POLICY AND PROCEDURE

DEPARTMENT: Member and Provider ~~Solutions~~Engagement	**DOCUMENT NAME:** Member & Provider Call Audit and Quality Criteria and Protocol
PAGE: 1 of 12	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:** HIM.MSPS.24
EFFECTIVE DATE: ~~1/1/15~~ March 2021	**REVIEWED/REVISED:** : ~~08/09; 03/10; 4/11; 08/11; 06/12; 10/12; 10/13; 7/14; 5/15; 09/15; 12/15; 1/17; 2/17; 4/17; 7/17;12/17; 12/18; 02/19; 10/20;~~ 3/21
PRODUCT TYPE: ~~MARKETPLACE,~~ MEDICAID~~, MEDICARE, and MMP~~	**REFERENCE NUMBER:** ~~CC~~LA.MSPS.24

SCOPE:
~~**Centene**~~ **Louisiana Healthcare Connections (LHCC)** Member and Provider ~~**Contact Center Agents**~~**Customer Service Representatives** (CSRs) supporting Medicaid~~**, Marketplace, Medicare, and MMP**~~**.**

PURPOSE:
To provide guidance for measuring and monitoring ~~**Centene**~~ **LHCC** Member and Provider CSR calls for accuracy of responses and phone etiquette.

POLICY:
It is the policy of the Member and Provider ~~**Solutions**~~ **Engagement** department to audit and evaluate a sample of incoming or outgoing calls for each CSR for accuracy and professional handling based on defined criteria. Each CSR must maintain a monthly average score of ***90%*** or higher.

~~**Centene Corporation**~~ **LHCC** has the authority to audit H~~**ealth Plan and Contact Center**~~ calls for quality and process improvement purposes.

PROCEDURE:

1. Each **new hire** CSR scheduled to take calls ~~should~~ will receive 8 to 10 evaluations of live or recorded calls per month. Evaluation frequency may increase if a CSR fails to meet the monthly Quality goal.
2. *Each agent that has a minimum of 6 months tenure and 6 months of consecutively meeting or exceeding the quality goal will receive 5 evaluations of live or recorded calls per month thereafter. Should the agent fail to meet the quality goal for a month or fail to meet the quality goal on an evaluated call, 8-10 evaluations of live or recorded calls per month will be conducted. This will remain until such time as the agent has established 6 consecutive months of meeting or exceeding the quality goal again.*

~~1.~~

~~2.~~3. Evaluators monitor CSR calls to score their performance against established quality guidelines reflected on the standard quality evaluation form.

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~~3.~~4. Changes to the quality evaluation form will be made annually, prior to the start of each calendar year. The quality evaluation form will not be changed after the start of the year unless required by specific business need.

~~4.~~5. Changes to the quality evaluation form must be approved by the Director of **Operations ~~Performance Management~~** in the Member and Provider **~~Solutions~~ Engagement** organization, or his or her immediate **~~manager~~People Leader**.

6. **If a Member or Provider Call Center Agent:**
   a. **Fails to meet the standard 2 out of 3 rolling months, the agent will be subject to verbal counseling and bi-weekly feedback on their progress.**
   b. **Fails to meet the standard 3 out of 4 rolling months, they will be subject to further discipline and will receive weekly feedback and follow-up on their progress. Five additional calls will be monitored for a total of 15 calls with feedback being provided immediately. Additionally, the agent will work with the Quality Coach and/or their Supervisor to complete an action plan aimed toward the specific elements needed to achieve a passing score.**
   c. **Fails to meet the standard 5 out of 6 rolling months, they will be subject to review for termination in accordance with the corporate PIP process.**
   d. **After 6 months of meeting performance standard the progressive counseling process noted above will revert to step 1 above.**

Scorecard Ratings

Each call is evaluated using 7 compliance scoring criteria, and each of those 7 items have a point value.
*Pass (90% and above): CSR met the required standards for the evaluation.
*Fail (below 90%): CSR failed to meet the required standards for the evaluation.

The Service Skills portion has four categories that a CSR can pass/fail: Greeting, Communication Skills, Complete & Correct Resolution, and Closing. Each category consists of multiple subcategories that are scored as Meets Expectations / Does Not Meet Expectations / Exceeds Expectations.

