Lisa Dixon (00:07):

Welcome to our podcast, Psychiatric Services From Pages to Practice. In this podcast, we highlight new research or columns published this month in the Journal Psychiatric Services. I'm Lisa Dixon, editor of Psychiatric Services, and I'm here with podcast editor and my co-host Josh Berezin. Hi, Josh.

Josh Berezin (00:26):

Hi, Lisa.

Lisa Dixon (00:27):

Today, we're going to talk about Medicare, Medicaid and some of the challenges based by people who have coverage from both programs. From the perspective of a clinically informed economist.

Josh Berezin (00:39):

We're very happy to have Dr. Eric Slade, who is a professor at the Johns Hopkins School of Nursing and at the Johns Hopkins School of Public Health here to talk about his and co-author's recent paper Psychiatrist and Non-Psychiatrist Physician Network Breadth and Dual Eligible Special Needs Plans. So, Dr. Slade, thank you so much for joining us.

Eric Slade (00:57):

Great to be here. Thank you.

Josh Berezin (00:59):

So it's perusing some of your prior research. I expected all this mental health services research to come up and that came up, but you've got a huge range of topics that you're collaborating on, so I'm interested in how you got into this particular topic and then also if and how you think it fits in with your broader research program.

Eric Slade (01:23):

Right. So it's probably worth mentioning that I'm a health economist by training and I got into mental health services research after graduate school when I was a faculty member who was part of...

Lisa Dixon (01:41):

Sometimes trainees feel like faculty members and-

Eric Slade (01:44):

Yeah.

Lisa Dixon (01:45):

Sometimes faculty members feel like trainees.

Eric Slade (01:47):

They feel like trainees. But I joined the faculty at Johns Hopkins School of Public Health in the '90s. And at that time there was an NIMH supported training center there focusing on health economics, and that's how I got into mental healthcare research. And then a couple of years ago I started working with a

colleague at the Johns Hopkins School of Public Health, Dan Polsky, who was very interested in Medicare and Medicare Advantage. And we started working together and got onto this topic of psychiatrist networks in Medicare Advantage.

Josh Berezin (02:24):

One of the biggest sins was naming Medicare and Medicaid with two letters that were different in the words. It's like could you design something that would be harder to interpret at a consumer level? So I just want to make sure we're all level setting. This is helpful for me. The listeners are like, "We all know." Sorry. But I think that it's helpful just to make sure we really know what we're talking about before we can get to the real body of your paper. So let's just start off real basic. Would you be able to explain what Medicaid and Medicare are in a couple sentences each?

Eric Slade (02:57):

Sure. So Medicaid is a primarily state run program that's governed by certain rules that the federal government sets from state Medicaid programs. Each program is different in different states, and Medicaid is primarily for people who wouldn't have private insurance because either they have low incomes or because they have certain serious conditions that prevent them from working and put them at risk of needing a lot of healthcare services. Medicare, on the other hand, is a federal program. It's essentially the same in all states and it's offered to people once they turn age 65. In fact, you're automatically enrolled in Medicare once you turn 65.

Lisa Dixon (03:49):

And I can tell you, you start getting mail about it a little bit before you're 65.

Eric Slade (03:53):

Yeah, probably.

Lisa Dixon (03:54):

Just in case you are interested.

Eric Slade (03:56):

That in the ARP, they're right on top of it. But then there's other routes that get people into Medicare before they turn age 65. And that includes particularly people with serious health conditions that make it so they can't work impair their ability to be employed. And so, you can be determined eligible for Medicare before age 65 due to a work disability or if you have certain conditions like cerebral palsy that you acquired in childhood and your parents are your guardians and they have Medicare and they pass away, you also become automatically eligible for Medicare even though you might only be in your 20s or 30s.

Josh Berezin (04:45):

It's so complicated because there's all these other routes into both of the programs. But I've always thought of Medicaid as a social safety net program, and Medicare as insurance for people who can't work either because they're retired at age 65 or for other reasons as they're going through the workforce. Is that a-

Eric Slade (05:06):

Yeah, I think that's a really good way to summarize it. Definitely. And again, the thing to realize about Medicaid is that because each state runs their own programs, some of the requirements for eligibility can vary a lot from state to state. So in some states, if you're pregnant and you meet a certain income threshold to your income is below the maximum income for Medicaid, you can receive pregnancy services, but then once you deliver, you may no longer be eligible for continued healthcare services in Medicaid in your state.

