

**AMENDING THE HCQIA OF 1986**  
**Proposed October 2003**

The key to drafting reasonable peer review legislation is:

1. Change the burden of persuasion from the Plaintiff and place it on the Defendant Hospital. The presumption of proper action by Hospital Committees needs to be replaced by a standard more in tone to that of the criminal arena where the Hospital should be forced to prove its case at least to a clear and convincing standard.
2. Mandate strict due process. Presently HCQIA states that a failure to meet the exact notice and hearing procedure does not by itself constitute a due process violation. Procedural fairness is the hallmark of our nation's jurisprudence and must be strictly adhered to.
3. Ca. Bus. and Prof Code 809 allows voir dire of the Hearing Panel and this should be a fixture of any federal legislation.
4. HCQIA in any revised form must expressly preempt any state statutory and case law as some state cases have been dismissed based on outdated pre-HCQIA case law.
5. There needs to be an appellate procedure that gets the process out of the Hospital. Possibly this would be an appropriate responsibility for a State Medical Board or a state-appointed commission.

**PROPOSED AMENDMENTS IN BLUE**

42 USCS § 11101 et seq. (2003)

**§ 11101. Findings:**

**The Congress finds the following:**

**(1) The increasing occurrence of **alleged** medical malpractice and the need to **assure ongoing** quality of medical care **are of significant interest to the interstate population as a whole and** warrant greater efforts than those that can be undertaken by any individual State.**

**( ) That a valid medical license and privileges to practice within a health care entity represent valuable property rights deserving of constitutional due process protection.**

**( ) There is increasing economic pressure on the medical community in general and that as reimbursement has declined, business expenses have increased and some physicians and health care entities in their need to**

obtain a competitive advantage, have sought to eliminate some of their colleagues for reasons unrelated to quality of care issues.

(2) There is a national need to restrict the ability of truly incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance and to consolidate a conflicting body of state statutory and common law under a single federal statutory mandate.

( ) That such incompetence must be proven by a preponderance of the evidence and commensurate with Constitutional due process protection as provided under the Vth and XIVth amendments to the United States Constitution regardless of whether the health care entity is public or private.

(3) This nationwide problem can be remedied through indemnification of effective professional peer review activities and through the preemption of any and all contradictory state common and statutory law while assuring that truly qualified, competent physicians are not forced from practice to the detriment of the public at large.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, can unreasonably discourage physicians from participating in effective professional peer review.

( ) That peer review, however, can and has been used for improper purposes including antitrust motives of competitors, the need for health care entities to eliminate physicians whose utilization is more costly, to quiet practitioners critical of the health care entity's practices and other factors unrelated to quality of care.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review while concurrently assuring procedural due process to those wrongly accused against whom peer review is initiated for improper purposes .

( ) There is an equally overriding national need to punitively discourage the utilization of the professional peer review process for reasons not conclusively demonstrated to be issues of quality of care.

## § 11111. Professional review

(a) In general.

(1) Limitation on damages for professional review actions. If a professional review action (as defined in section 431(9) [ 42 USCS § 11151

(9)) of a professional review body meets all the standards specified in section 412(a) [ [42 USCS § 11112 \(a\)](#)], except as provided in subsection (b)-

- (A) the professional review body,
- (B) any person acting as a member or staff to the body,
- (C) any person under a contract or other formal agreement with the body, and
- (D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, [42 U.S.C. 2000e](#), et seq. and the Civil Rights Acts, [42 U.S.C. 1981](#), et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 4C of the Clayton Act, [15 U.S.C. 15C](#), [ [15 USCS § 15c](#)] where such an action is otherwise authorized.

(2) Protection for those providing information to professional review bodies. Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing **truthful and unbiased** information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false **or professionally biased** and the person providing it knew or should have known that such information was false or professionally biased .

**( ) Such falsity and/or professional bias must be proven by a preponderance of the evidence to rebut information and/or testimony.**

(b) Exception. If, **upon appeal by the reviewed practitioner** , the Secretary has reason to believe that a health care entity has failed to report information in **procedural** accordance with section 423(a) [ [42 USCS § 11133 \(a\)](#)], the Secretary shall conduct an investigation.

**( ) Likewise, upon appeal by the reviewed practitioner, the substantive merits of any such report shall be investigated by the Secretary with the assistance of a panel of three appropriately credentialed third-party physicians from within the investigated practitioners specialty.**

If, after providing notice of noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing, the Secretary determines that a health care entity has failed substantially to report information in accordance with section 423(a) [ [42 USCS § 11133 \(a\)](#)] [procedurally and/or the substantive merits of the report are overruled by the appellate physician panel](#) , the Secretary shall publish the name of the entity in the Federal Register.