The Overall Service Skills Rating is determined by:
* 4 of 4 categories passed = Exceeds Expectations
* 3 of 4 sections passed = Meets Expectations
* Less than 3 sections passed = Does Not Meet Expectations

Sections identified as Exceeding Expectations have demonstrated any of the below criteria (not an all-inclusive list):
*Performance above and beyond
*Demonstrated superior listening skills in spite of anger or frustration from the caller
*Handled a disruptive or abusive caller in a professional manner
*Found and fixed an issue not brought up by the caller
*Consider the whole family beyond the caller
*Looked for future impacts
*Demonstrated empathy on a more personal level
*Delivered customized information
*Tailored their response to match caller's main concerns
*Demonstrated perseverance to ensure first call resolution
*Exhibited creative problem solving skills while taking ownership of a complicated inquiry
*Caller verbally acknowledged superior service received during the call.

To meet HIPAA requirements, information must be obtained for both members and providers before providing any account information. Providers must verify both the member's information *and* the provider's information.

HIPAA PROCEDURE:

1. In verifying the identity of a member submitting an oral or written request for disclosure of his/her protected health information, the CSR may rely on two (2) or three (3) of the following pieces of information, if such reliance is reasonable under the circumstances:
   (a) Date of birth

(b) Member's Name
(c) Member's Address
(d) Member's Phone Number
~~(b) **Health Plan/Product ID number**~~
~~(c) **Last four (4) digits of the Member's Social Security Number**~~

*__Disclaimers__
- Please refer to state regulations when required
- ~~**Please use discretion when searching for a member if the identifiers are not available [e.g. it is permissible to search for member using name]**~~

2. In verifying the identity of a member's guardian or personal representative submitting an oral or written request for disclosure of the member's protected health information, the CSR may rely on the written or oral verification of two (2) or three (3) of the following pieces of information, if such reliance is reasonable under the circumstances:
   (a) The caller's name matches the guardian or case head's name in the system of record
   (b) Member's date of birth
   (c) Member's Address
   ~~(b)~~**(d) Member's Phone Number**
   ~~**Member's Health Plan/Product ID number**~~
   ~~(c) **Last four (4) digits of the Member's Social Security Number**~~

3. In verifying the identity of a provider submitting an oral or written request for disclosure of a member's protected health information, the Corporation personnel may rely on the following, if such reliance is reasonable under the circumstances:
   (a) Provider information (verify one (1) set):
      i) Name and Tax ID Number
      ii) Name and NPI number

As well as, two (2) or three (3) of the following pieces of member information:

iii) Member's Date of Birth
iv) **Member's Health Plan/Product ID**
v) **Last four (4) digits of the Member's Social Security Number**
iv) Member's Name
v) Member's Address
vi) Member's Phone Number
vi)vii) Valid Claim Number and Date of Service

Exceptions for HIPAA Verification

Centene LHCC Member and Provider agents may rely on the exercise of professional judgment in making the following uses or disclosures of protected health information, while adhering to the requirements of applicable state or other laws:

(a) A use or disclosure to others for involvement in the member's care; or
(b) A disclosure to avert a serious threat to health and safety.

CSRs who determine it is necessary to alter or waive the caller verification process must do the following:

- Release only the minimum amount of information necessary to conduct the call
- Document the reasons for altering or waiving the caller verification process in the call notes
- Alert their supervisor at the conclusion of the call that the verification process was altered or waived

Rebuttal Process

This process is meant to foster communication between a CSR, a CSR's **leaderPeople Leader**, and the Quality team.

1. If a CSR disagrees with the scoring of a call, the CSR must send the evaluation to their **leader People Leader** for review, along with a specific explanation/evidence of why they feel the score should be changed.

