NORTON ROSE FULBRIGHT

DUFF & PHELPS

Protect, Restore and Maximize Value

Multi-State Behavioral Healthcare Strategies

VALUE CREATION AND CHALLENGES

MAY 2018

SECTION 1

Introduction

The behavioral healthcare industry continues to grow, with a significant imbalance between patient demand and patient access to care. In 2016, an estimated 44.7 million adults had a mental illness such as depression, anxiety or schizophrenia, but only 43% received proper treatment,[1] leaving more than 25 million Americans without adequate care. Similarly, over 19 million adults have an addiction problem, but only 16% are receiving proper treatment.[2] Behavioral health providers remain in high demand across the country. As of 2015, approximately 55% of the nation's 3,100 counties do not have any practicing psychiatrists, psychologists or social workers.[3] Healthcare providers and investors are responding to the imbalance by aggressively growing behavioral health practices organically or via acquisition to meet the high demand. As providers grow, they are inevitably faced with the prospect of expanding their practices across state lines. This article addresses the implications of a multi-state expansion strategy from a variety of viewpoints. It will discuss the value creation, regulatory and compliance challenges and other operating considerations of a multi-state behavioral healthcare practice.

1. Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
2. Kaiser Family Foundation, "Medicaid's Role in Behavioral Health," May 5, 2017, https://www.kff.org/infographic/medicaids-role-in-behavioral-health/
3. Rene Quashie, "The Boom in Telemental Health," TechHealth Perspectives, August 2015, https://www.techhealthperspectives.com/2015/08/24/the-boom-in-telemental-health/

SECTION 2

Creating Value Through Multi-State Strategies

According to IBISWorld, an estimated 77% of the 10,000 companies operating substance abuse treatment clinics have a single location, and 57% of all clinics have fewer than 20 employees.[4] As patient demand for care and the availability of governmental and commercial reimbursement continue to expand the industry, consolidation will reduce the number of small providers as large platform investments create regional and national practices. The advantages of multi-state practices compared to small, single-state providers will be quite notable. Multi-state practices have significant competitive advantages over small providers, including but not limit to, the stability of their cash flows and the opportunity to profitability expand those cash flows in the future.

Diversified Payor Base

While all healthcare practices face reimbursement risk, multi-state practices benefit from a diversified payor base that creates a more stable cash flow stream. Given the implementation and increasing enforcement of federal mental health parity laws and regulations across states, most behavioral healthcare providers, like all other healthcare providers, are now beholden to third-party payor reimbursement rates from private insurance or state-sponsored programs. Although contracting with governmental and commercial payors in multiple states comes with its challenges, multi-state practices are less impacted by changes in reimbursement policies by any one state, territory or payor, because of their diversified reimbursement base. This makes their overall annual cash flows more stable. Diversified reimbursement from a variety of payors, especially diversified Medicaid state reimbursement, lowers the financial risk profile of a multi-state behavioral health practice and therefore creates value for the owners of the practice. The payor universe for mental health and substance abuse centers is dominated by Medicaid, which accounted for approximately 33% of 2017 industry revenue of $16.3 billion.[5] According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid payments for inpatient services vary considerably across states, ranging from 49% to 169% of the national average.[6] Similar to a diversified stock portfolio where decreases in value of one position are often offset by increases in value of another, any impact of Medicaid reimbursement variability or changes thereto is likely less severe for practices with a diversified state payor mix. In 2018, Medicaid rates are expected to rise in 44 states for at least one provider type, such as inpatient and outpatient hospitals, primary care physicians, specialists, dentists or nursing homes.[7] However, only 17 states plan to increase inpatient hospital rates this year, while 33 states plan to cut or keep rates the same.[8]

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4. IBISWorld, Mental Health & Substance Abuse Centers in the US, March 2017
5. Ibid
6. "Medicaid Hospital Payment: A Comparison Across States and to Medicare," MACPAC, April 2017, https://www.macpac.gov/publication/medicaid-hospital-payment-a-comparison-across-states-and-to-medicare/
7. Virgil Dickson, "Medicaid Rates in 44 States to Rise in Fiscal 2018," Modern Healthcare, October 20, 2017, http://www.modernhealthcare.com/article/20171020/NEWS/171029989
8. Ibid

The underlying determinates of Medicaid reimbursement are complex and oftentimes political, with each state formulating its own plan and scope of services to be covered. This complexity makes it essential to diversify one's payor base and gives behavioral healthcare providers operating in multiple states a significant advantage because the risk of Medicaid reimbursement changes is unlikely to occur evenly across state programs.

