

2025 Population Health Assessment

Partners Health Management

CY2024



Population Health Department

February 2025

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Executive Summary

Partners Health Management (Partners) is committed to understanding the health needs of the populations we serve. Partners systematically collect, integrate, and assess member data to inform its population health management initiatives. We use the annual population health assessment to examine the demographic makeup of our members, characteristics of specific populations of members, and their service utilization patterns.

The 2025 Population Health Assessment reveals significant information which can help with measuring the effectiveness and impact of Partners' population health management strategies and inform strategic planning.

Key findings from the 2025 Assessment include:

- **Health Equity**

- Many of Partners' members, by virtue of qualifying for our plans, belong to groups experiencing health and social disparities (e.g., people with intellectual and developmental disabilities (I/DD), people with mental health conditions, people with substance use disorders, people with low incomes, etc.). We saw some notable differences in our member population compared to county- and state-level estimates. For example, the prevalence of diabetes among Medicaid Direct members was over 2.5 times that of the state estimate.
- The sex and age group distribution for Tailored Plan eligible members in the 2024 Assessment were similar to the Tailored Plan member demographics in this year's assessment. This showed that pre-launch estimates of this population were accurate.
- The missing ethnicity and race data issue identified in the 2024 Population Health Assessment was resolved. This allows us to better understand the racial and ethnic makeup of our member population groups.
- The racial and ethnic makeup of our member population overall is reflective of the areas we serve. We observed some disparate representation of racial minorities among Tailored Plan members with severe and persistent mental illness and members with sickle cell disease.
- About 90% of Innovations members are 21 years old or older.
- County-level disability prevalence information is useful to consider as our member population is at higher risk for having at least one disability. Rutherford County had the highest rates of disability across all disability types.

- **Social Determinants of Health (SDOH)**

- Forsyth, Cleveland, and Gaston Counties accounted for about half of all SDOH assessments. Previously, drivers of SDOH assessment completion, Burke and Catawba were in the bottom five counties.
- Employment and Insurance were two of the most common needs shown on the SDOH assessment, both needs have been increasing in prevalence over the last 2 SDOH summaries.
- Both Insurance and Medication needs have the highest percentage of assessments who identified them as a past and current issue which indicates a chronic need in those areas.
- Food-related concerns were reported as a top need for Forsyth and Rutherford counties; both counties were among the lowest in county-level food availability estimates

- **Health Outcomes**

- We see overlaps among several population groups. For example, among pregnant members, nicotine dependence and opioid use disorder are included in the most common chronic conditions. This shows a need for integration and cross-departmental awareness of available programs and resources as the presence of multiple conditions compounds member risk.

- The prevalence of high or very high opioid overdose risk for those with sickle cell disease increased by about 5%.
- Most Innovations members have multiple chronic conditions. We should assess the design of member education and resources we offer to ensure cognitive accessibility for all members, including those with intellectual disability. Members with I/DD may also be more likely to live with a guardian or in a congregate care setting which can influence their participation in population health programs. Population health program workgroups should be aware of such member needs when planning programs.
- **Service Utilization and Costs**
 - Partners provides Tailored Care Management (TCM) to slightly more than a quarter of all members eligible for TCM.
 - Acute inpatient admission accounted for the largest share of facility cost among Tailored Plan members in CY24. Mental health diagnoses (major depressive disorder, schizoaffective disorders, bipolar disorder, and schizophrenia) accounted for the top four primary discharge diagnoses for inpatient stays.
 - The top five medication classes by gross cost were very similar between Q1 and Q2 with antipsychotics/antimanic agents being the class with the highest gross cost. Trazadone and gabapentin were the most prescribed medications in Q1 and Q2. The two most expensive medications by total cost for Q1 and Q2 are Invega Sustenna and Vraylar.
 - PartnersACCESS received 11,399 calls in CY24; of those 4,991 were crisis calls. Most calls were in English; 2.1% in Spanish and 0.1% in another language.
 - Of the 120,000 Partners' members, 2,989 (about 2.5%) were enrolled in Pyx as of the end of December 2024. Of those, 1,114 were active Pyx users in 2024; among those were many “super users.” For example, 111 members completed 6,830 coloring book interactions during the year.
- **Community Health Indicators**
 - Most of our population lives or has a mailing address within Partners' catchment area. This number may be inflated due to members in Child Protective Services custody or other alternative living arrangements; these members may have Department of Social Services or other service agencies listed as their mailing address. However, the concentration of our members within catchment counties allows us to focus our resources.
 - Substance use and mental health appeared a combined 15 times on the top priority lists for our 15 catchment counties most recent Community Health Assessments
 - Many of our catchment county priorities are reflected in the 2024-2029 North Carolina Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD SUS) strategic plan priorities.

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: County Demographics, Member Populations, Service Utilization, and State and Local Priorities.

[Demographics](#) provides a snapshot of the demographics and key health outcomes in counties within Partners' catchment with consideration of population groups who may be at higher risk of poor health or health inequities. We also include a summary of our Social Determinants of Health Assessment.

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

- Tailored Plan members
- Children and adolescents
- Tailored Plan members with serious and persistent mental illness (SPMI)
- Members with Innovations/intellectual and developmental disabilities (I/DD)
- Members with multiple chronic conditions
- Members with sickle cell disease
- Members at risk of opioid misuse or overdose
- Members who use tobacco
- Pregnancy

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

- PartnersACCESS Call Lines
- Pyx Health
- Tailored Care Management
- Service utilization
- Length of stay
- 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.

For a list of HEDIS measures, see [Appendix A](#).

The data in each subcategory represents the entire population, the total Medicaid population, or the Tailored Plan population. Each table or figure will include a note on the population represented and the source of the data.

The Partners 2025 Population Health Assessment includes data collected Jan 1, 2024 – December 31, 2024, 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. See [Appendix B](#) for a complete list of sources.

Demographics

Member Demographics

Table 1. Member Demographics by payor

Member Population	All n=120,092	Medicaid Direct n=64,173	Tailored Plan n=47,625	State Funded n=8,294
Plan Type, %				
Medicaid Direct	53.4	100.0	0.0	0.0
Tailored Plan	37.1	0.0	93.5	0.0
Innovations	2.6	0.0	6.5	0.0
State Funded	6.9	0.0	0.0	100.0
Sex, %				
Female	52.1	58.8	45.2	39.8
Male	47.9	41.2	54.8	60.2
Age Groups, %				
0-20 years	26.1	15.1	44.6	4.5
21-64 years	49.7	40.7	55.1	88.8
65+ years	24.2	44.3	0.3	6.7
Race, %				
AI/NA	0.5	0.6	0.3	0.4
Asian	1.7	2.2	1.1	0.5
Black	26.9	28.3	26.5	19.3
Multiracial	0.1	0.0	0.0	1.6
PI	0.1	0.1	0.1	0.1
White	66.3	64.2	67.5	75.0
Other	0.2	0.0	0.0	2.7
Unknown	4.2	4.5	4.6	0.4
Ethnicity, %				
Hispanic	7.3	6.0	9.2	5.8
Non-Hispanic	90.2	90.6	89.0	93.9
Unknown	2.5	3.4	1.8	0.2
Live within catchment area, yes, %	94.9	94.5	95.0	96.7

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 most of our total membership and those receiving Medicaid Direct but are in the minority among Tailored Plan members and State Funded recipients. About half of all members and almost 90% 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.

Almost all (94.9%) of members reside in Partners' catchment area.

Source: HBI, 1-01-25 refresh, retrieved on 2/6/25

Member Diagnoses

Table 2 shows the prevalence of mental, behavioral, and neurodevelopmental disorders for the full population and by payer. Diagnostic categories were chosen by medical leadership. The variance among payer sources is expected. We see the highest prevalence of intellectual disabilities (11.7%) and pervasive and specific developmental disorders (22.9%) among those in the Tailored Plan; most Innovations members are part of the Tailored Plan and have intellectual and developmental disabilities. More than a quarter of all members/recipients have a substance use disorder; the prevalence is highest among state funded recipients (42.2%). Across all payers, about a quarter or more of members/recipients have anxiety disorders or mood(affective) disorders (range 23.8-36.9%)

	All	Medicaid Direct	Tailored Plan	State Funded
Diagnostic Category	n=120,092	n=64,173	n=47,625	n=8,294
F10-F19 Substance use disorders, %	28.4	23.6	32.4	42.2
F20-F29 Non-mood psychotic disorders, %	8.3	6.0	11.3	8.4
F30-F39 Mood (affective) disorders, %	26.6	23.8	28.8	36.2
F40-F48 Anxiety Disorders, %	31.8	28.6	36.9	26.3
F70-F79 Intellectual disabilities, %	6.9	4.1	11.7	1.2
F84 Pervasive and specific developmental disorders (autism), %	10.4	2.4	22.9	0.3
F90-F98 Child/adolescent behavioral and emotional disorders, %	13.5	6.9	24.1	3.3

Source: HBI, 1-01-25 refresh, retrieved on 2/6/25

	All	Medicaid Direct	Tailored Plan	State Funded
Diagnostic Category	n=120,092	n=64,173	n=47,625	n=8,294
E08-E13 Diabetes mellitus	17.6	27.4	7.0	1.8
E65-E68 Overweight, obesity & other hyperalimentation	17.8	21.2	16.0	2.1
E78 Disorders of lipoprotein metabolism and other lipidemia (high cholesterol)	27.2	41.3	12.6	2.3
G40 Epilepsy & recurrent seizures	5.9	6.3	6.2	0.5
I10-I1A Hypertensive diseases	33.2	49.7	16.2	3.8
J40-J4A Other chronic obstructive pulmonary disease	11.7	18.7	4.1	1.0
J45 Asthma	10.2	10.4	11.7	1.0

Source: HBI, 1-01-25 refresh, retrieved on 2/6/25

Table 3 shows the prevalence of non-psychiatric diagnoses by plan type. The diagnostic categories were chosen by medical leadership. Medicaid Direct members have the highest prevalence of diabetes (27.4%), obesity (21.2%), high cholesterol (41.3%), hypertension (49.7%), and COPD (18.7%). Lower numbers for Tailored Plan may be reflective of a lack of historical physical health data available for these members. Physical health data is not often available for State Funded members and may affect the observed prevalence.

Member Location

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

Table 5 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.

Table 4. County of Residence by Member Population

County	All n=120,092	Medicaid Direct n=64,173	Tailored Plan n=47,625	State Funded n=8,294
Burke	5,578	3,032	2,178	368
Cabarrus	8,757	4,446	3,683	628
Catawba	9,523	4,855	3,880	788
Cleveland	7,635	4,141	3,020	474
Davidson	8,242	4,468	3,379	395
Davie	2,112	1,189	741	182
Forsyth	21,124	11,538	8,144	1,442
Gaston	14,766	7,271	6,516	979
Iredell	7,953	4,145	3,166	642
Lincoln	4,329	2,304	1,779	246
Rutherford	5,267	2,864	2,004	399
Stanly	3,697	1,835	1,455	407
Surry	4,900	3,034	1,524	342
Union	7,875	4,308	2,994	573
Yadkin	2,155	1,223	777	155
Total	113,913	60,653	45,240	8,020

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

Source: HBI, 1-1-25 refresh, retrieved on 2/6/2, Catchment Counties Only

Table 5. County of Eligibility by Member Population, Catchment Counties Only

County	All n=120,092	Medicaid Direct n=64,173	Tailored Plan n=47,625	State Funded n=8,294
Burke	6,272	3,418	2,450	404
Cabarrus	9,603	4,903	4,037	663
Catawba	9,540	4,926	3,852	762
Cleveland	7,949	4,377	3,066	506
Davidson	9,721	5,308	3,984	429
Davie	2,110	1,167	764	179
Forsyth	21,618	11,887	8,312	1,419
Gaston	15,466	7,589	6,891	986
Iredell	8,562	4,516	3,409	637
Lincoln	4,265	2,249	1,758	258
Rutherford	5,232	2,861	1,988	383
Stanly	3,813	1,916	1,484	413
Surry	4,975	3,100	1,540	335
Union	8,522	4,665	3,274	583
Yadkin	2,237	1,268	804	165
Total	119,885	64,150	47,613	8,122

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

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25, Catchment Counties Only

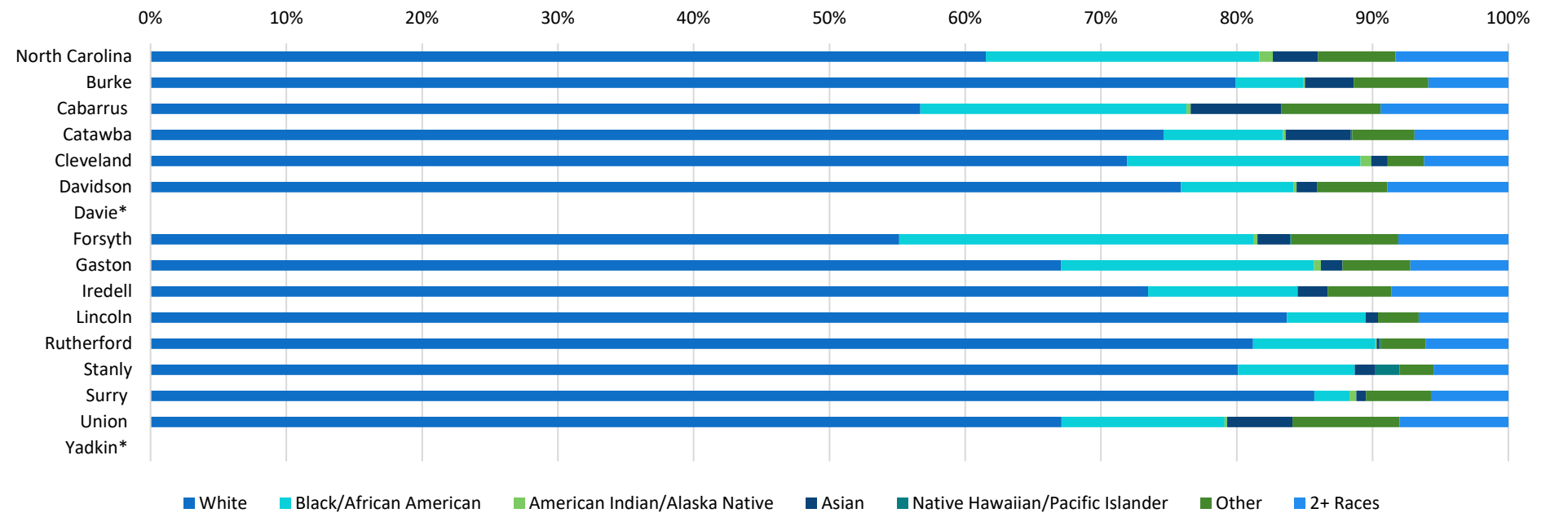
Catchment Demographics

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

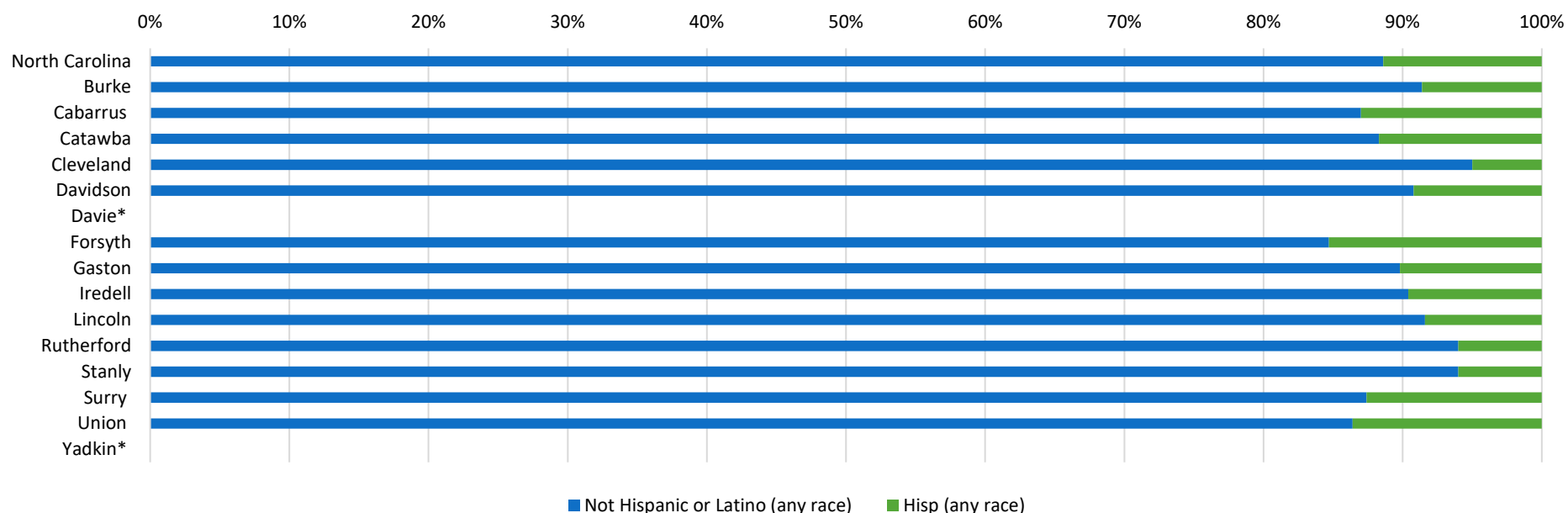
The population of Partners’ catchment counties are predominantly White and non-Hispanic (see Figures 1 and 2). We see the most diverse populations in Forsyth, Cabarrus, Gaston, and Union counties. Forsyth, Union, Cabarrus, and Surry counties have the highest prevalence of Hispanic residents.

Figure 1. Race by County in Partners' Catchment



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

Figure 2. Ethnicity by County in Partners' Catchment



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

Disability

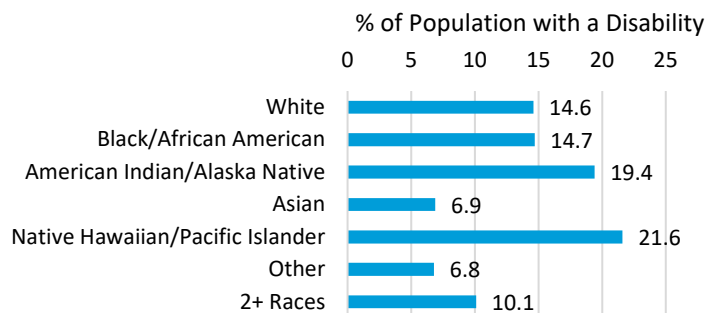
Respondents who report any of the disability types below are considered to have a disability. Partners has access to diagnostic data, however, the impact of any given diagnosis on an individual's functioning level may vary. Individuals may have multiple disabilities, not reflected in the data shown. 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

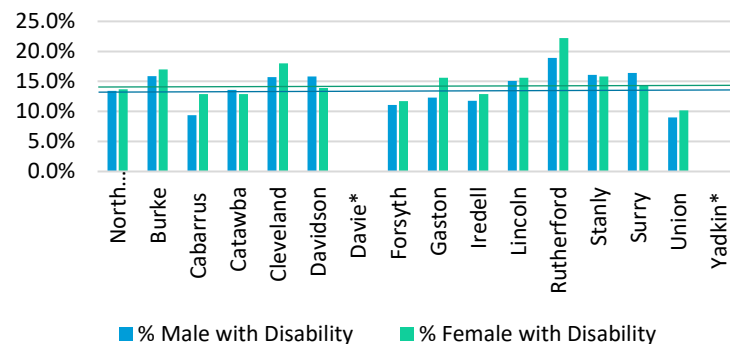
The overall disability prevalence in North Carolina is about 13%; the prevalence is highest among Native Hawaiians and Pacific Islanders and American Indians and Alaska Natives (Figure 3). In Figures 4-7, the horizontal line is state prevalence. The prevalence of disability among men and women is similar for North Carolina; within out catchment, more women report disability compared to men in nine (9) counties (Figure 4). Union and Cabarrus counties have the lowest prevalence of disability; Rutherford County has the highest (Figure 4).

Figure 3. Disability by Race in North Carolina



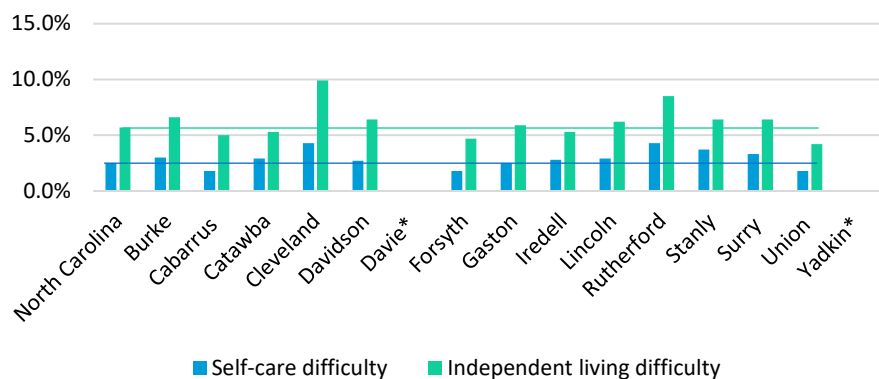
Source: American Community Survey, 2023

Figure 4. Disability by Sex in Partners' Catchment



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

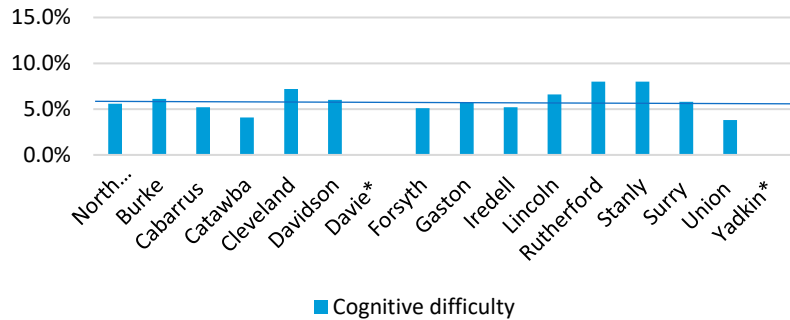
Figure 5. Self-care/Independent Living Difficulty by Catchment County



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

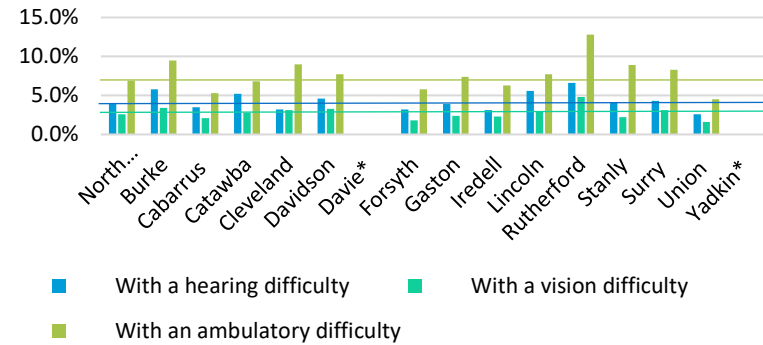
Figures 5-7 show prevalence by county of disability type. Most counties in Partners' catchment have similar prevalence of specific disability types; prevalence for Rutherford County is higher than the state in all disability types, most notably almost twice the state rate for ambulatory difficulty. Rates for Union County are consistently lower than the state rate across disability types.

