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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, AND FINANCE COMMITTEE STAFF RECOMMENDATIONS

COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

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Physicians' Assistants

Present Law

Under present law, part B of Medicare pays for physicians' services. Within the scope of paying for physicians' services, the program pays for services commonly rendered in a physicians' office by para-medical personnel. For example, if a nurse administers an injection in the office, Medicare will recognize a small charge by the physician for that service.

Medicare will not pay where a physician submits a charge for a professional service, performed by a para-medical person, in cases where the service is traditionally performed by a physician. For example, the program would not recognize a charge for a complete physical exam conducted by a nurse.

Additionally, Medicare will not recognize a physicians' charge for a service performed by a para-medical person outside of the physician's office. In other words, he would not be reimbursed for an injection administered by a para-medical employee in a nursing home.

Problem

Over the past few years, a number of programs have been developed to train physicians' assistants. These assistants are seen as a way to extend the physician's productivity and to bring care to many who would otherwise not receive it. HEW is currently supporting the training of these physicians' assistants. There are some 100 experimental training programs for physician assistants and nurse practitioners. Each of these, however, is structured differently, reflecting the lack of agreement among professionals on the experience and education that should be required of training program applicants, the content of the programs, or the responsibilities and supervision that are appropriate for their graduates. These unresolved issues have prompted the American Medical Association, the American Hospital Association, the American Public Health Association, as well as the Department (in its "Report on Licensure and Related Health Personnel Credentialing") and other organizations to ask for a moratorium on State licensure of the new categories of health personnel.

Some feel that it is inconsistent for HEW to support the training of these personnel, while Medicare does not, in some instances, recognize all their services as reimbursable items.

Others argue that Medicare does reimburse physicians for services provided by these new physicians' assistants, so long as they are services commonly provided by para-professional personnel in a physician's office. They go on to argue that, until the training and licensure of physicians' assistants becomes more uniform, it would be inappropriate for Medicare to take the lead in encouraging doctors—by generous reimbursement—to use physicians' assistants to work independently or to expand their responsibilities.

Proposal

The Department and the staff suggest demonstration projects be undertaken to determine the most appropriate and equitable methods of compensating for the services of physicians' assistants. The objectives are development of non-inflationary and less-costly alternatives which do not impede the continuing efforts to expand the supply of qualified physicians' assistants.

The staff would recommend that it be made clear that reimbursement under these demonstration projects would not be made to physicians for services performed by physicians' assistants unless such services are performed independently and unless such assistants are clearly trained and licensed to specifically perform those independent services.

For example, it would seem inappropriate to reimburse a physician his regular fee-for-service rate if the service was performed wholly by the physician's assistant. This would merely serve to vastly increase and inflate medical care costs in large part by increasing physicians' incomes.

It would seem more appropriate to reimburse on a salary-related fee basis where the service was performed wholly by the physician's assistant (such as a home call or visit to a nursing home). Medicare should be given demonstration authority to develop and make such types of reimbursement.

The Role of the Joint Commission on the Accreditation of Hospitals in Certifying Facilities for Participation in Medicare

Present Law

Present law specifies that an institution may be deemed to meet the certification requirements of Medicare if such an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

In addition, under the definition of a hospital, the section states that an institution must meet such requirements as the Secretary finds necessary in the interests of health and safety, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals. Another section of the law does allow an individual State to set higher standards.

The JCAH consists of representatives from the American Medical Association, the American Hospital Association, the American College of Surgeons, and the American College of Physicians. The Joint Commission has been surveying hospitals, which voluntarily request accreditation, for some 20 years. Hospitals which receive accreditation through the Joint Commission are automatically certified (except for utilization review requirements) under Medicare. Two-thirds of the hospitals, including almost all large hospitals, certified to participate in Medicare, received such certification as a result of JCAH accreditation. Of 6,772 hospitals approved to participate in Medicare, about 4,500 were certified on the basis of JCAH accreditation. Some 2,300 additional facilities were certified by the Social Security Administration following surveys performed by State health facility licensure agencies, as meeting statutory requirements and standards established by the Public Health Service.

