

2026 Population Health Assessment

Partners Health Management

CY2025



Population Health Department

February 2026

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Executive Summary

Partners Health Management (Partners) is committed to understanding the health needs of the populations we serve. Partners systematically collects, integrates, and assesses member data to inform its population health management initiatives. The 2026 Population Health Assessment covers calendar year (CY) 2025 data for approximately 120,000 unique members across 15 catchment counties in North Carolina. The assessment examines member demographics, social drivers of health, clinical outcomes, service utilization, and the impact of prevention and population health programs. Key findings are summarized below to guide strategic planning and population health initiatives for the coming year.

Key findings from the 2026 Assessment include:

- **Health Equity**
 - Tailored Care Management (TCM) engagement rates varied by race and gender: Black/African American members had slightly higher engagement (66.9%) compared to White members (59.4%), while female members had lower engagement (60.3%) than male members (63.6%).
 - Among members with 7 or more behavioral health inpatient admissions, Black/African American members comprised 32.6% of this high-utilization group compared to comprising only 23.4% of all members with any hospitalization - a statistically significant disparity ($p=0.038$) that may indicate a racial health equity gap.
 - About 11% of Tailored Plan members are Hispanic, yet language data remains unknown for nearly 29% of all members, limiting the ability to fully assess language-related disparities.
 - A disproportionate number of Hispanic members comprise the Innovations Waitlist (8.6%) compared to the proportion of Hispanic members with the Innovations Waiver (3.6%).
- **Social Drivers of Health (SDOH)**
 - A total of 10,108 fully completed SDOH assessments were collected in CY2025, with the majority submitted through Daymark and Monarch providers via the standalone SDOH assessment tool.
 - For the first time, food-related needs (Food Worry and Food Lasting) appeared in the top 3 needs for every catchment county — a notable shift from prior years.
 - The top three SDOH needs across all assessments were Food Worry, Food Lasting, and Transportation; among initial assessments, Employment replaced Transportation in the third position.
 - Over half (51.2%) of Pyx Health members who completed loneliness screening (UCLA-3) scored as lonely, underscoring the burden of social isolation among the member population.
- **Health Outcomes**
 - Childhood immunization rates are below the 95% herd immunity threshold for MMR across both Medicaid Direct (83.1%) and Tailored Plan (70.3%) members — a concern given the current measles outbreak nationally.
 - The most common psychological diagnoses in the total population are Other Anxiety Disorders (28.0%), Nicotine Dependence (19.9%), and Major Depressive Disorder, Recurrent (17.9%).
 - The most common physical health conditions are Essential Hypertension (30.9%), Disorders of Lipoprotein Metabolism (high cholesterol; 26.6%), Gastro-esophageal Reflux Disease (GERD; 18.3%), and Type 2 Diabetes (17.2%).
 - Tailored Plan inpatient readmission rates (all cause) were 32% higher than expected (Plan All Cause Readmission/NCQA; observed/expected ratio: 1.32), signaling continued opportunity to improve care transitions and post-discharge follow-up.

- **Service Utilization and Costs**

- Total cost of care for the Tailored Plan population in CY2025 was \$1.58 billion (\$2,735 PMPM); total Medicaid population cost was \$2.76 billion (\$2,290 PMPM).
- Research-Based Behavioral Health Treatment (RB-BHT) was the highest cost category of service at \$148.7 million (13.7% of total expenditures).
- Hydroxyzine Hydrochloride, an antihistamine commonly used off-label to manage anxiety, appeared consistently in the top 5 most prescribed medications.
- Only 3.3% of eligible members (3,934 of ~120,000) were enrolled in the Pyx Health app as of year-end, with 998 active users and 18,367 interactions during CY2025.

- **Community Health Indicators**

- The Innovations waiver waitlist includes 5,465 members with an average wait of 6.8 years across the catchment, with Forsyth County members waiting an average of 7.8 years.
- Mental health, substance use, and chronic disease are among the most common priorities identified in local Community Health Assessments (CHAs) across all 15 catchment counties.
- Drug-related death rates across Partners' catchment counties average 11% above the state rate, with Rutherford and Davidson exceeding 1.5 times the state average, and all counties except Cabarrus showing increased rates compared to 2024.
- Adult smoking rates average 16% across the catchment, consistent with state rates, with Cleveland (21%) and Davidson (21%) counties at the high end.
- Food insecurity rates in catchment counties range from 11-18%, with Burke (17%) and Rutherford (18%) counties among the highest. Several counties also report significant rates of limited access to healthy food.

- **Impact of Prevention and Population Health Programs**

- Breast Cancer Screening: Tailored Plan compliance reached 43.47%, approaching the 47% MY25 goal, reflecting meaningful progress from the 36.01% baseline since the program launched in July 2025.
- Prenatal and Postpartum Care (PPC): Both Medicaid Direct and Tailored Plan members surpassed the 50% compliance target for both timeliness of prenatal care (56.7% and 50.3%) and postpartum care (66.4% and 57.4%).
- Tobacco Cessation: 215 Tailored Plan members enrolled in the QuitLine NC/Quit for Life program in CY2025, with member interactions peaking in Q3. Use of paid tobacco cessation services declined slightly over the year.
- Chronic Condition Management of Diabetes: Of 13 program completers, 72% were compliant with the HbA1c monitoring measure (GSD) and 69.2% demonstrated improvement in knowledge of diabetes management.
- Chronic Condition Management of Asthma: Of 3 program completers with 6-month follow-up data, 100% experienced a decrease in ED risk score; 72.7% demonstrated improvement in asthma management.
- Medication Assisted Treatment (MAT): The number of unique members receiving MAT increased to 4,275 in CY2025, surpassing the target of 4,268. The MAT provider network grew from 38 to 47 providers during the year.
- Follow-up After Hospitalization: Tailored Plan follow-up after hospitalization for mental illness (30-day: 67.02%; 7-day: 44.57%) reflect overall improvement and exceed state goals (30-day: 45.00%; 7-day: 26.00%), while the plan all-cause readmission observed/expected ratio of 1.32 indicates elevated readmission risk.

- Intensive Care Management (ICM) for Complex Needs: The HEDIS Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) compliance rate for Tailored Plan members was 25.0%, surpassing the 24.8% target.
- **Highlighted Areas for Improvement**
 - Childhood Immunization Rates: MMR vaccination rates (83.1% Medicaid Direct; 70.3% Tailored Plan) are below the 95% herd immunity threshold and could benefit from targeted outreach, particularly given the current measles outbreak.
 - The plan all-cause readmission observed/expected ratio of 1.32 indicates elevated readmission risk.
 - Health Equity for High-Frequency Utilizers: The statistically significant over-representation of Black/African American members among those with 7+ behavioral health hospitalizations requires a focused, equity-centered care management response.
 - Food Security: The emergence of food-related needs as the top unmet need across all catchment counties for the first time signals an urgent need to strengthen food resource referral pathways and community partnerships.
 - Drug-related death rates across Partners' catchment counties average 11% above the state rate, with Rutherford and Davidson exceeding 1.5 times the state average, and all counties except Cabarrus showing increased rates compared to 2024.

The value of an in-depth population health assessment is more than understanding and identifying strategies to improve clinical outcomes and services for our members and recipients. The population assessment process is a tool to engage stakeholders, encourage leadership, and aid communities to secure resources to improve the health of populations. Partners will annually expand on each population health assessment to ensure we improve lives and strengthen communities through the Partners' population health initiatives.

Introduction

This population health assessment includes four main sections: Demographics, Member Populations, Service Utilization, and State and Local Priorities.

[Demographics](#) provides a snapshot of the demographics of our population and a summary of our Social Drivers of Health Assessment. [Appendix A](#) includes demographics and related health information for our catchment counties.

Within the [Member Populations](#) section, we report demographics, key health indicators, and population health program data for select member subpopulations:

- Members eligible for breast cancer screening
- Pregnancy
- Members with nicotine dependence
- Members with diabetes
- Members with asthma
- Members at risk of opioid misuse or overdose
- Members hospitalized for mental health diagnoses
- Members with complex needs
- Children and adolescents
- Members with HIV/AIDS
- Members with intellectual and developmental disabilities
- Members with hearing loss

[Utilization Information](#) describes the services used by our members and has data for the following subcategories:

- Pyx Health
- Tailored Care Management Engagement
- Total cost of care
- Utilization by facility type
- Primary discharge diagnoses
- Benefit plan and service cost trends
- Pharmacy utilization

[State and Local Priorities](#) highlights relevant state and county-level goals and initiatives which provide the opportunity to align with existing infrastructure and programs.

HEDIS measures related to subpopulations and prevention and population health programs are reported for calendar year 2025 using estimates from CareSeed, unless otherwise noted. These numbers are preliminary and subject to change due to claims lag and additional reporting. The full HEDIS measure report will be released later this year. Estimates reported in the Population Health Assessment should be used with caution.

The Partners 2025 Population Health Assessment includes data collected Jan 1, 2025 – December 31, 2025, for approximately 120,000 unique members from the following sources: medical and behavioral claims or encounters, pharmacy claims, health appraisal results, electronic health records, health services programs and advanced data sources. Each table or figure will include the source of the data.

The [Glossary/Abbreviations](#) section contains definitions and description of acronyms.

Demographics

Member Demographics

Table 1 shows sex, age, race, and ethnicity for all members/recipients, those with Medicaid Direct, those on the Tailored Plan, and State funded recipients. Females make up half our total membership and are in the majority of those receiving Medicaid Direct. Most Tailored Plan members and State Funded recipients are male. About half of all members and almost 85% of State Funded recipients are between the ages 21-64 years. Partners members are majority White and non-Hispanic. About a quarter of all members are Black. Race is unknown for fewer than 5% of all members; ethnicity is unknown for less than 3% of all members. About 10% of Tailored Plan members are Hispanic. Language data is collected upon enrollment. Data may be missing if the data was not requested or the member refused to share the information. Care managers may update member language data in Alpha. Missing language data restricts our ability to examine potential disparities related to language. Almost all (94.1%) members reside in Partners' catchment area. Please note that total population numbers may vary somewhat depending on when the data was accessed and from which source. Population numbers are dependent on the daily census.

Table 1. Member Demographics by Payor

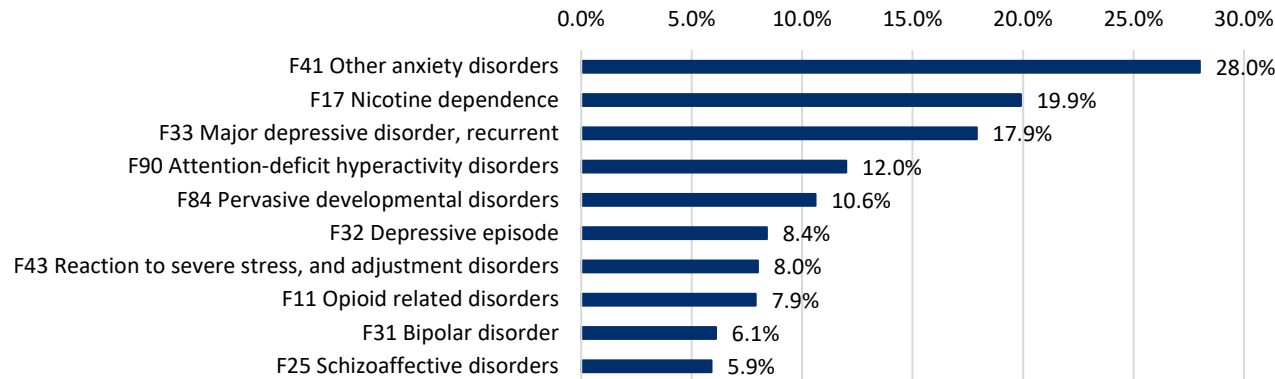
Member Population	All n=118,935	Medicaid Direct n=59,010	Tailored Plan n=53,545	State Funded n=6,380
Plan Type, %				
Medicaid Direct	49.9	99.9	0.0	0.0
Tailored Plan	42.6	0.0	96.0	0.0
Innovations	1.8	0.02	3.98	0.0
State Funded	5.7	0.0	0.0	100.0
Sex, %				
Female	50.9	58.9	43.3	39.9
Male	49.1	41.1	56.7	60.1
Age Groups, %				
0-20 years	24.8	5.1	49.1	8.0
21-64 years	49.1	43.6	50.7	84.8
65+ years	26.1	51.3	0.3	7.2
Language, %				
English	60.5	49.7	68.9	89.5
Spanish	2.0	1.6	2.4	1.6
French	0.01	0.01	0.01	0.0
Sign Language	0.02	0.02	0.02	0.1
Other	0.02	0.01	0.02	0.04
Unknown	37.5	48.6	28.6	8.8
Race, %				
AI/NA	0.6	0.8	0.4	0.3

Asian	1.9	2.7	1.2	0.9
Black	29.0	30.0	28.9	20.6
Multiracial	0.1	0.0	0.0	0.1
PI	0.1	0.2	0.1	0.1
White	63.8	61.6	64.8	75.7
Other	0.1	0.0	0.0	0.8
Unknown	4.5	4.7	4.6	0.47
Ethnicity, %				
Hispanic	8.9	7.2	11.0	6.9
Non-Hispanic	88.8	89.6	87.3	92.9
Unknown	2.4	3.2	1.7	0.3
Live within catchment area, yes, %	94.1	93.9	94.1	95.72

Source: HBI, 1-01-26 refresh, retrieved on 2/18/26

Member Diagnoses

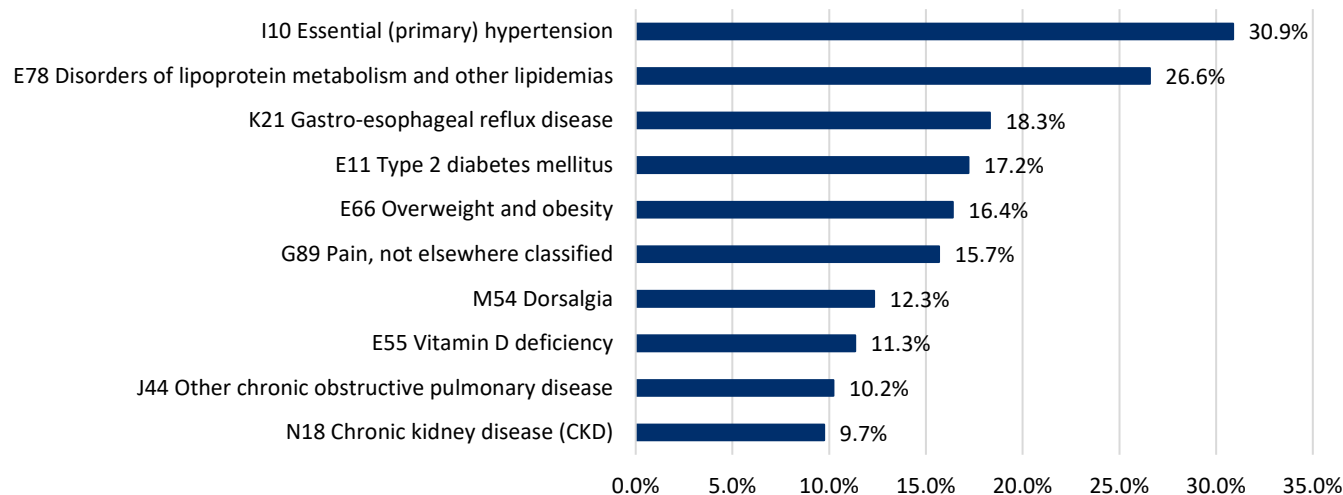
Figure 1. Top 10 Chronic Psychological Disorders for Total Population (n=124,771)



Source: HBI, refreshed on 12/1/2025, retrieved on 1/19/2026

Figure 1 displays the 10 most common psychological disorders among our total population. Over a quarter of our members have F41 Other anxiety disorders, and approximately 1 in 5 members is diagnosed with F17 Nicotine Dependence.

Figure 2. Top 10 Chronic Physical Health Conditions for Total Population (n=123,137)



Source: HBI, refreshed on 12/1/2025, retrieved on 1/19/2026

Figure 2 contains information regarding the most common physical health conditions among our total population. Almost 1 in 3 members has hypertension and about 1 in 4 members has high cholesterol.

Member Location

Table 2 shows the distribution of our members by county of residence. As shown in Table 4, the counties (catchment only) with the highest number of residing members are Forsyth and Gaston.

Table 3 displays the county of eligibility data by each member population. The counties of eligibility with the most members for every population are Forsyth and Gaston counties. The counties with the lowest numbers of residing and eligible numbers were Yadkin and Davie.

Table 2. County of Residence by Member Population, Catchment Counties Only

County	All n=118,935	Medicaid Direct n=59,010	Tailored Plan n=53,545	State Funded n=6,380
Burke	5,230	2,571	2,393	266
Cabarrus	8,554	3,913	4,158	483
Catawba	9,084	4,268	4,192	328
Cleveland	7,365	3,643	3,371	351
Davidson	8,474	4,245	3,841	388
Davie	2,018	1,006	855	1157
Forsyth	21,967	11,443	9,452	1,072
Gaston	14,374	6,528	7,132	714
Iredell	7,852	3,699	3,600	553
Lincoln	4,180	2,051	1,967	126
Rutherford	5,035	2,633	2,172	230
Stanly	3,735	1,755	1,665	315
Surry	4,702	2,767	1,693	242
Union	7,790	4,007	3,337	446
Yadkin	2,028	1,050	859	119
Total	112,388	55,579	50,687	6,122

Note: The totals do not reflect the total n for each category as some members live outside of the catchment area.

Source: HBI, 1-1-26 refresh, retrieved on 2/18/26, Catchment Counties Only

Table 3. County of Eligibility by Member Population, Catchment Counties Only

County	All n=118,935	Medicaid Direct n=59,010	Tailored Plan n=53,545	State Funded n=6,380
Burke	6,014	2,959	2,763	292
Cabarrus	9,404	4,306	4,582	516
Catawba	9,142	4,350	4,167	625
Cleveland	7,576	3,864	3,354	358
Davidson	9,992	5,034	4,538	420
Davie	2,003	974	868	161
Forsyth	22,691	11,921	9,627	1,045
Gaston	15,188	6,823	7,627	738
Iredell	8,414	4,022	3,826	566
Lincoln	4,075	1,974	1,932	169
Rutherford	5,020	2,640	2,157	223
Stanly	3,855	1,832	1,708	315
Surry	4,782	2,832	1,717	233
Union	8,443	4,345	3,651	447
Yadkin	2,075	1,066	883	126
Total	118,674	58,942	53,498	6,234

Note: The totals do not reflect the total n for each category as some members have eligibility outside of the catchment area

Source: HBI, 1-1-26 refresh, retrieved on 2/18/26, Catchment Counties Only

Table 4. Catchment County Population and Member Prevalence

County	County Population	Members with Partners County of Eligibility		Members with Partners County of Residence	
		n	% of county population	n	% of county population
Burke	89,572	6,014	6.71%	5,230	5.84%
Cabarrus	242,585	9,404	3.88%	8,554	3.53%
Catawba	168,248	9,142	5.43%	9,084	5.40%
Cleveland	99,774	7,576	7.59%	7,365	7.38%
Davidson	178,391	9,992	5.60%	8,474	4.75%
Davie	44,780	2,003	4.47%	2,018	4.51%
Forsyth	399,059	22,691	5.69%	21,967	5.50%
Gaston	244,800	15,188	6.20%	14,374	5.87%
Iredell	207,823	8,414	4.05%	7,852	3.78%
Lincoln	96,207	4,075	4.24%	4,180	4.34%
Rutherford	64,827	5,020	7.74%	5,035	7.77%
Stanly	66,665	3,855	5.78%	3,735	5.60%
Surry	71,360	4,782	6.70%	4,702	6.59%
Union	266,672	8,443	3.17%	7,790	2.92%
Yadkin	37,995	2,075	5.46%	2,028	5.34%
Total	2,278,758	118,674	5.21%	112,388	4.93%

Sources: 2024 Certified County Population Estimates, NC Office of State Budget and Management; HBI, 1-1-26 refresh, retrieved on 2/18/26, Catchment Counties Only

Table 4 shows, for each catchment county: the total population, the number of Partners members who are eligible and reside there, and each county's membership rate as a percent of its total population. Member population totals are not equal as members may have eligibility or residence outside our catchment area.

Forsyth and Gaston counties account for the largest number of Partners members, consistent with these counties having the largest populations in Partners' catchment. Of note, Rutherford and Cleveland counties have the highest prevalence of Partners' membership relative to the county population, indicating higher prevalence of need in those counties. Over 7.5% of the population in both Rutherford and Cleveland counties are Partner's members.

Social Drivers of Health (SDOH)

The Social Drivers of Health (formerly Social *Determinants* of Health) summary is based on data collected by Partners and providers between January 1 and December 31, 2025. We use the term *drivers* in lieu of *determinants* to shift our focus from fixed, unchangeable conditions to factors that can be addressed and changed through intervention. Use of *drivers* is in line with *Healthy North Carolina 2030: A Path Toward Health* published by the North Carolina Institute of Medicine.

We include the summary below with accompanying tables and figures. The SDOH data presented below is based on a convenience sample and is not reflective of all Partners' members and providers or representative of any subpopulation. Only completed assessments were included. Completed assessments were any assessments that had a yes or no answer to all the assessment questions. Answers of N/A or Member declined were excluded.

We collected 10,108 (8.5% of Partners' member population) fully completed assessments through three different channels: submitted by Provider through the SDOH form (PROMS), submitted by providers using an EHR connection to TruCare or collected/completed by care managers in TruCare. Assessments completed within TruCare included the SDOH section of the Care Management Comprehensive Assessment (CMCA), the SDOH section of the Care Needs Screening (CNS) or any of the standalone SDOH assessment (Figure 3). Of the fully completed assessments, 6,613 were identified as initial assessments for the members. Over 6,000 assessments were identified as Medicaid and included a Medicaid ID on the assessment. Of those assessments identified as Medicaid, there were 4,942 unique Medicaid IDs. The number of state funded members with assessments increased by 350% - to 2,434 assessments identified as state funded compared to 539 in CY24. There were also 686 assessments that were not identified as Medicaid or State. Of the fully completed assessments, 9,877 came from TruCare with the greatest number of assessments coming from the standalone SDOH assessments. Of the 6,079 standalone SDOH assessments, 6,019 were identified as being from the application programming interface (API), indicating that they were completed by Daymark or Monarch while 60 standalone SDOH assessments were identified as being completed by a care manager or other Partners staff. Additionally, SDOH data from the CMCA and CNS were included this year and accounted for 35% of all completed assessments. Of the 6,811 SDOH assessments included as part of CMCA or CNSs, 3,221 were determined "incomplete" and excluded due to missing data (Figure 4). Missing data included "n/a," "member declined to respond," and unanswered questions. Questions about food and safety were most frequently declined or left blank.

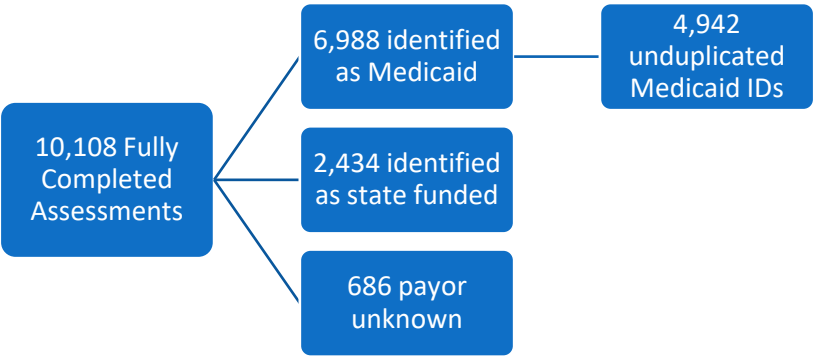
Potential strategies to increase % of population completing SDOH assessment collection include:

- Targeted systems integrations with currently available data: health providers and external TCM providers are completing assessments that are not ingested into Partners' systems.
- Partnership with primary care physicians to complete SDOH assessments during office visits and upload to Partners via interoperability interface.
- Development of a Partners' mobile phone application that will enable members to complete SDOH assessment via their mobile devices.

The highest number of assessments were of members residing in Forsyth and Gaston Counties while Rutherford and Davie Counties had the least number of assessments. Over 14% of all assessments were from Forsyth County. Food Worry and Food Lasting were in the top needs for all catchment counties. The other

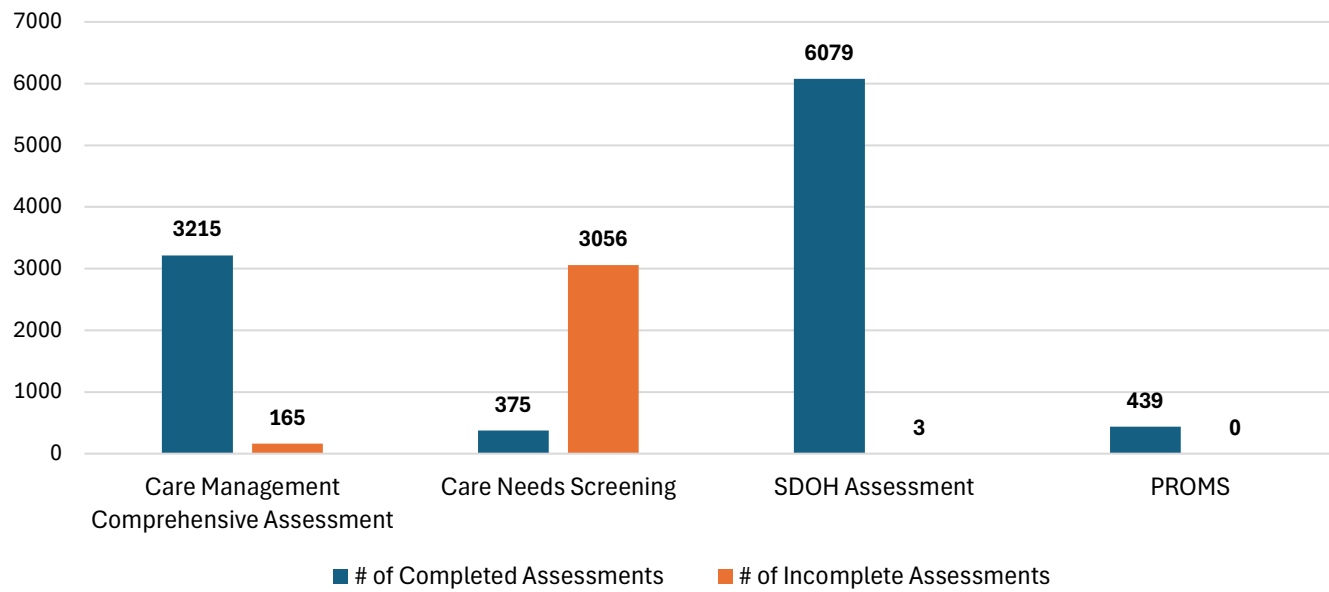
top needs included transportation, employment, insurance, medication and housing. This is the first time that Food Worry and Food Lasting have appeared in the top needs for all counties. The needs are similar across all catchment counties with Food related needs appearing in the top 3 needs for all counties.