Economies of Scale

Further value is created by multi-state practices from economies of scale. These size advantages can lead to improved profit margins and return on growth investments. As practices seek to gain larger market share appropriately structured marketing programs are crucial to increasing brand awareness, referrals and ultimately patient flow. National and regional marketing efforts leverage programs across larger patient populations, improving the cost structure as more locations are added and the marginal cost of marketing decreases. For example, AAC Holdings (AAC), a provider of inpatient and outpatient substance abuse treatment, has achieved success by developing a national brand, American Addiction Centers, through investment in its facilities and expertise in its national marketing program. The centralization of one national or regional marketing effort resulted in significant inbound volume from potential clients.[9] Furthermore, a multi-state geographic strategy and marketing plan covering a large region can capture a greater number of referrals, driving additional revenues to a practice.

Recruitment of physicians and other behavioral health professionals is crucial to the success of any healthcare practice. Multi-state practices have the benefit of notoriety and resources to enable the recruitment of top candidates. The issues of recruitment are compounded for single-state practices located in smaller or rural markets. Physicians are typically trained in large metropolitan areas and tend to stay in those areas following their training. Research shows that fewer than 3% of newly trained physicians prefer a community of 25,000 residents or less, while 59% prefer a community of 100,000 or more people.[10] Moreover, practices with multiple offices in close proximity can more effectively manage workflow for behavioral health professionals and mitigate staffing imbalances.

Advantages in marketing and physician recruitment are two examples that demonstrate how multi-state practices leverage economies of scale. Other economies of scale relate to general back-office support and technology services that reduce practice costs. For example, AAC maintains a 24/7 call center at its corporate headquarters that conducts benefits verification and handles communication with insurance companies for all its facilities. In addition, AAC centralizes functions such as accounting, billing and collections allowing its facilities to focus solely on providing clinical care.[11] Similarly, the use and implementation of electronic medical records (EMRs) in behavioral health has improved information capture, reporting and data aggregation. Technology enables behavioral health organizations to operate seamlessly across multiple geographies. A multi-state strategy also allows a practice to further scale its billing and collections efforts. Accounts receivable management for behavioral health practices is less complex than medical/surgical hospital providers because behavioral healthcare facilities have fewer billing codes and generally are paid on a per diem basis. Therefore, as behavioral health practices grow, billing and collections scale can provide operating leverage and margin improvement.[12]

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9. AAC Holdings Inc. 2017 10-K
10. Merritt Hawkins White Paper Series, "Rural Physician Recruiting Challenges and Solutions," 2016
11. Ibid
12. Acadia Healthcare Inc. 2017 10-K

Telehealth Services

The rapid growth of the telehealth industry over the past several years and its use in behavioral health settings provides opportunities to further improve operations for multi-state practices. Telehealth is generally defined as the use of electronic information and telecommunications technologies, such as videoconferencing and electronic messaging, to provide healthcare. The telehealth industry, which is expected to grow at nearly 10% over the next 5 years,[13] is leveraging advances in communication and medical technologies, such as wearable devices, digitized medical scans and more efficient treatment delivery. Telehealth is increasingly being used to deliver behavioral health services. With access to telehealth tools, patients and physicians in different locations can interact via live (synchronous) healthcare sessions, enabling behavioral health practices to expand coverage and provide services to patients in underserved areas. According to research studies, telehealth services can even prove more effective than in-person visits due to the comfort and ease of meetings with healthcare providers.[14] Telehealth enables providers of behavioral health services to potentially expand their service area across state lines, without the time and expense of burdensome state facility licensure requirements that may be required to build a brick and mortar facility. Telehealth allows providers to serve an increased patient population while delivering cost savings, specifically by reducing patient no-shows, cancellations and the costs associated with establishing and running multiple brick and mortar facilities.[15]

SECTION 3

Regulatory Considerations in Implementing a Multi-State Strategy

As discussed above, there are many advantages to a multi-state strategy in the provision of behavioral health services. However, key regulatory regimes applicable to behavioral health vary on a state-by-state basis and need to be considered and complied with in a manner that is effective and practical at an organizational level when executing a multi-state strategy.