Problem

Several problems have arisen with respect to the JCAH role in the Medicare certification process. The JCAH survey process is not subject to Federal review, and all JCAH survey reports are confidential, available only to the Commission and the concerned facility. Consequently, the Federal agencies responsible to the Congress for the administration of Medicare, are not in a position to audit the validity of the overall JCAH survey process and are thus unable to determine the extent to which specific deficiencies exist in the vast majority of participating hospitals, since JCAH survey reports are not available to the Social Security Administration. A further problem arises because, under present law, Medicare is barred from setting any standards which are higher than comparable JCAH requirements. This has been interpreted by Social Security to also bar establishment of any standards in an area where JCAH has remained silent. Since the law does not refer to any specific JCAH standard, but rather to any standards prescribed by the JCAH, the law serves as an almost total and blanket delegation of authority over hospital standards to a private agency. Thus, if the Joint Commission chooses to lower a standard, Medicare is obliged to also accept that reduced standard. Though the Federal Government is tied to JCAH standards, a State may promulgate higher standards for facilities within the State.

Proposal

The Department and the staff recommend that the relevant State certification agencies be authorized, as directed by the Secretary, to institute surveys on a selective sample basis (or where substantial allegations of non-compliance with such standards have been made) of JCAH accredited hospitals. This would serve as a mechanism to validate the JCAH survey process. If, in the course of such a survey, an institution were found to have significant deficiencies, the detailed Medicare standards and compliance procedures would be applied in place of the general JCAH standard.

To implement the sample survey authority, the Department and the staff recommends that, as a condition of participation in Medicare and Medicaid, JCAH accredited hospitals would agree to furnish the Secretary and State health agencies on a confidential basis with copies of the JCAH survey report.

The Department and the staff also recommends authorizing the Secretary to promulgate standards, as necessary for health and safety, without regard to JCAH standards.

In addition, the Secretary would be required to include in his Annual Report to the Congress on Medicare an evaluation of the JCAH accreditation process.

Maternal and Child Health

Present Law

Under the 1967 Social Security Amendments to title V $350 million is authorized for fiscal 1972 and each year thereafter for Maternal and Child Health Services.

The 1967 provision also contained an allocation formula which divided the title V authorizations for 1969 through 1972 in the following fashion:

(*a*) 50 percent of any appropriations for formula grants for the States.
(*b*) 40 percent of any appropriations for special project grants. ("Project grants" generally support clinics which provide direct health services.)
(*c*) 10 percent of any appropriations for research and training grants.

However, the 1967 amendments further stipulated that for fiscal year 1973 and each year thereafter, the allocation formula would be changed so that the project grants would terminate and that 90 percent of any appropriations would go to formula grants for the States with the remaining 10 percent going to research and training grants.

Problem

The intent of the 1967 Amendments was to divide available funds between formula grants to the States, and special project grants for a few years, so that the Federal Government could fund innovative special project grants which the States might not be able to support out of their formula funds. The 1967 Amendments terminated special project grants in fiscal year 1973 and converted all the project money to formula grants on the rationale that after a few years' time the States would recognize the value of and continue to support worthwhile project grants as part of an overall State program.

Two problems have occurred in the interim. First the special project has been utilized primarily in urban ghetto areas, while the formula funds are weighted in favor of rural States. Therefore, a shift of funds from urban States with project grants to rural States without project grants would occur if the project grants were terminated. Additionally, many project grant directors feel that with the pressure on State finances, State health departments would be reluctant to use new formula funds to continue support for project grants however worthy such projects might be.

Proposal

The staff recommends that the current allocation formula which divides funds between formula grants and project grants be continued for two additional years. (The Department recommends a one-year extension.) This would avoid the risk of worthy project grants being terminated immediately, and would allow the Congress to reassess the maternal and child health program (the Committee on Ways and Means is presently undertaking such a review), after further study of the broader issues of revenue sharing and in the context of other proposed health insurance legislation.

Increase in Maximum Medicaid Matching for the Virgin Islands

Present Law

Under present law, there is an annual ceiling of $650,000 on Federal matching for the Virgin Islands' Medicaid program.

Problem

There have been substantial increases in the unit costs of hospital and physicians' care over the past several years which are expected to increase. There has also been an increase in Medicaid eligibles.

Proposal

The Department and the staff suggests that the present $650,000 ceiling on Federal matching for Medicaid be increased to $1 million. This would treat the Virgin Islands equally with Puerto Rico, which would have an increase in its ceiling from $20 million to $30 million under another provision in H.R. 1. There would be no change in the 50-percent-matching rate.