Figure 3. SDOH Assessment Member Breakdown by Payor



Source: SDOH Assessments from TruCare and Proms 1/1/25-12/31/25

Figure 4. Comparison of Assessment Source and Completeness



Source: SDOH Assessments from TruCare and Proms 1/1/25-12/31/25

Table 5. Assessments Completed by County of Residence

	# of Assessments per county	County	Total # of Assessments
Catchment Counties	1,444	Forsyth	1,444
	1,069	Gaston	1,069
	973	Union	973
	928	Cleveland	928
	907	Stanly	907
	884	Cabarrus	884
	617	Iredell	617
	516	Davidson	516
	499	Catawba	499
	499	Burke	499
	457	Surry	457
	304	Lincoln	304
	239	Yadkin	239
	228	Rutherford	228
	210	Davie	210
	82	Mecklenburg	82
	46	No County	46
	31	Rowan	31
	22	Guilford	22
	17	Stokes	17
	≤15	Wake, Montgomery, Anson, Harnett, Wilkes, Randolph, Alexander, Out of State, McDowell, Brunswick, Buncombe, Caldwell, Richmond, Rockingham, Lee, Alamance, Avery, Wilson, Watauga, Cumberland, New Hanover, Madison, Orange, Granville, Pamlico, Johnson, Polk, Carteret, Durham, Lenoir	136
Grand Total			10,108

Source: SDOH Assessments from TruCare and Proms 1/1/25-12/31/2025

Table 6. Top 3 Needs Across all Counties

	All Assessments	Initial Only
Need 1	Food Worry	Food Worry
Need 2	Food Lasting	Food Lasting
Need 3	Transportation	Employment

Source: SDOH Assessments from TruCare and Proms 1/1/25-12/31/2025

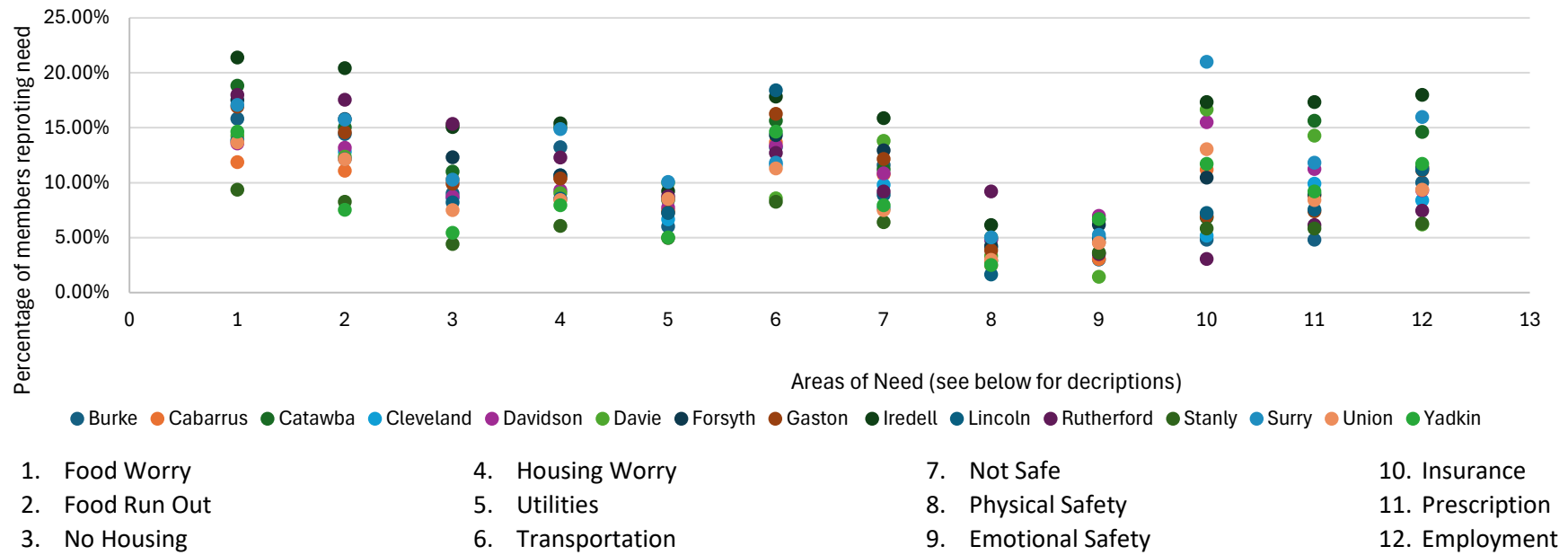
Table 7. Top 3 Reported Needs by County, All Assessments

County (# of assessments)	1	2	3
Burke (n=499)	Food Worry (79)	Food Lasting (72)	Housing Worry/Transportation (66)
Cabarrus (n=884)	Employment (121)	Transportation (121)	Food Worry (105)
Catawba (n=499)	Food Worry (94)	Transportation (78)	Food Lasting/Housing Worry/Employment (75)
Cleveland (n=928)	Food Worry (129)	Food Lasting (119)	Transportation/Employment (108)
Davidson (n=516)	Insurance (80)	Food Worry (70)	Transportation (69)
Davie (n=210)	Insurance (35)	No Housing (32)	Food Worry/Medication (30)
Forsyth (n=1,444)	Food Worry (253)	Food Lasting (228)	Transportation (207)
Gaston (n=1,069)	Food Worry (181)	Transportation (174)	Food Lasting (156)
Iredell (n=617)	Food Worry (132)	Food Lasting (126)	Employment (124)
Lincoln (n=304)	Transportation (56)	Food Worry (42)	Food Lasting (37)
Rutherford (n=228)	Food Worry (41)	Food Lasting (40)	No Housing (35)
Stanly (n=907)	Employment (87)	Food Worry (85)	Food Lasting/Transportation (75)
Surry (n=457)	Insurance (96)	Employment (85)	Food Worry (78)
Union (n=973)	Food Worry (133)	Insurance (127)	Employment (127)
Yadkin (n=239)	Employment (38)	Food Worry (35)	Transportation (35)

Columns 1, 2, and 3 list the most common reported need for each county.

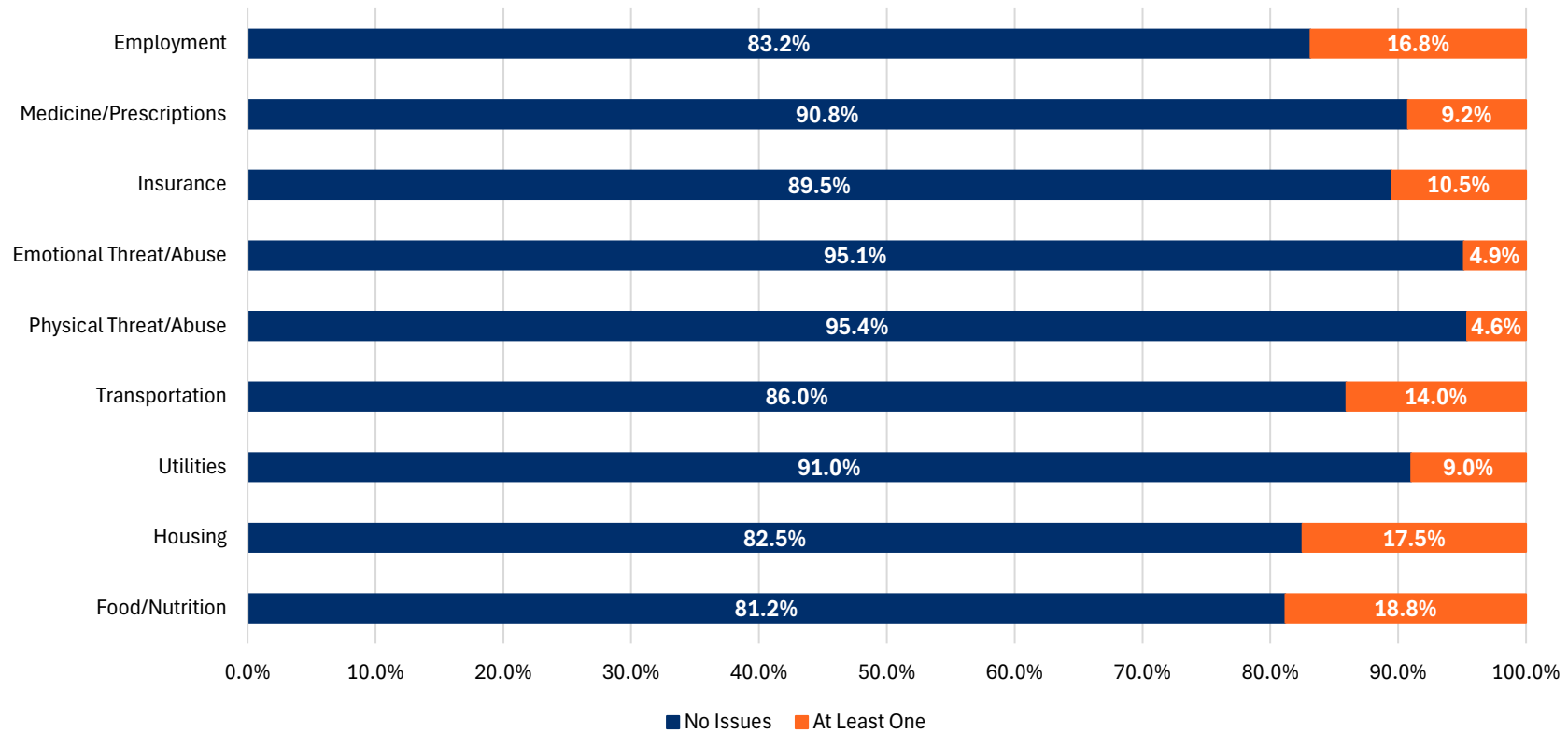
Source: SDOH Assessments from TruCare and Proms 1/1/25-12/31/25

Figure 5. SDOH Needs by County (%) All Assessments



Source: SDOH Assessments from TruCare and Proms 1/1/25-12/31/25

Figure 6. Prevalence of SDOH Needs by Domain (%) Initial Only



Source: SDOH Assessments from TruCare and Proms 1/125-12/31/25

Member Populations

Population Stratification

The Partners Prevention and Population Health Strategy and Plan is the basis for our annual prevention and population health management plan that outlines methods to promote improved health outcomes. The current Strategy and Plan was developed in June 2025 and covers FY26 (July 1, 2025-June 30, 2026). The Population Stratification table below reflects populations included in the FY26 Strategy and Plan (Table 8). The Partners current Strategy and Plan includes interventions for 9 subpopulations, outlined below. Outcomes and measures included in the following subpopulation sections reflect the current Strategy and Plan. Baselines for these measures are based on the data available as of June 2025.

Table 8. Population Stratification (N=118,935)

Population Subset	Eligibility Criteria	Targeted Intervention for Eligible Members	Number of Eligible Members	% of Membership
Women eligible for breast cancer screening	- Tailored Plan - Females - Ages 50-74 years	Breast Cancer Screening Program	1,644	1.4
Pregnant members	- All plans - All ages - Diagnosed with pregnancy	Pregnancy Program	1,301	1.10
Members with nicotine dependence	- All plans - Ages 18 and older - Diagnosed with nicotine dependence	Living Tobacco Free	24,600	20.7
Members with diabetes	- Tailored Plan - Ages 18 and older - Diagnosed with Type 2 Diabetes	Chronic Condition Management for Diabetes	3,019	2.5
Members with asthma	- Tailored Plan - All ages - Diagnosed with asthma - High or Very High risk for Emergency Department visit	Chronic Condition Management for Asthma	1,281	1.1
Members currently using or at risk of opioid misuse/overdose	- All plans - Up to age 64 years - Currently misusing or at high or very high risk for opioid misuse; or at high or very high risk for opioid overdose	Project Reducing Harm from Opioids	14,777	12.4

Members hospitalized for mental health diagnoses	• All plans • Ages 6 and older • Have been hospitalized for mental health diagnosis or intentional self-harm	Follow Up After Hospitalization	6,224	5.2
Members with complex needs	• Tailored Plan • All ages • Have a serious mental illness and/or I/DD • Be at very high risk of inpatient admission and emergency department utilization; • Have two or more chronic physical health conditions; • Are eligible for tailored care management (TCM); • Member or Legally Responsible Person (LRP) consent to Intensive Care Management; • Are assigned to Partners care management • Not currently enrolled in any other program providing care management	Intensive Care Management/ Complex Case Management	222	1.9
No associated data/ No risk factors	Members without risk factors or who do not meet criteria for above programs	• Pyx Health • Online Health and Wellness Information Healthwise Library • Monthly Member Cafe live health education webinars • On-demand member education webinars	84,411	71.0

Percentages in the % of Member Population column total to more than 100% due to some members being eligible for multiple programs.

Members Eligible for Breast Cancer Screening

Breast cancer screening is a critical tool in the fight against breast cancer, as it enables early detection before symptoms appear which significantly improves survival rates and treatment outcomes. Regular screening through mammography and other imaging allows healthcare providers to identify cancer at its most treatable stage, ultimately saving lives and reducing the need for more aggressive interventions. The Partners' Breast Cancer Screening program employs evidence-based interventions to communicate with members about the importance of early detection and screening and assist members in scheduling needed screenings in accordance with federal guidelines.

Tailored Plan, female members aged 50-74 are eligible for the Breast Cancer Screening program launched 7/1/25. Program interventions include reminder messages via postcard, email, or phone; one-to-one education delivered by care manager or health educator; educational information via Partners' website; social medial posts; and provider reminders.

Breast Cancer Screening program outcomes outlined in the FY26 Prevention and Population Health Strategy and Plan:

1. Of female Tailored Plan members ages 50-74 years, 47% will be compliant for recommended breast cancer screening as measured by the HEDIS Breast Cancer Screening measure (BSC-1) by June 30, 2026.

Baseline: 36.01% (MY23)

Target: 47.00%

The HEDIS BCS measure data are in Table 10. Currently, 43.47 Tailored Plan members eligible for breast cancer screening have received their exams.

Table 10. MY25 Breast Cancer-Related Encounter Based HEDIS Measures by Plan Type

Measure	Indicator Name	Plan	Eligible	Compliant	Compliant Rate, %	MY25 State Goal, %
BCS	Breast Cancer Screening	Medicaid Direct	4258	413	9.70	*
		Tailored Plan	649	273	43.47	47.00

*State goals not indicated on CareSeed report

Source: CareSeed, HEDIS MY2025 Jan Prelim Partners, 1/9/26

Table 9. Demographics - Members Eligible for Breast Cancer Screening Program (n=1,644)

Age, years	
Range	50-74
Mean	57.41
Median	57
Language, %	
English	79.1
Spanish	0.3
French	
Sign Language	0.1
Other	0.1
Unknown	20.4
Race, %	
American Indian/Native	0.30
Asian	0.67
Black/African American	27.01
Multiracial	0.00
Pacific Islander	0.00
White	70.62
Unknown	1.40
Ethnicity, %	
Hispanic	2.01
Non-Hispanic	96.35
Unknown	1.64
Reside in catchment area, %	
Yes	94.4

Sources: HBI, refreshed on 12/1/2025, retrieved on 1/19/2026; Reports Manager - Population Demographics

Pregnancy

Partners' Pregnancy Program provides support to members who are pregnant. Early identification and appropriate effective management of pregnancy can reduce or prevent serious complications and can improve outcomes for the member and infant.

The pregnancy program provides support for physical, mental, and social health needs throughout pregnancy and encourages members to seek early and consistent medical treatment throughout their pregnancies. A key component of the Pregnancy Program is the integration of Care Management for High-Risk Pregnancy (CMHRP), a specialized care management program for individuals at increased risk of pregnancy complications. CMHRP is offered through local health departments in North Carolina.

Members from all plans and of all ages, diagnosed with pregnancy are eligible for elements of the pregnancy program. Depending on plan eligibility, members may receive tailored care management, local health department Care Management for High-Risk Pregnancy program, information available via Partners' website, social media posts, community baby shower information and resources, StrongSTART value-added services, Pyx Health App, and Nurse Advice Line/nurse consultants.

HBI uses pregnancy-related claims to identify members who are likely pregnant. Partners uses this report monthly to inform member outreach for the Pregnancy Program. Table 11. provides demographics for members with pregnancy-related claims in CY25. The majority of members with pregnancy-related claims are part of the Tailored Plan (82.9%), under 35 years of age (87.4%), English speakers (61.3%), White (64.7%), non-Hispanic (91.5%) and reside in the catchment area (93.7%).

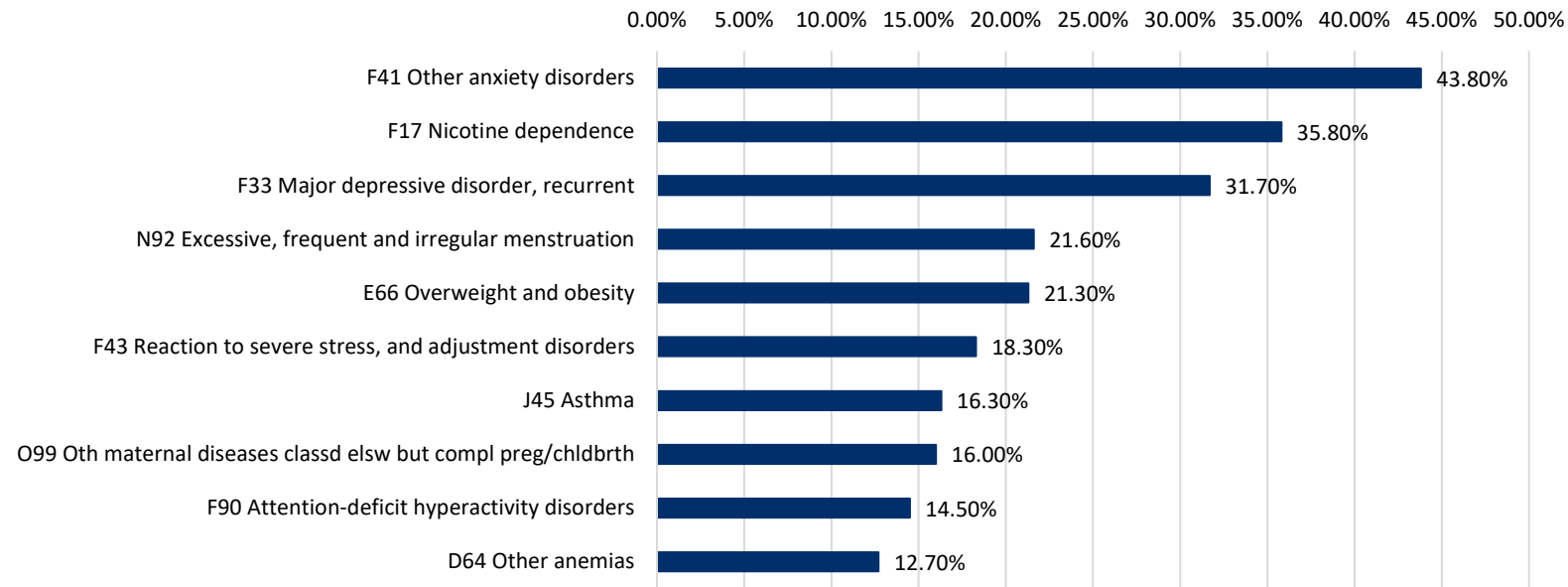
Table 11. Demographics – Members with Pregnancy-Related Claims

Member Population	All n = 1,301	Medicaid Direct n = 206	Tailored Plan n = 1,080	State Funded n = 15
Plan Type, %				
Medicaid Direct	15.8	100.0	0.0	0.0
Tailored Plan	82.9	0.0	99.8	0.0
TP Innovations	0.2	0.0	0.2	0.0
State Funded	1.2	0.0	0.0	100.0
Age Group, %				
12-20 years	23.7	24.3	20.8	20
21-34 years	63.7	61.7	64.0	73.3
35-49 years	12.5	14.1	12.2	6.7
50+ years	0.2	0.0	0.2	0.0
Language, %				
English	61.3	37.9	66.4	13.3
Spanish	1.3	0.5	1.5	0.0
French	0.1	0.0	0.1	0.0
Other	0.1	0.0	0.1	0.0
Unknown	37.3	61.7	31.9	86.7
Race, %				
American Indian/Native				
American	1.2	4.9	0.5	0.0
Asian	0.6	0.5	0.7	0.0
Black/African American	29.9	31.1	29.5	40.0
Pacific Islander	0.2	0.0	0.3	0.0
White	64.7	61.1	65.5	60.0
Unknown	3.4	2.4	3.6	0.0
Ethnicity, %				
Hispanic	7.8	8.3	7.9	0.0
Non-Hispanic	91.5	90.8	91.6	100.0
Unknown	0.5	0.0	0.6	0.0
Reside in catchment area, %				
Yes	93.7	94.7	93.4	100.0

Sources: HBI, refreshed on 12/1/2025, retrieved on 1/19/2026; CCM Program Member Tracker

Figure 7 displays the most common chronic diseases among members with pregnancy-related claims. Over a third have nicotine dependence or an anxiety disorder. The five most common chronic diseases among pregnant members were consistent with findings from CY24. Notably, opioid related disorders were among the 10 most common chronic diseases in CY24 data; this diagnosis was not among the top 10 for CY25.

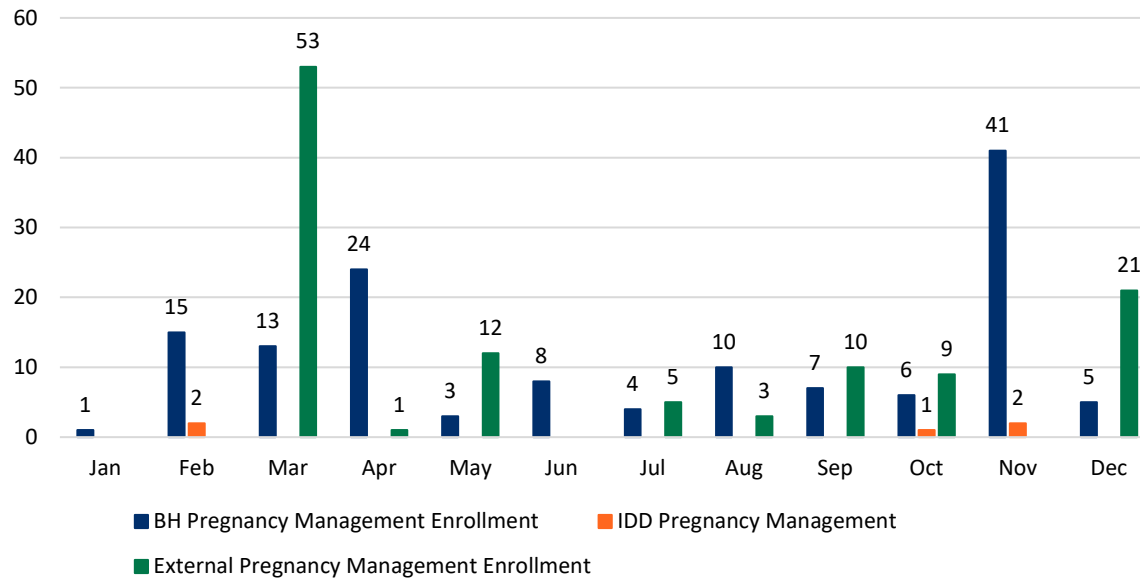
Figure 7. Most Common Chronic Diseases among Pregnant Members



Source: HBI, refreshed on 12/1/2025, retrieved on 1/19/2026

The Pregnancy Programs in TruCare were used to track members with confirmed pregnancy. The TruCare Programs were specific to those receiving Behavioral Health care management from Partners, those receiving Intellectual and Developmental Disability (IDD) care management from Partners, and those receiving care management from external providers. These members were referred to CMHRP and Pyx Health. Throughout CY25, 256 members were enrolled in Pregnancy Programs. Figure 8 shows program enrollment throughout the year.

Figure 8. Pregnancy Program New Enrollment - CY25



Source: CMHRP Monthly Interaction Report, January-December 2025

Pregnancy program outcomes outlined in the FY26 Prevention and Population Health Strategy and Plan include:

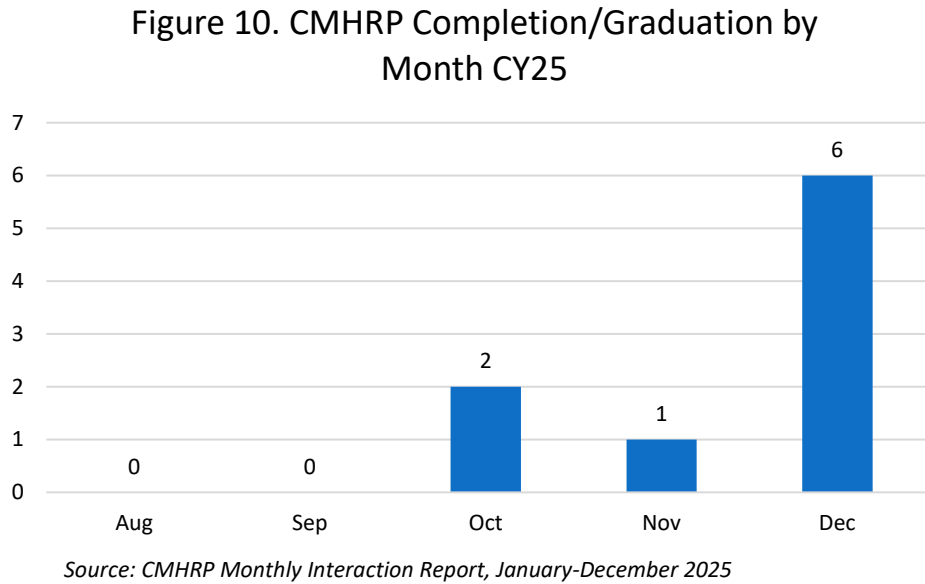
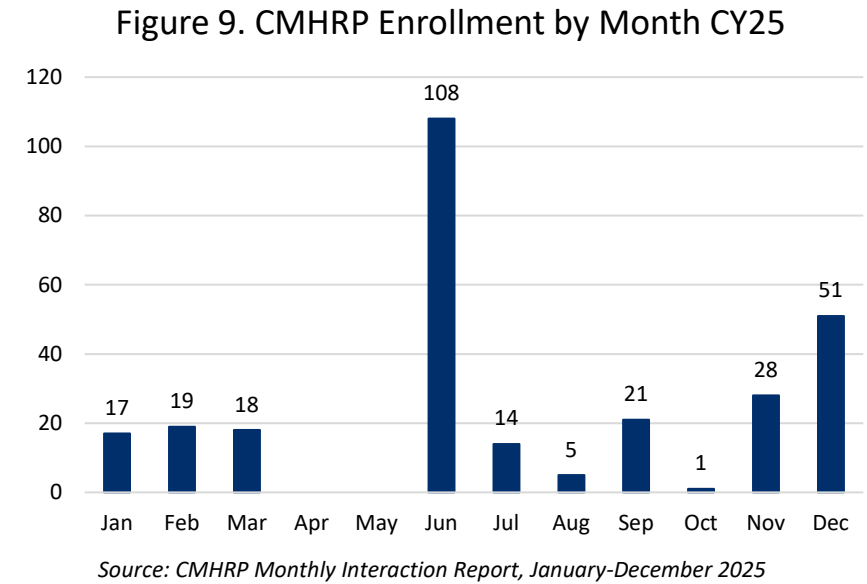
1. Of eligible members, 50% will be compliant with HEDIS Prenatal and Postpartum Care (PPC) measure by June 30, 2026.
Baseline: 45.3% (MY25, May 2025)
Target: 50%
2. Increase the number of members engaged or monitored in Care Management for High-Risk Pregnancy (CMHRP) by 25% over baseline by June 30, 2026.
Baseline: 192 (July 2024-March 2025)
Target: 240
3. Increase the number of members who complete the CMHRP program by 50% by June 30, 2026.
Baseline: 43 (July 2024-March 2025)
Target: 65

As of the end of 2025, we are on track to surpass our HEDIS Prenatal and Postpartum Care (PPC) goal for both Medicaid Direct and Tailored Plan members, with members in both categories surpassing 50% for prenatal and postpartum care (see Table 12).

