Substance Abuse Disorder Marketplace

Key Take-Aways From the Autism and Addiction Treatment Forum

Last week, **we attended the Autism and Addiction Treatment Forum (the "Forum") in Chicago to hear from key providers in the substance use disorder (SUD) marketplace** and get an updated perspective on their growth strategies and challenges. We are anticipating a broad-based pick-up in M&A activity across healthcare services in 2025, and we see the SUD space, in particular, as an area of potential elevated activity and transformation.

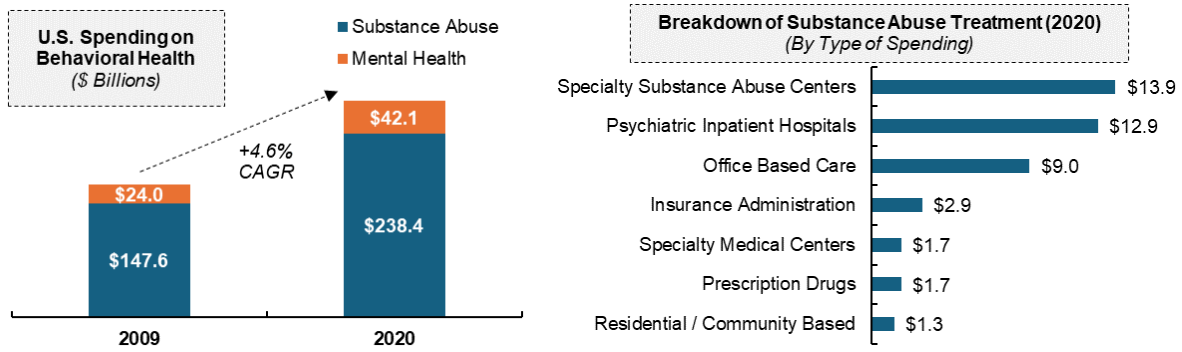
Access to patients was a central theme behind the growth strategies of many of the SUD providers at the Forum. There seemed to be a general consensus that the "cash pay" segment of the SUD market is phasing away with an increasing mix of patients now being covered by managed care. Accordingly, being broadly in-network with local Medicaid and commercial health plans is a must. Also, since substance abuse disorders tend to co-exist with other mental and physical health issues, being a pure-play SUD treatment provider is increasingly *not* considered to be a viable strategy. Many larger and sophisticated SUD providers have been adding adjacent behavioral health services through service line expansions, acquisitions, and partnerships. Finally, providers discussed ways to pursue new patient populations in Medicare and the criminal justice system -- as well as in neurodivergent populations.

Separately, **the Forum panel discussions reflected the important potential role of information technology** to address many of the challenges faced by SUD providers today -- most notably: labor shortages. In our view, there is limited reliable data on EHR and/or other IT adoption by SUD providers. However, by our experience, the SUD space is relatively under-invested in IT (vs hospitals). On top of improving labor productivity, we see IT adoption as core to other structural challenges, including: the lack of objective data on patients and treatment outcomes and the lack of quality standards. In our view, the lack of data on patients and treatments is a major problem that SUD providers need to collectively address to get recognized and rewarded for their care.

1) Patient Access Core to Provider Growth Strategies

Access to patients was central to the growth strategies of many of the SUD executives at the Forum. Notably, there was broad agreement that the "cash pay" segment of the SUD marketplace is phasing out with an increasing mix of patients now being covered by managed care plans. Accordingly, looking ahead, providers need to increasingly focus on being in-network with local Medicaid and commercial health plans in their local markets to be financially successful. Also, outside of managed care, there was discussion around service line expansions, specialty populations, and digital health and information technology adoption.

