



**United States House of Representatives  
Committee on Ways and Means**

Hearing on  
“America’s Mental Health Crisis”

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Testimony of Peggy Johnson, MD

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30 Winter Street  
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## **Introduction**

Chairman Neal, Ranking Member Brady, and members of the Committee:

Thank you for inviting me to participate in today's hearing.

My name is Dr. Peggy Johnson, and for the past seven years, I have served as the Vice President and Chief of Psychiatry for Commonwealth Care Alliance (CCA), which is headquartered in Boston, Massachusetts. Having trained in general adult psychiatry at Harvard Medical School's Cambridge Hospital Psychiatry Residency Program with an emphasis on community and public sector psychiatry, the entirety of my thirty-year career as a psychiatrist has been in clinical settings with a disproportionate percentages of mental health conditions and substance use disorders complicated by significant negative social determinant contributors. I have particularly focused on improving the quality of life and health outcomes for individuals with chronic and persistent mental illness.

### **Commonwealth Care Alliance**

Established in 2003, first as a primary care practice for those with significant disabilities, CCA is a fully integrated not-for-profit health care organization dedicated to improving care for individuals with the most complex needs. At CCA, we provide our members person-centered care across the continuum, including full integration of primary care, behavioral health, long-term care, and social needs as both a payer and provider of services. CCA presently serves more than 42,000 members in two nationally recognized Medicare-Medicaid programs in Massachusetts and has recently begun expanding our service areas into Rhode Island, Michigan, and California, serving an additional 22,000 members. In everything we do, CCA's mission is to improve the health and well-being of individuals by innovating, coordinating, and providing the highest quality, individualized care – including treating those with behavioral and mental illness.

CCA was a founding plan in the 2004 launch of Senior Care Options (SCO), the first dual eligible demonstration in Massachusetts and the fourth dual eligible demonstration in the nation approved by the Centers for Medicare & Medicaid Services (CMS). This product serves those dually eligible for MassHealth (Massachusetts' Medicaid program) and Medicare who are over the age of 65 as a Five-Star Fully Integrated Duals Special Needs Medicare Advantage Plan (FIDE-SNIP).

CCA played an integral role in the development and implementation of Massachusetts' other duals focused health plan - One Care, the first Medicare-Medicaid plan implemented through the Financial Alignment Initiative demonstration in 2013. This is the only such program in the nation dedicated solely to serving dually eligible enrollees ages 21 to 64.

### **CCA's Model of Care**

Before I talk about our unique approach and integrated care, I would like to share key demographics, that demonstrate the complexity of our membership<sup>1</sup>.

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<sup>1</sup> <https://www.commonwealthcarealliance.org/about-us/newsroom-publications/cca-annual-report/>

- 76.1% of our One Care members and 60.3% of our SCO members have a physical and/or behavioral health disability – nearly 70% of whom are diagnosed with a serious persistent mental illness
- 31.9% of our One Care members have a substance-use disorder
- 7.1% of our One Care members have been documented as homeless during their enrollment

CCA's approach to care is both holistic and member-centered, using a tailored and individualized approach keeping three pillars in mind: *assessment, access, and treatment*. Through our care model, we can produce successful outcomes for our members with mental illness and are proud to be considered a leader in the field. It is an evolving and difficult practice and one that CCA has remained fully committed to since our founding.

### **Assessment**

Good care for those with mental illness begins with assessment. Upon joining CCA, all members are assessed by a specially trained nurse for their medical, behavioral, and social needs. This comprehensive assessment informs the establishment of an individualized care plan, also known as a treatment plan and helps us identify those members who are the most complex. An important component of the assessment process includes behavioral health screening which is necessary in the early identification of acute and chronic behavioral health conditions for multiple reasons. First, diagnoses such as depression are a major cause of disability amongst our members (and in the United States as a whole). Secondly, individuals with chronic medical conditions - who also have a chronic mental health diagnosis - have higher rates of morbidity, mortality, and cost. Finally, those individuals considered as having diagnoses of serious and persistent mental illness have a reduction in life expectancy disparity of twenty-five years as compared to the general population.

