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Correspondence Memorandum

Date: July 18, 2019

To: Group Insurance Board

From: Sara Brockman, Health Program Manager
Office of Strategic Health Policy

Subject: Quarterly Health Plan Performance Report

This memo is for informational purposes only. No Board action is required.

Attached is the *Quarterly Health Plan Performance Report*. This report provides first quarter (Q1) performance outcomes for the one Medicare Advantage vendor and 10 fully-insured health plans contracted by the Group Insurance Board (Board) to provide Group Health Insurance Program (GHIP) coverage for plan year 2019.

Health plans are deidentified and listed in random order in this report.

Overall average health plan performance exceeded the performance target for all six key measures for Q1-2019.

Three individual health plans were unable to meet or exceed performance standards each month during Q1-2019, and therefore incurred possible penalties. These possible penalties are being held in abeyance (i.e. temporarily suspended) pending the completion of Q2-2019 performance reporting. Penalties were assessed against one health plan in Q1-2019 for late submissions to ETF's data warehouse vendor, IBM Watson.

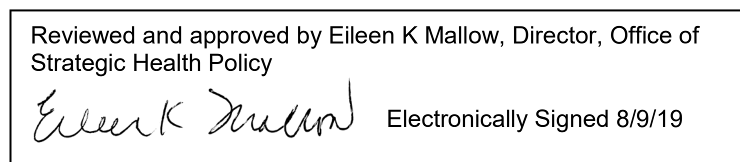
Additional performance and penalty assessment detail is outlined in the report.

Health plan provider performance and penalty outcomes for Q2-2019 will be reported to the Board at the November meeting.

Staff will be at the Board meeting to answer any questions.

Attachment: Q1-2019 Health Plan Performance Report

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy



Electronically Signed 8/9/19

Board	Mtg Date	Item #
GIB	8.21.19	10D

Attachment

Group Health Insurance Program

Quarterly Health Plan Performance Report

Q1-2019

July 18, 2019

Prepared for the Group Insurance Board, August 21, 2019

I. Overview

The Department of Employee Trust Funds (ETF), with direction from the Group Insurance Board (Board), administers the State of Wisconsin Group Health Insurance Program (GHIP) created under Chapter 40 of the Wisconsin Statutes. The Board contracted with one Medicare Advantage provider and 10 fully-insured health plan providers for plan year 2019 to offer GHIP coverage to employees and retirees of state agencies, University of Wisconsin System, University of Wisconsin Hospitals & Clinics Authority, and participating local government employees. ETF manages the contracted health plans on behalf of the Board.

This *Quarterly Health Plan Performance Report* is a summary of health plan provider performance for the first quarter (Q1) of plan year 2019. Health plans are deidentified and randomized for the purposes of this report. The random identifiers were newly generated for the Q1-2019 report.

The measures in this report were developed by ETF staff to reflect national best practices and are reviewed annually for continuation, modification, or retirement. Health plans submit performance metrics on a quarterly basis, using an ETF-provided reporting template. The performance report is accompanied by a quarterly vendor performance certification that attests all required performance standards were administered and completed in adherence with contractually stipulated terms and conditions.

Health plan performance reports are reviewed for performance standard compliance on a quarterly basis. Each performance standard has a related penalty, which is typically $5,000 for each percentage point for which a standard is not met in each month. Applicable penalties are also assessed on a quarterly basis. Penalties may be waived or held in abeyance (i.e. temporarily suspended) in certain circumstances when ETF staff determine it is warranted.

II. Quarterly Average Health Plan Performance Summary by Measure

The Q1-2019 average health plan performance exceeded the performance target for all six key measures. This is a marked improvement over Q1-2018, when the average health plan performance failed to meet the performance target for two of the six key measures:

- Call Answer Timeliness (-3.8%),
- Electronic Written Inquiry Response (-4.6%)

Three health plans incurred possible penalties for Q1-2019:

- “Plan 03”
- “Plan 04”
- “Plan 05”

ETF waived one possible penalty (see page 7) and is holding the remaining possible penalties in abeyance pending the completion of second quarter (Q2) reporting. Should a health plan finish Q2 without incurring additional penalties for the pertinent performance standard, the Q1 penalties will be waived.

