

Attachment C: Performance Guarantees

Insurer agrees the services provided under this Contract are critical to the success of FHKC's provision of quality services to Enrollees and the administration of the Program as part of Florida's CHIP.

The failure to meet the following performance guarantees (PGs) shall be deemed a default. For each such default, Insurer shall be liable to FHKC for financial consequences in addition to any other remedies available under the Contract. FHKC shall inform Insurer in writing, by email or mail, of any financial consequences incurred and how the amounts owed to FHKC should be remitted.

FHKC may waive financial consequences, in whole or in part, for any reason in its sole discretion. The waiver of financial consequences in one instance does not provide Insurer any right or expectation to future waived financial consequences under the same, or any other, circumstances.

When reporting PG results, Insurer shall round the results at the tenth decimal place to the nearest whole number.

- For percentages with numbers zero through four (0-4) in the tenth decimal place, round down.
- For percentages with numbers five through nine (5-9) in the tenth decimal place, round up.

PG-1: Average Speed to Answer

Ninety percent (90%) of inbound calls received by Insurer's enrollee services call center shall be answered by a live agent within thirty (30) seconds.

Reporting Frequency: Monthly

Financial Consequences: five hundred dollars (\$500) per percentage point below guarantee.

Calculation Methodology

- The answer time measurement threshold begins when the call is presented in the call queue for an agent to answer.
 - The time the caller spends navigating any automated systems is not included in the measurement time.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of inbound calls answered within thirty (30) seconds. Performance reported in any other manner, including the average

number of seconds for ninety percent (90%) of inbound calls to be answered is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 21

PG-2: Call Abandonment Rate

The percentage of calls received that are terminated by the caller before a live person answers shall not exceed three percent (3.0%).

Reporting Frequency: Monthly

Financial Consequences: five hundred (\$500) per percentage point below guarantee.

Calculation Methodology

- The abandonment measurement threshold begins when the call is presented in the call queue for an agent to answer.
 - Callers who terminate while navigating any automated systems are not included in the measurement.

Related Contract Reference: Section 21

PG-3: Blocked Calls

The percentage of inbound calls blocked from entering the call center system and those that are forced disconnects shall be zero percent (0.0%).

Reporting Frequency: Monthly

Financial Consequences: five hundred dollars (\$500) per percentage point above the guarantee.

Calculation Methodology

- The percentage of blocked calls shall be calculated by the number of calls blocked by Insurer's telecom provider and the number of calls that are forced disconnects divided by the total number of calls.

Related Contract Reference: Section 21

PG-4: First Call Resolution

Insurer's enrollee service representatives shall ensure that at least eighty-five percent (85%) of calls are resolved within the first call during the first Contract Year and at least ninety percent (90%) thereafter.

Reporting Frequency: Monthly

Financial Consequences: two hundred fifty dollars (\$250) per percentage point below the guarantee

Calculation Methodology

- Insurer shall audit a statistically valid random sample of all Florida Healthy Kids calls each quarter.
 - Insurer shall determine if the call is the first call the caller has made about the issue and if the enrollee services representative answering the call resolved the call during that initial call.
 - Resolution includes providing complete and clear information to the extent a call or other communication back to or from the caller is not needed. Insurer shall also review the caller’s record to ensure no follow up calls were placed to Insurer about the same issue.

Related Contract Reference: Section 21

PG-5: Call Quality Assurance Monitoring

Insurer shall ensure that the average call quality monitoring score resulting from call monitoring of all call center enrollee service representatives working on the Florida Healthy Kids account is at least ninety-five percent (95%).

Reporting Frequency: Monthly

Financial Consequences: two hundred fifty dollars (\$250) per percentage point below the guarantee

Calculation Methodology

- Insurer shall conduct quality assurance monitoring of all call center enrollee service representatives working on the Florida Healthy Kids account each quarter using an established review methodology for which the highest score possible is one hundred percent (100%). Insurer shall divide the sum of all quality assurance monitoring review scores by the total number of quality assurance monitoring reviews conducted during the quarter.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report performance based on the average score. Performance reported in any other manner, including the number of quality assurance monitoring reviews to meet ninety-five percent (95%) is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 21

PG-6: Enrollment Files

Insurer shall accurately process one hundred (100%) of enrollment files, including supplemental enrollment files within two (2) Business Days of receipt.