In-person assessments are conducted with every willing and reachable member within their first 90 days of enrollment and annually thereafter. Many of our members have historically been hard to reach and distrusting of the typical medical environment and its providers. CCA employs a team of engagement specialists who contact members, recognizing that many of them may have experienced harm through institutionalization, discrimination, and other forms of disenfranchisement. While most of these trauma-informed assessments take place in the member's home, we recognize that not all members have a stable housing environment, a barrier to starting a treatment plan. Therefore, we meet the member where they choose, whether it be at a provider's office, a family or friend's home, or a public venue that can afford appropriate privacy. CCA assessments have frequently been conducted in the Dunkin Donuts on Massachusetts Avenue as one (very Boston-specific) example. So, once an assessment is complete and a care plan developed with the member, what's next?

### **Access**

Access to treatment, especially for those with serious and persistent mental illness and/or substance use disorders is an onerous challenge. Unfortunately, stigma and misunderstanding of mental health diagnoses disincentivizes many to accept and look for appropriate care. At CCA, all members receive care tailored to their specific needs and unique circumstances including culturally specific and trauma informed interventions and because we operate as a fully

integrated payer and provider, we understand that mental health can be an important driver to one's morbidity and mortality. An example to illustrate this is a depressed person with a heart attack statistically does worse than someone without depression. Individuals with diabetes, one of the top five chronic medical conditions and a major contributor to others such as heart disease, also have worse morbidity and mortality outcomes. For us to successfully treat the individual, we must look at the whole picture.

In fully understanding the importance of mental health to individuals' total health and in recognizing the need to respond in a robust manner, CCA's behavioral health specialists support members with co-occurring disorders by providing the most appropriate community resources and interventions to meet their needs. Members may access CCA's owned Crisis Stabilization Units which provides an alternative for members who otherwise would require inpatient psychiatric care, which I will expand on later. CCA providers are highly experienced in the provision of care for complex individuals—from medical, mental health, social work, physical therapy, and occupational therapy.

For CCA, access means increasing the availability of providers and prioritizing unmet social and behavioral health needs as part of our approach to treating mental illness. CCA Care Partners and community health workers play a critical role in integrating behavioral health care needs into a holistic care plan, including medical and social determinants of health needs. This important team of dedicated professionals at CCA establish trusting, long-term relationships with members, integrate all care needs across the continuum, engage an interdisciplinary care team, and have close knowledge of diverse community resources. CCA seeks to address those social determinants that often trigger relapses and/or psychiatric decompensations including housing, nutrition, and transportation to name just a few.

## **Treatment**

Part of our approach to mental health treatment is access and ensuring that our services are reliable, available, and truly accessible. Unfortunately, barriers exist in the field of mental health treatment that make achieving that goal difficult at best. Many outpatient behavioral health care providers create barriers, for example, by establishing strict no-show policies or requiring individuals seeking medication management to be actively engaged in therapy, without flexibility for maintenance phases or diagnoses not clinically indicated to be successful with therapy.

We know first-hand the impact of the opioid epidemic which has only been exacerbated by the COVID-19 pandemic. Previously, 60-65,000 people were dying annually from an opioid or related overdose. Now, that number has jumped up to 90-100,000 people<sup>2</sup>. At CCA we are committed in bending that curve of people dying from largely preventable deaths, through safety and evidence-based interventions rooted in harm reduction and compassionate member-focused care. Our approach is to prevent the interruption of medication assisted treatment (MAT) and ultimately the overdose of opioids. As such, CCA is assertive in establishing a responsive network with MAT capacity and fully utilizes our own clinical capacity so that members who lose MAT prescribers can have their needs met without delay. This includes easy access to Naloxone. Every CCA member can access Naloxone by visiting any pharmacy regardless of network status. During the pandemic, we partnered with the State in removing even more

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<sup>2</sup> <https://nida.nih.gov/drug-topics/trends-statistics/overdose-death-rates>

barriers and increasing flexibility for members to get their prescriptions filled to avoid interruption, including partial refills and removal of prior authorization.

Another important treatment tool is the use of individuals with lived experiences as recovery coaches. CCA collaborates with the Commonwealth of Massachusetts and other health plans to further develop and implement the role of recovery coaches and recovery coach navigators. Those in substance use recovery and who can utilize their lived experience are key to holistic integration of services across the continuum; services and supports they provide are non-clinical and nonjudgmental. The most helpful supports include: 1) navigation of substance abuse and mental health systems; 2) support in managing symptoms and/or impulses to use; 3) advocacy; and 4) provision of information regarding other community resources.

