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Substance Use Disorder Market Update

Perspectives and Research

October 14, 2024

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Sector Coverage

Healthcare Services	Outsourced Services	Healthcare Technology
Infusion	Pharmacy Services	Virtual Care Enablement
Behavioral Health	Distribution	ProviderTech
Managed Care	HME / DME	Payor Services & Technology
Post-Acute	Labs	
PPM	Staffing	

Select Transaction Experience

Forefront Telecare	Magellan Healthcare	Magellan Healthcare
sale to SOC Telemed, a portfolio company of Patient Square Capital	Minority Equity Investment in Kaden	Acquisition of a Majority Interest in Bayless Integrated Healthcare
Sell-Side Advisory	*Buy-Side Advisory*	*Buy-Side Advisory*

Select Industry Relationships

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Key Take-Aways on the Substance Use Disorder Space

We see the substance use disorder (SUD) space as one of the most rapidly evolving verticals within broader healthcare services. Our recent conversations with executives of SUD providers and private equity investors highlighted THREE (3) interrelated trends: 1) a rising relevance of managed care, 2) a need to prepare for greater value-based reimbursement, and 3) a growing pressure to play catch-up with information technology. In our opinion, these trends create opportunities for SUD providers to competitively differentiate themselves and pursue greater economies of scale in their operations.

1

Rising Relevance of Managed Care. We see the relevance of managed care for SUD providers increasing on the heels of new "behavioral health parity" regulations in September 2024. There seems to be a consensus view among the SUD executives that we have spoken with that the "cash pay" segment of the SUD market is going away with more patients now being covered under managed care arrangements. With greater managed care coverage will come increased pressures on traditional fee-for-service reimbursement rates, a greater focus on lower-cost modalities of treatment (e.g., outpatient, IOP, and PHP, etc.), and heightened quality and compliance oversight.

2

Preparing for Value-Based Reimbursement. It is certainly early days for value-based reimbursement in the SUD space with the average provider generating less than 10% of its revenues from value-based reimbursement arrangements, by our conversations with SUD executives. However, we think SUD providers can get a head start defining their own financial futures by proactively restructuring their operations and investing in key information technologies now. In our opinion, this would include better integrating with mental health and primary care and adding lower-cost outpatient and telehealth services. Ultimately, we think that SUD providers should proactively embrace value-based contracting as a way to capture the full economic value of their services.

3

Focusing on Information Technology. We see a much stronger use case for electronic health record software and information technology in the coming years driven by new privacy regulations and labor shortages. Many of the SUD executives we have spoken with have argued that the onerous privacy rules for SUD patients have been a contributor to the relatively slow adoption of IT in the SUD space. Newly released privacy regulations should allow SUD providers to coordinate patient care in a much less burdensome way. At the same time, ongoing labor shortages have forced SUD providers to consider information technology to boost staff productivity. Finally, use cases for artificial intelligence are "top-of-mind" for almost every executive we have spoken with. Most interesting is the potential for conversational/generative AI to more directly deal with patients -- beyond just automating administrative tasks.

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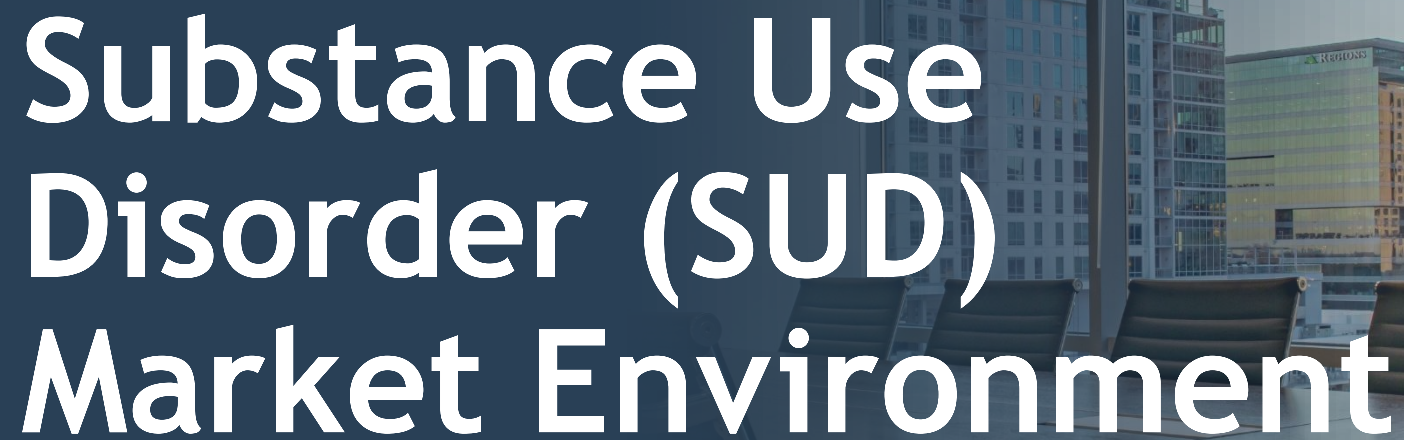
Substance Use Disorder (SUD) Market Environment



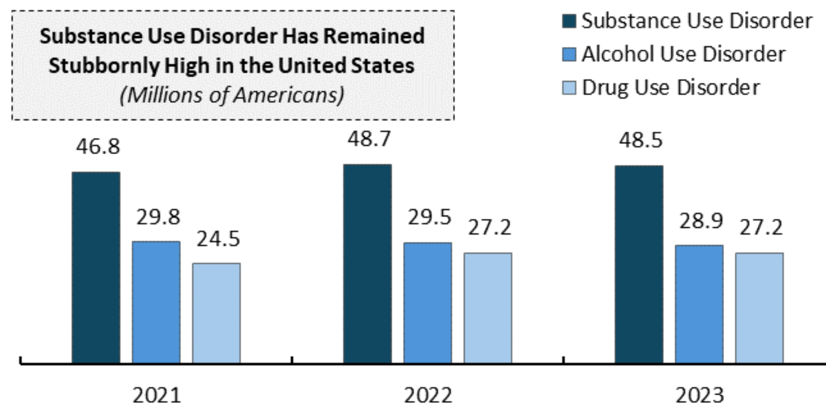
The Big Picture on Substance Use Disorders (SUDs)

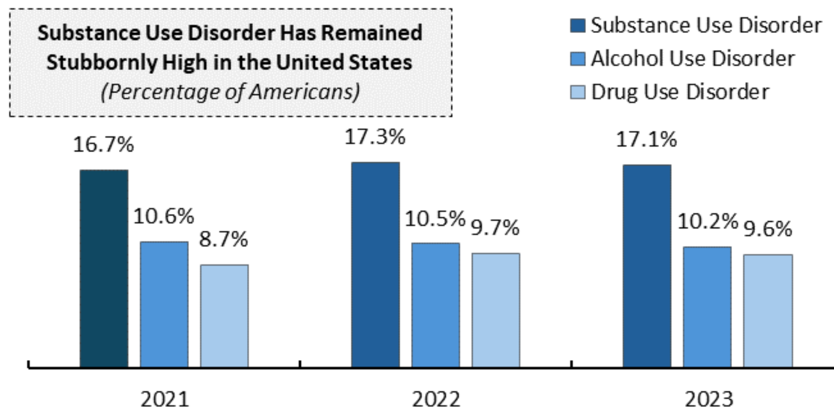
The prevalence of substance use disorders (SUDs) has remained stubbornly high in the United States over the years. At any point in time, there are 45 to 50 million Americans (aged 12 or older) who, to some degree, meet the Diagnostic and Statistical Manual Fifth Edition (DSM-5) criteria of a SUD. Very few of these Americans pursue or receive treatment.

In 2023, **there were 48.5 million Americans aged 12 or older (~17.1% of the total U.S. population) identified with a substance use disorder (SUD)**, according to the *Substance Abuse and Mental Health Services Administration* (SAMHSA). Most of those identified with a SUD struggle either with alcohol or drugs alone. However, ~7.5M of Americans (~2.6% of the population) struggle with both.

Over the past several years, **alcohol use disorder has been consistent at 28.9 million Americans aged 12 or older** (~10.2% of the population) and **drug use disorder has been stable at 27.2 million** (9.6% of the population). In both cases, prevalence is highest among young adults between 18 to 25 years of age (27.1% prevalence rate).

Of those with a drug use disorder, **~70.7% used marijuana and ~25.8% used prescription drugs.** A much smaller percent used methamphetamine (~6.6%), cocaine (~4.8%), and/or heroin (0.2%). In all cases, the highest prevalence was among young adults (18 to 25 years). Also, racially, the incidence rate of drug use disorder was much higher among minority groups, such as American Indians (19.7%), multiracial people (15.1%), and black people (11.4%).

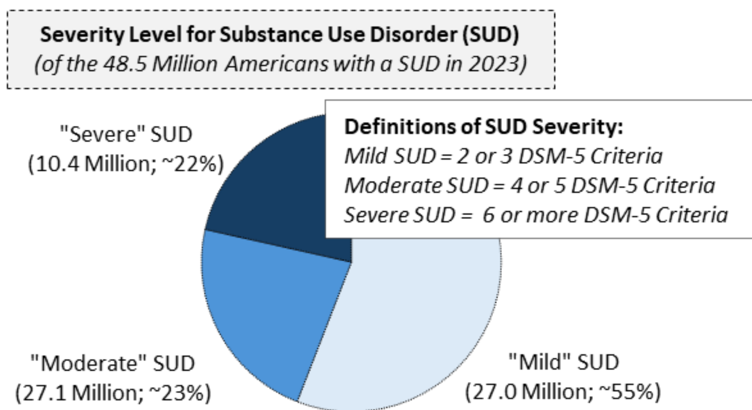


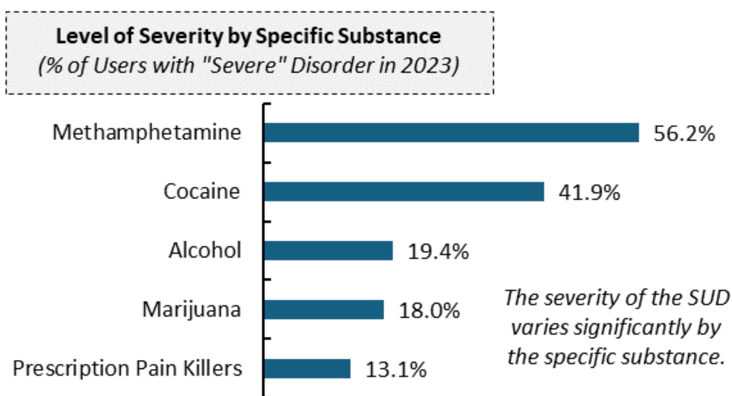


Sources: The Substance Abuse and Mental Health Services Administration (Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health; July 2024), and Bourne Partners

The Severity of Substance Use Disorders (SUDs)

Of the 48.5 million with a SUD in 2023, **10.4 million were considered to have a "severe" SUD**. A "severe" SUD is defined as an individual who meets six or more of the DSM-5 criteria (for at least one substance). Of note, a disproportionate number of those with a "severe" SUD were involved with illicit drugs, e.g., methamphetamine, cocaine, and marijuana.





Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

The Diagnostic and Statistical Manual of Mental Disorders, known as the "DSM," is a reference book on mental health and brain-related conditions and disorders. The fifth (and most recent) version was released in 2022.

1) Substance taken in larger amounts or over a longer period than intended
2) Unsuccessful efforts to cut down or control substance use
3) Significant time is spent on activities necessary to get/use a substance
4) Craving, strong desire, or urge to use the substance
5) Substance results in a failure with obligations at work, school or home
6) Continued substance use despite having persistent social or interpersonal problems caused by or exacerbated by the effects of the substance
7) Social, occupational, recreational activities given-up due to substance use
8) Recurrent substance use in situations in which it is physically hazardous
9) Substance use despite knowledge of recurrent physical or psychological problems caused or exacerbated by the substance
10) Markedly increased amounts of the substance to achieve desired effect, or diminished effect with continued use of the same amount of substance
11) For substances other than hallucinogens and inhalants that have a withdrawal criterion, there are two components of withdrawal symptoms, either of which meet the overall criterion for withdrawal symptoms: a) there is a required number of withdrawal symptoms that occur when substance use is cut back/stopped following a period of use. b) the substance or related substance is used to get over or avoid withdrawal

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Source: Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (July 2024)

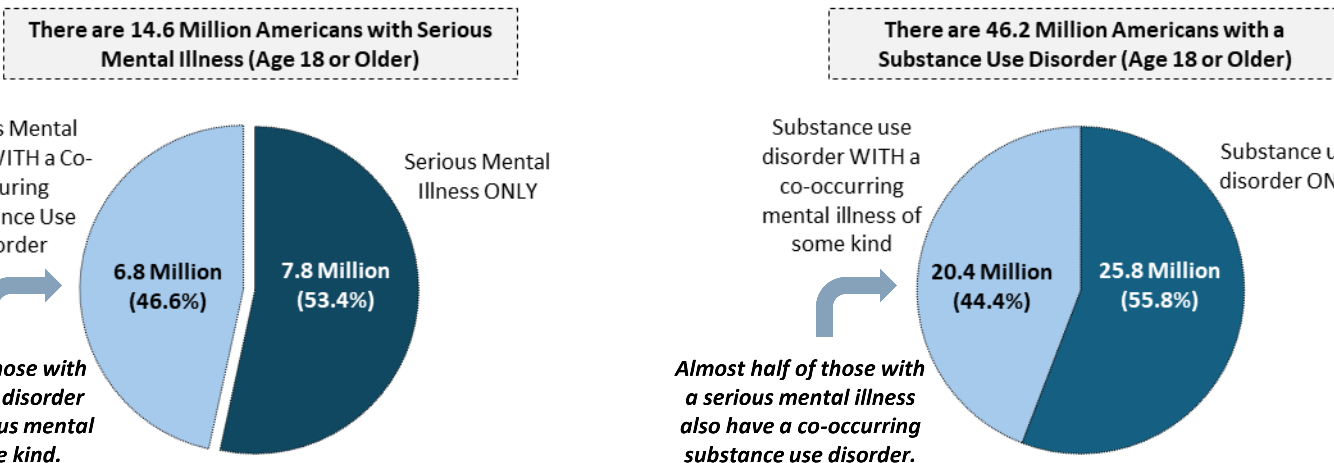
Substance Use Disorders and Mental Health Conditions

Substance use disorders (SUDs) tend to co-occur with other mental and physical health conditions. Almost half (~44%) of Americans with a SUD (aged 18 or older) also identify as having a co-occurring mental illness, of some kind. Conversely, of those Americans with a "serious" mental illness, almost half (~47%) report having a SUD.