(05:48):

And so, it's this crazy system where there are different paths into the programs and depending on where you live, which state you're in, and depending on your financial status, you can become eligible for Medicaid but then suddenly become ineligible. So there's a lot of dropping in and out of the program over time.

Josh Berezin (06:10):

One of my other take homes is if you're confused, it's because the programs are confusing. There's a lot of problem into that.

Eric Slade (06:18):

Insurance is one of the most complicated aspects of our healthcare system, and Medicare and Medicaid, you pointed out just the similarity, the names, people often get them confused, but Medicare is the federal program and Medicaid is the state program.

Josh Berezin (06:36):

And now, we're going to complicate things further in two ways. The first one is that you could be eligible for both Medicare and Medicaid. So talk about what would be a common circumstance where somebody would be dually eligible for Medicare and Medicaid?

Eric Slade (06:52):

Right. So there's over 12 million people who qualify for both programs simultaneously. An example of someone who would qualify for both would be someone who was employed as a young adult and then say in their 20s or early 30s, they started experiencing psychotic symptoms that eventually got so severe that they lost their job, couldn't find another job or was unable to work.

(07:23):

And at some point that person would qualify for Medicare because of this so-called work disability, and they would be eligible to receive cash income payments from the government under something called the Social Security Disability Income Program or SSDI. That same person, if they also, say, became homeless and lost all their assets, they could also qualify for Medicaid because they have essentially no income and they have no assets. And Medicaid does cover people who fall below a certain threshold of poverty. And at that point, they would be both Medicare and Medicaid eligible.

Josh Berezin (08:09):

So a couple questions on dual eligibility being both eligible for Medicare and Medicaid. You mentioned an example of somebody experiencing psychotic symptoms and having an onset of a mental health issue. Is that a common way to be dual eligible? Is that something that's common for dual eligibles or common for people with serious mental illness?

Eric Slade (08:31):

It's very common for people with serious mental illnesses that are really chronic and severe. I think there's roughly 4 million dual eligible persons or almost one in three who have some type of chronic mental illness, maybe not to the level of a psychotic disorder like schizophrenia or bipolar disorder, but with severe mood disorders or severe anxiety disorders. So that's makes up significant chunk of dual eligibles is the group with severe mental illness.

(09:07):

Another large group are elderly persons with dementias, Alzheimer's and other forms of dementia who do something in me Medicaid called spend down, which means that their healthcare expenses for nursing home care or for round the clock home care are so great that they eventually run through all of their assets, all of their income and all of their assets, and they become essentially wards of their state. And at that point, as I say, they do this thing that the government calls spend down, they spend down to the point where they are eligible for Medicaid. And so, at that point, since they're elderly, they already have Medicare and that they gain Medicaid coverage.

Josh Berezin (09:51):

So let's say I'm dual eligible, I both Medicare and Medicaid, and I go to the doctor. And let's say I go see my psychiatrist every month. So what happens on the backend with in terms of who pays for that care?

Eric Slade (10:06):

A situation where you're both Medicare and Medicaid coverage, Medicare is the so-called primary payer and Medicaid is the secondary payer. So Medicare does cover outpatient psychiatric care and usually pays, I think, 80% of the Medicare approved fee for psychiatric office visits. That amount would be covered by Medicare. Now, that leaves a 20% copay for the patient. So if they didn't have Medicaid, that copayment would come out of their pocket. And so, if it would say, a $400 visit, they might owe, say, $80 out of pocket, but because you're dually insured, Medicaid will pick up those out-of-pocket costs. And so, the $80 that's expected, at least some portion of that would go from Medicaid to the provider to supplement the Medicare payment.

Lisa Dixon (11:08):

And this is something to remember for later on when we actually discussed the paper, right?