As stated above, in addition to opioid and substance use disorder, a large percentage of CCA's population have been diagnosed with a serious and persistent mental illness. Mental health and substance use treatment is often siloed; many clinics focused on mental health do not sufficiently manage substance use disorder and many focused on substance use disorder do not know how to care for people with co-occurring mental health diagnoses. We have expertise in treating co-occurring disorders, along with their complex medical conditions. Increasing access to comprehensive, fully integrated care models like ours would increase the interdisciplinary, wraparound collaboration available to people with co-occurring disorders.

### **Barriers to Successful Treatment**

A significant barrier to treatment is the overall availability of mental health providers. Across the country there continues to be a mental health provider shortage<sup>3</sup>, especially among psychiatrists and those that choose a specialization. Even in Massachusetts, a heavily saturated area of medical and educational institutions that has thousands of providers, there is still not reliable access to these specially trained clinicians.

Exacerbating that lack of access, too many providers opt-out of public programs due to administrative burden and low reimbursement rates. Combined with the overall lack of providers, this negatively impacts our members both in availability but also choice of providers. CCA will contract with any willing provider, but we often find the reimbursement rate to be a barrier in contracting when we can identify a provider in the first place.

### **Emergency Department Boarding**

The established continuum of care for mental health needs improvement, as we continue to heavily rely on inpatient and other institutionalized forms of care. This reliance has led to a nationwide crisis of emergency department boarding, resulting in individuals of all ages spending days and sometimes weeks waiting for an available inpatient psychiatric placement. The lack of investment in alternatives and step-down programs results in delays of discharge and bottlenecks which has been especially difficult during pandemic. Any approach to expanding treatment options cannot be limited to the traditional inpatient or outpatient settings but needs to contemplate creating more levels of care that meet those with mental illness where they are in the most appropriate *and* accessible place.

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<sup>3</sup> <https://www.kff.org/3bfeb38/>

CCA has worked to address this in thinking creatively for our members with SPMI who theoretically could always meet inpatient level of criteria while working within a constrained system. Briefly mentioned before, our Crisis Stabilization Unit is an alternative to an inpatient setting that provides wraparound services in the community with the 24/7 high-intensity level of care that is typically provided in a hospital setting. CCA originally opened two such facilities, but the pandemic impacted operations significantly in 2020. One unit at Carney Hospital in Dorchester had to be returned to inpatient use for COVID-related treatment, and our Marie's Place® CSU in Brighton had to reduce capacity by providing each patient with a private room to mitigate transmission of the virus. Despite these challenges, Marie's Place® remains the only unit of its kind in Massachusetts and amassed 2,088 patient days among 400 members in 2020. Not only is this beneficial for the members but it resulted in 35% savings in average per diem cost for admission versus an average inpatient admission.

### **COVID's Impact on Mental Health**

One cannot address the state of mental health care in the United States today without acknowledging that the COVID pandemic has had a monumental impact on the health of the nation's individuals with mental illness. Don't take my word for it, the numbers speak for themselves. A recent report<sup>4</sup> from the Center for Health Information and Analysis (CHIA), that analyzed utilization and trends in hospital outpatient observation visits in Massachusetts, shows COVID's negative impact in real terms:

- Although the number of observation visits has remained relatively stable over the past four years, visits associated with behavioral health increased by 20.2%.
- Behavioral health primary diagnoses, including depressive disorders and alcohol-related disorders, were among the top 10 reasons for observation among patients between the age of 18 and 64.
- The proportion of observation visits with behavioral health primary diagnoses was over three times greater among visits with an expected primary payer type of Medicaid (13.3%) than the proportion for commercial insurance (4.0%) or Medicare (3.8%).

As in most sectors, COVID laid bare existing gaps in service and inequities in health care. In the beginning of 2020 when individuals isolated in their homes, members who lived alone experienced significant social isolation. At CCA we almost immediately saw an increase in utilization of behavioral health services, including inpatient level of care. Through an "all hands-on deck" approach, we proactively reached out to these members to provide wellness checks and remained in contact with all our members to connect them with resources and expedited mental health appointments. This resulted in a 78% increase of member interactions, totaling nearly 1.5 million individual touches.

