Healthcare Systems and Services Practice

The Medicaid Agency of the Future: What capabilities and leadership will it need?

Tim Ward, Andy Allison, and Katherine Linzer

The Medicaid Agency of the Future: What capabilities and leadership will it need?

Medicaid's scale and complexity are unprecedented. State Medicaid leaders will need to innovate if they are to develop the capabilities that will enable them to steer their agencies into the future.

Tim Ward, Andy Allison, and Katherine Linzer

Since its inception in 1965, Medicaid has grown to have an expanded role in state governance—it is usually the first- or second-largest state program. Nationwide, Medicaid agencies manage about $574 billion in annual spending.[1] In an average-sized state, Medicaid directors are the single largest purchaser in the health sector, overseeing about $10 billion each year in payments to providers (roughly 17% of the state's economy).[2] The agencies typically serve nearly one-quarter of their state's population[3] and, in our experience, procure the largest IT infrastructure projects in state government.

Recently, demands on state Medicaid agencies have grown. Increasingly, Medicaid agencies are playing a multi-part role, fulfilling their traditional responsibilities (i.e., payer-purchaser, operator) and taking on new ones (i.e., market shaper and innovator). And while they are doing this, the agencies must address an array of competing priorities, as well as uncertainty about future funding levels. To perform well in these new roles, the agencies must develop new, next-generation capabilities so they can address the needs of their state's citizens—even those not enrolled in Medicaid.

We believe the roles played by state Medicaid agencies will continue to evolve, but the agencies—in conjunction with the state government leaders they work with—can choose their strategic path forward (primarily, the extent to which they want to be market shapers). Those that pursue this path aggressively will be the first of their peers to evolve into a Medicaid Agency of the Future.

As we discuss below, all state Medicaid agencies will need to strengthen their capabilities if they are to meet the demands of the future—an issue that has important implications not only for the agencies themselves but also for state government leaders, managed care organizations (MCOs), local providers, and others. However, agencies focused on becoming market shapers will need to double down on capability building if they want to succeed on their chosen path.[4]

Trends shaping Medicaid

A number of trends are shaping what Medicaid agencies need to do to prioritize the direction of their efforts.

Spending growth is putting pressure on state budgets. Medicaid is putting continued cost pressure on state budgets. Program spending (including federal and state funding) increased from 20.5% of state budgets in 2008 to 29.0% in 2016.[5] The continued increase in Medicaid spending could have funding implications for other state programs, such as elementary and higher education, public assistance, and transportation. The cost pressures resulting from Medicaid spending are expected to continue regardless of what, if any, changes are made at the federal level.

Footnotes for this article appear on pp. 12–13.

Medicaid programs can lead to payment innovation. As program costs have risen, Medicaid directors have increasingly tried to slow the medical cost trend. One lever available to them is transitioning from fee-for-service reimbursement to payment innovations that include meaningful levels of provider risk-sharing. New payment models that reward providers for delivering high-quality care at lower cost have been shown to improve care quality and reduce costs by 5% to 10% when rolled out across the full spending base.[6] In several states, Medicaid programs have led multi-payer efforts to achieve payment innovation across the state.[7]

Medicaid plays an important role as both a payer and a convener. In the aggregate, Medicaid is the country's largest payer in terms of covered lives and, in many states, is the largest purchaser of healthcare services.[8] Thus, Medicaid agencies are uniquely positioned to facilitate change. In addition, the agencies can often bring together multiple stakeholders to help align on improvements that would affect not only Medicaid but also the entire healthcare market.

Recognition of Medicaid members as consumers is increasing. Some Medicaid agencies are beginning to approach Medicaid members as consumers. For example, they are offering members technological tools, such as apps and patient portals, that empower greater decision making (e.g., about choice of provider, care setting, or treatment). If well utilized, these tools can improve member experience and encourage higher-value care.

Awareness of social determinants is rising. Increasingly, states are turning their attention to non-health factors, such as housing, education, and transportation, that influence Medicaid members' ability to maintain their health and adhere to treatment. Some programs are beginning to address these determinants head on (e.g., by providing housing or transportation vouchers).

Experimentation in special needs care is underway. Integrated models typically deliver better quality and cost outcomes. For example, integrated behavioral and physical healthcare approaches for high-needs patients have been shown to reduce emergency department and inpatient visit spending by 10% to 25%.[9] The successes to date are paving the way for further innovation in other special needs areas.

Analytics is playing an increasing role. Advanced analytics and big data can help Medicaid and other public health officials better understand state needs, design programs, and target interventions to maximize the impact of limited funds. The emergence of new national data-sets, such as the Transformed Medicaid Statistical Information System (T-MSIS, which includes states' comprehensive claims and enrollment data) and CMS' online database of state waivers and state plan amendments, may enable states to draw on experiences elsewhere when designing new programs.[10]

In short, state Medicaid agencies are facing an increasingly complex and difficult set of challenges at a time when the expectations of multiple stakeholders—members, families, and advocates; providers and MCOs; the federal government, state leaders, and other state agencies—are rising. If Medicaid agencies are to address these challenges successfully, the role they play must evolve.

