IN THE UNITED STATES OF AMERICA
DEPARTMENT OF LABOR
ADMINISTRATIVE REVIEW BOARD
WASHINGTON, D.C.

In the Matter of:

OFFICE OF FEDERAL CONTRACT COMPLIANCE PROGRAMS, UNITED STATES DEPARTMENT OF LABOR,
Plaintiff,

v.

FLORIDA HOSPITAL OF ORLANDO,
Defendant.

ARB Case No. 11-011
ALJ Case No. 2009-OFC-0002

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Pursuant to the order of the Administrative Review Board ("Board") dated December 9, 2010, the American Hospital Association ("AHA") submits this brief as *amicus curiae* in support of Defendant Florida Hospital of Orlando ("Florida Hospital" or "Hospital").

SUMMARY OF ARGUMENT

The Summary Decision and Order ("SD&O") concludes the Hospital is a federal subcontractor solely because it is an "in-network" provider in the TRICARE program. The AHA urges reversal of this poorly reasoned and inadequately supported decision.

First, the Board should take note that hospitals already face significant administrative and paperwork burdens due to requirements imposed by both public and private payers. Hospitals have been significantly affected by the recent economic decline, making this burden particularly onerous. And in any event, hospitals are already subject to numerous workplace standards laws.

Second, the SD&O concluded that the TRICARE program is not "federal financial assistance" without following or even citing the applicable test for distinguishing between federal grant aid and federal contract payments. An extensive body of law addresses this issue, and contrary to the SD&O, TRICARE reimbursements are federal financial assistance. The SD&O's finding otherwise is not only erroneous, but it also creates an unnecessary inter-agency conflict with the Department of Defense ("DOD"), which has previously designated TRICARE providers as recipients of federal financial assistance subject to DOD's civil rights regulations.

Third, OFCCP's own regulations do not support a finding of subcontractor status, because the Hospital, like other TRICARE in-network providers, does not perform any portion of the benefit administration work performed by Humana Military Healthcare Services, Inc. ("Humana") or any other contractor. Nor did the Hospital "sell" any services to Humana that were necessary to Humana's performance of its contractual obligations.

ARGUMENT

I. THE NATION'S OVERBURDENED HOSPITALS ARE LEGITIMATELY CONCERNED ABOUT OFCCP UNNECESSARILY ASSERTING ITS JURISDICTION OVER RECIPIENTS OF TRICARE REIMBURSEMENT

A. Paperwork Burdens For Hospital Are Substantial And Contribute To The Troubled State Of Health Care

The current healthcare system imposes extensive administrative and paperwork requirements on the Nation's hospitals.

At the beginning of this decade, AHA commissioned a study by the independent accounting firm of PricewaterhouseCoopers ("PwC") to ask hospitals about their paperwork burdens.[1] The PwC study reached the stark conclusion that, "[f]or the various stages of care of a typical patient, paperwork adds at least 30 minutes to every hour of patient care provided and, in some settings, adds an hour of paperwork to every hour of patient care."[2] For instance, one hour of treatment in the emergency room generates one hour of paperwork, while an hour of surgical treatment results in 36 minutes of paperwork.[3]

Government reimbursement programs unfortunately contribute to this burden. For example, government payers require extensive "[s]econdary [p]ayer" questionnaires that must be repetitively completed.[4] Other government-mandated questionnaires are required even though the paying agency (such as the Centers for Medicare & Medicaid Services) does not even use them to calculate payment.[5]

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[1] AHA, *Patients or Paperwork? The Regulatory Burden Facing America's Hospitals* 3-5 (2001), http://www.aha.org/aha/content/2001/pdf/FinalPaperworkReport.pdf.

[2] *Id.* at 2.

[3] *Id.* at 3.

[4] *Id.* at 4.

[5] *Id.* at 5.

Although AHA noted these problems (and many others) more than a decade ago, hospitals have yet to receive any relief from burdensome government paperwork. A more recent AHA report noted that hospitals now spend at least 20.9% of their revenues on total administrative costs and billing – contributing to a health care system in which per capita spending on health administration costs is now $465.[6] "Likewise, hospitals must comply with thousands of pages of Medicare regulations and guidance issued yearly . . . . Hospitals must employ many people just to implement these policies and to ensure that their systems and processes are in compliance."[7]

B. Hospitals Already Face Significant Financial Challenges

Hospitals shoulder these significant administrative burdens while providing care at either no cost, or charging fees below their costs – including for government-subsidized health programs.