At the same time telemedicine came to the forefront for many disciplines across the country due to the need for vulnerable populations to stay isolated at home. Interestingly, before COVID, CCA and others in Massachusetts were not big utilizers of telemedicine. For years, clinicians (including mental health providers) in other parts of the country have primarily used

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<sup>4</sup> <https://www.chiamass.gov/outpatient-observation-database-reporting/>

telemedicine especially in rural areas (including East Texas where I'm from originally) as people do not have as many available providers in proximity. Therefore, telemedicine was used out of necessity instead of an option. That necessity didn't exist in Massachusetts – until Covid.

Now, two years into navigating the pandemic, it has been embraced and viewed as a necessary option to provide access. For CCA there were some members who had previously been unreachable that we were able to meet and discuss their care plan through use of telehealth. These were members who had historically declined to meet with us, so to have telehealth help cross that barrier and for the member to meet with us in the comfort of their own home has been a critical aspect of getting the first pillar – assessment – of our approach to mental health accomplished.

Before COVID, CCA was already using every available method to reach our members – particularly those with mental illness. Now as technology evolves, we can and should evolve our care model as well, to be able to accomplish the three pillars I have discussed – assessment, access, and treatment. In many ways, connectivity to the internet/broadband is the new transportation in terms of access to care. The ability to connect to the internet can be the difference between a successful treatment plan and a visit to the emergency room. Due to financial constraints, there are few ways for people on Medicaid to get this access. Non-emergency transportation is a benefit for all Medicaid beneficiaries across the country. Perhaps Congress should make access to broadband a required benefit as well.

One last mention of COVID that I am proud to present is CCA's own work during the pandemic above and beyond what we do every day for our members. In early 2020, CCA was approached by leadership in Governor Baker's Administration to partner in caring for Massachusetts' COVID-positive, marginally housed, and homeless population. Since April of 2020, CCA has collaborated with state partners and other organizations to develop a statewide program to temporarily house these individuals in hotel sites across the Commonwealth that were transformed into COVID-19 Isolation and Recovery Centers. At the height of the pandemic, we operated as many as six sites from Taunton to Pittsfield where guests were able to safely recover from the virus, while also having access to behavioral health and other services (such as recovery coaches and MAT) before discharge. This program has been responsive to the waxing and waning of infection rates and related variants in closing and opening sites as necessary and we currently operate three such sites still – including one Mr. Chairman just to the north of your district located in Northampton. To date, we have served more than 3,000 individuals and will run the program until there is no longer a need for this type of response to managing vulnerable, high risk COVID positive individuals. Ironically perhaps, it took a positive COVID test for some of these individuals to finally access to the mental health treatment they needed to escape the cycle of addiction and homelessness.

## **Conclusion**

Our accomplishments and unique approach show what can be possible as a fully integrated organization. In integrated programs like CCA, one entity is accountable for ensuring all members receive high-quality, cost-effective care. CCA blends Medicare and Medicaid capitation and services in our integrated to meet the full range of our members' needs. When one entity is responsible for the full continuum of services, it has incentives to provide effective, efficient, and high-quality care, such as avoiding preventable hospitalizations, adverse drug interactions, emergency department visits and more. The term "carve-out" has no place at CCA.

Because we operate in a more fully integrated Medicaid and Medicare system and are fully integrated ourselves, it gives us the flexibility to do this necessary and important work for these often hard to reach and otherwise vulnerable populations. A brief released from the Center for Health Care Strategies states that "...[integrated] care interventions are more effective than usual care for depression, anxiety disorders, and more serious conditions such as bipolar disorder and schizophrenia" and long-term analyses show that \$1 spent on [integrated] care saves \$6.50 in health care costs.<sup>5</sup>

This is what makes CCA unique in addressing mental health, I lead a dedicated team of in-house specialists with access to members' primary care physicians, psychiatrists, and other providers whose mission is to improve the lives of those that too often are left behind today.

CCA proves that successful care for those with mental illness in this country is possible if you remain dedicated to the mission of putting care and patients first.

Thank you again for this opportunity and I look forward to answering any questions you may have.

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<sup>5</sup> [https://www.chcs.org/media/HH\\_IRC\\_Collaborative\\_Care\\_Model\\_\\_052113\\_2.pdf](https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf)