McKinsey&Company

A report from McKinsey's Healthcare Systems and Services Practice

Improving care delivery to individuals with special or supportive care needs

Kara Carter, Razili Lewis, and Tim Ward

What states, private payors, providers, and technology companies are doing to control costs and improve outcomes for individuals with behavioral health conditions or in need of long-term services and support, including those with intellectual or developmental needs

Kara Carter (Kara_Carter@mckinsey.com) is a partner in McKinsey's San Francisco office.

Razili Lewis (Razili_Lewis@mckinsey.com) is an associate partner in its New Jersey office.

Tim Ward (Tim_Ward@mckinsey.com) is a senior partner in its Southern California office.

The authors would like to thank the numerous state Medicaid directors and other experts they interviewed for their time and insights. The authors would also like to thank Pavi Anand and Ellen Rosen for their extensive contributions to this article.

Improving care delivery to individuals with special or supportive care needs is published by the partners of McKinsey's Healthcare Systems and Services Practice.

McKinsey & Company
Healthcare Systems and Services Practice
150 West Jefferson, Suite 1600
Detroit, Michigan 48226

Table of contents

Executive summary

Individuals with serious behavioral health (BH) conditions, and those in need of long-term services and supports (LTSS) because of aging, complicated medical conditions, physical disabilities, or intellectual/developmental disabilities (I/DDs), often require very complex care and diverse services. As a result, they account for a significant share (more than 35%) of annual national healthcare expenditures—at least $800 billion, including over $450 billion on non-medical services.[a] The Medicaid program bears most of these costs; nearly two-thirds of its budget is spent on care for these individuals.

In the past decade, care delivery for these individuals has evolved significantly because of actions taken by state governments, private payors, and providers to control costs and improve outcomes. Technological advances are supporting many of the innovations. Because most of the innovations are comparatively new, firm evidence to support their use is still emerging.

States. Because they shoulder a meaningful percentage of all Medicaid costs, states have been at the forefront of innovation for these three groups. Most of the changes they have implemented focus on the following:

- Shifting to managed care, either by including, or "carving in," certain supportive services (most often, BH services) into existing managed care programs or by launching specialized programs (e.g., duals demonstration pilots for those eligible for both Medicaid and Medicare)
- Developing programs, such as health homes, that offer financial incentives to providers to encourage more active care coordination and accountability
- Using novel reimbursement models to shift financial accountability and risk to managed care organizations and providers as a way to reward efficiency and effectiveness, as well as to encourage additional innovations in care management
- Standardizing how quality of care is measured to determine which programs are having the greatest impact

Payors. To date, private payor involvement with the services required by individuals with special or supportive care needs has largely been through Medicaid managed care programs.

[a]The figures included here represent the cost of formally delivered healthcare and supportive care for the three groups of individuals; both administrative costs and personal expenditures for home care are excluded. Note, however, that accurate estimates of even formal costs are challenging because of the overlap among these populations and the lack of published research about their total healthcare expenditures, including medical expenditures. We were therefore able to estimate only the lower end of total healthcare spending for these populations. See the appendix for more details.

Medicaid/Medicare-focused players, which currently provide coverage for almost one-third of all individuals enrolled in Medicaid managed care programs, have focused on programs for those with BH conditions or needing LTSS care (other than those with I/DDs). Blues plans, regional/local insurers, and national carriers are increasing the services they provide to those two groups, as well as to members with I/DDs. Over the past five years, for example, national carriers have more than doubled the number of affected individuals enrolled in their Medicaid managed care programs. In many cases, payors are gaining the capabilities required to serve these members through acquisitions or by subcontracting with specialty vendors. However, the pace at which private payors have been building their capabilities largely reflects the pace at which various states have been introducing managed care for the relevant populations. For this reason, few payors have focused until recently on individuals with I/DDs.

Providers. The providers that have traditionally focused on servicing the needs of these populations (mental healthcare centers, nursing facilities, intermediate care facilities, and others) have often been small, independently owned businesses. Provider consolidation is increasing, but it is affecting the different populations in different ways. Consolidation among BH providers has been comparatively slow; however, greater care integration and co-location with primary care providers are growing trends. The rate of consolidation among most LTSS providers has been relatively high. In some cases, consolidation is being driven by acute care providers that want to acquire or partner tightly with long-term-care providers, or by long-term-care providers that want to acquire home health agencies. In both cases, the goal is to control the total cost of care while improving care delivery. At present, there is little evidence of consolidation among I/DD providers.

Technology companies. Private investments in and capital transitions for healthcare technologies targeted at the three groups reached about $3.3 billion in 2014. Most of this money was spent in three categories: administrative tools, care plan/data exchange, and remote monitoring. However, investments in these categories have remained steady or declined in recent years. By contrast, investments are increasing rapidly for technologies that enable remote medical consultations; help providers make quality-oriented, cost-effective clinical decisions; or enable providers to reduce risk and increase their overall clinical effectiveness. Early evidence suggests that these technologies may be able to improve the quality of care delivered and the affected individuals' quality of life, but whether they will be able to scale effectively remains an open question.

Introduction

Three groups of Americans can have especially complex care needs: those with behavioral health (BH) conditions, including substance abuse; those with intellectual or developmental disabilities (I/DDs); and those who need long-term services and supports (LTSS) because of chronic, complicated medical conditions or physical disabilities (both of which are often related to aging). These individuals typically require a combination of diverse medical and supportive services that must often be delivered for prolonged periods. (For simplicity's sake, we use the term *special/supportive care needs* in this report to refer to the combination of services required by the three groups.)

Although individuals with special/supportive care needs constitute less than 20% of the U.S. population, they account for more—perhaps far more—than 35% of total annual national health expenditures (over $800 billion, including more than $450 billion for non-medical services).[a]

States, payors, and providers have an opportunity to improve care delivery for these individuals. Several reasons help explain why it is important that they do so now:

- The size of this group is growing because of a number of factors, especially population aging, increased awareness of the conditions, and improved diagnostic criteria that make it easier to identify those affected. For example, estimates suggest that the number of people above age 65 will be 60% higher in 2030 than in 2010 and that at least 70% of those over 65 will eventually need LTSS.[1,b]
- Inadequate coordination reduces the quality of care and drives up costs. Historically, supportive care programs have been managed by a range of public and private entities, especially state agencies, and services have been delivered by a variety of discrete providers. Because the structural incentives for collaboration among the providers are weak, care is often poorly integrated. One estimate suggests that closer integration of medical and supportive care for individuals with BH conditions could save the country $26 billion to $48 billion annually.[2] Similar opportunities exist to improve the quality and cost of other special/supportive care services.
- Frequently, spending levels do not align with the acuity of a patient's condition or quality of care delivered. McKinsey research has found, for example, that in many cases the correlation between the level of need of individuals with I/DDs and the amount payors spend annually for their home- and community-based services (HCBS) is weak.[3] Similarly, our research has shown that the correlation between the per-diem rates charged by nursing homes and the homes' CMS star ratings (one broadly available proxy for quality) can be low.
- Care availability is uneven. Many of the individuals with special/supportive care needs find it difficult to access services, largely because of the scarcity of specialist providers and high cost of care. For example, about 300,000 individuals with assessed I/DD needs remain on waiting lists for HCBS each year.[4] Those with LTSS needs face these long waiting lists as well.

[a] The methodology used to derive these estimates is described in the appendix, and the total cost of care for these populations is likely underestimated in this analysis. (See the footnote in the executive summary for additional details.)
[b] Numbered references appear at the end of each chapter.

Many of the organizations involved in paying for or providing care to the three groups have innovated in recent years to improve care delivery. To investigate these innovations, we interviewed more than ten state Medicaid directors and other experts, built a comprehensive managed care database of all programs nationwide, and analyzed publicly available databases and other sources. In this report, we present our findings and offer insights into how states, payors, and providers are attempting to increase the quality and efficiency of care delivery for these individuals. In addition, we discuss new technologies that could further improve care delivery to them. Wherever possible, we describe the results achieved through innovation; we acknowledge, however, that because many of these models are new, evidence of their impact is still emerging.

It is worth noting that individuals with I/DDs are often considered a subset of those requiring LTSS care. In this article, however, we categorized the two groups separately because the primary services delivered to them are quite different.

> "Although individuals with special/supportive care needs constitute less than 20% of the U.S. population, they account for more—perhaps far more—than 35% of total annual national health expenditures..."

REFERENCES

1 U.S. Department of Health and Human Services statistics. (longtermcare.gov/the-basics/ and www.aoa.acl.gov/aging_statistics/future_growth/future_growth.aspx).
2 Milliman, Inc. and the American Psychiatric Association. *Economic Impact of Integrated Medical-Behavioral Healthcare.* April 2014.
3 McKinsey analysis based on blinded state Medicaid claims and skilled nursing facility ratings data.
4 United Cerebral Palsy. *The Case for Inclusion. 2014 Report*. (ucp.org/the-case-for-inclusion/past-reports/Case_For_Inclusion_Report_2014.pdf).

Why are these populations important?

Determining the size of, and spending on, the three groups is complicated by the fact that there is overlap among them. Exhibit 1 provides estimates of both variables based on the most recent data available.

