

**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

***Amicus* Brief of the American Hospital Association in Support of  
Defendant Florida Hospital of Orlando's Motion to Dismiss**

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Pursuant to the Order of the Administrative Review Board (“Board”) dated March 30, 2012, the American Hospital Association (“AHA”) submits this brief as *amicus curiae* in support of Defendant Florida Hospital of Orlando’s (“Florida Hospital” or “Hospital”) Motion to Dismiss Case As Moot Pursuant To Amendment To TRICARE.

### **INTRODUCTION**

In this case, the Office of Federal Contract Compliance Programs (“OFCCP” or “the Office”) continues to assert, in the face of a contrary congressional mandate, that hospitals participating as network providers in the TRICARE program run by the Department of Defense (“DOD”) are federal subcontractors as defined in 41 C.F.R. § 60-1.3.

Earlier in this litigation, an Administrative Law Judge (“ALJ”) issued a Summary Decision and Order (“SD&O”) adopting the Office’s position. Florida Hospital appealed that decision to this Board and the AHA, along with other interested parties, filed *amicus* briefs supporting Florida Hospital’s position. *See* AHA’s *Amicus* Brief in Support of Defendant Florida Hospital, ARB Case No. 11-011 (filed Dec. 29, 2010) (hereinafter “AHA *Amicus* Br.”). While the case was pending, Congress passed the National Defense Authorization Act for Fiscal Year 2012 (“NDAA FY12”), which included various amendments to the TRICARE program. *See* Pub. L. No. 112-81, 125 Stat. 1298 (2011). Section 715 of NDAA FY 12 directly addressed the federal subcontractor status of TRICARE network providers—the issue at the center of this case—stating:

**Sec. 715. Maintenance Of The Adequacy Of Provider Networks Under The TRICARE Program**

Section 1097b(a) of title 10, United States Code, is amended by adding at the end the following new paragraph:

“(3) In establishing rates and procedures for reimbursement of providers and other administrative requirements, including those contained in provider network agreements, the Secretary shall, to the extent practicable,

maintain adequate networks of providers, including institutional, professional, and pharmacy. For the purpose of determining whether network providers under such provider network agreements are subcontractors for purposes of the Federal Acquisition Regulation or any other law, a TRICARE managed care support contract that includes the requirement to establish, manage, or maintain a network of providers may not be considered to be a contract for the performance of health care services or supplies on the basis of such requirement.”

Pub. L. No. 112-81, § 715, 125 Stat. 1477. Florida Hospital subsequently filed the instant Motion to Dismiss. The Board asked the parties to submit briefing on Section 715’s impact on this case on January 13, 2012.

The OFCCP’s response to the passage of Section 715 is wrong but unsurprising. In its brief filed with the Board on March 13, 2012, the Office suggests that the Secretary of Labor should have greater authority than Congress in this area and that “Congress usurped that authority by limiting whether TRICARE network providers could be considered subcontractors under . . . the laws enforced by OFCCP.” *See generally* Plaintiff OFCCP’s Resp. to ARB’s Request for Briefing on the Impact of Section 715 of the National Defense Authorization Act, ARB Case No. 11-011 (filed Mar. 13, 2012) (hereinafter “OFCCP Br.”). Further, the Office’s retroactivity argument casts the Office as a personally aggrieved plaintiff whose “rights” were impaired by Section 715, rather than a neutral government agency fairly enforcing the laws.

The AHA, as an advocate for over 5,000 hospitals, health systems, and other health care organizations, has a strong interest in the resolution of the question of whether TRICARE network providers are “subcontractors” for the purposes of OFCCP jurisdiction. The AHA has advocated on behalf of its members both before this Board and in Congress, including strongly supporting the passage of Section 715. However, if the Office’s position in this case prevails, Section 715 will be rendered a virtual nullity, possibly subjecting up to 500,000 TRICARE network providers to the Office’s jurisdiction despite clear Congressional intent to the contrary.

