Provider Directory Task Force

A report filed with
the Joint Legislative Committee on Health Care Financing and
the Clerks of the Massachusetts Senate and House of Representatives
to be forwarded to
the President of the Senate,
the Speaker of the House of Representatives,
the Minority Leader of the Senate, and
the Minority Leader of the House of Representatives

2020

GARY ANDERSON
COMMISSIONER OF INSURANCE

Acknowledgments

Kevin Beagan, Niels Puetthoff, Nicole Sharma, and other staff members of the Division of Insurance ("Division"), have coordinated the work of the Provider Directory Task Force in the preparation of this report to respond to Section 4 of Chapter 124 of the Acts of 2019.

Table of Contents

EXECUTIVE SUMMARY

Insurance carriers who provide or arrange for the delivery of health services through a network of providers are expected to provide covered persons with access to clear and comprehensive information about the providers who are part of their networks. It is essential for patients that carriers and providers establish systems and protocols that will improve the accuracy and quality of provider directory information so that patients will be able to find providers when they need to obtain access to necessary care.

The Provider Directory Task Force presents the following recommendations so that they may be incorporated within Division of Insurance regulations affecting all managed care plans offered in the Commonwealth of Massachusetts:

Collecting Information

- Carriers should explore the creation of one centralized portal to collect all provider information to reduce administrative burden to providers and minimize errors
- Portals should collect information in a way that allows providers to choose from a series of standard options to the greatest extent possible
- Facility information should clearly explain the type of hospital and, for non-hospital behavioral health facilities, the range of services identified in DOI Bulletin 2009-11 that are available in the facility
- Non-facility providers need to report information about:
    - Ability to accept new patients;
    - Office location, including phone number, address, office hours, disability access, and interpreter availability;
    - How often the provider practices at that location;
    - Provider languages spoken, gender, age groups served, and populations of interest;
    - Telehealth availability;
    - Specialty of care; and
    - If a behavioral health provider
        - Subspecialty and whether treated subspecialty in past year
        - Modality of treatment.
    - Race and ethnicity information would be optional

Updating Information

- Providers should be educated about the importance of updating information regularly and should take steps to update information regularly
- Carriers should take steps to improve provider directory updates with the goal of eventually making real-time changes.
- Carriers should send reminders every 90 days for a provider or their designee to verify information

Presenting Information

- Provider directories should present information in a searchable way based on the following characteristics:
  - Whether the provider is available to accept new patients;
  - Hours that the practice is open to see patients;
  - Provider's availability on evenings and weekends (optional)[1];
  - Provider's specialty;
    - For behavioral health, subspecialty;
    - For behavioral health, treatment modality;
  - Ages treated (grouped for example by Child, Adolescent, Adult, Geriatric);
  - Provider's race/ethnicity (optional);
  - Languages spoken;
  - Populations served;
  - Office's accommodations for physical/intellectual disabilities;
  - Office's access to public transportation;
  - Affiliations with specific hospitals;
  - Availability for telehealth appointments; and
  - Distance from a specified starting location.

- In addition the provider's profile should include the following.[2]:
  - Provider's name, board certification, education, and for behavioral health, provider's licensure level;
  - Whether a provider's panel is (a) closed to new patients, (b) has limited availability to accept new patients, or (c) is open to new patients (which may still require a wait time)[3];
  - Locations (addresses and phone numbers) of provider practices;
  - Availability by location (more than once per week, more than once per month);
  - Business hours of the locations;
  - Whether locations are available for telehealth appointments;
  - Limitations on practice (e.g., only treating concierge patients or only providing inpatient services);
  - Languages spoken;
  - Populations served (as optionally reported by the provider); and
  - If a tiered network plan, the provider's tier and an explanation of how that tier was identified by plan, and impact on cost-sharing under the plan.

---

[1] The following Task Force members voted for carriers to optionally collect and display provider availability: Mr. Katzman, Ms. Miller, Ms. Granoff, Ms. Burgiel, Mr. Nefussy, Mr. Rennie, and Ms. Leahy. The following Task Force members voted to require carriers to collect and display provider availability: Mr. Wilkinson, Dr. Warkentin, and Ms. Vangeli.

[2] See Appendix L for more information about non-facility providers.

[3] Specific definitions for "closed to new patients," "limited availability to accept new patients," and "open to new patients" will be provided in the corresponding regulation.

- For a hospital facility:
  - Hospital name and hospital type;
  - Location (address and phone number) of hospital; and
  - Hospital accreditation status.
- For a non-hospital facility:
  - Facility name and facility type;
  - Types of services performed and, for non-hospital behavioral health facilities, the services identified in Division of Insurance Bulletin 2009-11;
  - Location (address and phone number) of facility; and
  - Facility accreditation status.

Auditing Information

- Carriers should explore and make the best efforts to create a consolidated process among carriers to arrange audits via telephone, email, or other methods, so that providers are not called by numerous carriers.
- Carriers should investigate and work with providers to correct any directory inaccuracies that covered persons or providers bring to their attention.

Managed Care and Provider Directories

Beginning in the 1970s, insurance carriers began offering health plans that provided benefits based on the insured's receiving care from a network of health care providers. Carriers and providers entered into contracts whereby the provider agreed to accept carriers' levels of reimbursement and would follow the carriers' billing and utilization system requirements in order to be considered for the inclusion as part of the carriers' networks.

In order for covered persons to effectively access covered benefits under these network health plans, it became essential for each insured to have a clear and comprehensive understanding of which providers were contractually part of a carrier's network. In the early history of these products, carriers relied on paper directories. Today, each carrier maintains web-based directories so that consumers can search for providers among those listed in the carrier's provider directory database. However, upon request carriers are required to provide a hard copy of the existing directory.

Original Managed Care Statute and Regulation

When enacted, Chapter 141 of the Acts of 2000 created M.G.L. c. 176O ("Chapter 141" or "Health Insurance Consumer Protections") so that the Bureau of Managed Care within the Massachusetts Division of Insurance ("Division") and the Office of Patient Protection[4] ("OPP") could establish standards for managed care and oversee health insurance carriers' managed care practices. The managed care requirements apply to all insured health products offered in Massachusetts that provide or arrange for health coverage through a network of providers or employ utilization review processes to evaluate whether services are medically necessary and appropriate to be covered under health plan benefits. In order to implement M.G.L. c. 176O, the Division promulgated 211 CMR 52.00 ("Managed Care Consumer Protections and Accreditation of Carriers").

Within M.G.L. c. 176O, § 6(a) requires the following:

> "A carrier shall issue and deliver to at least one adult insured in each household residing in the commonwealth, upon enrollment, an evidence of coverage and any amendments thereto. Said evidence of coverage shall contain a clear, concise and complete statement of…
> (4) the locations where, and the manner in which, health care services and other benefits may be obtained."

Within 211 CMR 52.02, an Evidence of Coverage is defined as any "certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an

[4] Chapter 141 of the Acts of 2000 created the Office of Patient Protection within the Massachusetts Department of Public Health. This Office was transferred to be within the Health Policy Commission with the enactment of Chapter 224 of the Acts of 2012.

Insured specifying the Benefits to which the Insured is entitled." As noted in 211 CMR 52.13(3)(f), the Evidence of Coverage is to include the following:

(f) A description of the locations where, and the manner in which, Health, Dental or Vision Care Services and other Benefits may be obtained, and, additionally, for Health Care Services:

1. the method to locate Provider directory information on a Carrier's website and the method to obtain a paper Provider directory;
2. an explanation that whenever a proposed admission, procedure or covered service that is Medically Necessary is not available to an Insured within the Carrier's Network, the Carrier will cover the out-of-Network admission, procedure or service, and the Insured will not be responsible for paying more than the amount which would be required for a similar admission, procedure or service offered within the Carrier's Network; and
3. an explanation that whenever a location where Health Care Services are provided is part of a Carrier's Network, the Carrier will cover Medically Necessary covered Benefits delivered at that location, and an explanation that the Insured will not be responsible for paying more than the amount required for Network services delivered at that location even if part of the Medically Necessary Covered Benefits are performed by out-of-Network Provider(s), unless the Insured has a reasonable opportunity to choose to have the service performed by a Network Provider.

Within 211 CMR 52.15, there is a requirement that carriers which coordinate care through a network of providers shall comply with the following provisions regarding provider directories:

(1) A Carrier shall deliver a Provider directory to at least one adult Insured in each household upon enrollment and to a prospective or current Insured upon request. Annually, thereafter, a Carrier shall deliver to at least one adult Insured in each household, or in the case of a group policy, to the group representative, a Provider directory. The Carrier may deliver a Provider directory through an Internet Website, provided that any Provider directory available through an Internet Website be updated at least on a monthly basis.

(a) The Provider directory must contain a list of Health Care Providers in the Carrier's Network available to Insureds residing in Massachusetts, organized by specialty and by location and summarizing on its Internet Website for each such Provider…"

An Act Relative to Children's Health and Wellness

On November 26, 2019, Chapter 124 of the Acts of 2019 ("Chapter 124") was enacted, and sections 2, 4, 5, and 6 established the following requirements to improving carriers' provider directories:

- Section 2 amends M.G.L c. 176O to add section 28 that establishes standards for carriers' provider directories to present clear, accurate and understandable listings of network providers.
- Section 4 directs the Division to establish a task force to develop recommendations about the implementation of section 28 of M.G.L. c. 17O and forward them to the Legislature by March 1, 2020.
- Section 5 directs the Division to promulgate regulations to implement section 28 of M.G.L. c. 176O by July 1, 2020.
- Section 6 indicated that carriers are to implement steps consistent with Division regulations by October 1, 2020.

Legislative Mandate for Provider Directory Task Force

Subsection (a) of Section 4 of Chapter 124 of the Acts of 2019 requires that the Division "establish a task force to develop recommendations to ensure the current and accurate electronic posting of carrier provider directories in a searchable format for each of the carriers' network plans available for viewing by the general public." As noted in subsection (f) of Section 4," [t]he task force shall file its recommendations, including any proposed regulations, with the clerks of the senate and house of representatives and the joint committee on health care financing not later than March 1, 2020." This report presents the work of the Provider Directory Task Force convened by the Division to accomplish the work of Section 4.

In completing its work, the Task Force is directed to consider the following as noted in Section 4:

(c) The task force shall develop recommendations on establishing:
- (i) measures to ensure the accuracy of information concerning each provider listed in the carrier's provider directories for each network plan;
- (ii) substantially similar processes and timeframes for health care providers included in a carrier's network to provide information to the carrier; and
- (iii) substantially similar processes and timeframes for carriers to include such information in their provider directories when:
  - (A) a contracting provider is no longer accepting new patients for that network plan and when a contracting provider is resuming acceptance of new patients or an individual provider within a provider group is no longer accepting new patients and when an individual provider within a provider group is resuming acceptance of new patients;
  - (B) a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient; provided, however, that the provider may direct the enrollee or potential enrollee to the carrier for additional assistance in finding a provider and shall inform the carrier immediately, if the provider has not done so already, that the provider is not accepting new patients;

(C) a provider is no longer under contract for a particular network plan;
(D) a provider's practice location or other information required under this section has changed;
(E) for a health care professional, at least 1 of the following has changed:
(1) name;
(2) contact information;
(3) gender;
(4) participating office location;
(5) specialty, if applicable;
(6) clinical and developmental areas of expertise;
(7) populations of interest;
(8) licensure and board certification;
(9) medical group affiliations, if applicable;
(10) facility affiliations, if applicable;
(11) participating facility affiliations, if applicable;
(12) languages spoken other than English, if applicable;
(13) whether accepting new patients; and
(14) information on access for people with disabilities including, but not limited to, structural accessibility and presence of accessible examination and diagnostic equipment;
(F) for a hospital, at least 1 of the following has changed: (1) hospital name; (2) hospital type; (3) participating hospital location and telephone number; and (4) hospital accreditation status;
(G) for a facility other than a hospital, by type of facility, at least 1 of the following has changed: (1) facility name; (2) facility type; (3) types of services performed; and (4) participating facility location and telephone number; and
(H) any other information that affects the content or accuracy of the provider directory has changed.

(d) The task force shall develop recommendations for carriers on:
(i) ways to include information in the provider directory that identify the tier level for each specific provider, hospital or other type of facility in the network, when applicable;
(ii) ways to include consistent language across carriers to assist insureds with understanding and searching for behavioral health specialty providers;
(iii) the feasibility of carriers making real time updates to each electronic network plan provider directory when health care providers included in a carrier's network provide information to the carrier pursuant to recommendations under subsection (c);
(iv) measures to address circumstances in which an insured reasonably relies upon materially inaccurate information contained in a carrier's provider directory; and
(v) measures for carriers to take to ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan based on the information provided to the carriers by network providers pursuant to recommendations under said subsection (c) including, but not limited to, periodic testing to ensure that the public interface of the provider directories accurately reflects the provider network, as required by state and federal law.

Provider Directory Task Force Members

Kevin Beagan, the designee of Insurance Commissioner Gary Anderson, convened the first meeting of the working group on January 17, 2020. The following individuals were identified to represent the organizations identified in Section 4:

Kevin Beagan	Chair, designee for Commissioner of Insurance
Elizabeth Leahy	Representative for the Massachusetts Association of Health Plans
Michael Katzman	Representative for Blue Cross and Blue Shield of Massachusetts
Karen Granoff	Representative for the Massachusetts Health and Hospital Association
Yael Miller	Representative for the Massachusetts Medical Society
Lori Burgiel	Representative for Healthcare Administrative Solutions
Wells Wilkinson	Representative for the Children's Mental Health Campaign
Danna Mauch	Representative for the Massachusetts Association for Mental Health
David Nefussy	Representative as an expert in the treatment for substance use disorders
Dr. Jennifer Warkentin	Representative as an expert in the treatment for mental health disorders
Alyssa Vangeli	Representative of a health consumer advocacy organization
Eva Marie Stahl	Representative for consumers
William Rennie	Representative for employer groups

The working group has met in open sessions that took place on the following dates:

January 17, 2020;
January 27, 2020;
February 4, 2020;
February 11, 2020;
February 18, 2020;
February 25, 2020;
March 12, 2020;
March 19, 2020;
March 27, 2020; and
April 3, 2020.

The final version of this report was approved by Task Force members on April 3, 2020.

Collecting Provider Information

In order to promote the greatest accuracy and consistency of provider information, the Task Force emphasized the need to standardize the collection of detailed information and explore all options whereby carriers can use a common web-based portal for providers to update and attest to the accuracy of their information. The Task Force stressed the need for the use of good and consistent educational tools to illustrate the importance of correct information and the need to update information when provider practices change. When new fields of information are to be collected, they must be verified by the provider through the designated web-based portal or other tool before being added to the provider directory.

Common Portal
Current law does not permit the Division to require all carriers to use one standard system, but this would reduce the administrative burden for providers (increasing the likelihood of compliance with the request to regularly validate and update existing information) and promote ways to reduce the potential for differing information being recorded on different carriers' provider directory systems.[5]

Electronic Interface
The Task Force supports that carriers should collect provider information digitally through web-based portals, and wherever possible that information should be collected in a "clickable" manner with drop-down menus that enable providers to choose among many standard options. With the advent of new technologies, all such systems should use standard questions and standard ways for providers to choose reporting categories.

The Task Force acknowledges that changes to certain information may be considered a contractual change – including a change in practice location or provider affiliation. Carriers may verify that these changes are consistent with the provider's contract and can be properly reflected in each carrier's systems.

Entering Facility Information
The Task Force supports that this information should be standardized as noted in the law so that the facility information clearly records the location and telephone number. For hospitals, the information should identify the type of hospital and its accreditation status. For non-hospital behavioral health facilities, there should be a list of standard services as identified

[5] The Division is aware that many carriers are planning to use a common portal being developed by the Council for Affordable Quality Healthcare, Inc. (CAQH) in coordination with work by HealthCare Administrative Solutions, Inc. (HCAS), and Blue Cross Blue Shield and that many national payers also use this tool. The Task Force recommended that carriers either consider using the CAQH portal for collecting and attesting to information or that carriers create a system that is substantially similar in order to ease provider use and facilitate the collection of information.

in DOI's Bulletin 2009-11 ("Access to Intermediate and Outpatient Mental Health & Substance Use Disorder Services")[6], and the provider should identify by population (e.g. Child, Adolescent, Adult Geriatric) which of those services are performed by that provider for both mental health and substance use.

Entering Provider and Provider Practice Information

The Task Force recognizes that provider information is entered by many different people, all of whom should be trained on the importance of accurate and timely information. The Task Force emphasizes that the portal should be able to capture provider-specific information (e.g., specialty, education, whether the provider is available to take new patients) and practice-specific information. This is important so that patients are aware of a practice's regular hours in case other providers at that practice are available.

Provider Availability to Take New Patients

This is identified as one of the most important pieces of information to maintain correctly, since patients rely on this when seeking health care. The Task Force recommends that a provider identify whether the provider's panel (a) is closed to new patients, (b) has limited availability to accept new patients, or (c) is open to accept new patients (which may still require a wait time).[7] The Task Force also suggests that the office practice indicate availability for evening or weekend office hours. There was a suggestion to request that providers identify the current or average wait time to get appointments, but those suggestions failed to be agreed upon by a majority of the Task Force.[8]

There is general agreement that carriers should collect the phone number and physical address of the office, where the provider is available to see new patients, as well as disability access for the location, availability of interpreter services, and telehealth capability according to HIPAA standards.[9] The Task Force agrees that the provider practice record should report the usual office hours that a practice is open and whether the individual provider sees patients in that location (a) at least once per week, (b) at least once per month, (c) as a cover/fill-in as needed, or (d) not at all.

There is general agreement that data should be collected on ages treated by an individual provider, with the information recorded according to specific ages identified by the provider rather than using standard age categories. Also, the provider should have the ability to

[6] See Appendix L

[7] Specific definitions for "closed to new patients," "limited availability to accept new patients," and "open to new patients" will be provided in the corresponding regulation.

[8] The following Task Force members voted to include current wait times: Dr. Warkentin, Mr. Wilkinson, Ms. Vangeli, and Ms. Stahl. The following Task Force members voted to include average wait times: Mr. Wilkinson, Ms. Vangeli, and Ms. Stahl.

[9] The following Task Force members did not vote to include information about public transit accessibility: Mr. Rennie, Ms. Burgiel, Mr. Katzman, and Ms. Leahy.

highlight special populations served[10], consistent with what is collected by the Mass Collaborative (see Appendix M) and MassHealth (see Appendix N), including for example whether the provider is available for certain cultural groups, veterans, deaf/hard-of-hearing, or LGBTQ patients. The providers should choose from a list of languages and identify their fluency or competence in speaking/understanding the language. Providers should have the option to identify their race and ethnicity. The Task Force agrees that the provider should identify behavioral health licensure, all relevant board certifications, education, and, for doctors who practice in hospitals, the hospital in which they have admitting privileges.

In order to identify which behavioral health specialties a provider treats, providers should choose among all the behavioral health subspecialties based on those identified by MassHealth (see Appendix N) and the by Massachusetts Taxonomy Commission (see Appendix O), with the addition of psychological assessment and neuropsychological assessment. Providers should report whether they have treated someone in that subspecialty within the past year. Also, the providers should identify whether they practice according to a particular treatment modality as defined by the Taxonomy Commission.

Lastly, the Task Force members agree that provider organizations should identify any limitations on their practice, including whether they will only treat patients on their concierge medicine panel or only see patients on an inpatient basis.[11]

Updating Provider Information

In order to maintain accurate information, it is necessary that the provider regularly updates their information if there are any changes to the provider's practice and regularly verify the information to reflect the current status of the provider. The information should regularly be verified by the provider or his/her designee to ensure that it reflects the current status of a provider. It is generally agreed that two of the most important pieces of information for providers are (1) whether the provider's panel is closed or open to new patients, since this can frequently change, especially for behavioral health patients; and (2) the accuracy of the telephone number and location.

