McKinsey & Company

COVID-19 Impact on Behavioral Health

National Council – Corporate and Affiliate Partners Meeting

June 2020

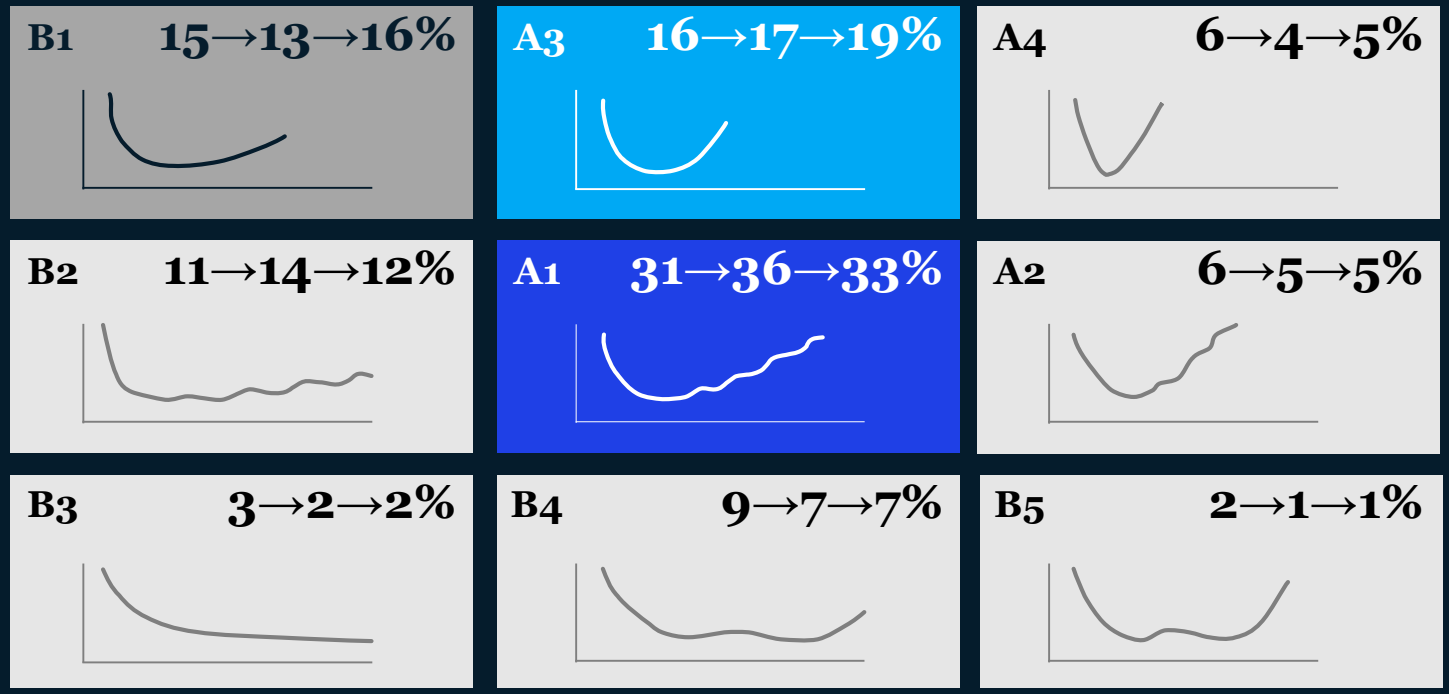
Shape of the COVID-19 impact: the view from global executives

"Thinking globally, please rank the following scenarios in order of how likely you think they are to occur over the course of the next year"; % of total global respondents[1]

World — **April → May → June surveys**

Virus spread and public health response

	Ineffective interventions	Partially effective interventions	Highly effective interventions
Rapid and effective control of virus spread	B1 15→13→16%	A3 16→17→19%	A4 6→4→5%
Effective response, but (regional) virus resurgence	B2 11→14→12%	A1 31→36→33%	A2 6→5→5%
Broad failure of public health interventions	B3 3→2→2%	B4 9→7→7%	B5 2→1→1%



Knock-on effects and economic policy response

1. Monthly surveys: April 2–April 10, 2020, N=2,079; May 4–May 8, 2020, N=2,452; June 1–5, N=2,174

Source: McKinsey surveys of global executives

There are 5 stages to "winning the battle" against COVID-19 for behavioral health and health-related basic needs

Resolve

Crisis-response efforts focused primarily on **rapidly defining and launching short-term actions** to stabilize the health system