Figure 6. Cognitive Difficulty by Catchment County



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

Figure 7. Sensory/Physical Disability by Catchment County

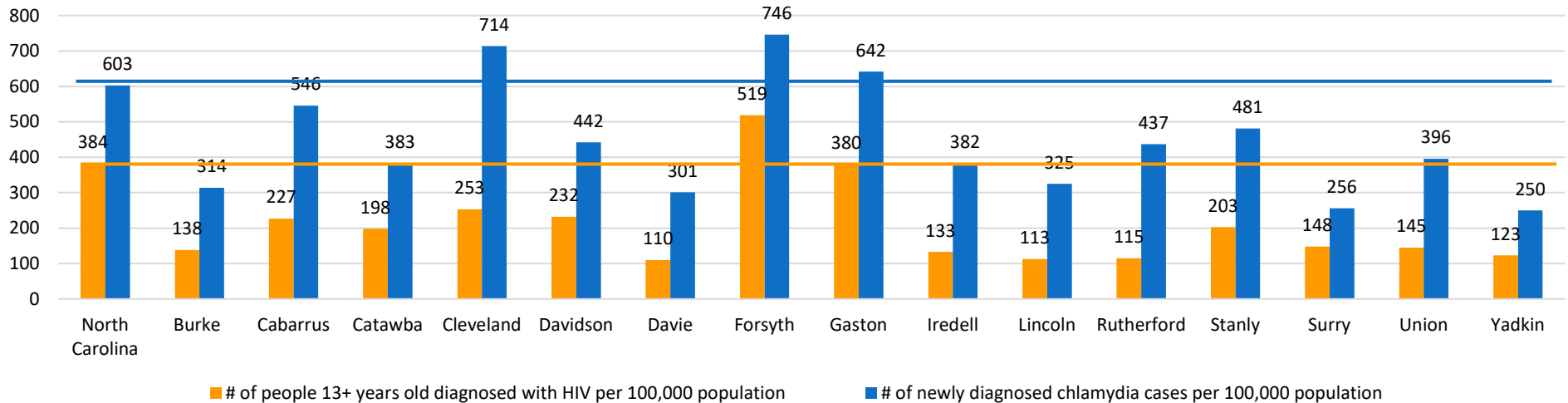


Source: American Community Survey, 2023; *insufficient data to report

Health Outcomes

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. Figure 8 below 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. All data from County Health Rankings was published in 2024; see [County Health Rankings and Roadmaps](#) for specifics on variable calculation and data source.

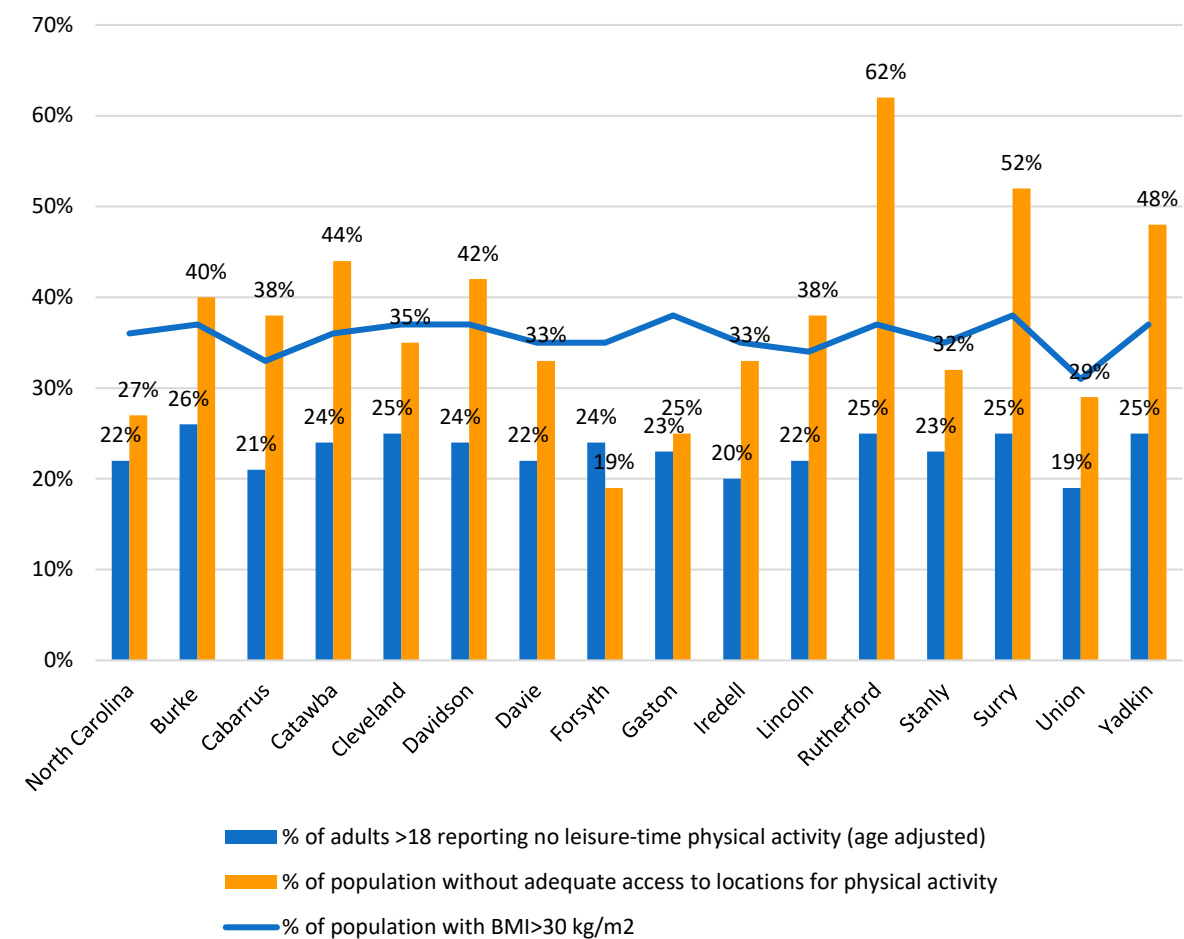
Figure 8. HIV & STI Prevalence - Partners Catchment



Source: County Health Rankings, 2024

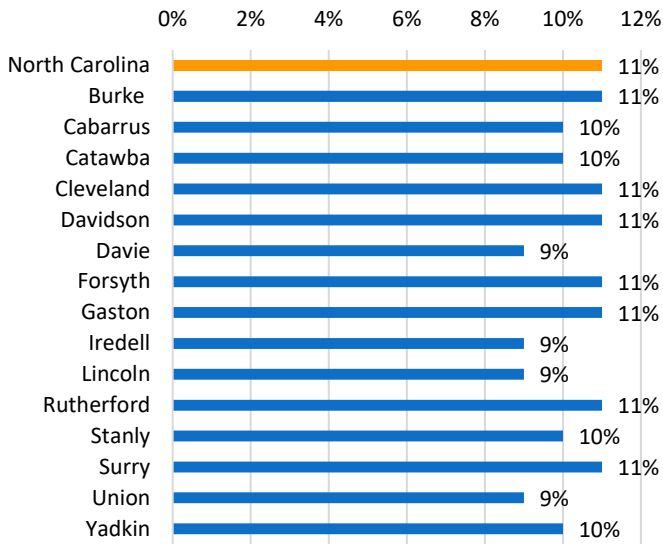
Rates of obesity are similar across Partners’ catchment counties and are consistent with the state rate (Figure 9). We also see similar rates of physical activity for the state and across the catchment county despite wide variability among those without adequate access to locations for physical activity (range 19-62%; Figure 9). Likewise, the prevalence of adults diagnosed with diabetes is mostly static across the 15 counties and in line with the state (Figure 10).

Figure 9. Obesity, Physical Inactivity, and Access to Exercise Opportunities - Partners Catchment



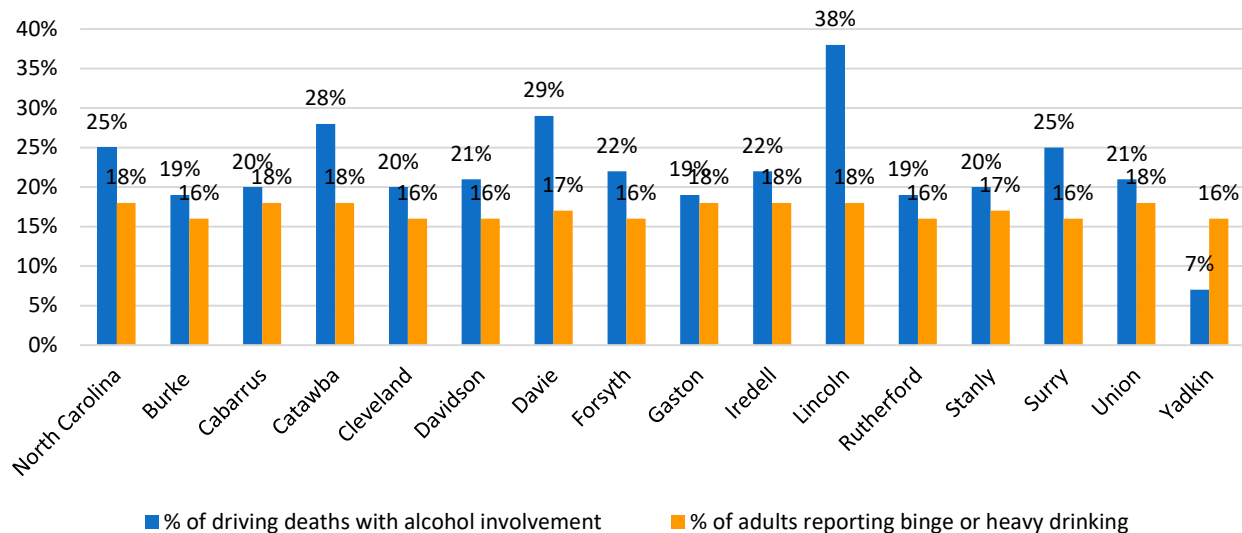
Source: County Health Rankings, 2024

Figure 10. Diabetes Prevalence Among Adults - Partners Catchment



Source: County Health Rankings, 2024

Figure 11. Alcohol-Impaired Driving Deaths & Adult Binge Drinking - Partners Catchment

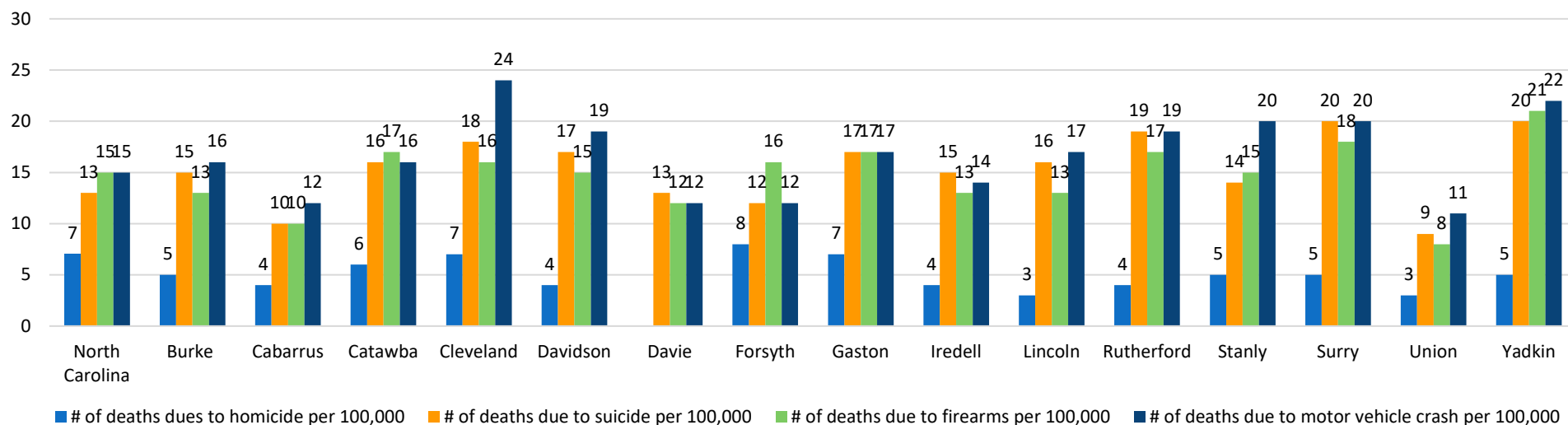


Within Partners catchment, the number of adults reporting binge drinking is fairly static (range 16-18%; Figure 11). However, Lincoln County has a noticeable proportion of driving deaths with alcohol involvement, 1.5 times that of the state average (Figure 11).

Figure 12 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 12. Deaths per 100,000 Population by Cause - Partners Catchment



Source: County Health Rankings, 2024

Social Determinants of Health (SDOH)

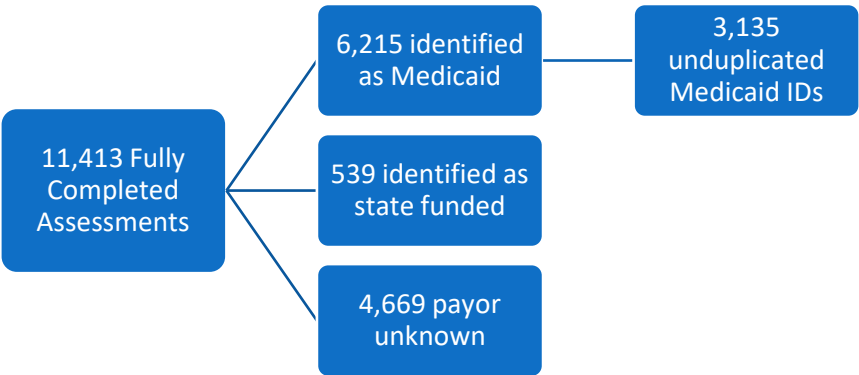
Partners’ Members

The Population Health Department compiled a Social Determinants of Health Summary based on data collected by Partners and providers between July 2023 and June 2024. We include the summary below with accompanying tables and figures. The SDOH data presented below is based on a convenience sample and is not representative of any subpopulation.

We collected 11,413 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. Of the fully completed assessments, 6,093 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 3,135 unique Medicaid IDs. A small number (529) of assessments were identified as state funded members. There were also 4,669 assessments that were not identified as Medicaid or State. Of the fully completed assessments, 9,877 came from TruCare either by application programming interface (API) or care manager and 1,536 came from PROMS. Further breaking down the 9877, 9777 were from the API meaning from the connection with Monarch and Daymark; 100 were completed by a care manager.

The most assessments were from members in Forsyth and Cleveland Counties while Rutherford and Davie Counties had the least number of assessments. Over 19% of all assessments were from Forsyth County. Employment, Health Insurance and Medication are the top needs across all the counties. Employment and Insurance needs have increased in prevalence over the last two SDOH summary reports. The top needs found in all assessments were similar to the top needs found in initial assessments. Insurance (16%) and Medication (14%) needs also had the highest number of initial assessments that show a chronic need or naming the need as both a current and a past need. The needs for each county are also similar to that of each other with employment appearing in the top three (3) needs for 14 counties, and insurance appearing 11 times.

Figure 13. SDOH Assessment Member Breakdown by Payor



Source: SDOH Assessments from TruCare and Proms 7/1/23-6/30/24

Table 6. Assessments Completed by County (All Counties)

	# of Assessments per county	County	Total # of Assessments
Catchment Counties	2,215	Forsyth	2,215
	1,398	Cleveland	1,398
	1,394	Gaston	1,394
	1,157	Stanly	1,157
	911	Cabarrus	911
	817	Union	817
	604	Iredell	604
	594	Lincoln	594
	575	Surry	575
	289	Yadkin	289
	276	Burke	276
	229	Davidson	229
	215	Catawba	215
	190	Davie	190
	162	Rutherford	162
	150	Mecklenburg	150
	42	Rowan	42
	30	Guilford	30
	16	Stokes, Montgomery	32
	15	Caldwell	15
	14	Anson	14
	13	Wake, Out of State	26
	12	Alexander	12
	10	Watauga, Richmond	20
	9	Wilkes	9
	5	Alamance	5
	4	Nash, Lee	8
	3	Moore, Randolph	6
	2	Brunswick, Alleghany, Harnett, Wilson, Buncombe, Madison, Robeson	14
	1	McDowell, Scotland, Avery, Columbus	4
	Grand Total		11,413

Source: SDOH Assessments from TruCare and Proms 7/1/23-6/30/24

Table 7. Top 3 Past or Current Needs Across all Counties

	All Assessments	Initial Only
Need 1	Employment, Past 12 Months	Employment, Past 12 Months
Need 2	Health Insurance, Past 12 Months	Health Insurance, Past 12 Months
Need 3	Medication, Past 12 Months	Food Worry, Past 12 Months

Source: SDOH Assessments from TruCare and Proms 7/1/23-6/30/24

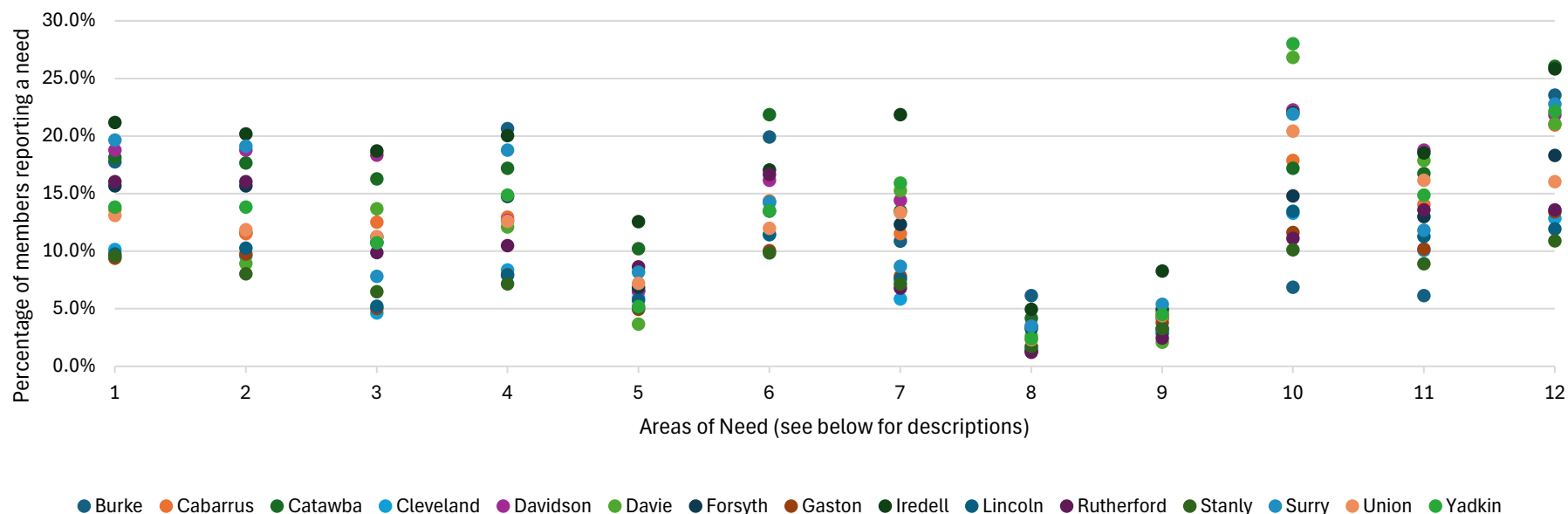
Table 8. Top 3 Reported Current Needs by County, All Assessments

