



CY 2025 Population Health Report

Van Buren

Southwest Michigan Behavioral Health

Prepared by:

Madeline Peterson, Data Analyst

Moira Kean, Data Analytics and Strategy Lead

September 2026

1.	Introduction	4
2.	Key Findings.....	5
3.	Who is in the Study.....	7
3.1.	Distribution of Van Buren County Enrollees by Zip Code	9
4.	Population Characteristics	10
4.1.	Age and Sex	10
4.2.	Race/Ethnicity.....	11
4.3.	Living Arrangements for CMH/PIHP-Served Population	12
4.4.	Medicaid-Medicare Dual Eligibility	15
5.	Behavioral Health	16
5.1.	Primary Behavioral Health Group Definitions	16
5.2.	Prevalence of Behavioral Health (BH) Conditions	17
5.3.	Behavioral Health Diagnosis Rates by County	23
5.4.	Behavioral Health Conditions Demographic Comparisons.....	26
6.	Chronic Health Conditions	33
6.1.	Overview and Methods	33
6.2.	Prevalence of Chronic Conditions	34
6.3.	Chronic Conditions by Age Group	38
6.4.	Chronic Conditions by Age Group and Dual Eligibility	41
6.5.	Multiple Chronic Conditions by Dual Eligibility (Adults)	43
6.6.	Chronic Conditions by Behavioral Health Diagnosis Group	44
6.7.	Chronic Conditions by Race/Ethnicity	49
6.8.	Chronic Conditions and Inpatient (IP) Hospitalization Risk	52
7.	Inpatient and Emergency Department Utilization.....	56
7.1.	Overview and Methods	56
7.2.	Overall Utilization	57
7.3.	Utilization by Age	58
7.4.	Utilization Among Individuals with Behavioral Health Diagnoses	60
7.5.	Medical Emergency Department and Hospital Utilization by Type of Behavioral Health Diagnosis	71
8.	Multimorbidity and Hospitalization Risk	73
8.1.	Overview and Methodology	73
8.2.	Multimorbidity Class Diagnosis Profiles	75
8.3.	Class Distribution and Utilization	77

9.	Healthcare Quality and Medication Monitoring.....	80
9.1.	Disease Management Metrics	80
9.2.	Behavioral Pharmacy Analysis.....	81
10.	Conclusion.....	89
11.	References.....	91

1. Introduction

Southwest Michigan Behavioral Health (SWMBH) developed this Population Health Analysis to examine the health characteristics and healthcare utilization of Medicaid enrollees in Van Buren County. The report primarily evaluates calendar year 2025 data while incorporating trend and historical analyses from 2022 through 2025 where appropriate. Areas of focus include demographic characteristics, behavioral and chronic health conditions, multimorbidity, healthcare utilization, prescribing patterns, and healthcare quality measures.

Medicaid populations may experience complex physical, behavioral, and social health needs that influence healthcare utilization and outcomes. By examining diagnoses, utilization, and quality measures together, this report provides a broader view of population health and helps identify patterns and populations that may warrant additional attention, planning, or quality improvement efforts.

Data sources include Medicaid enrollment and encounter records for medical, behavioral health, and pharmacy services for residents of Van Buren County, made available to SWMBH by the State of Michigan. The Behavioral Health Treatment Episode Data Set (BH-TEDS) was also used to supplement living arrangement information for individuals receiving PIHP- or CMH-funded services.

Behavioral health and chronic physical health conditions were organized into broader diagnosis groups to examine disease prevalence, multimorbidity, and associations with healthcare utilization. Utilization analyses include inpatient hospitalizations and emergency department visits, while quality and prescribing analyses examine preventive care measures and medication use. Results are stratified by demographic characteristics, including age, sex, race and ethnicity, and Medicare-Medicaid dual eligibility, to identify populations with elevated health needs and potential disparities.

Relias's Population Performance platform was used to support analyses of healthcare quality measures and prescription patterns.

2. Key Findings

The following highlights summarize key findings from the 2025 Population Health Analysis. They are intended to provide a high-level overview of the most important population health patterns, trends, and areas for continued attention identified throughout the report. Additional detail and interpretation are provided in the sections that follow.

- **Van Buren County's Medicaid population became smaller in 2025 while a greater proportion of enrollees used healthcare services.** Enrollment declined from 27,093 in 2024 to 23,356 in 2025, while the percentage receiving at least one Medicaid service increased from 78.6% to 82.1%. PIHP/CMH service use also continued its gradual increase, reaching 9.1% in 2025. These patterns may reflect a smaller Medicaid population with greater and more complex healthcare needs.
- **Van Buren County's Medicaid population became smaller in 2025 while a greater proportion of enrollees used healthcare services.** Enrollment declined from 27,093 in 2024 to 23,356 in 2025, while the percentage receiving at least one Medicaid service increased from 78.6% to 82.1%. PIHP/CMH service use also continued its gradual increase, reaching 9.1% in 2025. These changes provide important context for interpreting trends in documented health conditions and may indicate a population increasingly concentrated among individuals with ongoing healthcare needs.
- **Behavioral health diagnosis prevalence was generally lower than in the remainder of the SWMBH region, although IDD was an important exception.** Overall, 31.5% of Van Buren County Medicaid enrollees had a behavioral health diagnosis compared with 32.9% in the rest of the region. Depression, ADHD, adjustment disorder, SUD, bipolar disorder, impulse control/conduct disorders, and personality disorder were also significantly lower, while IDD was significantly higher.
- **Chronic health burden increased more clearly in 2025 and overlapped substantially with behavioral health needs.** Overall, 38.8% of enrollees had at least one chronic condition, with Metabolic Risk Factors the most commonly identified condition group. In the matched 2024–2025 population, any chronic condition increased significantly, driven in part by a significant increase in Metabolic Risk Factors. Across both adults and children, individuals with behavioral health diagnoses had substantially greater chronic-condition burden than those without a behavioral health diagnosis.
- **Dual-eligible adults represented a population with particularly high chronic health needs.** Among adults ages 18–64, dual-eligible enrollees had markedly higher chronic-condition prevalence than non-dual adults in the same age group, including substantially higher rates of Metabolic Risk Factors and several cardiovascular, respiratory, neurologic, and kidney conditions. Similar differences were present among older adults, although the small non-dual 65+ population warrants caution when interpreting individual comparisons.
- **Social and chronic health complexity were strongly associated with inpatient hospitalization.** Inpatient utilization increased markedly as the number of chronic conditions increased. In multivariable analysis, documented Social Determinants of

Health were associated with more than five times the adjusted odds of hospitalization, while several medical conditions—including urinary tract infection, liver disease, cardiac disease, epilepsy, traumatic brain injury, and chronic kidney disease—were also independently associated with elevated hospitalization odds.