Resilience

Evolving focus into near-term issues of better establishing support for health-related basic needs of vulnerable populations and responding to increased behavioral health needs

Return

Leaders may have to **balance mitigation measures** with the **population's behavioral health, support for basic needs, and economic needs**

Potential for a renewed crisis, with winter bringing a resurgence of the virus

Reimagination

Organizations will reinvent themselves, pushing the envelope on the adoption of digital tools and driving stronger integration of behavioral health, health-related basic needs and physical health

Reform

The aftermath of the pandemic may provide an opportunity to **overhaul care delivery models** to better support vulnerable populations at baseline and in times of crisis

Source: Beyond coronavirus: The path to the next normal - https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/beyond-coronavirus-the-path-to-the-next-normal

COVID-19 has led to vast unemployment, paired with pockets of income and racial disparities

~16% peak unemployment projected by the Congressional Budget Office, sustained at ~8-10% through end of 2021[1]

1.4-1.8x

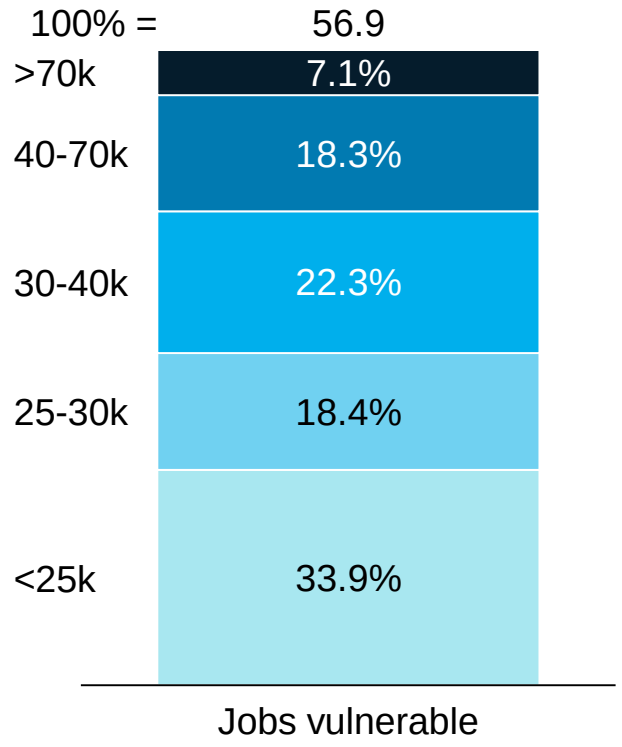
likelihood that Black Americans live in counties with highest risk of disruption from pandemic (vs. White Americans)[2]

$12.5B

in tribal government revenue at stake due to shutdown of tribal gaming enterprises, risking financial viability of healthcare infrastructure

On top of the financial toll, Navajo nation has higher per capita rate of COVID-19 infection than any U.S. state[3]

Vulnerable jobs, by income band,
millions of jobs



1 Congressional Budget Office, https://www.cbo.gov/publication/56351
2 https://www.mckinsey.com/industries/public-sector/our-insights/covid-19-investing-in-black-lives-and-livelihoods 3 The Harvard Project on American Indian Economic Development, https://ash.harvard.edu/files/ash/files/hpaied_covid_letter_to_treasury_04-10-20_vsignedvfinv02.pdf

Source: McKinsey & Company, Jobs at Risk (States)

Medicaid enrollment reached unprecedented levels which may persist through 2021

Factors contributing to Medicaid enrollment increase during COVID-19	Potential impact on enrollment through 2021
1 **Unemployment** resulting in individuals losing employer-sponsored coverage	Decrease in enrollment by end of 2020 as furloughed individuals are rehired and a portion of the unemployed find new jobs Yet, enrollment will likely remain higher than pre-COVID levels, as some COVID-19 related unemployment will likely persist through 2021
2 **Regulatory flexibilities** including autorenewal for all existing Medicaid enrollees, and "presumptive eligibility" which covers all COVID-19 related costs regardless of insurance coverage	Reduced churn from autorenewal will persist through 2020 Even when regulatory flexibility is lifted, states will likely phase in reintroduction of renewal requirements in lieu of a drastic cut to enrollment

In the short-term, the expanded federal match may alleviate some state budgetary pressures as Medicaid costs rise

