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# The Past, Present, and Future of Government Contracting in Healthcare

*James W. Kim\**

## I. THE PAST: THE GROWTH OF GOVERNMENT CONTRACTING IN HEALTHCARE

The largest single purchaser of healthcare in the United States is currently the federal government, although that has not historically been the case. In the past twenty-five years, federal government expenditures on healthcare expanded by leaps and bounds. Medicare spending jumped from \$52.1 billion in 1982 to \$431.2 billion in 2007, an increase of more than 280% in constant dollars.<sup>1</sup> During the same period, federal Medicaid program expenses rose from \$17.5 billion to \$186.1 billion, an increase of more than 394% in constant dollars.<sup>2</sup>

Between 1982 and 2007, total national health expenditures also increased rapidly, growing from \$330.7 billion to \$2.241 trillion, an increase of more than 215% in constant dollars.<sup>3</sup> Total health spending in 2009 in the U.S. has been projected to be over \$2.5 trillion, or 17.6% of GDP.<sup>4</sup> Of that amount, the proportion of federal health expenditures increased from 27.8% of total national health expenditures in 1982 to 33.7% in 2007.<sup>5</sup> Therefore, while the total amount of dollars spent on healthcare has more than doubled in the past quarter century, federal spending has outpaced that growth, becoming a larger and larger proportion of total healthcare expenditures.

A large proportion of federal healthcare dollars in the U.S. are spent on government contracts with private non-governmental entities. In 2002,

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1. [http://www.cms.hhs.gov/nationalhealthexpenddata/03\\_nationalhealthaccountsprojected.asp](http://www.cms.hhs.gov/nationalhealthexpenddata/03_nationalhealthaccountsprojected.asp) (follow "NHE Historical and projections, 1965-2018") (last visited Jan. 5, 2010).

2. *Id.*

3. *Id.*

4. *Id.* (follow "NHE Projections 2008-2018, forecast summary and selected tables").

5. [http://www.cms.hhs.gov/NationalHealthExpendData/02\\_NationalHealthAccountsHistorical.asp](http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp) (follow "NHE Summary including share of GDP, CY 1960-2008") (last visited Jan. 5, 2010).

federal government contract awards for medical services totaled \$6.3 billion, an amount which has grown to \$15.7 billion in 2009, an increase of more than 107% in constant dollars over just a seven year period.<sup>6</sup> In addition, State and local governments were estimated to spend more than \$1 trillion in 2008, which accounted for more than 13% of the nation's gross domestic product.<sup>7</sup> Of this amount, healthcare accounted for approximately one-third of those costs, with a significant portion of that total going to private sector contractors in the healthcare sector.

## II. THE PRESENT: HEALTHCARE GOVERNMENT CONTRACTING REGULATORY ENVIRONMENT

In the United States, government contracts generally are subject to compliance requirements contained in the Federal Acquisition Regulations (FAR). Based on the type of contract, its value and type of services and/or goods contracted, as well as the value of the contract, a government contract may be subject to a variety of regulatory requirements. Generally speaking, the greater the value of services, complexity of services and risk of fraud, abuse and waste, the greater the regulatory requirements for compliance.

Statutory and regulatory provisions in the FAR may mandate a certain method or process an agency must use to solicit a contract, how the agency is to negotiate, conduct discussions with potential awardees and how the agency is to award the resulting contract, in addition to specific accounting requirements for costs, contract management, and subcontracting requirements. However, a government contractor must be aware that it may also be required to comply with socio-economic policy concerns. These can include requirements related to affirmative action program implementation, nondiscriminatory hiring requirements, nondisplacement of service worker requirements, collective bargaining agreement responsibilities, drug-free work place, subcontracting, and minimum employee wage requirements.

In nearly all circumstances, a government contractor in the healthcare sector has substantial additional compliance requirements specifically related to the provision of health-related services that extend beyond the FAR. For example, in addition to federal procurement compliance requirements, contractors for healthcare services may also be subject to complex billing, accreditation, operational and quality/standard of care requirements pursuant to regulations promulgated by the Centers for Medicare and Medicaid Services, the Department of Defense and/or the National Institutes of Health. Ensuring compliance with both federal

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6. <http://www.usaspending.gov/fpds/tables.php?tabtype=t1&subtype=at&rowtype=b> (last visited Jan. 5, 2010).