The Task Force members agree that providers will be expected to provide a complete and detailed set of information when they initially complete their profile, but carriers should establish systems that make it easy for providers to check and update information. The

[10] The following Task Force members did not vote to include information about populations served: Mr. Rennie, Ms. Burgiel, Mr. Katzman and Ms. Leahy.

[11] The following members voted to require provider organizations to identify if referrals are dependent on their provider organization affiliation: Mr. Wilkinson, Mr. Nefussy, Dr. Warkentin, and Ms. Vangeli. The following members voted to omit this information as they believed it would be too complicated and would result in consumer confusion, inaccuracies, and appear that the network is more limited than it actually is: Ms. Granoff, Mr. Katzman, Ms. Miller, Ms. Burgiel, Mr. Rennie, and Ms. Leahy.

provider portal should be set up to enable the provider to go directly to the update area and not through the entire profile from the beginning, in an effort to reduce the administrative burden on the provider.

It is generally agreed by Task Force members that carriers should take all operational steps necessary to update information as quickly as technically possible, with systems prioritized to identify the provider's availability to take new patients. The carriers report that they are subject to federal Centers for Medicare and Medicaid Services (CMS) guidelines requiring that non-contractual changes be made to provider directories within 30 days.[12] There is general agreement that the federal timelines are long and that carriers should try to update their systems as quickly as possible.

The Task Force is of the opinion that carriers should do all they can to improve a patient's ability to get accurate information by striving to update provider directory information in 2-5 business days; however, while there is no general consensus to require a standard at this time, there is concern that delayed/extended lag time frames for health plan updates will disincentivize providers from completing their updates and give consumers potentially outdated information. The Division should monitor carriers' timeliness and consider establishing expected timelines by regulation as part of the Division's accreditation review.

In order to ensure provider directory improvements, the Division should also ask that carriers take all necessary technical steps to get closer to real-time updating of provider directory information as the provider makes changes to their information. Although a number of the Task Force members supported establishing real-time updates by carriers, it was not enough to constitute a majority. As technology to accomplish real-time updates becomes available, priorities for updating information in real time should be:

1. Whether the provider's panel is closed or open to new patients;
2. The accuracy of the telephone number and location; and
3. Whether the plan is accepted by the provider.

There is also general agreement that providers should receive reminders to check and verify their profiles so that plans can certify that the information is correct. Some of the Task Force members expressed concern that providers may feel overwhelmed with update requests unless reminders are kept to the current 90-day standard, and carriers should be encouraged to standardize when these reminders are sent. There is agreement that providers should regularly be educated about the importance of making changes when changes occur so that they may make the appropriate updates well in advance of the 90-day reminder notice.

Although it was discussed, there is no agreement for requiring incentives or penalties for providers – such as making additional/lower levels of reimbursement, withholding claims payments, or excluding them from provider directories – when providers do not properly

[12] CMS does not have time requirements for contractual change updates.

update their profile information. Task Force members did not agree that this is an appropriate approach. It is instead suggested that, for those providers who don't regularly update information, the provider directory should indicate that the provider has not certified or updated information within the last six months.

Furthermore, the Task Force recommends that the Division address Section 4(c)(iii)(B) of M.G.L. c. 176O, which requires that "a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient…(that) the provider may direct the enrollee or potential enrollee to the carrier for additional assistance in finding a provider and *shall inform the carrier immediately, if the provider has not done so already, that the provider is not accepting new patients* (emphasis added)."

Plans that have received notice of potentially inaccurate information through a consumer, provider, or audit and have been unable to validate the accuracy of the listing are recommended to take the following steps:

1. If the potential inaccuracy relates to the physical address or telephone number of the provider, the information shall be immediately removed from the online directory until the information is updated or be designated as "unverified" for 90 days, after which the information must be immediately removed;
2. If the potential inaccuracy relates to whether a provider is accepting new patients, the plan shall remove the designation "accepting new patients" for that provider until the information is updated;
3. If the potential inaccuracy relates to whether a provider is or continues to be an in-network provider, the plan shall remove the full provider listing from the online directory until it is updated.

Presenting Provider Information

Once the information has been consistently and accurately collected and verified through the provider registry portal, provider directory information is useful to covered persons when they can easily access and search the information to find providers who may be able to treat them. The Task Force members agree that the provider directory information should be available in a manner that enables the covered person to search or filter according to a number of variables, including[13]:

1. Whether the provider is available for new patients;
2. Provider's availability on evenings and weekends (if available);
3. Provider's specialty;
    a. For behavioral health, subspecialty;
    b. For behavioral health, treatment modality;
4. Ages treated;
5. Race/ethnicity (if available);
6. Languages spoken;
7. Populations served;
8. Office's accommodations for physical/intellectual disabilities[14];
9. Office's access to public transportation;
10. Affiliations with specific hospitals;
11. Availability for telehealth appointments; and
12. Distance from a specified starting location.

The Task Force members agree that, when presenting information for a non-facility provider, the profile should include the following:

1. Provider's name, board certification, education, and for behavioral health, provider's licensure level[15];
2. Whether provider's panel is full, limited availability, or open availability[16];
3. Locations (addresses and phone numbers) in which provider practices;
4. Availability by location (more than once per week, more than once per month);

[13] Certain health plan representatives wanted to highlight that each new search criterion adds an additional cost. Depending on the health plan's consumer facing directory and/or vendor capabilities, mandating the ability to search by additional fields will require significant financial investment in IT infrastructure, which increases costs for employers and consumers.

[14] Mr. Wilkinson wanted to highlight that there are specific federal requirements associated with accessibility for disabilities and that he thought it would be appropriate to report a provider's ability to meet the accessibility standards according to federal requirements and that these requirements should be prominently explained in the registration portal so that the provider could accurately reflect accessibility.

[15] A behavioral health worker may be referred to by a provider type, e.g. psychologist, psychiatrist, social worker.

[16] Specific definitions for "closed to new patients," "limited availability to accept new patients," and "open to new patients" should be provided in the corresponding regulation.

5. Business hours of those locations;
6. Whether locations are able to hold telehealth appointments;
7. Limitations on their practice (e.g., only treating concierge patients or those affiliated with certain provider organizations;
8. Languages spoken;
9. Populations served;
10. Areas of expertise, especially for behavioral health providers;
11. Race/ethnicity (if optionally reported by the provider); and
12. If a tiered network plan, the provider's tier and an explanation of how tier was identified by plan and impact on cost-sharing under the plan.

When presenting information for a facility provider, the profile should include the following:

1. Provider's name, license, telephone number;
2. If a hospital, the type of hospital and accreditation status; and
3. If a non-hospital behavioral health facility, the standard services as identified in DOI's Bulletin 2009-11 that are available in the facility.

There is information that is currently required by law to be in the provider directory: method to compensate the provider, the provider's price relativity, health status adjusted total medical expenses, and quality. The Task Force believes that this information may not need to be included in the provider's profile, but there could be a link to a separate section that would allow the interested party to see this information elsewhere.

Auditing Provider Information

There is general agreement that carriers should be expected to do periodic audits to ensure that provider information is correct, but some Task Force members expressed concern that provider offices might feel overwhelmed by unnecessary carrier calls. There is agreement that the carriers should explore the feasibility of setting a consolidated process to check information in a streamlined way by a centralized audit process that might do it on behalf of a number of carriers. Audits should be performed often enough to ensure accuracy while not being an unnecessary burden for providers.

The Task Force recommends that the Division require carriers undertake to audit their provider information on an annual basis as follows:

a. Consistent with agreements from the Attorney General's office, behavioral health providers should be audited on a quarterly basis, including 1) all behavioral health providers who have not submitted a claim within 12 months of the audit and who have not otherwise been audited or have not received an attestation in the past 12 months; and 2) a representative sample of no less than 15% of all behavioral health providers who have not been audited in the last 12 months or for whom an attestation has not been received in the past 120 days. This audit would be repeated each quarter,

excluding all behavioral health providers that have been audited in the last 12 months, or who have been removed from the provider directory. All carriers should plan to audit 100% of their auditable behavioral health providers each year. In the event that three successive quarterly audits demonstrate that at least 85% of the auditable behavioral health providers are listed in a manner that is 100% accurate, the carrier may shift to performing these audits on a semi-annual basis.

b. Non-behavioral health providers should be audited on an annual basis.

There was discussion about using claims information to verify that a provider is treating certain age groupings or providing services in certain subspecialties. The Task Force does not endorse this unless there is a uniform way to do this across all of the carriers' databases. The concern is that someone would be not shown as providing a service because it was not performed for Carrier A, but that same provider may have provided that same service to many patients for Carrier B.

There is general agreement that carriers should actively educate covered persons to notify them whenever any provider information is incorrect so that the carrier can contact the provider to correct the information quickly.

In order to ensure the accuracy of information in provider directories, carriers should test the accuracy of information submitted by behavioral health provider attestations on a quarterly basis in as streamlined a manner as possible. Carriers should compare at least 2% of the attestations received in the prior 120 days to the related information or changes in their provider directories.

The Task Force also understands that both consumers and providers will play an important role in reporting necessary corrections to inaccurate provider information. The Task Force recommends that the Division consider regulations for the training of customer service staff regarding how to communicate provider availability expectations and how to process reports of issues about Provider Directories and Provider network access, including member complaints. Customer service staff should be educated about appropriate forwarding of complaints to carrier staff for investigation and correction of Directory inaccuracies.

Similarly, the Task Force recommends that the Division adopt standards for providers to immediately notify carriers when they are not accepting new patients.

Consequences for Incorrect Information

Carriers are expected to provide information for covered persons to find adequate access to providers within the carrier's health care network. Carriers will be expected to have adequate systems to update and maintain their provider directories as part of their biennial managed care accreditation process.

Per statutory requirements, carriers must include in both the electronic and print formats of the provider directory a dedicated customer service email address and telephone number or electronic link that insureds, providers, and the general public may use to notify the carrier of inaccurate provider directory information. This customer service information must be disclosed prominently in the provider directory and on the carrier's website.

In any instances where a covered person is unable to locate a provider to treat their condition because of inaccuracies in the provider directory, they will be instructed to contact the carrier, notify the carrier about the inaccuracies, and request that the carrier assist them to obtain a necessary appointment with an in-network provider. Carriers should ensure that provider directories educate covered persons in limited network plans about how they may obtain in-network care from an out-of-network provider when an in-network provider is not available. Covered persons should be able to obtain such information through an interactive process working with the carrier or the Division of Insurance, including receiving direct assistance from the carrier in finding available providers.[17]

In the few circumstances where a patient is financially harmed because of inaccurate information – such as going to an incorrect address and being charged a missed appointment fee – the carrier should direct the member to contact the grievances and appeals department to address the financial harm.

[17] This would apply only for HMO or EPO plans; PPO or POS plans have out-of-network benefits and therefore can go to an out-of-network provider.

Next Steps

This report is being shared with the appropriate Legislative Committees, and the Division is expected to consider the content of this report when drafting proposed regulatory changes to 211 CMR 52.00 in order to implement the provisions of subsection (c) of Section 4 of Chapter 124 of the Acts of 2019. Prior to final promulgation, the proposed regulatory changes will be subject to a public hearing according to the provisions of M.G.L. c. 30A.

The Task Force considered developing a timeline for implementing the provisions of the report, but decided not to include such a timeline due to uncertainty that carriers and providers are going through as they are needing to devote their resources to addressing the COVID-19 public health crisis.

APPENDICES

Appendix A	Authorizing Statute for Provider Directory Task Force
Appendix B	Minutes for January 17, 2020 Meeting
Appendix C	Minutes for January 29, 2020 Meeting
Appendix D	Minutes for February 4, 2020 Meeting
Appendix E	Minutes for February 11, 2020 Meeting
Appendix F	Minutes for February 18, 2020 Meeting
Appendix G	Minutes for February 25, 2020 Meeting
Appendix H	Minutes for March 12, 2020 Meeting
Appendix I	Minutes for March 19, 2020 Meeting
Appendix J	Minutes for March 27, 2020 Meeting
Appendix K	Health Plans that use DirectAssure from CAQH
Appendix L	Bulletin 2009-11: Access to Intermediate and Outpatient Mental Health & Substance Use Disorders
Appendix M	Mass Collaborative Provider Information Change Form
Appendix N	MassHealth Behavioral Health Special Experience, Skills, and Training Questions
Appendix O	Taxonomy Commission Legislative Report

APPENDIX A

AUTHORIZING STATUTE FOR PROVIDER DIRECTOR TASK FORCE: CHAPTER 124 OF THE ACTS OF 2019

SECTION 4. (a) The division of insurance shall establish a task force to develop recommendations to ensure the current and accurate electronic posting of carrier provider directories in a searchable format for each of the carriers' network plans available for viewing by the general public.

(b) The task force shall consist of: the commissioner of insurance or a designee, who shall serve as chair; and 12 members to be appointed by the commissioner, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Medical Society, 1 of whom shall be a representative of Healthcare Administrative Solutions, Inc., 1 of whom shall be a representative of the Children's Mental Health Campaign, 1 of whom shall be a representative of the Massachusetts Association for Mental Health, Inc., 1 of whom shall have expertise in the treatment of individuals with substance use disorder, 1 of whom shall have expertise in the treatment of individuals with a mental illness, 1 of whom shall be from a health consumer advocacy organization, 1 of whom shall be a consumer representative and 1 of whom shall be a representative from an employer group.

(c) The task force shall develop recommendations on establishing: (i) measures to ensure the accuracy of information concerning each provider listed in the carrier's provider directories for each network plan; (ii) substantially similar processes and timeframes for health care providers included in a carrier's network to provide information to the carrier; and (iii) substantially similar processes and timeframes for carriers to include such information in their provider directories when:

(A) a contracting provider is no longer accepting new patients for that network plan and when a contracting provider is resuming acceptance of new patients or an individual provider within a provider group is no longer accepting new patients and when an individual provider within a provider group is resuming acceptance of new patients;

(B) a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient; provided, however, that the provider may direct the enrollee or potential enrollee to the carrier for additional assistance in finding a provider and shall inform the carrier immediately, if the provider has not done so already, that the provider is not accepting new patients;

(C) a provider is no longer under contract for a particular network plan;

(D) a provider's practice location or other information required under this section has changed;

(E) for a health care professional, at least 1 of the following has changed: (1) name; (2) contact information; (3) gender; (4) participating office location; (5) specialty, if applicable; (6) clinical and developmental areas of expertise; (7) populations of interest; (8) licensure and board certification; (9) medical group affiliations, if applicable; (10) facility affiliations, if applicable; (11) participating facility affiliations, if applicable; (12) languages spoken other than English, if applicable; (13) whether accepting new patients; and (14) information on access for people with disabilities including, but not limited to, structural accessibility and presence of accessible examination and diagnostic equipment;

(F) for a hospital, at least 1 of the following has changed: (1) hospital name; (2) hospital type; (3) participating hospital location and telephone number; and (4) hospital accreditation status;

(G) for a facility other than a hospital, by type of facility, at least 1 of the following has changed: (1) facility name; (2) facility type; (3) types of services performed; and (4) participating facility location and telephone number; and

(H) any other information that affects the content or accuracy of the provider directory has changed.

(d) The task force shall develop recommendations for carriers on: (i) ways to include information in the provider directory that identify the tier level for each specific provider, hospital or other type of facility in the network, when applicable; (ii) ways to include consistent language across carriers to assist insureds with understanding and searching for behavioral health specialty providers; (iii) the feasibility of carriers making real time updates to each electronic network plan provider directory when health care providers included in a carrier's network provide information to the carrier pursuant to recommendations under subsection (c); (iv) measures to address circumstances in which an insured reasonably relies upon materially inaccurate information contained in a carrier's provider directory; and (v) measures for carriers to take to ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan based on the information provided to the carriers by network providers pursuant to recommendations under said subsection (c) including, but not limited to, periodic testing to ensure that the public interface of the provider directories accurately reflects the provider network, as required by state and federal law.

(e) The task force shall establish recommended timelines for carriers to complete each of the task force's recommendations.

(f) The task force shall file its recommendations, including any proposed regulations, with the clerks of the senate and house of representatives and the joint committee on health care financing not later than March 1, 2020.

APPENDIX B

Meeting Minutes of the Provider Directory Task Force for the Meeting Held on Friday, January 17, 2020

January 17, 2020 Minutes of the Provider Directory Task Force Held in Conference Room 1-E, 1000 Washington Street, Boston, Massachusetts 02118

Members present:

Kevin Beagan	Chair, designee for Commissioner of Insurance
Lori Burgiel	Representative for Healthcare Administrative Solutions
Karen Granoff	Representative for the Massachusetts Health and Hospital Association
Michael Katzman	Representative for Blue Cross and Blue Shield of Massachusetts
Elizabeth Leahy	Representative for the Massachusetts Association of Health Plans
Danna Mauch	Representative for the Massachusetts Association for Mental Health
David Nefussy	Representative as an expert in the treatment for substance use disorders
William Rennie	Representative for employer groups
Eva Marie Stahl	Representative for consumers
Alyssa Vangeli	Representative of a health consumer advocacy organization
Dr. Jennifer Warkentin	Representative as an expert in the treatment for mental health disorders
Wells Wilkinson	Representative for the Children's Mental Health Campaign

Members participating via phone:

Yael Miller	Representative for the Massachusetts Medical Society

Members Not Attending:
None

Call of 1st Meeting to Order by Chairperson Kevin Beagan:
A quorum was determined to be present, and Mr. Kevin Beagan called the meeting to order at 10:30 A.M. Mr. Beagan thanked members for coming to the Division for this meeting of the Task Force and had all members introduce themselves.

Mr. Beagan then proceeded with an overview of the Massachusetts Open Meeting Law by reviewing an Open Meeting Law Guide prepared by the Massachusetts Attorney General's Office. Mr. Beagan indicated that minutes will be kept for each meeting. Further, Mr. Beagan announced that a website had been developed specifically for the Task Force which includes a link to the law establishing the Task Force, a list of Task Force members and will include minutes from all prior meetings.

Mr. Beagan specified that, as time allows, members of the public will be given an opportunity to speak or ask questions toward the end of each Task Force meeting. Any vote that takes place will require a quorum to be present in person. Finally, as the final outcome of the Task Force is to prepare a written report, any dissenting views from Task Force members will be able to be presented via dissenting votes when a vote takes place to approve the final report.

Review of Law Establishing Task Force
As the next item of business, Mr. Beagan reviewed the law establishing the Task Force, Chapter 142 of the Acts of 2019. Specifically, SECTION 4(a) states that "The division of insurance shall establish a task force to develop recommendations to ensure the current accurate electronic posting of carrier provider directories in a searchable format for each of the carriers' network plans available for viewing by the general public."

As part of the Task Force's work, Mr. Beagan suggested that future meetings be broken down so that one meeting would be held to help identify how to collect provider directory information; one meeting would be held to help identify how to best present provider directory information; and one meeting would be held to help identify how best to audit the provider directory information.

Mr. Beagan specified that the Division of Insurance will be required to promulgate regulations and that the recommendations of the Task Force will be taken into consideration during development.

Review of Timeline for Future Meetings

As the next course of business, Mr. Beagan asked for input from Task Force members on specific timelines for meetings and preparation of a report. Mr. Beagan proposed that the last meeting would be on February 25, 2020 to finalize agreement on the report; the meeting prior to that would be on February 18, 2020, for development of the report; and to conduct three meetings prior to that. It was agreed among the Task Force members that the next meeting would take place on January 27, 2020 from 2:30pm to 4pm.

