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ASAPs

Healthcare Industry

Hospitals Providing Medical Services to Federal Employees Through an HMO are Covered Subcontractors Under OFCCP's Jurisdiction

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For many years, health systems reasonably assumed that arrangements with a non-governmental entity to provide services or benefits to federal employees would not invoke the jurisdiction of the Office of Federal Contract Compliance Programs (OFCCP), and thus would not mandate federal equal employment and affirmative action obligations. This assumption particularly seemed rational where the subcontract expressly provided that the health system was *not* a federal contractor and because OFCCP's own March 2003 directive stated that health care providers having a relationship with Federal Employees Health Benefits Program (FEHBP) participants are *not* covered under OFCCP's programs based solely on that relationship. However, in a decision with immediate and far reaching implications for health systems across the nation, in May 2009, the Department of Labor's Administrative Review Board (ARB) held that three hospitals in Pittsburgh that received payments from an HMO in the course of providing medical services to U.S. government employees are covered federal subcontractors.[1] *OFCCP v. UPMC Braddock*, 2007-OFC-1 (ARB May 29, 2009). Healthcare employers must now be aware that they may indeed have involuntarily become "federal contractors," and, as a result, may now be subject to a wide range of reporting, record keeping and other obligations.

Background of the Ruling

The UPMC Health Plan, an HMO, signed a contract with the Office of Personnel Management

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(OPM) to provide medical services to federal employees. The HMO, in turn, put together its provider network by obtaining contractual commitments from various individual physicians, medical groups, and hospitals to provide the benefits advertised in the health plan brochure.

Despite the fact that the OPM contract expressly excluded the hospitals from its definition of a subcontractor, and despite the fact that a parallel Federal Acquisition Regulation also excluded the hospitals from the definition of a covered subcontractor, the ARB ruled that the parties could not agree to invalidate the equal employment opportunity provisions of federal law, which OFCCP enforces and which are implied in every government contract in excess of $10,000.

The UPMC Health Plan contract with OPM defined the term *subcontractor* to include suppliers, distributors and vendors "*except* for providers of direct medical services and supplies pursuant to the Carrier's health plan." (emphasis added) Moreover, the Federal Acquisition Regulations [FAR] exclude "providers of direct medical service" from the definition of subcontract found at 48 CFR section 1602.170-14. The ARB found neither argument persuasive. "Because the FAR regulation that the Defendants ask us to apply directly contradicts the Secretary's regulations, it is invalid, and we decline to apply it." In other words, OPM and the FAR could not remove the equal opportunity and affirmative action obligations that exist under federal regulations. Those obligation exists as a matter of law and there is no authority to make exceptions to their applicability

The hospitals also tried to align their factual situation with a prior case involving Bridgeport Hospital,[2] but the ARB was not persuaded. In the *Bridgeport* case, the Secretary of Labor held that Bridgeport Hospital was not a subcontractor under Executive Order 11246 despite the fact that Bridgeport Hospital received payments from Blue Cross/Blue Shield of Connecticut under Blue Cross/Blue Shield's contract with OPM to provide health insurance to federal employees. In that case, the ARB characterized the Blue Cross/Blue Shield contract as a contract to provide health *insurance* to federal workers, not medical services, and since Bridgeport Hospital was not subcontracted to provide insurance, but rather to provide medical services, Bridgeport Hospital was not found to be a covered subcontractor under that federal insurance contract. Following the decision in *Bridgeport*, OFCCP issued a directive in March 2003 confirming that health care providers having a relationship with FEHBP participants are not covered under OFCCP's programs based solely on that relationship.[3] The implications or effect of OFCCP's own directive to the contrary was never raised before the Administrative Law Judge in the *Braddock* case and thus was not at issue before the ARB, either.

The ARB's opinion in *Braddock* has effectively overturned this directive, at least with regard to health care providers participating in HMOs. Subsequent presidential administrations may favor expanding OFCCP's jurisdiction over hospitals and large medical service providers even further, and may wish to eliminate the distinction between HMOs and insurance arrangements established in *Braddock*.

