May 18, 2022

Commissioner Gary D. Anderson
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118

Submitted by email to doidocket.mailbox@mass.gov

Re: Docket No. G2022-01, Proposed Amendments to 211 CMR 52.00: Managed Care Consumer Protections and Accreditation of Carriers

Dear Commissioner Anderson:

On behalf of the Children's Mental Health Campaign (CMHC), thank you for the opportunity to comments on proposed regulatory amendments to the provider directory provisions of 211 CMR 52.00: Managed Care Consumer Protections and Accreditation of Carriers. The CMHC is a large statewide network that advocates for policy, systems, and practice solutions to ensure all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way.

The CMHC Executive Committee consists of six highly reputable partner organizations: Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Boston Children's Hospital, Parent/Professional Advocacy League, Health Care For All, Health Law Advocates, and the Massachusetts Association for Mental Health. Several CMHC members served on the Provider Directory Task Force, including Wells Wilkinson (Health Law Advocates) as the designated CMHC representative, Alyssa Vangeli (Health Care For All) and Danna Mauch (Massachusetts Association for Mental Health). We appreciate the diligence with which the Division of Insurance ("DOI" or "the Division") approached convening the Task Force, writing the Task Force report, and drafting the regulations that are the subject of this testimony.

We are also aware of the work to analyze carrier provider directories that preceded and influenced the passage of Chapter 124 of the Acts of 2019, the Provider Directory Task Force, and the proposed amendments to 211 CMR 52.00. A 2018 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.[1]

The work to improve the accuracy of provider directories, and thus help families more easily find providers who meet their needs, is a longstanding goal that we hope these regulations will help facilitate. We also recognize the work that has been underway through the Mass Collaborative since before the passage of Chapter 124 to streamline the process of updating provider information in directories through use of the CAQH system. Having a common platform is an important mechanism to lift the administrative burden from providers. These principles should be reflected in the regulations. In addition, since the passage of Chapter 124 and the final recommendations report of the Provider Directory Taskforce, changes have been implemented through the "No Surprises Act" provisions of the Consolidated Appropriations Act of 2021, including requirements around provider directory updates and accuracy. It is our understanding that DOI has entered into a joint-enforcement agreement with the Centers for Medicare and Medicaid Services, and we agree with other stakeholders that it would be helpful to release guidance about how the state law, these regulations, and the federal provisions interact. Please read below for specific comments regarding amendments to the provider directory provisions of the proposed regulations at 211 CMR 52.00.

52.15(1): Overview of carrier systems to collect, store and maintain information about in-network providers; expectations for educating members

We strongly support the language in subsection (1) requiring carriers to educate members through the provider directories about "how they may obtain in-Network care from an out-of-Network Provider when an in-Network Provider is not available." Given that provider directories are meant to serve as the single, comprehensive, and easy-to-navigate resource for consumers to find appropriate in-network providers for their health care needs, directories are also the appropriate resource to help consumers navigate how to access out-of-network providers when an in-network provider is not available.

However, the regulations, or at a minimum future sub-regulatory guidance from the Division, should stress upon the carriers the importance of developing common systems for submitting, attesting to, and auditing information such that providers are not overly burdened by wasteful and duplicative administrative processes. As the Task Force recommended, "**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.**"[2] Similarly, with respect to audits of provider information by carriers, in order to prevent providers from being "overwhelmed by unnecessary carrier calls… [t]here 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

[1] Massachusetts Division of Insurance, "Summary Report: Market Conduct Exam, Reviewing Health Insurance Carriers' Provider Directory Information," June 2018. Available at https://www.mass.gov/doc/provider-information-report-6-12-2018/download.
[2] Provider Directory Task Force Report, page 6.

of a number of carriers."[3] Regulations or regulatory guidance that urge carriers to collaborate through their vendors to do their regular audits could both reduce the unpaid administrative burden upon providers, while also fostering more efficient efforts by a collective of carriers. These kinds of collective approaches, while not mandated by Chapter 124, were repeatedly promised by carriers during and before the Task Force discussions.

52.15(2): Information carriers are required to collect from in-network health care providers

We recommend changes to clarify the information that carriers are required to collect, store and maintain about in-network providers in order to ensure that accurate and comprehensive information is contained in the provider directories. We recognize that most carriers in Massachusetts now use the CAQH system to collect this information from providers and that some data fields will be new and therefore will take time to update. We also recognize that providers will need to understand and adapt to responding to these new fields of information. As such, our recommendations aim to minimize any ambiguity regarding the information being collected, as well as ensure that the level of detail is sufficient for consumers to access the information they need when seeking an in-network provider.

First, we recommend that information about the provider's specialties be amended to ensure that the specialties reported reflect the provider's actual experience in the treatment of specific populations over a recent time period. The Task Force discussed and reached consensus around requiring providers to list the types of care that they specialize in based upon services that they actually provide, given that consumers rely on this information when selecting a provider. In addition, the 2019 Executive Office of Health and Human Services (EOHHS) Taxonomy Commission Legislative Report highlighted this issue:

> *[S]ome 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.*
>
> *…..*
>
> *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*

[3] Provider Directory Task Force Report, page 18.

particular condition or diagnosis, age, or provide the treatment modality that the consumer is seeking.[4]

We, therefore, recommended the following amended language to subsection 52.15(2):

(a) Health Care Provider's primary Specialty, secondary specialty (if applicable) and behavioral health specialty (if applicable) based upon their actual treatment of members of such populations or groups in the last 24 months.

52.15(2)(g): Definitions needed for open, closed, and limited 'availability to accept new patients'

With respect to proposed subsection 52.15(2)(g), we recommend the following amended language:

(2) The detailed information that the Carrier is required to collect, store ,and maintain about Health Care Providers who are a part of the Carrier's Network, shall include at least the following information for each Health Care Provider:
…

(g) whether the Health Care Provider ~~is~~:
1. is available to accept new patients covered by the Carrier; and, if applicable and known, the wait time for scheduling an appointment;
2. is not accepting new patients covered by the Carrier; or
3. has limited availability to accept ~~only accepting~~ new patients covered by the Carrier and, if applicable and known, the wait time for scheduling an appointment; ~~under limited~~ circumstances;

We propose to amend the original terms of "open to new patients" and "closed to new patients" which were largely framed in terms of a provider's panel status. We propose the more consumer-friendly terms "available to accept new patients," "is not accepting new patients," and has limited availability to accept new patients…." We also strongly recommend that these terms be expressly defined in these regulations, consistent with the recommendations by the Task Force. The Task Force understood that these terms needed uniform and consistent meanings, so that both providers and consumers can quickly and clearly understand them. Clear definitions of these terms will ensure that the information is easy for providers to furnish in a quick and reliable manner for use in carriers' provider directories. More importantly, the terms used in provider directories to describe each provider's capacity to accept new patients must be easy for consumers to understand.