- **Individuals with more complex behavioral health profiles experienced particularly high acute-care utilization.** SMI/SED and SUD populations consistently showed elevated medical ED and inpatient utilization compared with individuals without a behavioral health diagnosis, even within the same age groups. The multimorbidity analysis reinforced this pattern: Complex Behavioral Health and High Chronic Complexity represented only 9.7% of the ever-diagnosed population but had the highest ED and inpatient utilization rates.
- **Medication-management indicators identify several areas for continued clinical review.** Van Buren County performed slightly above the SWMBH regional rate on both adult disease-management measures examined. However, adult pharmacy quality indicators showed substantially higher triggering rates for concurrent opioid and benzodiazepine use and use of four or more psychotropic medications than the region overall. Pharmacy quality indicators were also associated with elevated hospitalization risk among both adults and children, although these relationships should be interpreted as markers of clinical complexity or potential care-coordination need rather than evidence that medication practices caused hospitalization.

3. Who is in the Study

The total Van Buren County Medicaid population in 2025 included 23,356 unique enrollees with full Medicaid or Health Michigan Plan benefits at some point during the one-year report period. Individuals enrolled with unmet spenddown or with coverage limited to maternal services or emergency services only were excluded. Individuals were included regardless of the number of months they were enrolled during the year.

Each enrollee was assigned to their most recent Medicaid county during 2025. As a result, county-level counts reflect an individual's latest county of enrollment rather than all counties in which they may have been enrolled during the year.

Of those enrolled, 82.1% had at least one Medicaid service during 2025, and 9.1% received at least one PIHP- or CMH-funded service. Enrollees were covered for an average of 9.7 months during the report period.

As shown in Table 1, total Medicaid enrollment declined from 27,093 in 2024 to 23,356 in 2025. At the same time, the percentage of enrollees receiving at least one Medicaid service increased from 78.6% to 82.1%. The percentage receiving PIHP/CMH-funded services also continued to increase, rising from 8.2% in 2022 to 9.1% in 2025. These patterns provide important context for interpreting changes in diagnosis prevalence and healthcare utilization later in the report.

Table 1: Enrollment and Service Utilization, 2022-2025 - Van Buren County			
Year	Total Enrollees	1+ Medicaid Service	1+ CMH/PIHP Service
2022	28,182	82.1%	8.2%
2023	29,381	81.1%	8.5%
2024	27,093	78.6%	8.7%
2025	23,356	82.1%	9.1%

Medicaid coverage varied across counties. Calhoun had the highest estimated Medicaid coverage rate at 35.8%, while Barry had the lowest at 20.8%. Berrien, Branch, Saint Joseph, and Van Buren each had coverage rates of approximately 30%. These differences provide additional context for interpreting county-level population health patterns throughout the report.

Unless otherwise specified, subsequent analyses in this report describe the Van Buren County Medicaid population defined above.

Table 2: County Population and Medicaid Coverage - CY 2025			
County	Medicaid Enrollees	Est. County Population	Medicaid Coverage Rate
Barry	13,333	63,991	20.8%
Berrien	46,972	152,444	30.8%
Branch	14,081	45,993	30.6%
Calhoun	47,743	133,408	35.8%
Cass	13,983	51,677	27.1%
Kalamazoo	68,218	263,795	25.9%
Saint Joseph	18,740	60,968	30.7%
Van Buren	23,356	76,071	30.7%

Estimated county population (total residents, not limited to Medicaid-eligible individuals) from U.S. Census Bureau county population estimates, CY 2025.

3.1. Distribution of Van Buren County Enrollees by Zip Code

The map below presents a heat map of the geographic distribution of the Van Buren County Medicaid cohort based on zip code of residence.