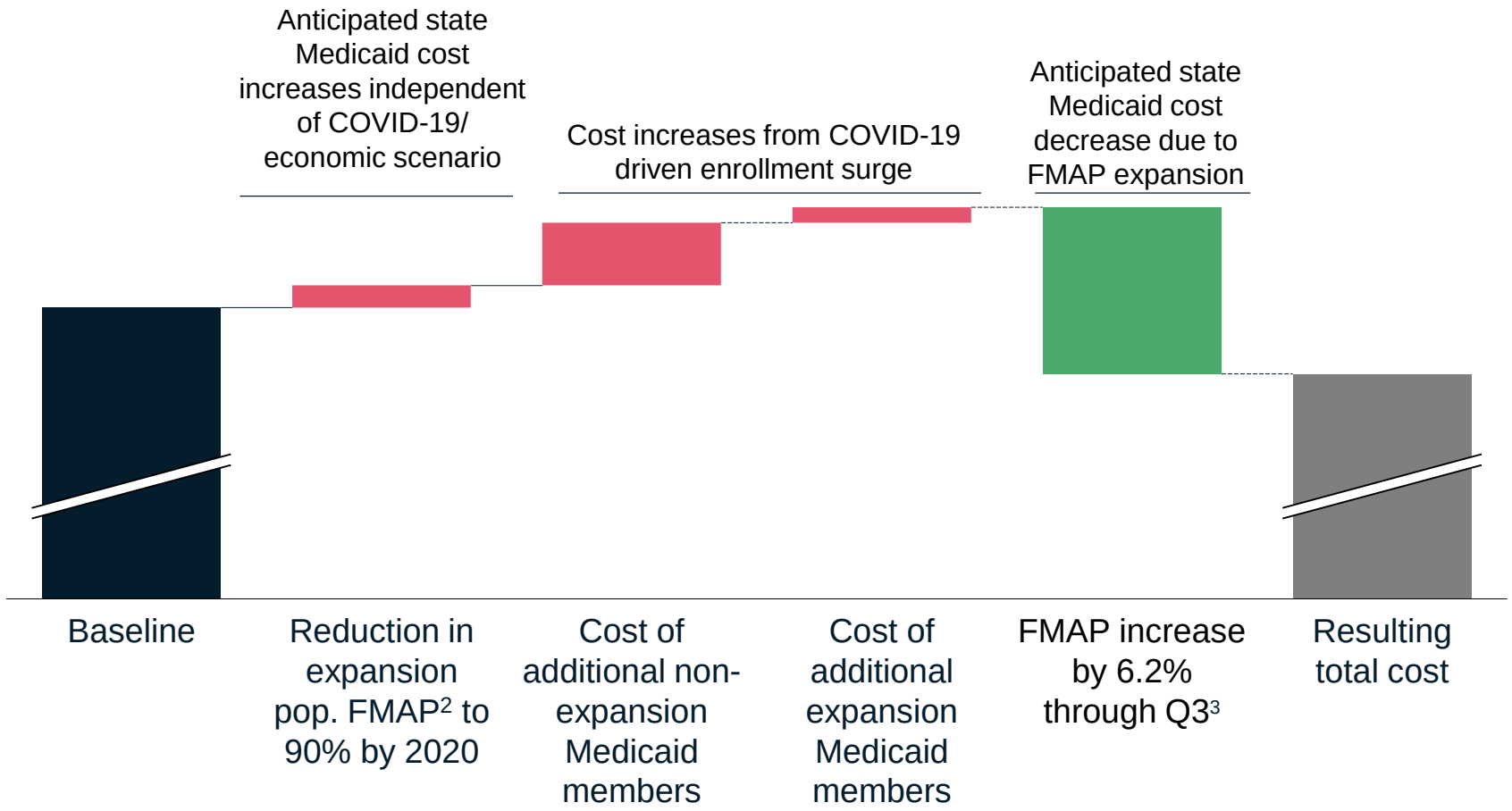
Though a slower than expected economic recovery would pose budgetary issues once expanded FMAP ends

Across expansion states, Medicaid cost as a percentage of total state revenues may increase, driven by:

- Increased enrollment of traditional and expansion members
- Anticipated changes to FMAP[2,4]
- Reduced state tax revenue

2020 projected state Medicaid costs[1] for expansion states in an economic downturn

California under B2 - Virus recurrence; slow long-term growth insufficient to deliver full recovery



1. Accounts for state portion of the cost (i.e., total cost less federal match). Assumes calendar year 2020 | 2. FMAP: Federal Medical Assistance Percentage, DSH: Disproportionate Share Hospital. | As of 6/10/20 DSH payment reductions have been deferred for 2020 and are thus not included | 3. Scheduled 6.2% increase in FMAP for non-expansion enrollees due to COVID-19