2. The ~~**leader**~~ **People Leader** must listen to the call, and if the ~~**leader**~~ **People Leader** agrees with the *original* scoring, the ~~**leader**~~ **People Leader** will advise the CSR and provide coaching.
3. If the ~~**leader**~~ **People Leader** disagrees with the scoring, they will enter the rebuttal into the SharePoint Rebuttal log. The rebuttal must include the ~~**leader's**~~ **People Leader's** specific explanation/evidence of why they feel the score should be changed.
4. A designated auditor who is **not** the original auditor of the call will review the call and the scoring. A quality reviewer will either change the original scoring or uphold it after reviewing the submission. The reviewer's decision, along with rationale for the decision, will be communicated to the ~~**leader**~~ **People Leader** and to the original auditor of the call.
5. If the ~~**leader**~~ **People Leader** agrees with the reviewer's decision, the ~~**leader**~~ **People Leader** will communicate this to the CSR and provide coaching.
6. If the ~~**leader**~~ **People Leader** wishes to dispute the reviewer's decision, the dispute, along with the ~~**leader's**~~ **People Leader's** specific explanation/evidence of why they disagree, must be entered as an escalated rebuttal in the rebuttal log.
7. The Quality Manager and/or the Director of ~~**Performance Improvement**~~ **Operations** will review the rebuttal and listen to the call together. Once they arrive at a final decision, the Manager will communicate the decision, along with rationale, to the original auditor and the ~~**leader**~~**People Leader**. The ~~**leader**~~ **People Leader** will then notify the CSR and provide any necessary coaching.
8. The Quality team will keep a record of all rebuttals and resolutions.
9. All rebuttals must be submitted within 72 business hours of completion of the evaluation. Once the rebuttal has been received, the reviewer has

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72 business hours to respond to the dispute. Rebuttals entered outside of the 72 hours will be considered on a case by case basis.

Quality Guidelines and Quality Scoring Forms

2020-2021 Member Services Quality Form

2020-2021 Member Services Quality Scori

Provider Contact Center_ 2020 Quality

2020-2021 Provider Contact Center Qualit

REFERENCES: CC.MSPS.40-Call Center Performance Improvement Plan document. CC.COMP.04-Confidentiality and Release of Protected Health Information CC.COMP.PRVC.12 - Verification of Entities Requesting Use or Disclosure of Protected Health Information

REVISION LOG	*DATE*
Updated Audit Criteria	7/14/09
Changed the Document Name from "Quarterly Monitoring of Member Services Incoming Call Service Level" to "Member & Provider Call Audit and Quality Criteria and Protocol"	03/15/10
Failure to verify HIPAA will result in a score of zero (0).	03/10/11
Procedure for new agents added.	03/10/11
Increased the weights for the audit form. More focus on HIPAA and Documentation in Maces or CRM	04/05/11
Updated New Agent Procedures, removed definitions for non-applicable information, added 95% as passing score.	8/11
Removed Claim Submission # from provider verification materials	10/12

Clarified information needed to validate HIPAA	7/14
Changed *Scope* from "Health Plan Member & Provider Services" to "Centene Member and Provider Call Center Agents."	5/12/15
"Policy" section: There is no longer a description of *what* a quality evaluation (audit) consists of (that it is a recording of audio and video of an agent's calls). And this section now contains reference to the call quality goal of 93%.	5/12/15
"Procedure" section 1: Removed content describing the QM/Avaya system and how it works. This section now refers to the number of evaluations required each month for each agent, 8-10, and the Corrective Action policy CC.MSPS.40.	5/12/15
"Procedure" section 2: Now refers to *the Call Monitoring Acknowledgement Form*, rather than a description of the number of audits per month, which was formerly 10 but is now 8-10 per the revised section 1.	5/12/15
"Procedure" section 3: No longer refers to the *Call Monitoring Acknowledgment Form*, but instead refers to the new, standard *Quality Evaluation Form*.	5/12/15
"Procedure" section 4: No longer refers to the evaluation form, but instead is a statement that the form will be reviewed and revised on an annual basis.	5/12/15
"Procedure" section 5: Removed reference that coaching must be completed "immediately" and also the examples of % based scoring and that the goal is a score of 95%. Section 5 now refers to protocol for approval of changes to the Quality evaluation form.	5/12/15
"Procedure" sections 6-10: Removed 6, which referred to "calls observed by designee no longer present," and 7-10, which were descriptions of reporting requirements.	5/12/15
"Quality Audit Form" section" is now called the "Quality Evaluation Form" section. This section refers to and describes the form that is attachment B, rather than the previous form.	5/12/15

