TRANSMITTAL

U.S. DEPARTMENT OF LABOR
Office of Federal Contract Compliance Programs

Number: 293 Date: December 16, 2010 OFCCP Order No. ADM Notice/Jur

1. **SUBJECT:** Coverage of Health Care Providers and Insurers

2. **PURPOSE:** To provide comprehensive guidance for assessing when health care providers and insurers are federal contractors or subcontractors based on their relationship with a Federal health care program and/or participants in a Federal health care program.

3. **FILING INSTRUCTIONS:**

Holders of ADM and LEG Binders only: File this Notice behind the "JUR" (jurisdiction) tab in your Administrative Practices Binder. Remove Transmittal Numbers 189 and 262 which are superseded by this Directive.

District and Area Office EOSs and EOAs only:
File this Notice behind the tab for ADM Directives in your FCCM Binder. Remove Transmittal Numbers 189 and 262 which are superseded by this Directive.

4. **OBSOLETE DATA**: This Directive supersedes two earlier Directives. They are: Directive Number 189, Health Care Entities that Receive Medicare and/or Medicaid (December 16, 1993); and Directive Number 262, Coverage of Health Care Providers Based on their Relationship with Participants in the Federal Employees Health Benefits Program (March 17, 2003).

5. **DISTRIBUTION**: A, B (both hard copy and electronically); C (hard copy only).

6. **EXPIRATION DATE:** This directive remains in effect until rescinded or modified.

Patricia A. Shiu
PATRICIA A. SHIU
Director
Office of Federal Contract Compliance Programs

12/16/10
DATE

U.S. DEPARTMENT OF LABOR
OFFICE OF FEDERAL CONTRACT COMPLIANCE PROGRAMS
WASHINGTON, D.C. 20210

OFCCP Order No. ADM Notice/Jur

1. **SUBJECT:** Coverage of Health Care Providers and Insurers

2. **PURPOSE:** To provide guidance for assessing when health care providers and insurers are federal contractors or subcontractors based on their relationship with a Federal health care program and/or participants in a Federal health care program.

3. **BACKGROUND:**

A wide range of relationships exist between health care providers and/or insurers, and Federal health care programs and/or participants in Federal health care programs. Some of these relationships constitute Federal contracts within OFCCP jurisdiction, while others do not. Recent case decisions and changes in the health care industry and Federal health care programs have given rise to questions about which health care provider/insurer relationships constitute covered Federal contracts. This Directive addresses these coverage questions with respect to three nationwide Federal health care programs – Medicare, TRICARE, and the Federal Employees Health Benefit Plan (FEHBP) - and provides guidance for assessing when a health care provider or insurer is a covered federal contractor for purposes of OFCCP jurisdiction.

Three significant OFCCP cases address health care provider coverage issues and provide the basis for a framework for the analysis of these issues. In *OFCCP v. UPMC Braddock, UPMC McKeesport, and UPMC Southside,* ARB Case No. 08-048 (May 29, 2009),[1] a case involving the FEHBP, the Department of Labor Administrative Review Board (ARB) determined that three hospitals under review by OFCCP were covered subcontractors. Each hospital had a Health Maintenance Organization (HMO) contract with UPMC Health Plan to provide medical products and services to Federal Government employees covered by the UPMC Health Plan, pursuant to the Health Plan's contract with the U.S. Office of Personnel Management (OPM). The decision found that, under the terms of the HMO contract, the hospitals were to provide the medical services necessary for the UPMC Health Plan to meet at least a portion of its contractual obligation to OPM to put an HMO into operation. Thus, the hospitals were subcontractors subject to OFCCP jurisdiction.

Following these same principles, in *OFCCP v. Florida Hospital of Orlando*, ALJ Case No. 2009-OFC-00002 (October 18, 2010), an Administrative Law Judge (ALJ) determined that the hospital was a covered subcontractor. In this case, the Humana Military Healthcare Services (Humana) held a prime contract with TRICARE to provide networks of health care providers for TRICARE beneficiaries. The Florida Hospital, a

[1] The *UPMC* case is still in litigation, as it is currently in federal court on judicial review under the Administrative Procedures Act. *See UPMC Braddock et al. v Solis,* Case No. 1:09-cv-01210-PLF (D. D.C.)

participating hospital, had an "agreement" with Humana to assume some of the prime contractor's responsibility to provide health care services to TRICARE beneficiaries. The hospital was, therefore, found to be a covered subcontractor.[2]