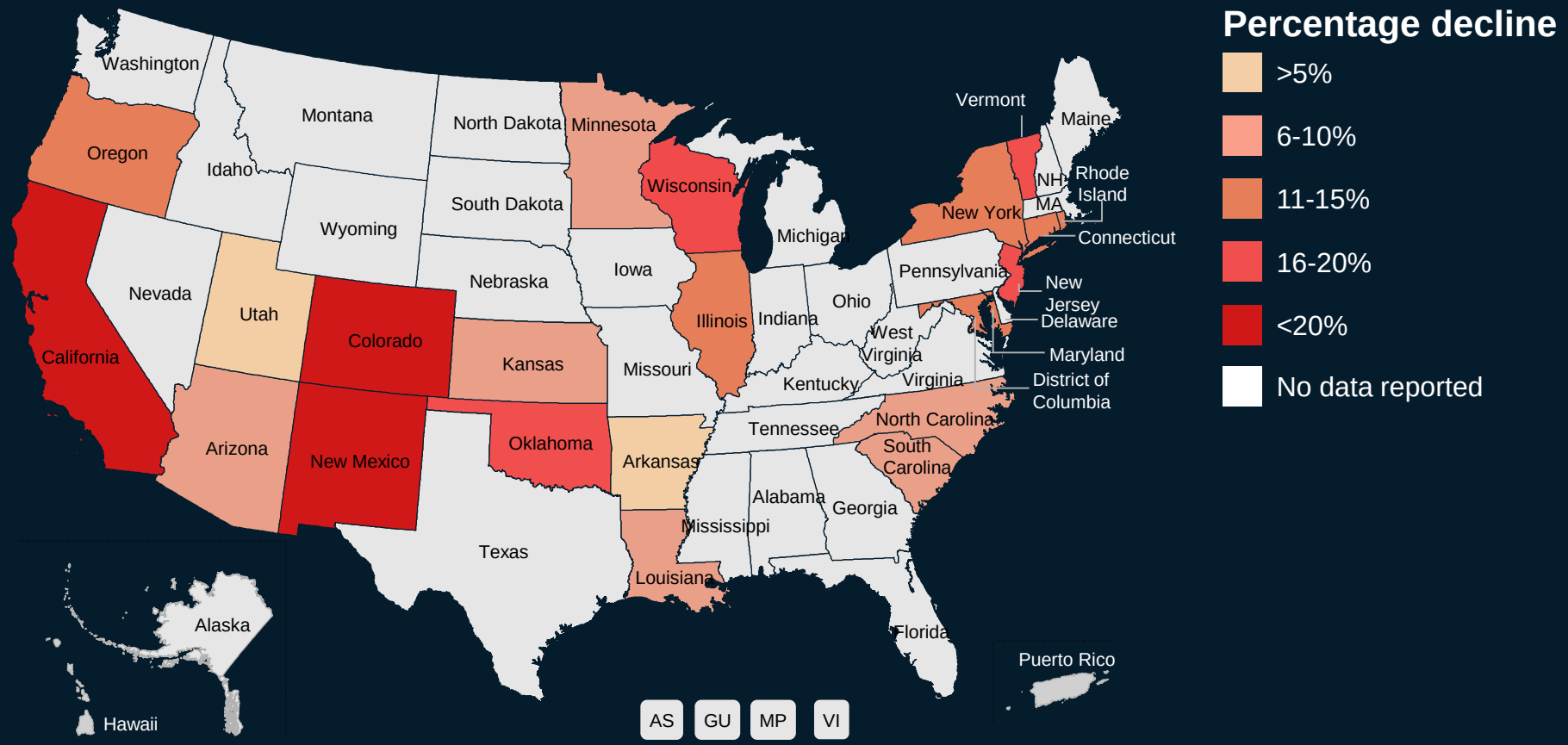
Source: Holahan J, The 2007–09 recession and health insurance coverage, Health Affairs, 2011;30(1):145–52; Jacobs PD et al, Adults are more likely to become eligible for Medicaid during future recessions if their state expanded Medicaid, Health Affairs, 2017;36(1):32–9; Moody's Analytics stress testing states, 2018; National Association of State Budget Officers, Fiscal survey of the states; McKinsey Healthcare Recession Model; McKinsey Medicaid Reform Model