Introducing the Medicaid Agency of the Future

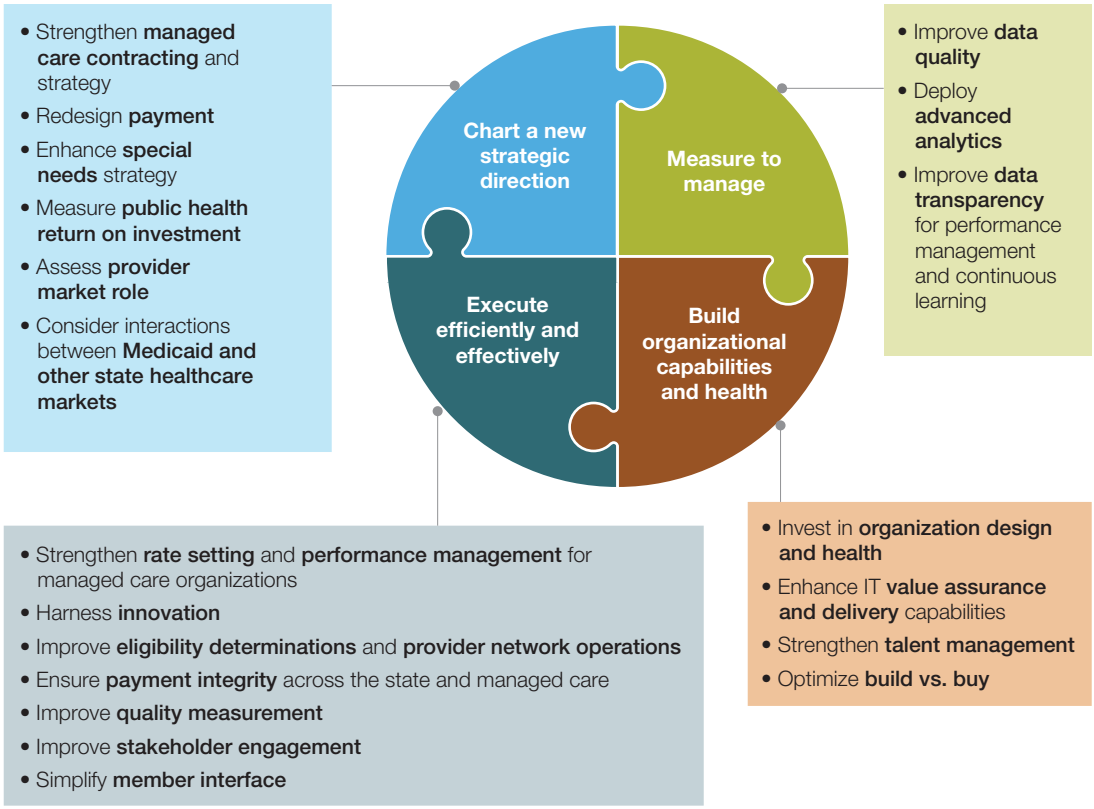
In the future, some state Medicaid agencies may opt to follow the path set by previous state leaders. In other cases, they may want to respond to the trends just discussed by taking the lead in transforming healthcare delivery in their programs and their states. These Agencies of the Future will have to be able to chart a strong strategic direction and execute the activities that follow both efficiently and effectively. To accomplish those goals, they will need to use a data-driven approach to program management, build new capabilities, and improve their organizational health (Exhibit 1).

Agencies that opt to follow a more traditional path would also benefit from strengthening their operational performance and organizational health, but the level of improvement needed is lower for them than for the Agencies of the Future. Both sets of agencies, however, will want to prioritize their strategic investments once they have chosen their path forward.

Chart a strategic direction

Given the complex landscape, many state Medicaid agencies are struggling today to define their strategic priorities. Our experience suggests that the agencies will be better able to develop a coherent approach

EXHIBIT 1 **What must be done to become a Medicaid Agency of the Future?**



to strategy if they consider the six dimensions described below.

Although it may seem counterintuitive, many agencies may find it easier to establish priorities by "thinking bigger" about their scope. For example, they may want to pull in other groups or agencies to achieve common strategic objectives. Strategic collaboration can enable all parties to leverage economies of scale, make use of limited resources and specialized skills, and reduce the time frame between strategy and execution.

Strengthen their approach to managed care. Today, 39 states have transitioned, at least partially, to managed Medicaid, and nearly half of all Medicaid service-related spending is allotted to MCO capitation. As a result, one of the largest strategic levers state Medicaid agencies have at their disposal is transforming their approach to managed care. Some studies suggest that well-run managed care programs (in comparison with a fee-for-service model) can reduce healthcare service costs,[11] which underscores the importance of strengthening managed care program management. Our calculations suggest that each percentage point improvement in MCO cost performance would translate to more than $2.5 billion in efficiencies nationally. Thus, many state Medicaid agencies might be interested in moving away from transactional sourcing approaches when selecting MCOs, instead building toward an advanced collaborative approach in which the agencies and MCOs are true strategic partners (Exhibit 2).

