

Improving Health Plan Provider Directories

*And the Need for Health Plan-Practice Alignment,
Automation and Streamlined Workflows*



Disclaimer: This white paper was developed to provide the health care industry with general guidance related to the maintenance and upkeep of provider directories based on policies and regulatory requirements at a specific point in time. This document represents the views of the contributors and is for informational purposes only. It is not intended as legal or consulting advice.

Executive Summary

The purpose of this paper, authored by the American Medical Association and CAQH, is to analyze the current state of the provider directory problem, identify best practices and recommend practical approaches that both health plans and practices can take to solve the problem.

The Situation:

- Most patients use health plan provider directories to make decisions on insurance coverage and to seek and select clinicians to provide healthcare services.
- The accuracy of these directories has been a longstanding problem and, despite significant efforts, minimal improvement has been observed.
- Patients encountering inaccuracies in health plan directories can experience delays in access to care and unexpected out-of-pocket expenses.
- Regulators and legislators continue to introduce new requirements aimed at improving the accuracy and timeliness of directories

The Solution:

- The root causes of the problem must be understood, and solutions need to be employed that align and position stakeholders to address them.
- This requires a recognition of shared responsibilities and a commitment to streamlining the process for patients to find in-network care. These responsibilities include:
 - Health plans streamlining data update channels and providing practices with a way to differentiate between locations where a clinician is seeing patients versus one where he or she is contracted but not regularly seeing patients.
 - Practices providing timely and accurate updates when key directory data, such as office address and phone number, change and associating clinicians to practice locations where they regularly see patients as opposed to registering every clinician at all possible practice locations in the event they are covering for colleagues.
- Voluntary standards must be adopted for provider directory data quality, governance and interoperability that will position health plans and practices for success.

Background

Patients rely on a variety of sources to find the care they need from the clinicians they prefer. These include search engines, doctor rating sites, social media and clinician and personal referrals. Among the more common resources that patients use are health plan provider directories which, according to two surveys conducted^{1,2} in 2020, more than half of patients use to select a physician.

Health plan provider directories allow members to search and view information about in-network providers, including the practice location, phone number, specialty, hospital affiliations, whether they are accepting new patients and other details. Some directories also provide information on health equity and accessibility issues, such as public transportation options, languages spoken, experience with specific patient populations and the ability to provide specific services.

Despite industry efforts, the accuracy of health plan provider directories is a persistent challenge. The Centers for Medicare and Medicaid Services' (CMS) audits of Medicare Advantage online provider directories have determined that more than 50% of entries have at least one inaccuracy — an error rate that remained largely unchanged in 2017 and 2018.³ A 2020 study published in *Health Affairs* similarly found that 53% of patients searching for behavioral care in provider directories found inaccuracies.⁴

When directory information is inaccurate, patients experience inconvenience (non-working phone numbers, longer time to find the right practitioner), and financial consequences (unplanned out of pocket expenses). Directory errors may also result in a patient selecting a health plan based on inaccurate information about which clinicians are in-network.

To address this issue, regulators and legislators at the federal and state levels have introduced measures that require health plans and practices

to put processes in place to improve the quality of provider directory data. Table 1 presents an overview of the national requirements and a sample of state requirements to demonstrate the impact on health plans and practices. These include requirements for the type of information presented in directories, and the frequency at which provider directories must be updated and, in some instances, standards for accuracy and completeness.

The No Surprises Act, signed into law in December 2020, establishes a turnaround time in which commercial health plans must update information and requires that they implement a process to remove clinicians and healthcare facilities from directories when information cannot be verified.⁵ While accelerated update requirements should theoretically achieve improved directory accuracy, there are other factors, described later, that need to be considered and likely impact the pursuit of overall directory improvements. The No Surprises Act sets the foundational requirements but does not supersede more rigorous state government requirements on provider directories. Directories are one of many administrative challenges that practices and health plans are facing, including those related to interoperability, prior authorization, price transparency and provider quality reporting.

To solve this problem, stakeholders must address the root causes of directory inaccuracies in a coordinated way. Today, consumers have become accustomed to convenient online search and booking experiences outside of healthcare, and they rely on the information to be correct. They are also beginning to use provider directories to find new types of information (e.g., the availability of telehealth, whether practices offer LGBTQ-friendly services). Therefore, it is important that health plans and practices align on their respective responsibilities to improve the accuracy of directories on which patients rely.