Theories why SUDs and mental illnesses co-occur vary. Current research suggests that substance use disorders (SUDs) and mental illnesses share a number of common risk factors. For instance, it is estimated that a large proportion (40%+) of an individual's vulnerability to a SUD and mental illness is genetic. Also, there are common environmental risk factors for both, including chronic stress, trauma, and adverse childhood experiences, among others.

Moreover, **it is frequently hypothesized that individuals with severe, mild, or even subclinical mental illnesses may use alcohol and/or drugs** as a form of self-medication/soothing -- i.e., to alleviate the unpleasant symptoms of the mental illness. Adding to this, in some cases, a mental health condition can enhance cravings and reduce the awareness of the negative effects of a SUD.

Finally, **substance use can sometimes lead to changes in some of the same brain areas that are disrupted by certain mental disorders**, such as schizophrenia, anxiety, mood, or impulse-control disorders, among others.



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Note: Individuals are deemed to have a "serious mental illness" if they had any mental, behavioral, or emotional disorder in the past year that "substantially interfered with or limited one or more major life activities." Source: Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health and the National Institute on Drug Abuse

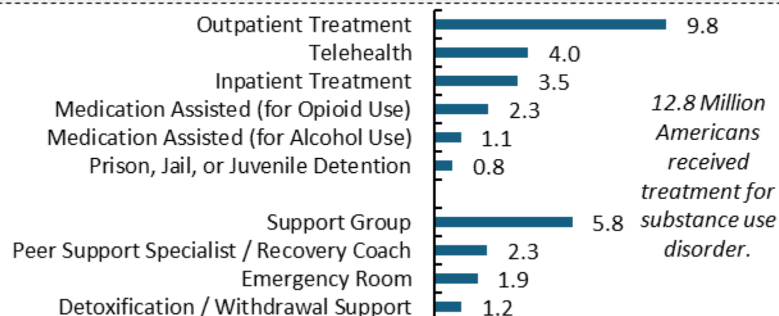
Getting Americans into Treatment and Recovery

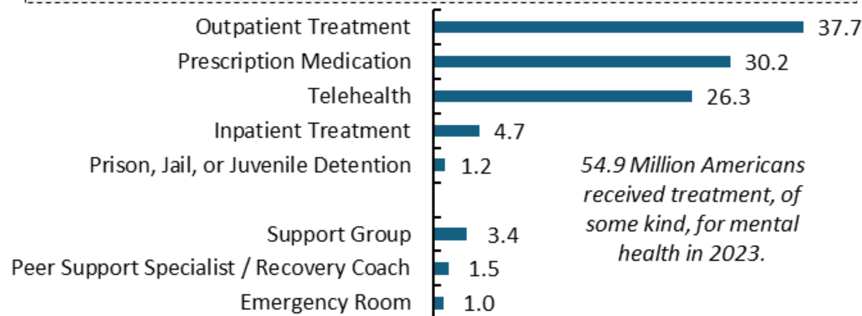
Only 12.8 million Americans (aged 12 or older) were in treatment for a substance use disorder (SUD) in 2023 -- or just over a quarter of the 48.5 million total Americans who profile as having a SUD of some kind. Even excluding those with "mild" SUD symptoms, only about half of Americans with a SUD ("moderate" or "severe") were in treatment.

There are various modalities of care for substance use disorder each with its own advantages and use cases. Often, they are applied together as a continuum of care (and integrated with mental health therapy).

Inpatient (residential) treatment programs are designed to treat serious substance use disorders with 24/7 care under a suite of staff. This removes patients from their typical environments, where there may be environmental triggers, allowing patients to focus on developing behavioral skills and new patterns of thinking. The length of time can range from 7 days to 90 days (or more), depending on medical necessity and other factors.

Outpatient treatments are growing in popularity since they allow patients the flexibility to receive treatment without the need to miss work, school, or other family responsibilities. The rising acceptance and use of telehealth post-COVID has further empowered this type of treatment. Health plans also tend to prefer outpatient treatment programs since they are relatively low-cost in nature. Outpatient programs are generally used for patients with mild or moderate SUDs.





Source: Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health and the National Institute on Drug Abuse

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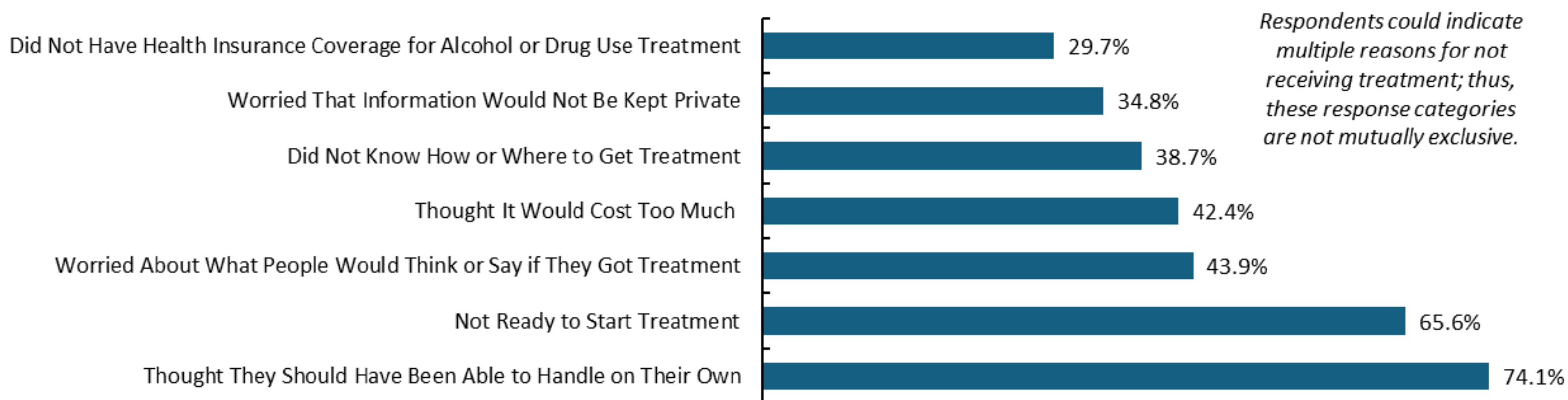
Common Barriers for Patients Seeking Treatment

The most common reason for an individual to not seek treatment for a substance use disorder (SUD) is simply the belief that one can handle addictive behavior by oneself (without any external help). This stems from a lack of appreciation (and education) about the "biological/medical nature" of alcohol and drug addiction, in our view.

Outside of the belief that addiction can be dealt with alone, **many individuals with a SUD who choose not to seek treatment report that they are "not ready to start treatment."** This reflects that they may be conflicted about their alcohol and drug use -- i.e., they are aware of a problem, but they feel that they "need" their addiction to cope with outside environmental stresses.

There is also considerable social and cultural stigma related to substance use disorders -- vs any other disease or health condition, including mental illness. This often results in people suffering with SUDs to resist available treatments.

Finally, **there are financial barriers to SUD treatment.** We think these financial challenges could increase in the coming years due to post-COVID Medicaid redeterminations. Since March 2023, Medicaid enrollments have fallen by well over 25 million as states continue to "unwind" their Medicaid enrollments of ineligibles, according to data from the Kaiser Family Foundation.



Source: Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (July 2024), U.S. Centers for Disease Control and Prevention, and Bourne Partners.

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Highly Fragmented Landscape of Treatment Providers

The landscape of substance use disorder (SUD) treatment providers is highly fragmented with no dominant player or business model. In general, we characterize the SUD space as comprising of hundreds of local/regional players -- each with limited economies of scale. Many of these smaller providers are currently facing significant financial headwinds from labor shortages and reimbursement pressures so we expect significant consolidation as the space matures.

	Public Company Providers	Scaled Providers	Telehealth (Virtual Care) Providers	Local/Regional Providers
Example Companies	Acadia Healthcare, amwell, LifeStance Health, Teladoc Health, UHS	BHG behavioral health group, Bradford Health Services, BayMark Health Services, Pinnacle Treatment Centers, BrightView, Summit BHC	Bicycle Health, Big Health, charlie health, denova collaborative health, groups recover together, lyra, headspace	crossroads, evolve, Harmony Health Group, GH, Kolmac Integrated Behavioral Health
Estimated Number of Providers	**Five (5)**	**Fifty-Plus (50+)**	**100+**	**200+**
Commentary	These are large, publicly traded companies with diversified behavioral health services. These companies have strong managed care relationships and access to capital to invest in technology and pursue strategic acquisitions.	These are multi-regional and national companies with more focused service offerings. This includes strong payer density with meaningful scale in multiple states and high-touch models with deep therapeutic expertise.	These companies have presence in multiple states, with strong coverage in select states Their models are capital-lite and IT/virtual platforms enable national reach and immediate patient accessibility.	These are smaller providers with local geographic footprints. They have local payer referral density in select markets with high-touch models with local referral relationships, and therapeutic expertise.

Source: Bourne Partners

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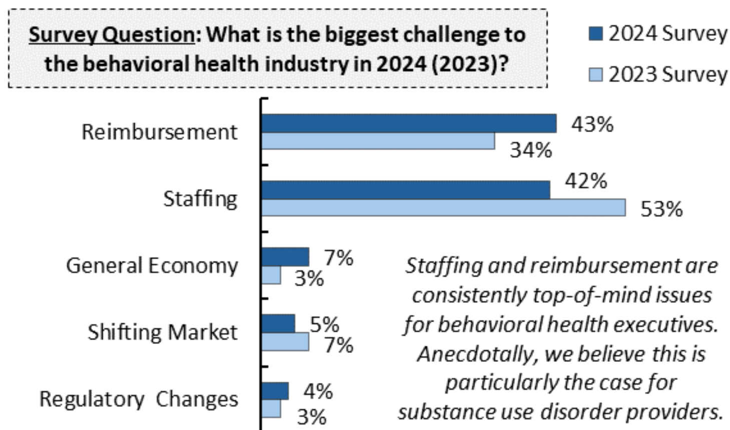
Common Barriers for Providers Offering Treatment

A top challenge that comes up in almost all discussions with substance use disorder (SUD) providers is staffing. Labor accounts for about two-thirds of the cost structure of a typical SUD provider, and access to labor is a precondition to any SUD provider's growth strategy given the 'high-touch' nature of treatment and recovery.

Shortages of labor have resulted in many SUD providers having to bid-up salaries, enhance benefits, and offer flexible work schedules. This has significant implications for profitability, and managing an increasingly limited pool of labor comes up in almost every conversation that we have had with SUD executives. Many SUD providers now have KPIs around employee retention and engagement that are evaluated regularly by management with a focus on training, career pathing, communications, and culture.

We think access to labor is particularly problematic for SUD providers due to the unique difficulties recruiting staff. This stems from the cultural 'stigma' of SUD patients and their association with degeneracy and criminality. We find that there is 'stigma' not just for patients, but also for those working in the space. Accordingly, we often find that a disproportionate mix of the staff at many SUD providers consists of people who have been "personally touched" by SUDs themselves -- either directly (ex addicts) or indirectly (families/loved-ones). These tend to be highly motivated and "mission driven" employees, but they are limited in number.



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Source: Behavioral Health Business (2024 Behavioral Health Outlook Survey and Report)

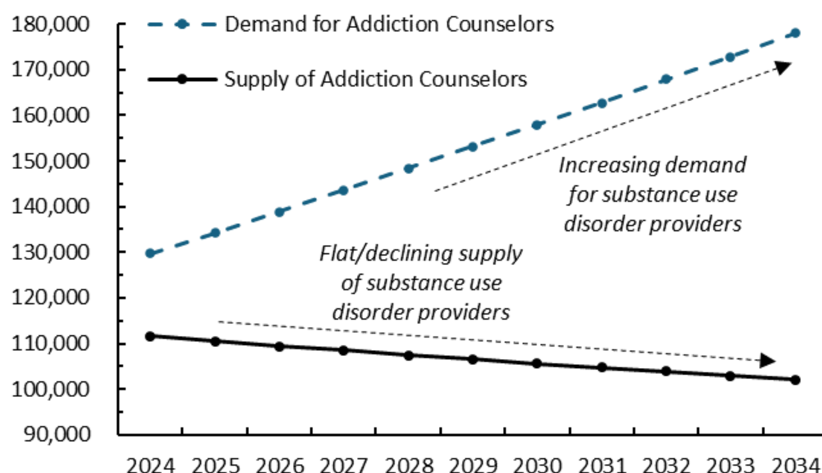
Labor Shortages Accumulating Over Time

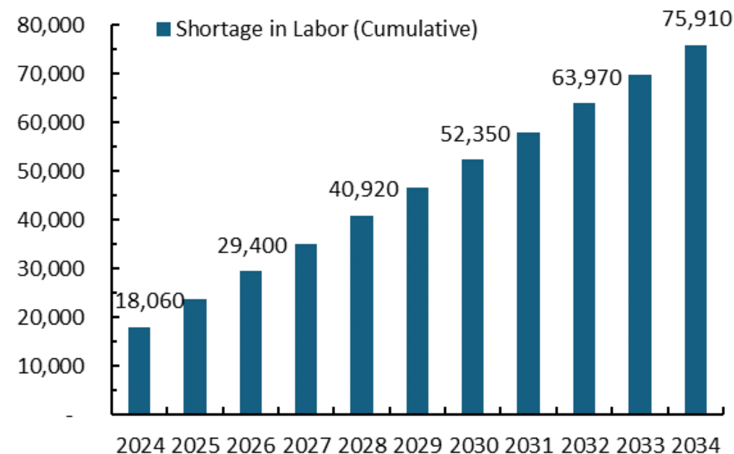
Labor shortages and costs are a common challenge across all healthcare services verticals. However, **shortages of labor in the behavioral health and substance use disorder (SUD) space is particularly bad**, according to data from the *National Center for Health Workforce Analysis*. For instance, the demand for addiction counselors is projected to increase by 3.2% annually from 2024 to 2034. However, the supply of addiction counselors is expected to decline by 0.8% annually. This accumulates to a labor shortage of 75,000+ by 2034 -- or ~57% of the labor needed to meet demand.