For the reasons stated below, as well as those in Florida Hospital's brief filed this same date, the Office's arguments should be rejected and the case should be dismissed as moot in light of Congress's amendment to the provisions governing TRICARE.

### **SUMMARY OF ARGUMENT**

Congress's passage of Section 715 clearly demonstrates that TRICARE network providers may not be considered federal subcontractors based solely on their participation in the TRICARE network. The OFCCP's arguments to the contrary attempt to render Congress's passage of Section 715 meaningless, imposing significant burdens on the Nation's health care providers and threatening the adequacy of the TRICARE network. The AHA urges the Board to reject the Office's position and dismiss this case.

*First*, Congress—and not the OFCCP—is vested with the right to identify the regulations that apply to funds expended by Congress. Congress has consistently exercised this power and Section 715 is only one of the more recent examples of Congress doing so. To the extent that the Secretary of Labor or the Director of the OFCCP has the authority to identify particular employers or industries as federal contractors or subcontractors, they are still required to act within their Congressional grants of authority.

*Second*, Section 715 amends 10 U.S.C. § 1097b, entitled "TRICARE program: Financial Management," to enhance the Secretary of Defense's ability to maintain an adequate number of qualified health care providers under the TRICARE program. In doing so, Congress recognized that hospitals are encouraged to participate in the TRICARE program both by providing adequate reimbursement rates and rationalizing the regulatory obligations placed on those health care providers who participate in TRICARE. This congressional purpose in adopting Section 715 is incompatible with the Office's interpretation of the statute.

*Third*, the OFCCP’s response to Congress’s passage of Section 715 is flawed. The Office acknowledges that Section 715 forecloses the Office’s previously stated basis for jurisdiction over Florida Hospital and other TRICARE network providers. The Office, however, suggests an unsupportable narrow interpretation of Section 715 that, when coupled with the Office’s new and overly-broad interpretation of its own regulations, essentially eviscerates the provision as passed by Congress and signed by the President.

### **ARGUMENT**

#### **I. CONGRESS, UNDER ITS APPROPRIATIONS POWERS, HAS THE AUTHORITY TO DETERMINE THE ADMINISTRATIVE REQUIREMENTS THAT APPLY TO RECIPIENTS OF FEDERAL FUNDS**

##### **A. Section 715 Is A Proper Exercise Of Congress’s Unquestionable Power To Control The Regulations Governing Receipt Of Federal Funds**

The OFCCP’s brief addressing the applicability of Section 715 makes the wholly unsupported claim that it, rather than Congress, has the authority to determine when regulations apply to the recipients of federal funds and that Congress, by passing Section 715, took “an unprecedented action” that “usurped” the Office’s authority. OFCCP Br. 10. To the contrary, Congress has inherent authority to appropriate funds and oversee the expenditure of those funds, including ensuring that recipients of federal funds are not subjected to unnecessary governmental requirements.

One of Congress’s primary objectives in the use of appropriated funds is to “promote economy, efficiency, and effectiveness in the procurement of . . . services . . . by and for the executive branch,” including by eliminating unnecessary administrative requirements. *See* Pub. L. No. 91-129, § 1, 83 Stat. 269 (1969); 31 U.S.C. § 6301(1). To further this objective, in 1969, Congress established a Commission to “improv[e] the quality, efficiency, economy, and performance of Government procurement organizations and personnel;” and “avoi[d] or

eliminat[e] unnecessary or redundant requirements placed on contract and Federal procurement officials.” Pub. L. No. 91-129, § 1(2), (4), 83 Stat. 269; *see generally Henke v. United States Dept. of Commerce*, 83 F.3d 1445, 1451-52 (D.C. Cir. 1996) (providing a history of the Federal Grant and Cooperative Agreement Act of 1977).

Congress subsequently passed the Federal Grant and Cooperative Agreement Act of 1977, 31 U.S.C. §§ 6301 *et seq.* (hereinafter “the Grant Act”), which provides guidelines for executive agencies regarding how to classify relationships between the government and federal fund recipients. *Id.* § 6301(2). Specifically, the Grant Act authorizes agency heads responsible for distributing funds to determine whether a relationship calls for a (1) procurement contract, (2) grant agreement, or (3) cooperative agreement. 31 U.S.C. §§ 6303-6305.