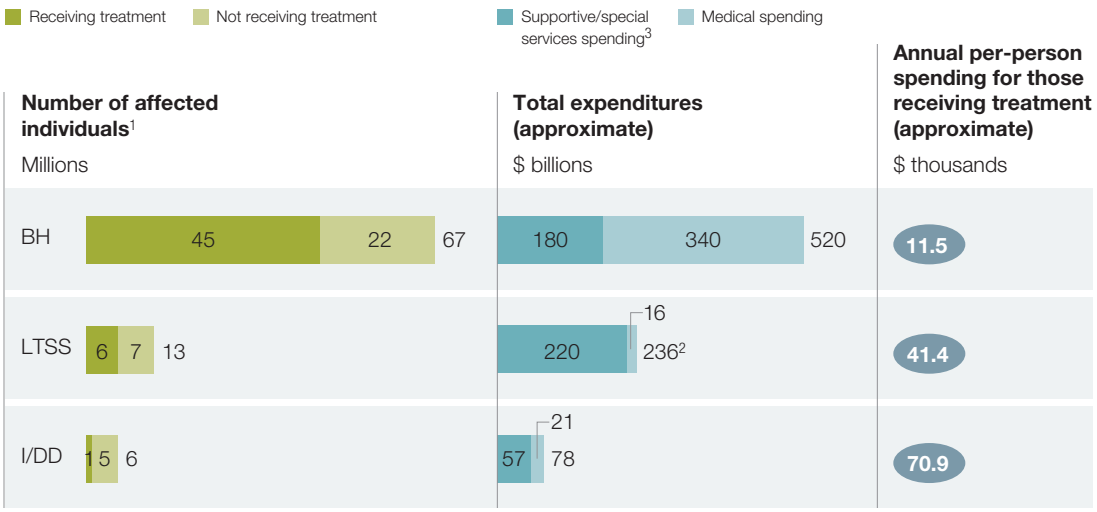
Behavioral health

BH conditions affect a broad range of individuals—from the child with ADHD who often interrupts his teacher in school, to the young adult who recently realized that her drinking may be an addiction, to the adult with severe schizophrenia who is trying to control his psychotic episodes with a combination of three different medications. At present, about 67 million Americans have BH conditions. Many are young—between one-fourth and one-third of them are under age 18.[1,2]

Depending on the severity of the BH condition, individuals may be treated with medication, nonpharmacologic therapy, or both, delivered at community mental health centers, physicians' offices, rehabilitation facilities, psychiatric hospitals, or other settings. Until recently, behavioral care and benefits were usually managed separately from medical care and benefits.

However, published studies suggest that closer integration between medical and behavioral care yields better outcomes,[3] such as fewer inpatient visits, leading to lower costs. This evidence has led many states and organizations to attempt to more closely coordinate care delivery for this population, especially those with serious and persistent mental illnesses.[a]

EXHIBIT 1 **Cost of care for individuals with special or supportive care needs**



BH, behavioral health; LTSS, long-term services and supports; I/DD, intellectual and developmental disabilities.
[1] Populations are not mutually exclusive (e.g., the I/DD population has significant overlap with the LTSS population).
[2] Likely a significant underestimate (see appendix).
[3] For the LTSS and I/DD populations, the category "supportive/special services" includes all services that help individuals perform activities of daily life, such as bathing, dressing, and preparing meals. For the BH population, the category includes both the services described previously and the care required for the BH conditions (e.g., therapy, rehabilitation).

Sources: See appendix

[a] Although this term is intended to cover all individuals whose mental illness has substantial impact on their daily life activities, the technical and diagnostic definition of it varies widely from one entity to another.

Long-term services and supports

The 13 million individuals in this group need assistance performing activities of daily living (e.g., bathing, cooking) for a prolonged period.[b] Roughly half of these individuals are above age 65 and generally have severe, chronic medical conditions or physical disabilities. The younger members of this group are more likely to have physical disabilities. In some cases, individuals are recovering after hospital discharge from an acute medical episode (e.g., hip surgery).

Nationwide, over two-thirds of individuals in need of LTSS care receive services at home or in the community. Estimates suggest that about half of them receive only informal care from family and friends.[4] The cost of this care is not included in the figures cited in this report, but it was estimated to be about $470 billion in 2013 alone.[5] The remaining individuals in need of LTSS services, 80% of whom are elderly, are cared for in institutional settings (e.g., nursing homes).

Given that a high percentage of all individuals in need of LTSS care are eligible for both Medicare and Medicaid, an emerging trend is closer coordination between Medicaid support services and Medicare medical services to improve the quality and cost-effectiveness of care. For example, CMS is currently supporting financial alignment demonstration programs for dual eligibles in 12 states.[c] In addition, a number of states are leveraging Medicare Part C authority and the D-SNP (dual eligible special need plans) platform to align Medicare and Medicaid benefits for this population.

Intellectual and developmental disabilities

The supportive services offered to individuals with I/DDs are similar to those given to other persons in need of LTSS care. However, the roughly six million individuals in this group often need more highly specialized care, not only because of their underlying disability but also because they have a high rate of medical and behavioral comorbidities.

Individuals with I/DDs may experience difficulties communicating or accomplishing daily activities, such as taking medications regularly or performing basic hygiene tasks. Often, their disabilities are diagnosed at a young age, and they typically require special services for their entire life.

Delivering high-quality care through an integrated, person-centered approach is especially important for individuals with I/DDs because of the complexity of their needs. It also often necessitates increased family and caregiver involvement, particularly for HCBS care. The proportion of the I/DD population receiving HCBS care has risen significantly in the past several years; at present, about three-quarters of individuals with I/DDs who are given any type of formal care receive HCBS.[d]

REFERENCES

1 National Alliance on Mental Illness. Fact sheet: Mental illness facts and numbers. (www2.nami.org/factsheets/mentalillness_factsheet.pdf).
2 National Institute of Mental Health. Fact sheets: Any disorder among children; Any mental illness among adults. (www.nimh.nih.gov/health/statistics/prevalence/index.shtml).
3 Unützer J et al. *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes*. CMS Health Home Information Resource Center Brief. May 2013.
4 Kaye HS, Harrington C, LaPlante MP. Long-term care: Who gets it, who provides it, who pays, and how much? *Health Affairs*. 2010;29(1):11-21.
5 Reinhard SC et al. Valuing the Invaluable: 2015 Update. AARP. July 2015.

[b] As noted earlier, we did not include individuals with I/DDs in this group.
[c] Administrative alignment demonstration projects are not included in this total.
[d] The remainder of care may be provided by unpaid family and other caregivers.

How are states innovating?

The individuals discussed in this report—those with BH conditions or I/DDs and those requiring LTSS care for other reasons—constitute roughly one-third of all Medicaid patients but almost two-thirds of all Medicaid spending.[a] Specifically, Medicaid is responsible for about one-third of total expenditures on BH conditions and more than half of all LTSS costs, including the vast majority of I/DD spending.

Because states shoulder a significant proportion of Medicaid costs—on average, about 40%[1]—and are responsible for overseeing Medicaid programs, they have been at the forefront of innovation, changing the Medicaid services they provide to these groups in four primary ways: shifting to managed care, integrating care more effectively, adopting new payment approaches, and standardizing how quality of care is measured.

Shifting to managed care

A growing number of states (44 to date[b]) have, to some degree, shifted away from fee-for-service (FFS) arrangements to Medicaid managed care programs. Since 2011, the proportion of all Medicaid beneficiaries nationwide who are enrolled in MCOs has risen from 50% to more than 64%.[2] Between 2011 and 2013 alone, this move increased the money allocated to managed care capitation by $40 billion, and the amount has likely increased significantly since then.[3]

However, states have been slower to enroll Medicaid beneficiaries needing BH, I/DD, or LTSS care into managed care programs. At present, 39 states and DC include some or all of these beneficiaries into managed care, either by "carving in" appropriate services into existing managed care programs or by launching sometimes quite limited specialized programs (e.g., duals demonstration pilots[c] or Pennsylvania's Adult Community Autism Program).

The states differ considerably in terms of which populations, if any, they have moved to MCOs (Exhibit 2). (Only seven states have introduced managed care for all three groups.) As a result, roughly 70% of the cost of all Medicaid services is still managed directly by the states rather than through managed care programs.[3] In recent years, the pace of change has accelerated, but considerable variability in terms of which groups are enrolled in managed care remains.

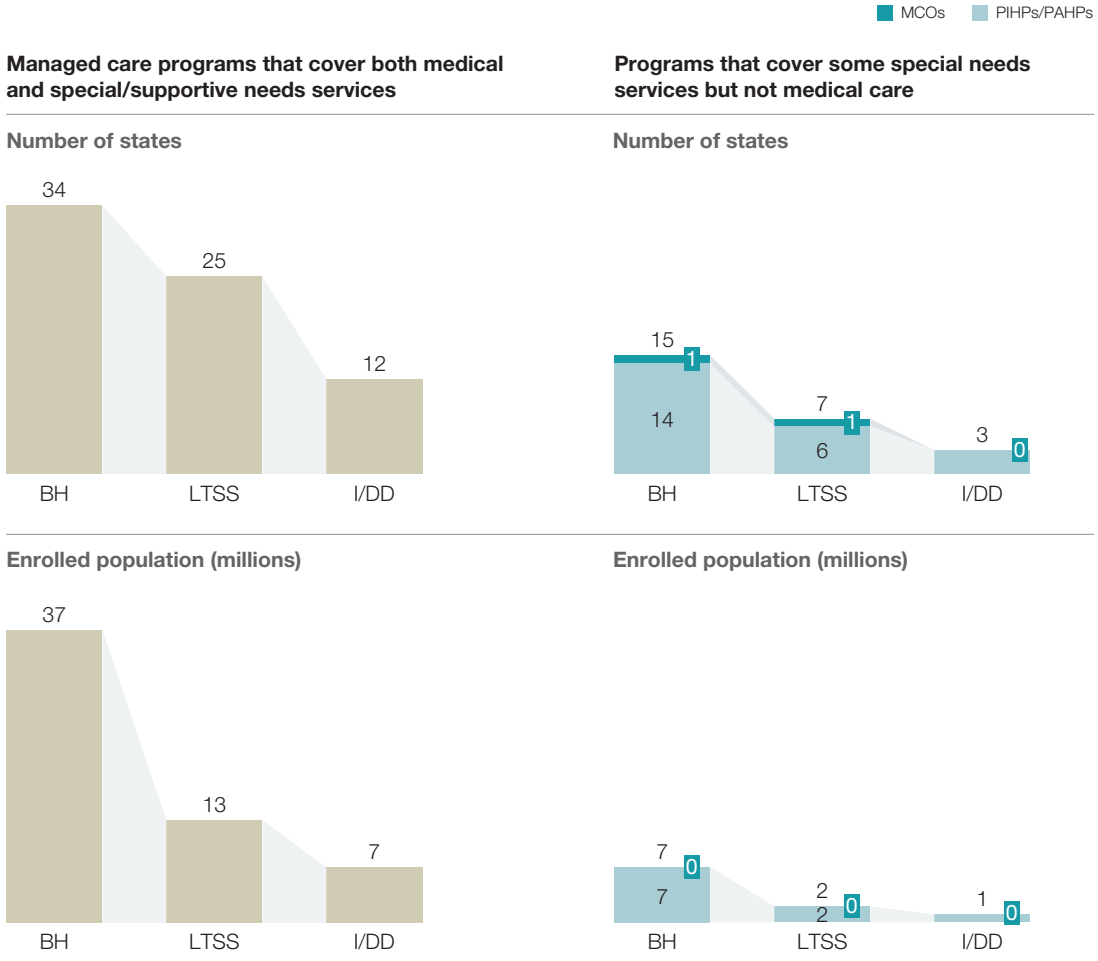
Behavioral health. Medicaid beneficiaries with BH conditions were the first of the three groups to be moved to managed care, beginning more than 20 years ago. At present, the proportion of Medicaid beneficiaries enrolled in MCOs is significantly higher among individuals with BH conditions than in the other two groups. Thirty-four states offer managed care programs that include BH treatment, and most of the MCOs in those states cover the full spectrum of inpatient and outpatient BH services. Together, the programs in these 34 states cover about 80% of all Medicaid managed care enrollees nationwide.[d] Several states (such as the 15 with PIHP and PAHP programs[e]) also have stand-alone programs that cover BH services only. However, many of the states have been moving to integrate these programs into medical managed care programs, primarily for two reasons: evidence for the effectiveness of BH carve-outs for individuals with serious mental conditions is mixed,[4] and medical costs are significantly higher for individuals with a BH comorbidity than for individuals