Table 1 - Federal and Sample State Provider Directory Requirements

Requirement	Medicare Advantage ⁶	Medicaid (MCOs) ⁷	Exchange/QHP ⁸	No Surprises Act	NAIC Model Legislation ⁹	California SB137 ¹⁰	New York ¹¹
Lines of Business	Medicare Advantage	Medicaid	Exchange	Commercial	All	All	All ¹²
Outreach to Providers (frequency)	Quarterly	N/A	N/A	Verification process every 90 days	N/A	Semi-annually (individual providers); annually (all other providers)	Annual
Practice response required	No	No	No	Implied, but subject to interpretation	No	Yes	No
Update timeframe (upon receipt of new information)	Monthly	Monthly	Monthly	2 days	Monthly	Weekly (online directories)	Within 15 days of affiliation change
Audits	Government audits can result in penalties	N/A	N/A	Verification process every 90 days	Health plan should periodically audit	N/A	N/A
Addressing patient complaints	Protocol required	N/A	N/A	Response protocol for network status inquiries	N/A	N/A	N/A
Machine-Readable Data	Provider Directory API	N/A	Machine-readable files	N/A	N/A	N/A	N/A
Practice Requirements	CMS states it does not have authority	CMS states it does not have authority	CMS states it does not have authority	Providers and healthcare facilities must submit data and can be removed from directory if not responsive	No explicit requirements	Providers and healthcare facilities must submit data and can be removed from directory if not responsive	No explicit requirements

What are patients looking for?

The importance of directory accuracy is best understood through the eyes of patients: What do they use the information for and how inaccurate directory information impacts the quality and value of care they receive?

Patients use directory information to identify the best clinicians for them based on specialty, location, hours and health plan participation. As such, many health plan directories have specialty and address as their first filter/search criteria (e.g., cardiologists in Fairfax, Virginia). However, CMS has found that nearly 70% of the errors in directories are ‘provider not at location.’ If a provider is not at the address that the health plan has on record, the patient might not be able to find or see that doctor. Similarly, if the phone number is not working, or if the phone number is not the practice’s appointment phone number (i.e., a billing or other administrative phone number), patients must search for an updated and/or correct phone number or choose another clinician altogether. Errors in location and contact information can lead to patient frustration and in many cases, delays in accessing care.

Information about participating clinicians and in/out of network status are also used by patients to choose a health plan and seek care that is covered by their plan. They rely on the accuracy of this information to avoid unexpected out-of-network bills. A 2020 study in the *Journal of General Internal Medicine* found that of patients receiving unexpected bills, 30% noted errors in their health plan’s provider directory.¹³ If information is incorrect, then the patient may find him or herself with unanticipated medical expenses and hours or days of administrative follow-up.

Other information, such as languages spoken and special skills and experience, also help patients identify physicians and practices that are a good fit for their specific needs. Today, this information is sparsely populated in health plan provider directories for a variety of reasons. The convergence of these issues represents additional barriers to care for patients navigating an already complex healthcare system.

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Why is keeping directory information accurate so difficult?

The information included in directories changes and the scope of required information keeps expanding. Practices move, physicians change practices and contracts between practices and health plans expire. Multiple industry reports^{14, 15, 16} state that between 20% and 30% of directory information changes annually. Yet, no single party is the exclusive keeper of this information. Some of the information is governed and controlled by the practice, such as contact information and the roster of clinicians who practice there. Other data, such as whether a clinician is accepting new patients under a specific plan, can be owned by the practice, the health plan or in some instances shared by both parties. Health plans manage information on which plans each clinician participates in and which practice locations are covered by contract. Having different authoritative sources depending on the data contributes to the difficulty for health plans and practices in keeping information accurate.

The process starts when practices provide data to health insurers initially as part of the credentialing and contracting process. The health plan then determines which clinicians and locations will be enrolled in which health plan products. This establishes the data that is used to initially populate provider directories. Both practices and health plans are then expected to provide updates when changes occur, including when clinicians are no longer affiliated with a practice or when the contractual relationship between the practice and the health plan changes.