Ms. Leahy asked if it would be acceptable to have delegates in place of a Task Force member. Mr. Beagan indicated that there are no concerns with having a delegate as long as there are no votes taking place during the meeting, which is only anticipated for the meeting during which the final report would be developed and voted on, including February 18 and 25.

Division of Insurance Provider Directory Project Report

Mr. Beagan then moved on to review a project that was previously undertaken by the Division of Insurance. As part of this project, the Division conducted a survey and issued a report to review the accuracy of provider directory information. The review found inaccuracies with both primary care and behavioral health information. The report also highlighted how carriers currently collect information used for the provider directory. It was pointed out in the project report that there is a continuous need for carriers to contact providers for regular updates for provider directory information. The report stressed the need to set standards that apply to all carriers.

HCAS Presentation

As the next order of business, Mr. Beagan invited Task Force Member Lori Burgiel to give a presentation on a current provider directory project undertaken by HealthCare Administrative Solutions (HCAS). Ms. Burgiel relayed that the goal of HCAS is to maintain current provider information for members and patients. She offered this current project as a way to showcase how Massachusetts carriers could move forward in improving the processing of provider directory information.

Currently, HCAS has a partnership with AllWays Health Partners, Boston Medical Center Health Plan, Fallon Health, Harvard Pilgrim Health Care, Health New England, and Tufts Health Plan. HCAS' goal in partnering with these health carriers is to simplify processes to collect provider directory information in one place to streamline the process for both providers and health plans.

Ms. Burgiel explained that HCAS uses the Council for Affordable Healthcare's (CAQH) ProView Data Repository. Through this repository, providers submit their own data to health plans, and the provider or administrative staff enters the data. Although many providers were already familiar with and using CAQH in Massachusetts and nationally, the ProView system was recently expanded to include directory information. As a way to keep information updated, CAQH requests providers review their data at least each quarter, while at the same time encouraging providers to update information each time a change has been made.

Ms. Burgiel indicated that three health carriers (AllWays Health Partners, Harvard Pilgrim Health Care, and Tufts Health Plan) have already begun piloting use of the system with providers as of September 2019. A task force member asked when HCAS would have health plans have all their providers using the system for

directory data collection. Ms. Burgiel discussed that health plans were expanding pilots and that timelines for providers to be included in the system into 2021 with plans continuing to collect directory data from providers through existing pathways until fully phased in. Mr. Katzman noted that BCBS had begun pilots and had a goal to include all providers in the CAQH process in Q1 2021.

Ms. Burgiel explained that per federal requirements, CAQH notifies providers to review and update directory information every 90 days, yet providers could update changes more frequently or between CAQH notifications. Dr. Warkentin commented about the difference between information that is entered for medical providers versus information that is entered for behavioral health and substance use providers, particular relating to the ability of providers to take on new patients, making it more important that this information can be updated more regularly. Mr. Beagan noted that the Task Force will not be able to fix everything. Rather, the hope is to look for more consistency and look for improvement of the current process.

A task force member inquired regarding inclusion of future regulator or statutory changes in the CAQH system. Ms. Burgiel further specified that HCAS has a contract with CAQH, as does Blue Cross and Blue Shield of Massachusetts. She noted that as part of the process that health plans have an agreement with CAQH to implement future requirements.

Considerations for Next Meeting

Mr. Beagan suggested that during the next meeting the Task Force will review which data elements that are required to be kept updated. Further, the Task Force will look to discuss whether the process described by Ms. Burgiel through CAQH is the way to move forward. Ms. Burgiel offered that she will circulate a video to Task Force members explaining CAQH in more detail.

In looking at the next meeting, Mr. Beagan asked that several questions be considered, including:

- Is the company following the law?
- Would we need to work with the company to modify their program in any way to ensure it follows the law in Massachusetts?
- How do we verify the information entered is accurate, especially if it is typed in by the providers?

Ms. Granoff noted that the issue of incorrect information in provider directories is not just a behavioral health issue. Mr. Beagan reminded members that inaccurate information can be found not only in behavioral health provider entries, but in non-behavioral health provider entries as well. It will be useful for Task Force members to watch the CAQH video and prepare a list of questions.

A motion was made by Mr. Beagan to adjourn the meeting, which passed unanimously. The meeting was adjourned at 11:36 A.M. on January 17, 2020.

The form of these minutes comports with the requirements of M.G.L. c. 30A, §22(a).

List of Documents Presented at the Meeting

- Open Meeting Law Guide
- Chapter 124 of the Acts of 2019
- Portion of 211 CMR 52
- Presentation by Ms. Burgiel on behalf of HCAS

APPENDIX C

Minutes of the Second Meeting of the Provider Directory Task Force Meeting
held on January 27, 2020 in Conference Room 1-E
1000 Washington Street, Boston, Massachusetts 02118

Members present:

Kevin Beagan	Chair, designee for Commissioner of Insurance
Lori Burgiel	Representative for Healthcare Administrative Solutions
Karen Granoff	Representative for the Massachusetts Health and Hospital Association
Michael Katzman	Representative for Blue Cross and Blue Shield of Massachusetts
Danna Mauch	Representative for the Massachusetts Association for Mental Health
Yael Miller	Representative for the Massachusetts Medical Society
David Nefussy	Representative as an expert in the treatment for substance use disorders
William Rennie	Representative for employer groups
Eva Marie Stahl	Representative for consumers
Alyssa Vangeli	Representative of a health consumer advocacy organization
Dr. Jennifer Warkentin	Representative as an expert in the treatment for mental health disorders
Wells Wilkinson	Representative for the Children's Mental Health Campaign

Members participating via phone:

Elizabeth Leahy	Representative for the Massachusetts Association of Health Plans

(Sarah Chiaramida was in attendance for Ms. Leahy to pick up any distributed materials)

Call of 2nd Meeting to Order by Chairperson Kevin Beagan A quorum was determined to be present, and Mr. Beagan called the meeting to order at 2:37 P.M. All members were officially sworn in as Task Force members by Ms. Jean Farrington from the Division of Insurance ("Division"), except for Ms. Leahy, who was participating by phone, and Ms. Stahl, who arrived after the swearing-in was complete. Both will be sworn in at a later date.

A motion was made and Task Force members voted unanimously to allow Ms. Leahy to participate by phone. A second motion was made and Task Force members voted unanimously to allow members to call in for any future meeting when contacting the chair due to exigent circumstances. Mr. Beagan reminded members that it is preferred for members to be participate in-person.

Mr. Beagan identified items that he hoped to discuss during the meeting:

1) Review materials presented about the CAQH system from the first meeting
2) Review the detailed elements expected to be discussed by the law;
2) Consider the recommendations of the March 2019 Taxonomy Commission; and
3) How often provider data should be updated, and incentives for providers to make updates.

January 17, 2020 Minutes

The draft minutes of the January 17, 2020 meeting were discussed and Task Force members suggested specific modifications. A motion was made and seconded to accept the minutes as modified to include Task Force member edits. The motion was unanimously passed and the amended minutes will be distributed in the next Task Force meeting.

Questions Regarding CAQH System

Mr. Beagan thanked Ms. Burgiel for the information that was presented in the first meeting about work that her organization and carriers were doing with CAQH to develop a common portal for providers to record and update provider information as well as for forwarding a web link for members to understand more about how

the CAQH system collects information. Task Force members discussed the CAQH system and the way that CAQH collects certain information.

Mr. Beagan reminded Task Force members that the CAQH system was an example of a system that many carriers may use, but since the Task Force cannot require that a particular system be used for collecting information, the Task Force should recommend standardized processes that should be in place for any system that a carrier may use.

Review of the Authorizing Statute

Mr. Beagan read the following from the Chapter 124 authorizing language to remind the Task Force members of the details to be considered in the meetings:

(c) The task force shall develop recommendations on establishing:
- (i) measures to ensure the accuracy of information concerning each provider listed in the carrier's provider directories for each network plan;
- (ii) substantially similar processes and timeframes for health care providers included in a carrier's network to provide information to the carrier; and
- (iii) substantially similar processes and timeframes for carriers to include such information in their provider directories when:
  - (A) a contracting provider is no longer accepting new patients for that network plan and when a contracting provider is resuming acceptance of new patients or an individual provider within a provider group is no longer accepting new patients and when an individual provider within a provider group is resuming acceptance of new patients;
  - (B) a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient; provided, however, that the provider may direct the enrollee or potential enrollee to the carrier for additional assistance in finding a provider and shall inform the carrier immediately, if the provider has not done so already, that the provider is not accepting new patients;
  - (C) a provider is no longer under contract for a particular network plan;
  - (D) a provider's practice location or other information required under this section has changed;
  - (E) for a health care professional, at least 1 of the following has changed:
    - (1) name;
    - (2) contact information;
    - (3) gender;
    - (4) participating office location;
    - (5) specialty, if applicable;
    - (6) clinical and developmental areas of expertise;
    - (7) populations of interest;
    - (8) licensure and board certification;
    - (9) medical group affiliations, if applicable;
    - (10) facility affiliations, if applicable;
    - (11) participating facility affiliations, if applicable;
    - (12) languages spoken other than English, if applicable;
    - (13) whether accepting new patients; and
    - (14) information on access for people with disabilities including, but not limited to, structural accessibility and presence of accessible examination and diagnostic equipment;
  - (F) for a hospital, at least 1 of the following has changed:
    - (1) hospital name;
    - (2) hospital type;
    - (3) participating hospital location and telephone number; and
    - (4) hospital accreditation status;
  - (G) for a facility other than a hospital, by type of facility, at least 1 of the following has changed:

(1) facility name;
(2) facility type;
(3) types of services performed; and
(4) participating facility location and telephone number; and

(H) any other information that affects the content or accuracy of the provider directory has changed.

Standardizing the Collection of Information

Measures to ensure the accuracy of information

Mr. Beagan noted that the 2019 Taxonomy Commission recommended that data be collected in a "clickable" way, so that providers "click" standard data categories and not need to type in a vast quantity of detailed information. It appeared that Task Force members were in agreement.

Ms. Burgiel said that CAQH developed a clickable format for some questions, including those related to behavioral health, to simplify the process of provider data entry

Ms. Vangeli had a question about whether systems should have a way to bypass the initial data entry stage when updating information, as this would be time consuming. Ms. Burgiel responded that under the CAQH approach, providers only need to enter information once, and after that it is easy to update pieces of information when there are changes. There was general agreement that the initial data file for a provider may take time to complete, but systems should make updating information as easy as possible for providers to minimize the time they need to spend on the system.

Ms. Burgiel discussed the importance to collect information about a provider office practices availability rather than an individual provider and noted that this is CAQH's approach. This assists patients who are seeking care and who may be interested in seeing another provider in the practice to make an earlier appointment.

Ms. Granoff asked for a list of what is considered contractual vs. not contractual changes, since plans assert that non-contractual changes can be done more quickly than contractual.

Provider availability to take appointments

Mr. Beagan asked the Task Force members about how to collect information about provider office hours. Mr. Wilkinson indicated that it was important that the information reflect that a provider was accepting office visit appointments and the information collected should identify if a provider only sees patients on an inpatient basis.

Several Task Force members discussed concerns about the accuracy of appointment availability. Ms. Granoff stated that there can be providers who may be accepting new patients, but may not have an available appointment for months. Dr. Warkentin indicated that it is difficult to collect information from a provider about a new patient might get an appointment because openings may occur. Mr. Beagan asked about cases where patients can make a first appointment, but must wait months until the second appointment because of unavailability. Dr. Warkentin said it's not uncommon for patients to wait months for a behavioral health assessment, but most behavioral health treatment providers can't project availability that far ahead. There was some agreement that providers should report if their panel is full and should update this information when their panel has room for new patients. It was also noted that due to the challenges of knowing precisely when a behavioral health practice may be open or closed to new patients and transmitting that information to health plans, it many make more sense to consider using the term "limited availability" and create a definition for that or open/closed as of a specific date.

Office location

Mr. Beagan asked what type of data should be collected regarding location. Other than physical location, each provider should record main telephone number and any e-mail address. There was discussion about whether to collect cell phone information and general agreement not to make it a required field. Mr. Beagan indicated

that CAQH collected information about whether a provider was available at that location at least once a week, only available once a month or only read tests in a location.

Populations served

Mr. Wilkinson spoke about capturing information about the populations that a provider generally serves. Dr. Warkentin indicated that CAQH does not make a distinction between the population a provider serves and a provider's specialty. Ms. Burgiel pointed out that CAQH allows users to specify exactly what ages they take. Dr. Warkentin responded that it may also be useful to separate adolescents into "children" and "teens". Mr. Katzman said that the most important aspect of categorizing the search feature is ensuring that carriers are consistent. Ms. Chiaramida said that the best method of displaying age search features is by having age "buckets", which several members of the Task Force agreed with. There was also some discussion about capturing information if providers are able to or regularly serve specific populations, including for example, the deaf and hard of hearing or cultural groups.

Other categories of interest

Mr. Beagan pointed out some of the other data categories identified in the law and asked if there were any other suggestions about any particular ways to collect some of the categories including: licensure/board certification; medical/physician/facility affiliations; or languages spoken. There was agreement that there should be a robust list of clickable languages. Ms. Vangeli commented that she thinks it's important for the directories to display languages spoken as well as whether interpreter services are available. Dr. Warkentin added that providers should identify whether their office has appropriate disability access, and the Task Force should define exactly what disability access standards may be. Ms. Burgiel said that there is likely to be federal language available that if located could be included in provider educational materials.

Specialties

Members did not appear to express any concern about listing specialties for non-behavioral health providers based on a provider's board certification for the specialty.

Regarding behavioral health provider subspecialties, Mr. Beagan asked the Task Force's thoughts on the list of specialties within the recommendations of the 2019 Taxonomy Commission report. HCAS suggested that the Task Force work towards one set of standards that takes into account Medicaid requirements and work with MassHealth to incorporate both into the final task force recommendation. There was general agreement that the noted subspecialties should be included in what is collected. Dr. Warkentin indicated that she thought psychological/neurological testing specialty should be added as another required subspecialty.

Mr. Wilkinson indicated that it would be useful to separate the adult age bucket into two separate categories, as he feels there are at least two distinct population groups within the 17-55 age range, currently classified as "adults". Mr. Nefussy said that behavioral health/substance abuse inpatient groups try to group patients by general age, but not all facilities have the resources to do so. Dr. Warkentin commented that such categorization may be too specific and might get too complicated to collect appropriately.

Ms. Granoff mentioned that it makes sense to separate specialty areas of practice from populations served rather than blend them together as the Taxonomy task force did. For example, "first responder" or "military/veterans" is really a population, and patients could be misled by choosing someone who sees veterans but may have no expertise in eating disorders or pregnancy loss. Separating these categories allows plans to create a more efficient and effective search protocol.

Mr. Beagan asked whether, for each subspecialty, the provider should "click" a subspecialty based on having the skill to treat a subspecialty or because the provider had treated a patient in a subspecialty within the past six months. Members debated if it is better to ask whether providers "are treating" for a certain specialty or if they "have seen a patient in the past six months" for a specialty. A task force member added that the question

could ask if providers are "currently accepting and providing services to a certain population and specialty," and then they must select specialties from the specialty categories.

Updating Information

Mr. Beagan asked how often the Task Force thought providers should be expected to update information. There was some discussion about whether updates should be required every 60 days or 90 days but there was not any conclusion. Ms. Miller noted that CMS currently requires health plans to contact providers every 90 days to update data and CAQH currently uses that time frame for notices. Therefore, to maintain consistency and standardization, the Massachusetts Medical Society would support 90 day notice and update processes.

Mr. Beagan also asked whether providers should face a penalty if they did not update their provider materials. He indicated in other states, the law permits a carrier to delay claims payments or removes a provider from a directory if they do not update information. Ms. Stahl indicated that there has to be some way to make sure that the information is updated so that parents who are trying to find providers, are not making calls based on outdated information. Dr. Warkentin talked about whether the providers should have both incentives and repercussions or just the later.

Mr. Beagan noted that the meeting was at the scheduled end time and that there may be more discussion on this issue in the next meeting.

Next Meeting and Adjournment

Mr. Beagan indicated that the next meeting of the Task Force was scheduled to take place in the same room on Tuesday, February 4 from 1:00 – 3:00 P.M. and would primarily discuss ways that information should be displayed by carriers within provider directory materials.

A motion was made and seconded to adjourn the meeting, which passed unanimously. The meeting was adjourned at 4:05 P.M. on January 27, 2020.

Please note that the form of these minutes have been drafted to comport with the requirements of M.G.L. c. 30A, §22(a).

List of Documents Presented at the Meetings

- Minutes of the Provider Directory Task Force for the January 17, 2020 meeting
- Open Meeting Law Guide and Educational Materials
- 2019 Taxonomy Commission Legislative Report

APPENDIX D

Meeting Minutes of the Provider Directory Task Force For the Meeting Held on Tuesday, February 4, 2020

February 4, 2020 minutes of the Provider Directory Task Force held in Conference Room 1-E
1000 Washington Street, Boston, Massachusetts 02118

Members present:

Kevin Beagan	Chair, designee for Commissioner of Insurance
Lori Burgiel	Representative for Healthcare Administrative Solutions
Karen Granoff	Representative for the Massachusetts Health and Hospital Association
Michael Katzman	Representative for Blue Cross and Blue Shield of Massachusetts
Elizabeth Leahy	Representative for the Massachusetts Association of Health Plans
Yael Miller	Representative for the Massachusetts Medical Society
David Nefussy	Representative as an expert in the treatment for substance use disorders
William Rennie	Representative for employer groups
Eva Marie Stahl	Representative for consumers
Alyssa Vangeli	Representative of a health consumer advocacy organization
Dr. Jennifer Warkentin	Representative as an expert in the treatment for mental health disorders
Wells Wilkinson	Representative for the Children's Mental Health Campaign

Members participating via phone:

Danna Mauch	Representative for the Massachusetts Association for Mental Health

Call of 3rd Meeting to Order by Chairperson Kevin Beagan

A quorum was determined to be present, and Mr. Kevin Beagan called the meeting to order at 1:05 P.M. Mr. William Rennie arrived after the start of the meeting.

Mr. Beagan reminded the Task Force members that this meeting's agenda will focus on data presentation while next week's meeting will focus on data auditing. The meeting on March 19, 2020 will be for voting on recommendations of the Task Force.

January 27, 2020 Minutes

The draft minutes of the January 27, 2020 meeting were discussed and the Task Force members suggested specific changes. A motion was made and seconded to accept the minutes as long as amended to include the edits presented by the Task Force members. This was accepted unanimously.

Updating Information

Mr. Beagan revisited the following section (c) in the authorizing statute that pertained to ensuring the accuracy of and updating provider directory information

> (c) The task force shall develop establishing: (i) measures to ensure the accuracy of information concerning each provider listed in the carrier's provider directories for each network plan; (ii) substantially similar processes and timeframes for health care providers included in a carrier's network to provide information to the carrier;...

Mr. Beagan said that the Task Force should determine the amount of time providers have to update changes. He also said that the Task Force should revisit the discussion on incentives and penalties for providers to update directory information more quickly. Mr. Beagan raised three questions that he thought the Task Force should try to answer: 1) how often the provider directory should be updated; 2) whether a carrier or system should

prompt providers to update information; and 3) if the provider directory should display the last time a provider updated information.

Frequency of updates to provider information

Dr. Warkentin said that health plans use different platforms to collect updates from providers and some use paper and online surveys. Mr. Nefussy questioned why the directories can't be updated in real time. Ms. Burgiel responded that they are not updated in real time as sometimes providers submit incorrect information such as when office staff in the same practice submit different responses to the same question. She added that she thinks the Task Force should focus more on provider education than on financial incentives or penalties to submit information. She also said that timelines to update information should be reciprocal for both providers and carriers.