Table 12. MY25 Pregnancy-Related Encounter Based HEDIS Measures by Plan Type						
Measure	Indicator Name	Plan	Eligible	Compliant	Compliant Rate, %	MY25 State Goal, %
PPC	Timeliness of Prenatal Care	Medicaid Direct	104	59	56.73	*
		Tailored Plan	608	306	50.33	46.00
	Postpartum Care	Medicaid Direct	104	69	66.35	*
		Tailored Plan	608	349	57.40	53.00

**State goals not indicated on CareSeed report*
Source: CareSeed, HEDIS MY2025 Jan Prelim Partners, 1/9/26

CMHRP enrollment and completion/graduation are displayed in Figures 9 and 10. A data transfer issue resulted in no data for April and May and what appears to be a spike in June. The spike in June is most likely related to the missing April and May data. The increase in CMHRP enrollment appears to correspond with the increase in pregnancy program member enrollment in November which would have resulted in an increase in CMHRP referrals.



Members with Nicotine Dependence

Tobacco use increases risk of many cancers, cardiovascular disease, and respiratory conditions. In addition, cigarette smoking has been linked to low birthweight and other adverse health outcomes. Partners' Living Tobacco Free program is designed to address tobacco use among members and recipients and to connect them with resources to help them quit or decrease their use.

We report prevalence of members with an F17 Nicotine Dependence diagnosis. A diagnosis is not a definitive measure of current nicotine use as nicotine diagnosis may be present in a member's record despite current use. Table 13 displays demographic information for members with nicotine diagnosis in CY25. Among the 24,600 members with nicotine dependence, just over half (54.6%) were female. Notably, females were in the majority for Medicaid Direct and Tailored Plan but comprised the minority (45.8%) of state funded members. Prevalence among age groups differed significantly among the plans, however, this is likely related to plan eligibility. English speakers make up around 71.2% of total membership; this number is skewed by missing language data for almost half (40.6%) of Medicaid Direct members. Most members with nicotine dependence are White (69.6%) and non-Hispanic (96.4%). Differences among the plans were not significant and overall distribution is reflective of our member population. Almost all of these members reside in Partners' catchment area.

Most of Partners catchment counties are at or above the state prevalence for adult smoking. Only

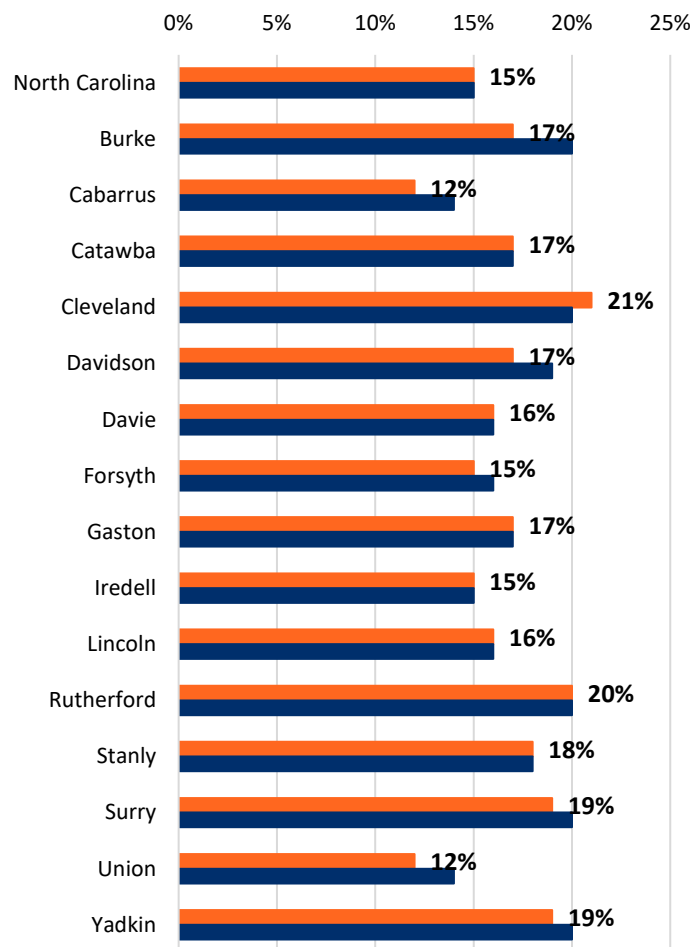
Table 13. Demographic Information for Members with F17 Nicotine Dependence

	All n = 24,600	Medicaid Direct n = 13,158	Tailored Plan n = 10,817	State Funded n = 625
Plan Type, %				
Medicaid Direct	53.5	100.0	0.0	0.0
Tailored Plan	46.7	0.0	99.3	0.0
Innovation	0.3	0.0	0.7	0.0
State Funded	2.5	0.0	0.0	100.0
Gender, %				
Female	54.6	55.0	54.7	45.8
Male	45.4	45.0	45.3	54.2
Age Group, %				
18-20 years	2.3	0.7	4.3	0.5
21-34 years	16.7	4.9	30.3	28.2
35-49 years	27.4	14.9	41.3	47.5
50-64 years	29.0	33.6	28.8	20.5
65+ years	24.8	46.0	0.3	30.4
Language*, %				
English	71.2	59.1	84.5	96.5
Spanish	0.3	0.3	0.4	0.5
Unknown	28.4	40.6	15.1	3.0
Race, %				
American Indian/Native American	0.5	0.6	0.4	0.3
Asian	0.4	0.5	0.3	0.8
Black/African American	27.2	31.1	23.2	15.8
Pacific Islander	0.1	0.1	0.1	0.0
White	69.6	65.6	73.8	80.5
Unknown	2.2	2.2	2.2	2.2
Ethnicity, %				
Hispanic	2.2	1.8	2.6	3.5
Non-Hispanic	96.4	96.7	96.2	96.5
Unknown	1.3	1.5	1.2	0.0
Reside in catchment area, %, yes	99.91	99.96	99.91	99.04

Sources: (1) HBI, refreshed on 12/1/2025, retrieved on 1/29/2026; (2) Reports Manager - Population Demographics, Jan 2026.

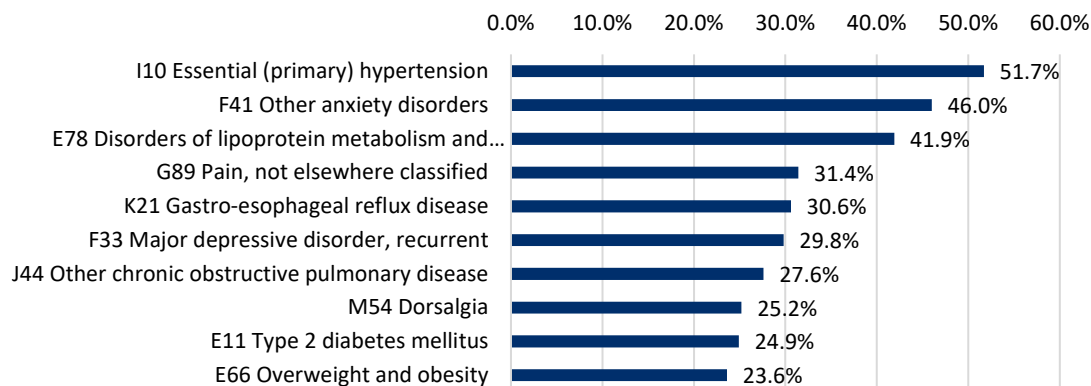
Union and Cabarrus have lower rates; both saw a decrease from 2024 to 2025. Hypertension and anxiety are the two most common chronic conditions among members with nicotine dependence (Figure 12). Additional comorbid conditions are included in Figure 12.

Figure 11. Adult Smoking - Partners Catchment
(2025 Average = 16%)



Source: County Health Rankings 2024, 2025

Figure 12. Most Common Chronic Conditions Among Members with Nicotine Dependence (n=25,057)



Source: HBI Solutions, 2/1/26 refresh, accessed 3/4/26

Living Tobacco Free outcomes outlined in the FY26 Prevention and Population Health Strategy and Plan include:

1. QuitlineNC will average at least 15 new member enrollments per month over 12-months by June 30, 2026.

Baseline: 10 (July 2024-April 2025)

Target: 15

2. Increase the number of members 18 years and older who receive smoking and tobacco use cessation counseling as evidenced by claims for 99406 and 99407 to 1100 members by June 30, 2026.

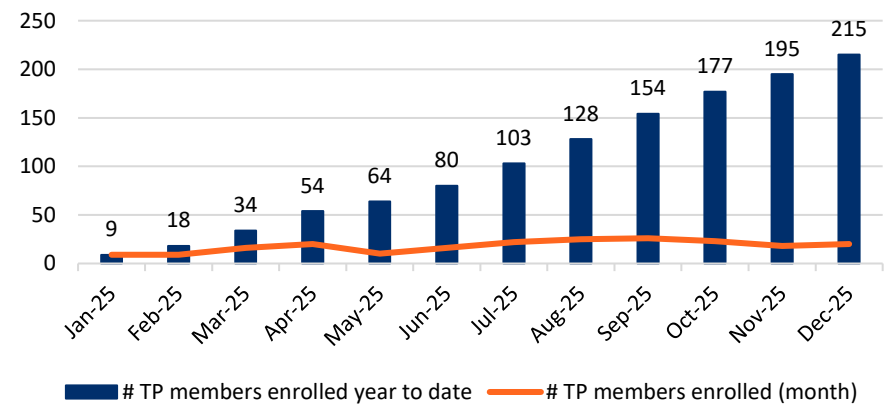
Baseline: 551 (May 2024-April 2025)

Target: 1100

To address the goals of Partners' Living Tobacco Free program, we are partnered with QuitLineNC to supply tobacco cessation training and support to members. We launched our partnership with QuitLineNC July 1, 2024. During the first six months of the program (July 1 – December 31 ,2024), 52 members enrolled in the program. In CY25, 215

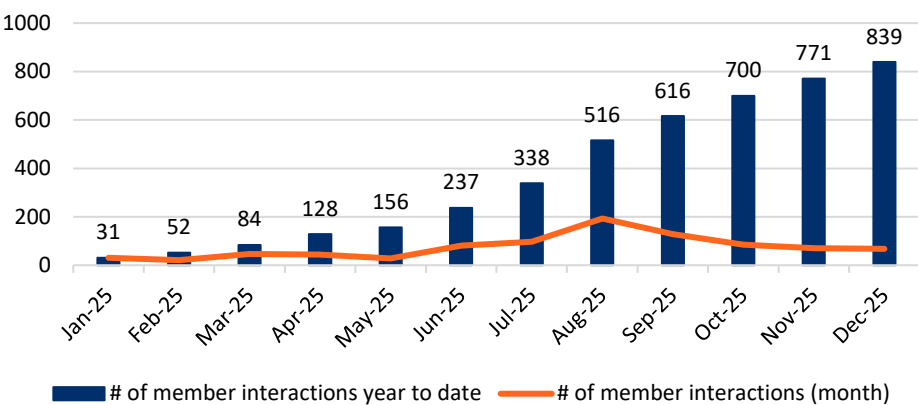
members enrolled (see Figure 13), an increase in average enrollment per month (CY24-8.7 vs. CY25-17.9). The number of member interactions (interacting with a live coach or using digital tools) per month gradually increased, with the largest number occurring from July-September. Most members interacted with a live coach; about half used digital tools (Figures 14 and 15). The average number of interactions per member per month remained about the same as the previous year (CY24-.39 vs. CY25-.33).

Figure 13. Quit for Life Enrollment - Tailored Plan Members



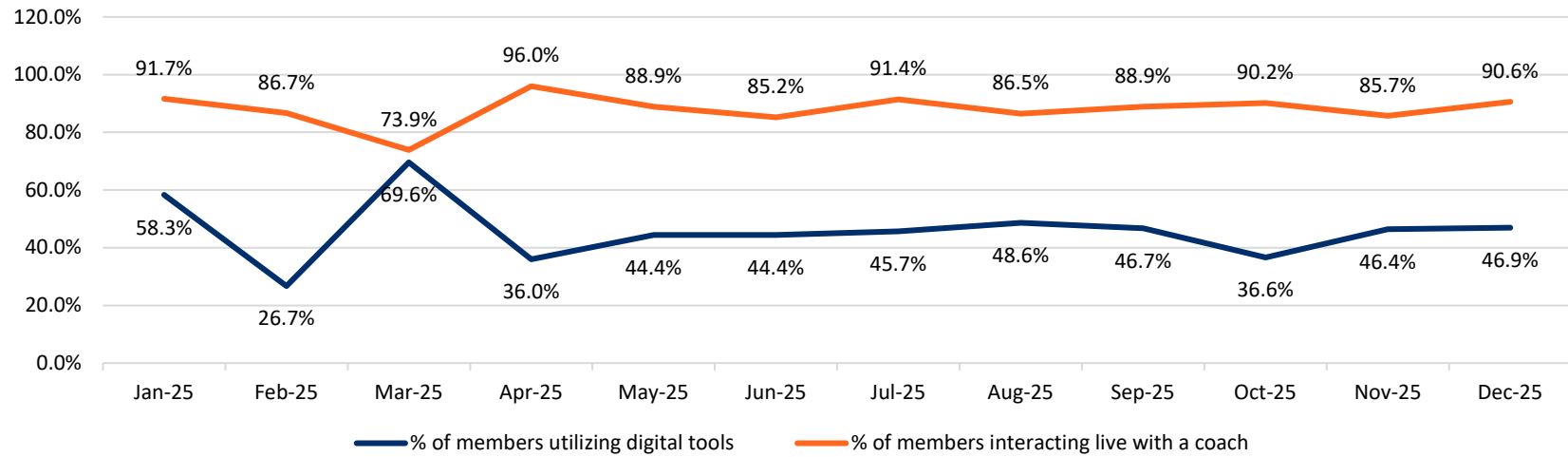
Source: QuitLine NC, 1/1/26, RVO/Optum

Figure 14. Member Interaction - Tailored Plan Members



Source: QuitLine NC, 1/1/26, RVO/Optum

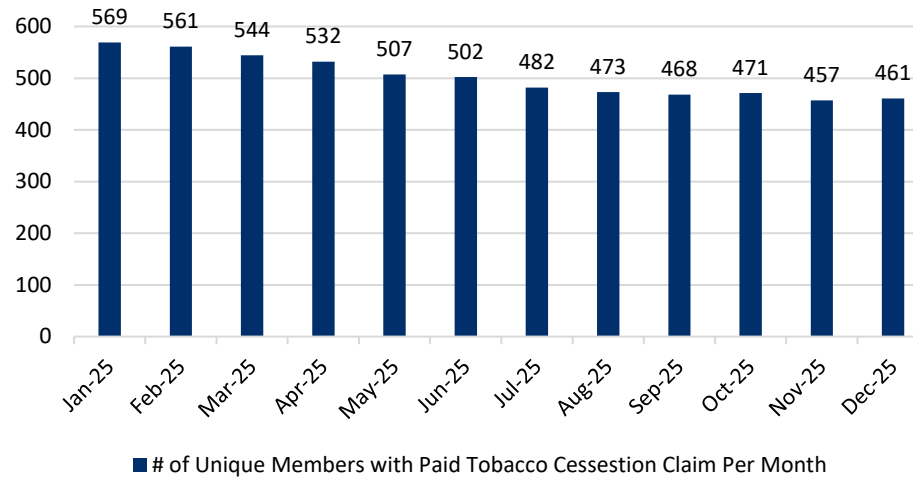
Figure 15. Type of Member Interaction - Tailored Plan Members



Source: QuitLine NC, 1/1/26, RVO/Optum

Use of tobacco cessation decreased throughout the year (Figure 16). Claims lag may account for lower numbers in the latter part of CY25.

Figure 16. Tobacco Cessation Usage



Source: Data Cubes, 1/16/26

Members with Diabetes

Diabetes management education is important for people with co-occurring behavioral health needs as these needs can impair a person's ability to maintain consistent blood sugar monitoring, follow dietary guidelines, and adhere to medication regimens, all of which are essential for preventing serious complications. Structured education on topics such as recognizing high and low blood glucose levels, nutrition, and when to seek emergency care empowers this population to better self-manage their condition, reducing the risk of hospitalizations and improving both physical and mental health outcomes.

Partners' Chronic Condition Management of Diabetes program supports members with diabetes and behavioral health needs by pairing them with health coaches who collaborate with care managers and nurse consultants to develop personalized, evidence-based goals and self-management plans that address barriers to care. The program provides targeted diabetes education, including maintaining normal blood glucose, recognizing high and low blood glucose levels, nutrition, and access to devices such as continuous glucose monitors, to empower members to control their condition.

Launched in mid-June 2025, the Chronic Condition Management (CCM) of Diabetes program is open to Tailored Plan members aged 18+ with a diagnosis of E11 Type 2 Diabetes Mellitus. Enrollment data represents 6 months of program data due to launch date. Interventions include person-centered health education, member portal access, nurse advice line, member and recipient services line, behavioral health crisis line, education and personalized action plans, health promotion and prevention education, and nursing support.

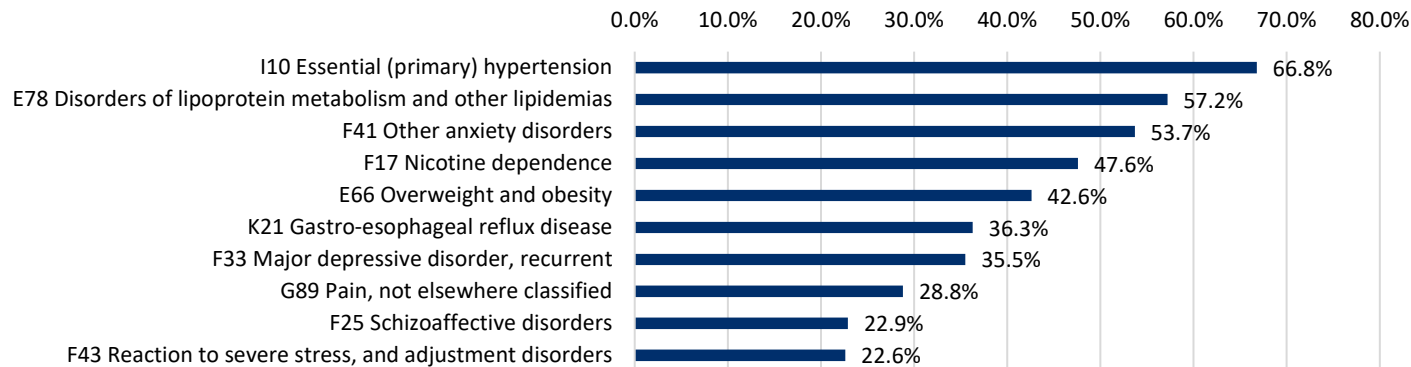
Demographic summaries for members eligible for and enrolled in the Chronic Condition Management of Diabetes program are presented in Table 14. Enrollment includes those who completed at least the pre-test before disenrolling from the program. Those eligible for the diabetes program are mostly older than 35 years (80.4%), female (55.4%), White (63.1%), non-Hispanic (94.1%) English-speakers (76.9%) who reside in the Partners' catchment area. In 2025, 57 individuals were enrolled in the Chronic Condition Management of Diabetes program and completed a Pre-Test that measured member knowledge of diabetes management. The majority of members enrolled in the program were older than 35 years (86.0%), White (63.2%), and non-Hispanic (98.3%); about half were female (49.1%). Demographics of those enrolled in the program are similar to those eligible. Of those, 13 completed the program by the end of CY25; 36 members disenrolled from the program without completing.

Table 14. Member Demographics – Chronic Condition Management of Diabetes

Member Population	All n = 3019	CCM Diabetes n = 57
Plan Type, %		
TP Medicaid	87.3	84.2
TP Innovations	12.7	7.0
Gender, %		
Female	55.4	49.1
Male	44.6	50.9
Age Group, %		
18-20 years	2.5	0.0
21-34 years	17.2	14.0
35-49 years	36.0	40.4
50-64 years	42.5	45.6
65+ years	1.9	0.0
Language, %		
English	76.9	77.2
Spanish	0.9	0.0
French	<0.1	0.0
Sign Language	0.1	0.0
Unknown	22.1	22.8
Race, %		
American Indian/Native American	0.3	0.0
Asian	0.8	1.8
Black/African American	32.6	35.1
White	63.1	63.2
Unknown	3.2	0.0
Ethnicity, %		
Hispanic	3.5	1.8
Non-Hispanic	94.1	98.3
Unknown	2.3	0.0
Reside in catchment area, %		
Yes	94.5	82.44

Hypertension and high cholesterol were the most common comorbid conditions among people with Type 2 Diabetes. Other common comorbid diagnoses are included in Figure 17.

Figure 17. Most Common Chronic Diseases Among Members with Type 2 Diabetes (n= 3,035)



Source: HBI Solutions, 2/1/26 refresh, accessed 3/4/26

Outcomes outlined in the FY26 Prevention and Population Health Strategy and Plan include:

1. Among those who complete the program, 50% will receive a semi-annual HbA1c/blood glucose test as documented by HEDIS Glycemic Status Assessment for Patients with Diabetes (GSD-1/GSD-2) measure by June 30, 2026.

Baseline: 40.91% of all eligible Tailored Plan members (May 2025)

Target: 50% of members completing the program

2. Of members who complete the diabetes program, 50% will demonstrate an increase in understanding of diabetes management as evidenced by an increase in assessment score (#) between the initial assessment and the final assessment by June 30, 2026.

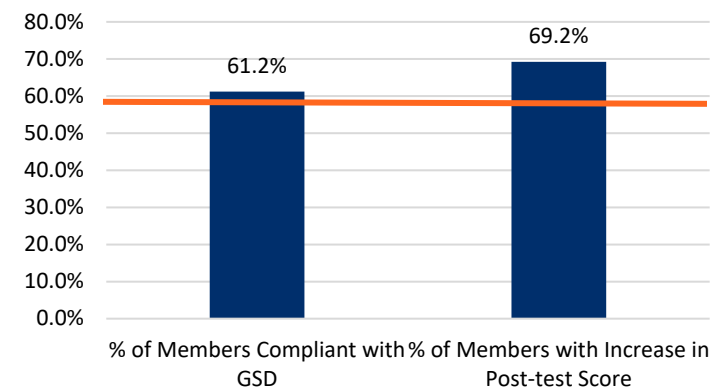
Baseline: 0

Target: 50%

Of the 13 members who completed the Chronic Condition Management of Diabetes program in CY25, 8 (61.2%) were compliant with the GSD (CDC) measure. Members received a standardized assessment of diabetes knowledge at the beginning and end of the Chronic Condition

Management program. The change in score was used to indicate change in the member's understanding of diabetes management. Of members who completed the program, 9/13 (69.2%) demonstrated an increase in post test score (average 1.5-point increase). Outcomes are displayed in Figure 18; the orange line represents the target value.

Figure 18. Chronic Condition Management of Diabetes Program Outcomes



Source: CareSeed; IruCare, July 1 – December 31, 2025

Members with Asthma

Asthma management education is especially critical for people with co-occurring behavioral health needs because conditions like depression and anxiety can reduce motivation and ability to follow complex medication regimens. Understanding triggers, proper medication use, and action plans also helps reduce asthma-related anxiety and emergency situations, which can otherwise worsen both physical and mental health outcomes for our members with asthma and behavioral health needs.

Partners' Chronic Condition Management of Asthma program supports members with asthma and behavioral health needs by pairing them with health coaches who collaborate with care managers and nurse consultants to develop personalized, evidence-based goals and self-management plans that address barriers to care. The program provides targeted asthma education, including symptom tracking, breathing strategies, and medication guidance to empower members to control their condition.

Launched in mid-June 2025, the Chronic Condition Management of Asthma program is open to Tailored Plan members of all ages with a diagnosis of J45 Asthma and high or very high risk of emergency department use. Enrollment data represents 6 months of program data due to launch date. Interventions include person-centered health education, member portal access, nurse advice line, member and recipient services line, behavioral health crisis line, education and personalized action plans, health promotion and prevention education, and nursing support.

Demographic summaries for members eligible for and enrolled in the Chronic Condition Management of Asthma program are presented in Table 15. Those eligible for the asthma program are mostly less than 50 years old (84.3%), female (67.2%), White (64.6%), non-Hispanic (92.4%) English-speakers (76.2%) who reside in the Partners' catchment area. In 2025, 35 individuals were enrolled in the Chronic Condition Management of Asthma program and completed a Pre-Test that measured member knowledge of asthma management. One member died while enrolled in the program. The majority of members enrolled in the program were female (76.5%), 0-20 years old (70.6%), White (55.9%), and non-Hispanic (92.4%). Of those, 11 completed the program by the end of CY25; 22 members disenrolled from the program without completing.

Table 15. Member Demographics – Chronic Condition Management of Asthma

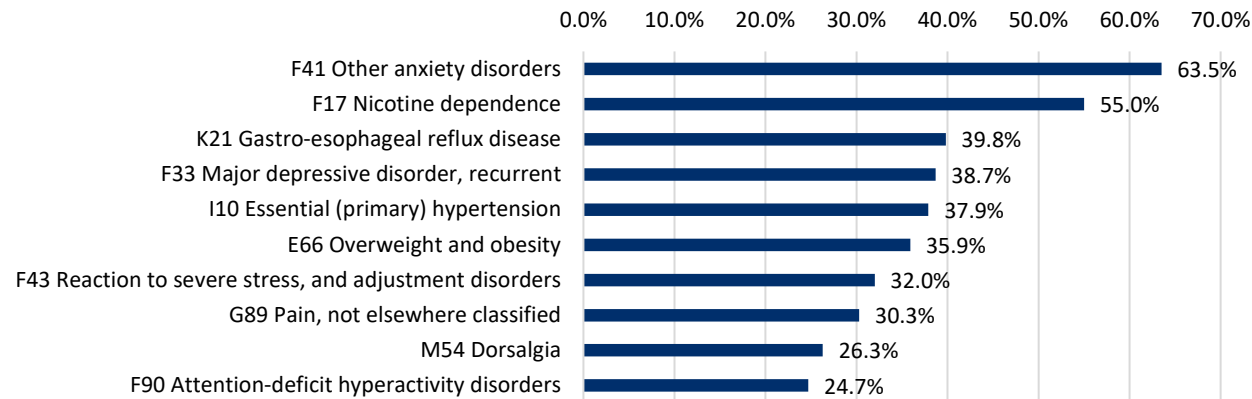
Member Population	All Eligible n = 1281	CCM Asthma n = 34
Plan Type, %		
TP Medicaid	97.0	100.0
TP Innovations	3.0	0.0
Gender, %		
Female	67.2	76.5
Male	32.8	23.5
Age Group, %		
0-20 years	24.6	70.6
21-34 years	31.3	5.9
35-49 years	28.4	5.9
50-64 years	15.3	14.7
65+	0.4	2.9
Language, %		
English	76.2	73.5
Spanish	0.9	0.0
Unknown	22.9	26.5
Race, %		
American Indian/Native	0.6	0.0
Asian	0.2	0.0
Black/African American	32.0	41.2
White	64.6	55.9
Unknown	2.7	2.9
Ethnicity, %		
Hispanic	5.4	2.9
Non-Hispanic	92.4	97.1
Unknown	2.2	0.0
Reside in catchment area, %		
Yes	94.7	100.0

TP: Tailored Plan

Source:

Anxiety is the most common chronic condition with 63.5% of members with asthma having anxiety. Nicotine dependence was also very common with over half of these members having a F17 diagnosis. Additional comorbid diagnoses are included in Figure 19.