Projected Change in Total Supply
-9,590 (Down ~9%)
(from 2024 to 2034)

Projected Change in Total Demand
+48,260 (Up ~37%)
(from 2024 to 2034)

Percent Adequacy of Supply in 2023
57%





Source: National Center for Health Workforce Analysis (data.HRSA.gov; downloaded in September 2024)

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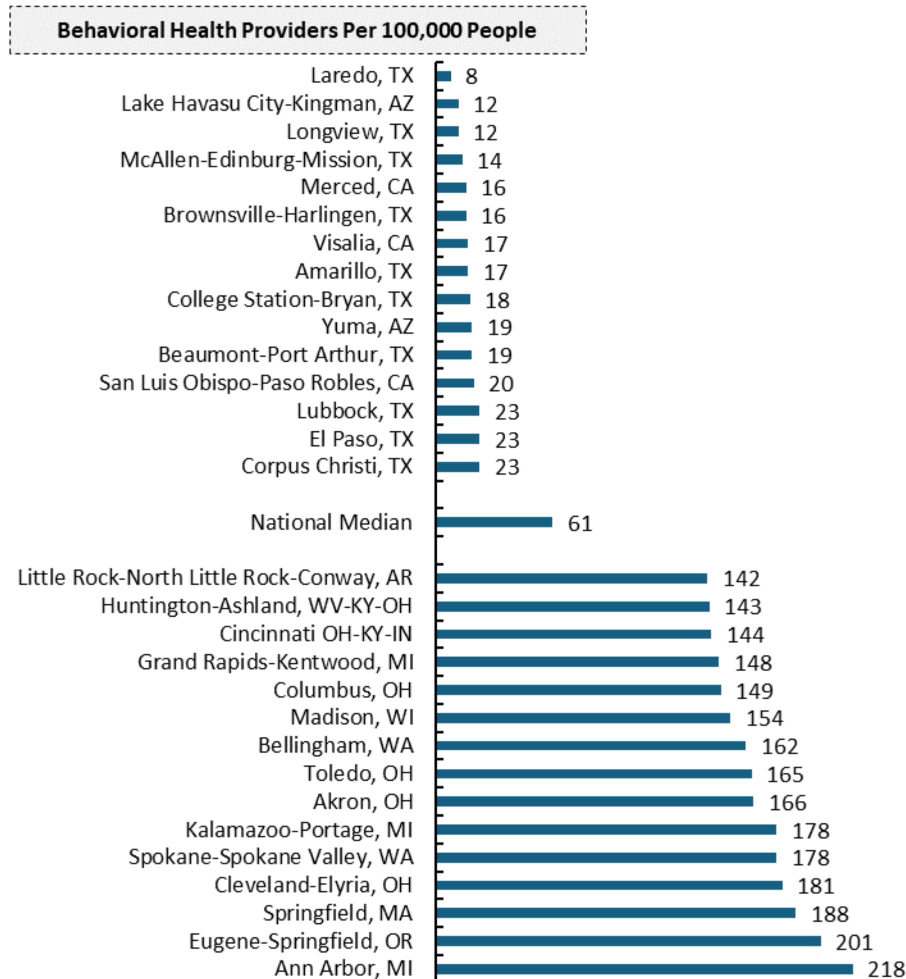
Labor Shortages Vary Significantly from Region to Region

Labor shortages in the behavioral health space is a nuanced topic because the labor environment varies significantly from geography to geography.

Data on Health Professional Shortage Areas (HPSAs) is one way to gauge the degree of provider shortages from region to region. There are 61 behavioral health providers per 100k people in the United States, on average. However, this ranges from a low of 8 (Laredo, Texas) to a high of 218 (Ann Arbor, Michigan).

As a result, **there are numerous behavioral health "deserts" in the United States.** In all, over half of the U.S. population lives in a "Health Professional Shortage Area" for behavioral health. In turn, Americans with behavioral health needs are increasingly showing up in hospital emergency departments (EDs). The latest data suggests that 12.3% of all ED visits have been for behavioral health needs, which is double the rate seen two decades ago.

In response, **many U.S. health systems are opening "behavioral health urgent care clinics"** that offer same-day outpatient mental health (and substance use disorder) care. Since 2019, upwards of 100 behavioral health urgent care clinics have been opened. However, these clinics have no ability to provide follow-up care.



Source: Trilliant Health Provider Directory

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Rising Relevance of Managed Care

The Rising Relevance of Managed Care

We see a rising relevance of managed care for substance use disorder (SUD) providers following the recent release of new behavioral health "parity" regulations that will likely bring more private coverage for patients in the coming years. This should lead to higher patient volumes, in our view. However, with this may also come increased pressure on fee-for-service reimbursement rates, a greater focus on lower-cost modalities of care, and heightened compliance oversight.

The *Patient Protection and Affordable Care Act of 2010* (the PPACA) originally helped bring managed care coverage into the SUD space, in our opinion. Prior to the PPACA, the predominate source of public funding for SUD treatment/recovery services was grant funding, including the *Substance Abuse Prevention and Treatment Block Grant* program. This changed with the PPACA. After the PPACA, state Medicaid expansions resulted in Managed Medicaid plans becoming a material payer for many SUD providers, and this gave SUD providers their first experience operating in a managed care environment.

In the private sector, **employer-based health coverage has improved steadily since the passage of the *Mental Health Parity and Addiction Equity Act* (the MHPAEA)** in 2008. The MHPAEA required private health plans and employers to offer SUD benefits at "parity" with other medical/surgical benefits. However, by almost all accounts, health plans and employers have not fully complied with these regulations due to a lack of clarity around a number of "gray areas" in the legislation. As such, private health coverage of SUDs -- although much improved -- still remains considerably inferior to other areas of healthcare.

In September 2024, the Biden administration introduced new regulations that directly address many of these "gray areas" of the MHPAEA, making the MHPAEA "parity" regulations much more enforceable, in our view. We expect this to materially increase private coverage of SUD patients in the coming years. There now seems to be a broad consensus view that the "cash pay" segment of the SUD market is going away with more and more patients being covered under managed care arrangements. Accordingly, for a SUD provider, being broadly in-network with local commercial health (and Managed Medicaid) plans is a must.

Potentially expanded managed care coverage should lead to higher volumes of patients for SUD providers. However, with this will come increased pressure on traditional fee-for-service reimbursement rates, greater focus on lower-cost modalities of treatment (e.g., outpatient, IOP, and PHP, etc.), and heightened quality and compliance oversight. We think this, in turn, will require greater operating economies of scale, and we anticipate more consolidation in the SUD space in the coming years.

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Source: Bourne Partners

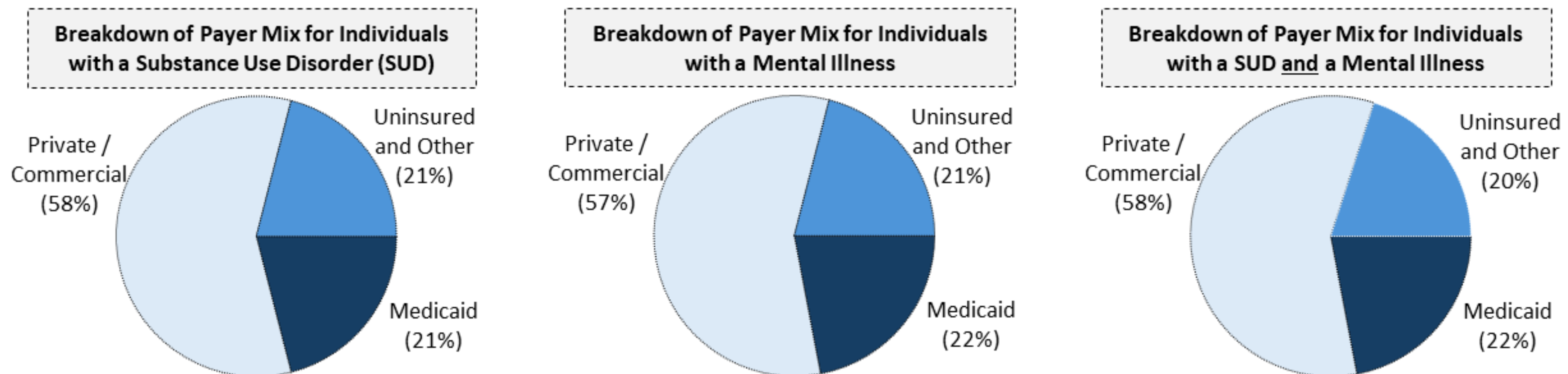
Expanded Medicaid Coverage, But Room for Improvement

State governments currently give a lot of flexibility to private Managed Medicaid plans with respect to their coverage of substance use disorder (SUD) treatments. This has resulted in variations of coverage from state to state with less than half of Managed Medicaid plans covering the full continuum of care for SUD patients.

SUDs are particularly prevalent in the Medicaid population. Medicaid is the payer for 21% of those with a mild, moderate, or severe SUD (over 10 million beneficiaries), despite covering 18% of the nonelderly adult population.

Post-PPACA, **a significant majority (75%+) of Medicaid beneficiaries are now covered through a Managed Medicaid plan.** A July 2024 study in *Health Affairs* showed gaps in SUD coverage. Most states mandate coverage of common treatments and prohibit annual maximums (and enrollee cost sharing). However, at least half of states do not require coverage of the full continuum of care. So, in some states, a beneficiary may be covered for detox, but not for intensive outpatient or residential treatment.

Adding to this, **many Managed Medicaid plans utilize utilization management techniques (such as prior authorizations)**, which can limit access to timely care for patients and burden providers with administrative work. This can result in delays in care and can deter patients from treatment. Fewer than a third of states prohibit managed care plans from imposing prior authorization.



Source: Health Affairs (July 2024), Kaiser Family Foundation ("Demographics and Health Insurance Coverage of Nonelderly Adults With Mental Illness and Substance Use Disorders in 2020"; June 2022), and Bourne Partners

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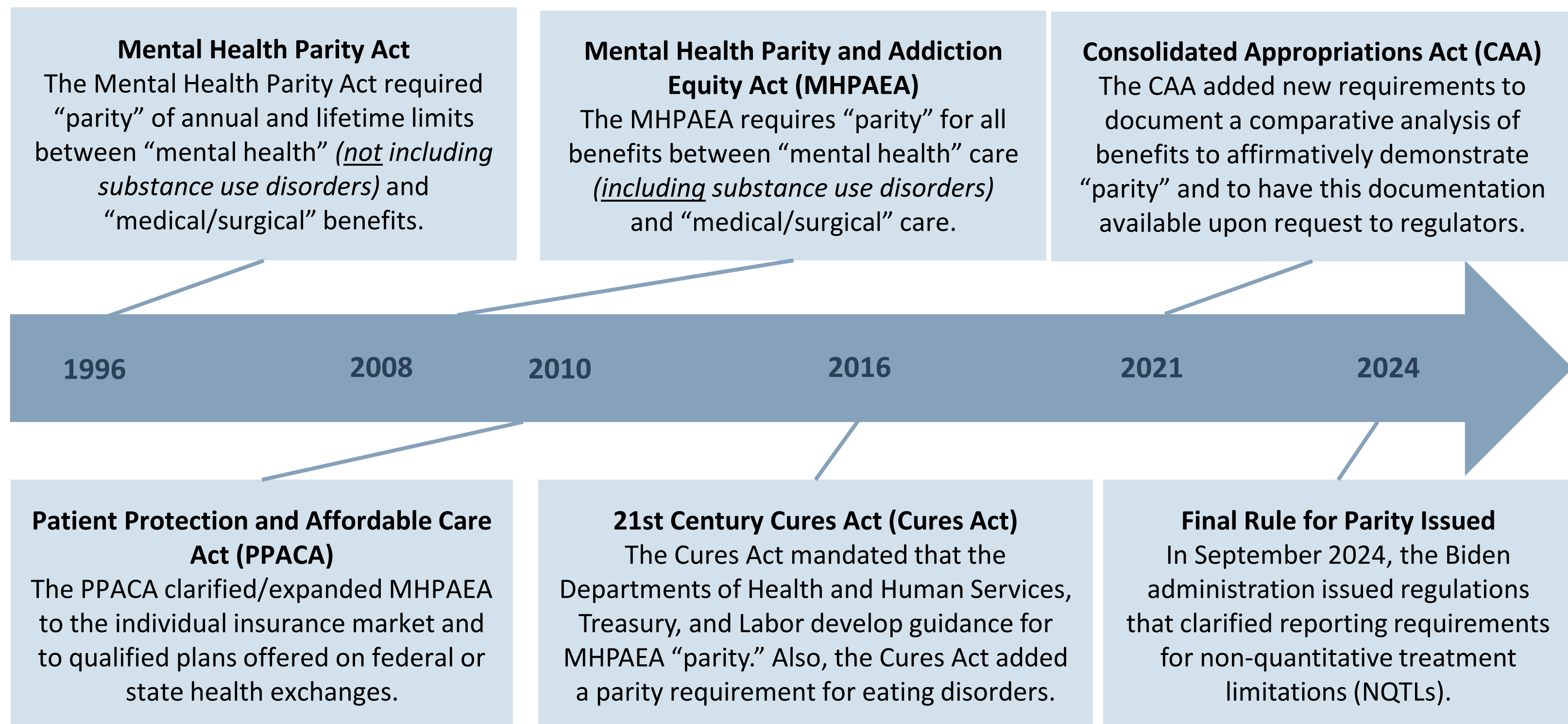
The Evolution of "Parity" in Private/Commercial Coverage

The concept of "parity" for private behavioral health coverage has been around for a long time -- dating back to the *Mental Health Parity Act* of 1996 -- with substance use disorders (SUDs) being added in 2008. However, in our view, the federal government only started serious enforcement of "parity" with the *Consolidated Appropriations Act* of 2021.

"Parity" in behavioral health is the idea that mental health and SUD services should be covered by health plans equally to (no more restrictive than) physical health services. This is an effort to address the stigma of mental illnesses and SUDs coupled with concerns that employers/health plans may discriminate against employees/members who struggle with these conditions.



Source: Bourne Partners

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Reports to Congress Show Poor Compliance with "Parity"

To date, **employers and health plans have generally not been in compliance with the "parity" regulations of the *Mental Health Parity and Addiction Equity Act of 2008* (the MHPAEA) and the *Consolidated Appropriations Act of 2021* (the CAA)**, particularly with respect to documenting non-quantitative treatment limitations (NQTLs).

The CAA amended the MHPAEA to require health plans to document comparative analyses of their use of NQTLs between medical/surgical benefits and mental health/substance use disorder benefits and make this documentation available to regulators upon request. The CAA also requires the U.S. Departments of Labor (DOL), Health and Human Services, and Treasury to issue annual reports to Congress on compliance with the MHPAEA "parity" regulations.

The 2022 Annual Report to Congress on the MHPAEA (January 2022) showed that NONE of the 216 NQTL analyses reviewed by the DOL and NONE of the 21 NQTLs reviewed by the Centers for Medicare and Medicaid Services contained sufficient information to prove that their NQTLs were at "parity."

The report attributed this poor MHPAEA compliance to a "lack of motivation" by employers and health plans to undertake the compliance work needed -- as well as a "lack of understanding" of many of the gray areas of the regulations. The report commented that there needs to be additional regulatory guidance to improve the understanding of what is required for a compliant comparative "parity" analysis.

The 2023 Annual Report to Congress on the MHPAEA (July 2023) continued to show a broad-based failure by health plans to have a sufficient comparative analysis of "parity", although the report showed some improvement. The report also commented that some comparative analyses remained deficient, even after multiple insufficiency letters (threats of financial penalties/fines).