The protections of subsection (a)(1) shall not apply to an entity the name of which is published in the Federal Register under the previous sentence with respect to professional review actions of the entity commenced during the 3-year period beginning 30 days after the date of publication of the name.

(c) Treatment under State laws.

(1) Professional review actions taken on or after October 14, 1989. Except as provided in paragraph (2), subsection (a) shall apply to State laws in a State only for professional review actions commenced on or after October 14, 1989.

(2) Exceptions.

(A) State early opt-in. Subsection (a) shall apply to State laws in a State for actions commenced before October 14, 1989, if the State by legislation elects such treatment.

(B) Effective date of election. An election under State law is not effective, for purposes of [subparagraph (A)], for actions commenced before the effective date of the State law, which may not be earlier than the date of the enactment of that law.

## § 11112. Standards for professional review actions

(a) In general. For purposes of the protection set forth in section 411(a) [ [42 USCS § 11111 \(a\)](#)], a professional review action must be taken--

(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,

( ) [after external review by an appropriately credentialed practitioner from within the reviewed practitioners specialty,](#)

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such 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 paragraphs (3) and ( ). **A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 411(a) [ 42 USCS § 11111 (a)] unless the presumption is rebutted by a preponderance of the evidence. (delete). The burden of proof and production shall be on the health care entity to establish by a preponderance of the evidence, a breach of the standard of care and/or some reasonable explanation mandating the peer review action rationally related to the quality of health care in order to obtain the protection set out in section 411(a) [ 42 USCS § 11111 (a)].**

(b) Adequate notice and hearing. A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action. The physician has been given notice stating--

(A) (i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

**( iii) what proposed remedial actions might potentially be sought in order to correct the perceived reasons for the proposed action,**

(B) (i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing. If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating--

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) an accurate list of the witnesses (if any) expected (delete) to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice. If a hearing is requested on a timely basis under paragraph (1)(b)--

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)--

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is **mutually acceptable** to the entity, the **practitioner under review**, and who is not in direct economic competition with him or her,

- (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
- (B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
- (C) in the hearing the physician involved has the right--
  - (i) to representation by an attorney or other person of the physician's choice,
  - (ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
  - (iii) to call, examine, cross-examine **and impeach** witnesses,
  - (iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
  - (v) to submit a written statement at the close of the hearing; and
- (D) upon completion of the hearing, the physician involved has the right--
  - (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
  - (ii) to receive a written decision of the health care entity, including a **detailed** statement **expressly specifying** the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall constitute failure to meet the standards of subsection (a)(3).

- (c) Adequate procedures in investigations or health emergencies. For purposes of section 411(a) [ **42 USCS § 11111 (a)**], nothing in this section shall be construed as--
- (1) requiring the procedures referred to in subsection (a)(3)--
    - (A) where there is no adverse professional review action taken, or
    - (B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or
  - (2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the **life or health** of any individual.

§ 11113. Payment of reasonable attorneys' fees and costs in defense of suit.

In any suit brought against a defendant, to the extent that a defendant has

met the standards set forth under section 412(a) [ [42 USCS § 11112 \(a\)](#)] and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

**Likewise, in any suit brought by a Plaintiff in which the Plaintiff substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing Plaintiff the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the original peer review claim, or the Defendant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.**

#### § 11114. Guidelines of the Secretary

The Secretary may establish, after notice and opportunity for comment, such voluntary guidelines as may assist the professional review bodies in meeting the standards described in section 412(a) [ [42 USCS § 11112 \(a\)](#)],

#### § 11115. Construction

(a) In general. Except as specifically provided in this part, nothing in this part shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities, or protection for **those engaged** in a professional review action that is in addition to or greater than that provided by this part. **Those engaged in a professional review action shall include both the professional review body and the respondent practitioner.**

(b) Scope of clinical privileges. Nothing in this part [ [42 USCS §§ 11111 et seq.](#)] shall be construed as requiring health care entities to provide clinical privileges to any or all classes or types of physicians or other licensed health care practitioners.

(c) Treatment of nurses and other practitioners. Nothing in this part [ [42 USCS §§ 11111](#) et seq.] shall be construed as affecting, or modifying any provision of Federal or State law, with respect to activities of professional review bodies regarding nurses, other licensed health care practitioners, or other health professionals who are not physicians.

