Editorial

Sham Peer Review at Federally Qualified Health Centers (FQHCs)

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As a result of changes that have occurred in the practice environment, sham peer review has increasingly affected employed physicians. This includes physicians who are employed by Federally Qualified Health Centers (FQHCs).

Sham peer review at FQHCs represents a complex situation steeped in a bureaucratic quagmire of laws, policies, and regulations that present a unique challenge to those who have been victimized.

A recent article published by the Commonwealth Fund reported that FQHCs provide primary care, dental care, and behavioral services to more than 20 million patients with low incomes, 17 million people of color, 15 million Medicaid recipients, and approximately 6 million uninsured patients.[1] FQHCs are frequently referred to as Community Health Centers (CHCs).[1] They are also sometimes referred to as safety-net providers.

Federally Qualified Health Centers receive funding through the Health Resources & Services Administration (HRSA), the same government agency that runs the National Practitioner Data Bank (NPDB). They typically also receive funds through Medicare and Medicaid (enhanced reimbursements). The HRSA reports that the agency funds about 1,400 health centers at more than 15,000 service sites.[2] FQHCs are present in all 50 states and the District of Columbia.[2] These outpatient clinics may be located in rural or urban areas and include:

- Community health centers
- Migrant health centers
- Homeless health centers
- Public housing primary care centers
- Health center program "look-alikes"
- Outpatient health programs or facilities operated by a tribe or tribal organization or an urban Indian organization.[3]

FQHCs must be certified by HRSA on an annual basis. In order to qualify as a FQHC, the clinic must meet the following requirements:

- Get a grant under Section 330 of the Public Health Service (PHS) Act or be funded by the same grant contracted to the recipient
- Get a grant as an FQHC "look-alike" based on a Health Resources & Services Administration (HRSA) recommendation
- Be treated by the HHS Secretary as a comprehensive federally funded health center since January 1, 1990, under Part B
- Operate as an outpatient health program or tribe or tribal organization facility under the Indian Self-Determination Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act.

To be certified as a FQHC, a facility must meet these requirements:

- Provide comprehensive services, including an ongoing quality assurance program and annual review
- Meet all health and safety requirements
- Not be approved as a rural health clinic (RHC)
- Meet all Section 330 of the PHS Act requirements, including:
  - Serve a designated medically underserved area (MUA) or medically underserved population (MUP)
  - Offer people with incomes below 200% of the federal poverty guidelines a sliding fee scale
  - Be governed by a board of directors, where most members get care at the FQHC.[3]

HRSA reports that the benefits of being a FQHC include funding through HRSA, medical malpractice liability coverage under the Federal Tort Claims Act (FTCA), federal loan guarantees for capital improvements, higher reimbursements at the FQHC rate (FQHC Prospective Payment System), and substantial drug discounts through the 340B Drug Pricing Program.[2] "Section 1861(aa) of the Social Security Act allows additional FQHC Medicare payments."[3]

A Commonwealth Fund National Survey reported that "CHCs [FQHCs] face persistent funding gaps as revenues and federal funding aren't enough to cover the costs of care they provide to uninsured patients."[1] This likely explains the intense pressure FQHCs often put on physicians and other practitioners to see large numbers of patients per day.

The information presented in this editorial is not intended as legal advice or opinion. It derives from my extensive study of court documents and relevant literature and from my experience serving as an expert in sham peer review for more than 20 years. Physicians should seek legal advice and opinion from their attorneys.

Federal Tort Claims Act (FTCA)

One of the benefits of being employed by a FQHC is that physicians do not have to purchase their own malpractice liability insurance. The U.S. government is their malpractice insurer. They are covered under the Federal Tort Claims Act (FTCA). This gives employed physicians statutory immunity from malpractice claims while acting within the scope of their employment.

The history and intent of FTCA coverage for physicians working at FQHCs is reviewed in the Federal Tort Claims Act Health Center Policy Manual.

