Customer Service Principles and Performance Standards for Exchange Call Centers

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The Affordable Care Act (ACA) commits to giving consumers applying for affordable health coverage a seamless, top-flight experience. Turning that lofty goal into reality will require performance standards to assure the expectation is met. In some instances, for example, consumers calling an Exchange (Federally Facilitated Exchange also known as an "FFE", or a state Exchange) may be transferred to another entity such as a state or county agency to make a full Medicaid eligibility determination. Hand-offs between agencies can result in a frustrating consumer experience. Clear performance guidelines are essential to optimize the possibility of a smooth, satisfactory experience.

In California, policymakers and advocates are immersed in developing the transition to a new unified application structure coordinated between the state's Exchange, Covered California, and the "single state agency" for Medicaid, the Department of Health Care Services. Further complexity exists in California, as in many states, because counties also play an important role as agents of the state responsible for making final Medicaid eligibility determinations. Consumers calling to apply for affordability program coverage may thus find themselves interacting with more than one agency, with potential transfers of callers between federal and state, or between state and county, agencies.

The principles and performance standards below by advocacy organizations in California were developed to ensure those who telephone Exchange Call Centers, whether at the FFE or state Exchanges, have a consumer-friendly, successful experience applying for coverage over the telephone. These suggested principles and standards are not intended to be all-inclusive, and do not cover web-based or walk-in applications. *Note that Covered California's "Service Center" is a centralized, multi-site hub that will receive applicants' phone calls, as well as perform other service functions. In this memo we use the term "Service Center" to indicate any Exchange entity that receives telephone applications.*

For further information contact Betsy Imholz, Special Projects Director at Consumers Union's West Coast Office, 415-431-6747, bimholz@consumer.org. *Thanks to Maureen Mahoney, Public Policy Fellow at Consumers Union, for her helpful research on customer service standards.*

I. General Principles:

1. **Seamless intake** -- Screening calls to the Service Center for possible Medicaid eligibility adds a potential additional step for callers to be transferred during phone-in applications. This complicates and lengthens the eligibility determination process. Safeguards, including clear performance standards, are critically important to ensure the overall experience is seamless to the caller and does not result in delays in enrollments.

2. **Parity for all consumer experiences** -- Policies and performance standards should be the same whether application processing is done by a Service Center, state Medicaid agency, a county, or any other entity. In order to ensure a uniform consumer experience, the standards for how applications are processed should be the same whether calls are handled by the original Service Center representative or by an entity that receives a transferred call.

3. **Consumer's first call allows for a completed application and final determination** -- The first call should result in an open application and a final determination made in "real-time," whenever possible ("real-time determinations" should occur in cases where the person can provide, or the data system obtain, all necessary information by telephone or electronic means during the first call).

4. **Consumers required to make only one call --** If transfers of callers are made, the transferred consumer should not then be required to call back or call another number (unless the consumer requests a call back due to lack of application information, e.g. information not electronically available). Rather, the agency to which the consumer has been transferred must have the capacity to follow through with the application on that same call.

5. **Consumer information provided one time only** -- Consumers should not have to provide their information more than once (even if transferred); all data given by the consumer during the initial call should be entered into the computer system, then transferred or made visible in real time to the transferee agency.

6. **Performance standards measured on an individual consumer basis, broken out by language spoken --** Performance standards, e.g. required phone pick-up times, need to apply to each caller to ensure a uniform customer experience across multiple languages. Aggregate, periodic (e.g. weekly) reports are useful for monitoring and determining whether structural adjustments are necessary, but do not ensure a real-time, satisfactory consumer experience.

7. **Accountability standards and enforcement mechanisms required --** There must be adequate accountability standards and enforcement mechanisms in place for all calls routed to non-Exchange entities, including state and county agencies, so that Exchanges remain responsible for the handling of all callers to their Service Centers.

II. Performance Standards for Starting an Application for "Affordability Programs"

All the recommended standards below should apply equally to Exchanges and any agencies to which their callers are transferred. And these standards should apply equally to English-speaking, Limited English Proficient (LEP), and hearing impaired callers.

1. **Calls need to be answered quickly** -- A predominant industry standard requires that incoming calls be answered **within 20-30 seconds.** North American Quitline Consortium (NAQC) notes that this "is a common goal for centers in the health care field"[1]; Covered California proposed 30 seconds as the standard for call handling at its "Service Center," as well as for counties and health plans.[2] There may be additional state law requirements to consider for state agencies answering telephones.

