**Taxonomy Commission**

Meeting Minutes

December 5, 2018

3:00-5:00 pm

Date of meeting: Wednesday, December 5, 2018

Start time: 3:05pm

End time: 5:01pm

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

Members present:

* Lauren Peters – Executive Office of Health and Human Services (Chair)
* Matthew Veno -- Division of Insurance
* 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
* 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.

Members absent:

* Claudia Rodriguez, MD -- Brigham and Women’s Hospital

**Proceedings**

Undersecretary Peters called the meeting to order at 3:05 pm. Ed Palleschi, Deputy Chief Secretary for Boards and Commissions from the Governor’s office swore in members with the oath.

David Giannotti, Public Education and Communications Division Chief of the State Ethics Commission, provided the commission with a brief overview of the State’s conflict of interest and ethics regulations. He explained commission members’ status as special state employees, and explained the considerations related to conflicts of interest and mandatory online ethics training they are required to complete within 30 days of their appointment.

Lauren Cleary, Associate General Counsel for the Executive Office of Health and Human Services, provided an overview of the Open Meeting Law. She emphasized the importance of transparency and reminded commission members that records, documents, and minutes from the commission’s meetings are public records.

Undersecretary Peters opened the discussion. Members briefly introduced themselves, noting relevant affiliations. Afterwards, Undersecretary Peters gave a brief introduction and summary of the commission’s charge.

Undersecretary Peters opened the discussion to the timeline of the commission’s work, and emphasized the importance of the commission’s work and her focus on “getting it right,” vs. “checking the box.” Undersecretary Peters then welcomed the commission’s members to note any scheduling limitations they have for future commission meetings, and various members stated their preferences. Undersecretary Peters provided a general review of the problem statement, using the PowerPoint presentation as a guide (see attached PowerPoint document).

Dr. Mahaniah clarified that the focus of the commission is to determine how to make it easy for patients to easily identify the services that they need, which was confirmed by all. Ms. Ginnis noted that while most physicians have a specialty that’s clearly credentialed, specialties are less well-defined among behavioral health providers, especially for social workers. She evoked examples of seeking providers for children, or an individual with autism, and how difficult that may be given this lack of clarity.

Dr. Duckworth raised the question of the degree of involvement by professional societies around the commission’s work. He explained that professional societies have the authority to create certification/licensure that would delineate behavioral health specialties, but that the status quo is that such specialties are self-reported. He emphasized that professional societies have been resistant to creating certifications. Dr. Deister noted that the commission may choose to allow providers to note whether they can treat certain populations due to self-reported experience or external qualifications. Dr. Duckworth explained that the position of professional societies is that an independently licensed person has a scope of practice without separate certifications, and that they are disinterested in independently determining which providers are certified in which areas. He evoked the example of a certification program at the University of Washington for a dialectical behavior therapy (DBT) subspecialty, and that if a provider had such a certification, health plans would like to know that, but that self-reporting is the current standard.

Undersecretary Peters explained the commission’s required deliverables and current ongoing work by other groups, using the PowerPoint as a guide.

Deputy Commissioner Veno provided an update on the Division of Insurance (DOI)’s ongoing work relative to this commission. He outlined the results of a completed Market Conduct Exam, and highlighted that because of the self-reported nature of behavioral health subspecialties, it was very hard for carriers to validate whether a provider had training in a certain area of practice. He outlined potential recommendations that the DOI is developing around the auditing of provider directories, and the need for dedicated patient navigators within carrier groups. He emphasized that the timing of this commission’s work is very complementary to the DOI’s work, and speculated that the two groups’ could feed into one another. He opened the discussion to questions; there were none.

Undersecretary Peters spoke about other ongoing work by the Mass. Association of Mental Health and the Network of Care Initiative. She noted that she has flagged the work of this commission to this group in order to facilitate the dovetailing of efforts, and that the deliverables from this commission could be incorporated into the Network’s work.

Ms. Chiaramida presented further examples of ongoing initiatives and pending legislation that would impact the commission’s focus. She talked through a draft Change Form (see attached materials) created by the Mass. Collaborative, a voluntary working group of hospitals, providers, payers, and trade associations which is working to develop updates to the provider information change form. She noted that the section of the form for behavioral health providers may be a helpful starting point as the commission moves forward to create a comprehensive list of provider specialties. She noted that this form has been submitted to the DOI, and is awaiting approval. Deputy Commission Veno questioned how much convergence there was among carriers in determining the list of areas of practice. Ms. Chiaramida clarified that a MassHealth list was used as a jumping off point and that other groups added additional fields. She went on to explain the ongoing work by CAQH to create an updated centralized data entry tool, to be used as a one stop portal for providers to update their information among all of the plans they contract with. She noted that this portal will not validate provider information, but will merely update it more consistently. She explained that there will be a lag between the introduction of this new portal and when changes will be reflected in provider directories to give providers time to input the information and for the carriers to update their systems to reflect the new information, but that this process is expected to begin in 2019, so it is important for the commission to work in tandem with this process. Dr. Duckworth noted that the Change Form uses modern terminology, and that he appreciated the framework it presents for areas of practice.