Congress later created the Office of Federal Procurement Policy to obtain maximum efficiency in government procurement and the expenditure of public resources. *See* 41 U.S.C. § 404. The Administrator of the Office of Federal Procurement Policy oversaw the creation of the Federal Acquisition Regulation (“FAR”), which is the primary regulation used by all federal agencies that purchase materials with appropriated funds. *See* General Services Administration, Federal Acquisition Regulation, *Foreward*, Vol. 1, (Mar. 2005), <http://www.acquisition.gov/far/reissue/FARvol1FORPAPERONLY.pdf>. (“FAR”). The FAR applies to all acquisitions “by contract with appropriated funds.” *See Id.* at 2.1-4. The FAR does not apply, however, to relationships that are classified as grants or cooperative agreements under the Grant Act. *Id.* at 2.1-5. Thus, an agency head exercising his or her discretion under the Grant Act can identify a relationship as a grant agreement or a cooperative agreement and, by doing so, can render the Federal Acquisition Regulation inapplicable.

Given Congress's authorization of executive agencies to remove agreements from the FAR's coverage, it is no surprise that Congress itself can remove classifications of agreements from the reach of the FAR or other administrative requirements. Indeed, Congress has repeatedly done so, long before Section 715 of the NDAA FY12. For instance, in 1992, Congress determined that contracts below \$10,000 were exempt from complying with Section 503 of the Rehabilitation Act of 1973. *See* 29 U.S.C. § 793; Pub. L. No. 102-569, 106 Stat. 4344 (Oct. 29, 1992) (increasing amount from \$2,500). And, in 1998 Congress determined that entities with federal contracts below \$100,000 would not be subject to affirmative action requirements to employ and advance qualified veterans. *See* 38 U.S.C. § 4212 (a)(1); Pub. L. No. 107-288, 116 Stat. 2033 (Nov. 7, 2002) (increasing amount from \$25,000).

Congress has also exempted entire categories of relationships from federal regulations. In 1995, Congress exempted the Federal Aviation Administration from coverage under the Federal Acquisition Regulation. *See* Department of Transportation and Related Agencies Appropriation Act of 1996, Pub. L. No. 104-50, 109 Stat. 436 (1995). Further, Congress has excluded "commercial items" and "commercially available off-the-shelf items" from numerous provisions of the Federal Acquisition Regulations. *See* 41 U.S.C. §§ 430, 431. Congress has also given the Secretary of Defense the authority to determine that weapon systems or subsystems are commercial items and thus exempt from the FAR, subject to certain limitations. *See* 10 U.S.C. § 2379.

Congress's passage of Section 715 is no different. Congress's decision to enact Section 715 and prohibit TRICARE network providers from being considered "subcontractors" for the purposes of the FAR or any other law is wholly consistent with Congress's long history of placing or removing restrictions on the recipients of appropriated funds administered by



executive agencies. Further, Section 715 codifies how federal agencies other than the OFCCP have previously treated TRICARE relationships. As explained in the AHA’s initial *amicus* brief, the Department of Defense—the agency responsible for TRICARE agreements and, under the Grant Act, responsible for classifying them—has specifically designated TRICARE as a form of federal financial assistance and *not* as a contractor/subcontractor relationship subject to OFCCP jurisdiction. *See* AHA *Amicus* Br. 9-10. Even the OFCCP has recognized that it does not have jurisdiction over federal financial assistance relationships. *See Partridge v. Reich*, 141 F.3d 920 (9th Cir. 1998). Congress, through Section 715, simply exercised its appropriations prerogative to codify its intent, and the Department of Defense’s intent, regarding the treatment of TRICARE network providers.