Figure 19. Most Frequent Chronic Conditions for Members with Asthma (n=1,408)



Source: HBI Solutions, 2/1/26 refresh, accessed 3/4/26

Outcomes outlined in the FY26 Prevention and Population Health Strategy and Plan include:

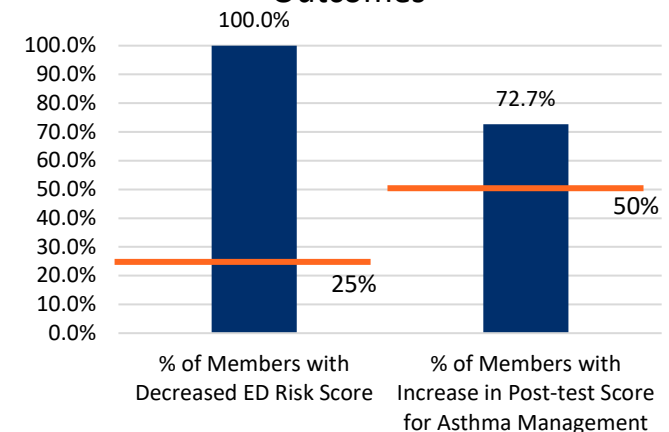
1. Among those who complete the program, 25% of all members who complete the program will exhibit a decrease in their risk score (#) for Emergency Department Visits within 6 months of program completion by June 30, 2026.
Baseline: 0
Target: 25%
2. Of members who complete the asthma program, 50% will demonstrate an increase in understanding of asthma management as evidenced by an increase in assessment score (#) between the initial assessment and the final assessment by June 30, 2026.

Baseline: 0

Target: 50%

Of the 11 members who completed the Chronic Condition Management of Asthma program in CY25, 3 have had a 6-month follow-up measure for ED risk score. All 3 (100%) experienced a decrease in ED risk score (average -16.7% point change; see Figure 20). Members received a standardized assessment of asthma knowledge at the beginning and end of the Chronic Condition Management

Figure 20. Chronic Condition Management of Asthma Program Outcomes



Source: TruCare, July 1 – December 31, 2025

program. The change in score was used to indicate change in the member's understanding of asthma management. Of members who completed the program, 8/11 (72.7%) demonstrated an increase in post test score (average 1.4-point increase; see Figure 20). Outcomes are displayed in Figure 20; the orange line represents the target value from the Prevention and Population Health Strategy and Plan.

Members at Risk of Opioid Misuse or Overdose

Opioid use increases risk of dependence, addiction, and potentially fatal overdose due to respiratory depression. Opioid use has been linked to cognitive impairment, neonatal abstinence syndrome in exposed infants, and other adverse health outcomes. Partners' Project Reducing Harm from Opioids (Project RHO) is intended to minimize the negative consequences of opioid use, both for individuals who are currently misusing opioids and for those who are high risk of doing so.

Project RHO includes members from all plans, up to age 64 years, who are currently misusing or at high or very high risk for opioid misuse or at high or very high risk for opioid overdose. Partners' interventions include member/recipient outreach via letter and follow-up phone call, provider outreach letters, and individual education delivered by care manager, health coach, or community health worker, and community education to increase awareness of opioid effects and implications.

Table 16 provides demographic information for members who are eligible for Project RHO. Those with present use or at high or very high risk for opioid misuse or overdose (n=14,777) comprise 12.4% of the total population. The majority are enrolled in the Tailored Plan (63.6%), aged 21-64 years (81.9%), speak English (99.3% of those for whom preferred language is known), are White (75.5%) and non-Hispanic (95.1%). A little over half (54.1%) are female. Almost all of the members eligible for Project RHO reside within catchment. The demographics of this group are similar to the demographics of the counties served.

Table 16. Demographics - Members Eligible for Project RHO

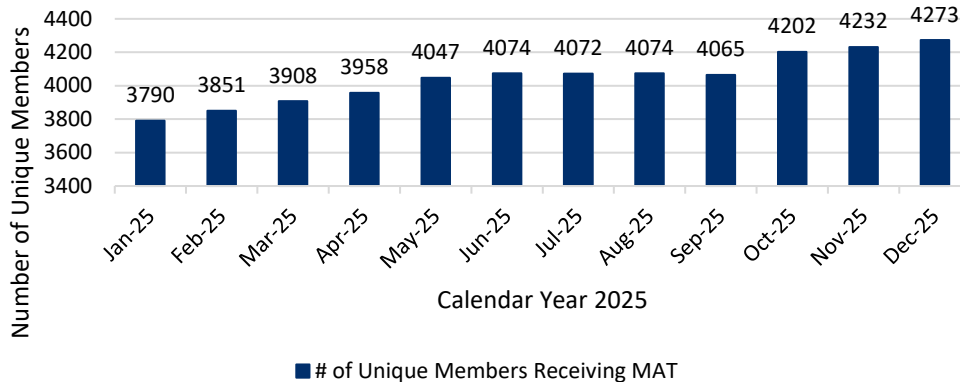
Member Population	All n = 14,777	Medicaid Direct n = 4,256	Tailored Plan n = 9,996	State Funded n = 525
Plan Type, %				
Medicaid Direct	28.8	100.0	0.0	0.0
Tailored Plan	63.6	0.0	94.0	0.0
Innovation	4.1	0.0	6.0	0.0
State Funded	3.6	0.0	0.0	100.0
Gender, %				
Female	54.1	56.3	53.6	46.3
Male	45.9	43.7	46.4	53.7
Age Group, %				
0-20 years	18.1	15.86	19.78	3.24
21-64 years	81.9	84.1	80.2	96.8
Language, %				
English	76.0	63.1	80.4	96.8
Spanish	0.45	0.12	0.60	0.38
French	0.02	0.00	0.03	0.00
Sign Language	0.02	0.05	0.01	0.00
Other	0.01	0.02	0.00	0.00
Unknown	23.5	36.7	19.0	2.9
Race, %				
American Indian/Native	0.5	0.7	0.4	0.4
Asian	0.5	0.4	0.5	1.0
Black/African American	20.6	23.3	19.9	12.4
Multiracial	0.01	0.00	0.00	0.19
Pacific Islander	0.08	0.07	0.09	0.00
White	75.5	72.9	76.1	83.2
Unknown	2.9	2.6	3.0	2.9
Ethnicity, %				
Hispanic	3.5	2.0	4.0	4.9
Non-Hispanic	95.1	96.1	94.7	94.9
Unknown	1.5	1.8	1.4	0.2
Reside in catchment area, %				
Yes	99.91	99.98	99.91	99.45

Sources: HBI, refreshed on 12/1/2025, retrieved on 1/19/2026; Reports Manager - Population Demographics

Outcomes outlined in the FY26 Prevention and Population Health Strategy and Plan include:

1. Decrease the number of members at High or Very High Risk of Opioid Abuse and/or Opioid Overdose by 5% by June 30, 2026.
 - a. Baseline: 15,231 (May 2025)
 - b. Target: 14,470
2. Increase in the number of unique members receiving Medication Assisted Treatment by 10% over 12 months by June 30, 2026.
 - a. Baseline: 3,880 (May 2024-April 2025)
 - b. Target: 4,268
3. Onboard at least 4 additional Medication Assisted Treatment providers to the Partners network by June 30, 2026.
 - a. Baseline: 39 (May 2025)
 - b. Target: 43

Figure 21. Number of Unique Members Receiving MAT During Calendar Year 2025



Source: Data Cubes, 2/12/26

From May 2025 to December 2025, the number of members at High or Very High Risk of Opioid Abuse and/or Opioid Overdose decreased from 15,231 to 14,470 members, a 5% decrease. Member risk is calculated based on opioid abuse and overdose risk factors. Interventions targeting these risk factors have included member and provider awareness campaigns related to concomitant opioid and benzodiazepine use, and community outreach and education.

The number of unique members receiving MAT by month is displayed in Figure 21. The number of unique members receiving MAT per month increased throughout CY25 with a total of 4273 unique members receiving MAT services during the year. The number of MAT providers in Partners' network increased from 38 in December 2024 to 47 in December 2025.

Table 17 displays HEDIS measures of importance (follow-up after emergency department visit for substance use) to those at risk of opioid misuse or overdose. The measures below are stratified by Medicaid Direct and Tailored Plan.

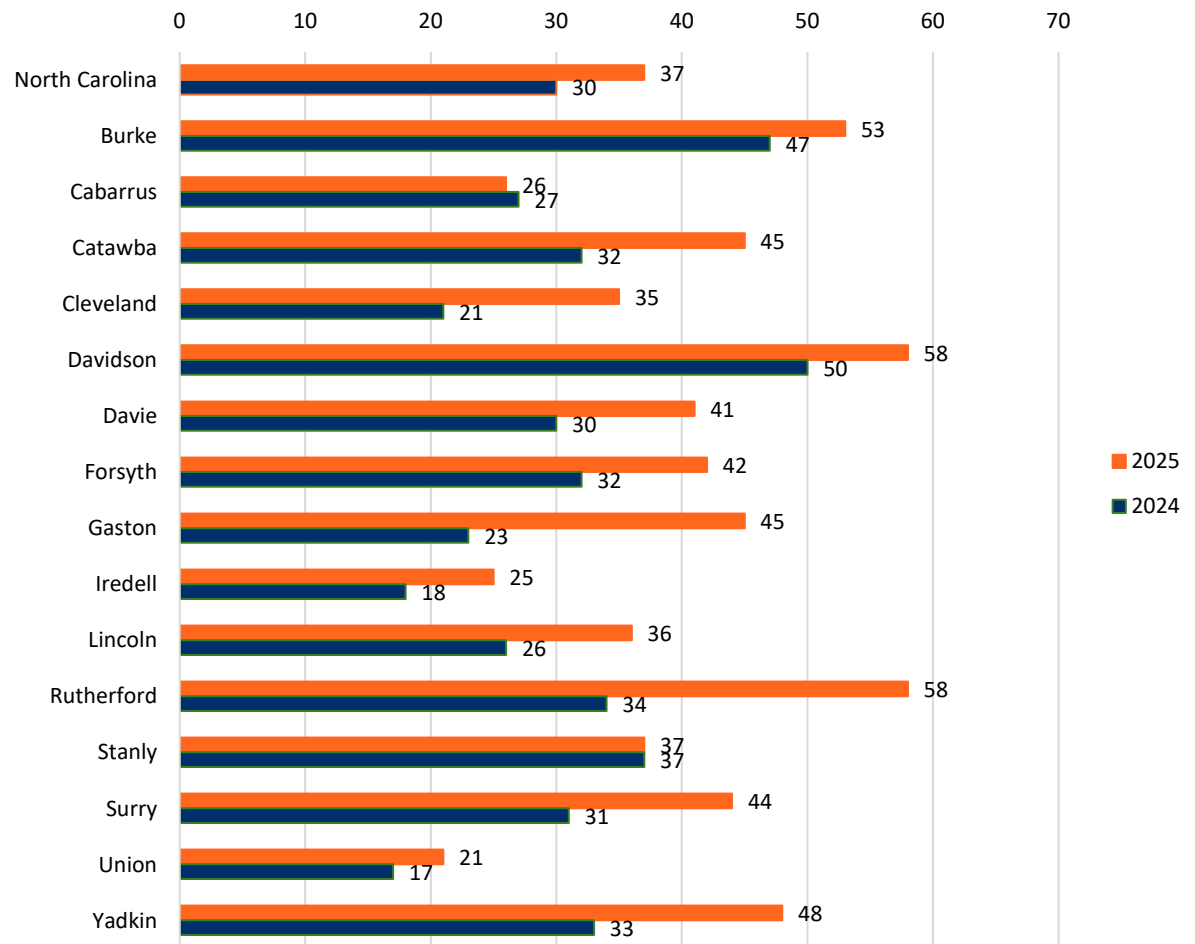
Table 17. MY25 Opioid-Related HEDIS Measures by Plan Type

Measure	Indicator Name	Plan	Eligible	Compliant	Compliant Rate, %	MY25 State Goal, %
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Day Follow Up	Medicaid Direct	727	206	28.34	32.00
		Tailored Plan	1552	722	46.52	47.00
		Medicaid Direct	727	134	18.43	18.00

Source: CareSeed, HEDIS MY2025 Jan Prelim Partners, 1/9/26

Figure 22 displays the rate of drug-related deaths per 100,000 population for the state and by catchment county. Drug-related deaths are defined as the number of deaths per 100,000 population resulting from accidental, intentional, or undetermined drug poisoning - including overdoses involving opioids, pain medications, sedatives, hallucinogens, and other substances. The average rate for Partners' catchment counties is 41, 11% higher than the North Carolina state average of 37. Compared to 2024, Burke and Davidson remain among the highest in Partners' catchment. Rutherford is also in the top three. Rutherford and Davidson have drug-related death rates at more than 1.5 times the state rate. Compared to 2024, we observed an increase in rate among all counties except for Cabarrus in 2025.

Figure 22. Drug-related deaths per 100,000 -
Partners Catchment



Source: County Health Rankings 2024, 2025

Members Hospitalized for Mental Health Diagnoses

Frequent hospital readmission is a significant concern for both member wellbeing and health system efficiency — so much so that the Affordable Care Act prompted the creation of the Hospital Readmission Reduction Program in 2013, which ties reimbursement decisions to readmission rates across most hospital settings. For members, repeated hospitalizations can erode confidence in the healthcare system, worsen mental and physical health, and create substantial financial burden, while at the system level readmissions strain resources and drive up the overall cost of care. Readmissions are often driven by preventable factors such as poor care transitions, inadequate follow-up, medication mismanagement, and unaddressed social drivers of health — highlighting the importance of coordinated, whole-person interventions to keep high-risk members stable in the community.

The Follow Up After Hospitalization program provides transitional care management for the purpose of increasing the percentage of members and recipients who receive timely follow-up care with a mental health provider following hospitalization. Members of all plans, ages 6 and older who have been hospitalized for mental health diagnosis or intentional self-harm are eligible for elements of the program. Interventions include transitional care management, hospitalization and discharge monitoring, member outreach, sharing of resource tool for transition staff to aid members following discharge, and sharing of resource tool for hospital and emergency departments to use in discharge planning.

The High Utilization Group was initiated in 2025 at Partners to reduce hospitalization rates of members with 7 or more behavioral health inpatient admissions within a 12-month period. This program monitors the number of admissions and the length of stay in hospitals of our members and employs combined efforts of tailored and transitional care management.

Table 18 presents demographic information for all members with behavioral health inpatient admission and those with 7+ behavioral health inpatient admissions in CY25. A total of 6,224 members were hospitalized for behavioral health diagnoses in a 12-month rolling basis from May 1, 2024, to November 2025. Members with 7+ Hospitalizations in the same timeframe (n=92) make up 1.5% of all members with behavioral health inpatient admission. In the total population and among all subgroups, males make up slightly higher portion of the total membership than females. The same is true on those either receiving Medicaid Direct or Tailored Plan. About 70% of all the hospital utilizers are between the ages 21-64 years. English speakers make up around 70% of total membership regardless the plan type, even with a high unknown number at 28%. If those unknown language members were identified, the ratio of English speakers would be higher.

Among members with 7+ hospitalizations, Black and African American members made of a greater proportion (32.61%) compared to members with any hospitalization (23.4%). In Chi-square testing, this difference is statistically different ($p=0.038$) and may indicate a racial health disparity.

Table 18. Member Demographics – Hospitalization for Mental Health Diagnosis

Member Population	Members with Any Hospitalization for Mental Health			Members Enrolled with 7+ Hospitalizations for Mental Health		
	All* n = 6,224	Medicaid Direct n = 2,622	Tailored Plan n = 4,125	All* n = 92	Medicaid Direct n = 49	Tailored Plan n = 83
Plan Type*, %						
Medicaid Direct	2.1	100.0	0.0	53.3	100.0	0.0
Tailored Plan	66.3	0.0	100.0	90.2	0.0	100.0
Gender, %						
Female	38.6	33.5	41.0	29.4	32.7	30.1
Male	43.8	41.1	46.8	63.0	57.1	63.9
Unknown	17.6	25.4	12.2	7.6	10.2	6.0
Age Group*, %						
3-12 years	4.7	4.50	4.44	0.0	0.0	0.0
13-17 years	13.8	11.4	14.9	1.1	0.0	1.2
18-20 years	5.3	4.0	6.1	6.5	8.2	6.0
21-34 years	27.4	22.3	30.9	34.8	40.8	36.1
35-64 years	45.9	48.3	44.6	57.6	51.0	57.8
65+ years	4.3	10.0	0.2	2.2	4.1	0.0
Language, %						
English	70.5	63.0	76.4	85.9	87.8	86.8
Spanish	0.74	0.42	0.95	0.0	0.0	0.0
Franch	0.02	0.04	0.00	0.0	0.0	0.0
Sign Language	0.05	0.08	0.02	0.0	0.0	0.0
Other	0.03	0.04	0.05	0.0	0.0	0.0
Unknown	28.6	36.4	22.6	14.1	12.2	13.3
Race, %						
American Indian/Native	0.3	0.2	0.3	0.0	0.0	0.0
Asian	0.5	0.3	0.6	0.0	0.0	0.0
Black/African American	23.4	21.5	24.2	32.61	40.82	28.92
Multiracial	0.02	0.00	0.02	0.0	0.0	0.0
Pacific Islander	0.11	0.08	0.15	0.0	0.0	0.0

White	55.5	50.0	59.6	58.70	46.94	63.86
Unknown	20.2	27.8	15.1	8.70	12.24	7.23
Ethnicity, %						
Hispanic	4.0	2.9	4.7	2.2	2.0	2.4
Non-Hispanic	77.0	70.2	81.8	90.2	87.8	91.6
Unknown	19.1	27.0	13.6	7.6	10.2	6.0
Live with catchment area, %						
Yes	100.0	100.0	100.0	100.0	100.0	100.0
No	0.0	0.0	0.0	0.0	0.0	0.0

*A patient may have more than one plan type or change age group during the reporting period.

Sources: (1) Hospital Utilizers data reported by Utilization Management Data Team from July 2025 to January 2026. Member data dated ranged from May 1, 2024, to November 30, 2025. (2) Reports Manager: Population Demographics 2025.

Outcomes outlined in the FY26 Prevention and Population Health Strategy and Plan for Follow Up After Hospitalization include:

1. Among those eligible for the HEDIS measure Follow Up After Hospitalization for Mental Illness 30-day (FUH-1), a 5-percentage point increase over baseline by June 30, 2026.
Baseline: 49.1% (MY25, May 2025)
Target: 54.1%
2. Among those eligible for the HEDIS measure Follow Up After Hospitalization for Mental Illness 7-day (FUH-2), a 5-percentage point increase over baseline by June 30, 2026.
Baseline: 26.5% (MY25, May 2025)
Target: 31.5%

Table 19 shows HEDIS measures of interest for members with mental health diagnoses. These measures were selected as they concern timeliness of follow up after hospitalization or emergency department visits as well as adherence to medication and compliance with metabolic monitoring needed while a member is prescribed antipsychotic medications. FUH: Follow-up after hospitalization for mental illness, is used to evaluate the Follow Up After Hospitalization Program, as described above. The PCR: Plan All-Cause Readmissions Rates measure reflects the observed/expected ratio for readmission. The index stay reflects the number of initial stays; 30-day readmit refers to the number of readmissions within 30 days of an index stay. A number of expected readmissions based on index stay characteristics is calculated (not shown). The number of observed readmissions is divided by the number of expected readmissions, producing the observed/expected (O/E) ratio. The 1.32 O/E ratio for Tailored Plan members indicates that the readmissions for that group was 32% higher than expected. The 2.01 O/E ratio for Medicaid Direct members indicates that readmission for that group was twice the expected rate.

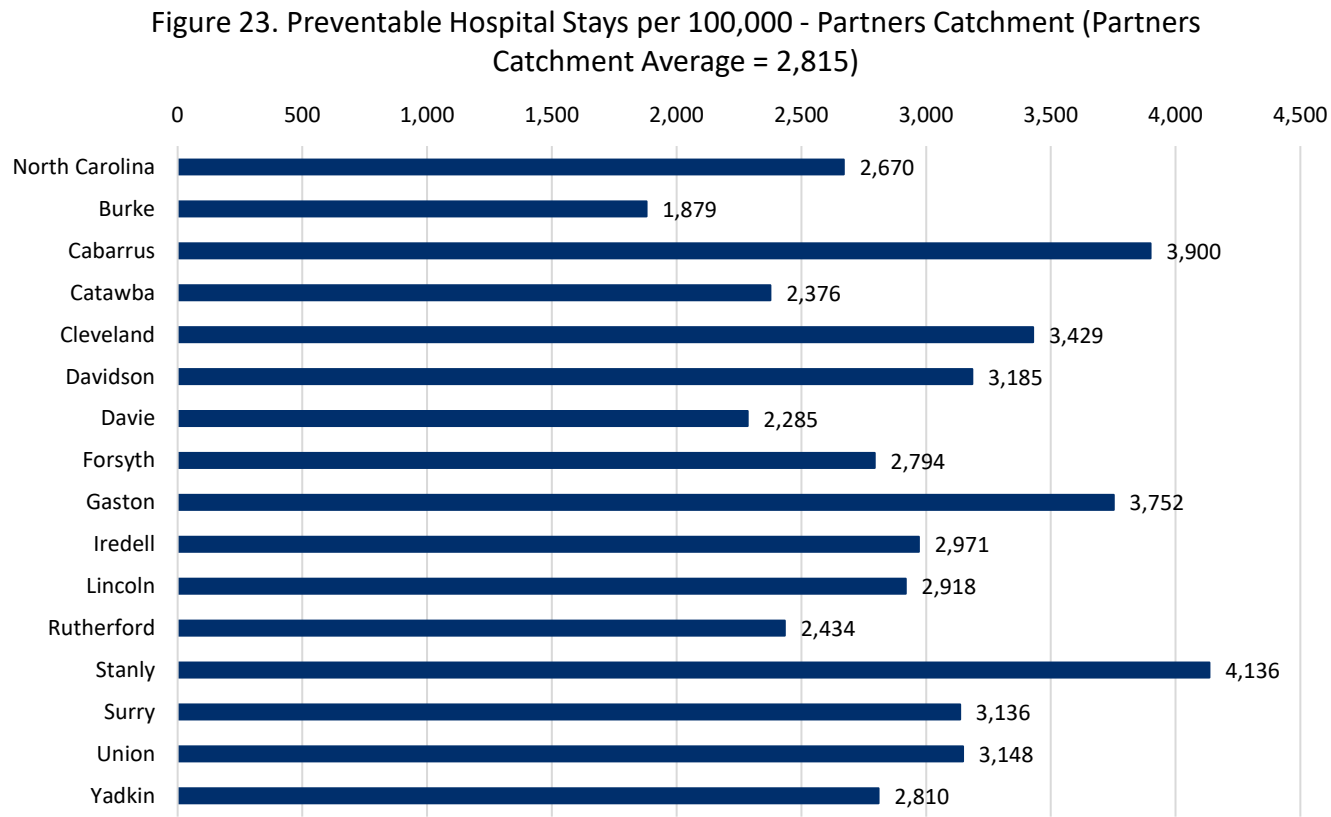
Table 19. MY25 Mental Health-Related HEDIS Measures by Plan Type

Measure	Indicator Name	Plan	Eligible	Compliant	Compliant Rate, %	MY25 State Goal, %
FUH	Follow-up after hospitalization for mental illness, 30-day follow-up	Medicaid Direct	1549	780	50.36	53.00
		Tailored Plan	3011	2018	67.02	45.00
	Follow-up after hospitalization for mental illness, 7-day follow-up	Medicaid Direct	1549	507	32.73	31.00
		Tailored Plan	3011	1342	44.57	26.00
FUM	Follow-up after emergency department visit for mental illness, 30-day follow-up	Medicaid Direct	2639	1301	49.30	73.00
		Tailored Plan	3610	2097	58.09	65.00
	Follow-up after emergency department visit for mental illness, 7-day follow-up	Medicaid Direct	2639	809	30.66	50.00
		Tailored Plan	3610	1358	37.62	46.00
Measure	Indicator Name	Plan	Index Stays	30-Day Readmits	Observed/ Expected Ratio	MY25 State Goal, %
PCR	Plan All-Cause Readmissions Rates Among Nonoutlier Members (18-64 years old)	Medicaid Direct	3188	644	20.20/10.04 (2.01)	*
		Tailored Plan	3448	410	11.89/9.01 (1.32)	*

**State goals not indicated*

Source: CareSeed, HEDIS MY2025 Jan Prelim Partners, 1/9/26

Figure 23 below shows the preventable hospital stays in 15 counties under the Partners catchment area vs. the North Carolina average. Preventable hospital stays are for conditions that could have been treated as outpatient. While not specific to mental health, these stays may include mental health and can be indicative of insufficient outpatient care (County Health Rankings, 2026). The average of the 15 counties of 2,815 per 100,000 people is 5% higher than the North Carolina state average of 2,670. The 3 counties with the highest hospital stays are Stanly, Cabarrus, and Gaston.



Source: County Health Rankings, 2025.

Members with Complex Needs

Members with comorbid physical and mental health conditions often have complex, interconnected care needs that require coordinated, whole-person support across multiple services - including medication management, behavioral health interventions, and social care - to prevent conditions from compounding one another. For those at high risk of emergency department or inpatient admission, proactive care management, timely access to community-based crisis support, and strong care transitions are essential to reducing avoidable utilization and keeping members stable in the least restrictive setting possible.

The Intensive Care Management program employs complex case management to improve the quality of life among members with chronic health conditions, reduce complications exacerbated by unmanaged depressive symptoms, and promote timely follow up after emergency department visit of people with high-risk multiple chronic conditions. It is open to Tailored Plan members of all ages with serious mental illness and/or intellectual and developmental disability, at very high risk of inpatient admission and emergency department utilization, have two or more chronic physical health conditions, are eligible for tailored care management (TCM), consent to Intensive Care Management, are assigned to Partners care management, and not currently enrolled in any other program providing care management. Interventions include 12-month structured, team-based whole person care.

Demographics for members with complex needs and those enrolled in the Intensive Care Management program in CY25 are presented in Table 20. For the purpose of this report, we identify Tailored Plan members with complex needs as those with 2 or more chronic mental and/or physical conditions at very high risk of emergency department or inpatient admission. These members may be eligible for ICM dependent on TCM eligibility, consent, and other program enrollment. The ICM program launched in June 2025. ICM member enrollment reflects those enrolled in the program from June-December 2025 who had completed WHO-5 and PHQ-9 assessments.

Most members with complex needs are female (61.7%), over age 35 (83.7%), English-speakers (86.0%), White (71.6%), non-Hispanic (93.2), and reside in Partners' catchment area (85.6%). Demographics for members enrolled in the ICM program are similar.

Anxiety is very common with 81% having a dx of anxiety. Nicotine dependence and hypertension are also very common with nearly 80% of members having them. Other common comorbid conditions are included in Figure 24.