Josh Berezin (11:13):

I promise we will get to the paper after one more brief diversion into managed care. So there's managed care in both Medicaid and in Medicare. So how do you make sense of that? Or even better, how would you make sense of that if you were just trying to understand the basics around these programs and how managed care fits in?

Eric Slade (11:36):

Again, managed care companies offer a variety of plans. A very popular type of managed care plan is called a health maintenance organization plan. These health maintenance organization plans that we've all heard of Kaiser Permanente are prepaid or capitated plans where the insurer is also the provider of care services and they manage those services.

(12:00):

So in the case of Kaiser Permanente, they're paid something called a capitation rate, a prepaid amount of money they get at the beginning of the plan year or monthly throughout the plan year. And they're then responsible, Kaiser is responsible for providing all the services and benefits that the enrollee is eligible for under their insurance plan. If it's a Medicare plan, the Kaiser Permanente would have to cover all of the Medicare benefits, their providers or those that they contract with within their network are the ones providing those services.

(12:39):

You can contrast that with a more traditional type of indemnity insurance plan or what we call a fee for service insurance plan. You might think of traditional Blue Cross Blue Shield preferred provider organization plans In those plans, you can pretty much see any provider you want to see. You don't have to see the HMO's providers. You choose your own provider, but then the insurance will reimburse the provider a standard rate depending upon who you saw and whether they're part of a preferred provider network, but you have more choice.

(13:17):

And managed care grew up in the 1980s and '90s at a time when our healthcare system was much more oriented towards delivering care in hospitals and had a smaller outpatient sector. And so, there was a lot of concern in the '70s and '80s about overuse of hospital-based services of inpatient services and that a lot of things could be done without a hospital stay. And so, one of the reasons that managed care became so popular in the '90s was that because the managed care company, the HMO is in a position to pre-authorize or pre-approve all hospital stays, they were able to shift a lot of unnecessary hospital stays into outpatient settings where those services cost less.

(14:09):

And so, managed care really grew on the promise that they could deliver care more efficiently and less expensively, and that they also would offer more preventive care and higher value because they are the ones who are financially responsible for paying for their beneficiaries costs in this capitation arrangement because the plan is the one who incurs the costs that exceed the capitation amount, the plan is incentivized then to ensure that their beneficiaries get preventive services like general healthcare services, primary care services, medications they need.

(14:53):

So you see in a lot of managed care HMO plans that there are very few copays for services, for preventive services. You're often assigned to a usual care provider when you join the plan. And they would for certain prescription medications like say cholesterol lowering medications, and for SSRI antidepressant medications, they probably would have very little or no copays for those medications. But you wouldn't be able to choose any medication you want. You choose the ones that are approved by the managed care organization. That's really different than in a traditional insurance arrangement where you can have any provider or any medication that's prescribed to you. It's just a question of how much the insurance will pay or not.

Lisa Dixon (15:47):

So they're real trade-offs is what I'm hearing you say between the traditional multi-choice and the more limited HMO type of trading?

Eric Slade (15:59):

Right. You're trading less choice in you, joining a managed care plan, an HMO plan in particular, you're going to face more restrictions on your choices of providers and treatments, but you benefit with some

advantages in terms of copays and in terms of value perhaps. There's a couple other things that are important about public managed care plans that serve Medicaid and Medicare. One thing is that all the managed care providers in Medicare and Medicaid are private companies. They may be for profit, many are for-profit companies. Companies like Kaiser Permanente are not for-profit, but United Healthcare is a for-profit company. And those are two of the larger providers of managed care services in the country.

(16:58):

And so, in public programs like Medicare and Medicaid, we care not just about quality, which we obviously care about and value, but in those programs we also care about equity and accessibility regardless of income level or regardless of where you live or who you know. There's some concern that in a private for-profit company that you may skimp on certain services that would disadvantage certain groups within the plan. And that's always been a concern with private providers of Medicaid and Medicare services.

Josh Berezin (17:42):

So is it right to think about Medicare and Medicaid are insurance programs, they're a package package of benefits? And then if you're in a managed Medicaid program or managed care Medicare, then there's another agency company that's managing that benefit through a network of providers in order to drive down costs.

Eric Slade (18:04):

Yeah. And in order to-

Josh Berezin (18:06):

And improve quality.