**B. The OFCCP’s Application Of Its Own Regulations Must Be Based In Congressional Grants Of Statutory Authority**

The OFCCP’s protestation that Section 715 is a “usurpation” of the Secretary of Labor’s authority reflects a fundamental misunderstanding of the boundaries of its own authority. As discussed above, the Grant Act gives Congress and agency heads—and not the OFCCP—responsibility for classifying relationships as procurement contracts, grants, or cooperative agreements. *See* Section I. A., *supra*. While the Office has the authority to promulgate regulations defining who is a “contractor” and “subcontractor” subject to the laws enforced by the Office, the application of those definitions to individual employers or categories of employers—for instance, TRICARE network providers—*must* be based in a statutory grant of authority. *See Chrysler Corp. v. Brown*, 441 U.S. 281, 304-06 (1979); *Liberty Mut. Ins. Co.*, 639 F.2d 164, 167-68 (4th Cir. 1981). As explained in the AHA’s prior *amicus* brief, no statutory authority exists for the Office’s proposed definition of who is a “subcontractor” under its regulations in this instance. *See* AHA *Amicus* Br. 14-15. Indeed, courts have previously rejected

such attempts by the OFCCP to expand its jurisdiction beyond that authorized by statute. In *Liberty Mutual*, for example, the Office attempted to assert jurisdiction over companies that provided workers' compensation insurance to prime federal contractors. *See* 639 F.2d at 166. The court attempted to identify a legislative source of authority that would allow the OFCCP to require Liberty Mutual to comply with Executive Order 11,246. *Id.* at 168-72. The court noted that grants of authority "need not be specific . . . but a court must reasonably be able to conclude that the grant of authority contemplates the regulations issued." *Id.* at 169 (quotation omitted). The court, after a careful analysis, was unable to find any indication that Congress intended for the OFCCP's regulatory authority to reach workers' compensation insurers dealing with federal contractors and dismissed the case for lack of jurisdiction. *Id.* at 172.

Here, the task is much more simple. There is no need to search for Congressional intent to grant the OFCCP this authority because Congress's intent is clear: it does not intend for TRICARE network providers to be considered "subcontractors" for the purposes of the FAR or any other law based on the provider's participation in TRICARE. Pub. L. No. 112-81, § 715. The OFCCP by pursuing this matter is not only acting outside of a legislative grant of authority, but also acting in open disregard of an explicit Congressional denial of authority.

## **II. SECTION 715 CLEARLY PROHIBITS THE OFCCP FROM ASSERTING JURISDICTION OVER HEALTH CARE PROVIDERS BASED ON THEIR STATUS AS TRICARE NETWORK PROVIDERS**

In Section 715, Congress explicitly confirmed that health care providers who agree to participate in TRICARE may not be subjected to the FAR or the laws enforced by the OFCCP based on their participation in TRICARE. By adding subparagraph (3) to 10 U.S.C. § 1097b(a), Congress provided the Secretary of Defense with additional authority to maintain the adequacy of provider networks under the TRICARE program.

As Florida Hospital explains in its reply brief, Section 715 of the NDAA FY 12 eliminates the nexus between Florida Hospital and Humana Military Healthcare Service (“HMHS”), or any network provider and a managed care support (“MCS”) contractor<sup>1</sup>, that could serve as a basis for OFCCP jurisdiction. Section 715 makes clear that the prime contract between TRICARE and a MCS contractor — here, HMHS — cannot be treated as “a contract for the performance of health care services or supplies” on the basis of the requirement that the prime contractor “establish, manage, or maintain a network of providers.” § 715, Pub. L. No. 112-81, 125 Stat. 1477. As a result, Section 715 prohibits the Office from asserting that a hospital participating in TRICARE that provides medical services is either performing services necessary to the prime contract or performing a portion of the prime contractor’s obligation because, after Section 715, the obligation to “create a network” is not connected to a hospital’s agreement to “provide medical services.”