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The Basis for OFCCP's Jurisdiction

There are three (3) principal ways in which OFCCP is likely to try to assert jurisdiction over hospitals and medical services suppliers who have 50 or more employees, and none of them have anything to do with Medicare or Medicaid reimbursements:[4]

1. **Direct Federal Contracts:**

   The hospital or medical service provider has a direct federal contract in the amount of $50,000 or more.[5] Websites such as www.usaspending.gov and www.fedspending.org are useful to determine whether the hospital has direct contracts. A common example of a direct federal contract would be one with the Department of Veterans Affairs to provide medical services to military veterans.

   Caution: Many federal entities have the power to enter into contracts as well as the power to disseminate grant funds. Grant funds do not subject the hospital or medical service provider to OFCCP's jurisdiction. If you have any doubts whether your arrangement is a grant or a contract, you should consult your legal advisor.
2. **Subcontracts to a TriCare Contract:**

   The hospital or medical service provider has signed on to provide medical services to TriCare beneficiaries (active and retired military personnel) through contractual agreements with TriWest, Health Net, or Humana Military, and it receives more than $50,000 in payment or reimbursement from them.
3. **Subcontracts to provide medical services to federal employees:**

   The hospital or medical service provider provides medical services to federal employees similar to the subcontract arrangement that three Pittsburgh hospitals signed, and, like (2) above, the value of payment or reimbursement exceeds $50,000. The Office of Personnel Management arranges with many HMOs and other health networks to supply federal employees with medical services. Those arrangements are contracts in which the EEO obligations are always implied as a matter of law.

What Should Hospitals and Other Health Care Providers Do To Assess the Likelihood that OFCCP Could Assert Jurisdiction

At all times, OFCCP has the burden to prove jurisdiction when it seeks to audit a hospital that has either inadvertently self-identified itself as a federal government contractor on the annual EEO-1 filing or was selected because it is affiliated in a corporate structure with other covered contractors.

In prior efforts to retain jurisdiction over hospital clients, OFCCP has inquired into the facts of

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various reimbursement situations. Thus, as we describe below, it will be important following the *Braddock* decision for hospital counsel to anticipate these requests and assess the jurisdictional objection for itself.

1. Hospitals should go to the websites listed above and determine whether the U.S. government views them as direct federal government contractors or would likely assert that the hospital/provider is part of a corporate entity that has been deemed a direct federal contractor. If your company appears on these websites with a contract for more than $50,000, it is highly visible to OFCCP for selection as an audit target, and you should be taking steps to ensure that your organization becomes compliant as soon as possible. If your hospital appears affiliated with an entity that has direct federal contracts, but does not have them itself, you should heed our recommendations in (3) and (4) below, and you should also seek legal advice regarding whether the hospital could assert a single entity objection.[6]
2. If your company is not a direct federal government contractor, you need to be actively monitoring personnel who are submitting requests for federal funding. Some government projects are funded with grant monies; others are funded through contracts. Grants do not subject the hospitals to OFCCP's jurisdiction; contracts do. If the organization decides to accept funds through an agency contract and not a grant, you need to go into the arrangement "eyes wide open" on the affirmative action obligations.
3. Know whether your hospital is providing care to military members and their beneficiaries indirectly through the TriCare program. There are three TriCare program managers: TriWest, Humana Military, and HealthNet. When your hospital receives reimbursement from these program managers, can you discover relatively easily which payments are being made for rendering services to military service members and their beneficiaries, or does your hospital receive reimbursement without your being able to parse out military beneficiaries?
4. Go to the Office of Personnel Management's website, and specifically, the health benefit plans being offered to federal employees.

   Click on your state and print out the names of all the federal health benefit plans. Be sure the printout includes the Plan Codes to the right of each plan name. Take the list to your accountants and/or medical reimbursement experts. Find out:
   a. Does the hospital participate in any of the HMO plans?
   b. When the hospital bills these plans, does the hospital know which patients are federal employees?
   c. When the government reimburses the hospital, does the documentation identify by plan code or group number which employees are federal employees?
   d. What are the answers to questions (a) – (c) with respect too the non-HMO plans?

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If your financial systems have the ability to distinguish one type of payment from the other, or the HMO or Network is making that distinction in coding its sends you (meaning it knows whether you treated a federal beneficiary, or not), then it would be important to know whether in 2008, and going forward in 2009, you have received more than $50,000 in reimbursement for the treatment and care of federal employees and military beneficiaries, especially if under the Tri-Care program or a FEHBP HMO.