(d) Treatment of patient malpractice claims. Nothing in this title [ [42 USCS §§ 11101](#) et seq.] shall be construed as affecting in any manner the rights and remedies afforded patients under any provision of Federal or State law to seek redress for any harm or injury suffered as a result of negligent treatment or care by any physician, health care practitioner, or health care entity, or as limiting any defenses or immunities available to any physician, health care practitioner, or health care entity.

#### § 11131. Requiring reports on medical malpractice payments

(a) In general. Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 424 [ [42 USCS § 11134](#)], information respecting the payment and circumstances thereof.

(b) Information to be reported. The information to be reported under subsection (a) includes--

- (1) the name of any physician or licensed health care practitioner for whose benefit the payment is made,
- (2) the amount of the payment,
- (3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated,
- (4) a **specific** description of the acts or omissions and injuries or illnesses upon which the action or claim was based

**( ) whether appellate procedural and substantive review was conducted by the Secretary and the findings of such review , and**

(5) such other information as the Secretary determines is required for appropriate interpretation of information reported under this section.

(c) Sanctions for failure to report. Any entity that fails to report information on a payment required to be reported under this section shall be subject to a civil money penalty of not more than \$ 10,000 for each such payment involved. Such penalty shall be imposed and collected in the same manner

as civil money penalties under subsection (a) of section 1128A of the Social Security Act [ [42 USCS § 1320a-7a](#)] are imposed and collected under that section.

(d) Report on treatment of small payments. The Secretary shall study and report to Congress, not later than two years after the date of the enactment of this Act [enacted Nov. 14, 1986], on whether information respecting small payments should continue to be required to be reported under subsection (a) and whether information respecting all claims made concerning a medical malpractice action should be required to be reported under such subsection.

#### § 11132. Reporting of sanctions taken by Boards of Medical Examiners

(a) In general.

(1) Actions subject to reporting. Each Board of Medical Examiners--

(A) which revokes or suspends (or otherwise restricts) a physician's license or censures, reprimands, or places on probation a physician, for reasons relating to the physician's professional competence or professional conduct, or

(B) to which a physician's license is surrendered, shall report, in accordance with section 424 [ [42 USCS § 11134](#)], the information described in paragraph (2).

(2) Information to be reported. The information to be reported under paragraph (1) is--

(A) the name of the physician involved,

(B) a **specific** description of the acts or omissions or other reasons (if known) for the revocation, suspension, or surrender of license, and

(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

(b) Failure to report. If, after notice of noncompliance and providing opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (a), the Secretary shall designate another qualified entity for the reporting of information under section 423 [ [42 USCS § 11133](#)].

**§ 11133. Reporting of certain professional review actions taken by health care entities**

**(a) Reporting by health care entities.**

**(1) On physicians. Each health care entity which--**

**(A) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;**

**(B) accepts the surrender of clinical privileges of a physician--**

**(i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or**

**(ii) in return for not conducting such an investigation or proceeding;**

**or**

**(C) in the case of such an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in the society, shall report to the Board of Medical Examiners, in accordance with section 424(a) [ [42 USCS § 11134 \(a\)](#)], the information described in paragraph (3).**

**(2) Permissive reporting on other licensed health care practitioners. A health care entity may report to the Board of Medical Examiners, in accordance with section 424(a) [ [42 USCS § 11134 \(a\)](#)], the information described in paragraph (3) in the case of a licensed health care practitioner who is not a physician, if the entity would be required to report such information under paragraph (1) with respect to the practitioner if the practitioner were a physician.**

**(3) Information to be reported. The information to be reported under this subsection is--**

**(A) the name of the physician or practitioner involved,**

**(B) a description of the acts or omissions or other reasons for the action or, if known, for the surrender, and**

**(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.**

**(b) Reporting by Board of Medical Examiners. Each Board of Medical Examiners shall report, in accordance with section 424 [ [42 USCS § 11134](#)], the information reported to it under subsection (a) and known instances of a health care entity's failure to report information under subsection (a)(1).**

**(c) Sanctions.**

**(1) Health care entities. A health care entity that fails substantially to meet the requirement of subsection (a)(1) shall lose the protections of section 411(a)(1) [ [42 USCS § 11111 \(a\)\(1\)](#)] if the Secretary publishes the name of the entity under section 411(b) [ [42 USCS § 11111 \(b\)](#)].**

**(2) Board of Medical Examiners. If, after notice of noncompliance and providing an opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (b), the Secretary shall**

designate another qualified entity for the reporting of information under subsection (b).