By contrast, an earlier decision, *OFCCP v. Bridgeport Hospital*, ARB Case No. 00-234 (January 31, 2003), illustrates circumstances in which a hospital was not a federal contractor. In this FEHBP case, the ARB found that an agreement between the hospital and Blue Cross/Blue Shield that provided solely for ***reimbursement to the hospital*** for the cost of medical services the hospital provided to Federal Government employees enrolled in the Blue Cross insurance plan was not a covered subcontract. Such a reimbursement agreement – between a medical service provider (Bridgeport) and an insurer (Blue Cross) - was not necessary to the performance of the prime health insurance contract Blue Cross had with OPM to reimburse Blue Cross ***policyholders*** for their medical costs. Consequently, the hospital was not a covered subcontractor.

4. DIRECTIVE DEFINITIONS:

- **Government contract/Federal contract** – means any agreement or modification thereof between any contracting Federal agency or department and any person for the purchase, sale or use of personal property and nonpersonal services. (See 41 CFR §§ 60-1.3, 60-250.2(i), 60-300.2(i), 60-741.2(i)) Unless otherwise noted, the term "contract" encompasses both contracts and subcontracts.

- **Subcontract** – means any agreement or arrangement between a federal contractor and any person, not in an employer/employee relationship: (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 a contract, or (2) under which any portion of the federal contractor's obligation under the contract is performed, undertaken or assumed. (See 41 CFR §§ 60-1.3, 60-250.2(l), 60-300.2(l), 60-741.2(l)).

- **Health care plans/Plans** – are plans or programs for the delivery of health care services. There are two basic types of plans, and some health plans contain elements of both basic plan types. The two basic types of plans are:

    - **Managed/coordinated care plans** – are health care plans designed to control health care costs through a variety of mechanisms such as controls on inpatient admissions and lengths of stay, access to a select group of health care providers, etc. These plans include a variety of arrangements such as Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Provider Sponsored Organizations (PSO).

    - **Fee-for-service plans** – are plans that provide "traditional" health insurance that allows the beneficiary to make most health care decisions independently.

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[2] The *Florida Hospital* case is still in litigation, as Florida Hospital has filed Exceptions to the ALJ's decision with the ARB.

Typically, the plan beneficiary pays for the health care service and receives reimbursement from the health plan if the service is covered under the insurance policy.

- **Health care provider** – includes hospitals and medical facilities, doctors and medical professionals, and any other professional, company, or entity that provides medical services and supplies. Health care providers may contract directly with the contracting Federal agency or be subcontractors.

- **Insurance reimbursement agreement/reimbursement agreement** –There are two general kinds of insurance reimbursement agreements. A reimbursement agreement may be a contract or agreement between a health care provider and an insurer (that has a prime contract with a Federal health care program) to provide payment (reimbursement) to the health care provider for medical services it provides to patients covered by the health care program. This type of reimbursement agreement is usually associated with "fee for service plans" that provide traditional health insurance to plan beneficiaries. A reimbursement agreement may also be a contract or an agreement between a health care provider and Medicare/Medicaid (or its contracting agency) to accept payment directly from Medicare/Medicaid for medical services provided to patients that are reimbursable under Medicare Parts A, B and/or Medicaid. See additional information regarding Medicare Parts A and B in the Basic Principles section and in section 6, Procedures: A2 below.

- **Insurer** – a company that has a contract to provide health insurance for the benefit of Federal health care program members and beneficiaries.

- **Federal health care programs (Federal Programs)** – The three major nationwide Federal health care programs are:

    - **Medicare** - is a social insurance program administered by the U.S. Government, providing health insurance coverage to people who are aged 65 or over, or who meet other special criteria. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS), a component of the U.S. Department of Health and Human Services (HHS). The Medicare program includes: Medicare Part A (medical insurance); Medicare Part B (hospital insurance); Medicare Advantage (Part C) (managed/coordinated care plans); Medicare Part D (prescription drug plans); and Medicaid (a State-administered health care program primarily for those with low income).

    - **TRICARE** - is the Federal health care program serving active duty military service members, members of the National Guard and Reserve, and military retirees. TRICARE also serves the families of military service members, and certain former military spouses worldwide. TRICARE is administered by the TRICARE Management Activity (TMA), a program of the U.S. Department of Defense. TRICARE includes insurance and supplemental insurance, direct

health care services, managed/coordinated care, and special needs plans. Eligibility for TRICARE's various components and plans varies.

