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Executive Office of Health and Human Services
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March 29, 2019

Michael Hurley
Senate Clerk
Office of the Clerk of the Senate
24 Beacon Street, Room 335—State House
Boston, MA 02133

Steven T. James
House Clerk
Office of the Clerk of the House
24 Beacon Street, Room 145—State House
Boston, MA 02133

Dear Senate Clerk Hurley and House Clerk James,

On August 9, 2018, Governor Baker signed into law Chapter 208 of the Acts of 2018, An Act for Prevention and Access to Appropriate Care and Treatment of Addiction. Section 102 of the law establishes a Taxonomy Commission, to recommend a taxonomy of licensed behavioral health clinician specialties and to recommend a process that may be used by carriers to validate a licensed behavioral health clinician's specialty.

The Commission is charged with filing 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.

Attached for your review is our report, along with copies of the minutes from each Commission meeting. These minutes are appended to provide additional context for the recommendations put forth in the report. They can also be accessed at: https://www.mass.gov/lists/taxonomy-commission-meeting-materials.

Please feel to contact me should you have any questions regarding the recommendations contained in the report.

Sincerely,

Lauren Peters
Undersecretary for Health Policy

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.

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.

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.

Taxonomy Commission

Meeting Minutes
January 17, 2019
3:00-5:00 pm

Date of meeting: Thursday, January 17, 2019
Start time: 3:05pm
End time: 5:06pm
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
- 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 Chiaramida, Esq. -- Mass. Association of Health Plans
- Ken Duckworth, MD -- Blue Cross Blue Shield of Mass.
- Claudia Rodriguez, MD -- Brigham and Women's Hospital

Members absent:

- Kiame Mahaniah, MD -- Lynn Community Health Center
- Sarah Coughlin, LICSW, LADC-I -- National Association of Social Workers

Proceedings

Undersecretary Peters called the meeting to order at 3:05 pm.

Dr. Rodriguez, who was not present at the December 5th meeting, introduced herself to the group and described the scope of her work.

Vote: The Undersecretary introduced a motion to approve the December 5th minutes, which was seconded and unanimously approved.

Vote: The Undersecretary introduced a motion to allow for remote participation in future meetings of the commission, which was seconded and unanimously approved.

Undersecretary Peters reintroduced the commission's first charge of devising a taxonomy of behavioral health clinician specialties, and presented working materials that the commission requested at the end of its last meeting. The materials used (see attached) were lists of specialty areas/areas of practice listed across three sources: the DSM-V, the Psychology Today "Therapist Finder" website, and the Draft Provider Information Change Form presented by Ms. Chiaramida at the Dec. 5 meeting. Common terms/areas across all three sources were grouped in categories for the commission's review and discussion (e.g. Psychology Today lists "Adoption," and the Draft Change Form lists "Adopting parents" and "adoptee;" these terms were grouped together, with their original sources shown, for the group to choose from or alter to describe this area of practice).

The commission agreed before beginning this process that the language from the Draft Change Form would be their "basis" for choosing the language of each group, that if that language made sense to the commission, they would default to using that as the taxonomy item. Undersecretary Peters emphasized the need for specificity of the language chosen for each practice area, in order to further the goal of "[providing] clear information for the patient seeking services."

Dr. Deister arrived at 3:14pm.

The commission reviewed these groupings one by one and determined which, if any, of the language from each grouping would be added to the recommended taxonomy. The commission discussed whether or not certain phrases should be included as "reference" terms for some taxonomy items, as a patient may search for that term rather than the language chosen for the taxonomy(e.g., a patient seeking services for Bipolar Disorder may search "manic depressive"). It was agreed that reference terms would be included as an ancillary list to the recommended taxonomy, so that carriers may use them to develop more robust and user-friendly directories.

Undersecretary Peters outlined the work plan for future meetings of the commission: the next meeting will focus on completing the recommended taxonomy, as well as assembling a list of treatment modalities, and the following meeting will focus on developing a process for validating a behavioral health clinician's specialty (the second charge of the commission).

Ms. Chiaramida brought up a conversation from the Dec. 5 meeting around inviting professional societies to present on their methods for credentialing providers. Undersecretary Peters noted that because of the commission's limited timeline, it would instead move forward with collecting various credentialing systems from professional societies and DMH, and bring them in as models for discussion. Ms. Chiaramida agreed.