The practice perspective.

Practices are expected to notify health plans when clinicians leave a group or are no longer practicing at a specific location. Practices should also provide updates when locations and phone numbers change. Health plans depend on these updates to keep directory information current.

While this may appear straightforward, practices must juggle a variety of administrative burdens that

interfere with their ability to comply with requests for directory updates.

To further complicate the situation, practices are often inundated with requests for provider directory information from multiple health plans through varying channels (e.g., phone calls, e-mails, health plan-specific portals) that can result in inaccurate information inadvertently being shared or updates not being shared at all. On average, practices have more than 20 health plan contracts that require provider directory updates.¹⁷ Additionally, some practices note that the updates they provide to health plans do not always appear in the health plan's directories.

Many practices separate their credentialing information (about the clinician) from contracting information (about practice locations and health plan participation) and appointment scheduling data (on availability). When information is siloed, a practice may struggle to bring the disparate data together accurately and make it available to health plans and other parties.

Finally, an important aspect of the relationship between health plans and practices is financial: clinicians are paid for services via the claims submission and adjudication process. Practices need to be able to report when a clinician leaves the practice without incurring issues with payment for care provided prior to his or her departure. The ability to report this information will help health plans better improve their directories while avoiding administrative issues around expected claims payments.

The financial relationship also drives how practices submit information to health plans. Because some plans contract and approve/deny claims by location, practices may list all clinicians at every location when, in fact, each clinician primarily practices at only one or two. Practices may do this in the

event a clinician provides care or coverage at a location other than his or her primary site(s). While this approach may help avoid claim denials and payment delays, it has the unintended consequence of contributing to directory inaccuracy. CMS observed this in its three audit reports between 2016 and 2018¹⁸ and suggested that health plans remind provider groups “that listing all providers at all locations causes plans to be out of compliance.”

The health plan perspective.

Health plans are expected by their members and their contracted practices to display a provider directory to the public that represents an accurate reflection of their networks. It is the most public-facing data that health plans provide, and patients are dependent on accurate directories to access care. Being listed correctly in a directory is a fundamental component of a practice-health plan contract.

The contract between the health plan and practice is the authoritative source on which clinicians may see patients in certain plans and products, either by explicitly listing the clinicians or by contractually delegating that responsibility to the practice or other third party. Plans also maintain claims data that provide a variety of other insights into the practice, care provided to patients and billing activities.

Most directory regulation and legislation identify health plans as the party accountable for provider directory accuracy, and many plans have devoted significant resources to comply. These efforts include contacting practices by phone, leveraging web portals to capture directory updates, utilizing claims and other data for data corrections and employing artificial intelligence.

Yet, in audits from 2016 to 2018, CMS identified no measurable improvements in health plan provider directory accuracy. Consequently, legislators and regulators continue to assess ways to address this important issue including the No Surprises Act which introduced new requirements and shortened the timeliness for directory updates to be actioned to two days.

While pockets of high quality data exist, the industry has yet to converge upon a widely recognized source-of-truth. The proliferation of data collection channels and correction methods has made it more difficult for an authoritative source to emerge. CMS has stated in its 2018 report that “it has become clear that a centralized repository for provider data is a key component missing from the accurate provider directory equation.”

Similarly, while some health plans have worked towards establishing an internal source of truth, many face their own data silos that result in delayed updates and inaccurate data overwriting good data. This mirrors the data governance issues that practices have encountered. This internal misalignment of data requires health plans to take additional steps to re-validate information, creates incremental effort for practices and can dilute the effect of data quality improvements. In addition to siloed data sources, adjacent regulatory requirements also affect improvement efforts. Regulators like CMS have established requirements for both network adequacy and directory accuracy for health plans. While these requirements go hand-in-hand, efforts to improve directory accuracy and network adequacy can impact each other.

The confluence of industry data silos and misalignment between health plans and practices on roles, responsibilities and compliance with regulatory requirements has presented barriers to realizing provider directory improvement.

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How can health plans and practices work together?