Professional Licensure and Telehealth

Physician and other behavioral health professional licensure requirements vary by state and can present issues for providers wishing to administer behavioral health services across state lines. There are also inconsistencies among states' laws and regulations regarding the practice of medicine. Thus, a physician engaged in telehealth services across state lines may be responsible for complying with multiple sets of licensure laws and medical practice regulations. Physicians who want to practice telemedicine in multiple states may be eligible to apply for a license through the Interstate Medical Licensure Compact (IMLC), which allows licensed physicians to practice

13. IBISWorld, Telehealth Services in the US, May 2017
14. Meredith Lawrence, "The Benefits of Telemental Health to Patient and Provider," January 2015, http://theworkspacetoday.com/2015/01/20/benefits-telemental-health-patient-provider-qa-dr-marlene-maheu/
15. Zereana Jess-Huff, "How Telehealth Can Transform Behavioral Health Care," April 2016, http://www.benefitspro.com/2016/04/26/how-telehealth-can-transform-behavioral-health-car?t=wellness&page=2&slreturn=1518137153

medicine across state lines if they meet certain eligibility requirements and are located in one of the 22 IMLC member states. However, states also have varying requirements applicable to telehealth communication modalities (video, audio, etc.), e-prescriptions, the establishment of patient-provider relationship, and locations where the services can be provided (e.g., the patient's home versus an outpatient setting where the patient resides).

State and Federal Privacy Regimes

State and federal privacy laws and regulations contain varying protections for patients' behavioral health records. On the federal side, these laws include the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively, HIPAA), and the Confidentiality of Alcohol and Drug Abuse Patient Records regulations (42 CFR Part 2) promulgated by SAMHSA, often referred to as the SAMHSA Regulations. The SAMHSA Regulations are applicable to any patient records maintained by an alcohol and drug treatment program that receives federal funding (e.g., Medicare, Medicaid or a grant of tax-exempt status) and are much more stringent than HIPAA, providing few avenues for sharing patient information (e.g., between providers) without patient consent for each disclosure. The SAMHSA Regulations were amended effective March 21, 2017, with the intent of facilitating integration of care and incorporating new healthcare delivery models while also protecting the privacy of patients seeking treatment for substance use disorders. There is a divergence of viewpoints between those who want more data sharing to improve care coordination and those who are concerned about the negative consequences (e.g., employment discrimination and potential prosecution, etc.) of the release of sensitive substance abuse information, as to whether the SAMHSA Regulations, as amended, go too far or not far enough. Regardless, the disclosure requirements of the SAMHSA Regulations continue to be more stringent than and not aligned with HIPAA, and substance use disorder programs that receive federal reimbursement are required to comply with both federal regulatory regimes.

In addition, all states and the District of Columbia have enacted laws to protect their citizens' health records. The challenge from a compliance perspective is the many inconsistencies between federal and state privacy laws. Some state privacy laws directly conflict with the standards set forth in HIPAA. In these instances, the more stringent law will apply, which is often the case with state privacy laws applicable to behavioral health. Thus, a multi-state behavioral health organization would need to enact a privacy compliance program that incorporates both HIPAA and the most stringent state law requirements, and if it operates any federally funded substance use disorder programs, the SAMHSA Regulations as well.

Corporate Practice of Medicine

The corporate practice of medicine (CPOM) doctrine has its roots in seeking to prohibit non-physicians from interfering with a physician's professional judgment by barring legal entities not owned or controlled by physicians from employing physicians to practice medicine and charging for those professional services. However, the actual restrictions and permitted exceptions vary significantly by state, and some states do not have a CPOM restriction at all. Further, depending on the state, the doctrine often extends beyond physicians to other licensed professionals such as psychologists and licensed social workers. In states with CPOM restrictions, the professional practices must generally be owned by physicians or other licensed professionals only, and ownership by non-licensed individuals or corporate entities is not permitted.