Durable Medical Equipment

Present Law

Reimbursement is presently made under part B of Medicare for expenses incurred for the rental or purchase of durable medical equipment used in the patient's home. In the case of the purchase of such equipment payment of 80 percent of the price (after the deductible) is generally made in monthly installments equivalent to amounts that would have been paid had the equipment been rented. Payments continue for as long as the equipment is medically required by the individual's condition. Payment in the case of the purchase of inexpensive equipment (presently defined as equipment for which the reasonable charge is $50 or less) may be made in a lump sum if such method of payment is less costly or more practical than periodic payment. The beneficiary has the option to rent or purchase.

Problem

Where the beneficiary elects to rent, the program is obligated to continue indemnifying him for his rental expenses as long as his medical need for the item persists. A study done by the U.S. General Accounting Office showed that rental payments for durable medical equipment often exceed the purchase price in cases, by as much as 500 percent.

Proposal

The Department and the staff suggest that the Secretary be authorized to experiment with reimbursement approaches designed to eliminate unreasonable expenses to the program which have resulted from prolonged rentals of durable medical equipment. The Secretary would be authorized to implement without further legislation approaches found to be workable, desirable, and economical. The experiment would include a test of the feasibility of an approach under which suppliers would contract with the Secretary and agree to accept conditions such as the following:

1. Medicare payment for a covered item of durable medical equipment would be made to the supplier in a lump sum (as is now the case with inexpensive items) where the carrier determines, in accordance with guidelines of the Secretary, that outright purchase would probably be more economical than lease-purchase.

2. Incentives could be provided for beneficiaries to purchase used equipment (such as wheelchairs) by waiving the 20 percent coinsurance requirement where the purchase price of the used equipment is at least 25 percent less than the reasonable cost of new equipment.

Coverage of Outpatient Speech Therapy

Present Law

At present, speech therapy services are covered under part A of Medicare as "other therapeutic services" when provided by approved hospitals (on both an inpatient and outpatient basis) extended care facilities, or home health agencies. The services may be provided by an employee of the provider or by an outside source (agency, clinic, or independent practitioner) under contract to the provider. Speech therapy services are also covered under Part B as incident to physician services, provided they are furnished under the direct supervision of the physician.

Problem

While speech therapy services are generally useful to aged persons with certain disorders, such services are relatively inaccessible to the aged due to the small percentage of speech therapists who are employed by providers eligible to participate in the Medicare program. Part of the problem is the fact that the provider clinic or agency must be physician-directed.

Proposal

The Department and the staff suggest that Medicare part B coverage include speech therapy services furnished to beneficiaries on an outpatient basis by organized agencies, clinics or other health centers without necessarily requiring as at present, physician direction of such agencies, clinics, or centers. Providers would be required to meet conditions established by the Secretary to assure proper coordination, continuity, and quality of care. Individuals should continue as under present law, to be referred by a physician for services furnished by or under the direct supervision of a qualified speech therapist, under a plan for the individual's total care, established and periodically reviewed by the physician who retains overall responsibility for the individual's care. Reimbursement for services would be made to the agency, clinic, or center on the basis of reasonable cost. Estimated part B cost: Probably less than $10 million annually.

Coverage of Services of Clinical Psychologists Under Medicare

Present law

Coverage of the services of clinical psychologists is presently available on a basis similar to that described for speech therapy; including the requirement that the services of such psychologists must be rendered in a physician-directed setting.

Problem

The requirement that such care be rendered in a physician-directed clinic or organized setting apparently restricts the availability of such services to the elderly as there are many psychological clinics which are not physician-directed.

Proposal

The Department and the staff recommend that the requirement under Part B limiting services to a physician-directed setting be removed retaining however, the other requirements of present law

as well as those additional general requirements described with respect to broadened coverage of speech therapy. Additionally, with respect to psychological treatment, such costs should be included in and limited by the overall $250 annual limitation on outpatient treatment of mental illness.

Estimated cost not available.

Services of Podiatric Residents and Interns Under Part A of Medicare

Present Law

At present physicians' professional services to patients are covered under part B of Medicare. Such services are specifically excluded from coverage under part A, except for the services to hospital inpatients provided by medical, osteopathic, and dental interns and residents under programs approved by the official organization of each of these professions. The services of such interns and residents are reimbursed under part A on a cost basis as part of the inpatient care furnished by the institution.