Redesign payment. States are pursuing a range of payment innovations, including one-sided and two-sided risk sharing. State Medicaid agencies need to assess their readiness for these innovations and clarify the role they want to play. For example, do they want to allow MCOs to deploy payment innovations independently—or be more prescriptive about what MCOs can do? Do they want to act on their own or collaborate with other organizations within their state?

Enhance their special needs strategy. Today, nearly two-thirds of a typical Medicaid budget is spent on care for special needs populations,[12] a proportion likely to grow in the future. Many of the organizations that provide services to those populations rely heavily on Medicaid funding. However, comparatively few of these organizations have been involved in the types of payment innovation that are being used increasingly with primary and acute care providers. A more strategic approach to care provision for the special needs populations could enable state Medicaid agencies to achieve better outcomes at the same or lower cost. Exhibit 3 shows some of the decisions the agencies would need to make when developing such a strategy.

Measure public health return on investment (ROI). It is becoming increasingly important for state Medicaid and other healthcare agencies to determine the ROI on the money they are spending and identify opportunities to improve it. Although such calculations are difficult, they can be done. For example, we found that one public health agency had reduced its run-rate costs by 17% after shifting its investments toward primary prevention. Furthermore, estimating expected ROI can help state Medicaid agencies determine which programs to prioritize.

Assess provider market role. Both state government leaders and Medicaid agencies should consider what role the state should play in

providing certain services, especially those for special needs populations.[13] Either or both groups may want to investigate whether care quality might increase, and spending decrease, if some of the facilities providing those services were operated or owned by private organizations.

Consider interactions between Medicaid and other state healthcare markets. States differ significantly in how they view their healthcare markets. Some states would like to include Medicaid with other efforts to improve healthcare access and delivery—for example, by reducing churn between different types of coverage or gaining greater leverage for healthcare purchasing across state agencies. In these states, Medicaid agencies may want to play a leadership role (e.g., through 1332 waivers). Other states, however, may view the Medicaid market as a stand-alone entity and ask their Medicaid agencies to focus on core functions, such as determining eligibility and enrolling members. All states, however, should consider what impact their Medicaid programs are having on other state healthcare markets—and on the participants who may move between these markets.

EXHIBIT 2 **Providing Medicaid managed care: The stages of evolution**

As agencies advance through the evolutionary stages, new capabilities are added to existing ones