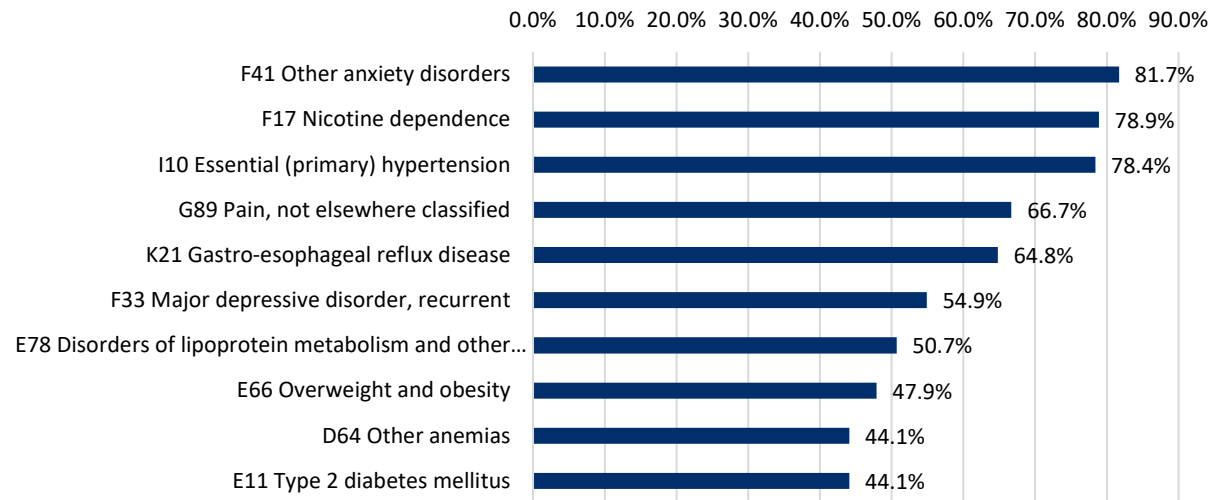
Table 20. Member Demographics – Intensive Care Management (Complex Case)

Member Population	Complex Needs n = 222	ICM n = 35
Plan Type, %		
TP Medicaid	97.8	100.0
TP Innovations	2.3	0.0
Gender, %		
Female	61.7	57.1
Male	38.3	42.9
Age Group, %		
0-20 years	1.8	2.9
21-34 years	14.4	5.7
35-49 years	39.6	45.7
50-64 years	44.1	45.7
65+	0.0	0.0
Language, %		
English	86.0	85.7
Spanish	0.5	0.0
Unknown	13.5	14.3
Race, %		
American Indian/Native American	0.9	0.0
Black/African American	24.3	28.6
White	71.6	71.4
Unknown	3.2	0.0
Ethnicity, %		
Hispanic	4.5	2.9
Non-Hispanic	93.2	97.1
Unknown	2.3	0.0
Reside in catchment area, %		
Yes	85.6	97.14

TP: Tailored Plan

Source:

Figure 24. Most Frequent Chronic Diseases Among Members with Complex Needs (n=213)



Source: HBI Solutions, 2/1/26 refresh, accessed 3/4/26

Outcomes outlined in the FY26 Prevention and Population Health Strategy and Plan for the Intensive Care Management Program include:

1. Among those who complete the program, 25% will have an increase in quality of life from month 1 to month 12 as measured by the WHO-5 by June 30, 2026.
Baseline: 0
Target: 25%
2. Among those enrolled in the program, 25% will experience a reduction in depressive symptoms as measured by the PHQ-9 by June 30, 2026.
Baseline: 0
Target: 25%
3. Among those who complete the program, 50% will have a decrease in risk for emergency department visit within 12 months as indicated by a decrease in emergency department risk score as calculated by HBI Solutions by June 30, 2026.
Baseline: 0
Target: 50%
4. Among those who complete the program, 50% will have a decrease in risk for inpatient admission within 12 months of enrollment as indicated by a decrease in inpatient admission risk score as calculated by HBI Solutions by June 30, 2026.
Baseline: 0

Target: 50%

5. Among Tailored Plan members eligible for the HEDIS measure Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions (FMC), a 2-percentage point increase over baseline by June 30, 2026.

Baseline: 22.8% (MY25, May 2025)

Target: 24.8%

Outcomes 1-4 will be calculated at the end of the fiscal year. Current population rates for HEDIS measure FMC are in Table 21. Compliance among Tailored Plan members is 25.0%, surpassing the set target.

Table 21. MY25 Complex Needs-Related Encounter Based HEDIS Measures by Plan Type

Measure	Indicator Name	Plan	Eligible	Compliant	Compliant Rate, %	MY25 State Goal, %
FMC	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions	Medicaid Direct	1007	280	27.81	*
		Tailored Plan	564	141	25.00	*

**State goals not indicated on HBI*

Source: HBI Solutions, HEDIS MY2025 1/1/26 refresh, accessed 2/18/26

Children and Adolescents

Overall, 33,216 members are aged 0-20 years old. Table 22 shows the majority of child and adolescent members are male (59.9%), White (65.1%), non-Hispanic (84.8%), and are assigned to the Tailored Plan (71.1%). Language is unavailable for more than half of these members (51.8%). Language data is collected upon enrollment and can be updated in Alpha. Data may be missing if the data was not requested or the member refused to share the information. Demographics remained similar to findings in the 2025 Population Health Assessment.

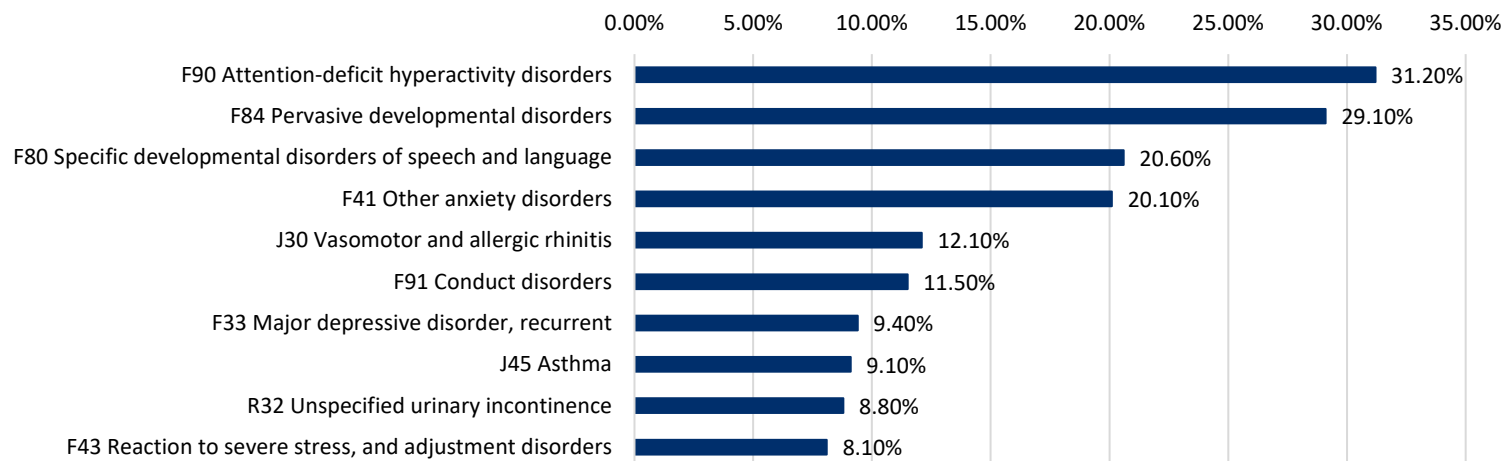
Table 22. Demographics – Children and Adolescents				
Member Population	All n = 33,216	Medicaid Direct n = 9,280	Tailored Plan n = 23,608	State Funded n = 328
Plan Type, %				
Medicaid Direct	27.9	100.0	0.0	0.0
Tailored Plan	70.2	0.0	98.8	0.0
TP Innovations	0.9	0.0	1.2	0.0
State Funded	1.0	0.0	0.0	100.0
Gender, %				
Female	40.1	48.1	36.8	46.0
Male	59.9	51.9	63.2	54.0
Age Group, %				
0-5 years	15.5	21.1	13.5	3.7
6-10 years	26.4	26.6	26.6	6.1
11-15 years	28.2	28.8	27.9	27.1
16-20 years	29.9	23.5	32.0	63.11
Language, %				
English	45.4	12.3	57.8	85.7
Spanish	2.8	0.3	3.8	2.1
Sign Language	<0.1	0.0	0.0	0.3
Unknown	51.8	87.3	38.4	11.9
Race, %				
American Indian/Native				
American	0.6	1.3	0.3	0.6
Asian	1.3	0.9	1.5	2.4
Black/African American	28.3	26.5	29.2	16.8
Multiracial	<0.1	0.0	0.0	2.4
Pacific Islander	0.1	0.1	0.14	1.5
White	65.1	67.3	64.1	75.0
Other	<0.1	0.0	<0.1	1.5

Unknown	4.5	3.9	4.8	1.2
Ethnicity, %				
Hispanic	13.9	7.5	16.34	88.4
Non-Hispanic	84.8	90.8	82.4	11.6
Unknown	1.3	1.7	1.2	0.0
Reside in catchment area, %				
Yes	94.01	90.18	95.5	93.9

Sources: HBI, refreshed on 12/1/2025, retrieved on 1/19/2026; CCM Program Member Tracker

Figure 25 shows the top 10 chronic diseases with all members between the ages of 0-20 years old. The most common chronic disease within this population is F90 attention-deficit hyperactivity disorder (31.2%). Attention-deficit hyperactivity disorder was also the most common chronic condition for child and adolescent members in CY24. Compared to the 2025 Population Health Assessment, the most common chronic conditions remained very similar for the child and adolescent population. The only notable difference is the presence of F34 Reaction to severe stress, and adjustment disorders replaced E66 Overweight and obesity this year. The prevalence of all other conditions in the table remained within 5 percentage points of last year's prevalence.

Figure 25. Most Common Chronic Conditions Among Children and Adolescents (Aged 0-20 years)



Source: HBI 12/01/25 Refresh, Accessed 1/16/26

Table 23 presents HEDIS measures of particular interest to the Children and Adolescent population. Measures include follow up care for members receiving certain medications, wellness visits, and immunizations. High childhood immunization rates protect individual children from serious disease while also creating herd immunity that shields vulnerable people who cannot be vaccinated – keeping dangerous diseases suppressed or eliminated at the community level (CDC,

2024). Given the current measles outbreak, the compliance rate for the MMR vaccination is of note. According to the World Health Organization (WHO, 2019), about 95% of the population should be vaccinated to prevent the spread of measles.

Table 23. MY25 Child and Adolescent-Related Encounter Based HEDIS Measures by Plan Type

Measure	Indicator Name	Plan	Eligible	Compliant	Compliant Rate, %	MY25 State Goal, %
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	Medicaid Direct	348	166	47.70	63.00
		Tailored Plan	599	270	45.08	59.00
	Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	Medicaid Direct	133	66	49.62	75.00
		Tailored Plan	271	125	46.13	68.00
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol	Medicaid Direct	51	16	31.37	48.00
		Tailored Plan	1659	557	33.57	38.00
CIS	Childhood Immunization Status: Combination 10	Medicaid Direct	160	24	15.00	*
		Tailored Plan	31	1	2.70	41.00
	Childhood Immunization Status: DTaP	Medicaid Direct	160	74	46.25	*
		Tailored Plan	37	9	24.32	*
	Childhood Immunization Status: IPV	Medicaid Direct	160	81	50.63	*
		Tailored Plan	37	13	35.14	*
	Childhood Immunization Status: MMR	Medicaid Direct	160	133	83.13	*
		Tailored Plan	37	26	70.27	*
	Childhood Immunization Status: HiB	Medicaid Direct	160	89	55.63	*
		Tailored Plan	37	17	45.95	*
	Childhood Immunization Status: Hepatitis B	Medicaid Direct	160	62	38.75	*
		Tailored Plan	37	10	27.03	*
	Childhood Immunization Status: VZV	Medicaid Direct	160	133	83.13	*
		Tailored Plan	37	25	67.57	*
	Childhood Immunization Status: Pneumococcal conjugate	Medicaid Direct	160	69	43.13	*
		Tailored Plan	37	10	27.03	*
	Childhood Immunization Status: Hepatitis A	Medicaid Direct	160	134	83.75	*
		Tailored Plan	37	25	65.57	*
	Childhood Immunization Status: Rotavirus	Medicaid Direct	160	73	45.63	*
		Tailored Plan	37	10	27.03	*
	Childhood Immunization Status: Influenza	Medicaid Direct	160	53	33.13	*

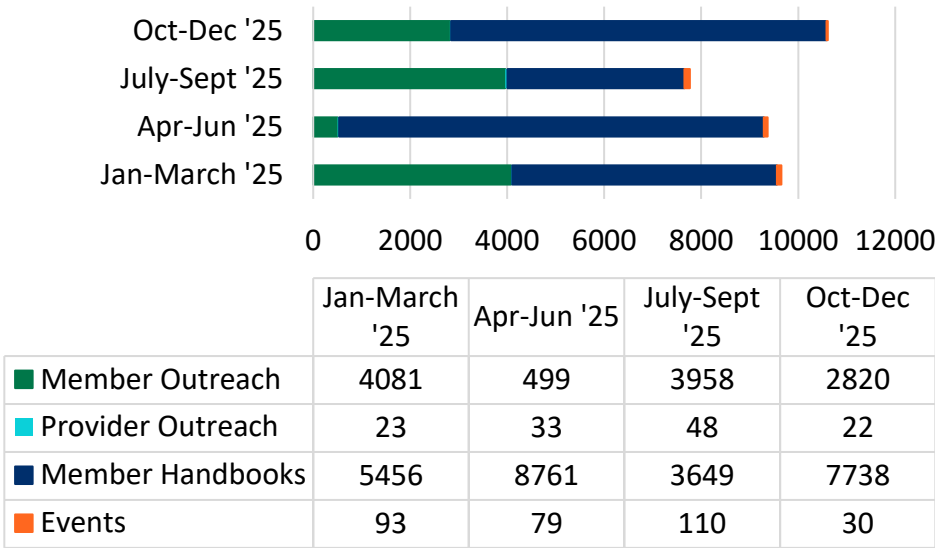
		Tailored Plan	37	4	10.81	*
IMA	Immunizations for Adolescents: Meningococcal	Medicaid Direct	422	317	75.12	*
		Tailored Plan	954	685	71.80	*
	Immunizations for Adolescents: Tdap	Medicaid Direct	422	304	72.04	*
		Tailored Plan	954	645	67.61	*
	Immunizations for Adolescents: HPV Vaccinations	Medicaid Direct	422	110	26.07	*
		Tailored Plan	954	200	20.96	*
W30	Well-Child Visits in the First 30 Months of Life: Well-Care Visits (15 mo)	Medicaid Direct	114	44	38.60	*
		Tailored Plan	4	0	0.00	58.00
	Well-Child Visits in the First 30 Months of Life: Well-Care Visits (15-30 mo)	Medicaid Direct	161	105	65.22	*
		Tailored Plan	43	23	53.49	76.00
WCV	Well-Care Visit	Medicaid Direct	1438	558	38.80	*
		Tailored Plan	19902	8708	43.75	56.00

**State goals not indicated on CareSeed report*

Source: CareSeed, HEDIS MY2025 Jan Prelim Partners, 1/9/26

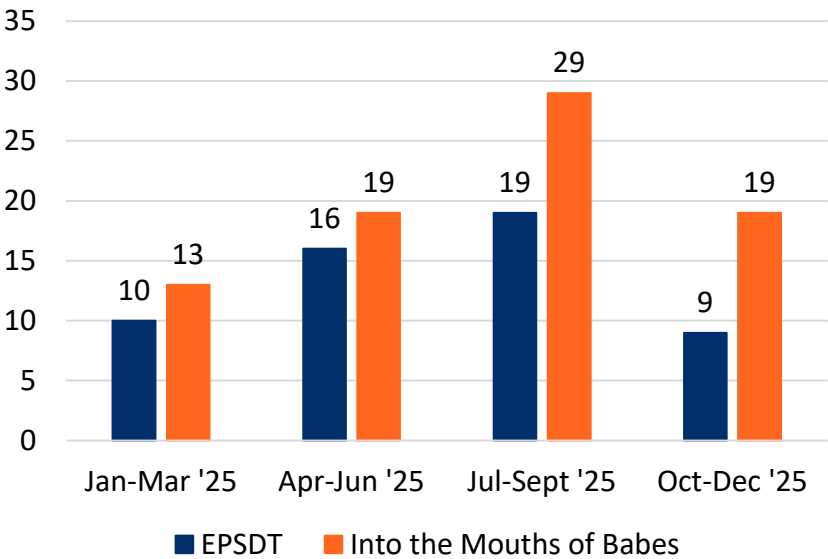
Partners supplies Early and Periodic Screening, Detection, and Treatment (EPSDT) benefit information and services to members from birth to 20 years old. Services are delivered within the standard of care that implements and adheres to all EPSDT policies and protocols as defined by the Centers for Medicare and Medicaid Services (Medicaid.gov, n.d.). Partners’ goal is to engage our members and supply the most accurate and up-to-date health information to empower our members for both physical and behavioral health needs.

Figure 26. Member and Provider Outreach



Source: Member Engagement STK002-M & MEM003-M Activities Report, Reports Manager: Mailings & EPSDT TruCare Tracking 2/3/25
Data for Q4 Member Outreach not available at time of submission.

Figure 27. EPSDT Trainings by Quarter



Source: Training & Development Webinar Registration Report

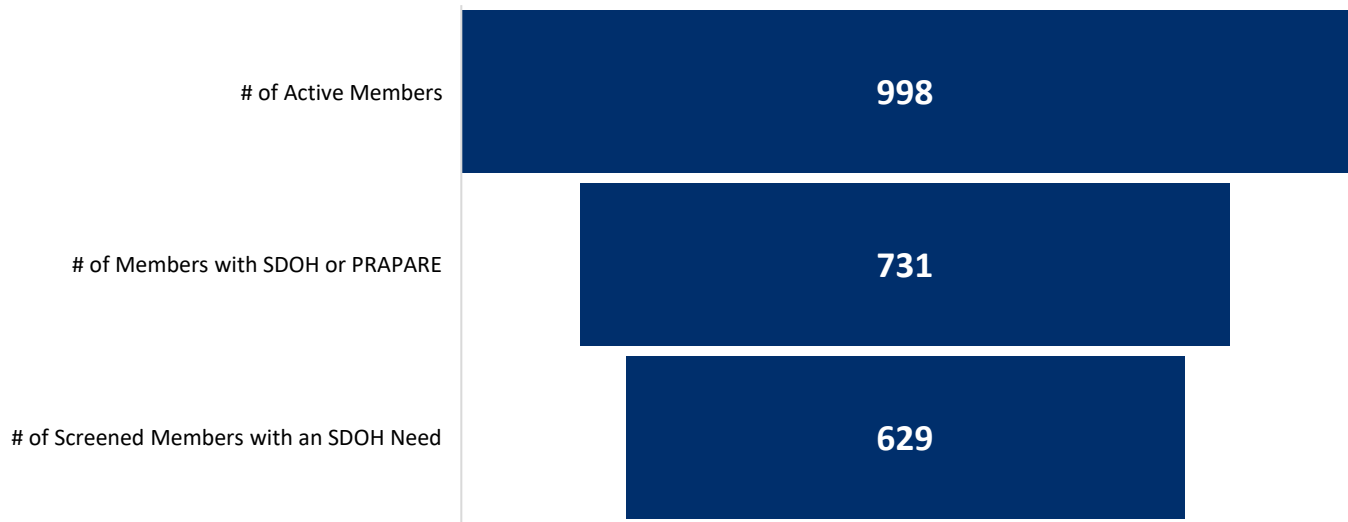
Outreach is provided by Partners’ Health Outreach Specialist, Member Engagement Specialists, Community Engagement team, and Care Managers. Member outreach includes wellness visit reminder mailings, care manager outreach, member events, and social media outreach. Provider outreach includes EPSDT and Into the Mouth of Babes webinars and provider outreach conducted by Carolina Complete Health. Figure 26 highlights member and provider outreach completed each quarter. This includes the number of handbooks provided to members, member outreach, provider outreach, and events completed in the community. Figure 27 shows the number of “EPSDT” and “Into the Mouths of Babes” trainings completed each quarter. The EPSDT training equips providers to better serve our child and adolescent members by providing education on the services and supports available through EPSDT. “Into the Mouths of Babes” is a North Carolina program that trains primary care providers to deliver preventive oral health services to young children.

Members Engaged with Pyx Health

Pyx Health is a wellness application for adults aged 18 years and older and is available to all Partners’ Medicaid members or State-Funded recipients. Pyx Health is free and may be downloaded to a mobile device, computer, or tablet. The app addresses loneliness, social isolation, and other behavioral health conditions through compassionate technology, humor, prompt human connection, and interventions. Pyx Health can help members and recipients improve their physical and mental health, as well as access other support related to health and barriers to receiving services and support.

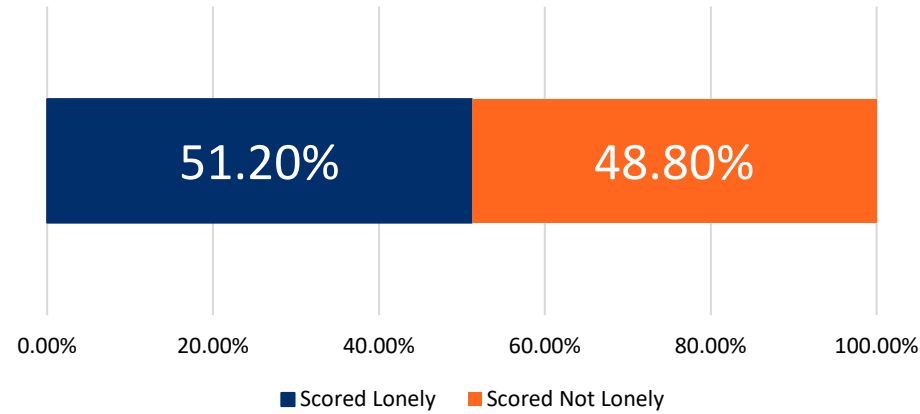
Figures 28 and 29 and Table 32 illustrate the current Pyx Health usage by Partners’ members. Of the 120,000 Partners' members, 3,934 (about 3.3%) were enrolled in Pyx as of the end of December 2025. During calendar year 2025, There were 998 active users and there were 18,367 interactions within the app. The most common activity types were the coloring book, resource center, Andy calls, mental health screeners (PHQ-4 for depression screening/UCLA-3 for loneliness and isolation screening), social drivers of health assessments (PRAPARE/SDOH) and mytools. The coloring book feature of the application has been linked with stress reduction, improved focus, enhanced mindfulness, creative expression, and anxiety and depression relief. The Andy calls are a feature of Pyx Health that connect members to via phone or text to trained support staff who can connect members to resources, provide companionship, address social drivers of health, and improve mood and motivation. The mytools activities include mindfulness activities, games such as sudoku or snake and meditation.

Figure 28. Pyx Health SDOH Screening Utilization



Source: Pyx Health Data, Jan-Dec 2025

Figure 29. Percentage of Members with UCLA-3 Screening (n=787)



Source: Pyx Health Data, Jan-Dec 2025

Table 32. Most Common Pyx App Activity Types

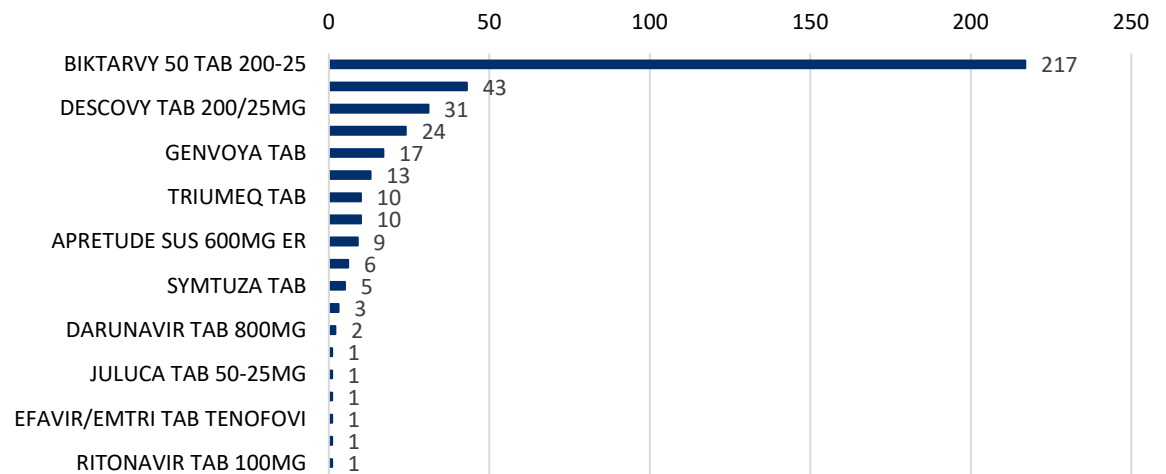
Activity Type	# of Interactions	# of Members
Resource	4780	459
Coloring Book	4366	54
BH Screening	3448	809
AndyCall	2624	720
MyTools	1321	246

Source: Pyx Health Data, Jan-Dec 2025

Members with HIV/AIDS

In CY25, antiretroviral medication Biktarvy was among the top expenditures of pharmacy spending. Based on pharmacy claims, 396 members received antiretroviral medications between January 1, 2025 and December 31, 2025. The most prescribed antiretroviral was Biktarvy with 217 members filling this medication during CY25. Most of the members receiving antiretrovirals are assigned to external providers with only 20.2% of these members assigned to Partners for Tailored Care Management. Of the 80 members assigned to Partners for TCM, 25% or 20 members have an open case identifying them as unengaged with TCM. Over 38% of members assigned to Partners have an open behavioral health case, indicating the member is enrolled in either tailored care management (TCM) for long term services and support (BH LTSS; 16) or behavioral health (BH TCM; 15). Members with no TCM are assigned to Partners for TCM and do not currently have an assigned care manager. Members with duplicative service are assigned to Partners but are not eligible for TCM due to enrollment in programs that provide care management services (e.g., ACTT, CAP/C, CAP/DA, etc.). Unengaged members are assigned to Partners for TCM and are assigned to Screening and Referral due to lack of response to outreach.

Figure 30. Number of Unique Members Prescribed Each Antiretroviral Medication



Source: CVS Claims from 1/1/25-12/31/25 Retrieved 2/23/26

Table 24. TCM Assignment for Members Prescribed Antiretrovirals

TCM Provider	# of Members
Assigned to Partners	80
Assigned Externally	273
Not Assigned	23
Not TCM Eligible	20

Source: CVS Claims with TCM Eligibility 1/1/25-12/31/25, Retrieved 2/23/26

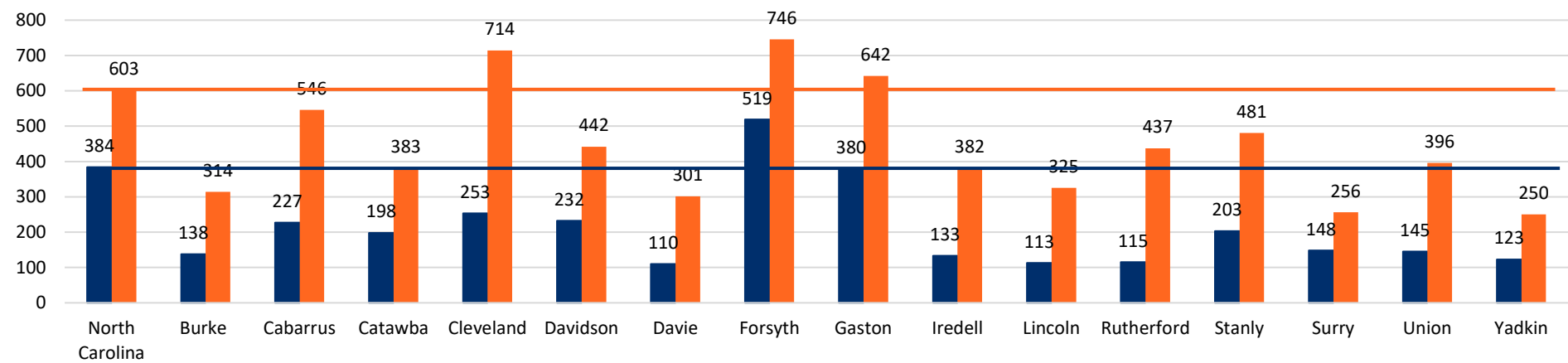
Table 25. Open Cases for Members Assigned to Partners

Type of Case	# of Members
Unengaged	20
BH LTSS	16
BH TCM	15
Duplicative Services	12
No Open TCM Case	7
IDD/Innovations TCM	5
Opt Out	4
Care Coordination Only	1

Source: CVS Claims with TCM Eligibility 1/1/25-12/31/25, Retrieved 2/23/26

Figure 31 includes rates of HIV and STI in North Carolina and among the 15 catchment counties. Forsyth County has a higher prevalence than the state rate for both HIV and chlamydia diagnoses.