Health plans and practices will continue to encounter these challenges unless they can work together in a coordinated way. It starts with identifying the respective responsibilities of each party and the best approaches to execute on those responsibilities. Both practices and health plans must establish data governance practices that breakthrough legacy data silos and ensure that the right data is being made available for patients seeking in-network care. Data quality definitions and assessment approaches must be established among practices and health plans and used to drive continuous improvement. Opportunities for interoperability and data standards should

be leveraged, to streamline the flow of accurate provider directory data between health plans and practices and within each organization.

Awareness of the legal and regulatory requirements will also be important on a market-by-market basis and will benefit both parties as they work to reduce administrative burden. Finally, individuals, departments and vendors that are responsible for managing data on behalf of practices and health plans must be fully equipped to do so: they must understand when their scope of service includes the directory use case, have access to the right data, and be able to deliver it accurately and timely.

Health plan responsibility

Health plans should streamline the methods by which they request practices to submit data. Many practices have expressed a desire for health plans to align on fewer and more consistent update channels. A clear and concise workflow for updating this information would benefit all parties with greater predictability and opportunities for automation.

Over time, this could lead to additional standards-based system-to-system integration that allow bulk and real-time updates. To support this, health plans should also look for opportunities to harmonize their data systems and eliminate data siloes.

To address unexpected out-of-pocket expenses for patients, health plans must provide more usable plan-product information to practices and ensure it is correct in directories. While practices and health plans agree that their contract is the ‘source of truth’ on whether a clinician is participating, the question of whether a clinician is accepting insurance for a particular patient or accepting new patients is more dynamic. These agreements can contain many nuances: providers participating in multiple plan-products, contracts including a subset of locations and specialties and ‘accepting new patients’ being a function of both the contract and whether the clinician’s panel is full. Practices and health plans should agree, based on how a contract is structured and the practice’s current situation, how information about whether a clinician is accepting insurance and is accepting new patients should be presented. This will have an impact not only on health plan directories but also practice web sites, government-mandated APIs and other online venues. It will be challenging to produce a streamlined search experience that considers and simplifies the permutations of practice-health plan relationships. Getting this right will require an intense focus on the patient experience, collaboration across stakeholders, a sustainable division of responsibilities and adoption of approaches that prove to be successful. A long-term commitment towards this will result in greater alignment ensuring that patients are able to discover and access the care they need.

Health plans also have a responsibility to reflect updates from clinicians and practices within their

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systems and directories in a timely manner. The No Surprises Act requires this to occur within two days. To make this a reality, health plans will need to eliminate or manage internal data siloes. They also need to invest in greater systems automation when data is measured to be of consistently high quality. If health plans identify issues with directory updates from practices, they should communicate and coordinate with the practices in a timely manner. Doing so can result in a positive feedback loop that results in higher quality data and leads to less frustration between the health plan and practice.

Health plans should provide a method for practices to indicate that a location is affiliated with a group but should not be published within a directory for a specific clinician. This allows claims to be paid when ‘covering for colleagues’ without reflecting inaccurate locations in a directory. In 2018, two national health plans introduced the concept of a “directory publish” flag where practices can indicate whether contracted locations should be associated with a clinician when published in a directory. These health plans observed that practices are now more willing to indicate when locations should not be published, resulting in increased data accuracy.

Finally, there needs to be more transparency and better communication between the health plans and practices. Health plans need not rely only on regulator-driven audits but could instead utilize industry-wide data quality assessments and benchmarking to see how they are performing. Health plans can also

encourage practices to review and correct the directory information via government-mandated APIs or via widely adopted portals for directory updates. Where directory data quality issues are driven by specific practices and health systems, a constructive “meeting of the minds” should occur to make sure both parties have a common understanding of the issue and identify interventions that they can both employ to improve data quality.

In an example of a unified approach, several health plans in Massachusetts have been working¹⁹ since 2018 to align among themselves and with prominent health systems in the Commonwealth on the use, definition and best practices for provider directory data collection. More efforts like this can improve directory accuracy and ultimately the patient experience in other states. Better coordination and information sharing will enable upstream improvements that minimize the administrative burden for all parties.

