A JOURNAL OF THE APA 50 YEARS

CONFERENCE REPORT: APA CONFERENCE OF EXPERTS ON MEDICARE LEGISLATION FOR PSYCHIATRIC DISORDERS AUGUST 9–10, 1965, WASHINGTON, D.C.

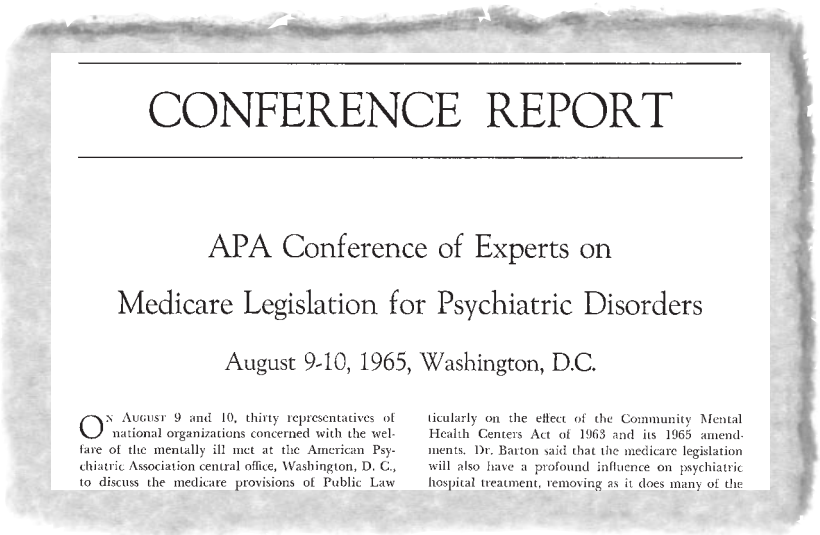
Editor's Note: **The report on an American Psychiatric Association conference on Medicare legislation reprinted below was published in the October 1965 issue of *Mental Hospitals*. The conference was convened to draft recommendations to be used in setting standards for care in psychiatric facilities that wished to participate in the Medicare program. Richard G. Frank, Ph.D., discusses the dramatic impact of the Medicare and Medicaid programs on mental health care in a commentary and analysis beginning on page 465. (*Psychiatric Services* 51:461–464, 2000)**

On August 9 and 10, thirty representatives of national organizations concerned with the welfare of the mentally ill met at the American Psychiatric Association central office, Washington, D.C., to discuss the medicare provisions of Public Law 89-97 (Social Security Amendments of 1965) that pertain to psychiatric care. The conference of experts was called by the APA in order to formulate recommendations to guide the Secretary of Health, Education, and Welfare in establishing standards of psychiatric care that will be required of institutions that wish to participate in medicare programs.

Because the Secretary was to begin drafting these regulations on September 1, only a month after the law had been passed by Congress, the conference was of necessity an emergency session. The participants did not have time to make special advance preparations for it; indeed, several members interrupted vacations or urgent business in order to attend. Rather than representing their organizations' official viewpoints, the participants acted as a committee of individual experts and were represented as such in the conference recommendations transmitted to the Secretary of HEW. The conference report is to be circulated through the official channels of each organization, however, to serve as a possible basis for any official position statement that the organizations might wish to submit later to the Secretary of Health, Education, and Welfare.

Walter E. Barton, M.D., APA medical director, served as chairman of the conference. He noted the impact of recent social legislation upon medical practice and medical institutions, commenting particularly on the effect of the Community Mental Health Centers Act of 1963 and its 1965 amendments. Dr. Barton said that the medicare legislation will also have a profound influence on psychiatric hospital treatment, removing as it does many of the discriminatory restrictions against assistance to the mentally ill that had existed in previous social security provisions.

