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**Health Care Provider Disclosure Obligations related to
Scheduling Admissions, Procedures or Services,
or Making Referrals to Another Provider**

On January 1, 2021, Governor Baker signed *An Act Promoting a Resilient Health Care System that Puts Patients First* (“*Patients First*”) into law which makes significant changes to the state’s healthcare laws. Among the changes are updates to G.L. c. 111, s. 228 that require health care providers to notify patients about charges and payments for proposed admissions, procedures, services, and referrals that are specific to the patient’s insurance carrier. These requirements were originally set to begin on January 1, 2025. However, in December 2024 the Legislature changed the implementation date to January 1, 2027.

1. Impacted Health Care Providers

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.

2. Notice Requirements

The law requires health care providers to notify patients or prospective patients on whether the provider participates in the patient’s health plan, upon scheduling an admission, procedure, or service that is related to a non-emergency medical condition.

- This notice must be given at the time an admission, procedure, or service is scheduled for a condition that is not an emergency medical condition, or upon request by the patient.
- After initial notice is provided, patients can waive this requirement for subsequent admissions, procedures, or services that are part of a continued course of treatment.

There are also various requirements described below for health care providers based on the provider's participation in the patient's health plan, and for referrals.

Provider DOES participate in a patient's health plan (in-network)

Requirements in G.L. c. 111, s. 228: At the time of scheduling an admission, procedure or service that is not for an emergency medical condition, a health care provider must provide notice that:

- The health care provider participates in the patient's health benefit plan.
- Patients may request the allowed amount and any facility fees for the admission, procedure, or service, to be disclosed by the health care provider.
 - This information must be provided within two days upon the patient's request.
- Where a health care provider is unable to quote a specific amount due to the inability to predict specific treatment or diagnostic codes, the provider must disclose the estimated maximum amount and any facility fees.
- Patients may obtain additional information in real time about applicable out-of-pocket costs from their insurance carrier's toll-free number or website.

Provider does NOT participate in a patient's health plan (out-of-network)¹

Requirements in G.L. c. 111, s. 228:

- If the appointment was scheduled **more than 7 days in advance** of the admission, procedure, or service, the health care provider must inform the patient the health care provider does not participate in the patient's health plan verbally and in writing at the time of scheduling (no less than 7 days before the appointment).
 - Providers who fail to provide such notice are prohibited from billing the insured beyond any applicable copayment, coinsurance, or deductible that would be payable if the insured received the service from a provider who participates in the patient's health plan.
- If the appointment was scheduled **less than 7 days in advance** of the admission, procedure, or service the health care provider must verbally inform the patient that the health care provider does not participate in the patient's health plan, at the time of scheduling (no less than two days or as soon as practicable before the appointment). The provider must also give written notice upon the patient's arrival for the appointment.
 - Providers who fail to provide such notice are prohibited from billing the insured beyond any applicable copayment, coinsurance, or deductible that would be

¹ Note: G.L. c. 111, s. 228 contains billing prohibitions relating to non-compliance of this requirement – see topic 7 in the FAQ below.

payable if the insured received the service from a provider who participates in the patient's health plan.

- Provide the charge and amount of any facility fees for the admission, procedure, or service at the time of scheduling.
- Notice that the patient will be responsible for the charges not covered through the patient's plan.
- Notice that the patient may be able to obtain the admission, procedure or service at a lower cost from a health care provider who participates in the patient's health plan.

Provider referring a patient to another health care provider (referral)

Requirements in G.L. c. 111, s. 228:

- Disclose if the referred provider is part of or represented by the same provider organization² as the referring provider.
- Inform the patient that the referred provider may not participate in the patient's health plan, that there may be applicable out-of-network rates, and that the patient has an opportunity to verify whether the referred provider participates in their health plan prior to making an appointment or agreeing to use the provider's services.
- Provide the patient with sufficient information about the referred provider so that the patient may obtain additional information about whether the referred provider participates in their health plan and any applicable out-of-pocket costs should the patient use the referred provider's services.

Provider directly scheduling, ordering, or otherwise arranging health care services for a patient with another provider (referral)

Requirements in G.L. c. 111, s. 228: Prior to a provider directly scheduling, ordering, or otherwise arranging health care services for a patient with another provider ("referred provider") must:

- 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 the network status of the referred provider could not be verified.

² G.L. c. 111, s. 228 specifically references G.L. c. 6D, s1, which defines "provider organization" as follows: "any corporation, partnership, business trust, association or organized group of persons, which is in the business of health care delivery or management, whether incorporated or not that represents 1 or more health care providers in contracting with carriers for the payments of health care services; provided, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations and any other organization that contracts with carriers for payment for health care services."

3. Penalties

The law authorizes the Massachusetts Department of Public Health (DPH) to penalize health care providers who fail to comply with these requirements, with a penalty of up to \$2,500 in each instance. Effective January 1, 2027, the Department will accept and investigate complaints. The initial penalty amount will be \$0, to give providers time to come into compliance.