Specifically, **the DOL issued 138 insufficiency letters regarding 290 unique NQTLs and 53 initial determination letters of a MHPAEA violation.** The Centers for Medicare and Medicaid Services issued 35 insufficiency letters regarding 44 unique NQTLs and 15 initial determination letters of a violation.

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Source: U.S. Department of Labor and Bourne Partners

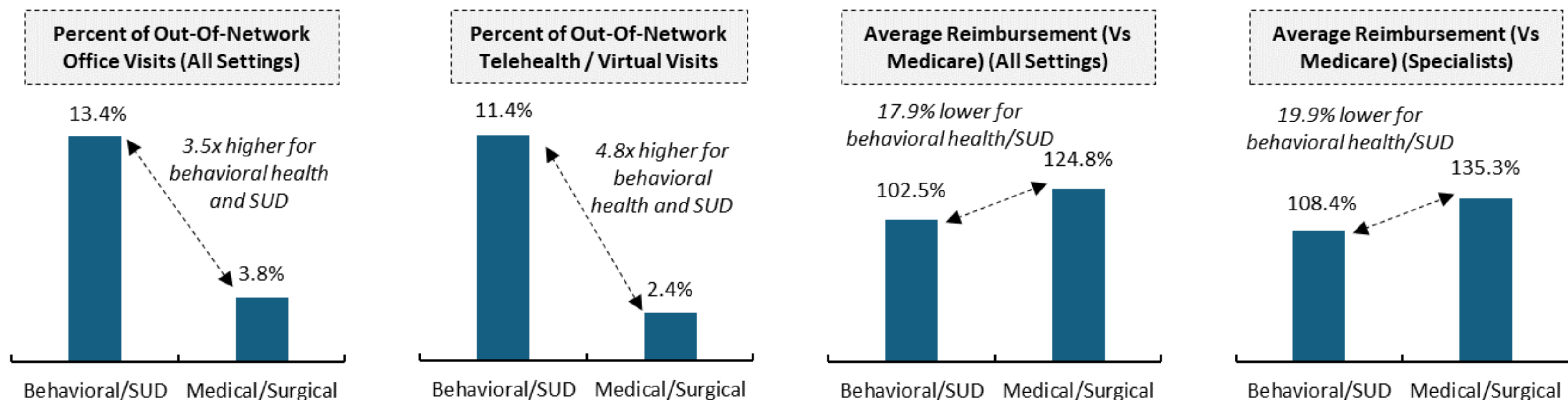
Ongoing Evidence of Not Meeting "Parity" Regulations

Advocates for behavioral health parity argue that private health plans continue to provide significantly inferior coverage for mental health services and substance use disorder treatments (vs medical/surgical care) in 2024, despite the multiple previous reports to Congress that highlighted poor compliance with "parity" regulations.

An April 2024 study by the Research Triangle Institute (RTI) of commercial insurance claims data showed that **out-of-network patient visits for behavioral health conditions and substance use disorders (SUDs) were significantly higher than out-of-network visits for medical/surgical treatments** -- for both in-person and telehealth care. This suggests inferior behavioral health/SUD provider networks and higher financial burdens for behavioral health/SUD patients.

The study also highlighted significantly lower reimbursement for in-network office visits for behavioral health/SUD providers (vs medical/surgical providers). This disincentivizes behavioral health/SUD providers from participating in-network. In fact, psychiatrists and psychologists were seen to have lower reimbursement than physician assistants.

We would caveat this data by pointing out that some of this lack of parity could reflect the realities of **behavioral health labor shortages and relative underinvestment in information technology** -- i.e., less productivity and less patient capacity.



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Source: Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International and Bourne Partners

New Efforts to Strengthen "Parity" Regulations

The Biden administration is currently attempting a major push for "behavioral health parity" with new regulations that close some of the "gray areas" around non-quantitative treatment limitations (NQTLs). This is hoped to give health plans, employers, and regulators greater clarity with respect to documenting regulatory compliance.

On September 9, 2024, **the Biden administration (via the U.S. Departments of Health and Human Services, Labor and Treasury) released final regulations that clarify and expand "behavioral health parity" standards** for health plans under the *Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.* Specifically, the final rule focuses on defining "parity" for non-quantitative treatment limitations (NQTLs). Also, the final rule expands the application of MHPAEA compliance to non-federal (state and local) government health plans, which is expected to add 200+ health plans under the regulations.

The new "parity" regulations will impact group health plans in 2025 and individual health plans in 2026. Also, starting in 2026, the final rule says that "meaningful benefits" for behavioral health must cover the "core treatment" for the condition for all federal classifications of care for which the plan covers medical/surgical care. Finally, in 2026 NQTLs cannot be based on "discriminatory factors," data collection, and evaluation requirements.

Faced with new burdensome and costly regulations, **the risk is that employers and health plans may simply choose to not cover behavioral health altogether** or meaningfully increase premiums. Note, the MHPAEA does not require that employers cover behavioral health and SUD treatments; rather, the legislation states that if an employer does cover behavioral health and SUD treatments, the employer must cover it equally to medical and surgical care.

Final Rules under the Mental Health Parity and Addiction Equity Act (MHPAEA)
Fact Sheet

On September 9, 2024, the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) released new final rules implementing MHPAEA. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations to set forth content requirements and timeframes for responding to requests for nonquantitative treatment limitation (NQTL) comparative analyses required under MHPAEA, as amended by the Consolidated Appropriations Act, 2021 (CAA, 2021). The final rules reflect and address the thousands of comments received from the public during the comment period on the proposed rules that were published on August 3, 2023. The Departments appreciate the feedback and insight received through this process on this critically important issue.

The United States of America continues to experience a mental health and substance use disorder crisis. In the almost 16 years since the enactment of MHPAEA, disparities in coverage between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits have persisted and grown. These final rules aim to further MHPAEA's fundamental purpose – to ensure that individuals in group health plans or group or individual health insurance coverage who seek treatment for covered MH conditions or SUDs do not face greater burdens on access to benefits for those conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or a surgical procedure. These final rules are critical to addressing barriers to access to MH/SUD benefits.

Among other things, these final rules:

- Make clear that MHPAEA protects plan participants, beneficiaries, and enrollees from facing greater restrictions on access to MH/SUD benefits as compared to M/S benefits.
- Reinforce that health plans and issuers cannot use NQTLs that are more restrictive than the predominant NQTLs applied to substantially all M/S benefits in the same classification. Examples of NQTLs include prior authorization requirements and other medical management techniques, standards related to network composition, and methodologies to determine out-of-network reimbursement rates.
- Require plans and issuers to collect and evaluate data and take reasonable action, as necessary, to address material differences in access to MH/SUD benefits as compared to M/S benefits that result from application of NQTLs, where the relevant data suggest that the NQTL contributes to material differences in access.
- Codify the requirement in MHPAEA, as amended by the Consolidated Appropriations Act, 2021, that health plans and issuers conduct comparative analyses to measure the impact of NQTLs. This includes evaluating standards related to network composition, out-of-network reimbursement rates, and medical management and prior authorization NQTLs.
- Prohibit plans and issuers from using discriminatory information, evidence, sources, or standards that systematically disfavor or are specifically designed to disfavor access to MH/SUD benefits as compared to medical/surgical benefits when designing NQTLs.

Source: The U.S. Department of Labor and Bourne Partners

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Value Based
Reimbursement

Preparing for a Future of Value-Based Reimbursement

It is certainly early days for value-based reimbursement in the substance use disorder (SUD) space. However, we think that SUD providers can get a head start defining their financial futures by starting the process of rethinking their business operations and their use of information technology now -- well in advance of a changing payment environment.

The transition of U.S. healthcare to value-based reimbursement has consistently been a bipartisan goal for many years. Today, the U.S. *Department of Health and Human Services* (HHS) has a stated policy vision of having every Medicare beneficiary, half of all Medicaid beneficiaries, and half of the commercially-insured population under value-based reimbursement by 2030. The HHS has seen steady progress towards this goal over time, although progress appears to have stalled since the COVID-19 pandemic.

In our opinion, **financial success in a value-based reimbursement environment (for a SUD provider) involves greater integration with mental health and primary care**, which may require service line expansions, acquisitions, and partnerships. SUDs rarely occur in isolation to other physical and mental health conditions, so including SUD services as part of a broader continuum of care is viewed by many as a way to improve patient outcomes. Also, value-based reimbursement tends to favor lower-cost outpatient services. Finally, standing up a built-for-purpose telehealth/virtual care platform has been shown to improve patient engagement and retention in care, both of which are critical factors for success in a value-based reimbursement environment.

Granted, **value-based reimbursement in the SUD space significantly lags other parts of U.S. healthcare** with respect to federal and state payment reform efforts. Today, we estimate the average SUD provider generates less than 10% of its revenues from value-based arrangements, based on our conversations with industry executives. This has left many SUD executives skeptical (and some dismissive) of any major shift towards value-based payments in the near-term. However, bringing together different healthcare services into an integrated "whole" takes time so we think that it behooves SUD providers to consider their strategies now.

Also, **we think SUD providers should proactively embrace value-based contracting as a way to realize the full economic value of their services** and differentiate from competitors. The *U.S. Department of Health and Human Services* estimates that the total economic cost of SUDs is well over **$400 billion annually** -- with respect to its downstream impact on healthcare costs and social determinants of health. *This is over twenty times what many estimate to be the size, in revenues, of the entire SUD space today.*

Source: Bourne Partners

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A Vision for Value Based Reimbursement By 2030

The U.S. Department of Health and Human Services (HHS) remains firmly committed to its official policy vision of having *every* Medicare beneficiary and *half* of Medicaid beneficiaries under value-based reimbursement by 2030. Also, the HHS wants *half* of the commercially insured population under value-based reimbursement models by 2030 as well.

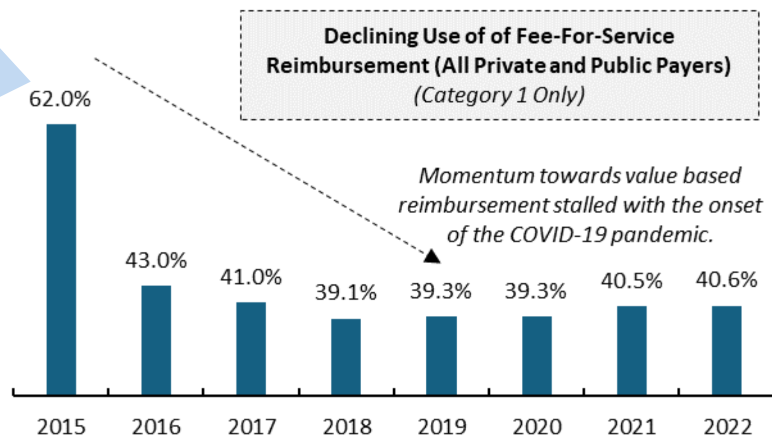
The Center for Medicare and Medicaid Innovation (CMMI) created the Health Plan Learning & Action Network to track and evaluate the adoption of value-based reimbursement models, across public and private payers, through four "categories" of reimbursement.

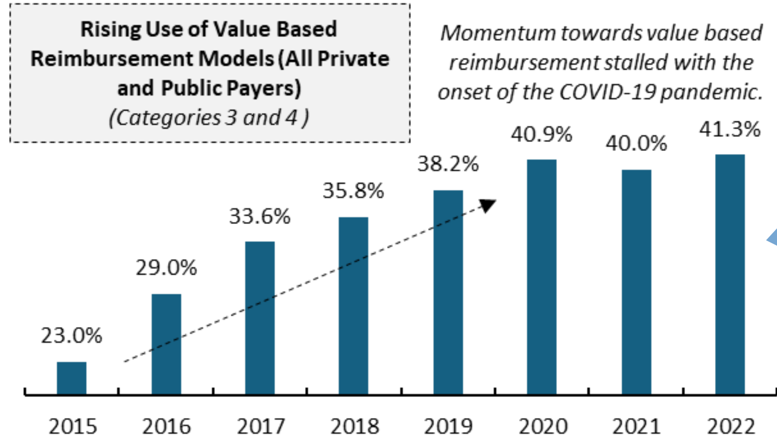
Category 1: Fee-For-Service (No Link to Quality or Value). Payments are based solely on the volume of services delivered with no link to quality or efficiency.

Category 2: Fee-For-Service (Linked to Quality and/or Value). At least a portion of payments vary based on the quality or efficiency of healthcare delivery.

Category 3: Alternative Payment Models Built on Fee-For-Service Architecture. Payments are linked to the management of a segment of the population or an episode of care. This includes opportunities for shared savings or 2-sided risk.

Category 4: Population Based Payment. Payment is not directly triggered by service delivery, so payment has no association with volume. Payment covers the care of a beneficiary for a period-of-time (e.g., over a year).





Source: The Health Care Payment Learning & Action Network

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Payment Reform Has Lagged for Substance Use Disorders

To date, **the substance use disorder (SUD) space has largely been left out of federal investments that have been driving the transition towards value-based reimbursement.** The good news is that the funding and regulatory environment seems to be moving to more value-oriented care. For instance, the *Certified Community Behavioral Health Clinics* (CCBHC) model in Medicaid is producing more coordinated care, and it has now become a permanent part of Medicaid.

At the state level, **the *Patient Protection and Affordable Care Act* of 2010 (the PPACA) helped bring managed care into the SUD space,** in our opinion. Prior to the PPACA, the predominate source of public funding for SUD treatment/recovery services was grant funding, including the *Substance Abuse Prevention and Treatment Block Grant* program. After the PPACA, state Medicaid expansions resulted in Medicaid becoming a material payer for many SUD providers, and these Medicaid expansions have given SUD providers their first experience operating in managed care environments. This sets the stage for more value-based reimbursement in Medicaid over time.

At the federal level, the *Center for Medicare and Medicaid Innovation* (CMMI) has largely focused on physical health services with very limited focus on SUDs. However, we feel this has changed somewhat in recent years with the introduction of new voluntary alternative payment model demonstrations for SUD providers. Experiential data is still too early to evaluate. Initial challenges reported by the CMMI have been difficulties measuring outcomes given the chronic/long-term nature of SUD treatment and recovery -- as well as the administrative burdens on SUD providers who are not accustomed to collecting and reporting data to third-parties.

2010: The Patient Protection and Affordable Care Act (the PPACA)

The PPACA significantly expanded the use of alternative payment models (APMs), such as accountable care organizations, and it created the Center for Medicare & Medicaid Innovation (CMMI) to develop, test, and evaluate value-based reimbursement models in Medicare, Medicaid, and CHIP.

2015: Medicare Access & CHIP Reauthorization Act (the MACRA)

The MACRA ended the sustainable growth rate formula method of controlling Medicaid spending and materially enhanced the PPACA by streamlining quality programs and providing provider bonuses for participation in certain APMs.