Eric Slade (18:07):

Offer greater value. Both perhaps for their shareholders and for the public.

Josh Berezin (18:12):

Apologies for getting rid of the [inaudible 00:18:16].

Eric Slade (18:15):

I think that's probably how they would view it.

Josh Berezin (18:17):

Yeah. Now, we're almost there. The managed medicare programs are called Medicare Advantage, correct?

Eric Slade (18:26):

That's correct.

Josh Berezin (18:27):

So when you hear Medicare Advantage, that's just managed Medicare?

Eric Slade (18:31):

I would say private Medicare.

Lisa Dixon (18:34):

I love the way it's called Advantage, right? There's a little play language manipulation there, but...

Josh Berezin (18:42):

We should have a spinoff podcast just about Medicare, Medicaid. But for the purposes of this podcast, people sign up for a Medicare Advantage plan. You can choose, right? Between Medicare and Medicare Advantage, and you can go on Medicare Advantage Plan, which is managed care with the Medicare.

Eric Slade (19:02):

That's right. You may be offered dozens of plans in your area.

Josh Berezin (19:06):

And then within Medicare Advantage, there's a special program called dual eligible special needs population. And that is what you are looking at in this paper. So with all that background, could you explain to us what those are, those dual eligible special needs plan, and then what are you looking at here? What are you trying to find out about them in your study?

Eric Slade (19:28):

Back in 2003, the Centers for Medicare and Medicaid Services who run Medicare and Medicaid created a category of Medicare Advantage plan called special needs plans. And these were to serve those groups within Medicare who had special needs. And there were three types of special needs plans, chronic illness special needs plans or C-SNPs, institutional special needs plans for people living in nursing homes. And those are I-SNPs. And then a third category, dual special needs plans, and those were for this special category of people with dual Medicare and Medicaid insurance coverage.

(20:14):

And so these dual special needs plans only enroll people with dual Medicare and Medicaid coverage, and that's the population they serve. And these D-SNPs plans have grown rapidly over time. They're by far the most common type of special needs plans or SNPs of the three, and they now enroll over 4 million people out of 12 million duals. So one in three duals is in a D-SNP plan.

Josh Berezin (20:45):

That's huge percentage.

Eric Slade (20:46):

Right. They've really grown rapidly over time. And one of the reasons is people have found that dual special needs plans have a higher profit margin because the way the government pays these dual special needs plans ends up giving them extra moneys because they're serving a relatively more complex, more severely ill group that has higher needs and higher costs. But it ends up being that the special needs plans generate a profit of around 6% per person per year, and the regular MA plans are more like four and a half, 5%. And so, there's an incentive to be part of this D-SNP market if you're a managed care company.

Josh Berezin (21:34):

So from the consumer side, what would it be like to be in a D-SNP rather than just having either regular old Medicare Advantage, or does it simplify everything? It's very confusing to have both Medicare and Medicaid, and does it make it simpler, easier or?

Eric Slade (21:55):

Yeah, that was the idea. Originally, with these D-SNPs was they were created for the purpose of being able to coordinate between Medicare and Medicaid. And the idea was because these are managed plans that the managed care company would be in a position to track things and sort out the different discrepancies between the two programs. And we've already talked about how insurance, just even the terms of Medicare and Medicaid are confusing. I think for everybody, insurance and what it pays for and how to go about getting access to care that you need, it's confusing for everyone.

(22:34):

Well, imagine if you have two plans, you have a Medicare plan and a Medicaid plan, you have two different insurance cards, you have two separate login IDs for the different companies. You have different things covered by the different plans. So Medicaid will pay for skilled nursing care and other long-term care that Medicare does not pay for. Medicaid also pays for a lot of home-based healthcare services and other community-based specialized behavioral health services that Medicare doesn't pay for.

[NEW_PARAGRAPH]An example would be a service Lisa knows something about called critical time intervention. Some Medicaid programs do cover services, either critical time intervention or similar transition services when you're transitioning people from hospitals to home that Medicare does not cover. And so, it's unbelievably complicated. And the idea of D-SNPs was that they would coordinate via these benefits, but it actually has turned out we're starting to learn that they haven't been doing that so well in most cases.

