

appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee,

for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

**(2) Penalties for retaliation**

If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than \$200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1320a-7(b) of this title, or both.

**(3) Requirement to post notice**

Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.

**(e) Procedure**

The provisions of section 1320a-7a of this title (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

**(f) Definitions**

In this section, the terms “elder justice”, “long-term care facility”, and “law enforcement” have the meanings given those terms in section 1397j of this title.

(Aug. 14, 1935, ch. 531, title XI, §1150B, as added Pub. L. 111-148, title VI, §6703(b)(3), Mar. 23, 2010, 124 Stat. 800.)

**§ 1320b-26. Funding for providers relating to COVID-19**

**(a) Funding**

In addition to amounts otherwise available, there is appropriated to the Secretary, for fiscal year 2021, out of any monies in the Treasury not otherwise appropriated, \$8,500,000,000 for purposes of making payments to eligible health care providers for health care related expenses and lost revenues that are attributable to COVID-19. Amounts appropriated under the preceding sentence shall remain available until expended.

**(b) Application requirement**

To be eligible for a payment under this section, an eligible health care provider shall submit to the Secretary an application in such form and manner as the Secretary shall prescribe. Such application shall contain the following:

(1) A statement justifying the need of the provider for the payment, including documentation of the health care related expenses attributable to COVID-19 and lost revenues attributable to COVID-19.

(2) The tax identification number of the provider.

(3) Such assurances as the Secretary determines appropriate that the eligible health care provider will maintain and make available such documentation and submit such reports (at such time, in such form, and containing such information as the Secretary shall prescribe) as the Secretary determines is necessary to ensure compliance with any conditions imposed by the Secretary under this section.

(4) Any other information determined appropriate by the Secretary.

**(c) Limitation**

Payments made to an eligible health care provider under this section may not be used to reimburse any expense or loss that—

- (1) has been reimbursed from another source; or
- (2) another source is obligated to reimburse.

**(d) Application of requirements, rules, and procedures**

The Secretary shall apply any requirements, rules, or procedures as the Secretary deems appropriate for the efficient execution of this section.

**(e) Definitions**

In this section:

**(1) Eligible health care provider**

The term “eligible health care provider” means—

(A) a provider of services (as defined in section 1395x(u) of this title) or a supplier (as defined in section 1395x(d) of this title) that—

(i) is enrolled in the Medicare program under subchapter XVIII under section 1395cc(j) of this title (including temporarily enrolled during the emergency period described in section 1320b-5(g)(1)(B) of this title for such period);

(ii) provides diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; and

(iii) is a rural provider or supplier; or

(B) a provider or supplier that—

(i) is enrolled with a State Medicaid plan under subchapter XIX (or a waiver of such plan) in accordance with subsections (a)(77) and (kk) of section 1396a of this title (including enrolled pursuant to section 1396a(a)(78) or section 1396u-2(d)(6) of this title) or enrolled with a State child health plan under subchapter XXI (or a waiver of such plan) in accordance with subparagraph (G) of section 1397gg(e)(1) of this title (including enrolled pursuant to subparagraph (D) or (Q) of such section);

(ii) provides diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; and

(iii) is a rural provider or supplier.

**(2) Health care related expenses attributable to COVID-19**

The term “health care related expenses attributable to COVID-19” means health care re-

lated expenses to prevent, prepare for, and respond to COVID-19, including the building or construction of a temporary structure, the leasing of a property, the purchase of medical supplies and equipment, including personal protective equipment and testing supplies, providing for increased workforce and training (including maintaining staff, obtaining additional staff, or both), the operation of an emergency operation center, retrofitting a facility, providing for surge capacity, and other expenses determined appropriate by the Secretary.

**(3) Lost revenue attributable to COVID-19**

The term “lost revenue attributable to COVID-19” has the meaning given that term in the Frequently Asked Questions guidance released by the Department of Health and Human Services in June 2020, including the difference between such provider’s budgeted and actual revenue if such budget had been established and approved prior to March 27, 2020.

**(4) Payment**

The term “payment” includes, as determined appropriate by the Secretary, a prepayment, a prospective payment, a retrospective payment, or a payment through a grant or other mechanism.

