Analysis

Aggressive New Assertions of Jurisdiction by OFCCP over Hospitals and Other Healthcare Providers

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Hospitals, nursing homes, home health providers, and other healthcare providers are increasingly finding themselves in receipt of notices from the U.S. Department of Labor (DOL), specifically its Office of Contract Compliance Programs (OFCCP), to provide a copy of their affirmative action plans and supporting documentation. This is the first stage of a compliance review by the OFCCP to determine if employers are in full compliance with the three affirmative action laws enforced by the OFCCP: (a) Executive Order 11246 (requiring affirmative action with regard to the employment of minorities and women); (b) the Rehabilitation Act of 1973[1] (requiring affirmative action with regard to the employment of disabled individuals); and (c) the Vietnam Era Veterans Readjustment Assistance Act of 1974[2] (requiring affirmative action with regard to the employment of most classes of veterans) (collectively, AA Laws).

In general, the AA Laws impose substantial recordkeeping, outreach, and affirmative action obligations on employers that contract or subcontract with the federal government to supply goods or nonpersonal services. Failure to comply with the AA Laws subjects an employer to penalties and sanctions, ranging from remedial relief similar to that under federal nondiscrimination laws to a potential debarment or suspension (or loss of the ability to do business with the government). If the courts uphold recent administrative decisions, the sanctions could include loss of eligibility to participate in the TRICARE program, certain Medicare programs, and the Federal Employee Health Benefits Program (FEHBP).

Hospitals and healthcare providers (collectively referred to herein, for ease of reference, as hospitals) have long thought themselves to be outside of OFCCP's reach because they are not covered government contractors or subcontractors. Indeed, OFCCP's recent assertions of jurisdiction in the healthcare arena are at odds with almost 20 years of OFCCP history, and more importantly, at odds with the historic and current positions of other major stakeholders in the government healthcare arena—most notably the federal Office of Personnel Management (OPM), responsible for FEHBP (the insurance programs for most federal government employees), and the Department of Defense (DOD), which administers the TRICARE program, the health insurance system for DOD employees.

Many hospitals believe they are not covered by the AA Laws for several reasons: (1) the programs at issue involve federal financial assistance and not contracts; (2) they are not covered subcontractors, as that term is appropriately defined; and (3) for those reasons, their agreements with insurers expressly say they are not covered by the AA Laws and flow-down obligations.

However, based on recent administrative decisions and OFCCP pronouncements, to the extent an entity is providing healthcare services to TRICARE beneficiaries or individuals insured under the government's FEHBP policies, OFCCP will likely take the position that the entity is covered by the AA Laws, regardless of implementing regulations of other government agencies and regardless of the terms of the contracts themselves.

Historical Interpretation of the AA Laws' Reach in the Healthcare Arena

By OFCCP regulations, the AA Laws apply to contracts and subcontracts with the federal government to supply goods or *nonpersonal services*. The areas of controversy and ambiguity relate to the legal definitions of "subcontract" and "nonpersonal services."

OFCCP regulations define subcontracts to include "any agreement or arrangement between a contactor and any person (in which the parties do not stand in the relationship of an employer and an employee) . . . for the purchase, sale or use of personal property or *nonpersonal services* which, in whole or part, is necessary to the performance of any one or more contracts . . ."[3]

The term "nonpersonal services" is largely undefined by OFCCP, except that it "includes but is not limited to, the following services: Utilities, construction, transportation, research, insurance, and fund depository."[4] Thus, by regulation, any entity that enters into a contract with the federal government to supply insurance services is a government contractor, and those entities with which the contractor subcontracts to provide nonpersonal services necessary to the performance of the prime contract are covered subcontractors. That much is clear.

What is not clear is whether medical service providers that enter into provider agreements with insurers other than traditional insurers may appropriately be deemed to be government subcontractors. This issue is the subject of recent administrative decisions and an OFCCP Directive.

OFCCP has long sought to assert jurisdiction over healthcare providers. Prior to 1993, it claimed jurisdiction over any

employer that participated in the Medicare and Medicaid programs. Many hospitals contested OFCCP jurisdiction, contending that Medicare and Medicaid were viewed by the Department of Health and Human Services (HHS) to constitute "federal financial assistance," and not federal "contracts." In 1993, following several judicial determinations that Medicare and Medicaid in fact constitute federal financial assistance, OFCCP issued a formal Directive acknowledging that participation in those programs did not subject an employer to the AA Laws.[5]

