FTCA & Quality Management Frequently Asked Questions (FAQ)

based on Participants’ “Burning Questions” at Peer To Peer (P2P) Networking Session

“Federal Tort Claims Act (FTCA) & Quality Management: From Applications to Claims: Sharing Challenges, Best Practices, Solutions, & Resources”

at NACHC’s Policy & Issues Forum, March 2015

I. Deeming Applications:

Question #1: The deeming application requires listing all claims filed over the past five years. Do you have to list claims in the application that are not FTCA claims?

Answer: Yes, the CY2016 deeming application required that all claims and suits, not only FTCA claims and suits be included in the list submitted with the deeming application.

Question #2: When may a new applicant apply for deeming?

Answer: The Federally Supported Health Centers Assistance Act provides for no waiting period for applications for non-deemed health centers. However, the Health Resources and Services Administration (HRSA) has implemented rules that prohibit new organizations from applying prior to six months of operation. Further, HRSA policy permits submission of deeming applications only when the Electronic Handbook is open, typically from April to December of any year.

Question #3: The deeming application wants detailed information on “resolved” cases. What is a “resolved” case?

Answer: A “resolved” case in this context means a claim or suit that has exhausted all of the possible remedies. For example, a malpractice suit that has gone to trial and been appealed as far as possible is “resolved”. A claim that has been settled and payment made is “resolved”. For purposes of the deeming action assume that all claims are not “resolved” unless you have written confirmation from the government that it is closed (resolved).

Question #4: Do physicians need to be listed in the FTCA deeming application in order to have the protections of the FTCA program?

Answer: No, physicians and other providers do not need be listed in the deeming application to be covered by the FTCA. The staff list that is provided in the deeming application is only used to determine if your credentialing program is operating in accordance with HRSA policy. It is not a list of deemed individuals.
II. Credentialing, Privileging, & Peer Review

Question #1: What is the difference between credentialing and privileging?

Answer: Policy Information Notice (PIN) 2001-16 Credentialing and Privileging of Health Center Practitioners states “credentialing is the process of assessing and confirming the qualifications of a health care practitioner”. When credentialing, the organization is doing its due diligence to make certain that the individual who claims to have certain education and work experiences in fact has those experiences. The process includes primary source and secondary source verification of education and work experience claimed by an individual. Privileging is “the process that health care organizations employ to authorize practitioners to provide specific services to their patients” (PIN 2001-16). Health centers will use the information garnered during the credentialing process to determine what services and/or procedures it will permit the individual to perform at the health center. Privileges are granted on a site specific basis.

Question #2: What peer review protection is available to health centers?

Answer: Practically every state has passed peer review protection in some form. However, the Federal government has taken a more fragmented approach. There is statutory peer review protection for the Department of Defense, the Department of Veterans Affairs and the Indian Health Service. There is no Federal peer review legislation for Department of Health and Human Services, the Health Resources and Services Administration, or for health centers in particular. In an FTCA case, health center peer review information has no statutory protection. State laws regarding peer review protection are not controlling in a Federal Tort Claims Act case. However the Patient Safety and Quality Improvement Act of 2005 (PSQIA) may, under certain circumstances, provide some protection for health center peer review materials. Contact counsel for more information on this potential protection for peer review materials.

III. What & Who is Covered by FTCA?

Question #1: Are physical therapy and yoga covered by the FTCA program?

Answer: Physical therapy, if in the scope of project, can be covered by the FTCA program. Yoga may or may not be covered. First it would have to be in the scope of project. Second, the Department of Health and Human Services (DHHS) would have to determine that yoga is a medical, surgical, dental, or related activity. We know of no claims that have been based on yoga so we do not know the DHHS nor the Department of Justice (DOJ) position on this issue.

Question #2: Is it better to put more or less information on form 5C Other Activities and Locations?

Answer: It is better to be more inclusive than less inclusive on Form 5C. Listing information on locations and activities on this form, is not a requirement for FTCA coverage nor will it guarantee coverage. However, the information on the Form could be of great help if there are any questions about a claim being covered by the FTCA. Therefore, health centers should include on this form all locations where they provide or may provide care to patients and all activities outside the health center in which they will be engaged.
Question #3: Are there examples of good or bad narrative statements?

Answer: While we have no examples of narrative statements we can share we can say that yes, there are good and bad narrative statements. The DHHS Office of the General Counsel asks that every practitioner involved in an FTCA claim submit a “narrative statement of the health care provided by each treating health professional pertaining to the allegations contained in this case. If the health professional(s) does not wish to provide a narrative statement or is/are no longer working for the health center and cannot be located, please have the Medical Director, Clinical Director or someone familiar with the incident prepare a synopsis of care”. A good narrative statement is simply a summary of the medical record with no additional information whatsoever. A bad narrative statement is one that gives any information that can cause DHHS to deny FTCA coverage. This could include information on why the clinician saw a particular patient, what caused the clinician to be at a hospital to care for the patient, or information on the clinicians’ specialty. The best course of action is stick to the facts as stated in the medical record.

Question #4: Does a contractor have to have a formal written contract in order to have FTCA coverage?

Answer: Contractors may be eligible for FTCA coverage if they are full time or if they are part time providers of ob/gyn, family practice, internal medicine, or pediatrics. While there does not appear to be a requirement for a formal written contract we strongly urge all health centers to have written agreements with all contractors, to renew them annually, and to keep copies in the event that a claim is filed some years in the future. These documents, as well as employed provider position descriptions, detailing the duties they will be performing should include requirements to maintain hospital privileges or participation in cross coverage agreements where appropriate. FTCA coverage is only available for individual contractors, not corporate contractors.