For any applicable performance standard that is not met in Q2, the Q1 and Q2 penalties will both be imposed, subject to the 3% cap in the related quarter, as specified in the contract.

One health plan, “Plan 08”, was assessed penalties for late data warehouse file submissions in Q1-2019 (see page 12).

Table 1 provides an overview of quarterly average performance by key measure. The difference between the performance target and the actual quarterly average performance is noted for each measurement in the column titled Q1 Average Variance. Throughout this memo, measures that exceeded the performance target are noted in green, while measures that failed to meet the performance target are noted in red.

Table 1 – Average Health Plan Performance Summary by Key Measure: Q1-2019

Performance Measure	Performance Target	Q1 Average Performance	Q1 Average Variance	Report Detail Page
A. Claims Processing				
1) Processing Accuracy	97%	99.4%	2.4% ▲	Page 4
2) Claims Processing Time	95% processed within 30 days	98.9%	3.9% ▲	Page 5
1) Call Answer Timeliness	80% ≤ 30 seconds	86.9%	6.9% ▲	Page 6
2) Call Abandonment Rate	≤ 3% of calls abandoned	1.6%	-1.4% ▼	Page 7
3) Open Call Resolution Turn-Around Time	90% resolved within 2 days	96.6%	6.6% ▲	Page 8
4) Electronic Written Inquiry Response	98% response within 2 days	99.5%	1.5% ▲	Page 9

▲▼ *Plan performance exceeds measurement performance target*
▲▼ *Plan performance failed to meet measurement performance target*

III. Claims Processing

1) Processing Accuracy

Accurate claims processing prevents numerous potential negative impacts for program participants, such as account posting errors and incorrect patient statements, and helps health plans to prevent financial losses and payment delays.

- **Measurement Description**
  - At least 97% level of processing accuracy
  - Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed
- **Key Findings:**
  - All 11 participating health plans met or exceeded the performance target each month and for Q1 overall
  - No health plans incurred penalties for this measure during Q1-2019

Table 2A – Processing Accuracy: Average Health Plan Performance for Q1 2019

Performance Measure	Performance Target	Q1 Average Performance	Q1 Average Variance
Processing Accuracy	97%	99.4%	2.4% ▲

Table 2B – Processing Accuracy: Quarterly Performance by Health Plan

Health Plan	Q1	Q2	Q3	Q4	Average Quarterly Performance YTD	Average Target Variance YTD
Plan 01	100%	--	--	--	100%	3% ▲
Plan 02	100%	--	--	--	100%	3% ▲
Plan 03	100%	--	--	--	100%	3% ▲
Plan 04	99%	--	--	--	99%	2% ▲
Plan 05	99%	--	--	--	99%	2% ▲
Plan 06	100%	--	--	--	100%	3% ▲
Plan 07	100%	--	--	--	100%	3% ▲
Plan 08	99%	--	--	--	99%	2% ▲
Plan 09	98%	--	--	--	98%	1% ▲
Plan 10	99%	--	--	--	99%	2% ▲
Plan 11	99%	--	--	--	99%	2% ▲

2) Claims Processing Time

Claims processing time is an important factor in containing program costs and improving participant satisfaction. Prompt claims processing provides members with timely billing statements, which is especially important for participants with a higher amount of shared costs.

