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Kara Carter,
Razili Lewis,
and Tim Ward

Improving healthcare for people with special or supportive-care needs

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Certain individuals have especially complex medical and supportive-care needs. US state governments, private payors, providers, and technology companies are innovating to address them.

Three groups of individuals often have especially complex medical and supportive-care needs: those with behavioral-health (BH) conditions, including substance abuse; those with intellectual or developmental disabilities (I/DDs); and those requiring long-term services and support (LTSS) because of chronic, complicated medical conditions or physical disabilities.

For simplicity's sake, we use the term *special or supportive-care needs* to refer to the combination of services these three groups require. Although the groups constitute less than 20 percent of the US population, they account for more—perhaps far more—than 35 percent of the country's total annual health expenditures (Exhibit 1).

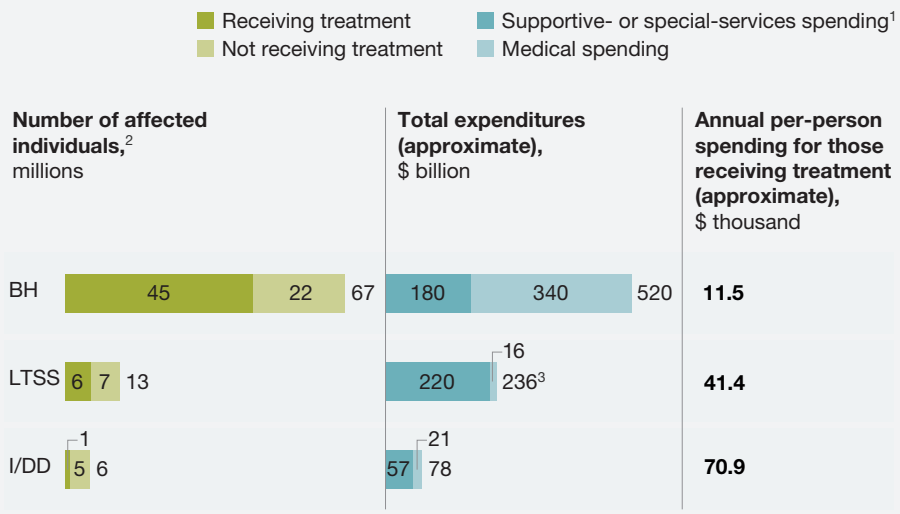
Most individuals in the three groups require a diverse combination of medical and supportive services, usually for prolonged periods. However, the needed care is not always available; even when it is, coordination among service providers is often inadequate. Historically, the care has been delivered by a variety of providers, overseen by a range of public and private entities. Too often, the structural incentives for collaboration among these entities are weak.

As a result, the amount spent on special or supportive-care needs often bears little relationship to the severity of someone's condition or the quality of care delivered. McKinsey research has found, for example, that the correlation between the level of need of individuals with I/DDs and the amount payors spend annually for their care is frequently poor.

Unless better ways are found to coordinate care delivery, spending on the three groups will rise significantly (without any improvement in care delivery), in part because the number of affected individuals is growing. Population aging accounts for some of the growth—estimates suggest that the number of Americans above age 65 will be 60 percent higher in 2030 than in 2010,

Exhibit 1

The cost of care for individuals with special or supportive-care needs is high.



[1]For populations in need of long-term services and support (LTSS) and with intellectual and developmental disabilities (I/DD), category "Supportive or special services" includes all services that help individuals perform activities of daily life, ie, bathing, dressing, and preparing meals. For behavioral-health (BH) population, category includes both services described previously and care required for BH conditions (eg, therapy and rehabilitation).
[2]BH, LTSS, and I/DD populations are not mutally exclusive (eg, I/DD population has significant overlap with LTSS population).
[3]Likely a significant underestimate.

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and that 70 percent or more of those over 65 will eventually need LTSS. However, increased awareness of the underlying conditions and improved diagnostic criteria that make it easier to identify affected individuals are also contributing to the rising prevalence.

In recent years, state governments, private payors, and providers have undertaken a range of innovations to improve care delivery to these groups. Technological advances are supporting many of the innovations.

State governments

States have been at the forefront of innovation because of their involvement with Medicaid. Individuals with special or supportive-care needs constitute roughly one-third of all Medicaid patients but account for almost two-thirds of the program's spending. Not only do states administer the Medicaid program, they also shoulder, on average, about 40 percent of its costs.

States have been changing the Medicaid services they provide to these groups in four primary ways: increasingly shifting the groups and the services they need to managed care, implementing models to integrate care more effectively, adopting new payment methods, and standardizing how the quality of care is measured. However, states vary considerably with respect to which approaches they are using and which populations they are focusing on.