[a] About one-third of all individuals in the three groups are covered under Medicaid.
[b] All numbers in this chapter are as of January 2016, when this report was initially prepared, unless otherwise noted.
[c] The pilots are integrated programs for individuals covered by both Medicare and Medicaid that combine the two funding streams under one managed care organization. The individuals included are often the sickest and poorest people covered by either program, and the cost of their care is disproportionately high.
[d] As of November 2015.
[e] Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) are managed care programs that cover a subset of the beneficiaries' services for a capitated amount.

without a BH comorbidity.[5] Tennessee, Arizona, and New York are examples of states that recently made the move to integrate BH services into their MCO programs.

Long-term services and supports. The number of managed care LTSS programs has more than doubled in the past ten years.[6] Twenty-seven states and DC have to some degree transitioned LTSS care into their managed Medicaid programs, either by integrating them into their general medical MCO programs or by developing a specialized managed care program for this population.

EXHIBIT 2 **States with managed Medicaid programs that cover special and supportive needs services**[1]



BH, behavioral health; LTSS, long-term services and supports; I/DD, intellectual and developmental disabilities; MCOs, managed care organizations; PIHPs, prepaid inpatient health plans; PAHPs, prepaid ambulatory health plans.

[1] The programs counted include both restrictive "carve-in" plans (which cover medical services as well as one or more types of special/supportive needs services, but only individuals who meet certain criteria are eligible for the special/supportive needs coverage) and nonrestrictive plans (which cover both types of services for all enrollees). Data as of January 2016.

Sources: McKinsey Center for U.S. Health System Reform Medicaid Managed Care Program Database

Together, these programs cover roughly 20% to 30% of all Medicaid beneficiaries nationwide who are enrolled in an MCO. Some states plan to transition these programs into duals demonstration projects for increased care integration. In addition, 30 states have established Programs of All-Inclusive Care for the Elderly (PACE), which also cover disabled Medicare beneficiaries.[7] These programs deliver small-scale, fully integrated managed care through long-term-care providers that act as MCOs. However, PACE enrollment is only about 35,000 nationwide, and the programs have proved challenging to scale up because of fragmentation among the long-term-care providers involved.

Intellectual or development disabilities. Until recently, I/DD services were largely excluded from managed care. At present, 13 states and DC include medical care for Medicaid beneficiaries with I/DDs in some form of managed care (significantly more states than did so just a couple of years ago), and 12 states include some or all of the non-medical services these patients also need, mostly through small-scale or demonstration programs. The programs offered by these 12 states cover only 10% to 20% of all Medicaid beneficiaries enrolled in MCOs nationwide. At least 7 additional states have expressed interest in incorporating I/DD services and populations into their Medicaid MCOs within the next few years and are working with advocacy groups and stakeholders to develop a path forward.

Because many of the innovative efforts to include supportive services in Medicaid managed care programs are comparatively new, the evidence to support them is thin. Nevertheless, examples of how these efforts may improve quality and costs are beginning to emerge. Both carve-in and carve-out managed care programs for individuals with BH conditions have been proved to decrease inpatient hospitalization rates (in comparison with fee-for-service programs), although there is not clear consensus on which approach is more effective.[8,9] Most studies of managed LTSS programs suggest that they increase the use of HCBS and decrease institutionalization, resulting in lower costs and greater consumer satisfaction.[10,11] Managed care programs for Medicaid beneficiaries with I/DDs are too new to provide data on outcomes or savings.

The early evidence remains to be confirmed. Furthermore, investments in program design, quality oversight, and ongoing monitoring are needed to determine whether these programs can achieve impact at scale.

Integrating care more effectively

To promote closer care coordination and integration, many states are pursuing a range of provider incentive programs (in addition to or as an alternative to managed care). These efforts include enhanced primary care case management (PCCM) and integrated health home programs. Uptake of health home programs, in particular, has been boosted by the increased federal matching funds available to states that chose to implement them.

PCCM programs, which pay primary care providers a fee to coordinate patient care, exist in 19 states today.[12] A handful of states, including Oklahoma, North Carolina, and Colorado, have enhanced PCCM programs

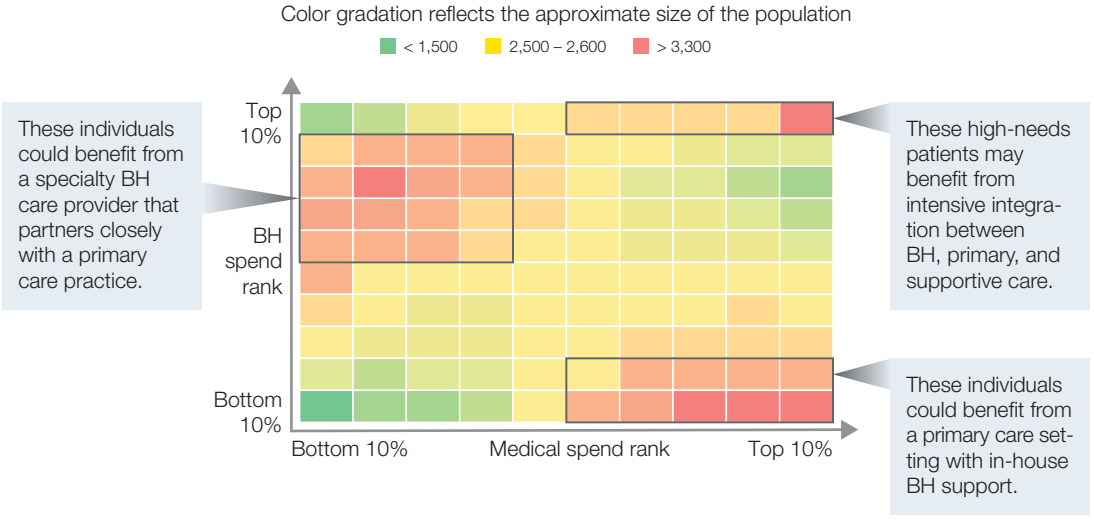
in which the providers receive a higher fee to manage the care of more complex patients. These programs (both basic and enhanced) provide incentive payments for quality but do not require providers to take on additional financial risk. However, some states are now scaling down their PCCM programs and shifting enrollees to managed care.

Similarly, integrated health home programs pay providers a higher care coordination fee for intensive team-based case management of patients with chronic conditions. In many cases, this is an opportunity to have care management embedded in the provider setting, rather than administered solely through a payor or MCO. At present, CMS-approved integrated health home models that include coverage for individuals with serious mental illnesses exist in 17 states; health homes targeting only at this population exist in 11 states.[f,13] In these programs, pay-for-performance metrics (e.g., rate of inpatient readmission; percentage of patients screened for depression) help measure care quality and indirectly control costs while increasing provider accountability for patient outcomes.

Although these programs help address the need for more integrated care delivery, most are too new to have produced evidence of quality or cost impact, especially for those with complex care needs. However, many states are moving ahead with their efforts to coordinate care more effectively, either through these programs or other innovative approaches. Advanced analytics is now making it possible to tailor programs to specific subsets of patients (Exhibit 3).

EXHIBIT 3 **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 one state; McKinsey Healthcare Analytics's proprietary Behavioral Health Diagnostic tool

[f] Note, however, that Kansas decided to end its health home program as of June 2016.

Adopting payment innovations

To encourage innovations in care management, many states are exploring new reimbursement mechanisms as a way to share financial accountability with Medicaid MCOs and, in some cases, providers.

A variety of models are being used to incentivize the MCOs. A handful of states have already achieved results through the use of capitated rates to increase care quality. Although many states have achieved improvements by shifting to community-based care, this shift continues to be one of the single largest value drivers (for both cost and quality) in LTSS care. Arizona, for example, has used a combination of capitated payments and incentives for more than 20 years to improve the services delivered to individuals in need of LTSS care; through this program, it has rebalanced the percentage of these individuals being cared for in nursing facilities from 95% to 30%.[14] Furthermore, nearly 75% of the 39 states with Medicaid MCOs have put some type of quality bonus or incentive structure in place.[2] Louisiana, for example, has developed an innovative program that includes a benchmark for what the state would have spent in the absence of managed care. The program also includes safeguards to ensure care quality and access. The state shares up to 60% of the savings achieved (in comparison with the benchmark) with the MCOs, and those organizations then share up to 50% of the savings they receive with their providers.[15] In addition, 10 states are testing capitated duals demonstration projects that include a three-way contract signed by the state, CMS, and an MCO. The MCO receives combined Medicare and Medicaid funding streams to provide comprehensive, coordinated care and take on risk.