What Obligations Are Imposed On Covered Federal Contractors?

Broadly speaking, entities covered by OFCCP's jurisdiction are required to prepare three Affirmative Action Plans (AAP) each year: an AAP for Veterans, an AAP for Individuals with Disabilities, and an AAP for Women and Minorities. The AAPs for veterans and individuals with disabilities do not contain any data analysis. Under the Veterans' regulations, though, contractors are required to list all vacancies being filled externally with the local unemployment office and to engage in specific and targeted outreach for returning service men and women and other covered veterans. In addition, the Veterans' regulations require contractors to file a VETS-100 form by September 30 each year. In order to file the form, contractors are required to solicit the covered veterans status of all employees and all new hires.

The regulations implementing Section 503 of the Rehabilitation Act of 1973, pertaining to individuals with disabilities, requires contractors to engage in targeted outreach to individuals with disabilities. Documentation of a contractor's good faith efforts for individuals with disabilities, as well as veterans, females and minorities, is critical to success in the event of an audit.

The most intensive amount of preparation and record keeping however, is associated with the Women and Minorities' AAP. Each annual AAP examines three principle areas for equal employment opportunity:

1. current employment percentages of females and minorities against benchmark availability data that the contractor itself develops, with the obligation to set goals if employment is less than availability;
2. 12-month analyses of hires, promotions and terminations to determine whether, across managers, across departments, looking at the organization more "as a whole," there are any policies or practices that are having an adverse impact on females or minorities; and
3. compensation to determine whether similarly situated employees are being compensated fairly, given the factors that influence compensation.

In order for an employer to evaluate the hiring rates of females and minorities, it needs to track applicant flow and solicit the race and gender of applicants, where possible. Applicant flow data, however, is often not tracked properly and presents the most exposure for most contractors. In fiscal year 2008, OFCCP obtained more than $67.5 million in financial remedies from contractors. The vast majority of this amount was the result of insufficient applicant tracking and record keeping practices—situations where the company maintained records of who applied and

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who was hired, but maintained very little documentation of what happened in between those steps. Because of the overwhelming number of applicants for each vacancy, many contractors may not be keeping adequate records of candidates that are not considered for hire, but they should be defaulting such expressions of interest to "not considered" on their applicant tracking logs. Companies should also keep track of candidates who are no-shows to interviews, or who self-select out. In audits, OFCCP easily discovers examples of recruiters and managers who were very inconsistent in determining which candidates advanced to the next step in the employer's hiring process and which candidates were rejected. Hired employees frequently have much poorer credentials and resumes than did some rejected candidates, without any explanation as to why the rejected candidates were not even called for an interview.

It is recommended that hospitals that provide medical services to federal employees, especially if through an HMO, take immediate steps to assess their compliance with OFCCP's record-keeping obligations, including tracking of data on hires, promotions and terminations. Getting a handle on record keeping, and training both recruiters and hiring managers in OFCCP's regulations, are two critical steps towards ensuring compliance and reducing exposure in audits.

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[1] The Administrative Review Board is the highest level of adjudication within the Department of Labor. Should the hospitals wish to challenge the Secretary of Labor's decision, they will have to file in federal district court. If they choose not to pursue the matter in federal court, they will have to submit their affirmative action plans and employment data to OFCCP for review and undergo the compliance evaluation process, to which they objected many years ago on jurisdictional grounds.

[2] *OFCCP v. Bridgeport Hosp.*, 1997-OFC-1 (ALJ Jan. 21, 2000).

[3] http://www.dol.gov/esa/ofccp/regs/compliance/directives/dir262.pdf.

[4] The OFCCP confirms that Medicare/Medicaid reimbursement is not a basis for jurisdiction in its Frequently Asked Questions:
http://www.dol.gov/esa/ofccp/regs/compliance/faqs/juristn.htm#Q5.

[5] At the $10,000 threshold, basic principles of equal opportunity in employment arise. At the $50,000 threshold, the obligation to have written affirmative action plans arises, including the obligation to conduct annual adverse impact analyses of hires against applicants, among many other obligations. For all practical purposes, OFCCP is not interested in auditing companies with contracts for less than $50,000.

[6] http://www.dol.gov/elaws/esa/ofccp/single_entity_test.asp.

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