> The Federally Supported Health Centers Assistance Acts (FSHCAA) of 1992 (Pub. L. 102-501) and 1995 (Pub. L. 104-73) extend Federal Tort Claims Act (FTCA) protections under 29 U.S.C. 1346(b), 2401(b), and 2679-81 to eligible health centers funded under the Health Center Program, section 330 of the Public Health Services (PHS) Act (42 U.S.C. 254b), as amended. Eligibility for FTCA protections has been extended to:
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> - Community Health Centers (CHC), funded under section 330(e);
> - Migrant Health Centers (MHC), funded under section 330(g);

- Health Care for the Homeless (HCH), funded under section 330(h); and
- Public Housing Primary Care (PHPC) Health Centers, funded under section 330(i).[4]

The FTCA coverage for FQHCs is commonly referred to as the FTCA Medical Malpractice Program.[4]

> The intent of the Health Center FTCA Medical Malpractice Program is to increase the availability of funds to health centers to provide primary health care services. By reducing or eliminating health centers' malpractice insurance premiums, more health center dollars are available for:
> - Increasing the number of patients served;
> - Increasing enabling services like case management and health education;
> - Reducing financial, geographic, and cultural/linguistic barriers to care; and
> - Implementing and expanding programs such as quality improvement/assurance and risk management and other appropriate section 330-funded activities.[4]

The FTCA Health Center Policy Manual further delineates who is covered and the types of activities that are covered under the FTCA.

> FSHCAA provides that certain persons, referred to here as covered individuals (i.e. governing board members, officers, employees, and certain individual contractors) of FTCA covered entities (e.g., health centers that receive section 330 funds and have been approved for coverage or "deemed" as employees of the Public Health Service by the Secretary) be treated as PHS employees for purposes of medical malpractice liability coverage. Covered activities are acts or omissions in the performance of medical, surgical, dental, or related functions resulting in personal injury, including death, and occurring within the scope of employment. Further discussion of the "scope of employment" is set forth below.
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> Under FSHCAA, these covered individuals have medical malpractice protection for covered activities. Covered activities include those activities that:
> - Are approved within each individual's scope deemed of employment (this term includes activities within an applicable individual contract for services with the health center);
> - Are within the scope of the approved Federal section 330 grant project of the deemed health center; and
> - Take place during the provision of services to health center patients and, in certain circumstances, to non-health center patients.[4]

Some FQHC officials have taken the position that the Health Center and all of its individual employees have absolute immunity from *all* claims, including claims for fraud. It is therefore important that an attorney representing a physician in a lawsuit against a FQHC review the formal job descriptions which may be included in employee contracts. Fraud, of course, will not be listed among the official duties of an employee.

A Health Center's coverage under FTCA is not automatic from one year to the next. The Health Center must submit an application annually and must demonstrate that they meet the deeming requirements under section A.2 of the Federal Tort Claims Act Health Center Policy Manual.[4]

> The FQHC is required to show that it:
> - Has implemented appropriate policies and procedures to reduce the risk of malpractice and the risk of lawsuits arising out of any health or health-related functions performed by the health center
> - Has reviewed and verified the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians [including physicians whose sole duty is to supervise others] and other licensed or certified health care practitioners
> - Has no history of claims under section 224 of the PHS Act or, if such a history exists, fully cooperates with the Attorney General in defending against any such claims, and takes any necessary steps to assure against such claims in the future
> - Will fully cooperate with the Attorney General and other applicable agencies in providing required information under section 224 of the PHS Act.[5]

Again, Title 42, Chapter 1, Subchapter A, Part 6 is very specific that "covered acts and omissions" apply *only* to claims related to medical, surgical, or dental care and only for acts or omissions within the scope of employment:

> (Section 6.5 (b)) Only claims for personal injury, including death, resulting from the performance of medical, surgical, dental or related functions are covered by this part.
>
> (Section 6.5 (c)) With respect to covered individuals, only acts and omissions within the scope of their employment (or contract for services) are covered.[6]