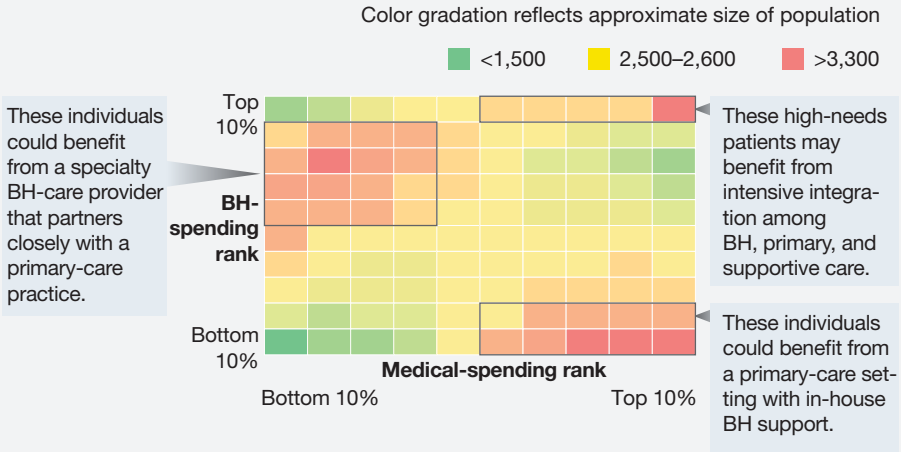
Because most of the innovations states have adopted are comparatively new, they have not yet produced conclusive evidence of impact, but preliminary results are promising. Arizona (in addition to several others), for example, has structured its payment rates to influence the setting of care delivered to individuals in need of LTSS care; through this program, it has increased the percentage of these individuals being cared for at home or in community-based settings to 70 percent, from 5 percent.

States are also increasingly using advanced analytics to tailor programs to specific subsets of patients. For example, many patients have both medical and BH conditions. In some cases, the medical problems are far more severe than the BH conditions; in other cases, the reverse is true. By using advanced analytics to evaluate Medicaid claims data, a state can determine whether a given patient is better treated by a primary-care practice with in-house BH support or by a BH-care provider that partners closely with a primary-care practice (Exhibit 2). Advanced analytics can also be used to identify patients who are not adhering to treatment properly.

Exhibit 2

Advanced analytics makes it possible to tailor treatment to specific patient profiles.

Heat map of behavioral-health (BH) patients, based on their BH and medical-care costs



Source: Blinded claims data analysis from 1 state; McKinsey Behavioral Health Diagnostic

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Payors

To date, private-payor involvement with most individuals with special or supportive-care needs has largely been through Medicaid managed-care programs. The pace at which private payors have been building the required capabilities largely reflects the pace at which states have been introducing managed care for the relevant populations. For this reason, most payors have focused on individuals with BH conditions or those in need of LTSS care. Only recently have states—and hence payors—begun to focus on individuals with I/DDs.

Many payors are gaining capabilities through acquisitions or by subcontracting with specialty vendors, a trend likely to continue. Many payors see the states' managed-care programs for individuals with LTSS needs (especially "dual eligibles"—those covered under both Medicaid and Medicare) as critical strategic areas for investment. Furthermore, the increasing nationwide emphasis on BH care (as indicated by such actions as the introduction of mental-health parity laws) may encourage payors to continue investing in BH capabilities.

Providers

Historically, most of the providers offering services to individuals with special or supportive-care needs were not for profits or small, independently owned businesses. However, the industry has started to consolidate, primarily for three reasons. First, consolidation makes it easier for the providers to invest in the back-office infrastructure necessary to improve operations, decrease costs, and measure and report care quality. Second, the payment innovations states are implementing could compress provider margins if the providers do not respond effectively (for example, by taking steps to improve operational efficiency). Third, the providers must build contracting capabilities if they are to respond to the growing adoption of managed care for individuals in need of BH, LTSS, or I/DD services.

At the same time, some providers are differentiating themselves in other ways. For example, a few LTSS providers are offering smaller, more home-like environments. Some individuals prefer these settings to traditional nursing homes because of the personalized attention they receive, and many of these providers have been shown to deliver better outcomes at lower cost.

Technology companies

At present, more than $5 billion is being invested annually in new healthcare technologies, many of which could improve care delivery to individuals with special or supportive-care needs. New administrative tools are making it possible for smaller providers to automate many aspects of practice management. New remote-monitoring devices are making it easier to deliver services at home and to detect gaps in care. Other technologies with considerable promise include remote medical consultations, decision-support tools, and devices that objectively assess a patient's functional status.

Only time will tell whether the evolution of care delivery for individuals with special or supportive-care needs lives up to its promise. Emerging evidence suggests, however, that there is reason to hope.

Kara Carter is an alumna of McKinsey's San Francisco office, **Razili Lewis** is an associate partner in the New Jersey office, and **Tim Ward** is a senior partner in the Southern California office.

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