Bullish Behavioral Health Market Drives Investment

By Geoff C. Cockrell, Amber McGraw Walsh and Richard S. Grant, McGuireWoods LLP, and Jason F. Shafer, HCP & Co.

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In our last article on behavioral health,[1] we explained why the market is ripe for private equity investment. Strong market demand for behavioral health services, underserved markets and increased reimbursement for services, among other factors, all contribute to what we see as a thriving market for private equity investment.

We've listened closely to the recent Cain Brothers' House Calls on behavioral health[2] and, like many professionals in this market, we believe these factors and others will continue to drive investment. As a result, we remain bullish on this sector of health care. Moreover, there are additional factors that contribute to a strong market and private equity investors are well situated to take advantage of the opportunity.

A Dynamic Market

The "behavioral health" sector provides acute care, extended-term care (30-90 days) and ongoing intensive outpatient care for a range of patient issues. Behavioral health services include hospitalization-based behavioral treatment for those that are at risk of hurting themselves or others, addiction treatment (substance abuse, eating disorders, gambling and other vices), services focused on intellectual development disabilities (including autism), and dual-diagnosis therapies that, in addition to promoting the foregoing services, also treat co-occurring fundamental disorders, such as cognitive (dementia and delirium), personality (schizophrenia, paranoia, borderline, obsessive compulsive), mood (major depression, bipolar) and anxiety (generalized anxiety, phobias, severe panic) disorders.

Behavioral health providers are assisted by a variety of service providers (telepsychiatric services, clinical and administrative software and consulting services). The behavioral health industry is also served by specialty managed behavioral health organizations that help payors control costs by implementing network management, utilization and clinical authority, quality assurance and contracting, credentialing and claims administration services.

Treatment for many of these conditions can be highly specialized, while some aspects of treatment overlap. Historically, much of the treatment for behavioral health was provided either through community-based residential facilities that were publicly funded (local psychiatric hospitals), or through privately funded and expensive inpatient residential facilities (Betty Ford Center and "celebrity" rehab centers). These facilities often only served a narrow range of patients who fit their treatment model: individuals with severe mental disorders (publicly funded residential facilities) and wealthy individuals seeking treatment for addiction, family therapy or other similar disorders (rehab centers).

Increased Demand

Market trends and various business model characteristics combine to offer strong growth prospects in an undeniably significant market, with estimated current industry spending of $147.4 billion for mental health treatment and $24.3 billion for substance abuse treatment services.[3]

Jason Shafer, a principal at HCP & Co., where he leads its health care services growth equity investments, explains the complexity of the sector and the opportunity for investment. According to Shafer, behavioral health comprises “a diverse and complex landscape of service providers and niche managed care offerings.” This is “almost universally ... characterized by outpaced demand drivers, coupled with an insufficient and inadequate supply of quality providers. This supply and demand imbalance creates an investment environment primed for outsized private equity returns.”

The behavioral health market has changed dramatically over the last several years. Demand for treatment has increased considerably, influenced by a number of factors. One important factor is a change in social attitudes about seeking treatment for behavioral health conditions.

In the past, a social stigma could be associated with these conditions, often deterring people from seeking treatment. This has changed in recent years to the point where celebrity status is often attached to those who seek treatment for addiction. That is not to say there has been a complete shift in how the public views treatment, as many still suffer from a negative social stigma attached to revelations of addiction and, as a result of the stigma, are deterred from seeking treatment.[4]

Likewise, better recognition of conditions, such as autism spectrum disorders and increased diagnoses of conditions, has led to a significantly greater population of patients for which treatment is available. For instance, the number of children and teens seeking treatment for various mental health conditions has been increasing, with mental health conditions being the fourth most common reason for hospital admissions for children in 2009.[5]

A recent report indicated that at least 4 million children and adolescents in the United States suffer from a serious mental disorder.[6] Shafer notes that “many limiting factors to accessing mental health care have, to a certain extent, dissipated due to bipartisan regulatory support and the unfortunate quantity and scale of highly publicized mental health-driven tragedies (Sandy Hook, congresswoman Gabrielle Gifford, Aurora movie theater, Fort Bragg and Northern Illinois University, among others) that have thrust the inadequacy of U.S. mental health care into standard public discourse.” And treatment for behavioral health conditions is now available in outpatient or other similar settings, as opposed to long-term institutionalization of patients, which historically was the prevalent treatment model.

