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Insights For Behavioral Health

Navigating Trends & Embracing Innovation For The Treatment Of Co-Morbid Disorders In Behavioral Health

A Payer Reference Guide

September 2025 00US25EUA0038

Advancing Whole-Person Care Through Data & Design

This supplemental guidebook was developed to support health plan leaders and policymakers in better understanding and addressing the complexities of co-morbid behavioral and physical health conditions.

Individuals living with serious mental illness (SMI), substance use disorders (SUD), intellectual and developmental disabilities (I/DD), ADHD, or PTSD often experience significantly higher risks of chronic medical conditions and poorer health outcomes. These intersections result in higher utilization and costs, but more importantly, reflect unmet clinical and social needs.

This guide is organized to take the reader from data to action — with national prevalence and risk benchmarks, scalable care models, and promising real-world examples.

Health Plans Can Use These Insights To:

1. **Benchmark** their populations against national trends.
2. **Prioritize** interventions for high-risk members.
3. **Adapt** proven models of integrated, team-based care.
4. **Reinforce** the economic case for earlier identification and proactive management.

SMI = Serious Mental Illness
SUD = Substance Use Disorder
I/DD = Intellectual and Developmental Disabilities
ADHD = Attention Deficit Hyperactivity Disorder
PTSD = Post-Traumatic Stress Disorder

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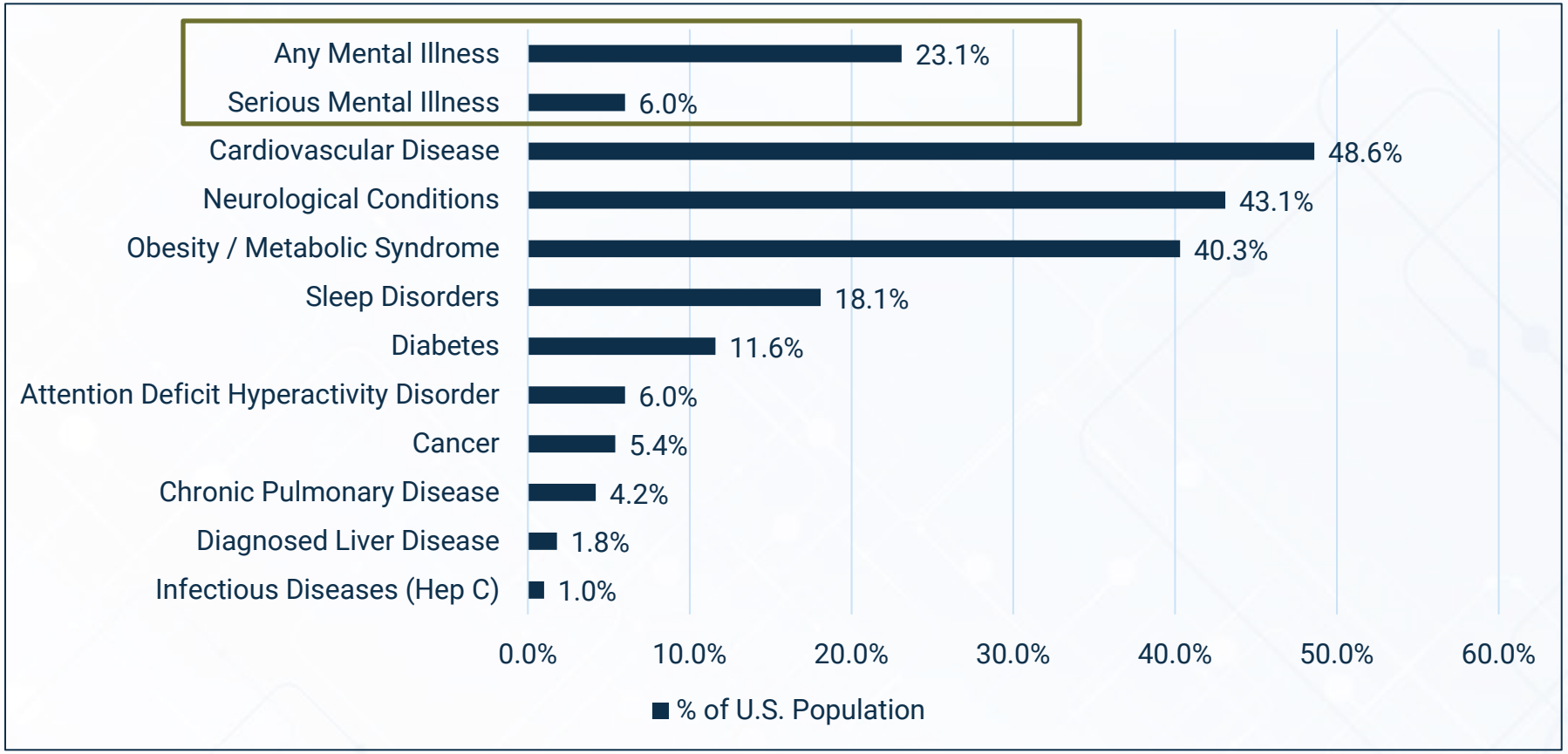
The Prevalence & Risk Of Co-Morbid Disorders In The U.S. Health Care System

1. The Prevalence Of Chronic Health Disorders For U.S. Adults 18 & Older[1-11]



National prevalence data enables benchmarking of member populations against national rates and identifies gaps in service delivery.

Among the most common chronic health disorders, neurological conditions and metabolic syndrome affect 43.1% and 40.3% of U.S. adults, respectively. Mental illness ranks fourth, with a prevalence of 23.1%.

Sources in the Reference List

2. Co-Morbid Chronic Conditions Prevalence & Health Care Spending[12]

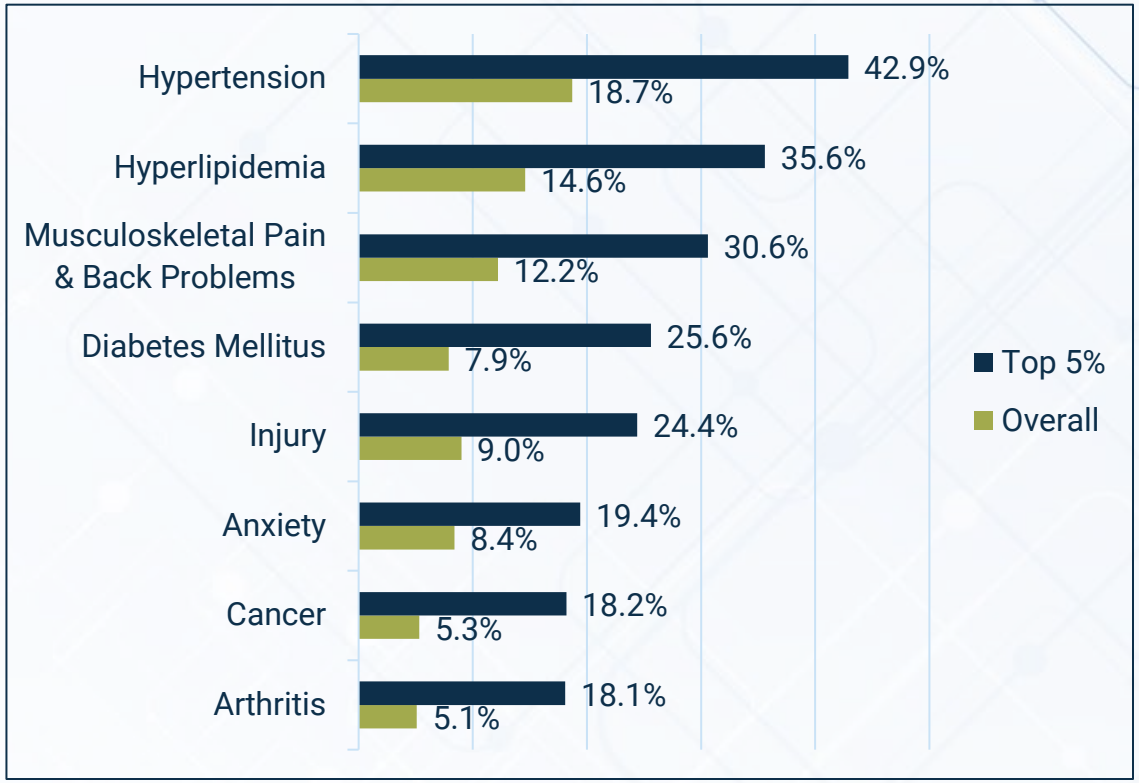
Comorbid Chronic Conditions & Healthcare Spending Rank

Number Of Priority Conditions	Overall	Bottom 50%	Top 50%	Top 10%	Top 5%
Two Or More Conditions	42.8%	22.9%	54.8%	72.5%	75.1%
One Conditions	24.7%	27.2%	24.4%	17.4%	14.9%
No Conditions	32.5%	49.9%	20.7%	10.1%	9.9%