“Quality Audit Form Section,” the HIPAA verification description has been revised for clarity: It now specifically mentions that provider *and* member information must be verified when a provider calls.	5/12/15
“Procedure for New Agents” section has been removed, as the quality standard does not differ for new agents. A call center has some discretion regarding when an agents evaluations will be counted towards that agent’s metrics.	5/12/15
Added “Quality Evaluation Dispute Process” section.	5/12/15
Replaced the attachment *Member & Provider Services Representative Call Quality Audit Form* with *2015 Call Quality Form.*	5/12/15
Added “and may result in progressive disciplinary action” to the disconnecting/ignoring a caller paragraph in Section 5.	5/12/15
“Procedure” section: Removed reference to *Call Monitoring Acknowledgment Form,* which was formerly section 2. Removed this form, which was formerly attachment A.	9/15/15
Updated “Quality Evaluation Form” section with new points possible and new point values per section, per the updated 2016 version of the form, which is attachment A. Added The 2016 Enterprise Call Quality Scoring Guidelines document as attachment B.	12/29/15
Updated *Department* to “Member and Provider Solutions” from “Member and Provider Services.”	1/20/16
Updated *Scope* of policy by specifying “Medicaid and Marketplace” as the products.	1/20/16
Under the “Quality Evaluation Form” section, updated the HIPAA verification elements required to match those of Medicare.	1/20/16
Added a section “If Call Recording is Temporarily Suspended,” which addresses protocol for these situations.	1/20/16

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Updated the “Quality Evaluation Form” section with revised point values per section, aligning it with the *2017 Enterprise Call Quality Evaluation Form*, which is attachment A and replaces the 2016 form.	1/12/17
Added The 2017 *Enterprise Call Quality Scoring Guidelines* document as attachment B, replacing the 2016 Guidelines.	1/12/17
Changed the “Quality Evaluation Form” section by increasing the minimum passing score from 93 to 94.	
Updated the “Quality Evaluation Form” section regarding HIPPA to include that *it is mandatory to identify the name of the caller.*	1/12/17
Updated the “Quality Evaluation Form” section to include s*howing extreme rudeness to the caller* among the agent behaviors that will result in a score of “0” for the entire call.	1/12/17
In SCOPE section, added references to Medicare and MMP	1/29/17
Per Compliance, eliminated a passage from Attachment B (Scoring Guidelines) in the “Followed HIPAA Guidelines” section. This passage gave examples of what is *not* considered PHI.	2/22/17
Added guidance to Attachment B (Scoring Guidelines), “Verification” section, which addresses how the agent is to handle situations when verification could cause caller abrasion.	4/1/17
Added guidance to the “Quality Evaluation Form” section addressing situations when the standard HIPAA verification process can by bypassed.	7/7/17
Changed the “Policy” section to reflect an increase in the minimum passing score from 94 to 95.	12/29/17
Updated the “Quality Evaluation Form” section with revised point values for each section, aligning it with the *2018 Enterprise Call Quality Evaluation Form*, which is attachment A and replaces the 2017 form.	12/29/17

Updated the "Quality Evaluation Form" section to include that inappropriate release of PHI or change to account information will result in a "0" for the entire call.	12/29/17
Updated the "Quality Evaluation Form" section to include that the HIPAA verification process is covered in the "Account and caller identification" component on the Quality Form	12/29/17
Added the *2018 Enterprise Call Quality Scoring Guidelines* document as attachment B, replacing the 2017 Guidelines.	12/29/17
The behaviors that will result in a "0" for the entire call were reduced to three specific behaviors: Inappropriate release of PHI, Mishandling an emergency or crisis call, and contributing to an Access to care issues	1/31/19
The "Evaluation form" section was updated to reflect the 2019 form, which is comprised of two sections, Compliance and Service Skills, with only the Compliance components having point values.	1/31/19
A slightly different step by step process for rebuttals and disputes replaces the 2018 process. The two major changes are that a first level rebuttal will be reviewed by a peer and not the original auditor, and the final decision is made by the Manager and Director of Performance Improvement.	1/31/19
The 2019 Quality Form (Attachment A) and the 2019 Quality Guidelines (Attachment B) replace the 2018 versions of these.	1/31/19
Annual Review: Updated header according NCQA conventions	2.6.19
Updated passing score to 90%; updated sections of Quality Audit form; updated HIPAA verification metrics; attached updated Member and Provider Quality Forms and Quality Guidelines	10/2020
Changed "Contact Center Agents" to "Customer Service Agents"; changed "leader" to "People Leader"	**3/21**

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The electronic approval retained in Archer is considered equivalent to a physical signature.