(d) References to Board of Medical Examiners. Any reference in this part [ [42 USCS §§ 11131](#) et seq.] to a Board of Medical Examiners includes, in the case of a Board in a State that fails to meet the reporting requirements of section 422(a) [ [42 USCS § 11132 \(a\)](#)] or subsection (b), a reference to such other qualified entity as the Secretary designates.

#### § 11134. Form of reporting

(a) Timing and form. The information required to be reported under sections 421, 422(a), and 423 [ [42 USCS §§ 11131](#), 11132(a), 11133] shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date (not later than one year after the date of the enactment of this Act [enacted Nov. 14, 1986]) specified by the Secretary.

(b) To whom reported. The information required to be reported under sections 421, 422(a), and 423(b) [ [42 USCS §§ 11131](#), 11132(a), 11133(b)] shall be reported to the Secretary, or, in the Secretary's discretion, to an appropriate private or public agency which has made suitable arrangements with the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of the information under this part [ [42 USCS §§ 11131](#) et seq.].

(c) Reporting to State licensing boards.

(1) Malpractice payments. Information required to be reported under section 421 [ [42 USCS § 11131](#)] shall also be reported to the appropriate State licensing board (or boards) in the State in which the medical malpractice claim arose.

(2) Reporting to other licensing boards. Information required to be reported under section 423(b) [ [42 USCS § 11133 \(b\)](#)] shall also be reported to the appropriate State licensing board in the State in which the health care entity is located if it is not otherwise reported to such board under subsection (b).

## **§ 11135. Duty of hospitals to obtain information**

**(a) In general.** It is the duty of each hospital to request from the Secretary (or the agency designated under section 424(b) [ [42 USCS § 11134 \(b\)](#)]), on and after the date information is first required to be reported under section 424(a) [ [42 USCS § 11134 \(a\)](#)]]--

**(1)** at the time a physician or licensed health care practitioner applies to be on the medical staff (courtesy or otherwise) of, or for clinical privileges at, the hospital, information reported under this part [ [42 USCS §§ 11131 et seq.](#)] concerning the physician or practitioner, and

**(2)** once every 2 years information reported under this part [ [42 USCS §§ 11131 et seq.](#)] concerning any physician or such practitioner who is on the medical staff (courtesy or otherwise) of, or has been granted clinical privileges at, the hospital.

A hospital may request such information at other times.

**(b) Failure to obtain information.** With respect to a medical malpractice action, a hospital which does not request information respecting a physician or practitioner as required under subsection (a) is presumed to have knowledge of any information reported under this part to the Secretary with respect to the physician or practitioner.

**(c) Reliance on information provided.** Each hospital may rely upon information provided to the hospital under this title [ [42 USCS §§ 11101 et seq.](#)] and shall not be held liable for such reliance in the absence of the hospital's knowledge that the information provided was false.

## **§ 11136. Disclosure and correction of information**

With respect to the information reported to the Secretary (or the agency designated under section 424(b) [ [42 USCS § 11134 \(b\)](#)]) under this part [ [42 USCS §§ 11131 et seq.](#)] respecting a physician or other licensed health care practitioner, the Secretary shall, by regulation, provide for--

**(1)** disclosure of the information, upon request, to the physician or practitioner, and

**(2)** procedures in the case of disputed accuracy of the information.

## § 11137. Miscellaneous provisions

(a) Providing licensing boards and other health care entities with access to information. The Secretary (or the agency designated under section 424(b) [ [42 USCS § 11134 \(b\)](#)]) shall, upon request, provide information reported under this part with respect to a physician or other licensed health care practitioner to State licensing boards, to hospitals, and to other health care entities (including health maintenance organizations) that have entered (or may be entering) into an employment or affiliation relationship with the physician or practitioner or to which the physician or practitioner has applied for clinical privileges or appointment to the medical staff.

(b) Confidentiality of information.

(1) In general. Information reported under this part [ [42 USCS §§ 11131 et seq.](#)] is considered confidential and shall not be disclosed (other than to the physician or practitioner involved) except with respect to professional review activity, as necessary to carry out subsections (b) and (c) of section 425 [ [42 USCS § 11135 \(b\), \(c\)](#)] (as specified in regulations by the Secretary), or in accordance with regulations of the Secretary promulgated pursuant to subsection (a). Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure. Information reported under this part [ [42 USCS §§ 11131 et seq.](#)] that is in a form that does not permit the identification of any particular health care entity, physician, other health care practitioner, or patient shall not be considered confidential. The Secretary (or the agency designated under section 424(b) [ [42 USCS § 11134 \(b\)](#)]), on application by any person, shall prepare such information in such form and shall disclose such information in such form.