Reporting Frequency: Monthly

Financial Consequences: one thousand dollars (\$1,000) per Calendar Day

Calculation Methodology

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the number of days to process one hundred percent (100%) of enrollment files percentage of enrollment files. Performance reported in any other manner, including the percent of files processed within two (2) Business Days is insufficient to meet the requirements of this PG.
- Financial Consequences apply to each Calendar Day beyond the due date until accurately processed, inclusive of the date processed.

Related Contract Reference: Section 18

PG-7: Ad hoc Enrollment Data

Insurer shall accurately process one hundred percent (100%) of ad hoc enrollment requests, including changes in demographic information, within one (1) Business Day.

Reporting Frequency: Monthly

Financial Consequences: one thousand dollars (\$1,000) per incident per Calendar Day

Calculation Methodology

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the number of Calendar Days beyond one (1) Business Day for which it takes Insurer to process one hundred percent (100%) of ad hoc enrollment requests. Performance reported in any other manner, including the percent of ad hoc enrollment requests processed within one (1) Business Days is insufficient to meet the requirements of this PG.
- Financial Consequences apply to each Calendar Day beyond the due date until accurately processed, inclusive of the date processed for each ad hoc enrollment request.

Related Contract Reference: Section 18

PG-8: Enrollment Packages

Insurer shall provide complete enrollment packages, including ID cards, to one hundred percent (100%) of new Enrollees within five (5) Business Days of receipt of the enrollment information.

Reporting Frequency: Monthly

Financial Consequences: two thousand dollars (\$2,000) per percentage point below guarantee.

Calculation Methodology

- “Provide” is used in the same manner as 42 CFR 438.10(g)(3) except that a physical ID card must be mailed to each Enrollee.
- Enrollment packages returned undeliverable due to no fault of Insurer are not included in the measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of enrollment packages provided to Enrollees within five (5) Business Days. Performance reported in any other manner, including the number of days to process one hundred percent (100%) of enrollment packages is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 18

PG-9: Appeal and Grievance Resolution Timeframe

Insurer shall resolve one hundred percent (100%) of Appeals and Grievances within the timeframes below. Any of the timeframes below may be extended by fourteen (14) Calendar Days if the conditions of 42 CFR 438.408(c) are met.

- Standard Grievances: Ninety (90) Calendar Days
- Standard Appeals: Thirty (30) Calendar Days
- Expedited Appeals: Seventy-two (72) hours

Reporting Frequency: Quarterly

Financial Consequences: two thousand five hundred dollars (\$2,500) per percentage point below guarantee.

Calculation Methodology

- When determining the percentage of Appeals and Grievances resolved timely, the denominator includes all Appeals and Grievances received for which the latest acceptable resolution date fell within the reporting period, regardless of when the Appeal or Grievance was actually resolved. For example, an Appeal or Grievance for which the latest acceptable resolution date falls in quarter B shall be included in the

denominator for quarter B regardless of the quarter during which the Appeal or Grievance was resolved.

- The “latest acceptable resolution date” includes the fourteen (14) Calendar Days extension only if the required conditions were met **and** the extension was taken for the Appeal or Grievance.
- When determining the percentage of Appeals and Grievances resolved timely, the numerator includes all Appeals and Grievances included in the denominator that were resolved timely.

Related Contract Reference: Section 23

PG-10: Independent Review Timeframes

Insurer shall ensure that Insurer’s contracted IRO completes one hundred percent (100%) of the independent reviews within the timeframes below.

- Standard Review: forty-five (45) Calendar Days
- Expedited Review: Seventy-two (72) hours

Reporting Frequency: Quarterly

Financial Consequences: two thousand five hundred dollars (\$2,500) per percentage point below guarantee.

Calculation Methodology

- When determining the percentage of reviews resolved timely, the denominator includes all reviews received for which the latest acceptable resolution date fell within the reporting period, regardless of when the review was actually resolved. For example, a review for which the latest acceptable resolution date falls in quarter B shall be included in the denominator for quarter B regardless of the quarter during which the review was resolved.
- When determining the percentage of reviews resolved timely, the numerator includes all reviews included in the denominator that were resolved timely.

Related Contract Reference: Section 23

PG-11: Electronic Claims Processing

Insurer shall process ninety percent (90%) of electronic claims within fifteen (15) Calendar Days.

Reporting Frequency: Quarterly

Financial Consequences: five hundred (\$500) per percentage point below guarantee.