2018 to 2023: Notable Alternate Payment Models Launched by the CMMI

1) The Integrated Care for Kids Model (Launched in August 2018)

2) The Maternal Opioid Misuse Model (Launched in July 2021)

3) Value in Opioid Use Disorder Treatment Demonstration (Launched in May 2022)

Source: The Centers for Medicare and Medicaid Services and Bourne Partners

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Value Based Reimbursement in Medicaid Is Still Nascent

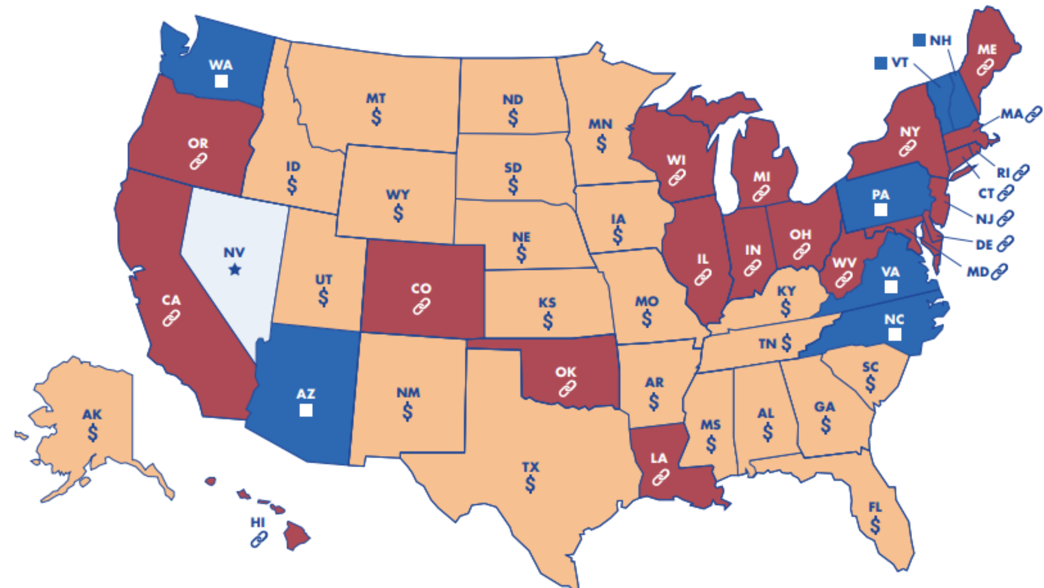
Value based-reimbursement for substance use disorders (SUDs) is still early-days in Medicaid. By our count, only eight (8) states have ongoing value-based reimbursement models (involving APMs based on fee-for-service architectures) for SUD treatment/recovery services, while 20 states have little or no value-based reimbursement at all.

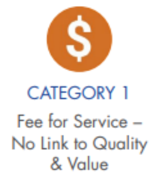
States are taking different approaches to value-based reimbursement for SUDs, some using Section 1115 waivers and others using funding from the SUPPORT Act. States have been generally cautious to impose value-based reimbursement on SUD providers given access to care challenges.

Pennsylvania, for instance, offers quality bonuses to providers that can show their adherence to certain clinical pathways for admitted patients with opioid use disorder.

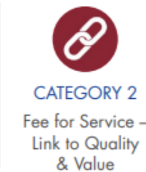
Similarly, Virginia, Rhode Island, and Vermont offer incremental monthly bundled payments for providers that maintain certain clinical best practices and quality standards.

Other states address SUD value-based reimbursement at the payer level, not at the provider level. This alleviates some of the administrative burden of having individual providers calculate and report performance.




CATEGORY 1
Fee for Service – No Link to Quality & Value

CATEGORY 1 & 2


CATEGORY 2
Fee for Service – Link to Quality & Value

CATEGORY 2 & 3

CATEGORY 3
APMS Bulit on Fee-For-Service Architecture

Source: Center for Financing Reform and Innovation (CFRI) ("Exploring Value-Based Payment for Substance Use Disorder Services in the United States", November 2023)

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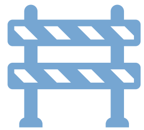
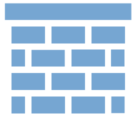
Unique Challenges to Value Based Reimbursement

The use of value-based reimbursement in the substance use disorder (SUD) space has unique challenges that other sectors of U.S. healthcare do not, in our view. This includes poor integration with the broader healthcare system, a lack of information technology adoption, and limited consensus on how one defines "quality" care, among other challenges.

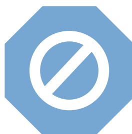


One of the first barriers to value-based reimbursement in the SUD space is the lack of integration between SUD treatment providers and the rest of healthcare. This comes up in almost all of our conversations with provider executives. SUD providers have evolved from unique financial and regulatory environments, making it difficult to operationally integrate with local health systems. Even within the SUD space, different levels of care have evolved in isolation from each other in fee-for-service structures (based on encounters, procedures, or per diem day rates).



Also, **one of the "cultural" barriers to the use of value-based reimbursement in the SUD space is a lack of good data and a lack of agreement (and infighting among providers) around defining quality of care.** This lack of data and consensus makes it difficult for individual providers to be financially rewarded for the value they provide to the broader healthcare ecosystem. Also, SUD providers themselves often lack the necessary data to manage and evaluate the quality of their own downstream provider partners and create sustained patient outcomes (which is often how they are evaluated).

We have found considerable variation among SUD providers on measures of quality. There are standard symptom-based measures, e.g., the Brief Addiction Monitor (BAM), Patient Health Questionnaire (PHQ-9), and General Anxiety Disorder-7 (GAD-7), among many others. Other providers we spoke with look at "access-to-care" metrics (the ability to meet patients at the time of need) and "retention-in-care" metrics (the ability to retain patients in treatment). Also, many providers focus on quality-of-life outcomes based on the goals of each individual patient -- e.g., reuniting with family, going back to school, getting a job, etc. In this case, net promoter scores would be an appropriate measure (during and after treatment).



Finally, while "days abstinent" may be a gold-standard outcome for many, **we see other SUD providers focusing on "harm reduction."** Health outcomes are inversely related to the volume/severity of substance abuse and many patients are not initially ready to stop using a substance when they come into treatment. In these cases, reducing the volume and intensity of usage can be considered a success (or transitioning a patient to a less harmful substance).

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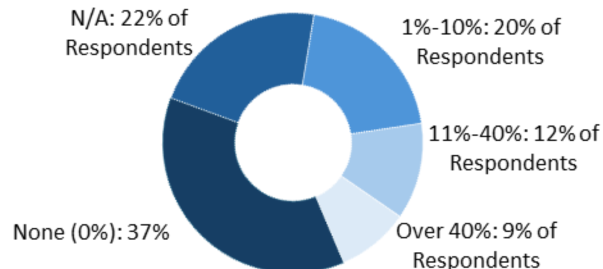
Value Based Reimbursement as a Strategy

In our view, **substance use disorder (SUD) providers should welcome value-based reimbursement** as a way to capture the full value of their services -- and to avoid the inevitable pressures of fee-for-service reimbursement. The *U.S. Department of Health and Human Services* estimates that the total economic cost of SUDs is **well over $400 billion annually** -- with respect to its downstream impact on both healthcare costs and social determinants of health.

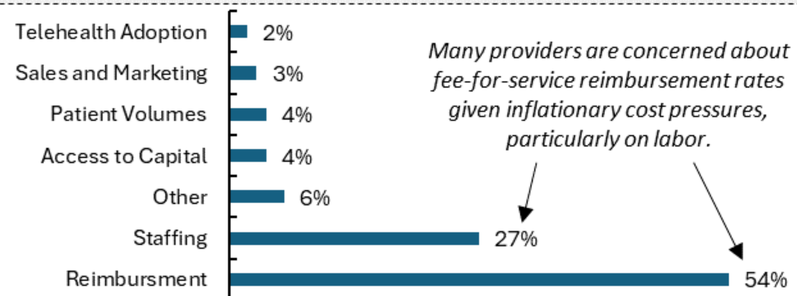
We see an opportunity for SUD providers to use value-based contracting as a competitive differentiator and a way to secure patient referrals. We estimate the average SUD provider generates less than 10% of its revenues from value-based arrangements, based on our conversations with executives. Most SUD providers are entirely reliant on fee-for-service reimbursement.

Value based reimbursement can ultimately lead to more collaborative (win-win) relationships with health plans and at-risk provider organizations, in our view. However, the challenge that we hear from SUD providers is managing payer expectations. The risk with value-based contracts is that payers will want to update performance metrics as contracts renew. (This can result in the "moving of goal posts" to the disadvantage of the provider.) To avoid this, SUD providers really need to know what they are good at before they attempt to negotiate these contracts. We believe an incremental approach can sometimes make sense -- i.e., focusing initially on taking-on risk in targeted areas where the provider has relative strength. As the provider gains experience and as trust builds between the provider and the payer, the contract can be expanded gradually into different areas.

Survey Question: What percentage of your revenues are currently coming from some form of value-based payment arrangement?



Survey Question: What is the greatest area of financial strain the behavioral health industry will face next year?



Source: Behavioral Health Business (2024 Behavioral Health Outlook Survey and Report)

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Information Technology Adoption

Increasing Information Technology Adoption

In the coming years, **we see an increasing use case for information technology in the substance use disorder (SUD) space** following new regulations that simplify the exchange of personal health information on SUD patients. Many have cited unique privacy regulations around SUD treatments as a barrier to care coordination, and some have argued that these regulations have been a major reason why there has been slow adoption of EHR software among SUD providers.

In February 2024, **the *U.S. Department of Health and Human Services* released new final rules that better align previous privacy rules for SUD treatment information with standard HIPAA regulations.** The new streamlined privacy regulations should allow providers to exchange SUD patient/treatment information in a much less burdensome way, which is intended to facilitate better care coordination, greater unification of processes/systems, and a more holistic view on patients. These regulations will go into effect in February 2026, giving SUD providers time to develop the necessary internal compliance processes and infrastructure.

Over time, **we think that the ability of SUD providers to exchange patient health information more freely should improve the value proposition of electronic health record (EHR) software** and other information technology. Today, SUD providers significantly lag the rest of healthcare with respect to EHR software adoption with only a 29% adoption rate.

Greater core EHR and information technology adoption should support the use of artificial intelligence (AI) applications. Much of the current discussion around AI is centered on documentation during the patient intake process (e.g., prior authorizations) and at the point of patient care (e.g., virtual scribes). Early case studies have been impressive. However, perhaps more interesting is the potential for generative AI to more directly engage with patients -- beyond just automating administrative tasks. For instance, some SUD providers have highlighted the potential of AI to be used post-treatment as an “early detection” service by analyzing a patient’s behavioral and communication patterns to identify early signs (and risk factors) for a relapse.

Our primary near-term concern for the SUD space is potential regulation from the *U.S. Drug Enforcement Administration* (DEA) limiting to the ability of providers to freely prescribe ‘controlled substances’ via telehealth visits. Since the COVID-19 pandemic, telehealth has become fully entrenched in the SUD space. Today, almost 20% of SUD patients see their providers through telehealth visits and we estimate that over 15% of SUD treatments involve the use of prescription medications -- many of which are Schedule II controlled substances such as methadone, buprenorphine, and naltrexone, among others.

Source: Bourne Partners

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New Data Sharing Regulations to Catalyze IT Adoption

We see recent regulatory updates to patient privacy regulations (i.e., 42 CFR Part 2) as a significant potential catalyst for the substance use disorder (SUD) space by reducing the administrative burdens of sharing patient data. In our view, this should lead to greater information technology adoption (and use of value-based reimbursement models).

In February 2024, **the U.S. Department of Health and Human Services released its final rule related to long-awaited regulatory changes to the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations** under 42 CFR Part 2 (or "**Part 2**"). These regulations will go into effect in **February 2026**, giving SUD providers time to develop the necessary internal compliance processes and infrastructure.

In essence, **the new "Part 2" streamlines patient privacy requirements for SUD providers** by creating greater alignment with HIPAA with respect to patient consent for the sharing of SUD treatment information and the subsequent sharing of information with third party providers. In our view, this should expedite data sharing in a much less burdensome way. Providers have long cited Part 2 as a barrier to exchanging patient data needed to truly coordinate care. Some further argue that Part 2 has been a major reason why there has been slow adoption of electronic health record (EHR) software and clinical systems by SUD providers.

Also, **the Part 2 final rule removes language related to the segregation of SUD records from other patient records** and aligns a definition of SUD counseling notes with the existing HIPAA definition of psychotherapy notes. This is notable since providers will no longer need to segregate records when received via a single consent form. This should facilitate a unification of processes/systems and a more holistic view of patients.

12472 **Federal Register** / Vol. 89, No. 33 / Friday, February 16, 2024 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

42 CFR Part 2

RIN 0945–AA16

Confidentiality of Substance Use Disorder (SUD) Patient Records

AGENCY: Office for Civil Rights, Office of the Secretary, Department of Health and Human Services; Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services.

ACTION: Final rule.

SUMMARY: The United States Department of Health and Human Services (HHS or "Department") is issuing this final rule to modify its regulations to implement section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The Department is issuing this final rule after careful consideration of all public comments received in response to the notice of proposed rulemaking (NPRM) for the Confidentiality of Substance Use Disorder (SUD) Patient Records. This final rule also makes certain other modifications to increase alignment with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to improve workability and decrease burden on programs, covered entities, and business associates.

DATES:

Effective date: This final rule is effective on April 16, 2024.

Compliance date: Persons subject to this regulation must comply with the applicable requirements of this final rule by February 16, 2026.

FOR FURTHER INFORMATION CONTACT: Marissa Gordon-Nguyen at (202) 240–3110 or (800) 537–7697 (TDD).

SUPPLEMENTARY INFORMATION:

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TABLE OF ACRONYMS

Acronym	Meaning
ACO	Accountable Care Organization.
ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act.
ADT	Admit, Discharge, Transfer.
APCD	All-Payer Claims Database.
BLS	Bureau of Labor Statistics.
CARES Act	Coronavirus Aid, Relief, and Economic Security Act.
CBO	Community-based Organizations.
CFR	Code of Federal Regulations.
CHIP	Children's Health Insurance Program.
CMP	Civil Money Penalty.
CMS	Centers for Medicare & Medicaid Services.
COVID–19	Coronavirus Disease 2019.
CSP	Cloud Service Provider.
DOJ	U.S. Department of Justice.
E.O.	Executive Order.
EHR	Electronic Health Record.
ePHI	Electronic Protected Health Information.
FDA	Food and Drug Administration.
FOIA	Freedom of Information Act.
FR	Federal Register.
GS	General Schedule.
Health IT	Health Information Technology.
HHS or Department	U.S. Department of Health and Human Services.
HIE	Health Information Exchange.
HIN	Health Information Network.
HIPAA	Health Insurance Portability and Accountability Act of 1996.
HITECH Act	Health Information Technology for Economic and Clinical Health Act of 2009.
HIV	Human Immunodeficiency Virus.
ICR	Information Collection Request.
IHS	Indian Health Service.
ISDEAA	Indian Self-Determination and Education Assistance Act.
MAT	Medication Assisted Treatment.
MHPAEA	Mental Health Parity and Addiction Equity Act.
MOUD	Medications for Opioid Use Disorder.
MPCD	Multi-Payer Claims Database.
NIST	National Institute of Standards and Technology.
NOAA	National Oceanic and Atmospheric Administration.
NPP	Notice of Privacy Practices.
NPRM	Notice of Proposed Rulemaking.