[4] https://www.mass.gov/doc/taxonomy-commission-final-report/download

DOI should ensure consistency of these terms of provider availability among providers and carriers by including definitions in these regulations, as the agency consistently agreed to when asked during the Provider Directory Task Force deliberations.[5]

Defining reasonable and uniformly applicable standards for provider "availability to accept new patients" is necessary to create consistent standards and practices by carriers, which will also help providers who may currently struggle to assess their availability under the different standards developed and adopted by each carrier. Greater uniformity by carriers and providers will ultimately improve the accuracy of provider directory information for consumers seeking a provider.

We believe the proposed term "only accepting new patients . . . under limited circumstances" should be replaced with the term "limited availability to accept new patients..." The proposed language "only accepting new patients . . . under limited circumstances" is vague and could be interpreted as referring to the provider picking and choosing between new patients based upon the patient's individual circumstances and a provider's preferences toward one type or kind of patient over another, rather than reflecting the degree of fullness of the provider's current panel. In addition, the Task Force deliberations and final recommendations repeatedly suggest using the specific language "has limited availability to accept new patients" that would be further defined by regulation.[6]

We recommend the following definitions be included in subsection 52.15(2)(g):

> "Not available to accept new patients" shall mean that a provider is currently not able to accept new patients.
>
> "Limited availability to accept new patients" shall mean that the provider is available to accept a limited number of no more than two (2) new patients, with any wait time for a first appointment that is no greater than the standard expected wait time for that type of health care practice or specialty, or 6 weeks, whichever is longer.
>
> "Available to accept new patients" shall mean that a provider is immediately available to accept three (3) or more new patients, with any wait time for a first appointment that is no greater than the standard expected wait time for that type of health care practice or specialty, or 6 weeks, whichever is longer.

Please define the term "available to accept new patients" with consistent standards related to wait times for an appointment.

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[5] Provider Directory Task Force Report (p. 5, footnote 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." See also p. 13, footnote 7 (same); p.17, footnote 16 (same).

[6] Provider Directory Task Force Report (p. 13) "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)."

We propose that a provider who is available should be able to see a new patient in no more than six weeks at the outside, except for those rare cases of specialties, such as surgeons, etc., that typically have longer wait times for non-urgent care.

The Task Force was not able to reach consensus on requiring carriers to be transparent (i.e., to collect and display) the wait times for an available appointment. This was largely because wait times can be difficult, if not impossible, to predict. However, carriers and the Division should create by regulation or regulatory guidance, some uniform reasonable standards for wait times that carriers can hold their providers to when indicating that they are available to accept new patients.

Such standards are also long overdue, because they are essential to consumer exercise their long-standing state law rights to access an out-of-network provider when no in-network provider is available.[7]

Anecdotal reports indicate that some providers in Massachusetts previously described their offices as "available to accept new patients" even in instances when their first available appointment was six or more months later. In addition, the Division's Market Conduct Examination noted that the vendor gathering data for the examination collected and assessed the carrier's own internal "Provider Availability Standards pertaining to wait times for members to schedule an appointment with providers, and the extent to which each carrier monitors these standards and holds providers accountable…."[8]

To help make the information about provider availability more meaningful, both for directory accuracy, and for consumer rights to access out-of-network care when provider networks are inadequate, we recommend that the Division use these regulations or at a minimum, sub-regulatory guidance, to create some uniform standards for carrier, and their contracting providers, to accurately convey their availability in light of wait times for first appointments.

Finally, the Task Force did not reach consensus on recommending that a provider's predicted wait times to accept a new patient should be collected or displayed in provider directories. However, the consumer advocates on the Task Force strongly supported making this information available. For example, this information is critical for consumers who are struggling to find an available provider. Such information is routinely required and displayed by some providers who participate in MassHealth, who typically have experience estimating and managing longer wait times.[9] Therefore, we recommend including "wait times" as an optional piece of information to collect from providers, and to display to consumers when it is provided, since some providers

[7] M.G.L c. 176O § 6(a)(4)("[W]henever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network;") *See also* 211 CMR §52.14(1)(f)3("[T]he carrier, if necessary, shall obtain or arrange for out-of-network services if they are unavailable within the network."); 211 CMR 52.13(3)(f)2.

[8] Division of Insurance Market Conduct Examination Reviewing Health Insurance Carriers' Provider Directories (p. 8): https://www.mass.gov/doc/provider-information-report-6-12-2018/download.

[9] See Massachusetts Behavioral Health Access website: https://www.mabhaccess.com/Home.aspx.

may be able to accurately estimate this information and may wish to convey it to consumers. It would be useful for insureds to know in advance of outreaching to those providers, especially if a provider's status of "accepting new patients" comes with a significant wait time for providers in a particular specialty.

Related amendments to Network adequacy regulation 52.12(g)(3).

We recommend that after the Division establishes some consistent definitions of "limited availability to accept new patients" and definitions of "available to accept new patients" under this section 52.15(2)(g), further conforming amendments must also be made to the network adequacy regulations under 52.12(g)(3), so as to include carrier information about providers who have such "limited availability to accept new patients…" in the network adequacy assessments done by carriers. This should be done with respect to both behavioral health providers and non-behavioral health providers. See subsections 52.12(g)(3)(b), (d), (e) and (m).

52.15(2)(k): Distinguishing between the different types of accessibility barriers and accommodations for physical and intellectual or developmental disabilities in provider directories

We recommend adding further details to clarify the information collected on whether "providers are accessible to persons with disabilities, including both physical and intellectual disabilities." We believe additional information is necessary in order to understand the specific accessibility standards and competencies of the provider and their offices or treatment rooms for different types of disabilities. Specifically, we recommend the following amended language:

> (k) whether the office and/or Providers are accessible to persons with disabilities, in accordance with the Americans with Disabilities Act of 1990 (ADA) and other state or federal accessibility requirements, including the following information: ~~both physical and intellectual disabilities;~~
>
> 1. whether the Provider's listed treatment location ~~whether the office and/or Provider~~ is accessible to persons with physical disabilities, including whether offices or treatment rooms have equipment, such as lifts and adjustable height examination beds, and trained staff to operate them; and
>
> 2. whether the Provider's ~~office or~~ listed treatment location is accessible to persons with intellectual or developmental disabilities, including but not limited to providing low sensory spaces for persons with autism spectrum disorder;