Congress’s passage of Section 715, and the broader context of 10 U.S.C. § 1097b, recognizes the “practical realities” and difficulties in retaining TRICARE network providers. *See Amicus* Brief of Humana Military Health Services, Inc., Health Net Federal Services, LLC, and TriWest Healthcare Alliance 2 (hereinafter “MCS Contractor *Amicus* Br.”). Specifically, the three primary contractors responsible for administering TRICARE have stated that “[s]ubjecting the network providers to federal affirmative action requirements will make it more difficult for the MCS contractors to find and retain providers willing to sign network agreements due to the added compliance requirements.” *Id.* As the MCS contractors noted, they were already

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<sup>1</sup> While Section 715 refers to the three contractors responsible for running TRICARE as “managed case support contractor[s],” they are alternatively referred to as “regional administrators.” For purposes of clarity, they are HMHS; Health Net Federal Services, LLC; and TriWest Healthcare Alliance, who collectively filed an *Amicus* brief in this case on December 29, 2010.

experiencing difficulty attracting and retaining network providers even prior to the OFCCP's articulated position with respect to TRICARE. *Id.*

Section 1097b, as amended by Section 715, assisted the Secretary of Defense in maintaining the adequacy of TRICARE provider networks in two ways. First, Section 1097b(a)(1) and (2) allow the Secretary to increase reimbursement rates above those otherwise authorized "if the Secretary determines that application of the higher rates is necessary in order to ensure the availability of an adequate number of qualified health care providers" under TRICARE. 10 U.S.C. § 1097b(a)(1). Allowing the Secretary the ability to ensure that participating in TRICARE remains a fiscally viable option for health care providers recognizes that participation in TRICARE is not a revenue generating proposition. TRICARE reimbursement rates are generally linked to the same Medicare and Medicaid payment schedules that result in chronic underpayment for services provided to many government beneficiaries. *See AHA Amicus Br. 4 & n.16.* Underpayments from these government funded programs to hospitals amounted to \$36,500,000,000 in 2009—a ten-fold increase since 2000. *Id.*

Second, Section 715 amends Section 1097b in order to ensure that the significant burdens placed on federal contractors and subcontractors by the FAR and the OFCCP's regulations are not imposed on hospitals merely through participation in the TRICARE program. The Nation's hospitals currently face substantial burdens from already-existing administrative and regulatory paperwork obligations, generating between 30 minutes and an hour of paperwork for every hour of patient care. *See Id.* 2-3. A recent AHA report concluded that hospitals spend at least 20.9% of their revenues on administrative costs and billing. *Id.* Health care providers required to comply with the OFCCP's regulations would face additional paperwork burdens, a fact that the OFCCP itself recognizes. The OFCCP recently requested an increase in the number of approved

burden hours, estimating that the average contractor will spend 70 hours per year complying with the Office's regulations.<sup>2</sup> Recognizing these burdens as a potential barrier to participation in the TRICARE network, Congress passed Section 715 in order to both maintain the adequacy of network providers and further its long-recognized interest in "avoiding or eliminating unnecessary or redundant requirements." *See* § 1(4), Pub. L. No. 91-129.

While OFCCP officials have decried the passage of Section 715 as "a sad day for civil rights," such sentiment is misplaced. *See Shiu Says OFCCP Will Assess Its Policies In Light Of Subcontractor Provision In NDAA*, 245 Daily Lab. Rep. (BNA) A-11 (Dec. 21, 2011). Health care providers are still covered by a panoply of regulations and laws mirroring those enforced by the OFCCP. *See AHA Amicus* Br. 5-6 & nn. 21-22. The passage of Section 715 merely continues Congress's efforts to maintain the adequacy of provider networks while codifying what everyone other than the OFCCP had previously concluded—participating as a network provider in TRICARE does not and should not subject health care providers to OFCCP jurisdiction.