To align provider incentives, some states are introducing episode-based payment models for the services needed by one or more of the three groups, which give a single "quarterback" provider full accountability for the cost, quality, and coordination of care. To date, five states have launched,[h] or have announced plans to launch, these models, enabled by CMS State Innovation Model grants. The episode-based payments can be given prospectively (the appropriate amount is determined and provided ahead of time for care delivered for a set time period) or retrospectively (the amount is calculated after care delivery based on the average expenditures—including charges from specialists and ancillary providers—for a given condition within that provider's panel). In Arkansas, retrospective episode-based payments have been launched for ADHD and oppositional defiant disorder; positive results (lower costs and improved care quality) have already been reported for ADHD episodes.[16] The prevalence of such reimbursement mechanisms is likely to increase over the next several years, fueled by many states' commitment to having the majority of their healthcare spending in value-based arrangements.

A few states have also introduced payment innovations for a purpose other than aligning financial accountability with MCOs and providers. These states have chosen to offer Medicaid beneficiaries with I/DDs the option of receiving needed services through self-directed care. A variety of approaches are being used under two major models. In some cases, the individuals and their families are given the right to decide who should provide

[g] Five states have announced episode models for a variety of conditions. At least three of them plan to launch an episode model for BH conditions, I/DDs, or LTSS care.

care, what services are needed, and when those services should be provided. (This approach allows the individuals or their family to act, in some ways, as the "employer" of the caregivers, and is referred to as the "employer authority" model.) In other cases (under the "budget authority" model), the individuals/families are given a capitated sum by the state and can choose for themselves how and where to spend the dollars, not only on caregivers but also on disability-related goods and services.

Standardizing how quality of care is measured

As states have increased their focus on quality improvement through new managed care programs and reimbursement models, national quality standards for the care delivered to individuals needing BH, I/DD, or LTSS care have begun to emerge. A number of widely accepted metrics that cover some of the services required by these groups have been established. However, most of the current metrics focus on clinical services. National standards for measuring and reporting the quality of most or all of the supportive services these groups require are still in development, as are metrics that would gauge, from each individual's perspective, the impact the services have on quality of life. A key challenge has been the difficulty in identifying objective metrics that could be used not only to assess quality but also to influence payment.

Behavioral health. The Healthcare Effectiveness Data and Information Set (HEDIS) includes a few BH metrics, such as the percentage of patients who received a follow-up after mental health hospitalization. However, the HEDIS metrics do not address access to care or the quality of supportive services. In 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed national standards that have been endorsed by National Quality Forum and comprehensively address care quality for this population.[17] However, it is unclear how widely these metrics have been linked to payment by the states.

"As states have increased their focus on quality improvement through new managed care programs and reimbursement models, national quality standards for the care delivered to individuals needing BH, I/DD, or LTSS care have begun to emerge."

Long-term services and supports. Standard Medicare quality indicators exist for nursing facilities and home health, but validated national outcomes metrics for HCBS services are lacking. As a result, many states use very different measurement sets,[h] which makes national comparisons and validation challenging. Recognizing this gap, CMS has prioritized the creation of a uniform set of quality metrics to measure functional improvement in individuals receiving LTSS care as part of its electronic LTSS (eLTSS) effort and its Testing Experience and Function Tools (TEFT) grants. Organizations may be able to adopt and use these metrics in their payment strategies by the end of 2017.[18] In addition, the National Association of States United for Aging and Disabilities (NASUAD) has adapted the Na-

[h] Examples of these metrics include those developed by the Long Term Quality Alliance, the Measure Applications Partnership, and the Agency for Healthcare Research and Quality.

tional Core Indicators (NCIs, described below) to create a set of person-centered measures appropriate for the aged and physically disabled (NCI-AD). NASUAD piloted use of the NCI-AD metrics in three states beginning in June 2014 and expanded the program to 14 states in June 2015. Time will tell whether these metrics prove to be effective.

Intellectual or developmental disabilities. Academic organizations and interagency groups have been developing process and survey metrics for individuals with I/DDs. The National Core Indicators (NCIs),[19] used by 39 states, are the most widely reported metrics. The NCIs track person-centered indicators such as independence, quality of life, and family involvement in the care of individuals with I/DDs. Given the relative subjectivity of these metrics, however, the outputs do not lend themselves easily to statistical analysis and thus make the link to payment challenging.

Some of the emerging metrics are likely to become widely adopted national standards, especially because many MCOs are pushing for standardization across the states they serve. Once this occurs, we expect to see the movement to shift the three groups into managed care and payment innovations to accelerate. However, more work remains to be done until there are national standards that truly measure quality of care and quality of life outcomes for these individuals.

REFERENCES

1 Kaiser Family Foundation. Federal and state share of Medicaid spending. (kff.org/medicaid/state-indicator/federalstate-share-of-spending/).
2 McKinsey Center for U.S. Health System Reform Medicaid Managed Care Program Database.
3 McKinsey analysis of data from the CMS-64 Medicaid Financial Management Reports, 2013.
4 Busch AB, Frank RG, Lehman AF. The effect of a managed behavioral health carve-out on quality of care for Medicaid patients diagnosed as having schizophrenia. *Archives of General Psychiatry*. 2004;61:442-448.
5 Melek S, Norris D. *Chronic Conditions and Comorbid Psychological Disorders*. Milliman, Inc. July 2008.
6 Center for Healthcare Strategies. Contracting for managed LTSS: Best practices and cautionary tales. Presentation given to the CMS/LTC/CCO Study Group. June 11, 2013.
7 National PACE Association. PACE Innovation Act passes US Senate (news release). August 16, 2015.
8 National Council for Community Behavioral Health Care. *Increasing Access to Behavioral Healthcare. Managed Care Options and Requirements*. July 2011.
9 Hutchinson AB. The effect of Medicaid managed care on mental health care for children. *Mental Health Services Research*. 2003;5(1):39-54.
10 Saucier P, Burwell B, Gerst K. *The Past, Present, and Future of Managed Long-term Care*. Policy brief for the US Department of Health and Human Services. April 2005.
11 Community Catalyst. Long-term Services and Supports: Balancing Incentive Program. (www.communitycatalyst.org/resources/tools/medicaid-report-card/long-term-services-and-supports/long-term-services-and-supports-balancing-incentive-program).
12 Kaiser Family Foundation. Medicaid enrollment in comprehensive managed care by plan type. (kff.org/medicaid/state-indicator/enrollment-by-medicaid-mc-plan-type/).
13 Centers for Medicare & Medicaid Services. Approved Medicaid health home state plan amendments. September 2015. (Note, however, that Kansas recently decided that it will be ending its health home program as of June 2016.)
14 Mathematica Policy Research. Rate setting for Medicaid managed long-term services and supports (MLTSS) in integrated care programs. Presentation at the World Congress 7th Annual Leadership Summit on Medicaid Managed Care. February 25, 2014.
15 McKinsey interviews with state Medicaid directors.
16 Health Care Payment Improvement Initiative. Building a healthier future for all Arkansans. April 28, 2014.
17 Substance Abuse and Mental Health Services Administration. National behavioral health quality framework. (www.samhsa.gov/data/national-behavioral-health-quality-framework).
18 Office of the National Coordinator for Health Information Technology. Electronic Long-Term Services & Supports (eLTSS) Initiative. November 18, 2014.
19 National Core Indicators website (www.national-coreindicators.org/indicators).

What moves are private payors making?

Because a significant portion of private payor involvement with the BH, LTSS, and I/DD populations is through Medicaid managed care programs, our discussion focuses primarily on those programs. Note, however, that private insurance pays for the majority of all spending on BH conditions, and that Medicare and Medicare Advantage programs provide coverage for the medical needs of most individuals in need of LTSS.

Which payors are active—and where

Medicaid/Medicare-focused carriers provide coverage for almost one-quarter of all individuals who are enrolled in Medicaid MCOs (Exhibit 4). These carriers' overall earnings have typically been higher than those of other payors involved in Medicaid managed care.[1]

However, provider-owned plans, Blues plans, and regional/local payors are increasing their presence in Medicaid managed care, as are some national players. The pace at which states have been adopting managed care for individuals in need of these services has been a key determinant of the pace at which private payors launch Medicaid managed care programs and build capabilities in that area.

Behavioral health. The types of payors offering managed care programs covering BH services are roughly the same as those offering managed care programs to the general Medicaid population. The majority of large payors subcontract with specialty BH vendors to manage benefits for both their commercial and Medicaid lines of business. These specialty BH vendors, which include companies like Beacon Health Options (formerly Value Options) and Magellan Health, have shown strong growth over the past several years. Value Options, for example, increased its revenues 50% between 2012 and 2013 alone.[2] Magellan has also reported revenue growth.[3] Some large payors, however, have established internal BH capabilities. For example, Centene's internal BH organization (Cenpatico) is active in 19 states.[4] Nationwide emphasis on BH care (as indicated by such actions as the introduction of BH parity laws and the ongoing shift to managed care) may lead many large payors to continue investing in internal BH capabilities.