52.15(2)(l): Information regarding providers specializing in treatment of specific genders

We recommend that the language on the provider's experience in the treatment of specific genders or gender identities be amended to clarify the information shall refer to a specific provider, rather than being descriptive of the entire practice, since only one or more providers

within a practice could have this expertise. In addition, we believe the phrase "specializes in" is more accurate than "geared to." We recommend the following amended language:

> (l) whether the practice or provider specializes in ~~is geared to~~ the treatment of specific genders and identification of those specific genders or gender identities based upon the Provider's actual treatment of members of such populations or groups in the last 24 months;

52.15(2)(m): Information regarding providers specializing in treatment of specific age groups or populations

Information on ages and special populations that the provider treats, as well as the race and ethnicity of the provider, should not lumped together since these are distinct categories of information that warrant separate responses and specific details. The Task Force agreed to a specific category of information for ages of patients treated by the provider.[10] In addition, the provider's race and/or nationality should be separated out in order to clarify that only that category of information is optional, while the other categories of information are required. We, therefore, propose replacing the existing language in (m) with the following and separating information regarding a provider's race and/or nationality into new subsection (n):

> ~~(m) any specific age groups, special populations or cultural groups treated by the Health Care Provider, as well as the Provider's race and nationality, if the Provider so chooses;~~
>
> (m) identification of:
>
> 1. the age groups treated by the Health Care Provider, indicated by specific ages identified by the Provider rather than using standard age categories, based upon the Provider's actual treatment of members of such populations or groups in the last 24 months;
>
> 2. any special populations or and cultural groups treated by the Health Care Provider including, but not limited to, ethnic or cultural groups, veterans, refugees, immigrants, individuals who are deaf or hard-of-hearing, and LGBTQ populations, if applicable, based upon the Provider's actual treatment of members of such populations or groups in the last 24 months;
>
> (n) the Provider's own race, ethnicity and/or nationality, if the Provider voluntarily chooses to disclose that information;

[10] Task Force Report (p. 13): "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."

52.15(2)(n): Additional financial requirements (such as concierge or facility fees) from unrelated barriers to access based on hospital or inpatient status.

As currently drafted, subsection (n) groups two different types of information – provider fees and limitations to hospital-only care. We suggest separating out these two types of data following the above redrafted language:

> (o) whether the Health Care Provider requires a patient to pay a concierge medicine facility fee, or other administrative fee, in order to be treated by the Health Care Provider;
>
> (p) whether the Health Care Provider's practice is limited to hospital or facility inpatients;

52.15(2)(p): Information about providers available for consultation via telehealth

With the increase in use of telehealth in the provision of health care services, as discussed in other provisions of the proposed regulations, it is vitally important that consumers understand both whether a provider is able to provider care using telehealth or whether a provider is *only* providing services through telehealth. This is especially important in behavioral health, as a growing number of clinicians are no longer providing in-person care.

Therefore, we recommend the following small – but important – amendment to subsection (2)(p) (as renumbered to new subsection (2)(q)):

> (q) whether the Health Care Provider is available for consultation via Telehealth or whether the Health Care Provider is available for consultation only via Telehealth.

52.15(3): Information carriers are required to display in the provider directory for non-facility in-network providers

We have recommendations to ensure that the information displayed in the provider directory for non-facility in-network providers contains additional details or clarifications in alignment with our recommendations in the previous section regarding information collected. In order to avoid an inadvertent oversight of leaving out some information, we propose that the information to be displayed be defined in a manner that is consistent with the specific terms, definitions, and limitations on information that is to be collected from providers. In general, displaying the information as collected would prevent the carriers from being responsible for interpreting and translating the data collected, which could cause delays and errors, except that for categories of technical information, carriers may opt to use terms that are more understandable to the general public.

First, as explained above, providing clear information on the provider's ability to accept new patients is critical since patients rely on this information when seeking care. We, therefore, propose the same amended language as recommended above for how this information is displayed:

> (d) whether the Health Care Provider ~~is~~:

1. is accepting new patients covered by the Carrier, and, if applicable and known, the wait time for scheduling an appointment;
2. is not accepting new patients covered by the Carrier; or
3. ~~only~~ currently has limited availability to accept~~ing~~ new patients covered by the Carrier

Second, consistent with our recommendations above regarding access for people with disabilities, we believe the current language contained in (h) is overly broad and would likely not contain the level of detail needed for someone seeking to find a provider with particular accommodations, experience, and expertise in treating people with physical, intellectual, and/or developmental disabilities. Therefore, we recommend the following amended language:

(h) whether the office and/or Providers are accessible to persons with disabilities, in accordance with the Americans with Disabilities Act of 1990 (ADA) and other state or federal accessibility requirements, including the following information: ~~both physical and intellectual disabilities;~~

1. whether the office and/or Provider is accessible to persons with physical disabilities , including whether offices or treatment rooms have equipment, such as lifts and adjustable height examination beds, and trained staff to operate them; and

2. whether the Provider's office or treatment location is accessible to persons with intellectual or developmental disabilities, including but not limited to providing low sensory spaces for persons with autism spectrum disorder;

Third, we recommend amending subsection 52.15(3)(i), below, to be consistent with the information collected from providers regarding language access, given that the level of fluency for a particular language could be an important consideration for someone when selecting a provider. The Task Force report includes a recommendation that providers identify their fluency levels in languages they speak.[11] Therefore, we recommend the following amended language:

(i) all languages understood and spoken by the Health Care Provider, including level of fluency;

Fourth, we believe the information contained in (j) should be separated out into two subsections, (j) and (k), because these are distinct categories of information that an insured may want to look for when seeking a provider, and because the former one is mandatory, but the latter one is optional. We recommend the information be displayed according to the following separate categories:

~~(j) age groups and special populations, genders or cultural groups that the Health Care Provider treats on a regular basis, as well as the Provider's race and nationality, if the Provider so chooses;~~

[11] Task Force Report (p. 14) "The providers should choose from a list of languages and identify their fluency or competence in speaking/understanding the language."

(j) identification of:

1. the specific age groups treated by the Health Care Provider, indicated by specific ages;

2.any special populations or and cultural groups treated by the Health Care Provider, including but not limited to ethnic or cultural groups, veterans, refugees, immigrants, individuals who are deaf or hard-of-hearing, and LGBTQ populations, if applicable;

3. whether the provider specializes in the treatment of specific genders or gender identities and identification of those specific genders or gender identities;

with an explanation on the main page of the provider directory in a glossary or similar tool that the listing of a provider's specialty or particular ages or populations treated is based on a Provider's actual treatment of patients in the immediately preceding 24 months. [12]

(k) the Provider's own race, ethnicity and/or nationality, if provided;

For purposes of consumer education, the fact that the carrier has instructed their Providers to list their subspecialties, age groups ,or special populations treated based upon that Provider's actual treatment of such patients in the last 24 months should be explained in a Glossary or other background information section of a provider directory.

