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Whole Child Care

The Solution to Costly Fragmentation

Dane Block, Jr. | Archē Partners
Co-Founder & Managing Partner

THE BURDEN

The Cost Is Enormous, and Climbing on Both Ledgers.

Neurodevelopmental disability is now among the most prevalent and most expensive conditions of childhood. One in 31 U.S. children carries an autism diagnosis and one in six has a developmental disability. Yet the dollars attached to these conditions are widely misunderstood. The lifetime cost of supporting a single individual with autism is estimated at **\$1.4 million** without co-occurring intellectual disability and **\$2.4 million** with it. At the national level, the annual societal cost of autism was estimated at roughly **\$268 billion** in 2015 and projected to climb toward half a trillion dollars by 2025 in the base case, with upper estimates exceeding \$1 trillion — a forecast, not a measured figure, and one that rising prevalence suggests understates today’s reality rather than overstates it.

Those totals are climbing on *both* sides of the ledger. Direct medical costs are substantial and rising: children with autism incur medical expenditures roughly **four to six times** those of their peers, driven by higher rates of hospitalization, emergency care, and prescription use. Alongside them sit even larger indirect costs — special education, adult residential care, and the lost earnings of parents, whose mothers earn an estimated **56% less** than mothers of children with no health limitation and whose families earn roughly **28% less**. No single provider directly controls those indirect costs. But they are not fixed, either. They are *influenced* — bent upward or downward — by whether a child’s care is early, coordinated, and whole. Proper whole-child care is the lever. It cannot erase the bill, but it can change its trajectory across both ledgers.

1 in 31 U.S. children with an autism diagnosis (CDC, 2025)	\$1.4–2.4M estimated lifetime cost per individual, without / with intellectual disability	56% lower earnings among mothers of children with autism	4–6× higher medical costs for children with autism vs. peers (Shimabukuro et al.)
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THE LEVER WE HAVE

Direct medical costs are large and rising; indirect costs are larger still and outside any one provider’s control. Neither is fixed. Early, coordinated, whole-child care is the lever that influences both — the difference between a bill that compounds and one that bends.

• Buescher et al., JAMA Pediatrics (2014, 2011 USD) • Shimabukuro, Grosse & Rice, J. Autism Dev. Disord. (2008) • Cidav et al., Pediatrics (2012) • Leigh & Du (2015, forecast) • CDC / ADDM (2025)

THE REFRAME

A Diagnosis Is Not One Condition. It Is Many.

The prevailing model treats a neurodevelopmental diagnosis as a single condition addressed by a single dominant therapy. The clinical reality is different. Autism and related neurodevelopmental conditions are better understood as an intermingled set of comorbidities that a child develops and carries over time — medical, behavioral, and developmental problems that compound one another. Roughly **40%** of children with autism have co-occurring intellectual disability, with another quarter in the borderline range. Nearly **half** experience gastrointestinal symptoms. Between **50% and 80%** have disrupted sleep. About **one in ten** develops epilepsy. Roughly **28%** meet criteria for ADHD and **20%** for an anxiety disorder, and feeding difficulties and motor-coordination problems are common. These are not footnotes to a diagnosis. Lived day to day, they *are* the diagnosis.

And they are routinely missed. Sleep disturbance is present in a majority of children with autism but formally diagnosed in a minority. The pain of untreated reflux or constipation, or the disorientation of an unrecognized seizure, is frequently recorded as “behavior” — a failure clinicians call **diagnostic overshadowing**. When the underlying

medical driver is invisible, the system responds to the surface behavior and never reaches the cause. A child does not outgrow an untreated comorbidity. They accumulate the consequences of it.

~40% co-occurring intellectual disability (CDC ADDM, 2025)	~49% experience gastrointestinal symptoms (Wang et al., 2022)	50–80% experience sleep disturbance	~28% meet criteria for ADHD (Lai et al., 2019)
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DIAGNOSTIC OVERSHADOWING

When a child’s hunger, pain, or seizure is mislabeled as “behavior,” the system treats the symptom and misses the cause. The comorbidities driving a child’s presentation are precisely the ones a single-modality model is built not to see.

• CDC MMWR / ADDM Network (2025) · Wang et al., Front. Psychiatry (2022) · Liu et al., Autism (2022) · Lai et al., Lancet Psychiatry (2019)

THE COST OF FRAGMENTATION

Untreated Comorbidity Does Not Disappear. It Compounds.