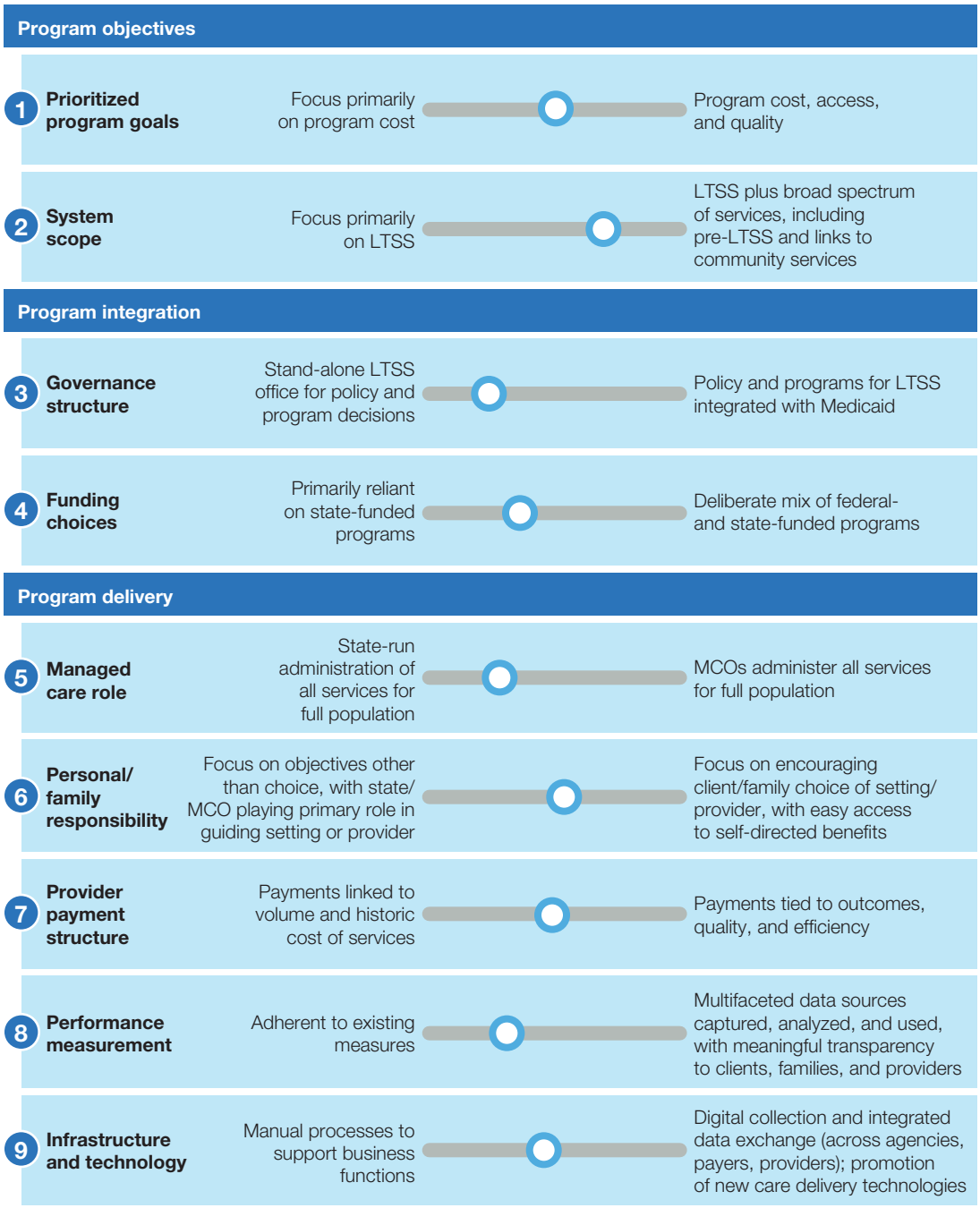
Transactional sourcing: Shifting to managed care	**Strategic sourcing:** Maturing MCO management	**Supplier collaboration:** Advanced MCO management
Description	**Description**	**Description**
• RFPs are scored on a set rubric and awarded to MCOs with most points • Mandatory requirements are met • Ad hoc improvement initiatives are underway • Performance conversations focus on compliance	• Focus on quality, outcomes, and member engagement increases • Integration of care across behavioral and physical health is strengthened • Comprehensive, deliberate sourcing strategy is used • Fact-based, holistic performance conversations are held	• Agency and MCOs are open to joint innovation and collaboration • Both sides partner to improve care coordination and integration • Cost and investment transparency to support shared prioritization is in place • Attention is paid to MCO capability development • Payment is based on quality, value, and outcomes
Characteristics		
• Monitoring focuses on contractual compliance • "Firefighting" on unexpected issues is common • Basic KPIs/performance management processes are in place	• Structured sourcing and contract negotiations are used • Program integrity and performance management are effective • Complex categories are managed • Path to program-wide payment innovation is established	• Performance-based partnerships are in place • Advanced analytics is used to improve quality and efficiency • MCO portfolio is actively managed • Partnerships are used to address non-core Medicaid policy goals

KPIs, key performance indicators; MCO, managed care organization; RFPs, requests for proposals.

EXHIBIT 3 **Elements of a long-term services and supports strategy**

ILLUSTRATIVE STATE EXAMPLE

Options states can consider when focusing their strategy



LTSS, long-term services and supports; MCO, managed care organization.

Execute efficiency and effectively

As complexity increases, strong execution becomes even more important to ensure that state Medicaid agencies meet their goals. To determine where they most need to improve their capabilities, the agencies can create "from–to" maps to assess their ability to undertake the following activities:

Strengthen MCO rate setting and performance management. Among the states that have at least partially transitioned to managed care, more than 20 MCO contracts are up for renewal within the next two years. We have found that a best-in-class approach to rate determination can unlock substantial value, which state Medicaid agencies can then spend on other priorities. The agencies may also benefit by studying some of the best-in-class contracting approaches used in other industries (e.g., the defense industry tightly links rewards and penalties to performance against quality and other contract measures).

To complement these efforts, many agencies would benefit from a comprehensive transparency strategy that includes public reporting of both MCO performance (assessed regularly) and contract-based performance incentives (Exhibit 4).

Harness innovation. Medicaid agencies—especially those that aspire to become next-generation Agencies of the Future—will need to innovate in a number of areas, including payment, benefits, and policies to promote efficiency. The Agencies of the Future will have the policy and execution backbone that will allow them to affect citizens beyond Medicaid enrollees, through efforts across lines of business. In many cases, these agencies will tackle previously intractable problems, such as the social determinants of health and the digitization of citizen services.

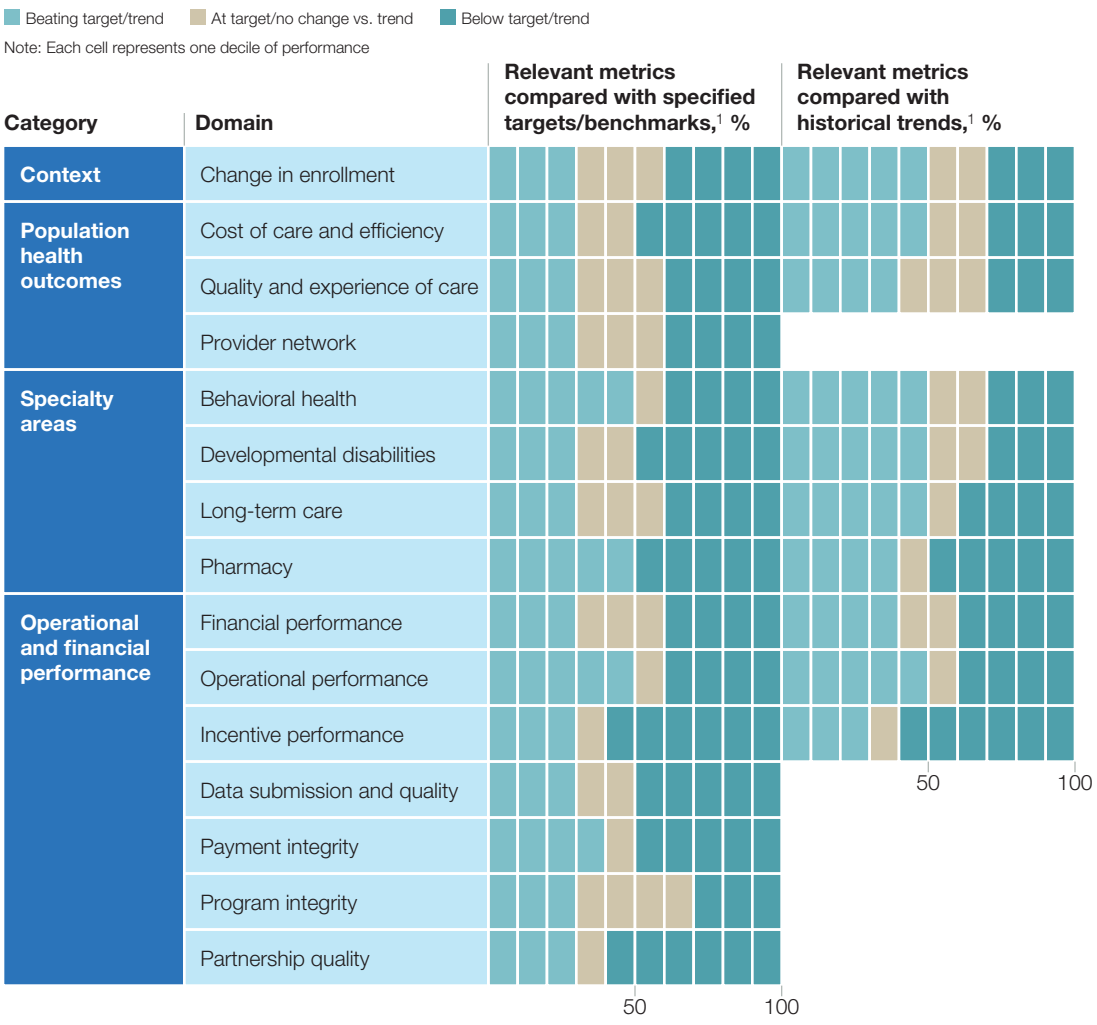
Playing this leadership role will require new aspirations and a new level of supporting capabilities. Many states, including Ohio, Virginia, and Washington, have already created small teams focused on policy and program innovation in Medicaid; often, the efforts extend to integrated healthcare innovation across markets. Other states are likely to follow suit. Experimentation in multiple states makes it possible for all of them to identify and adopt the best innovations. Federally collected datasets, including T-MSIS, are making it possible for state Medicaid agencies to compare their innovations against benchmarks from other states. However, data alone will not be enough; the agencies will need to begin acting today if they want to acquire a next-generation mindset of leadership on behalf of a broad citizenry.

Ensure program integrity across the state and managed care. State Medicaid agencies will also need to strengthen program integrity by putting greater focus on program and payment design, as well as the management of provider and member relationships. Enhancing program integrity can, in our experience, reduce overall program costs by 1% to 2%, and sometimes more. Leading state Medicaid agencies have already established dedicated payment integrity units that prioritize opportunities based on impact, and track prevention and recovery efforts. For the Agencies of the Future, adequately addressing fraud, waste, and abuse will require a number of steps—for example, ensuring senior leadership alignment on a broad aspiration; developing a clear strategy for value capture from MCOs and other vendors; and aligning appropriate resourcing, including people, knowledge, and technology.

Improve quality measurement. Achieving meaningful rather than incremental improvements in care quality and outcomes requires planning and interagency coordination. Given that more than 600 nationally endorsed quality measures are currently available, monitoring can easily become inconsistent. State Medicaid agencies should select a consistent set of about 20 to 40 quality metrics that can be used in all parts of the program, including population health, payment innovation, and managed care initiatives.