52.15(3)(m): Information carriers are required to display in the provider directory relative to telehealth

Consistent with our comment above regarding information carriers are required to collect, we recommend an amendment to 52.15(3)(m) that adds information about whether a health care provider is currently providing services only through telehealth.

(m) whether the Health Care Provider is available for consultation via Telehealth or whether the Health Care Provider is available for consultation only via Telehealth.

[12] The Task Force agreed to collect information on providers treatment of specific age groups within the last six months. See Task Force report, at p. 46. The Task Force discussed limiting listed treatment specialties to patients treated in the last six months, at pp. 31, 35. The Task Force discussed limiting treatment modalities used by behavioral health providers to those used in the last six months, at p.36. With respect to behavioral health subspecialties, the Task Force ultimately recommended that "Providers should report whether they have treated someone in that subspecialty within the past year," At p. 14. However, due to the significant disruptions caused by COVID, we feel that carriers to collect and Providers to report age group, populations served, and specialty information based upon their actual treatment in the past 24 months is more inclusive. We recommend that the Division start with this standard for the first two years of implementation of these regulations, but then re-evaluate whether the Task Force's Recommendations of 6 to 12 months would be more appropriate.

52.15(4): Information carriers are required to display in the provider directory for facility in-network providers

The information regarding whether the office is ADA compliant should contain further specificity regarding the accommodations for different types of disabilities, as well as specify the accommodations for both building access and in the treatment rooms. We, therefore, recommend the following amended language:

> (e) whether the office and/or Providers are accessible to persons with disabilities, in accordance with the ADA and other state or federal accessibility requirements, including the following information: ~~to address physical and intellectual disabilities;~~
>
> 1. whether the office and/or Provider is accessible to persons with physical disabilities, including whether offices or treatment rooms have equipment, such as lifts and adjustable height examination beds, and trained staff to operate them; and
>
> 2. whether the Provider's office or treatment location is accessible to persons with intellectual or developmental disabilities, including but not limited to providing low sensory spaces for persons with autism spectrum disorder;

52.15(6): Carrier requirements for delivering updates to a hard copy of the provider directory

This subsection erroneously cross-references a section of the regulation, 211 CMR 52.15(1), which has been significantly amended pursuant to the current proposed changes. We, therefore, recommend deleting this cross-reference and moving the provisions around updates to a paper copy of the provider directory to 52.15(25), which also addresses updates to paper copies of the directory.

As described in our comments regarding 52.15(24) below, we also have concerns that the provision allows updates to be sent just to the "group representative" and not directly to the insured members on the plan.

52.15(8): Carrier requirements for delivering a provider directory through an internet website, and subsections 52.15(22), 52.15(23), 52.15 (24) and 52.15 (26)

We recommend that the proposed subsection 52.15(8) be amended as follows, based on the clear requirements of Chapter 124[13]:

> (8) A Carrier shall make their Provider directory available in searchable format through an internet website that is accessible to the general public through a clearly identifiable link or

[13] Chapter 124 states: "A provider directory that is electronically available shall: (i) be in a searchable format; and (ii) make accessible to the general public the current health care providers for a network plan through a clearly identifiable link or tab without requiring the general public to create or access an account, enter a policy or contract number, provide other identifying information or demonstrate coverage or an interest in obtaining coverage with the network plan." Codified at M.G.L. c. 176O, s. 28(a).

tab without requiring the general public to create or access an account, enter a policy or contract number, provide other identifying information, or demonstrate coverage or an interest in obtaining coverage with the network plan. ~~A Carrier may deliver a Provider directory through an internet website. References to the term "internet website" shall include "intranet websites," "electronic mail," and "e-mail." If the Carrier refers an Insured to access Provider directory information through an Internet Website, provided the Carrier must be able to demonstrate compliance with the following:~~

(a) ~~The Carrier issues and delivers written notice to the Insured that includes:~~ The carrier shall deliver notice of the provider directory to at least one adult in the household of each insured, by direct mail, or by electronic mail if the insured has agreed to communicate electronically, that includes:

1. all necessary information and a clear explanation of the manner by which Insureds can access their specific Provider directory available through an Internet Website;
2. a list of the specific information to be furnished by the Carrier through an Internet Website;
3. the Insured's right to receive, free of charge, a paper copy of the Provider directory at any time, by mail, to be sent by the carrier postmarked within 5 days of the request;
4. the manner by which the Insured can exercise the right to receive a paper copy at no cost to the Insured; and
5. a toll-free number for the Insured to call with any questions or requests including instructions about how the Insured can contact the carrier if they want assistance in locating an available provider.

(b) The Carrier shall take reasonable measures to ensure that the Provider directory information and documents furnished in an Internet Website are substantially the same as that contained in the Carrier's paper documents.

Furthermore, we are concerned that the language in 52.15(8) may narrow the definition of "internet website" to include only "intranet websites," "electronic mail," and "email." This is contradictory of the clear language of Chapter 124. Also, as proposed above, we also recommend that 52.15(8)(a)(5) be amended to clarify that insureds can contact the carrier for assistance in finding a provider. We further recommend that subsection 52.15(23) be deleted, because it is largely redundant, and it also proposes that a person who requests a print version of a provider directory could be sent a shorter, truncated version of the directory that is limited to their geographic region. We think this is not an appropriate option for a carrier's response to an insured who makes such a request, either because they have low computer proficiency or poor internet access. Consumers from across the state often come to hospitals and specialists located hours away when they need specialty care. They deserve access to a full print directory upon request, unless they only request a list of providers in their area or region.

In addition to deleting proposed subsection 52.15(23), we also recommend that the proposed subsections 52.15(22), (24), and (26) all be deleted, as they are redundant, and potentially contradictory to the clear mandate under Chapter 124 to make provider directories publicly available on the internet to current and prospective members.

52.15(9): Requirements for electronic provider directories, including updates

We strongly recommend amendments to this section regarding the timeframes that carriers must follow when updating information in the electronic provider directories. While all information should be updated in a timely manner, it is especially important that information regarding when a carrier is no longer accepting new patients, resuming accepting new patients, or limiting when they are accepting new patients be provided as quickly as feasible given that this information can change frequently and is therefore more subject to inaccuracies and resulting consumer frustration and confusion.