Ms. Leahy called for collaboration between carriers and providers and said that sometimes information requested to be updated by providers needs to be validated and sometimes reviewed against contract provisions, which can cause delays. Ms. Leahy indicated sometimes a change may not be consistent with what is required in the provider's contract, including for example when a provider needs to give notice before terminating participation in a plan. Dr. Warkentin added that providers that use CAQH are already accustomed to 90 day timeframes to update information. She added that she doesn't believe making the attestation phase more cumbersome will make the provider information more accurate.

Dr. Warkentin asked the Task Force if they think three weeks is a reasonable amount of update time. Ms. Leahy said that information related to non-contractual items can updated in 2-5 days, but information related to contractual items can take 30 days. Mr. Katzman said that at Blue Cross Blue Shield of Massachusetts, updates related to non-contractual items are made within a 30 day timeframe but often more quickly. He added that not every change gets validated. Ms. Burgiel said that even though providers who use CAQH are accustomed to this time frame, providers can make changes and do not have to wait 90 days to supply new information. Updated information can be supplied at any time.

Mr. Katzman suggested that provider directories could link to the providers' personal websites, so they wouldn't have to wait for validation to share such information with their patients. Dr. Warkentin expressed concern with this idea because it could lead to too many inconsistencies.

Preplanned updates

Ms. Granoff asked if providers can make changes that will be updated at a later date; for example, if a provider knows that they're going to change office locations in a couple months. Mr. Katzman said that providers generally submit updates 60 days in advance of a change and carrier validation is completed within the 60 days, as opposed to the provider having 60 days to submit information and BCBSMA having 60 days to approve. He also said that in his experience at BCBSMA most changes are contractual.

Contractual vs non-contractual updates

Dr. Warkentin asked what health plans meant by contractual and non-contractual updates, and asked whether health plans should have different timeframes for each. Ms. Leahy added that CMS has set a 90 day standard for health plans to outreach providers to verify directory information. Dr. Warkentin questioned what the deadlines are in other states. Mr. Nefussy asked if contracts are updated every time demographic changes are made, which Ms. Burgiel said that would result in much long contracts than exist today if the documents included that level of detail. Mr. Beagan said that it would be useful for the Task Force to learn which elements are contractual and asked MAHP to make a presentation in the next meeting. Mr. Beagan suggested additional discussion about the topic be tabled until next meeting when carriers can give further details on what items are contractual.

Presenting Information in Provider Directories

Mr. Beagan revisited the following sections (c) and (d) the authorizing statute that pertained to provider directory information:

> (c) The task force shall develop establishing: ...(iii) substantially similar processes and timeframes for carriers to include such information in their provider directories when... (iii) substantially similar processes and timeframes for carriers to include such information in their provider directories..."
>
> (d) The task force shall develop recommendations for carriers on: (i) ways to include information in the provider directory that identify the tier level for each specific provider, hospital or other type of facility in the network, when applicable; (ii) ways to include consistent language across carriers to assist insureds with understanding and searching for behavioral health specialty providers; (iii) the feasibility of carriers making real time updates to each electronic network plan provider directory when health care providers included in a carrier's network provide information to the carrier pursuant to recommendations under subsection

Mr. Beagan suggested that it may be good to talk about good ways that information is available and accessible in electronic directory information. He asked Ms. Stahl, Ms. Vangeli and Mr. Wilkinson, as Task Force members representing consumer organizations, if they might talk about some of the most important information to be available and what may be good or bad ways of presenting information. All agreed that it would be best allowing the consumer to search based on certain criteria. Mr. Nefussy indicated that most available engines only allow the consumer based on one or two criteria, but maybe it should allow for more options.

Mr. Wilkinson responded that one of the most important elements to be updated frequently is provider availability. Mr. Nefussy added that it would be a concern if a provider is listed as available even though the provider is only available on one day. He indicated it would be preferable to show information on a group basis. Mr. Wilkinson also added that the directory could collect restrictions, such as to exclude doctors that only see patients on an inpatient basis. Ms. Burgiel noted that more hospitals have hospitalists programs that treat patients only on an inpatient basis and these providers would not be included in carrier directories.

Ms. Stahl responded that it's most helpful to see the age groups that a provider serves, especially for those who provide behavioral health. When a behavioral healthcare provider lists 15 different specialties, it's hard to discern which areas they really specialize in. Therefore, it would be helpful to see what services a provider has performed in the prior six months.

Ms. Stahl also said that it is important to include up-to-date availability. She also said that the provider directory should clarify between office and provider hours. To this, Dr. Warkentin responded that it could be useful for the software to sort by types of provider hours, such as if they have nights or weekends available, or are available after school. Ms. Leahy pointed out that CAQH collects office hours from providers by asking providers to input their office hours for each day of the week.

Ms. Stahl also said that providers could have pictures or a notes section where they write about themselves. Although this might not be displayed prominently on the directory, it is a good secondary source and allows providers to add information about themselves that the "clickable" system may not capture.

Dr. Warkentin indicated that a directory could include if a provider specializes in certain populations, such as refugees. The information could also allow for searching by language.

Ms. Stahl mentioned the importance of displaying distance information. Mr. Nefussy pointed out that online directories allow you to filter for mileage. Dr. Warkentin asked if transportation information is listed online.

Another Task Force member also wondered if a consumer could search for information based on office accessibility

Modalities
Dr. Warkentin suggested that it would be helpful for the provider directory to include information about the type of modality a behavioral health provider may use, including, for example, whether a provider uses talk therapy. Mr. Beagan questioned if it would be confusing to include modalities because there are so many options.

Ms. Stahl responded that Connecticut's website is a good example, and she would share the link before the next meeting. Dr. Warkentin said that if modalities are included, there should be a link to explain what each one means in accessible language. Mr. Wilkinson questioned if displaying modalities would be too limiting. Dr. Warkentin responded that it should be thought of more as something that users can use if they want to, but can also easily search without inputting any modalities. Furthermore, there are some providers that strictly specialize in one type of modality. Dr. Warkentin added that the modalities used in the 2018 Taxonomy Report could be used for the directory. She added that she thinks the question should ask providers to identify which modalities they have practiced in the past six months. Mr. Nefussy suggested that more consumer education is needed, so that they know what information to search.

Massachusetts Behavioral Health Access (MABHA) webpage
The Massachusetts Behavioral Health Access (MABHA) search page was disseminated to show examples of how information is displayed online. Mr. Nefussy said that it seems like the MABHA page shows fewer categories for facilities, and that the Task Force should add definitions into the directory. Dr. Warkentin said that the ability for providers to add comments on the MABHA website is nice, and a similar feature should be added to the CAQH system.

At this point Mr. Beagan asked for a brief recess to allow for the two remaining members to be sworn in.

Tiers
Mr. Beagan asked the Task Force where they think information about tiers should be displayed. Ms. Vangeli commented that she receives a lot of questions about tiers. Ms. Burgiel said that in her experience, there could be more education for provider offices about tiers to assist them to collect the correct repayment amount during an office visit. Ms. Vangeli commented that the HCFA helpline receives several question on tiering.

Affiliations
Mr. Beagan asked if information should be available about whether a provider is affiliated with certain hospitals or other providers. Mr. Wilkinson responded that in behavioral health, there are many providers that only refer to other in-network providers, so it could be useful to give consumers this information. He added that sometimes, a plan may make it appear as though there are several doctors in the area, but several of those doctors can only be seen on an inpatient level at a specific hospital. He said that the best method at the moment – going to the hospital's website and looking for a provider, then cross checking to see which providers are in a patient's network – is confusing and time consuming. Dr. Warkentin questioned how CAQH would display if a provider works for one plan at more than two locations, to which Ms. Burgiel responded that CAQH allows providers to include information for multiple locations.

Existing Regulations
Mr. Beagan reminded Task Force members that there are existing directory requirements and as an example pointed to Division of Insurance Regulation 211 CMR 52.15(1)(a), related to methods of reimbursement and information on current quality measure sets. Mr. Beagan asked Task Force members to share their thoughts on how to address these existing requirements, including displaying information on whether any of the following were useful or should be modified:

(a) The Provider directory must contain a list of Health Care Providers in the Carrier's Network available to Insureds residing in Massachusetts, organized by specialty and by location and summarizing on its Internet Website for each such Provider:

1. The method used to compensate or reimburse such Provider, including details of measures and compensation percentages tied to any Incentive Plan or pay for performance provision;
2. The Provider price relativity, as defined in and reported under M.G.L. c. 12C, § 10;
3. the Provider's health status adjusted total medical expenses, as defined in and reported under M.G.L. c. 12C, § 10; and
4. current measures of the Provider's quality based on measures from the Standard Quality Measure Set, as defined in 957 CMR 4.00: *Uniform Provider Reporting of the Standard Quality Measure Set* promulgated by the Center for Health Information and Analysis established by M.G.L. c. 12C, § 2; provided, that the Carrier shall prominently promote Providers based on quality performance as measured by the standard quality measure set and cost performance as measured by health status adjusted total medical expenses and relative prices.

a. Nothing in 211 CMR 52.15(1)(a) shall be construed to require disclosure of the specific details of any financial arrangements between a Carrier and a Provider.

b. If any specific Providers or type of Providers requested by an Insured are not available in said Network, or are not a covered benefit, or if any Primary Care Provider or behavioral health or substance use disorder Health Care Professional is not accepting new patients, such information shall be provided in an easily obtainable manner, including in the Provider directory.

c. Notwithstanding any general or specific law to the contrary, a Carrier shall ensure that all Participating Provider Nurse Practitioners and Participating Provider Physician Assistants are included and displayed in a nondiscriminatory manner on any publicly accessible list of Participating Providers for the Carrier.

Mr. Beagan agreed to disseminate the text of the existing regulation so that members could review the requirements and comment at the next meeting.

Considerations for Next Meetings

Mr. Beagan said that it was interesting to see even within the Task Force how members use search features differently, and having different perspectives will allow the Task Force to develop a more flexible tool. Mr. Katzman said that he looks forward to converting to the more automated CAQH program. He recognizes that the switch will be difficult in the short-term, but will be worth it in the long-run. Mr. Beagan said that it's worthwhile to highlight how the system will be set up by the end of this Task Force, even if it takes some time for it to be fully implemented.

Ms. Vangeli added that's it's better for the Task Force to make changes to CAQH now rather than further down the line when more people use it. Mr. Beagan indicated that he would like the Task Force to spend time next week discussing data auditing, and making changes when they may be considered contractual and non-contractual in relation to carrier agreements.

Mr. Beagan entertained a motion made and seconded to adjourn the meeting which passed unanimously. The meeting was adjourned at 2:56 P.M. on February 6, 2020.

The form of these minutes comports with the requirements of M.G.L. c. 30A, §22(a).

List of Documents Presented at the Meetings

- Minutes of the Provider Directory Task Force for the meeting held on January 27, 2020
- Chapter 124 of the Acts of 2019
- 211 CMR 52
- MABHA Provider Search Page

APPENDIX E

Meeting Minutes of the Provider Directory Task Force for the Meeting Held on Tuesday, February 11, 2020

February 11, 2020 minutes of the Provider Directory Task Force held in Conference Room 1-E 1000 Washington Street, Boston, Massachusetts 02118

Members present in person:

Kevin Beagan	Chair, designee for Commissioner of Insurance
Lori Burgiel	Representative for Healthcare Administrative Solutions
Karen Granoff	Representative for the Massachusetts Health and Hospital Association
Michael Katzman	Representative for Blue Cross and Blue Shield of Massachusetts
Elizabeth Leahy	Representative for the Massachusetts Association of Health Plans
Danna Mauch	Representative for the Massachusetts Association for Mental Health
Yael Miller	Representative for the Massachusetts Medical Society
David Nefussy	Representative as an expert in the treatment for substance use disorders
William Rennie	Representative for employer groups
Alyssa Vangeli	Representative of a health consumer advocacy organization
Dr. Jennifer Warkentin	Representative as an expert in the treatment for mental health disorders
Wells Wilkinson	Representative for the Children's Mental Health Campaign

Members participating via phone:

Eva Marie Stahl	Representative for consumers

Call of 4th Meeting to Order by Chairperson Kevin Beagan

A quorum was determined to be present, and Mr. Beagan called the meeting to order at 1:07 P.M. Mr. Rennie arrived after the start of the meeting.

Minutes

January 27, 2020 Minutes

Dr. Warkentin requested a minor amendment to the minutes from the January 27, 2020 meeting minutes. A motion was made and seconded to accept the minutes as further amended, which was accepted unanimously.

February 4, 2020 Minutes

The draft minutes of the February 4, 2020 minutes were discussed, with edits submitted by several Task Force members. A motion was made and seconded to accept the minutes with the edits. Ms. Mauch abstained, and the remaining Task Force Members voted unanimously to accept the minutes as amended.

Updating Information

Contractual vs non-contractual agreements

Mr. Beagan reminded the Task Force that a couple of items had been tabled from last meeting until this meeting. During the last meeting, he had asked Ms. Leahy and Mr. Katzman to explain which information is considered contractual and which is considered non-contractual when providers make changes to their profiles and how this may impact the time that information is updated in the provider directory materials. Ms. Leahy said that although carriers do not have strict categories of what is considered contractual or non-contractual information, as an example, if a provider's phone number changes because the provider's affiliation has changed, this is considered a contractual change. If a provider's phone number changes or availability changes, these are not usually considered to be contractual changes. Ms. Leahy indicated that non-contractual changes can be updated in 2-5 days for some plans while it may take 30 days to update for contractual changes so that the carrier can

verify the information. Mr. Katzman agreed with Ms. Leahy's assessment and also indicated that Blue Cross expects providers to submit contractual changes60 days in advance of the change.

Frequency of updates

Ms. Granoff questioned why it takes so long to conduct the verification checks and why information can't be processed in real-time. Mr. Katzman indicated that it takes time to make sure that a carrier reaches and verifies information with providers to ensure accuracy of information in the directory, while also serving as a protection for providers. Mr. Beagan asked if the 60 days includes both submission and verification, which Mr. Katzman confirmed to be correct.

Dr. Warkentin questioned whether the 2-5 day timeline for non-contractual changes is calendar days or business days. If the latter, she said that 5 days should be the maximum amount of time, and carriers should aim for the changes to be as quick as possible. She said that with a 5 day timeframe, it's possible that providers notifying a carrier that they can take new patients may have had changes in the 5 days so that their panel is full and the updated information is incorrect. She also indicated that in order to get providers to update their information there has to be some expectation that carrier provider directories are updated quickly or providers will lose any incentive to update accurately if the carriers' systems take too long to reflect the changes.

Mr. Katzman indicated that the 2 to 5 days is a short time frame. CMS requires non-contractual updates to be posted within 30 days, and although Blue Cross and Blue Shield of Massachusetts (BCBSMA) strives to post updates faster, enforcing a 2-5 day timeline is aggressive.

Mr. Wilkinson countered that when consumers are having a mental health crisis and do not already have a relationship with a provider, they call their healthcare plan to help them find a provider. Furthermore, many members assume all providers listed in the provider directory have available space for new patients. Dr. Warkentin commented that when a directory is not updated quickly, it can be a deterrent to finding a provider. For example, a member seeking help for depression may not be willing to continue to call providers to determine availability after repeatedly get turned down.

Ms. Miller said that rapid updates are important, and especially for those looking for behavioral health providers. Ms. Granoff thought that correct information was necessary whether the patient had a behavioral health or a medical crises. Mr. Nefussy offered that members can use telehealth to access behavioral health providers, which cannot be used in medical crises. Ms. Burgiel made a comment during this discussion that provider directory data was to reflect whether the provider was accepting new patients and that patients use that data to contact a provider office to call for appointment availability.

Mr. Beagan said that he believes that the goal of the Task Force is to improve the overall provider directory not just for certain categories of providers He requested Ms. Leahy and Mr. Katzman to be ready to present information at the next meeting about why the 5day standard for non-contractual information and the 30-day standard for contractual information was reasonable and why plans could not be expected to do better.
Mr. Rennie questioned whether carriers collect data on current usage, which Ms. Burgiel responded she doesn't believe so. Mr. Beagan indicated that there is substantial anecdotal information, especially for behavioral health, and that it may be good to discuss some any available information that Task Force members may have in the next meeting.

Revisiting Existing Regulations

Mr. Beagan highlighted the following existing requirements for provider directories in Division of Insurance Regulation 211 CMR 52.15(1)(a), items 1-4:

(a) The Provider directory must contain a list of Health Care Providers in the Carrier's Network available to Insureds residing in Massachusetts, organized by specialty and by location and summarizing on its Internet Website for each such Provider:

1. The method used to compensate or reimburse such Provider, including details of measures and compensation percentages tied to any Incentive Plan or pay for performance provision;
2. The Provider price relativity, as defined in and reported under M.G.L. c. 12C, § 10;
3. the Provider's health status adjusted total medical expenses, as defined in and reported under M.G.L. c. 12C, § 10; and
4. current measures of the Provider's quality based on measures from the Standard Quality Measure Set, as defined in 957 CMR 4.00; *Uniform Provider Reporting of the Standard Quality Measure Set* promulgated by the Center for Health Information and Analysis established by M.G.L. c. 12C, § 2; provided, that the Carrier shall prominently promote Providers based on quality performance as measured by the standard quality measure set and cost performance as measured by health status adjusted total medical expenses and relative prices.

a. Nothing in 211 CMR 52.15(10(a) shall be construed to require disclosure of the specific details of any financial arrangements between a Carrier and a Provider.

b. If any specific Providers or type of Providers requested by an Insured are not available in said Network, or are not a covered benefit, or if any Primary Care Provider or behavioral health or substance use disorder Health Care Professional is not accepting new patients, such information shall be provided in an easily obtainable manner, including in the Provider directory.

c. Notwithstanding any general or specific law to the contrary, a Carrier shall ensure that all Participating Provider Nurse Practitioners and Participating Provider Physician Assistants are included and displayed in a nondiscriminatory manner on any publicly accessible list of Participating Providers for the Carrier.

Mr. Beagan asked for any suggestions on these items.

Ms. Leahy indicated that it was important to consider whether the noted information was useful to consumers and did not add to the overall confusion when picking providers. Ms. Vangeli stated that while it is important to know out-of-pocket costs – such as what is available from on-line tools – some of the regulatorily required information may not be as helpful and could be provided as a link or other information or as a "hover-over." Dr. Warkentin indicated that there needs to be a balance between the level of information given and the usefulness. She believed it may be better to err on the side of less information to avoid confusion. Ms. Miller added that the information required in the noted section mostly relates to PCPs, so that it would be difficult to include information for specialists. She further suggested that should this information on quality, price relativity or HSATME be provided, they be presented at the organizational level and not on the individual physician level to ensure validity.

Mr. Beagan asked if there were any other thoughts to put on record about what to present in provide directory information. Ms. Granoff shared information on current federal proposals on provider directory changes. Mr. Beagan read from an email Ms. Granoff had sent to the Task Force that contained sections from two federal bills: the House Ways & Means Committee's *Consumer Protection Against Surprise Medical Bills Act of 2020* and the Committee on Education and Labor's *Ban Surprise Billing Act*.

Data Auditing

Next, Mr. Beagan read the following selected subsections from the Task Force authorizing statute, Chapter 124 of the Acts of 2019:

(c) The task force shall develop recommendations on establishing: (i) measures to ensure the accuracy of information concerning each provider listed in the carrier's provider directories for each network plan;

(d) The task force shall develop recommendations for carriers on (iv) measures to address circumstances in which an insured reasonably relies upon materially inaccurate information contained in a carrier's provider directory; and (v) measures for carriers to take to ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan based on the information provided to the carriers by network providers pursuant to recommendations under said subsection (c) including, but not limited to, periodic testing to ensure that the public interface of the provider directories accurately reflects the provider network, as required by state and federal law.