EXHIBIT 4 **MCO performance management dashboard**

ILLUSTRATIVE SUMMARY SCORECARD



- This summary scorecard provides an overview of the performance of each domain
- It displays in a glance how many activities are being performed at, above, or below relevant targets

MCO, managed care organization.
[1]Benchmarks, targets, and trends are defined on a metric-by-metric basis.

Improve stakeholder engagement. State Medicaid agencies are increasingly interacting with an expanded array of stakeholders on an interconnected set of issues. In the past, community stakeholder engagement may have focused on getting input and buy-in, but today many agencies are looking to co-create programs with community groups (e.g., to address social determinants of health). The changing nature of these interactions may require the involvement of more senior leaders. For example, establishment of value-based payment models may require the joint efforts of a state's Medicaid director, local hospital CEOs, and MCO executives. However, broad stakeholder engagement can sometimes slow the pace of change. State Medicaid agencies should therefore be purposeful about their approach to stakeholder engagement and partner selection to ensure that they can continue to push innovation forward.

Simplify member interface. Medicaid member interfaces remain an important lever, particularly for states with robust fee-for-service infrastructure. To ensure consistent member engagement, state Medicaid agencies should ensure that members have transparency into their choice of providers, payers, and programs, as well as the touch points needed to support those choices. For example, Colorado's PEAK app enables fee-for-service Medicaid members to apply for benefits, determine eligibility, select facilities, and communicate with providers.[14] In addition, Medicaid agencies can encourage members to select value-based care models and, for instance, make sure they have materials appropriate for diverse cultural and linguistic audiences. Consumer engagement is often vital for supporting other levers, such as quality of care and personal responsibility.

Measure to manage

As a growing amount of data becomes available and states develop increasingly aspirational strategies, state Medicaid agencies will need to develop more effective performance management approaches.

Improve data quality. Data quality will likely be the backbone of all future activities. Thus, Medicaid agencies will have to determine and perhaps strengthen their data capabilities in a number of areas, including:

- Data uniqueness (e.g., ensuring meaningful and comparable population identifiers)
- Internal consistency (e.g., resolving incomplete or overlapping program designations)
- Field validity (e.g., correcting invalid national provider identification codes)
- Data completeness and timeliness (e.g., ensuring linkage between professional and facility claims)
- Data correctness (e.g., ensuring consistent calculation of such measures as emergency department utilization or generic prescription rates)

Deploy advanced analytics. In the future, Medicaid agencies will benefit from the ability to deploy advanced analytic approaches that blend best-in-class analysis with distinctive visualization. Today, many state Medicaid leaders use static data to set policy, but the Agency of the Future will employ dynamic forecasting and use data to introduce real-time care interventions, mirroring innovations already achieved in other industries. (The specific analytic focus would depend on how the data is being used and what each agency's strategic goals are.) Thus, one of the hallmarks of the Agency of the Future will be project-based collaboration between the agency's program leaders, its professional staff, and its analytic team(s).

Improve data transparency. Making data more transparent to providers, consumers, and others can strengthen performance management, enable continuous learning, and achieve other strategic goals. For example, Arizona's Health Plan Report Cards make MCOs' quality performance and customer satisfaction scores available to consumers, enabling more informed consumer choice.[15] Releasing physician performance data publicly can alter physician behavior even in the absence of financial incentives: once New York began publishing providers' mortality and complication rates after cardiac bypass surgery, risk-adjusted mortality declined 41%.[16] Public sharing of performance data also can help to avoid duplication, fraud, waste, and abuse, and to increase accountability for Medicaid agencies.

Build organizational capabilities and health

Organizational health lays the foundation for achieving any organization's aspirations. Building new capabilities will likely require investments—both financial and nonfinancial. While all investments must be made carefully, we have found that leaders who focus on organizational health using a deliberative approach usually deliver more value to their beneficiaries, taxpayers, and other stakeholders than those who do not. Furthermore, our cross-industry studies have shown that organizations that choose to focus on health typically see improvement quickly (on average, an 18% improvement in earnings within one year[17]).

Key activities Medicaid agencies should focus on to achieve these goals include:

Invest in organization design and health. Building and maintaining organizational health is vital for ensuring sustainable change. Agencies should regularly assess their health across the range of dimensions, including the organization's aspirations, leadership, strategy, culture and values, funding, level of innovation, and other dimensions (Exhibit 5).

Good organizational design supports good organizational health. However, different agencies will need different designs, depending on several factors. For example, does the agency want to lead in shaping its state's healthcare market—or play a subordinate role? How has it opted to integrate its special needs efforts with its broader programs? What are its key priorities?

Enhance IT value assurance and delivery capabilities. Not long ago, McKinsey and the University of Oxford collaborated to assess the performance of several thousand IT projects.[18] The study uncovered several common themes that can help managers anticipate potential overruns in a project's total cost and schedule (e.g., IT projects are often unable to recover from early schedule slips or overruns). Medicaid agencies should be cognizant of the widespread challenges to successful IT upgrades and transformation projects so they can prioritize the ones that will be most meaningful and also minimize risk.