OFCCP next asserted jurisdiction over healthcare entities that provided medical services to federal government employees insured under FEHBP programs. However, in 2003, OFCCP conceded its jurisdiction in that regard, following a DOL Administrative Review Board (ARB) decision in *OFCCP v. Bridgeport Hospital*.[6] The underlying facts in Bridgeport involved a federal government (OPM) contract with Blue Cross/Blue Shield (BC/BS) to provide insurance services. BC/BS utilized provider agreements with various hospitals, including Bridgeport Hospital, to reimburse the hospitals for medical services provided to member plans' insureds, including federal government employees. Having entered into a federal contract to provide insurance, BC/BS unquestionably was a government contractor. However, the contracted hospitals were not deemed by the ARB to be covered subcontractors. The ARB's rationale was that BC/BS contracted to provide insurance, not medical services. The hospitals thus were contracting to provide something different (medical services) than what BC/BS was providing under its contract with the federal government (insurance services). This decision was in accord with FEHBP regulations, which provided that agreements between an insurer and a provider of medical services are not covered "subcontracts."

That victory was relatively short-lived. Although the *Bridgeport Hospitals* decision appeared to resolve the issue of OFCCP jurisdiction over healthcare entities, OFCCP continued to seek to narrow the reach of the decision. In recent months, it has succeeded in doing so, through two controversial administrative decisions. Both of those victories are included in a newly issued OFCCP directive, "Directive 293."

The Recent Administrative Decisions

OFCCP v. UPMC Braddock

In May 2009, an ARB decision in *OFCCP v. UPMC Braddock*,[7] substantially narrowed the effect of the 2003 administrative decision in *Bridgeport Hospital*, providing OFCCP its first substantial victory in its attempts to assert jurisdiction over hospitals. At issue in that case was a contract, much like that in *Bridgeport Hospital*, which UPMC, the insurance carrier for UPMC HMO (the Health Plan), entered into with OPM to provide insurance services to FEHBP insureds. By entering into that insurance contract, the Health Plan became a government contractor. The legal issue was whether the hospitals with which the Health Plan had provider agreements became "subcontractors" subject to the AA Laws. The Health Plan's agreement with OPM defined "subcontractor," in accord with applicable Federal Acquisition Regulations (FAR), to expressly exclude "providers of direct medical services or supplies pursuant to [the] health benefit plan."[8]

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Years before becoming a government contractor, the Health Plan had entered into provider agreements with several hospitals, pursuant to which those hospitals provided medical services to UPMC's insureds. OFCCP asserted that those hospitals became government subcontractors when they later began to provide medical services to federal government employees who were insured through the Health Plan. Both the Health Plan and the hospitals contended that the hospitals contracted to provide *medical services* to Health Plan members, and thus by virtue of implementing FAR regulations, the face of the contract, and the business relationship, were not covered subcontractors. The Health Plan contended that it was identical to BC/BS in that it had contracted to provide insurance services only, and that it had no obligation to flow down AA Law obligations to the hospitals.

OFCCP contended that the Health Plan's participating hospitals were subcontractors, that other government agencies lacked the authority to carve out "medical services" from the definition of "subcontract," and that OFCCP's definition of subcontractor was controlling. OFCCP also argued that the Health Plan had in fact contracted to provide both insurance and medical services, and that the hospitals consequently were providing a service that UPMC was obligated to provide under its contract. They were, therefore, covered subcontractors for OFCCP's purposes.

In a 2009 decision, the ARB sided with OFCCP and found that the hospitals were performing a portion of the "necessary" services the Health Plan was obligated to provide under its contract with OPM. As a result, the ARB ruled that the hospitals were covered subcontractors.

Analysis

This case is on appeal to the U.S. District Court for the District of Columbia.[9] In the appeal, the Health Plan and the hospitals contend that the ARB decision is based on a misinterpretation of the Health Plan's business, and that the case is indistinguishable from *Bridgeport Hospital*. In stipulated facts submitted to the court, the parties appear to agree that the Health Plan entered into an agreement with OPM to provide insurance, and that the Health Plan in turn entered into healthcare services agreements with hospitals. Although, in rare circumstances, a health maintenance organization (HMO) may provide both insurance and healthcare services, UPMC asserts that it did not do so. It notes that it employs no physicians, provides no medical services, and did not contract to provide medical services. Thus, the hospitals argue that they are not "subcontractors" because they are not providing goods or nonpersonal services to the Health Plan that the Health Plan is obligated by contract to provide to the government. The hospitals also contend that the medical services they provide to federal government employees do not fall within the definition of "nonpersonal services," and thus cannot be classified, even under OFCCP regulations, as a government "contract" or "subcontract." In addition, the contract between the Health Plan and OPM, consistent with FAR regulations, defines "subcontractor" to *expressly exclude* "providers of direct medical services or supplies pursuant to the Carrier's health benefits plan." They also argue that because OFCCP regulations contain only a truncated and internally inconsistent definition of "nonpersonal services," the FAR definitions are controlling.