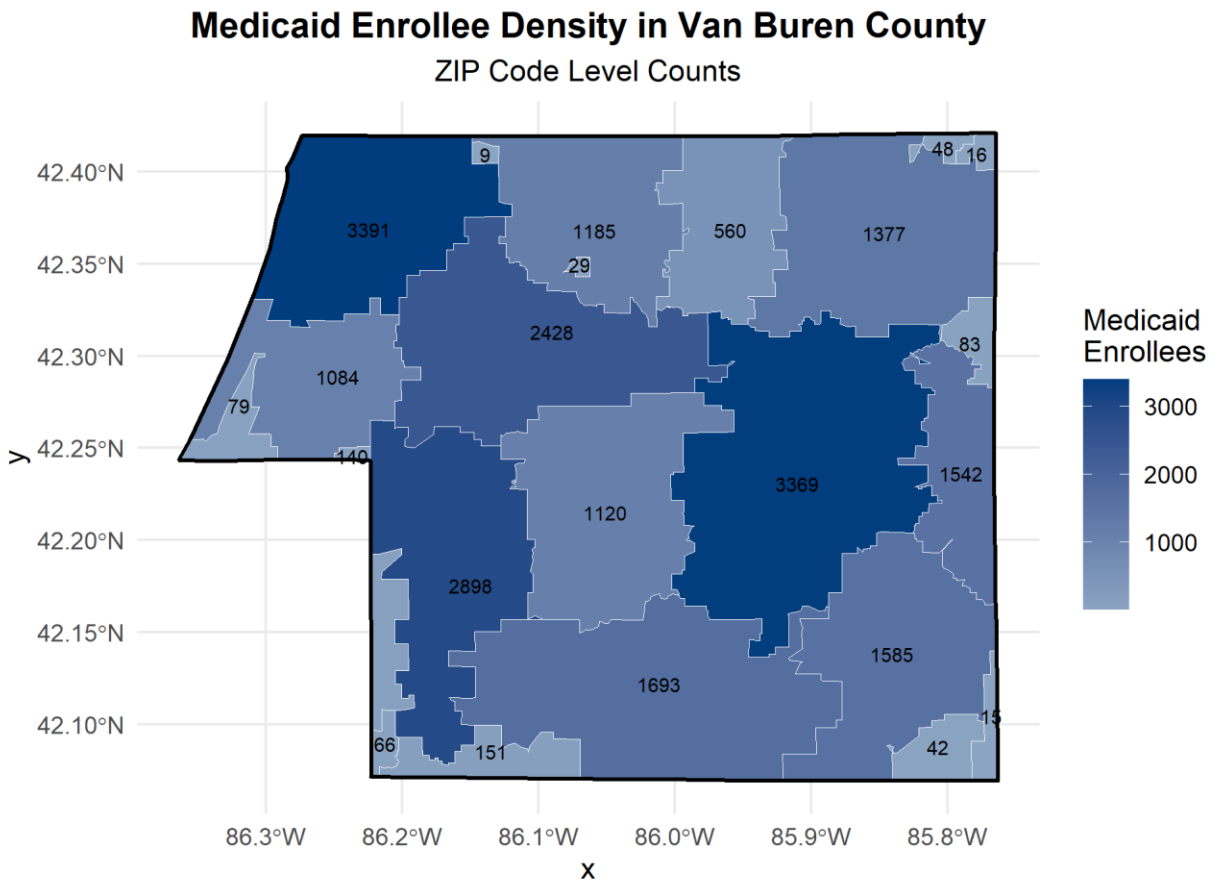


Figure 1: Count of CY 2025 Medicaid enrollees by zip code of address.

4. Population Characteristics

Understanding the demographic characteristics of the Medicaid population provides important context for interpreting the health conditions, healthcare utilization, and outcomes presented throughout the remainder of this report. This section summarizes the population by age, sex, race and ethnicity, living arrangement, and Medicare-Medicaid dual eligibility to provide a baseline description of the individuals included in the analysis.

4.1. Age and Sex

Age is strongly associated with patterns of disease burden and healthcare utilization, while both age and sex provide important context for understanding differences across the Medicaid population (Atella et al., 2019). Figure 2 shows the age distribution of Medicaid enrollees by sex, with percentages calculated within each sex to allow comparison of enrollment patterns across the lifespan. In Van Buren County, the average age at the end of 2025 was 29.2 years. Overall, 38.7% of enrollees were younger than 18 years, 53.8% were between 18 and 64 years, and 7.5% were 65 years or older. The population was 46.4% male and 53.6% female.

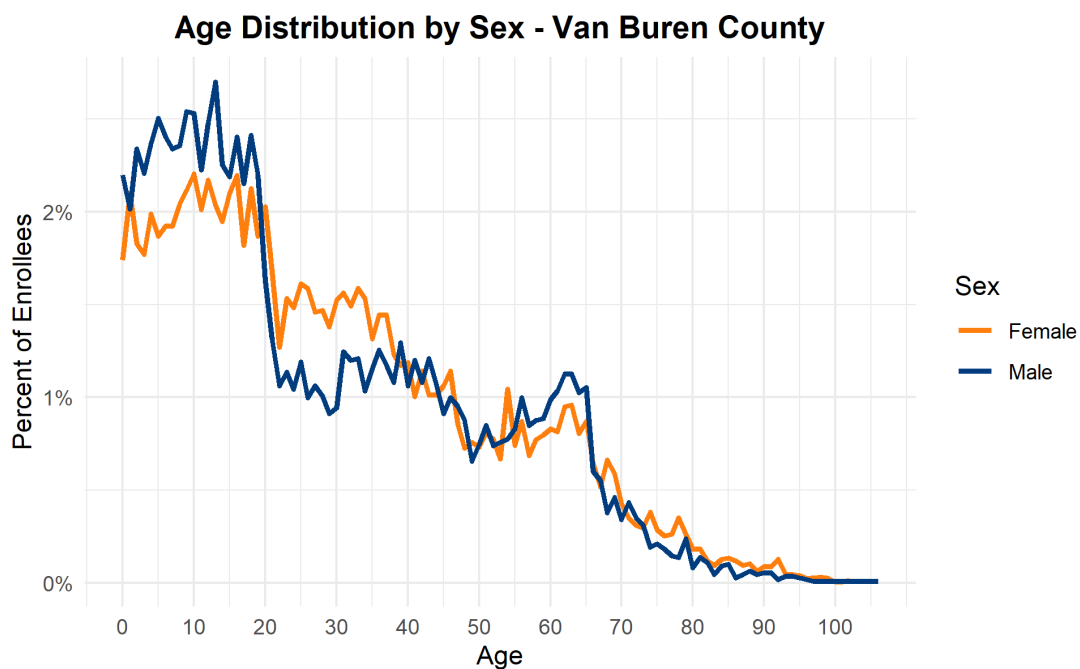


Figure 2: Percent of enrollees at each single year of age, by sex.

Male enrollees make up a larger share of the population throughout childhood and adolescence, while female enrollment becomes more prominent beginning in early adulthood, particularly through the 20s and 30s. The distributions become more similar through middle adulthood, although males represent a somewhat larger share again in portions of the 50s and early 60s. At older ages, females generally make up the larger share of enrollees. The higher representation of women during early adulthood may partly reflect Medicaid eligibility pathways related to pregnancy and parenting.

4.2. Race/Ethnicity

Race and ethnicity provide important context for identifying potential differences in health conditions, healthcare utilization, and quality of care across population groups. Throughout this report, race and ethnicity are used to examine whether meaningful disparities are present within the Van Buren County Medicaid population.