Long-term services and supports. Most payors have recognized the opportunity to control costs and improve quality of life for patients in need of LTSS through effective care coordination and care provision in the right setting. Large insurers are increasing their involvement in LTSS services; many of them have indicated that they see the states' managed LTSS and duals programs as critical strategic areas for future investment and expansion of their Medicare and Medicaid lines of business.[5] However, a number of comparatively small provider-owned plans and Blues carriers have, in the aggregate, already enrolled a large portion of the Medicaid beneficiaries

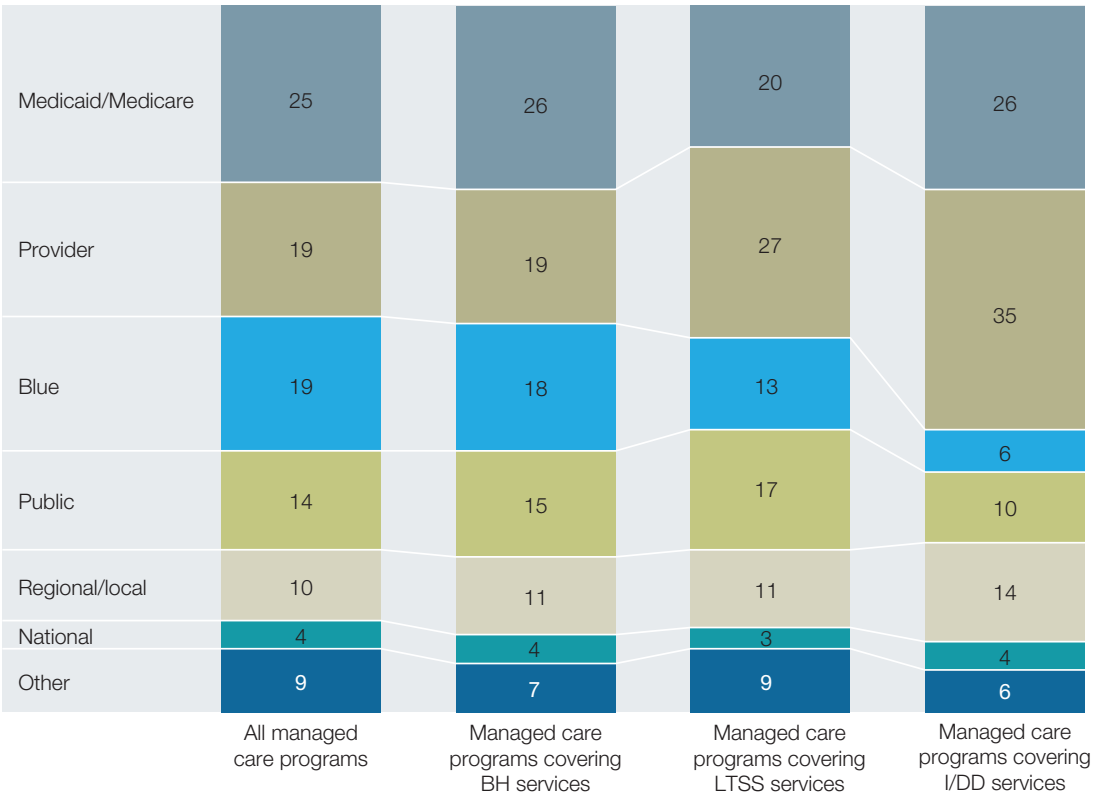
"Nationwide emphasis on BH care (as indicated by such actions as the introduction of BH parity laws and the ongoing shift to managed care) may lead many large payors to continue investing in internal BH capabilities."

in need of LTSS. These carriers may have advantages in their regional population knowledge, relationships at the state level, close provider networks, and, in the case of the Blues, strong local brand. Given the proposed investments from large insurers, it is likely that states (and, in some cases, their Medicaid beneficiaries) will be able to select from a wider array of MCOs that cover LTSS.

Intellectual and developmental disabilities. Because only a small number of states offer I/DD services under managed care plans, few large payors have focused on this area. There are, of course, a few exceptions, one of them being Centene, which has a presence in three of the states that cover I/DD services.[6] In 2015, Centene also acquired LifeShare, a provider of home and community-based services for people with I/DDs. Given the pace at which states have been carving I/DD services into managed care, it may not be surprising that payors have been slow to develop capabilities in this area. This may be changing,

EXHIBIT 4 **Payors offering managed Medicaid programs covering special/supportive needs services**

% of individuals covered by each program, by carrier type and services covered



[1] The payors included in this chart exclude PACE programs.

Source: McKinsey Center for U.S. Health System Reform Medicaid Managed Care Program Database

though—some payors appear to be thinking about innovative ways to offer services to individuals with I/DDs through their Medicaid MCOs.

Strategic moves

The leading payors in managed care for individuals requiring BH, I/DD, or LTSS services have gained their positions primarily through acquisitions and partnerships, reflecting the difficulty of building capabilities in these areas from the ground up. For example, the two largest payors (UnitedHealthcare and Anthem) gained share through the acquisition of Medicaid/Medicare-focused players (Americhoice and Amerigroup, respectively). We anticipate that more such partnerships and acquisitions are likely to emerge, because these deals help payors gain the specialized staff and skill sets needed for increased care coordination and management. Specialized capabilities in these areas will be particularly important for payors that want to expand their service offerings to include options that promote independence and increase quality of experience (e.g., supportive employment, peer support programs).

Many payors are also leveraging their existing relationships with states to begin serving these populations. (Almost 50% of the managed care states use the same MCO for more than one state program.[6]) As new programs are proposed and launched, payors can build on their existing relationships and knowledge of the local landscape to demonstrate enhanced capabilities.

The federal HCBS setting rule of 2014 has also altered how MCOs must operate under contract with state Medicaid agencies. Among the capabilities MCOs must now have are person-centered planning and also employment and community integration.

REFERENCES

1 Based on forward-looking price/earning ratios for 2016, Capital IQ; Annual Reports.
2 Council J. ValueOptions prepares for reform, growth. *Inside Business*. 2013.
3 Vault company profiles, Magellan Health, Inc.
4 Cenpatico website. (www.cenpatico.com/improving-lives/in-the-community/our-service-area/).
5 Earnings calls transcripts.
6 McKinsey Center for U.S. Health System Reform Medicaid Managed Care Program Database.

What are providers doing?

The organizations that provide services to individuals with special/supportive care needs include hospitals, mental healthcare centers, HCBS providers, home health agencies, nursing facilities, intermediate care facilities, and others. Until recently, most of these providers (with the exception of hospitals) were small, independently owned businesses. However, the rate of consolidation is increasing, albeit at a variable pace in the three needs areas. Analysis showed that the number of mergers and acquisitions for BH, home healthcare, and long-term-care services grew 19% annually between 2012 and 2014,[a] and the average deal value increased 25% during that time.[1] About 75% of all of the deals were interstate, showing the geographic reach of this consolidation.

In some cases, consolidation is being driven by acute care providers (e.g., hospital systems, integrated delivery networks) that want to acquire or partner tightly with long-term-care providers so they can more closely integrate and better control the cost of care, especially for individuals in need of formal LTSS or other types of long-term care. A key factor the acute care providers frequently consider is whether the long-term-care providers have a similar geographic footprint, given the length of post-acute care that is often needed and patients' desire to remain close to home. In other cases, long-term-care providers are joining forces with home health agencies.

Three primary factors underlie the desire for increased scale of specialized providers. First, new reimbursement models are intensifying the financial risks they face and compressing their margins, making operational efficiencies increasingly important. Second, the providers must be able to invest in back-office infrastructure to measure and report quality, decrease costs, and improve operations. Third, they must build contracting capabilities with managed care companies if they are to respond to the growing adoption of managed care for individuals in need of BH, LTSS, or I/DD services.

Behavioral health. Consolidation among providers of BH services has been relatively low (only 50 deals nationwide in the past three years).[1] Nevertheless, care integration has been a key trend among these providers, which are adopting a variety of models.[2] The models being used most often are case management, care coordination, and co-location of services.

Physical co-location of behavioral and medical professionals is a model that is being piloted and implemented in small pockets nationwide. It has been shown to improve service access and quality, especially when coupled with integrated clinical workflows and care management.[3] As part of their effort to enable this new care model, some primary care practices have begun to develop basic capabilities for treating mild BH conditions, such as having specially trained staff on site and using standard screening tools. Co-location has the potential to help more individuals with milder BH conditions gain access to treatment; however, it does not, in and of itself, provide the intensive follow-up that is often required for those with serious conditions, who typically require additional case management.

Long-term services and supports. Home healthcare and long-term-care providers have been consolidating with each other at a faster pace (827 deals in the past three years). Many of the providers that are not consolidating are forming networks of close collaboration to

[a] Excludes I/DD providers.

build managed care contracting capabilities and undertake quality improvement projects. Private equity investment interest in long-term-care providers—particularly skilled nursing facilities and assisted/senior living communities—is also growing: real estate investment trusts made 29% of the acquisitions of long-term-care providers in the past three years, and both the number of deals and the deal prices have been increasing.[4]

Consolidation is occurring across as well as within provider types. For example, about 15% of the organizations that acquired home health agencies in the past three years were long-term-care providers. In many cases, the acquirers were seeking to offer the full spectrum of post-acute services. As hospital systems increasingly take on risk for readmission metrics and the total cost of care (beyond what is incurred within their own facilities), they need post-acute partners with a comparable geographic presence and the scale that would enable them to coordinate across the full continuum of care and keep total costs low. In addition, changing reimbursement regulations governing where patients discharged from a hospital can seek care have put providers that can offer post-acute care settings and services at an advantage.

At the same time, some LTSS facilities are differentiating themselves by providing smaller, more home-like environments. Some individuals prefer these settings to traditional nursing homes because of the personalized attention they receive, and these environments have been linked to better outcomes and lower cost. For example, the home-like Green House model has been shown to have lower hospitalization rates and costs than traditional nursing homes do.[5]

Intellectual and developmental disabilities. There is little evidence of consolidation among most providers of I/DD services. However, advocacy for deinstitutionalization and the continued movement of individuals to HCBS settings has caused more than 80% of large state facilities to close down over the past 30 years; only about 130 such facilities still exist nationwide.[6]

Even among HCBS providers, case management models for individuals with I/DDs have been changing in recent years. Rather than relying on their traditional single-dedicated-case-manager model, these providers are experimenting with ways to give beneficiaries and their family members increased decision making and autonomy. Another important issue for individuals with I/DDs is the seemingly perpetual waiting list for waiver services (primarily HCBS services, not residential care) resulting from continuing budget shortfalls, provider shortages, and the widespread lack of infrastructure to support HCBS providers.

