POLICY TITLE	Member Network Experience Assessment	NUMBER	NET 004
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PURPOSE

Embright is committed to ensuring high quality services and a supportive member experience. A key element of that experience is that the member is able to access network services appropriately and then receives needed care in a supportive care team approach. Member feedback is an important tool in understanding the member experience and responding to specific incidents as well as addressing overall patterns of concern or opportunities for improvement in the network.

POLICY

This policy and procedure describes how Embright routinely collects and analyzes member feedback, complaints, appeals and out-of-network requests to understand patterns, address concerns and implement strategies to improve access and the member experience.

DEFINITION

CAHPS	Consumer Assessment of Healthcare Providers and Systems. A set of standardized surveys that measure patient satisfaction with the experience of care.
Clinical Integration Committee (CIC)	The Committee is advisory to the Board of Managers ("Board"). Based on recommendations, status updates and other briefings from Company management, the Committee will make recommendations to the Board regarding certain care integration activities or will make decisions where the Board has delegated decision-making authority.
Member	A person insured or otherwise provided coverage by a health insurance organization.
Utilization Management	Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinicians or patients, in cooperation with other parties, to ensure appropriate use of resources

PROCEDURE

1. Assessment of Member Experience Accessing the Network – Data Collection

    1.1. The Senior Provider Network Manager oversees the collection, analysis and summarization of member experience data. Most of the data is collected quarterly but minimally all data is summarized and analyzed annually based on the processes described in this policy and procedure.

    1.2. Member experience data is obtained from a variety of sources including:

        1.2.1. Complaints – Embright receives a summary of complaints quarterly from its member services department and from payor partners. The data includes categories of complaints about network access, quality of care and network service levels.

        1.2.2. Appeals – Embright provides review support to payors on appeals related to the network and assists in administering the appeals. Embright then receives quarterly summaries of appeals related to its network from payor partners. The appeals data is summarized and analyzed to evaluate concerns related to network composition or additional needs in the network, network access concerns, quality of care or general network service concerns.

1.2.3. Surveys – Embright receives annual member survey information annually from payor partners. These surveys may be standardized surveys such as CAHPS or may be custom surveys that the health plans have administered. Embright analyzes the responses to questions related to network access, quality and service.

1.2.4. Other Sources – Embright and the payor partners may conduct more targeted approaches to collecting member experience data such as focus groups or virtual surveys regarding specific experiences. When these surveys are conducted, Embright incorporates the results into the annual report on member experience.

1.3. Non-Behavioral and Behavioral Out-of- Network Activity

Embright recognizes the value of analyzing out-of-network activity. Analyzing this data supports the ability of Embright to identify opportunities for network expansion or development by specialty or in a specific geographic area. It can also help identify providers who may have limited access or opportunities to expand office hours. Annually, Embright compiles data on member requests for out-of-network services and data on actual out-of-network utilization to identify and monitor issues with access to non-behavioral healthcare services, practitioners, and providers. The approach includes analysis of:

1.3.1 Utilization Management and Out-of-Network Requests - Embright, working with payor partners, analyzes member/practitioner requests for out-of-network services, including:

- Urgent concurrent, urgent preservice, nonurgent preservice and post-service requests.
- Final determinations resulting from these requests (approvals and denials, regardless of reason code)

1.3.2 Coverage Requests - Embright, working with payor partners, compile and analyze requests and final determinations for in-network level of benefit coverage.

1.3.3 Claims Data - Embright analyzes summary claims data provided by payors to identify out-of-network patterns, claims denied for out-of-network activity or paid at out-of-network rates and reimbursement levels.

Embright analyzes the data separately for non-behavioral and behavioral providers as well as practitioner and provider (facility-based) care in order to develop specific strategies to address issues.

2. Analysis and Reporting

2.1. The Senior Provider Network Manager is responsible for the annual summarization, analysis and reporting of the results of member experience data collection and the out-of-network data collection.

2.2. The annual report by Embright includes a quantitative and qualitative analysis, by product/product line, of member complaint and appeal data related to network adequacy (e.g., requests for out-of-network services, appeals, complaints specific to access) and member experience (CAHPS or member experience survey). This analysis helps monitor and identify specific issues with access.

2.3. The data is analyzed and trended over time in order to evaluate whether access and other concerns are improving or not. This analysis is also used to evaluate whether strategies and interventions are having an impact.

2.4. Embright analyzes data for non-behavioral requests for and utilization of out-of-network services and reports that data on a per thousand member rate at the product-line level.

2.5. Embright also conducts additional drill-down analysis to identify route causes and specific areas for improving access, service levels and network composition.

3. Opportunities to Improve Access to Non-Behavioral Healthcare Services

   The annual report summarizes the impact of prior year interventions and strategies, identifies opportunities to improve access to non-behavioral health care services and recommends future strategies and actions.

4. Opportunities to Improve Access to Behavioral Healthcare Services

   The annual report summarizes the impact of prior year interventions and strategies, identifies opportunities to improve access to behavioral health care services and recommends future strategies and actions.

5. Annual Report Distribution

   The annual report and recommendations are presented to the Clinical Integration Committee. That committee approves the recommended interventions and may revise or add interventions. The Senior Provider Network Manager then implements the interventions. The annual report and Clinical Integration Committee recommendations are presented to the Board of Directors.

REGULATION

NCQA HP 2020 NET 3: Assessment of Network Adequacy

REVISION

Revision Date	Revision