Lack of Adequate Providers

The pace of new treatment options and facilities has not kept up with demand, creating a shortage of providers in the market — particularly in smaller communities, which tend to be underserved.[7] This coincides with a declining population of physicians in the psychiatric

field.[8] Also, many behavioral services are delivered in “one-off” facilities that are not well coordinated, or not coordinated at all, with other mental health providers. As a result, they are often unable to provide the full suite of services needed for treatment of many conditions. Some smaller communities have little or no services at all and instead rely on community facilities that may not be able to provide the specialized treatment required for many behavioral health conditions.

Increased Sources of Payment

Meaningful progress to improve access occurred when Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, which requires large group health insurance plans to equalize coverage standards for mental health treatment. For example, if an insurance plan offered mental health benefits, those benefits could not be more restrictive (i.e., higher deductibles and copays, lower annual and lifetime caps, less access to qualified providers, etc.) than offered medical benefits.

MHPAEA’s positive industry impact increased in 2013 when clarifying regulations adopted structural frameworks to monitor and sanction insurance companies that do not comply with parity requirements. These regulations, in addition to similar federal standards required in the Medicare Improvements for Patients and Providers Act (MIPPA) (also created in 2008), increased mental health access for Medicare, Medicaid and commercially insured patients.

The recent passage of the Patient Protection and Affordable Care Act (PPACA), and especially the inclusion of mental health and substance abuse disorder benefits as one of 10 essential health benefits, are critical to continuing to eliminate coverage gaps for behavioral services.

Specifically, PPACA expands the applicability of parity requirements from large commercial groups and federal insurance payors to the individual and small group markets. PPACA also helps to provide access to the previously uninsured through the expansion of Medicaid and increased coverage for younger Americans.

PPACA’s impact on Medicaid is particularly relevant because this patient population has higher incidence of mental health needs relative to overall demand. Last but not least, PPACA’s removal of lifetime coverage caps and limits on annual coverage by qualified insurance plans is particularly valuable, given the typical chronic nature of most mental health disorders (though it should be noted that state mandates can still impose caps on an individual basis).

Until recently, the pay model for behavioral health services was largely private pay for high-cost services (inpatient treatment facilities for alcohol and drug addiction) or state-funded services provided through community-based facilities. Third-party payors were not required to provide coverage for behavioral health services. Many plans either did not provide coverage or payment for mental health treatment was covered at much lower levels than physical illness.[9]

Over the past several years, state and federal laws mandated that third-party payors provide equivalent coverage for mental health services. The federal MHPAEA requires mental health coverage “parity,” which has forced insurance carriers to expand coverage for many behavioral

health services for which there was little or no coverage in the past.[10]

Legislation in a number of states, most notably California, has increased coverage for mental health treatment. California's Mental Health Parity Act, which went into effect in 2000, mandates coverage for a number of "severe mental illnesses," including certain eating disorders.[11]

Recently, a California appeals court ruled in favor of women with eating disorders who filed a proposed class action against Blue Cross, holding that the insurer was required to cover treatment, even though the policy expressly excluded coverage for the condition. Similarly, in June 2012, the Ninth Circuit ruled in favor of the plaintiff in a case involving a claim for coverage of a stay in a residential treatment facility, although such treatment was excluded under the policy.[12] The United States Supreme Court declined to review that decision.

The Affordable Care Act's expansion of insurance coverage for young adults has increased treatment access, particularly impacting 18- to 25-year-olds. Previously, many people in this demographic did not have insurance to pay for treatment. The Affordable Care Act expands dependent coverage to those who are 25 years old or younger, which has contributed to over 3 million young adults gaining insurance coverage since 2010.[13]

Interacting Subsectors

An attractive investment subsector that is sizable and fragmented is therapy for autism spectrum disorders (ASD), a segment within the intellectual and developmental disability services industry. Even very conservative estimates of narrowly defined therapy services imply a $16 billion opportunity.[14]

Providers of ASD therapy tend to be localized, with a limited number of care centers owned by a given organization. Over 36,000 service providers support individuals with ASD with a variety of needs,[15] with the top national providers currently representing aggregated sales of approximately 1/100 (0.01 percent) of the total industry. There are currently 36 states, representing a 400 percent increase from just eight states in 2008, that currently mandate managed care companies to provide mental health benefits for intensive therapy, which is typically applied behavior analysis (ABA)-based. At least six additional states are in the process of trying to pass ASD managed care insurance reform.