Hospitals throughout the nation provide "uncompensated care," *i.e.*, "hospital care provided for which no payment was received from the patient or insurer."[8] In addition to unanticipated "bad debt," which "is often generated by medically indigent and/or uninsured patients," hospitals also provide "charity care," which is offered to patients who are unable to pay.[9] AHA's data shows that uncompensated care cost the Nation's hospitals $39.1 billion in 2009, which constituted 6.0% of their total expenses (exclusive of bad debt).[10]

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[6] AHA, *Trendwatch—Redundant, Inconsistent and Excessive: Administrative Demands Overburden Hospitals* 1-2 (July 2008), http://www.aha.org/aha/trendwatch/2008/twjuly2008admburden.pdf (noting that some studies show one-quarter of hospital spending is for administration).

[7] *Id.* at 4.

[8] AHA, *Uncompensated Hospital Care Cost Fact Sheet* 1 (Dec. 2010), http://www.aha.org/aha/content/2010/pdf/10uncompensatedcare.pdf.

[9] *Id.* at 2.

[10] *Id.* at 1-2, 4.

In addition to wholly uncompensated care, reimbursement for care provided to Medicare and Medicaid patients, which "account[s] for 56 percent of all care provided by hospitals," frequently "result[s] in underpayment."[11] This underpayment results from the fact that the "[p]ayment rates for Medicare and Medicaid . . . [generally] are set by law rather than through a negotiation process," and "[t]hese payment rates are currently set below the costs of providing care" in most hospitals.[12]

According to aggregate data generated from the AHA's Annual Survey of Hospitals, "hospitals received payment of only 90 cents for every dollar spent . . . caring for Medicare patients in 2009," and "only 89 cents for every dollar spent . . . caring for Medicaid patients in 2009."[13] Combined underpayments amounted to $36.5 billion in 2009, a massive increase from 2000, when the equivalent amount was only $3.8 billion.[14]

Critical to the issue here, reimbursements under TRICARE are keyed to the same Medicare payment schedule that results in chronic underpayments to hospitals.[15] Participation as an in-network provider does not confer higher reimbursements on hospitals; indeed, the record in this case demonstrates that Florida Hospital, as an in-network provider, generally must accept *less than* the standard TRICARE reimbursement rate.[16]

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[11] AHA, *Underpayment by Medicare and Medicaid Fact Sheet* 1 (Dec. 2010), http://www.aha.org/aha/content/2010/pdf/10medunderpayment.pdf.

[12] *Id.*

[13] *Id.* at 2.

[14] *Id.* at 3.

[15] *See* Tricare.mil ("The TRICARE allowable charge is tied by law to Medicare's allowable charge whenever practical"), http://www.tricare.mil/mybenefit/home/Medical/Costs/AllowableCharges?; Stipulated Facts Ex. C at 111-120 (describing TRICARE reimbursement rates and methodologies with repeated reference to Medicare guidelines).

[16] *See also* Stipulated Facts Ex. B, Attach. B-1 (providing for payment at discounts from Medicare/CHAMPUS rates); *see also* Attach. B (agreeing that "in no event shall payments made for medical services provided to Beneficiaries exceed one hundred percent (100%) of any TRICARE allowable [payment]. . . ."); Ex. C ("Payments made to network providers for medical services rendered to TRICARE beneficiaries shall not exceed 100 percent of the TRICARE-allowable charges.").

Not surprisingly, then, hospitals were particularly vulnerable to the recent economic crisis. An AHA survey conducted this year concluded: "Nearly three-quarters of hospitals reported reduced operating margins."[17] These responses were similar to those received in an AHA study conducted in August of 2009, which showed that a third of hospitals experienced losses in the first half of 2009 and nearly half of hospitals suffered a moderate or significant decrease in operating margins.[18] Likewise, as of November of 2008, Moody's "downgraded the outlook for the not-for-profit hospital sector from stable to negative."[19] As documented in an AHA survey this year, 87% of hospitals report increased bad debt and charity care as a percentage of total revenues, 65% report increased percentages of patients covered by Medicaid and similar programs, and 72% report decreased numbers of elective procedures.[20]

C. Hospitals Are Already Subject To Extensive Workforce Regulations

Even before OFCCP began to claim jurisdiction over TRICARE's in-network health providers, those providers, like most other hospitals, were already subject to myriad requirements regarding their labor and employment practices:

- Virtually every hospital in the United States qualifies as an employer under Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act, and the Uniformed Services Employment and Reemployment Rights Act (USERRA)

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[17] AHA, *Hospitals Continue to Feel Lingering Effects of the Economic Recession* 1 (June 2010) ("*Lingering Effects*"), http://www.aha.org/aha/content/2010/pdf/10june-econimpact.pdf.