The type of malpractice coverage provided by the FTCA is the occurrence type, meaning that the physician is covered for all acts or omissions that occur while providing medical care at an FTCA-covered FQHC and coverage continues for those occurrences even after the physician is no longer employed by the Health Center. No tail coverage is needed once the physician leaves the Health Center.[4]

Coverage under FTCA also differs from private malpractice insurance in that FTCA coverage "does not have a specific coverage limit with a monetary cap."[4] Also, under FTCA, "no punitive damages are allowed."[4] And, no jury trials are allowed: "Cases are heard in Federal District Court without a jury, and are defended by the Department of Justice (DOJ) with the assistance of the HHS OGC [Health and Human Services (HHS), Office of General Counsel]."[4]

When a lawsuit is filed against a FQHC, the Health Center forwards the complaint to the Department of Health and Human Services, Office of General Counsel, General Law Division, Claims and Employment Law Branch, which in turn, forwards the complaint to the U.S. Attorney General (AG). The AG determines whether the claims involve acts or omissions in the provision of medical care and whether the events fall within the scope of employment. Once a determination is made, the AG informs HHS and HHS informs the Health Center whether the claims will be defended by the government.[4]

If the AG declines to defend the claims (e.g. claims for fraud, for instance), then the Health Center and named employees are left with defending themselves and will be liable for payment of any judgment or settlement amount.

Shockingly, not all FQHCs have a formal peer review process.

FQHC attorneys may argue that they do not need one or are not required to have one to qualify for FQHC status and because they have a Human Resources (HR) Department that adjudicates all matters relating to employed physicians/practitioners.

But HR departments typically consist of non-licensed bureaucrats—there are no peers. An HR department does not provide any peer review hearing or peer review appeal process. Attempting to convince others that they are doing peer review is a knowingly false representation.

FQHCs that lack any formal peer review process compound their wrongdoing when they report an employment termination to the NPDB. Employment terminations that do not result from a peer review process should not be reported to the NPDB. Only employment terminations that are the result of a peer review process (professional review action) are reportable to the NPDB. The reporting requirements provided in the NPDB Guidebook make this very clear.

> **2. A hospital filed a report with the NPDB announcing the revocation of a practitioner's clinical privileges. The reporting hospital had established a system of professional review under its bylaws, and it also had an employment termination procedure. In this case, the hospital used the employment termination procedure, not the professional review process. The practitioner's privileges were revoked by the employment termination process, but no action was taken through the professional review process. The practitioner was not given a choice of which process (system of professional review or employment termination procedure) the hospital would use. Should the hospital have filed a report with the NPDB?**
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> No. The termination was not a result of a professional review action and, therefore, was not reportable. It does not matter that the employment termination process automatically resulted in the end of the practitioner's clinical privileges. However, if the hospital had performed a professional review of the practitioner's clinical privileges and revoked the practitioner's privileges as a result of the review, the professional review action would have been reportable, even if the action started as an employment termination. In order to be reportable to the NPDB, adverse actions must be the result of professional review. Generally, the reporting entity decides when a professional review has occurred.[7(FAQ,#2 p. E-44)]

In the event that the AG declines to defend a FQHC and named employees in a lawsuit brought by a physician based on a sham peer review against him, the FQHC may, in desperation, try to claim immunity under HCQIA even though the FQHC had no formal peer review process. It will cite 42 USC §11137(c), which states:

> (c)Relief from liability for reporting
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> No person or entity (including the agency designated under section 11134(b) of this title) shall be held liable in any civil action with respect to any report made under this subchapter (including information provided under subsection (a)[1] without knowledge of the falsity of the information contained in the report.[8]

However, adverse action reports in the NPDB are by definition professional review actions and must comply with the Standards for Professional Review Actions under 42 U.S. Code §11112(a)(1-4), which requires that the entity provide adequate notice and hearing procedures:

> (a) In General
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> For the purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken—
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> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3).[9]

Regarding paragraph (3) above, there is nothing fair about depriving the physician of due process by virtue of the fact the FQHC has no formal peer review process at all.