Undersecretary Peters discussed the February 9th report deadline, and reemphasized the need for this commission to "get this [report] right." The commission discussed the possibility of submitting a letter to legislature requesting a reporting deadline extension in order to hold two or three more meetings before the report submission.

Vote: Dr. Duckworth introduced a motion for the commission to submit a request for a reporting deadline extension to March 31, 2019, which was seconded and unanimously approved.

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

The meeting was adjourned at 5:06 pm.

Taxonomy Commission

Meeting Minutes
February 14, 2019
2:00-4:00 pm

Date of meeting: Thursday, February 14, 2019
Start time: 2:07pm
End time: 4:01pm
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
- Kate Ginnis, MSW, MPH, MS -- Boston Children's Hospital
- Sarah Chiaramida, Esq. -- Mass. Association of Health Plans
- Kiame Mahaniah, MD -- Lynn Community Health Center
- Sarah Coughlin, LICSW, LADC-I -- National Association of Social Workers

Members calling in:

- Scott Weiner, MD, MPH -- Brigham and Women's Hospital
- Diana Deister, MD -- Boston Children's Hospital
- Claudia Rodriguez, MD -- Brigham and Women's Hospital
- Ken Duckworth, MD -- Blue Cross Blue Shield of Mass.

Proceedings

Undersecretary Peters called the meeting to order at 2:07pm.

Vote: The Undersecretary introduced a motion to approve the January 17th minutes, which was seconded and approved, by roll-call vote. Dr. Mahaniah abstained due to his absence from the January 17th meeting.

Undersecretary Peters asked if members had any changes they'd like to suggest to the current draft of the recommended taxonomy. Dr. Rodriguez suggested changing the current language used around substance use disorders. The commission deliberated and agreed on a solution, before moving on to the unaddressed categories for the recommended taxonomy. The commission deliberated and finalized the working draft of the recommended taxonomy.

Undersecretary Peters opened the discussion of treatment modalities to be included in the commission's recommendations. Similar to the process used for the recommended taxonomy terms, the commission used the Draft Change Form document as a basis for its deliberations, looking to additional modalities from the Psychology Today "Therapist Finder" tool for consideration.

Dr. Rodriguez left the meeting via conference call at 2:45pm.

The commission continued to deliberate. Ms. Chiaramida suggested looking, during a future meeting, at the Council for Affordable Quality Healthcare (CAQH) directory structure to help the commission understand the level of detail that should be included in its recommendations. Undersecretary Peters agreed with this suggestion.

Undersecretary Peters opened the discussion of which medical conditions to include in the draft taxonomy item of "Coping with medical illness." The commission deliberated and agreed to either recommend a list of ten medical conditions based on prevalence and impact within behavioral health practice, or to recommend the capability for "free text" search for conditions, if this was technologically feasible within provider directories. Ms. Chiaramida offered to ask among stakeholders what would be feasible.

Undersecretary described the commission's next steps, of looking at validation processes used by other groups and using them to build recommendations. Ms. Chiaramida recommended looking at the work of Aperture, Inc. as an example. Undersecretary Peters emphasized that the recommended validation process should not "create additional hurdles for behavioral health providers," as that would be "antithetical to the goals of this group." She explained that the standard of the "reasonable person" may be used by the commission in its next meeting when thinking about its recommendations. She then explained that she will be having a conversation with a representative from Aperture before the next meeting to determine what their current function/capacity for validation is, and that she would then report out those findings to the group.

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

The meeting was adjourned at 4:01pm.

Taxonomy Commission

Meeting Minutes
March 1, 2019
9:00-11:00 am

Date of meeting: Friday, March 1, 2019
Start time: 9:10am
End time: 10:03am
Location: Michael Matta Conference Room, 11th Floor, One Ashburton Place, Boston, MA 02108
Members present:

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

Members calling in:

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

Members absent:

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

Proceedings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The meeting was adjourned at 11:03am.

Taxonomy Commission

Meeting Minutes
March 20, 2019
11:00 am-1:00 pm

Date of meeting: Wednesday, March 20, 2019
Start time: 11:11 am
End time: 11:50 am
Location: Michael Matta Conference Room, 11th Floor, One Ashburton Place, Boston, MA 02108
Members present:

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

Members calling in:

- Diana Deister, MD -- Boston Children's Hospital
- Kiame Mahaniah, MD -- Lynn Community Health Center
- Claudia Rodriguez, MD -- Brigham and Women's Hospital

Proceedings

Undersecretary Peters called the meeting to order at 11:11am.