[18] AHA, *The Economic Crisis: Ongoing Monitoring of Impact on Hospitals* 12-13 (Nov. 11, 2009), http://www.aha.org/aha/trendwatch/2009/09nov-econimpsurvresults.pdf.

[19] AHA, *The Economic Downturn and its Impact on Hospitals* 2 (Jan. 2009), http://www.aha.org/aha/trendwatch/2009/twjan2009econimpact.pdf.

[20] *Lingering Effects* at 1.

which prohibit the same types of employment discrimination regulated by Executive Order 11246, VEVRAA, and Section 503 of the Rehabilitation Act.[21]

- Based on their receipt of "federal financial assistance," hospitals must operate any "program or activity" without discrimination based on race, color, national origin, or disability under statutes including Title VI of the Civil Rights Act of 1964 ("Title VI") and Section 504 of the Rehabilitation Act of 1973 ("Section 504").[22]
- Hospitals receiving Medicare reimbursement are subject to rules requiring the exclusion of costs incurred in response to union organizing.[23]
- Hospitals are subject to applicable state employment discrimination laws.
- Most hospitals are "employers" subject to the National Labor Relations Act, or in the case of public hospitals, subject to state and local labor relations legislation.

In sum, hospitals are already subject to numerous regulations of their labor and employment practices.

D. Applying OFCCP Regulations To TRICARE In-Network Providers Would Impose Significant Burdens On Hospitals When They Can Least Afford It

Regardless of their salutary purposes, the affirmative action requirements imposed by OFCCP regulations are undoubtedly time-consuming and paperwork-intensive. On an *aggregate*

[21] *Compare* Civil Rights Act of 1964, Title VII, § 703(a), 42 U.S.C. § 2000e-2(a)(1) (prohibiting race, color, religion, sex, or national origin discrimination) *with* Executive Order 11246 § 202 (prohibiting contractors from discriminating based on race, color, religion, sex, or national origin); *compare also* Americans with Disabilities Act, Title I, § 102, 42 U.S.C. § 12112(a) (prohibiting disability discrimination in employment) *with* Rehabilitation Act of 1973, § 503, 29 U.S.C. § 793(d) (providing that claims of employment discrimination against federal contractors are decided using same standard as claims under ADA); *compare also* Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. § 4311 (prohibiting employment discrimination "who is a member of, applies to be a member of, performs, has performed, applies to perform, or has an obligation to perform service in a uniformed service") *with* 41 C.F.R. § 60-250.20-.25 (pursuant to VEVRAA, prohibiting discrimination against enumerated categories of veterans).

[22] Civil Rights Act of 1964, Title VI, 42 U.S.C. § 2000d (prohibiting program or activity discrimination based on race, color, or national origin); Rehabilitation Act of 1973 § 504, 29 U.S.C. § 794 (same for disability).

[23] *See* 42 U.S.C. § 1395x(v)(1)(N).

basis, the official Paperwork Reduction Act estimate states that compliance with OFCCP's recordkeeping and reporting requirements for "supply and service" contractors affects 99,028 businesses who in total spend 10,045,984 "burden hours" completing the necessary paperwork – an average of 101 burden hours per affected contractor.[24] This average figure does not, of course, capture consulting or legal fees often associated with OFCCP compliance.

In addition, the Department is planning to release new proposed rules that will increase the burden of OFCCP compliance. Two new regulations under consideration would adopt cumbersome, numbers-driven affirmative action planning under VEVRAA and Section 503.[25] There are also plans to reinstate the controversial Equal Opportunity Survey, which OFCCP previously acknowledged as a "significant" burden on government contractors.[26] In light of the serious financial issues noted above, and the existing extensive workplace regulations of hospitals, it is unfair and unnecessary to place these additional burdens on the Nation's hospitals – certainly when, as shown below, there is no legal basis for doing so.

