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Designing Resilient Health Systems Under Policy Volatility: An Integrated Care and Financing Framework for Gender-Affirming Care, Substance Use Harm Reduction, and Affirming Mental Health

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Abstract *- The qualitative conditions of policy instability that influence the practices of health systems are becoming more and more demanding concerning their provision of gender-affirming care, substance use harm reduction services, and affirming mental health interventions. Although operational and financial risk are present where the provision of care is disjointed, variability in regulatory interpretation, payer policy, and service availability creates operational and financial risk. The impact of this volatility is especially felt by lesbian, gay, bisexual, transgender, queer, and other sexual and gender minority communities not due to the fact that such populations are niche clinical populations, but rather because they are structurally positioned to experience the impact of health system stressors with the first and most obvious effects. This paper offers a resilience-based health system design, which incorporates gender-affirming continuity of care, harm reduction of substance use, and affirming mental health services into one accountable operating platform. With a healthcare management and finance prism, we propose the Resilient Minority-Integrated Medical Framework, a model of delivery and financing with a specific design to operate in the conditions of policy uncertainty. Using clear assumptions of utilization and cost modeling and contracting, we show how integrated design can decrease unnecessary high-acuity utilization, stabilize access to care, and provide a financially viable channel of payers and providers. The framework is pegged as a practical solution to volatility and integrating and financially disciplined, as opposed to political affiliation.*

Key Terms: *Resilient, Health Systems, Policy, Volatility, Care, Gender-Affirming*

I. INTRODUCTION

The concept of policy volatility is becoming the new trend in healthcare delivery in the United States, as opposed to policy stability. Providing gender-affirming, substance use harm reduction, and preventive mental health services differ by jurisdiction, payer schemes and regulatory interpretations (Barraza, 2022). To healthcare organizations, such variability breaks the continuity of care, complicated workforce planning, and brought financial uncertainty. To patients, it leads to a delay in care, disjointed treatment channels and dependence on crisis-services.

According to Ryan (2025), these disruptions are disproportionate in lesbian, gay, bisexual, transgender, queer, and other sexual and gender minority groups. It is described in extensive literature that there is a high level of exposure to discrimination, more care avoidance, and higher levels of untreated mental health issues in these communities (Gabija et al., 2025). This is not the result of identity, but structural aspects of health systems that cannot offer stable, affirmative, and easy to access care.

Regarding the finance and management of healthcare, such dynamics have foreseeable downstream impacts. The utilization is not lost when the stabilization outpatient services are not available; they are transferred to emergency rooms, inpatient services, and other acute care services. This trend implies that the volatility of the policy, as an operational risk, can be anticipated and addressed with the help of design.

This article develops the idea that populations that are the most sensitive to variability of access act as a first

warning of system malfunction. Creating health systems that keep LGBTQ+ populations afloat in unstable environments, thus, is not a niche intervention, but a policy to enhance overall system resiliency and financial outcomes.

1.1 Conceptual Framework

The Resilient Minority-Integrated Medical Framework is based on three principles:

Synthesis rather than analysis.

Interdependent care domains need to be under one accountable structure in terms of finances and clinical management.

Under constraint continuity.

The health systems must be structured in a way that ensures continuity of care despite the regulatory, payer, or policy changes.

Monetary responsibility of down stream effects.

Avoidable high-acuity utilization needs to be seen as a failure of the upstream system design and not an inevitable cost.

Within this model, there is no distinction between gender-affirming care or substance use harm reduction and affirming mental health services (Ryan, 2025). They are incorporated parts of a single operating platform, and joint clinical and financial responsibility.

II. METHODS

2.1 Study Design

This paper has used health services research and healthcare finance modelling methodology to test the economic plausibility of the Resilient Minority-Integrated Medical Framework. It is quantitative and conceptual analysis, aimed at proving the possibility, but no specific results. Assumptions are conservative and in line with published assumptions of high-risk publicly insured or managed care population.

2.2 Modeled Population

The model assesses a sample of ten thousand ascribed members that have a high behavioral health and substance use risk(Gabija et al., 2025). This is the size of the population that is usually applied in the population health management, care coordination, and value-based contracting efforts.

2.3 Utilization and Cost Assumptions

Baseline utilization rates and unit costs were selected based on national estimates for emergency department visits and inpatient admissions among high-risk populations. These assumptions are summarized in Table 1 and represent intentionally conservative estimates to avoid overstating potential financial impact.