Calculation Methodology

- The measurement for electronic claims includes clean claims and claims for which all information requested by Insurer to continue processing the claim has been received.
- The measurement begins on the date a clean claim is received or on the date stamped on information received for non-clean claims. The measurement ends on either the date a payment is made, as indicated by the date on the payment, or the date the claim is denied, as indicated by the date on the denial notice.
- Claims currently pending response from Providers are not included in this measurement.
- Claims related to investigations for potential fraud, waste or abuse are not included in this measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of electronic claims processed within fifteen (15) Calendar Days. Performance reported in any other manner, including the number of days to process ninety percent (90%) of electronic claims is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-12: Paper Claims Processing

Insurer shall process ninety percent (90%) of paper claims within twenty (20) Calendar Days.

Reporting Frequency: Quarterly

Financial Consequences: five hundred (\$500) per percentage point below guarantee.

Calculation Methodology

- The measurement for paper claims includes clean claims and claims for which all information requested by Insurer to continue processing the claim has been received.
- The measurement begins on the date a clean claim is received or on the date stamped on information received for non-clean claims. The measurement ends on either the date a payment is made, as indicated by the date on the payment, or the date the claim is denied, as indicated by the date on the denial notice.
- Claims currently pending response from Providers are not included in this measurement.
- Claims related to investigations for potential fraud, waste or abuse are not included in this measurement.

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of paper claims processed within twenty (20) Calendar Days. Performance reported in any other manner, including the number of days to process ninety percent (90%) of paper claims is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-13: Claims Payment Financial Accuracy

Ninety-eight percent (98%) of claims Insurer audits in a statistically valid quarterly audit of Florida Healthy Kids claims using representative sampling shall be free from financial errors.

Reporting Frequency: Quarterly

Financial Consequences: five hundred dollars (\$500) per percentage point below guarantee.

Calculation Methodology

- Financial accuracy shall be measured as (the number of claims free from financial error divided by the number of claims in the audit sample) multiplied by (the number of claims in the strata population divided by the number of claims in the population).
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of claims free from financial error. Performance reported in any other manner, including the percentage of paid dollars that were for claims free from financial error is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-14: Non-financial Claims Processing Accuracy

Ninety-five percent (95%) of claims Insurer audits in a statistically valid quarterly audit of Florida Healthy Kids claims using representative sampling shall be free from non-financial errors.

Reporting Frequency: Quarterly

Financial Consequences: five hundred dollars (\$500) per percentage point below guarantee.

Calculation Methodology

- Non-financial claims processing accuracy shall be measured as (the number of claims free from non-financial error divided by the number of claims in the audit sample) multiplied by (the number of claims in the strata population divided by the number of claims in the population).

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of claims free from non-financial error. Performance reported in any other manner, including the percentage of paid dollars that were for claims free from non-financial error is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-15: Provider Overpayment Recovery

Insurer shall recover eighty percent (80%) of overpayments to Providers within sixty (60) Calendar Days of discovery.

Reporting Frequency: Quarterly

Financial Consequences: five hundred dollars (\$500) per percentage point below guarantee.

Calculation Methodology

- The measurement timeframe begins the date a payment is determined to be an overpayment and ends the date Insurer receives full compensation for the overpaid amount.
- When determining the percentage of overpayments recovered timely, the denominator includes all identified overpayments for which the latest acceptable recovery date fell within the reporting period regardless of when the overpayment was actually recovered.
 - The “latest acceptable recovery date” means sixty (60) Calendar Days from the date the overpayment was identified.
- Overpayments recovered by netting the overpaid amount from amounts owed to a Provider may be considered recovered only if payments of funds owed to the Provider sufficient to recover the entire overpaid amount have been fully processed by Insurer.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of overpayments recovered from Providers within sixty (60) Calendar Days. Performance reported in any other manner, including the number of Calendar Days to recover eighty percent (80%) of Provider overpayments is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-16: Standard Prior Authorization Processing Timeliness

Insurer shall process 100 percent (100%) of all standard prior authorizations within fourteen (14) Calendar Days.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars (\$1,000) per percentage point below guarantee.

Calculation Methodology

- The measurement begins from the date Insurer receives the request and ends the date Insurer makes a final decision and communicates such decision to the requesting Provider.
 - Requests for prior authorization pending additional information from the requesting Provider are not included in the measurement so long as the prior authorization was extended appropriately as described in 42 CFR 438.210.
 - Prior authorizations for which Insurer extended beyond the fourteen (14) Calendar Days as permitted by law are excluded from this measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of prior authorizations processed within fourteen (14) Calendar Days. Performance reported in any other manner, including the number of Calendar Days to process one hundred percent (100%) of prior authorizations is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-17: Expedited Prior Authorization Processing Timeliness

Insurer shall process 100 percent (100%) of all expedited prior authorizations within seventy-two (72) hours.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars (\$1,000) per percentage point below guarantee.