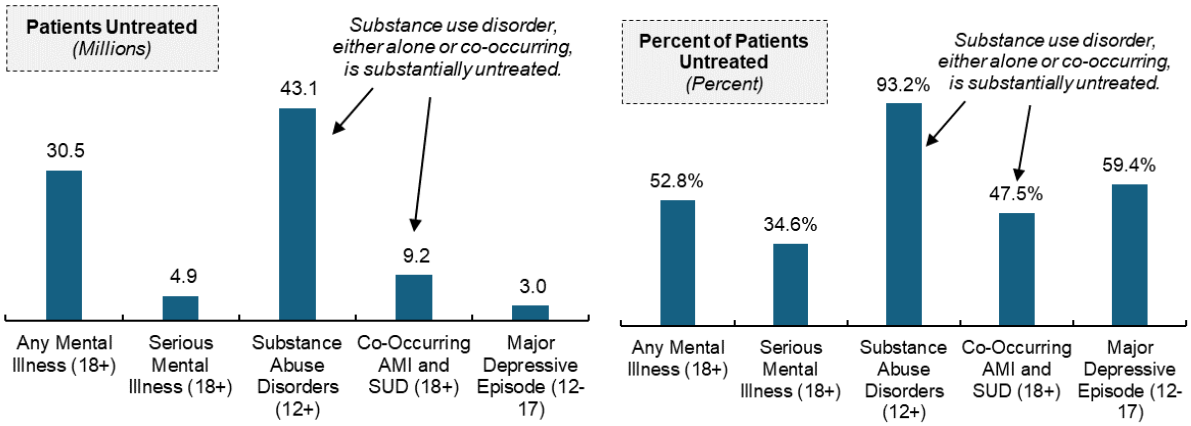
Figure 1: Breakdown of Behavioral Health and Substance Abuse Disorder Spending



Source: S&P Global Market Intelligence, Wall Street Research, and Bourne Partners

1. Service Line Expansion. Many larger and more sophisticated SUD providers have been branching out into adjacent behavioral health services through organic service line expansions, acquisitions, and partnerships. Being a pure-play SUD provider is increasingly considered to not be a financially viable strategy. Having a broader continuum of service offerings helps to attract larger volumes of patients since substance abuse disorders tend to co-exist with other mental and physical health issues. Also, including SUD as part of a broader continuum of care is also viewed by some as a way to improve patient outcomes, attract quality clinicians, and strengthen payer negotiations. One successful case study of this that came up during the Forum discussions was the Certified Community Behavioral Health Clinic (CCBHC) model in Medicaid. The CCBHC model has now expanded across many states and many providers expect CCBHCs to evolve into a permanent part of the broader Medicaid ecosystem.

Figure 2: Substantial Untreated Population in Substance Abuse Disorders



Source: Substance Abuse and Mental Health Services Administration (SAMHSA) and Bourne Partners

Many providers discussed their service line expansion strategies. In our opinion, the key take-away was "to take it slow." It was broadly recommended that expanding services should be done thoughtfully with a focus on adding services that build on existing services. In other words, providers should focus on how they can elongate the time that they can service a patient, adding adjacent services along the patient journey -- from detox to residential care to outpatient/home-based services. Also, providers reported that self-insured employers and health plans are warming up to home-based SUD offerings, which were previously viewed as not medically necessary. One emerging area is digital behavioral health through employer-sponsored health benefits. Employers pay more for SUD than the government does, which is a positive. Also, employers are starting to look at SUD and mental health and they are interested in low-cost solutions. Finally, patients want treatment that fits with their normal family and work lives.

2. Specialty Populations. Providers also discussed growth strategies with respect to new specialty populations, such as adolescents, first responders, and skilled labor trades. One interesting area was the opportunity for providers to offer SUD treatments to neurodivergent populations. Another provider commented on seeing rising demand for care for impulse control disorders. Demand from these targeted populations likely varies by geographic region. Also, several providers highlighted success stories with public-private partnerships (e.g., departments of corrections, state government seeking to serve uninsured populations, and prison discharges). Finally, multiple providers referenced a "hidden" need for SUD in traditional Medicare with the prevalence of SUD in Medicare being likely double what is publicly reported because much of it is hidden as chronic pain management and long-term opioid medications patients.

