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OFCCP DIRECTIVE NO. 293 CONTINUES EXPANSION OF FEDERAL CONTRACTOR STATUS FOR HEALTH CARE PROVIDERS

In recent years, health care providers have found themselves under the microscope of the Office of Federal Contract Compliance Programs ("OFCCP"). Many of these providers are being told—for the first time—that they are parties to a federal contract or subcontract and, as a result, are subject to the rules, regulations, and laws enforced by the OFCCP. On December 16, 2010, the OFCCP issued Directive No. 293, an internal memorandum entitled "Coverage of Health Care Providers and Insurers" ("Directive No. 293"). Directive No. 293, which does not appear to have been published publicly by the OFCCP, is a 12-page document offering instructions for how the Office intends to carry out its coverage assessments in the health care industry. Directive No. 293 includes the Office's first formal statement that participating in Medicare Part C (Advantage) or Medicare Part D (covering prescription drug plans) may subject a health care provider to the OFCCP's jurisdiction.

Directive No. 293 comes at a time when the OFCCP is engaged in two major pieces of litigation involving health care providers' federal contractor or subcontractor status. First, in *OFCCP v. UPMC Braddock*, ARB No. 08-048 (ARB May 29, 2009), the Department of Labor's Administrative Review Board ("ARB") held that three hospitals that did not directly contract with the federal government were nevertheless federal subcontractors subject to the OFCCP's jurisdiction. The ARB found that the hospitals were federal subcontractors by virtue of an HMO health plan contract covering federal government employees. That case is currently on appeal to the U.S. District Court for the District of Columbia. *See UPMC Braddock v. Solis*, No. 1-09-CV-01210 (D.D.C. filed June 30, 2009).

Second, a Department of Labor administrative law judge ruled that Florida Hospital of Orlando was a federal subcontractor based on its participation in TRICARE—a U.S. Department of Defense military health care program providing coverage to active and retired U.S. military personnel. *See OFCCP v. Florida Hospital*, 2009-OFC-00002 (Oct. 18, 2010). In that case, the administrative law judge found that Florida Hospital was a federal subcontractor based

on an agreement it had with a private company responsible for administering the TRICARE program. Florida Hospital filed exceptions to the administrative law judge's decision, and the case is currently pending before the ARB. *See OFCCP v. Florida Hospital*, ARB Case No. 11-011. (Jones Day, together with in-house counsel for the American Hospital Association, submitted an *amicus curiae* brief in the pending ARB case on behalf of the AHA.)

One of the few reassuring aspects of Directive No. 293 is that the OFCCP reasserts its position that as a general rule, a health care provider's participation in Medicare Part A, Medicare Part B, or Medicaid is the receipt of federal financial assistance and does not subject the provider to the OFCCP's jurisdiction. The OFCCP has maintained this position since its December 16, 1993 Directive No. 189, which is now superseded by Directive No. 293.

This reassuring good news is outweighed by two significantly troubling statements in Directive No. 293. First, even though the *Florida Hospital* litigation is on appeal within the Department of Labor itself, the OFCCP is proceeding with its position that a TRICARE participant is a covered federal subcontractor, regardless of other factors, including the Department of Defense's many contrary statements. Although some audits based on TRICARE participation were delayed based on the pending *Florida Hospital* case, Directive No. 293 may signal that the OFCCP will renew those audits and seek out new hospitals to audit.

Second, Directive No. 293 is the Office's first formal statement that a health care provider who participates in Medicare Parts C or D may be subject to the Office's jurisdiction. The OFCCP was previously noncommittal on whether receipt of reimbursements under Medicare Parts C or D would confer federal contractor or subcontractor status. In December 2009, the Office wrote that it had "not taken a position yet on whether…Medicare Part C and D agreements are covered under laws enforced by OFCCP."[1] And, in a June 2010 webinar, the Office stated that "Medicare Parts C&D…may be federal contracts depending on the circumstances."[2] Directive No. 293, however, now states, as a matter of official agency enforcement policy, that OFCCP believes it has jurisdiction over providers participating in Medicare Parts C and D.

Directive No. 293 also discusses scenarios where a health care provider is not a covered federal contractor or subcontractor, as the ARB found in *OFCCP v. Bridgeport Hospital*, ARB Case No. 00-234 (Jan. 31, 2003). In that case, the ARB found that an agreement between Bridgeport Hospital and Blue Cross/Blue Shield—which provided benefits to enrolled federal government employees—was an agreement solely for reimbursement to the hospital for medical services provided. Based on *Bridgeport Hospital*, *UPMC Braddock*, and *Florida Hospital*, the OFCCP states in Directive No. 293 that health care providers will not be considered to be contractors or subcontractors based on reimbursement agreements where the insurer agrees to pay providers directly for the cost of medical goods or services.

Subjecting Medicare Part C participants to the OFCCP's jurisdiction has a potentially vast reach. Consider the following example from the Directive:

> Company G has a reimbursement agreement with Medicare Parts A and B to receive payment for services it provides to Medicare A and B beneficiaries. Company G also contracted with Medicare (CMS) to establish a Medicare Advantage PPO and to be reimbursed for the health care services provided by the PPO. The PPO contract also includes the establishment of a prescription drug plan and claims processing services. The reimbursement agreement with Medicare A and B **does not** create a contractor relationship because Medicare A and B are Federal financial assistance.

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1 Jurisdiction Webinar, (Dec. 3, 2009) (on file with author).

2 "How To Comply With Executive Order 13496," *available at* http://www.dol.gov/ofccp/regs/compliance/Contractor_Compliance_presentation.ppt (last visited Jan. 24, 2011).

> However, Company G's contract with Medicare (CMS) to establish a Medicare Advantage PPO creates a covered prime [direct] contract pursuant to which Company G may subcontract with other companies to provide the required health care services, prescription drug program, and claims processing. **If Company G does enter into such subcontracts, the companies holding them will be covered subcontractors.** (Emphasis added).

In that example, the reach of Directive No. 293 with respect to Medicare Part C becomes clear: it makes both the company that arranges the services as well as the individual service provider a federal contractor and subcontractor.

In short, Directive No. 293 continues the expansion of OFCCP's jurisdiction over health care providers. As many health care providers have relationships with the federal government beyond Medicare Part A, Medicare Part B, and Medicaid, including participation in the TRICARE program, health care providers should carefully review their current contractual arrangements to assess their federal contractor or subcontractor status in light of Directive No. 293. Review of those arrangements should include all sources of federal funding, whether contracts, financial assistance, or grants. Further, health care providers should consider coordinating between legal departments, human resources, and procurement offices to ensure that any future agreements do not subject the provider to federal contractor or subcontractor status.

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