OFCCP v. Florida Hospital of Orlando

More recently, OFCCP was victorious in *OFCCP v. Florida Hospital of Orlando*.[10] In that case, an Administrative Law Judge (ALJ) ruled that the Florida Hospital of Orlando was a covered subcontractor subject to OFCCP jurisdiction because it provides medical services to TRICARE beneficiaries. The basis for that ruling was that the Hospital participated in a healthcare provider network established by Humana Military Healthcare Services Inc. (HMHS) to provide medical services to military service members and their families insured by TRICARE. The DOD's TRICARE Management Activity agency, which administers the program, contracted with HMHS to provide managed care support, including underwriting healthcare costs and "provid[ing] a managed, stable, high-quality network, or networks, of individual and institutional healthcare providers." In meeting its obligations under the contract, HMHS subcontracted with healthcare providers, including Florida Hospital of Orlando, to join its network and provide healthcare services to TRICARE beneficiaries. DOD regulations and its TRICARE Operations Manual designate that TRICARE is a federal financial assistance program and state that healthcare providers under network agreements are not subcontractors. This position is consistent with the judicial decisions preceding OFCCP's 1993 Medicare Directive.

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In reaching his decision that Florida Hospital is a covered subcontractor, the ALJ found the contracting arrangement to be akin to *UPMC* rather than *Bridgeport Hospital*. The ALJ was not persuaded by the FAR regulations or the express terms of the contracts, and simply concluded that DOD lacked the authority to designate TRICARE a federal financial assistance program.

OFCCP's New "Directive 293"

In December 2010, armed with its two administrative victories, OFCCP issued "Directive 293," which sets out its plan to assert jurisdiction over entities that provide medical services to FEHBP insureds and TRICARE beneficiaries. The newly issued directive asserts broad jurisdiction, rescinds prior directives, and sets forth a number of principles and procedures by which OFCCP will make determinations of covered contractor or subcontractor coverage. These include the following:

- Perhaps most importantly, though not expressly stated, OFCCP will differentiate between contracts with traditional insurance companies and contracts with other forms of health plans and HMOs. This is in recognition of the limitations imposed by the *Bridgeport Hospital* decision. If an entity is providing healthcare services reimbursed through a managed care company rather than a traditional indemnity insurer, OFCCP is more likely to assert jurisdiction over the entity as a subcontractor, and will attempt to apply the reasoning of *UPMC*.

- OFCCP will assert jurisdiction over any type of entity that contracts directly with the government (FEHBP, TRICARE, Medicare Advantage, and Part D) to provide healthcare services (including HMOs, preferred provider organizations (PPOs)), point of service organizations, or other forms of managed care) or insurance (including fee-for-service and PPO plans). This position is being taken despite the fact that TRICARE, Medicare Advantage, and Medicare Part D have been designated federal financial assistance (and thus not contracts) by the agencies that oversee the programs.

- An insurance reimbursement agreement between a healthcare provider and a covered contractor that is under contract with a government agency to provide health insurance only, and not healthcare services, will not provide the OFCCP with jurisdiction over a healthcare provider that renders the medical services paid for by the insurance company. This is also in recognition of the limitations imposed by *Bridgeport Hospital*. However, where a reimbursement agreement is combined with an agreement to provide medical services, a covered subcontract is created.

- OFCCP reserves the right to make determinations of contractor status on a case-by-case basis, due to the wide array of healthcare plans, providers, services, and arrangements available. OFCCP notes that under each of the major federal healthcare programs, a provider may enter into a prime contract with a government agency to provide insurance, healthcare services, administrative support, or a combination of these services. OFCCP will make its own determination of what is being provided by the contract, regardless of the language of the agreement.

- OFCCP will apply its own broad definition of the terms "contractor" and "subcontractor" without regard to implementing regulations of other federal government contracting entities that the provision of medical services is not a contract for "nonpersonal services."

- OFCCP will make its own determination of "subcontractor" status based on its judgment whether a prime contractor is subcontracting the performance of any of its obligations under its contract to one or more providers. If it determines that supplies or services necessary to the performance of a prime contract are being provided by another entity, OFCCP will assert coverage over the "subcontractor" as defined by OFCCP.

- If an entity is providing healthcare services to TRICARE beneficiaries, OFCCP is likely to assert jurisdiction over the entity as a subcontractor, even though (a) TRICARE regulations expressly provide that providers are recipients of federal financial assistance and not contractors; (b) the language of the reimbursement agreement expressly describes the services as "personal services," and (c) the services are personal services under any ordinary meaning of that term.