When the whole child is not treated, the unaddressed problems do not resolve. They escalate into the most expensive settings in the system. Consider the default response to difficult behavior: medication. Among young children with autism who are prescribed a psychotropic, roughly **60% never received behavioral therapy at all**. Nearly half of Medicaid-enrolled youth with autism are on at least one psychotropic in a given year, and about **one in five of those medicated** take two or more psychotropic medications at once. Medication has a legitimate role, but too often it substitutes for addressing the sleep, feeding, gastrointestinal, or communication problem driving the behavior in the first place.

The endpoint of that substitution is crisis care. Autism-related visits as a share of all pediatric emergency-department visits **rose roughly 50%** between 2016 and 2021, and a large share are driven by challenging behavior rather than medical emergency. Psychiatric emergency visits, boarding, and inpatient stays are among the costliest events in pediatric care — and many are preventable, the downstream product of comorbidities left unmanaged upstream. Poor sleep worsens aggression, self-injury, and inattention; untreated gastrointestinal pain intensifies distress; unaddressed communication deficits produce the very behaviors that trigger placement. Skipping whole-child care does not save money. It defers the cost, and it raises it.

~60% of medicated young children never received behavior therapy first	~1 in 5 of medicated youth with autism on concurrent psychotropic polypharmacy	~50% rise in autism’s share of pediatric ED visits, 2016–2021	Preventable much crisis-driven spend traces to untreated comorbidity
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THE SUBSTITUTION TRAP

Reaching for medication instead of the underlying driver converts a treatable comorbidity into years of escalating, crisis-driven spend. Fragmented care is not cheaper care — it is deferred, compounded, and ultimately more expensive care.

• Wiggins et al., J. Pediatrics / CDC (2021) · Rast et al., J. Autism Dev. Disord. (2023) · Trivedi et al., NHAMCS analysis (2024)

THE DISTINCTION

Comprehensive Is Not the Same as More.

There is a legitimate objection to any argument for additional services. The pediatric behavioral health sector has just lived through a decade of volume growth — applied

behavior analysis visits alone rose **267%** between 2019 and 2024 — that outpaced any reasonable estimate of clinical need and provoked the rate cuts, audits, and hour caps now reshaping the market. A call for “comprehensive care” that simply stacks more billable disciplines onto every child would repeat exactly that mistake, and payors would be right to reject it.

The distinction is **dosing and fit**. The most rigorous recent evidence finds that more hours do not produce better outcomes. A 2024 meta-analysis of 144 studies and more than 9,000 children found **no significant dose-response relationship between the amount of intervention delivered and the outcomes achieved**. The Department of Defense’s own evaluations of its TRICARE Autism Care Demonstration point the same way: the number of ABA hours delivered did not predict improvement on the program’s primary outcome measure, average symptom change was small and often sub-clinical, and what improvement did occur concentrated among the most severely affected children at baseline and the families with the highest treatment-plan adherence. Meanwhile, parent-mediated and group-based models achieve meaningful gains at a fraction of the cost of high-hour, one-to-one therapy.

The conclusion is not “more.” It is “right.” Whole-child care means treating the comorbidities that are actually present, at the intensity each child actually needs — and no more than that.

SELECTIVE, NOT MAXIMAL

Selective behavioral therapy means matching each child to a personalized plan — often fewer hours, often delivered in group settings — rather than fitting every child to the same forty-hour prescription. Not every child benefits from ABA in the same way or to the same degree, and the evidence no longer supports pretending otherwise. Personalization is not a softening of the model. It is the model.

• Sandbank et al., JAMA Pediatrics (2024) · U.S. Dept. of Defense, TRICARE Autism Care Demonstration Annual Report · Cheng et al., J. Autism Dev. Disord. (2023) · Trilliant Health (2025)

CARE THAT COMPOUNDS

Four Pillars — and the Proof They Require.

A whole-child model has a recognizable shape, and four pillars define it. It is **coordinated** — beginning with early assessment across disciplines (speech and language, occupational and physical therapy, feeding, sleep, gastrointestinal health, and behavioral support) so the comorbidities driving a child’s presentation are identified rather than overshadowed. It is **dosed** — intensity matched to need, favoring parent-mediated and group delivery where the evidence supports it, and de-prescribing as readily as prescribing. It is **caregiver-integrated** — building the parent in as the between-session engine that makes gains generalize and hold, a mechanism parent-implemented intervention has shown to produce meaningful outcomes across dozens of studies; the operational framework for delivering this at scale is the Caregiver Optimization Model™, developed by Melissa Kozak, BCBA, an Archē Network member. And it is **measured** — outcomes-gated, so services that are not producing progress are changed or stopped, not renewed by default.