7. *Id.*

contracting requirements as well as these additional requirements all involve additional compliance costs and liability risks for a healthcare entity.

A similar expansion in federal government contract awards in the healthcare sector in recent decades has resulted in light of the rapid increase in actual and projected healthcare expenditures. As a natural outgrowth of this expansion, opportunities for fraud, waste and abuse in the private sector have also increased. In response to an increasing awareness of fraud, waste, and abuse in the government contracting process, the federal government has enacted legislative and regulatory reforms in recent years that target waste in the healthcare sector, a trend which has continued through the end of 2009.

#### *A. Medicare Contracting Reform—Medicare Administrative Contractors*

Section 911 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) mandated that CMS replace the current fiscal intermediaries and carriers used to administer the Medicare Part A and Part B Fee for Service programs, contained in §§ 1816 & 1842 of the Social Security Act, with a new Medicare Administrative Contactor (MAC) authority utilizing a competitive procurement regulated under the FAR.

Since November 2005, CMS has developed the acquisition process for the Medicare Administrative Contractor authority implementation. CMS plans to award a total of nineteen MAC contracts through three procurement cycles. Following the second procurement cycle awards in January of 2009, unsuccessful bidders filed a series of bid protest actions with the Government Accountability Office, resulting in CMS taking voluntary corrective action on four of the five awards. The fiscal intermediaries and carriers that were providing services prior to the MAC contract awards are continuing to provide services pending resolution of this corrective action.<sup>8</sup>

#### *B. Recent Department of Labor Administrative Review Board Decision*

In addition to increasing regulatory oversight by legislative modifications to the contracting process for the MACs, a recent decision from the Department of Labor imposes new regulatory requirements on healthcare entities that were once considered outside of the scope of government contractor requirements. On May 29, 2009, the U.S. Department of Labor's

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8. [http://www.cms.hhs.gov/MedicareContractingReform/07\\_PartAandPartBMedicareAdministrativeContractor.asp](http://www.cms.hhs.gov/MedicareContractingReform/07_PartAandPartBMedicareAdministrativeContractor.asp) (last visited Jan. 5, 2010).

Administrative Review Board (ARB) held in *Office of Federal Contracts Compliance Programs v. UPMC Braddock* that three University of Pittsburgh Medical Center (UPMC) hospitals that provided medical services to U.S. government employees under a contract between the UPMC Health Plan and a federal agency constituted “federal subcontractors,” distinguishing the ARB’s prior *OFCCP v. Bridgeport Hospital* decision<sup>9</sup>. In *Bridgeport*, the ARB had held that a Connecticut hospital was not a subcontractor within the meaning of Executive Order 11246 because it only held a contract with a local Blue Cross Blue Shield plan that contracted with OPM to provide health insurance to federal employees, not actual medical services.<sup>10</sup> The ARB distinguished *Bridgeport* by observing that the UPMC Health Plan had utilized the three hospitals and other medical professionals as healthcare delivery providers, constituting “ample evidence that the Defendants were operating primarily as health care delivery providers and not strictly as insurance providers,” thus making them federal subcontractors. As federal subcontractors, the ARB held that UPMC must comply with the Office of Federal Contract Compliance Program (OFCCP), including that the requirement that hospitals develop and maintain affirmative action plans in accordance with Executive Order 11246, the Rehabilitation Act, and the Vietnam Era Veterans Readjustment Assistance Act.

Hospitals and other health systems that receive insurance payments for providing medical services to federal employees thus may now be considered covered federal subcontractors for purposes of compliance with OFCCP requirements, even if the hospital does not hold any direct federal contracts to provide the services in question. This distinction requires hospitals and other healthcare providers to carefully examine what services they deliver to federal employees, and, if any medical services are provided, to carefully analyze whether compliance with OFCCP requirements is necessary.