REFERENCES

1 Analysis from Levin database for behavioral health, home health, and long-term care providers. (Note, however, that only 75% of transactions included price data in the Levin database.)
2 Heath B et al. *A Standard Framework for Levels of Integrated Healthcare*. SAMHSA-HRSA Center for Integrated Health Solutions. April 2013. (Note that HRSA stands for the Health Resources and Services Administration.)
3 Medicaid.gov. *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes*. May 2013.
4 Council J. ValueOptions prepares for reform, growth. *Inside Business*. 2013.
5 Horn SD et al. Cost of care in Green House home compared to traditional nursing home residents. Working paper. 2012.
6 Larson S et al (eds). *Residential Services for Persons with Intellectual and Developmental Disabilities: Status and Trends through Fiscal Year 2011*. University of Minnesota. 2011.

What are technology companies doing?

Private investments in and capital transactions for healthcare technologies continue to grow—in 2014, more than $5 billion was invested in healthcare technologies, up 15% to 20% from 2013.[1] Because many of the new technologies are relevant to individuals needing BH, I/DD, or LTSS services, we analyzed the top 80% of investments and transactions by size to determine how much money was being invested in relevant offerings. The answer: about two-thirds of the total (about $3.3 billion), most of which was clustered into three categories: administrative tools, care plan/data exchange, and remote monitoring. It is noteworthy, though, that investments in these three categories have remained steady or declined in recent years (Exhibit 5).

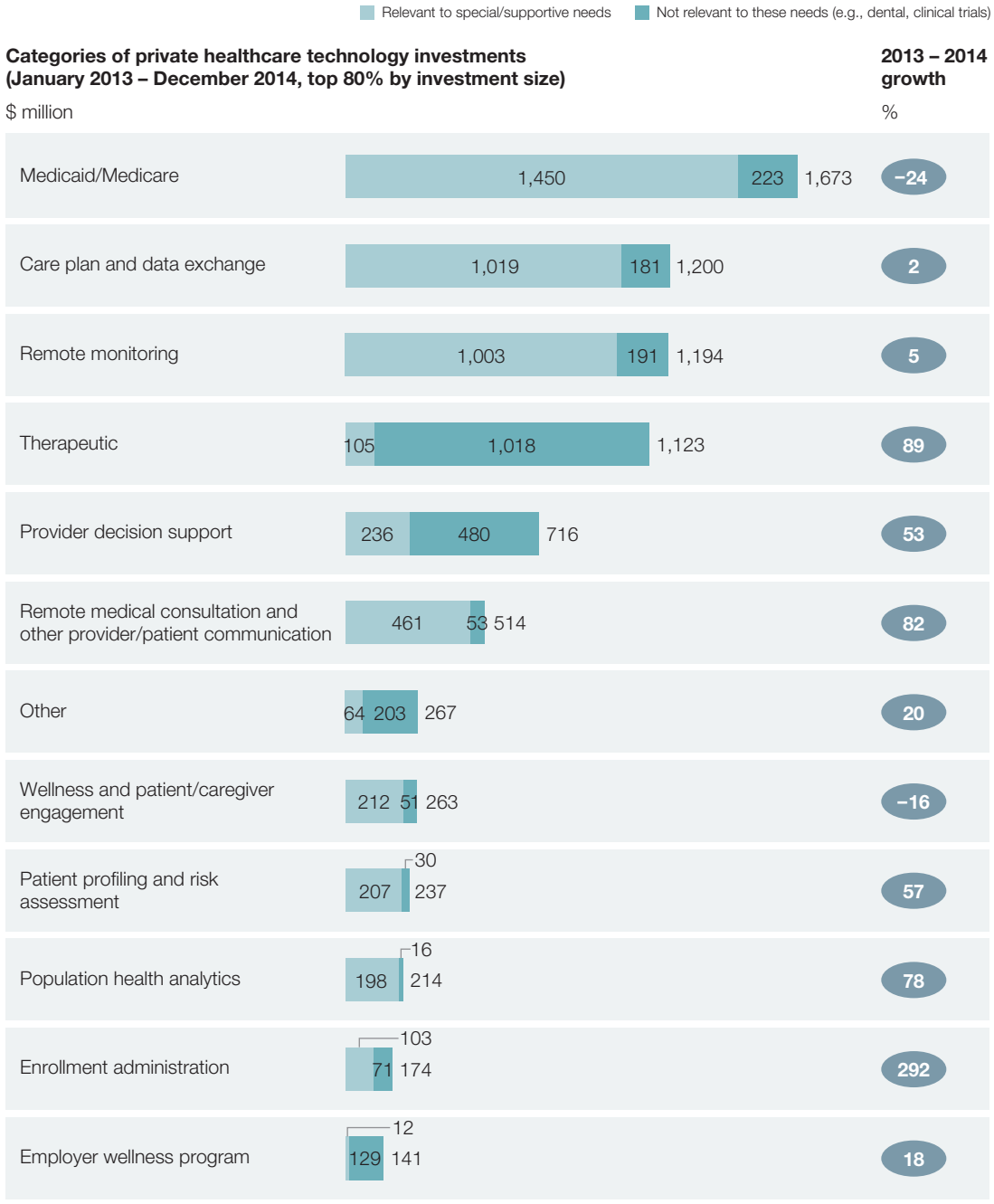
In 2013 and 2014, about 20% of all private investments focused on administrative tools, which may be especially important for providers of BH, I/DD, and LTSS services, given their generally small size. The adoption of managed care by state Medicaid programs and changing reimbursement approaches for individuals with commercial insurance are continuing the trend toward integration and imposing new requirements (e.g., quality reporting). Administrative tools help by automating many aspects of practice management, streamlining electronic health records, facilitating reimbursement requests, and more. Although many of the tools are geared to physical health and traditional medical providers, technology companies (e.g., Homecare Homebase or NextGen) are expanding their focus to address the administrative needs of supportive services providers, such as electronic health records (EHRs) designed specifically for BH treatment.

Care plan/data exchange tools and remote monitoring (which have some overlap with the administrative tools discussed above) each received about 15% of the 2013–2014 private investments. A number of mid-size players with similar technologies are developing care plan/data exchange tools, which allow providers to easily share medical data with other supportive care providers, payors, and patients. These tools could become critical enablers as states and payors increase coordination within fragmented delivery systems. However, many of them are relatively new and have not been extensively implemented, and thus there are no clear widely preferred tools currently in the market.

Remote monitoring has drawn attention as payors and providers experiment with different ways to capture real-time patient data and test whether the data can improve outcomes. At present, several smaller players are working on remote monitoring devices, but only a few companies are doing it at scale. Some providers are piloting the use of the real-time data to adjust patients' care plans on a monthly or weekly basis. Studies have shown that remote monitoring has measurable impact in reducing readmission rates and improving early detection and diagnosis of certain conditions.[2,3] In other cases, remote monitoring is being used to check for—and address—potential gaps in care. Many states are using remote monitoring this way to help ensure that needed services are delivered in timely fashion, to gather point-of-service quality satisfaction data, and to engage the on-site care provider as a member of the care team (e.g., the provider can send real-time status updates to a care coordinator regarding changes in status that warrant intervention.

Private investment levels, although still small, are growing rapidly in several areas that have

EXHIBIT 5 **Technology investments relevant to individuals with special/supportive needs**



Source: McKinsey analysis of Rock Health and Capital IQ databases; may not contain a comprehensive view of all healthcare investments and acquisitions. See appendix for more information

> "Many states are investing, or mandating that the MCOs they work with invest, in needs assessment tools that measure how well individuals can perform activities of daily living (ADLs)."

strong potential to influence care delivery for individuals needing BH, I/DD, or LTSS services. These areas include:

- Remote medical consultations, which have proved in many cases to be just as effective as in-person consultations.[4] (For more information about the use of remote monitoring, see p. 24.)

- Technologies that can help providers reduce risk and increase their overall clinical effectiveness, such as patient profiling and risk assessment tools, and population health analytics. Given their small size, providers of BH, I/DD, or LTSS services often band together to implement these solutions more effectively.

- Decision support tools that help providers make quality-oriented, cost-effective clinical decisions at the point of care (an increasingly important issue as providers take on risk for the total cost of care).

In addition, many states are investing, or mandating that the MCOs they work with invest, in needs assessment tools that measure how well individuals can perform activities of daily living (ADLs). These tools are particularly important to ensure that individuals with BH conditions or I/DD and those needing LTSS receive the level of care appropriate for their level of functionality; however, they remain difficult to administer logistically and sometimes show poor inter-rater reliability. As the use of these tools has expanded, new technologies have been emerging to streamline data collection and care plan development. An evolution of this concept is to utilize remote monitoring to enable real-time ADL assessment.

However, it is not yet clear which of these tools and technologies will be most effective, or what type of impact they will have on the quality of care delivered, outcomes achieved, or the affected individuals' perception of quality of life.

REFERENCES

1 McKinsey analysis of Rock Health and Capital IQ databases; top 80% of companies by investment amount from January 2013 to December 2014 analyzed. The Rock Health database is comprehensive for digital health US deals over $2 million, leveraging a variety of sources (press releases, news outlets, CapIQ, SEC filings, etc.). Capital IQ captures the vast majority of deals below $2 million and includes a combination of private investments and acquisition deals. See the appendix for more information.
2 Snell A. The role of remote care management in population health. *Health Affairs* blog. April 4, 2014.
3 Furukowa T, et al. Effectiveness of remote monitoring in the management of syncope and palpitation. *Europace*. 2011;13(3):431-7.
4 American Telemedicine Association. *Research Outcomes: Telemedicine's Impact on Healthcare Cost and Quality.* April 2015.

What types of innovations are happening?

Across the country, state governments and other organizations have adopted a range of new approaches for delivering services to Medicaid beneficiaries with special or supportive needs. The examples given below, although far from exhaustive, demonstrate the breadth of that range. In many cases, the innovations were put in place only recently and hence proof of efficacy has not yet emerged.

Kansas: KanCare

The state's KanCare program covers more than 90% of its Medicaid population, including those in need of BH, I/DD, or LTSS services. The state contracts with three commercial MCOs to deliver and coordinate care.[1] When the program was launched in 2013, Kansas estimated that the savings it would realize over five years was $800 million; $126 million of this was expected to come from I/DD services.[2] Results to date have not yet been reported, but the state is tracking not only cost data but also specific quality indicators for various patient groups to monitor the success of the program over time. If the projected savings from I/DD services are realized, Kansas has said that it plans to reinvest the money in increased supportive services.