Question #5: How do you distinguish between an employer and a contractor?

Answer: HRSA has stated in the FTCA Manual that they will use the Internal Revenue Service (IRS) definition of a contractor. DHHS Office of the General Counsel has taken the same approach. When a claim is filed DHHS will ask to see the Form 1099 for a contractor or Form W-2 for an employee. If you have questions about proper classification of individuals as employees or contractors consult your attorney or tax advisor.

IV. Gap Insurance:

Question #1: Do you have any recommendations on GAP insurance?

Answer: Whether or not a health center needs gap insurance is an individual decision. It depends on the centers size, complexity, scope of services, and ability to take risk. The way the FTCA Program is managed, a deemed health center never knows if it is covered until a claim is made. Only then does DHHS make a decision regarding FTCA coverage. And even with a positive decision, the DOJ may take a contrary position. If a health center decides it needs gap insurance it should shop among a number of carriers for the coverage that best suits it. The health centers should work with agents that have a good understanding of their FTCA program.

Question #2: How many health centers have gap insurance?

Answer: In a small study done in 2009 by the Triton Group it was estimated that over 50% of health centers had gap insurance. We believe that number could be larger now.
V. Electronic Health Record Systems (EHRs):

Question #1: Using EHR systems to improve quality of care seems intuitive. Are there any overarching themes regarding use of EHRs in Q/A that we should be aware of?

Answer: Yes, there are three primary underlying themes that framed our discussions on health centers use of EHRs and quality assurance:

- The health center should begin by developing specific self-selected standards for addressing quality issues (and thus related Risk Management and FTCA issues) via the EHR. A critical area for these standards to address is referrals and tracking, which turned out to be the main thrust of discussion in each of the P2P session groups. Prime among the selected standards will be those relating to FTCA deeming and Patent Centered Medical Home (PCMH) recognition. Other appropriate standards should then be added as desired (e.g., Meaningful Use, etc.), with awareness that standard sets can often overlap and contain some duplicate standards.

- Next, based on its Mission / Vision / Values, the health center must undertake intensive internal discussions leading to prioritized decisions about what’s most important to track, based on shared knowledge of available resources and constraints.

- Finally, a critical feature of these internal discussions is that they should involve a broadly representative team – including managers and critical HIT staff – in order to generate comprehensive decisions on how to select, optimally design, and fully utilize the EHR. This team must include both operational staff and Quality/Risk Management staff, and all team members must “speak the same language” in addressing common quality issues. In practice, it comes down to all affected parties actively talking to one another in order to make intentional decisions on organizational priorities.

Question #2: How do we prioritize what things to track and follow up on, given resource constraints?

Answer: While in a perfect world everything would be tracked via the EHR, in real-world practice this is usually not possible given resource constraints. Thus, the organization must deliberately prioritize tracking activities based on specific internal decisions. Once these prioritization decisions have been made, the key is to document what is to be tracked, then to actively track what you have thus documented.

Question #3: How do we get the needed information out via the EHR in order to prove what we’re doing (or identify what we need to improve)?

Answer: This is a tough question with no simple answer, given the number of EHR systems with differing capabilities and operational mechanics. The key is to optimally design the selected EHR to address all of the center’s self-selected “critical issues”, then fully utilize all of that EHR’s capabilities. This mandates both ongoing decision-making by a broad-based EHR team comprising key managers and IT staff, and intensive internal training on how to optimally use the EHR. It could also involve identifying / purchasing add-on technologies that specifically address prioritized needs.
Question #4: How do we document “self-management” notes (with or without templates)?

Answer: Again, the key is selecting and developing an EHR system that will fully work on the center’s behalf, including reporting. This should be done through a broadly representative EHR team, and it should include a mandate for comprehensive, ongoing staff training in how to optimally use the EHR’s capabilities.

Question #5: How can we know (and prove) if we’re actually doing enough, given the broad range of “referral and tracking” options?

Answer: This again involves actively self-selecting, through team-based discussion, what the center believes is most important to track. Then based on these decisions, the center must optimize both EHR reporting and the staff’s ability (through intensive ongoing training) to appropriately document all needed information. The key: “Better training leads to better documentation, better documentation leads to better reporting, and better reporting leads to better decision-making.”

Question #6: How do we decide between what we’re doing “for paperwork only” vs. “for real risk reduction”?

Answer: Simply put, once a representative internal team has decided what is and isn’t truly important to document/report, anything left over is probably just a paperwork exercise – and such busy-work should be eliminated. Two related principles: (1) don’t document simply because “we’ve always done it”; and (2) don’t duplicate work by simultaneously documenting on paper and via the EHR.
Additional Resources

Federal Tort Claims Act (FTCA) Health Center Policy Manual (Updated 07/21/2014)

HRSA Program Assistance Letter (PAL) 2015-03: Calendar Year 2016 Requirements for Federal Tort Claims Act (FTCA) Coverage for Health Centers

Policy Information Notice (PIN) 2001-16: Credentialing and Privileging of Health Center Practitioners


HRSA Risk Management and Quality Improvement (Includes link to ECRI Clinical Risk Management Services for Health Centers. When subscribing, ask about free membership.)

Feldesman, Tucker, Leifer, Fidell Comprehensive Compliance, FTCA and HIPAA resources