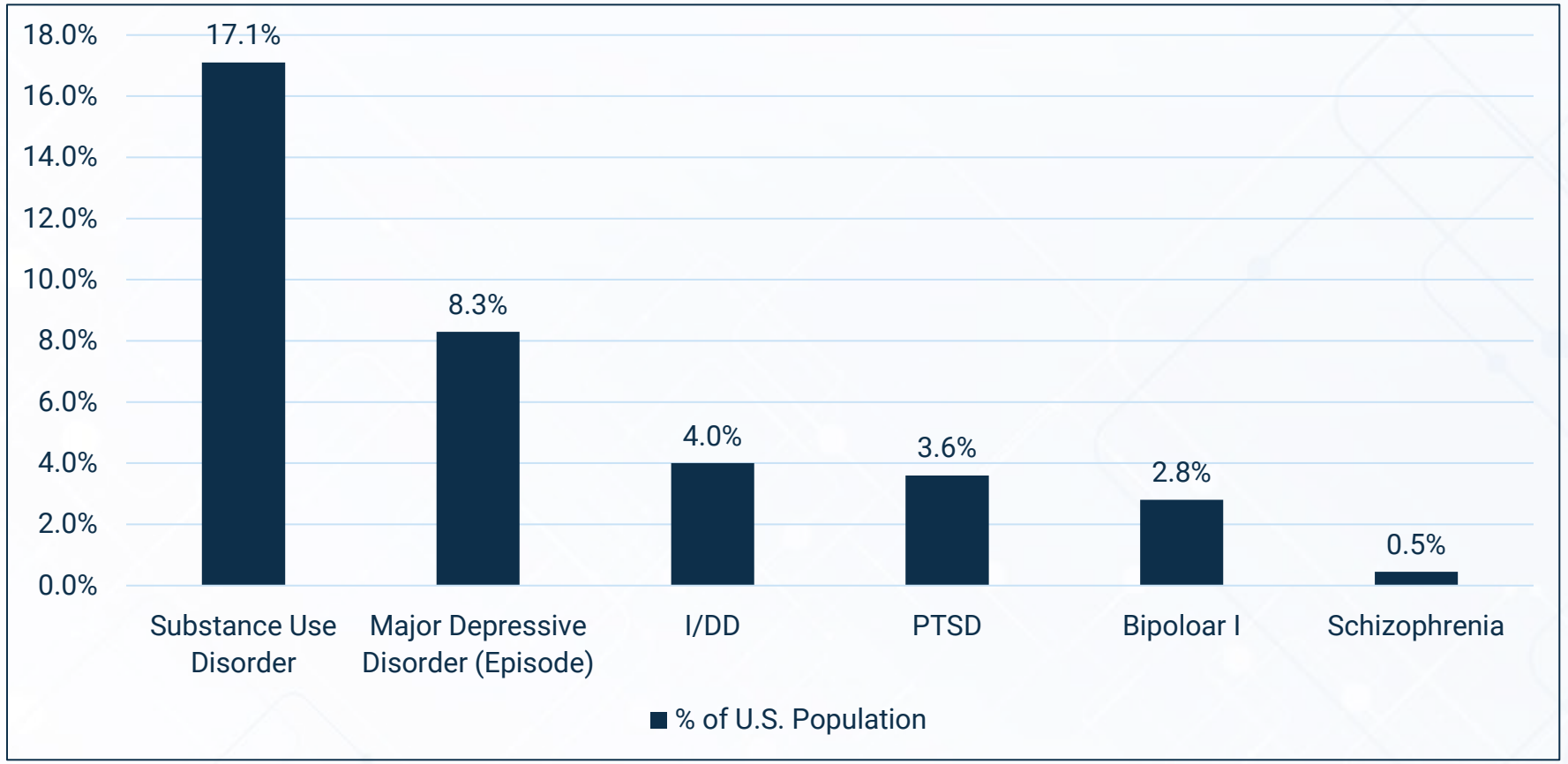
An Agency for Healthcare Research and Quality (AHRQ) report found that the top 1% of Americans accounted for 21.7% of total health care spending, while the bottom 50% accounted for just 2.8%. On average, individuals in the top 1% spent $147,071 in 2022. Those with the highest medical complexity and comorbid conditions drive the majority of healthcare costs. This information can be used to prioritize integrative care models for high-need, high-cost members.

Sources in the Reference List

Prevalence Of Chronic Conditions Among Individuals In Top 5% Of Spending, 2022



3. The Prevalence Of Behavioral & Cognitive Disorders In The U.S. Adult Population[13-18]



This allows for comparison of internal data against national averages for major behavioral health conditions.

Notably, SUD prevalence is 8.8 points higher than MDD and 13.1 points higher than I/DD.

High SUD prevalence suggests need for reassessment in investment strategies for engagement and treatment programs.

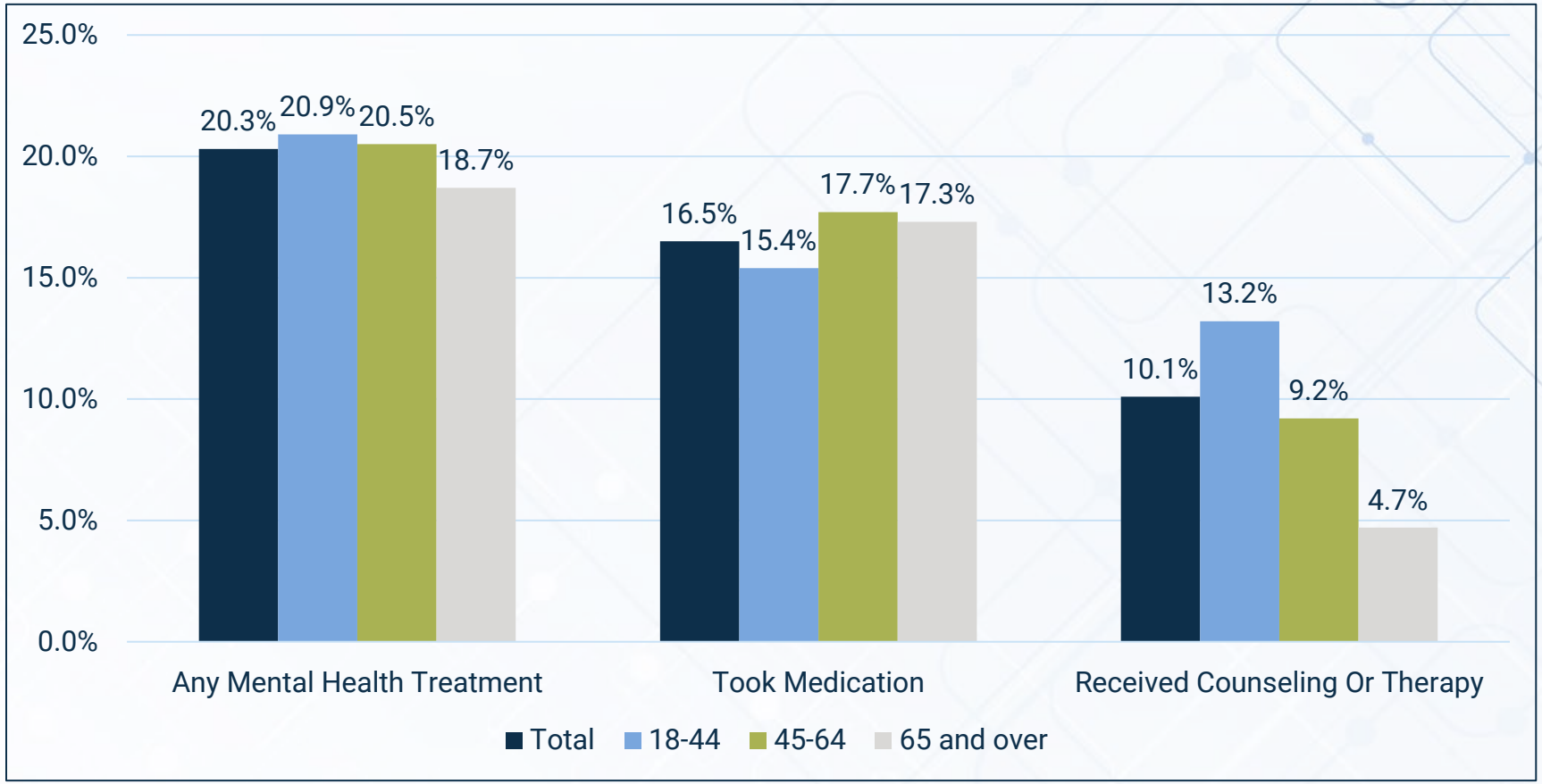
Sources in the Reference List

4. Percentage Of U.S. Adults Who Received Mental Health Treatment, Took Medication For Their Mental Health, Or Received Counseling Or Therapy In The Past 12 Months[19]

In 2022, 23.1% of U.S. adults had a mental illness.[1] In 2020, middle-aged adults showed the highest rates of psychotherapy use (17.7%).[19]

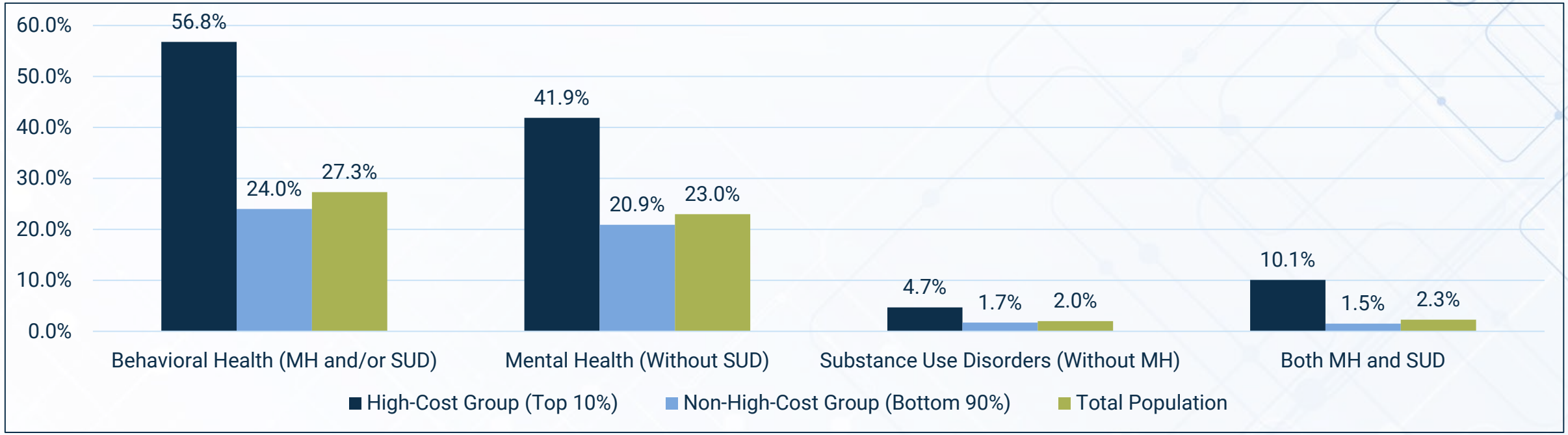
Telehealth played a large role—nearly 4 in 10 adults received psychotherapy through telehealth.[20] However, disparities in digital access, insurance coverage, and income levels created gaps in who received treatment.