Problem

When podiatrists were added to the definition of "physician" by the 1967 amendments to the Medicare law, a conforming change to make the services of podiatric interns and residents reimbursable as part of the hospital's services was not included in the legislation. As a result, a hospital having an "approved" podiatry intern and/or residency program must seek reimbursement for the costs of such resident and intern services under part B.

The American Podiatry Association, through its Council on Podiatry Education, officially approves hospital-based residency and intern programs for graduates of colleges of podiatry. The operation of these programs within the hospital is essentially identical to the operations of approved medical, dental, and osteopathic residency and intern programs. Inclusion of such podiatric teaching programs under the definition of inpatient hospital services covered under part A of Medicare would make treatment of all "physician" residency and intern programs consistent.

Proposal

The Department and the staff recommend that section 1861(b) of the Social Security Act, which describes the types of services which are covered as inpatient hospital services (and are reimbursable on a cost basis to the hospital), be expanded to include the services provided in the hospital by an intern or resident-in-training under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association.

Provide Secretary Greater Discretion in Selection of Intermediaries and Assignment of Providers to Them

Present Law

A group or association of providers of services—hospitals, extended care facilities, and home health agencies—have the option of nominating an organization (including the Federal Government) to act as the "fiscal intermediary" between the providers and the Govern-

ment. (No such nomination is available with respect to carriers in part B of Medicare.)

The Secretary is authorized to enter into an agreement with an organization or agency only if he finds that to do so would be consistent with effective and efficient administration of the program. The Secretary may terminate an agreement with an intermediary if he finds that it has failed to carry out the agreement or that continuation of the agreement is inconsistent with efficient administration of the program.

Problem

While it may have been appropriate during the initial stages of Medicare that relationships between providers and intermediaries be given primary consideration this approach does not serve as well today.

It would be helpful to strengthen administrative prerogatives in the assignment of new providers to intermediaries and the reassignment of existing providers. The Secretary should have the primary authority to determine to which intermediary providers may be reassigned when they wish to change intermediaries or where continued availability of a particular intermediary in a given locale is inefficient, ineffective, or otherwise not in the best program interest. That is, the Secretary should consider the wish of the provider, but be able to take a different course of action in the interest of effective program operation.

Proposal

The Department and the staff propose that language be inserted in section 1816 authorizing the Secretary to assign and reassign providers to available intermediaries. He would take into account the wishes of the providers, but would not be bound by their choice. The primary consideration for his action would be the effective and efficient administration of the Medicare program.

Disclosure of Information Concerning Medicare Agents and Providers

Problem

As part of its responsibility for administration of the Medicare program, the Social Security Administration regularly prepares formal evaluations of the performance of contractors—carriers and intermediaries—and State agencies, which assist SSA in program administration. In addition, SSA also prepares program validation review reports, which are intended to be used as management devices for informing intermediaries of findings and recommendations concerning selected providers of services and some of the aspects of their own Medicare operations.

These evaluations and reports are of significant help in reviewing either the overall administrative performance of an individual contractor or a particular aspect of its operation. Additionally, the summary evaluations comparing the performance of one contractor with that of another are very useful. However, these evaluations and reports are not available to the public in general.

The Department and the staff recognize the dichotomy which exists in this situation. On the one hand is the need for public awareness of the deficiencies of contractor performance with the accompanying pressures for improvement in administration that only such awareness can bring. On the other hand, there is the fact that these

evaluations and reports require review of details some of which do not provide a basis for conclusions as to overall performance that the public might make. Should there be public disclosure of this type of information there is a need to provide contractors with sufficient opportunity to respond to the information in the reports before their publication to avoid release of erroneous findings, without rebuttal, which may prove damaging to their reputation as efficient businesses.

Proposal

To meet this problem, the Department and the staff propose that the SSA regularly make public the following types of evaluations and reports: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews; (2) comparative evaluations of the performance of contractors—including comparisons of either overall performance or of any particular contractor operation; (3) program validation survey reports—with the names of individuals or identification of specific facilities deleted, but including sufficient information to identify the State in which the facility is located and the intermediary involved.

The proposal would require public disclosure of future reports, beginning shortly after authorizing legislation took effect. Such reports would include only those which are official in nature and not include internal working documents such as informal memoranda, etc. Under the proposal, public disclosure of evaluations and reports would not be made until the contractor, State agency, or facility was given suitable opportunity—say, 60 or 90 days—for comments as to the accuracy of the findings and conclusions of the evaluation or report with such comments being made part of the report where the portions originally objected to have not been modified in line with the comment.