To align with MDHHS methodology for Core Set measures, race and ethnicity were assigned using the most recent Medicaid enrollment record available at the time of data extraction. Individuals identified as Hispanic ethnicity were classified in the Hispanic or Latino group regardless of reported race. For all other individuals, classification was based on the primary race field reported in Medicaid enrollment records.

Figure 3 summarizes the racial and ethnic composition of Medicaid enrollees in Van Buren County. Overall, 67.4% identified as White, 18.7% identified as Hispanic or Latino, 6.8% identified as Black or African American, 5.3% identified as Other Race, 1.5% identified as American Indian or Alaska Native, 0.2% identified as Asian, 0.1% identified as Native Hawaiian or Other Pacific Islander.

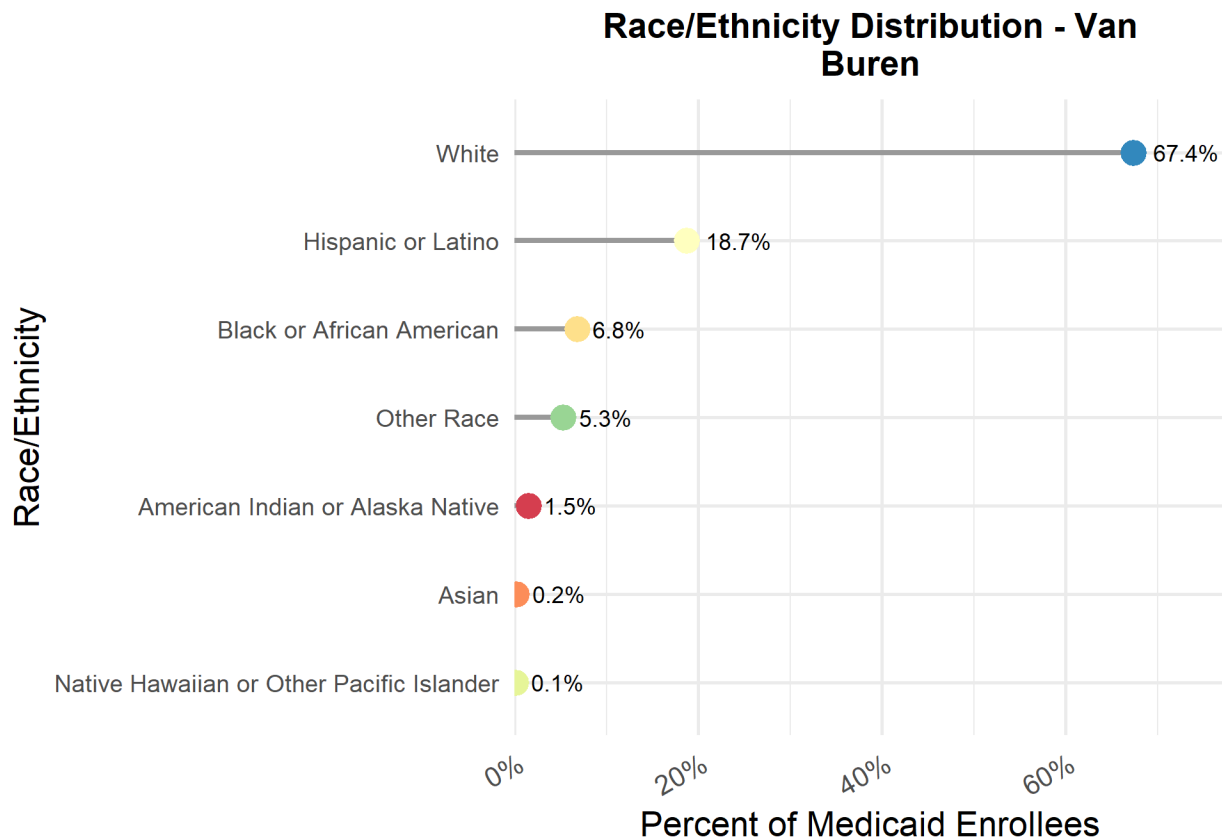


Figure 3: Percentage of Medicaid enrollees by race and ethnicity.

4.3. Living Arrangements for CMH/PIHP-Served Population

Living arrangement provides important context for understanding social support and housing stability among individuals receiving behavioral health services. Because living arrangement information is collected through the Behavioral Health Treatment Episode Data Set (BH-TEDS), this analysis is limited to Medicaid enrollees who received PIHP- or CMH-funded services and had a recorded living arrangement.

Living arrangements were grouped into four categories: dependent, independent, unhoused, and unknown. Individuals classified as “Other” were excluded from this analysis.

The following table compares the distribution of living arrangements in Van Buren County with the remainder of the SWMBH region. Living arrangements in Van Buren County differed from the rest of the SWMBH region. Among PIHP/CMH-served Medicaid enrollees with recorded living arrangement information, 14.7% were living dependently compared with 10.9% in the rest of the region, a significantly higher rate. In contrast, Van Buren County had a significantly lower percentage of individuals identified as unhoused (3.0% vs. 6.7%). Independent living was nearly identical in Van Buren County and the remainder of the region (82.3% vs. 82.2%).

Table 3. Living Arrangement - Van Buren vs. Rest of Region

Percent in each living arrangement category (2025)

Condition	Van Buren (N=2,648)	Rest of Region (N=30,999)
Dependent	14.7% ↑	10.9%
Independent	82.3%	82.2%
Unhoused	3.0% ↓	6.7%
Unknown	0.1%	0.1%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

4.3.1. Living Arrangement Trends (2022-2025)

Monitoring living arrangements over time helps identify changes in housing stability among individuals receiving behavioral health services. The figure below displays annual trends in living arrangement categories from 2022 through 2025, allowing changes in the distribution of living arrangements to be compared across years. Exact annual percentages are presented in the table below the figure.