### **III. THE OFCCP'S ASSERTION THAT, NOTWITHSTANDING SECTION 715, IT STILL HAS JURISDICTION OVER TRICARE NETWORK PROVIDERS BASED ON THEIR PARTICIPATION IN TRICARE IS FLAWED**

The OFCCP suggests that, even after Congress's passage of Section 715, it still has jurisdiction over TRICARE network providers such as Florida Hospital. *See* OFCCP Br. 11. To reach that conclusion, the Office comingles an overly-narrow interpretation of Section 715's reach with an overly-broad interpretation of its own regulations. *See id.* 6-8. As a result, the

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<sup>2</sup> The AHA submitted comments regarding the Office's estimated burden hours. Based on our own calculations and the experience of our members, an estimate of 70 hours per year grossly underestimates actual experiences. The request does reveal, however, the Office's aggressive expansion of jurisdiction, increasing the number of supply & service contractor establishments from 99,028 to 171,275—an increase of 72,247 contractors. *See* Office of Info. & Regulatory Affairs, *Final Supply & Serv. Supporting Statement*, Office of Mgmt. & Budget, 1 (Sept. 12, 2011), available at [http://www.reginfo.gov/public/do/PRAViewDocument?ref\\_nbr=201104-1250-001](http://www.reginfo.gov/public/do/PRAViewDocument?ref_nbr=201104-1250-001).

Office's position nullifies Section 715, leaving virtually all TRICARE network providers subject to its jurisdiction, clearly contrary to Congressional intent.

The OFCCP's regulations regarding what is a "subcontract" and thus who is a "subcontractor" provides two methods for establishing that an agreement is a covered subcontract. *See* 41 C.F.R. § 60-1.3. Specifically, the regulations define "subcontract" as:

[A]ny agreement or arrangement between a contractor and any person (in which the parties do not stand in the relationship of an employer and an employee):

- (1) For 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; or
- (2) Under which any portion of the contractor's obligation under any one or more contracts is performed, undertaken or assumed.

*Id.* The OFCCP acknowledges, as it must, that Section 715 of the NDAA FY 12 prohibits the Office from continuing to rely on "prong two" of the definition of "subcontract"—those relationships where a party has undertaken some portion of a prime contractor's obligation. *See* OFCCP Br. 5-6.

Nonetheless, the Office has engaged in an ill advised attempt to retain jurisdiction over the entirety of the Nation's TRICARE providers by suggesting that "§ 715 does not address the first prong of OFCCP's subcontract definition." *Id.* The Office then states that "Florida Hospital's services as a participant in the network were 'necessary to the performance' of the TRICARE-HMHS prime contract," satisfying "prong one" of the "subcontract" definition. *Id.* The Office's position, if accepted, essentially would nullify Section 715, contrary to Congressional intent.

**A. The Office’s Overly-Narrow Interpretation Of Section 715 Is Unsupported.**

Nothing in either Section 715 or its legislative history supports the Office’s interpretation of Section 715 as being limited to only the second prong of its definition of “subcontract.” Indeed, the only “legislative history” cited by the OFCCP is not “legislative history” at all. Rather, it is the White House’s Statement of Administration Policy, which correctly noted that the initial version of Section 715 “categorically exclude[d]” network providers from being considered subcontractors on any basis whatsoever. *See* Statement of Administration Policy, National Defense Authorization Act for FY 2012, S. 1867, 111th Cong. (2011). Likewise, the OFCCP’s brief recognizes that the initial version of Section 715 was “a blanket exemption” from OFCCP jurisdiction for TRICARE network providers. OFCCP Br. 7.

Congress subsequently amended the language of Section 715 into the version that was passed and signed into law. The Office infers—without any evidence—that Congress’s amendment of Section 715 must have been in response to the Statement of Administration Policy and intended to “create a more narrow exception from TRICARE coverage.” OFCCP Br. 8. The more reasonable interpretation, however, is that Congress recognized that its initial version of Section 715 created “a blanket exemption” that “categorically exclude[d]” TRICARE network providers from being treated as subcontractors, on any basis, for the purposes of the FAR or any other law. S. 1867, 112th Cong. (as passed by Senate, Dec. 1, 2011). The version of Section 715 passed by Congress and signed by the President accurately reflects that Congress’s intent was only to prohibit treating network providers as subcontractors based on their relationship with a TRICARE MCS contractor.