Source: U.S. Department of Health and Human Services (February 2024)

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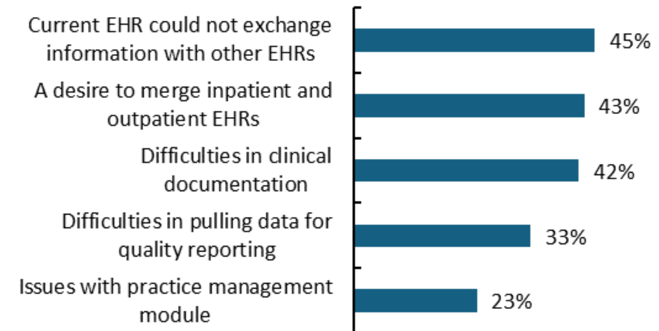
Improving EHR Software / Information Tech Adoption

Substance use disorder (SUD) providers significantly lag the rest of healthcare with respect to EHR software adoption with only a 29% adoption rate (per a 2022 report from the *Medicaid and CHIP Payment and Access Commission*). We think this could improve, over time, with the introduction of the new streamlined Part 2 privacy regulations that reduce the administrative burdens of sharing SUD patient-related data with third-party providers.

The current underinvestment in EHR software and information technology (IT) by the SUD space is a legacy of it being left out of federal government subsidies for EHR software, notably the *Health Information Technology for Economic and Clinical Health Act* (the HITECH Act) of 2009. The HITECH Act included billions of "stimulus" incentives to hospitals and physicians to "meaningfully use" EHR software. This resulted in almost all hospitals and physician practices today using EHRs in their clinical care.

There have been several attempts to extend the HITECH Act to the behavioral health/SUD space, but all have failed. The latest attempt is the *Behavioral Health Information Technology Coordination Act*, introduced in late 2023, which proposed dedicating $20M of annual grant funding over five years to mental health, SUD, and other behavioral health providers to help them purchase and upgrade their IT systems and support services.

Outside of a lack federal support/incentives, **there are multiple other barriers to EHR adoption** that we have heard from SUD providers that have resulted in them choosing not to invest in IT. Barriers to EHR adoption include the cost of the software and implementation as well as a lack of technical know-how. Also, there are technical barriers such as a lack of SUD-specific common data elements, a lack of standardized vocabulary, and limited data segmentation into some EHR systems.



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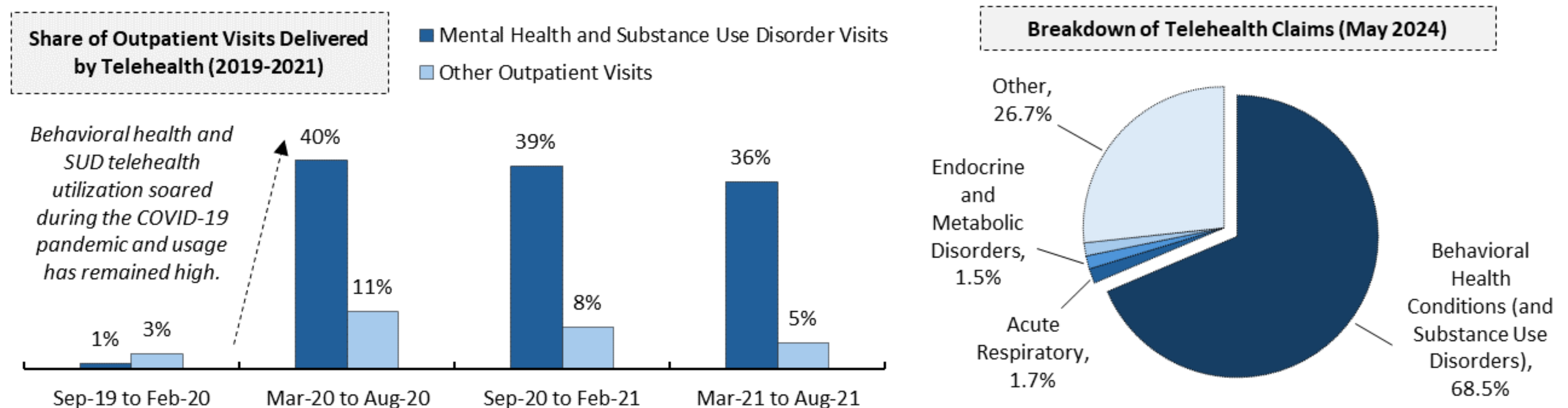
Source: The Medscape 2023 "Physicians and Electronic Health Records Report" (November 29, 2023) and Bourne Partners

Telehealth Now Fully Entrenched in the SUD Space

The one area of information technology where the substance use disorder (SUD) space actually leads other areas of healthcare services is telehealth. Telehealth is now fully entrenched in the SUD space with ~80% of providers offering telehealth services. Research shows that telehealth combined with in-person care can materially improve outcomes.

Recent research suggests that telehealth alone for SUDs results in similar patient outcomes as in-person therapy. However, **a hybrid approach of telehealth and in-person care leads to materially better patient outcomes** due to higher retention rates and decreased dropouts. SUD is a chronic condition so sustained engagement with the patient helps to ensure clinical success over time. SUDs thrive on loneliness, isolation, and lack of connection and accountability. Also, telehealth makes care more accessible for patients in rural areas and/or with limited transportation access. Finally, being able to receive care in the privacy of one's home helps with the stigma that is often associated with seeking treatment for SUDs.

While telehealth is entrenched in the SUD space, **we find that utilization does vary state to state.** For instance, less than half of providers in Mississippi and South Carolina offered telehealth care, while all providers in Delaware, Maine, New Mexico and Oregon do. Also, surveys of wait times show significant variations from a low of 4 days in North Carolina to a high of 75 days in Maine. Finally, private SUD providers are nearly twice as likely to offer telehealth services (vs public providers).



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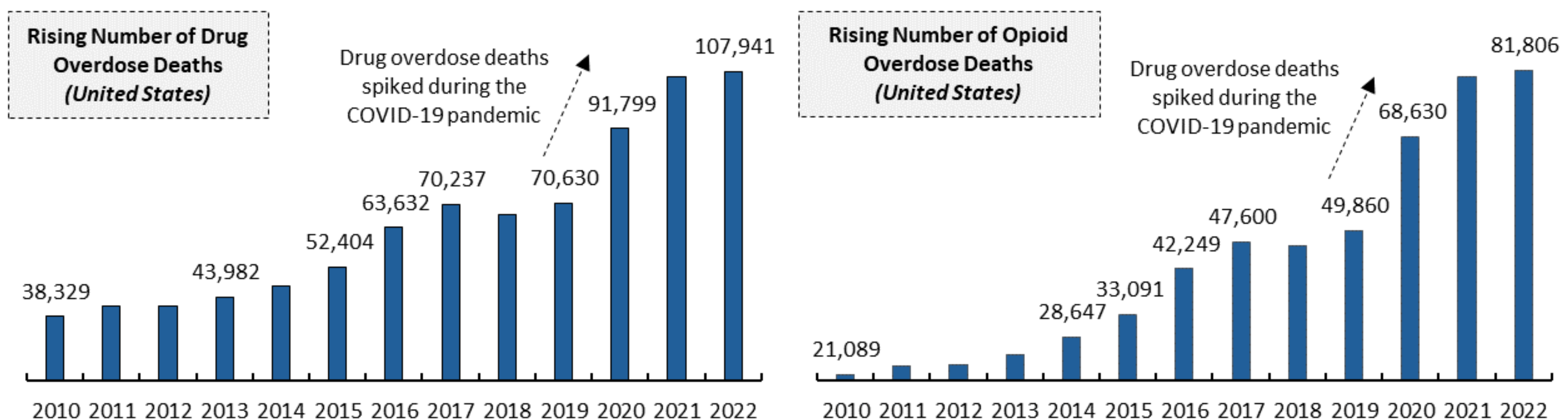
Source: Fair Health, Kamma HK, Alabbas M, Elashahab M, Abid N, Manaye S, Cheran K, Murthy C, Bornemann EA, Arcia Franchini AP. The Efficacy of Telepsychiatry in Addiction Patients: A Systematic Review. Cureus. 2023 Apr 25;15(4):e38133, and Bourne Partners.

Concerns About Regulations on Controlled Substances

Despite the industry's success with telehealth, **we are concerned that the U.S. Drug Enforcement Administration (DEA) may reestablish restrictive regulations on the prescribing of controlled substances via telehealth.** Limiting the use of scripts via telehealth would exacerbate patient access challenges that already exist in the substance use disorder space.

During the COVID-19 pandemic, **the DEA temporarily waived restrictions on providers prescribing controlled substances via telehealth through December 2024.** For substance use disorder (SUD) providers, this included medications such as methadone, buprenorphine, and naltrexone. In the SUD space, almost 20% of treatments were done via telehealth in 2023, and over 15% of SUD treatments included the use of prescription medications.

A re-establishment of pre-COVID restrictions on the prescribing of controlled substances could affect SUD providers in THREE (3) ways. 1) The pending DEA proposed rule might restrict providers from prescribing Schedule II substances when a patient and provider have not had an initial in-person visit (unless the prescriber is a specialist). Drugs under the DEA's Schedule III, IV and V might continue to be prescribed via telehealth without an in-person visit to a provider. 2) The proposed DEA rule might only allow providers to do 50% of their prescribing online. 3) The proposed rule might require providers to check all state prescription drug monitoring programs before prescribing a controlled substance to a patient not seen before in-person.



Source: U.S. Department of Health and Human Services (February 2024)

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Artificial Intelligence Transformation

Use cases for artificial intelligence (AI) are "top-of-mind" for almost every provider executive we have spoken with in the substance use disorder (SUD) space. We see opportunities for AI to transform the entire treatment process. However, this will take time to play out since it presumes broad-based adoption of interoperable EHR software systems.

Pre-Treatment

During the patient intake process, AI software applications can help take notes and ensure that all needed prior authorization documentation is captured from the patient (and from referral sources) to ensure maximum revenue collection. Also, we see AI having enormous potential to personalize care for patients by directing them to the optimal clinical resources -- i.e., the right service and clinician -- as fast as possible. There is often a wide selection of clinical and treatment services available, and the patient may not be familiar with the options available to him/her. Finally, if there is a need for collaborative information from a referral source, the software can flag business development staff who can jump in and support. This makes the provider a good referral partner.

Point of Care

"Virtual scribe" AI software applications that employ natural language processing technologies are rapidly being embraced across healthcare. We see no reason why the same would not occur in the SUD space. Essentially, a "virtual scribe" can listen to a therapy session, fill out a clinical note, integrate relevant data about the patient (clinical, socio-demographic, etc), and make clinical suggestions. This allows the clinician to focus entirely on the patient. The risk is that clinicians can get overly reliant on these AI applications. AI tools should be viewed as an assistant, not a replacement for a clinician, and the clinician must always be expected to review decisions. As a final point, patients must consent to the use of AI in their care. This has not been a material issue in other areas of healthcare services.

Post-Treatment

Specialized AI applications can help providers stay engaged with patients after a clinical encounter. Generative (conversational) AI can be available to patients round-the-clock, offering coping strategies and uninterrupted support between traditional therapy sessions. This includes being an "educational" support to address follow-up patient questions and concerns. Also, AI can be used to optimize the structure of peer support groups based on the likelihood of negative behavior within the peer group. Finally, through the use of mobile apps and biometric devices, AI can function as an "early detection" service by analyzing a patient's behavioral and communication patterns to identify early signs (risk factors) for a relapse. This allows for timely interventions that can help to cut off the escalation of addiction.

Source: Bourne Partners

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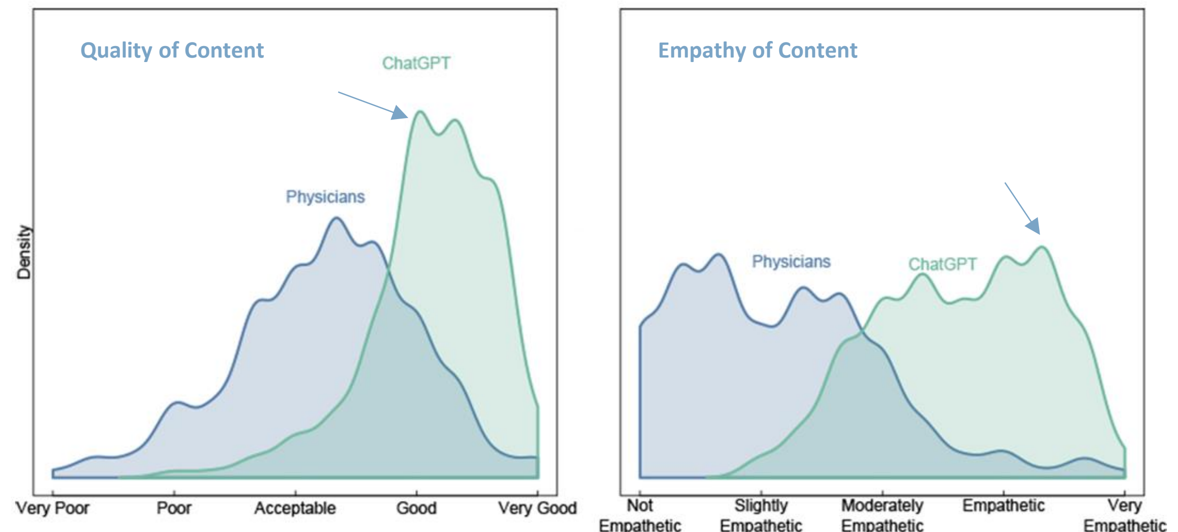
Artificial (Emotional) Intelligence

Recent research suggests that generative AI software can be trained to be just as (if not more) empathetic than humans. This suggests that generative AI bots might ultimately have a future role engaging more directly with patients -- beyond just automating administrative tasks, e.g., writing letters to health plans and transcribing medical notes.

A 2023 study published in *JAMA Internal Medicine* evaluated the "quality of content" in the responses to patient questions by an AI chatbot assistant (ChatGPT) as compared to responses to the same questions by human physicians. The evaluators rated the quality of the AI content as "good" or "very good" 79% of the time -- vs only 22% of the time for human physician responses.