In addition, under the requirements of 52.15(15), providers are required to inform the carrier "immediately" when the provider is not accepting new patients. If a provider must notify the carrier "immediately" if their status of availability changes, as per subsection (15), then the carriers should have a comparable duty in 52.15(9) to make this information available as quickly as possible, such as within 48 hours. The final Task Force report acknowledged that carriers should take all necessary steps to get closer to real-time updating of provider directory information as the provider makes changes to their information.[14] The provider representatives on the Task Force also discussed at length that if the providers report this information promptly, but then the carriers do not make the changes promptly, the providers will have no incentive to report this information because it will be outdated and inaccurate once it is reflected in the directory.[15] Furthermore, if this change in status is coming directly from the provider rather than a reported inaccuracy from a consumer, the carrier will not have to engage in the same process of investigation and verification, which can take additional time.

In the time since the Massachusetts law was enacted and the Task Force concluded their discussions and recommendations in early 2020, relevant new requirements for all health plans under the "No Surprises Act" provisions of the Consolidated Appropriations Act of 2021 have been implemented. Under this law, carriers must ask providers to update their information every 90 days and must display updated provider information within 2 business days of the carrier receiving the update from the provider. In addition, if an individual relies on incorrect provider directory information and, as a result, receives services from an out-of-network provider or out-

[14] Task Force report (p.15) "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 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."

[15] Task Force Report (p. 15) "…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."

of-network health care facility, the plan and provider must only charge in-network cost-sharing.[16]

We, therefore, recommend that the language in subsections (d) and (e) of 52.15(9) be amended in the following way:

> (9) A Provider directory that is electronically available shall:
> …..
> (d) be updated in no less than 48 hours, or in real time where feasible, when a Carrier is informed by a contracting Provider that:
>
> 1. such Provider is no longer accepting new patients for that Network plan, the provider has limited availability to accept new patients, or that such Provider has resumed accepting new patients;
>
> 2. such Provider is no longer in the network for the plan.
>
> (e) be updated as soon as practicable and not less often than monthly or as directed by the Commissioner or as required by federal law**;** provided, however, that an electronic Network plan Provider directory shall be updated as quickly as is feasible, and more frequently than monthly, or as required by the Commissioner, when the Carrier is informed of and upon confirmation that:
>
> ~~1. a contracting Provider is no longer accepting new patients for that Network plan or an individual Provider within a Provider group is no longer accepting new patients;~~
>
> 1. a Provider or Provider group is no longer being under contract for a particular Network plan;
> 2. a Provider's practice location or other Provider directory information has changed;
> 3. a Provider has retired or ceased practice; or
> 4. any other information that affects the content or accuracy of the Provider directory has changed.

We also recommend that the provision in 52.15(9) that directs carriers to prominently display the dedicated customer service email address and telephone number be expanded to ensure that information about seeking assistance with finding a provider and accessing out-of-network services if needed is also prominently displayed:

> (e) A Provider directory shall include a dedicated customer service email address and telephone number and electronic link, set forth prominently in both the directory and on the Carrier's website, and ~~will~~ shall contain a prominent statement on the directory's first page that (a) invites and encourages Insureds to contact the carrier in the event that they want assistance or are encountering any difficulty in locating a provider; (b) informs Insureds of their right to access an out-of-network provider in the event that no in-

[16] Consolidated Appropriations Act, 2021 (H.R. 133, Section 116): https://www.congress.gov/bill/116th-congress/house-bill/133/text. Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act).

network provider is available; and (c) educates ~~members~~ Insureds on how to notify the Carrier of inaccurate Provider directory information.

Regarding the requirements for investigating reports of potential inaccuracies, we recommend adding further emphasis on working to investigate the reported inaccuracies more promptly:

> [(e) cont'd] The Carrier shall investigate reports of Provider directory inaccuracies promptly and conclude such investigations in no later than ~~within~~ 30 days of receiving notice of the inaccuracy. The Carrier shall modify the Provider directory as quickly as feasible, but not longer than ~~within~~ 30 days after ~~of~~ a finding of an inaccuracy.

Finally, we strongly support the provisions in this section that direct carriers to assist insureds when they are unable to locate or schedule an appointment with a provider listed in the directory as accepting new patients, including assisting with scheduling an appointment and contacting providers who were unavailable to schedule an appointment to understand the reasons. The sentence that begins with "Carrier[s] will establish a dedicated toll-free telephone number…" through the end of that paragraph are critical improvements that will help ensure that consumers are able to access providers that treat their particular age group or health condition in a timely manner.

52.15(13): Responses to requests by insured for available providers, or for excluded services

With respect to both regulating a carrier's adequate response to an insured's request for information about whether a class or type of providers "are excluded from coverage" and with respect to a request to find an available provider, the proposed subsection (13) immediately above is over-broad, and thus is in potential conflict with other currently existing laws and DOI regulations.[17]

More generally, it is unclear what the purpose of proposed subsection (13) may be. We presume that this subsection makes specific reference to the availability of Primary Care or Behavioral Health providers, and not all Network providers, due to the network adequacy standards under 52.13. However, Chapter 124 draws no such distinction with respect to these limited types of providers, so this subsection needs no such limitation.

Also, the proposed language in subsection (13) about including information about a "type of Providers requested by an insured [that are] not a covered benefit" would not be appropriate to include in the provider directory because exclusions of covered services are required to be

[17] In response to a specific request for an insured for assistance to find an available provider, current law and DOI regulations create a clear duty for carriers to actively assist members to find providers that are "available" to accept new patient. See 211 CMR 52.14(1)(f)1 and 2; see also M.G.L. c. 176O, s.7(a)(7). However, under the subsection (13) as currently proposed, a carrier would satisfy this duty simply by providing such information "in an easily obtainable manner, including in the provider directory." As such, proposed subsection 25.12(13) is confusing and potentially contradictory to 211 CMR 52.14(1)(f)1 and (1)(f)2 and M.G..L c. 176O, s. 7(a)(7).

described in the Evidence of coverage document, not in the provider directory.[18] If a consumer asks about accessing a type of provider that is excluded from coverage, or a type of service that is excluded from coverage, the carrier should respond by referring them to, and, if desired, furnishing them with a copy of, the specific provisions in the Evidence of Coverage document that exclude that type of service or that type of provider.