This interpretation of Section 715 is not only the more reasonable one, it is also consistent with the statutory context of Section 715. As discussed above, 10 U.S.C. § 1097b is focused on the “financial management” of TRICARE and authorizes the Secretary of Defense to

take action “to ensure the availability of an adequate number of qualified health care providers under that program.” 10 U.S.C. § 1097b(a)(1). Section 715 adds a new subparagraph (3), which also ensures the “maintenance of the adequacy of provider networks under the TRICARE program” by eliminating TRICARE participation, alone, as a basis for subcontractor jurisdiction under the FAR or any other law.

Although the Office speculates that Congress may have “desire[d] to not interfere” with the Office’s interpretation of its own regulations, *see* OFCCP Br. 8 n.11, its speculation is at odds with OFCCP Director Shiu’s comments at the time. Shortly after Section 715’s passage, Director Shiu commented that Congress passed the bill “despite the objection of the White House.” *See* 245 Daily Lab. Rep. (BNA) A-11. That statement belies the OFCCP’s current position that Section 715, as enacted, represents an intentional narrowing of the Section in response to the White House’s position. In any event, the likely sequence of events is that Congress (1) became aware of a dispute between the Office, which asserted jurisdiction based on TRICARE, and the Department of Defense, which classified it as federal financial assistance;<sup>3</sup> (2) recognized the concerns raised by Florida Hospital, TRICARE MCS contractors and the AHA and other *amici*; and (3) passed Section 715 to preserve the viability of the TRICARE network. Thus, Section 715, when properly interpreted, is not a “narrow exception from TRICARE coverage.” OFCCP Br. 8. It is a prohibition on doing what the OFCCP continues to do in this very case, i.e., classifying a network provider as a “subcontractor” based solely on their participation in TRICARE.

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<sup>3</sup> *Florida Hospital* has been well publicized in both the legal field and health care and federal contractor trade publications. *See, e.g.*, Karen M. Buesing & Martin R. Dix, *The OFCCP’s Expanding Reach: Healthcare Providers as Federal Contractors*, ABA Health eSource, Vol. 8, No. 4 (Dec. 2011), [http://www.americanbar.org/newsletter/publications/aba\\_health\\_esource\\_home/aba\\_health\\_law\\_esource\\_1112\\_buesing.html](http://www.americanbar.org/newsletter/publications/aba_health_esource_home/aba_health_law_esource_1112_buesing.html) (last visited Apr. 20, 2012); Joe Carlson, *Equal-opportunity Burden*, *Modern Healthcare* (Dec. 6, 2010, 12:01 AM), <http://www.modernhealthcare.com/article/20101206/MAGAZINE/101209971/1138&template=mobile>.



**B. The Office’s Overly-Broad Application Of “Prong One” Eliminates “Prong Two”**

Shortly after the passage of Section 715, the Office indicated its understanding that Section 715 exempted TRICARE network providers such as Florida Hospital from its jurisdiction. *See* 245 Daily Lab. Rep. (BNA) A-11 (calling it a “sad day for civil rights when . . . Congress seeks to exempt certain subcontractors from civil rights laws . . .”). Now, however, the OFCCP has made the unsupported argument that Florida Hospital is still a subcontractor under “prong one” because the Hospital’s “services as a participant in the network were ‘necessary to the performance’” of the TRICARE-HMHS contract,” which required HMHS to create and administer a provider network. *See* OFCCP Br. 6. That argument should be rejected.<sup>4</sup>

The Office’s interpretation of “prong one” should be rejected because it is so overly-broad that it swallows “prong two.” The two methods for classifying an agreement as a “subcontract” are markedly different. In order for an agreement to be a “subcontract” under “prong one,” the agreement must be “[f]or the purchase, sale or use of personal property or nonpersonal services.” 41 C.F.R. § 60-1.3. Further, the “personal property or nonpersonal services” must be “in whole or in part . . . necessary to the performance of any one or more contract[ ].” *Id.* The first prong of the OFCCP’s subcontract definition focuses on procurement, capturing relationships where a subcontractor is providing the contractor with a piece of “personal property” or “nonpersonal service” that is “necessary” for the contractor to complete its contractual obligations. “Prong two” is essentially the opposite. Under “prong two,” a prime contractor delegates—i.e., subcontracts—a portion of its contractual obligation to another party.