It is also recommended that in its report on this proposal the Committee make clear that the requirement of disclosure of such evaluations and reports should not lessen the effort of SSA in its present effective and efficient information-gathering activities nor is the provision in any way to be interpreted as otherwise limiting disclosure of information required under the Freedom of Information Act.

Termination of the Medical Assistance Advisory Council

Present Law

At the present time there is a 21-member Advisory Council established for the purpose of advising the Secretary on matters of general policy in the administration of Medicaid. This group was established under the 1967 Social Security Amendments.

Problem

A major problem in the Department of Health, Education, and Welfare—indeed, in all the departments—is the tremendous number of advisory groups. Many of these advisory councils appear to provide a crutch for administrators unwilling to make necessary policy decisions.

It is helpful from time to time to review the necessity for various advisory groups, and determine whether they should continue to function, or whether their responsibilities can safely be assumed by the administrators or by another existing advisory group.

Much of the areas of concern and organizational representation of the Medical Assistance Advisory Council overlap those of the Health Insurance Benefits Advisory Council under Medicare. The principal differences are that the Medical Assistance Advisory Council is concerned with State Medicaid programs which vary in terms of eligibility requirements and covered health services, while Medicare operates with a uniform national program and eligibility. But, the similarities between the two programs are considerably greater and more important than the differences. Both are concerned with hospital, medical and related care (skilled nursing home care in Medicaid and extended care in Medicare), as the major and most costly items of service provided. Patterns of payment and standards of care are related between the programs. A single advisory group would avoid duplicative activity and lend greater focus to and coordination in treatment of common concerns. A subcommittee approach might be the appropriate method of attending to those areas peculiar to Medicaid.

Proposal

The staff suggests that the 21-member Medical Assistance Advisory Council be terminated 3 months following enactment of H.R. 1 and that responsibility for advising the Secretary on matters of general policy affecting Medicaid be lodged with the Health Insurance Benefits Advisory Council.

Modification of the Role of the Health Insurance Benefits Advisory Council

Present Law

The Health Insurance Benefits Advisory Council was established under the 1965 Social Security Amendments to advise the Secretary of Health, Education, and Welfare on matters of general policy in the administration of the Medicare program, including the formulation of regulations. The 1967 Amendments expanded the functions of the Council to include the responsibility for reviewing and reporting to the Congress on the effectiveness of the Medicare program and on possible improvements in the administration of the program and in the law itself.

Problem

The need for and role of the Health Insurance Benefits Advisory Council have substantially changed since the initiation of Medicare. During the formative years of Medicare there was some advantage to having a group such as HIBAC, broadly representative as it was and is of the major health care interests, to review and offer recommendations to the Secretary on the formulation, almost from scratch, of a large body of regulations and program policies. However, much of that work is now completed and there seems little need for permanent authority to deal with the often routine modifications and refinements in Medicare in view of the present status of Medicare and the development of administrative expertise and capabilities. The National Professional Standards Review Council, which would be established under the PSRO amendment previously approved by the Committee, would undertake functions with respect to evaluation of utilization of health care services presently part of HIBAC's charge.

Because of the decreasing need for the Council to focus on major features of the program, there is an increasing tendency for it to become involved in everyday program operation and administration. To a large degree this involvement duplicates the activities of the operational agencies themselves and those of the ad hoc sources of consultation and advice that the Department has developed over the past 5 years. For example, the Department has established formal consultation procedures with Medicare carriers and intermediaries to deal with operational problems related to the claims process.

The present status of Medicare would seem to require different kinds of advice from outside advisors. During the initial years of the program, advisory bodies broadly representative of the major health care and consumer interests were a source of information about the possible reactions of their constitutencies to proposed policies and regulations. Now that the major policy features of the program have been established and additional formal and informal lines of communication with the major interests set up, there is a decreased need for such advice. In addition, the Secretary would now seem to require advice and consultation of a more technical nature than can reasonably be expected from HIBAC. Although the members of the Council are knowledgeable, with some possessing technical expertise, the basis for selecting the members of the Council and their role as representatives of specific interests impedes consideration of difficult technical areas.