ASD is the fastest-growing developmental disorder, and demand for ASD care is increasing significantly. A study released in March 2014 by the Centers for Disease Control and Prevention revealed that the prevalence of ASD has grown by over 100 percent in the past decade, up to one case per 68 children (from one in 250 measured in 2001). The recent CDC study also found that ASD is more common in boys at a rate of one in 42, or four times more common than in girls.

There is increasing evidence that ABA therapy for ASD significantly improves treatment quality and effectiveness. In addition to growing support for ABA therapy, other early therapies, such as floor time and the Early Start Denver Model (ESDM), are showing promise in helping patients overcome challenges of autism and reducing the need for longer-term treatment.

The same CDC study recognized that earlier diagnosis improves the likelihood of quality care and access to ongoing treatment beyond standard ABA therapies.[16] A lifetime's worth of care (without intervention therapy) for one patient with autism costs approximately $3.2 million, which can be reduced by 75 percent with early diagnosis and intervention. Early treatment programs often have higher upfront costs for more intensive therapy at an early stage of children's lives, while leading to better outcomes, less reliance on future care and lower aggregate spending.[17]

An example of an attractive sector subsegment where HCP has developed significant expertise is chemical dependency services for the emerging adult (18 to 26 years old) patient population. Addiction and substance abuse is most prevalent among emerging adults, but treatment for such issues is more common among older adults (26-plus).[18]

The emerging adult cohort accounts for the most newly insured individuals under the PPACA, with children under age 26 now covered by their parents' insurance, suggesting a potentially attractive growth opportunity. According to 2012 figures from the Substance Abuse and Mental Health Services Administration (SAMHSA), 7.8 percent of persons in the 18-25 age bracket suffer from illicit drug dependence or abuse, almost twice as large a proportion as the next highest age bracket (12-17 at 4 percent).[19]

The Challenge of Developing Clinical Models and Standards of Successful Treatment

One of the biggest challenges facing investors in behavioral health is the lack of accepted models for measuring success of treatment. If providers wish to prove their concept to the market, they, like all other enterprises, will need to show that their services work. In the future, third-party payors are likely to hinge payment for service on proof of successful treatment. Unlike many other medical conditions, however, within the behavioral health industry there are few models by which payors can evaluate the success of treatment. And there is even some disagreement within the medical community over what constitutes successful patient treatment and outcomes for those suffering with behavioral health conditions.[20]

When treating a patient for a physical disease (say, heart disease or diabetes), often there is consensus within the medical community over whether or not the treatment is successful, measured by concrete standards. Often there is a clear paradigm for determining success: Whether the patient has exceeded a certain life expectancy, avoided surgery or other invasive treatment, or met or exceeded other similar measurements milestones.

Evaluating the success of behavioral health conditions is often trickier and the standards for evaluating success are still evolving. Treatment is often provided on an "acute" basis — that is, inpatient treatment for a fixed duration — and success is evaluated for a fixed period of time to determine whether treatment resulted in "recovery."[21]

In the past, a simple black-and-white test was applied — has the patient abstained from the behavior? But the industry is evolving and seems to be recognizing that measuring success is more difficult. For instance, for a person seeking treatment for a drug or alcohol addiction, a

more realistic measurement — and one that may be more clinically relevant — is whether the patient is able to function in a “typical” fashion. That is, did the treatment help the patient return to work and enjoy a stable family and personal life over a significant period of time.

Private equity investors who enter the behavioral health market will need to understand that their long-term success may hinge on the ability of the health community to adopt uniform standards of success and the provider’s ability to meet those standards.[22]

The Opportunity for Private Equity Investors

Private equity investors are uniquely situated to take advantage of the market opportunity created from the combination of increased demand, lack of adequate providers and increased sources of payors. These investors have the resources to scale their investments in behavioral health, creating efficiencies that smaller providers cannot.