Mr. Beagan discussed how the Division of Insurance conducted an examination and found that the directory information was inaccurate and expected the carriers to do a better job of verifying the information within the directories. Mr. Beagan asked the representatives of the carriers to explain what changes they have made since this had happened.

Ms. Leahy responded that the carriers have a phone call audit process. She said that CAQH has a 90 day outreach to providers to submit changes to directory information and practice locations, as well as other data discussed by the Task Force earlier, such as language spoken. The data submitted is also reconciled with other submitted data to see if there are inconsistencies, and use federal databases as well. HCAS participating plans are developing a collaborative audit process to be employed after the CAQH implementation is complete.

Mr. Nefussy asked how long it would be before a carrier would remove a provider from the directory if there is no response during outreach. Mr. Katzman indicated he believed it was two quarters which would equate to 180 days. Ms. Burgiel stated that terminating a provider is disruptive to the consumer and that health plans have a process that may include additional provider outreach before a provider is removed from a carrier network. Mr. Katzman shared that BCBSMA conducts audits of a representative sample of providers and based on the findings, will determine if a secondary audit is needed and what outreach may be useful with providers to improve accuracy.

Dr. Warkentin shared a concern that providers may be inundated with calls for verification of information. Ms. Burgiel stated that, using CAQH reduces the work associated with submitting information to multiple health plans and that providers should take time to enter data as accurately as possible to reduce errors. She continued and noted that per Ms. Leahy's earlier comments, HCAS health plans were discussing whether to conduct additional outreach to non-responsive providers centrally through HCAS to reduce provider outreach by each carrier. Dr. Warkentin suggested that a central location should be making these phone calls, so that providers are not receiving multiple calls from different carriers for verification of the same information.

Mr. Wilkinson indicated that he would be concerned if a name disappears from a provider directory due to a nonresponsive provider because a patient in active treatment may believe that a provider has been terminated from a provider network. He thought it may be more useful to add information to the directory that indicates the provider has been nonresponsive.

Mr. Beagan indicated that care should be taken in behavioral health about whether or not a provider treats certain conditions or classes of patients. He said that he would want to see information that shows who provided the care, how it was treated, and for what services. He suggested that there be some analysis of past claims practices to see whether a provider actually provides certain types of care for that type of care to be so noted in the provider directory.

Dr. Warkentin cautioned that this may cause an additional administrative burden for plans and providers and may not necessarily be an accurate reflection of their practice. Mr. Beagan stated that there needs to be some

thought about what plans may need to do to minimize the difference between what is in the listed provider information and what is said on the phone to a member.

Next, Mr. Beagan asked how complaints should be integrated into the provider directory verification process. Ms. Burgiel said that the process needs to be consistent. Mr. Wilkinson questioned what happens when members use out-of-network providers when there are no in-network providers available.

When a Patient Has Financial Consequences for Inaccurate Information
Mr. Beagan read the following section from the authorizing statute:

> "The task force shall develop recommendations for carriers on... (iv) measures to address circumstances in which an insured reasonable relies upon inaccurate information contained in a carrier's provider directory."

Mr. Wilkinson expressed concern when customer service information is wrong and members are relying on this information at the time they have a medical need. Dr. Warkentin said that she would like to see a link with the Task Force explaining to consumers what actions to take if they cannot find an in-network provider.

Mr. Beagan agreed that there needs to be a way to get better information and asked the group to consider whether carriers may need to accept financial responsibility in cases where the directory may have caused a problem such as when a patient goes to an incorrect address for an appointment and gets charged by a provider for a missed appointment. Mr. Katzman said that such a process could be confusing in practice for consumers with cost sharing that could include deductibles, coinsurance can copays.

Considerations for the Next Meetings
Mr. Beagan said that next week he would like members to look into the feasibility of real time changes as required in the authorizing statute.

Mr. Beagan added that he would like members to begin thinking about recommendations. He said that his plan is to review the past minutes and see where there is consensus. Mr. Beagan also indicated that on any items where there is not consensus, members have the opportunity to add a dissenting opinion on the final report. He asked members to look for recommendations that would both help the Division put forth regulations as well as help inform the legislature.

Mr. Beagan entertained a motion made and seconded to adjourn the meeting, which passed unanimously. The meeting was adjourned at 2:50 P.M. on February 11, 2020.

The form of these minutes comports with the requirements of M.G.L. c. 30A. §22(a).

List of Documents Presented at the Meetings

- Minutes of the Provider Directory Task Force for the meeting held on January 27, 2020
- Minutes of the Provider Directory Task Force for the meeting held on February 4, 2020
- The Child Health and Development Institute's Evidence-Based Practices Directory
- Chapter 124 of the Acts of 2019

APPENDIX F

Meeting Minutes of the Provider Directory Task Force
for the Meeting Held on Tuesday, February 18, 2020
held in Conference Room 1-E 1000 Washington Street, Boston, Massachusetts 02118

Members present in person:

Kevin Beagan	Chair, designee for Commissioner of Insurance
Lori Burgiel	Representative for Healthcare Administrative Solutions
Karen Granoff	Representative for the Massachusetts Health and Hospital Association
Michael Katzman	Representative for Blue Cross and Blue Shield of Massachusetts
Elizabeth Leahy	Representative for the Massachusetts Association of Health Plans
Danna Mauch	Representative for the Massachusetts Association for Mental Health
Yael Miller	Representative for the Massachusetts Medical Society
David Nefussy	Representative as an expert in the treatment for substance use disorders
William Rennie	Representative for employer groups
Eva Marie Stahl	Representative for consumers
Alyssa Vangeli	Representative of a health consumer advocacy organization
Dr. Jennifer Warkentin	Representative as an expert in the treatment for mental health disorders
Wells Wilkinson	Representative for the Children's Mental Health Campaign

Call of 5th Meeting to Order by Chairperson Kevin Beagan
A quorum was determine to be present, and Mr. Beagan called the meeting to order at 1:08 P.M.

February 11, 2020 Minutes
The draft minutes of the February 11, 2020 minutes were discussed, with edits submitted by several Task Force Members. A motion was made and seconded to accept the minutes as amended, which was accepted unanimously.

Introduction
Mr. Beagan commented that if there is a significant disagreement about recommendations within the Task Force, both a report and a dissenting report could be created. He reminded the Task Force that the law expects the report be completed by March 1, 2020.

Ms. Burgiel noted for the Task Force's information that in addition to the companies that were previously noted as using the CAQH system, she understands that Cigna, Humana, Aetna, United, Beacon Health Options, and Envolve Benefit Options use the CAQH system also.

Discussions about Possible Recommendations

STANDARDIZING THE COLLECTION OF INFORMATION
Measures to ensure the accuracy of information
As suggested by the Taxonomy Commission, collecting information in a "clickable" way
Mr. Katzman indicated that the recommendations should leave this language open to be adaptable to future technological advances.

Collecting information online, as opposed to collection by paper updates
Dr. Warkentin said that she thinks the Task Force's recommendations should seek to minimize administrative burdens, and streamline the process for reporting information. Even though the law does not require all providers to use the same software, the Task Force could encourage carriers to try to use common systems and should look to recommend similar language be used across carriers' systems.

Mr. Katzman agreed with the need to seek administrative simplification and said providers currently send changes to their information on a form by email. by BCBSMA is investigating ways to add this to online processes in the future.

Collecting detailed initial information, then updating pieces when there are changes
There appeared to be general agreement that systems be set up so that the initial profile collects detailed information and that updates are done in a much easier manner.

Collecting information for each provider and each provider office
Ms. Miller said there is some information that is specific to the provider and some to the provider office. For example, the business hours should reflect the provider office rather than the provider since an individual provider's hours may shift frequently. Having the provider office information would allow a patient to call when the normal hours are open so the patient could always find out about the availability of other providers in the office. Mr. Katzman commented that the person entering the information, which may not be the providers themselves, would need to ensure the accuracy of information for each provider at each location, which could be challenging and confusing. Mr. Beagan indicated that the Task Force should think about the correct data elements, rather than the person entering the data. As the elements are defined, all should be educated about how the information is to be entered.

Provider availability to take appointments
Day-by-day office hours
Mr. Nefussy said that providing the office hours for individual providers would not be as helpful as the office hours of the practice location. Dr. Warkentin indicated the importance of having an office module that is managed by the office manager to collect office hours of the practice location and other relevant location information like ADA accessibility.

Ms. Burgiel commented that within the CAQH system, it could be at the discretion of the provider to include either personal or group practice hours, but that education and training would be used to stress inclusion of the practice hours of operation. That would offer patients more flexibility when they are interested in the availability of another provider in the office. Dr. Warkentin suggested that there could be room for providers to indicate if they're generally available for weekend and evening appointments.

Telehealth capability
Dr. Warkentin noted that this should reflect a provider office's capability to do telehealth. When the carrier used the information in their directory, it was up to them to display the telehealth information for those providers under contract for telehealth services.

Restrictions on referrals or seeing patients only on an inpatient basis
Mr. Wilkinson thinks there needs to be information collected about whether a physician only sees patients on an inpatient basis or in an individual office. He also thought that there needed to be information collected about whether there are limitations on whether a provider will only see patients referred from certain practices and that the name of the practice should be collected. Ms. Granoff added that this information would be available on the health plan/ACO side and did not need to be collected in this process. Ms. Leahy indicated that the carrier information may not always be accurate.

Dr. Warkentin said that if the space to collect such information already exists in the CAQH system, it should be collected. Providers can be given the option to leave it blank as well. There was a split on the inclusion of this information so that it was left for a vote in the next meeting.

Phone number, address, email, online tool to make appointment or contract provider
Ms. Leahy thought that the phone number would be appropriate and asked what could be used as an online tool. Mr. Katzman indicated that he thought only a provider's address and phone number should be required, but providers could provide more means of communication if they chose. Dr. Warkentin suggested an option to link to a webpage should also be included, to which Ms. Granoff responded it would be frustrating if the links are broken. Ms. Miller added that she has concerns about specifying the word email as new technology may arise. The Task Force agreed that only phone number and office address would be required.

Availability by location (once or more per week, once or more per month, no office visit)
Mr. Nefussy suggested that the noted providers are available for weekend and evening appointments by location, which the Task Force agreed with.

Access to provider location for those with disabilities
Dr. Warkentin said the recommendations should have specific definitions for disability access. Ms. Leahy said that this could look too cluttered, and it could be better to add a feature where links to further information are given when a user hovers over the section regarding a provider's location. At the same time, she reminded that Task Force that the price to create the Provider Directory will rise as more features are added. Ms. Mauch said that it should include access information for those with both physical and intellectual disabilities. She suggested that instead of trying to provide access information that addresses every disability, it could focus on the most common ones. Ms. Burgiel said that important elements already included in the data collection process are how to access the provider's location by public transit, if the provider's office is handicap accessible and has ramps and elevators, and whether they serve populations with intellectual disabilities that is a question required by MassHealth for behavioral health providers.

Availability of interpreter services
There was agreement that this should be stated.

Availability
There appeared to be agreement that the provider should check whether "panel is full," "limited availability for new patients," or "open for new patients."

Mr. Wilkinson indicated that he thought there should be information collected about average waiting time to obtain an appointment. He indicated that MassHealth lists 4-8 weeks as standard wait times, so maybe the providers should be asked to report according to similar parameters. Ms. Granoff suggested that instead of using specific timeframes which can vary often and instead supported that the Provider Directory say that providers have limited availability. Dr. Warkentin said that providers will be averse to putting specific waiting times because they may not want to be held accountable to those timeframes and may have different wait times based on the patient's need or the type of appointment. She suggested the Directory can add a feature to show that providers have open waiting lists.

Ms. Vangeli said that if a provider is shown to be accepting new patients, that should mean they can see new patients without significant wait times. Ms. Miller responded that this depends on the type of service offered. For example, annual check-ups and urgent care visits have very different acceptable wait times. Dr. Warkentin suggested that instead of including this in the directory, maybe it could be included in provider education efforts. Mr. Beagan said that he thinks this data may be too difficult to collect right now.

Upon the suggestion of Mr. Beagan, the Task Force voted on whether they thought data should be collected about waiting times. Four members voted yes, so the motion failed.

Only accepting patients through a concierge practice
Mr. Beagan indicated that the Division of Insurance thought that it was important that patients know when a provider may require a concierge fee as a condition of being part of the provider's panel. There was not any objection about this information being collected.

Populations of interest
Age groups? Age buckets? Children? Teens?
Mr. Katzman suggested that the Task Force recommend the same age groups as used by the Taxonomy Commission Report. Ms. Burgiel said that CAQH is designed to collect exact ages treated by a provider from youngest to oldest. Ms. Burgiel noted this was a good approach, as providers may define terms such as adolescent in different ways and using the exact ages is clearer for providers and consumers. Dr. Warkentin said that this would help someone doing a search in a provider directory to use their own age rather than a category as child or teen which might differ from one carrier to another.

Age groups treated in last six months
The question considered was whether there should be some way to record whether a provider has treated someone in specific age group within the past six months. Ms. Mauch said this is not common information to be collected, and the Task Force agreed collect information about this issue.

Practice targeted towards certain cultural/other groups
Dr. Warkentin said that the Taxonomy Commissioner mixed both populations served and areas of specialty. She said that it's important to have two separate categories; just because someone has a disability does not mean they're seeking service for that disability. By collecting information about cultural and other groups served by a provider, it would enable individuals to search a database based on these attributes. Ms. Burgiel said it could be useful to work with the Mass Collaborative for consistency, and Ms. Leahy said it could be useful to have a common a list of populations served, which the Task Force agreed with.

Languages spoken
Ms. Stahl said that it is important to clarify that languages are spoken relatively fluently, as opposed to using translation technology. Ms. Burgiel that CAQH has a list of languages that can be selected by the provider.

Provider profile
Personal description of practice
Ms. Leahy expressed concern about allowing providers to use free form language to describe their practice, and the Task Force agreed that this did not need to be part of the collected information.

Provider Picture
Ms. Miller indicated that this was not necessary and the Task Force agreed.

Gender? Race/Ethnicity? Licenses? Board certifications? Educations?
Mr. Katzman said board certification and education are already collected questioned if licensure information was necessary to collect. Dr. Warkentin responded that this information needs to be collected in order to understand a provider's certifications, and to provide information to patients when choosing providers.

Practice Type
Medical specialty/physician/facility affiliations
It was generally agreed that the medical specialty and relevant physician/facility affiliations should be on record.

Behavioral Health: Subspecialties identified in 2019 Taxonomy Report
There was general agreement that the collection tool should use the subspecialties identified within the 2019 Taxonomy Report. Dr. Warkentin suggested that neuropsychological testing assessment and psychological assessment should be added to the list of subspecialties in the report and the Task Force agreed.

Behavioral Health: Ability to treat a subspecialty vs. having treated patient in subspecialty
The Task Force generally agreed with the need to identify what a provider can do but also whether they have been providing certain types of care. Ms. Miller suggested that the question be whether they have provided the type of behavioral health care within the past year and the Task Force was in agreement.

Behavioral Health: Modalities of treatment
There was general agreement that the modality of treatments used by the provider should be collected as part of this tool.

UPDATING INFORMATION
There was a general conversation about the need for providers to be educated to update information promptly after every practice or informational change. Providers need more training and their staff to be aware how outdated information prevents patients from properly getting appointments for care.

Contacting providers to remind to review and periodically update information
Ms. Burgiel said that she thinks applying the 90 day provider notification in compliance with federal guidelines is a good approach. Others believed that there needs to be the balance of having correct information but also not creating a regulatory burden on provider practices.

Carrier steps to check accuracy of provider information and update provider directory
Mr. Katzman said that in addition to provider attestations through CAQH and a separate audit process that check accuracy of information, BCBSMA verifies many of the non-contractual changes reported by providers. He said these changes are less complex with little or no financial impact on the provider, and are sent to BCBSMA on a form by email, and with a high volume of inventory and a process that is not automated, it can take up to 30 days for the changes to be reflected in the directory, although usually much faster. He reminded the Task Force that changing this method would be more expensive, and he thinks there are more important areas for the Task Force to focus on. He also said that he thinks the Task Force should continue to recommend a 30 day timeframe for non-contractual changes.

Ms. Leahy said that 2-5 days is the usual timeframe for plans that use the CAQH system. She said that unless all carriers use a software that updates with a daily feed like CAQH, we cannot hold them to a 2-5 day timeframe. She also said that real time changes are unattainable because carriers must verify the information submitted by providers. Dr. Warkentin responded that more than five business days is too long for non-contractual changes. Ms. Burgiel responded health plans may already do samplings or internal audits to validate data and that even if health plans display information that was supplied incorrectly by a provider, the carriers are held accountable. Mr. Rennie expressed concerns on the burden this would have on carriers, and said the technology isn't there for real time updates.

Mr. Katzman said that contractual changes, like a change in affiliation, should be submitted to BCBSMA by providers 60 days before the date of change so there is enough time for verification and adding the change into the directory. If the timeframe is too small, this can lead to inaccurate information being shared.

Dr. Warkentin said that although it may not be possible to recommend a shorter timeframe at this moment, plans should prioritize updating information faster, particularly patient availability, which can change on a daily basis.

PRESENTING INFORMATION IN PROVIDER DIRECTORIES

Searching online

There was general agreement that online provider directory information should allow for the patient to search according to the following categories:

i. *Taking new appointments*
ii. *Provider specialty/subspecialty*
iii. *Gender of provider*
iv. *Race/ethnicity of provider*
v. *Ages treated*
vi. *Populations of interest*
vii. *Language spoken*
viii. *Provider affiliations with hospitals*
ix. *Availability for telehealth appointments*
x. *Distances from location or zip codes*
xi. *Disability access*

Dr. Warkentin said treatment modality should be added to this and the Task Force agreed. The group also discussed adding accessibility to public transportation, as well as the gender and race/ethnicity of the provider.

Information to be presented

There was general agreement that online provider directory information for a provider should include the following categories:

i. *Phone number and address for provider location*
ii. *Accessibility of location for physically disabled*
iii. *Day-by-day office hours of each provider location*
iv. *Availability of provider at the location (once or more per week, once or more per month, no office visit)*
v. *Availability at provider location for telehealth*
vi. *Access to interpreter services at provider location*
vii. *Whether provider's panel is full, there is limited availability for new patients or open for new patients*
viii. *Specialty of treatment*
ix. *For behavioral health, subspecialties, including which ones have treated patients in the past year*
x. *For behavioral health, practice modalities*
xii. *Licenses, Board Certifications, Education*
xiii. *Languages spoken*
xiv. *Access to public transportation*
xv. *If a tiered network plan, clear delineation of provider tiers*

There was general agreement that number of years practicing would not be necessary.

Regarding tiering information, there was a thought that there be a list of all tiers that the provider could be in based on the products offered by a carrier. Ms. Leahy responded that different providers have different tiers depending on their product, so this may not be useful to collect and it would be better to have different search engines that are based on the type of products the patient may be in. This way, the patient would see the search for the tiered plan separate from the search for the limited network plan.

There was a suggestion that information be somehow provided to allow the patient through a link to allow the patient information about how the carrier assigns providers to tiers and how cost-sharing may differ when choosing a tier 1 provider compared to a tier 2 provider.

Information in current regulation
Mr. Beagan reminded the Task Force that the following information is currently required by law and regulation to be included in the provider directory and he wanted to allow the Task Force to comment on whether they recommended that this information be continued or modified.

Method used to compensate provider: capitation? Fee for service?
Provider price relativity
Provider health status adjusted total medical expenses
Provider quality

Ms. Miller suggested that this could be helpful but may not be as useful as the information on the main provider page. Some of it is only relevant and reported at a provider practice level. She suggested that this information could be made available through a linked website. Ms. Vangeli said that provider health status adjusted for total medical expenses should be provided next to provider quality but agreed that it may be better for the Provider Directory to have a link to gain access to this information, as we don't want there to be too much information on one page.