### C. FERA Changes

On May 20, 2009, President Obama signed into law the Fraud Enforcement and Recovery Act of 2009 (FERA). FERA, in part, amends the False Claims Act and expands potential liability for companies that do business with the government, such as government contractors in the healthcare sector. Specifically, FERA reverses the United States Supreme Court’s decision in *Allison Engine Co. v. United States*, 128 S.Ct. 2123

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9. *Office of Federal Contracts Compliance Programs v. UPMC Braddock*, ARB No. 08-048 (2009).

10. *Office of Federal Contracts Compliance Program v. Bridgeport Hospital*, ARB, No. 00-034 (2003).

(2008), eliminating the FCA's "specific intent" requirement that a violator must have the specific intent to violate the FCA. In addition, FERA codifies the "materiality" requirement into the FCA, defining "materiality" as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property and expands the Civil Investigative Demand powers granted to the attorney general. These changes expand the ability of the federal government to enforce FCA violations and deter fraud, waste and abuse in the procurement system.

#### *D. Executive Orders and Proclamations*

President Obama has made it a clear goal to reduce fraud, waste and abuse in government contracting and procurement. On March 4, 2009, President Obama stated in his "Remarks by the President on Procurement" that upwards of \$40 billion in savings could be realized each year by "reforming our broken system of government contracting."<sup>11</sup> The Administration instructed federal agencies to save \$40 billion a year through strengthened contracting practices and management oversight, beginning with a 3.5% reduction for FY 2010 and a further 3.5% reduction in FY 2011. On December 21, 2009, President Obama announced in a press release that federal agencies are on track to save \$19 billion through improvements to their contracting and acquisition practices, in line with the FY 2009 3.5% reduction target.<sup>12</sup>

### III. THE FUTURE: INEVITABLE EXPANSION AND FURTHER REGULATION

It seems clear that regardless of the changes that will occur in the near future with regard to healthcare reform, the general demographic and economic trends dictate that an expansion in the regulatory environment for healthcare government contracting will continue as the need for additional contracting grows. It is highly likely that the federal government's expenditures on healthcare will not be reduced substantially from current levels, although a reduction in growth rate is likely, due to the unsustainability of current growth levels in costs. The inevitability of this growth is made more apparent in the long term by population demographics. Between 1995 and 2008, approximately 550,000 new Medicare beneficiaries were added to the rolls each year; as the baby boomers reach age 65, Medicare enrollment is expected to increase each year by 1.6 million beneficiaries and is projected to reach 79 million

11. [http://www.whitehouse.gov/the\\_press\\_office/Remarks-by-the-President-on-Procurement-3/4/09/](http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-on-Procurement-3/4/09/).

12. <http://www.whitehouse.gov/the-press-office/president-obama-announces-agencies-save-19-billion-contracting-reforms>.

enrollees in 2030, a doubling since 2000.<sup>13</sup>

As a result of the rapidly expanding expenditures in this area and concern over proclamations by the current Administration, legislative changes to the MAC procurement process, as well as the FERA changes and recent decisions of the Department of Labor ARB all seem to indicate a trend towards increased regulation of healthcare government contracts. This growth is expected to continue based on pure demographics and the greater likelihood of expansion of federal involvement in healthcare based on historical trends, leading to increased incentive for fraud, waste, and abuse. In response, it is more likely than not that the federal government will continue to expand regulatory oversight of the procurement process in healthcare, and it is almost certain that the regulatory environment will therefore continue to evolve with this expansion.

Healthcare providers that engage in contracts with the federal government, whether directly or indirectly, will need to continue to closely monitor changes in the federal procurement environment and carefully monitor their own compliance with recent changes in OFCCP and other government contractor requirements. As federal contracting in the healthcare sector continues to expand to nearly every aspect of the industry, and with the growth in healthcare expenditures projected into the next twenty-five years, healthcare insurers, providers, manufactures, and other organizations will need to maintain vigilance regarding the evolving regulatory landscape of government contracting.

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13. Lisa Potetz, *Financing Medicare: An Issue Brief* (Jan. 2008), available at <http://www.kff.org/medicare/upload/7731.pdf>.