Missouri: Health homes

Missouri has implemented a state-wide system of health homes for Medicaid beneficiaries with serious and persistent mental illness. The health homes, which are community mental health centers, coordinate all medical and BH care, help patients access services, and provide extensive follow-up. These homes have already enrolled more than 10,000 individuals. Preliminary results showed a 27% decline between 2011 and 2012 in the number of individuals who needed one or more hospitalizations.[3]

Ohio: Improved medication adherence

Medication adherence is an important aspect of effectively serving individuals receiving HCBS care. CareSource, an MCO in Ohio, has implemented an intensive medication management program using enrollment and claims records to identify non-adherence. It then uses a web-based interface to notify pharmacists, who follow up with patients as appropriate. The program has already produced several favorable outcomes, including reduced emergency room utilization, resulting in an estimated return on investment of 8:1.[4]

Oregon: Coordinated care organization (CCO) model

Oregon's CCO model covers about 90% of the state's Medicaid population, including all of those with BH conditions or I/DDs and those in need of LTSS.[5] The model consists of 15 regional networks of providers, each of which receives a capitated payment to deliver and coordinate all care. When the model was launched in 2012, projections suggested it could save the state $11 billion over ten years and improve health outcomes.[6] Although estimates of cost savings have not been released, some evidence of quality improvements has emerged: between 2013 and 2014, the program bettered its scores on more than half of the 44 metrics it is tracking. In particular, the program nearly tripled the percentage of adults screened for alcohol or substance misuse and increased the proportion of infants screened for developmental problems by almost 30%.[7]

Washington: Expanded employment programs

Washington is a leader in supported employment programs, having inaugurated its Medicaid-funded competitive employment program, called "Employment First," in 2005. The program has helped an increasing number of individuals with I/DDs hold jobs (5,314 people, according to the most recent report). As a result, Washington has significantly improved its performance on I/DD National Core Indicators and has shown that the program can produce a positive ROI to the state from income taxes alone.[8] Washington has since acted as a mentor to other states launching similar programs.

Remote monitoring initiatives

Remote monitoring programs for individuals in need of BH, LTSS, or I/DD services are emerging across the country. However, remote monitoring is being used somewhat differently in each of the three groups, as the examples below illustrate.

BH. Ginger.io, a smartphone app, detects symptomatic flare-ups in individuals with mental illnesses based on their smartphone activity (e.g., lethargy, lack of social interaction). It then alerts providers to intervene before the individuals require inpatient care. Preliminary evidence from a pilot program suggests that the app reduces hospitalization rates and improves patient-reported outcomes.[9]

LTSS. Eleven states have implemented a remote monitoring program for Medicaid beneficiaries receiving LTSS. Many of these programs also include telehealth services. In Colorado, for example, Centura Health at Home implemented a program that includes remote monitoring of vital signs, weight, and behavioral health status, as well as a clinical 24/7 call center to monitor results and coordinate care. This small-scale program achieved a 62% reduction in 30-day rehospitalizations and a significant decrease in emergency room visits.[10]

I/DD. In 2011, the Ohio Medicaid program was one of the first to receive a waiver to use remote monitoring specifically for individuals with I/DDs.[11] Since then, it has reimbursed for the use of such technologies as door monitors, video cameras, shock sensors, and biometric sensors, as well as 24/7 staff for monitoring and support. Participating individuals have reported significantly increased independence, security, and quality of life.

REFERENCES

1 McKinsey Center for U.S. Health System Reform Medicaid Managed Care Program Database.
2 Interviews with state Medicaid directors.
3 Nardone M, Snyder S, and Paradise J. *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*. Kaiser Family Foundation Issue Brief. 2014.
4 The Menges Group. *Prescription Drug Adherence in Medicaid Managed Care*. October 2014.
5 Oregon.gov. Spotlight on Oregon's CCOs. (cco.health.oregon.gov/Pages/Home.aspx).
6 Robeznieks A. Off-trail in Oregon. *Modern Healthcare*. May 5, 2012.
7 Oregon Health Authority. *Oregon's Health System Transformation. 2014 Final Report*. Released June 24, 2015.
8 United Cerebral Palsy. *The Case for Inclusion*. 2014.
9 Centerstone Research Institute. CRI, Ginger.io and Verizon partner to solve healthcare's superutilizer challenge. 2014. (centerstoneresearch.org/centerstone-research-institute-ginger-io-verizon-partner-solve-healthcares-superutilizer-challenge/).
10 Broderick A, Steinmetz V. *Centura Health at Home: Home Telehealth as the Standard of Care*. The Commonwealth Fund. January 2013.
11 Ohio Department of Developmental Disabilities. Remote monitoring is supporting independence. *Pipeline Quarterly*. January 2014.

Conclusion

The evolution of care delivery for individuals needing BH, I/DD, or LTSS services holds promise of significantly improving quality of care and outcomes achieved while controlling costs. However, it requires that most states, private payors, and providers develop new capabilities.

A state, for example, should have a detailed understanding of the current and future demographics of the three groups within its own borders, the services utilized by each group, and variations in the cost of these services. To develop this understanding, most states will have to be able to integrate data from multiple agencies to get a holistic view of these issues. In addition, a state should have a long-term strategy for managing the three groups. A critical enabler of this strategy would be robust analytics to identify opportunities for care improvement, enable innovative reimbursement models, and measure performance (including metrics for quality of care) across its provider and managed care networks.

A state that is considering implementing new programs (e.g., health homes) as a way to address the needs of these groups should also develop expertise in program design. In particular, it should be able to accurately ascertain how well the program complements or fits within its existing managed care strategy (if applicable); focuses on the segments of the population that require enhanced care management; ties incentives directly to measurable outcomes; and ensures that providers have, or are on the path to developing, the ability to manage risk over time.

A private payor that wants to offer coverage for the full range of BH, LTSS, and I/DD services, or for just one of those segments, would need care management capabilities targeted to one or more of the three populations, as well as the tools required to manage a large network of specialized providers. The payor might also have to build the infrastructure required to support the new services (e.g., updated billing and claims systems, new utilization management policies). The extent to which it makes economic sense for a payor to invest in capabilities, tools, and infrastructure will depend on its overall corporate strategy, its Medicare Advantage strategy, the type(s) of additional populations or products it wants to develop, and the number of states it would like to offer the programs in.

The capabilities a provider would have to consider acquiring depend, in part, on the answers to two questions:

- Does it wants to be a first mover in more closely integrating care delivery (e.g., a BH provider that integrates with a primary care, an LTSS provider that offers a range of long-term-care services, an acute care provider that wants to increase its ability to control the full spectrum of costs related to a given episode)?

- Does it need to increase its scale before it can justify investments to improve operational efficiency and adapt to new reimbursement models?

A specialized provider that wants to join forces with an acute care system would have to prove its ability to positively influence the total cost of care or demonstrate strong willingness to learn how to do that. However, a specialized provider that wants to remain independent would require the skill to create a distinctive value proposition, especially if its market became increasingly consolidated and efficient.

Only time will tell whether the evolution of care delivery for individuals needing BH, I/DD, or LTSS services lives up to its promise. Emerging evidence suggests, however, that there is reason to hope.

Appendix

Exhibit 1: Cost of care for individuals with special/supportive care needs

The estimates in this exhibit were derived from a number of sources. Some were directly cited from well-respected sources; others were estimated from available data. Here, we summarize how we arrived at the numbers listed:

Behavioral health

Total population size: In 2013, SAMHSA reported that **43.8 million** adults had suffered from any mental health condition in the past year. The National Institute for Mental Health (NIMH) corroborated this figure and noted that **9.6 million** children and adolescents under age 18 had suffered from a mental health condition (a 13% prevalence, given that the total population under age 18 was 74.1 million, according to the US Census Bureau). SAMHSA also reported that **12.6 million** adults had a substance abuse disorder (without comorbid mental illness) in 2013 and that **1.1 million** adolescents had such a condition in 2012. These figures sum to **67.1 million**.

Population receiving treatment: In 2013, SAMHSA reported that **34.6 million** adults were receiving treatment for mental health conditions; in 2012, it reported that **3.1 million** children received treatment in a specialty mental health setting. (This figure may underestimate the number of children receiving treatment, given that it did not include services that were delivered in other settings). It also reported that **6.9 million** adults and **0.6 million** adolescents received treatment for substance abuse (without comorbid mental illness) in 2012. These figures sum to **45.2 million**. The Milliman American Psychiatric Association Report provides a similar estimate: that 41.1 million individuals received treatment for BH conditions in 2014.

Approximate total spending: The Milliman Report stated that in 2014, the "total spending … across all service categories for those with mental health/substance use disorders is estimated to be **$525 billion** annually." However, that report suggests that the total amount spent on BH treatment specifically in 2014 was **$87.9 billion**, which is substantially lower than the estimate provided by SAMHSA (see below). SAMHSA excludes dementia and mental retardation from its definition of BH conditions, whereas Milliman includes them.

Total support services spending: SAMHSA estimated that total spending on support services for mental health/substance use disorders (excluding administrative costs) was **$180 billion** in 2012.

SOURCES

SAMHSA. Substance use and mental health estimates from the 2013 National Survey on Drug Use and Health: Overview of findings. *The NSDUH Report*. September 4, 2014.

SAMHSA. Results from the 2012 National Survey on Drug Use and Health: Mental health findings. December 2013.

National Institute of Mental Health. Any disorder among children. (www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml).

Milliman, Inc. and the American Psychiatric Association. *Economic Impact of Integrated Medical-Behavioral Healthcare*. April 2014.

SAMHSA. Projected National Expenditures for Treatment of Mental Health and Substance Abuse Disorders, 2010-2020. August 5, 2014.

Long-term services and supports

Total population size: An article by Kaye et al published in *Health Affairs* reported that, using a broad definition of individuals in need of LTSS services, 0.8% of the under-18 population, 2.8% of the 18–64 population, and 15.5% of the over-65 population required LTSS in 2009. When population-adjusted for 2012 (based on US census data), the result is **12.8 million** individuals.

