**APPENDIX-9 SAMPLE PERFORMANCE GUARANTEE METRICS**

# EMPLOYER NAME: XYZ Company

**Employer Group Number(s): TBD**

Effective for the Settlement Period beginning **mm/dd/yyyy** and ending **mm/dd/yyyy**

| **SERVICE - Medical** | **Defined Performance Guarantees** | **Performance Guarantee** | **Percentage  of the Administrative Charge at Risk**  **mm/dd/yyyy-mm/dd/yyyy** |
| --- | --- | --- | --- |
| Claims Processing Turnaround Time – All Claims | **Claims Processing Turnaround Time** means the period beginning on the date the Claim Administrator receives a Claim for processing through the date the Claim passes all system edits and benefits are approved or denied by the Claim Administrator. The performance guarantee is measured as a percent of all Claims processed within 30 calendar days.  Method of Measurement: The number of Claims processed in 30 calendar days divided by the total number of claims. Measurement is based on Employer-specific Claims. | 95.0% - 100%  90.0% - 94.9% 0% - 89.9% | 0%  1%  2% |
| Claim Processing Accuracy | **Claim Processing Accuracy** is defined as the percent of Claims processed accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator. Claim Processing Accuracy refers to Claims without processing errors such as:   1. Coding - incorrect claim data entry. 2. Failure to adhere to the Employer’s health care benefit program design. 3. Failure to adhere to the administrative procedures. 4. System generated errors, benefit programming errors, calculation errors. 5. Excluding: 6. Any administrative inaccuracies that do not impact claims disposition or customer reporting; 7. Errors entered by providers of service; 8. Benefits provided to an ineligible claimant due to the Employer’s failure to provide timely and accurate eligibility information to the Claim Administrator.   Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims processed during the settlement period. A Claim Processing Accuracy percentage is calculated for each stratum by dividing the number of accurately processed Claims by the number of Claims selected in the stratum. Each accuracy percentage is then weighted according to the total claim population. The Claim Processing Accuracy rate is determined by summing the weighted accuracy from each stratum. Measurement is based on an audit of Employer-specific Claims. | 97.0% - 100%  95.0% - 96.9%  0% - 94.9% | 0%  1% 2% |
| Claim Financial Accuracy | **Claim Financial Accuracy** means the percent of dollars paid accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator.  Method of measurement: The accuracy rate is determined from a statistically random ratio stratified sample audit of all Dollars paid during the Settlement Period. Calculated as the total audited paid dollars minus the absolute value of overpayments and underpayments, divided by the total audited paid dollars. Measurement is based on an audit of Employer-specific Claims. | 99.0% - 100%  97.0% - 98.9% 0% - 96.9% | 0%  1% 2% |
| Customer Service | **Average Speed of Answer of Telephone Calls,** calculated over the complete business day, is defined as the time a caller spends on hold until a Customer Advocate becomes available.  Method of measurement: The average speed of answer will be calculated by dividing the total length of time for all calls, measured from the time a call is queued by the automated telephone system for the next available Customer Advocate until the time the caller is connected with a Customer Advocate, by the total number of calls connected with a Customer Advocate during the Settlement Period. The Average Speed to Answer is provided by telephone reports that compute the average number of seconds that Callers spend on hold waiting for their Call to be answered. Standard is measured using member calls on an Employer-specific basis.  **Abandoned Calls** are defined as calls, calculated over the complete business day, that reach the facility and are placed in a queue, but are not answered because the caller hangs up before a Customer Advocate becomes available. Any calls abandoned or terminated by the caller prior to 30 seconds will not be counted as Abandoned Calls. Standard is measured using member calls on an Employer-specific basis. | 0-30 seconds  31-60 seconds  61 seconds or more  0%-3.5%  3.6%-7.0%  7.1%-100% | 0%  1%  2%  0%  1%  2% |
| Account Management | **Account Management** means the Employer’s satisfaction with Account Management and will be measured by the Employer, using the Claim Administrator’s Account Management Report Card or through a web-based survey. Performance will be measured in the following areas:   1. Provides effective support in preparing for, and conducting, open enrollment events/sessions. 2. Provides client with timely notification of issues impacting members. 3. Responds to issues & questions in a timely, comprehensive manner. 4. Develops, follows through on action plans; effective coordination to resolve open issues. 5. Is accessible and attends scheduled meetings 6. Delivers agreed upon reports and communication of program results in a timely manner. | Composite Score  3.0 - 5.0  0 - 2.9 | 0%  3.5% |
| ID Card Processing | **ID Cards Processing** is defined as ID cards being mailed within 10 business days after receipt of eligibility file by the Claim Administrator. | 99.0%-100.0%  97.0%-98.9%  0%-96.9% | 0%  0.5%  1.5% |
| Reports | **Standard Monthly/Quarterly/Annual Reports** will be delivered within 30 days of the end of the reporting period. Delivery of Standard reports. | Met  Not Met | $50 per late report delivered after report submission date |
| Customer Satisfaction | **Overall Satisfaction** is defined as the percent of the enrolled members who respond to the Continuous Tracking Study, rating the overall performance of their health plan as Excellent, Very Good, or Good.  Standard is measured based on statistically valid sample of Covered Persons under the Claim Administrator’s PPO program.  Standard is measured on a Unit basis. | 85%-100%  80%-84.9%  0%-79.9% | 0%  1% 2% |
| **Total Medical** |  |  | **17%** |

|  |  |  |  |
| --- | --- | --- | --- |
| Care Management Participation | **Care Management** - is defined as the percentage of targeted members who are actively engaged in a care management program. Actively engaged means the member or member’s provider is actively participating in bi-directional communication with the claim administrators designated clinician/member care coordinator.  The measurement will exclude members who were identified as not appropriate for the program or have missing/invalid phone numbers. | 30% or more  15% - 29.9%  0% - 14.9% | 0%  3%  6% |
| **Total Medical Management** | The level of performance guarantee is based on results at the Plan level. |  | **6%** |