The history of attempts to enact federal aid to health insurance was traced by Bertram S. Brown, M.D., chief of the Community Mental Health Facilities Branch of the National Institute of Mental Health. Dr. Brown said that there are more than 19 million persons over 65 years of age in the United States. Each year about 60,000 persons in this age group are admitted to public and private mental hospitals; they comprise 20 per cent of all admissions to



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Medicare Legislation for Psychiatric Disorders

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public mental hospitals and 9 per cent to private mental hospitals. In 1963, 150,000 of the 500,000 patients resident in state and county mental hospitals were over 65, as were 5000 of the 13,000 patients in private mental hospitals. The cost of caring for them may be as much as $100 million a year—more than the federal government's annual support of community mental health programs. The number of persons over 65 admitted to the psychiatric services of general hospitals is not known, but is estimated at around 10 per cent of psychiatric admissions, which would be around 41,000 according to 1963 figures. Estimates as to how many new beds will be needed in institutions of all types as a result of medicare range from 15 to 50 per cent of the number presently in use.

Dr. Brown noted that one third of all general hospitals and two thirds of all mental hospitals are not accredited by the Joint Commission on Accreditation of Hospitals. If the law restricted medicare assistance to care given in an accredited hospital, many elderly persons would be unable to receive the care for which they are eligible.

Dr. Brown noted that one third of all general hospitals and two thirds of all mental hospitals are not accredited by the Joint Commission on Accreditation of Hospitals. There are some areas of the country that have no accredited hospitals. If the law restricted medicare assistance to care given in an accredited hospital, many elderly persons would be unable to receive the care for which they are eligible. Also, the burden on accredited hospitals could become unmanageable. However, in lieu of accreditation, the law permits a hospital to be eligible for reimbursement if it "meets such other requirements as the Secretary finds necessary in the interest of health and safety [of patients] except that such other requirements may not be higher than the comparable requirements [for Joint Commission accreditation]." Also, a distinct part of a psychiatric hospital would be eligible if it met the standards prescribed by the Secretary of HEW.

It was noted that there is precedent for accreditation of a unit within an institution. The Joint Commission presently accredits the hospital sections of institutions for the mentally retarded and has accredited the hospital unit of the Jewish Home and Hospital for the Aged in New York City. The group felt, however, that even though such a procedure might be expedient to fill the needs created by medicare, in the long run it may be unwise to single out a particular service of a hospital for accreditation. Those hospitals that are not now accredited might attain a probationary approval for medicare purposes upon evidence of making improvement with intent to meet accreditation standards.

The conference participants agreed, and they endorsed a recommendation so stating, that ultimately all public and private psychiatric institutions should be accredited by the Joint Commission. Until that objective can be reached, however, the interim standards to be applied must be attainable and yet require high quality care, so that existing programs can be upgraded to the point where they are eligible for accreditation.

The question was raised whether the Joint Commission would be able to fulfill the increasing number of requests that will arise for accreditation inspections. Obviously, if all the 2000 general and 330 psychiatric hospitals that are not presently accredited were to request inspection, this would put a tremendous burden on the Joint Commission. It was suggested that the commission might secure a grant to enable it to extend its work and speed up its inspections. It was said that it would even be appropriate to request a grant from trust funds provided in medicare legislation to do this. There will remain, however, the problem of recruiting enough qualified, full-time inspectors, particularly psychiatrists.

Hugh Carmichael, M.D., a Chicago psychiatrist who is one of the seven representatives of the American Medical Association on the Joint Commission, discussed briefly the accreditation procedures. He said that the commission's standards for each component of a hospital are based on those set by the pertinent professional organizations. The inspection guidelines used for psychiatric facilities are the APA standards, as last revised in 1958, and the document, "Emerging Patterns of Administration in Psychiatric Facilities," which was prepared by the APA Committee on Standards and Policies for Hospitals and Clinics and published in June 1964, as Volume 2, Number 9 of *Psychiatric Studies and Projects.* Dr. Carmichael noted that two of the Joint Commission inspectors are psychiatrists.

An extensive presentation was made of the scope of intensive care required to meet the physical and mental needs of the elderly. It was recommended that programs should include, besides medical and neurological attention, group therapy, milieu therapy, recreation, rehabilitation, and other services that will help prevent deterioration and restore the patient to his optimum level of functioning. In addition to full-time hospital care, there should be provisions for day care, extramural care, and home care. Thus, in planning, it might be useful to think not in terms of beds needed but in terms of program units needed.