Practice Responsibility

Practices have a responsibility to provide health plans with data updates through the appropriate channel. This includes reporting changes to clinicians at the practice, addresses, phone numbers and, if applicable, ‘accepting new patients’ status in a timely manner. The No Surprises Act requires practices to have in place business processes to ensure the timely provision of provider directory information.

As health plans provide feedback to practices when their data is in question, practices should offer that same constructive feedback to health plans. If practices observe that patients are encountering difficulties accessing care due to a health plan’s directory, practices should submit these errors to health plans to resolve. Methods to report issues to health plans are mandated by multiple government regulations, and these are available to consumers and practices alike.

Practices should view health plans as an important channel by which patients can identify clinicians and seek care, in addition to the role they play as financial intermediary. Practices should submit information based on current practice locations, where clinicians are regularly seeing patients and avoid listing clinicians at locations they may provide coverage for on the rare occasion. This mindset should impact how practices and their vendors manage and submit data to health plans.

Practices should take advantage of the mechanisms that some health plans make available to them to communicate when clinicians are affiliated with a location but not taking appointments at the location. Communicating these indicators accurately to health plans will minimize their risk of denied claims due to unlisted practice locations and ensure that health plans are publishing accurate directory information for patients.

Just as health plans should look to harmonize their data across silos, practices should similarly look for these opportunities. This will require better coordination between the credentialing, contracting and appointment systems that supports these activities. Some practices regularly cleanse their information in doctor review web sites, doctor-finder utilities and other popular resources using listings management services. Performing the same activities or ensuring the data updates are also flowing to health plan directories is critical. As discussed earlier, these health plan directories are often identified by patients as an important resource for seeking care. In many practices, this will require better integration between their marketing and health plan enrollment departments to harmonize data and streamline the way accurate data is submitted to health plans. Identifying the right internal repositories from which to source data is an important aspect of improving directory data quality.

Conclusion

In an increasingly complex healthcare system with more clinicians and practices offering specialized services to diverse populations and health plans offering more benefit options, patients today have a greater need for accurate directory information to choose a doctor who is right for them. Given how accustomed consumers are to instant access to precise information, their expectations are also higher than ever before. If a solid foundation of basic provider directory information is not established, then addressing rapidly evolving patient needs (e.g., virtual or specialized care) becomes more difficult.

Previous efforts to improve directory accuracy have been stymied, in part, by a lack of shared understanding and responsibility between clinicians and health plans and a lack of data standards and fragmented systems to collect and transmit this information. This is exacerbated by already burdensome administrative requirements. By working together, health plans, clinicians and practices now have an opportunity to solve this persistent problem for patients once and for all.

Table 2 - Summary of Health plan and Provider Responsibilities

Health plan Responsibilities	Provider Responsibilities
<ul style="list-style-type: none"> • Streamline data update channels • Follow best practices and standards on data collection and required data fields • Provide practices with a way to differentiate between locations where a clinician is regularly seeing patients versus one where the clinician is contracted but not seeing patients • Update directories quickly and provide transparency to practices when updates cannot be made • Proactively inform and resolve data conflict issues with the practice • Harmonize internal systems and invest in automation for high quality updates • Simplify plan participation information 	<ul style="list-style-type: none"> • Provide timely and accurate updates on clinicians, practice addresses, phone number and 'accepting new patients' when clinician discretion is included in the contract • Report clinicians at the practice locations that they regularly see patients as opposed to registering every clinician at all possible practice locations • Source data from the best internal systems that support similar use cases like appointments and doctor search • Establish procedures for staff and vendors responsible for submitting data to health plans to reflect directory use case • Provide timely feedback to health plans if data is incorrect or collection processes are overwhelming to the practice

Working together will require health plans and practices to agree on the definition of a minimum directory data set and accept their shared responsibility to produce, manage and present accurate data to patients. Practices should identify the best sources for directory data, make timely and accurate updates and establish the right processes so that their teams and vendors can deliver the best data possible for provider directories. Health plans should similarly make timely updates, streamline processes for practices to submit the data and leverage interoperability and automation where possible so that updates are made as quickly as possible. It will take time and investment for these types of changes to occur, but working together is critical to minimizing administrative burden while addressing directory needs for patients. If health plans and practices do their part to address provider directory inaccuracy, patients will realize better access to care

Endnotes

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