	1	2	3
Burke (n=276)	Employment (65)	Housing Worry (57)	Transportation (55)
Cabarrus (n=911)	Employment (191)	Insurance (163)	Transportation (131)
Catawba (n=215)	Employment (56)	Transportation (47)	Food Worry (39)
Cleveland (n=1,398)	Insurance (180)	Employment (180)	Transportation (160)
Davidson (n=229)	Insurance (51)	Employment (50)	Food Worry/Food Lasting/Medication (43)
Davie (n=190)	Insurance (51)	Employment (40)	Medication (34)
Forsyth (n=2,215)	Employment (406)	Food Lasting (347)	Food Worry (347)
Gaston (n=1,394)	Employment (187)	Insurance (162)	Transportation (140)
Iredell (n=604)	Employment (156)	Insurance (133)	Not Safe (132)
Lincoln (n=594)	Insurance (80)	Employment (71)	Transportation (68)
Rutherford (n=162)	Transportation (27)	Food Lasting (26)	Food Worry (26)
Stanly (n=1,157)	Employment (126)	Insurance (117)	Transportation (114)
Surry (n=575)	Employment (131)	Insurance (126)	Food Worry (113)
Union (n=817)	Insurance (167)	Medication (132)	Employment (131)
Yadkin (n=289)	Insurance (81)	Employment (64)	Not Safe (46)

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

Source: SDOH Assessments from TruCare and Proms 7/1/23-6/30/24

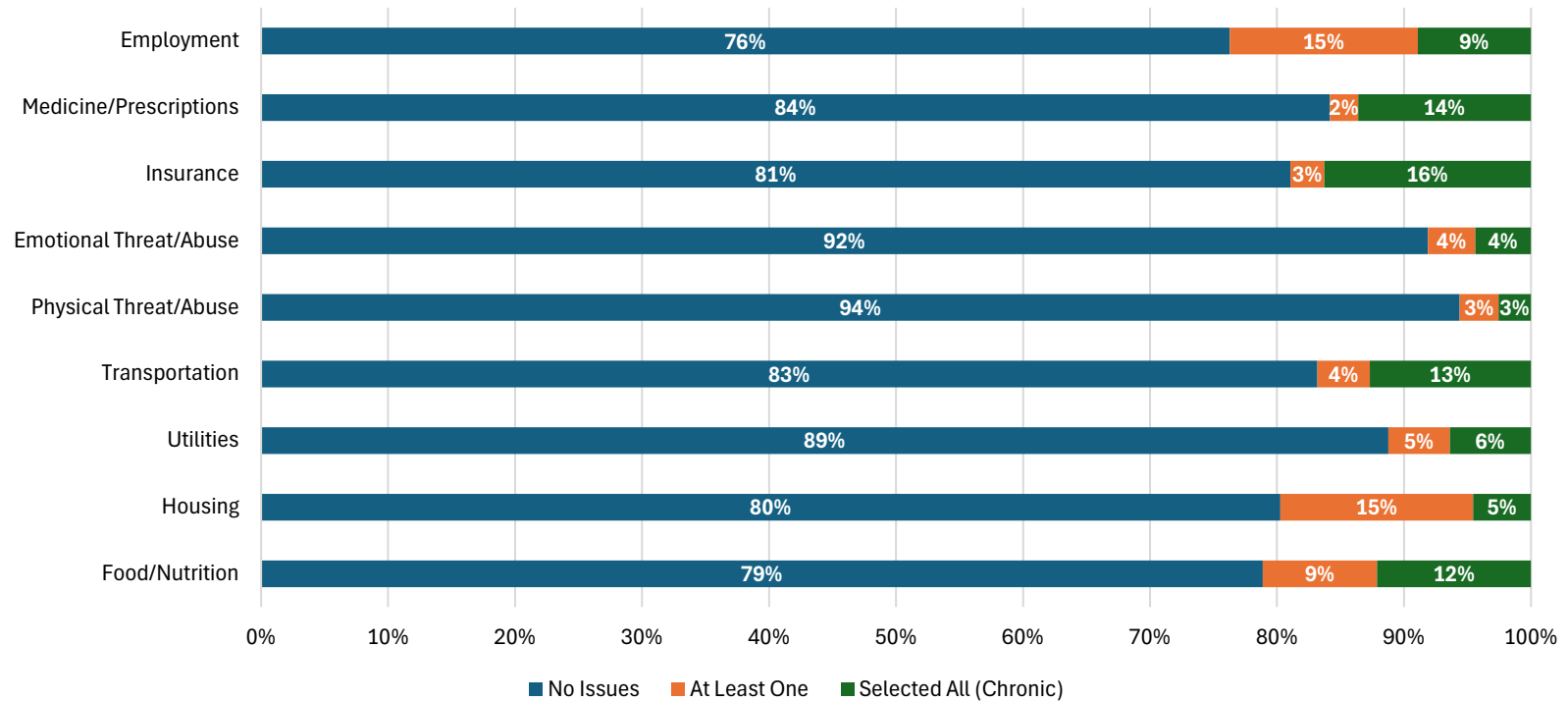
Figure 14. Current SDOH Needs by County (%) All Assessments



Source: SDOH Assessments from TruCare and Proms 7/1/23-6/30/24

- | | | | |
|-----------------|-------------------|---------------------|------------------|
| 1. Food Worry | 4. Housing Worry | 7. Not Safe | 10. Insurance |
| 2. Food Run Out | 5. Utilities | 8. Physical Safety | 11. Prescription |
| 3. No Housing | 6. Transportation | 9. Emotional Safety | 12. Employment |

Figure 15. Comparison of Current and Past SDOH needs by Chronicity (%) Initial Only



Source: SDOH Assessments from TruCare and Proms 7/1/23-6/30/24

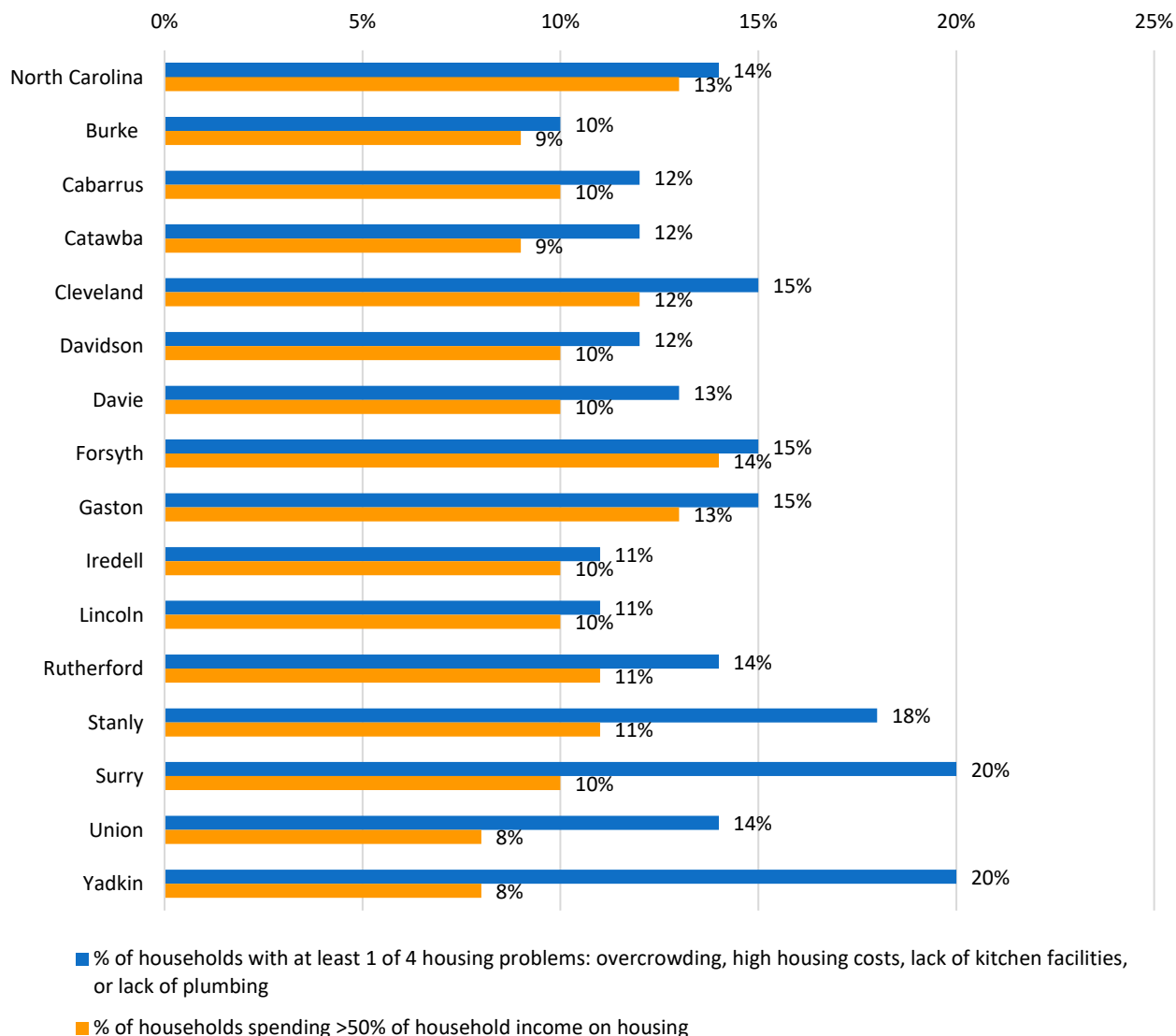
County-level SDOH Indicators

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 16 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 (e.g., Stanly, Surry, and Yadkin). These results are based on data from 2016-2020. 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.

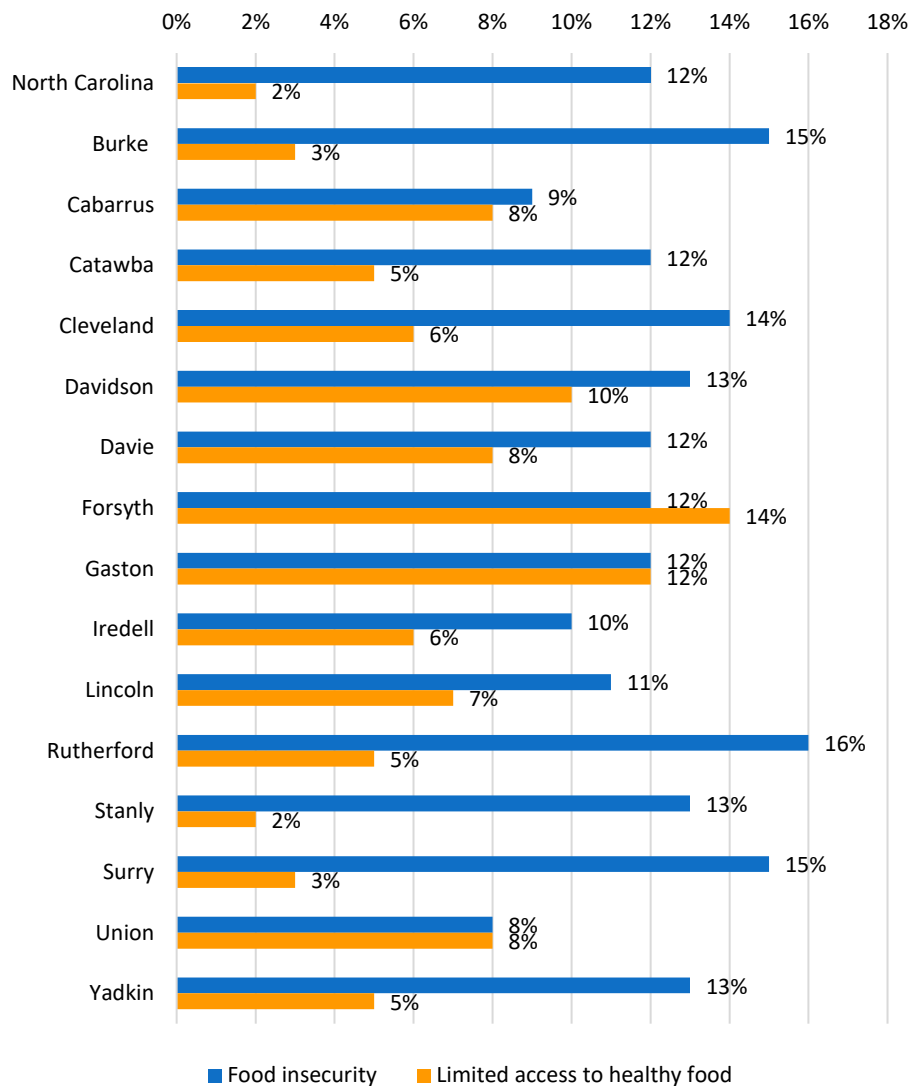
Figure 16. Housing Indicators - Partners Catchment



Source: County Health Rankings, 2024

Food Security, Accessibility, and Affordability

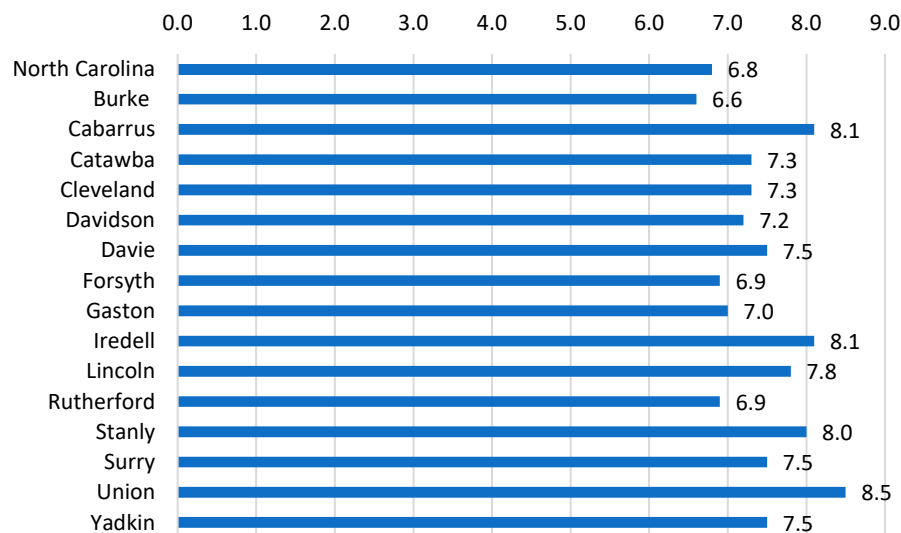
Figure 17. Food Insecurity & Limited Access to Healthy Foods - Partners Catchment



Source: County Health Rankings, 2024

Figures 17 and 18 provide information about the overall landscape of nutritional access within Partners' catchment counties. Figure 17 presents the percentage of the population reporting food insecurity (blue bar) and limited access to healthy foods (orange bar). Figure 18 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 17 and 18, 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. Forsyth and Gaston 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, Forsyth and Gaston have equally, if not higher, limited access to healthy foods. Results for Forsyth and Gaston show a potential combination of factors that may compound food-related concerns for residents in these counties.

Figure 18. Food Environment Index - Partners Catchment



Source: County Health Rankings, 2024

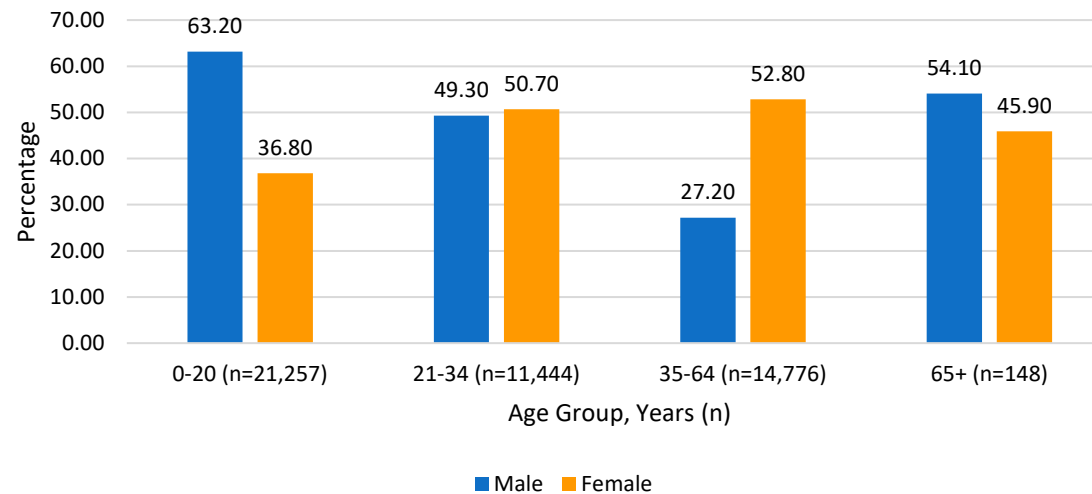
Member Populations

Tailored Plan

Tailored Plan members are identified as members who have Tailored Plan Medicaid or Tailored Plan Innovations Medicaid. There are 47,625 members who are identified as having Tailored Plan Medicaid as of January 1st, 2024.

Overall, Tailored plan members are 55% male and 45% female. However, as seen in Figure 19, the proportion of males and females shifts notably as this group ages. At the youngest ages (0-20 years), the population is majority male (63.2%). By ages 35-64 years, the population begins to shift to more female (52.8%). The Tailored Plan population is overwhelmingly under 65 years (99.7%) and 44.6% of Tailored Plan members are under 20 years.

Figure 19. Tailored Plan Population Age/Gender Breakdown
(n=47,625)



Source: HBI, 1-1-25 refresh, retrieved 2/6/25

Table 9 shows race and ethnicity demographic information for the Tailored Plan Population. The majority of the Tailored Plan Population is White (67.5%). Most of the Tailored Plan Population is Not Hispanic (89%).

Table 9. Tailored Plan Race/Ethnicity Matrix (n=47,625)

Ethnicity	Race							
	AI/NA (n=143)	Asian (n=511)	Black (n=12,599)	Multiracial (n=0)	Unknown (n=2,190)	Other (n=0)	Pacific Islander (n=54)	White (n=32,128)
Unknown (n=878)	4	16	163	0	209	0	1	484
Not Hispanic (n=42,378)	122	452	12,098	0	998	0	33	28,675
Hispanic, Puerto Rican (n=2)	0	0	0	0	0	0	0	2
Hispanic, Other (n=4,361)	17	43	337	0	983	0	20	2,961
Hispanic, Mexican American (n=6)	0	0	0	0	0	0	0	6
Hispanic, Cuban (n=0)	0	0	0	0	0	0	0	0

Note: Unknown includes members who did not supply their race or ethnicity and those who did not receive race and ethnicity from the Department or other reporting agencies.

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Table 10 displays the most common chronic diseases for Tailored Plan members. The most common diagnosis is F41 Other Anxiety Disorders with 32.2% of the Tailored Plan population having a diagnosis. Most of the Tailored Plan population have multiple chronic conditions with 37,098 or 77.9% having 2 or more chronic conditions (Figure 20).

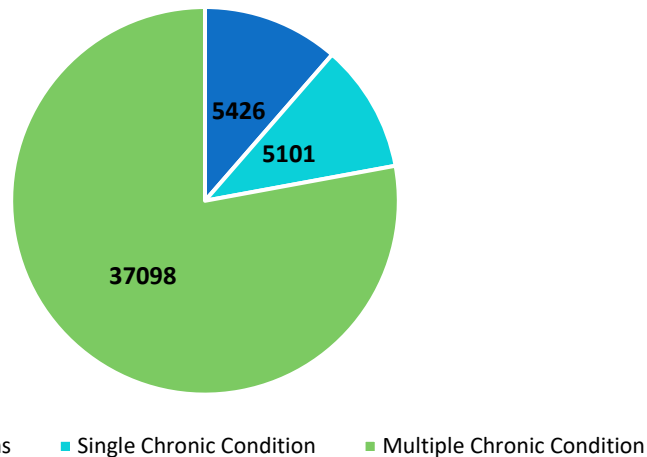
Most (95%) Tailored Plan members live within Partners' 15 catchment counties. Outside the Partners' catchment area, Tailored Plan members live mainly in Mecklenburg (n=650), Guilford (n=325), and Rowan (n=217) counties (Table 11).

Table 10. Most Common Chronic Diseases for Tailored Plan Members (n=47,625)

Chronic Disease	# Members	% Members
F41 Other Anxiety Disorders	15,345	32.2
F84 Pervasive Developmental Disorders	10,907	22.9
F90 Attention-Deficit Hyperactivity Disorders	10,394	21.8
F17 Nicotine Dependence	10,219	21.5
F33 Major Depressive Disorder, Recurrent	8,872	18.6

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Figure 20. Tailored Plan Members and Chronic Conditions



Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Table 11. Counties of Residence Outside of Catchment for Tailored Plan Members (n=2,385)

County	# Members
Mecklenburg County, NC	650
Guilford County, NC	325
Rowan County, NC	217
Caldwell County, NC	96
Alexander County, NC	89
Stokes County, NC	82
Buncombe County, NC	81
Randolph County, NC	64
Wake County, NC	59
McDowell County, NC	47
Anson County, NC	42
Durham County, NC	38
Alamance County, NC	37
Wilkes County, NC	33
Rockingham County, NC	29
Brunswick County, NC	23
Watauga County, NC	21
Lenoir County, NC	20
Other NC Counties	253
Other	173
Total	2,385

Note: Other NC Counties include all counties with less than 20 members; Other includes Unknown (those without a permanent address or an invalid address), and those living out of state

Source: HBI, 1-01-25 refresh, retrieved on 2/6/25

Children and Adolescents

Partners supplies Early and Periodic Screening, Detection, and Treatment (EPSDT) benefit information and services to members between birth and their 21st birthday. Services are delivered within the standard of care that implements and adheres to all EPSDT policies and protocols as defined in *Section V.B.2.ii Early and Periodic Screening, Diagnostic and Treatment for Medicaid members*. 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.

Overall, 31,292 members are eligible for EPSDT services. Table 12 shows the majority of child and adolescent members are male (59.6%) and the other being female (40.4%). The chart breaks down the EPSDT demographics by payor source (Tailored Plan and Medicaid Direct). We also show selected risk and prevalence of diabetes, hypertension, and asthma.