It was stressed that there should be a medical department in every psychiatric hospital that has a geriatric pro-

gram, just as there should be a psychiatric department, or at least a psychiatric consultant, in every general hospital that has a geriatric service. Also mentioned was the need to upgrade general hospital psychiatric services so that they can offer elderly patients comprehensive care of the scope and quality that many public and private psychiatric hospitals offer. These services must have not only qualified psychiatrists and well-trained nurses but also representatives of the other mental health professions. It was pointed out that many general hospitals do not now provide such services as psychiatric social work, psychology, occupational therapy, and rehabilitation.

The conference participants agreed that where such professional personnel were not available, the hospitals should seek qualified consultants in these fields and develop training programs to give their personnel the needed competence to care for geriatric patients. Participants also agreed that consultants should be utilized by psychiatric hospitals, to reinforce the quality and strength of their department staffs. This was thought to be particularly important in cases where members of the full-time staff do not meet prescribed standards of education or certification.

In discussing what standards should be prescribed for staff members, Dr. Barton asked the organizations represented at the conference to send him copies of the standards they set for the members of their respective professions. In general, it was felt that the psychiatrist should be certified by the American Board of Psychiatry and Neurology; the supervising nurse should be an R.N. with a master's degree; the psychology service should be headed by a clinical psychologist with a Ph.D.; the social work department should be headed by a qualified social worker with an M.S.W.; and the occupational therapy department should be headed by a registered occupational therapist. The program might also include other qualified personnel, including an internist, a podiatrist, a registered physical therapist, a dietitian, a chaplain, and a director of volunteers.

It was emphasized that when psychiatric hospitals could not secure such qualified staff, they, like general hospitals, should utilize consultation services and develop continuing education programs to upgrade the staff.

The conferees also considered standards for medical records. The Joint Commission's standards for record keeping were felt to be desirable and adequate. There arose, however, the question of maintaining confidentiality when a patient is transferred from one facility to another or when information about him is transmitted to an insurance carrier. The group felt that records should be kept so as to assure a uniform reporting system to supply essential data that will be required by the utilization review committee and that will be available to all components of a treatment complex in order to ensure adequate and comprehensive care. The form of the data should be appropriate to the required purpose and at the same time should preserve the confidentiality of any sensitive information.

The law requires a utilization review committee for each participating institution, to ensure the quality of care given to medicare recipients. The review committee must ascertain the necessity of the care given and its appropriate quality as well as the most effective utilization of the hospital in the network of the community's medical resources. The committee can be composed of two or more staff physicians, with or without other professional personnel, or a similarly constituted group from outside the hospital that is organized by the local medical society in cooperation with some or all of the hospitals and the facilities for extended care in the locality.

The conferees passed two motions concerning the utilization review committee. One was that the Joint Commission on Accreditation of Hospitals be asked to modify its bylaws to include a utilization review committee as one of the requirements for accreditation. The second motion recommended that members of the utilization review committee be chosen so as to represent both the internal hospital needs and the community needs in order to ensure efficient use of all available resources. It was suggested that, when feasible, members of the mental health professions be included on these committees, as well as representatives of the various community agencies. It was thought particularly advisable to have a psychiatrist on the review committee of any general hospital that has a psychiatric service.

On the national level, two federal advisory agencies—the National Medical Review Committee and the Health Insurance Benefits Advisory Council—were created by the new law to guide the course of medicare programs. The conferees recommended that a psychiatrist be named to each of these agencies. It was suggested that if this recommendation is accepted by the Secretary of HEW, the psychiatric representatives should be named by the American Psychiatric Association and consideration should be given to having representatives of the other mental health professions. This was felt to be important because the psychological and emotional aspects of aging have relevance to all patients over 65.

On the state level, the law says that standards must be established to give evidence that participating institutions provide the required diagnostic services and intensive treatment. Any state agency may be designated to implement the program, although in most states it will probably be the state health department. The relationship between the mental health authority and the administrative agency will be of great importance. Regarding evidence of progress in providing comprehensive psychiatric care, conferees believed that a state could comply by establishing at least one community mental health program each year. They agreed that the new directions suggested by medicare legislation should be incorporated into the states' comprehensive planning efforts.

The conferees considered the questions concerning reimbursement for providing services under medicare. It was felt likely that insurance agencies such as Blue Cross and Blue Shield will be designated as administrative intermediaries to process payments to hospitals and physicians. The law excludes from coverage items or services "for which the individual has no legal obligation to pay" and

"which are paid for directly or indirectly by a governmental entity (other than under this act)"; how these exclusions are interpreted may affect a state institution's eligibility for reimbursement.