Health plans and provider networks must address access barriers—such as digital equity, literacy, and reimbursement—to close treatment gaps among underserved.



Sources in the Reference List

5. Behavioral Health Prevalence Rates Among High-Cost Members[21]

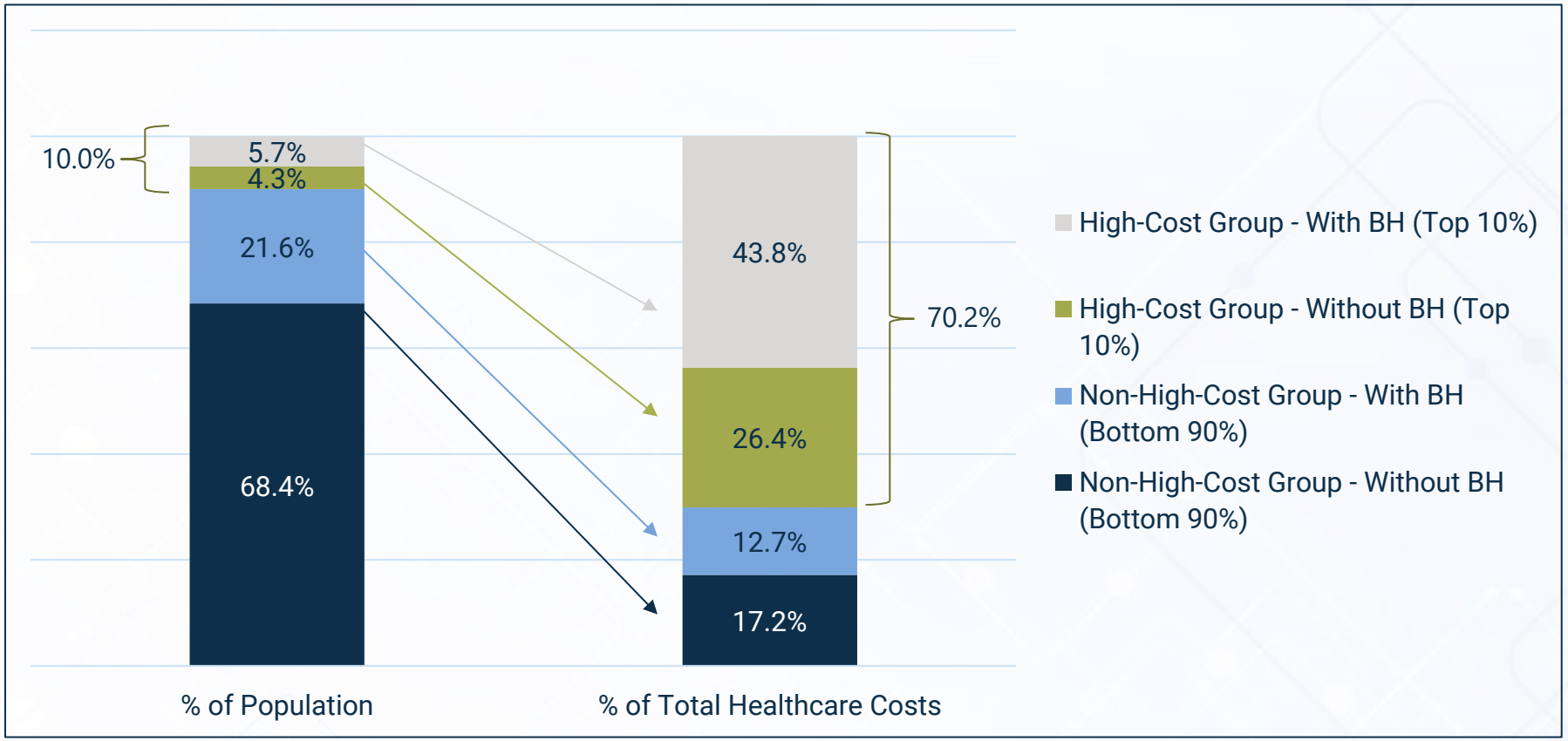


High-cost members often experience multiple co-occurring conditions. Behavioral health conditions like anxiety and depression are particularly common among these populations, further complicating treatment and care navigation. This reinforces the need for member engagement strategies that address both behavioral and physical health, especially among high-cost, high-need segments.

MH = Mental Health

Sources in the Reference List

6. Cost To Prevalence Ratio Of Chronic Health Disorders For U.S. Adults 18 & Older[21]



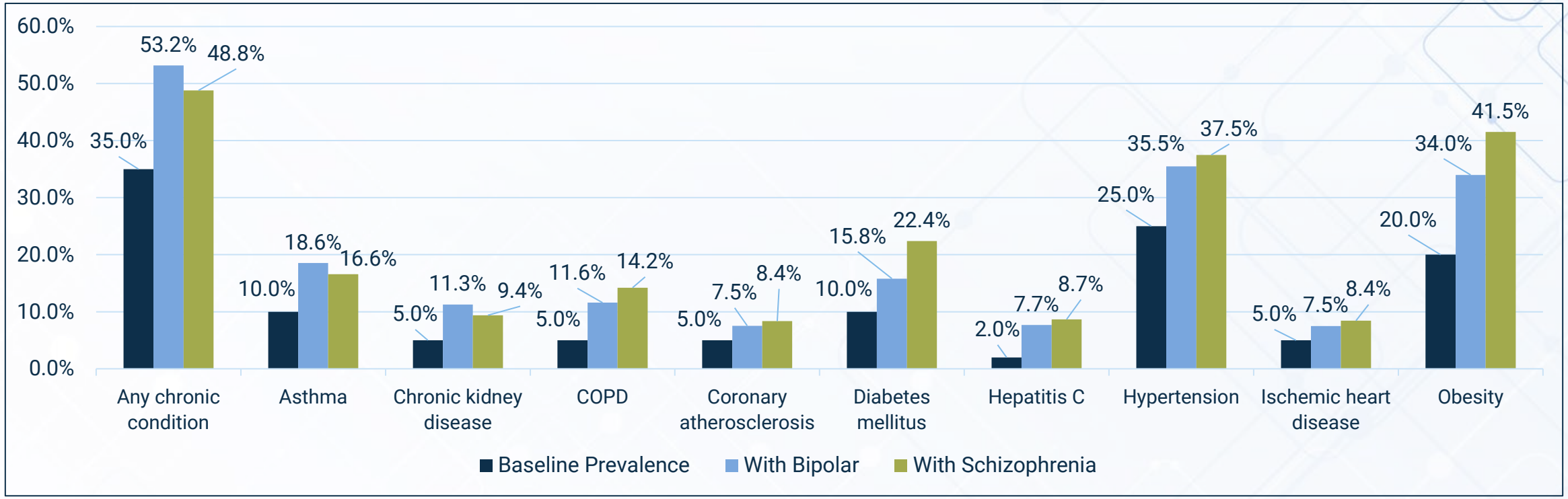
Individuals in the High-cost Behavioral Subgroup represent 5.7% of the study population; however, this same set of individuals contributes 43.8% of total healthcare costs.

Investing in outpatient BH services can reduce overall costs. Explore performance-based contracts and service models that expand access and engagement.

BH = Behavioral Health

Sources in the Reference List

7. Estimated Comorbidity Prevalence In SMI Populations[22]

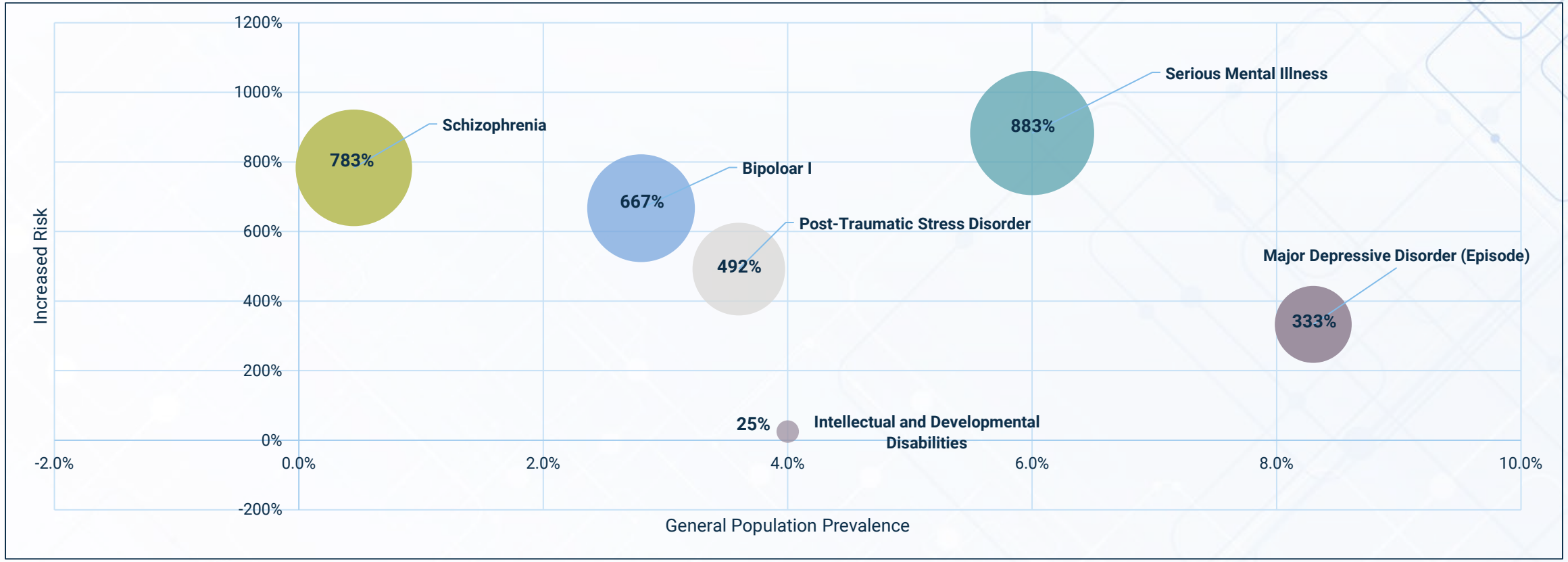


This table translates odds ratios into estimated prevalence percentages to more clearly reflect the scope of chronic medical conditions in people with bipolar disorder and schizophrenia. These insights support care management, resource planning, and program design.