(23:50):

And one of the reasons is because the person's Medicaid coverage could be from an entirely different company than the one who covers, who's the Medicare advantage provider for Medicare. So the Medicare Advantage managed care organization may have little or no financial incentive to coordinate with essentially a competing organization that covers a different set of services entirely. I think this is where we get to the current research. And the reason for our paper is that we really don't know a whole lot about these dual special needs plans and the type of quality of services they provide. And it's an active area of investigation to try to figure out are these dual special needs plans, in fact, doing what they were intended to do. That's one of the reasons why we wanted to look at provider networks.

Josh Berezin (24:50):

So that's surprising that we're 20 years in to this and we don't really know what's going on under the hood, right? So getting more into your study, you're talking about provider network. So my understanding is that these D-SNPs are serving dual eligible people, like significant proportion of them have serious mental illness, and that you would expect hope maybe even that the D-SNPs would have a broader network of mental healthcare providers than the regular Medicare Advantage plans. And my understanding of the driving question of your paper, is that true? Do D-SNPs have a wider network for mental health services?

Eric Slade (25:35):

Yes. I mean, that's what I expected going into this because I thought, well, as you point out that there's a disproportionate number of people with serious mental illnesses who have dual insurance coverage. And so, these plans are covering a special population that has a high need for mental health care and substance use services, or also for coordinating mental health and physical health services because people in this group tend to have more than three quarters, have at least one serious medical condition in addition to their serious mental illness.

(26:17):

And so, we thought that for this special population, you would certainly need a broader range and a greater number of behavioral healthcare providers. And we had data on psychiatrists. So unfortunately, our study is limited and that we didn't have any data available on providers other than physicians. So we don't know, for example, about the numbers of psychologists and the numbers of social licensed clinical social workers in these plans, but we do know about physicians. And so, we were able to isolate the networks for psychiatric care separately from these managed care networks for other types of providers, primary care providers and other specialists like neurologists and cardiologists, and so forth.

Josh Berezin (27:07):

So just 10,000 foot overview. What did you do and then what were some of your findings? And did they correspond with what you had had expected to find?

Eric Slade (27:17):

Our address, again, was in comparing different Medicare Advantage provider networks on how inclusive they were of the psychiatrists and the other physicians in their service areas. And so, what we did is we looked at all providers, all psychiatrists and all other types of physicians in each of the areas served by the D-SNPs and by other MA plans. And we compared the percentage of those areas, psychiatrists and other providers, who were within the networks of these D-SNPs and other MA plans.

(27:57):

And again, our main purpose was try to compare with the expectation that the D-SNPs would be more inclusive of a service area's psychiatrists than the MA plans given their membership. Once we were able to create a common measure of that inclusiveness or breadth as we call it in the paper, we could quantitatively compare. And so, we looked at psychiatrist network breadth and non-psychiatrist network breadth for other physicians, and we ended up finding that the psychiatric or psychiatrist networks were smaller on average than the non psychiatrist networks. Overall, there was a difference of 0.303, so 30.3% of psychiatrists were within network in all types of Medicare Advantage plans, and 35.5% of non-psychiatrists.

(28:59):

So there was a difference of about 15 to 20%. The psychiatrist networks were 15 to 20% less inclusive than the non-psychiatrist networks. And then when we compared the D-SNPs to other types of the regular MA plans, we found that essentially the same difference held in both types of plans that the psychiatrist networks were smaller than the non-psychiatrist networks. The D-SNPs were slightly better in terms of breadth. So I'm reading here from the paper that mean psychiatrist network breadth than D-SNPs was 31.9% and mean psychiatrist breadth in other MA plans was 29.9%.

(29:49):

So roughly an 8% or 9% difference with D-SNPs being slightly broader. But even that difference wasn't statistically significant, so we couldn't even conclude that there was a difference.

Josh Berezin (30:02):

So not what you expected or hoped for, right? You had what you were going in looking for was that the D-SNPs would have a larger psychiatrist network than the other types of Medicare Advantage plans because they're serving more people with a mental health issues. But if there is difference, very small, not statistically significant to Medicaid and... Why? Do you have a sense about why this is?