2. **Hold times must be minimized** -- The answer rate is less significant if an automated voice system picks up a call; the more important indicator is how long it takes to get a live agent on the phone, i.e. hold time. Hold times should be limited to less than 2 minutes for all callers, including LEP and hearing impaired consumers. If hold time will be greater than 2 minutes, the consumer should be able to choose to be called back by an agent when their call is next in the queue from when they called. The NAQC encourages call centers to keep these times as short as possible.[3]

3. **No one should experience a busy signal --** The standard of "no busy signals" should apply to calls to the Exchanges and to transferee agencies. NAQC states that the general benchmark is 2% (at most) of calls unable to get through, noting that this would be unacceptable for 911 or a similar service.[4] The Exchanges must have a process in place to retain and fully process calls if the Service Center staff gets a busy signal when attempting to transfer a call. Covered California has proposed a "no busy signals" goal for calls to its Service Center requiring transfers.[5]

4. **Use of voice mail should be avoided** -- Voice mail is never consumer-friendly and cannot by its nature accomplish immediate "real time" coverage. But if customers must leave a voice mail at the Service Center, 90% of the callers should hear back from an agent within one business day.[6]

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1 NAQC, "Call Center Metrics: Best Practices in Performance Measurement and Management to Maximize Quitline Efficiency and Quality," 2010, p. 10, calls for 80% of incoming calls to be answered in 20-30 seconds.

2 Covered California "Customer Service Center Updates," pp. 15 and 16, accessed Jan. 30, 2013, http://www.healthexchange.ca.gov/StakeHolders/Documents/CA%20Service%20Center%20Protocols%20Presentation.pdf ; Covered California, Qualified Health Plan Contract ("QHPC"), Attachment 3: "Performance Guarantees," p. 90.

3 NAQC, p. 15.

4 NAQC, pp. 8-9.

5 Covered California "Customer Service Center Updates," p. 15, accessed Jan. 30, 2013, http://www.healthexchange.ca.gov/StakeHolders/Documents/CA%20Service%20Center%20Protocols%20Presentation.pdf; see also QHPC, p. 91.

6 Covered California has suggested two business days for QHPs. QHPC, p. 91.

5. **Call "abandonment rates" must be minimal and are a key measure** -- The "abandonment rate," or rate at which frustrated callers hang up because they can't get through to an agent or because an interactive voice response (IVR) system does not provide the needed connection, should be lower than 3%.[7] The NAQC recommends that call centers strive to achieve a 0% abandonment rate, but notes that 10-20% is common.[8]

6. **Automated systems should be limited** -- **No more than two automated questions** should be asked before customers are guided to the most knowledgeable, available agent.[9] The customer also should be able to opt out of the automated system and be routed to an agent.

III. Additional Standards for Ongoing Performance Assessment

1. **Aim for a zero error rate on eligibility determinations for affordability programs --** Callers to Exchanges will be unlikely to know which, if any, of the affordability programs they qualify for. The Exchange will be responsible for assuring the proper eligibility assignment to Medicaid, subsidized Exchange products, and unsubsidized Exchange products, regardless of whether the Exchange or a delegated agency does the final determination, and the goal should be for a correct determination, most favorable to each consumer each time.

2. **Aim high on customer satisfaction** -- Approval rates for the application experience through Exchanges should be 95% or above.[10]

3. **Have 24/7 phone access to apply, at least during the first open enrollment period** -- As Turbo Tax provides during tax filing season, 24/7 enrollment assistance should be available when enrollment first begins.[11] After hours calls (e.g. voicemail messages) should be monitored to determine if hours need to be extended during any period without 24/7 access.[12]

4. **Respond to consumer inquiries quickly** -- Standards for telephone application responses are described in detail above. Emails and letters should receive a 90% response rate within two business days.[13]

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7 NAQC, p. 9; QHPC, p. 91.

8 NAQC, p. 9.

9 See Genesys, "Customer Service Strategies for the Healthcare Industry," 2008, p. 12, advocating for skills-based routing and encouraging use of automation. We believe, however, that for the population applying for Affordability Programs access to a live agent will be especially important.

10 Covered California has proposed customer satisfaction standards for Qualified Health Plans, as determined through customer surveys, of 92%. QHPC, p. 91.