Another issue arising at FQHCs that have no formal peer review process is false certification to the NPDB.

False Certifications and Reports Made to the NPDB

In order to be authorized to report and query the NPDB, the entity must comply with eligibility requirements. The NPDB defines an eligible entity as follows:

> Entities that participate in the NPDB are defined in the provisions of Title IV, Section 1921, Section 1128E, and implementing regulations. In addition, a few federal agencies also participate with the NPDB through federal memorandums of understanding. Eligible entities are responsible for complying with all reporting and/or querying requirements that apply; some entities may qualify as more than one type of eligible entity. Each entity must certify its eligibility in order to report to the NPDB, query the NPDB, or both.
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> To be eligible to file reports with the NPDB, an entity must be:
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> - Under the authority of Title IV
> - A hospital
> - A health care entity that provides health care services and follows a formal peer review process for the purpose of furthering quality health care.[10]

Professional societies can also register as authorized reporting entities provided that they have a formal peer review process for the purpose of furthering quality health care.[7, p. B-19]

The NPDB website defines the term "formal peer review process" as follows:

> It is defined in 45 CFR § 60.3 of the NPDB regulations as *"the conduct of professional review activities through formally adopted written procedures which provide adequate notice and an opportunity for a hearing"* [emphasis in original].
>
> In order for an entity to register with the NPDB, the entity must be able to provide the following documentation regarding its peer review process:

- Written procedures outlining the entity's peer review process that provide for *adequate notice and an opportunity for a hearing* [emphasis in original]; and
- Evidence that the entity formally adopted and implemented its peer review process.[11]

Shockingly, the NPDB does not verify that an entity actually meets the eligibility requirements. That is akin to simply accepting a person's word that he is licensed to practice medicine and not verifying it through the state medical board. The NPDB Guidebook provides the following:

> **2. Can the NPDB certify or verify that an organization is eligible to report or query?**
>
> No. Each entity must determine its own eligibility to participate [emphasis in original] in the NPDB and must certify that eligibility to the NPDB. NPDB officials reserve the right to review and verify all elements of the documentation submitted with a registration and also reserve the right to reject the registration if the entity is determined to be ineligible. Eligible entities are responsible for complying with all statutory and regulatory requirements that apply to them.[7, p. B-18]

Thus, it is not hard to see how some FQHCs can get away with falsely certifying their eligibility to be an authorized reporting entity.

In determining the definitions for the adverse actions classified in the NPDB code lists, the NPDB takes the same approach, namely it is up to the reporting entity to determine what the various terms mean (personal communication with NPDB, Oct 21, 2024). This leaves physicians at the mercy of reporting entities that are allowed to define terms as they wish. As Humpty Dumpty put it:

> When I use a word, Humpty said in a rather scornful tone, it means just what I choose it to mean—neither more nor less.
>
> The question is, said Alice, whether you can make words mean so many different things.
>
> The question is, said Humpty, which is to be master—that's all.[12]

When healthcare entities knowingly and willfully falsely certify to the NPDB that they have a formal peer review process, when in actuality they have none, so as to register with the NPDB and be able to file reports with the NPDB, they are violating 18 USCS §1001. Section 1001 provides:

> (a) Except as otherwise provided in this section, whoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully—
>
> (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact;
>
> (2) makes any materially false, fictitious, or fraudulent statement or representation; or
>
> (3) makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry;
>
> Shall be fined under this title, imprisoned not more than 5 years.…[13]

Moreover, when unauthorized entities, which have falsely certified to the NPDB that they meet the requirements of eligibility, file an adverse action report with the NPDB against a physician, they are causing the NPDB to circulate false information—i.e., false reports. Those who query the databank naturally presume that the reporting entity is lawfully authorized to make reports and has complied with a formal written peer review procedure. This constitutes another violation of 18 USCS § 1001.

