps.

Payspan's Quality Incentive Communications System (QICS) takes the raw clinical data from your health plan and translates it into clear, easy-to-understand care gap notifications with guidance on quality measures and reports that track and monitor your providers' status with care gap closures and incentive payouts.

We leverage our secure epayments network to enable you to share quality communications via attachments electronically. Your providers, in turn, share

proof of care gap closures to receive their incentive payments over the network. It's that simple.

Would like to like to learn more? Maybe we could schedule a quick call for me to share a little more detail. Here's my card, etc.

Operations Persona

Age: 45-60

Gender Ratio: Operational: 70% male
Finance: Mostly male

Titles: COO
VP, Claims, Claims Ops or Provider Reimbursement
VP, Operational Strategy
VP, Treasury or Finance

Personality Traits: Black and white, process-oriented, task-oriented, results-driven, no time for "fluff"

Persona Summary: The Operations persona is the "Doctor Know it All" or the "Fixer" of the health plan – the one that everybody in the organization comes to for solutions to problems. They typically take on challenges that other parts of the health plan would prefer to avoid. For instance, if a client wants a customized service that is completely out of the scope of what the health plan normally provides, the operations person is the one to decide if and how to proceed.

Operations leaders often have an encyclopedic knowledge of the health plan's operations. They understand the nuts and bolts of operations down to the granular detail. They are more business-oriented than the other personas, motivated to beat their budgets, and unlike the other personas, exclusively focused on the bottom line.

When Operations Combines with Finance
In some cases, like with regional plans, the CFO or a VP-level person in finance may be involved with managing operations as well as finance, but his focus will be financial regardless. While the Operations people will be looking at how a vendor can improve efficiencies, both the operations and finance leaders will want to see the financial benefits and ROI of contracting with a vendor.

Career Path:

Operations
The Operations persona most likely started their career in the industry as a claims reviewer before climbing the ladder to supervisor, manager, director and then VP. In some instances, they may have a financial background. They usually have worked for the organization for many years and that's why they know the operations processes so thoroughly. Currently, there is a growing number of operations people with Six Sigma certifications.

Operations/Finance
The finance operations people started out as an accountant and moved up in the treasury to management positions.

Job Description:

Operations
This persona manages processes for everything from when a new member enters the books to paying providers for the claims and everything in between. They manage huge budgets and have large teams reporting to them. They decide whether claims get paid and what vendors manage the claims and payments for them.

Responsible for:

- Operational & financial metrics reporting
- Claims operations
- Compliance – making sure all regulations are met
- Adjudication systems – right tools to ensure claims are edited correctly and have all the right procedure codes to get paid, all forms are filled out correctly
- Enforce CMS claims processes
- Decisions regarding vendors
- Manage provider calls asking why claim denied
- Manage "squeaky wheels" complaints from clients
- New provider network contracts
- Making sure nothing goes wrong

Operations/Finance
If they are finance/operations people, they are also responsible for the money and banking relationships, as well as treasury operations, reporting, taxes and audits. They have a tremendous amount of influence in terms of what gets funded.

Authority:

They are the top decision-makers regarding vendors.

Decision-making on a scale of 1-5:

5

Primary Goals:

Operations

- Optimize operational services that support all functions
- Boost star ratings and HEDIS scores
- Improve operational metrics
- Drive revenue by beating budgets and reducing costs
- Reduce obstacles to positive metrics, e.g., claims delays
- Avoid CMS sanctions

Operations/Finance

- Meet requirements for MLR
- Make sure HP is getting ROI for investments across all departments
- Make financial decisions that increase vs. decrease revenue
- Reduce costs

Secondary Goals:

- Improve quality
- Improve member satisfaction & engagement
- Improve provider engagement

Challenges:

- Pressure to reduce administrative expenses
- Taking too long to solve problems
- Low star ratings & HEDIS scores
- Adjudication delays due to inaccuracies and inefficiencies
- Large volume of client complaints about processes not working
- Large volume of provider complaints about claims rejections and delays
- Keeping up with regulatory audits with limited resources (regionals in particular)

Common Objections:

- "Show me, don't tell me"
- Length of time to solve problems
- Implementation complexity
- Want proof and references

Key Messages:

- Payspan knows that you need a reliable epayments vendor that can work easily with your team behind the scenes to transition you to paperless checks and remittances while freeing you to focus on more important projects.
- Our core business is helping health plans reduce administrative and labor costs associated with processing paper checks. We are here to help you beat your budget and meet your MLR requirements. In 2017, all of our clients achieved annual cost savings, up to $2 million for one client.
- Payspan has achieved paperless adoption rates from 90% to 99% for both regional and large health plans. Health plans that follow our best practices can attain 100% electronic provider payments.
- Payspan annually moves $90 billion in healthcare payments for 330 million claims and manages $400 million in credit card transactions.
- As the first company to build an entire epayment network to facilitate EFT/ACH as the preferred payment option, Payspan has built the largest healthcare network for epayments connecting 750+ health plans with 1.3 million provider payees. Every day, 40,000 providers log on to our network, while 500,000 receive electronic payments monthly.
- Our solutions complement your existing processes, enabling your team to process payments more quickly and reducing obstacles to positive metrics that keep you in good stead with CMS and boost your star ratings and HEDIS scores.
- Our network removes inefficiencies in your processes that result in claims delays that keep you mired in fixing problems instead of focusing on special projects that drive revenue.

- Just so you know, Payspan has leveraged its network to move beyond electronic payment adoption to offer solutions that advance member engagement and value-based care reimbursement.
- Our Premiums/Member Engagement Solution gives your members what they want – digital payment options that lead to positive payment experiences and higher member satisfaction scores.
- Our Quality Incentive Communications System (QICS) reduces provider barriers to value-based care by making it easy and affordable for providers to participate in closing care gaps and applying quality measures. We leverage our network to enable health plans to share care gap alerts, guidance on quality measures and incentives reports via attachments. Providers, in turn, share proof of care gap closures to receive incentives.
- Payspan's solutions, together or apart, give you the support you need to reduce avoidable costs, boost star ratings, HEDIS and member satisfaction scores, and drive revenue.

Elevator Pitch: (for email or in person at an event)

Subject line: Beat your budget, go paperless with Payspan

Payspan knows that you can get so bogged down with cost containment issues that you don't have time to focus on initiatives that drive revenue.

We can take a key cost driver off your plate – paper communications with providers.

Payspan helps you beat your budget by transitioning your health plan to paper checks and remittances. We guarantee 100% paperless payments with providers for health plans that follow our best practices.

In addition, we help you meet your value-based care goals by letting you share quality information with your providers over our secure epayment network via attachments, making it easier and affordable for your providers to participate.

Payspan has achieved paper adoption rates from 90% to 99% for both regional and large health plans, and last year, achieved cost savings for all of our health plan clients, up to $2 million for one client.

Would like to like to learn more? Maybe we could schedule a quick call for me to share a little more detail. Here's my card, etc.