Each discipline already shows the logic at the unit level: behavioral sleep intervention is cost-effective and reduces medication use, intensive feeding therapy is a cost-effective alternative to long-term tube dependence, and earlier coordinated intervention is associated with better educational outcomes and less reliance on special education. But intellectual honesty requires naming the gap. The claim that comprehensive care lowers the *total* cost of care is well-supported in its mechanism and in its parts, yet it has not been proven at whole-population scale in a rigorous controlled trial. That is precisely why measurement is not optional. The value of whole-child care is realized only when it is delivered as an outcomes-driven system that can prove — child by child, discipline by discipline — that the right care, correctly dosed, improves function while avoiding

the crises and lifetime costs that fragmentation makes near-certain. This is **care that compounds**: each coordinated intervention raising the value of the others, so that the whole is worth more than the sum of the visits.

Coordinated	Dosed	Caregiver	Measured
one assessment across every relevant discipline, not siloed referrals	intensity matched to need; de-prescribe when progress stalls	integrated as the between-session engine (Kozak, Caregiver Optimization Model™)	outcomes-gated services that must earn renewal

THE CASE, AND THE CAVEAT

The economics favor whole-child care through avoided crises and recovered family productivity, where the evidence is strongest — and external estimates suggest a large share of neurological-care cost (on the order of £30 billion a year in the UK, across neurological conditions broadly) could be mitigated through better-coordinated delivery of existing care. Proving total-cost-of-care savings at population scale is the work still to be done — and the reason measurement must be built into the model from the first day, not bolted on to satisfy a payor later.

• Cheng et al., J. Autism Dev. Disord. (2023) · Kozak, M., Caregiver Optimization Model™ (2026) · Engel et al., Sleeping Sound CEA (2024) · Williams et al. (2007) · Dimian et al. (2021) · Economist Impact / Neurological Alliance (2024)

WHY ARCHĒ

Better Care and a Better Business Are the Same Bet.

Archē Partners invests directly in the care delivery itself — not only the infrastructure around it — backing models that create greater value than any single visit can. The fragmentation of neurodevelopmental care is not only a clinical failure; it is one of the market's largest unpriced inefficiencies, a system paying premium, downstream, crisis-driven prices for the predictable consequences of care it declined to coordinate upstream. The providers who organize care around the whole child — early, personalized, correctly dosed, caregiver-integrated, and measured — will convert that inefficiency into durable clinical and economic value.

We have spent a combined 15+ years working with founders and operators in multi-site healthcare services and medical technologies, executing transformational growth through inflection points. Across 85+ healthcare transactions as investors in equity and credit, we know what institutional buyers value: scaled leadership, clean financials, defensible economics, and a tangible growth story that outcomes data can substantiate. Whole-child care, delivered as an outcomes-driven system, produces exactly the evidence the next generation of payor contracts will require — and exactly the enterprise value the next generation of buyers will pay for. That alignment, between better care and a better business, is the thesis.

THE INVESTMENT THESIS

Pediatric neurodevelopmental care is fragmented, under-measured, and entering a proof-of-outcomes era that will separate the platforms worth owning from those that will not survive the transition. The most durable returns come from backing the whole-child, outcomes-driven model before consolidation prices it in.

Behavioral health's greatest challenges are not clinical — they are operational. The organizations that will define the next era are those that deliver breakthrough gains in operational efficiency and clinical throughput, while building care systems that adapt to the individual rather than forcing the individual to adapt to the system. This demands more than capital. It requires strategic partnership that has experienced the operational realities firsthand and possess both the insight, resolve and operating network to solve them at scale. Operational execution centered on whole-child care is how a fragmented, costly model becomes one defined by early action, measurable outcomes, and genuine personalization. The builders who seize it will deliver lasting impact and enduring value.



The Strategic Partner for the Builder

Dane Block, Jr. | dane@archepartnersgroup.com · Jack Beardslee | jack@archepartnersgroup.com

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