II. THE DEPARTMENT OF DEFENSE CORRECTLY DETERMINED THAT IN-NETWORK TRICARE PROVIDERS ARE RECIPIENTS OF FEDERAL FINANCIAL ASSISTANCE, NOT FEDERAL SUBCONTRACTORS

The SD&O begins and ends its analysis with OFCCP's own regulatory definition of the term "subcontractor," 41 C.F.R. §§ 60-1.3, 60-250.2, 741.2, and ultimately agrees with OFCCP's

[24] *See* ICR – OIRA Conclusion, OMB Control No. 1250-0003 (approved Dec. 8, 2010).

[25] *See* Department of Labor, *Semiannual Regulatory Agenda* 2 (Apr. 26, 2010), Regulation Identifier Number ("RIN") 1250-AA00 (anticipating initiation of rulemaking that would require statistical analyses and goal-setting as part of affirmative action programs under VEVRAA); RIN 1250-AA02 (same for Section 503). Such requirements are presently limited to the Executive Order 11246 program.

[26] *See* Secretary of Labor Hilda Solis, *Prepared Remarks to the Middle Class Task Force* (July 20, 2010), http://www.dol.gov/sec/media/speeches/20100720_MCTF.htm (announcing plan to issue Advance Notice of Proposed Rulemaking to reinstate Equal Opportunity Survey); Notice of Proposed Rulemaking, *Affirmative Action and Nondiscrimination Obligations of Contractors and Subcontractors,* 71 Fed. Reg. 3373, 3378 (Jan. 20, 2006) (noting "significant" burden of 21 hours per respondent despite survey's lack of "sufficient programmatic value").

argument that in-network providers are subcontractors because they have "undertaken" the obligations of HMHS under its contract with DOD.

This was error. DOD has designated TRICARE providers as recipients of federal financial assistance, not as contractors. As will be demonstrated below, it is *not* the case that each executive agency is free to construct its own definitions of "contractor" and/or "recipient of federal financial assistance" and that contradictory results between agencies must therefore be tolerated. Instead, uniform and express statutory criteria govern this determination. Under these criteria, the DOD correctly determined that TRICARE reimbursements are "federal financial assistance" and, accordingly, cannot constitute federal contract payments for purposes of OFCCP coverage.

A. The Federal Grant and Cooperative Agreement Act, Not OFCCP's Own Regulations, Determines Whether TRICARE Reimbursements Are A Form Of Federal Financial Assistance

OFCCP's own regulations do not expressly address the distinction between a contractor and a recipient of federal financial assistance. OFCCP, however, has previously relied on the Federal Grant and Cooperative Agreement Act[27] ("Grant Act") to differentiate between the two categories of payees. In *Partridge v. Reich,* 141 F.3d 920 (9th Cir. 1998), OFCCP applied Grant Act criteria to determine that the Clark County (Nevada) Fire Department was a recipient of federal financial assistance, not a contractor, and OFCCP declined to assert jurisdiction. In ensuing litigation with an aggrieved Fire Department employee, the DOL argued that the distinction between a grant and a contract required it to decline jurisdiction over grantees such as the Fire Department. The Ninth Circuit Court of Appeals agreed and upheld summary judgment in favor of DOL.[28]

[27] 31 U.S.C. §§ 6301-6305.

[28] 141 F.3d at 925-26.

The Grant Act was enacted by Congress in order to "eliminate unnecessary administrative requirements on recipients of Government awards . . ."[29] by establishing standards for distinguishing federal assistance programs from government contracts. In addition, as the Ninth Circuit noted in *Partridge*, the Grant Act serves the important purpose of avoiding differing definitions of a federal "contract" among federal agencies:

> We think it wise to consider the Grant Act because it was designed to "prescribe criteria for executive agencies in selecting appropriate legal instruments to achieve uniformity in their use by executive agencies," among other things. That suggests that later interpretations of those instruments for other legal purposes should also rely upon the Grant Act's definitions.[30]

B. Application Of The Correct Analysis Forecloses The Argument That TRICARE Providers Are Federal Subcontractors

The Grant Act states that a procurement contract is the appropriate instrument to use when:

> (1) the principal purpose of the instrument is to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the United States Government; or
>
> (2) the agency decides in a specific instance that the use of a procurement contract is appropriate.[31]

Here, of course, the DOD has specifically *disavowed* a contractor/subcontractor relationship with TRICARE providers, meaning that prong 2 of the Grant Act definition is not met. Indeed, the DOD has specifically designated TRICARE reimbursements as a form of federal financial assistance.[32] More generally, DOD has stated that any program or activity that

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[29] 31 U.S.C. § 6301(1).