DATA AUDITING
Dr. Warkentin said that the need for steady and ongoing auditing should be reduced as providers are better educated about the need to correct information. Mr. Wilkinson added that carriers are already required to check this every two years, and Mr. Beagan agreed that it's a reflection of what carriers do already. Ms. Stahl said that one of the goals of the Provider Directory is to reduce ghost networks, and auditing is needed to get closer to reducing inaccurate information.

Responding to member complaints about errors in directory
There was general agreement that carriers should make covered persons aware that they should contact the health plan if they find any provider directory information that is incorrect and the carrier should have protocols to promptly contact the provider and attempt to obtain corrected information that can be used to update the directory.

Changing status of provider who does not update directory information
Although other jurisdictions may penalize providers who do not update directory information by excluding them from directories or holding up claims, the Task Force agreed that this was impractical and not a preferred method to ensure compliance, and think one of the best ways to keep providers accountable is to show the date of the late information update. Mr. Katzman said that there should be further ramifications for providers that fail to comply, as it feels like the burden of the Provider Directory accuracy is solely on the carriers, but was willing to agree with the group at this time.

CONSEQUENCES FOR INACCURATE INFORMATION
There was general agreement that patients should be sufficiently educated that if they have trouble with information in the provider directory that they should contact the health plan and if they have trouble finding an appropriate provider, they should request that the health plan to assist them in finding an available provider. Patients should be aware that out-of-network care may be available if in-network care is not available, but they should not go to an out-of-network provider unless their health plan approves or if the Division of Insurance agrees that the carrier has not been helpful to the consumer's request for assistance to find an available in-network provider.

There was general agreement that health plans may be financially responsible if incorrect information in a provider directory leads to a patient's financial liability, when for example, a patients relies on an address that is incorrect, misses an appointment and gets charged a missed appointment charge. These would need to be handled on a case-by-case basis.

Considerations for Next Meeting
Mr. Beagan said that by the next meeting, the report would be complete and the Task Force members would have a chance to discuss it and make changes before it is submitted.

Mr. Beagan entertained a motion made and seconded to adjourn the meeting, which passed unanimously. The meeting was adjourned at 3:20 P.M. on February 18, 2020.

The form of these minutes comports with the requirements of M.G.L. c. 30A, §22(a).

List of Documents Presented at the Meetings
Minutes of the Provider Directory Task Force for the meeting held on February 11, 2020

APPENDIX G

Meeting Minutes of the Provider Directory Task Force
for the Meeting Held on Tuesday, February 25, 2020
held in Conference Room 1-E 1000 Washington Street, Boston, Massachusetts 02118

Members present in person:

Kevin Beagan	Chair, designee for Commissioner of Insurance
Lori Burgiel	Representative for Healthcare Administrative Solutions
Karen Granoff	Representative for the Massachusetts Health and Hospital Association
Michael Katzman	Representative for Blue Cross and Blue Shield of Massachusetts
Elizabeth Leahy	Representative for the Massachusetts Association of Health Plans
Yael Miller	Representative for the Massachusetts Medical Society
David Nefussy	Representative as an expert in the treatment for substance use disorders
William Rennie	Representative for employer groups
Eva Marie Stahl	Representative for consumers
Alyssa Vangeli	Representative of a health consumer advocacy organization
Dr. Jennifer Warkentin	Representative as an expert in the treatment for mental health disorders
Wells Wilkinson	Representative for the Children's Mental Health Campaign

Members participating via phone:

Danna Mauch	Representative for the Massachusetts Association for Mental Health

Call of 6th Meeting to Order by Chairperson Kevin Beagan
A quorum was determined to be present, and the meeting was called to order at 1:07 P.M.

February 18, 2020 Minutes
The draft minutes of the February 18, 2020 minutes were discussed, with edits submitted by several Task Force members. A motion was made and seconded to accept the minutes as amended, which was accepted unanimously.

Review of the Draft Report
Ms. Leahy and Ms. Miller suggested that an appendix should be added that includes a list of the companies that currently use the Council for Affordable Quality Healthcare, Inc. (CAQH) system. Ms. Burgiel said she would provide the Task Force with this list before the next meeting.

Managed Care and Provider Directories
Several Task Force members submitted grammatical and technical edits. There was general consensus regarding these edits, and the Task Force agreed to accept them.

Collecting Provider Information

Common portal
The draft report stated that "The Division is aware that many carriers are planning to use a common portal being developed by CAQH in coordination with work by HealthCare Administrative Solutions, Inc. (HCAS) and Blue Cross Blue Shield of Massachusetts (BCBSMA). Mr. Katzman and Ms. Leahy suggested that the report not specify vendors but rather keep the language general as the goal is to develop a common process, not recommend a specific portal. Ms. Granoff responded that it is important to show the vendors being used right now, even if the vendors change later on. Mr. Beagan suggested that this information be included as a footnote, to which the Task Force agreed.

Entering Facility Information

The draft report states.

> "The Task Force supports that this information should be standardized as noted in the law so that the facility information clearly records the location and telephone number. For hospitals, the information should identify the type of hospital and also its accreditation status. For non-hospital facilities, there should be a list of standard services, and the facility should identify which of those services are performed in that facility."

Mr. Katzman thought the last sentence of this section should be deleted, as this information should only be required for behavioral health facilities. Mr. Beagan referred the Task Force to Chapter 124 of the Acts of 2019 § 4 (c) (iii) (G)

> "The task force shall develop recommendations on establishing: substantially similar processes and timeframes for carriers to include such information in their provider directories when: for a facility other than a hospital, by type of facility, at least 1 of the following has changed: (1) facility name; (2) facility type; (3) types of services performed; and (4) participating facility location and telephone number."

Ms. Burgiel said that it could be a burden for non-hospital facilities to collect such information, and the way it is outlined in the law is too broad. Mr. Nefussy said that some carrier websites list individual clinicians for non-hospital facilities, which is misleading because most clinicians have limited availability at these facilities, and it is common for only a small portion out of all the clinicians listed to be available each day. Ms. Vangeli responded that, in this context, it is important to make a distinction between providers available and services available. Mr. Katzman said that because the law is so vague, it will place a significant burden on carriers to determine exactly what data to collect. He suggested that instead, the provider directory could have a link to non-hospital facility websites.

Mr. Beagan said that this information is more important for behavioral health providers than non-behavioral health providers, and asked the Task Force if they would like to vote on whether the language should be changed to apply to only behavioral health providers. After discussion among the Task Force, Mr. Beagan suggested that instead, the Task Force vote to change "non-hospital facility" to "non-hospital behavioral health center." Ms. Leahy asked how the Task Force would determine what services should be included, and reminded the Task Force that complex data collection raises the cost for carriers.

Mr. Beagan suggested that the Task Force use the same list of behavioral health services as provided in the Taxonomy Report. After discussion among Task Force members, Mr. Beagan amended this suggestion to include the list from Bulletin 2009-11: Access to Intermediate and Outpatient Mental Health & Substance Abuse Disorders. The Task Force unanimously agreed.

Entering provider and provider practice information

The draft report states that,

> "...the portal should be able to capture provider-specific information (e.g. hours open, location). This is important so that patients are aware of a practice's regular hours in case other providers at that practice are available when a provider may be sick or busy."

Ms. Miller suggested that the office practice, rather than the provider, list this availability. Mr. Wilkinson said that determining which hours to list should be at the discretion of the provider. Ms. Granoff said that there will be a large difference between hours provided for a one person practice and a large office, and Ms. Burgiel added that allowing providers to pick which hours to list will lead to confusion. Mr. Katzman said that BCBSMA does not collect office hours at the practice level, and agreed this would be confusing. He reminded the Task Force that the provider directory's purpose is not to help members make appointments.

but to help them find providers that are available. The Task Force agreed to take out the section about collecting hours of operation at the practice level.

Provider availability to take appointments

The report states,

> "The Task Force recommends that a provider be expected to identify whether the provider's panel is (a) full, (b) has limited availability to make appointments; or (c) is open for new patients."

Ms. Miller recommended that "full" should specify that the provider is continuing to take existing patients. Ms. Vangeli and Mr. Wilkinson recommended that instead of saying a provider "has limited availability to make appointments," the report should request providers to report average wait time for an appointment, and that this should be shown as a range to reflect minimum and maximum wait times throughout the year. Mr. Burgiel and Mr. Katzman thought that this would be too much information for providers to calculate, and Dr. Warkentin agreed. Ms. Vangeli suggested the Task Force vote on whether to include average wait time. The Task Force voted to keep the language as is, with three members voting to include average wait time: Ms. Stahl, Ms. Vangeli, and Mr. Wilkinson

The report further states that "the Task Force agrees that the provider practice record should report the day-to-day hours that a practice is open…" There was some discussion on whether "practice" should be changed to "provider," but Dr. Warkentin and Ms. Burgiel said that CAQH specifies that it collects office practice hours for this data, so the Task Force decided to keep the language as is.

The report says that

> "There is general agreement that carriers should collect the exact phone number and physical address of the office, as well as disability access for the location, availability of interpreter services, telehealth capability according to HIPAA standards, and accessibility by public transportation."

Ms. Leahy said that the collection of public transportation is not something currently collected, and that it should be omitted. Mr. Rennie questioned how access to public transportation would be defined, and it was suggested by a Task Force member that it be optional, like several other elements. Mr. Beagan suggested the Task Force vote on whether to include this or not. The Task Force voted to include this optionally, with four dissenting votes: Ms. Burgiel, Mr. Katzman, Ms. Leahy, and Mr. Rennie.

Next, the report states that

> "the provider should highlight certain populations served, consistent with what is collected by the MassCollaborative and in line with the recommendations of the Taxonomy Commission and MassHealth, including for example whether the provider is available for certain cultural groups, veterans, deaf/hard-of-hearing, or LBGTQ patients."

Ms. Leahy said that the Mass Collaborative form, the Taxonomy Commission report, and MassHealth recommend these elements only for behavioral health providers, and the Task Force should do the same for consistency. Mr. Katzman agreed, and said that this could be misinterpreted by members if included for non-behavioral health providers. The Task Force agreed to keep this section but highlighted that it is optional for providers to fill out. Ms. Granoff suggested the term "certain populations" be changed to "special populations" so that members don't think it is exclusive to the populations listed. The Task Force accepted this change.

The report also states that "Providers may also be asked to identify their race, ethnicity, or religion." Ms. Miller, Mr. Katzman, Ms. Leahy, and Ms. Burgiel thought this should be omitted, as not only could it be misinterpreted, but it also includes data that is not currently collected or captured in CAQH. Ms. Granoff suggested that the Task Force recommend this to be optional, and Mr. Katzman said that, if included, should

only be for behavioral health providers. He also said that even if it is optional, it could put pressure on providers to feel as though they must include it if other providers do. Ms. Stahl said that people of color often benefit from having doctors of color.

The Task Force agreed to omit the option to provide religion, and confirmed that ethnicity and race is optional. Upon the suggestion of Mr. Beagan, the Task Force voted on whether optionally listing ethnicity and race should be limited to behavioral health providers. The majority of the Task Force voted that it should not be limited to behavioral health providers, with four members voting to include the limitation: Ms. Burgiel, Mr. Katzman, Ms. Leahy, and Mr. Rennie.

Next, the report says that, "The Task Force agrees that the provider should identify their licensure, all relevant board certifications, education, and, for doctors who practice in hospitals, the hospital in which they have admitting privileges." Mr. Wilkinson suggested that this section should include specialty training. Dr. Warkentin questioned how specialty training would be defined, and Mr. Wilkinson withdrew his suggestion.

The report also says that "…providers should identify any limitations on their practice, including whether they will only treat patients on their concierge medicine panel, or only patients within their provider organization, or only patients referred by other affiliation organizations." Ms. Miller recommended that instead of saying providers can only see patients within their provider organization, it should say that practices should report that they may have limitations based on their hospital system affiliation. The Task Force agreed to this change.

Mr. Wilkinson suggested that limitations should include providers that only see patients on an inpatient basis, and this could be contextualized for only behavioral health providers. The Task Force voted on whether to include this specification, with nine members voting for the change, three opposing, and one abstaining.

Updating Provider Information
The report stated that "some carrier contracts indicate that providers send notice of certain changes at least 60 days in advance." Mr. Rennie said the time specification should be omitted as this may not be the same for all carriers and could change in the future. The Task Force agreed.
The report says that "it is suggested that providers who don't regularly update information have a date on which those providers' information was last updated." Dr. Warkentin suggested this be amended to say "to indicate whether a provider has not attested and/or updated information in the past six months." The Task Force accepted this change.

Considerations for Next Meeting
The time elapsed before the Task Force could complete a review of the draft report. Mr. Beagan suggested they meet during the week of March 2, 2020 to complete the review, which the Task Force agreed to.

A motion was put forth and seconded to adjourn the meeting, which passed unanimously. The meeting was adjourned at 3:40 P.M on February 25, 2020.

The form of these minutes comports with the requirements of M.G.L. c. 30A, §22(a).

List of Documents Presented at the Meetings
- Minutes of the Provider Directory Task Force for the meeting held on February 18, 2020
- Draft Provider Directory Task Force Report

APPENDIX H

Meeting Minutes of the Provider Directory Task Force
for the Meeting Held on Thursday, March 12, 2020
held via phone

Members present via phone:

Kevin Beagan	Chair, designee for Commissioner of Insurance
Lori Burgiel	Representative for Healthcare Administrative Solutions
Karen Granoff	Representative for the Massachusetts Health and Hospital Association
Michael Katzman	Representative for Blue Cross and Blue Shield of Massachusetts
Elizabeth Leahy	Representative for the Massachusetts Association of Health Plans
Yael Miller	Representative for the Massachusetts Medical Society
David Nefussy	Representative as an expert in the treatment for substance use disorders
William Rennie	Representative for employer groups
Alyssa Vangeli	Representative of a health consumer advocacy organization
Dr. Jennifer Warkentin	Representative as an expert in the treatment for mental health disorders
Wells Wilkinson	Representative for the Children's Mental Health Campaign

Members not present

Danna Mauch	Representative for the Massachusetts Association for Mental Health
Eva Marie Stahl	Representative for consumers

Call of 7th Meeting to Order by Chairperson Kevin Beagan
A quorum was determined to be present, and the meeting was called to order at 1:07 P.M.

February 18, 2020 Minutes
The draft minutes of the February 18, 2020 minutes were discussed. A motion was made and seconded to accept the minutes as amended, which was accepted unanimously.

February 25, 2020 Minutes
The draft minutes of the February 25, 2020 minutes were discussed, with edits submitted by several members. A motion was made and seconded to accept the minutes as amended, which was accepted unanimously.

Review of the Draft Report

Executive Summary

Presenting information
The draft report states that "provider directories should present information in a searchable way based on the following characteristics: … provider's availability on evenings and weekends."
Ms. Granoff recommended that it should list practice, not provider availability. After deliberation, the Task Force decided to vote on carriers being required to show practice availability and have the option to show provider availability, as opposed to both practice and provider availability being required. The majority of the Task Force voted for provider availability to be optional, supported by Mr. Katzman, Mr. Miller, Ms. Granoff, Ms. Burgiel, Mr. Nefussy, Mr. Rennie, and Ms. Leahy.

The draft report also states that "a non-facility provider's profile should include the following information: …whether provider's panel is full, limited availability, or open availability."

Ms. Granoff. Ms. Burgiel. and Ms. Miller raised concerns about including this language in the report without providing clear definitions. Mr. Began suggested that instead of deciding on standardized definitions. the report include a footnote stating that clear definitions will be included in the regulation but won't be decided by the Task Force. The Task Force agreed to include this edit.

Collecting Provider Information

Provider availability to take new patients
The draft report states that "the Task Force members agree that provider organizations should identify any limitations on their practice. including whether they will only treat patients on their concierge medicine panel. or only patients within their provider organization. or whether referrals are dependent on their provider organization.
The Task Force had differing opinions on whether to omit the last section of this section. and a vote was taken. The Task Force decided to omit this section. with Ms. Granoff. Mr. Katzman. Ms. Miller. Ms. Burgiel. Mr. Rennie. and Ms. Leahy voting to strike it.

Updating Provider Information

Mr. Wilkinson proposed to add that priorities for real-time updates should be: 1) whether the provider's panel is closed or open to new patients: 2) the accuracy of the telephone number and location: and 3) whether the plan is accepted by the provider. The Task Force agreed to this addition.

Next. Mr. Wilkinson suggested that "carriers should test the accuracy of information submitted by provider attestations on a quarterly basis: by comparing 2% of the attestations received in the prior 120 days with the related information or changes in their provider directories." Ms. Leahy suggested this only be relevant to behavioral health providers. which the Task Force agreed with.

Lastly. Mr. Wilkinson suggested that:

> "the Task Force recommends that the Division adopt standards for carriers to train their customer service staff regarding how to process reports of issues about Provider Directories and Provider network access. including member complaints. to the appropriate carrier staff for investigation and correction of Directory inaccuracies. Similarly. the Task Force recommends that the Division adopt standards for providers to immediately notify carriers when they are not accepting new patients."

The Task Force agreed to accept this recommendation.

Mr. Katzman suggested that the two latter recommendations be moved to the auditing section of the report. which the Task Force also agreed to.

Mr. Wilkinson requested that the Division issue regulations or guidance clarifying how the provider duty to notify the carrier that they are not accepting new patients. in response to receiving a call from a plan member seeking to become a new patient. under
Ch. 124 §4(c)(iii)(B). intersects with the carrier's timeline for updating information regarding ability to accept new patients. The Task Force agreed with this recommendation.

Attorney General's AODs

Several Task Force members voiced their concerns about the filing of AODs recently that offer conflicting recommendations to the Task Force on provider directories. Mr. Beagan assured the Task Force that he was spoken to the Attorney General's office about this. and they said they would still consider the recommendations of the Task Force's report in the future. Mr. Beagan suggested the Task Force not make any changes to the recommendations they have already agreed to.

The form of these minutes comports with the requirements of M.G.L. c. 30A. §22(a).

List of Documents Presented at the Meetings

- Minutes of the Provider Directory Task Force for the meeting held on February 18. 2020
- Minutes of the Provider Directory Task Force for the meeting held on February 25. 2020
- Draft Provider Directory Task Force Report

APPENDIX I

Meeting Minutes of the Provider Directory Task Force
for the Meeting Held on Thursday, March 19, 2020
held via phone

Members present via phone:

Kevin Beagan	Chair, designee for Commissioner of Insurance
Lori Burgiel	Representative for Healthcare Administrative Solutions
Karen Granoff	Representative for the Massachusetts Health and Hospital Association
Michael Katzman	Representative for Blue Cross and Blue Shield of Massachusetts
Elizabeth Leahy	Representative for the Massachusetts Association of Health Plans
Danna Mauch	Representative for the Massachusetts Association for Mental Health
Yael Miller	Representative for the Massachusetts Medical Society
David Nefussy	Representative as an expert in the treatment for substance use disorders
William Rennie	Representative for employer groups
Eva Marie Stahl	Representative for consumers
Alyssa Vangeli	Representative of a health consumer advocacy organization
Dr. Jennifer Warkentin	Representative as an expert in the treatment for mental health disorders
Wells Wilkinson	Representative for the Children's Mental Health Campaign

Call of 8th Meeting to Order by Chairperson Kevin Beagan
A quorum was determined to be present, and the meeting was called to order at 2:05 P.M. Mr. Rennie arrived at 2:15, and Dr. Warkentin left the meeting at 2:50 P.M.