2.4 Design and Analytical Framework of the study

This paper uses an economic analysis of health services research and healthcare finance modeling method to examine the economic feasibility of the Resilient Minority-Integrated Medical Framework. It is both conceptual and quantitative analysis that is aimed at proving the possibility but does not forecast the precise results. The methodology framework combines the principles of actuarial science with population health management strategies and calculates the potential of the return on investment using the model of total cost of care (TCOC). The analytical approach uses a payer and healthcare system perspective of operation in a 12-month time frame, and the assumption is made that the conditions are stable. According to Saito & Podestà, (2024), high-risk, publicly insured or managed care population conservative assumptions are consciously used and set on published literature standards to ensure that potential financial impact is not overstated but analytical credibility is achieved.

2.5 Definition and Characteristics of the target population

The model assesses one of ten thousand attributed members that have a high risk of behavioral health and substance use. This is the size of the population intended to represent the population size that may be typically applied in population health management, care coordination, and value-based contracting programs, which offers adequate statistical power to permit meaningful analysis but is not too large to be practically operational in a health system implementation (Gabija et al., 2025). The target population will be everyone who is an adult (18-64 years old) with identified high-risk profiles (greater prevalence of mental health issues, substance use disorders, and previous trends of high-acuity healthcare use). Demographic assumptions assume that there is a representative proportion of sexual and gender minorities, the insurance coverage of which is a combination of Medicaid (60%), commercial (30%), and noninsured (10) populations.

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2.6 Sources of Data and Bases of Evidence

The baseline utilization rates and unit costs were selected using systematic literature review about peer-reviewed articles published in 2019-2024, national administrative data, and industry benchmarking reports. The sources of primary data will be Healthcare Cost and Utilization Project (HCUP), Substance Abuse and Mental Health Services Administration (SAMHSA) databases, and Centers for Disease Control (CDC) surveillance data. The criteria of quality assessment put much emphasis on the methodological rigor, adequacy of the sample size, and relevance to the target population (Shaheen et al., 2023). The adjustment of post-COVID utilization pattern included the adjustment to changes in the organization of healthcare delivery, whereas the geographic variation was taken into consideration by applying geographic cost indexes to ensure national representativeness (Saito & Podestà, (2024).

2.7 Utilization and Cost Modeling Approach

The assumptions related to baseline utilization are emergency department visit rate of 900 per 1,000 members per year and inpatient admission rate of 120 per 1,000 members per year based on national estimates on high-risk groups with behavioral health and substance use issues. These rates indicate reported rates among sexual and gender minority populations that have high healthcare demands because of structural factors and late access to affirming care (Ryan, 2025). The unit costs are set at the blended medical and behavioral health average of $1,500 per emergency department visit and $14,000 per inpatient admission with the costs adjusted to reflect the geographic variation. Conservative estimation procedures lower literature-based means by 10-15 percent of the means to compensate differences in implementation and do not exaggerate the possible implications.

2.8 Limitations and Methodological Constraint

It is analyzed using model assumptions, not replacing a real-world implementation analysis based on empirical data on its implementation. The cross-sectional modeling technique restricts the evaluation of long-term continuity of care, and long-term improvement on population health outcomes that may maximise financial returns in the long term (Prior et al., 2025). The geographic and demographic generalizability constriction recognizes that the real performance will differ broadly based on the local market conditions, provider capacity, the regulatory setting as well as the population specifics. Although the assumptions about conservativeness enhance the credibility of the analysis, they might underestimate the possible advantages of the integrated care delivery, especially in terms of quality improvement and patient satisfaction outcomes. Park et al. 2025), suggests that assumptions of implementation fidelity might not be consistent with the real-life challenges of operation, staffing levels, and integration issues with technology that might interfere with the utilization and cost impacts projected.

III. RESULTS

3.1 Baseline Utilization and Cost Profile

As shown in Table 1, the modeled population exhibits high rates of emergency department utilization and inpatient admissions. Primary drivers of utilization include untreated mental health conditions, substance use crises, and delayed access to preventive and continuity-based care.