Figure 31. HIV & STI Prevalence - Partners Catchment



Source: County Health Rankings, 2024

Members with Intellectual and Developmental Disabilities

Members with I/DD were identified as those having Innovations Medicaid or Tailored Plan Innovations Medicaid or on the Innovations Waitlist. We use this population to be representative of our I/DD population. There are 3,180 members or 99.75% of the Innovations population who are also part of the Tailored Plan population. Most of the Innovations population is male with 61.6% of members identified as male while 38.4% are identified as female. The Innovations population has less children and adolescents than other populations; 91.1% of Innovations members are over the age of 21 (Table 25). This population is also primarily White and non-Hispanic; 63.5% of Innovations members are white and 92.1% are identified as non-Hispanic (Table 25). Table 25 also includes data for our members who are on the waitlist for the innovation waiver. There are 5,465 members on the waitlist. Members on the waitlist are younger than those who already have an innovations slot with 52.2% of waitlist members being under the age of 21 while less than 10% of current waiver members are under 20. Notably, the proportion of Hispanic members on the waitlist is more than twice the proportion of members with the waiver.

Table 25. Demographics – Innovations Waiver and Innovations Waitlist

Member Population	Innovations Waiver n = 3,188	Innovations Waitlist n = 5,465
Plan Type, %		
Medicaid Direct	0.4	0.0
TP Innovations	99.6	0.0
TP Medicaid	0.0	92.3
Medicaid	0.0	7.7
Age Group, %		
0-20 years	8.9	52.2
21-34 years	45.9	25.8
35-64 years	41.4	19.3
65+ years	3.8	2.8
Gender, %		
Female	38.4	35.2
Male	61.6	64.9
Language %		
English	56.8	96.5
Spanish	0.7	2.4
French	0.03	0.0
Sign Language	0.1	0.0
Other	0.3	1.1
Unknown	42.1	0.0
Race, %		
American Indian/Native American	0.1	0.3

Table 26. Partners Catchment Counties with Longest Waitlist

County	Average Wait (Years)	# of Members
Forsyth	7.8	905
Gaston	5.6	616
Iredell	4.55	397
Union	4.13	450
Cabarrus	3.92	525
All Catchment	6.8	5,465

Source: MEM016 – Innovations Waitlist Retrieved 1/30/26

Asian	1.4	1.7*
Black/African American	24.2	24.6
Pacific Islander	0.1	1.7*
White	63.1	53.3
Unknown	11.2	20.0
Ethnicity, %		
Hispanic	3.5	8.6
Non-Hispanic	92.3	87.3
Unknown	4.1	4.1
Reside in catchment area, %		
Yes	94.2	99.9

Source: HBI 12/02/25 Refresh, Accessed

Table 27-29 shows the prevalence of neurodevelopmental disorders among Innovations members, qualifying waitlist diagnoses and top conditions for innovations members. Almost half are diagnosed with moderate intellectual disabilities. The total prevalence for all intellectual disability diagnoses totals more than 100%, indicating that many members are likely to have multiple intellectual disability diagnoses. Over 40% of Innovations members have pervasive developmental disorders a diagnosis which includes autism spectrum disorder. The prevalence of neurodevelopmental disorders for this population is similar to the prevalences reported in the 2025 Population Health Assessment. The five most common qualifying diagnoses for the waitlist are very similar to the neurodevelopmental disorders among Innovations members with pervasive developmental disorders and varied levels of intellectual disabilities showing up in both lists. Epilepsy and anxiety are the two most prevalent conditions among innovations members with nearly a quarter of members having epilepsy and/or anxiety. Table 30-31 shows the top five services utilized by members on the waitlist by the number of unique members and the amount spent. Tailored Care Management, All Inclusive Room and Board as well as 1915i services appear in both tables.

Table 27. Neurodevelopmental Disorders among Innovations Members (n=3,185)

Chronic Disease	# Members	% Members
F71 Moderate intellectual disabilities	1,563	49.1
F84 Pervasive developmental disorders (autism)	1,348	42.3
F70 Mild intellectual disabilities	1,187	37.3
F79 Unspecified intellectual disabilities	878	27.6
F72 Severe intellectual disabilities	977	27.5

Source: HBI, 1-1-26 refresh, retrieved on 2/6/26

Table 28. Most Common Qualifying Diagnosis for Waitlist Members (n=5,465)

Chronic Disease	# Members	% Members
F84 Pervasive developmental disorders (autism)	2,096	38.4
F70 Mild intellectual disabilities	933	17.1
F71 Moderate intellectual disabilities	888	16.2
F79 Unspecified intellectual disabilities	558	10.2
R62 Delayed Milestone in Childhood	209	3.8

Source: MEM016 – Innovations Waitlist Retrieved 1/30/26

Table 29. Most Common Chronic Conditions among Innovations Members (n=3,185)

Chronic Disease	# Members	% Members
G40 Epilepsy and recurrent seizures	817	25.70
F41 Other anxiety disorders	787	24.70
R32 Unspecified urinary incontinence	739	23.20
E78 Disorders of lipoprotein metabolism and other lipidemias	733	23.00
K21 Gastro-esophageal reflux disease	592	18.60
E66 Overweight and obesity	583	18.30
I10 Essential (primary) hypertension	565	17.70
G80 Cerebral palsy	544	17.10
F90 Attention-deficit hyperactivity disorders	467	14.70
J30 Vasomotor and allergic rhinitis	420	13.20

Source: HBI, 1-1-26 refresh, retrieved on 2/6/26

Table 30. Top 5 Most Utilized Services for Waitlist Members

Category of Service	Unique Members	Amount Expensed	Units Expensed
Tailored Care Management	2,433	\$34,622,138.58	127,925
Outpatient E&M (Code 30)	1,139	\$2,646,545.30	27,130
Outpatient Evaluation	706	\$826,195.59	5,140
1915i CLS Services	694	\$39,669,073.53	5,295,765
All-Inclusive Room And Board Plus Ancillary	674	\$162,310,071.80	560,001

Source: Innovations Top 10 Report CY25, retrieved 3/12/26

Table 31. Top 5 Costliest Services for Waitlist Members

Category of Service	Unique Members	Amount Expensed	Units Expensed
All-Inclusive Room And Board Plus Ancillary	674	\$162,310,071.80	560,001
97153 RB-BHT All	570	\$73,435,535.16	3,585,243
1915i CLS Services	694	\$39,669,073.53	5,295,765
Tailored Care Management	2,433	\$34,622,138.58	127,925
1915i Services	562	\$24,146,550.48	1,892,898

Source: Innovations Top 10 Report CY25, retrieved 3/12/26

Members with Hearing Loss

Hearing loss may be congenital or acquired. Some individuals with hearing loss identify as hard of hearing (HOH) or d/Deaf. The term “deaf” using a lowercase “d” refers to a medical condition whereas “Deaf” with a capital “D” refers to a cultural identity. Deaf culture has common norms, values, traditions, behaviors, and a shared language (American Sign Language). Many older adults experience hearing loss but do not identify as culturally Deaf. The data included below is based on medical diagnoses (H90: Conductive and sensorineural hearing loss; H91: Other and unspecified hearing loss; and Q16: Congenital malform of ear causing impairment of hearing). Using medical diagnoses does not allow for analysis based on Deaf identity and includes those with congenital and acquired hearing loss.

Among members with hearing loss, most are over 50 years old (62.9%), White (69.0%), non-Hispanic (87.6%), and reside in Partners’ catchment area (94.1%). Notably, language information is missing for about half of all members with hearing loss (Table 32).

Table 32. Demographic Information for Members with Hearing Loss

	All n = 4,425	Medicaid Direct n = 3,416	Tailored Plan n = 992	State Funded n = 17
Plan Type, %				
Medicaid Direct	77.2	100.00	0.0	0.0
Tailored Plan	19.0	0.0	84.7	0.0
Innovation	3.4	0.0	15.3	0.0
State Funded	0.4	0.0	0.0	100.0
Gender, %				
Female	59.1	62.8	46.1	58.8
Male	41.0	37.2	53.9	41.2
Age Group, %				
18-20 years	21.2	11.5	54.6	0.0
21-34 years	7.1	3.5	19.6	23.5
35-49 years	8.8	7.9	11.6	23.5
50-64 years	18.1	19.5	13.0	41.2
65+ years	44.8	57.6	1.2	23.5
Language*, %				
English	49.8	47.4	57.5	88.2
Spanish	2.2	1.9	3.0	0.0
Sign Language	0.4	0.4	0.4	0.0
French	<0.1	0.0	0.1	0.0
Unknown	47.6	50.3	39.0	11.8
Race, %				
American Indian/Native American	0.5	0.6	0.3	0.0
Asian	3.0	3.4	1.8	0.0
Black/African American	20.2	20.0	21.2	0.0
Multiracial	<0.1	0.0	0.1	0.0
Pacific Islander	0.2	0.2	0.2	0.0
White	69.0	69.1	68.2	100.0
Unknown	7.1	6.8	8.3	0.0
Ethnicity, %				
Hispanic	9.5	8.1	14.5	0.0
Non-Hispanic	87.6	89.3	81.4	100.0
Unknown	2.9	2.6	4.1	0.0
Reside in catchment area, %, yes	94.1	93.9	94.8	100.0

Source: HBI 12/1/25 Refresh, pulled 12/3/25; Reports Manager, Population Demographics

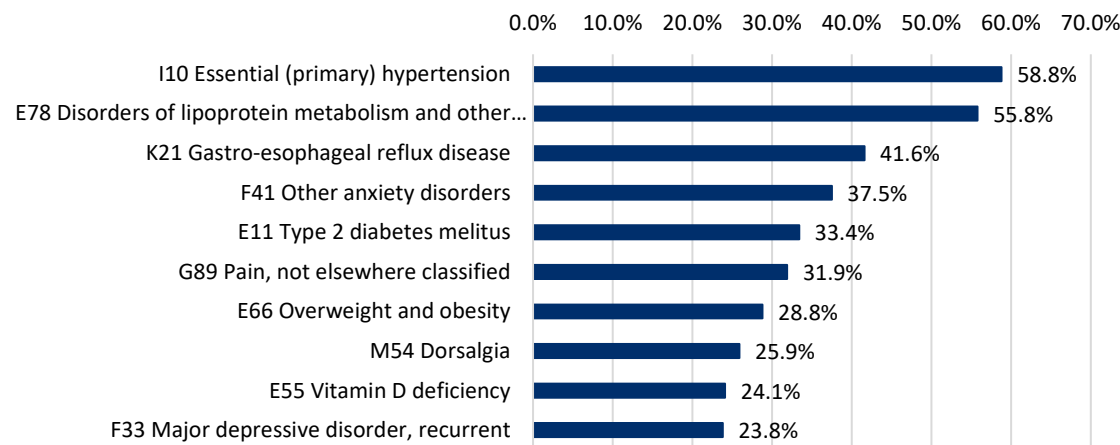
Table 33. Cost of Care by Category: Members with Hearing Loss

Cost Category	Total Patients	Total Member Months	Total Cost (\$)	Actual Cost PMPM (\$)
Total Cost of Care:				
Physical & Behavioral	4,244	55,614	\$156,926,897	\$2,822
Physical Health	4,244	55,614	\$99,977,510	\$1,798
Facility: IP	4,244	55,614	\$11,245,463	\$205
Facility: ED	4,244	55,614	\$2,377,609	\$43
Facility: Other	4,244	55,614	\$36,118,442	\$649
Professional	4,244	55,614	\$50,055,996	\$900
Behavioral Health	4,244	55,614	\$56,949,387	\$1,024
Facility: IP	4,244	55,614	\$814,416	\$15
Facility: ED	4,244	55,614	\$132,036	\$2
Facility: Other	4,244	55,614	\$15,697,991	\$282
Professional	4,244	55,614	\$40,304,944	\$725

Source: Cost of Care by Category. Tailored Plan Members with hearing loss diagnosis. HBI, 2-1-25 refresh, retrieved on 3/11/25

The overall cost of care for members with hearing loss was higher per member per month than that of the full population (\$2,822 vs. \$2,074). The largest gap was observed in physical health care costs (\$1,798 vs. \$1,205) in which members with hearing loss had higher per member per month cost in every sub-category.

The cost of care per member, per month for members with hearing loss for behavioral health care was slightly higher (\$1,024 vs. \$869) compared to the full population. Per member, per month cost for inpatient behavioral health and emergency department behavioral health were the only subcategories in which members with hearing loss had lower cost.

Figure 32. Most Frequent Chronic Diseases Among Members with Hearing Loss (n=4,244)

Source: HBI 1/1/26 Refresh; Accessed 2/20/26

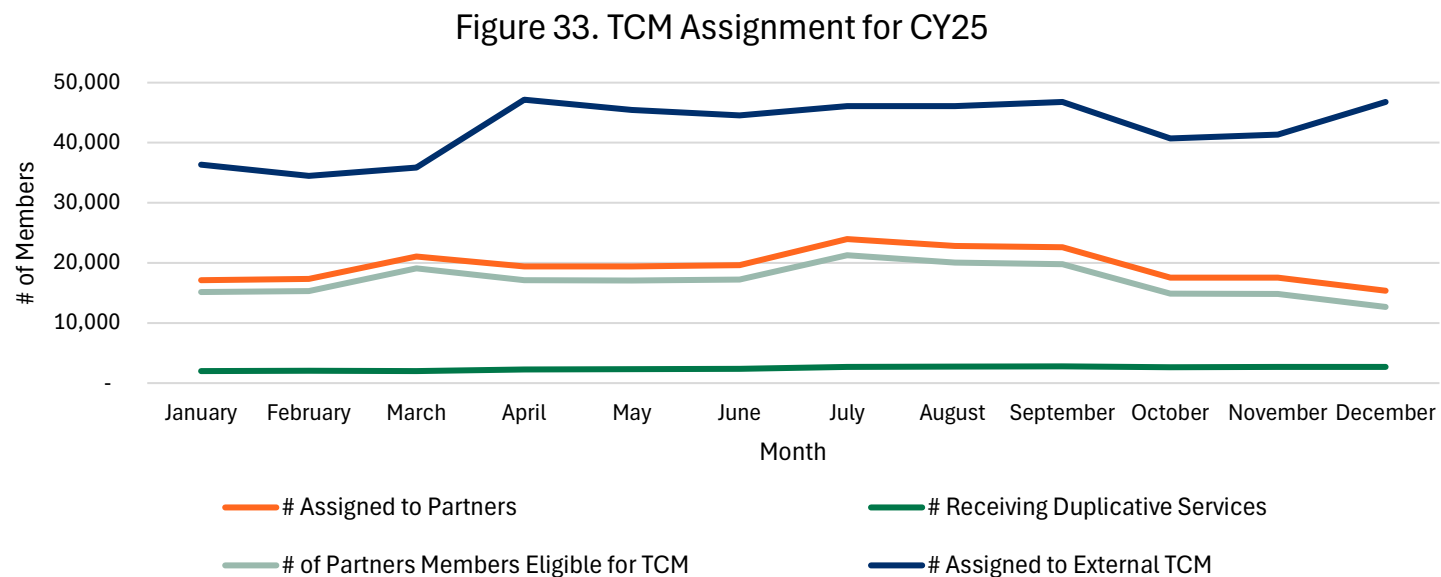
The most common chronic diseases, not including hearing loss, for all members with hearing loss are shown in Figure 32. Over half of this group has hypertension or high cholesterol. Of note for Partners' diabetes program, about one-third of this group (n=1,416) has Type 2 Diabetes. This suggests a need to examine the accessibility of the program, as the interventions are primarily delivered telephonically.

Utilization Information

This section has utilization information for the total Medicaid population and the Tailored Plan population, as well as care management data and benefit plan and service cost trends for the entire population. We included data from claims, our electronic health record system, and the Pyx Health application.

Tailored Care Management Engagement

Approximately 17,575 members are assigned to Partners for tailored care management services; approximately 44,000 members are assigned to external care management agencies. Tailored Care Management is a specialized service within North Carolina's Tailored Plan Medicaid program that provides individualized support to members with the most complex behavioral health, intellectual/developmental disability, and traumatic brain injury needs. A dedicated care manager works closely with each member to coordinate their physical health, behavioral health, and social services, ensuring they receive the right care at the right time through a personalized, whole-person approach.

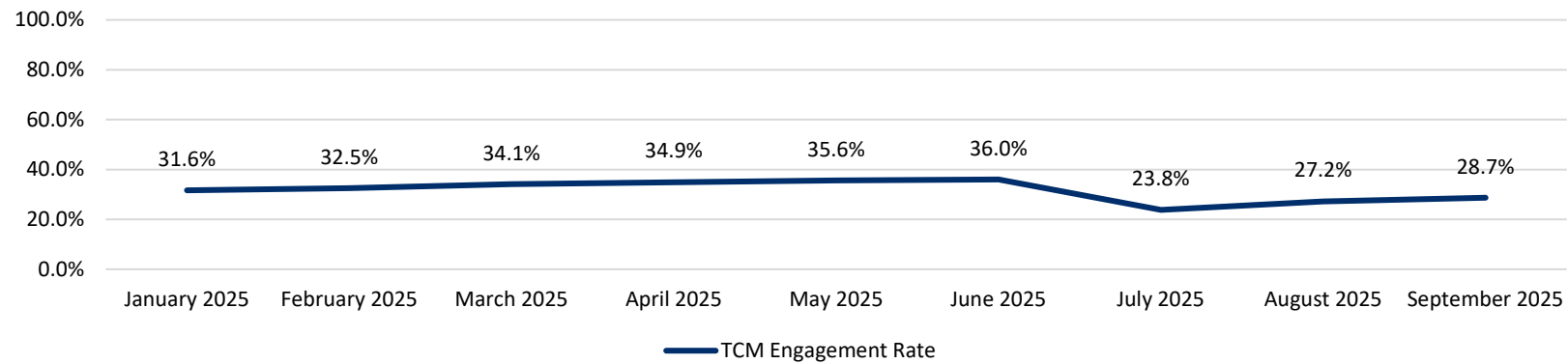


Source: TCM Assignment Files 1/1/25-12/31/25

Figure 33 displays TCM assignment and engagement trends throughout CY25. The number of Tailored Plan eligible members assigned to external care management agencies has increased over the year as Partners has shifted the risk stratification to keep the highest risk members assigned to internal care management. The number of members receiving duplicative services has slightly increased over the year which reduces the number of internally assigned members who are eligible for tailored care management.

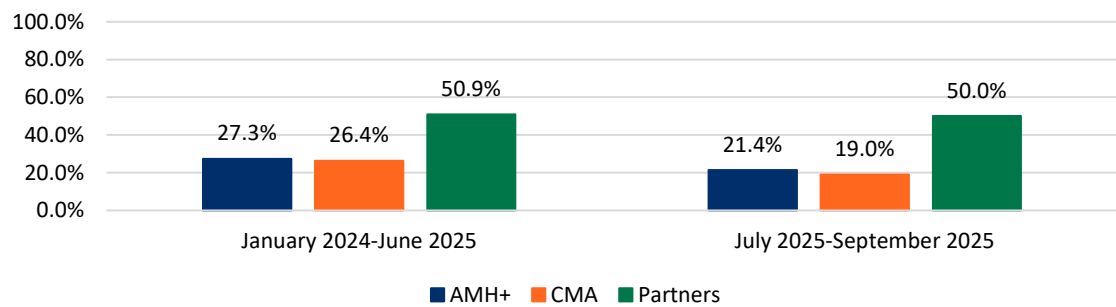
Aggregate monthly overall cumulative TCM engagement rates are available from NCDHHS from January 2025-September 2025. Quarter 4 data were not available at the time of this report. Aggregate engagement rates by TCM provider category from NC DHHS are available for the time periods July 2024-June 2025 and July 2025-September 2025. Numbers reflect those with a paid claim for TCM engagements divided by the number of members assigned for TCM. Figure 34 shows the overall cumulative engagement rate for all Partners Tailored Plan members in TCM from January 2025-September 2025. We observed a dip in engagement rates in July 2025 which appears to be trending upward. Figure 35 shows aggregate engagement rate by TCM provider category. Members with Partners TCM had the highest engagement rates of the three care management entity types.

Figure 34. Overall Cumulative TCM Engagement Rate



Source: NC Analytics TCM Claims, July 1, 2024-September 30, 2025.

Figure 35. Engagement Rates for all Assigned Members by Care Management Entity



Source: NC Analytics TCM Claims, July 1, 2024-September 30, 2025.

Figure 36 shows the proportion of members assigned to Partners TCM with an open case, and of those the proportion engaged in TCM by quarter. Proportion of open TCM case is the number of members with open cases (i.e., assigned to a care manager) divided by number of members eligible for Partners TCM. Open case and engaged is of those with the open TCM case (e.g., assigned to a care manager) who had billable contact within the quarter. This type of stratification is not available for external TCM providers.

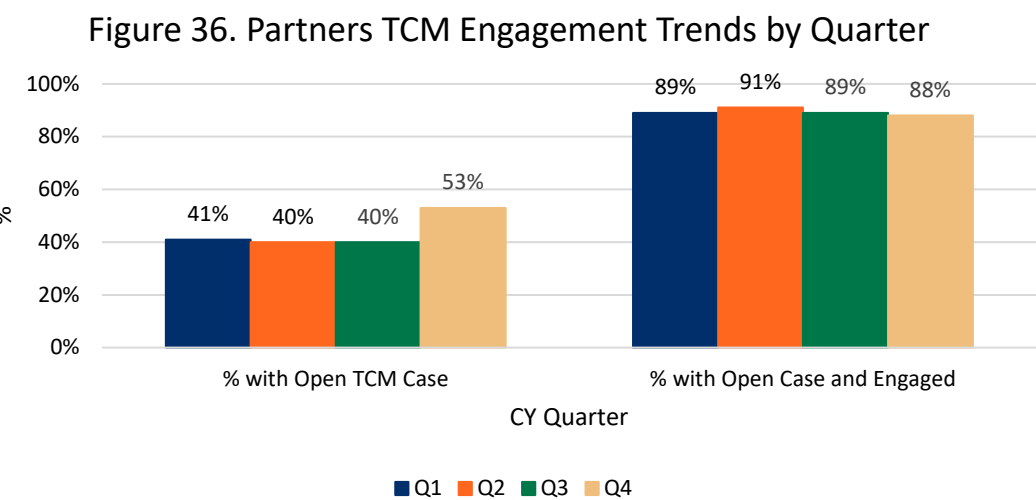
Tables 34 and 35 display internal TCM engagement stratified by race and gender. This data reflects members who were eligible for TCM in November 2025 and reflects any TCM engagement between January 1 and December 31. Over 60% of all members assigned to Partners in November have had at least 1 billable contact by Partners TCM staff during CY25. TCM engagement rates were slightly lower for females (60.3%) than males (63.6%). External TCM engagement by race and gender was not available for CY25.

Table 34. Partners TCM Engagement by Race							
	All (n=17,575)	American Indian/Native (n=50)	Asian (n=173)	Black/African American (n=4,454)	Pacific Islander (n=17)	Unknown (n=2,470)	White (n=10,411)
Engaged	62.2	58.0	64.2	66.9	58.8	65.3	59.4
Unengaged	37.9	42.0	35.8	33.1	41.2	34.7	40.7

Source: November TCM File with CY25 Engagement Added

Table 35. Partners TCM Engagement by Gender				
	All (n=17,575)	Male (n=8,759)	Female (n=7,180)	Unknown (n=1,636)
Engaged	62.2	63.6	60.3	62.5
Unengaged	37.9	36.4	39.7	37.5

Source: November TCM File with CY25 Engagement Added



Source: Open TCM Cases and TCM Engagement Data 1/1/25-12/31/25

Total Cost of Care

Tables 36 and 37 show the total cost of care and the actual cost per member per month (PMPM) for physical health and behavioral health facilities. The “other” category includes any claim that is not an IP or ED claim. The “professional” category often includes claims from doctor’s office visits. The first table displays information for the Tailored Plan population, and the second table displays information for the total Medicaid population. The total cost of care for the Tailored Plan population was \$1,575,691,773 and \$2,762,135,471 for the total Medicaid population.

Table 36. Cost of Care by Category: Tailored Plan Population

Cost Category	Total Members	Total Member Months	Total Cost (\$)	Actual Cost PMPM (\$)
Total Cost of Care	53,545	576,110	\$1,575,691,773	\$2,735
Physical Health	53,545	576,110	\$678,515,855	\$1,178
Facility: IP	53,545	576,110	\$163,263,736	\$283
Facility: ED	53,545	576,110	\$68,014,752	\$118
Facility: Other	53,545	576,110	\$152,359,388	\$264
Facility: Professional	53,545	576,110	\$294,877,979	\$512
Behavioral Health	53,545	576,110	\$897,175,918	\$1,557
Facility: IP	53,545	576,110	\$36,224,257	\$63
Facility: ED	53,545	576,110	\$4,862,446	\$8
Facility: Other	53,545	576,110	\$62,119,407	\$108
Facility: Professional	53,545	576,110	\$793,969,807	\$1,378

Source: Cost of Care by Category. Medicaid Population. HBI, 1-1-26 refresh, retrieved on 2/18/26.

Table 37. Cost of Care by Category: Total Medicaid Population

Cost Category	Total Members	Total Member Months	Total Cost (\$)	Actual Cost PMPM (\$)
Total Cost of Care	112,555	1,206,168	\$2,762,135,471	\$2,290
Physical Health	112,555	1,206,168	\$1,600,794,034	\$1,327
Facility: IP	112,555	1,206,168	\$211,790,287	\$176
Facility: ED	112,555	1,206,168	\$75,292,788	\$62
Facility: Other	112,555	1,206,168	\$649,411,079	\$538
Facility: Professional	112,555	1,206,168	\$664,299,881	\$551
Behavioral Health	112,555	1,206,168	\$1,161,341,436	\$963
Facility: IP	112,555	1,206,168	\$40,100,777	\$33
Facility: ED	112,555	1,206,168	\$5,295,560	\$4
Facility: Other	112,555	1,206,168	\$211,866,624	\$176
Facility: Professional	112,555	1,206,168	\$904,078,476	\$750

Source: Cost of Care by Category. Medicaid Population. HBI, 1-1-26 refresh, retrieved on 2/18/26

Utilization by Facility Type

The following tables illustrate utilization for multiple facility types. This data depicts which facilities members are using the most, as well as the total costs associated with each facility type.

Tables 38 and 39 display utilization by facility type for the Tailored Plan population and the total Medicaid population. Facility type includes claims from all sources (e.g., behavioral health, physical health, and integrated care). Each table has information for 10 different facility types. For the Tailored Plan population, the highest total cost of care was in Long Term Care (LTC) with \$47,186,261 in cost for CY25. For the total Medicaid population, the highest total cost of care was in Skilled Nursing Facilities (SNF) with \$411,254,977.

Tables 40 and 41 show IP admits per 1000, IP days per 1000, and ED admits per 1000 for the Tailored Plan and total Medicaid populations.

“Admits per 1,000” is a term representing how many individuals are admitted to a hospital, healthcare facility or treatment center for every 1,000 individuals who seek care at the facility. Many individuals enter through the emergency department or in-patient admissions at hospitals, but other types of medical providers are included, such as psychiatric facilities. Hospitals and other medical facilities encounter ongoing challenges to prepare budgets and cost estimates for future years. Admits per 1,000 is one-way healthcare organizations can project future financial needs based on the past year's actual member statistics. This ratio can help healthcare centers to find solutions to minimize costs, manage resources, and adjust budgets.