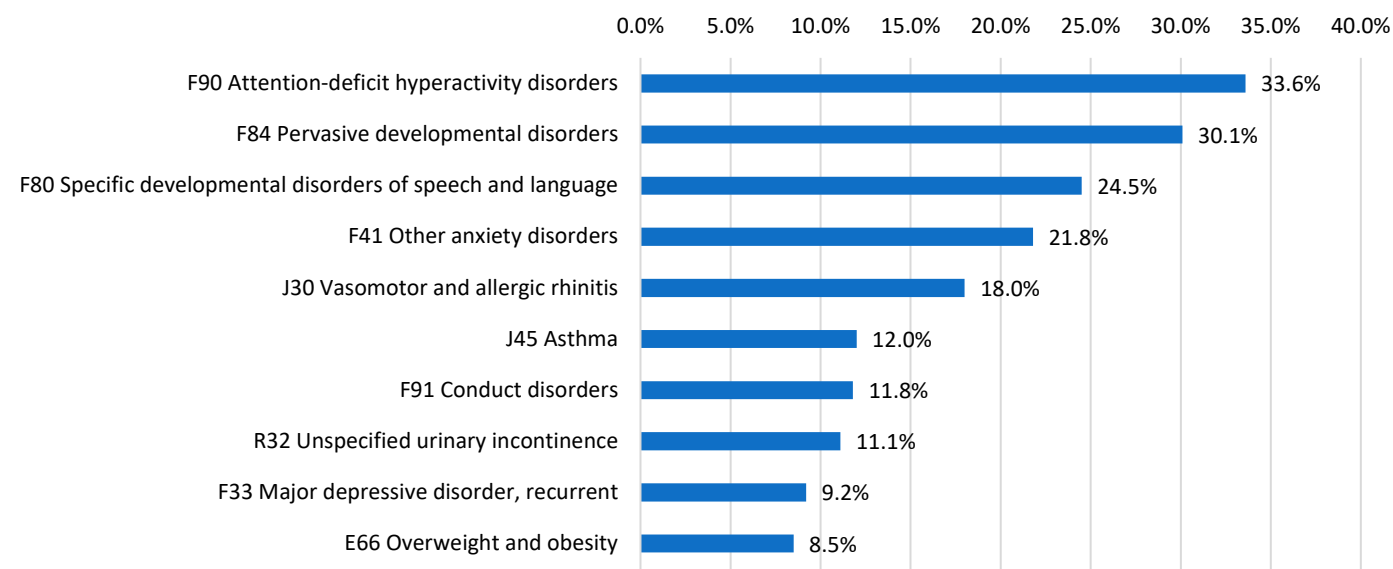
Table 12. Demographics and Selected Disease Risk, Members Aged 0-20 years old

Members aged 0-20 years old	All 31,292		Tailored Plan 21,257 (67.9%)		Medicaid Direct 9,661 (30.9%)	
	n	%	n	%	n	%
Sex						
Male	18,648	59.6	13,423	63.1	5,030	52.1
Female	12,644	40.4	7,833	36.8	4,631	47.9
Race						
American Indian/Native American	170	0.5	52	0.2	118	1.2
Asian	398	1.3	301	1.4	94	1.0
Black/African American	8,535	27.3	6,065	28.5	2,408	24.9
Multiracial	11	<0.1	0	0.0	0	0.0
Pacific Islander	42	0.1	29	0.1	13	0.1
White	20,709	66.2	13,771	64.8	6,659	68.9
Other	13	<0.1	0	0.0	0	0.0
Unknown	1,414	4.5	1,039	4.9	369	3.8
Ethnicity						
Hispanic	4,114	13.1	3,364	15.8	705	7.3
Non-Hispanic	26,682	85.3	17,629	82.9	8,726	90.3
Unknown	496	1.6	264	1.2	230	2.4
Diabetes - Very High Risk or current diagnosis of Type 1 or Type 2	419	1.4	310	1.5	106	1.1
Hypertension – Very High Risk or current diagnosis	1,040	3.3	767	3.6	266	2.8
Asthma – Current diagnosis	3,748	12.0	2,709	12.7	1,030	10.7

Source: HBI, 1-1-25 refresh, retrieved 2/10/25

Figure 21 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 (33.6%). This trend is common through both Tailored Plan (35.7%) and Medicaid Direct (29.9%) Members.

Figure 21. Top 10 Chronic Diseases Among All Members Aged 0-20 years



Source: HBI, 1-1-25 refresh, retrieved 2/10/25

Tables 13 and 14 present HEDIS measures of particular interest to the Children and Adolescent population. All HEDIS measures in this section are filtered to only include members in the Children and Adolescent population. Many of our child and adolescent members may have private insurance coverage which can affect our knowledge of physical health care. This lack of data affects our ability to track items such as immunizations. Therefore, it may appear that our members are not receiving services when they have.

Table 13. MY24 Encounter Based HEDIS Measures for Total Children and Adolescent Population						
Measure Year	Measure Id	Measure Name	Eligible	Compliant	Compliant Rate	Internal Target Rate
2024	ADD-1	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	1,537	850	55.3%	40.8%
2024	ADD-2	Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase	1,537	0	0%	89.0%

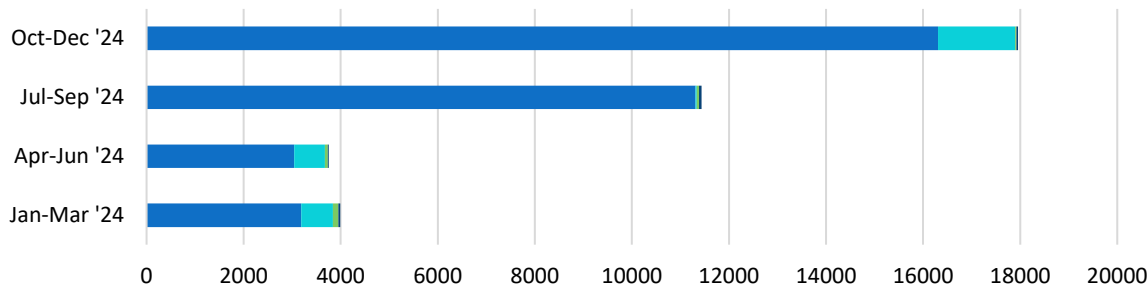
Source: HBI, 1-1-25 refresh, retrieved on 2/10/25

Table 14. MY24 Person Based HEDIS Measures for Total Children and Adolescent Population

Measure Year	Measure Id	Measure Name	Eligible	Compliant	Compliant Rate	Internal Target Rate
2024	APM-1	Metabolic Monitoring for C&A on Antipsychotics – Blood Glucose Testing	2,291	1,220	53.3%	35.0%
2024	APM-2	Metabolic Monitoring for C&A on Antipsychotics – Cholesterol Testing	2,291	853	37.2%	0%
2024	APM-3	Metabolic Monitoring for C&As on Antipsychotics – Blood Glucose and Cholesterol	2,291	808	35.3%	0%
2024	CIS-1	Childhood Immunization Status - DTaP	535	0	0.0%	20.0%
2024	CIS-10	Childhood Immunization Status - Influenza	535	26	4.9%	20.0%
2024	CIS-2	Childhood Immunization Status - IPV	535	1	0.2%	20.0%
2024	CIS-3	Childhood Immunization Status - MMR	535	129	24.1%	20.0%
2024	CIS-4	Childhood Immunization Status - HiB	535	6	1.1%	20.0%
2024	CIS-5	Childhood Immunization Status – Hepatitis B	535	0	0.0%	20.0%
2024	CIS-6	Childhood Immunization Status - VZV	535	131	24.5%	20.0%
2024	CIS-7	Childhood Immunization Status – Pneumococcal Conjugate	535	0	0.0%	20.0%
2024	CIS-8	Childhood Immunization Status – Hepatitis A	535	168	31.4%	20.0%
2024	CIS-9	Childhood Immunization Status - Rotavirus	535	7	1.3%	20.0%
2024	IMA-1	Immunizations for Adolescents - Meningococcal	1,748	814	46.6%	20.0%
2024	IMA-2	Immunizations for Adolescents -Tdap	1,748	780	44.6%	20.0%
2024	IMA-3	Immunizations for Adolescents - HPV	1,748	241	13.8%	20.0%
2024	W30-1	Well-Child Visits in the First 30 Months of Life (<15 months)	356	27	7.6%	20.0%
2024	W30-2	Well-Child Visits in the First 30 Months of Life (15-30 months)	788	162	20.6%	20.0%
2024	WCV-1	Child and Adolescent Well-Care Visits	31,443	14,725	46.8%	20.0%

Source: HBI, 1-1-25 refresh, retrieved on 2/10/25

Figure 22. EPSDT-Related Member and Provider Outreach CY2024



Source: STK-002-T, STK-002-M, MEM-003-M; TruCare; Jan-Dec 2024

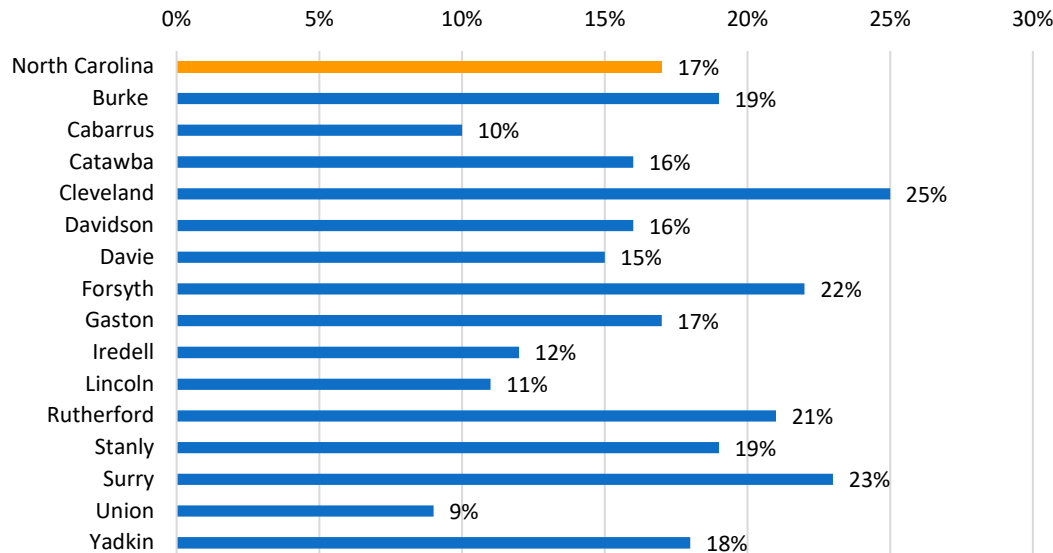
Member Outreach	651	634	27	1592
Provider Outreach	111	58	43	27
Events	38	20	52	30

Member Handbooks Member Outreach Provider Outreach Events

Outreach is provided by the Health Outreach Specialist, Member Engagement Specialists and Community Engagement team.

Figure 22 highlights member and community outreach completed each quarter. This includes the number of handbooks provided to members, member outreach, provider outreach, and events completed in the community. In CY24, 140 EPSDT-related events were held in the communities served by Partners.

Figure 23. Children in Poverty - Partners Catchment



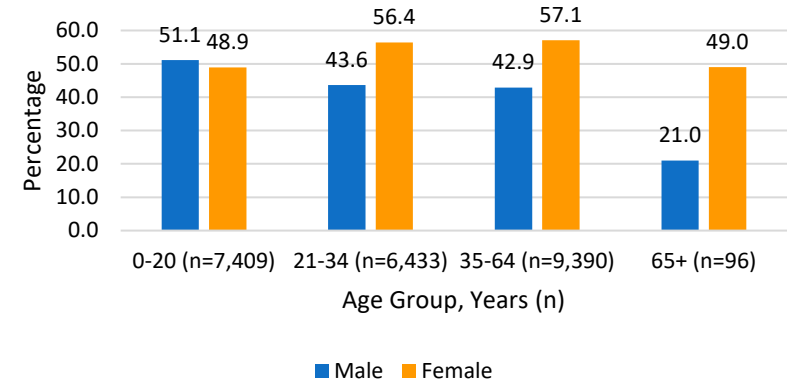
Source: County Health Rankings & Roadmaps, 2024

About half of the counties in Partners' catchment have a higher proportion of children in poverty compared to the state average; Cleveland County has the highest proportion (25%; Figure 23).

Tailored Plan Members with SPMI

We identified Tailored Plan Members with Severe and Persistent Mental Illness (SPMI) using a list of diagnoses. Of those members with Tailored Plan Medicaid, 23,328 also had an SPMI diagnosis. The Tailored Plan SPMI population is slightly more female (54%) than male (46%). Figure 24 displays the breakdown of age and gender which reveals that younger members of this population are more likely to be male but that reverses for the 21-34, 35-64 and 65+ age groups where more of the population is female. Table 15 displays the breakdown of race and ethnicity for this population.

Figure 24. Tailored Plan SPMI Age/Gender Breakdown (n=23,328)



Source: HBI, 1-1-25 refresh, retrieved 2/6/25

Table 15. Tailored Plan Members with SPMI Race/Ethnicity Matrix (n=23,328)

Ethnicity	Race							
	AI/NA	Asian	Black	Multiracial	Unknown	Other	Pacific Islander	White
Unknown	3	11	80	0	64	0	0	251
Not Hispanic	67	159	5,553	0	431	0	7	5,010
Hispanic, Puerto Rican	0	0	0	0	0	0	0	0
Hispanic, Other	6	13	110	0	441	0	10	917
Hispanic, Mexican American	0	0	0	0	0	0	0	4
Hispanic, Cuban	0	0	0	0	0	0	0	0

AI/NA = American Indian/Native American

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Nearly 95.5% of this population had multiple chronic conditions while 4.5% only had a single chronic condition (Figure 25). All members with a single chronic condition only had one chronic condition diagnosis which is the SPMI diagnosis that qualified them for this population. The most common SPMI diagnosis was Other Anxiety Disorders and the most common non-SPMI diagnosis was Nicotine Dependence (Tables 16 and 17).

Table 16. Most Common Chronic Diseases for Tailored Plan Members with SPMI (excluding SPMI Diagnoses) (n=23,328)

Chronic Disease	# Members	% Members
F17 Nicotine Dependence	7,743	33.2
F90 Attention Deficit Hyperactivity Disorders	6,327	27.1
I10 Essential (primary) Hypertension	5,902	25.3
E66 Overweight and Obesity	5,487	23.5
E78 Disorders of Lipoprotein Metabolism	4,738	20.3

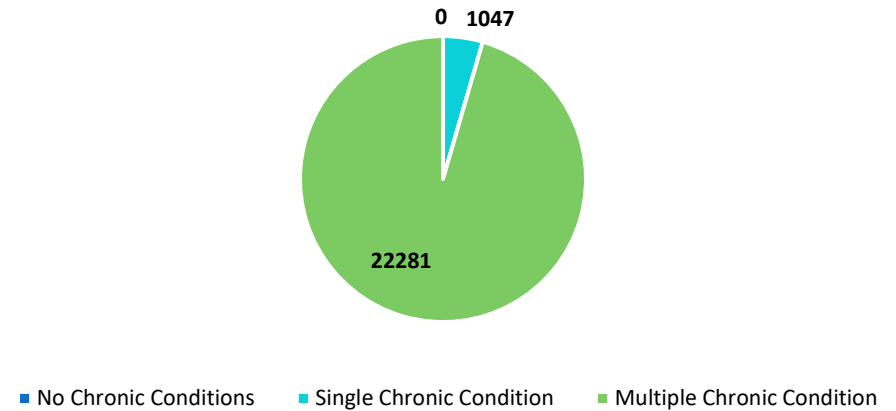
Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Table 17. Most Common SPMI Diagnoses for Tailored Plan Members with SPMI (n=23,328)

SPMI Diagnoses	# Members	% Members
F41 Other Anxiety Disorders	15,345	65.8
F33 Major Depressive Disorder, recurrent	8,872	38.0
F43 Reaction to Severe Stress and Adjustment Disorders	5,577	23.9
F32 Depressive Episode	4,925	20.3
F25 Schizoaffective Disorders	3,971	17.0

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Figure 25. TP Members with SPMI and Chronic Disease



Source: HBI, 1-1-25 refresh, retrieved 2/6/25

Tables 18 and 19 show HEDIS measures of interest for members with SPMI. Both tables display data for the entire Tailored Plan population, not just those with an SPMI diagnosis. 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.

Table 18. MY24 Encounter Based HEDIS Measures for Entire Tailored Plan Population

Measure Year	Measure Id	Measure Name	Eligible	Compliant	Compliant Rate	Internal Target Rate
2024	FUH-1	Follow-Up After Hospitalization for Mental Illness – 30 Day Follow Up	2,598	1,615	62.2%	80.0%
2024	FUH-2	Follow-Up After Hospitalization for Mental Illness – 7 Day Follow Up	2,598	842	32.4%	65.0%
2024	FUM-1	Follow-Up After Emergency Department Visit for Mental Illness – 30 Day Follow Up	1,387	806	58.1%	78.0%
2024	FUM-2	Follow-Up After Emergency Department Visit for Mental Illness – 7 Day Follow Up	1,387	566	40.87%	67.0%

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Table 19. MY24 Person Based HEDIS Measures for Entire Tailored Plan Population

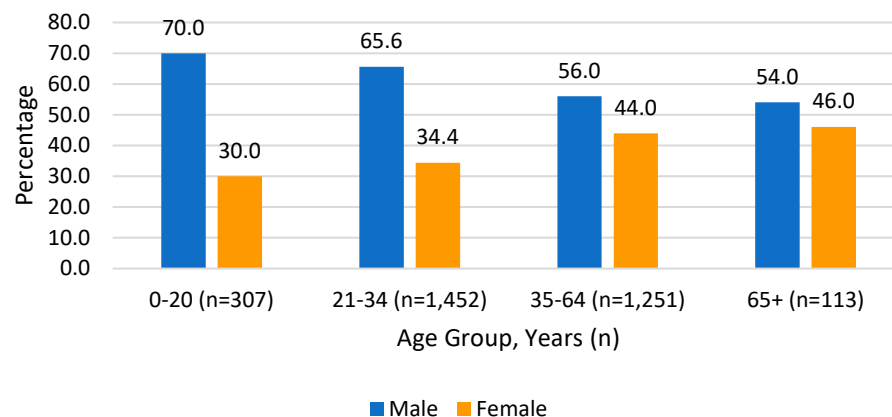
Measure Year	Measure Id	Measure Name	Eligible	Compliant	Compliant Rate	Internal Target Rate
2024	AMM-1	Antidepressant Medication Management – Effective Acute Phase Treatment	1,643	1,108	67.4%	85.0%
2024	AMM-2	Antidepressant Medication Management – Effective Continuation Phase Treatment	1,643	857	52.2	75.0%
2024	APM-1	Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose Testing	1,131	673	59.5%	35.0%
2024	APM-2	Metabolic Monitoring for Children and Adolescents on Antipsychotics – Cholesterol Testing	1,131	438	38.7%	0%
2024	APM-3	Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose and Cholesterol Testing	1,131	416	36.8%	0%
2024	SSD-1	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	3,410	2,665	78.2%	60.7%

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Members with Innovations/IDD

Members with Innovations/IDD were identified as those having Innovations Medicaid or Tailored Plan Innovations Medicaid. We use this population to be representative of our I/DD population. There are 1,397 members or 44.7% of the Innovations population who are also part of the Tailored Plan and SPMI population. Most of the Innovations population is male with 62% of members identified as male while 38% are identified as female. The Innovations population has less children and adolescents than other populations; 90.2% of Innovations members are over the age of 21 (Figure 26). 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 20).

Figure 26. Age/Gender of Innovations Members
(n=3,123)



Source: HBI, 1-1-25 refresh, retrieved 2/6/25

Table 20. Race/Ethnicity Matrix for Innovations Members (n=3,123)

Ethnicity	Race							
	American Indian/Native American	Asian	Black	Multiracial	Unknown	Other	Pacific Islander	White
Unknown	0	5	23	0	43	0	0	67
Not Hispanic	1	29	721	0	249	0	0	1,877
Hispanic, Puerto Rican	0	0	0	0	0	0	0	0
Hispanic, Other	0	5	6	0	55	0	0	39
Hispanic, Mexican American	0	0	0	0	0	0	0	0
Hispanic, Cuban	0	0	0	0	0	0	0	0

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Table 21 shows the prevalence of neurodevelopmental disorders among 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. Almost 40% of Innovations members have pervasive developmental disorders a diagnosis which includes autism spectrum disorder.

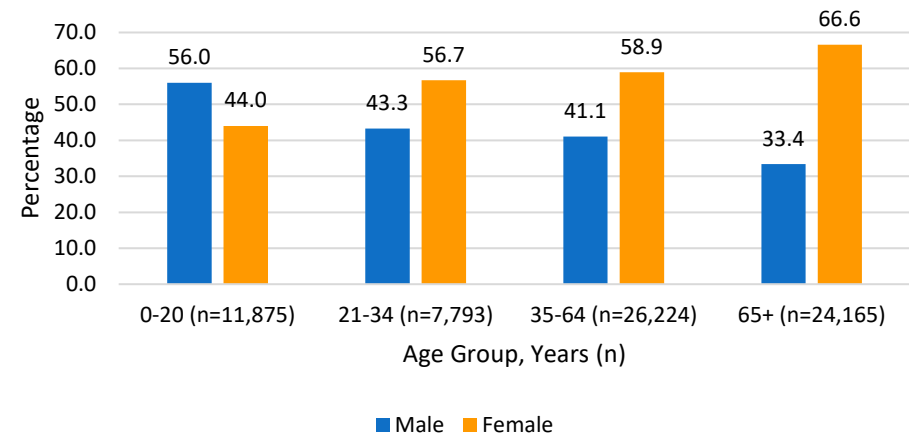
Table 21. Neurodevelopmental Disorders among Innovations Members (n=3,123)		
Chronic Disease	# Members	% Members
F71 Moderate intellectual disabilities	1,535	49.2
F84 Pervasive developmental disorders (autism)	1,309	41.9
F70 Mild intellectual disabilities	1,173	37.6
F79 Unspecified intellectual disabilities	999	32.0
F72 Severe intellectual disabilities	914	29.3

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Members with Multiple Chronic Conditions

We defined Members with Multiple Chronic Conditions (n=70,061) as Medicaid members (Medicaid Direct or Tailored Plan) with 2 or more physical health diagnoses. Over half (59%) of this population is female while 41% are male. Females make up more of this population for each age group except for the under 20 age group where 56% of members under 20 in this population are male (Figure 27). Over 65% of this population is White while approximately 28% are Black and 7% are other races (Table 22).