- **FEHBP** – is the Federal health care program serving civilian federal employees, retirees and their families. The program is administered by the U.S. Office of Personnel Management (OPM). The FEHBP offers federal employees and retirees a variety of health plans to choose from, including insurance and supplemental insurance plans, health care services plans, and other special needs plans.

5. POLICY:

This directive transmits the basic principles and procedures for determining whether a covered prime contract or subcontract relationship is created based on a company's relationship with a Federal health care program and/or with participants in a Federal health care program. This directive will remain in effect until it is rescinded or modified.

BASIC PRINCIPLES:

- A health care provider or insurer must have a covered federal contract or subcontract in order for there to be OFCCP jurisdiction over the provider or insurer. The wide array of health care plans, providers, services, and arrangements available necessitates a case-by-case approach when determining whether federal contractor or subcontractor coverage may be established.

- Any agreement or other arrangement that effectively creates a covered contractual (or subcontractual) relationship between the parties is a contract as defined in OFCCP regulations, whether or not it is labeled a "contract," or "subcontract" by the parties.

- Contractor (or subcontractor) obligations mandated by OFCCP programs cannot be altered, limited, or defeated by the inclusion in the contract of provisions contrary to such obligations.

- Under each of the major Federal health care programs, a company may enter into a prime contract with a Government agency to provide insurance, health care services, administrative support, (e.g., claims processing), or a combination of these services.

- Under each of the major Federal health care programs, a prime contractor may subcontract the performance of elements of its contract to one or more companies or may subcontract for supplies or services necessary to the performance of the contract. This creates a subcontract relationship and establishes coverage over the company(ies) providing/fulfilling an element of the prime contract or providing the necessary supplies or services.

- When a covered subcontractor contracts with another company to provide supplies and services necessary to the performance of the prime contract or to fulfill an

element of the prime contract, another subcontract relationship is created and OFCCP has jurisdiction over both subcontractors. If a covered subcontractor has such contracts with multiple companies, OFCCP has jurisdiction over all of the subcontractors, so long as they are providing goods and services necessary to the performance of the prime contract or are fulfilling an element of the prime contract.

- An insurance reimbursement agreement between a health care provider, (e.g., a doctor or hospital), and a federal contractor contracted to provide health insurance only (and not health care services) does not create a covered subcontract relationship. Such a reimbursement agreement does not provide OFCCP with jurisdiction over the health care provider.

- Reimbursements made pursuant to Medicare Parts A and/or B (or Medicaid) are Federal financial assistance, not contracts.[3] Therefore, health care providers that enter into agreements to receive such reimbursements for services provided to Medicare beneficiaries are recipients of Federal financial assistance, and are not considered contractors because of the reimbursement relationship.

- Federal health care programs may offer grants for eligible companies and individuals. While the receipt of a true grant does not create a contractual relationship, a grant recipient may also be a contractor if it has, or enters into, a Government contract or subcontract.

6. PROCEDURES

OFCCP must first establish the existence of a federal contractor or subcontractor relationship in order to exercise jurisdiction over a company, e.g., a health care provider or insurer. In the initial stages of a compliance evaluation or complaint investigation, OFCCP will determine whether there is contract coverage for the time period in question. This will include obtaining and reviewing a copy of each relevant prime contract and subcontract. If a company holds a covered Government contract or is a subcontractor to a Government contract, then all of the company's establishments and facilities are subject to OFCCP regulatory requirements, regardless of where the contract is to be performed.

There are a variety of relationships that may exist among health care providers, insurers, companies providing supplies and non-medical services, and Federal health care programs (Federal Programs). Medicare, TRICARE and FEHBP, through their Federal contracting agencies, may contract for the delivery of such supplies and services. The Federal Programs may also award Federal financial assistance or grants to health care providers or other companies to provide reduced or no-cost services to specified communities, groups or individuals. Generally, receipt of Federal financial assistance or a grant, by itself, does not establish a covered contractual relationship.

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[3] The legislative history of Medicare Parts A and B, and the Medicaid programs indicates that these are Federal financial assistance programs designed to provide a National health insurance program for eligible beneficiaries.

Under each of the Federal Programs, a company may enter into a direct (prime) contract with a Government agency, and/or a prime contractor may subcontract elements of its contractual obligations to provide health care services, insurance, administrative support or other supplies and services. It is these contractual relationships over which OFCCP has enforcement authority.