A review of the most recent annual reports of the Health Insurance Benefits Advisory Council indicates that the Council as originally envisioned may not provide the most appropriate source of advice to the Secretary at the present time and that the present structure of the Council is an impediment to the fulfillment of its mandate under the 1967 Social Security Amendments to oversee the effectiveness of the Medicare program and offer recommendations for improvements. The second HIBAC annual report did little more than outline the problems facing Medicare; and the most recent annual report essentially included recommendations of provisions already approved by the House as part of H.R. 1.

Proposal

The staff suggests that the statute be amended to provide that the role of the Health Insurance Benefits Advisory Council shall be limited to that of advising the Secretary on matters of general policy in the administration of Medicare and Medicaid. With such a role there would be little need for the Council to meet frequently or employ independent staff or engage independent consulting firms.

Authorize Administration of Oaths and Affirmations Under Title XVIII

Problem

Under present law, the Social Security Administration has the right to take affidavits under oath from beneficiaries, other witnesses, and principals in cases involving possible fraud, but only with respect to instances involving title II benefits. There is no provision in title XVIII which authorizes the administration of oaths and affirmations in cases involving the Medicare program. As a result, Social Security

Administration personnel have been limited in their program integrity operations because they are able to obtain only statements from claimants and other persons involved in potential fraud cases, as opposed to affirmations under oath. Witnesses are less likely to change their testimony at the time of trial if an affidavit is originally taken, since they generally attach more legal significance to such an affidavit as opposed to a statement completed on an administrative form.

Proposal

The Department and the staff suggest that authority be provided the Secretary to administer oaths and affirmations in connection with any hearing, investigation, or other proceeding involving title XVIII.

Access to Subcontractors' Records

Problem

It has come to the Committee's attention that subcontractors under the Medicare program apparently can create subsidiary and related organizations to avoid requirements in Medicare contracts calling for production of any directly pertinent books, documents, papers and records of the subcontractor involving transactions related to the subcontract. Although the Medicare statute does not require production by a subcontractor of his records, the Secretary generally has obtained access under the terms of his prime contracts. There seems to be no valid reason for allowing the avoidance of this disclosure requirement by a subcontractor through the creation of intermediate or unnecessary organizations.

Proposal

To remedy this situation, the Department and the staff suggest inclusion of a requirement under titles XVIII and XIX providing that the Secretary must include in any prime contract a provision that prime contractors which arrange for performance of part of their services by subcontractors, would make available to the government, on a consolidated basis, cost and financial data for subcontractors and organizations related to the subcontractor which perform any part of the services where the aggregate subcontract cost is $25,000 or more.

Similarly, it would be required that subcontracts specify that the subcontractor, and organizations related to the subcontractor, which perform any part of the subcontract would produce pertinent books, documents, papers and records upon request by the Secretary, the Comptroller General, the Inspector General, and, in the case, of the Medicaid program, appropriate State officials.

Failure to comply with these requirements would be grounds for terminating an intermediary's or carrier's (the prime contractor) participation in the Medicare program.

Duration of Subcontracts

Problem

Under present law, Medicare intermediaries and carriers (the prime contractors) are generally contracted for under terms which permit the Secretary to cancel the contract at the end of each year. If he fails to give the necessary notice of cancellation, the contract is automatically renewed for another year.

Instances have come to light where some of these prime contractors have entered into subcontracts which extend beyond the time at which the Secretary could terminate the prime contract. This seems inconsistent with the concept of the annual contract renewal procedure.

Proposal

The Department and the staff suggest that the committee may want to specify in the statute that subcontracts may not be entered into for periods longer than the remaining term of a prime contract unless such subcontracts are subject to the same contract renewal limitations applicable to the prime contract.

Excess Profits Under Medicare Subcontracts

Problem

Under present law, Medicare carriers and intermediaries (the prime contractors) are reimbursed for their "reasonable costs." However, there is no requirement that subcontractors be limited to reimbursement of their costs. Thus, a subcontractor theoretically could make exhorbitant profits under a Medicare subcontract, profits which would not be allowed to a prime contractor.

Proposal

The Department and the staff suggest that subcontractors should continue to be allowed a reasonable profit for their Medicare subcontracts, but that exhorbitant profits should be subject to recapture by the Secretary under a procedure similar to price redeterminations applied under procurement contracts by the Department of Defense. Specifically, this price redetermination would apply in the case of future subcontracts involving aggregate amounts of $100,000 or more, unless the subcontract was let under an effective competitive bidding procedure.