[30] 141 F.3d at 924 (citations omitted).

[31] 31 U.S.C. § 6303.

[32] *See* 32 C.F.R. § 56.7(b)(21) (pursuant to Section 504, designating payments under Title 10, Chapter 55 of the United States Code as federal financial assistance); TRICARE Operations Manual 6010.51-M [Stipulated Facts Ex. D], § 5.1 (all hospitals "determined to be authorized providers under TRICARE are subject to the provisions of Title VI").

provides "services, financial aid, or other benefits to individuals" is a form of federal financial assistance.[33]

Thus, it would be proper to find subcontractor status only if TRICARE reimbursements are for "the direct benefit or use of the United States Government" (prong 1 of the Grant Act definition).

OFCCP cannot reasonably argue, however, that TRICARE reimbursements are for the direct benefit or use of the government. Instead, common sense and the language of the relevant legislation establishes that, literally, the "beneficiaries" of TRICARE are the servicemembers, veterans, and eligible dependents who receive medical services—that is, the benefits of the program. *See* 10 U.S.C. § 1072(5) (defining "covered beneficiary"); § 1097 (establishing TRICARE as a means for delivering benefits to "covered beneficiaries"); *see also* 32 C.F.R. § 199.4 (CHAMPUS benefits are "designed to provide financial assistance to CHAMPUS beneficiaries for certain prescribed medical care obtained from civilian sources"). This is analogous to Medicare, where the government makes payments to hospitals, but the relationship is not contractual, because the payments benefit the public – "or, more precisely, . . . that portion of the public entitled to Medicaid or Medicare coverage."[34]

Moreover, the U.S. government as a *payer* for services – and as a litigant in disputes with those whom it pays – has historically been loath to agree that payments benefiting individuals or the public at large are contractual in nature. Thus, in *Trauma Service Group, Ltd. v. United States*, 33 Fed. Cl. 426 (1995), *aff'd on other grounds*, 104 F.3d 1321 (Fed. Cir. 1997), the U.S.

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[33] 32 C.F.R. § 195.2(e) (pursuant to Title VI of the Civil Rights Act of 1964, defining programs or activities deemed to constitute federal financial assistance).

[34] *United States v. Univ. Hosp. of the State Univ. of New York*, 575 F. Supp. 607, 613 (E.D.N.Y. 1983) (holding that Medicare payments to a hospital were in the nature of federal financial assistance and not a procurement contract), *aff'd*, 729 F.2d 144 (2d Cir. 1984).

Court of Federal Claims rejected a claim that a CHAMPUS provider's agreement with the DOD could be an enforceable procurement contract, specifically holding that:

> the principal purpose of the MOA [Memorandum of Agreement], as authorized by § 1096, is mutual assistance in carrying out the purposes of the CHAMPUS program, facilitating the delivery of care to third-party CHAMPUS beneficiaries, and reducing costs for both parties. Thus, the MOA is not primarily for the "direct benefit or use" of the government.[35]

This is in accord with numerous other cases finding that the conferral of benefits on third parties does not create a contract within the meaning of the Grant Act.[36] Notably, in each and every one of these cases, it was *federal executive agencies* that advanced the view, accepted by the courts, that a contract which primarily benefits third parties is not for the direct benefit of the government. The SD&O therefore not only ignores the applicable law related to the definition of a federal financial assistance program, but also misapplies that law and creates dissension among federal agencies and confusion in the provider community.[37]

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[35] 33 Fed. Cl. at 429.

[36] *Rick's Mushroom Serv., Inc. v. United States*, 521 F.3d 1338, 1344 (Fed. Cir. 2008) (agreement to subsidize waste transfer facility costs did not create a contract because "the agreement did not provide for transfer of goods or services to the government, there was no evidence of a buyer-seller relationship, and the government did not receive a direct benefit from the operation of the . . . transfer facility."); *Partridge,* 141 F.3d at 925 (agreement to fund rescue services was designed "to carry out a public purpose authorized by federal statute, and not to acquire property or services for the direct benefit of the United States Government"); *see also Amfac Resorts, L.L.C. v. U.S. Dep't of the Interior,* 282 F.3d 818, 835 (D.C. Cir. 2002) (permits to operate concessions on National Park Service are not procurement contracts because their "primary" purpose is to benefit park visitors; rejecting view that a contract exists simply because "any 'benefit' can be traced to the government"), *vacated as unripe,* 538 U.S. 803 (2003); *Delta S.S. Lines, Inc. v. United States*, 3 Cl. Ct. 559, 569 (1983) (funding of merchant marine shipbuilding did not create a contract; ships would be owned by third parties and there was no "direct procurement of property, services, and construction, to be used directly by the government").