OFCCP takes a case-by-case approach to the issue of whether a federal contractor or subcontractor relationship exists and OFCCP jurisdiction may be established. Guidance regarding when there is and is not a contractual relationship is provided below.

1. Determining That a Federal Contract Relationship Exists

A. Direct Contract Coverage

Direct or "prime" contract coverage is established when a contract exists between a Government agency/Federal Program and a health care provider, insurer, or other type of company to provide specific supplies or perform particular services. Once a direct contract is found, OFCCP will examine the nature and purpose of the contract and determine its value and duration to ensure that coverage thresholds are met.[4] Direct contracts may exist between one or more Federal Program(s) and any of the following typical types of health care related entities.

1) *Health Care Providers*

Direct contracts with health care providers usually provide that the health care provider will provide specified health care services to members and beneficiaries of one or more health plans within a Federal Program. A contract between a Government agency/Federal Program and a health care provider may also provide that the health care provider will establish and/or operate a managed or coordinated care plan, (e.g., an HMO), or facility. Direct contracts with health care providers are used by TRICARE, FEHBP, and Medicare's Advantage and Part D programs.

> EXAMPLE: A Federal Program contracts with Hospital A to provide an HMO Plan for the members and beneficiaries of one of its health plans. Hospital A is a direct (prime) contractor and OFCCP jurisdiction is established.

> EXAMPLE: An outpatient medical facility contracts with the Department of Veterans' Affairs and the Department of Defense to provide health care services to active duty and retired military personnel under the TRICARE program. The outpatient medical facility is a direct (prime) contractor and OFCCP jurisdiction is established.

[4] Throughout this directive and in all of the examples provided, it is assumed that contract thresholds have been met, unless stated otherwise.

2) *Insurers*

TRICARE, FEHBP, and/or Medicare's Advantage and Part D programs may enter into direct contracts for the provision of health insurance for members and beneficiaries of a number of their health plans, including fee-for-service and PPO plans. Under such circumstances, a direct Federal contract exists with the insurer and OFCCP jurisdiction is established.

Thus, for example, in the *Bridgeport* case[5], the ARB determined that there was a direct contract between the Office of Personnel Management (the contracting agency for the FEHBP) and Blue Cross/Blue Shield (the insurer) to provide health insurance to certain federal employees and beneficiaries. OFCCP therefore had jurisdiction over Blue Cross/Blue Shield.

Medicare Advantage and Medicare Part D both offer a variety of plans, including fee-for-service plans that provide insurance, but not supplies or medical services to plan members and beneficiaries. Like the contract at issue in *Bridgeport,* these insurance-only plans are direct Federal contracts that establish OFCCP jurisdiction over the insurer.

3) *Other Types of Direct Contracts*

Federal Programs and/or their contracting agencies may also enter into contracts for the provision of various other supplies and services for one or more of their health plans, or for the Federal Program as a whole. These may include contracts for the provision of administrative support, claims and data processing, customer service, marketing, medical savings plans/flexible spending plans, etc. Such contracts are Government supply and service contracts, over which there is OFCCP jurisdiction.

> EXAMPLE: A Federal Program contracts with Company X to provide claims processing services and regional administrative service centers for the benefit of its members and beneficiaries. A direct contract relationship exists between Company X and the Federal Program.

B. Potential Subcontract Relationships

OFCCP jurisdiction may also be established when a subcontractor relationship exists. To determine if a subcontractor relationship exists, it must first be determined whether there is an underlying prime contract between a Federal Program and/or its contracting agency and a company, insurer, or health care provider, and if so, what the obligations are under that contract. Next, it must be determined whether there is also an agreement or arrangement between the prime contractor and the subcontracting company:[6] (1) for the purchase, sale or use of personal property or

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[5] See *OFCCP v. Bridgeport Hospital,* ARB Case No. 00-234, (January 31, 2003).
[6] Excluding employer/employee agreements or arrangements.

nonpersonal services[7] which, in whole or in part, is necessary to the performance of the underlying contract, or (2) under which any portion of the prime contractor's contractual obligation is performed.

To assess whether there is a subcontract within OFCCP's jurisdiction, the nature and purpose of BOTH the prime contract AND the subcontract at issue will be examined. If the subcontract satisfies at least one of the two prongs discussed above, then a subcontract within OFCCP jurisdiction exists.[8]

Provided below are examples of some typical health care related subcontractor relationships. However, it is important to note that the terms of individual contracts and subcontracts vary, and that assessments of contract coverage are made on a case-by-case basis.