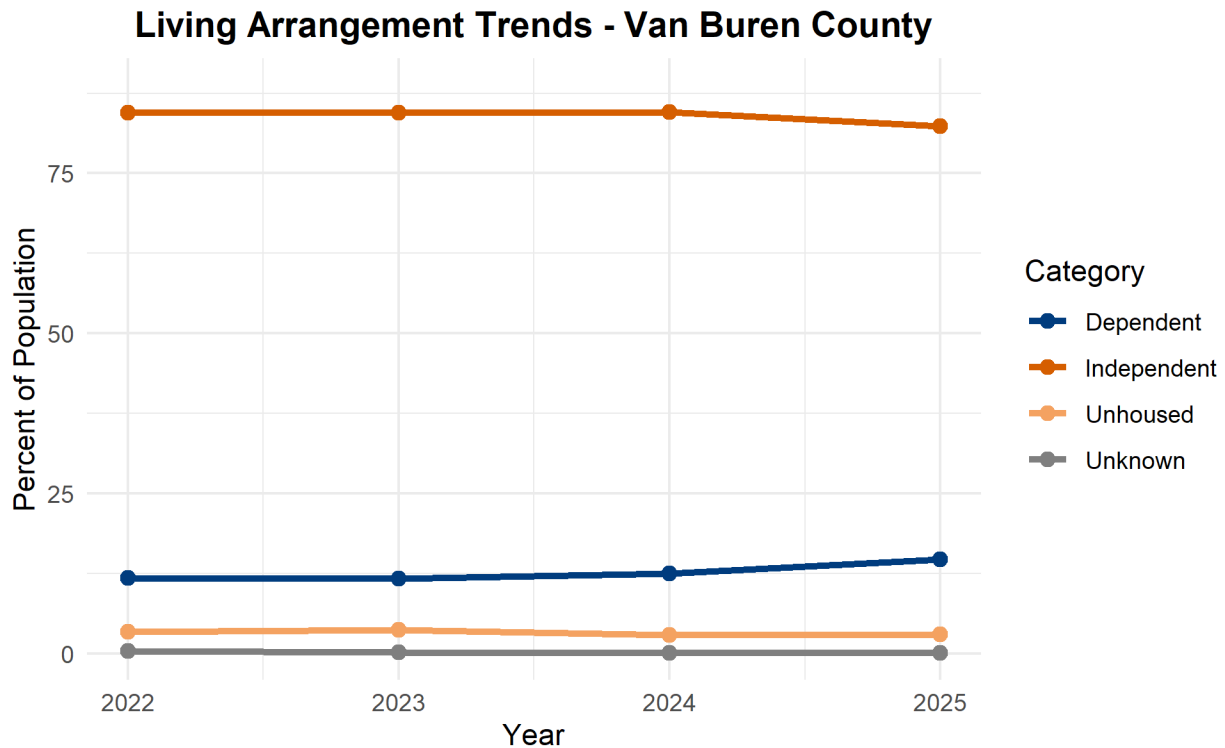


Figure 4: Percent of population in each living arrangement category, 2022-2025.

Table 4. Living Arrangement Trends

Percent of the population in each living arrangement category, 2022–2025.

Living Arrangement	2022	2023	2024	2025
Independent	84.4%	84.4%	84.5%	82.3%
Dependent	11.8%	11.7%	12.5%	14.7%
Unhoused	3.4%	3.7%	2.9%	3.0%
Unknown	0.4%	0.2%	0.1%	0.1%

Living arrangements were relatively stable from 2022 through 2024 before shifting in 2025. The percentage identified as living independently remained near 84.5% during the first three years, then declined to 82.3% in 2025. At the same time, dependent living increased from 12.5% in 2024 to 14.7% in 2025.

Unhoused status remained comparatively low and changed little over the four-year period, ranging from 2.9% to 3.7%. Overall, the 2025 change appears to reflect a shift from independent to dependent living rather than an increase in unhoused status. Continued monitoring may help determine whether this represents a temporary change or an emerging increase in support needs among the PIHP/CMH-served population.

4.4. Medicaid-Medicare Dual Eligibility

Medicare-Medicaid dual eligibility identifies individuals enrolled in both Medicare and Medicaid. Dual-eligible populations often have greater medical complexity and healthcare needs, making dual eligibility an important consideration when interpreting differences in disease burden and healthcare utilization later in this report.

In 2025, 12.2% of the Van Buren County Medicaid population was also enrolled in Medicare in 2025. This report compares adults with Medicaid-only coverage to those who are dually enrolled in both Medicaid and Medicare. Dual enrollment increases sharply with age: 9.5% of adults aged 18 to 64 and 94.9% of those aged 65 and older were enrolled in both programs. No individuals younger than 18 in the study population were identified as Medicare-enrolled.

Table 5: Medicare Coverage by Age Group - Van Buren County			
Age Group	Total Enrollees	Enrolled in Medicare	Percent Medicare
<18	9,050	0	0.0%
18-64	12,554	1,196	9.5%
65+	1,752	1,663	94.9%
All Ages	23,356	2,859	12.2%

5. Behavioral Health

Behavioral health conditions are an important contributor to healthcare utilization, quality of care, and overall population health. Understanding the prevalence and distribution of behavioral health conditions helps identify populations with greater service needs, monitor changes over time, and support planning for behavioral health programs and resources.

This section summarizes the prevalence of behavioral health diagnoses among Medicaid enrollees, trends from 2022 through 2025, differences across demographic groups, and geographic variation within Van Buren County.

5.1. Primary Behavioral Health Group Definitions

To summarize the behavioral health population, individuals with a behavioral health diagnosis were assigned to a single primary behavioral health diagnosis group. Assignment was based on the behavioral health diagnosis category that appeared most frequently across an individual's Medicaid encounter history from 2022 through 2025. These groups provide a consistent way to compare healthcare utilization, chronic physical health conditions, and other outcomes throughout the remainder of this report.