Any patient who has not received the required notice may submit a complaint, in writing, to the health care provider's professional licensing board, or in the case of a licensed facility, to the Bureau of Health Care Safety and Quality. The board will notify the health care provider of the complaint and give the provider 10 days to submit written documentation demonstrating compliance with the notice requirements.

Please see options below for how a patient/patient designee can file a complaint.

File a complaint with the DPH Bureau of Health Professions Licensure (BHPL)

For complaints against nurses, pharmacists, dentists, social workers, chiropractors, and psychologists, visit the BHPL website: [mass.gov/info-details/file-a-complaint-against-a-health-care-professional-or-facility](https://www.mass.gov/info-details/file-a-complaint-against-a-health-care-professional-or-facility)

File a complaint with the DPH Bureau of Health Care Safety and Quality (BHCSQ)

- Hospital complaints: [mass.gov/how-to/file-a-complaint-regarding-a-hospital](https://www.mass.gov/how-to/file-a-complaint-regarding-a-hospital)
- Long Term Care Facility and other DPH-licensed health care facility complaints (including clinics): [mass.gov/how-to/file-a-complaint-regarding-a-nursing-home-or-other-health-care-facility](https://www.mass.gov/how-to/file-a-complaint-regarding-a-nursing-home-or-other-health-care-facility)

File a complaint with the Board of Registration in Medicine's (BORIM) Consumer Protection Division

All complaints and reports to BORIM: [mass.gov/submit-a-complaint](https://www.mass.gov/submit-a-complaint)

Patient or patient representative complaints against physicians: [mass.gov/service-details/submit-a-complaint-against-a-physician](https://www.mass.gov/service-details/submit-a-complaint-against-a-physician)

For purposes of determining compliance, the Department will review the patient's complaint and the health care provider's documentation that it has provided the required notice to the patient. If the health care provider submits documentation that the required notice was provided at the appropriate time, the Department will dismiss the complaint. Where health care providers are required to provide notice only upon patient request for certain information, providers should document whether a patient made the request for such information.

All health care providers must provide patients with information on how to file a complaint with the Department of Public Health if the patient has not received all required notices.

Frequently Asked Questions

1. What is an emergency medical condition?

G.L. c. 111, s. 228 specifically references G.L. c. 176O, s1, which defines “emergency medical condition” as follows:

“a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U. S.C. section 1395dd(e)(1)(B).”

2. If the patient requires a series of admissions, procedures or services as part of a continued course of treatment, does the health care provider need to disclose participation in the patient’s health plan after the first one?

When a health care provider participates in a patient’s plan, the patient may waive the requirement to receive such disclosure for subsequent admissions, procedures or services. It is the patient’s option whether to waive the requirement. However, even after a patient waives the requirement, a health care provider must inform the patient of any change in the health care provider’s network status during the continued course of treatment. The waiver is not applicable to the verbal and written requirements set for health care providers who do not participate in a patient’s plan.

3. What is the “allowed amount”?

G.L. c. 111, s. 228 defines “allowed amount” as “the contractually agreed-upon maximum amount paid by an insurance carrier to a health care provider for a health care service provided to an insured.”

4. What if the provider is unable to predict the specific treatment or diagnostic code?

G.L. c. 111, s. 228 provides that if a health care provider is unable to quote a specific amount in advance due to the health care provider’s inability to predict the specific treatment or diagnostic code, the health care provider shall disclose the estimated maximum allowed amount for the admission, procedure or service.

5. *What can the provider do if the patient is having trouble accessing information through the patient's insurance carrier's toll-free number and website?*

G.L. c. 111, s. 228 allows, but does not mandate, health care providers to assist patients or prospective patients to use the patient's insurance carrier's toll-free number and website.

6. *What happens if a health care provider does not comply with these requirements?*

Beginning January 1, 2027, the Commissioner of the Department of Public Health is authorized to impose penalties on health care providers who fail to comply with the requirements of G.L. c. 111, s. 228. The penalty imposed may be in an amount up to \$2500.00 for each instance of non-compliance. Health care providers will be held liable for payment of the penalties imposed.

7. *What happens if a health care provider does not participate in a patient's health insurance benefit plan and does not provide verbal and written notice to the patient within the applicable time frames for a scheduled admission, procedure or service?*

A health care provider who does not participate in a patient's health insurance benefit plan and does not provide verbal and written notice to the patient within the applicable time frames for a scheduled admission, procedure or service is prohibited from billing the patient except for the amount that the patient would have been required to pay as a copayment, coinsurance or deductible if the health care provider participated in the patient's plan. It should be noted that refraining from billing does not relieve the health care provider from compliance with the remaining notice requirements in the law. Rather, a health care provider who does not participate in a patient's plan and does not provide verbal and written notice to the patient within the applicable time frames for a scheduled admission, procedure or service, may be subject to penalty imposed by the Commissioner of the Department of Public Health as well as the billing prohibition.