1) *Provision of Health Care Services*

In addition to offering insurance plans, each of the Federal Programs (and/or its contracting agency) offer health care plans that provide actual health care services, rather than only insurance, to its members and beneficiaries. Health care plans that provide actual health care services include HMOs, and may include PPOs, PSOs, or other forms of managed or coordinated care[9]. To offer such plans, a Federal Program will typically contract with a health care plan or company to establish or provide the desired managed care plan. Often, the health care company will then contract with one or more health care providers to provide some or all of the medical services the plan is contractually obligated to provide to the Federal Program. Under such circumstances, the health care provider is a covered subcontractor.

The *UPMC* case[10] illustrates this situation. There the ARB determined that a prime contract existed between OPM (the FEHBP Program contracting agency) and the UPMC Health Plan (the health plan company) to put an HMO into operation. Each of the hospitals (health care providers) was under a contract with UPMC to provide members and beneficiaries of the UPMC health plan with medical supplies and services required by UPMC's prime contract with OPM. Consequently, the ARB determined the hospitals were covered subcontractors.

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[7] The term "nonpersonal services" includes, but is not limited to, the following services: Utilities, construction, transportation, research, insurance, and fund depository. 41 CFR § 60-1.3.

[8] As noted in the Basic Principles section, above, the same analysis applies in determining whether there is OFCCP jurisdiction over a contract between a covered subcontractor and a third company.

[9] HMOs, PPOs, and PSOs, are all managed/coordinated care plans that vary in how they are organized and administered, whether they include a specific "network of providers," and the types of services they provide. It is imperative that each plan is examined on a case-by-case basis, rather than just assuming based on a label (e.g., PPO) that the plan works in a particular manner or otherwise imposes certain obligations on the plan.

[10] See *OFCCP v. UPMC Braddock, UPMC McKeesport, and UPMC Southside*, ARB Case No. 08-048 (May 29, 2009).

These same principles were applied in the *Florida Hospital* case.[11] In this case, an ALJ determined that a prime contract existed between TRICARE and Humana in which Humana was obligated to establish provider networks through contractual arrangements. Florida Hospital had an "agreement" with Humana to provide health care services for TRICARE beneficiaries. The ALJ thus determined that Florida Hospital performed a portion of Humana's obligations by providing some of the medical services to TRICARE beneficiaries that Humana had contracted to provide. For this reason, the ALJ concluded that Florida Hospital was a covered subcontractor.

> EXAMPLE: CMS, Medicare's contracting agency, contracts with a health plan company to provide a PPO Health Plan that includes a prescription drug plan (Medicare Part D), for Medicare Advantage members. The health plan company then contracts with a pharmaceutical company to provide the necessary prescription drugs. The health plan company also contracts with a hospital to provide the health care services the PPO requires. The pharmaceutical company is a covered subcontractor because it has contracted to fulfill a portion of the prime contract between CMS and the PPO Health Plan company. The hospital is also a covered subcontractor because its contract is to fulfill the prime contract's requirement to provide health care services.

2) *The Provision of Insurance and Reimbursement Agreements*

When the prime contract is for the provision of health insurance, the insurer (insurance carrier) is a covered prime contractor and must comply with OFCCP regulations. Generally, an insurer does not provide direct health care services to the insured. Rather, it provides payment or partial payment to defray the costs of obtaining certain medical supplies and services. In some cases, the insured must pay the health care provider the full cost of services he or she receives and then seek reimbursement from the insurance plan. However, insurers often enter into agreements with health care providers to directly pay, (i.e. "reimburse"), the provider for the cost or a portion of the cost of eligible medical goods or services that it provides to an insured, saving the insured the cost and inconvenience of having to first pay the provider and then seek reimbursement from the insurer. These reimbursement agreements between insurers and health care providers do **not** create a covered subcontractor relationship. Because the prime contract is an insurance contract **solely** for the provision of health insurance to Federal Program members and beneficiaries, the payment of fees directly to health care providers is neither necessary to the performance of the prime contract, nor the fulfillment of an element of the prime contract.

This issue was addressed in the *Bridgeport* case[12] in which the ARB found that the reimbursement agreement between the hospital and the insurance provider, Blue Cross/Blue Shield, was not a Government subcontract. This was because Blue

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[11] See *OFCCP v. Florida Hospital of Orlando*, ALJ Case No. 2009-OFC-00002 (October 18, 2010).
[12] See *OFCCP v. Bridgeport Hospital,* ARB Case No. 00-234, (January 31, 2003).