Table 1. Baseline Utilization and Cost Assumptions for the Modeled Population

Metric	Assumption	Rationale
Attributed population size	10,000 members	Typical scale for population health programs
Emergency department visits	900 visits per 1,000 members per year	Consistent with high-risk publicly insured cohorts
Inpatient admissions	120 admissions per 1,000 members per year	Reflects elevated behavioral and substance use acuity
Average cost per emergency department visit	$1,500	National average estimates
Average cost per inpatient admission	$14,000	Blended medical and behavioral health estimate
Primary utilization drivers	Mental health crises, substance use events, delayed preventive care	Documented in population health literature

The outcomes of the modeled population of 10,000 members show that the rate of emergency department utilization and inpatient admission is high, which is primarily caused by untreated mental health issues, substance use crisis, and lack of access to prevention services. The ED visit has been estimated at 900 per 1,000 employees per year and the inpatient at 120 per 1,000. Such statistics demonstrate that the healthcare requirements of this high-risk group are significant and should be considered as the priorities of the integrated service model that will be able to cope with the existing problems and promote the overall rates of health.

Resilient Minority-Integrated Medical Framework suggests to offer a single approach to service delivery through offering gender-affirming care, substance use harm reduction, and mental health services. It is hoped that this integrated model will result in a 15 percent decrease in emergency department visits as well as inpatient admissions. In particular, it will mean that the emergency visits and inpatient admissions will be reduced by about 135 and 18 per 1,000 members annually, which will enable to achieve improved continuity of care and improved health condition management (Penketh & Nolan, 2022). The model focuses on collective responsibility and integrated care, and this model may result in significant increases in patient health.

The savings that this combined measure will result in are substantial in terms of money. The model expects a total of about 454,500 dollars of the 10,000-member cohort population to be saved annually by decreasing the emergency department visits and inpatient admissions. This entails savings of 202,500 costs of emergency department and 252,000 inpatient admissions. The findings depict the economic viability of the Resilient Minority-Integrated Medical Framework and strengthen the usefulness of integrated care in addressing high costs of healthcare and enhancing accessibility and quality of care to vulnerable populations.

3.2 Integrated Service Model

According to Nallamothu et al. (2025), the Resilient Minority-Integrated Medical Framework is an amalgamation of three critical domains of service into a singular accountable platform. First, it has a focus on the continuity of care that is gender affirming by using evidence-based assessments, prescribing, and follow-up, so that care is both available and consistent (Ryan, 2025). Second, it focuses on harm reduction of substance use through access to medications to treat opioid use disorder, education to prevent overdose, distribution of naloxone, and access to infectious disease prevention and treatment. And finally, it provides confirming mental health services that target rapid access, measurement-based care, and crisis prevention and, therefore, lessening the need to enlist emergency departments. This integration renders collective responsibility over the outcome, where concerns that may have been addressed in separate systems would be addressed.

3.3 The Impact on utilization and Costs, modeled.

The model would entail a 15 percent decrease in emergency department visits and a 10 percent decrease in inpatient admissions based on available evidence on integrated care interventions as a result of better continuity, access to better behavioral health, and effective harm reduction. These savings are equal to about 3.7 million gross medical savings per year to the member cohort of 10,000 as described in Table 2. This is the huge saving in expenses which highlight the economic feasibility of the Resilient Minority-Integrated Medical Framework and it shows that it can enhance the health outcomes whilst reducing healthcare spending in general.

The model proposes that of the integrated care and care management interventions, the emergency department visit will decrease by fifteen percent, and the inpatient commitment will decrease by ten percent due to the integration of continuity, behavioral health access, and harm reduction (Goldzahl et al., 2022). These savings result in an estimated gross in the form of medical cost savings of about three point seven million dollars per annum to the ten thousand member cohort as listed in Table 2.

Table 2. Estimated Annual Financial Impact of the Resilient Minority-Integrated Medical Framework

Category	Baseline Volume	Modeled Reduction	Avoided Events	Estimated Annual Cost Avoidance
Emergency department visits	9,000 visits	15 percent reduction	1,350 fewer visits	$2,025,000

Inpatient admissions	1,200 admissions	10 percent reduction	120 fewer admissions	$1,680,000
Total gross medical cost avoidance	—	—	—	$3,705,000

3.4 Operating Cost Structure

The model of the integrated platform will have an operating cost of one hundred and twenty dollars per member per month, which will include the staffing, care coordination, behavioral health services, data infrastructure, and administrative support. This amounts to about fourteen point four million dollars yearly operating cost to ten thousand members. The concept of financial sustainability will not rely on the reduction in short-term utilization only (Gleißner et al., 2022). Instead, it occurs due to aligned contracting mechanisms that enable providers to share the value generated by prevented high-acuity utilization and better quality outcomes.