COPD = Chronic Obstructive Pulmonary Disease

Sources in the Reference List

8. The Risk Of A Co-Morbid Substance Use Disorder For U.S. Adults With A Mental Illness Or Cognitive Disorder[1,14-17, 23-28]

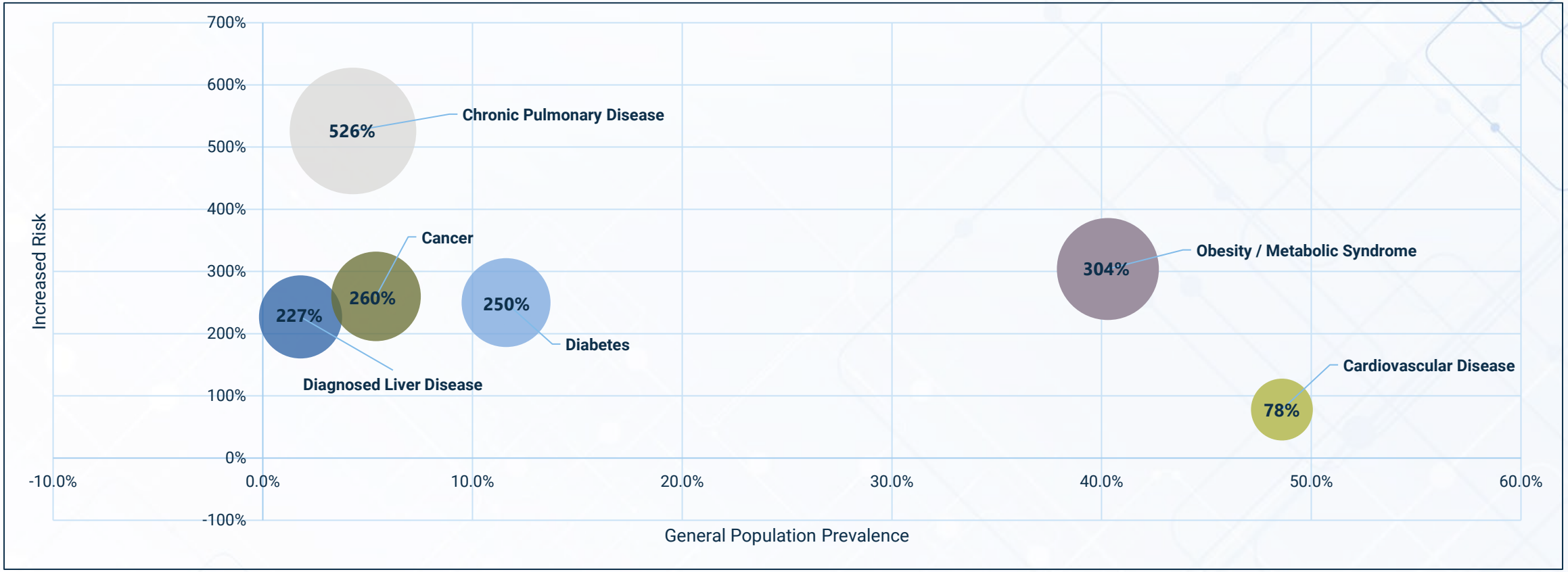


Sources in the Reference List

Individuals with SMI are 883% more likely to develop SUD; those with schizophrenia, 783%. Risk data allows plans to benchmark their population and assess whether existing care models and engagement efforts address members most vulnerable to dual diagnoses. High risk of SUD in individuals with schizophrenia and SMI suggests the need for integrated interventions and substance use programming within mental health care.

9. The Risk Of Co-Morbid Chronic Health Disorders For U.S. Adults With An SMI[2,4,6,8-11, 13, 29-34]

*Risk of Hepatitis C was an outlier at 24.86 times the chance for adults with SMI.



Sources in the Reference List

Individuals with serious mental illness (SMI) have a 526% increased risk of developing chronic pulmonary disease compared to the general population.

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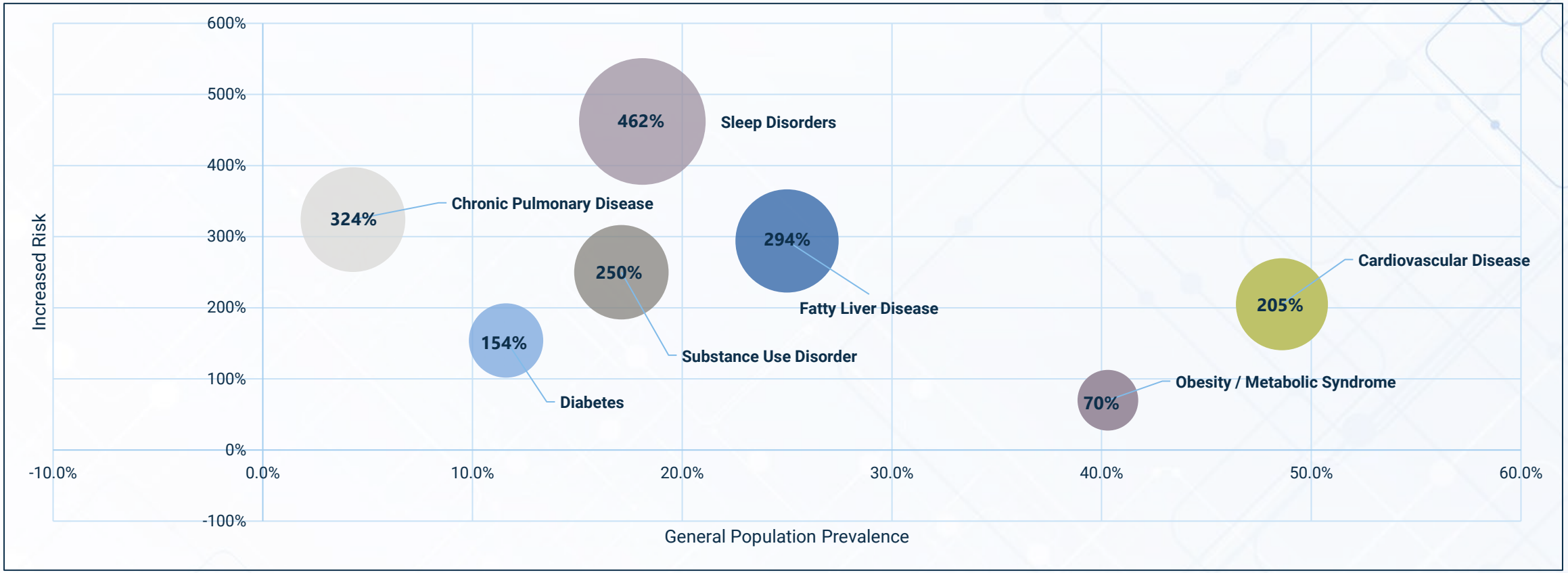
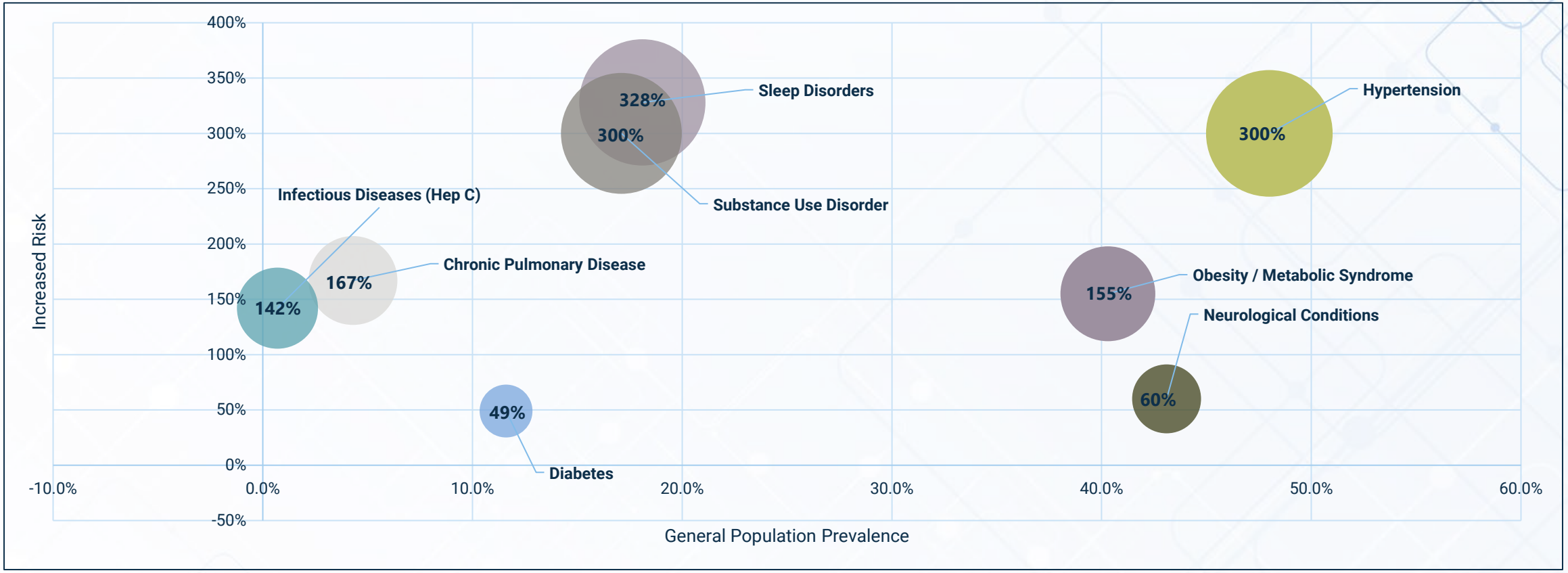
10. The Risk Of A Co-Morbid Chronic Health Disorder & SUD For U.S. Adults With ADHD[2,4-7,9,10, 35-41]



