Quality Persona

Ellen Fields
VP, Clinical Strategy

Age	30s-50s
Gender Ratio	60% women; Chief Medical Officers are mostly male
Titles	CMO; 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

Authority Level	1 2 3 4 5
Authority Description	Most often the final decision-maker but still must check in if they report to CMO.
Traits	Dedicated, mission-drive, idealistic

Persona Summary

Ellen is driven to positively impact the health insurance business and be a part of helping to improve the overall healthcare system. She is highly educated, experienced, knowledgeable and passionate about what she does. Driven to make a difference, she believes she is helping people by improving their healthcare. She reports to the CMO, Dr. Richard Smith, who is involved in the buyer process. Sometimes, he manages the vendor process. He is arrogant with a superior attitude and hard for vendors to impress. He makes sure everyone knows he is the smartest guy in the room.

Job Description

Ellen must continually evaluate the health plan's performance against Star Ratings and HEDIS scores and come up with strategies to effectively manage members with the greatest clinical needs who generate the highest healthcare costs. As part of those efforts, she must develop and manage quality programs to ensure that health plans can earn their incentive bonuses from CMS. She is held accountable by the health plan for earning those dollars. While under a lot of pressure with many responsibilities, she has a lot of power to make decisions. She sets the budget and determines where the money will be spent.

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
- Improve quality cost-effectively for sickest Medicare/Medicaid members
- Improve quality cost-effectively for sickest Medicare/Medicaid members
- Identify and engage highest risk members as quickly as possible

Challenges

- Effect behavior change in providers and members
- Engage members in healthy behaviors
- Overcome provider obstacles to engagement in value-based care, including:
  - Little incentive to participate due to small volume of members
  - Financial incentives not worth the labor time and costs
  - Too many offers from health plans for new tools that require too many resources to learn and set up
- Lack of clinical data from providers to show value-contracts are improving care and health outcomes and to provide risk adjustment fees.
  - Providers get multiple requests for same data from multiple plans
  - 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 so they can focus on care delivery.

Common Objections

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

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 600+ 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.

Elevator Pitch

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.