Given that many patients require continuing treatment from multiple providers, investors who are best able to provide data sharing among providers and coordinate care may be able to provide more services more efficiently and with better results.[23] Owning multiple facilities also allows investors to develop treatment models and prove their success, which, as discussed above, is likely to be an important factor in reimbursement decisions made by third-party payors.

Likewise, many owners of behavioral health providers own only a single facility and, therefore, are unable to allocate the resources to build the infrastructure needed to deliver services cost-effectively. This affords private equity investors with the opportunity to undertake “roll-up” transactions to consolidate ownership, much like the consolidation that has taken place in dental management and physician management models.

In underserved markets, private equity investors have the resources to start new operations in a cost-effective manner. New facilities can share resources with existing operations, which obviates the need to spend resources on infrastructure, such as billing centers, standardized patient record systems, methods of coordinating care, marketing, and the like. And centers that focus solely on behavioral health treatment are not saddled with the overhead of high-cost services that multidiscipline facilities experience (for instance, cardiac units at large hospitals). Instead, private equity can focus its investment on behavioral health treatment without a dilution of resources.

Private equity investors are also well-situated to increase their service capacity by investing in partnerships with local health care professionals and providers. This is the approach taken by middle-market private equity firm Trinity Hunt Partners, which has closed three behavioral health care deals in the past few years.[24] These arrangements also provide opportunities for behavioral health providers to give the medical community the proper tools to identify patients who would benefit from treatment and ensure that those patients are educated about treatment options. This referral network, while strong in most medical disciplines, is often lacking in behavioral health.[25]

Attractive Business Model

Compared to many other medical providers, dedicated behavioral health providers may have more attractive growth prospects, recurring revenue and profitability. The reasons for this include:

- Extended-term therapeutic programming and ongoing intensive outpatient (IOP) services are favored by referral sources and payors because they lead to better patient outcomes. Also, these extended services allow for more stable patient volumes and reduced client turnover, creating customer acquisition, intake and other clinical and administrative efficiencies that benefit net margins, which typically exceed 25 percent.

- The majority of behavioral health disorders are chronic in nature and are often present in persons with co-occurring diseases/disorders and other significant health care problems. When mental health and substance abuse disorders are not diagnosed and treated, complications from co-occurring secondary behavioral and medical diseases often require longer and more costly treatment. These co-morbid complex patients offer an attractive margin opportunity for providers that can effectively treat and manage them.

- Operators and owners are often alumni of behavioral services, especially within the addiction treatment industry. Therefore, existing managers typically are focused on clinical care and patient outcomes and largely deficient in business or financial expertise, creating easily identifiable growth and margin enhancement drivers for professionalized private equity owners.

- Simpler billing and other administration requirements from more focused services lead to shorter cash conversion cycles, less compliance risk and lower administrative overhead. For instance, mental health facilities may have as few as 17 diagnosis related group (DRG) treatment codes, as opposed to over 700 DRG codes for general acute care hospitals.[26]

Conclusion

The confluence of increased patient demand, lack of adequate services in many markets, and increased availability of payment has created a market opportunity for private equity investors. Those investors who are able to create efficiencies across multiple geographic markets and provide “proof of concept” will be poised for the greatest success.

—By Geoff C. Cockrell, Amber McGraw Walsh and Richard S. Grant, McGuireWoods LLP, and Jason F. Shafer, HCP & Co.

Geoff Cockrell is a partner in McGuireWoods' Chicago office and co-chairman of the firm's private equity group. Amber Walsh is a partner in the firm’s Chicago office. Richard Grant is the managing partner of the firm's Los Angeles office.

Jason Shafer is principal at HCP & Co., a Chicago-based private equity firm.

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[1] "PE Investors Should Consider Behavioral Health," Amber Walsh, Geoffrey Cockrell and Anna Timmerman, McGuireWoods LLP, Law 360, May 17, 2013.