The amounts paid for services provided are to be the "reasonable cost of such services." How are reasonable fees to be determined for outpatient treatment and for hospital care? The group advocated the principle that reasonableness of fees should be determined at the local level. Committees to review outpatient fees could be created by local medical societies and/or APA District Branches, where such committees do not already exist. There is some control upon hospital charges through the contract that each participating hospital must make with the Secretary of HEW.

The law stipulates that agencies giving posthospital care are not eligible if they are "primarily for the care and treatment of mental diseases." The conference members felt that this restriction is, however, a defect in the law and that it might seriously impair the movement toward comprehensive mental health care.

The conference participants considered the medicare provisions related to home care and nursing homes. There was agreement that the stipulation that a patient must have at least three days of inpatient care in a hospital for at least three consecutive days before he is transferred to a nursing home will enable patients to receive a thorough medical examination. The quality of care given by nursing homes is subject to the same scrutiny and review by a utilization committee as that given by hospitals. At present, however, there is no single accreditation body for nursing homes; the American Hospital Association and American Nurses' Association, with other organizations, and a joint committee of the American Medical Association and the American Nursing Home Association have been inspecting and rating nursing homes. Both groups are said to accept the principle of having a single accrediting body, the Joint Commission on Accreditation of Hospitals, take over their functions. The conference group endorsed the move to have the Joint Commission serve as the sole accrediting body for all nursing homes as well as for all hospitals.

The law stipulates that agencies giving posthospital care are not eligible if they are "primarily for the care and treatment of mental diseases." This means that specialized agencies would have to broaden their programs to include other geriatric patients. The conference members felt that this restriction is, however, a defect in the law and that it might seriously impair the movement toward comprehensive mental health care.

It was suggested during the conference that the statement of recommendations to the Secretary of HEW should have a preamble recommending a bridge in the regulations to span what is now available in staffing and programs and what should ultimately be developed. The preamble, as suggested, would emphasize that good psychiatric care and good medical care are equally important and often interdependent in care of the aged. It would also indicate the trends being developed toward comprehensive community mental health programs and urge a liberal interpretation of benefits to enable the development of a broader system of extramural care than the law presently recognizes as being essential.

Those present at the conference were Robert C. Love, M.D., American Hospital Association; Lindsay E. Beaton, M.D., Walter W. Wollmann, M.D., and Bernard A. Harrison, M.D., American Medical Association; Hugh T. Carmichael, M.D., AMA representative on the Joint Commission on Accreditation of Hospitals; Helen V. Connors, R.N., American Nurses' Association; June L. Mazer, American Occupational Therapy Association; Arthur Brayfield, Ph.D., executive director, American Psychological Association, and Leonard Pearson, Ph.D., John J. Brownfain, Ph.D., and John J. McMillan, Ph.D., American Psychological Association; Melvin J. Herman, executive secretary, National Association of Private Psychiatric Hospitals; and Major Fernando G. Torgerson, National Association of Social Workers. Bertram S. Brown, M.D., Howard Davis, Ph.D., Glenn E. Morris, M.S., Marie McNabola, M.S.W., Richard Elwell, R.N., Matthew Huxley, Lucy D. Ozarin, M.D., Donald Morrison, M.D., Alan Levenson, Ph.D., and Cecil Wurster of the National Institute of Mental Health were resource persons.

Representing the American Psychiatric Association were Alvin I. Goldfarb, M.D., chairman, APA Committee on Aging; Edward M. Litin, M.D., chairman, APA Committee on Mental Hospitals; Joseph J. Baker, M.D., chairman, APA Committee on Standards and Policies; Harold M. Visotsky, M.D., chairman, APA Committee on Constitution and Bylaws; Robert W. Gibson, M.D., medicare representative; and John M. Cotton, M.D., member, APA Task Force on Prepaid Health Insurance. APA staff members present included Walter E. Barton, M.D., medical director; Bartholomew W. Hogan, M.D., deputy medical director; and Donald W. Hammersley, M.D., chief, professional services. ♦