Sources in the Reference List

It is estimated that 6.0% of U.S. adults have been diagnosed with ADHD. Adults diagnosed with ADHD have a 462% higher risk of sleep disorders compared to the general population, and a 324% higher risk for chronic pulmonary disease than the general population. This creates greater demand for coordinated care and increases the long-term cost burden.

11. The Risk Of A Co-Morbid Chronic Health Disorder & SUD For Adults With PTSD[3-6,9,11,13,15,42-49]



Sources in the Reference List

It is estimated that 3.6% of U.S. adults have PTSD. Adults diagnosed with PTSD have a 328% higher risk of sleep disorders and a 300% higher risk of developing a substance use disorder and/or hypertension compared to the general population. These overlapping conditions exacerbate symptoms, increase medical complexity, and lead to higher care costs. Effective treatment models must address the interplay of anxiety, trauma, and physical health to improve both cost and clinical outcomes.

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Resources: Care Management & Treatment Models

The following slides describe select program models used by U.S. health plans to serve members with complex behavioral and medical needs. Each includes information on program design, population served and reported outcomes.

12. Assertive Community Treatment (ACT)[50]

Impact

ACT reduces avoidable hospitalization costs, addresses barriers to community-based care, and improves outcomes for high-need members with SMI. Embedding ACT-like supports into benefit designs can support value-based contracting and total cost of care reduction goals.

Reference:
https://my.clevelandclinic.org/health/treatments/assertive-community-treatment-act

ACT programs are intensive, evidence and team based mental health services designed to support individuals with serious mental illness by providing comprehensive, wraparound care in their own environments. Commonly, ACT is used for individuals with Serious Mental Illness (SMI)—including schizophrenia, bipolar disorder, and borderline personality disorder—who require intensive, coordinated support outside of traditional outpatient settings. ACT teams deliver personalized services in members' homes and communities, addressing both clinical needs and social determinants of health.

Members are supported by a multidisciplinary team of behavioral health professionals, nurses, peer specialists, and case managers. Services are available 24/7 and may include support for housing, employment, food security, co-occurring substance use, and medication adherence.

ACT participation is tailored to individual recovery goals, with most members engaged for several months. Outcomes consistently show reductions in hospital readmissions and length of stay, improved quality of life, and greater treatment engagement. Medicaid is the primary payer, although some commercial plans are beginning to explore similar models.

Key Features:

1. **Multidisciplinary, mobile teams delivering home- and community-based care**
2. **24/7 support access**
3. **Strong emphasis on recovery, function, and social determinants of health**
4. **Coordination of behavioral, medical, and social services**
5. **Flexible program length based on member goals**

13. The Collaborative Care Model (CCM)[51-52]

Impact

CCM improves access to behavioral health services within existing primary care infrastructure. It drives earlier intervention, improves behavioral health outcomes, and reduces total cost of care by preventing condition escalation. The model is especially relevant for adult and adolescent members with mild to moderate depression or anxiety.

References:
https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn

https://aims.uw.edu/team-structure/

The Collaborative Care Model (CCM) is an evidence-based approach developed by the University of Washington and adopted by health systems nationwide to embed behavioral health into primary care. CCM supports early detection and treatment of mental illness by embedding behavioral health services directly into the medical home.

A care team is led by the primary care provider (PCP) and includes a behavioral health care manager and a consulting psychiatrist. Together, the team monitors outcomes, adjusts treatment, and ensures members receive timely, evidence-based care. CCM uses validated tools (e.g., PHQ-9, GAD-7) to measure symptom improvement and treatment adherence.

The model is designed to align with value-based reimbursement structures and supports population-level tracking of behavioral health needs.

Key Features:

1. **PCP-led team includes a behavioral health care manager and psychiatric consultant**
2. **Measurement-based care using PHQ-9, GAD-7, and other tools**
3. **Stepped treatment adjustments based on outcomes**
4. **Built-in care coordination and frequent follow-up**
5. **Compatible with value-based payment structures and primary care transformation models**

14. Integrated Dual Diagnosis Treatment (IDDT)[53-55]

Impact

IDDT reduces cost and risk by unifying services for high-need members with complex behavioral health needs. The model supports improved treatment adherence, fewer crisis episodes, and stronger member engagement—key factors in value-based and performance-aligned payment models.

References:

https://pubmed.ncbi.nlm.nih.gov/30352668/

https://pubmed.ncbi.nlm.nih.gov/15618940/

https://library.samhsa.gov/product/integrated-treatment-co-occurring-disorders-evidence-based-practices-ebp-kit/sma08-4366

Integrated Dual Diagnosis Treatment (IDDT) is an evidence-based care model that delivers coordinated mental health and substance use disorder services within a single, cohesive treatment plan to improve outcomes for individuals with co-occurring disorders. Commonly, IDDT is used for individuals living with both serious mental illness (SMI) and substance use disorders (SUD). Unlike parallel or sequential approaches—where mental health and substance use are treated in separate systems—IDDT delivers both interventions through one integrated team. This unified model reduces fragmentation, ensures continuity of care, and promotes long-term engagement.

A multidisciplinary care team—including behavioral health clinicians, addiction specialists, and peer support professionals—works together to address both conditions simultaneously. The model uses stage-based interventions aligned with a member's readiness to change, along with motivational interviewing, medication management, and assertive outreach. Services are often provided in community settings and tailored to individual needs, including housing, employment, and psychosocial supports.

IDDT has demonstrated improved outcomes in substance use reduction, fewer psychiatric hospitalizations, and greater adherence to treatment plans. The model is endorsed by SAMHSA and widely adopted across behavioral health systems seeking to improve care for members with co-occurring conditions.

Key Features:

1. **Single care team addresses both SMI and SUD in one coordinated plan**
2. **Motivational interviewing and stage-based care aligned to member readiness**
3. **Assertive outreach and community-based recovery support**
4. **Focus on long-term engagement, including housing and employment support**
5. **Peer services and medication management integrated into care**

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Best Practices & Case Examples

15. Coordinating Physical & Behavioral Health Services For Dually Eligible Members With Serious Mental Illness[56]

Led By:

UPMC for Life Dual and UPMC Community Care — part of UPMC Insurance Services Division.

Overview:

Developed a risk stratification-driven care management model to proactively engage dually eligible members with SMI, SUD, and chronic medical conditions. Teamed to target adults (18+) enrolled in UPMC for Life Dual, diagnosed with SMI and substance use disorder, and with at least one chronic medical condition.

Timeline & Geography:

Pittsburgh and western Pennsylvania, implemented as part of UPMC's dual-eligible program beginning ~2018.

Program Strategy:

The program uses data-driven identification of high-risk members for enrollment in an intensive care management model. Trained care managers provide longitudinal support for individuals with complex medical and behavioral health needs, with coordinated outreach across BH and medical teams. Services emphasize prevention, self-management, and routine monitoring using tools like PHQ-9 and GAD-7, with continuous identification and engagement triggered by real-time risk indicators from claims and EHR data.

UPMC for Life
UPMC Health Plan Medicare Program

Source Link: https://www.chcs.org/resource/coordinating-physical-and-behavioral-health-services-for-dually-eligible-members-with-serious-mental-illness/

Why It Worked:

A unified care management team improved continuity and accountability, while specialized training equipped staff to address both mental and physical health needs. Shared records enabled better coordination across providers, and increased focus on follow-up and prevention helped reduce reliance on acute care services.

Impact:

- 10% drop in 30-day readmission rate
- 11.2% reduction in ED visits per 1,000
- 4.3% decrease in medical PMPM costs
- Trend toward increased follow-up after psych hospitalization within 5 days

Takeaways & Implementation Tips For Health Plans:

Targeted engagement for dual-diagnosis members helps reduce high-cost utilization. Care managers should be trained across BH, SUD, and chronic conditions. Embedding tools like PHQ-9 and GAD-7 supports real-time care adjustments, and ongoing risk stratification using both medical and BH data is essential for timely intervention.

16. Achieving Depression & Anxiety Patient-Centered Treatment Collaborative Care Program In A Large, Integrated Health Care System: A Mixed Methods Observational Study Protocol[57]

KAISER PERMANENTE®

Mental Health Training Program
Northern California

Source Link:
https://www.thepermanentejournal.org/doi/10.7812/TPP/22.050?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed

Led By:

Kaiser Permanente Northern California (KPNC) – Primary Care, Behavioral Health, Pharmacy, and Quality leadership teams. The ADAPT program embeds routine screening and measurement-based care into primary care workflows. Interventions include team-based care (physician, behavioral health specialist, pharmacist), patient-centered treatment plans, scalable telehealth integration, and reimbursement models supporting care management and psychotherapy. Excludes those at acute suicide risk or SMI.