Recovery of Amounts Due Medicare by Terminated Providers

Problem

Many hospitals and extended care facilities which have terminated their agreements to participate in Medicare did so owing the program sizable amounts totaling millions of dollars. At five intermediaries in three States, GAO found that overpayments of about $8.1 million had been made to 384 of the 700 institutions which had left the program since its inception in fiscal year 1967 through April 1970. As of November 1970, 270 hospitals and ECF's still owed the program about $4.6 million. GAO noted that improvements were needed at both the intermediary and Federal level to minimize and recoup overpayments.

About 66 percent of the 136 institutions included in GAO's review that voluntarily withdrew from the Medicare program continued to participate in the State Medicaid programs. Under the State Medicaid programs, which are administered at the Federal level by HEW, the Federal Government pays from 50 to 83 percent of the costs incurred by the States in providing health services to individuals who are unable to pay for such care.

As of November 1970, about 60 percent of those institutions that had remained in Medicaid either had Medicare overpayments outstanding of about $760,000 or had not submitted cost reports to ac-

count for Medicare payments of about $1.3 million. These institutions had received payments under Medicaid that in some cases far exceeded the amounts owed by the institutions to Medicare.

Proposal

GAO, the Department and the staff recommend that the Congress provide the Secretary with authority to withhold (subsequent to 60 days, notice to a State) future Federal participation in State Medicaid payments to those institutions which have withdrawn from Medicare, and which refuse to refund Medicare overpayments or to submit cost reports to account for Medicare payments to them during their participation in that program.

Proposed Committee Report Language Concerning Overlapping Regulation of Clinical Laboratories

Problem

Regulation of clinical laboratories by the Department of Health, Education, and Welfare needs to be coordinated more effectively. At present, the Department regulates and enforces laboratory operations and performance under two different programs—the Medicare program administered by its Social Security Administration component, and the interstate program administered by the Center for Disease Control under the Health Service and Mental Health Administration component of the Department. The two Federal programs issue separate regulations; apply different standards; require duplicate inspections; and are administered by different personnel. As a result, the many laboratories in interstate commerce which participate both in the interstate licensing and Medicare certification programs are confronted with conflicting ground rules and policies, and are subjected to burdensome duplicate inspections and regulation.

This overlapping Federal regulation results in wasteful expenditures of scarce enforcement resources and prevents the development of uniform Federal policies that could serve as the Nation's standard to be followed by the States in developing their own intrastate laboratory programs.

Proposal

The staff suggests that the Committee, in its report, request the Secretary of HEW to initiate such administrative changes in the two programs as might result in (*a*) uniform standards and policies, and (*b*) the placing of responsibility for regulating interstate laboratories in one organizational component of the Department. The Committee could also request the Secretary to report back not later than 6 months after enactment, concerning any changes initiated, and recommendations, if any, as to legislative action which might be required in order to solve this problem.

Optometrists' Services Under Medicaid

Present Law

Under Medicaid, coverage of the services of optometrists is optional with the States.

Problem

In 1969, a Committee amendment authorizing States to reduce care and services under their Medicaid programs was approved by both Senate and House. Optometrists were concerned, however that in a State which eliminated optometric coverage from Medicaid, physicians would still be permitted to render services which an optometrist was also licensed to provide.

Senator Long, as floor manager of the 1969 bill, clarified the situation with respect to optometric services in States which removed them from Medicaid. He remarked that in a State which covered but then eliminated services of optometrists from its program, it was intended that such services would continue to be covered if a State in defining physician's services *specifically* authorized a physician to render services which an optometrist was licensed to provide in that State

Some States have not, according to the optometrists, complied with the legislative intent.

Proposal

The staff suggests that the legislative intent expressed by the Chairman in 1969 be incorporated as an amendment to H.R. 1 to avoid ambiguity.

Christian Science Sanatoriums

Present Law

Under present law, Christian Science sanatoriums participate in Medicaid as skilled nursing homes, if such sanatoriums meet the general requirements for skilled homes under title 19.

Problem

A number of the skilled nursing home requirements relate to medical care—such as the requirement that SNH's have transfer arrangements with hospitals and maintain medical records. The Christian Scientists feel it is inappropriate, such medical requirements to their facilities.

Recommendations

The staff recommends that title 19 be amended (as it was by the committee in 1970) to make it clear that Christian Science sanatoriums are not skilled nursing homes for purposes of certain of the medical requirements.

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