[37] OFCCP now appears to argue that quality requirements imposed on TRICARE providers evidence contractor status. *See* Office's Response to Exceptions, at 2-3 & 14-15. OFCCP cites no authority for this apparent argument, nor is the AHA aware of any, since it would lead to a finding that many other federal programs are "contracts." The Grant Act itself confirms that "substantial involvement" by the government is not incompatible with grant status. *See* 31 U.S.C. § 6305 (providing that a grant program involving "substantial involvement" by the government should be administered as a non-contractual "cooperative agreement.").

C. DOD Did Not Usurp DOL's Jurisdiction When It Asserted Jurisdiction Over TRICARE Providers As Recipients Of Federal Financial Assistance

The SD&O considered Florida Hospital's argument that the OFCCP should be bound by the DOD's designation of TRICARE reimbursements as "federal financial assistance," but rejected the argument. The SD&O ostensibly reaches the result because the Secretary of Defense lacks jurisdiction to construe the laws enforced by OFCCP. Thus, the SD&O continues, DOL may override the "contrary" views of other agencies.

In so doing, the SD&O entirely missed the point of DOD's actions. DOD, like all federal departments and agencies, is *required* to regulate recipients of its federal financial assistance, which is what it did here.[38] DOD accordingly issued regulations defining who is a recipient of federal financial assistance (including but not limited to TRICARE) and designating officials to enforce nondiscrimination mandates with respect to those recipients.[39] These officials have in turn deferred nondiscrimination enforcement with respect to TRICARE hospitals to the U.S. Department of Health and Human Services Office of Civil Rights.[40]

Thus, far from usurping DOL's role, DOD was duty-bound to determine whether TRICARE providers are recipients of federal financial assistance. Indeed, OFCCP itself has now arguably usurped the role of another agency (DOD) by refusing to accept DOD's determination that TRICARE in-network providers receive federal financial assistance. This calls into question DOD's jurisdiction to enforce Title VI and other statutes governing nondiscrimination by recipients of federal financial assistance, and is likely to lead to overlapping assertions of civil

[38] *See* 42 U.S.C. § 2000d-1 (Title VI) (each federal department and agency extending federal financial assistance "is authorized *and directed*" to rules and regulations to ensure nondiscrimination by recipients of financial assistance) (emphasis added).

[39] *See* 32 C.F.R. § 56.7(b)(21) (listing payments under Title 10, Chapter 55 of the United States Code as a form of federal financial assistance under Section 504); 32 C.F.R. § 195.2(e) (setting general standard under Title VI) & § 195.5 (designating officials).

[40] *See* TRICARE Operations Manual 6010.51-M [Stipulated Facts Ex. D], § 5.2.

rights jurisdiction by both the OFCCP and DOD.[41] This result undermines the very purpose of the Grant Act, which was to create a uniform system of characterizing federal awards that did not impose unnecessary administrative requirements on awardees. It will also lead to confusion in the health care community regarding the appropriate jurisdiction of the two agencies and overlapping compliance requirements.

III. EVEN UNDER OFCCP'S OWN REGULATIONS, THERE IS NO BASIS FOR FINDING IN-NETWORK PROVIDERS TO BE FEDERAL SUBCONTRACTORS

As we have argued above, the Grant Act definitively resolves the status of TRICARE reimbursements as a form of federal financial assistance. However, even under OFCCP's own regulations, the SD&O should be overruled.

The SD&O relied on prong 2 of the regulatory definition of "subcontractor" to conclude that Florida Hospital was subject to OFCCP's jurisdiction.[42] The AHA agrees with Florida Hospital that this was incorrect. As the Hospital has already argued below and in its exceptions, all of the duties listed by Humana relate to the administration and reimbursement of health benefits, not the delivery of care to individual TRICARE beneficiaries.[43] As such, the Hospital did not perform, undertake or assume any Humana obligations under the contract, as would be required for a prong 2 finding.