Table 38. Utilization by Facility Type: Tailored Plan Population

Facility Type	Total Visits	Unique Members	Total Cost (\$)	Cost/Visit (\$)	Visits/1000
LTC	16,612	417	\$47,186,261	\$2,840	39,837
Acute IP	4,074	2,596	\$32,630,210	\$8,009	1,569
ED Visits	6,186	3,368	\$5,954,190	\$963	1,837
Outpatient Services	2,195	1,052	\$562,417	\$256	2,087
SNF	114	16	\$479,491	\$4,206	7,125
Outpatient Surgery	35	25	\$111,450	\$3,184	1,400
Hospice	19	3	\$97,810	\$5,148	6,333
Home Health	30	7	\$9,127	\$304	4,286
Urgent Care	2	2	\$233	\$117	1,000

Source: Utilization by Facility Type. Tailored Plan Population. HBI, 1-1-26 refresh, retrieved on 2/20/26.

Table 39. Utilization by Facility Type: Total Medicaid Population

Facility Type	Total Visits	Unique Members	Total Cost (\$)	Cost/Visit (\$)	Visits/1000
SNF	151,854	5,608	\$411,254,977	\$2,708	27,078
LTC	39,238	944	\$146,338,237	\$3,730	41,566
Acute IP	14,481	9,947	\$69,840,391	\$4,823	1,456
Hospice	3,162	543	\$22,538,974	\$7,128	5,823
ED Visits	41,240	19,913	\$11,554,827	\$280	2,071
Outpatient Services	102,662	26,418	\$11,462,748	\$112	3,886
Outpatient Surgery	10,565	6,052	\$5,529,757	\$523	1,746
Home Health	2,613	301	\$457,287	\$175	8,681
Urgent Care	808	709	\$92,391	\$114	1,140
Other OP	231	197	\$76,511	\$331	1,173

Source: Utilization by Facility Type. Medicaid Population. HBI, 1-1-26 refresh, retrieved on 2/20/26.

Table 40. Admits Per 1000: Tailored Plan Population

	Total Members	Total Member Months	Actual Per Year	Actual Per Month
IP Admits/1000	53,545	576,110	219	18
Physical Health	53,545	576,110	137	11
Behavioral Health	53,545	576,110	82	7
IP Days/1000	53,545	576,110	1,339	112
Physical Health	53,545	576,110	748	62
Behavioral Health	53,545	576,110	591	49
ED Visits/1000	53,545	576,110	1,038	86
Physical Health	53,545	576,110	936	78
Behavioral Health	53,545	576,110	102	8

Source: Admits per 1000. Tailored Plan Population. Source: HBI, 1-1-26 refresh, retrieved on 2/20/26

Table 41. Admits Per 1000: Total Medicaid Population

	Total Members	Total Member Months	Actual Per Year	Actual Per Month
IP Admits/1000	112,555	1,206,168	212	18
Physical Health	112,555	1,206,168	163	14
Behavioral Health	112,555	1,206,168	49	4
IP Days/1000	112,555	1,206,168	1,285	107
Physical Health	112,555	1,206,168	931	78
Behavioral Health	112,555	1,206,168	353	29
ED Visits/1000	112,555	1,206,168	853	71
Physical Health	112,555	1,206,168	792	66
Behavioral Health	112,555	1,206,168	61	5

Source: Admits per 1000. Medicaid Population. HBI, 1-1-26 refresh, retrieved on 2/20/26.

Pharmacy Utilization

Tables 42-43 and Figure 35 show the classes of medication with the highest cost, the medications with the highest number of prescriptions and point of sale prescription expenditures for January 1 - December 31, 2025. The top five medication classes by gross cost were very similar between each quarter with Antipsychotics/antimanic agents being the highest cost class and the same five classes appearing in the top five throughout the year. The top five prescriptions remained nearly the same over the whole year with the top prescription remaining Trazadone throughout the year. Figure 37 shows the pharmacy cost as calculated by our pharmacy vendor, CVS. The pharmacy cost has increased over the year but has remained around 55-56 million since Quarter 3.

Table 42. Top 5 GPI Therapeutic Classes by Total Gross Cost for CY25

Q1	Q2	Q3	Q4
Antipsychotics/Antimanic Agents	Antipsychotics/Antimanic Agents	Antipsychotics/Antimanic Agents	Antipsychotics/Antimanic Agents
ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiant	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiant	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiant	Anticonvulsants
Anticonvulsants	Anticonvulsants	Anticonvulsants	Dermatologicals
Antivirals	Antivirals	Dermatologicals	Antivirals
Dermatologicals	Dermatologicals	Antivirals	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiant

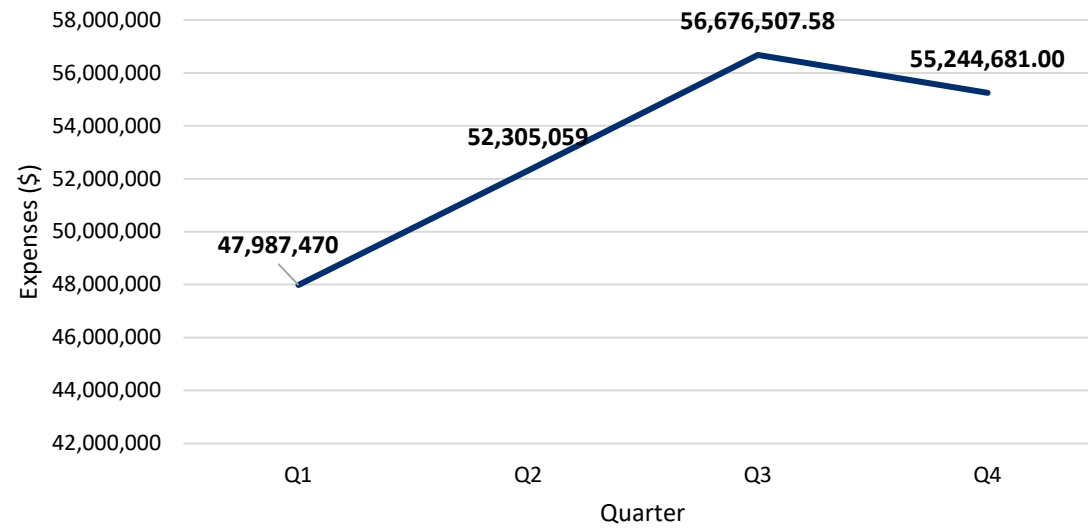
Source: CVS Pharmacy Claims 1/1/25-12/31/25

Table 43. Top 5 Prescriptions by Utilization for CY25

Q1	Q2	Q3	Q4
Trazadone Hydrochloride	Trazadone Hydrochloride	Trazadone Hydrochloride	Trazadone Hydrochloride
Gabapentin	Cetirizine Hydrochloride	Gabapentin	Gabapentin
Cetirizine Hydrochloride	Gabapentin	Cetirizine Hydrochloride	Hydroxyzine Hydrochloride
Clonidine Hydrochloride	Ventolin HFA	Ventolin HFA	Cetirizine Hydrochloride
Amphetamine/Dextroamphetamine	Hydroxyzine Hydrochloride	Hydroxyzine Hydrochloride	Clonidine Hydrochloride

Source: CVS Pharmacy Claims 1/1/25-12/31/25

Figure 37. Point of Sale Prescription Expenses by Quarter



Source: CVS Pharmacy Claims 7/1/24-12/31/24

State and Local Priorities

The State of North Carolina requires that all local health departments complete a Community Health Assessment (CHA) with a 3- or 4-year cycle for accreditation purposes. Table 52 displays the top three priorities named by each of our catchment counties in their most recent CHA. The CHA provides local health departments with an opportunity to gather data about the needs of their community and to develop priorities to focus on during the next 2-3 years.

Across the 15 catchment counties, mental health and substance use disorder emerge as the most universally shared health priorities, appearing together in most counties. Chronic disease, including obesity and diabetes, is also a recurring concern throughout our catchment. However, there is notable variation among counties - some, like Cleveland, focus on upstream social determinants such as poverty and structural racism, while others emphasize specific conditions like infant mortality or cancer. These county-level priorities inform a broader understanding of the health needs across the entire LME/MCO catchment area, helping to shape a comprehensive population health strategy for the region.

County	Date of Last CHA	Priority #1	Priority #2	Priority #3
Burke	2022	Mental Health	Substance Use Disorder	Obesity with Risk Factors
Cabarrus	2020	Housing	Mental and Behavioral Health	Early Childhood Education and Development
Catawba	2023	Access to Healthy Food	Brain Health	Safe, Engaging and Active Spaces
Cleveland	2023	Poverty	Economic Security	Structural Racism
Davidson	2021	Substance Misuse	Mental Health	Chronic Disease
Davie	2022	Mental Health	Substance Use	Access to Transportation
Forsyth	2021	Infant Mortality	Youth Violence	Chronic Disease
Gaston	2021	Access to Healthcare	Infant and Maternal Health	Substance Use
Iredell	2023	Cancer	Heart Disease	Obesity
Lincoln	2022	Access to Care	Health Behaviors	Substance Use
Rutherford*	2024	Substance Use	Pre-Diabetes/Diabetes	Mental Health
Stanly	2024	Mental Health	Substance Use	Chronic Disease Prevention
Surry	2022	Substance Abuse	Obesity	Mental Health
Union	2022	Chronic Disease Prevention	Mental Health	Substance Use
Yadkin	2023	Behavioral Health	Childhood Health	Senior Health

Rutherford County is part of Foothills Health District which includes McDowell County

Source: Most recent county CHAs, linked above

Many of the catchment county priorities can be found in or are related to the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) current strategic plan priorities for 2024-2029 (see Figure 38).

Figure 38.



Source: DMH/DD/SUS Strategic Plan 2024-2029

Appendix A. Care Opportunities

Within member profiles in TruCare, care managers can view individual open quality measures by member, including selected (not all) HEDIS measures. By default, the Care Opportunities section of the member profile shows any open care opportunities that the member has. These include any member level HEDIS measure that the member is identified as being not compliant. Table A1 presents aggregate data for care opportunities available through the member record in TruCare. Measurement scores highlighted green indicate that preliminary data suggests Partners has met or surpassed the state goal in MY25.

One key opportunity for improvement includes CBP: Controlling High Blood Pressure. High blood pressure is the most common chronic condition among Partners' members; almost one-third of members have a hypertension diagnosis. The CBP measure indicates that we have room to grow in helping members with hypertension control their blood pressure. Among Tailored Plan members with hypertension, 29.67% have their condition adequately controlled, short of the state goal (53.00%).

Well-care visits for children and adolescents impact almost 20,000 Partners' Tailored Plan members. Among Tailored Plan child and adolescent members, 43.75% had a well-care visit, short of the state goal (56.00%). This data indicates a need to consider different or additional opportunities to promote well-care visits for this population.

Table A1. Care Opportunities Measures - Aggregate Data, CY25

Measure	Indicator Name	Plan	Eligible	Compliant	MY25 Compliant Rate, %	MY25 State Goal, %	MY24 Compliant Rate, %
ADD	Follow-up care for children prescribed ADHD medication: Initiation phase	Medicaid Direct	348	166	47.70	63.00	48.05
		Tailored Plan	599	270	45.08	59.00	0.00
	Follow-up care for children prescribed ADHD medication: Continuation and maintenance phase	Medicaid Direct	133	66	49.62	75.00	55.88
		Tailored Plan	271	125	46.13	68.00	0.00
APM	Metabolic monitoring for children and adolescents on antipsychotics – Blood glucose testing	Medicaid Direct	51	28	54.90	67.00	59.46
		Tailored Plan	1659	885	53.35	59.00	57.02
	Metabolic monitoring for children and adolescents on antipsychotics – Cholesterol testing	Medicaid Direct	51	16	31.37	51.00	46.43
		Tailored Plan	1659	598	36.05	41.00	39.19
	Metabolic monitoring for children and adolescents on antipsychotics – Blood glucose and cholesterol testing	Medicaid Direct	51	16	31.37	48.00	44.11
		Tailored Plan	1659	557	33.57	38.00	37.26
APP	Use of first-line psychosocial care for children and adolescents on antipsychotics	Medicaid Direct	175	118	67.43	53.00	53.92
		Tailored Plan	314	146	46.50	49.00	44.95
BCS-E	Breast cancer screening	Medicaid Direct	4258	413	9.70	*	^

		Tailored Plan	649	273	43.47	47.00	^
CBP	Controlling high blood pressure	Medicaid Direct	12908	3941	30.53	*	^
		Tailored Plan	3128	928	29.67	53.00	^
CCS	Cervical cancer screening	Medicaid Direct	10068	756	7.51	*	^
		Tailored Plan	10358	3235	31.23	55.00	23.59
CHL	Chlamydia screening in women	Medicaid Direct	165	52	31.52	*	^
		Tailored Plan	2573	1522	59.15	59.00	57.42
CIS	Childhood immunization status – DtaP	Medicaid Direct	160	74	46.25	*	^
		Tailored Plan	37	9	24.32	*	^
	Childhood immunization status – Influenza	Medicaid Direct	160	53	33.13	*	^
		Tailored Plan	37	4	10.81	*	^
	Childhood immunization status – IPV	Medicaid Direct	160	81	50.63	*	^
		Tailored Plan	37	13	35.14	*	^
	Childhood immunization status – MMR	Medicaid Direct	160	81	50.63	*	^
		Tailored Plan	37	13	35.14	*	^
	Childhood immunization status – HiB	Medicaid Direct	160	89	55.63	*	^
		Tailored Plan	37	17	45.95	*	^
	Childhood immunization status – Hepatitis B	Medicaid Direct	160	62	38.75	*	^
		Tailored Plan	37	10	27.03	*	^
	Childhood immunization status – VZV	Medicaid Direct	160	133	83.13	*	^
		Tailored Plan	37	25	67.57	*	^
	Childhood immunization status – Pneumococcal Conjugate	Medicaid Direct	160	69	43.13	*	^
		Tailored Plan	37	10	27.03	*	^
	Childhood immunization status – Hepatitis A	Medicaid Direct	160	134	83.75	*	^
		Tailored Plan	37	25	65.57	*	^
GSD	Childhood immunization status – Rotavirus	Medicaid Direct	160	73	45.63	*	^
		Tailored Plan	37	10	27.03	*	^
	Glycemic status assessment for patients with diabetes – Glycemic status (<8.0%)	Medicaid Direct	10712	2335	21.80	*	^
		Tailored Plan	2853	603	21.14	*	^
FMC	Follow-up after emergency department visit for people with multiple high-risk chronic conditions	Medicaid Direct	1007	280	27.81	*	^
		Tailored Plan	564	141	25.00	*	^

FUA	Follow-Up after emergency department visit for alcohol and other drug dependence, 30-day follow-up	Medicaid Direct	727	206	28.34	32.00	37.35
		Tailored Plan	1552	722	46.52	47.00	49.71
	Follow-Up after emergency department visit for alcohol and other drug dependence, 7-day follow-up	Medicaid Direct	727	134	18.43	18.00	27.21
		Tailored Plan	1552	516	33.25	33.00	37.28
FUH	Follow-up after hospitalization for mental illness, 30-day follow-up	Medicaid Direct	1549	780	50.36	53.00	48.53
		Tailored Plan	3011	2018	67.02	45.00	65.80
	Follow-up after hospitalization for mental illness, 7-day follow-up	Medicaid Direct	1549	507	32.73	31.00	33.36
		Tailored Plan	3011	1342	44.57	26.00	48.30
FUI	Follow-up after high-intensity care for substance use disorder, 30-day follow-up	Medicaid Direct	409	91	22.25	*	^
		Tailored Plan	1081	574	53.10	*	^
	Follow-up after high-intensity care for substance use disorder, 7-day follow-up	Medicaid Direct	409	44	10.76	*	^
		Tailored Plan	1081	363	33.58	*	^
FUM	Follow-up after emergency department visit for mental illness, 30-day follow-up	Medicaid Direct	2639	1301	49.30	73.00	50.27
		Tailored Plan	3610	2097	58.09	65.00	49.85
	Follow-up after emergency department visit for mental illness, 7-day follow-up	Medicaid Direct	2639	809	30.66	50.00	35.75
		Tailored Plan	3610	1358	37.62	46.00	35.64
IMA	Immunizations for adolescents – Meningococcal	Medicaid Direct	422	317	75.12	*	^
		Tailored Plan	954	685	71.80	*	^
	Immunizations for adolescents – Tdap	Medicaid Direct	422	304	72.04	*	^
		Tailored Plan	954	645	67.61	*	^
	Immunizations for adolescents – HPV	Medicaid Direct	422	110	26.07	*	^
		Tailored Plan	954	200	20.96	*	^
PPC	Prenatal and Postpartum Care – Timeliness of prenatal care	Medicaid Direct	104	59	56.73	*	^
		Tailored Plan	608	306	50.33	46.00	56.57
	Prenatal and Postpartum Care – Postpartum care	Medicaid Direct	104	69	66.35	*	^
		Tailored Plan	608	349	57.40	53.00	43.07
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	Medicaid Direct	224	171	76.34	88.00	77.64
		Tailored Plan	3520	2765	78.55	86.00	81.91

W30	Well-child visits in the first 30 months of life (0-15 months)	Medicaid Direct	114	44	38.60	*	^
		Tailored Plan	4	0	0.00	58.00	0.0
	Well-child visits in the first 30 months of life (15-30 months)	Medicaid Direct	161	105	65.22	*	^
		Tailored Plan	43	23	53.49	76.00	76.92
WCV	Child and adolescent well-care visits	Medicaid Direct	1438	558	38.80	*	^
		Tailored Plan	19902	8708	43.75	56.00	52.86
Measure	Indicator Name	Plan	Index Stays	30-Day Readmits	MY25 Observed/Expected Ratio	MY25 State Goal, %	MY24 Observed/Expected Ratio
PCR	Plan All-Cause Readmissions Rates Among Nonoutlier Members (18-64 years old)	Medicaid Direct	3188	644	20.20/10.04 (2.01)	*	^
		Tailored Plan	3448	410	11.89/9.01 (1.32)	*	^

*State goals not indicated

^ Some MY24 measures not available due to adoption of CareSeed as our HEDIS engine in CY25. Only CareSeed numbers are reported to maintain maximum continuity of sources.

Source: CareSeed, HEDIS MY2025 Jan Prelim Partners, 1/9/26

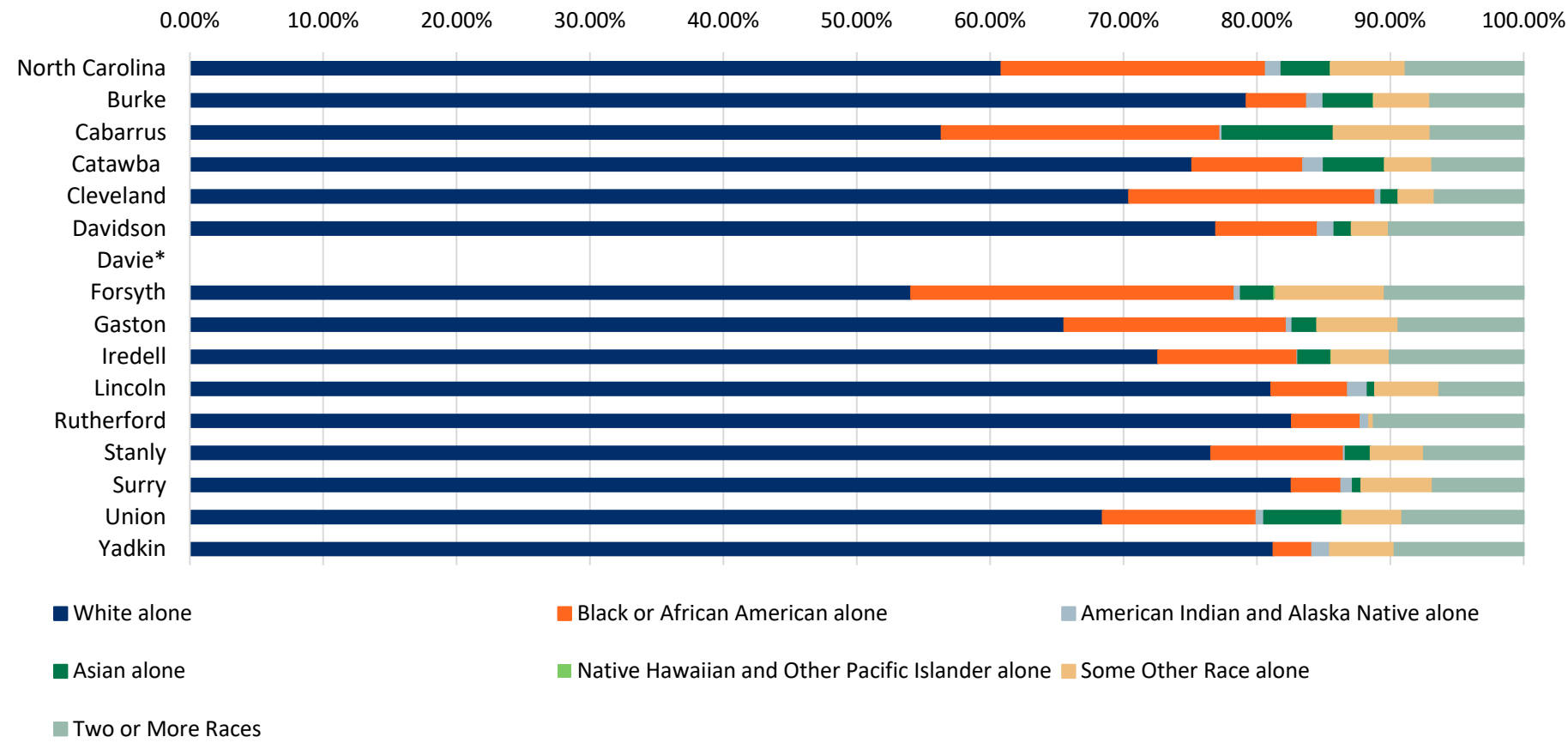
Appendix B. Catchment Demographics

The American Community Survey (administered by the US Census Bureau) provides annual demographic estimates for areas with populations of 65,000 or more people; estimates for Davie and Yadkin Counties are unavailable due to populations less than 65,000.

Race and Ethnicity

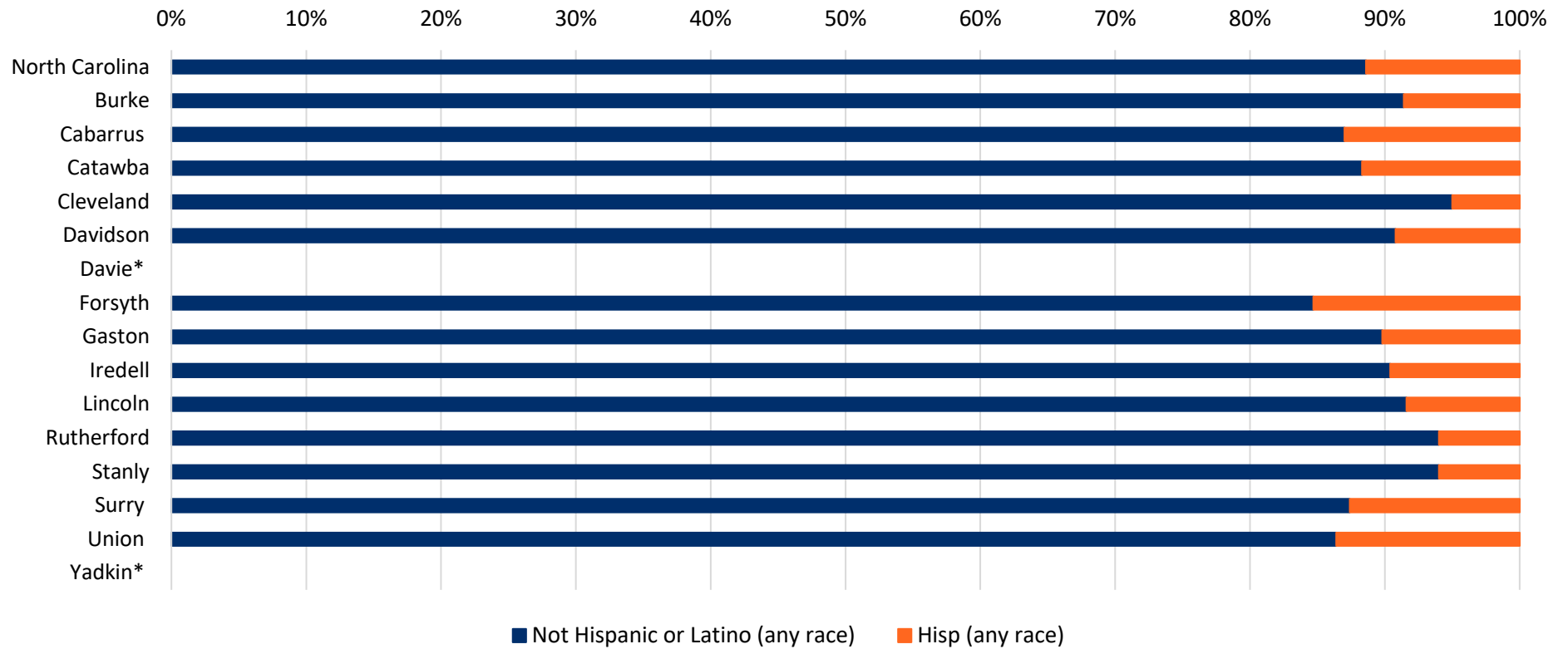
The population of Partners' catchment counties are predominantly White and non-Hispanic (see Figures B1 and B2). We see the most diverse populations in Forsyth, Cabarrus, Gaston, and Union counties. Forsyth, Union, Cabarrus, and Surry counties have the highest prevalence of Hispanic residents.

Figure B1. Race by County in Partners' Catchment



Data Source: American Community Survey, 2024; *Insufficient data to report

Figure B2. Ethnicity by County in Partners' Catchment



Source: American Community Survey, 2023; *Insufficient data to report

Disability

Respondents who report any of the disability types below are considered to have a disability. Partners has access to diagnostic data, however, the impact of any given diagnosis on an individual's functioning level may vary. Individuals may have multiple disabilities, not reflected in the data shown. We recognize there may be wide variability in the presentation of functional disability, and the inclusion of disability is to broaden our understanding of the needs within our communities. A better understanding of disability can alert us to resources, services, staff expertise that may be needed in a particular area and help us consider accessibility needs within our provider network.

The American Community Survey estimates the prevalence of disability by county and state based on a set of six (6) yes/no questions:

- **Hearing difficulty:** deaf or having serious difficulty hearing.
- **Vision difficulty:** blind or having serious difficulty seeing, even when wearing glasses
- **Cognitive difficulty:** because of a physical, mental, or emotional problem, having difficulty remembering, concentrating, or making decisions
- **Ambulatory difficulty:** having serious difficulty walking or climbing stairs
- **Self-care difficulty:** having difficulty bathing or dressing
- **Independent living difficulty:** because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping

The overall disability prevalence in North Carolina is about 13%; the prevalence is highest among Native Hawaiians and Pacific Islanders and American Indians and Alaska Natives (Figure B3). In Figures 40-43, the horizontal line is state prevalence. The prevalence of disability among men and women is similar for North Carolina; within our catchment, more women report disability compared to men in nine (9) counties (Figure B4). Union and Cabarrus counties have the lowest prevalence of disability; Rutherford County has the highest (Figure B4).