(2) Penalty for violations. Any person who violates paragraph (1) shall be subject to a civil money penalty of not more than \$ 10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalty of not more than \$ 10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act [ [42 USCS § 1320a-7a](#)] are imposed and collected under that section.

(3) Use of information. Subject to paragraph (1), information provided under section 425 [ [42 USCS § 11135](#)] and subsection (a) is intended to be used solely with respect to activities in the furtherance of the quality of health care.

(4) Fees. The Secretary may establish or approve reasonable fees for the disclosure of information under this section or section 426 [ [42 USCS § 11136](#)]. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary (or, in the Secretary's discretion, to the agency designated under section 424(b) [ [42 USCS § 11134 \(b\)](#)]) to cover

such costs.

(c) Relief from liability for reporting. No person or entity (including the agency designated under section 424(b) [ [42 USCS § 11134 \(b\)](#)]) shall be held liable in any civil action with respect to any report made under this part [ [42 USCS §§ 11131 et seq.](#)] (including information provided under subsection (a)[]) without knowledge of the falsity of the information contained in the report.

(d) Interpretation of information. In interpreting information reported under this part [ [42 USCS §§ 11131 et seq.](#)], a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.

#### § 11151. Definitions

In this title [ [42 USCS §§ 11101 et seq.](#)]:

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.

(2) The term "Board of Medical Examiners" includes a body comparable to such a Board (as determined by the State) with responsibility for the licensing of physicians and also includes a subdivision of such a Board or body.

(3) The term "clinical privileges" includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity.

**( ) The term those engaged in peer review shall include the respective Board of Medical Examiners, health care entity reviewing body or board, individual reviewing physicians and the respondent physician being reviewed.**

(4) (A) The term "health care entity" means--

(i) a hospital that is licensed to provide health care services by the State in which it is located,

(ii) an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary), and

(iii) subject to subparagraph (B), a professional society (or committee thereof) of physicians or other licensed health care practitioners that

follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary).

(B) The term "health care entity" does not include a professional society (or committee thereof) if, within the previous 5 years, the society has been found by the Federal Trade Commission or any court to have engaged in any anti-competitive practice which had the effect of restricting the practice of licensed health care practitioners.

(5) The term "hospital" means an entity described in paragraphs (1) and (7) of section 1861(e) of the Social Security Act [ [42 USCS § 1395x](#) (e)(1), (7)].

(6) The terms "licensed health care practitioner" and "practitioner" mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services.

(7) The term "medical malpractice action or claim" means a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.

(8) The term "physician" means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).

(9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this title, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on--

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care

practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

(10) The term "professional review activity" means an activity of a health care entity with respect to an individual physician--

(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,

(B) to determine the scope or conditions of such privileges or membership, or

(C) to change or modify such privileges or membership.

(11) The term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

(12) The term "Secretary" means the Secretary of Health and Human Services.

(13) The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(14) The term "State licensing board" means, with respect to a physician or health care provider in a State, the agency of the State which is primarily responsible for the licensing of the physician or provider to furnish health care services.

## 11152. Reports and memoranda of understanding

(a) Annual reports to Congress. The Secretary shall report to Congress, annually during the three years after the date of the enactment of this Act [enacted Nov. 14, 1986], on the implementation of this title [ [42 USCS §§ 11101](#) et seq.].

(b) Memoranda of understanding. The Secretary of Health and Human Services shall seek to enter into memoranda of understanding with the Secretary of Defense and the Administrator of Veterans' Affairs [Secretary of Veterans' Affairs] to apply the provisions of part B of this title [ [42 USCS §§ 11131](#) et seq.] to hospitals and other facilities and health care providers under the jurisdiction of the Secretary or Administrator, respectively. The Secretary shall report to Congress, not later than two years after the date of the enactment of this Act [enacted Nov. 14, 1986], on any such memoranda and on the cooperation among such officials in establishing such memoranda.

**(c) Memorandum of understanding with Drug Enforcement Administration.** The Secretary of Health and Human Services shall seek to enter into a memorandum of understanding with the Administrator of Drug Enforcement relating to providing for the reporting by the Administrator to the Secretary of information respecting physicians and other practitioners whose registration to dispense controlled substances has been suspended or revoked under section 304 of the Controlled Substances Act [ [21 USCS § 824](#)]. The Secretary shall report to Congress, not later than two years after the date of the enactment of this Act [enacted Nov. 14, 1984], on any such memorandum and on the cooperation between the Secretary and the Administrator in establishing such a memorandum.