March 12, 2020 Minutes
The draft minutes of the March 12, 2020 minutes were discussed. A motion was made and seconded to accept the minutes as amended, which was accepted unanimously.

Review of the Draft Report

Updating provider information
Ms. Leahy added the following paragraph after the end of the March 12, 2020 meeting:

It is further recommended that plans who have received notice of potentially inaccurate information through a consumer, provider, or audit and who are unable to validate the accuracy of the listing take the following steps:

4. *If the potential inaccuracy relates to the physical address or telephone number of the provider, the information be immediately removed from the online directory until the information is updated or be designated as "unverified" for 90 days, after which the information must be immediately removed;*
5. *If the potential inaccuracy relates to whether a provider is accepting new patients, the plan shall remove the designation "accepting new patients" for that provider until the information is updated;*
6. *If the potential inaccuracy relates to whether a provider is or continues to be an in-network provider, the plan shall remove the full provider listing from the online directory until it is updated.*

The Task Force accepted this addition.

Presenting provider information
Certain members of the Task Force wanted to add a footnote highlighting that each new search adds an additional cost for the health plans. Ms. Burgiel wanted to remind the Task Force that making changes to CAQH is a process that requires several steps. She said that it is difficult for HCAS to develop a timeline of how long it will take to implement all the changes until the report is finalized.

Auditing provider information
Mr. Wilkinson added the following:

The Task Force recommend that the Division require carriers undertake to audit their provider information on an annual basis as follows:

- *c. Consistent with agreements from the Attorney General's office, behavioral health providers should be audited on a quarterly basis, targeting no less than 15% of all behavioral health providers who have not submitted a claim or an attestation to the carrier in the last 12 months. This audit would be repeated each quarter, excluding all behavioral health providers who have been audited in the last 12 months, or that have been removed from the provider directory. All carriers should plan to audit 100% of their auditable behavioral health providers each year. In the event that three successive quarterly audits demonstrate that at least 85% of the auditable behavioral health providers are listed in a manner that is 100% accurate, the carrier may shift to performing these audits on a semi-annual basis.*
- *d. Non-behavioral health providers should be audited on an annual basis.*

Although initially more information was included about auditing non-behavioral health providers, the Task Force decided to leave the specifications to the discretion of the Regulation.

Consequences for incorrect information
Mr. Wilkinson added the following:

Per statutory requirements, carriers must include in both the electronic and print formats of the provider directory a dedicated customer service email address and telephone number or electronic link that insured, providers and the general public may use to notify the carrier of inaccurate provider directory information. This customer service information must be disclosed prominently in the provider directory and on the carrier's website.

The Task Force agreed to this addition.

Timeline
Mr. Wilkinson provided the Task Force with a proposed timeline for the implementation of these changes to the provider directories. The Task Force voiced concerns about listing exact dates given the outbreak of COVID-19 and resulting delays, and decided to revisit this topic at the next meeting.

The form of these minutes comports with the requirements of M.G.L. c. 30A. §22(a).

List of Documents Presented at the Meetings

- Minutes of the Provider Directory Task Force for the meeting held on March 12, 2020
- Draft Provider Directory Task Force Report

APPEXDIX J

Meeting Minutes of the Provider Directory Task Force
for the Meeting Held on Friday, March 27, 2020
held via phone

Members present via phone:

Kevin Beagan	Chair, designee for Commissioner of Insurance
Lori Burgiel	Representative for Healthcare Administrative Solutions
Karen Granoff	Representative for the Massachusetts Health and Hospital Association
Michael Katzman	Representative for Blue Cross and Blue Shield of Massachusetts
Elizabeth Leahy	Representative for the Massachusetts Association of Health Plans
Yael Miller	Representative for the Massachusetts Medical Society
David Nefussy	Representative as an expert in the treatment for substance use disorders
William Rennie	Representative for employer groups
Eva Marie Stahl	Representative for consumers
Alyssa Vangeli	Representative of a health consumer advocacy organization
Dr. Jennifer Warkentin	Representative as an expert in the treatment for mental health disorders
Wells Wilkinson	Representative for the Children's Mental Health Campaign

Members not present:

Danna Mauch	Representative for the Massachusetts Association for Mental Health

Call of 9th Meeting to Order by Chairperson Kevin Beagan
A quorum was determined to be present, and the meeting was called to order at 2:10 PM.

March 12, 2020 Minutes
The Task Force reviewed the final version of the March 12, 2020 minutes. A motion was made and seconded to accept the minutes, which was accepted unanimously.

March 19, 2020
The draft minutes of the March 19, 2020 minutes were discussed. A motion was made and seconded to accept the minutes as amended, which was accepted unanimously.

Review of the Draft Report

The Task Force recommended edits to the draft report. The edits focused on clarifying certain sections of the draft report and making grammatical changes. There were no major edits to the content of the report.

Timeline
The statutory mandate under Chapter 124 requires the Task Force to recommend a timeline within the final report. At the last Task Force meeting, Mr. Wilkinson shared a timeline with the other members of the Task Force. Several Task Force members continued to express concern about including statutory deadlines given the COVID-19 crisis. Ms. Granoff and Mr. Beagan suggested that the report include a statement addressing the crisis and that there are more immediate consumer responsibilities carriers have, and that the timeline be revisited once the emergency is over. Dr. Warkentin suggested that provider education can start in the meantime, which other Task Force members agreed with. Mr. Katzman said that BCBS is moving ahead with the implementation of a centralized portal, and work on the portal will continue during the crisis. Ms. Leahy agreed that while some plans may be able to continue working on developing their provider directory during the crisis, others may not be able to. Ms. Burgiel said that HCAS is able to continue working on the CAQH

system during this time and there would not be a slow-down in the work done on the provider-directory portal. Mr. Wilkinson agreed to withdraw the request to include a timeline within the report.

Mr. Beagan suggested the Task Force review the final edits to the report and meet one more time to go over any other changes. A motion was made by Mr. Beagan to adjourn the meeting, which passed unanimously. The meeting was adjourned at 3:00 P.M. on Friday, March 27, 2020.

The form of these minutes comports with the requirements of M.G.L. c. 30A. §22(a).

List of Documents Presented at the Meetings

- Minutes of the Provider Directory Task Force for the meeting held on March 12, 2020
- Minutes of the Provider Directory Task Force for the meeting held on March 19, 2020
- Draft Provider Directory Task Force Report

APPENDIX K

Health Plans that use DirectAssure from CAQH

Aetna
AllWays Health Partners, Inc.
Beacon Health Options
Blue Cross Blue Shield of Massachusetts
Boston Medical Center HealthNet
Capital District Physicians Health Plan
Centene
Cigna
Evolve Benefit Options
Fallon Community Health Plan
Harvard Pilgrim Health Care
Health New England
Humana
Molina Healthcare
Tufts Health Plan
United Healthcare

APPENDIX L

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
One South Station • Boston, MA 02110-2208
(617) 521-7794 • FAX (617) 521-7758
http://www.mass.gov/doi

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

GREGORY BIALECKI
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

BARBARA ANTHONY
UNDERSECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION

NONNIE S. BURNES
COMMISSIONER OF INSURANCE

BULLETIN 2009-11

TO: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations

FROM: Nonnie S. Burnes, Commissioner of Insurance
Barbara A. Leadholm, Commissioner of Mental Health

DATE: September 4, 2009

RE: Access to Intermediate and Outpatient Mental Health & Substance Use Disorder Services

The purpose of this Bulletin is to clarify mandated benefits for immediate and outpatient services for mental health and substance use disorders as required by Chapter 80 of the Acts of 2000 and Chapter 256 of the Acts of 2008. Please refer also to Division of Insurance Bulletins 2000-10, 2002-07, 2003-11, and 2009-04.

Mental Health & Substance Use Disorders[18]

In accordance with the above-noted Acts, health plans offered under M.G.L. chapters 175, 176A, 176B, and 176G (hereinafter referred to as insured health plans[19]), must include coverage for a range of inpatient, intermediate and outpatient mental health services for the treatment of mental health disorders so that medically necessary and active, noncustodial treatment may take place in the least restrictive clinically appropriate setting.

[18] For purposes of this Bulletin, all subsequent references to mental health disorders and services includes substance use disorders and services.
[19] An insured health plan is one that is offered by a licensed health carrier through which the carrier assumes the risk to pay the cost of specified medically necessary health treatment(s) in return for the receipt of premiums.

As used above, "mental health disorders" means mental health disorders as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association ("DSM").

Mental health services required to be covered by insured health plans are those that diagnose and/or treat an illness, disease or health condition in order to reduce or alleviate symptoms and/or improve an individual's emotional or behavioral functioning. Educational services to improve an individual's academic performance or developmental functioning are not required services under the benefit mandate for mental health services. *For example, mandated services for a child who has frequent tantrums would include coverage for treatment sessions with appropriate mental health professionals to address the child's emotional issues in order to reduce symptoms and improve the child's emotional functioning.* The treatment sessions could be with the child and/or with parent(s) and/or other caregivers.

Medical Necessity

Pursuant to M.G.L. c. 1760, §16(b), insured health plans are required to cover health care services if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. Insured health plans that are accredited by the Division of Insurance as managed care companies under M.G.L. c. 1760 may employ utilization review systems in making decisions about whether services are medically necessary. Utilization review is defined in M.G.L. c. 1760 as "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings."
An insured health plan must consider the individual health care needs of the insured in applying such guidelines. In accordance with M.G.L. c. 1760, an individual may appeal a decision by his or her health plan to reduce or modify a request for authorization of covered intermediate care based on the health plan's medical necessity criteria.

Levels of Service

Inpatient Services - 24-hour services, delivered in a licensed general hospital, a psychiatric hospital or a substance abuse facility, that provide evaluation and treatment for an acute psychiatric condition or substance use diagnosis, or both.

Intermediate Services - A range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate Services, include, but are not limited to, the following:

> *Acute and other residential treatment*[20] - Mental health services provided in a 24-hour setting, with clinical staff and appropriately trained professional and

[20] Community Based Acute Treatment (CBAT) is an example of a program that falls within this definition.

paraprofessional staff to insure safety for the individual, while providing active treatment and reassessment.

Clinically managed detoxification services - 24 hour, seven days a week, clinically managed detoxification services in a licensed non-hospital setting that include 24 hour per day supervision, observation and support, and nursing care, seven days a week.

Partial hospitalization - Short-term day/evening mental health programming available five to seven days per week. These services consist of therapeutically intensive acute treatment within a therapeutic milieu and include daily psychiatric management.

Intensive Outpatient Programs (IOP) – Multimodal, inter-disciplinary, structured behavioral health treatment provided over the course of two to three hours per day for multiple days per week in an outpatient setting. Includes, but is not limited to, diagnosis, evaluation and treatment of mental health and substance use disorders.

Day treatment[21] - Services based on a planned combination of diagnostic, treatment and rehabilitative approaches to a person with mental illness or substance use disorder who needs more active or intensive treatment. Day treatment programs encompass generally some portion of a day or week rather than a weekly visit to a mental health clinic, individual provider's office or hospital outpatient department. The individual does not need 24-hour hospitalization or partial hospitalization.

Crisis stabilization -Short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services.

In-home therapy services[22] - An intensive combination of diagnostic and treatment interventions delivered in the home and community to a youth and family designed to sustain the youth in his or her home and/or to prevent the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other psychiatric treatment setting.

The following are not considered intermediate services and are not required to be covered by an insured health plan:

[21] Structured Outpatient Addiction Program (SOAP). SOAP/Enhanced and Psychiatric and Enhanced Psychiatric Day Treatment are examples of programs that fall within this definition.
[22] Family Stabilization (FST) is an example of a program that falls within this definition.

- Programs in which the patient has a pre-defined duration of care without the health plan's ability to conduct concurrent determinations of continued medical necessity for an individual.
- Programs that only provide meetings or activities that are not based on individualized treatment planning.
- Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to amelioration of specific psychiatric symptoms or syndromes.
- Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. The health plan must provide coverage for medically necessary outpatient or intermediate services provided while the individual is in the program, subject to the terms of the member's evidence of coverage including any network requirements or co-payments/coinsurance provisions.
- Programs that provide primarily custodial care services.

Outpatient services[23] - Services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office or home-based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional (a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist) acting within the scope of his/her license.

Services Provided in an Intermediate Care Setting

In a particular case, a health plan may determine that a specific level of intermediate care is not medically necessary but instead the plan indicates it would provide coverage for outpatient services or a different level of intermediate care. If, despite such determination, the patient elects to receive the originally requested intermediate care, the health plan must provide coverage for any medically necessary outpatient services or other authorized level of intermediate care provided while the individual is in the intermediate care setting, subject to the terms of the member's evidence of coverage including any network restrictions or co-payment/coinsurance provisions. Medically necessary outpatient or other intermediate services may not be prohibited by a health plan simply because the patient is receiving non-authorized intermediate care. These outpatient services or other intermediate care services may be reviewed under the health plan's concurrent review system.

[23] Ambulatory detoxification services, cognitive behavioral therapy, and dialectical behavioral therapy are examples of services that fall within this definition.

For example, a patient requests coverage in a residential facility. The health plan determines that residential treatment is not medically necessary but would cover outpatient therapy or partial hospitalization. If the patient chooses to proceed with the residential placement, the health plan must cover any authorized medically necessary outpatient therapy or partial hospital sessions if the care is billed separately and otherwise meets any network requirements.

Level of Benefits for Intermediate Care Services

The duration of intermediate care services authorized for any particular individual will vary according to that person's individual needs. Because Chapter 80 of the Acts of 2000 and Chapter 256 of the Acts of 2008 do not specify a minimum benefit for intermediate care, authorizations for intermediate care should be based on medical necessity rather than any arbitrary number of days or number of visits. Additionally, the authorization of benefits for intermediate care shall not affect the minimum benefits mandated for inpatient care (60 days) or outpatient visits (24) for non-biologically based conditions.

If you have any questions regarding this bulletin, please call Nancy Schwartz at (617) 521-7347.

APPENDIX M

Mass Collaborative Provider Information Change Form

STANDARDIZED PROVIDER INFORMATION CHANGE FORM

COMPLETE ALL APPLICABLE INFORMATION. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.
NOT FOR NEW PROVIDERS OR CONTRACTUAL OR CREDENTIALING CHANGES.

***1. INDICATE CHANGE(S) BEING SUBMITTED:** *(Check all that apply — please include effective date for each item checked.)*
**Section required.*

	Effective date		Effective date
☐ Practice information *(Complete sections 2, 3, 6)*		☐ Practice status *(Complete sections 2, 4, 6)*	
☐ Billing information *(Complete sections 2, 3, 6)*		☐ Termination *(Complete sections 2, 5, 6)*	
☐ Provider name *(Complete sections 2, 6)*			

Indicate documents included: ☐ W9 ☐ Provider Roster ☐ Other _____

PLEASE COMPLETE THE APPLICABLE SECTIONS BELOW TO UPDATE YOUR INFORMATION.
IF CHANGING TAX INFORMATION, YOU ARE REQUIRED TO SUBMIT AN UPDATED W9 WITH THIS FORM.

***2. PROVIDER INFORMATION** **Section required.*

Provider Last Name:	First Name:	MI:	Credential:
Provider Former Name *(if applicable)*:			
NPI#:	Medicaid ID# *(if applicable)*:	PTAN# *(if applicable)*:	TAX ID#:	Gender:
Provider type: ☐ Substance Use Provider ☐ PCP ☐ Specialist ☐ Hospitalist only ☐ Ancillary/Allied/Mid-Level ☐ Behavioral Health Provider ☐ Moonlighting/Covering			
Practice/Business name:			
Institutional Affiliation:			
Street:			
City:	State:	Zip:	
Phone:	Fax:		
Provider Email Address:	Provider Website:		
Board Certification 1:	Board Certification 2:		

IF APPLICABLE, PLEASE ATTACH A SEPARATE LIST WITH THE NAMES AND NPI NUMBERS OF ALL OF THE PROVIDERS IN THIS GROUP FOR WHOM THE ADDRESS CHANGE IS APPLICABLE.

3. ADDRESS INFORMATION

ENTER NEW OR ADDITIONAL ADDRESSES BELOW		ENTER DATA THAT IS NO LONGER APPLICABLE	
Address type: ☐ Primary ☐ Billing ☐ Secondary ☐ Mailing		Address type: ☐ Primary ☐ Billing ☐ Secondary ☐ Mailing	
Address line 1:	Suite #:	Address line 1:	Suite #:
Address line 2:	Suite #:	Address line 2:	Suite #:
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
☐ Suppress Address		☐ Suppress Address	
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Provider or Office Staff:		Languages Spoken by Provider or Office Staff:	
Address type: ☐ Primary ☐ Billing ☐ Secondary ☐ Mailing		Address type: ☐ Primary ☐ Billing ☐ Secondary ☐ Mailing	
Address line 1:		Address line 1:	
Address line 2:		Address line 2:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
Office Hours:	Disability Access: ☐ Yes ☐ No	Office Hours:	Disability Access: ☐ Yes ☐ No
Languages Spoken by Provider or Office Staff:		Languages Spoken by Provider or Office Staff:	

Contact person completing form: _____ Phone: _____

continued on next page

Field Code Changed

STANDARDIZED PROVIDER INFORMATION CHANGE FORM (*CONTINUED*)

Provider Name: _____

4. PRACTICE STATUS: *May be impacted by contract terms and follow-up may be required.*

Practitioner availability status:

- ☐ Accepting new patients
- ☐ Accepting existing patients only
- ☐ Closed *(not accepting new patients and not accepting existing patients)*
- ☐ Concierge practice
- ☐ Skilled nursing facilities
- ☐ Other *(please specify)*: _____

Do you offer telemedicine/telehealth (i.e., video visits)? ☐ Yes ☐ No

Do you offer lactation counseling services? ☐ Yes ☐ No

5. TERMINATION: *Effective date may be impacted by contract terms and follow-up may be required.*

Reason for termination, please check only one box:

- ☐ Resigned
- ☐ Retired
- ☐ Deceased
- ☐ Leave of absence*
- ☐ Moved out-of-state
- ☐ Practice closed
- ☐ Provider sanctioned*
- ☐ Sabbatical*
- ☐ Provider transferred to *(group name)*: _____
- ☐ Other _____

*Please provide a separate explanation of the details to the plan (i.e., duration of absence for leave/sabbatical or sanction details).

6. CONTACT PERSON SUBMITTING INFORMATION: **Section required*

Name:	Title:
Phone:	Fax:
Email:	
Date of submission:	

7. BEHAVIORAL HEALTH PROVIDERS:
Please indicate your areas of practice, treatment methods, and ages and populations served.