- **Measurement Description:**
  - At least 95% of claims received must be processed within 30 business days of receipt of all necessary information, except for those claims which the health benefit program is the secondary payer
- **Key Findings:**
  - 9 out of 11 participating health plans exceeded the performance target each month during Q1
  - "Plan 03" failed to meet the performance target in March and incurred a possible penalty of $40,000
    - The penalty will be held in abeyance pending completion of Q2-2109 reporting
  - "Plan 05" failed to meet the performance target in January and incurred a possible penalty of $10,000
    - The penalty will be held in abeyance pending completion of Q2-2109 reporting

Table 3A – Claims Processing Time: Annual Average Health Plan Performance

Performance Measure	Performance Target	Q1 Average Performance	Q1 Average Variance
Claims Processing Time	95% processed within 30 days	98.9%	3.9% ▲

Table 3B – Claims Processing Time: Quarterly Performance by Health Plan

Health Plan	Q1	Q2	Q3	Q4	Average Quarterly Performance YTD	Average Target Variance YTD
Plan 01	100%	--	--	--	100%	5% ▲
Plan 02	100%	--	--	--	100%	5% ▲
Plan 03	95%[1]	--	--	--	95%	0%
Plan 04	100%	--	--	--	100%	5% ▲
Plan 05	96%[2]	--	--	--	96%	1% ▲
Plan 06	99%	--	--	--	99%	4% ▲
Plan 07	100%	--	--	--	100%	5% ▲
Plan 08	100%	--	--	--	100%	5% ▲
Plan 09	100%	--	--	--	100%	5% ▲
Plan 10	98%	--	--	--	98%	3% ▲
Plan 11	100%	--	--	--	100%	5% ▲

1: "Plan 03" incurred possible penalty in March, penalty held in abeyance pending completion of Q2-2109 reporting
2: "Plan 05" incurred possible penalty in January, penalty held in abeyance pending completion of Q2-2109 reporting

IV. Customer Service

1) Call Answer Timeliness

The ability for a participant to connect with a live customer service representative in a short period of time is important for customer satisfaction and improves the likelihood of timely and accurate issue resolution.

- **Measurement Description:**
  - At least 80% of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within 30 seconds
- **Key Findings:**
  - 8 out of 11 participating health plans exceeded the performance target each month during Q1
  - "Plan 03" failed to meet the target in January and incurred a possible penalty of $20,000
    - The penalty was waived, as the variance was caused by a force majeure event (i.e. the polar vortex)
  - "Plan 04" failed to meet the target in January and incurred a possible penalty of $5,000
    - The penalty will be held in abeyance pending completion of Q2-2109 reporting
  - "Plan 05" failed to meet the performance target in January and February and incurred a possible penalty of $395,000
    - This possible penalty exceeds the allowable penalty amount of 3% of total medical premium for the given quarter, and would therefore be capped if assessed
    - The penalty will be held in abeyance pending completion of Q2-2109 reporting

Table 4A – Call Answer Timeliness: Annual Average Health Plan Performance

Performance Measure	Performance Target	Q1 Average Performance	Q1 Average Variance
Call Answer Timeliness	80% ≤ 30 seconds	86.9%	6.9% ▲

Table 4B – Call Answer Timeliness: Quarterly Performance by Health Plan

Health Plan	Q1	Q2	Q3	Q4	Average Quarterly Performance YTD	Average Target Variance YTD
Plan 01	93%	--	--	--	93%	13% ▲
Plan 02	88%	--	--	--	88%	8% ▲
Plan 03	86%[1]	--	--	--	86%	6% ▲
Plan 04	97%[2]	--	--	--	87%	10% ▲
Plan 05	58%[3]	--	--	--	58%	-22% ▼
Plan 06	100%	--	--	--	100%	20% ▲
Plan 07	82%	--	--	--	82%	2% ▲
Plan 08	95%	--	--	--	95%	15% ▲
Plan 09	87%	--	--	--	87%	7% ▲
Plan 10	88%	--	--	--	88%	8% ▲
Plan 11	92%	--	--	--	92%	12% ▲

1: "Plan 03" incurred possible penalty in January, penalty waived, variance caused by force majeure event
2: "Plan 04" incurred possible penalty in January, penalty held in abeyance pending completion of Q2-2109 reporting
3: "Plan 05" incurred possible penalties in January and February, penalties held in abeyance pending completion of Q2-2109 reporting

2) Call Abandonment Rate

Call abandonment rates have a direct relation to the amount of time a participant must wait to speak with a customer service representative. Lower call abandonment rates typically indicate short waiting times and increased customer satisfaction.