What is surprising to many is that AI is increasingly considered as *more empathetic than human providers*. In the same *JAMA Internal Medicine* study, the evaluators ranked 45% of AI-generated responses as "empathic" or "very empathic" compared to just 5% of the human physician responses. The study referenced the AI generated responses as having less "doctor-speak" than the human responses in the study. This highlights the ability of large language models to learn how to demonstrate compassion.

That said, **AI has a long way to go before replacing humans.** Surveys show that most patients (60%) are uncomfortable relying on technology over doctors for diagnoses and medical care. Also, there continues to be the problem of generative AI "hallucinating" and providing seemingly expert answers that are completely wrong with references that do not exist. In all cases, AI generated messages should be reviewed for accuracy and bias.



Source: Ayers JW, Poliak A, Dredze M, et al. Comparing Physician and Artificial Intelligence Chatbot Responses to Patient Questions Posted to a Public Social Media Forum. JAMA Intern Med. 2023;183(6):589–596

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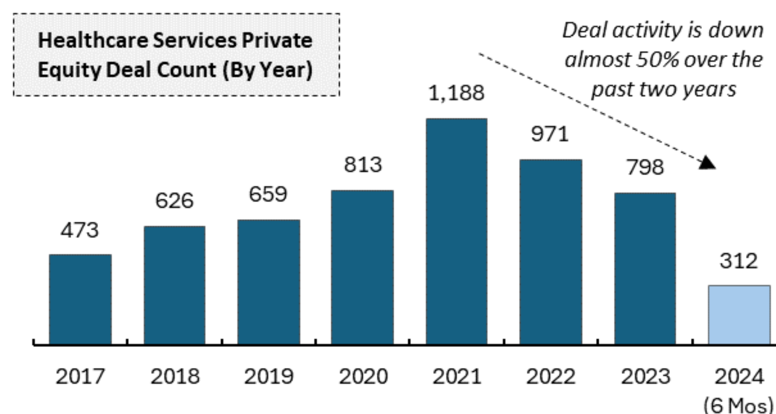
Valuation
Considerations

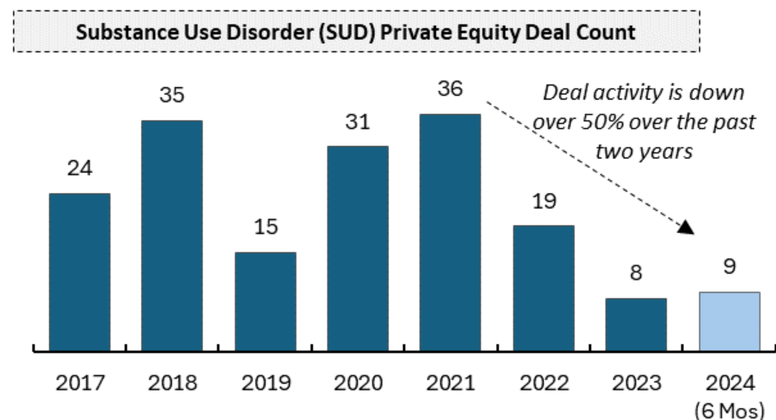
Private Equity Deal Activity in Substance Use Disorders

We expect private equity (and strategic) deal activity in the substance use disorder (SUD) space to reaccelerate in 2025 and 2026. In our view, platform SUD providers will be able to bring greater economies of scale to an increasingly managed care dominated marketplace with more value-based reimbursement and information technology demands.

Overall healthcare services private equity deal activity remains at healthy levels, in our view. Although deal activity is down from the "bubble levels" in 2021, it is important to keep in mind that deal activity is still generally in-line with pre-COVID levels -- despite the Federal Reserve raising its interest rate target by 500 bps since early 2022 -- the steepest rise in rates in the shortest period since the 1980s. In mid-September, the Fed cut its target by 50 basis points with a median projection for one or two more cuts in the near-term. Debt financing is common in acquisitions so acquirers may be now more willing/able to deploy cash with declining rates, and private equity funds have been holding on to record levels of dry powder.

Behavioral health (including SUDs) has been a "bright spot" within healthcare services over the past few years. There have been several behavioral health and SUD platforms that have come to market. For instance, in September 2024, Bradford Health Services acquired Lakeview Health as part of a service and geographic expansion strategy. Also, in April 2024, Avesi Partners acquired First Steps Recovery, a medically-focused substance use disorder provider. This follows Avesi Partners' January 2023 acquisition of Muir Wood.





Source: Pitchbook (Healthcare Services Report; June 2024) and Bourne Partners

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Five (5) Key Drivers of Valuation for SUD Providers

Valuations for substance use disorder (SUD) providers can vary depending on the scale of the provider's platform, the breadth of the provider's services, and the quality of the provider's payer relationships, among other factors. Over the past three years, we have seen valuations ranging from 11.0x to 17.0x trailing EBITDA for large scale and professionalized assets.

Size and Scale of the Platform

We find that the market values for SUD providers are highly positively correlated with the size and scale of the provider's operations -- both financially and geographically. Larger platform SUD providers have significant advantages with respect to negotiating with managed care plans, entering value-based contracts, and scaling software and other technology investments.

Integration within the Continuum

SUD providers that are part of a broader continuum of services are often able to attract larger volumes of patients since SUDs rarely occur in isolation from other mental (and physical) health conditions. Also, including SUD as part of a broader continuum of care is viewed by many as a way to improve the coordination of patient care, referral relationships, and managed care coverage.

Managed Care Relationships

There seemed to be a consensus view that the "cash pay" segment of the SUD market is phasing away with an increasing mix of patients now being covered by managed care. This trend may accelerate in the coming years due to the recent "parity" regulations released in September. As such, being broadly in-network with local commercial health plans is a must.

Technology Enablement

The use of software automation and information technology will increasingly be a differentiator for SUD providers, in our view. Interoperable information technology is a necessary element to a provider's success in value-based reimbursement models. Also, having a strong foundation in information technology sets a provider up to take advantage of advances in artificial intelligence.

M&A / Finance Sophistication

Many SUD providers are evaluating potential acquisitions (and partnerships) to develop the size and scale that they will need to be competitive in an increasingly managed care dominated environment. However, integrating acquisitions and expanding services takes time. So, we think that it behooves SUD providers to consider strategies sooner rather than later.

Source: Bourne Partners

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Behavioral Health and SUD Precedent Transactions (1 of 2)

Scaled Providers

Announced	Target	Target Description	Acquirer	Enterprise Value	EV/ EBITDA	EBITDA ($ Millions

To access the full unblinded report, contact:
research@bourne-partners.com

Source: Bourne Partners

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Behavioral Health and SUD Precedent Transactions (2 of 2)

Scaled Providers

Announced	Target	Target Description	Acquirer	Enterprise Value	EV/ EBITDA	EBITDA ($ Millions

To access the full unblinded report, contact: research@bourne-partners.com

Source: Bourne Partners

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Elevated Buyer Interest in Low-Cost Modalities of Care

We see elevated interest in lower-cost modalities of treatment, e.g., outpatient, IOP, and PHP. We think this is a logical effect of the increasing presence of managed care in the behavioral health and substance use disorder (SUD) space. Also, these potentially lower-cost settings often play well in value-based reimbursement environments.

Select IOP and PHP Providers Acquired Since August 2023

To access the full unblinded report, contact: *research@bourne-partners.com*

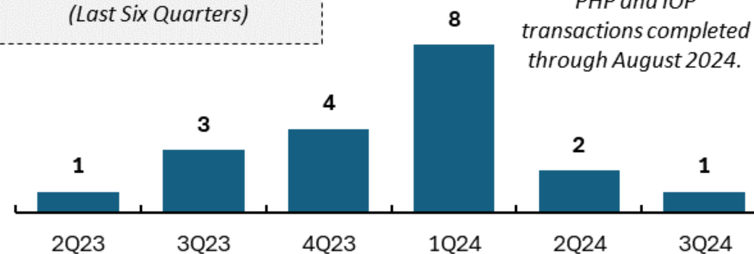
With private equity looking to put capital to work in behavioral health and SUD providers, there is an increasing focus on PHP and IOP platforms While inpatient and residential treatment is appropriate for high acuity patients, several concerns exist for investors, including:

1) Drawing patients from a wider geographic area, necessitating broader cross-state geographic coverage

2) Managed care is pushing for options with shorter inpatient stays

3) Higher acuity businesses are struggling to retain employees

4) Headline risk is inherently greater higher for higher-acuity settings



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Source: Bourne Partners

Valuations Vary Widely Across Behavioral Health Providers

In our view, **valuations for publicly traded behavioral health (and substance use disorder) companies vary widely** -- generally falling between valuations for hospitals and home care. The higher current valuation for LifeStance Health (LFST-NASDAQ) reflects a higher mix of outpatient revenues, in our view. By contrast, the lower valuation for Teladoc Health (TDOC-NASDAQ) reflects an uncertain outlook for its Better Help business unit (~35% of R4Q adjusted EBITDA).

		Enterprise	Projected CY2025		Projected CY2025			Debt
Company Name	**Ticker**	**Value**	**Revenue**	**Growth**	**EBITDA**	**Growth**	**Multiple**	**Ratio**
Behavioral Health Care								
Acadia Healthcare Company, Inc.	ACHC	$6,988	$3,532	10.0%	$824	10.2%	8.5x	2.3x
LifeStance Health Group, Inc.	LFST	3,073	1,385	13.8%	126	35.4%	24.5x	3.3x
Teladoc Health, Inc.	TDOC	2,002	2,552	2.0%	365	6.0%	5.5x	1.2x
Universal Health Services, Inc.	UHS	19,166	16,599	5.7%	2,345	5.6%	8.2x	2.1x
Average (Mean / Median)				**7.9%**		**14.3%**	**11.7x**	**2.2x**
Facilities Based Care								
Community Health Systems, Inc.	CYH	$12,867	$13,088	4.8%	$1,649	5.6%	7.8x	7.4x
DaVita Inc.	DVA	24,734	13,263	3.3%	2,787	4.0%	8.9x	4.0x
HCA Healthcare, Inc.	HCA	143,676	74,819	5.3%	14,804	5.5%	9.7x	2.8x
Pediatrix Medical Group, Inc.	MD	1,589	1,950	2.6%	223	2.4%	7.1x	2.5x
Tenet Healthcare Corporation	THC	24,922	21,646	4.9%	4,051	6.4%	6.2x	2.5x
Average (Mean)				**4.2%**		**4.8%**	**7.9x**	**3.8x**
Average (Median)				**4.8%**		**5.5%**	**7.8x**	**2.8x**
Home and Community Based Care								
Amedisys, Inc.	AMED	$3,479	$2,515	7.4%	$276	5.1%	12.6x	1.2x
Aveanna Healthcare Holdings Inc.	AVAH	2,417	2,095	4.9%	174	9.1%	13.9x	8.4x
BrightSpring Health Services, Inc.	BTSG	5,486	11,856	8.9%	623	8.0%	8.8x	4.6x
Encompass Health Corporation	EHC	12,448	5,788	8.4%	1,161	9.2%	10.7x	2.4x
Option Care Health, Inc.	OPCH	5,897	5,263	8.4%	495	11.0%	11.9x	1.7x
Select Medical Holdings Corporation	SEM	9,252	7,331	5.1%	933	6.9%	9.9x	5.2x
Average (Mean)				**7.2%**		**8.2%**	**11.3x**	**3.9x**
Average (Median)				**7.9%**		**8.6%**	**11.3x**	**3.5x**

Note: Market values are as of the close of business October 11, 2024.
Source: S&P Global Market Intelligence and Bourne Partners

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Behavioral Health Trades at a Premium to Many Providers

Acadia Healthcare (ACHC-NASDAQ), the bellwether publicly-traded behavioral health provider, has traded, on average, with a low-teens multiple of forward EBITDA. This is a modest discount to home and community-based providers (e.g., home care), and a premium to more traditional facilities-based providers (e.g., hospitals). Note, ACHC share price dipped significantly in late September due to the announcement of government fines over billing issues in prior years.

Trading Valuations (EV-to-EBITDA (NTM)
Last Five Years (Weekly)

ACHC
Home and Community Based Care
Facilities Based Care Providers
S&P 500 Index

18.0x
16.0x
14.0x
12.0x
10.0x
8.0x
6.0x

Oct-19 Dec-19 Feb-20 Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24

S&P 500 (15.2x)
Home and Community Based Care Providers (12.8x)
Facilities Based Care Providers (9.7x)
ACHC (9.1x)
Note: ACHC shares fell 20%+ following the announcement of government fines related to prior period over-billing of medical claims.

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Note: See Slide 43 for breakdown of indices. Market values are as of the close of business October 11, 2024.
Source: S&P Global Market Intelligence and Bourne Partners

Selected Substance Use Disorder Provider Profiles (1 of 6)

Acadia Healthcare
Franklin, Tennessee
www.acadiahealthcare.com

Acadia Healthcare provides a broad range of behavioral health services across a national network of 225+ facilities. This includes specialty treatment facilities, which mostly serve patients with alcohol/drug addiction. In total, these specialty treatment facilities generated $615M of revenue in 2023 (~21% of total revenues).

Acadia is also involved in 20+ joint ventures with traditional hospitals and health systems, which rely on Acadia for its behavioral health expertise and to expedite patients out of their emergency rooms (to free up space for patients with medical emergencies).

Acadia Healthcare is publicly traded on the NASDAQ under the ticker "ACHC."

Bradford Health Services
Birmingham, Alabama
www.bradfordhealth.com

Bradford Health Services offers a full continuum of SUD services through a network of locations mostly in the Southeast of the United States. Bradford is backed by Lee Equity Partners, which acquired a majority stake in Bradford in October 2022.

We expect Bradford to look to grow to become a major SUD provider in the Eastern half of the United States.

Most recently, in September 2024, Bradford acquired Lakeview Health. Lakeview Health expands Bradford geographically into Florida and adds an eating disorder treatment facility. The acquisition of Lakeview Health follows Bradford's acquisition of Vertava Health of Mississippi in November 2023.

BrightView
Cincinnati, Ohio
www.brightviewhealth.com

Founded in 2015, BrightView provides evidence-based outpatient addiction treatment to patients in recovery from substance use disorder at 85 centers across seven states. Each of these centers is generally able to dispense medications on-site, which makes treatment comfortable and convenient for patients. Also, BrightView offers individual counseling, group therapy, and wraparound social services as well as work on co-occurring disorders.

BrightView is backed by health care-focused private equity firm Shore Capital Partners. BrightView has grown through a balanced approach of acquisitions of existing providers and the opening of new facilities.