- Reimbursements made pursuant to Medicare Parts A and/or B (or Medicaid) alone are not sufficient to invoke OFCCP jurisdiction. However, arrangements under Medicare Advantage (Medicare Part C) and Part D may result in OFCCP jurisdiction. If a company has a prime contract with CMS to establish a Medicare Advantage PPO and it contracts with others to provide the required healthcare, prescription drug program, and claims processing services, all of those entities will be deemed to be government contractors or subcontractors. However, this position overlooks that HHS has designated Medicare Parts C and D providers as recipients of federal financial assistance.[11]

- Grants offered by federal healthcare programs do not alone create a covered contractual relationship.

- Medical device providers and suppliers may be covered by the AA laws.

- Although it remains the case that OFCCP must first establish the existence of a federal contractor or subcontractor relationship to exercise jurisdiction over a hospital or other healthcare provider, OFCCP's reach will be broad.

What OFCCP May Have Gotten Wrong

1. While it appears that OFCCP has authority to assert jurisdiction over entities that enter into prime contracts with the government to provide insurance services or supplies, there is a question as to its authority over those that enter into contracts to provide medical services. This is because of the limitations in the definitions of the terms "contract" and "subcontract" to include contracts for goods or nonpersonal services. The term "nonpersonal services" is largely undefined, and OFCCP's arguments with regard to the intended definition arguably are circular and internally inconsistent.

2. OFCCP's authority to assert jurisdiction over alleged subcontractors by disregarding the language of the contracts of other contracting agencies and substituting its judgment for the express language of the contracts is questionable. FAR regulations implementing the government's purchase of federal employees' health benefits clearly and unequivocally exclude providers of direct medical services or supplies from the definition of covered subcontractor. (Notably, neither the Executive Order nor the AA Laws defines "subcontractor," although implementing regulations contain

a broad definition). OFCCP's response to this argument is that parties may not by contract override statutory and Executive Order requirements.

3. OFCCP is revisiting its jurisdiction over programs that constitute federal financial assistance, a door that had appeared to close in 1993. Under the Federal Grant and Cooperative Agreement Act,[12] its right to do so is questionable. The result of Directive 293 is that hospitals will be forced to comply with both Title VI and other laws applying to the recipients of federal financial assistance as well as with the AA Laws.

4. To the extent that OFCCP determines that a contract for insurance is a contract for medical services and insurance (reportedly the position it is taking in *UPMC*), it may be taking a position that an entity is providing services it cannot legally or otherwise provide.

5. The state of the law and Directive 293 are creating substantial confusion, which seems contrary to public policy. An entity should be able to know and understand what laws apply to it, and understand the source of those obligations.

Recommendations for Hospitals and Other Healthcare Providers

Directive 293 has costly repercussions for hospitals and other healthcare providers that have long operated under the premise that, unless they are a party to a contract with a federal government agency, they are not subject to the obligations imposed under the AA Laws. Although the *UPMC Braddock* case is on appeal under the Administrative Procedure Act to a federal district court and the *Florida Hospital of Orlando* case is pending before an ARB, unless and until decisions are reached overturning the results, hospitals and other healthcare providers are subject to the Directive. They place themselves at risk if they choose not to comply with its terms. A review of the terms of their provider agreements will not be enough to determine their exposure to the Directive because OFCCP deems it irrelevant that a contract expressly states that providers of medical services are not subject to the AA Laws. Rather, they should closely scrutinize whether the HMOs and network administrators with which they have agreements are under contract with any government agencies to provide healthcare services to federal employees and their dependents, and consult with counsel accordingly. C

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Endnotes

1 29 U.S.C. § 701 *et seq.*
2 38 U.S.C. § 4211 *et seq.*
3 41 C.F.R. 60-1.3.
4 *Id.*
5 Directive Number 189, Health Care Entities That Receive Medicare and/or Medicaid (Dec. 16, 1993).
6 ARB Case No. 00-234 (2003).
7 ARB Case No. 08-048 (May 29, 2009).
8 48 C.F.R. § 1602.170-14.
9 Case No. 1:09-cv-01210 (D.D.C. Judge Friedman).
10 ALJ Case No. 2009-OFC-00002 (Oct. 18, 2010) (appeal pending before a DOL ARB).
11 *See, e.g.,* FAQ: Health Care providers participating in the Children's Health Insurance Program (CHIP), Medicare Part A, Medicare Part C and Medicare Part D are considered Federal Financial Assistance? www.hhs.gov/ocr/civilrights/faq/Procedures/301.html.
12 31 U.S.C. § 6301 *et seq.*