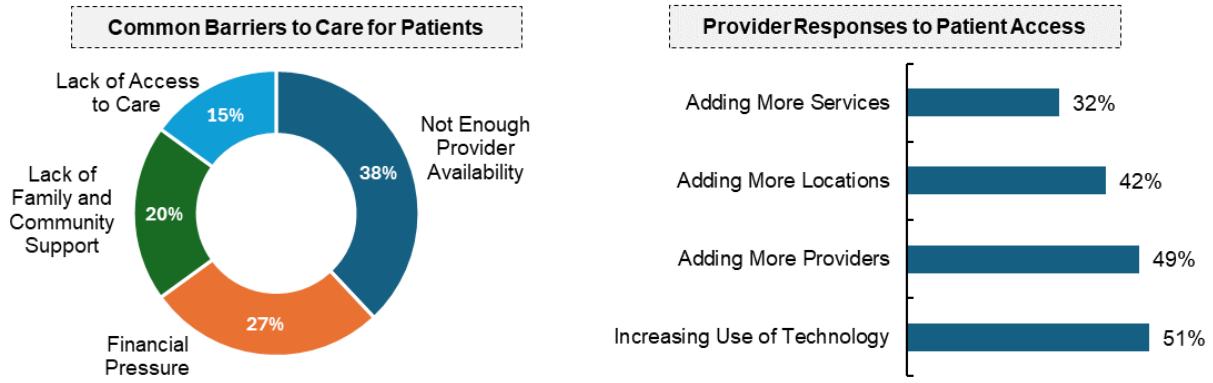
3. Digital Health and Information Technology. There was a lot of interest by SUD providers in use cases for artificial intelligence (AI) and natural language processing (NLP). To date, the major use cases for AI and NLP tend to revolve around documentation. A variety of software vendors are developing AI/NLP applications that can listen to a patient office visit, fill out a clinical note, and make suggestions. Also, similar AI applications have been released to support intake call centers. All these use cases improve clinician/employee productivity allowing more time to be spent face-to-face with patients. Also, AI/NLP applications can materially improve revenue cycle management processes -- notably, prior authorizations. Prior authorizations are, by far, the number one reason

for a medical claim denial and they are a top revenue challenge for all SUD providers. As a caveat, in all cases, vendors and providers alike warned that these AI/NLP applications should be designed and used as an assistant to the provider, not as a replacement of the provider. The clinician must always be held responsible for all clinical decisions.

Another emerging use case for generative artificial intelligence that came out of the Forum is its potential to improve the real time responsiveness of SUD providers and addiction support counselors to changing patient needs and circumstances. This is particularly the case during the intake process to ensure a patient gets directed to the right care at the right time as rapidly as possible (at the time of need). Also, it is critical for counselors to have real time visibility to data on their patients so that they can respond to patient needs in real time as life circumstances change. We think that the use of generative AI (large language models) for real-time digital messaging is particularly interesting. A number of recent studies, including a well-publicized April 2023 study in the Journal of the American Medical Association (JAMA), have shown that responses to patients by AI-enabled chatbots are more accurate and *empathetic* than the responses of real doctors. Many health systems are piloting chatbot technologies to field routine patient medical and billing questions, and we see tremendous opportunity for this technology in the SUD space too.

To facilitate AI-enablement and digital workflows, multiple providers highlighted the importance of having a unified technology platform strategy with a limited number of vendors -- ideally one. Having a single technology platform (a "single source of truth") gives providers a 'cleaner' picture of their patients and it facilitates better collaboration among staff (and engagement with the patient). A single technology platform strategy also helps with data collection, which, in turn, helps to inform treatment decisions and educate the patient. Some providers have taken the step to create their own "Intranets" that store all the information needed by staff in one location. Finally, limiting the number of vendors helps to mitigate cybersecurity risks. Cybersecurity events are going to continue to happen across healthcare, but having fewer vendors is viewed as a way to limit exposure.