Figure 27. Age/Gender for Medicaid Members with Multiple Chronic Conditions (n=70,061)



Source: HBI, 1-1-25 refresh, retrieved 2/6/25

Table 22. Race/Ethnicity Matrix for Medicaid Direct & Tailored Plan Members with Multiple Chronic Conditions (n=70,061)

Ethnicity	Race							
	American Indian/Native American	Asian	Black	Multiracial	Unknown	Other	Pacific Islander	White
Unknown	7	85	332	0	381	0	3	1,005
Not Hispanic	262	1,095	19,006	0	1,693	0	44	41,888
Hispanic, Puerto Rican	0	0	0	0	0	0	0	1
Hispanic, Other	17	54	232	0	1,163	0	38	2,751
Hispanic, Mexican American	0	0	0	0	0	0	0	4
Hispanic, Cuban	0	0	0	0	0	0	0	0

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

The most common chronic health condition for Members with Multiple Chronic Conditions is I10 Essential Hypertension (53.2%) (Table 23).

Table 23. Most Common Chronic Diseases for Medicaid Direct & Tailored Plan Members with Multiple Chronic Conditions (n=70,061)

Chronic Disease	# Members	% Members
I10 Essential (primary) hypertension	37,304	53.2
E78 Disorders of lipoprotein metabolism and other lipidemia	32,445	46.3
F41 Other anxiety disorders	26,658	38.0
K21 Gastro-esophageal reflux disease	22,566	32.2
E11 Type 2 diabetes mellitus	20,605	29.4

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Table 24 displays 4 HEDIS measures of importance to members with chronic conditions. All HEDIS measures in this section have been filtered to only include members who have multiple chronic conditions. We chose these measures as they specifically address the management of chronic health conditions such as high blood pressure or diabetes.

Table 24. MY24 Person Based HEDIS Measures for Medicaid Direct & Tailored Plan Members with Multiple Chronic Conditions

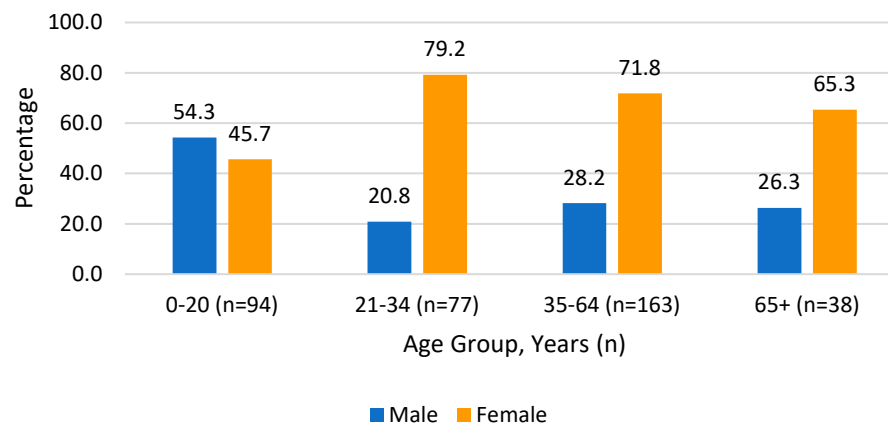
Measure Year	Measure Id	Measure Name	Eligible	Compliant	Compliant Rate	Internal Target Rate
2024	CBP-1	Controlling High Blood Pressure	16,895	3,577	21.2%	70.0%
2024	GSD-1	Glycemic Status Assessment for Patients with Diabetes HbA1c Control <8%	13,838	1,763	12.7%	0%
2024	GSD-2	Glycemic Status Assessment for Patients with Diabetes HbA1c Poor Control >9%	13,923	4,195	30.1%	0%
2024	SSD-1	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	2,714	2,355	86.8%	60.7%

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

Members with Sickle Cell Disease

We identified Members with Sickle Cell Disease (n=372) using HBI to filter for Medicaid members (Medicaid Direct and Tailored Plan) who with a D57-Sickle Cell Disorders diagnosis. A quarter (25.3%) of members with Sickle Cell are under the age of 21 and 43.9% are between the ages of 35-64 (Figure 28). Members with Sickle cell are predominantly Black and non-Hispanic with 92% identified as Black and 93.5% identified as non-Hispanic (Table 25).

Figure 28. Age/Gender for MD & TP Members with Sickle Cell Disease (n=372)



Source: HBI, 1-1-25 refresh, retrieved 2/6/25

Table 25. Race/Ethnicity Matrix for Medicaid Direct & Tailored Plan Members with Sickle Cell Disease (n=372)

Ethnicity	Race							
	American Indian/Native American	Asian	Black	Multiracial	Unknown	Other	Pacific Islander	White
Unknown	0	0	10	0	0	0	0	1
Not Hispanic	0	3	333	0	0	0	0	12
Hispanic, Puerto Rican	0	0	0	0	0	0	0	0
Hispanic, Other	0	1	2	0	1	0	0	9
Hispanic, Mexican American	0	0	0	0	0	0	0	0
Hispanic, Cuban	0	0	0	0	0	0	0	0

The most common chronic disease is I10 Essential Hypertension (Table 26). All members with Sickle Cell have multiple chronic conditions. Opioid use and overdose risk is somewhat common within this population as 54 members or 14.5% have had an opioid prescription filled in the last months and 80 members or 21.5% are at high or very high risk of having an opioid overdose.

Table 26. Most Common Chronic Diseases for Medicaid Direct & Tailored Plan Members with Sickle Cell Disease (n=372)

Chronic Disease	# Members	% Members
I10 Essential (primary) hypertension	165	44.4
G89 Pain, not elsewhere classified	154	41.4
F41 Other anxiety disorders	143	38.4
E55 Vitamin D deficiency	113	30.4
J45 Asthma	110	29.6

Source: HBI, 1-1-25 refresh, retrieved on 2/6/25

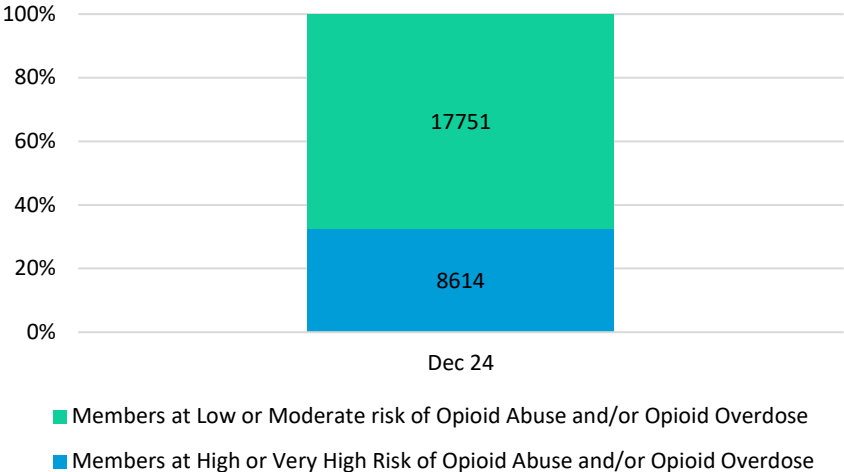
Members at Risk of Opioid Misuse or Overdose

Partners’ Project Reducing Harm from Opioids (Project RHO) is intended to decrease the number of members and recipients who are at an elevated risk of 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. Outcomes include:

- 1. Decrease in percentage of members at High or Very High Risk of Opioid Abuse and/or Opioid Overdose.
- 2. Increase in the number of unique members receiving medication assistant treatment (MAT).
- 3. Increase in the number of MAT providers in the Partners network.

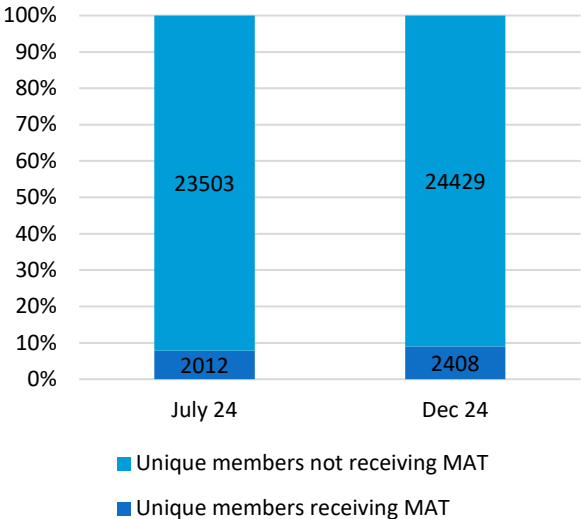
Between 7/1/24-12/31/24, we observed a modest increase in the number of unique members receiving MAT (Figure 30), and a slight increase in the number of MAT providers in Partners’ network (from 36 in July 2024 to 38 in December 2024).

Figure 29. Member Risk of Opioid Abuse and/or Overdose, TP Members Aged 21+, excluding present Opioid Abuse



Source: HBI refresh 1/1/24

Figure 30. TP Members aged 21+ receiving MAT



Source: Data Cubes, Service dates Jan-Jun2024 and Jul-Dec 2024

Table 27 displays 2 HEDIS measures of importance to those at risk of opioid misuse or overdose. The measures below are stratified by plan type.

Table 27. MY24 Opioid-Related Encounter Based HEDIS Measures by Plan Type							
Measure Year	Measure Id	Measure Name	Plan	Eligible	Compliant	Compliant Rate	Internal Target Rate
2024	FUA-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Day Follow Up	Medicaid Direct	295	48	16.3%	23.0%
			Tailored Plan	1,161	413	35.6%	
2024	FUA-2	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Day Follow Up	Medicaid Direct	295	28	9.5%	17.0%
			Tailored Plan	1,161	272	23.4%	

Source: HBI, 01-01-25 refresh, retrieved on 2/14/25

Figure 31. Drug Deaths per 100,000 - Partners Catchment

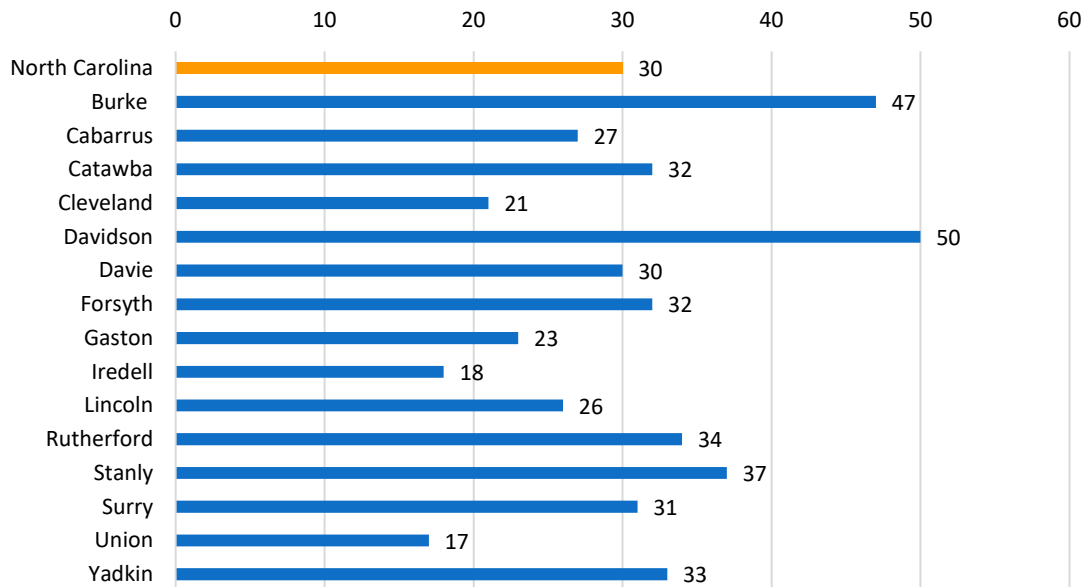


Figure 31 displays the rate of drug deaths per 100,000 population for the state and by catchment county. Two counties within Partners' catchment (Burke and Davidson) have drug-related death rates at more than 1.5 times the state rate.

Source: County Health Rankings, 2024

Members Who Use Tobacco

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.

We are not able to accurately capture the rates of members who currently smoke as nicotine diagnosis may be present in a member's record despite efforts to quit. County Health Rankings reports the percentage of adults who are current smokers (see Figure 32). Most Partners' catchment counties are at or above the state proportion (15%). Medicaid recipients are more likely to smoke compared to those with private insurance (DiGiulio et al., 2024). A recent economic evaluation reported that, in addition to improving health outcomes, reducing the national smoking prevalence by 1% would result in median state savings of \$25 million (Glantz, 2019).

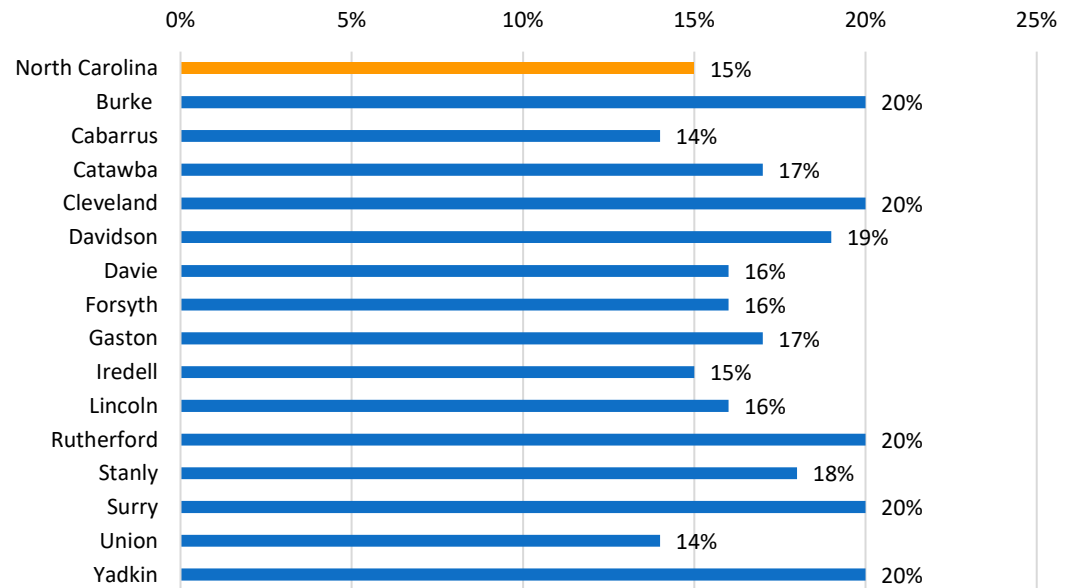
Partners' Living Tobacco Free program is designed to address tobacco use among members and recipients and to connect them with resources to help them quit or decrease their use.

Outcomes include:

1. Increase the number of members who complete the QuitlineNC/Quit for Life program.

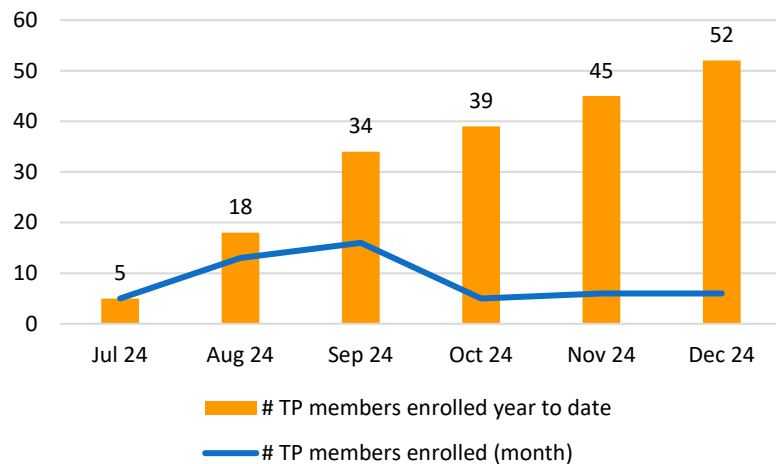
To address the goals of Partners' Living Tobacco Free program, we have partnered with RVO/Optum to supply tobacco cessation training and support to members. Between July-December 2024, 5/52 (9.6%) Tailored plan members had completed at least four coaching sessions in the Quit for Life program. Figures 33-35 display additional key metrics from this program.

Figure 32. Adult Smoking - Partners Catchment



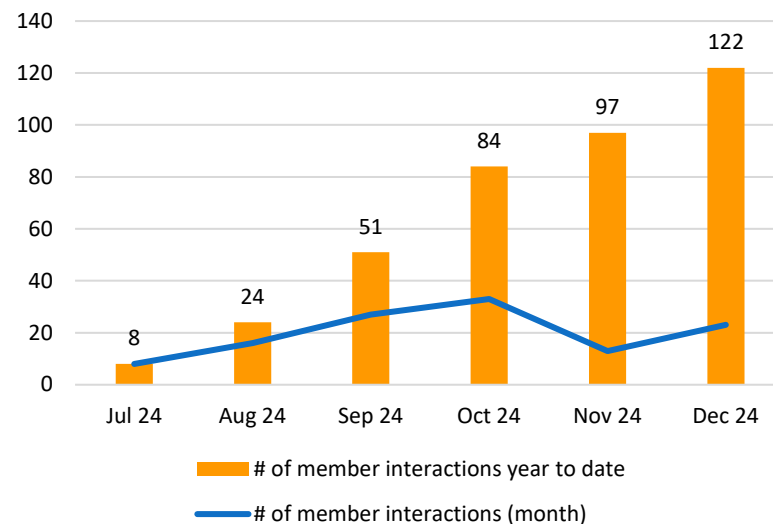
Source: County Health Rankings, 2024

Figure 33. Quit for Life Enrollment - Tailored Plan Members



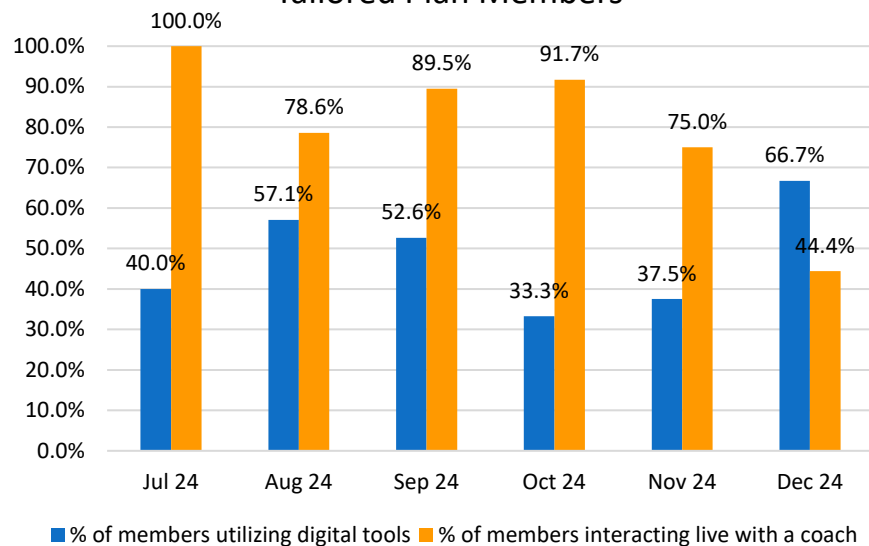
Source: Quit for Life, 1/1/25, RVO/Optum

Figure 34. Member Interaction - Tailored Plan Members



Source: Quit for Life, 1/1/25, RVO/Optum

Figure 35. Type of Member Interaction - Tailored Plan Members



Source: Quit for Life, 1/1/25, RVO/Optum

Pregnancy

We identified Tailored Plan members who were likely pregnant (n=329) using HBI to filter for those members with a paid claim or diagnosis that showed pregnancy. Most pregnant members (66.6%) are between the ages of 21-34 years old, followed by those 18-20 years old (17.0%), 34-49 years old (9.7%), and 13-17 years old (6.9%). Pregnant members are majority White and non-Hispanic (63.5%). About 26.1% are Black.

Table 28. Race/Ethnicity Matrix for Pregnant Tailored Plan Members (n=329)

Ethnicity	Race							
	American Indian/Native American	Asian	Black	Multiracial	Unknown	Other	Pacific Islander	White
Unknown	0	0	1	0	0	0	0	1
Not Hispanic	2	3	84	0	1	0	0	209
Hispanic, Puerto Rican	0	0	0	0	0	0	0	0
Hispanic, Other	0	0	1	0	10	0	0	17
Hispanic, Mexican American	0	0	0	0	0	0	0	0
Hispanic, Cuban	0	0	0	0	0	0	0	0

Source: HBI, 1-1-25 refresh, retrieved on 2/21/25

According to data from the National Center for Health Statistics, the proportion of birthing people with chronic conditions has increased since 2015. As of 2022, 35.2% of people giving birth had at least one chronic condition (obesity, hypertension, diabetes, cigarette smoking). Obesity was the most common condition (31.6%). Partners catchment counties had consistently higher rates of chronic conditions compared to the national average. Figure 36 describes the factors most impacting the vulnerability of birthing people by catchment county.