Overview:

Launched the Achieving Depression and Anxiety Patient-Centered Treatment (ADAPT) program to detect and manage depression/anxiety in medical settings using collaborative care principles. Kaiser Permanente Northern California, targeting adults (18+) in primary care with mild to moderate-severe depression or anxiety based on PHQ-9/GAD-7.

Timeline & Geography:

Regional implementation across Northern California starting ~2021, piloted in primary care clinics with phased expansion. Screening at initial and follow-up visits ensures early detection and longitudinal monitoring.

Program Strategy:

The program embedded PHQ-9 and GAD-7 into routine primary care to guide care decisions at every visit. Stepped care pathways included medication, brief therapy, and psychiatric consults, with BH consultants collaborating directly with PCPs. Value-based reimbursement supported care coordination, BH staffing, and innovations like pharmacist-led medication management and social needs screening.

Why It Worked:

Systematic screening enabled early detection and timely treatment, while integrated, team-based care reduced delays and normalized behavioral health in primary care. The scalable design supported multi-site expansion without overburdening specialty services. EHR protocols enabled warm handoffs, and a strong focus on training, leadership, and evidence-based practices ensured consistency and sustainability.

Impact:

- Though full outcome data is pending, preliminary evidence shows:
  - Improved initiation of depression care
  - More members reached remission benchmarks on PHQ-9
  - Reduced variation across clinics in behavioral health treatment initiation
- Positioned to align with HEDIS metrics and reduce medical spend from untreated BH conditions
- Program demonstrates scalable, value-based care for depression/anxiety, facilitating access, reducing fractured care, and supporting network providers. Full outcomes are pending, but initial uptake shows promise for improved behavioral health outcomes and cost containment.

Takeaways & Implementation Tips For Health Plans:

Embedding screening and stepped behavioral health care into primary care improves access and outcomes. Successful collaborative care requires workflow redesign—not just co-location. Scalable models depend on aligned reimbursement, such as bundled payments or enhanced primary care rates.

17. Coordinating Mental Health & Substance Use Disorder Services & Supports In Medicaid[58]

Led By:

Elevance Health (formerly Anthem) in partnership with state Medicaid programs in Iowa, Indiana, West Virginia, and Tennessee; included state agencies, care management vendors, peer specialists, and prescribing providers. Focus on Medicaid members with mental health and/or substance use disorders.

Overview:

Deployed a multi-state strategy to reduce avoidable inpatient admissions by improving coordination of mental health, SUD, and medical care for high-risk Medicaid members. State-customized care coordination, pharmacy interventions to address polypharmacy, peer support networks, data sharing, and alternative payment models. Includes direct care manager engagement and care plan updates with behavioral and primary care teams.

Timeline & Geography:

State-level Medicaid interventions between 2018–2023, tailored per state with support from Elevance's central population health analytics team. Continuous: Targeted interventions are initiated when members are identified as high-risk (e.g., multiple psychotropic prescriptions, recent hospitalization).

Program Strategy:

Iowa: Created a centralized care coordination hub targeting high-utilizers with BH and SUD needs

West Virginia: Built peer support capacity into care management to engage hard-to-reach members

Indiana: Conducted prescribing audits to identify members with risky psychotropic polypharmacy, followed by care manager/MD outreach

Tennessee: Piloted integrated data-sharing models to link physical and behavioral health providers and tested alternative payment models for improved collaboration.

Elevance Health

Source Link: https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/7/07_report.pdf

Why It Worked:

State-customized strategies effectively addressed systemic gaps like polypharmacy and behavioral health fragmentation. Peer support fostered trust and boosted engagement, while data analytics enabled precise risk identification and outcome tracking. Strong partnerships with states provided policy flexibility for innovation, resulting in fewer avoidable inpatient stays and deaths, improved medication safety, and more coordinated whole-person care.

Impact:

- Indiana: 86% of members on duplicative psychotropic meds had regimens reduced/discontinued
- Iowa: >13% reduction in mental health and SUD-related inpatient stays
- Improved engagement metrics in peer-supported programs
- Progress toward value-based care alignment across BH and SUD services

Takeaways & Implementation Tips For Health Plans:

Effective risk stratification combined with peer engagement improves targeting and member retention. Reducing psychiatric polypharmacy enhances safety, adherence, and lowers costs. Multistate programs should adapt to local provider networks and regulations, while partnering with state Medicaid supports sustainable care innovations. Key strategies include analyzing claims data to identify high-risk members, integrating peer support and case management into Medicaid contracts, and promoting continuous data sharing between primary care and behavioral health.

18. Cancer Support Program To Improve Behavioral Health[59]

Led By:

Geisinger Health Plan (GHP), serving ~550,000 members, in partnership with OncoHealth®, a digital health platform specializing in oncology navigation, behavioral health, and supportive care with a focus on those undergoing cancer treatment.

Overview:

Developed a whole-person support model for members undergoing cancer treatment, integrating behavioral health, nursing, nutrition, and psychosocial support into oncology care. The support program offers 24/7 virtual navigation (oncology, mental health, nutrition), connects to financial and psychosocial supports (wig, transportation, local counseling), and targets behavioral health needs related to cancer journeys.

Timeline & Geography:

Program launched in 2023 across Geisinger's Pennsylvania service area, with virtual access and remote navigation available 24/7. Available on demand and throughout the patient's oncology care pathway; members are referred or self-enroll as cancer diagnosis is made.

Program Strategy:

Members are enrolled upon cancer diagnosis or referral from oncology clinics and supported through a virtual navigation hub staffed by oncology nurses, behavioral health clinicians, nutritionists, and social service coordinators. The program offers telehealth counseling, financial and transportation assistance, and navigation to resources such as local wig programs, smoking cessation, and wellness services. It also provides medication adherence and symptom management support. Navigation is fully integrated into the EMR, enabling care team alerts and streamlined documentation workflows.

Geisinger

Source Link: https://www.geisinger.org/about-geisinger/news-and-media/news-releases/2024/05/08/14/49/ghp-and-oncohealth-to-provide-comprehensive-cancer-support-to-members

Why It Worked:

Cancer patients often face depression, anxiety, and trauma, and access to behavioral health care improved significantly through on-demand virtual services. Wraparound support helped reduce delays in care, treatment non-adherence, and unplanned hospital use. The program addressed the high psychosocial burden of cancer, particularly in rural and underserved populations, aligned with value-based oncology care by enhancing patient experience and reducing fragmentation, and closed behavioral health access gaps—lowering overall costs while supporting quality of life.

Impact:

- Early results (full outcomes pending) indicate:
  - High patient satisfaction with virtual BH access
  - Reduced emergency visits for unmanaged symptoms
  - Improved medication adherence
- Model serves as proof-of-concept for BH integration into other high-acuity medical lines (e.g., cardiac, renal)

Takeaways & Implementation Tips For Health Plans:

Treating behavioral health alongside complex physical illness reduces costs and improves outcomes. Virtual navigation expands access, especially in areas with behavioral health shortages, while integration of behavioral health enhances plan reputation, member retention, and CAHPS scores. Key strategies include partnering with specialty navigation vendors, incorporating behavioral health screening into oncology pathways, and integrating social supports into cancer care protocols.

19. Special Needs Plan With Individual Attention For Complex Members Living In New York City[60]

Led By:

Amida Care, a nonprofit Medicaid Managed Care Plan - Special Needs Plan (SNP) for High-need, Complex NYC Members specializing in serving people with HIV/AIDS, those who are homeless, transgender individuals, and other marginalized populations with complex behavioral and physical health needs. Serves 9,500 New York City residents.

Overview:

Implemented a Special Needs Plan (SNP) with intensive, personalized care coordination integrating behavioral health, chronic disease management, and social supports, focused on highly vulnerable populations. Provides enhanced care management, behavioral health integration, chronic disease management, and tailored social services (e.g., homelessness programs, extra hospital days, housing support).

Timeline & Geography:

Ongoing since early 2000s; model refined under New York's Medicaid Redesign initiatives and expanded through the 2010s across NYC boroughs.

Program Strategy:

Each member was assigned a dedicated care coordinator trained in HIV care, trauma-informed behavioral health, and housing navigation. Services were delivered through both mobile and clinic-based models, including behavioral health counseling, primary care, infectious disease management, and housing placement with wraparound supports. The program ensured access to transgender-affirming care, PrEP, medication-assisted treatment (MAT), and HCV treatment. Coordinators partnered with community-based organizations, shelters, and health centers to locate and re-engage members. HEDIS metrics and social determinant tracking were used to monitor outcomes and identify gaps in care.

AMIDA CARE HEALTH. ADVOCACY. CARE.

Source Link: https://www.amidacareny.org/about-us/advocacy-and-research/

Why It Worked:

The program worked by building trust through culturally competent, identity-affirming care and addressing critical unmet needs—such as housing, stigma, trauma, and food insecurity—that often disrupt treatment adherence. Flexible benefit design and additional service days under SNP rules allowed for more responsive care delivery, while embedding peers and community health workers from the served communities strengthened member engagement and support.

Impact:

- HEDIS outcomes showed:
  - +6% in Hemoglobin A1c control for members with diabetes (vs. state average)
  - -5% in eye exam screening for diabetes — still above national Medicaid average considering member complexity
- Over 90% of engaged members remained connected to both medical and BH services after 12 months
- Demonstrated feasibility of aligning BH and chronic disease care with social determinant interventions
- Challenges persist in certain areas (e.g., eye exams), reflecting structural barriers.

