

# Health Care Providers: The \$900 Billion COVID-19 Stimulus Package Impacts You

Congress voted last night to approve a \$900 billion COVID-19 stimulus package that includes key measures for health care providers. President Trump has indicated he will sign the new legislation once it reaches his desk.

We will provide a targeted, in-depth analysis of the new law in the coming weeks, including implications with respect to Provider Relief Fund (PRF) reporting and surprise medical billing, as well as taxation of Paycheck Protection Program (PPP) loans.

The following are some initial impressions to keep in mind in the days ahead:

## Provider Relief Fund

- An additional \$3 billion will be added to the Provider Relief Fund (PRF). This is significantly less than the \$35 billion that prior relief package proposals released earlier this month suggested.
- PRF recipients may calculate “lost revenues” using the Frequently Asked Questions (FAQs) guidance released by the U.S. Department of Health and Human Services (HHS) in June 2020, including the difference between a recipient’s budgeted and actual revenue for 2020, if the recipient’s budget had been established and approved prior to March 27, 2020. This is yet another material revision to the calculation of lost revenue for purposes of reporting use of PRF funds to HHS, and as some commentators have correctly noted, it essentially overrides the most recent guidance from HHS.
- PRF recipients will no doubt welcome this congressional definition of lost revenue, as it should allow them to retain greater portions of their PRF distributions. Remember, back in the summer, FAQs from HHS had indicated that a recipient could estimate lost revenue by any reasonable method. Then in September, HHS narrowed its definition of lost revenue, advising that lost revenue was limited to the difference in year-over-year net operating income from patient care. Then again in October, HHS shifted its approach in response to negative feedback from industry stakeholders, advising that lost revenue meant the difference in year-over-year actual patient care revenue.
- It is unclear at this time what impact this revised definition of lost revenues will have on PRF recipients as their first reporting deadline looms (opening January 15, 2021, and closing February 15, 2021). However, we expect that HHS will be scrambling to amend and revise its FAQs and determine whether further extensions to the reporting deadlines are appropriate given the new legislation.

## Surprise Medical Billing

- The **No Surprises Act** has been passed as part of this latest COVID-19 stimulus package. The Act provides that patients are only required to pay their in-network cost-sharing amounts to out-of-network providers in certain “surprise” situations, and it prohibits out-of-network providers in these instances from balance billing patients for anything more than their in-network cost-sharing amount. In this way, patients are protected from high out-of-network “surprise” medical billing scenarios.
- The revised Act now requires that a patient’s insurer and provider resolve any reimbursement disputes created by the out-of-network services in these situations by first negotiating for 30 days. If the dispute remains unresolved, they may refer to a binding arbitration process, in which patients are not required to participate. Each party will submit an offer to the arbitrator who considers information presented to determine the appropriate reimbursement. Such information may include the median in-network payment rate for the service at issue, the training of the provider, the parties’ market share, prior contracting history between them, complexity of the services rendered, and other information submitted. Notably, Medicare and Medicaid rates are excluded from consideration by the arbitrator.

- If a patient receives sufficient notice from an out-of-network provider in advance of treatment and consents to being treated, the out-of-network provider may avoid the potential dispute resolution procedures outlined above. Sufficient notice means that the patient receives and acknowledges notification of its out-of-network care, including an estimation of the cost for such care, at least 72 hours in advance. Out-of-network services provided without such notice and acknowledgement are subject to the patient protection and independent dispute resolution provisions of the new legislation.

*Our Chambliss team will continue to analyze the new legislation and developing guidance from HHS on these topics. Please contact [Jed Roebuck](#), [Courtney Keehan](#), or your relationship attorney if you have questions or need additional information.*

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