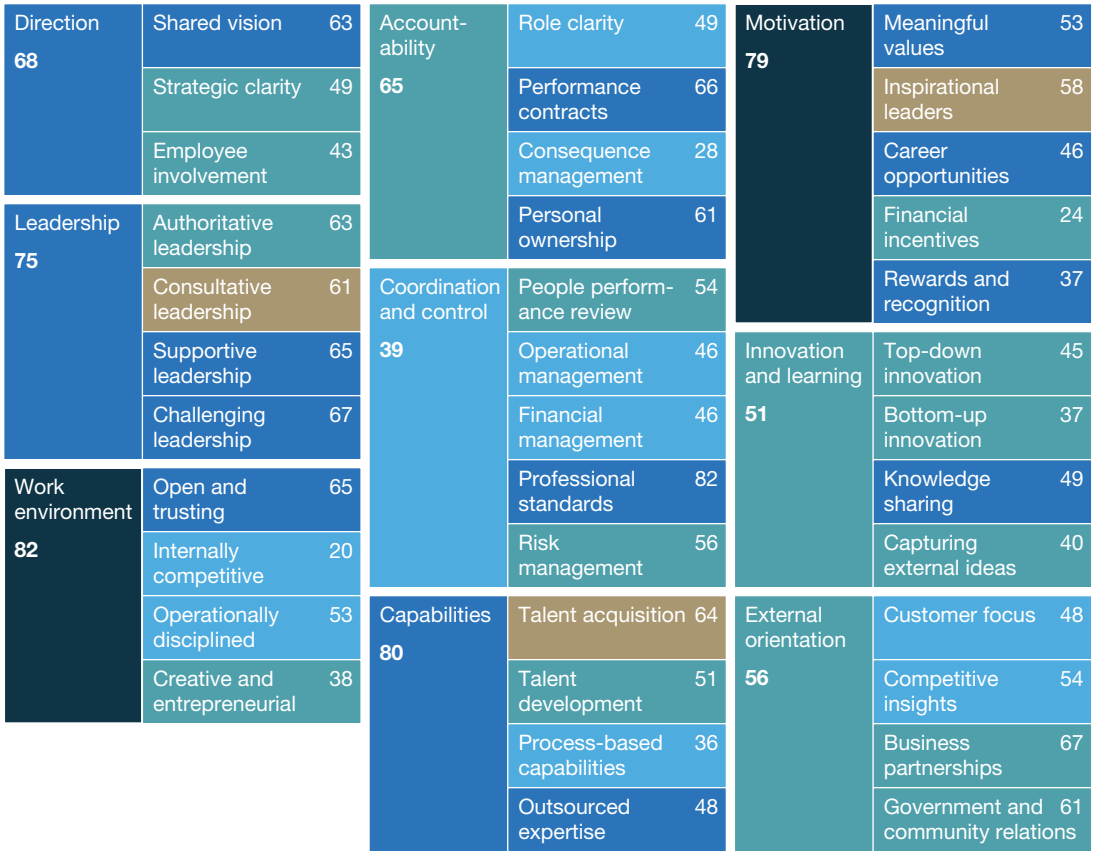
Strengthen talent management. The more ambitious the agenda, the more critical it is that Medicaid agencies look to develop strong, end-to-end talent capabilities—including the ability to attract, develop, deploy, reward, and retain top talent. A growing number of studies suggest that talent constraints at Medicaid agencies can be a barrier to good performance and a reason why some of the agencies underperform comparable organizations.[19,20] A particular problem is that the current average tenure of a Medicaid director is less than two years.[21] Agencies

should therefore consider what they can do to increase the tenure of talented leaders.

Optimize build vs. buy. Increasingly, Medicaid leaders will need to make informed decisions about what to keep in-house and what it could outsource. This decision is particularly critical given that most agencies are making greater use of managed care, implementing value-based purchasing at scale, and/or replacing the business information system platforms they use for eligibility determinations, claims processing, and provider management. In our experience, certain activities—e.g., policy recommendations—must be retained by the agencies; other activities would best be retained in-house.[22] However, other areas (e.g., member interactions) may be more efficiently handled if outsourced or delivered through a hybrid model. Among the factors agencies

EXHIBIT 5 **Example of organizational health results**

Overall results: The results shown here reveal a healthy organization with above-average health and an effective leadership profile



Source: ALPHA (n=127); Benchmark (n=1,583,787; number of surveys=750)

should consider when contemplating outsourcing are strategic priorities, the managed care landscape, existing talent, and the availability of high-quality vendors.