Figure 3: Barriers to Patient Access



Source: Kipu and Behavioral Health Business, Behavioral Health Growth Opportunities and Challenges Survey (2023)

2) Using Information Technology to Address Key Challenges

In our view, **the Forum discussions highlighted THREE (3) challenges faced by SUD executives: 1) staffing (capacity) shortages, 2) limited data, and 3) lack of standards.** Challenges with staff turnover and recruitment came up as a key topic across multiple panel discussions. This is a consistent theme across all healthcare services segments we cover. Turnover is particularly a problem with many providers reporting employee turnover rates of less than a year. We view SUD providers as particularly challenged with labor given the cultural stigma around drug addiction. Several providers at the Forum commented that much of their staff consists of individuals who have been personally touched by addiction (e.g., ex-addicts or relatives of an addict). These employees tend to be highly motivated because they have a "mission-oriented" perspective on their work; however, there are limited numbers of them available. To broadly attract and recruit individuals not personally impacted by addiction, providers are having to regularly increase salaries, be creative with benefit packages, and offer flexible work hours and schedules. All of this is negatively impacting profit margins. In response, more and more SUD providers are adopting digital health tools, automation and artificial intelligence. In our view, the SUD space is relatively

under-invested in information technology, but we have seen information technology materially improve employee productivity and reduce turnover in other healthcare services segments. We do not see why the SUD space would be any different.

Shortages in staffing capacity are particularly notable for the SUD space given the potential for significant upside in demand. The *actual* SUD market is likely a lot bigger than many realize since we know there is a very large undiagnosed population. Currently, ~46M Americans meet the definition of having a substance use disorder, according to estimates by the National Institutes for Health (NIH). However, the vast majority of these individuals (90%+) do not seek formal treatment -- thinking that they can manage their addiction alone. This likely reflects a lack of appreciation by the public that addiction is a brain disease coupled with the social stigma of seeking treatment for substance abuse. Even if a small number of the undiagnosed SUD population were to seek treatment, it would easily overwhelm the capacity of SUD providers (who are already struggling with staffing shortages).

A second challenge that came up repeatedly throughout the Forum is the lack of objective data on patient and treatment outcomes. This makes it difficult for SUD providers to get recognized and financially rewarded for their care and it confuses patients. This lack of objective data has also limited the use of value-based reimbursement models in the SUD space -- outside of a limited number of "bundled" models offered by individual health plans and payers. In theory, we think that SUD providers should be very relevant in a capitated environment since over half of SUD patients have co-occurring mental health conditions (often depression and anxiety) and/or physical health issues (such as hep-c, diabetes, and hypertension). In particular, SUD providers often get evaluated based on their ability to drive better patient behavior over a sustained period of time. However, this requires data from payers that tracks the performance of downstream referral partners. The absence of this data makes it difficult for SUD providers to thoughtfully direct patient referrals and coordinate patient care. This has resulted in the SUD space being poorly integrated with the rest of healthcare. We see this problem resolving over time as more SUD providers adopt interoperable electronic health record (EHR) software systems from an increasing number of specialized vendors in the space.

A third (and related) challenge is the lack of agreed upon standards for SUD treatment. Health plans often have their own in-house outcome measures for SUD providers using their own claims data with respect to emergency room visits and inpatient stays. However, providers tend to argue for a more patient-centric view of SUD treatments. This makes measuring the "quality" of care for SUD treatments challenging because patients often have highly personalized goals with respect to their treatment and recovery -- e.g., going back to school, getting a job, etc. "Days abstinent" is one obvious measure, but many providers philosophically argue that reducing the quantity of substance abuse is also important. As much as a third of the patients that come into the door of a SUD provider might not be ready to fully stop abusing a particular substance. So, helping these patients reduce the intensity of their substance abuse may be all that is possible initially. To capture the personalized nature of substance abuse, we think that basic consumer metrics, such as net promoter scores, could serve as a catch-all measure. One common quality measurement that did come up repeatedly is "retention-in-care" because mortality and morbidity rates do drop when patients are in long-term treatment. Another measure is how quickly a provider can get a patient into treatment since being able to meet the patient at the "time of need" is also a critical leading indicator of success.

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