Cross's prime contract with OPM only provided for health insurance for the health plan members, not for the provision of health care services from providers. On the other hand, if a prime insurance contractor were to subcontract out its obligation (or any part of it) to provide health insurance, then that subcontract would be subject to OFCCP jurisdiction.

It should be noted that in some situations a reimbursement agreement may be combined with a contractual obligation, e.g., to provide medical services. In such circumstances, a covered subcontract is created. Thus, if one of the contract's provisions creates a covered subcontract, the mere fact that the contract also contains a reimbursement agreement does not defeat the subcontractor relationship.

EXAMPLE: Company D has a prime contract with OPM to establish and manage a PPO for one of the FEHBP's health plans. The contract includes ensuring the availability of a network of health care providers to provide specific health care services to the beneficiaries of the health plan. Company D contracts with Medical Practice F to provide some of these medical services. The contract between Company D and Medical Practice F also contains a reimbursement agreement for the medical services that are provided. Medical Practice F is a covered subcontractor because its contract with Company D is necessary to the performance of the prime contract Company D holds with OPM. The inclusion of the reimbursement clause in the contract does not alter or defeat the existence of the covered subcontract relationship.

In sum, a covered subcontractor relationship exists when the contract at issue is necessary to the performance of a covered prime contract, or when the subcontract's purpose is to perform any portion of the prime contractor's obligation. Whether a particular contract is a covered subcontract must be determined on a case-by-case basis, considering all of the contract's provisions and their relation to the prime contract. If it is not clear whether a covered subcontract exists in a particular situation, the Compliance Officer (CO) will contact the Division of Program Operations for guidance.

2. Special Relationships That Are Not Covered Contracts

A. Health Care Entities that Receive Medicare Part A, Medicare Part B, or Medicaid Reimbursements

Medicare Parts A and B are Federal financial assistance programs that provide medical and hospital insurance to Medicare beneficiaries. The Medicare Program receives Federal funding to provide this insurance coverage to eligible beneficiaries. When a health care provider, (e.g., a hospital, physician, or other medical service), enters into an agreement with Medicare to be reimbursed for services covered by Medicare Parts A and B, a covered contract relationship is not formed. Rather, the reimbursed health care provider is considered a recipient of Federal financial assistance.

Medicaid, jointly funded by the Federal Government and the various State governments, is a State-administered health care program. Federal funding is provided to the State-administered health care programs, and the State reimburses health care providers for the services provided to Medicaid beneficiaries. As in the case of Medicare A and B reimbursements, such Medicaid reimbursement arrangements do not create a covered contract.[13]

However, OFCCP may have jurisdiction over a health care provider receiving Medicare reimbursements if the health care provider also holds a separate covered Federal contract or subcontract. Potential covered contracts or subcontracts may include contracts related to Medicare Advantage (Part C) or Part D programs, contracts with another Federal Program, and/or contracts with prime contractors of other Federal Programs.

> EXAMPLE: 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 programs.
>
> However, Company G's contract with Medicare (CMS) to establish a Medicare Advantage PPO creates a covered prime 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.

B. Other Grants and Federal Financial Assistance

Under the Federal health care programs, individuals and health care providers may be eligible for specific grants and/or Federal financial assistance. If a health care provider or other company is **only** a recipient of a grant or Federal financial assistance, contract coverage is not established. For example, a health care

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[13] In *United States v. Baylor University Medical Center*, 564 F. Supp. 1495 (N.D. Tex. 1983) the court concluded that Medicare (Parts A and B) and Medicaid are Federal financial assistance programs. In reaching its conclusion, the court considered the legislative history of the Medicare Program and other civil rights statutes, and that the HHS's regulatory interpretation of the Medicare statute expressly stated that Medicare and Medicaid are Federal financial assistance for purposes of Section 504 of the Rehabilitation Act. The Fifth Circuit in 736 F.2d 1039 (5th Cir. 1984) affirmed the district court's decision in relevant part and the U.S. Supreme Court denied a petition for *certiorari* in 469 U.S. 1189 (1985).

provider may be awarded a grant or other Federal financial assistance exclusively for educational or research purposes, or to provide services to a targeted group, (e.g. rural populations that are underserved because of their distance from health care facilities).

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