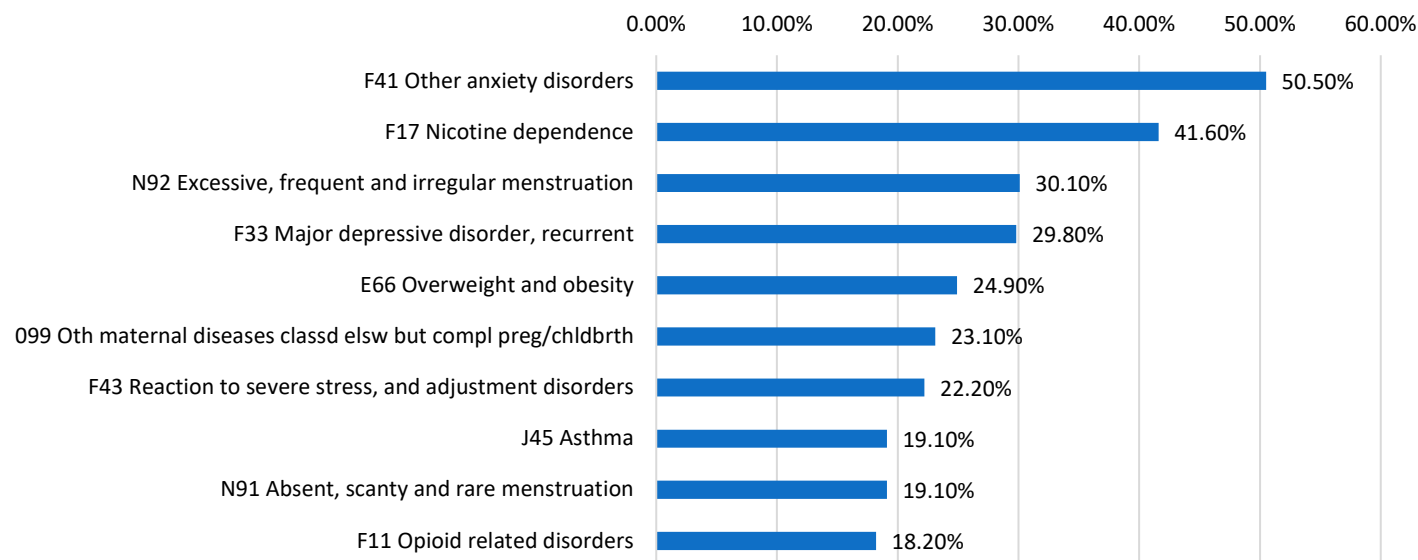
Among Partners' Tailored Plan members who are pregnant, over half are diagnosed with anxiety disorders and over 40% have a history of nicotine dependence. Additional common chronic conditions are presented in Figure 37.

Figure 36. Factors impacting the vulnerability of birthing people within Partners Catchment counties.



Source: Surgo Ventures, MVI 2022

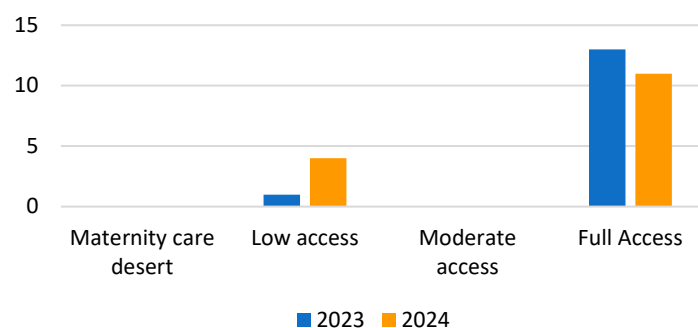
Figure 37. Most Common Chronic Diseases Among Pregnant TP Members



Source: HBI, 1-1-25 refresh, retrieved 2/21/25

Pregnancy care access is inconsistent across the US and within North Carolina. The March of Dimes [released a report in 2024](#) detailing areas of concern for maternity care based on US county. Maternity care deserts are those counties with no hospitals or birth centers offering obstetric care, no obstetric clinicians per 10,000 births (including OB-GYNs, certified nurse-midwives, certified midwives, and family physicians who reported delivering babies), and any proportion of women 18-64 without health insurance. Counties considered to have low access had less than 2 hospitals and birth centers offering obstetric care, less than 60 obstetric clinicians per 10,000 births, and more than 10% of women 18-64 without health insurance. Within the Partners catchment area, four counties were classified as having low access to care (Davidson, Davie, Lincoln, and Yadkin) in 2024 (see Figure 38). This was an increase from one county with low access in 2023 (Davidson). All other counties in the Partners catchment area were classified as having full access to maternity care.

Figure 38. Access to Maternity Care within Partners' Catchment



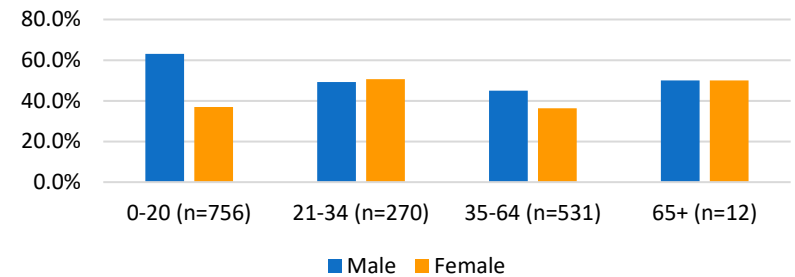
Source: March of Dimes, 2023-2024

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 Tailored Plan Members with hearing loss, over half (54.4%) are aged 0-20 years and of all ages (Figure 39), over half (n=855, 61.6%) are male (not shown in a table). Members with hearing loss are predominantly White and not Hispanic (Table 29, 57.7%).

Figure 39. Tailored Plan Members with Hearing Loss (n=1,389)



Source: HBI, 2-1-25 refresh, retrieved 3/17/25

Table 29. Race/Ethnicity Matrix for Tailored Plan Members with Hearing Loss (n=1,389)

Ethnicity	Race							
	American Indian/Native American	Asian	Black	Multiracial	Unknown	Other	Pacific Islander	White
Unknown	0	0	12	0	0	11	0	29
Not Hispanic	4	17	260	0	0	55	0	801
Hispanic, Puerto Rican	0	0	0	0	0	0	0	0
Hispanic, Other	1	3	6	0	0	52	3	134
Hispanic, Mexican American	0	0	0	0	0	0	0	1
Hispanic, Cuban	0	0	0	0	0	0	0	0

Source: HBI, 2-1-25 refresh, retrieved on 3/17/25

Table 30. Cost of Care by Category: Tailored Plan Members with Hearing Loss

Cost Category	Total Member		Total Cost (\$)	Actual Cost PMPM (\$)
	Total Patients	Months		
Total Cost of Care	1,389	16,190	\$58,533,554	\$3,615
Physical Health	1,389	16,190	\$17,310,228	\$1,069
Facility: IP	1,389	16,190	\$4,643,444	\$287
Facility: ED	1,389	16,190	\$1,066,161	\$66
Facility: Other	1,389	16,190	\$3,674,991	\$227
Professional	1,389	16,190	\$7,925,631	\$490
Behavioral Health	1,389	16,190	\$41,223,327	\$2,546
Facility: IP	1,389	16,190	\$1,272,506	\$79
Facility: ED	1,389	16,190	\$134,411	\$8
Facility: Other	1,389	16,190	\$5,518,652	\$341
Professional	1,389	16,190	\$34,297,757	\$2,118

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

The cost of care for members with hearing loss was higher than that of the full Tailored Plan population (see Tables 30 and 40).

The cost of care per member, per month (PMPM) for members with hearing loss was almost twice that of the total Tailored Plan population (\$3,615 vs. \$1,869). Emergency department and inpatient costs PMPM for members with hearing loss was similar to that of the full Tailored Plan population. However, the cost for members with hearing loss PMPM in all other categories was at least 1.8 times higher with the greatest difference observed in Behavioral Health Facility: Other (\$341 vs. \$90 PMPM; 378.9% higher).

Among members with hearing loss, 1376 out of 1389 (99.1%) had multiple chronic conditions and 14.4% were Innovations members (source: HBI, 2-1-25 refresh, retrieved 3/11/25; not shown in tables). The most common chronic diseases for Tailored Plan members with hearing loss are listed in Table 31.

Table 31. Most Common Chronic Diseases for Tailored Plan Members with Hearing Loss (n=1,389)

Chronic Disease	# Members	% Members
H90 Conductive and sensorineural hearing loss	937	67.5%
H91 Other and unspecified hearing loss	713	51.3%
F41 Other anxiety disorders	499	35.9%
F84 Pervasive developmental disorders	444	32.0%
F80 Specific developmental disorders of speech and language	427	30.7%

Source: HBI, 2-1-25 refresh, retrieved on 3/11/25

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 the data cubes, HBI, and reports manager.

PartnersACCESS Call Lines

There were 11,399 calls received between the Crisis Call line and the Member Line during CY24. The vast majority, 97.7%, were conducted in English. Spanish and Sign Language were the second most common language for PartnersACCESS Calls. The crisis line is specifically individuals in crisis or those who need immediate help. The member line is for questions about providers, benefits, eligibility, or other general questions. Member calls were more common than crisis calls with 56.2% of all calls being member calls.

Table 32. PartnersACCESS Calls for CY24 by Call Language and Call Reason

Language	Crisis Calls	Member Calls	Total # Calls
English	4905	6233	11,138
Spanish	80	165	245
Sign Language	5	2	7
Vietnamese	1	2	2
Chinese (Mandarin)	0	1	1
French	0	1	1
Arabic	0	2	2
Russian	0	1	1
Ukrainian	0	1	1
Grand Total	4,991	6,408	11,399

Source: PEGA Call Data, retrieved on 2/3/25

Pyx Health

Pyx Health is a wellness app 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. Figure 40 and Table 33 illustrate the current Pyx Health Usage by Partners’ members. Of the 120,000 Partners' members, 2,989 (about 2.5%) were enrolled in Pyx as of the end of December 2024. During calendar year 2024, There were 1,114 active users and there were 28,012 interactions within the app. The most common activity types were the coloring book, resource center, Andy calls, screeners (PHQ-4/UCLA-3), and SDOH questions. 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.

Figure 40. Pyx Health Utilization and Screening



Source: Pyx Health Data, Jan-Dec 2024

Table 33. Top 5 Pyx App Activity Types

Activity Type	# of Interactions	# of Members
Coloring Book	6830	111
Resource	5822	674
Andy Calls	4230	879
Screener	2540	877
SDOH	750	637

Source: Pyx Health Data, Jan-Dec 2024

Tailored Care Management

Tailored Plan launched on 7/1/24 and members had the opportunity to opt out of Tailored Care Management (TCM) or select a TCM provider. Table 34 below displays the TCM assignment for Tailored Plan members as of January 1st, 2025. Care management helps members manage illnesses by coordinating care. A variety of case types exist to best serve members. A case is opened for each need of a member, which means a member can have multiple cases open at one time. Care management data represents cases opened between January 1st, 2024, and December 31st, 2024. Open cases may include members who are receiving Tailored Care Management (TCM) from an external CMA/AMH+ (Care Management Agency/Advanced Medical Home Plus) if that CMA/AMH+ is using our platform, TruCare. Of the 36 external TCM providers (CMA/AMH+), 9 are using TruCare as their case management platform and are also using our Partners' TruCare platform to share information about their assigned members. Cases can also be created by departments outside of Care Management such as Utilization Management. All UM cases include UM in their title.

Table 35 displays the number of cases and the number of members by case type for CY24. The highest number of care management cases opened was for BH TCM (Partners). There were 3,374 cases opened in this category. In total, there were 53,718 cases for 27,695 members.

Table 34. TCM Assignment as of 01/01/25

TCM Provider	# of Members
Partners	17,370
External TCM Provider	35,472
Opted Out	3,595
Not Assigned	3,582
Duplicative Services	423
Total	60,442

Source: TruCare, 1/1/25

Table 35. Cases and Members by Case Type

Case Type	# Cases	# Unique Members
UM RB-BHT	5048	2558
UM MH ADULT	3811	3178
UM Innovations	3384	3166
BH TCM (Partners)	3374	3116
CTT Inpatient	3057	2180
UM IP MCD	2910	2083
BH S&R TCM Unengaged (Partners)	2803	2693
BH S&R TCM Opt Out (Partners)	2712	2642
UM IIH-CADT	2654	2018
UM IDD State-B(3)-1915(i)	1842	1361
CTT TFU	1538	1263
BH TCM (CMA/AMH+)	1479	985
UM ICF	1467	730
UM FBC	1271	956
UM SU ADULT-CHILD	1176	1036
IDD S&R TCM Unengaged (Partners)	1174	1149
TCL RSVP	1067	862
UM RESI	1011	604
IDD Innovations Registry (Partners)	925	919
IDD S&R TCM Opt Out (Partners)	856	840
BH LTSS TCM (Partners)	757	724
Innovations TCM (Partners)	710	675
BH NON TCM Care Coordination Only	622	592
BH TCM Outreach (Partners)	603	594
IDD TCM (Partners)	558	537
TCL In Reach	549	496
UM STATE	529	512
UM 3 WAY	459	438
IDD SIS (Partners)	426	424
TCL In Transition	388	372
Personal Care Services	364	356

TCL Follow Along	327	318
CTT ED	320	264
BH TCM Foster Care-In DSS Custody (Partners)	315	279
MHSU Inpatient	229	219
Registry and Referral	218	217
BH S&R TCM Duplicative Services (Partners)	205	200
MHSU Child Residential	202	184
Healthy Opportunities Pilot (HOP)	177	167
IDD Residential Monitoring (Partners)	169	165
UM IMD	164	150
UM PH	150	117
BH S&R TCM Outreach (Partners)	147	147
IDD Inreach (Partners)	127	125
BH Pregnancy Management (Partners Only)	124	115
CTT Inpatient State Hospital	124	117
MHSU Family Partner	120	70
UM TFC L1&L2	113	103
TCL OT Evaluator	106	105
TCL RN Evaluator	105	104
IDD S&R TCM Outreach (Partners)	93	93
HUD Grant Funding-BOS Back at Home	79	78
BH Birth-3 TCM	72	70
BH Placement Coordination	52	49
IDD S&R TCM Duplicative Services (Partners)	51	51
Innovations TCM (CMA/AMH+)	43	43
Innovations TCM Opted Out (Partners)	41	41
IDD TCM (CMA/AMH+)	37	37
MHSU AOT	35	31
Re-Entry	32	32
IDD NON TCM-Care Coordination Only	28	26
MHSU Complex Needs	27	26
IDD Transition (Partners)	25	25
Innovations TCM (CMA/AMH+) PQA	24	24

BH LTSS TCM (CMA/AMH+)	21	21
MHSU Comprehensive Care Management	13	13
MHSU DJJ	11	11
BH TCM Clinical Support	11	11
HUD Grant Funding NC0099	7	7
HUD Grant Funding NC0042	6	6
IEM - No TCM	6	6
1915i non TCM Care Coordination Only	6	6
Pyx App	4	3
CTT State Hospital TFU	3	3
MHSU ED/Jail Diversion	3	3
Adult Corrections	3	3
UM 3WAY ENHANCED	3	3
Innovations TCM(CMA/AMH+) The Arc	2	2
TCL Housed	2	2
IDD TCM Outreach (Partners)	2	2
TCL Community Care Management	2	2
HUD Grant Funding NC0166	2	2
MHSU CM Model Demo	2	2
UM ADATC	1	1
IDD CM Extender (Partners)	1	1
UM ECT	1	1
Innovations TCM (CMA/AMH+) Covenant	1	1
Total	53718	27695

Source: Number of Cases by Case Name from Case Summary Report in Reports Manager. Cases Opened Between 1/1/2024-12/31/2024

Service Utilization

Table 36 shows the utilization of HEDIS measure, all-cause readmissions, for MY24 for the Tailored Plan population.

Table 36. MY24 Utilization HEDIS Measures for Tailored Plan Population

Measure Year	Measure Id	Measure Name	Eligible	Member Months	Observed Events	Individuals Observed	Observed per 1000 Members	Observed per 1000 Member Months	Observed %
2024	PCR-1	All-Cause Readmissions	3,094	34,595	1,103	614	356	32	19.8%

Source: HBI, 01-01-25 refresh, retrieved on 2/18/25

Table 37 displays information on Medicaid In lieu of services procedure codes in CY24. The highest amount expensed was for Group Living Level 5 and the lowest amount expensed was for High Fidelity Wrap Around Encounters.

Table 37. Medicaid In Lieu of Services: Total Medicaid Population

Procedure Codes	# Unique Members	Amount Billed (\$)	Average Units per Member	Amount Expensed (\$)
T2016 U5 U6 - Group Living LTCS Level 5	224	\$21,274,175.98	273	\$16,187,633.08
T2016 U5 U1 - Home Living LTCS Level 1	328	\$8,636,159.53	133	\$6,288,021.42
T2016 U5 U3 - Companion Living LTCS Level 3	88	\$7,092,209.33	254	\$4,867,836.59
H2022 U5 U1 - Family Centered Treatment Core	522	\$6,860,826.95	4	\$5,792,220.01
T2016 U5 U4 - Supervised Living LTCS Level 4	33	\$3,809,611.11	274	\$2,693,166.99
H0032 U5- High Fidelity Wrap Around	178	\$2,727,720.90	6	\$1,932,168.00
T2016 U5 U2 - Independent Living LTCS Level 2	47	\$2,710,301.34	240	\$1,946,115.74
S5145 U5 - Rapid Response Bed TFC	70	\$1,175,854.19	58	\$989,897.77
H0040 HA U5 - ACTT Youth Initial	54	\$1,160,369.40	17	\$923,336.60
T2016 U5 - Behavioral Health Urgent Care (BHUC)	821	\$1,101,450.00	2	\$878,366.72
H2022 HE U5 - In Home Therapy Services (IHTS)	9	\$52,780.30	18	\$48,300.30
H0040 U5 - Assertive Community Trtmt - Step Down (ACT-SD)	1	\$2,760.00	6	\$2,392.08
H0040 HA U5 EN - ACTT Youth Encounter	53	\$20.48	35	\$18.64
H0032 U5 U1- High Fidelity Wrap Around (Encounter)	110	\$18.18	14	\$15.41
Total	2305	\$56,604,257.69	70	\$42,549,489.35

Source: Levels of Care from Data Cubes. Service Dates 1/1/2024-12/31/2024. Retrieved on 2-18-25

Length of Stay (LOS)

Length of stay (LOS) is the amount of time between a member's admittance and discharge. LOS is important because a longer LOS can lead to increased risk for medical complications for members and increased cost. LOS was examined for inpatient, emergency department, ICF-IDD, facility-based crisis, and PRTF.

Table 38 displays emergency department utilization for the total Medicaid population; 617 active consumers used the emergency department for behavioral health needs in May 2024, which was the highest amount throughout the year. The lowest count of active consumers was September 2024, with 450 active consumers.

Table 39 shows LOS for inpatient, ICF-IDD, facility-based crisis and PRTF for the total Medicaid population. Inpatient had the greatest number of unique members and the greatest number of new admits in CY24. ICD-IDD had the longest average LOS while facility-based crisis had the shortest average LOS.

Table 38. Emergency Department Utilization: Total Medicaid Population

# of ED Admits	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Members with MHDDSA diagnoses	647	656	756	718	794	689	631	598	605	674	619	562
Active consumers	507	501	577	550	617	531	489	451	450	499	473	455
Readmissions within 30 days	176	238	334	333	382	372	268	238	201	317	370	378

Source: ED Utilization from Reports Manager. Medicaid Population. Service Dates 1/1/2024-12/31/2024.

Table 39. Average LOS: Total Medicaid Population

	# Unique Members	# of New Admits in CY24	# with Admit in Prior 30 Days	# with Admit in Prior 31-60 Days	# with Admit in Prior 61-90 Days	Average LOS
Inpatient	3,904	4,763	1,035	673	587	10.65
ICF-IDD	307	280	358	12	9	372.67
Facility-Based Crisis	1,318	1,868	499	309	229	7.9
PRTF	269	253	124	52	32	166.27

Source: Facility Admit/Discharge from Auth from Reports Manager. Medicaid Population. Service Dates 1/1/2024-12/31/2024.

Table 40. Cost of Care by Category: Tailored Plan Population

Cost Category	Total Members	Total Member		Actual Cost
		Months	Total Cost (\$)	PMPM (\$)
Total Cost of Care	47,625	502,932	\$939,927,057	\$1,869
Physical Health	47,625	502,932	\$244,466,425	\$486
Facility: IP	47,625	502,932	\$78,387,578	\$156
Facility: ED	47,625	502,932	\$14,235,490	\$28
Facility: Other	47,625	502,932	\$45,862,551	\$91
Facility: Professional	47,625	502,932	\$105,980,806	\$211
Behavioral Health	47,625	502,932	\$695,460,632	\$1,383
Facility: IP	47,625	502,932	\$37,358,396	\$74
Facility: ED	47,625	502,932	\$3,935,457	\$8
Facility: Other	47,625	502,932	\$45,171,618	\$90
Facility: Professional	47,625	502,932	\$608,995,161	\$1,211

Source: Cost of Care by Category. Medicaid Population. HBI, 1-1-25 refresh, retrieved on 2/18/25.

Total Cost of Care

Tables 40 and 41 show the total cost of care and the actual cost per member per month (PMPM) for physical health and behavioral health facilities, and pharmacy. 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 \$939,927,057 and \$2,051,877,243 for the total Medicaid population.