**(5) Rural provider or supplier**

The term “rural provider or supplier” means—

(A) a—

(i) provider or supplier located in a rural area (as defined in section 1395ww(d)(2)(D) of this title); or

(ii) provider treated as located in a rural area pursuant to section 1395ww(d)(8)(E) of this title;

(B) a provider or supplier located in any other area that serves rural patients (as defined by the Secretary), which may include, but is not required to include, a metropolitan statistical area with a population of less than 500,000 (determined based on the most recently available data);

(C) a rural health clinic (as defined in section 1395x(aa)(2) of this title);

(D) a provider or supplier that furnishes home health, hospice, or long-term services and supports in an individual’s home located in a rural area (as defined in section 1395ww(d)(2)(D) of this title); or

(E) any other rural provider or supplier (as defined by the Secretary).

(Aug. 14, 1935, ch. 531, title XI, §1150C, as added Pub. L. 117-2, title IX, §9911, Mar. 11, 2021, 135 Stat. 236.)

PART B—PEER REVIEW OF UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

**§ 1320c. Purpose**

The purpose of this part is to establish the contracting process which the Secretary must follow pursuant to the requirements of section 1395y(g) of this title, including the definition of the quality improvement organizations with which the Secretary shall contract, the func-

tions such quality improvement organizations are to perform, the confidentiality of medical records, and related administrative matters to facilitate the carrying out of the purposes of this part.

(Aug. 14, 1935, ch. 531, title XI, §1151, as added Pub. L. 97-248, title I, §143, Sept. 3, 1982, 96 Stat. 382; amended Pub. L. 112-40, title II, §261(a)(2)(C), Oct. 21, 2011, 125 Stat. 423.)

**Editorial Notes**

PRIOR PROVISIONS

A prior section 1320c, act Aug. 14, 1935, ch. 531, title XI, §1151, as added Oct. 30, 1972, Pub. L. 92-603, title II, §249F(b), 86 Stat. 1429; amended Aug. 13, 1981, Pub. L. 97-35, title XXI, §2113(a), 95 Stat. 794, set out the Congressional declaration of purpose of former part B, in the general revision of this part by Pub. L. 97-248.

AMENDMENTS

2011—Pub. L. 112-40 substituted “the quality improvement organizations” for “the utilization and quality control peer review organizations” and “such quality improvement organizations” for “such peer review organizations”.

**Statutory Notes and Related Subsidiaries**

EFFECTIVE DATE OF 2011 AMENDMENT

Pub. L. 112-40, title II, §261(e), Oct. 21, 2011, 125 Stat. 426, provided that: “The amendments made by this section [amending this section and sections 1320c-1 to 1320c-5, 1320c-7, 1320c-9, 1320c-10, 1395g, 1395k, 1395u, 1395x, 1395y, 1395cc, 1395dd, 1395ff, 1395mm, 1395pp, and 1395ww of this title] shall apply to contracts entered into or renewed on or after January 1, 2012.”

EFFECTIVE DATE

Section 149 of Pub. L. 97-248, as amended by Pub. L. 98-369, div. B, title III, §2354(c)(3)(C), July 18, 1984, 98 Stat. 1102, provided that: “The amendments made by this subtitle [subtitle C (§§141-150) of title I of Pub. L. 97-248, enacting this part, amending sections 1395b-1, 1395g, 1395k, 1395l, 1395x, 1395y, 1395cc, 1395pp, 1396a, and 1396b of this title, and enacting provisions set out as notes under sections 1305 and 1320c of this title] shall, subject to section 150 [section 150 of Pub. L. 97-248, set out as a note below], be effective with respect to contracts entered into or renewed on or after the date of the enactment of this Act [Sept. 3, 1982].”

IOM STUDY OF QIOS

Pub. L. 108-173, title I, §109(d), Dec. 8, 2003, 117 Stat. 2173, provided that:

“(1) IN GENERAL.—The Secretary [of Health and Human Services] shall request the Institute of Medicine of the National Academy of Sciences to conduct an evaluation of the program under part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.]. The study shall include a review of the following:

“(A) An overview of the program under such part.

“(B) The duties of organizations with contracts with the Secretary under such part.

“(C) The extent to which quality improvement organizations improve the quality of care for medicare beneficiaries.

“(D) The extent to which other entities could perform such quality improvement functions as well as, or better than, quality improvement organizations.

“(E) The effectiveness of reviews and other actions conducted by such organizations in carrying out those duties.

“(F) The source and amount of funding for such organizations.

“(G) The conduct of oversight of such organizations.