Undersecretary Peters thanked all Commission members for their feedback on the drafted final report. She established the goal of the meeting: to review the report and provide any needed clarifications, to be captured in meeting minutes which will be submitted along with the report.

Ken Duckworth arrived at 11:13 am.

Vote: The Undersecretary introduced a motion to approve the March 1st minutes, which was seconded and unanimously approved by roll call.

Undersecretary Peters pointed out a change that had been made on page 9 to a single phrase (changing a reference from CAQH to be to HCAS).

She then opened the discussion to review the entire report, reminding members that all meeting minutes will be appended to the report and included in the formal record of the Commission.

First Deputy Commissioner Veno commented on the recommendation that the DOI review the taxonomy on an ongoing basis. He noted that MAHP (Massachusetts Association of Health Plans) "also wanted to have some analysis done about how providers are actually engaging in the process." He explained that while not referenced

directly in this report, as the DOI updates the taxonomy, they would like to have a "broader dialogue" about how the process is running; "Is it being used in the way we'd expect and are recommending?"

Ms. Chiaramida agreed that as the list is continuously reviewed, it is important to make sure that how it is being used is appropriate. She expressed the importance of continuing to look into whether additional primary source certifications are being established, and how that impacts providers' self-identification processes.

The Commission continued to review the draft report. Ms. Ginnis explained her desire to include language around "levels of care" within the taxonomy. She also explained that while the Commission did not deliberate on this topic, she feels it is important for provider directories to first offer options for consumers to select the area of modality of care they are seeking, before selecting provider type. Ms. Chiaramida expressed that this issue is a separate question, outside of the Commission's charge. She also emphasized the need to balance streamlining processes on the consumer end with making these changes expeditiously: "We want to make sure we get this first part done correctly and in a timely manner."

Undersecretary Peters suggested that the Commission turn its attention to reviewing the recommended process for carrier validation. She summarized that rather than one singular process, the output of the report is a variety of approaches that are not mutually exclusive, and that different players in the system can take to ensure that "we meet our ultimate goal of accurate information being available to patients and their families at the time that they are looking for it."

Ms. Chiaramida noted that one of the goals of a provider directory is to have one-stop shopping for providers to enter their information. She noted that one concern of MAHP was that the report provides the appropriate context around the relationships that carriers have with HCAS and CAQH, that these are contracted relationships: "They are vendors, so those are the organizations we've contracted with to provide those services. So while there is a goal of having one platform or process, we want to make sure that we don't put forth recommendations that down the line may favor one vendor over another. We want to be clear that right now, these are our vendors, but we may explore others in the future." She also wanted to clarify that the report does not intend to say that whatever platform is chosen must use their in-house primary source verification function. The Commission deliberated on the language of the report, and agreed to change it to reflect this clarification.

Undersecretary Peters informed the Commission that the Mass. Medical Society had sent a letter on the morning of the meeting with comments on the report. Dr. Weiner read excerpts from the letter and summarized their concerns. The Commission discussed these concerns; Undersecretary Peters noted that the Commission's priority was to not recommend any process that would create any further barriers to behavioral health services, and to ensure that the information that was made available was accurate, rather than imposing limitations on what providers can or cannot provide. She reported that she would contact the Society to discuss their concerns.

The Commission continued to review the report. Ms. Ginnis noted that the phrase "parent-infant dyad psychotherapy" should instead read "parent-infant psychotherapy." The Commission deliberated and agreed to this change. Ms. Ginnis also wanted to note that the Appendix, where potential reference terms are listed is "far from an exhaustive list of reference terms."

Undersecretary Peters offered the correction of changing First Deputy Commissioner Matthew Veno's title throughout the report to add the word "First."

Vote: Ms. Ginnis introduced a motion to approve the final report, with all agreed upon amendments, which was seconded and unanimously approved by roll call.

Undersecretary Peters thanked the Commission for their work and offered to keep members updated about the progress of the recommendations.

Vote: The Undersecretary introduced a motion for the meeting to adjourn, which was seconded and unanimously approved by roll call. The meeting adjourned at 11:50am.

Taxonomy Commission Legislative Report

Executive Office of Health and Human Services

March 2019

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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-occurring 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
- Biofeedback/Neurofeedback
- Cognitive Behavioral Therapy (CBT)
- Couples Therapy
- Dialectical Behavioral Therapy (DBT)
- Electroconvulsive Therapy (ECT)
- Exposure-Response Prevention (ERP)

- 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
- 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	