Table 41. Cost of Care by Category: Total Medicaid Population

Cost Category	Total Members	Total Member		Actual Cost
		Months	Total Cost (\$)	PMPM (\$)
Total Cost of Care	111,798	1,191,842	\$2,051,877,243	\$1,721
Physical Health	111,798	1,191,842	\$1,018,984,516	\$855
Facility: IP	111,798	1,191,842	\$128,656,884	\$108
Facility: ED	111,798	1,191,842	\$21,013,588	\$18
Facility: Other	111,798	1,191,842	\$462,226,720	\$388
Facility: Professional	111,798	1,191,842	\$407,087,324	\$342
Behavioral Health	111,798	1,191,842	\$1,032,892,726	\$867
Facility: IP	111,798	1,191,842	\$45,359,048	\$38
Facility: ED	111,798	1,191,842	\$4,492,466	\$4
Facility: Other	111,798	1,191,842	\$227,522,854	\$191
Facility: Professional	111,798	1,191,842	\$755,518,358	\$634

Source: Cost of Care by Category. Medicaid Population. HBI, 1-1-25 refresh, retrieved on 2/18/25

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 42 and 43 display utilization by facility type for the Tailored Plan population and the total Medicaid population. Each table has information for 10 different facility types. For the Tailored Plan population, the highest total cost of care was in Acute Inpatient facilities with \$73,115,841 in cost for CY24. For the total Medicaid population, the highest total cost of care was in Skilled Nursing Facilities (SNF) with \$388,124,910.

Tables 44 and 45 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 42. Utilization by Facility Type: Tailored Plan Population

Facility Type	Total Visits	Unique Members	Total Cost (\$)	Cost/Visit (\$)	Visits/1000
Acute IP	6,676	4,100	\$73,115,841	\$10,952	1,628
LTC	16,680	328	\$43,528,155	\$2,610	50,854
ED Visits	20,978	10,764	\$16,561,540	\$789	1,949
Outpatient Services	28,767	11,452	\$8,640,436	\$300	2,512
Outpatient Surgery	1,943	1,512	\$6,653,816	\$3,425	1,285
Home Health	1,710	302	\$367,640	\$215	5,662
SNF	63	13	\$317,423	\$5,038	4,846
Hospice	46	14	\$207,380	\$4,508	3,286
Urgent Care	125	106	\$169,127	\$1,353	1,179
Other Outpatient	4	4	\$1,618	\$404	1,000

Source: Utilization by Facility Type. Tailored Plan Population. HBI, 1-1-25 refresh, retrieved on 2/18/25.

Table 43. Utilization by Facility Type: Total Medicaid Population

Facility Type	Total Visits	Unique Members	Total Cost (\$)	Cost/Visit (\$)	Visits/1000
ED Visits	58,140	28,463	\$22,981,210	\$395	2,043
Urgent Care	961	860	\$314,252	\$327	1,117
Acute IP	16,811	11,341	\$120,253,794	\$7,153	1,482
SNF	146,559	5,324	\$388,124,910	\$2,648	27,528
LTC	47,993	1,066	\$183,697,812	\$3,828	45,022
Outpatient Services	130,061	37,715	\$19,680,898	\$151	3,449
Outpatient Surgery	12,755	7,701	\$12,421,849	\$974	1,656
Hospice	2,987	511	\$20,702,666	\$6,931	5,845
Home Health	5,095	696	\$965,627	\$190	7,320
Other Outpatient	189	164	\$53,307	\$282	1,152

Source: Utilization by Facility Type. Medicaid Population. HBI, 1-1-25 refresh, retrieved on 2/18/25.

Table 44. Admits Per 1000: Tailored Plan Population

	Total Members	Total Member Months	Actual Per Year	Actual Per Month
IP Admits/1000	47,625	502,932	232	19
Physical Health	47,625	502,932	127	11
Behavioral Health	47,625	502,932	105	9
IP Days/1000	47,625	502,932	1,532	128
Physical Health	47,625	502,932	729	61
Behavioral Health	47,625	502,932	802	67
ED Visits/1000	47,625	502,932	501	42
Physical Health	47,625	502,932	401	33
Behavioral Health	47,625	502,932	100	8

Source: Admits per 1000. Tailored Plan Population. Source: HBI, 1-1-25 refresh, retrieved on 2/18/25

Table 45. Admits Per 1000: Total Medicaid Population

	Total Members	Total Member Months	Actual Per Year	Actual Per Month
IP Admits/1000	111,798	1,191,842	202	17
Physical Health	111,798	1,191,842	148	12
Behavioral Health	111,798	1,191,842	54	5
IP Days/1000	111,798	1,191,842	1,297	108
Physical Health	111,798	1,191,842	855	71
Behavioral Health	111,798	1,191,842	443	37
ED Visits/1000	111,798	1,191,842	586	49
Physical Health	111,798	1,191,842	528	44
Behavioral Health	111,798	1,191,842	57	5

Source: Admits per 1000. Medicaid Population. HBI, 1-1-25 refresh, retrieved on 2/18/25.

Primary Discharge Diagnoses

Primary discharge diagnosis refers to a member's main diagnosis when discharged from a facility. Tables 46-49 include the number of visits for each discharge diagnosis, as well as the percentage of visits that each discharge diagnosis includes out of all visits. The tables show discharge diagnoses for four facility types: ED visits, IP stays, urgent care visits, and SNF stays.

Tables 46-49 show the top 20 discharge diagnoses for the Tailored Plan population for all four facility types.

The primary discharge diagnoses for ED visits were abdominal and pelvic pain with 995 visits (5% of visits) and pain in throat and chest with 797 visits (4% of visits). The primary discharge diagnoses for IP stays were recurrent major depressive disorder with 854 stays (13% of stays) and schizoaffective disorder with 820 stays (12% of stays).

Table 46. Primary Discharge Diagnosis for ED Visits: Tailored Plan Population (n=20,978)

Diagnosis	# Visits	% Visits
R10 Abdominal and pelvic pain	995	5%
R07 Pain in throat and chest	797	4%
F41 Other anxiety disorders	497	2%
R11 Nausea and vomiting	493	2%
R45 Symptoms and signs involving emotional state	480	2%
F10 Alcohol related disorders	473	2%
M54 Dorsalgia	407	2%
M79 Oth and unsp soft tissue disorders, not elsewhere classified	389	2%
M25 Other joint disorder, not elsewhere classified	388	2%
F32 Depressive episode	365	2%
J06 Acute upper resp infections of multiple and unsp sites	312	1%
J02 Acute pharyngitis	295	1%
R51 Headache	290	1%
L03 Cellulitis and acute lymphangitis	269	1%
F19 Other psychoactive substance related disorders	267	1%
F15 Other stimulant related disorders	260	1%
F25 Schizoaffective disorders	251	1%
F20 Schizophrenia	250	1%
R56 Convulsions, not elsewhere classified	245	1%
S01 Open wound of head	223	1%

Source: Primary Discharge Diagnosis for ED Visits. Tailored Plan Population. HBI, 1-1-25 refresh, retrieved on 2/18/25.

Table 47. Primary Discharge Diagnosis for IP Stays: Tailored Plan Population (n=6,676)

Diagnosis	# Visits	% Visits
F33 Major depressive disorder, recurrent	854	13%
F25 Schizoaffective disorders	820	12%
F31 Bipolar disorder	632	9%
F20 Schizophrenia	343	5%
F10 Alcohol related disorders	308	5%
A41 Other sepsis	200	3%
F34 Persistent mood [affective] disorders	184	3%
F32 Depressive episode	158	2%
F15 Other stimulant related disorders	155	2%
F43 Reaction to severe stress, and adjustment disorders	142	2%
F11 Opioid related disorders	122	2%
F39 Unspecified mood [affective] disorder	98	1%
F19 Other psychoactive substance related disorders	82	1%
F29 Unsp psychosis not due to a substance or known physical cond	79	1%
G40 Epilepsy and recurrent seizures	78	1%
J44 Other chronic obstructive pulmonary disease	66	1%
L03 Cellulitis and acute lymphangitis	66	1%
O99 Oth maternal diseases classd elsw but compl preg/chldbrth	63	1%
E10 Type 1 diabetes mellitus	61	1%
K85 Acute pancreatitis	50	1%

Source: Primary Discharge Diagnosis for IP Stays. Tailored Plan Population. HBI, 1-1-25 refresh, retrieved on 2/18/25.

The primary discharge diagnoses for urgent care visits were asthma with 27 visits (22% of visits) and other chronic obstructive pulmonary disease with 16 visits (13% of visits). The primary discharge diagnoses for SNF stays were other disorders of central nervous system with 12 stays (19% of stays) and Intracranial injury with 10 stays (16% of stays)

Table 48. Primary Discharge Diagnosis for Urgent Care: Tailored Plan Population (n=125)

Diagnosis	# Visits	% Visits
J45 Asthma	27	22%
J44 Other chronic obstructive pulmonary disease	16	13%
R06 Abnormalities of breathing	16	13%
E84 Cystic fibrosis	11	9%
R05 Cough	6	5%
Z01 Encntr for oth sp exam w/o complaint, suspected or reprtd dx	4	3%
R91 Abnormal findings on diagnostic imaging of lung	3	2%
R94 Abnormal results of function studies	3	2%
I11 Hypertensive heart disease	2	2%
I50 Heart failure	2	2%
J43 Emphysema	2	2%
M32 Systemic lupus erythematosus (SLE)	2	2%
M48 Other spondylopathies	2	2%
N13 Obstructive and reflux uropathy	2	2%
N52 Male erectile dysfunction	2	2%
B33 Other viral diseases, not elsewhere classified	1	1%
C50 Malignant neoplasm of breast	1	1%
D44 Neoplasm of uncertain behavior of endocrine glands	1	1%
D57 Sickle-cell disorders	1	1%
E66 Overweight and obesity	1	1%

Source: Primary Discharge Diagnosis for Urgent Care. Tailored Plan Population. HBI, 1-1-25 refresh, retrieved on 2/18/25.

Table 49. Primary Discharge Diagnosis for SNF: Tailored Plan Population (n=63)

Diagnosis	# Visits	% Visits
G96 Other disorders of central nervous system	12	19%
S06 Intracranial injury	10	16%
J44 Other chronic obstructive pulmonary disease	8	13%
G93 Other disorders of brain	7	11%
M86 Osteomyelitis	5	8%
R27 Other lack of coordination	5	8%
R52 Pain, unspecified	5	8%
N39 Other disorders of urinary system	3	5%
S43 Disloc and sprain of joints and ligaments of shoulder girdle	2	3%
T82 Complications of cardiac and vascular prosth dev/grft	2	3%
G80 Cerebral palsy	1	2%
G90 Disorders of autonomic nervous system	1	2%
M62 Other disorders of muscle	1	2%
Z47 Orthopedic aftercare	1	2%

Source: Primary Discharge Diagnosis for SNF. Tailored Plan Population. HBI, 1-1-25 refresh, retrieved on 2/18/25.

Note: SNF discharges are not true discharges, rather they are billing periods.

Benefit Plan and Service Cost Trends

Tables 50-52 display benefit plan and services cost trends data for CY24. Table 50 includes expenses by member benefit plan. In CY24, \$945,348,502.29 was expensed, with an average of \$16,970.93 expensed per client. The highest expenses were for Medicaid Direct at \$572,472,269.82 expensed and an average expense per client of \$13,852.26.

Table 51 includes expenses for CY24 by category of service – the two highest services expensed include Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD) at \$178,103,928.41 and Outpatient at \$118,559,389.28, while the lowest expensed service was HOP Transportation Services at \$78.25. When examining expenses for CY24 by procedure group, All-Inclusive Room and Board Plus Ancillary (\$178,103,928.41), Community Living & Supports (\$114,566,267.47) and 97153 RB-BHT ALL (\$80,450,543.78) were the highest expensed procedure groups. The lowest expensed services were Outpatient Individual (\$535.73) and HOP Transportation Services (\$78.25)

Table 50. Expenses for CY24 by Member Benefit Plan

Member Benefit Plan	Amount Expensed	Unique Members	Average Expense Per Client
Healthy Opportunities	\$319,377.55	155	\$2,060.50
Medicaid Direct	\$572,472,269.82	41,327	\$13,852.26
Medicaid-Tailored Plan	\$336,141,410.70	28,050	\$11,983.65
State	\$36,415,444.21	10,418	\$3,495.44
Total	\$945,348,502.29	55,704	\$16,970.93

Source: Data Cubes. Service Dates 1/1/2024-12/31/2024

Table 51. Expenses for CY24 by Category of Services

Category of Service	Amount Expensed	% of Total Cost	Unique Members	% of Unique Members (n=49,336)	Average Expense Per Client
ICF/IDD	\$178,103,928.41	18.84%	1,430	2.57%	\$124,548.20
Outpatient	\$118,559,389.28	12.54%	39,381	70.70%	\$3,010.57
CAP Other	\$117,320,767.27	12.41%	2,817	5.06%	\$41,647.41
CAP Residential Supports	\$81,642,746.66	8.64%	1,152	2.07%	\$70,870.44
BH Long-Term Residential	\$59,770,494.97	6.32%	1,904	3.42%	\$31,392.07
RB-BHT	\$55,536,513.47	5.87%	2,061	3.70%	\$26,946.39
Inpatient	\$53,802,661.12	5.69%	5,207	9.35%	\$10,332.76
Tailored Care Management	\$47,686,845.43	5.04%	22,987	41.27%	\$2,074.51
CAP Day Supports	\$37,938,583.23	4.01%	1,441	2.59%	\$26,327.96
PRTF	\$30,497,598.35	3.23%	261	0.47%	\$116,849.04
IIHS	\$20,660,230.90	2.19%	1,538	2.76%	\$13,433.18
Crisis	\$20,096,308.39	2.13%	4,332	7.78%	\$4,639.04
ACTT	\$18,636,980.63	1.97%	1,311	2.35%	\$14,215.85
CAP Home Supports	\$18,473,477.89	1.95%	1,032	1.85%	\$17,900.66
Community Support Team	\$14,053,056.94	1.49%	3,038	5.45%	\$4,625.76
1915i	\$13,230,007.75	1.40%	1,026	1.84%	\$12,894.74
Peer Support	\$12,849,904.63	1.36%	4,309	7.74%	\$2,982.11
Partial Hospital/Day Treatment	\$12,653,708.65	1.34%	754	1.35%	\$16,782.11
Psych Rehab	\$8,901,569.74	0.94%	778	1.40%	\$11,441.61
CAP Respite	\$8,205,211.38	0.87%	1,307	2.35%	\$6,277.90
CAP Supported Employment	\$5,473,203.08	0.58%	444	0.80%	\$12,327.03
B-3 Services	\$4,304,732.95	0.46%	493	0.89%	\$8,731.71
THREE WAY HOSPITAL	\$2,828,517.00	0.30%	1,065	1.91%	\$2,655.88
Case Management	\$1,999,458.54	0.21%	248	0.45%	\$8,062.33
MST	\$1,775,328.08	0.19%	153	0.27%	\$11,603.45
HOP - Food Services TP	\$158,076.18	0.02%	106	0.19%	\$1,491.28
HOP - Housing Services TP	\$157,845.77	0.02%	82	0.15%	\$1,924.95
THREE WAY HOSPITAL (Enhanced)	\$27,900.00	0.00%	10	0.02%	\$2,790.00
HOP - Cross-Cutting Services TP	\$3,376.85	0.00%	6	0.01%	\$562.81
HOP - Transportation Services TP	\$78.75	0.00%	3	0.01%	\$26.25
Total	\$945,348,502.29		55,704		\$16,970.93

Source: Data Cubes. Service Dates 1/1/2024-12/31/2024

Table 52. Expenses for CY24 by Procedure Group

Procedure Group	Amount Expensed	% of Total Cost	Unique Members	% of Unique Members (n=49,336)	Average Expense Per Client
All-Inclusive Room and Board Plus Ancillary	\$178,103,928.41	18.84%	1430	2.57%	\$124,548.20
Community Living and Supports	\$114,566,267.47	12.12%	2014	3.62%	\$56,884.94
97153 RB-BHT ALL	\$80,450,543.78	8.51%	2094	3.76%	\$38,419.55
Tailored Care Management	\$47,686,845.43	5.04%	22987	41.27%	\$2,074.51
DAY SERVICES	\$37,830,803.11	4.00%	1372	2.46%	\$27,573.47
Residential Supports Level IV-AFL	\$29,453,770.81	3.12%	413	0.74%	\$71,316.64
PRTF	\$29,306,586.39	3.10%	243	0.44%	\$120,603.24
METHADONE ADMINISTRATION	\$28,597,270.42	3.03%	3473	6.23%	\$8,234.17
FOSTER CARE THERAPEUTIC CHILD	\$25,938,748.25	2.74%	568	1.02%	\$45,666.81
INPATIENT HOSPITAL	\$19,608,808.98	2.07%	2035	3.65%	\$9,635.78
ASSERTIVE COMMUNITY TREATMENT TEAM	\$18,636,980.63	1.97%	1311	2.35%	\$14,215.85
Community Networking	\$18,473,477.89	1.95%	1032	1.85%	\$17,900.66
Crisis Services	\$17,866,766.52	1.89%	2838	5.09%	\$6,295.55
Room & Board--Private (medical or General) -- Psychiatric	\$17,339,915.80	1.83%	1885	3.38%	\$9,198.89
RESIDENTIAL LEVELS 3 AND 4	\$17,328,267.66	1.83%	300	0.54%	\$57,760.89
97155 RB-BHT ALL	\$16,333,700.49	1.73%	2060	3.70%	\$7,928.98
INTENSIVE IN-HOME SERVICES	\$14,754,408.21	1.56%	966	1.73%	\$15,273.71
PEER SUPPORT HDD INDIVIDUAL	\$12,849,904.63	1.36%	4309	7.74%	\$2,982.11
Residential Supports Level III-AFL	\$12,350,648.86	1.31%	204	0.37%	\$60,542.40
CHILD/ADOLESCENT DAY TREATMENT	\$11,827,809.66	1.25%	589	1.06%	\$20,081.17
COMMUNITY SUPPORT TEAM	\$11,804,010.72	1.25%	1141	2.05%	\$10,345.32
All-Inclusive Room and Board	\$11,646,270.93	1.23%	830	1.49%	\$14,031.65

Outpatient Individual Therapy	\$11,190,877.47	1.18%	14754	26.49%	\$758.50
Residential Supports Level III	\$10,230,795.47	1.08%	168	0.30%	\$60,897.59
Residential Supports Level IV	\$9,770,268.91	1.03%	145	0.26%	\$67,381.16
PSYCHOSOCIAL REHABILITATION	\$8,901,569.74	0.94%	778	1.40%	\$11,441.61
OUTPATIENT E&M (Code 30)	\$8,338,684.13	0.88%	20945	37.60%	\$398.12
Supported Living	\$8,058,639.02	0.85%	115	0.21%	\$70,075.12
IDD & TBI Residential	\$7,954,957.78	0.84%	76	0.14%	\$104,670.50
Respite: Individual	\$7,884,966.00	0.83%	1281	2.30%	\$6,155.32
Residential Supports Level II	\$6,661,167.23	0.70%	117	0.21%	\$56,933.05
Family Center Treatment	\$5,905,822.69	0.62%	628	1.13%	\$9,404.18
Supported Employment Services: Individual	\$5,470,566.64	0.58%	440	0.79%	\$12,433.11
ADULT RESIDENTIAL	\$5,369,237.10	0.57%	814	1.46%	\$6,596.11
1915i CLS Services	\$5,000,542.22	0.53%	493	0.89%	\$10,143.09
Residential Supports Level II - AFL	\$4,623,360.33	0.49%	83	0.15%	\$55,703.14
B-3 Services	\$4,304,732.95	0.46%	493	0.89%	\$8,731.71
SA COMPREHENSIVE OUTPAT TXT PROGRAM	\$4,025,357.74	0.43%	618	1.11%	\$6,513.52
1915i Services	\$3,949,563.53	0.42%	507	0.91%	\$7,790.07
OUTPATIENT	\$3,756,290.73	0.40%	3023	5.43%	\$1,242.57
Individual and Transitional Support Services	\$3,300,505.00	0.35%	158	0.28%	\$20,889.27
Hospital Based Psychiatric Services	\$3,279,674.08	0.35%	3418	6.14%	\$959.53
Outpatient Evaluation	\$3,209,363.51	0.34%	15208	27.30%	\$211.03
Emergency Room Physician Services	\$2,878,406.07	0.30%	4814	8.64%	\$597.92
THREE WAY HOSPITAL	\$2,828,517.00	0.30%	1065	1.91%	\$2,655.88
SUBSTANCE ABUSE INTENSIVE OUTPATIENT	\$2,519,929.10	0.27%	1132	2.03%	\$2,226.09
97151 RB-BHT ALL	\$2,309,908.88	0.24%	2032	3.65%	\$1,136.77
MOBILE CRISIS MANAGEMENT	\$2,229,541.87	0.24%	2724	4.89%	\$818.48