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[41] Similar conflicts may be looming with respect to Medicare Parts C and D. OFCCP has left open the door to a determination that these programs come within OFCCP's jurisdiction. *See, e.g.*, OFCCP's Resp. to Pl.'s Summ. J. Mot. at 6 n.4. However, the U.S. Department of Health and Human Services Office of Civil Rights has already designated Medicare Parts C and D providers as recipients of federal financial assistance. *FAQ: Are Medicaid, The Children's Health Insurance Program (CHIP) And Medicare Considered Federal Financial Assistance?*, http://www.hhs.gov/ocr/civilrights/faq/TitleVl/403.html.

[42] *See* SD&O at 4 (citing 41 C.F.R. § 60-1.3 (defining a subcontract as an agreement or arrangement "(2) [u]nder which any portion of the contractor's obligation under any one or more contracts is performed, undertaken or assumed.")).

[43] We also agree with the Hospital that the Board should consider the actual evidence submitted by the parties, as opposed to the SD&O's misleading characterizations of the parties' stipulations and/or its citation to an obvious typographical error in one of the briefs below. This is especially important here, where the issue to be decided is of national significance.

Nor is OFCCP correct in arguing to the Board that prong 1 of the "subcontractor" definition supports an assertion of jurisdiction. Prong 1 directs a subcontractor finding if the subsidiary agreement is "[f]or the purchase, sale or use of personal property or nonpersonal services which, in whole or in part, is necessary to the performance of any one or more contracts." 41 C.F.R. § 60-1.3.

As an initial matter, prong 1 of the regulation is essentially prong 2 in reverse. As Humana was not obliged to provide any individual medical services, plainly hospitals do not "sell" to Humana a service that is "necessary" to Humana's performance of its own duties. Moreover, Humana does not "purchase" medical services from hospitals; instead, it either underwrites those costs pursuant to a complex arrangement with DOD, or it directly reimburses providers and/or beneficiaries from government funds. In either case, Humana reimburses only eligible services, subject to government-imposed maximums. And in no case does Humana itself purchase, *i.e.*, acquire, medical services. Instead, services are provided directly to the beneficiary, who chooses his or her provider, and who receives the services that his or her physician deems medically necessary and appropriate. In sum, the Hospital Agreement between Humana and Florida Hospital lacks the attributes of a buyer-seller relationship.[44]

Finally, in light of *Liberty Mutual Insurance Co. v. Friedman*, 639 F.2d 164 (4th Cir. 1981), the Board should be wary of accepting OFCCP's invitation to adopt an overly broad view of its "subcontractor" jurisdiction. In that case, the Court of Appeals held that even where a "subcontractor" relationship could be established by reference to OFCCP's regulations, OFCCP

[44] *See also Rick's Mushroom Serv., Inc.*, 521 F.3d at 1344 (Grant Act) (lack of transfer of goods or services to the government, lack of buyer-seller relationship, and lack of direct benefit to government indicated that funding arrangement was not a contract); *New Era Constr. v. United States*, 890 F.2d 1152, 1157 (Fed. Cir. 1989) (Contract Disputes Act) (Department of Housing and Urban Development did not "procure" property when it agreed to contribute to the cost of building subsidized housing, because HUD "was not seeking in the contributions contract to obtain for itself the low-cost housing.").

could not assert jurisdiction under Executive Order 11246 unless a nexus to efficiency and economy in government procurement was established.[45] The court concluded that a prime contractor's payments for worker's compensation insurance did not create a "subcontract."[46] Similarly here, there has been no showing that a "subcontractor" determination will promote efficiency in procurement.

CONCLUSION

America's hospitals should not be discouraged from participating in federally subsidized health programs, yet the SD&O, if affirmed, will lead to that result. While OFCCP dismisses this concern as speculative, DOD itself has already stated that "onerous federal contracting rules" will harm the TRICARE program.[47] More generally, Congress has also expressed concern about the imposition of "unnecessary administrative requirements" when executives agencies mischaracterize their awards.[48]

The Board should apply the correct legal standard and conclude that OFCCP erred when it asserted jurisdiction over Florida Hospital.

Dated: December 29, 2010.

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[45] 639 F.2d at 169-70.

[46] *See id.* at 171-72.

[47] Def.'s Mot. for Summ. J., Def. Ex. "3."

[48] 31 U.S.C. § 6301(1).

CERTIFICATE OF SERVICE

I hereby certify that on the 29th day of December 2010, a true and correct copy of the foregoing was sent both by facsimile, and certified mail, return receipt requested, to the following:

M. PATRICIA SMITH
Solicitor of Labor
STANLEY E. KEEN
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CHANNAH S. BROYDE
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