Takeaways & Implementation Tips For Health Plans:

Tailored SNPs help close equity gaps for individuals with overlapping behavioral, physical, and social risks. Trauma-informed, culturally responsive care improves retention, while aligning medical, behavioral, and social supports under one plan strengthens outcomes and member experience. State support for SNP flexibility—like added services and housing—is key to sustainability. Success depends on cross-sector partnerships and culturally competent care teams. HEDIS metrics ensure accountability and highlight areas for improvement.

20. Intensive Wraparound Support For Homeless Individuals With SMI, SUD, & High Service Use[61]

Led By:

Los Angeles County Department of Mental Health (LACDMH), community-based mental health providers, housing agencies, and substance use disorder (SUD) treatment partners.

Overview:

Implemented a Full Service Partnership (FSP) model offering 24/7 intensive field-based services for individuals with SMI, co-occurring SUD, and chronic homelessness. Clients receive housing placement, medical and psychiatric care coordination, and wraparound supports.

Timeline & Geography:

Initiated in 2005 under California's Mental Health Services Act (MHSA); scaled countywide across L.A. through 2022.

Program Strategy:

The program used interdisciplinary teams composed of licensed clinicians, case managers, peer support specialists, and housing specialists. Field-based outreach is conducted in settings such as streets, encampments, hospitals, and jails to engage hard-to-reach individuals. Services include psychiatric medication management, medication-assisted treatment (MAT) for substance use disorders, benefits assistance, and landlord mediation. Caseloads were intentionally capped at approximately 10–15 clients per team member to ensure intensive, personalized support. A "whatever it takes" funding model allows for flexible service delivery, including providing essentials like cell phones, food, and clothing.

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Source Link: https://dmh.lacounty.gov/our-services/outpatient-services/fsp/

Why It Worked:

The model worked by building trust through consistent, flexible engagement outside traditional clinical settings. It supported care continuity through transitions like jail release, detox, and shelter stays, while strong partnerships with housing providers reduced barriers to permanent housing. Peer support staff played a key role in modeling recovery and re-engaging members who had dropped out of care.

Impact:

- 87% of housed participants retained housing at 12 months
- 49% reduction in psychiatric hospitalizations
- 34% decrease in jail bookings
- Estimated $20,000/year savings per person due to reduced crisis service use

Takeaways & Implementation Tips For Health Plans:

FSP models show a strong return on investment by delivering intensive engagement to high-utilizing populations. Success depends on integrated teams supported by flexible funding and coordination across agencies. Embedding peer support and housing services directly into clinical teams boosts engagement and improves recovery outcomes.

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Conclusion

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Conclusion: Addressing Complexity Through Integration – Key Takeaways

The insights and models within this supplement reinforce a central truth: real-world health is complex, and siloed solutions are insufficient.

Co-morbid behavioral and physical health disorders not only drive poor outcomes—they represent a call to redesign care and financing around whole-person needs.

Risk isn't evenly distributed: Adults with SMI face a 526% higher risk of pulmonary disease; ADHD and PTSD are linked with hypertension, SUD, and sleep disorders—especially among Medicaid and dually eligible members.[9,33]

Proven models exist and can scale: ACT, IDDT, and Collaborative Care have shown reduced readmissions, improved PHQ-9/GAD-7 scores, and stronger follow-up after discharge.[50-55]

Integration is essential: Health plans like UPMC report a 4.3% drop in PMPM costs and 11.2% fewer ED visits by embedding behavioral health into complex care management.[56]

Early impact is measurable: Several programs report a 10% decrease in 30-day readmissions and faster follow-up—before full claims-based ROI is even available.[56,61]

Whole-person care drives value: Programs that combine medical, behavioral, and social supports—like housing navigation or 24/7 cancer support—reflect where value-based care is headed.[59]

Definitions[1,18]

Name	Definition
Any Mental Illness (AMI)	Defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below).” – National Institute of Mental Health
Serious Mental Illness (SMI)	Defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.” – National Institute of Mental Health
Major Depressive Disorder (Episode)	“The NSDUH study definition of major depressive episode is based mainly on the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5): A period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities, and had a majority of specified symptoms, such as problems with sleep, eating, energy, concentration, or self-worth. No exclusions were made for major depressive episode symptoms caused by medical illness, substance use disorders, or medication. – National Institute of Mental Health

*No child and adolescent data was included in this supplement.

References List

1. U.S. Department of Health and Human Services. (2024, September). *Mental illness*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness
2. *More than half of U.S. adults don't know heart disease is leading cause of death, despite 100-year reign*. American Heart Association. (2024, January 24). https://newsroom.heart.org/news/more-than-half-of-u-s-adults-dont-know-heart-disease-is-leading-cause-of-death-despite-100-year-reign
3. The global prevalence of Brain Disease | American brain foundation. (2024, July 2). https://www.americanbrainfoundation.org/the-global-prevalence-of-brain-disease/
4. Prevalence of the metabolic syndrome defined by the International Diabetes Federation among adults in the U.S. | diabetes care | american diabetes association. (2005, November 1). https://diabetesjournals.org/care/article/28/11/2745/25200/Prevalence-of-the-Metabolic-Syndrome-Defined-by
5. Ohayon, M. M. (2011, March 24). epidemiological Overview of sleep Disorders in the General Population. https://www.sleepmedres.org/upload/pdf/smr-2-1-1.pdf
6. Centers for Disease Control and Prevention. (2024, May 15). *National Diabetes Statistics Report*. Centers for Disease Control and Prevention. https://www.cdc.gov/diabetes/php/data-research/index.html
7. *What is ADHD?*. Psychiatry.org - What is ADHD? (2022, June 22). https://www.psychiatry.org/patients-families/adhd/what-is-adhd
8. *Statistics and Graphs*. Statistics and Graphs | Division of Cancer Control and Population Sciences (DCCPS). (2025). https://cancercontrol.cancer.gov/ocs/statistics
9. Centers for Disease Control and Prevention. (2025, July 15). *FASTSTATS - chronic lower respiratory disease*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/fastats/copd.htm
10. How many people have liver disease? (2023, September 11). https://liverfoundation.org/about-your-liver/facts-about-liver-disease/how-many-people-have-liver-disease/

References List

11. Centers for Disease Control and Prevention. (2023, March 17). *CDC recommendations for hepatitis C screening among adults - United States, 2020*. Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm
12. Hernandez-Viver, A., & Mitchell, E. M. (2025, March). *Concentration of Healthcare Expenditures and Selected Characteristics of People with High Expenses, United States Civilian Noninstitutionalized Population, 2018-2022*. Concentration of healthcare expenditures and selected characteristics of people with high expenses, United States civilian noninstitutionalized population, 2018-2022. https://meps.ahrq.gov/data_files/publications/st560/stat560.shtml
13. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. (2024a). Highlights for the 2023 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/NSDUH%202023%20Annual%20Release/2023-nsduh-main-highlights.pdf
14. *Understanding IDD - IEC (Institute for Exceptional Care)*. Institute for Exceptional Care. (2024, May 7). https://www.ie-care.org/about-idd/
15. U.S. Department of Health and Human Services. (n.d.). *Post-traumatic stress disorder (PTSD)*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/post-traumatic-stress-disorder-ptsd
16. U.S. Department of Health and Human Services. (n.d.-a). *Bipolar disorder*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/bipolar-disorder

References List

17. U.S. Department of Health and Human Services. (n.d.-c). *Schizophrenia*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/schizophrenia
18. U.S. Department of Health and Human Services. (2023, July). *Major depression*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/major-depression
19. Terlizzi, E. P., & Norris, T. (2021, July 29). *Mental Health Treatment Among Adults: United States, 2020*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/products/databriefs/db419.htm
20. *New nationwide poll shows an increased popularity for telehealth services*. Psychiatry.org - New Nationwide Poll Shows an Increased Popularity for Telehealth Services. (2021, May 26). https://www.psychiatry.org/news-room/news-releases/new-nationwide-poll-shows-an-increased-popularity
21. Davenport, S., Gray, T., & Melek, S. (2020, August 12). *How do individuals with behavioral health conditions contribute to physical and total healthcare spending?*. Milliman. https://www.milliman.com/en/insight/how-do-individuals-with-behavioral-health-conditions-contribute-to-physical
22. Bahorik, A. L., Satre, D. D., Kline-Simon, A. H., Weisner, C. M., & Campbell, C. I. (2017, September). *Serious mental illness and medical comorbidities: Findings from an Integrated Health Care System*. Journal of psychosomatic research. https://pmc.ncbi.nlm.nih.gov/articles/PMC5576509/#TFN7
23. Preuss, U. W., Schaefer, M., Born, C., & Grunze, H. (2021, November 17). *Bipolar disorder and comorbid use of illicit substances*. Medicina (Kaunas, Lithuania). https://pmc.ncbi.nlm.nih.gov/articles/PMC8623998/

References List

24. Lortye, S. A., Will, J. P., Marquenie, L. A., Goudriaan, A. E., Arntz, A., & Waal, M. M. de. (2022, July 19). *Treating posttraumatic stress disorder in substance use disorder patients with co-occurring posttraumatic stress disorder: Study protocol for a randomized controlled trial to compare the effectiveness of different types and timings of treatment - BMC psychiatry*. BioMed Central. https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03366-0
25. *Depression & Substance Abuse Treatment Plans, medication, therapy*. American Addiction Centers. (2025, March 31). https://americanaddictioncenters.org/co-occurring-disorders/depressive-disorders
26. Chang, S., Jeyagurunathan, A., Lau, J. H., Shafie, S., Samari, E., Cetty, L., Mok, Y. M., Verma, S., & Subramaniam, M. (2025, September 4). *Problematic drug use among outpatients with schizophrenia and related psychoses*. Frontiers. https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2021.762988/full
27. Allen, J. R. (2019, March 1). *Addressing substance use in patients with intellectual disability: 5 steps*. MDedge. https://www.mdedge.com/psychiatry/article/195235/addiction-medicine/addressing-substance-use-patients-intellectual
28. *Co-occurring psychiatric and Substance Use Disorders*. Missouri Department of Mental Health. (n.d.-a). https://dmh.mo.gov/mental-illness/initiatives/co-occurring
29. Johns Hopkins Medicine. (2012, July 18). *Cancer and injuries more likely in people with serious mental illness*. ScienceDaily. https://www.sciencedaily.com/