Areas of Practice		Modalities/Treatment Methods	Ages
☐ ACOA/codependence	☐ Immigrant/refugee issues	☐ Ambulatory detox	☐ Children under age 6
☐ Adoptee	☐ Infertility	☐ Applied behavioral analysis	☐ Children ages 6-12
☐ Adopting parents	☐ Internet addictions	☐ Behavioral therapy	☐ Adolescents 13-18
☐ AIDS/HIV	☐ Medical illness/diagnosis MGMT	☐ CBT	☐ Adults 18-64
☐ Anger issues	☐ Military/veterans issues	☐ Couples therapy	☐ Geriatric 65+
☐ Anxiety disorders	☐ Multicultural issues	☐ Dialectical behavioral therapy	**Populations Served**
☐ Attention deficit/hyperactivity disorder	☐ Obsessive-compulsive disorders	☐ ECT	☐ Disabled
☐ Autism spectrum disorders	☐ Opioid use disorders	☐ EMDR	☐ First responders
☐ Bariatric counseling/obesity	☐ Panic/phobias	☐ Faith-based counseling	☐ Health care population
☐ Bipolar disorder	☐ Personality disorders	☐ Family therapy	☐ Hearing impairment
☐ Chronic mental disorders	☐ Physical abuse	☐ Group therapy	☐ Homebound
☐ Chronic pain	☐ Pregnancy/postpartum/loss	☐ Hypnotherapy	☐ LGBTQ
☐ Conduct/oppositional defiant disorders	☐ Psychotic disorders	☐ MAT for substance use disorders	☐ Nursing home patients
☐ Depressive disorders	☐ PTSD	☐ Neuropsych assessment	☐ Refugees/immigrants
☐ Developmental disabilities	☐ Sexual abuse	☐ Pain management services	☐ Veterans, military
☐ Disability management	☐ Sexual addictions	☐ Play therapy	☐ Visual impairment
☐ Domestic violence	☐ Sexual dysfunction	☐ Psychological assessment	
☐ Dual diagnosis	☐ Sleep disorders	☐ Suboxone/buprenorphine prescribing	
☐ Eating disorders	☐ Substance use disorders	☐ Transcranial magnetic stimulation	
☐ First responder issues	☐ Trauma		
☐ Gambling addictions			
☐ Gender identity/sexuality issues			
☐ Grief counseling			

2

Massachusetts Collaborative – Standardized Provider Information Change Form — August 2018

APPENDIX N

MassHealth Behavioral Health Special Experience, Skills, and Training Questions

Special Experience, Skills and Training

Please select one or more special experience, skills and training that apply from the list below:

- Adolescents
- Anger Issues
- Anxiety
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorders
- Bipolar Disorder
- Blindness Or Visual Impairment
- Children
- Children in the Care or Custody of DCF (Department of Children and Families)
- Child Welfare
- Chronic Illness
- Co-occurring Disorders
- Deafness Or Hard of Hearing
- Depression
- Dialectical Behavioral Therapy (DBT)
- Gender Identity Disorder
- Geriatric Behavioral Health
- Group Therapy
- Homelessness
- Other
- HIV/AIDS
- Lesbian, Gay, Bisexual, Transgender (LGBT) Issues
- Marriage and Family Therapy
- Medical Illness and Therapy
- Medication Management and Therapy
- Neuropsychological Testing (Adolescents)
- Neuropsychological Testing (Children)
- Obsessive Compulsive Disorder (OCD)
- People with Disabilities
- Physical Disabilities
- Play Therapy
- Postpartum Depression and or Psychosis
- Psychological Testing (Adolescents)
- Psychological Testing (Children)
- Serious Mental Illness
- Sleep Disorders
- Substance Abuse
- Trauma
- Youth Affiliated with DYS (Department of Youth Services) Either Detained or Committed

APPENDIX O

Taxonomy Commission Legislative Report

Executive Office of Health and Human Services

March 2019

TABLE OF CONTENTS

Legislative Mandate

Chapter 208 of the Acts of 2018

An Act for Prevention and Access to Appropriate Care and Treatment of Addiction

SECTION 102. There shall be a commission to review evidence-based treatment for individuals with a substance use disorder, mental illness or co-occurring substance use disorder and mental illness. The commission shall recommend taxonomy of licensed behavioral health clinician specialties. Notwithstanding any general or special law to the contrary, the taxonomy of licensed behavioral health clinician specialties may be used by insurance carriers to develop a provider network. The commission shall recommend a process that may be used by carriers to validate a licensed behavioral health clinician's specialty.

The commission shall consist of 11 members: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of insurance or a designee; and 9 persons to be appointed by the secretary of health and human services, 1 of whom shall have expertise in the treatment of individuals with a substance use disorder, 1 of whom shall have expertise in the treatment of adults with a mental illness, 1 of whom shall have expertise in children's behavioral health, 1 of whom shall be an emergency medicine expert with expertise in the treatment of addiction, 1 of whom shall be a hospital medicine expert with expertise in the treatment of addiction, 1 of whom shall be a licensed behavioral health clinician, 1 of whom shall be a representative of the National Association of Social Workers, Inc., 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., and 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc. The secretary may appoint additional members who shall have expertise to aid the commission in producing its recommendations.

The commission shall file a report of its findings and recommendations, together with drafts of legislation necessary to carry those recommendations into effect, with the clerks of the senate and the house of representatives not later than 180 days after the effective date of this act.

Introduction

The Commonwealth of Massachusetts ranks high among states on behavioral health care quality and access measures.[1] The Commonwealth also has among the highest number of primary care physicians (PCPs) and psychiatrists per capita.[2,3,4] However, despite the relatively high number of behavioral health providers on a per capita basis as compared nationally, patients and their families experience significant challenges accessing behavioral health services.[5] One factor inhibiting timely access to behavioral health services is the lack of available and accurate information about providers and specific treatments offered.[6]

There are several factors that contribute to gaps and inaccuracies in information. First, there is a lack of easily identifiable or verifiable sub-specialization among behavioral health professionals. Unlike physicians, who have formally licensed specialties (e.g., dermatologist, cardiologist), most behavioral health providers do not have a professional designation other than their academic degree. In fact, providers with different degrees may all provide the same types of care, resulting in confusion among consumers as to which providers are most appropriate for the care they are seeking. This makes it difficult, for example, for a parent trying to find a provider with appropriate expertise for their child with autism because there is no standard designation for a provider to indicate a specialization in autism spectrum disorder or a focus in children and adolescents.

Second, some providers may believe they are incentivized to indicate as many specialties as possible on carrier credentialing applications in order to increase their likelihood of being accepted into a carrier's network; providers who indicate that they can treat certain individuals, in practice may not. Because the information on provider applications is used to populate a carrier's provider directory, this often results in the carrier's network and provider directory reflecting a greater number of available providers and specialties than are actually available. This practice particularly impacts families who are trying to find care for children and adolescents, and other populations in need of highly specialized treatment.

[1] Health System Data Center, Explore Regional Performance, "Massachusetts State Health System Ranking," available at http://datacenter.commonwealthfund.org/scorecard/state/23/massachusetts/

[2] Association of American Medical Colleges, "2017 State Physician Workforce Data Report," November 2017, available at https://members.aamc.org/eweb/upload/2017%20State%20Physician%20Workforce%20Data%20Report.pdf

[3] American Academy of Child & Adolescent Psychiatry, "Workforce Maps by State," available at www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

[4] Bureau of Health Workforce, Health Resources and Services Administration, U.S. Department of Health and Human Services, "Designated Health Professional Shortage Areas Statistics: Fourth Quarter of Fiscal Year 2018 Designated HPS A Quarterly Summary," as of September 30, 2018, available at https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false

[5] The State of Mental Health in America 2018, available at http://www.mentalhealthamerica.net/issues/state-mental-health- america-2018

[6] Blue Cross Blue Shield Foundation Massachusetts, "Access to Outpatient Mental Health Services in Massachusetts," October 2017

A 2018 Division of Insurance (DOI) special examination into this issue found that information in carriers' provider directories is often not completely accurate, including for behavioral health providers. The examination found that among 14 health insurance carrier groups, (1) of the sample of behavioral health providers who had not submitted a claim in 2015, 36-71% of provider information was not completely accurate, (2) most behavioral health care clinicians' subspecialties are self-reported and cannot be regularly and independently verified by carriers, and (3) the majority of behavioral health subspecialties are not subject to licensure or certification that would enable a carrier to use a state or national licensing board for validation.[7]

This lack of accurate and standardized provider information leaves many consumers and their families not knowing what services are available, or where they can access them. Attempts to use provider directories often result in consumers contacting listed providers who do not actually treat that consumer's particular condition or diagnosis, age, or provide the treatment modality that the consumer is seeking. Although the DOI issued Bulletin 2018-06 to require carriers to assist consumers to locate and obtain appointments with in-network providers[8], directory inaccuracies can lead to delays in treatment, individuals seeking care in the emergency department, or individuals foregoing needed care altogether. A 2017 Blue Cross Blue Shield of Massachusetts Foundation report indicates that this is particularly true for children and adolescents, MassHealth members, and individuals needing specialty treatment, who were shown to experience longer wait times for behavioral health appointments than the general population.[6]

[7] Massachusetts Division of Insurance, "Summary Report: Market Conduct Exam, Reviewing Health Insurance Carriers' Provider Directory Information," June 2018

[8] DOI Bulletin 2018-06, available at https://www.mass.gov/files/documents/2018/10/02/Bulletin%202018-06%20%28Accessing%20Care%29.pdf

Commission Overview

The Taxonomy Commission, established in August 2018 with the enactment of Chapter 208 of the Acts of 2018, was created to address the incongruities and information gaps that exist in the current behavioral health system. The 11-member Commission was charged with: **(1) recommending a taxonomy of licensed behavioral health clinical specialties that may be used by insurance carriers to develop a provider network**; and **(2) recommending a process that may be used by carriers to validate a licensed behavioral health clinician's specialty**. Due to the limited nature of the Commission, the focus was on outpatient service providers as this is the provider group with the greatest ambiguity; however, the recommendations included herein are generalizable to other levels of care.

The Commission was comprised of the Undersecretary of Health and Human Services, who chaired the Commission, First Deputy Commissioner from the DOI and a diverse panel of behavioral health professionals, clinicians, and insurance carrier representatives. See Appendix A for list of commission members.

The Commission met five times from December 2018 through March 2019. All of the Commission's meetings were open to the public and detailed minutes from each meeting, along with copies of all presentations and reading materials publicly considered by the Commission, were made available to the public through a webpage created for the Commission.[9]

Commission's Recommendations

1. Recommended Taxonomy of Licensed Behavioral Health Clinician Specialties

In developing its recommendations for a taxonomy of behavioral health specialties, the Commission considered terms and classifications from existing and well-recognized sources. To formulate the "Treatment Specialty" recommendations list, the Commission reviewed terminology used in the following three sources: (1) the draft Provider Change Form, as currently being developed by the "Massachusetts Collaborative" a voluntary group of providers, carriers, and trade associations, (2) Psychology Today's "Therapist Finder" online tool, and (3) the DSM-V Diagnostic Criteria and Codes. The Commission then deliberated to combine these three sources into a comprehensive, streamlined taxonomy. The Provider Change Form and Psychology Today's "Therapist Finder" online tool were also used to source the "Treatment Modality" portion of the recommended taxonomy.
The Commission recommends the following taxonomy of specialties and treatment modalities, and further recommends that the DOI establish a process for reviewing and updating the taxonomy on an ongoing basis, as necessary.

[9] Commission webpage: https://www.mass.gov/orgs/taxonomy-commission

Treatment Specialty/ Focus Area

- Adjustment disorders
- Adoptee
- Adoptive parents
- Anger
- Anxiety/panic
- Attention deficit hyperactivity disorder (ADHD)
- Autism spectrum disorder
- Bipolar disorder
- Conduct/oppositional defiant disorders
- Coping with medical illness
- Depressive disorders
- Developmental disorders
- Eating disorders
- Elimination disorders
- Family conflict
- First responder
- Gambling
- Gaming/internet addictions
- Gender identity/sexual orientation
- Geriatrics
- Grief
- Immigrant/refugee
- Infertility
- Intellectual disability
- Intimate partner violence
- Learning disability
- Military/veterans
- Men's mental health
- Obesity
- Obsessive-compulsive disorder (OCD)
- Pain
- Paraphilic disorders
- Parenting
- Personality disorders
- Phobias
- Post-traumatic stress disorder (PTSD)/ trauma
- Pregnancy/postpartum
- Psychotic disorders
- Racial/cultural/ethnic/religious/spiritual identity
- Relationships
- Sexual addiction
- Sex therapy
- Sexual trauma
- Sleep disorders
- Somatic disorders
- Substance use disorder, including opioid use disorder
- Substance use disorder, excluding opioid use disorder
- Substance use with co-occuring mental health disorder (dual diagnosis)
- Substance use in families
- Traumatic brain injury (TBI)
- Women's mental health

Treatment Modality

- Acceptance/Commitment Therapy (ACT)
- Addiction-focused Therapy
- Applied Behavioral Analysis
- Attachment Therapy
- Behavioral Therapy
- Exposure Therapy
- Expressive Therapies
- Eye Movement Desensitization and Reprocessing (EMDR)
- Faith-based Therapy
- Family Therapy
- Forensic Evaluation
- Group Therapy
- Home-based Therapy
- Hypnotherapy
- Medication/ Psychiatric Medication
- Medication for addiction treatment, including opioid use disorder
- Biofeedback/Neurofeedback
- Cognitive Behavioral Therapy (CBT)
- Couples Therapy
- Dialectical Behavioral Therapy (DBT)
- Electroconvulsive Therapy (ECT)
- Exposure-Response Prevention (ERP)
- Medication for addiction treatment, excluding opioid use disorder
- Parent-Infant Psychotherapy
- Play Therapy
- Psychological/Neuropsychological testing and evaluation
- Psychodynamic Therapy
- Talk Therapy
- Teletherapy
- Transcranial Magnetic Stimulation (TMS)
- Trauma-focused therapy

Recommended Taxonomy Usage

Recognizing that how the recommended taxonomy is used is equally as important as the taxonomy itself, the Commission reached consensus on a set of recommended uses. The recommended uses are reflective of the Commission's primary goal, which is to ensure that timely, accurate information is available to individuals and their families seeking behavioral health care. The proposed uses of the recommended taxonomy also support the goal of improving administrative processes for patients, providers, and carriers. Accordingly, the Commission recommends that the recommend taxonomy be considered for the following uses:

- Standardize language across payers' provider directories (See Appendix B for recommended taxonomy with potential reference terms to be incorporated into provider directory platforms, if search functionality is available); in addition, provider directories should be organized to allow consumers to choose the kind of care they are seeking (e.g., treatment specialty, focus area, treatment modality) followed by an option to choose provider type (e.g., psychiatrist, psychologist, social worker, etc.).
- Standardize provider credentialing applications and change forms.
- Identify areas of practice and treatment modalities for which there are not currently any board certifications or practice standards.
- Reference in applicable DOI regulations, specifically in sections pertaining to provider directories.
- Incorporate into other tools and platforms that assist patients and families identify and access behavioral health services, such as the Network of Care initiative.

2. Recommended Process for Carrier Validation

In considering a process for carrier validation of treatment specialties and focus areas, the Commission examined existing approaches, such as Aperture Credentialing Inc.'s process for external primary-source validation that is currently provided to carriers, through a contract with HealthCare Administrative Solutions, Inc. (HCAS), as well as relevant resources to assist in validation, such as the Center for Health Information Analysis's (CHIA) All-Payer Claims Database (APCD).

Today, most behavioral health specialties are self-reported by providers and unable to be verified by carriers. The Commission's charge highlighted the challenge of validating specialties and treatment modalities that are not formally recognized through licensure or certification. However, keeping the individual patient's experience at the fore, there was consensus that the goal of any recommended validation process should be to ensure that providers are actually providing and accepting patients for all specialty services and age groups that they self-report on their application and that therefore appear on a carrier's provider directory, recognizing that validation of many of the specialties/areas of focus and treatment modalities with absolute certainty may not be possible.

To achieve this goal, the Commission identified not one process, but a series of recommendations, including varying approaches to validation and future opportunities to strengthen these processes:

- Require that all carriers use a universal credentialing platform and a primary-source verification function.
- Recommend that the DOI establish a process to ensure carriers validate that providers listed in their directories are currently treating patients within their indicated specialty areas and age groups (e.g., children, adolescents, geriatrics).
- Require licensing boards to develop standardized elements to be used for primary source verification processes, guidelines, and standards for behavioral health clinicians.
- Update the provider applications and change form to include:
    - Clear language that instructs providers to only check off specialty areas and age groups served if they are currently accepting patients and providing services in that area or age group
    - Clear language that provider specialties are subject to verification and examination.
    - Denotation of specialties that require a special license or certification
- Require carriers to establish a simplified process for providers to regularly review and update their directory profiles and information therein.

Appendices

A. Taxonomy Commission Members

Name	Affiliation
Undersecretary Lauren Peters	Mass. Executive Office of Health and Human Services
First Deputy Commissioner Matthew Veno	Division of Insurance
Deirdre Calvert, LICSW	Column Health
Kiame Mahaniah, MD	Lynn Community Health Center
Kate Ginnis, MSW, MPH, MS	Boston Children's Hospital
Scott Weiner, MD, MPH	Brigham and Women's Hospital
Claudia Rodriguez, MD	Brigham and Women's Hospital
Diana Deister, MD	Boston Children's Hospital
Sarah Coughlin, LICSW, LADC-I	National Association of Social Workers
Sarah Chiaramida, Esq.	Mass. Association of Health Plans
Ken Duckworth, MD	Blue Cross Blue Shield of Mass.

B. Recommended Taxonomy with Potential Search Reference Terms

Treatment Specialty	Potential Search/Reference Term(s)
Adjustment disorders	School issues
Adoptee	
Adoptive parents	
Anger	
Anxiety/panic	
Attention deficit hyperactivity disorder (ADHD)	Attention Deficit Disorder, ADD
Autism spectrum disorder	Asperger's, PDD
Bipolar disorder	Manic-depressive, mania
Conduct/ oppositional defiant disorders	
Coping with medical illness	Bariatric counseling
Depressive disorders	
Developmental disorders	

Eating disorders	Bulimia, anorexia, binge eating
Elimination disorders	
Family conflict	
First responder	
Gambling	
Gaming/internet addictions	
Gender identity/ sexual orientation	
Geriatrics	
Grief	
Immigrant/refugee	
Infertility	
Intellectual disability	
Intimate partner violence	Domestic violence
Learning disability	
Military/veterans	
Men's mental health	
Obesity	
Obsessive-compulsive disorder (OCD)	Hoarding, skin picking, body dysmorphic disorder, trichotillomania
Pain	
Paraphilic disorders	
Parenting	
Personality disorders	Antisocial personality, borderline personality, narcissistic personality
Phobias	
Post-traumatic stress disorder (PTSD)/ Trauma	
Pregnancy/postpartum	
Psychotic disorders	Schizophrenia spectrum, dissociative disorders
Racial/cultural/ethnic/religious/spiritual identity	
Relationships	Peer relationships, marital and premarital, infidelity, divorce
Sexual addiction	
Sex therapy	Sexual dysfunction
Sexual trauma	
Sleep disorders	
Somatic disorders	Hypochondria, conversion disorder

Substance use disorder, including opioid use disorder	
Substance use disorder, excluding opioid use disorder	
Substance use with co-occurring mental health disorder (dual diagnosis)	
Substance use in families	
Traumatic brain injury (TBI)	Concussion
Women's mental health	

Treatment Modality	**Potential Search/Reference Term(s)**
Acceptance/Commitment Therapy (ACT)	
Addiction-focused Therapy	
Applied Behavioral Analysis	
Attachment Therapy	
Behavioral Therapy	
Biofeedback/Neurofeedback	
Cognitive Behavioral Therapy (CBT)	Rational Emotive Behavior Therapy (REBT)
Couples Therapy	
Dialectical Behavioral Therapy (DBT)	
Electroconvulsive Therapy (ECT)	
Exposure-Response Prevention (ERP)	
Exposure Therapy	
Expressive Therapies	Art Therapy, Dance/Movement Therapy, Sand Play
Eye Movement Desensitization and Reprocessing (EMDR)	
Faith-based Therapy	
Family Therapy	
Forensic Evaluation	
Group Therapy	
Home-based Therapy	
Hypnotherapy	
Medication/ Psychiatric Medication	
Medication for addiction treatment, including opioid use disorder	
Medication for addiction treatment, excluding opioid use disorder	
Parent-Infant Psychotherapy	

Play Therapy	
Psychological/Neuropsychological testing and evaluation	
Psychodynamic Therapy	
Talk Therapy	
Teletherapy	
Transcranial Magnetic Stimulation (TMS)	
Trauma-focused Therapy	