- **Measurement Description:**
  - Less than 3% of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received
- **Key Findings:**
  - 10 out of 11 participating health plans exceeded the performance target each month during Q1
  - "Plan 05" failed to meet the performance target in January and February, thereby incurring a possible penalty of $125,000
    - This possible penalty exceeds the allowable penalty amount of 3% of total medical premium for the given quarter, and would therefore be capped if assessed
    - The penalty will be held in abeyance pending completion of Q2-2109 reporting

Table 5A – Call Abandonment Rate: Annual Average Health Plan Performance

Performance Measure	Performance Target	Q1 Average Performance	Q1 Average Variance
Call Abandonment Rate	≤ 3% of calls abandoned	1.6%	-1.4% ▼

Table 5B – Call Abandonment Rate: Quarterly Performance by Health Plan

Health Plan	Q1	Q2	Q3	Q4	Average Quarterly Performance YTD	Average Target Variance YTD
Plan 01	0%	--	--	--	0%	-3% ▼
Plan 02	1%	--	--	--	1%	-2% ▼
Plan 03	1%	--	--	--	1%	-2% ▼
Plan 04	1%	--	--	--	1%	-2% ▼
Plan 05	10%[1]	--	--	--	10%	7% ▲
Plan 06	0%	--	--	--	0%	-3% ▼
Plan 07	1%	--	--	--	1%	-2% ▼
Plan 08	0%	--	--	--	0%	-3% ▼
Plan 09	1%	--	--	--	1%	-2% ▼
Plan 10	2%	--	--	--	2%	-1% ▼
Plan 11	1%	--	--	--	1%	-2% ▼

1: "Plan 05" incurred possible penalties in January and February, penalties held in abeyance pending completion of Q2-2109 reporting

3) Open Call Resolution Turn-Around Time

Prompt open call resolution typically results in fewer repeated calls and improved customer satisfaction and may also reflect the overall efficiency of a customer service team.

- **Measurement Description:**
  - At least 90% of customer service calls that require follow-up or research will be resolved within two business days of initial call
  - Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two business days, divided by the total number of issues initiated by the call
- **Key Findings:**
  - All 10 of the measured health plans met or exceeded the performance target each month and for Q1 overall
  - No health plans incurred penalties for this measure during Q1-2019
  - “Plan 11” was granted a data reporting exemption due to system limitations
    - A written summary of annual activity will be submitted instead

Table 6A – Open Call Resolution Turn-Around Time: Annual Average Health Plan Performance

Performance Measure	Performance Target	Q1 Average Performance	Q1 Average Variance
Open Call Resolution Turn-Around Time	90% resolved within 2 days	96.6%	6.6% ▲

Table 6B – Open Call Resolution Turn-Around Time: Quarterly Performance by Health Plan

Health Plan	Q1	Q2	Q3	Q4	Average Quarterly Performance YTD	Average Target Variance YTD
Plan 01	100%	--	--	--	100%	10% ▲
Plan 02	94%	--	--	--	94%	4% ▲
Plan 03	98%	--	--	--	98%	8% ▲
Plan 04	98%	--	--	--	98%	8% ▲
Plan 05	93%	--	--	--	93%	3% ▲
Plan 06	98%	--	--	--	98%	8% ▲
Plan 07	95%	--	--	--	95%	5% ▲
Plan 08	98%	--	--	--	98%	8% ▲
Plan 09	97%	--	--	--	97%	7% ▲
Plan 10	95%	--	--	--	95%	5% ▲
Plan 11[1]	n/a	n/a	n/a	n/a	n/a	n/a

1: Data reporting exemption granted due to system limitation, annual written summary of activity submitted as substitute

4) Electronic Written Inquiry Response

Prompt electronic written inquiry response times typically lowers the number of contacts a participant has with a health plan to resolve a question and is likely to improve customer satisfaction.