References List

30. Lambert, T., Middleton, T., Chen, R., & Sureshkumar, P. (2023, January 18). *Prevalence of, and factors associated with, diabetes mellitus in people with severe mental illness attending a multidisciplinary, Outpatient Cardiometabolic Health Assessment Service*. BMJ Open Diabetes Research & Care. https://drc.bmj.com/content/11/1/e003055
31. Jer-Hwa, H. (2019, March 22). *Increased risk of chronic liver disease in patients with major depressive disorder: A population-based study*. Journal of Affective Disorders. https://www.sciencedirect.com/science/article/abs/pii/S0165032719303428
32. Hughes, E., Bassi, S., Gilbody, S., Bland, M., & Martin, F. (2016, January). *Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness: a systematic review and meta-analysis*. The Lancet Psychiatry. https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(23)00363-2/abstract
33. Himelhoch, S., Lehman, A., Kreyenbuhl, J., Daumit, G., Brown, C., & Dixon, L. (2004, December). *Prevalence of chronic obstructive pulmonary disease among those with serious mental illness*. The American journal of psychiatry. https://pubmed.ncbi.nlm.nih.gov/15569908/
34. Afzal, M., Siddiqi, N., Ahmad, B., Afsheen, N., Aslam, F., Ali, A., Ayesha, R., Bryant, M., Holt, R., Khalid, H., Ishaq, K., Koly, K. N., Rajan, S., Saba, J., Tirbhowan, N., & Zavala, G. A. (2021, November 25). *Prevalence of Overweight and Obesity in People With Severe Mental Illness: Systematic Review and Meta-Analysis*. ResearchGate. https://www.researchgate.net/publication/355873536_Prevalence_of_Overweight_and_Obesity_in_People_With_Severe_Mental_Illness_Systematic_Review_and_Meta-Analysis

References List

35. *General prevalence of ADHD in adults*. CHADD. (2025, July 31). https://chadd.org/about-adhd/general-prevalence-adults/
36. Martínez-Raga, J. (2022, May 24). *When ADHD and substance use disorders coexist*. CHADD. https://chadd.org/attention-article/when-adhd-and-substance-use-disorders-coexist/
37. Li, L., Chang, Z., Sun, J., Garcia-Argibay, M., Rietz, E. D., Dobrosavljevic, M., Brikell, I., Jernberg, T., Solmi, M., Cortese, S., & Larsson, H. (2022, October 21). *Attention-deficit/hyperactivity disorder as a risk factor for cardiovascular diseases: A nationwide population-based Cohort Study*. World psychiatry : official journal of the World Psychiatric Association (WPA). https://pubmed.ncbi.nlm.nih.gov/36073682/
38. Du Rietz, E., Brikell, I., Butwicka, A., Leone, M., Chang, Z., Cortese, S., D'Onofrio, B. M., Hartman, C. A., Lichtenstein, P., Faraone, S. V., Kuja-Halkola, R., & Larsson, H. (2021, September). *Mapping phenotypic and aetiological associations between ADHD and physical conditions in adulthood in Sweden: A genetically informed Register Study*. The lancet. Psychiatry. https://pmc.ncbi.nlm.nih.gov/articles/PMC8376653/
39. Constance, L. (2022, March 31). *Study: Risk for diabetes 50% higher for adults with ADHD*. ADDitude. https://www.additudemag.com/adhd-and-diabetes-risk-research/?srsltid=AfmBOooSjx_CwzT8-PZjLjOP5YLO0t4HRqscAoRp1NfxSDH5cY8rZUoN
40. Cortese, S., Moreira-Maia, C. R., St Fleur, D., Morcillo-Peñalver, C., Rohde, L. A., & Faraone, S. V. (2015, August 28). *Association between ADHD and obesity: A systematic review and meta-analysis*. The American journal of psychiatry. https://pubmed.ncbi.nlm.nih.gov/26315982/

References List

41. Pesantez, N. (2022, June 15). *Study: Adults with ADHD face elevated risk for 34 physical health conditions*. ADDitude. https://www.additudemag.com/physical-health-conditions-risk-adult-adhd-news/?srsltid=AfmBOoqRMvlcnYDSIdTORFW2LfpaEIuf3gwZ3apKbDJ_qquZv9PrpV3u
42. McCauley, J. L., Killeen, T., Gros, D. F., Brady, K. T., & Back, S. E. (2012, September 1). *Posttraumatic stress disorder and co-occurring substance use disorders: Advances in assessment and treatment*. Clinical psychology : a publication of the Division of Clinical Psychology of the American Psychological Association. https://pmc.ncbi.nlm.nih.gov/articles/PMC3811127/
43. Bartoli, F., Crocamo, C., Alamia, A., Amidani, F., Paggi, E., Pini, E., Clerici, M., & Carrà, G. (2015, October). *Posttraumatic stress disorder and risk of obesity: Systematic review and meta-analysis*. The Journal of clinical psychiatry. https://pubmed.ncbi.nlm.nih.gov/26528647/
44. Yu, Y., Hu, G., Yang, X., Bai, S., Wu, J., Tong, K., & Yu, R. (2024, September 4). *Effect of post-traumatic stress disorder on type 2 diabetes and the mediated effect of obesity: A mendelian randomization study*. Frontiers. https://www.frontiersin.org/journals/endocrinology/articles/10.3389/fendo.2024.1375068/full
45. *Estimated Hypertension Prevalence, Treatment, and Control Among U.S. Adults*. Million hearts. (2023, May 12). https://millionhearts.hhs.gov/data-reports/hypertension-prevalence.html
46. Krantz, D. S., Gabbay, F. H., Belleau, E. A., Aliaga, P. A., Wynn, G. H., Stein, M. B., Ursano, R. J., & Naifeh, J. A. (2024, April). PTSD, Comorbidities, Gender, and Increased Risk of Cardiovascular Disease in a Large Military Cohort. https://www.medrxiv.org/content/10.1101/2024.04.13.24305769v1.full

References List

47. Abrams, T. E., & Blevins, A. (2015, October). *Chronic obstructive lung disease and posttraumatic stress disorder: Current perspectives*. International journal of chronic obstructive pulmonary disease. https://pubmed.ncbi.nlm.nih.gov/26508851/
48. Gupta, A., Shebl, F. M., Tong, Y., Wagner, K., Bassett, I. V., Page, K., & Winstanley, E. L. (2022, October 20). *Association of co-occurring mental health problems with hepatitis C status among young people who inject drugs in rural New Mexico, 2016–2018 - addiction science & clinical practice*. BioMed Central. https://ascpjournal.biomedcentral.com/articles/10.1186/s13722-022-00340-3
49. Yoder, M., & Norman, S. (2015, September 10). Co-occurring PTSD and Neurocognitive Disorder (NCD). https://www.ptsd.va.gov/professional/treat/cooccurring/ncd_cooccurring.asp
50. *Assertive community treatment*. Cleveland Clinic. (2025, June 30). https://my.clevelandclinic.org/health/treatments/assertive-community-treatment-act
51. *Learn About the Collaborative Care Model*. Psychiatry.org - Learn. (n.d.). https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn
52. *Team Structure - AIMS Center*. AIMS Center -. (2025, April 23). https://aims.uw.edu/team-structure/
53. Kikkert, M., Goudriaan, A., de Waal, M., Peen, J., & Dekker, J. (2018, September 29). *Effectiveness of integrated dual diagnosis treatment (IDDT) in severe mental illness outpatients with a co-occurring substance use disorder*. Journal of substance abuse treatment. https://pubmed.ncbi.nlm.nih.gov/30352668/

References List

54. Douglas, Z. M. (2004, December 9). *Integrated treatment of co-occurring mental illness and addiction: Clinical intervention, program, and System Perspectives*. CNS spectrums. https://pubmed.ncbi.nlm.nih.gov/15618940/
55. *Integrated treatment for co-occurring disorders evidence-based practices (EBP) kit*. SAMHSA Library. (2010, January). https://library.samhsa.gov/product/integrated-treatment-co-occurring-disorders-evidence-based-practices-ebp-kit/sma08-4366
56. Soper, M. H., & Kelly, L. (2021, August 9). *Coordinating physical and behavioral health services for dually eligible members with serious mental illness*. Center for Health Care Strategies. https://www.chcs.org/resource/coordinating-physical-and-behavioral-health-services-for-dually-eligible-members-with-serious-mental-illness/
57. Rideout, K. K. (2022, November 9). Evaluating Implementation and Outcomes of the Achieving Depression and Anxiety Patient-Centered Treatment Collaborative Care Program in a Large, Integrated Health Care System: A Mixed Methods Observational Study Protocol. https://www.thepermanentejournal.org/doi/10.7812/TPP/17-003
58. Elevance Health. (2020, December). Coordinating Mental Health and Substance Use Disorder Services and Supports in Medicaid . https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/7/07_report.pdf
59. Geisinger Health Plan. (2024, May 7). GHP and OncoHealth to provide comprehensive cancer support to members. https://www.geisinger.org/about-geisinger/news-and-media/news-releases/2024/05/08/14/49/ghp-and-oncohealth-to-provide-comprehensive-cancer-support-to-members

References List

60. *Advocacy and research: Amida care: Health. advocacy. care.* Amida Care. (2023, June 14). https://www.amidacareny.org/about-us/advocacy-and-research/
61. *Adult Full Service Partnership Program*. Department of Mental Health. (2024, November 14). https://dmh.lacounty.gov/our-services/outpatient-services/fsp/

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