A multi-state behavioral health provider must examine whether each state in which it plans to operate has CPOM restrictions, and, if so, how the operation of its business in that state should be structured to comply with the requirements. For example, many CPOM states will allow a business entity that is not owned by licensed professionals to provide non-clinical business management and administrative services (e.g., financial management, office space, clerical staff, billing and collections) to the licensed, professional-owned entity that employs the behavioral health providers. However, states vary in their requirements related to permissible financial arrangements between the professional entity and the management services organization. Further, arrangements between the management services organization and the professional entity must be structured to ensure that non-licensed professionals cannot influence the professional judgment of the providers employed by the professional services entity.

Facility and Program Licensure

Another area where pertinent regulations vary on a state-by-state basis relates to the licensure to establish, significantly modify or wind-down behavioral health facilities and programs. For example, New York requires a wide range of behavioral health facilities and programs to obtain a license from the New York State Office of Mental Health, including psychiatric emergency programs, residential treatment programs, psychiatric units in general hospitals, free-standing psychiatric hospitals and outpatient programs.

As another example, California allows voluntary facility certification for day treatment, outpatient and nonresidential detoxification facilities that meet or exceed specific service quality and program standards. On the other hand, licensure is required to operate community residential treatment systems and skilled nursing facilities which treat patients with acute or chronic psychiatric conditions. Licensure is also required to operate non-medical residential facilities in California that provide care and supervision to people who are unable to live by themselves but who do not need full-time nursing care, and who can benefit from detoxification programs, group and individual counseling and recovery treatment planning offered at the facilities.

The licensure requirements are intended to allow the state to establish standards for the quality and adequacy of behavioral health facilities and programs in the state, and to enable the applicable state agency to conduct surveys, inspections and investigations of facilities and programs, including their books and records. Non-compliance by licensed facilities and programs may result in a requirement to submit a plan of corrective action, fines or loss of licensure.

States can vary widely with respect to types of licenses required, the process and timing to obtain the licenses and the requirements for maintaining them. Licensure applications and renewals often involve substantial disclosures regarding the program, community needs, staffing, finances, facilities, ownership and various other matters, as well as inspections by and meetings with the state regulators. Thus, a multi-state operator of behavioral health facilities and programs needs to dedicate adequate time and resources to ensure compliance with individual state requirements.

Reimbursement

Governmental and commercial reimbursement rates for behavioral health services can vary significantly across states. For example, see the discussion regarding Medicaid reimbursement in Section 2 above. In addition, multi-state operators often need to negotiate separate governmental and commercial contracts for each state in which they operate. Negotiating and administering these contracts requires a considerable level of resources.

Moreover, a multi-state operator must engage in extensive financial planning to account for the variability in rates across states. While diversity in rate regimes and reimbursement schedules may provide some revenue stability, complex planning and patient and payor analytics may be necessary to execute a profitable multi-state strategy.

SECTION 4

Growth Considerations for Multi-State Practices

While there is inherent value in operating as a multi-state practice, the challenges to effectively grow and scale into a larger operation, as outlined in Section 3, must be considered. One of the first topics to consider is a contiguous state approach versus a noncontiguous state approach. A contiguous state approach will provide geographic economies of scale such as advertising, patient referrals and physician recruitment. Furthermore, a contiguous strategy may provide the opportunity to develop more vertically integrated care delivery models where behavioral health practices integrate with primary care and other specialties. Research has shown that integrated care improves patient outcomes, reduces reimbursement issues, increases employee productivity, boosts employee satisfaction and decreases costs.[16] Practices that operate across primary care and behavioral care are able to treat patients within their practice more efficiently by providing comprehensive care services, likely improving outcomes for the patient and increasing revenue opportunities. According to research from the University of Michigan, best practices in integrated care require creating a culture of collaboration within the organization, engaging employees in orientation or training programs, and using a cooperative approach to foster a system of "warm hand-offs" between physicians to improve patient care.[17]

