**Taxonomy Commission**

Meeting Minutes

March 1, 2019

9:00-11:00 am

Date of meeting: Friday, March 1, 2019

Start time: 9:10am

End time: 10:03am

Location: Michael Matta Conference Room, 11th Floor, One Ashburton Place, Boston, MA 02108

Members present:

* Lauren Peters – Executive Office of Health and Human Services (Chair)
* Matthew Veno -- Division of Insurance
* Kate Ginnis, MSW, MPH, MS -- Boston Children’s Hospital
* Sarah Coughlin, LICSW, LADC-I -- National Association of Social Workers
* Scott Weiner, MD, MPH -- Brigham and Women’s Hospital
* Ken Duckworth, MD -- Blue Cross Blue Shield of Mass.
* Sarah Chiaramida, Esq. -- Mass. Association of Health Plans

Members calling in:

* Kiame Mahaniah, MD -- Lynn Community Health Center
* Claudia Rodriguez, MD -- Brigham and Women’s Hospital

Members absent:

* Deirdre Calvert, LICSW -- Column Health
* Diana Deister, MD -- Boston Children’s Hospital

**Proceedings**

Undersecretary Peters called the meeting to order at 9:10am.

**Vote:** Deputy Commissioner Veno introduced a motion to approve the February 14th minutes, which was seconded by Ms. Ginnis and unanimously approved by roll call.

Undersecretary Peters reminded the Commission that the charge is not to recommend specific legislation, but to recommended guidance to the legislation so that they can proceed accordingly; recommending a framework, and not a specific proposal. She stated her goals of coming to a vote on both the recommended taxonomy and recommended validation process. She reminded the Commission of the March 31st reporting deadline.

Undersecretary Peters reviewed the recommended taxonomy as of February 14th, and asked the Commission to review it to confirm that it reflected deliberations up until this point.

Dr. Weiner suggested changing the item of dual diagnosis to say “Substance use disorder, with co-occurring mental health disorder,” so that it would be grouped with other substance-use related items. The Commission agreed and the change was made.

Undersecretary Peters reminded the Commission that the “reference terms” associated with the taxonomy would only come into play if payers had the IT capability within their directories to include it, and that it was not part of the official recommended taxonomy.

Ms. Chiaramida entered the room at 9:16am; she had been calling in to the meeting until that point.

Undersecretary Peters reviewed the treatment modalities included in the recommended taxonomy and opened the floor for comments. Ms. Chiaramida mentioned that the “medication” modality may be unclear for some. The commission deliberated and agreed to rename the item “Medication/ Psychiatric Medication.” Ms. Coughlin proposed adding “Psychodynamic Therapy” as a modality; the Commission deliberated and agreed. Ms. Ginnis proposed changing “Faith-based Counseling” to “Faith-based Therapy;” the commission deliberated and agreed.

Dr. Mahaniah left the meeting by conference call at 9:30am.

Dr. Rodriguez proposed including specific modalities around therapies for addictions; the Commission deliberated and agreed to add “Addiction-focused Therapy.”

Undersecretary Peters reviewed the potential uses of the recommended taxonomy [see slide deck]. Ms. Chiaramida suggested adding a recommendation that MassHealth incorporate the taxonomy into their provider directories. The commission deliberated and agreed. Undersecretary Peters emphasized that the onus of a universal credentialing platform should not merely by on private payers, and agreed that public payers should be held to the same standards.

Ms. Chiaramida emphasized the need to limit the frequency of updates to these recommendations, and the importance to balance keeping things “up to date” with potentially presenting operational issues when other systems cannot adapt as quickly. Deputy Commissioner Veno agreed that the list will be “dynamic over time,” so a regulatory framework to accommodate that is necessary. The Commission deliberated and agreed that the recommendations will include the suggestion that the DOI establish a process through regulation to keep the list current, along with other administrative simplification efforts.

Deputy Commissioner Veno raised the point that one potential purpose of the recommended taxonomy can be to highlight the gaps between recommended specialties/modalities and those specialties/modalities that cannot be validated by any current professional boards; that this work could serve as a flag to the relevant bodies that additional credentials need to be developed to accommodate the current roster of behavioral health work occurring. The Commission deliberated and agreed.

Undersecretary Peters turned the conversation to the process of recommending a validation process for behavioral health clinician specialties.

