Updates on the Consolidated Appropriations Act

The No Surprises, Continuity of Care, and Provider Directories provisions of the Consolidated Appropriations Act (CAA) of 2021 went into effect last month. Here is what you need to know.

Surprise Billing

The No Surprises Act, aimed at protecting members from unanticipated out-of-network medical bills, outlines an array of requirements and processes impacting providers and health plans.

Under this provision, members are only responsible for in-network cost-sharing amounts for out-of-network services rendered in the following scenarios: 1) certain ancillary services provided by out-of-network providers at in-network facilities such as care received during emergencies at emergency departments and also during air ambulance transport, and 2) out-of-network care provided at in-network facilities without a provider notification to the patient including a good faith estimate of services and the patient's informed consent.

There are many helpful resources on Surprise Billing provided by the Centers for Medicare and Medicaid Services (CMS) including fact sheets and consumer protection that can be found on www.cms.gov/nosurprises.

Continuity of Care

Continuity of Care (CoC) legislation is meant to ensure continuation of care for patients in the middle of complex care in the case when their provider's contract is terminated.*

Under CAA laws, continuing care patients can stay with a terminated Provider* if receiving treatment for pregnancy, a serious and complex condition, or a terminal illness. Inpatients and individuals scheduled for non-elective surgery may also stay with a terminated Provider. Providers must continue care until treatment ends or 90 days after notice of termination is received, whichever is sooner, and also must accept payment, follow policies and procedures, and meet quality standards as if the expired contract were still in place.

* Unless the Provider is terminated for reasons other than fraud or failure to meet quality standards.

Provider Directories

The Provider Directories provision of the CAA requires payers to establish a verification process to confirm provider directory information at least every 90 days, including removing providers or facilities that are non-responsive. Additionally, the provision requires updating directory information within 48 contiguous hours of receiving information from a provider or facility, not including weekends and holidays.

Blue Shield successfully deployed, and is now compliant with, the additional Provider Directories requirements. These include requirements that plans must also develop a protocol to respond to member network questions within one business day, and that members who receive inaccurate information that a provider is in-network can only be liable for in-network cost-sharing. Members can find the most up to date provider information using the Blue Shield Find a Doctor tool or by calling the Customer Care number on their Blue Shield member ID card.