However, the contiguous state approach may not lend itself to targeting the largest potential customer base. Behavioral health demand is spread across the country, with mental health issues varying by state and region. For example, in 2017, an estimated 12.5% of California's population 12 years of age and older experienced substance dependence or abuse, with no other state in the Western region experiencing more than 3%. Similarly, in 2017, Texas, Minnesota, Florida and North Carolina all experienced levels above 3% with no contiguous state above the 3% threshold.[18] With concentration spread so unevenly across the country, behavioral health practices may look to high-demand regions for growth, requiring noncontiguous state expansion strategies.

16. University of Michigan, "Primary Care and Behavioral Health Workforce Integration: Barriers and Best Practices", February 2017, http://www.behavioralhealthworkforce.org/wp-content/uploads/2017/02/FA2P3_Team-based-Care-Case-Studies_Full-Report.pdf
17. Ibid
18. IBISWorld, Mental Health & Substance Abuse Centers in the US, March 2017

Private equity firms looking to invest in behavioral health practices can be helpful in developing and implementing a multi-state strategy. Financial sponsors focus on adding value to investments through improving margins and driving growth via organic expansion or acquisitions. Private equity backed acquisition roll-ups of smaller providers may be able to drive significant economies of scale, resulting in both clinical and administrative standardization. In other areas of the healthcare market, such standardization has resulted in improved health outcomes and decreased costs.[20] Multi-state practices will likely receive more attractive valuations given the potential for growth and expansion, whether completed organically or via acquisition. Behavioral health practices with large multi-state operations and a demonstrated track record of successful entry into new geographies are likely to command premium valuations.

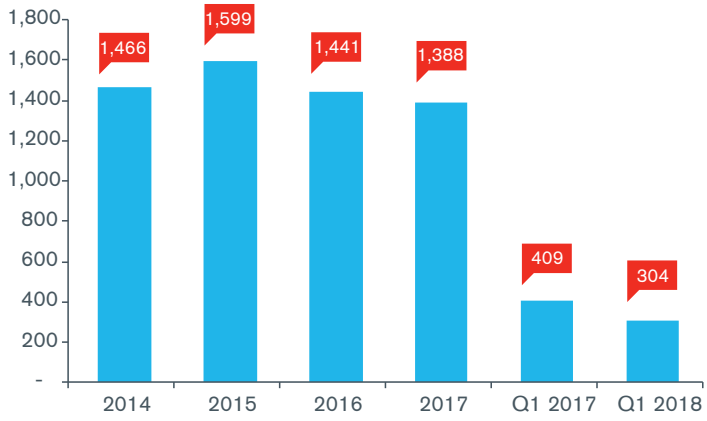
SECTION 5

2017 M&A Activity

In 2017, according to S&P Capital IQ, 62 behavioral health transactions were announced, which shows a steady increase from the 55 transactions announced in 2016, continuing a robust trend of acquisition activity in the behavioral health sector. Behavioral health transaction multiples have remained strong, with a 2017 median EBITDA multiple of 10.1x, falling in line with recent multiples.

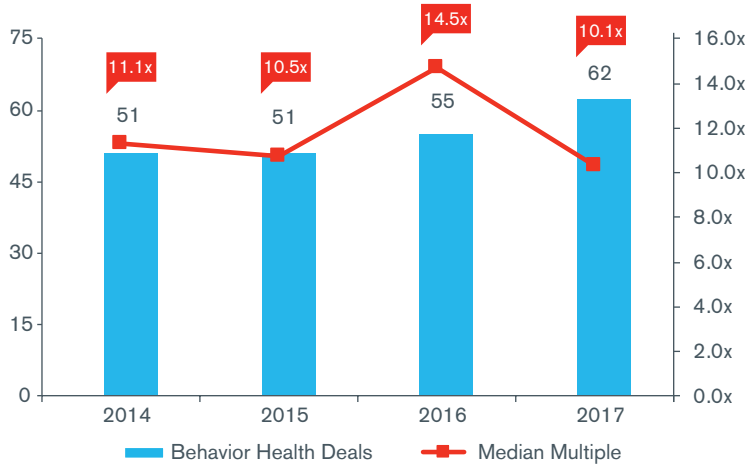
Given the continuing imbalance between patient demand and patient access to care, provider market fragmentation, and continued expansion of reimbursement based on the continued implementation and enforcement of federal mental health parity laws, we expect to see continued growth in deal volume in the area of behavioral health in the years to come.