Yet, financial pressures will persist as several states are projecting significant revenue declines

Among the largest states- including New York, California, and Illinois - **state revenues have fallen by 13%** on average[1]

California and New York have projected **budget shortfalls** at $61 and $54.3 billion respectively for FY 2020[2]

Revised state fiscal year 2021 revenue declines



1. National Conference of State Legislatures; https://www.ncsl.org/research/fiscal-policy/coronavirus-covid-19-state-budget-updates-and-revenue-projections637208306.aspx
2. LA Times : “Governors across U.S. face tough choices as coronavirus takes its toll on state budgets” https://www.latimes.com/world-nation/story/2020-05-16/coronavirus-states-reopen-business-economy-deficit-jobs

Source: National Conference of State Legislatures; https://www.ncsl.org/research/fiscal-policy/coronavirus-covid-19-state-budget-updates-and-revenue-projections637208306.aspx

State financial pressure paired with growing public spend has the potential to create a shortfall in behavioral health (BH) spending[1]

BH has suffered budget cuts from financial pressures in the past	Medicaid comprises a higher portion of BH spend today than it ever has	The impact of budget cuts may be exacerbated by a broader reliance on public funding of BH
Mental Health (MH)		
$1.8B of state budgets for mental health (~8%) cut from 2009-2011 after recession[2]	**74%** Growth in Medicaid expenditure for MH from 2009-2019, the highest growth rate of any payer[3]	**43%** Increase in private MH spending from 2009-2019[3] **69%** Increase in public MH spending from 2009-2019[3]
Substance Use Disorders (SUD)		
24% decrease in real value of Substance Abuse Block Grant from 2009-2019, which provides treatment services for 1.5 million Americans each year, and covers 68% of state costs for SUD preventive[4]	**30%** projected growth in Medicaid expenditure for substance use from 2009-2019, the highest projected growth rate of any payer[5]	**71%** of SUD funding projected to be from public sources by 2020[5]

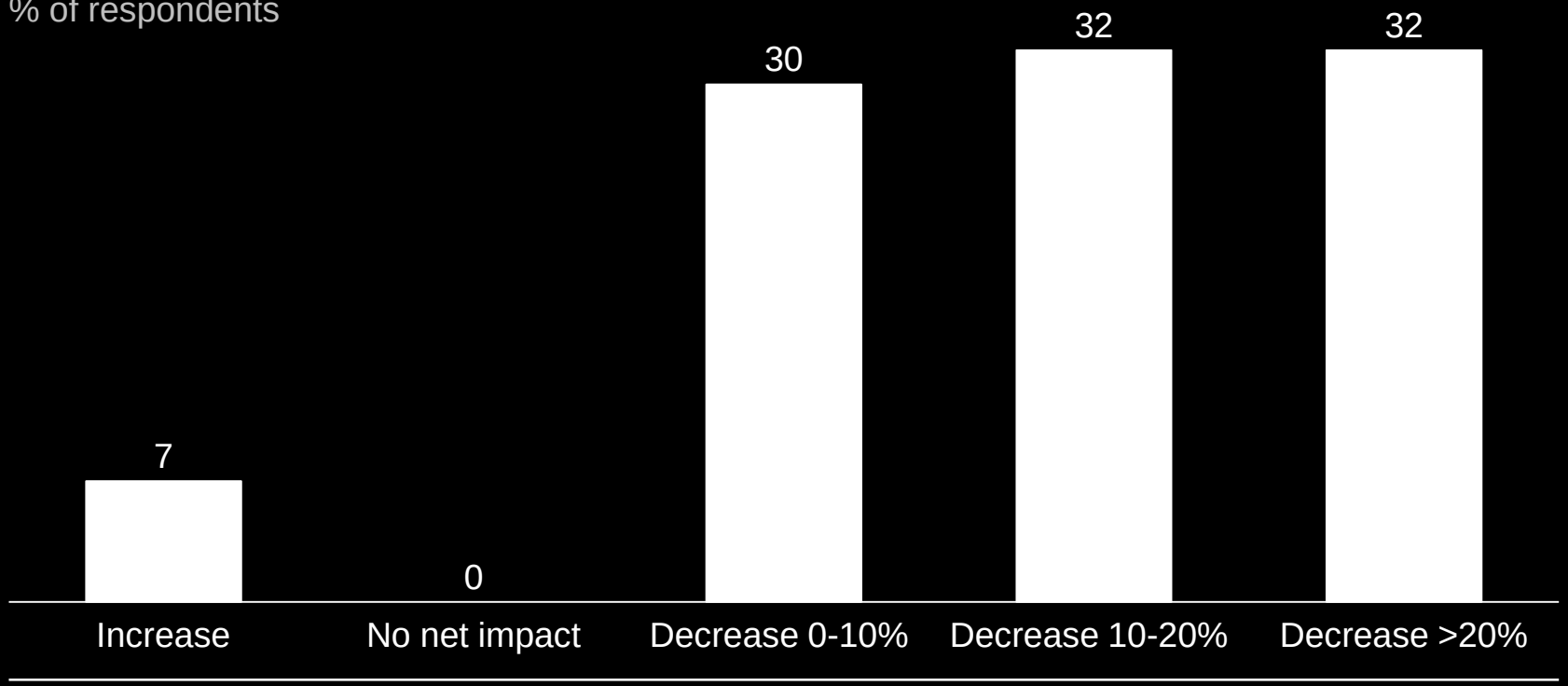
1 Inclusive of mental health and substance use; 2 ; Kaiser Health News: https://khn.org/news/state-mental-health-budgets-fall-during-recession/ ; 3 Open Minds, The U.S. Mental Health Market, 2019; 4 NASADAD (2020) Combatting an Epidemic: Legislation to Help Patients with Substance Use Disorders; 5 SAMHSA Projections of National Expenditures for Treatment of Mental Health and Substance Use Disorders, 2010-2020