Each enrollee was assigned to only one primary behavioral health diagnosis group, so the groups do not overlap. The primary behavioral health diagnosis groups used in this report are:

- **Intellectual/Developmental Disabilities (IDD):** Intellectual disabilities and pervasive developmental disorders such as autistic disorder are included.
- **Mild/Moderate Mental Illness:** This group is primarily comprised of anxiety disorders, ADHD, and mild to moderate forms of depressive and bipolar disorders.
- **Serious Mental Illness (SMI) / Serious Emotional Disturbance (SED):** This group is primarily comprised of schizophrenia and severe forms of depressive and bipolar disorders. SMI is the adult-focused term and SED is the child/adolescent-focused term for the same underlying diagnostic severity category.
- **Substance Use Disorders (SUD):** Includes addictive and substance use-related disorders including gambling disorder.
- **Other:** This group includes behavioral health conditions not included in the other groups, such as conditions with known physiological causes (e.g., dementia), specific learning disorders, communication disorders, and unspecified mental health conditions.

5.2. Prevalence of Behavioral Health (BH) Conditions

Figure 5 summarizes the proportion of Medicaid enrollees with and without a behavioral health diagnosis in 2025. Behavioral health diagnoses include mental health conditions, substance use disorders, and intellectual/developmental disabilities identified through Medicaid encounter data. Overall, 31.5% of the Van Buren County Medicaid population had a recorded behavioral health diagnosis in 2025. Among those with a behavioral health diagnosis, 58.2% had primarily Mild/Moderate MI diagnoses, 18.1% had primarily SMI/SED diagnoses, 11.3% had primarily Other diagnoses, 6.6% had primarily IDD diagnoses, 5.9% had primarily SUD diagnoses.

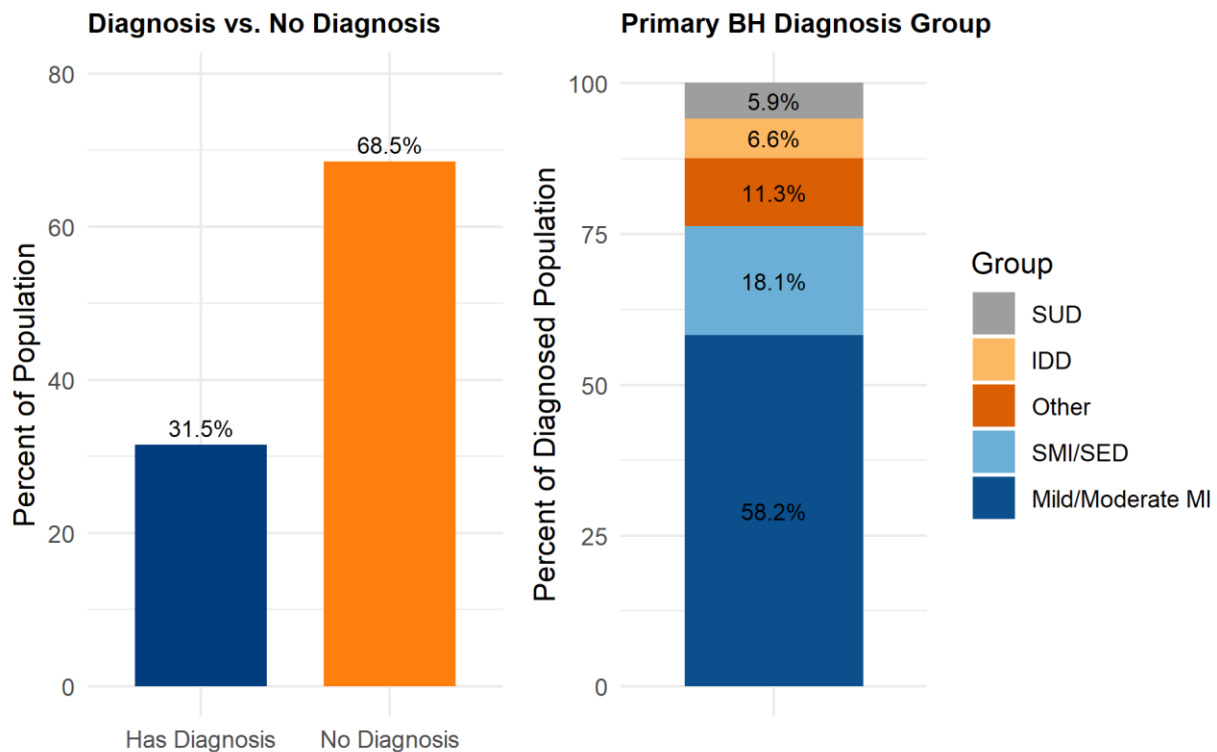


Figure 5: Left: percentage with and without a recorded BH diagnosis. Right: breakdown of primary BH diagnosis group among those with a diagnosis.

5.2.1. BH Condition Comorbidity by Primary Diagnosis Group

Behavioral health diagnoses often co-occur with one another. The following table summarizes the prevalence of individual behavioral health conditions within each primary behavioral health diagnosis group, illustrating how commonly additional diagnoses occur alongside the predominant diagnosis category.

Because each individual is assigned to only one primary behavioral health diagnosis group, the primary group reflects the diagnosis category most frequently represented in the individual's encounter history rather than the only behavioral health condition present. Several of the conditions shown are also used to define the primary diagnosis groups; therefore, this table is descriptive and was not statistically tested. Shading is used to highlight differences in diagnostic patterns across groups.