• • •

Medicaid has become the largest-ever experiment in federalism, as well as the largest centrally managed program in most states. Thus, many aspects of the program's nature and scale are unprecedented. As a result, all Medicaid leaders will have to innovate to find the best practices that will allow them to steer their agencies forward. The need to innovate will be felt especially strongly by those who aspire to lead the Medicaid Agencies of the Future.

***Tim Ward** (Tim_Ward@mckinsey.com) is a senior partner in McKinsey's Southern California office. **Andy Allison** (Andy_Allison@mckinsey.com) is a senior expert in the Dallas office. **Katherine Linzer** (Katherine_Linzer@mckinsey.com) is an associate partner in the Chicago office.*

The authors wish to thank Anne Conlin, Brian Latko, Pamela Sedmak, Penny Thompson, and Bryony Winn for their contributions to this article.

FOOTNOTES

[1]Total annual Medicaid spending is currently about $574 billion. Not all of that sum is paid by the states, given the federal government's contribution, but it is managed by the states. (Kaiser Family Foundation State Health Facts. Total Medicaid spending, FY 2016.)

[2]Medicaid spending, including both the state and federal shares, is the overall funding that Medicaid agencies manage in their states. This spending accounts for an average of 29% of state budgets. (National Association of State Budget Officers. *State Expenditure Report*. November 17, 2016.)

[3]Kaiser Family Foundation. Medicaid pocket primer. January 3, 2017.

[4]Our recommendations apply regardless of the model of agency (i.e., one state agency overseeing Medicaid or many). In either case, activities need to be well coordinated and well executed.

[5]Between 2015 and 2016 alone, state spending on Medicaid grew 6.9%, whereas overall state spending rose only 4.0%. (National Association of State Budget Officers. *State Expenditure Report*. November 17, 2016.)

[6]Patient-Centered Primary Care Collaborative. *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012*.

[7]For example, Ohio has led multi-payer efforts for episodes of care, patient-centered medical homes, and behavioral health; the efforts have involved five Medicaid plans and four commercial payors (Ohio Department of Medicaid website on payment innovation). Tennessee has engaged both Medicaid and commercial payors on efforts around long-term services and supports, primary care transformation, and episodes of care (Division of TennCare website on the Tennessee Health Care Innovation Initiative).

[8]Kaiser Family Foundation. State Health Facts: Health insurance coverage of the total population. 2015.

[9]Reiss-Brennan B et al. Association of integrated team-based care with health care quality, utilization, and cost. *JAMA*. 2016;316(8):826-34.

[10]Information on all of the data-sets can be found on the Medicaid.gov web pages for:
–Transformed Medicaid Statistical Information System (T-MSIS).
–Medicaid state plan amendments.
–State waivers list.

[11]Although the evidence supporting managed care use currently comes primarily from non-peer-reviewed studies, the evidence base is continuing to expand. The reports below provide a synthesis of the evidence:
–Sparer M. *Medicaid Managed Care: Costs, Access and Quality of Care*. Robert Wood Johnson Foundation. September 2012.
–Lewin Group. *Medicaid Managed Care Cost Savings—A Synthesis of 24 Studies*. America's Health Insurance Plans. Updated March 2009.
–Duggan M, Hayford T. Has the shift to managed care reduced Medicaid expenditures? Evidence from state and local-level mandates. NBER Working Paper. July 2011.
–The Menges Group. *Projected Savings of Medicaid Capitated Care: National and State-by-State*. October 2015.
See also: Allison A, Lewis R, Ward T, Wynn B. Looking ahead in Medicaid: Options for states and implications for payors and providers. McKinsey white paper. May 2017.

[12]These populations include individuals with behavioral health conditions or intellectual or developmental disabilities, as well as those in need of long-term services and supports.
[13]Some states currently own nursing homes, psychiatric hospitals, and/or facilities for individuals with intellectual or developmental disabilities.
[14]Colorado PEAK website and app.
[15]Arizona Health Care Cost Containment System website. Health plan report card.
[16]Hannan EL et al. New York State's cardiac surgery reporting system: Four years later. *Annals of Thoracic Surgery*. 1994;58(6):1852-7.
[17]Keller S, Price C. *Beyond Performance: How Great Organizations Build Ultimate Competitive Advantage*. 2011. (In this book, earnings were measured as EBITA.)
[18]Bloch M, Blumberg S, Laartz J. Delivering large-scale IT projects on time, on budget, and on value. *Financial Times*. August 21, 2012.
[19]National Association of State Medicaid Directors. *State Medicaid Operations Survey: Second Annual Survey of Medicaid Directors*. February 2014.
[20]Medicaid and CHIP Payment and Access Commission. *Report to Congress on Medicaid and CHIP*. March 2016.
[21]The average tenure fluctuates over time but was reported to be 23 months by the National Association of Medicaid Directors in November 2016.
[22]In the case of infrastructure decisions, for example, internal infrastructure enables agility.

Editor: Ellen Rosen

For media inquiries, contact Julie Lane (Julie_Lane@mckinsey.com)
For non-media inquiries, contact the authors