3.5 Architecture of Contracting and Financing.

The Resilient Minority-Integrated Medical Framework is financially feasible based on contracting structures that align the payer and provider incentives. A typical contracting and financing arrangement is presented in Table 3.

Table 3. Contracting and Financing Structure for the Resilient Minority-Integrated Medical Framework

Component	Description	Financial Rationale
Per-member-per-month care coordination payment	Risk-adjusted monthly payment supporting integrated delivery	Provides predictable operating revenue
Shared savings arrangement	Provider participation in verified medical cost avoidance	Aligns incentives to reduce avoidable utilization
Quality-based incentive payments	Payments tied to retention in care and mental health improvement	Protects quality while reducing cost
Initial downside risk protection	Limited downside exposure during early implementation	Encourages adoption
Catalytic or mission-aligned capital	Time-limited funding for infrastructure development	Supports start-up without permanent subsidy
Transition to payer-supported sustainability	Reduction of external capital as benchmarks are achieved	Establishes long-term viability

3.6 Contracting and Financing Architecture

The financial sustainability of the Resilient Minority-Integrated Medical Framework will be based on the innovative contracting designs that effectively work to align incentives of the payers and the providers. This coordination is essential to have every stakeholder keen on the idea of integrated care and foster better health outcomes and reduce unwarranted spending (Achor et al., 2025). Table 3 shows one such typical setting of the contracting and financing structure that would support this framework.

Per-Member-Per-Month Care Coordination Payment: This element entails a risk-adjusted payment in terms of monthly payments that help to promote services that are integrated in nature. This type of payment enables healthcare providers to concentrate on quality, coordinated care, without the worry of having to meet daily reimbursement fluctuations, which this model provides a predictable operating revenue.

Shared Savings Arrangement: This aspect encourages the providers to engage in attested medical cost avoidance participation. With the savings achieved by distributing savings realized by decreased avoidable utilization, providers are motivated to adopt measures that create better care coordination and patient outcomes, thereby reducing the overall healthcare costs. Payments based on patient retention in the care and changes in mental health outcomes secure the quality of care and are also aimed at lowering the costs. This will keep the providers on track to provide effective and affirming care to vulnerable populations.

To boost a quick adoption of the framework, the component will provide minimal down side exposure in the first implementation phase. This safety net will

enable the providers to adopt integrated care practices with a lot of ease since they will not be afraid of incurring huge losses. This is a time-based capital that aids in the framework of developing infrastructures needed to implement it. This capital allows healthcare organizations to develop their capacities without having to depend on the permanent subsidies.

Lastly, the Transition to Payer-Supported Sustainability provides the ability to gradually reduce the external capital as the performance standards are met, creating the long-term sustainability of the integrated care model. These elements combined will form an effective financial framework that will create sustainable and high-quality healthcare provision to minority groups.

IV. DISCUSSION

Combining the utilization assumptions in Table 1, the cost implications in Table 2, and the contracting structures in Table 3 will make the reader understand that integrated delivery with the help of the Resilient Minority-Integrated Medical Framework is economically feasible and strategically sound. Expansion of regulatory growth and political affiliation are not necessitated in the framework. It rather views policy volatility as a structural constraint and plans to be resilient in the constraint.

The model is able to overcome fragmentation that promotes avoidable utilization by combining gender-affirming care, substance use harm reduction, and affirming mental health services (Gabija et al., 2025). Notable, those populations that are the most shaped by the variability of the policy are the initial signs of inefficiency in the system, so this method is widely applicable outside of the LGBTQ+ communities.

4.1 Limitations

It is an analysis that is made on the basis of modeled assumptions that does not replace empirical analysis, based on real-world implementation data. The reality will be different depending on the population characteristics, payer mix, regulatory environment, and local cost structures. Future studies are to be conducted using longitudinal outcomes and confirming the use effects in a variety of settings.

V. CONCLUSION

Healthcare delivery has now become characterized by policy volatility. Under these circumstances, fragmentation results in foreseeable clinical and financial downfall. The Resilient Minority-Integrated Medical Framework is a financially based model of providing continuity of care to lesbian, gay, bisexual, transgender, queer, and other sexual and gender minority communities and enhancing system-level resilience. Through embracing integration as a management and finance strategy as opposed to an ideological standpoint, health systems are able to manage the risk where it manifests itself most and create long-lasting value in the face of uncertainty.

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