11 The Kaiser Commission on Medicaid and the Uninsured suggests as a performance measure whether 24/7 customer assistance is available at call centers. "Performance Measurement Under Health Reform: Proposed Measures for Eligibility and Enrollment Systems and Key Issues and Trade-offs to Consider," December 2011, p. 8.

12 NAQC, p. 11.

13 Covered California has suggested this timeframe for QHPs. QHPC, p. 91.

5. **Monitor social media** (e.g. Yelp) **for uncensored feedback --** In order for Service Center managers to continuously identify problems in service and address them in the system, user experience should be reviewed periodically through social media.[14]

6. **Seek multi-lingual customer feedback** -- To ascertain the consumer experience, as well as which standards customers value, feedback should be regularly sought from all consumers, including non-English speakers. After evaluating the feedback, performance standards should be adjusted accordingly.[15] Surveys should measure not only speed, but also quality and accuracy of service provided.

7. **Regularly compare all performance standards** -- Review performance standards, including customer satisfaction, among the various Exchange Service Center components and delegated entities (e.g. counties), to raise the bar for all.

8. **Require random monitoring by Exchange staff --** Have staff listen in on calls in progress (both calls to the Service Center and transferred calls, if technologically possible) to hear how calls are handled and the information is given. This is a fairly common tracking process in the commercial world.

9. **Require each Exchange to have an ombudsman** -- Having a party to whom people can go if they have had a problem with customer service, e.g. their call got dropped or they were on hold for excessive time, is an important check and balance. Ombudsman programs in public agencies and private endeavors are quite common and successful, allowing for resolution of individual complaints as well as tracking recurring problems that warrant systemic change. For example, seeking to improve its customer service the California State Controller's Office established an ombudsman office for its Unclaimed Property Division and has found it helpful in reducing errors and improving quality of service.

10. **Ensure employees** (at Exchange Service Centers and other agencies handling phone applications) **all have the continuous training and tools needed** to provide quality service for applicants -- Having ongoing training and a communication feedback loop for telephone agents to note problems and successes will allow Exchanges to troubleshoot and provide a more uniform, high quality consumer experience. Also, providing Service Center employees incentives based on accurate work and satisfied customers will promote a positive consumer experience, as well as create job growth opportunities for employees that will, in turn, improve the consumer experience.[16]

11. **If performance standards are not met, institute a corrective action plan --** Any sub-contractor or agent agreements should ensure there are effective corrective actions plans, including termination and penalty clauses for breach of performance standards.

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[14] Tim Montgomery, "Five Attributes of the Best 'Real Time Customer' Call Centers," Contact Center Pipeline, April 2009, pp. 1- 2.

[15] NAQC, p. 7.

[16] See generally, Montgomery, p. 2, and NAQC, pp. 6-7.

Resources:

Baker, Juli and Tobin, Craig, "Service Center Status Update," Covered California, Board Meeting Materials, January 31, 2013.

California Health Benefit Exchange, Exchange Customer Service Center Design, Board Options Brief, "Consumer-Centric Exchange Customer Service Center," Discussion Draft, June 15, 2012.

Connolly, John, Insure the Uninsured Project (ITUP), "Creating a Streamlined Service Center for California's Health Subsidy Programs," December 10, 2012.

Covered California, Qualified Health Plan Contract (QHPC), Attachment 3, "Performance Guarantees," pp. 88-94, January 11, 2013.
http://www.healthexchange.ca.gov/Solicitations/Documents/1st%20DRAFT%20QHP%20Model%20Contract%20%201%2011%2013.pdf

Genesys, "Customer Service Strategies for the Healthcare Industry," 2008.

Kaiser Commission on Medicaid and the Uninsured, "Performance Measurement Under Health Reform: Proposed Measures for Eligibility and Enrollment Systems and Key Issues and Trade-offs to Consider," (sets out six metrics by which the user experience should be judged for eligibility and enrollment systems: whether they are available at all times (24/7), the number of "completed contacts," "average wait time," "number of complaints," the "percentage of enrollees highly satisfied with application/renewal process," and "number of appeals submitted related to program eligibility"), Table 2, p.8, December 2011.

Montgomery, Tim, "Five Attributes of the Best 'Real Time Customer' Call Centers," Contact Center Pipeline, April 2009.

North American Quitline Consortium (NAQC), Call Center Metrics: Best Practices in Performance Measurement and Management to Maximize Quitline Efficiency and Quality. Quality Improvement Initiative (Reynolds, P.). Phoenix, AZ, 2010.