Eric Slade (30:26):

We can speculate about it. We don't have any real data at this point. This is the question that we want to answer. Why wouldn't they? And we think that it has to do with the incentives that these plans face and also with government regulations. So as we talk about in the paper, one aspect of this is the requirements for Medicare Advantage plans in terms of their coverage of psychiatrists. We talk about in the paper how the Centers for Medicare and Medicaid services has this rule that 90% of beneficiaries within a plan should live within a certain number of miles of at least one provider of 27 different specialty types. So psychiatry would be one of those provider types.

(31:19):

And so, when you think about that, in one sense, that's a good requirement in the sense that it means that most people, nearly everybody, would be, I guess you could say within striking distance or within driving distance of a psychiatrist. But then when you think of it more in terms of, "Well, is that a really adequate requirement to ensure that people would have access to psychiatric care?" And it's on its face, it looks like it's way too low, right? If you only have one psychiatrist serving hundreds of thousands of people, that type of requirement isn't going to guarantee access by any means.

Josh Berezin (32:01):

It seemed low to me. And so, I wasn't misreading the rule, especially coming from... I'm living in Brooklyn and I'm thinking, you could have a huge plan here, and to meet that requirement would be not adequate to serve the population. So I'm sure there's not sure, but whether or not there's other things that ensure that you have a wider network than that.

Lisa Dixon (32:26):

Well then you throw in the fact that now with telemedicine and telepsychiatry, how does that affect all this? But I understand that that's-

Eric Slade (32:35):

That's not a part of current requirements for MA plans networks. And so the government does have an oversight role here. On the other hand, one of the concerns that I've been hearing about and reading about is that if you make these network requirements too difficult, you're going to make it impossible for the plan and they won't even offer the plan. So there's a broader concern that we know about that there's an enormous shortage of psychiatrists and other behavioral healthcare providers in a lot of regions within the country. And that shortage also makes it difficult for managed care companies.

(33:15):

And then when you to recruit behavioral healthcare providers into their network, and then you add on top of that, the fact that I think something like 20% to 30% of psychiatrists don't accept any insurance because the insurance pays less than they can charge patients who are paying privately. And many psychiatrists are able to work that way.

Lisa Dixon (33:42):

And I should just say some will say that the insurance payment doesn't even cover their expenses.

Eric Slade (33:47):

Right. And this has been a longstanding problem in insured mental healthcare, I guess, or in mental health insurance. And as a result, we think that the participation in Medicare Advantage provider networks is low among psychiatrists generally. And so, that's part of the problem. And then in the paper, it's also pointed out that a lot of psychiatrists are not volunteering to work with people who have really severe complex mental health and physical health conditions like you find among people with dual eligibility.

(34:28):

And so, there's a certain fraction of providers who want to serve public plans, who are active serving public plans. But most of the research indicates that those providers that are serving Medicare and Medicaid enrollees with serious mental illnesses is a relatively narrow group who provide the most of the care. And so, it's really important that these D-SNPs networks would have a lot of those Medicaid, particularly psychiatric providers within their networks.

(35:04):

But again, there's this in misalignment of incentives in most D-SNPs because the D-SNP is only responsible for providing Medicare services. They're not responsible for providing services that are covered by Medicaid but not by Medicare. And that includes a lot of specialty mental healthcare services that you may have heard of, like assertive community treatment and supported employment, and critical time intervention is another one. And services that often are team based specialized services that are supporting people, people's ability to live in a community residence and not in an institution.

(35:46):

Those types of specialized services are Medicaid covered, but they're not covered by Medicare. And so the Medicare advantage companies, including these D-SNPs, are not inclined to bring those providers into their networks. And this is a enormous problem that extends well beyond mental healthcare. But mental health is one of the areas that affects.

Lisa Dixon (36:06):

I just have to say that it's such a pleasure, Eric, to hear an economist speaking with an understanding and knowledge of the needs in a more complex way than I think is ordinary of the needs of people with a variety of different mental health conditions and severity. So I really appreciate that, and thank you for tackling this space.

Eric Slade (36:31):

Thank you for helping educate me and train me, Lisa. Really appreciate it.