Source: American Community Survey, 2023

Figure B3. Disability by Race in North Carolina

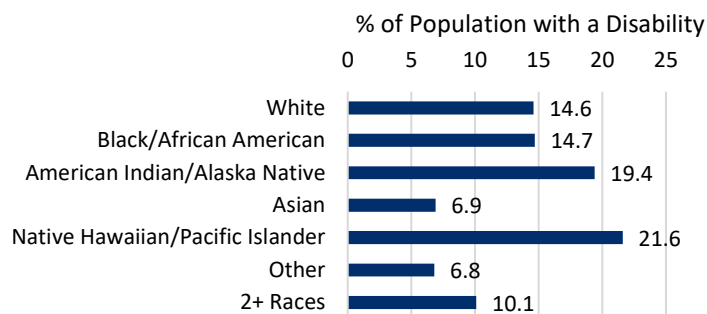
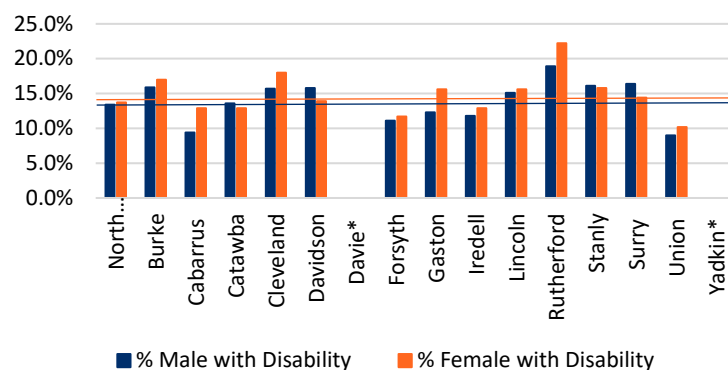
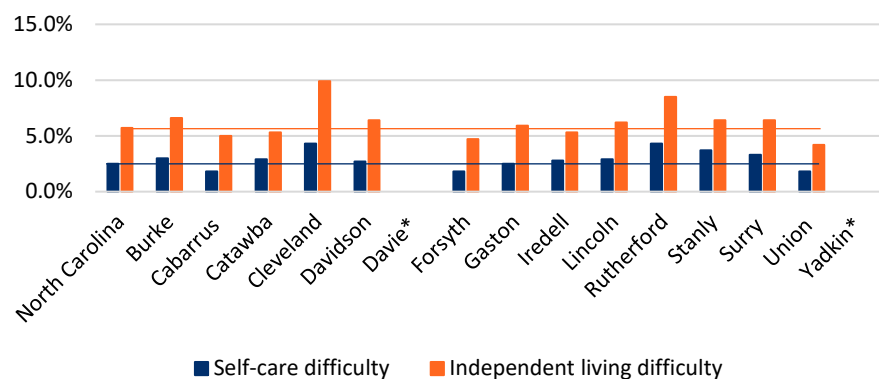


Figure B4. Disability by Sex in Partners' Catchment



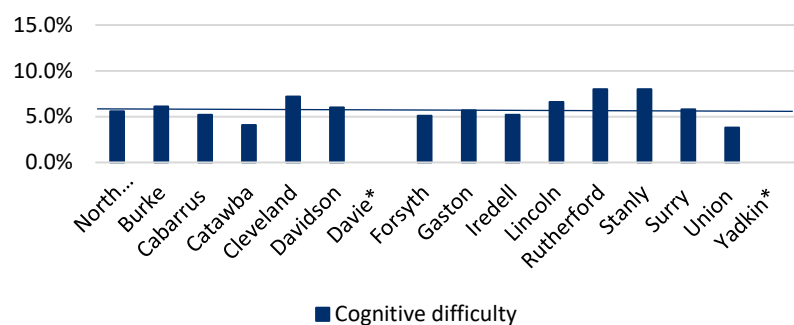
Source: American Community Survey, 2023; *insufficient data to report

Figure B5. Self-care/Independent Living Difficulty by Catchment County



Source: American Community Survey, 2023; *insufficient data to report

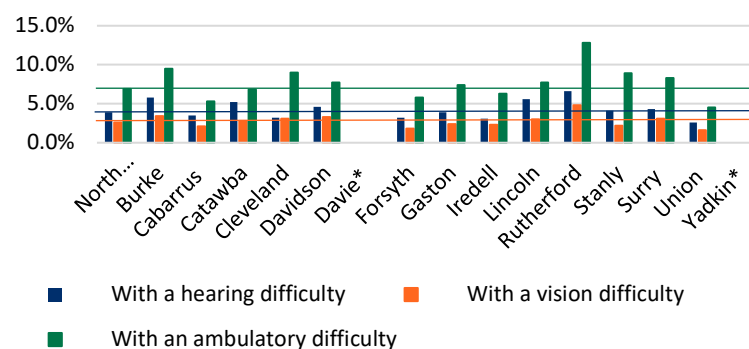
Figure B6. Cognitive Difficulty by Catchment County



Source: American Community Survey, 2023; *insufficient data to report

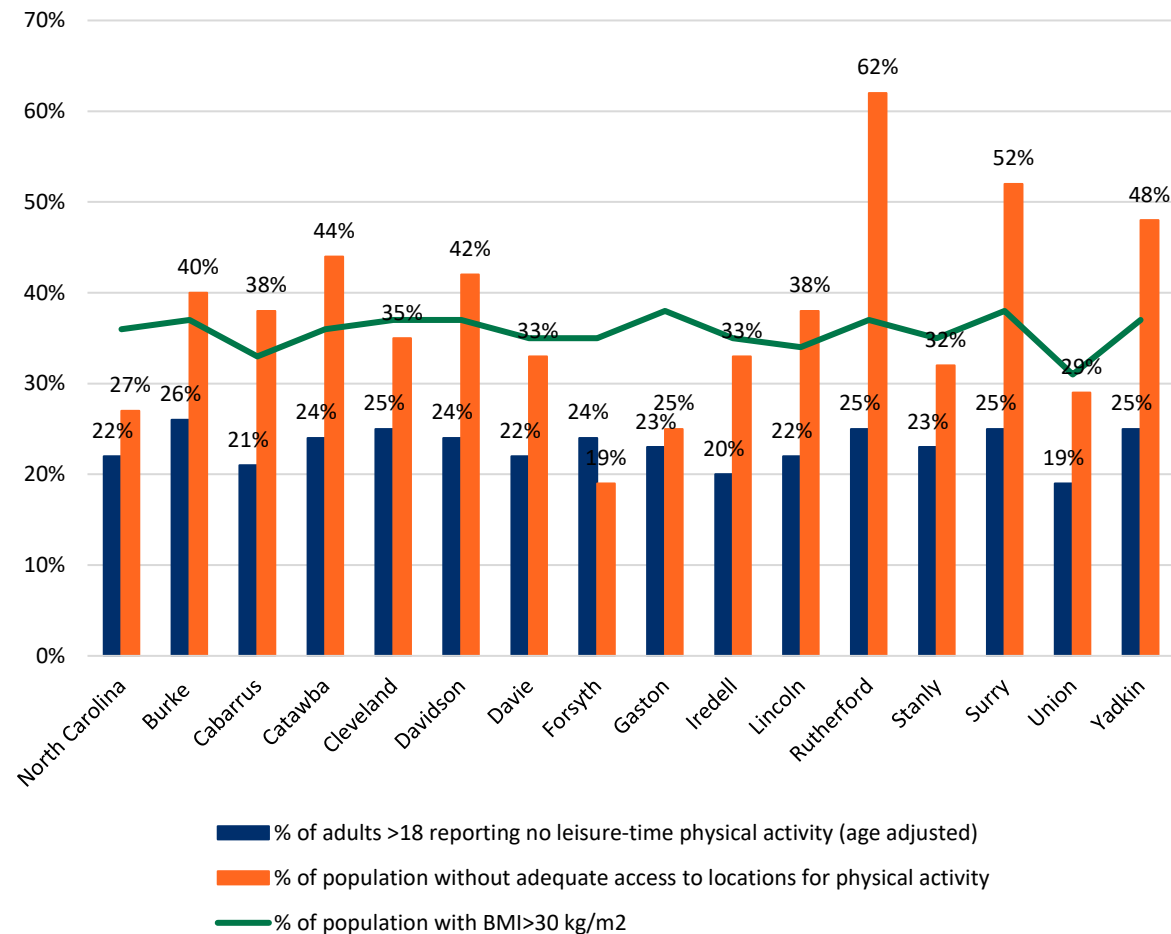
Figures B5-B7 show prevalence by county of disability type. Most counties in Partners' catchment have similar prevalence of specific disability types; prevalence for Rutherford County is higher than the state in all disability types, most notably almost twice the state rate for ambulatory difficulty. Rates for Union County are consistently lower than the state rate across disability types.

Figure B7. Sensory/Physical Disability by Catchment County



Source: American Community Survey, 2023; *insufficient data to report

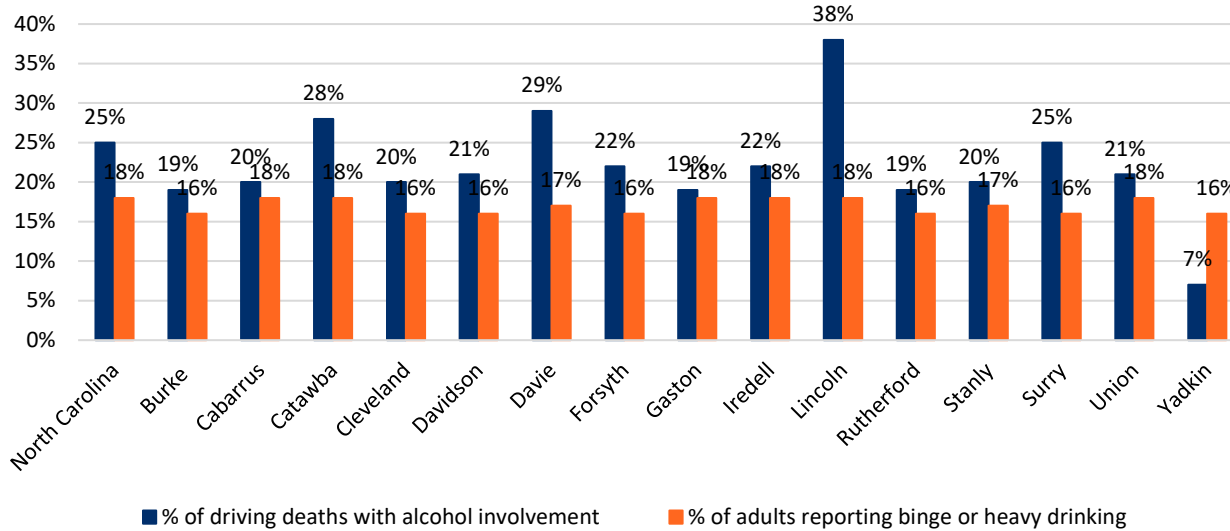
Figure B8. Obesity, Physical Inactivity, and Access to Exercise Opportunities - Partners Catchment



Source: County Health Rankings, 2024

County Health Rankings supply county level data for various health outcomes and indicators which can help us better understand the communities in which our members and recipients live. All data from County Health Rankings was published in 2024; see [County Health Rankings and Roadmaps](#) for specifics on variable calculation and data source. Rates of obesity are similar across Partners' catchment counties and are consistent with the state rate (Figure B8). We also see similar rates of physical activity for the state and across the catchment county despite wide variability among those without adequate access to locations for physical activity (range 19-62%; Figure B8).

Figure B9. Alcohol-Impaired Driving Deaths & Adult Binge Drinking - Partners Catchment

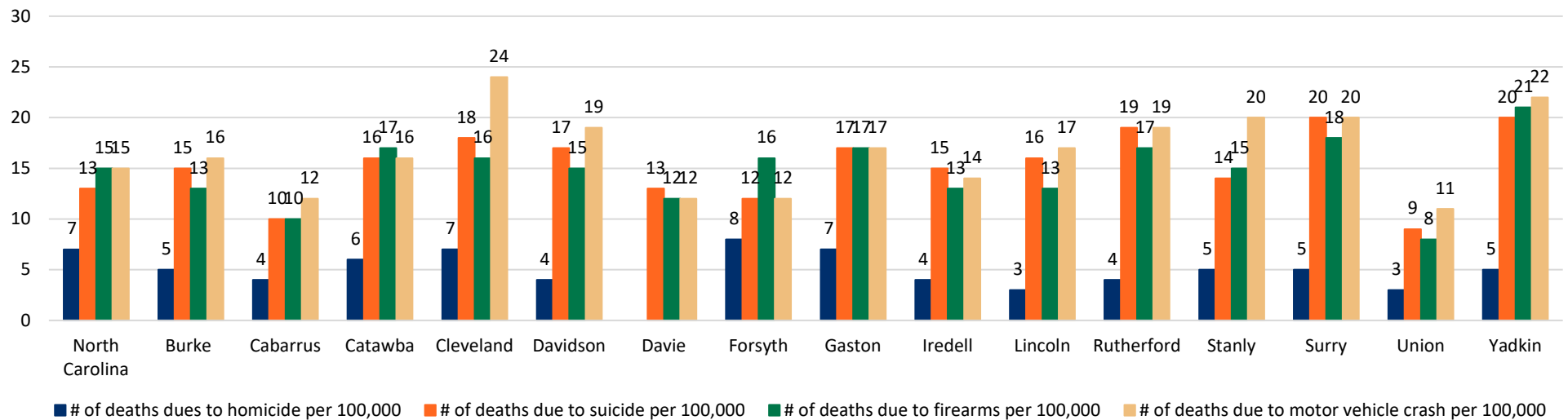


Within Partners catchment, the number of adults reporting binge drinking is fairly static (range 16-18%; Figure B9). However, Lincoln County has a noticeable proportion of driving deaths with alcohol involvement, 1.5 times that of the state average (Figure B9).

Figure B10 presents death rates by cause for the catchment counties. These rates are calculated as the number of deaths per 100,000 people. Forsyth County has the highest rate of homicide (8 per 100,000); Surry and Yadkin counties have the highest rates of death due to suicide (20 per 100,000); Yadkin County has the highest rate of death due to firearm (21 per 100,000); Cleveland County has the highest rate of deaths due to motor vehicle crash (24 per 100,000).

Source: County Health Rankings, 2024

Figure B10. Deaths per 100,000 Population by Cause - Partners Catchment



Source: County Health Rankings, 2024

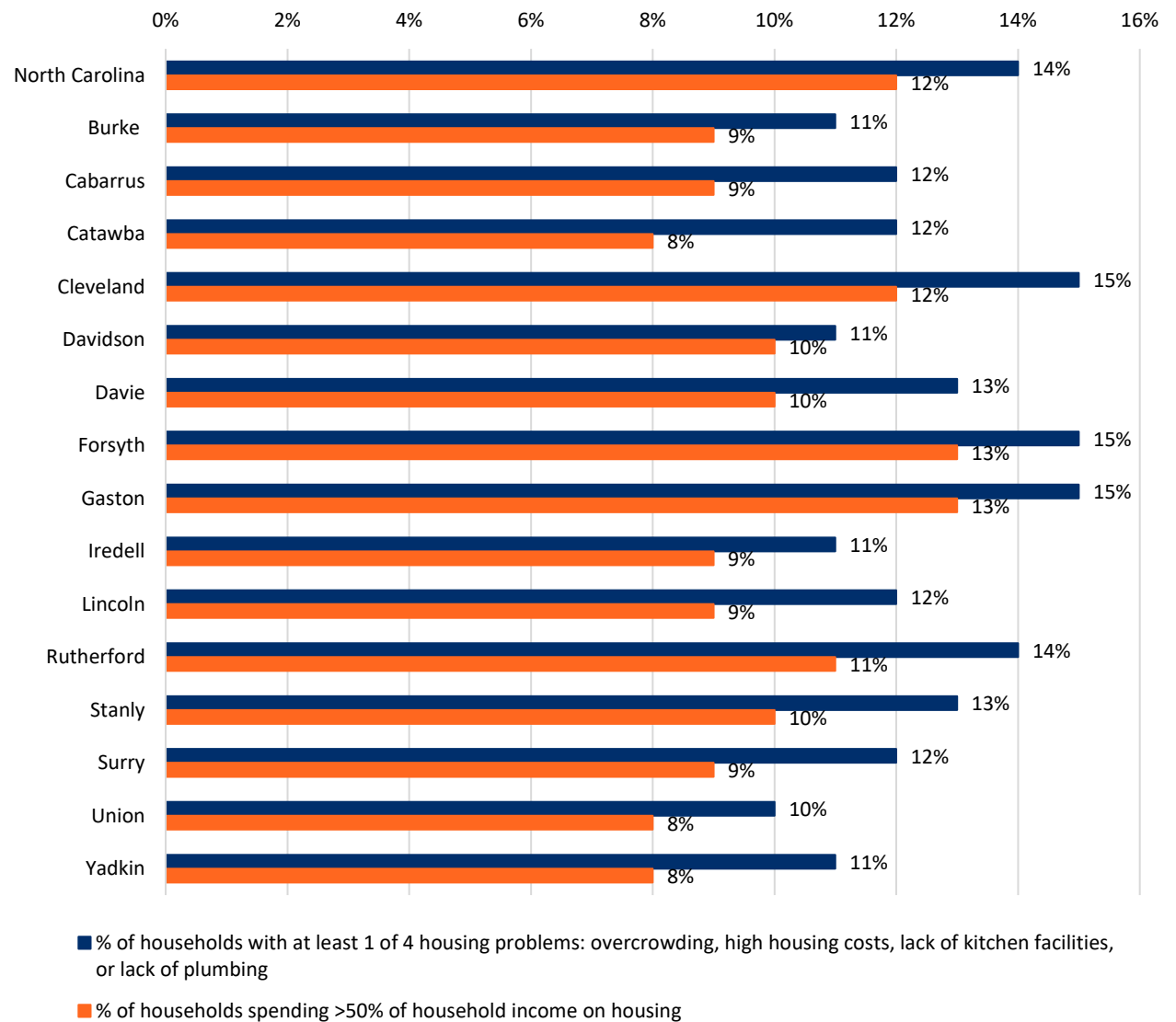
County-level SDOH Indicators

County Health Rankings reports several SDOH indicators at the state and county levels. Medicaid recipients often experience more SDOH needs compared to the general population. Medicaid recipients living in areas with a greater proportion of SDOH needs may be at even greater risk of SDOH needs which may affect their physical and mental health.

Housing

Figure B11 has two indicators of housing needs. The blue bar is the percentage of households with at least 1 of 4 identified housing concerns (i.e., overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing); the orange bar is the percentage of households spending more than half of the household income on housing. For many counties, housing cost appears to be a major driver of overall housing concerns. Other factors appear to drive housing problems in counties where housing concerns are most prevalent. These results are based on data from 2017-2021. Given known increases in housing cost and availability, combined with lasting effects from Hurricane Helene in affected counties, we can assume that housing needs are greater than presented.

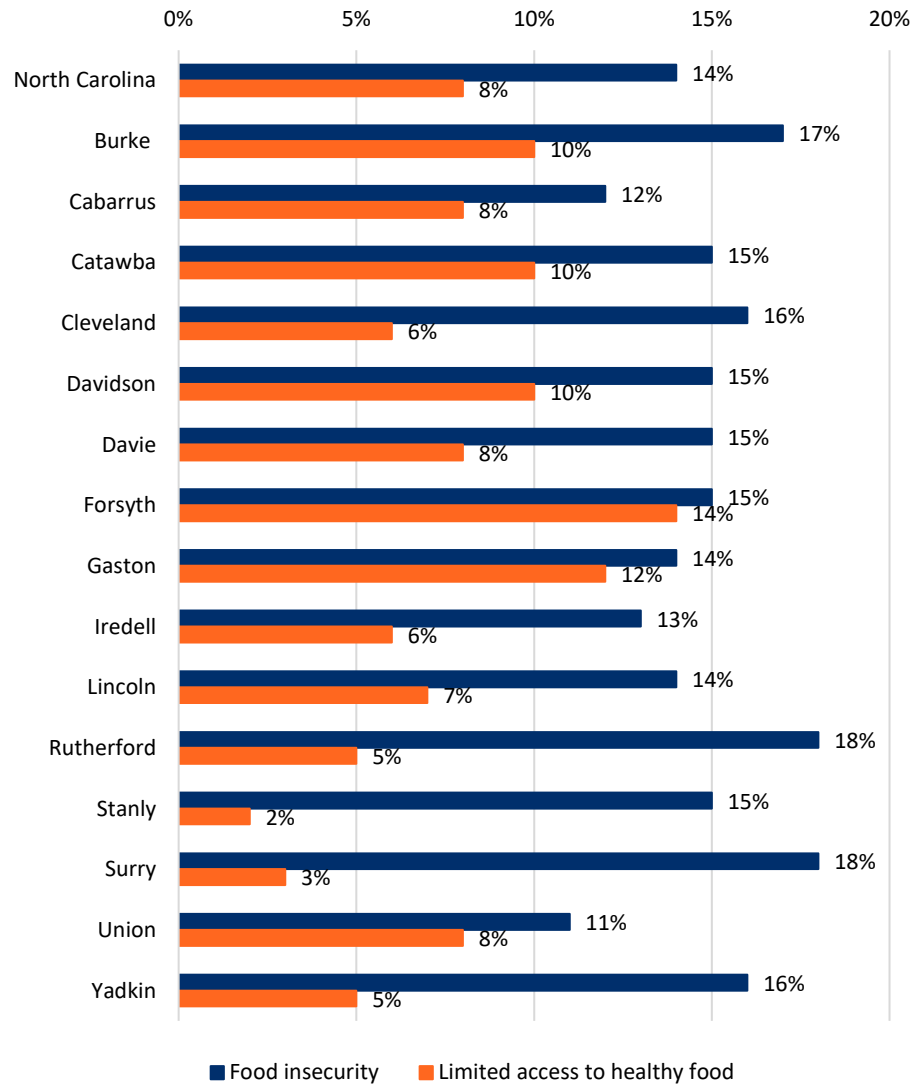
Figure B11. Housing Indicators - Partners Catchment



Source: County Health Rankings, 2025

Food Security, Accessibility, and Affordability

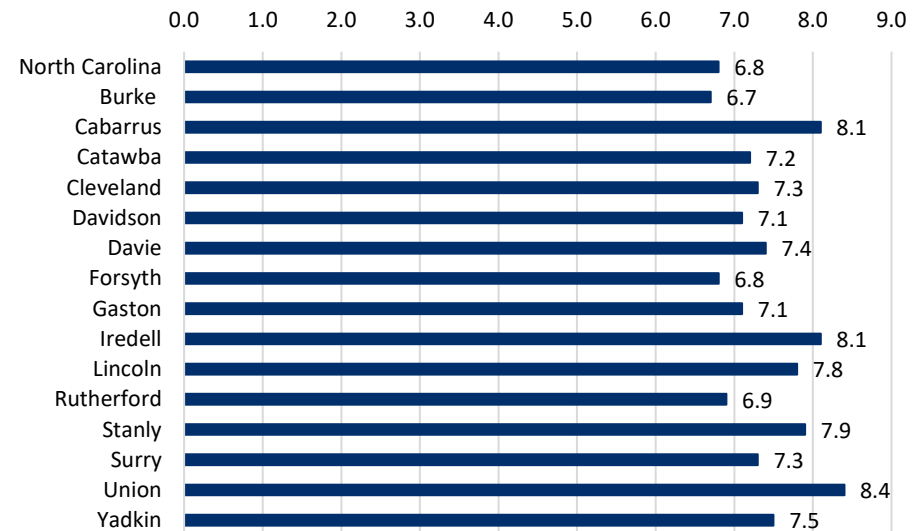
Figure B12. Food Insecurity & Limited Access to Healthy Foods - Partners Catchment



Source: County Health Rankings, 2025

Figures B12 and B13 provide information about the overall landscape of nutritional access within Partners' catchment counties. Figure B12 presents the percentage of the population reporting food insecurity (blue bar) and limited access to healthy foods (orange bar). Figure B13 presents the Food Environment Index, an index of factors (e.g., proximity to healthy foods, income) that contribute to a healthy food environment. Comparing results for Figures B12 and B13, the counties with the highest Food Environment Index (Union, Cabarrus, and Iredell) also have the lowest reported food insecurity, suggesting that there is a relationship with ensuring proximity to healthy foods and income with which to buy foods. Burke and Forsyth counties are among the lowest Food Environment Index scores within the catchment. Whereas most counties have lower prevalence of limited access to healthy foods compared to food insecurity, Food insecurity has increased statewide and within catchment. The food environment index had very little change when

Figure B13. Food Environment Index - Partners Catchment



compared to last year.

Source: County Health Rankings, 2025

Glossary/Abbreviations

- ACTT:** Assertive Community Treatment Team; multidisciplinary, mobile group of professionals that provides comprehensive, community-based care for individuals with severe, persistent mental illness
- ADHD:** Attention-deficit/hyperactivity disorder; a common neurodevelopmental disorder marked by persistent inattention, hyperactivity, and impulsivity that interferes with daily functioning
- AFL:** Alternative Family Living; North Carolina-based, residential support model where individuals with intellectual or developmental disabilities (I/DD) live with a trained caregiver in a private home setting
- AMH+:** Advanced Medical Home Plus; specialized North Carolina Medicaid primary care providers (Tier 3) certified to deliver integrated, whole-person care management to beneficiaries with complex behavioral health, I/DD, or TBI needs. They serve as the primary care manager, coordinating physical, behavioral, and social needs.
- BH:** Behavioral health
- CAP/C:** Community Alternatives Program for Children; North Carolina Medicaid waiver program designed for medically fragile children from birth through age 20
- CAP/DA:** Community Alternatives Program for Disabled Adults; North Carolina Medicaid Home and Community-Based Services waiver program
- CMA:** Care management Agency; provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to the BH I/DD Tailored Plan eligible population, and hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model
- CY:** Calendar year; January 1 to December 31
- ED:** Emergency department
- EMTALA:** Emergency Medical Treatment and Labor Act (EMTALA) is a 1986 federal law requiring Medicare-participating hospitals with emergency departments to provide a medical screening exam and stabilizing treatment for any patient, regardless of insurance or ability to pay.
- FY:** Fiscal year; July 1 to June 30
- GPI:** Generic Product Identifier; a 14-character, hierarchical code used to classify drugs by their therapeutic class, subclass, and specific characteristics created by Wolters Kluwer's MediSpan
- HEDIS:** Healthcare Effectiveness Data and Information Set; set of standardized performance measures used to evaluate the quality of care and service provided to health plan members
- HBI:** HBI Solutions is Partners' population health management and predictive analytics platform
- HOP:** Healthy Opportunities Pilot; a North Carolina Department of Health and Human Services Initiative testing the integration of evidence-based, non-medical interventions into Medicaid managed care; provided services to qualifying Medicaid members addressing social drivers of health
- I/DD:** Intellectual and developmental disabilities
- IP:** Inpatient
- LTC:** Long-term care
- LTSS:** Long-term services and supports
- MY:** Measure year; Used for HEDIS reporting; January 1 to December 31
- Other OP:** Other outpatient
- PRAPARE:** Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences; a standardized, 21-core-question tool designed to identify and address patient social determinants of health (SDOH), including housing, income, transportation, and safety. It is widely used to improve care and act on non-clinical factors.

PROMS: Patient reported outcomes measure system; this system allows providers to submit SDOH assessments directly to Partners in lieu of an electronic health record connection

Reports Manager: Partners' repository of reports that combine data from claims, authorizations, eligibility, and care management

RVO/Optum: Provides tobacco cessation services through QuitLineNC and program data to Partners

SDOH: Social drivers of health; the non-medical, environmental, and social conditions where people are born, live, learn, work, and age that significantly impact health outcomes and quality of life

SNF: Skilled Nursing Facility

TCM: Tailored care management

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