Ms. Ginnis asked if behavioral health would be included in the initial iteration of the CAQH portal. Ms. Chiaramida responded that the behavioral health component of the system will come second in the process, but is already being initiated; fields specific to behavioral health currently required by MassHealth have already been incorporated into the CAQH portal.

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Dr. Mahaniah asked whether or not behavioral health clinicians agree with the areas of practice listed in the Change Form, and whether they think of themselves as “generalists or specialists.” Dr. Duckworth responded that this line of questioning brings up the issues associated with self-reporting, that the absence of certification “lends itself to this kind of vagary.” Dr. Deister proposed creating a self-reporting scale, e.g. ratings from 0-5 in which providers can self-report various levels of expertise or experience with a specialty.

Ms. Ginnis pointed out that generalist providers, such as social workers, aim to “cast as wide a net as possible” in order to be able to serve a wide client population. She expressed concerns that requiring providers to identify their specialties may reduce the number of clients who seek their services, and threaten their livelihood, especially for providers working in remote communities. Undersecretary Peters, Ms. Calvert, and Ms. Ginnis all agreed that the commission should avoid unintended consequences that would limit access. Dr. Duckworth proposed that such providers could list themselves as generalists in directories; Deputy Commissioner Veno expressed concerns about patient accessibility and that patients would not know how to identify providers who fit their needs. Dr. Deister proposed that generalist providers could also indicate their areas of practice beneath such a category.

Dr. Mahaniah described a debate within the behavioral health care field about whether or not providers even require specialized training to address specific populations, such as those requiring trauma care. Deputy Commissioner Veno emphasized the need to “accommodate all dimensions,” for generalists to be able to indicate special populations they work with, but also to provide a framework for those who have specialized training to indicate as such.

Dr. Deister brought up the “Therapist Finder” feature on the Psychology Today website, through which patients can search for therapists by zip code, view their insurance networks, age groups served, areas of therapy, blurbs about their practice, etc. Undersecretary Peters mentioned how this format relates to the efforts of the Network of Care group, and agreed that the ability to search by location/region is important. Ms. Ginnis noted that this website is much more robust and accurate in its information than the average provider directory.

Dr. Mahaniah raised the distinction in medical practice, where there is a “clear delineation” between family medicine practice vs. surgical practice, for which a clinician needs to “prove that [they] can do it,” and inquired if there is an equivalent in behavioral health practice, in which certain areas are considered more “dangerous” and therefore shouldn’t be self-reported/ should require some standardized additional training. Dr. Duckworth reiterated that professional societies have not created the conditions to provide this distinction; that the certification doesn’t exist. Dr. Mahaniah brought up electroconvulsive therapy (ECT) as an example, and Dr. Deister explained that she could “buy an ECT machine and open a shop with my license and hire an anesthesiologist.” Dr. Duckworth further explained that there is not board certification in ECT, but in order to perform it in a hospital, a clinician would need credentials with that facility.

Undersecretary Peters noted that facilities set their own internal standards, which the commission could potentially leverage in its work. She reiterated that the goal of the commission is to devise a standard/uniform way to specify services, and to specify “what we mean when we say that someone does something.” Ms. Calvert confirmed that within her practice, standards we internally set.

Dr. Mahaniah asked if the system that the commission creates would be reexamined regularly. Undersecretary Peters confirmed this, and explained that the commission may choose to recommend in its report that the DOI conduct a reevaluation of the document every year.

Dr. Mahaniah left the meeting early, at 4:25pm.

Dr. Deister asked if a list of all licensed clinicians in the state is accessible, and Undersecretary Peters confirmed that it is.

Dr. Weiner asked if there are any other bodies that the commission can gather input from. Dr. Duckworth recommended looking at the Mass. Psychological Association. Ms. Chiaramida brought up the CMS taxonomy code. Undersecretary Peters explained that this code set could be used as a “straw man” as a jumping off point, and emphasized the importance of describing subspecialty areas consistently in different places. She asked the group if there were any areas of practice that are less understood, either in the taxonomy code set or the Change Form. Ms. Ginnis offered that “chronic mental disorders” should be struck from the list, that “domestic violence” should be replaced with “intimate partner violence,” and that other updates need to be done. She asked what “first responder issues” relates to, and Dr. Weiner suggested it may indicate PTSD. Ms. Calvert agreed that this category is too broad.

Dr. Deister added that subgroups may be added for medically complicated patients, e.g. children with cancer. Ms. Coughlin added that in treating substance abuse disorders (SUDs), some providers may treat specific substances. Dr. Deister added that “pain management” is a modality but not an area of practice, and agreed that there were a number of “semantic issues” in the existing lists.