The financial impact of COVID-19 on health systems and how CFOs are responding

94% of health systems expect operating margin reductions in 2020

Expected impact of COVID-19 on 2020 operating margin vs. plan,

% of respondents



64% of respondents expect COVID-19 to reduce operating margin by 10% or more

Source: McKinsey CFO/Finance VP Financial Resilience Survey of Health Systems ≥$1 billion annual revenue, 5/21/20-5/29/20, N=44

For some health systems, the financial impact will be devastating

24%

have <90 days of cash on hand

COVID-19 is likely to create both headwinds and tailwinds for value-based care (VBC) in BH

Three key trends during COVID-19 have positioned VBC to accelerate

1. Capitation-based arrangements have provided **financial stability** as providers suffer losses from reduced utilization

2. Adoption of **technology-enabled remote monitoring and telehealth** (in a survey of 245 providers[1], 49% of alternative payment models [APM] participants have used remote monitoring during COVID-19 vs. 30% for non-APM providers)

3. Enhanced focus on **holistic and integrated care,** particularly as BH needs increase due to COVID-19 (82% of APM provider participants have used care management support to manage COVID-19 vs. 51% for non-APM providers)

1 Premier, Inc. survey: https://www.premierinc.com/newsroom/press-releases/premier-inc-survey-clinically-integrated-networks-in-alternative-payment-models-expanded-value-based-care-capabilities-to-manage-covid-19-surge
2 American Academy of Family Physicians, National Association of ACOs: https://www.naacos.com/survey-shows-acos--concerns-about-the-effect-of-covid-19

On the other hand, some fear COVID-19 may derail progress made towards value-based care

56% *of ACO survey respondents participating in Medicare Shared Savings Program[2] said they were at least somewhat likely to drop out to avoid financial losses*

To respond to the challenges and fears providers are facing during COVID-19, payers can make accommodations to VBC programs:

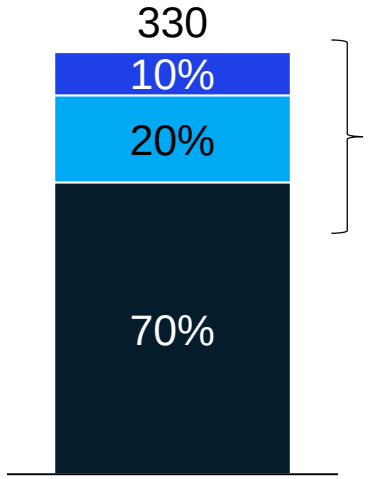
- ✓ Temporary adjustments to technical elements
- ✓ Easing admin requirements
- ✓ Adjusting timing of payments

Behavioral health need prevalence could experience a 50% increase after the COVID-19 pandemic

Increases mainly from healthcare workers, new BH needs from quarantine, and those unemployed

