

**Healthcare Provider Disclosure Obligations under An Act Promoting a Resilient Health Care System the Puts Patients First - updates to G.L. c. 111, s. 228**

*It is important to note that the requirements do not differentiate among provider types. What differs is who is responsible for giving the patient cost information and under what circumstances. Participating providers have a different responsibility that non-par providers in terms of providing cost information (the former is upon request by the patient; the latter is for all patients regardless of request). When a patient is being referred to another provider, there are also specific requirements as noted below.*

***Who does this law apply to?***

*The requirements of G.L. c. 111, s. 228 apply to health care providers as defined at G.L. c. 111, s. 1 and include doctors of medicine, osteopathy and dental science; registered nurses; social workers; doctors of chiropractic; psychologists; interns, residents, fellows or medical officers licensed per c. 112, s. 9; registered pharmacists; hospitals, clinics or nursing homes; and public hospitals.*

***The following highlights provider obligations in each scenario:***

**Here’s what all providers have to do (does not matter if PCP, specialist, psychologist, LICSW):**

* When scheduling a non-emergency admission, service, or procedure, **all providers** must notify patients of their network status.
* If the patient is receiving repeated services as part of the same course of treatment, the patient can waive this requirement for subsequent treatments (eg. Allergy injections, infusions, etc.)

**If the provider is IN NETWORK:**

* Inform the patient that they may request the allowed amount and any facility fee for the service, to be provided within two days upon patient request and that specific information about out-of-pocket costs can be obtained from their health plan. Provider can also assist patient in using the health plan’s toll-free number or website.
* If unable to quote a specific amount because precise treatment is unknown, disclose estimated maximum amount and any facility fees.

**If the provider is OUT OF NETWORK:**

* For appointments scheduled 7+ days in advance, inform the patient verbally and in writing at the time of scheduling that provider does not participate in patient’s health plan. For appointments scheduled less than 7 days in advance, inform the patient verbally at the time of scheduling (no less than two days or as soon as practicable before the appointment) and provide written notice upon patient’s arrival.
* Failure to inform patient in either scenario means provider is prohibited from billing the insured beyond applicable copayment or deductible or coinsurance.
* Provide the charge and the amount of any facility fees and inform patient that they will be responsible for charges not covered by their health plan
* Inform the patient that they may be able to obtain the services at lower cost from an in-network provider

**If the provider is referring the patient to another provider:**

* Inform the patient if the referred provider is part of or represented by the same provider organization
* Inform the patient that the referred provider may not participate with the patient’s health plan and provider the patient with sufficient information about the referred provider so that the patient may verify participation status and any applicable out of pocket costs prior to making an appointment

**If the provider is directly scheduling or arranging services for a patient:**

* Verify whether the referred provider participates in the patient’s health plan
* Notify the patient if the referred provider does not participate in the patient’s health plan or if status could not be verified

**Link to DPH Notice**

<https://www.mass.gov/news/pricing-transparency-provisions-of-an-act-promoting-a-resilient-health-care-system-that-puts-patients-first-patients-first>