Undersecretary Peters asked if the modality element should be included in a provider network. Ms. Ginnis replied that yes, it should, because it is useful to know if a therapist does cognitive behavioral therapy (CBT). She emphasized that the modality is “just as important as the area of practice.” Undersecretary Peters clarified that when the commission talks about a recommended taxonomy, it is discussing a “uniform list of areas of practice, and a uniform list of modalities of treatment.”

Ms. Ginnis expanded to say that the system could be “branched,” e.g. when looking for SUD specialists, a patient could then look into the subspecialties of medication-assisted treatment (MAT), alcohol use, etc. Ms. Chiaramida emphasized the need to align the commission’s work with CAQH’s work, so that there’s no need to remake the platform once it’s established.

Undersecretary Peters described that part of the Network of Care initiative is to work with BSAS to populate their platform, and expressed that it would be helpful to carry the commission’s recommendations over to this initiative so that the language and granularity of the language is consistent across sources.

Ms. Ginnis suggested that looking to how HMO’s manage their internal systems may be helpful for the commission to look at, and offered to reach out to acquaintances that may be able to offer insight. Undersecretary Peters confirmed that it would be helpful to “identify where there are good catalogues in place.”

Dr. Deister suggested that the DSM-V list of APA-acknowledged conditions would be a helpful starting point, which was affirmed by all members; Ms. Ginnis clarified that chapter levels would be most helpful, as compared to the complete list of disorders.

Undersecretary Peters summarized that for the next meeting of the commission, they would look to the DSM-V (to be circulated in advance, and reviewed individually by members), and at that time suggest additions or edits to that list. She suggested that after this process, the commission can start addressing the issue of validating clinicians’ specialties. Dr. Deister clarified that the commission would look to the DSM-V in conjunction with the areas of practice from the Change Form. She also noted that there was a need to differentiate subgroups of patients with chronic conditions (e.g. subgroup for HIV+ patients). Dr. Duckworth recommended organizing specialties by category, rather than alphabetically. Undersecretary Peters agreed, and emphasized the need for meaningful groupings in order to promote accessibility.

Ms. Ginnis noted that comparing the DSM-V to the Change Form will be helpful in terms of identifying discrepancies. For example, LGBTQ issues are not listed in the DSM-V as a diagnosis, but are identified in the Change Form as an area of practice. She suggested that the commission’s produced taxonomy should not just be diagnosis-based (as the DSM-V is), also because many patients do not know their diagnosis when initially seeking care. Dr. Weiner suggested also using the Psychology Today “Therapist Finder” list of specialties. Undersecretary Peters agreed, and summarized that these three sources will be compiled and presented to the commission as a new “straw man,” to be circulated before the next meeting prior to discussion.

Dr. Duckworth proposed inviting representatives from professional societies to come speak to the commission about the issues surrounding clinician self-reporting. Undersecretary Peters noted that if the commission’s recommendations don’t address the issue of self-reporting, it could still recommend that the DOI conduct a regular audit, or to allow the carrier to audit clinician’s self-reports. Dr. Duckworth replied that pressing clinicians with regular monitoring may reduce the number of network-participating clinicians.

Ms. Ginnis noted that there is “high motivation in behavioral health clinicians” who is seeking to contract with a network that is already full to “check every box.” She noted that increased transparency about the lack of oversight for clinicians who are already in-network is needed and that there is a “mismatch of motivations between the clinicians and the network.” (E.g. Clinicians who specify that they see mostly depressed and anxious adults, therefore accommodating the need for specificity, may risk being kicked out of the network because they are perceived as having a limited scope of care).

Deputy Commissioner Veno replied that there is an obligation on the part of the provider “to not misrepresent the care they provide.” Dr. Weiner inquired how many behavioral health subspecialties have associated additional certification. Ms. Calvert answered that none do, that there is no standard for certification. Ms. Chiaramida questioned if there was an opportunity for the commission to bring in the Board of Registration to discuss this. Undersecretary Peters explained that different areas are licensed by different boards. Ms. Chiaramida suggested that there is a role in this process for licensure bodies.

Undersecretary Peters suggested that there could be a criteria or benchmark met without certification. For example, if someone claims to specialize in eating disorders, plans could implement a process by which they could retrospectively confirm this by looking at how many patients with eating disorders were treated by that clinician in the prior year. Ms. Coughlin replied that because most clinicians contract with multiple carriers, that number may not add up to pass a benchmark when looking at the claims submitted to a single plan. Dr. Duckworth affirmed that he would rather “pursue certification than audit,” and that if the Change Form had definitions that are “clear and universally applied,” that would be an improvement.

Dr. Deister suggested that there could be a system of colleague reporting, where a peer reviews a clinician’s charts and writes a letter affirming that person’s experience with certain specialties. Ms. Ginnis disagreed, stating that such a system would be “glorified self-reporting.”

Undersecretary Peters summarized, and stated that the commission would finalize a list of practice areas at the next commission meeting, and then look towards devising a system of validating credentials.

In closing, Undersecretary Peters thanked members for their participation in the commission’s work.

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

The meeting was adjourned at 5:01 pm.