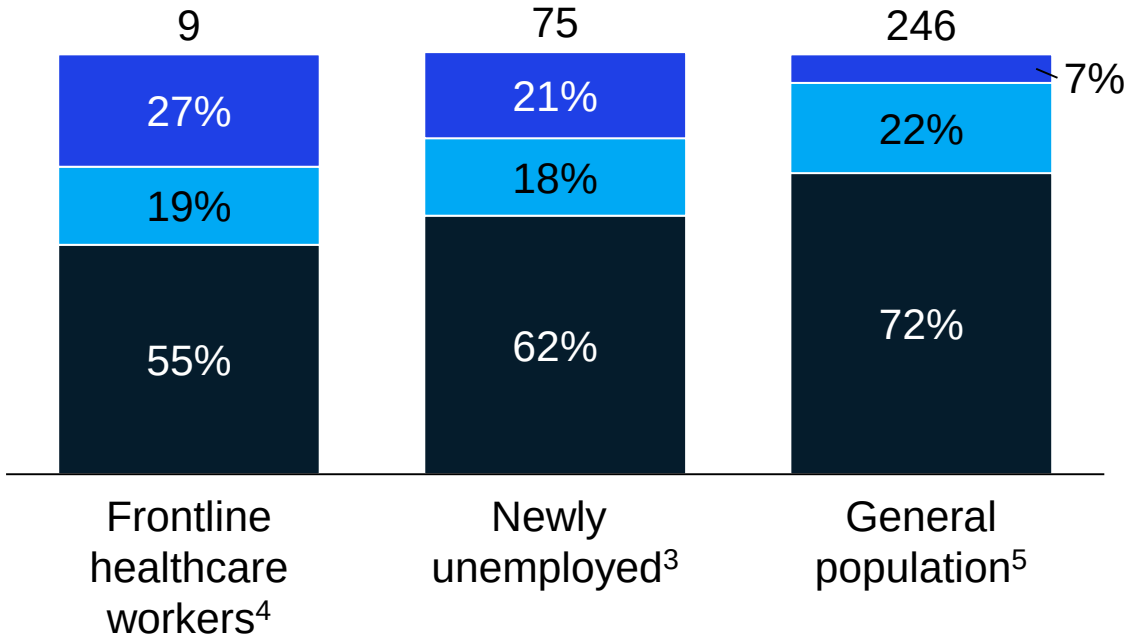
New BH need[1] Existing BH need[2] No BH need

Potential BH need in overall US population in 2021, millions



1 in 3 individuals could have a BH need in 2021[7]

Segments of the 2021 population with potentially heightened BH need due to COVID-19, millions



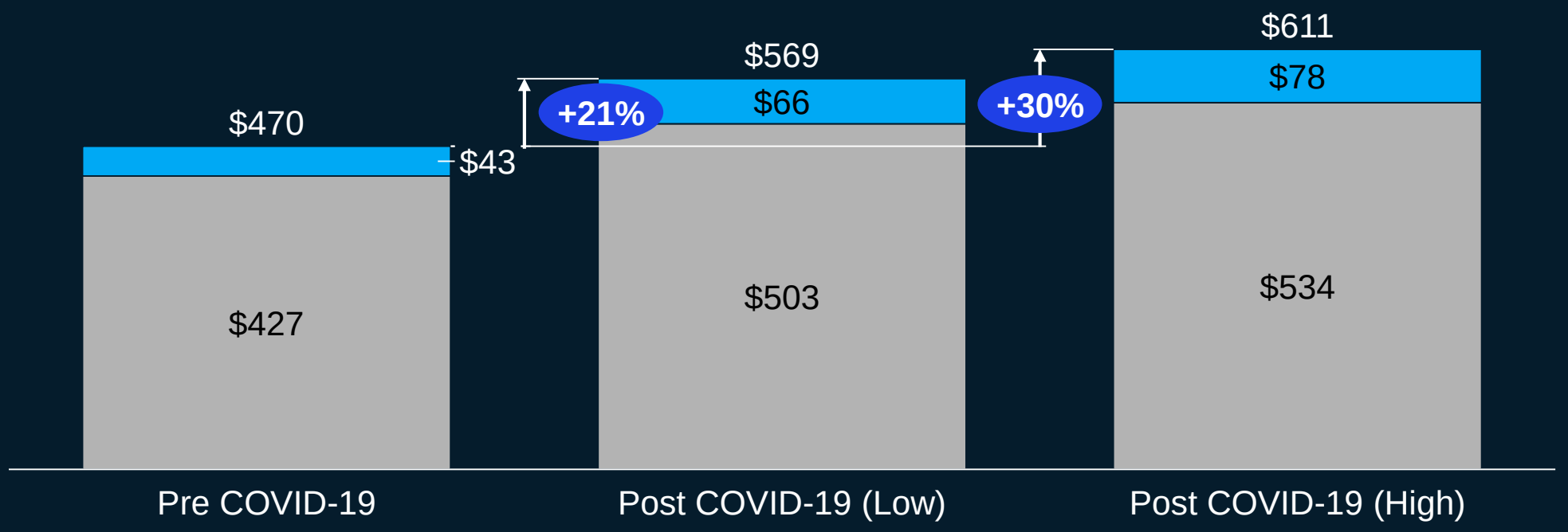
~35 million additional people may experience BH conditions, including **1.6M** directly affected by COVID-19 illness or loss