Ms. Chiaramida described the work of Aperture CVO, a private primary source credentialing body that works with CAQH. She explained that the range of behavioral health clinicians that Aperture can validate is narrower than the Commission’s recommended taxonomy, and that there is a need to consider the “relationship between [the Commission’s] list and whether there is actually a way to verify” all of the items on it. She suggested the possibility of provider directories indicating which specialties can be independently validated and which are self-reported.

Undersecretary Peters explained that the options laid out [see slide deck] are “straw men proposals” for the Commission to brainstorm around. She explained more background about Aperture’s work. Ms. Chiaramida emphasized that the Commission’s recommendation can highlight what cannot be validated and therefore put the “onus on the boards to create these certifications and credentials.”

Undersecretary Peters raised the pros and cons of explicitly demarcating which specialties can be validated and which cannot. Ms. Ginnis explained the incentive on providers to check more boxes in the hopes that it will help them to be included in a provider network. She suggested that the two options presented to the commission [see slide deck] are not mutually exclusive, that third party validation can be a “front end” option and that claims audit can supplement.

Deputy Commissioner Veno raised the question of whether there are provisions in provider contracts that state that self-reported credentials must be a fair and accurate representation of a provider’s capabilities. Dr. Duckworth answered that he believes that there are. Deputy Commissioner Veno expressed the importance of providers “tak[ing] pause” and not misrepresenting themselves in order to gain access to a network. Ms. Chiaramida offered to check on what language is used on the CAQH application, and whether a disclaimer of this kind is present. She agreed that there is a need for a statement in the contracts that providers will be held accountable for the information provided; Undersecretary agreed to the need for a “minimum bar” warning.

Ms. Ginnis brought up the need for a “cultural shift” in the incentives for providers to “check all the boxes” on application forms and that “you want to do zero things to disincentivize any providers from joining networks.”

Ms. Chiaramida mentioned that the Commission’s report needs to recognize that there is no way to validate many of the specialties listed. Undersecretary Peters questioned the importance of pointing out which specialties are independently verifiable. Dr. Duckworth voiced his strong belief that it is important, and that the transparency of that information will put pressure on other bodies to create more verifiable certifications.

Undersecretary Peters proposed that the recommendation have two components—how to give providers pause as they fill out applications, but also to recommend what is driving the need for them to “check all the boxes.” Ms. Ginnis proposed calling them “areas of clinical focus;” all agreed.

Undersecretary Peters emphasized that the goal of the recommendation should be to improve upon the current system, and that if the Commission were to recommend using a third party entity for primary source validation, if would be up front that the entity won’t be able to validate every recommended taxonomy item, but that items will be validated to the extent possible.

Ms. Ginnis emphasized that plans should communicate to providers that they will be accepted into networks regardless of how many specialties they check, in order to create more accurate provider networks. She added that the plans should be required to audit provider claims. Undersecretary Peters suggested that this can be called a “special examination,” which is currently under DOI purview.

Undersecretary Peters explained the feasibility of looking at claims data to use patient volume as a proxy for specialty verification. She described certain limitations of the system, including nuance around private pay, distinctions between billing and rendering providers, and of the consistency of secondary diagnoses being included in claims. Ms. Chiaramida expressed that using CHIA claims data, as described, would be more comprehensive than a one-plan audit; plans are constrained by using only their own claims.

Ms. Coughlin brought up the idea of recommending changes to the CAQH interface, so that the system routinely required providers to ensure that information around what services they are currently offering be accurate, and that those services not currently being provided become “un-checked.” Ms. Chiaramida agreed and offered to check if CAQH had the ability to make this change, and was not already using language to communicate to providers that their given information was subject to verification.

Undersecretary Peters summarized that a recommendation for CAQH would be the addition of language on provider applications and change forms to say “What services are you currently providing? (Subject to verification or special examination).” She also summarized the other validation recommendations: that plans use third-party credentialing entities, to encourage payers to use one source as a universal credentialing platform, and that DOI or some other government entity devise a process to do periodic special examinations of claims data. Ms. Chiaramida added that recommendations should include that licensing boards look to continue to look for ways to develop primary source verification processes/guidelines/definitions; all agreed.

Dr. Rodriguez suggested adding “Home-based Therapy” to the treatment modalities list; all agreed. Ms. Ginnis suggested adding “Teletherapy;” all agreed.

The Commission discussed their schedule moving forward, and agreed to review a draft report and to respond with comments before the next meeting on March 20th, at which time a final vote will be called to approve the recommendations.

**Vote:** The Undersecretary introduced a motion for the meeting to adjourn, which was seconded and unanimously approved, by roll call.

The meeting was adjourned at 11:03am.