- **Measurement Description:**
  - At least 98% of customer service issues submitted by email and website are responded to within two business days
- **Key Findings:**
  - All 11 participating health plans met or exceeded the performance target each month and for Q1 overall
  - No health plans incurred penalties for this measure during Q1-2019

Table 7A – Electronic Written Inquiry Response: Annual Average Health Plan Performance

Performance Measure	Performance Target	Q1 Average Performance	Q1 Average Variance
Electronic Written Inquiry Response	98% response within 2 days	99.5%	1.5% ▲

Table 7B – Electronic Written Inquiry Response: Quarterly Performance by Health

Health Plan	Q1	Q2	Q3	Q4	Average Quarterly Performance YTD	Average Target Variance YTD
Plan 01	100%	--	--	--	100%	2% ▲
Plan 02	100%	--	--	--	100%	2% ▲
Plan 03	100%	--	--	--	100%	2% ▲
Plan 04	99%	--	--	--	99%	1% ▲
Plan 05	100%	--	--	--	100%	2% ▲
Plan 06	99%	--	--	--	99%	1% ▲
Plan 07	99%	--	--	--	99%	1% ▲
Plan 08	100%	--	--	--	100%	2% ▲
Plan 09	100%	--	--	--	100%	2% ▲
Plan 10	99%	--	--	--	99%	1% ▲
Plan 11	99%	--	--	--	99%	1% ▲

V. Additional Key Performance Measures

Table 8 provides an overview of additional key measures pertaining to enrollment and major system changes. These additional key measures are reported for each month on a quarterly basis. Overall, health plans met or exceeded the additional key performance measurement requirements. "Plan 05" was the only health plan to incur a possible penalty

Table 8 – Additional Key Performance Measures

Performance Measure	Measurement Description	Performance Target	Average Q1 Performance
A. Enrollment			
1) Enrollment File	The health plan must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within 2 business days of the file receipt.	Daily 834 file acceptance and processing	100%
2) Enrollment Discrepancies and Exceptions	The health plan must resolve all enrollment discrepancies (any difference of values between ETF's database and the health plan's database) as identified within 1 business day of notification by ETF or identification by the health plan.	Database = 1 day of notification	100%
	The health plan must correct the differences on the exception report within 5 business days of notification by the department.	Exception report = within 5 days of notification	95.7%[1]
3) Identification (ID) Cards	The health plan shall issue ID cards within 5 business days of the generation date of the enrollment file containing the addition or enrollment change, except during the It's Your Choice Open Enrollment Period.	Issue ID cards within 5 days	96%[2]
B. Other			
1) Major System Changes and Conversions	The health plan shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the GHIP without specific prior written notice of a least 180 days.	Major system changes or conversions planned	None reported
		180 day written notice submitted	n/a

1: "Plan 05" incurred a possible penalty for 11 days of non-compliance in January, penalty held in abeyance pending completion of Q2-2109 reporting
2: "Plan 05" incurred a possible penalty for 10 days of non-compliance in January, penalty held in abeyance pending completion of Q2-2109 reporting

VI. Data Warehouse

Table 9 provides an overview of additional key measures related to data warehouse file submissions to the data warehouse vendor, IBM Watson. IBM Watson assesses penalty fees to ETF in the event a health plan fails to meet its data submission requirements. These penalty fees are in turn assessed against non-compliant health plans by ETF for the preceding quarter.

Table 9 – Data Warehouse Performance Measures

Performance Measure	Measurement Description	Performance Target	Average Q1 Performance
A. Data File Transfers			
1) Claims File Data Transfer	Health plans are to submit a Claim File for services paid in the previous month. The Claim File is due no later than the date mutually agreed upon by the health plan and ETF.	Submit data by mutually agreed upon due date	99%[1]
2) Provider File Data Transfer	Health plans are to submit a Provider File for network providers for the previous month. The Provider File is due no later than the date mutually agreed upon by the health plan and ETF.	Submit data by mutually agreed upon due date	99%[2]

1: "Plan 08" assessed a $3,000 penalty for submitting claims files to IBM Watson three days late in February
2: "Plan 08" assessed a $3,000 penalty for submitting provider files to IBM Watson three days late in February