1. Individuals with new onset of a BH condition (~6% increase in BH population) as a result of experiences related to COVID-19 pandemic (e.g., depression, anxiety, PTSD)
2. Existing BH need extrapolated to total US population based upon Medicare LDS, blinded state Medicaid data, and Truven Commercial data. Assumes ~51.1M existing low BH needs, and ~1.7M existing high BH needs
3. Assumes ~24% unemployment rate in 2021 (total unemployment of ~75M) due to economic impact of COVID-19 and ~1.3X increase in BH prevalence for this population
4. Increase in BH condition prevalence (~1.5-1.9X) among hospital and residential care facility healthcare workers primarily driven by PTSD, anxiety, and depression
5. Individuals with existing or new BH needs that are not either newly unemployed or frontline healthcare workers (e.g., individuals and families sheltering in place, essential workers)
6. Includes increased BH prevalence (~1.5-1.9X) among those hospitalized due to COVID-19 or those that had a close family member die from COVID-19
7. Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Source: Analysis includes claims data from the Medicare FFS Limited Data Set from the Centers for Medicare & Medicaid Services, deidentified Medicaid data, and the International Business Machines Corporation's Truven MarketScan Commercial Database. Any analysis, interpretation, or conclusion based on these data is solely that of the authors and not International Business Machines Corporation

A potential 50% increase in prevalence of BH conditions could lead to $100B to $140B of additional spend

Potential changes in total spend for people with BH needs before and during first year post COVID-19[1,2], $ billions



1. This does not include Tricare, individual market, or uninsured populations
2. Accounts for reduction in spend for people losing employment and not gaining Medicaid coverage

Source: Analysis includes claims data from the Medicare FFS Limited Data Set from the Centers for Medicare & Medicaid Services, deidentified Medicaid data, and the International Business Machines Corporation's Truven MarketScan Commercial Database. Any analysis, interpretation, or conclusion based on these data is solely that of the authors and not International Business Machines Corporation

The Center for Societal Benefit through Healthcare aims to drive positive innovation in areas that are critical for the benefit of society

Initial focus areas

The Center is a **global network of experts**, combining McKinsey's business insights with **leading thinking across the five focus areas**

Behavioral Health	**Mental Health**	**Each year, one in five adults experiences a mental illness**, and one in two will experience one at some point in their lives **Those with poor mental health are four times more likely to have multiple unmet social needs and over twice as likely to have a substance use disorder** As with physical health, there are disparities in mental health – racial/ethnic minorities have less access to mental health services and are less likely to receive high-quality care when they are treated
	Substance Use	~20 million adults have a substance use disorder; more than 130 people in the United States die every day after overdosing on opioids Though opioid use disorder rates are ~30% higher for blacks than whites (3.5% for blacks, 4.7% for whites), white patients' rate of access to buprenorphine is 35 times higher than that of every patient of another race or ethnicity who received a buprenorphine prescription
Rural Health		One in six of all Americans – 46 million people – live in rural areas. There is a significant **gap in health between rural and urban Americans**, with rural Americans more likely to die from conditions such as heart disease, cancer, and opioid overdoses; disparities in health access and outcomes also exist by race and ethnicity
Social Determinants		Nearly **40 percent of health outcomes are based on underlying social factors** such as economic stability, employment, education, food security, housing, transportation, social support, and safety In addition, factors such as race, ethnicity, gender and sexual orientation, disability, and age can influence health status. For example, in 2017, 22% of African American households and 18% of Latinx households reported food insecurity, while the national food insecurity rate was 12%
Maternal Health		Over the past two decades, **maternal mortality rates in the US have increased by 50 to 70 percent**, and rates of severe maternal morbidity have more than doubled Pregnancy-related mortality ratios for black women with at least a college degree are five times as high as white women with a similar education