Table 6. BH Condition Comorbidity by Primary Diagnosis Group - Van Buren County

Percent with each condition, by primary BH diagnosis group among members with a BH diagnosis (2025)

Condition	IDD (N=483)	Mild/Moderate MI (N=4,282)	Other (N=834)	SMI/SED (N=1,330)	SUD (N=432)
Anxiety	21.9%	64.2%	9.2%	41.4%	24.3%
Depressive	9.9%	43.3%	7.3%	43.7%	20.4%
SUD	1.0%	5.0%	0.1%	17.1%	100.0%
Bipolar	5.6%	5.9%	0.7%	28.8%	8.6%
Schizophrenia/Psychosis	6.6%	2.5%	1.7%	28.3%	4.2%
Personality Disorder	3.5%	2.0%	0.2%	9.8%	0.9%
OCD	4.3%	1.6%	0.4%	2.8%	0.5%
Adjustment Disorder	3.9%	19.0%	2.9%	8.9%	6.2%
Dementia	0.8%	0.8%	17.7%	1.6%	0.2%
Impulse Control/Conduct	9.1%	2.9%	1.9%	7.9%	0.0%
Autism Spectrum	66.0%	2.1%	9.8%	3.2%	0.0%
IDD	47.8%	2.0%	1.7%	5.9%	0.0%
Trauma-Related (PTSD)	9.7%	11.3%	2.0%	38.9%	9.0%
ADHD	20.1%	24.2%	8.9%	14.7%	3.9%

Shading reflects diagnosis rate magnitude (lighter = lower, darker = higher). No statistical testing was performed for this table.

Distinct patterns of behavioral health comorbidity were evident across the primary diagnosis groups. Among individuals in the IDD group, autism spectrum disorder was particularly common (66.0%), while 47.8% had an IDD diagnosis and 20.1% had ADHD. The Mild/Moderate MI group showed substantial overlap with ADHD (24.2%), adjustment disorder (19.0%), and trauma-related diagnoses (11.3%).

Among those classified as SMI/SED, trauma-related diagnoses were especially common at 38.9%, alongside bipolar disorder (28.8%), schizophrenia/psychosis (28.3%), and SUD (17.1%). Anxiety (41.4%) and depression (43.7%) were also common in this group, illustrating the broad behavioral health complexity represented within SMI/SED.

The Other group was distinguished by a relatively high prevalence of dementia (17.7%), while individuals in the SUD group also showed notable overlap with anxiety (24.3%), depression (20.4%), and trauma-related diagnoses (9.0%).

These patterns reinforce that the primary behavioral health groups represent broader profiles of behavioral health need rather than mutually exclusive diagnoses. Individuals within a single primary group may therefore require care addressing multiple co-occurring behavioral health conditions.

5.2.2. Behavioral Health Diagnosis Trend (2022-2025)

Monitoring diagnosis rates over time helps identify changes in the behavioral health needs of the Medicaid population. Figure 6 displays annual trends in the percentage of Medicaid enrollees with at least one behavioral health diagnosis from 2022 through 2025.

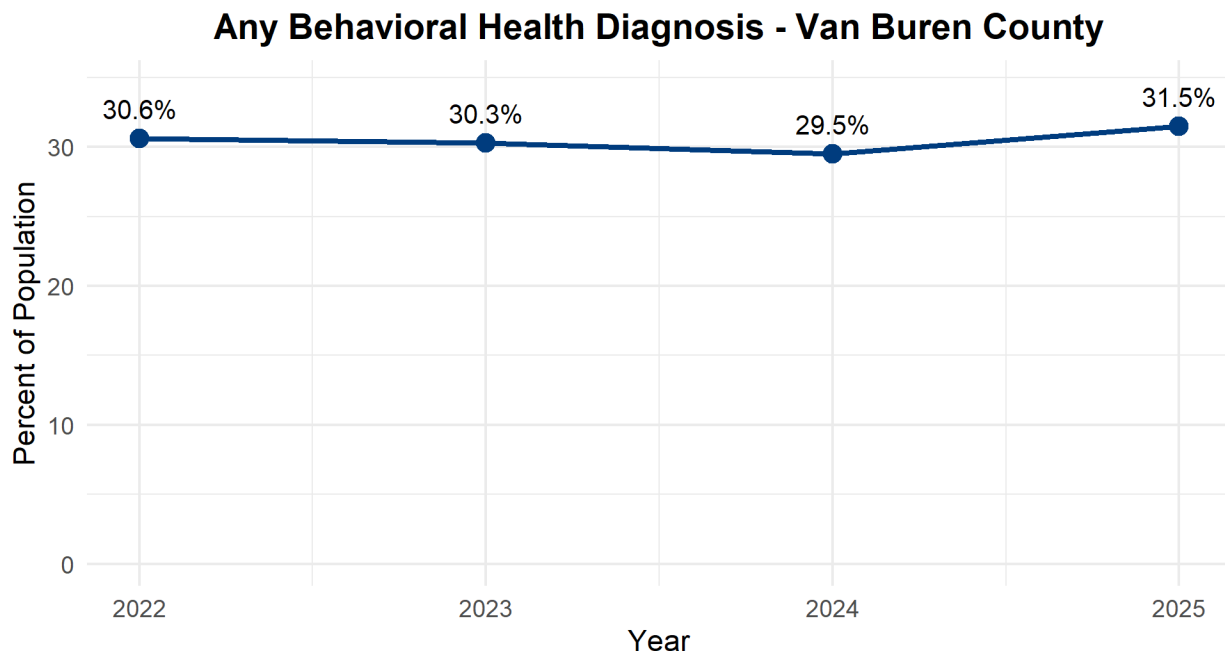


Figure 6: *Percent of population with any behavioral health diagnosis, 2022-2025.*

Behavioral health diagnosis prevalence remained relatively stable from 2022 through 2024 before increasing from 29.5% in 2024 to 31.5% in 2025. The percentage of enrollees receiving at least one Medicaid service also increased in 2025 after declining during the prior two years, suggesting that greater contact with the healthcare system may have contributed to increased identification of behavioral health conditions. However, the available data cannot determine whether the increase reflects greater underlying behavioral health need, increased identification or treatment, or a combination of factors.

5.2.3. Behavioral Health Diagnosis Trend by Primary Group (2022-2025)

Examining trends within each primary behavioral health diagnosis group helps identify whether changes in overall behavioral health prevalence are driven by specific diagnosis categories. The figure below displays annual trends in the percentage of Medicaid enrollees by primary behavioral health diagnosis group from 2022 through 2025. Exact annual percentages for each diagnosis group are presented in the table below the figure.