Source: Company filings and Bourne Partners

Selected Substance Use Disorder Provider Profiles (2 of 6)

Crossroads
Greenville, South Carolina
www.crossroadstreatmentcenters.com

Founded in 2005, Crossroads is a well-known provider of mental health and substance use disorder treatments. Today, Crossroads operates 100+ outpatient clinics across nine states with a concentration in Virginia, Pennsylvania, and New Jersey.

Recently, in September 2024, Crossroads began offering injectable forms of buprenorphine for patients with opioid use disorder.

In January 2022, Revelstoke Capital Partners and Caisse de dépôt et placement du Québec completed a recapitalization of Crossroads, involving a significant injection of capital. Revelstoke has been an owner of Crossroads since December 2014.

Embark Behavioral Health
Chandler, Arizona
www.embarkbh.com

Embark Behavioral Health provides mental health and substance use disorder treatment for adolescents and young adults. This includes a continuum of services, including residential treatment centers, day treatment, partial hospitalization programs, intensive outpatient programs, and virtual intensive outpatient programs.

In February 2023, Consonance Capital Partners took a controlling equity position in Embark. Housatonic Partners had previously backed Embark Behavioral Health since 2016. In September 2024 Embark appointed Scott Filion as its CEO. Filion has a broad background in healthcare, software, and technology companies.

Evolve Treatment Centers
El Segundo, California
www.evolvetreatment.com

Evolve Treatment Centers provides adolescent behavioral health services with specializations in mental health, trauma, and substance abuse disorders. Today, Evolve operates from a network of 17 locations throughout the state of California as well as a virtual/online program for alcohol and drug addiction.

Evolve was acquired by Galen Partners through an LBO in January 2020. Since then, Evolve has expanded its network of facilities. Most recently, in September 2024, Evolve opened its fourteenth residential treatment center in La Mesa, California. The La Mesa home will offer individual therapy, group therapy, family therapy, and experiential therapies.

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Source: Company filings and Bourne Partners

Selected Substance Use Disorder Provider Profiles (3 of 6)

GateHouse Treatment
Nashua, New Hampshire
www.gatehousetreatment.com

Founded in 2009, GateHouse Treatment provides a range of addiction treatment services, including 60-day PHP and IOP programs, sober living, and in-house medication treatment (MAT) clinics. This results in patients being fully supported throughout their recovery journey while also giving them immediate access care.

Of note, GateHouse has a unique relationship with the New Hampshire state government in which it provides transitional housing for patients who need to wait for a treatment placement (oftentimes at GateHouse itself) from the New Hampshire Department of Health and Human Services.

GateHouse is backed by ICBD Holdings.

Groups Recover Together
Birmingham, Massachusetts
www.joingroups.com

Groups Recover Together offers in-person and virtual support groups for people with opioid addiction. Groups was founded in 2014 based on an evidence-based model of outpatient weekly group therapy and medication-assisted treatment (Suboxone).

Groups is fully (100%) focused on value-based reimbursement contracts. Also, Groups is involved in a number of public-private partnerships -- e.g., departments of corrections and state government seeking to serve various uninsured populations, etc.

Groups is a founder-owned company with a variety of co-investors, including Oak HC/FT, Bessemer Venture Partners, and Optum Ventures, among others.

Hazelton Betty Ford Foundation
Birmingham, Alabama
www.hazeldenbettyford.org

The Hazelden Betty Ford Foundation is a nonprofit treatment provider operating out of 17 facilities. Originally, the Foundation focused solely on residential care. However, providing a full continuum of has been a major strategic focus and the Foundation has expanded into outpatient care, recovery management services, and coaching. Today, 20%+ of its revenue comes from non-residential services.

Recently, the Foundation has been focused on employer-sponsored programs. The Foundation currently is in market with a bundled solution that includes both residential and outpatient care as well as a variety of online portals and resources.

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Source: Company filings and Bourne Partners

Selected Substance Use Disorder Provider Profiles (4 of 6)

LifeStance Health
Scottsdale, Arizona
www.lifestance.com

LifeStance Health is a national provider of virtual and in-person outpatient behavioral health for patients of all ages. LifeStance (and its supported practices) employ ~7k providers.

Notably, LifeStance offers a range of treatments for substance use disorders as well as behavioral addictions like gambling or internet addiction. This is integrated with LifeStance's treatments for other mental health conditions.

LifeStance was founded in 2015 with investments from Summit Partners and Silversmith Capital Partners. Later, LifeStance secured $1.2B from TPG Capital in 2020 and completed an IPO in June 2021. Today, LifeStance is publicly traded on the NASDAQ (ticker: "LFST").

Muir Wood
Petaluma, California
www.muirwoodteen.com

Founded in 2013, Muir Wood offers short-term residential behavioral health services, focused on adolescents with mental health and substance use disorders. Currently, Muir Wood operates out of eighteen campuses in California. These campuses are carefully designed to feel home-like to enable treatment and recovery.

Also, Muir Wood offers supplemental education programs to allow adolescents to remain in treatment and sustain their education.

In January 2023, Avesi Partners acquired Muir Wood. Of note, in April 2024, Avesi also acquired First Steps Recovery, a medically-focused substance use disorder provider.

Pinnacle Treatment Centers
Mount Laurel, New Jersey
www.pinnacletreatment.com

Pinnacle Treatment Center was founded in 2015 to offer substance abuse disorder treatment and recovery services. Today, Pinnacle has expanded over the years through de novo start-ups and acquisitions to a current network of 135+ centers. Notable recent acquisitions include MBA Wellness (December 2022), Stepping Stone of North Carolina (June 2022), and HealthQwest (August 2020)

Government partnerships have been key to Pinnacle's growth strategy and most of Pinnacle's revenues are generated from Medicaid managed care plans such as Centene.

Linden Capital acquired a controlling equity stake in Pinnacle in 2016.

Source: Company filings and Bourne Partners

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Selected Substance Use Disorder Provider Profiles (5 of 6)

Promises Behavioral Health
Brentwood, Tennessee
www.promises.com

Promises Behavioral Health offers integrated mental health and substance use disorder treatment out of nine facilities across the Eastern half of the United States (and Texas). Each facility offers medical drug detox, alcohol and drug rehab, trauma treatment, mental health treatment for depression and mood disorders, anxiety and personality disorders, eating disorders treatment, and sex addiction treatment, among others.

Of note, Promises completed a debt-for-equity restructure in November 2021 via a loan provided by Assured Healthcare Partners. This loan was subsequently converted into an equity stake in the company.

Recovery Centers of America
King of Prussia, Pennsylvania
www.recoverycentersofamerica.com

Recovery Centers of America is a provider of inpatient and outpatient substance abuse treatments with 12 locations across seven states. Recently, in June 2024, RCA also announced a referral partnership with Pelago, a vendor of digital addiction services to businesses and health plans.

RCA has been recognized multiple times in Newsweek's America's Best Addiction Centers rankings. This year, in April 2024, RCA disclosed superior outcomes (vs national averages) as measured by readmission rates, Brief Addiction Monitor (BAM) scores, and patient satisfaction rates.

RCA is backed by Deerfield Management and other investors.

Summit Behavioral Healthcare
Franklin, Tennessee
www.summitbhc.com

Summit manages a national network of 37 freestanding facilities providing inpatient psychiatric and substance use disorder care. Key services include residential chemical dependency programs, acute psychiatric care, detoxification programs, and partial hospitalization. In July 2024 Summit announced Everest Outpatient Services.

Summit was founded in 2013 with an in-network commercial strategy to provide patients with greater access to affordable care.

In September 2021, Patient Square Capital acquired Summit from FFL Partners and Lee Equity Partners. FFL and Lee Equity had previously acquired Summit in October 2017.

Source: Company filings and Bourne Partners

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Selected Substance Use Disorder Provider Profiles (6 of 6)

Tulip Hill Healthcare
Brentwood, Tennessee
www.tuliphillhealthcare.com

Tulip Hill Healthcare is a newly formed substance use disorder provider, created in May 2024 via the merger of Tulip Hill Recovery, the Louisville Addiction Center, and the Lexington Addiction Center. The newly formed provider offers residential care, partial hospitalization, intensive outpatient programs, and outpatient care.

The merger was intended to set up Tulip Hill for growth. In August, Tulip Hill acquired two detox centers: Tennessee Detox Center and Live Again Detox. Also, Tulip Hill is reportedly looking to open locations in Massachusetts and Kentucky in underserved areas. Finally, media reports suggest the company is also planning to expand its services.

Universal Health Services
King of Prussia, Pennsylvania
www.uhs.com

Universal Health Services is one of the largest health systems in the U.S. Universal entered the behavioral health space through its acquisition of Psychiatric Solutions in 2010.

Today, Universal's behavioral health business generates $6.2B+ of net revenue out of 300+ facilities. This includes a large presence in substance use disorders. In the past, Universal has focused on more traditional drug and alcohol detox, step-down, sober living, and aftercare programs. Recently, Universal has started to offer more medication assisted treatments (MAT) to address opioid use disorders.

Universal is a public company traded on the NYSE, under the ticker "UHS."

Your Behavioral Health
Torrance, California
www.yourbehavioralhealth.com

Your Behavioral Health is a regional provider of mental health and substance use disorder treatments with 17 locations in Southern California. This includes inpatient, outpatient, interventional psychiatry, and residential care across various brands, e.g., Clear Recovery Center, New Life House, and Neuro Wellness Spa.

In June 2023 Comvest Partners acquired Your Behavioral Health from its founder-owners and Comvest plans to grow the platform with investments in key technologies and additional outpatient and telehealth services. The original founders continue to manage the platform alongside the existing management team.

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Source: Company filings and Bourne Partners

Appendix: Bourne Partners Overview

Bourne Partners Overview

Our Service Offering

For over twenty years, Bourne Partners has focused exclusively on providing investment banking advisory services and making direct investments in the Healthcare Services, Pharmaceutical, Pharma Services, Pharmacy Services, and Consumer Health and Wellness industries. Since 2015, we have successfully executed on **over $15B** in transactions, having worked with many leading companies and private equity investors in these core focus areas.

Investment Banking

Mergers and Acquisitions
Sell-side and buy-side assignments
Transaction Experience: $10M - $3.5B

Capital Sourcing
Debt / Equity / Hybrid
$10 - $500 million raises

Business Development Support
Development stage and approved products
Local and international

Strategic Capital

Investment Focus
Direct investments in private companies
Selective approach in vital focus areas

Other Criteria
Cash flow positive opportunities
Complex situations with creative structures
Actionable growth stage or middle market business
Flexible investment targets with established private equity relationships

Geographic Coverage

Sector Expertise

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Bourne Partners Expertise in Healthcare Services

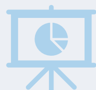
Healthcare Services Sector Expertise

Industry Segments

Healthcare Services
- Post Acute Care
- Behavioral Health
- Managed Care
- Physician Practice Management
- Alternate Site

Outsourced Services
- Distribution
- Home Medical Supplies / DME
- Labs
- Pharmacy & Pharmacy Services
- Staffing

Technology & Tech-Enabled Services



- Virtual Care-Enablement
- ProviderTech
- Payor Services & Technology

Transaction Structures
- Sell/Buy-Side M&A
- Carveouts
- Alternative Financing Solutions

Healthcare Services

Pharma Services

Pharma

Consumer Healthcare

Representative Healthcare Services Transaction Activity

H.I.G. Capital — Growth Recapitalization and Fund-to-Fund transfer of Soleo Health	Lincare (A Linde company) — Sale of Home Infusion Assets to KabaFusion (Patient-Focused Infusion Therapy); A portfolio company of PPC Partners	bioscrip — Advisor to Board of Directors on Strategic Alternatives	Forefront Telecare — Sale to SOC Telemed; A portfolio company of Patient Square Capital; *Sell-Side M&A*
Magellan Healthcare — Acquisition of a Majority Interest in Bayless Integrated Healthcare	Magellan Healthcare — Minority Equity Investment in Kaden; Exclusive financial advisor to Magellan Health	Quorum Health — Financial Advisor to Quorum Health on its Chapter 11 Reorganization	Kinderhook Industries — Advisor to Kinderhook on its acquisition of MCS; *Buy-Side M&A*
brand new day (Healthcare you can feel good about) — Sell-side Advisor to Brand New Day; Bright HealthCare	BlueCross BlueShield Arizona — Buyside Advisor to BCBS of Arizona; Steward Health Care Network Health Choice Massachusetts	evariant (Moving healthcare ahead) — Sale to healthgrades; A portfolio company of Vestar; *Buy-Side M&A*	Vytalize — Private Placement; Exclusive Placement Agent

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Note: Includes transactions completed at prior firms.

The Bourne Team

Senior Leadership

Banks Bourne
Founder & CEO

Jeremy Johnson
Senior Managing Director

Aaron Olson
Managing Director

Xan Smith
Managing Director

Todd Bokus
Director

Robert Stanley
Director

Strategic Advisory & Administration

Matt Bullard
Strategic Advisor

Scott Emerson
Strategic Advisor

Bruce Montgomery
Strategic Advisor

Paul Campanelli
Strategic Advisor

Martin Zentgraf
Strategic Advisor

Minor Hinson
CIO, BPSC

Chris Inklebarger
Chief Operating Officer

Calli Lewis
Chief of Staff

Support Team

Vice Presidents

Associates

Analysts

- ✓ **Deep Industry Expertise**
- ✓ **Excellent M&A Execution**
- ✓ **Thorough Sponsor Coverage**
- ✓ **Broad Senior Support**
- ✓ **Detailed Thought Leadership**

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Thought Leadership

Bourne Perspective

After 20+ years of exclusive industry and capital markets coverage, we know the space and we are committed to providing actionable insights to our clients. We provide cutting-edge thought leadership on all things Pharma, Pharma Services, and Consumer Health.

Through leveraging resources and insights of both Bourne Partners Strategic Capital and Investment Banking divisions, **we provide differentiated perspectives to our clients from our unique vantage point**. Our goal is to deliver heavy-hitting, timely reports in an easy-to-read format tailored specifically for executives within our industry coverage.

Deal Profiles

DEAL PROFILE
Amgen | Horizon Therapeutics
VALUES
$28.3bn ~34.9x ~21.0x

Market Conference Commentary

BIO BRIEFING
Xan Smith

Industry Update Posts

INSIGHT
Industry Update
Recent Trends & Transactions

Weekly Newsletter

Week of July 18, 2023 | Vol. 12, Issue 28
INSIGHT
Newsletter
Recent Trends & Transactions
In This Issue
Quick Links
Contact Information
Industry Snapshot

Market Reports

Biostorage Services
Market Insight
2023

Expert Interviews

MARKET INSIGHT: USING DIVESTITURES TO DELIVER EXCESS RETURNS
READ

Sector Updates

Pharmaceutical Sector Update
Bourne Market Report
1H 2023

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BOURNE PARTNERS