| POLICY TITLE | Assessment of Physician Directory Accuracy | NUMBER | NET 007 |
|---|---|---|---|
| DEPARTMENT | Network Development | PAGE | **1** of **3** |

## PURPOSE

Embright supports routine assessment of service quality in order to proactively identity and resolve issues and continually assess and maintain network information accuracy. Embright implements routine information checks in order to ensure a quality member experience with the network by validating that physician information in directories is accurate and offices provide appropriate information to members.

## POLICY

This policy and procedure describes how Embright annually evaluates physician office information and offices for accuracy and awareness of the physician's office regarding their participation in the Embright network.

## DEFINITION

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| 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. |

## PROCEDURE

### 1. Scope of Annual Assessment

1.1. The Senior Provider Network Manager oversees the annual Embright evaluation of physician directories to include an assessment of:

1.1.1. Accuracy of office locations and phone numbers.

1.1.2. Accuracy of hospital affiliations.

1.1.3. Accuracy of accepting new patients.

1.2. The Senior Provider Network Manager is also responsible for the annual assessment of awareness of the physician office staff of physician's participation in Embright's networks.

### 2. Annual Assessment Methodology and Analysis

2.1. In order to assess accuracy, Embright develops a statistically valid sample of all physicians listed in the directory. The typical methodology used is to pull a single, representative sample of primary care practitioners and specialists across the network using a 95 percent confidence level and a 5 percent confidence interval (margin of error).

2.2. Embright sends a survey to the selected offices with requests for information that relates to assessment of accuracy of locations, phone numbers, hospital affiliations and whether the practice is accepting new patients. Embright compares the survey responses with the information listed in the web directory within 30 calendar days of receiving a response, to minimize the chance that differences were due to real changes in physician information over time. If the provider's survey response matched the information published in its web directory, the information was considered accurate.

2.3. Embright does direct outreach to all providers who do not respond to the survey in order to achieve a higher rate of return.

2.4. Embright then compares the responses to directory information and documents where information differs. When information differs Embright calls to confirm and validate the correct information. If the new information is correct, Embright submits this information to the data correction process as well as noting the accuracy level for the report.

2.5. Embright provides members with accurate information on in-network physicians to avoid barriers to access. The organization determines if there is a lack of awareness on the part of physician office staff or if the organization has incorrectly listed a physician as in-network. In order to assess staff knowledge of participation in all Embright contracted networks Embright uses a "secret shopper" method and calls the sampled offices to query whether they participate in the network. Embright then records the response accuracy

**3. Report and Recommendations**

3.1. The Senior Provider Network Manager develops the written annual report and includes the background and a description of:

3.1.1. The sampling methodology used and the sample universe

3.1.2. The accuracy rate for each factor measured

3.1.3. Numerators and denominators for each factor that is measured

3.1.4. Follow-up methods used to ensure greater participation in the survey process

3.2. The report also includes the quantitative results for each measure and qualitative analysis based on the following measures

3.2.1. Office location/phone numbers
*Numerator:* Number of respondents with correct addresses/phone numbers listed in the directory.
*Denominator:* Total number of physician offices sampled.

3.2.2. Hospital affiliations
*Numerator:* Number of respondents with correct hospital affiliations listed in the directory.
*Denominator:* Total number of physicians sampled.

3.2.3. Accepting new patients
*Numerator:* Number of respondents correctly listed in the directory as accepting new patients.
*Denominator:* Total number of physician offices sampled.

3.2.4. Current network participation
*Numerator:* Number of respondents who correctly identified the networks in which they participate and the directory matched its contracts.
*Denominator:* Number of physician offices in the sample.

3.3. The Network Management Team reviews the results and drafts recommended interventions to improve accuracy. In addition, all changed information that is validated is processed so directories can be updated.

3.4. The report includes a summary of:

3.4.1. Opportunities for improvement to improve the accuracy of directory information – this can include provider or administrative issues, and

3.4.2. Recommended actions and interventions – can include actions such as implementing enhanced or targeted provider training or initiating easier processes for providing new information

3.5. The Senior Provider Network Manager presents the report and recommendations to the Clinical Integration Committee and reports on the impact of prior year interventions.

## REGULATION

NCQA HP 2020 NET 5.C-D: Physician and Hospital Directories

## REVISION

| Revision Date | Revision |
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