TARGETED CASE MANAGEMENT MH/SA	\$1,999,458.54	0.21%	248	0.45%	\$8,062.33
Specialized Consultation Services	\$1,887,809.40	0.20%	762	1.37%	\$2,477.44
MULTI-SYSTEMIC THERAPY (MST)	\$1,775,328.08	0.19%	153	0.27%	\$11,603.45
Therapeutic Leave	\$1,693,706.00	0.18%	235	0.42%	\$7,207.26
Emergency Room	\$1,676,328.64	0.18%	3083	5.53%	\$543.73
OUTPATIENT PSYCHIATRIC	\$1,601,719.98	0.17%	3101	5.57%	\$516.52
RESIDENTIAL LEVEL 2 GROUP TYPE	\$1,485,578.18	0.16%	47	0.08%	\$31,608.05
OUTPATIENT GROUP - NON-FAMILY	\$1,295,496.81	0.14%	2747	4.93%	\$471.60
Other Behavioral Health Treatment Services	\$1,191,011.96	0.13%	42	0.08%	\$28,357.43
97156 RB-BHT ALL	\$1,109,665.82	0.12%	1834	3.29%	\$605.05
Tenancy Supports	\$1,012,609.73	0.11%	260	0.47%	\$3,894.65
Room & Board-- Privat (Medical or General) -- General classification	\$1,000,103.76	0.11%	139	0.25%	\$7,194.99
NC Core IPS SE	\$961,169.00	0.10%	165	0.30%	\$5,825.27
97152 RB-BHT ALL	\$884,205.43	0.09%	404	0.73%	\$2,188.63
MENTAL HEALTH PARTIAL HOSPITALIZATION	\$825,898.99	0.09%	167	0.30%	\$4,945.50
OUTPATIENT E&M (Code 38)	\$665,113.71	0.07%	3137	5.63%	\$212.02
OUTPATIENT FAMILY THERAPY	\$565,558.51	0.06%	1434	2.57%	\$394.39
Room & Board--Private (medical or General-- Pediatric	\$555,610.22	0.06%	37	0.07%	\$15,016.49
DEVELOPMENTAL DAY	\$500,951.46	0.05%	53	0.10%	\$9,451.91
SA Monitored Community Residential Tx	\$490,774.93	0.05%	97	0.17%	\$5,059.54
OUTPATIENT EVALUATION / ASSESSMENT	\$445,235.95	0.05%	1416	2.54%	\$314.43
Milieu Therapy	\$439,641.00	0.05%	1	0.00%	\$439,641.00
Individual Goods and Services	\$389,551.02	0.04%	181	0.32%	\$2,152.22
Residential Supports Level I	\$388,250.56	0.04%	12	0.02%	\$32,354.21
In Home Skill Building Individual	\$365,703.50	0.04%	24	0.04%	\$15,237.65
ADVP	\$283,367.37	0.03%	56	0.10%	\$5,060.13

Room & Board-Private (Medical or General)- Detoxification	\$276,924.91	0.03%	62	0.11%	\$4,466.53
SUPPORTED EMPLOYMENT	\$261,769.66	0.03%	23	0.04%	\$11,381.29
Nursing Respite-Innovations	\$198,543.72	0.02%	18	0.03%	\$11,030.21
Outpatient Psychiatric Services	\$196,421.72	0.02%	702	1.26%	\$279.80
N/A	\$192,725.05	0.02%	1021	1.83%	\$188.76
TELEMEDICINE ORIGINATING SITE FEE	\$185,538.86	0.02%	4129	7.41%	\$44.94
ASSERTIVE ENGAGEMENT	\$172,426.00	0.02%	1564	2.81%	\$110.25
PUBLIC PSYCHIATRY	\$160,310.00	0.02%	1	0.00%	\$160,310.00
HOP - Food Services TP	\$158,076.18	0.02%	106	0.19%	\$1,491.28
THERAPEUTIC INJECTION	\$152,965.08	0.02%	1639	2.94%	\$93.33
HOP - Housing Services TP	\$143,070.26	0.02%	76	0.14%	\$1,882.50
Respite: Group	\$121,701.66	0.01%	31	0.06%	\$3,925.86
97154 RB-BHT ALL	\$116,053.59	0.01%	174	0.31%	\$666.97
Home Visit	\$110,034.79	0.01%	416	0.75%	\$264.51
Day Supports Developmental Day	\$107,780.12	0.01%	81	0.15%	\$1,330.62
Residential Supports Level I - AFL	\$105,845.47	0.01%	4	0.01%	\$26,461.37
NON-HOSPITAL MEDICAL DETOXIFICATION	\$99,162.86	0.01%	66	0.12%	\$1,502.47
Out of Home Crisis	\$98,962.88	0.01%	388	0.70%	\$255.06
Nursing Facility Care	\$56,683.61	0.01%	454	0.82%	\$124.85
HOSPITAL DISCHARGE TRANSITION	\$47,851.50	0.01%	371	0.67%	\$128.98
Follows Base Code	\$43,491.51	0.00%	971	1.74%	\$44.79
PHYSICIAN SERVICES	\$29,270.09	0.00%	91	0.16%	\$321.65
THREE WAY HOSPITAL (Enhanced)	\$27,900.00	0.00%	10	0.02%	\$2,790.00
97157 RB-BHT ALL	\$19,850.71	0.00%	83	0.15%	\$239.17
Community Guide -Monthly	\$18,228.00	0.00%	14	0.03%	\$1,302.00
DAY ACTIVITY	\$17,922.00	0.00%	3	0.01%	\$5,974.00

Community Transition supports	\$12,473.00	0.00%	5	0.01%	\$2,494.60
OUTPATIENT GROUP	\$7,762.24	0.00%	46	0.08%	\$168.74
HOP - Cross Cutting Services TP	\$3,376.85	0.00%	2	0.00%	\$1,688.43
Supportive employment Services: Group	\$2,636.44	0.00%	5	0.01%	\$527.29
NEUROBEHAVIORAL EXAM	\$2,184.27	0.00%	19	0.03%	\$114.96
Family Therapy	\$1,116.00	0.00%	22	0.04%	\$50.73
OUTPATIENT INDIVIDUAL	\$535.73	0.00%	11	0.02%	\$48.70
HOP - Transportation Services TP	\$78.75	0.00%	1	0.00%	\$78.75
Total	945,348,502.29		55704		\$16,970.93

Source: Data Cubes. Services Dates 1/1/2024-12/31/2024

Pharmacy Utilization

Beginning July 1, 2024, Partners began receiving prescription claims for our Tailored Plan members from CVS Pharmacy. Tables 53-55 show the classes of medication with the highest cost, the medications with the highest number of prescriptions and the top medications by total cost for July 1-December 31, 2024. The top five medication classes by gross cost were very similar between Q1 and Q2 with antipsychotics/antimanic agents being the class with the highest gross cost. Trazadone and Gabapentin were the most prescribed medications in Q1 and Q2. The two most expensive medications by total cost for Q1 and Q2 are Invega Sustenna and Vraylar.

Table 53. Top 5 GPI Therapeutic Classes by Total Gross Cost for FY25

Q1	Q2
Antipsychotics/Antimanic Agents (\$9,338,157.73)	Antipsychotics/Antimanic Agents (\$10,395,045.59)
Anticonvulsants (\$3,655,684.11)	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiant (\$3,801,859.21)
Antivirals (\$3,335,510.77)	Anticonvulsants (\$3,697,646.16)
ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiant (\$3,056,179.17)	Antivirals (\$3,575,814.75)
Dermatologicals (\$2,546,836.20)	Dermatologicals (\$3,083,085.89)

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

Table 54. Top 5 Prescriptions by Utilization for FY25

Q1	Q2
Trazadone Hydrochloride (1,642)	Trazadone Hydrochloride (5,321)
Gabapentin (1,583)	Gabapentin (4,991)
Cetirizine Hydrochloride (1,418)	Cetirizine Hydrochloride (4,329)
Clonidine Hydrochloride (1,331)	Clonidine Hydrochloride (4,165)
Ventolin HFA (1,144)	Aripiprazole (3,663)

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

Table 55. Top 5 Medications by Total Net Cost for FY25

Q1	Q2
Invega Sustenna (\$983,827.47)	Invega Sustenna (\$3,083,821.58)
Vraylar (\$508,656.39)	Vraylar (\$1,655,098.40)
Biktarvy (\$371,895.25)	Invega Trinza (\$1,221,792.98)
Abilify Maintena (\$366,114.26)	Abilify Maintena (\$1,183,817.02)
Dupixent (\$338,786.14)	Vyvanse (\$1,024,275.50)

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 56 displays 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. Some common priorities among the 15 catchment counties are mental health, substance use and healthy living.

Table 56. Top 3 Priorities for Each Catchment County

County	Date of Last CHA	Priority #1	Priority #2	Priority #3
Burke	2022	Homelessness	Public Health Misinformation	Mental Health
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	2021	Substance Misuse/Overdose	Healthy Living	Mental Health
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 41).

Figure 41.



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

Appendix A - HEDIS Measures (Complete List)

Table A1. MY24 Person Based HEDIS Measures for Tailored Plan Members

Measure Year	Measure Id	Measure Name	Eligible	Compliant	Compliant Rate	Internal Target Rate
2024	AMM-1	HEDIS MY2024 Antidepressant Medication Management - Effective Acute Phase Treatment	1,643	1,108	67.4%	85.0%
2024	AMM-2	HEDIS MY2024 Antidepressant Medication Management - Effective Continuation Phase Treatment	1,643	857	52.2%	75.0%
2024	APM-1	HEDIS MY2024 Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood glucose testing	1,707	903	52.9%	35.0%
2024	APM-2	HEDIS MY2024 Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol testing	1,707	606	35.5%	0.0%
2024	APM-3	HEDIS MY2024 Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood glucose and cholesterol testing	1,707	573	33.6%	0.0%
2024	APP-1	HEDIS MY2024 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	455	207	45.5%	0.0%
2024	CBP-1	HEDIS MY2024 Controlling High Blood Pressure	2,441	463	19.0%	70.0%
2024	CCS-1	HEDIS MY2024 Cervical Cancer Screening	11,704	2,802	23.9%	43.6%
2024	CHL-1	HEDIS MY2024 Chlamydia Screening in Women	2,758	1,462	53.0%	20.0%
2024	CIS-1	HEDIS MY2024 Childhood Immunization Status - DTaP	205	0	0.0%	20.0%
2024	CIS-10	HEDIS MY2024 Childhood Immunization Status - Influenza	205	2	1.0%	20.0%
2024	CIS-2	HEDIS MY2024 Childhood Immunization Status - IPV	205	0	0.0%	20.0%
2024	CIS-3	HEDIS MY2024 Childhood Immunization Status - MMR	205	17	8.3%	20.0%
2024	CIS-4	HEDIS MY2024 Childhood Immunization Status - HiB	205	0	0.0%	20.0%
2024	CIS-5	HEDIS MY2024 Childhood Immunization Status - Hepatitis B	205	0	0.0%	20.0%
2024	CIS-6	HEDIS MY2024 Childhood Immunization Status - VZV	205	17	8.3%	20.0%
2024	CIS-7	HEDIS MY2024 Childhood Immunization Status - Pneumococcal Conjugate	205	0	0.0%	20.0%

2024	CIS-8	HEDIS MY2024 Childhood Immunization Status - Hepatitis A	205	27	13.2%	20.0%
2024	CIS-9	HEDIS MY2024 Childhood Immunization Status - Rotavirus	205	1	0.5%	20.0%
2024	GSD-1	HEDIS MY2024 Glycemic Status Assessment for Patients with Diabetes - Glycemic status (<8.0%)	2,679	205	7.7%	0.0%
2024	GSD-2	HEDIS MY2024 Glycemic Status Assessment for Patients with Diabetes - Glycemic status (>9.0%)	2,696	1,521	56.4%	0.0%
2024	IMA-1	HEDIS MY2024 Immunizations for Adolescents - Meningococcal	1,192	536	45.0%	20.0%
2024	IMA-2	HEDIS MY2024 Immunizations for Adolescents - Tdap	1,192	507	42.5%	20.0%
2024	IMA-3	HEDIS MY2024 Immunizations for Adolescents - HPV	1,192	145	12.2%	20.0%
2024	POD-1	HEDIS MY2024 Pharmacotherapy for Opioid Use Disorder	1,993	0	0.0%	20.0%
2024	SSD-1	HEDIS MY2024 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	3,474	2,706	77.9%	60.7%
2024	W30-1	HEDIS MY2024 Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months	64	0	0.0%	20.0%
2024	W30-2	HEDIS MY2024 Well-Child Visits in the First 30 Months of Life - Well-Child Visits for Age 15 Months-30 Months	413	37	9.0%	20.0%
2024	WCV-1	HEDIS MY2024 Child and Adolescent Well-Care Visits	21,902	10,059	45.9%	20.0%

Source: HBI, 1-01-25 refresh, retrieved on 2/18/25

Table A2. MY24 Encounter Based HEDIS Measures for Tailored Plan Members

Measure Year	Measure Id	Measure Name	Eligible	Compliant	Compliant Rate	Internal Target Rate
2024	ADD-1	HEDIS MY2024 Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	1,123	610	54.3%	40.8%
2024	ADD-2	HEDIS MY2024 Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance (C&M) Phase	1,123	0	0.0%	89.0%
2024	FMC-1	HEDIS MY2024 Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions - Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	2,729	966	35.4%	0.0%
2024	FUA-1	HEDIS MY2024 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-day follow-up	1,161	413	35.6%	23.0%
2024	FUA-2	HEDIS MY2024 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-day follow-up	1,161	272	23.4%	17.0%
2024	FUH-1	HEDIS MY2024 Follow-Up After Hospitalization for Mental Illness - 30-day follow-up	2,659	1,636	61.5%	80.0%
2024	FUH-2	HEDIS MY2024 Follow-Up After Hospitalization for Mental Illness - 7-day follow-up	2,659	851	32.0%	65.0%
2024	FUI-1	HEDIS MY2024 Follow-Up After High-Intensity Care for Substance Use Disorder - 30-day follow-up	657	293	44.6%	0.0%
2024	FUI-2	HEDIS MY2024 Follow-Up After High-Intensity Care for Substance Use Disorder - 7-day follow-up	657	123	18.7%	0.0%
2024	FUM-1	HEDIS MY2024 Follow-Up After Emergency Department Visit for Mental Illness - 30-day follow-up	1,546	904	58.5%	78.0%
2024	FUM-2	HEDIS MY2024 Follow-Up After Emergency Department Visit for Mental Illness - 7-day follow-up	1,546	641	41.5%	67.0%
2024	PPC-1	HEDIS MY2024 Prenatal and Postpartum Care - Timeliness of prenatal care	509	204	40.1%	20.0%
2024	PPC-2	HEDIS MY2024 Prenatal and Postpartum Care - Postpartum care	509	131	25.7%	20.0%

Source: HBI, 1-01-25 refresh, retrieved on 2/18/25

Table A3. MY24 Utilization HEDIS Measures for Tailored Plan Members

Measure Year	Measure Id	Measure Name	Eligible	Member Months	Observed Events	Individuals Observed	Observed per 1,000 Members	Observed per 1,000 Member Months	Observed %
2024	PCR-1	HEDIS MY2024 Plan All-Cause Readmissions	3,094	34,595	1,103	614	356	32	19.8%

Source: HBI, 1-01-25 refresh, retrieved on 2/18/25

Table A4. MY24 Person Based HEDIS Measures for Entire Population

Measure Year	Measure Id	Measure Name	Eligible	Compliant	Compliant Rate	Internal Target Rate
2024	AMM-1	HEDIS MY2024 Antidepressant Medication Management - Effective Acute Phase Treatment	1,976	1,340	67.8%	85.0%
2024	AMM-2	HEDIS MY2024 Antidepressant Medication Management - Effective Continuation Phase Treatment	1,976	1,019	51.6%	75.0%
2024	APM-1	HEDIS MY2024 Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood glucose testing	2,291	1,220	53.3%	35.0%
2024	APM-2	HEDIS MY2024 Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol testing	2,291	853	37.2%	0.0%
2024	APM-3	HEDIS MY2024 Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood glucose and cholesterol testing	2,291	808	35.3%	0.0%
2024	APP-1	HEDIS MY2024 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	662	326	49.2%	0.0%
2024	CBP-1	HEDIS MY2024 Controlling High Blood Pressure	16,948	3,579	21.1%	70.0%
2024	CCS-1	HEDIS MY2024 Cervical Cancer Screening	27,347	3,763	13.8%	43.6%
2024	CHL-1	HEDIS MY2024 Chlamydia Screening in Women	3,485	1,800	51.6%	20.0%
2024	CIS-1	HEDIS MY2024 Childhood Immunization Status - DTaP	535	0	0.0%	20.0%

2024	CIS-10	HEDIS MY2024 Childhood Immunization Status - Influenza	535	26	4.9%	20.0%
2024	CIS-2	HEDIS MY2024 Childhood Immunization Status - IPV	535	1	0.2%	20.0%
2024	CIS-3	HEDIS MY2024 Childhood Immunization Status - MMR	535	129	24.1%	20.0%
2024	CIS-4	HEDIS MY2024 Childhood Immunization Status - HiB	535	6	1.1%	20.0%
2024	CIS-5	HEDIS MY2024 Childhood Immunization Status - Hepatitis B	535	0	0.0%	20.0%
2024	CIS-6	HEDIS MY2024 Childhood Immunization Status - VZV	535	131	24.5%	20.0%
2024	CIS-7	HEDIS MY2024 Childhood Immunization Status - Pneumococcal Conjugate	535	0	0.0%	20.0%
2024	CIS-8	HEDIS MY2024 Childhood Immunization Status - Hepatitis A	535	168	31.4%	20.0%
2024	CIS-9	HEDIS MY2024 Childhood Immunization Status - Rotavirus	535	7	1.3%	20.0%
2024	GSD-1	HEDIS MY2024 Glycemic Status Assessment for Patients with Diabetes - Glycemic status (<8.0%)	13,899	1,765	12.7%	0.0%
2024	GSD-2	HEDIS MY2024 Glycemic Status Assessment for Patients with Diabetes - Glycemic status (>9.0%)	13,984	4,208	30.1%	0.0%
2024	IMA-1	HEDIS MY2024 Immunizations for Adolescents - Meningococcal	1,748	814	46.6%	20.0%
2024	IMA-2	HEDIS MY2024 Immunizations for Adolescents - Tdap	1,748	780	44.6%	20.0%
2024	IMA-3	HEDIS MY2024 Immunizations for Adolescents - HPV	1,748	241	13.8%	20.0%
2024	POD-1	HEDIS MY2024 Pharmacotherapy for Opioid Use Disorder	2,308	0	0.0%	20.0%
2024	SSD-1	HEDIS MY2024 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	3,792	2,927	77.2%	60.7%
2024	W30-1	HEDIS MY2024 Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months	356	27	7.6%	20.0%
2024	W30-2	HEDIS MY2024 Well-Child Visits in the First 30 Months of Life - Well-Child Visits for Age 15 Months-30 Months	788	162	20.6%	20.0%
2024	WCV-1	HEDIS MY2024 Child and Adolescent Well-Care Visits	31,443	14,725	46.8%	20.0%

Source: HBI, 1-01-25 refresh, retrieved on 2/18/25

Table A5. MY24 Encounter Based HEDIS Measures for Entire Population

Measure Year	Measure Id	Measure Name	Eligible	Compliant	Compliant Rate	Internal Target Rate
2024	ADD-1	HEDIS MY2024 Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	1,537	850	55.3%	40.8%
2024	ADD-2	HEDIS MY2024 Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance (C&M) Phase	1,537	0	0.0%	89.0%
2024	FMC-1	HEDIS MY2024 Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions - Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	3,642	1,185	32.5%	0.0%
2024	FUA-1	HEDIS MY2024 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-day follow-up	1,496	476	31.8%	23.0%
2024	FUA-2	HEDIS MY2024 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-day follow-up	1,496	307	20.5%	17.0%
2024	FUH-1	HEDIS MY2024 Follow-Up After Hospitalization for Mental Illness - 30-day follow-up	3,915	2,209	56.4%	80.0%
2024	FUH-2	HEDIS MY2024 Follow-Up After Hospitalization for Mental Illness - 7-day follow-up	3,915	1,161	29.7%	65.0%
2024	FUI-1	HEDIS MY2024 Follow-Up After High-Intensity Care for Substance Use Disorder - 30-day follow-up	853	323	37.9%	0.0%
2024	FUI-2	HEDIS MY2024 Follow-Up After High-Intensity Care for Substance Use Disorder - 7-day follow-up	853	133	15.6%	0.0%
2024	FUM-1	HEDIS MY2024 Follow-Up After Emergency Department Visit for Mental Illness - 30-day follow-up	2,171	1,254	57.8%	78.0%
2024	FUM-2	HEDIS MY2024 Follow-Up After Emergency Department Visit for Mental Illness - 7-day follow-up	2,171	877	40.4%	67.0%
2024	PPC-1	HEDIS MY2024 Prenatal and Postpartum Care - Timeliness of prenatal care	581	229	39.4%	20.0%
2024	PPC-2	HEDIS MY2024 Prenatal and Postpartum Care - Postpartum care	581	151	26.0%	20.0%

Source: HBI, 1-01-25 refresh, retrieved on 2/18/25

Table A6. MY24 Utilization HEDIS Measures for Total Population

Measure Year	Measure Id	Measure Name	Eligible	Member Months	Observed Events	Individuals Observed	Observed per 1,000 Members	Observed per 1,000 Member Months	Observed %
2024	PCR-1	HEDIS MY2024 Plan All-Cause Readmissions	10,392	118,500	2,117	1,346	204	18	13.0%

Source: HBI, 1-01-25 refresh, retrieved on 2/18/25

Appendix B – Data Sources

Table B1. Data Sources

Data Source	Medical/ Behavioral Claims	Pharmacy Claims	Lab Results	Health Appraisal Results	Electronic Health Records	Health Services Programs	Advanced Data Sources	Other
Data Cubes	X							
HBI	X	X		X	X		X	
PEGA Call Data						X		
Reports Manager	X	X		X	X		X	
Pyx Health				X			X	
SDOH Assessment				X				
CVS Pharmacy Claims		X						
Quit for Life						X		
CMHRP							X	
County Health Rankings								X
American Community Survey								X
March of Dimes								X
National Center for Health Statistics								X
Community Health Assessments								X

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