EXHIBIT 1: TOTAL U.S. HEALTHCARE M&A VOLUME



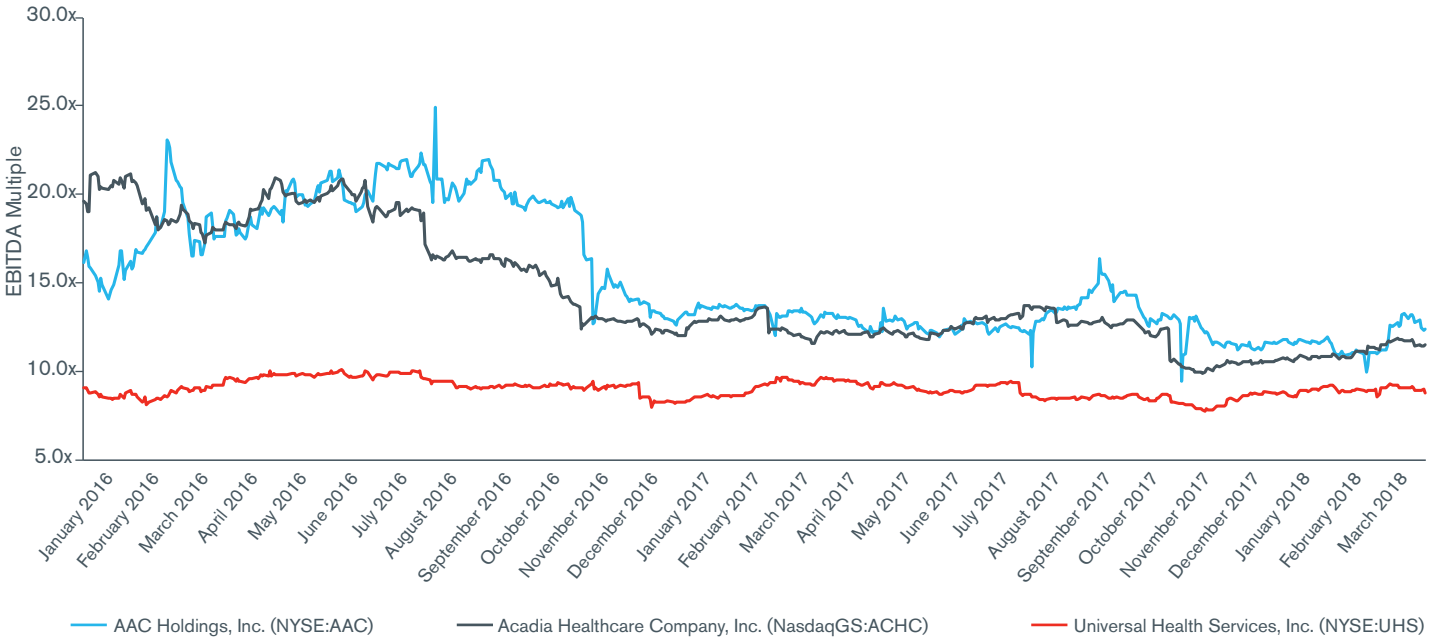
Source: S&P Capital IQ

EXHIBIT 2: U.S. BEHAVIORAL HEALTH M&A VOLUME



Sources: S&P Capital IQ, PitchBook, Mergermarket, company press releases and other news sources

EXHIBIT 3: COMPARABLE PUBLIC COMPS EBITDA MULTIPLES



Source: S&P Capital IQ

EXHIBIT 4: STOCK PRICE INDEX (JANUARY 1, 2017–MARCH 31, 2018)