State Laws—Due Process Requirements

FQHCs must comply with all Federal, State and local laws including licensure of the clinic or center. Title 42, Chapter IV, Subchapter G, Part 491, Subpart A, § 491.4 states:

> § 491.4 Compliance with Federal, State and local laws.
>
> The rural health clinic or FQHC and its staff are in compliance with applicable Federal, State and local laws and regulations.
>
> (a) **Licensure of clinic or center.** The clinic or center is licensed pursuant to applicable State and local law.
>
> (b) **Licensure, certification or registration of personnel.** Staff of the clinic or center are licensed, certified or registered in accordance with applicable State and local laws[14] [emphasis in original].

States may have specific due process requirements for peer review.

In Massachusetts, for example, the physician must be provided with due process before restricting or revoking privileges. The Commonwealth of Massachusetts General Laws Part I, Title XVI, Chapter 112, Section 5(e) states:

> (e) a description of revocation or involuntary restriction of privileges by a hospital, clinic or nursing home under chapter 111, or of any employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth, for reasons related to competence or character that have been taken by the governing body or any other official at the hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth ***after procedural due process has been afforded…*** [emphasis added]

In California, Business & Professions Code 809.2 specifies in great detail the due process that should be afforded to the physician under review. It provides:

> (a) The hearing shall be held, as determined by the peer review body, before a trier of fact, which shall be an arbitrator or arbitrators selected by a process mutually acceptable to the licentiate and peer review body, or before a panel of unbiased individuals who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the same matter, and which shall include, where feasible, an individual practicing the same specialty as the licentiate.[15]

Section 809.2 (c) specifies the right of the physician to voir dire the panel members and hearing officer, and the right to challenge the impartiality of any member or hearing officer.[15]

Section (d) provides the right to receive relevant documents. And Section (f) provides for the exchange of the witness list of both parties.[15]

Section (e)(1-4) provides the factors the hearing officer must consider in making determinations of relevancy.[15]

And section (h) provides specific time requirements:

(h) A hearing under this section shall be commenced within 60 days after receipt of the request of hearing, and the ***peer review process*** shall be completed within a reasonable time, after the licentiate ***receives notice*** of a final proposed action or an immediate suspension or restriction of clinical privileges, unless the arbitrator or presiding officer issues a written decision finding that the licentiate failed to comply with subdivisions (d) and (e) in a timely manner, or consented to the delay [emphasis added].[15]

Note that this California law *presumes* that a formal peer review process is in effect at the hospital or clinic.

Conclusions

Those who conduct sham peer reviews at FQHCs are often emboldened by the false belief that they have absolute immunity under the FTCA for all claims filed against them, including claims for fraud.

Some FQHCs have embraced a strategy of deception so as to be able to conduct sham peer review with impunity. They have exploited the complexity of laws, rules, policies and regulations so as to mislead the NPDB and judges to believe that they are a lawfully authorized NPDB reporting entity even when they lack a required formal written peer review process.

When FQHC attorneys argue that they are not required to have a formal written peer review process, they are intentionally confusing the requirements for FQHC certification with the requirements for NPDB certification as an authorized reporting entity. The NPDB requires that a healthcare entity certify that they have a formal written peer review process in order to be an authorized reporting entity.

It is obvious that FQHCs that do not have any formal written peer review process, know that they have no formal peer review process, and, therefore, have full knowledge of the falsity of willfully certifying to the NPDB that they meet the requirements for certification. FQHCs that knowingly and willfully report such false information to the NPDB and to courts need to be held accountable for violating 18 U.S.C. § 1001.

FQHCs that have no formal written peer review process may also be in violation of state law.

The Health and Human Services Office of Inspector General and U.S. Attorney General should be notified when FQHCs have knowingly and willfully filed false certification information with the NPDB, and a demand should be made that the NPDB void all reports that were filed by the unauthorized reporting entity. Moreover, if the FQHC subsequently implements a formal peer review process and successfully obtains authorized reporting status, a demand should be made that they be prohibited from filing replacement reports due to the willful and intentional violation of 18 U.S.C. § 1001.

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