Population receiving treatment: The same article suggested that 0.6% of the under-18 population, 1.1% of the 18–64 population, and 7.2% of the over-65 population received formal LTSS in 2009. When adjusted for the 2012 population, the result is **5.7 million**.

Approximate total spending: During an extensive literature search, we were unable to locate an estimate of the total spending for individuals requiring LTSS. However, CMS reported that total national health expenditures in 2012 for home health care, nursing facilities, continuing care retirement communities was **$236 billion**. This estimate does not take into account care for these individuals in settings other than those mentioned and thus should not be used to represent total spending.

Total support services spending: The National Health Policy Forum reported that total LTSS spending for support services was **$220 billion** in 2012.

SOURCES

Kaye HS, Harrington C, LaPlante MP. Long-term care: Who gets it, who provides it, who pays, and how much? *Health Affairs*. 2010; 29(1):11-21.

CMS. *Quick Reference: National Health Expenditures 2013 Highlights*. (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf).

National Health Policy Forum. National spending on long-term services and supports (LTSS), 2012. March 27, 2014.

Developmental disabilities

Total population size: The Bethesda Institute reviewed a number of sources and reported that roughly 1.5% to 2.5% of the U.S. population has an intellectual or developmental disability (approximately **6.3 million** individuals in 2012).

Population receiving treatment: Data from the United Cerebral Palsy Case for Inclusion website suggested that **1.1 million** individuals with intellectual or developmental disabilities are receiving care (in all care settings, including a family home, their own home, family foster care, congregate care, and large state institutions).

Approximate total spending: The CDC reported that individuals with I/DDs accounted for 15.7% of Medicaid healthcare expenditures in 2009 (equivalent to **$64 billion** in 2012). If we add in the non-Medicaid portion of I/DD expenditures (23% of $57 billion, or $13 billion, as reported by The State of the States in Developmental Disabilities Project of the University of Colorado), the total becomes **$78 billion**.

Total support services spending: The State of the States in Developmental Disabilities Project of the University of Colorado reported that national spending for I/DD support services is **$57 billion**; 77% of this amount is covered by Medicaid. This estimate was corroborated by a report from the National Residential Information Systems Project of the University of Minnesota.

SOURCES

Bethesda Institute. *How Prevalent Are Intellectual and Developmental Disabilities in the United States?* March 2012.

United Cerebral Palsy. *The Case for Inclusion*. 2014 Report.

Centers for Disease Control and Prevention (CDC)/National Center on Birth Defects and Developmental Disabilities (NCBDDD) Health Surveillance Work Group. U.S. surveillance of health of people with intellectual disabilities. September 10-11, 2009.

State of the States in Developmental Disabilities. *United States: Total Public I/DD Spending for Services: FY 1977-2013*. 2014.

Research & Training Center on Community Living Institute on Community Integration (UCEDD). *Residential Services for Persons with Intellectual and Developmental Disabilities: Status and Trends through Fiscal Year 2011*. 2013.

Exhibit 2: States with managed Medicaid programs that cover special and supportive needs services

The analysis for Exhibit 2 came from the McKinsey Medicaid Managed Care Program Database (described below). The programs are defined as follows:

Managed care programs that cover both medical and special/ supportive needs services

These programs cover behavioral health, long-term services and supports, and/or intellectual and developmental disability services in addition to medical services for their members. The enrollment figures stated include the total of all individuals enrolled in the programs, not necessarily those who are using any of the special needs services.

Programs that cover some special needs services but not medical care

These programs do not cover medical services, but focus on coverage of one or more types of special needs services. The enrollment figures stated include the total of all individuals enrolled in the program, not necessarily those who are using any of the special needs services.

Exhibit 3: Advanced analytics makes it possible to tailor treatment to specific patient profiles

The analysis for Exhibit 3 came from the proprietary Behavioral Health Diagnostic tool from McKinsey Healthcare Analytics (see the section "Proprietary McKinsey tools used" for a more detailed explanation of this tool). The analysis was done on blinded claims data from one state's Medicaid data set.

Exhibit 4: Payors offering managed Medicaid programs covering special/supportive needs services

McKinsey's Medicaid Managed Care Program Database (described below) was used for this analysis. Every managed care organization (MCO) found in the database was classified into one of 11 categories based on its primary line of business or characteristic (determined by reviewing their websites):

- Medicaid/Medicare-focused player
- Regional/local commercial plan
- Provider-owned or operated plan
- Blue Cross Blue Shield Association plan
- National commercial insurer
- Other, which includes government agencies (state or municipal), co-operative plans (owned by the individuals the plans insure), university/academic center owned plans, specialty BH providers, specialty LTSS providers, and other specialty (e.g., AIDS, maternity care) providers.

Analyses were done for the BH, LTSS, and I/DD services markets based on which payors carve in all or part of those services into their managed care plans.

Exhibit 5: Technology investments relevant to individuals with special/supportive needs

Analysis of private healthcare technology investments and acquisitions was done using the Rock Health and Capital IQ databases. The Rock Health database is comprehensive for digital health US deals over $2 million, leveraging a variety of sources (press releases, news outlets, CapIQ, SEC filings, etc.). Capital IQ captures the vast majority of deals below $2 million and includes a combination of private investments and acquisition deals. The top 80% of companies by investment amount from January 2013 to December 2014 were analyzed for inclusion in the figure; the bottom 20% of investments by investment amount (which included more than 600 companies) were not included. Companies were categorized into one of 12 categories based on their primary offering (determined by reviewing their websites):

- *Administrative tools:* Provider (and to some degree payor) administration, practice management, efficiency, and revenue cycle management tools
- *Care plan and data exchange:* Tools that help enter and follow up on a care plan and share the plan and other medical data with providers, payors, and patients to coordinate care
- *Remote monitoring:* Sensors and other methods for passive or active monitoring of a patient's condition and transmission of the data to providers, caregivers, or other parties
- *Therapeutic:* Technologies that provide direct clinical therapy or care for conditions

- *Provider decision support:* Analytics and tools that assist with decision making for providers on care patient care and interventions, usually at point of care
- *Remote medical consultation and other provider/patient communication:* Tools that allow providers and patients to communicate, via text, video, etc., for telehealth consultations or advice
- *Wellness and patient/caregiver engagement:* Platforms that assist with coaching on lifestyle and patient engagement in health (also involving caregivers)
- *Patient profiling and risk assessment:* Tools that take patient/EHR data and analyze, usually in real time, patient risk to help manage high-risk cases
- *Population health analytics:* Tools that use patient/EHR data and other available data sources and produce informative reports and ways to interpret overall health and performance of providers' patient panel
- *Enrollment administration:* Tools that assist individuals with selecting and enrolling in health plans
- *Employer wellness program:* Wellness programs targeted at helping companies manage the health of their employees and their health insurance costs
- *Other:* A catchall bucket for technologies that didn't fit into any of the above categories

Companies were also classified as "relevant to the BH, LTSS, and/or I/DD populations" or "not relevant those populations." All general tools (e.g., provider administrative tools, general population health analytics and risk assessments) were classified into the "relevant" category, with the exception of specific targeted therapies, genomics research, clinical trials software, neurology tools and software, and other technologies that do not directly bear relevance to the care of our populations. This was done to get a sense of what technologies were likely to be having real impact in shaping care for these individuals.

Proprietary McKinsey tools used

McKinsey Medicaid Managed Care Program Database

The Medicaid Managed Care Program Database offers a granular and comprehensive view of all capitated managed care programs (including MCOs, HIOs, PIHPs, PAHPs, and PACE programs) across the country, broken down by state and program, as of January 2015. This database was built through weeks of intensive research and includes program-specific details such as participating MCOs, current program enrollment, services included and excluded (with detail on specialized services, such as BH programs, LTSS programs, and services for individuals with I/DDs), eligibility, geography, mandatory vs. voluntary enrollment, quality incentives, waiver entities, and more.

Specifically, the database includes:

- Data across all 125 managed care programs and 500+ participating managed care organizations in the U.S.
- Managed care programs broken down by MCO, MCO parent company, and parent company type, showing the MCO's date of entry, services covered, and number of lives covered
- Information on complete state programs, including total managed care spending,

total enrollment, use of quality incentives, and trends associated with managed care

- Insight on types of managed care programs, including MCO, PACE, PIHP, PAHP, HIO, and non-emergency transportation and dental programs

The data was gathered from a number of sources, including state Medicaid websites and enrollment reports, state agency websites, MCO websites, MCO contracts and requests for proposals, reports from reliable sources such as CMS.gov, and more. The enrollment data found in the database includes the most recent publicly available information as well as a few enrollment reports obtained directly from states. The reports are from the following years:

- 28% from 2015
- 41% from 2014
- 1% from 2013
- 30% from 2012 (from the 2012 Medicaid.gov managed care enrollment report)

Behavioral Health Diagnostic Tool (McKinsey Healthcare Analytics)

The Behavioral Health Diagnostic Tool developed by McKinsey Healthcare Analytics uses healthcare claims information (including professional, facility, and prescription claims) to analyze, identify, and segment both differences in the behavioral health populations and patterns in their treatment and care. These analyses can be performed on any claims data set to reveal opportunities for improved care of this population. The analyses were created with significant clinician input, validated across multiple data sets, and syndicated with leaders in behavioral health population management. Examples of questions that can be answered through the use of this proprietary tool include:

- What percentage of the overall population has a diagnosed and treated behavioral health condition? What percentage has a diagnosed but untreated behavioral health condition? What percentage may have an undiagnosed behavioral health condition?
- What is the profile of the individuals with behavioral health conditions that have the highest needs, and what percentage of total spending is concentrated on them?
- How does the severity of behavioral health needs exacerbate medical conditions?
- How does the treatment profile differ between high-needs individuals and the rest of the behavioral health population in terms of the types of providers visited and frequency of visits?
- What percentage of high-needs individuals remain in this subgroup year after year?

For more information, contact McKinsey_on_Healthcare@mckinsey.com

www.mckinsey.com/client_service/healthcare_systems_and_services