As noted above, consumers enrolled in fully-insured managed care plans have important statutory rights to receive help from their carriers to quickly identify participating providers that are available to accept new patients. And if no in-network providers are available, insureds have the right to be covered for treatment by out-of-network providers under their in-network terms.[19]

To extent that subsection 52.15(13) is intended to address how a carrier should respond to an insured's question about whether a specific provider is taking new patients, we propose the revising and simplifying this subsection as follows:

> (13) ~~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.~~ If an insured requests information about whether a specific Provider is covered by the plan or if a specific Provider is available to accept new patients, a carrier should:
>
> (a) Ascertain whether the insured has access to their provider directory, either online or in print form, and offer to provide the insured with either version as the insured prefers.
> (b) To the extent that an insured has already attempted to but was unable to use their existing access to the Provider Directory to answer this question, or to the extent that an insured is not able to access the online version of the provider directory, due to lack of internet access, low degree of computer proficiency, or any other barrier, the carrier shall provide the information to the insured verbally over the phone, and offer to send the information to the insured electronically or by snail mail, as the insured prefers.

To address consumer requests for assistance in finding providers who furnish services that are excluded from coverage, the Division could clarify the carrier's obligations by including the following additional language in an additional subsection labelled 52.15(13)(c):

> (c) In response to a consumer or insured's request for services that are excluded under the plan, or such a type of provider that only furnish such excluded services, the carrier should start a prompt process to review the terms of the Evidence of Coverage,

[18] *See* 21 CMR 52.13((3)(a); M.G.L. c. 176O, s. 6(a)(1).
[19] M.G.L c. 176O § 6(a)(4)("[W]henever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network;") *See also* 211 CMR §52.14(1)(f)3("[T]he carrier, if necessary, shall obtain or arrange for out-of-network services if they are unavailable within the network."); 211 CMR 52.13(3)(f)2.

for the specific provisions in the plan documents that would exclude any such services or types of providers, and then offer to send the information to the insured electronically or by snail mail, as the insured prefers.

Finally, some measure of record-keeping by the carrier should accompany any consumer request for help finding a provider. For purposes of accountability, we propose the following language for a new subsection 52.15(13)(d) to standardize record-keeping requirements, in a manner that is consistent with federal law.

> (d) The carrier shall retain records of any such inquiry by an insured, and of the carrier's subsequent communications, in the insured's file for at least 2 years. [20]

52.15(14): Participating provider nurse practitioner and physician assistant lists

As currently drafted, we are concerned that subsection (15) would allow for carrier to create a separate "list of Participating Providers" that could differ from the information contained in the provider directory. If carriers use multiple lists that are not consistent with the public facing provider directory, this could be a potential source of consumer misinformation and confusion. We therefore recommend amending this subsection as follows:

> (14) Notwithstanding any general or specific law to the contrary, a Carrier shall ensure that all Participating Provider Nurse Practitioners and Participating Provider Physician Assistants with whom a member can make an appointment are included and displayed in a nondiscriminatory manner in the Carrier's Provider Directory. ~~on any publicly accessible list of Participating Providers for the Carrier.~~

52.15(15): Contract requirements for provider notification on accepting new patients

We strongly support the language that carriers' new and renewing provider contracts require providers to inform that carrier immediately when the provider is not accepting new patients. As discussed above, this is time sensitive information that directly impacts the ability of a consumer to find an appropriate health care provider in a timely manner.

As the Campaign previously commented to the Division in 2018, in the past, carriers have often conditioned contracts with providers upon the provider's blanket agreement to accept any insured seeking care as a new patient. This is important to carriers because it affects network adequacy reporting and standards under 211 CMR 52.12(g)3. However, behavioral health providers report that this routine contracting practice by carriers forces them to agree -- on paper -- to accept new patients under the contract, even when in fact they cannot accept such patients. The artifice of this contractual obligation – to always accept new patients – perpetuates the

[20] New federal law under the No Surprises Act requires effectively the same response, namely that a health plan must "responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and "(B) retains such communication in such individual's file for at least 2 years following such response."

falsehood that the carrier's network is adequate, when in reality it is not. Providers must be able to accurately communicate when their practice can accommodate new patients, without fear of reprisal by the plan.[21] In light of this issue, a carrier should be prohibited from conditioning participation in a network upon a provider's agreement to universally accept all new patients. Therefore, we recommend that the proposed regulation be amended to include additional restrictions on carrier-provider contracts as follows:

> (15) Carriers' new and renewing Provider contracts shall require Providers to inform the Carrier immediately when the Provider is not accepting new patients. Such contracts shall be prohibited from requiring a Provider to agree to accept new patients when the Provider is unable to do so.

To reinforce this requirement, subsection 211 CMR 52.11(5), which relates to carrier contracts, also should be amended to include the following provision:

> (f) requires the provider to agree to accept new patients.

52.15(17): Carrier actions following notice of potentially inaccurate information

We propose the following amendment to subsection 52.15(17):

> (17) Carriers 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~~ shall ~~are recommended to~~ take the following steps:
>
> (a) If the potential inaccuracy relates to the physical address or telephone number of the Provider, the Carrier shall ~~should~~ either immediately remove the information from the online directory until the information is updated, or designate the information as "unverified" for no longer than 90 days, after which the information must be immediately removed;
>
> (b) If the potential inaccuracy relates to whether a Provider is accepting new patients, the Carrier ~~should~~ shall immediately remove the designation "accepting new patients" for that Provider until the information is updated;
>
> (c) If the potential inaccuracy relates to whether a Provider is or continues to be an in-Network Provider, the Carrier shall ~~should~~ remove the full Provider listing from the online directory until it is updated.

We strongly support the spirit of proposed 52.17(17) that would require carriers to make certain changes to their Provider Directory listings very quickly upon notice that some information is inaccurate, to avoid further misleading plan members during the time which the carrier engages

[21] Aside from concerns about accuracy, such a requirement is also unfair to providers. Some providers report that reimbursement rates by some carriers or carve-outs for behavioral health services are so low that their practices would not survive financially if their 'payer-mix' included too many clients from the low-paying carrier(s) or carve-outs. In such a context, or if a carrier reduces their reimbursement rates, a provider, out of concern for their patients, may reasonably wish to continue to treat their current patients who are insured by that carrier/carve-out, without being forced by contract to agree to accept any and all new patients from that carrier. Such conduct by a provider would not be discrimination against a patient or a consumer; it would be a reasonable market-based reaction by the provider to the low reimbursement rate of that carrier or carve-out.

in their own internal process to investigate and confirm the new information. This recommendation from the Task Force, just like all of the recommendations included in the Task Force's extensive Report, should be required under the regulations, and not just a suggested best practice that some carriers might choose to follow, but that other carriers may not follow.[22]

This is justified because the sources of information about a potential inaccuracy -- provider themselves, or a carrier's own audit-- are highly reliable. We strongly support the language in 52.15(17)(b) recommending that the carrier remove the designation "accepting new patients" if that potential inaccuracy relates to whether a provider is accepting new patients, but such an update should be done immediately. Consistent with the language in 52.15(17)(a) for potential inaccuracies regarding the physical address or telephone number, we recommend that 52.15(17)(b) be amended to specify that the designation be removed "immediately."