[2] Addiction and Substance Use Treatment House Call on Behavioral Health, April 22, 2014; Psychiatric Hospitals House Call on Behavioral Health, April 29, 2014; Intellectual Disabilities and Community Based Programs House Call on Behavioral Health, May 14, 2014; and Eating Disorders House Call on Behavioral Health, May 27, 2014.

[3] Levit, Federal Spending on Behavioral Health.

[4] See, for example, "In the Limelight: Celebrities Struggling With Mental Health," Robert T. Muller, Ph.D., Psychology Today, July 26, 2013.

[5] Yu, H., et al. (August 2011). Hospitals Stays for Children, 2009. Agency for Healthcare Research and Quality. Statistical Brief #118.

[6] U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, M.D.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[7] "For the Mentally Ill, Finding Treatment Grows Harder," Gary Fields and Jennifer Corbett Dooren, Wall Street Journal, Jan. 16, 2014.

[8] "Between 2005 and 2010, when the general population grew 4.7 percent, the number of psychiatrists in the U.S. barely changed, dropping slightly from 38,578 to 38,289, according to the Association of American Medical Colleges. In addition nearly 57 percent of the psychiatrists still practicing are at least 55 years old, meaning they're often both established and approaching retirement and more likely to only take patients who can afford to pay out of pocket." Id.

[9] See, for example, "Federal Parity for Mental Illness and Addiction," National Alliance on Mental Illness.

[10] Id.

[11] Marissa Rea et al., v. Blue Shield of California, case number B244314, in the Court of Appeal of the State of California, Second Appellate District (2014).

[12] Harlick v. Blue Shield of California, 686 F.3d 699 (9th Cir. 2012)

[13] ASPE Issue Brief: "Number of Young Adults Gaining Insurance Due to The Affordable

Care Act Now Tops 3 Million," Benjamin D. Sommers, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, July 31, 2012.

[14] Estimated based on the CDC's 1/88 prevalence, the number of children below age 12 (49 million in the U.S.), and monthly costs of $2,458 as benchmarked by the Early Start Denver Model (ESDM) intervention program; much larger market size estimates may include other related therapy services and care provided to older patients, pushing the market size beyond $24 billion.

[15] Based on Autism Speaks family services national directory; this number, while including certain types of services that would be out of scope for HPE III, also may not include all therapy-focused providers in its sample.

[16] Prevalence of Autism Spectrum Disorders — Autism and Developmental Disabilities Monitoring Network, Centers for Disease Control, March 2014.

[17] For instance, in a study sponsored by Autism Speaks, the Early Start Denver Model (ESDM) lowered after-intervention monthly costs by over 29 percent.

[18] Behavioral Health Barometer 2013, Substance Abuse and Mental Health Services Administration; for example, 7.8 percent of the 18-25 cohort showed dependence on illicit drugs in the past year, and 11.9 percent of them received treatment, while 2.6 percent of the 26-54 cohort showed dependence and 17.7 percent received treatment; alcohol usage also exhibits this tendency.

[19] IBISWorld Industry Report: Mental Health & Substance Abuse Clinics in the US, March 2014.

[20] "Reconsidering the Evaluation of Addiction Treatment: From Retrospective Follow-Up to Concurrent Recovery Monitoring," A. Thomas McLellan, James R. McKay, Robert Forman, John Cacciolal and Jack Kemp, 2005 Horizons Review, pp. 447-458.

[21] A. Thomas McLellan, James R. McKay, Robert Forman, John Cacciolal and Jack Kemp, 2005 Horizons Review, supra, at 450.

[22] Id.

[23] Id. at 452.

[24] "Trinity Hunt Partners announces majority investment in Lakeview Health Systems, Shannon Brys, Behavioral Healthcare, Jan. 8, 2013.

[25] "Primary care physicians face greater hurdles obtaining mental health services than other medical services. Primary care is an important entry point for mental health services, yet inadequate referral systems between medical and mental health services may be hampering access." "Referral Gridlock, Primary Care Physicians and Mental Health Services," Sally Trude,

Ph.D., and Jeffrey J. Stoddard, M.D., Journal of General Internal Medicine, June 2003, 18(6): 442-449.

[26] U.S. Behavioral Health Sector Outlook 2011, GE Healthcare Financial Services.