Source: S&P Capital IQ

EXHIBIT 5: FINANCIAL SPONSOR-BACKED BEHAVIORAL HEALTH COMPANIES

Investment Date	Behavioral Health Company	Business Description	Financial Sponsor Ownership
Dec-17	Liberation Way	Drug and alcohol addiction treatments	Fulcrum Equity Partners
Oct-17	BrightView	Outpatient addiction medicine services	Shore Capital Partners
Oct-17	Delphi Behavioral Health Group	Behavioral health services	The Halifax Group
Oct-17	Summit Behavioral Healthcare	Addiction treatment and behavioral health services	FFL Partners, Lee Equity Partners
Aug-17	Sequel Youth and Family Services	Diversified behavioral health services	Altamont Capital Partners
Jun-17	Bradford Health Services	Addiction treatment services	Centre Partners
Jan-17	Health Connect America	Behavioral health services	Harren Equity Partners
Dec-16	Lakeview Health	Drug and alcohol rehabilitation services	The Riverside Company
Oct-16	Infinity Malibu	Addiction-rehabilitation services	New State Capital Partners
Oct-16	Logan River Academy	Residential treatment center	Pharos Capital Group
Sep-16	Perimeter Healthcare	Mental and behavioral health services	Ridgemont Equity Partners
Sep-16	Restoration Counseling & Community Services	Rehabilitation and behavioral healthcare services	Latticework Capital Management
Aug-16	Calo Programs	Clinical and therapeutic programs providing behavioral health services	Housatonic Partners
Aug-16	Pinnacle Treatment Centers	Drug-addiction treatment services	Linden Capital Partners
May-16	Beacon Specialized Living Services	Behavioral healthcare services	Pharos Capital Group
May-16	Constellation Behavioral Health	Rehabilitation programs and addiction treatments	New MainStream Capital
May-16	KP Counseling	Mental health counseling, diagnostic and treatment services	Crestview Partners
Apr-16	Haven Behavioral Healthcare	Inpatient psychiatric stabilization and treatments	Brown Brothers Harriman
Dec-15	LifeStance Health	Treatment services for addiction, substance abuse and eating disorders	Silversmith Capital Partners, Summit Partners
Dec-15	Meridian Behavioral Health	Addiction treatment services	Audax Group

Source: S&P Capital IQ, Pitchbook

EXHIBIT 5: FINANCIAL SPONSOR-BACKED BEHAVIORAL HEALTH COMPANIES (CONT'D)

Investment Date	Behavioral Health Company	Business Description	Financial Sponsor Ownership
Dec-15	Sprout Health Group	Behavioral health and substance abuse treatment services	Housatonic Partners
Sep-15	Community Intervention Services	Specialized behavioral health treatment facilities and programs	H.I.G. Growth Partners
Sep-15	Monte Nido Holdings	Treatment for eating disorders and exercise addiction	Levine Leichtman Capital Partners
Jul-15	Bay Area Addiction Research and Treatment	Abuse treatment and other healthcare services	Webster Capital
Jul-15	Community Psychiatry Management	Behavioral health practice management company	New Harbor Capital
Jun-15	Sunspire Health	Behavioral health treatment services	Kohlberg & Company
Mar-15	CHE Behavioral Health Services	Mental health services	Altamont Capital Partners
Jan-15	Odyssey Behavioral Healthcare	Specialty behavioral health and addictive disease rehabilitation and treatment	Nautic Partners
Dec-14	Beacon Health Strategies	Behavioral health services	Bain Capital, Diamond Castle Holdings
Aug-14	Pyramid Healthcare	Behavioral health and substance abuse treatment services	Clearview Capital
Aug-14	Recovery Ways	Addiction treatment services	Chicago Pacific Founders
Jan-13	Seaside Healthcare	Mental health treatment services	Pharos Capital Group
Dec-11	InnerChange	Residential treatment services	Cressey & Company
Aug-11	Behavioral Health Group	Opioid addiction treatment services	Frontenac
Aug-11	Center for Discovery	Residential treatment addressing underlying issues and eating disorder behavior	Webster Capital
Oct-10	Springstone	Psychiatric hospitals	Welsh, Carson, Anderson & Stowe

Source: S&P Capital IQ, Pitchbook

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