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<sup>4</sup> The AHA asserts that the Office’s interpretation and application of “prong one” should be rejected as an unreasonable interpretation of 41 C.F.R. § 60-1.3 and as an attempt to eviscerate Section 715 as applied to all TRICARE network providers. On the merits of the analysis, however, the AHA incorporates by reference Florida Hospital’s arguments stressing that its agreement with HMHS was not one for the “sale or use of personal property or nonpersonal services . . . necessary to the performance of any one or more contracts.”

*Id.* “Prong two” captures the subcontractor relationship as it is traditionally understood to mean the delegation of work otherwise to be performed by the prime contractor.

Here, the OFCCP argues that (1) TRICARE’s contract with HMHS obligated HMHS to create and maintain a network of providers and (2) when HMHS discharged a portion of that obligation by contracting with Florida Hospital, that agreement was “necessary to” HMHS’s completion of its obligation. OFCCP Br. 6. As a result, the Office has interpreted “prong one” to mean that any time a prime contractor enters an agreement with another party that covers “a portion of the prime contractor’s obligation,” that agreement will be a subcontract because it is “necessary to” the prime contractor’s fulfillment of its obligation. In short, the OFCCP now interprets “prong one” to cover exactly the kind of agreement covered by “prong two.”

The Office’s interpretation of “prong one” not only renders “prong two” meaningless, but it ignores that “prong one” contains a number of specific requirements before an agreement can be treated as a subcontract. For instance, the Office ignores the requirement that the contract be for the “sale or use” or “personal property or nonpersonal services.” *See* 41 C.F.R. § 60-1.3. The OFCCP makes no attempt to satisfy that showing here. Nor could they. Florida Hospital and the *amici* MCS contractors have carefully explained the nature of the relationship between the parties and why it does not satisfy either prong of the Office’s definition of a “subcontract,” with or without Congress’s intervention. *See* MCS Contractor *Amicus* Br. 8-10; Fl. Hosp. Def.’s Exceptions to Recommended SD&O 3-7, 10-11.

Finally, the OFCCP’s argument as a whole renders Section 715 meaningless. By first interpreting Section 715 to apply to only “prong two,” and then interpreting “prong one” in such a way that the Office never will need to rely on “prong two,” the OFCCP has attempted to circumvent Congress’s clear intent in passing Section 715. Congress has explicitly addressed the

subcontractor status of Florida Hospital and all other TRICARE network providers yet the Office, far beyond limiting itself to its Congressional grants of authority, continues to pursue this action after having its authority to do so clearly circumscribed. The AHA as *amicus* respectfully submits that the Board should not condone such an unsupportable position.

### CONCLUSION

*Amici* in these proceedings and others have warned that placing the burdens of OFCCP compliance on the Nation's TRICARE network providers will only increase the difficulty of attracting and retaining health care providers for the Nation's military personnel, military retirees, and their families. Congress responded to the OFCCP's assertion of jurisdiction over TRICARE network providers by clearly stating that participation in TRICARE could not be a basis for considering those providers to be subcontractors. Because the Office's strained efforts to establish jurisdiction over those entities is contrary to Congressional intent and nullifies the Office's own regulations, the AHA respectfully submits that the Board should reject those arguments and grant Florida Hospital's motion to dismiss the case as moot.

Dated: April 24, 2012.

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I hereby certify that on the 24th day of April 2012, a true and correct copy of the foregoing was sent by First Class U.S. Mail to the following:

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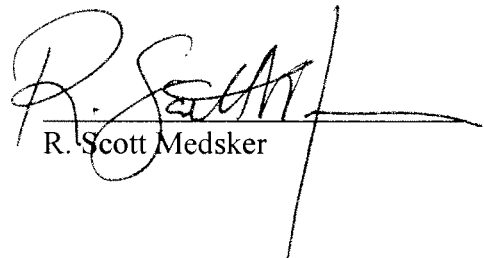
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