We additionally recommend a technical amendment to 52.15(17)(a) to clarify that the carrier can "designate the information as unverified for no longer than 90 days, after which the information must be immediately removed."

We recommend striking the language "and have been unable to validate the accuracy of the listing" because there is no clear process or time frame for a carrier to do so. Thus, this language would undermine the intended immediacy for making update to a directory when information sources (a carrier's audit or the provider themselves) are highly reliable.

Finally, we recommend removing the reference to "Consumer" reports of inaccurate information, because regulation subsection 52.15(9) already lays out a distinct process for when and how a carrier shall respond to and investigate a report from a consumer or plan member about an inaccuracy in the directory.

52.15(18): Carrier audits of behavioral health providers' provider directory information; 52.15(19): Behavioral health audit exclusions and frequency of audits

We strongly support the audit approach in the proposed regulations 52.15(18), (19) and (20), with the following technical amendments.

First, the term "Behavioral Health Provider" is not included in the 'Definitions' section of the regulation, 211 CMR 52.02. This term should not be defined by reference to providers who furnish

[22] See Provider Directory Task Force Report at p.16. The Task Force discussions and deliberations were all framed in terms of overall recommendations that the Division would consider in developing and issuing subsequent regulations. This is completely consistent with Chapter 124, which required that "The task force shall develop recommendations for carriers" and that "The task force shall file its recommendations, including any proposed regulations, with the clerks of the senate and house of representatives" before "The division of insurance shall promulgate regulations implementing section 28 of chapter 176O of the General Laws not later than July 1, 2020 and shall consider the recommendations of the task force established under section 4 of this act when developing such regulations." Chapter 124, Section 4, 5. There is no distinction in the Task Force's recommendations on page 16, regarding these immediate updates, and their many other recommendations throughout pages 12 to 20 of the Report.

Behavioral Health Services because many behavioral health services are currently provided by primary care providers that primary care providers that practice under a broader medical license that includes both medical and behavioral health services.[23] Nevertheless, for purposes of clarity of defining which providers in a carrier's network should be audited on this more frequent basis, we propose a functional definition of Behavioral Health Provider be added in new subsection 52.15(18)(f).

Also, subsection 211 CMR 52.15(18) and (19) seem to inadvertently exclude non-hospital behavioral health facilities from the auditing process. These sections also introduce the term "Behavioral Health Audits" that is similarly undefined. Therefore, we propose the following minor amendments to combine subsections 52.15(18) and 52.15(19) as follows:

> (18) Carriers shall audit ~~Behavioral Health Providers'~~ Provider directory information of Behavioral Health Providers and non-hospital Behavioral Health facilities on a quarterly basis, including information with respect to:
>
> (a) all such ~~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
>
> (b) a representative sample of no less than 15% of all such ~~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; and
>
> (c) Carriers should compare at least 2% of the attestations received from such Providers in the prior 120 days to the related information or changes in their Provider directories.
>
> (d) Such ~~(19) Quarterly Behavioral Health~~ audits shall exclude such ~~Behavioral Health~~ Providers that have been audited in the last 12 months, or which have been removed from the Provider directory.
>
> (e) In the event that three successive quarterly audits demonstrate that at least 85% of such~~the~~ auditable ~~Behavioral Health~~ Providers are listed in a manner that is 100% accurate, the Carrier may shift to conducting ~~Behavioral Health~~ audits of such Behavioral Health Providers on a semi-annual basis.
>
> (f) For purposes of this subsection 52.15(18), Behavioral Health Provider means an individual provider that is licensed to provide primarily or exclusively behavioral health services.

52.15(20): Carrier audits of non-behavioral health care providers

We strongly support the need for regular audits of non-Behavioral Health Providers and of hospitals and other facilities that are not behavioral health facilities. We propose the following

[23] Blue Cross Blue Shield Foundation, Help for the Front Line: Approaches to Behavioral Health Consultation for Primary Care Providers, March 2022. Available at https://www.bluecrossmafoundation.org/publication/help-front-line-approaches-behavioral-health-consultation-primary-care-providers

technical amendments to subsection 52.15(20), including renumbering it to subsection 52.15(19), and eliminating the use of other undefined terms, as follows.

> (19) ~~(20) Non-Behavioral Health Care Providers'~~ Provider directory information for Health Care Providers other than Behavioral Health Providers and non-Hospital Behavioral Health Facilities should be audited to ensure accuracy of Provider directory information on at least an annual basis, or as directed by the Commissioner. On a quarterly basis, Carriers should compare at least 2% of the attestations received from such Health Care Providers in the prior 120 days to the related information or changes in their Provider directories.

This regular, quarterly process would require carriers to regularly compare the attestations that they are receiving from all types of providers -- not just those in behavioral health -- to the information that is being updated and displayed in their directories. This is a way for the carriers to engage in some level of quality control, to ensure that all carrier vendors, carrier staff, and carrier data exchanges systems are working properly.

Finally, the audits should start promptly, considering that the carriers have had years of notice that their directories were replete with inaccuracies, including as a result of the Market Conduct Examination by the Division concluded in 2018. Carriers also have known that these inaccuracies were all in violation of longstanding state and federal law. Therefore, we propose the following new subsection 52.15(20) as follows:

> (20) ~~Non-Behavioral Health Care Providers' Provider directory information should be audited to ensure accuracy of Provider directory information on at least an annual basis, or as directed by the Commissioner.~~ Carriers shall initiate these required audits no later than the start of the second calendar quarter after these regulations are promulgated in final form, with audits to continue quarterly or annual thereafter, as described in subsections 52.15(18) and (19).

52.15(21): Carrier maintenance of provider audits

We strongly support the requirement that carriers maintain records of their audits. We feel that the Division could provide some clarity as to how long this duty to retain documentation continues. We propose the following technical amendments:

> (21) Carriers will maintain files of all Provider audits for no less than seven (7) years from the completion of any audit so that they may be reviewed by Division staff upon request.