Calculation Methodology

- The measurement begins from the date and time Insurer receives the request and ends the date and time Insurer makes a final decision and communicates such decision to the requesting Provider.
 - Requests for prior authorization pending additional information from the requesting Provider are not included in the measurement so long as the prior authorization was extended appropriately as described in 42 CFR 438.210.
 - Prior authorizations for which Insurer extended beyond the seventy-two (72) hours as permitted by law are excluded from this measurement.

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of prior authorizations processed within seventy-two (72) hours. Performance reported in any other manner, including the number of Calendar Days or hours to process one hundred percent (100%) of prior authorizations is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-18: Systems Availability

Insurer shall maintain availability, which includes standard accessibility, of systems critical to Enrollees and Providers, including the public and private plan website(s), any Provider portal or website, and enrollment system, twenty-four hours a day, seven days a week (24/7) except during scheduled maintenance. Insurer shall resolve unscheduled unavailability of these systems within forty-eight (48) hours of identification of the unavailability, when such unavailability is within Insurer’s direct or indirect control.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars (\$1,000) per Calendar Day

Calculation Methodology

- Financial Consequences apply to each Calendar Day beyond the allowable forty-eight (48) hours, including the date the systems regain availability.

Related Contract Reference: Sections 5, 21, and 24

PG-19: Network Access

Insurer shall provide ninety percent (90%) of Enrollees residing in Insurer’s Service Area with access to one Provider for each of the provider types below within the timeframe and distance listed for rural and urban counties.

Provider Type	Time (in minutes)		Distance (in miles)	
	Rural	Urban	Rural	Urban
PDP	30	20	30	20
Specialist	40	20	30	20
Orthodontist	70	30	50	20
Telehealth	Report			

Reporting Frequency: Quarterly

Financial Consequences: five hundred dollars (\$500) per percentage point below guarantee per measurement.

Enrollment	Quarterly Financial Consequences Cap
<25K	\$20,000

25-50K	\$30,000
50-75K	\$40,000
75K+	\$50,000

Calculation Methodology

- Network access shall be calculated separately for each provider type and access type (time or distance) and geographical location type (rural or urban).
 - This PG requires twelve (12) separate measurements.
 - Financial Consequences shall be assessed for each of the twelve (12) measurements, including each access and geographical type and for each Provider type, for which Insurer fails to meet the guarantee.
 - Insurer shall be assessed total financial consequences for the PG based on the sum of the financial consequences for provider type, access type, and geographical location type measurements.
 - The quarterly financial consequences cap applies to the PG and not the twelve (12) separate measurements.
- The most recent U.S. census data available is used to determine whether a county is rural or urban.
- For rural measurements, all rural counties in Insurer’s Service Area are included in the measurement, regardless of whether the counties are all in the same Region.
- For urban measurements, all urban counties in Insurer’s Service Area are included in the measurement, regardless of whether the counties are all in the same Region
- Insurer shall use estimates of actual driving time and actual driving distance to determine access.
 - Insurer may not use “as-the-crow-flies” methodology for determining driving time or mileage.
- The measurements should exclude geographical areas for which Insurer has a current network access waiver for the specified provider type.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of Enrollees with access within the standard. Performance reported in any other manner, including the percentage or number of Providers within the access standard for ninety percent (90%) of Enrollees is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-20: Appointment Access Standards

Ninety percent (90%) of network Providers maintain appointment availability within the timeframes required below:

Type of Care	Timeframe
Emergency	Immediately
Urgent	Within twenty-four (24) hours
Routine sick visit care	Seven (7) Calendar Days
Routine preventive care	Within four (4) weeks of request

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars (\$1,000) per percentage point below guarantee per measurement.

Calculation Methodology

- Appointment access shall be determined by Insurer’s internal audit and quality assurance activities, using appropriate stratification to avoid over or under representation of any appointment type.
- Appointment access shall be calculated by dividing the sum of network Providers maintaining appointments within the specified timeframes by the total number of network Providers evaluated. This measure is a single calculation encompassing all appointment types.

Related Contract Reference: Section 24