Lisa Dixon (36:35):

Eric and I worked together for many years, so...

Josh Berezin (36:37):

How would you hope that a policymaker would take these results?

Eric Slade (36:43):

Well, hopefully, our results and other results that are coming out on this topic will be somewhat of a wake-up call to the state organizations and advocacy organizations that have an interest and a stake in mental healthcare that they should be paying a lot of attention to these network requirements. One of the things that hasn't happened yet, but that is starting to change, is that nearly all D-SNP plans do not have their own contract with CMS.

(37:22):

The D-SNPs are offered underneath or within an existing Medicare Advantage contract with CMS. And so it's impossible for CMS to set separate requirements in that instance with the D-SNP itself. It can only set requirements for the Medicare Advantage plans in general that it's contracting with. And so, we're starting to move towards a situation where CMS has direct contracts with these D-SNPs and can be more assertive about the types of requirements they might have or might need to have for mental healthcare. It gets very wonky when you get into these details, but they matter for what actually can happen.

Lisa Dixon (38:12):

That's another lesson I wanted to make sure we underline, because these kinds of nuances can make a huge difference for the life of a person with serious mental illness. And so, we have to somehow educate ourselves and get behind, and get involved with this level of policy if we really want to improve the care of people.

Eric Slade (38:36):

That's right. As an economist, we look at these data that we have, but underneath the data are actual people. And if you're in a D-SNP that has a very narrow psychiatric network that is not including a lot of the providers near you, you're going to have to go out of network. And although people who have dual coverage, they don't end up facing higher costs necessarily when that happens. The problem is that when you go out of the network, then your care is no longer really being managed by the managed care company. It's being farmed out and it leads to a lot of fragmentation so that there's no one provider who's coordinating the services that you might need as a beneficiary of the plan.

(39:27):

And what we want is a system that's both comprehensive for these people with very serious conditions and also accessible. And where people with serious mental illness are being engaged to be part of the planning. So what the concern is about D-SNPs is results suggest that everything they should be doing, they might not be doing on behalf of their beneficiaries. And that's really where the concern comes in.

Josh Berezin (39:56):

As we're coming to an end, are there any take homes for a clinician who would be... Somebody's primarily a clinician seeing clients when either reading the paper or thinking about some of these really, like you said in the weeds, policy questions?

Eric Slade (40:15):

Yeah, I think it's important to emphasize that Medicare needs psychiatrists and that every clinician has to make a decision about whether it's worth it for them personally and financially to participate in managed care provider networks. But there's definitely a great need out there among patients and something to consider.

(40:36):

A lot of the problems that we see with D-SNPs have to do with government regulations and the way the program works creates poor economic incentives. And so, a lot of the solutions are more at that regulatory system level rather than at a individual clinician level.

Josh Berezin (40:54):

Well, I do think that one thing that it does do, just even on the clinician level, is it increases some empathy for people who are receiving these. It's incredibly complicated. When you mentioned just having two password log ons, I was like, "I'm out. No way." So we really appreciate you educating the policy end of things, but also our clinic because I think it's important for people to understand what's going on under the hood that's really making the lives difficult for some of the recipients that we work with. I just want to echo Lisa for thanking you for coming on and your clarity of explaining these really thorny and complex issues, so thank you so much.

Eric Slade (41:38):

Well, thank you so much for inviting me, Josh and Lisa. And thank you, Josh, for helping me walk through this podcast. It's been a great pleasure. Thank you.

Lisa Dixon (41:49):

That's it for today. We invite you to visit our website, ps.psychiatryonline.org to read the article we discussed in this episode as well as other great research. We also welcome your feedback. Please email us at psjournal@psych.org. I'm Lisa Dixon.

Josh Berezin (42:06):

I'm Josh Berezin.

Lisa Dixon (42:07):

Thank you for listening. We'll talk to you next time.

Speaker 4 (42:10):

The views and opinions expressed in this podcast are those of the individual speakers only and do not necessarily represent the views of the American Psychiatric Association. The content of this podcast is provided for general information purposes only and does not offer medical or any other type of professional advice. If you're having a medical emergency, please contact your local emergency response number.