52.15(22): Delivery of a Directory to one household adult; 52.15(23): Requirements for mailing print copies of the provider directory; 52.15(24): Delivering a provider directory to a group representative; and 52.15(26): Delivering a provider directory to insureds upon enrollment

As stated in the discussion of subsection 52,15(8) above, we propose deleting subsections 52.15(22), (23), (24), and (26).

> ~~(22) A Carrier shall deliver a notice to at least one adult Insured in each household upon enrollment annually about how to access the Carrier's Provider directory.~~
>
> ~~(23) A Carrier shall deliver a Provider directory to an Insured or a prospective Insured upon request. The print copy of the requested Provider directory information shall be provided to the requester, free of charge, by mail postmarked no more than five business days after the date of the request, and the print copy may be limited to the geographic region in which the requester resides or works or intends to reside or work.~~
>
> ~~(24) In the case of a group policy, the Carrier delivers a paper copy of the shall deliver a Provider directory to the group representative. on at least an annual basis.~~
>
> ~~(26) A Carrier shall not be required to deliver a Provider directory upon enrollment if a Provider directory is delivered to the prospective or current Insured, or in the case of a group policy, to the group representative, during applicable open enrollment periods.~~

Subsection 52.15(22) is redundant to subsection 52.15(8). The remaining subsections are inconsistent with the clear mandate in Chapter 124 that requires that provider directories be available online for all plan members, and even prospective plan members, to access freely through a publicly available internet site.[24]

Chapter 124 accurately reflects how technology has progressed and the preferred mode for most to use a provider directory is electronically, not on paper. Yet many of the regulatory subsections seem to dwell upon the burdens to the carriers of updating and mailing print directories. For instance, subsection 52.15(26) seems concerned with a carrier's burden to "deliver" a provider directory" when all that must be delivered is an email, or perhaps a letter instructing an insured about how to create a log-in for the plan or to call the carrier for assistance.

Circumstances when an insured reasonably relies upon materially inaccurate information in a carrier's provider directory

We recommend that the regulation include an additional subsection to address circumstances in which an insured reasonably relies upon materially inaccurate information contained in a

[24] Chapter 124 states: "A provider directory that is electronically available shall: (i) be in a searchable format; and (ii) make accessible to the general public the current health care providers for a network plan through a clearly identifiable link or tab without requiring the general public to create or access an account, enter a policy or contract number, provide other identifying information or demonstrate coverage or an interest in obtaining coverage with the network plan." Codified at M.G.L. c. 176O, s. 28(a).

carrier's provider directory. Federal law has changed significantly in this area since the convening of the Task Force, giving consumers new rights to be held harmless, and charged no more than their regular cost-sharing amount when they see a provider in reliance upon an incorrect provider directory. Therefore, to be consistent with federal law, the Division should add a new subsection which requires that:

> (28) For plan years beginning on or after January 1, 2022, if an item or service furnished to an insured by a non-participating provider or non-participating facility would have otherwise been covered if furnished by an in-network provider or facility, and the insured received information from the carrier about a provider directory listing for that provider which was inaccurate, or inaccurate information from the carrier in a communication with customer service about a provider, the carrier shall cover the item or service as if the provider had been an in-network provider, with no greater cost-sharing or deductible for the insured.

This is consistent with Section 116, Protecting Patient and Improving the Accuracy of Provider Directory Information, as enacted in the No Surprises Act provisions of the Consolidated Appropriations Act, 2021, and codified at 42 U.S.C. § 300gg–115.[25]

52.16(12) Telehealth information in provider directories

As stated above, we support DOI's inclusion of telehealth information in provider directories, and similarly suggest that in 52.16(12), information be included about whether a provider is only providing services through telehealth, with a cross-reference to the provider directory regulations at 52.15(2)(p) and 52.15(m), as follows:

> (12) Carriers are to include information within Network Directories which Providers are available to deliver services via Telehealth. Network Directories also shall include information about which Providers are only available to deliver services via Telehealth, in accordance with sections 52.15(2)(p) and 52.15(3)(m).

Comment on the urgent need for prompt implementation

We note that the obligation to furnish members with accurate provider directories has existed under state law since 2011. *See* M.G.L. c. 176O, § 7(a) – (a)(1). This obligation has also been in effect under federal law for plan years beginning on January 1, 2016. *See* 45 C.F.R. §156.230(b). State law changes under Chapter 124 were enacted in 2019 and the law directed the Division to finalize and promulgate these rules by July of 2020. More recent federal law requirements under the No Surprises Act were enacted in December 2020 and went into effect on January 1, 2022. In

[25] Consolidated Appropriations Act, 2021 (H.R. 133, Section 116): https://www.congress.gov/bill/116th-congress/house-bill/133/text.

fact, DOI's own Market Conduct Examination, published in June of 2018, noted that the carriers had started to develop a common portal which they planned to complete in "1-2 years…."[26]

In this context of repeated promises of coming solutions by carriers and their agents, consumers facing the worst behavioral health care access crisis in recent memory, and current legal obligations continuing to be unmet, we recommend that the Division take a firm stand to reject the continuing requests by carriers for yet another year to implement these regulations, especially in all the areas where these requirements are duplicative of current obligations under federal law. Most of the requirements under these regulations – such as updating provider directories about provider status to accept new patients, or de-listing providers who are no longer under contract with a carrier's plan, and how a carrier must respond to a consumer who reports an inaccuracy in a directory – are not new. For other sections, such as their auditing requirements, most of the carriers have been required to start regular audits of their behavioral health providers in late 2020 under their agreements with the Massachusetts Attorney General. The carriers should have established these systems in the last two years. For other specialized requirements, such as gathering and listing new information from providers concerning their sub-specialties for behavioral health, their office hours at various locations, or their languages fluency, etc., the carriers should be given a reasonable time of no more than six months to implement these systems and begin updating this information.

Thank you again for the opportunity to provide detailed comments with regards to the provider directory provisions of the proposed amended regulations at 211 CMR 52.00 and ask that the Division include the above recommended changes in the final regulations. We are encouraged by the progress to date to improve the accuracy of health insurance carrier provider directories in Massachusetts and we think these changes will further advance these efforts, helping families to more easily find a provider that meets their needs. Please contact Wells Wilkinson at wwilkinson@hla-inc.org or Suzanne Curry at scurry@hcfama.org with any questions or to discuss these comments further.

Sincerely,

Wells Wilkinson, Esq.
Senior Supervising Attorney
Health Law Advocates

Suzanne Curry
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Health Care For All

On behalf of the Children's Mental Health Campaign

[26] MCE at p. 13. "Efforts to develop statewide databases are planned for 1-2 years from now and thus will not address members' current need for clear and accurate information."