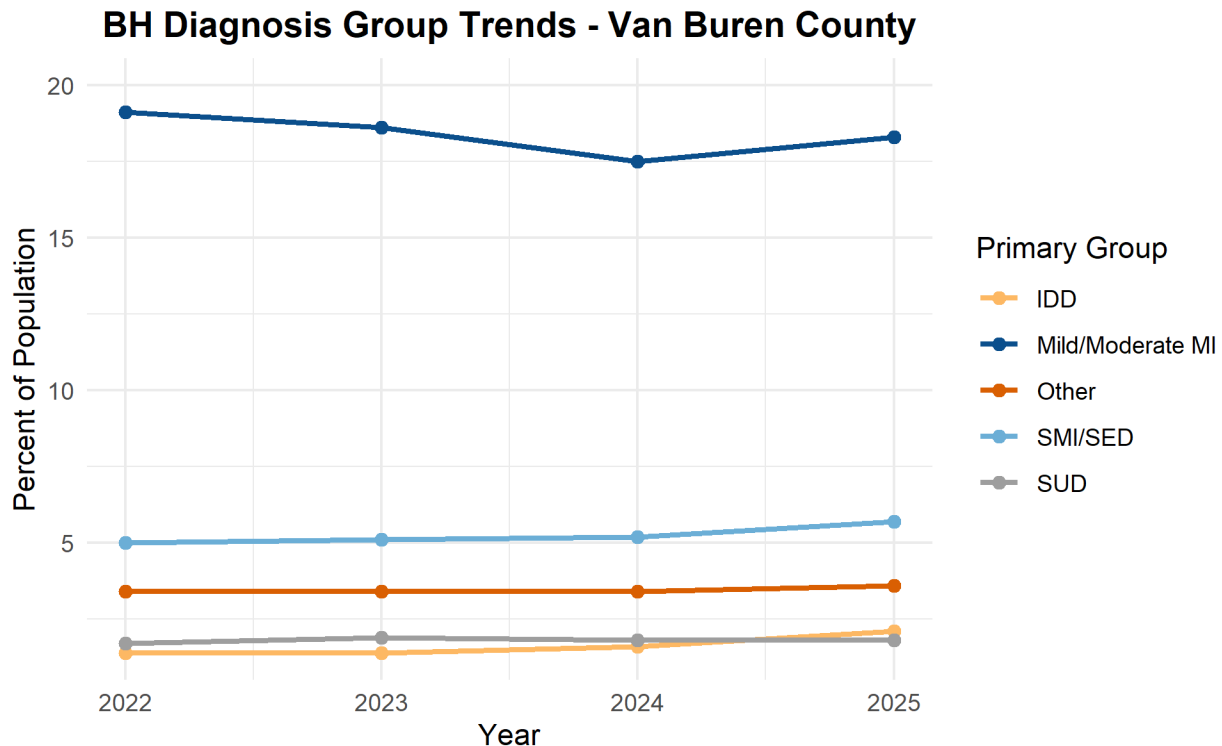


Figure 7: Percent of population with each primary BH diagnosis group, 2022-2025.

Table 7. BH Diagnosis Group Trends

Percent of the population in each primary behavioral health diagnosis group, 2022–2025.

Primary BH Diagnosis Group	2022	2023	2024	2025
IDD	1.4%	1.4%	1.6%	2.1%
Mild/Moderate MI	19.1%	18.6%	17.5%	18.3%
Other	3.4%	3.4%	3.4%	3.6%
SMI/SED	5.0%	5.1%	5.2%	5.7%
SUD	1.7%	1.9%	1.8%	1.8%

Trends varied across primary behavioral health groups. Mild/Moderate MI remained the largest group throughout the study period, declining from 19.1% of the Medicaid population in 2022 to 17.5% in 2024 before increasing to 18.3% in 2025.

IDD and SMI/SED showed more consistent increases over the four-year period. IDD rose from 1.4% in 2022 to 2.1% in 2025, while SMI/SED increased from 5.0% to 5.7%. In contrast, SUD remained relatively stable at approximately 2%, and the Other group changed little, ending at 3.6% in 2025.

5.2.4. Year-Over-Year Change (2024 vs. 2025)

Changes in behavioral health diagnosis prevalence between 2024 and 2025 were evaluated among Medicaid enrollees who were active in both years (N = 19,617). Using the same individuals in both years reduces the influence of changes in Medicaid enrollment on the year-over-year comparison. As individuals age and remain engaged in care, additional conditions may be identified and documented over time; however, the matched comparison also provides insight into changes in the clinical complexity of the continuously enrolled population. Statistical significance was evaluated using McNemar's test with Bonferroni correction for multiple comparisons.

Table 8: Year-Over-Year Change - Van Buren County (N matched = 19,617)

Condition	2024 %	2025 %	Change
Any BH Diagnosis	32.7%	32.5%	-0.2 ↓
Anxiety	15.9%	15.9%	0
Depressive	11.7%	11.5%	-0.2 ↓
ADHD	5.9%	6.3%	+0.4 ↑
Trauma-Related (PTSD)	4.6%	4.8%	+0.2 ↑
Adjustment Disorder	4.4%	4.3%	-0.1 ↓
SUD	3.8%	3.7%	-0.1 ↓
Bipolar	2.9%	3.0%	+0.1 ↑
Autism Spectrum	2.2%	2.4%	+0.2 ↑
Schizophrenia/Psychosis	2.1%	2.3%	+0.2 ↑
IDD	1.7%	1.8%	+0.1 ↑
Impulse Control/Conduct	1.3%	1.3%	0
Personality Disorder	0.8%	1.0%	+0.2 ↑
Dementia	0.8%	0.8%	0
OCD	0.6%	0.6%	0

Bold, colored Change values are statistically significant (McNemar's test, Bonferroni-corrected): red = significant increase, green = significant decrease.

Behavioral health diagnosis prevalence remained relatively stable within the matched Van Buren County population, with any behavioral health diagnosis decreasing slightly from 32.7% in 2024 to 32.5% in 2025. Autism Spectrum diagnoses showed the only statistically significant change, increasing by 0.2 percentage points, while ADHD had the largest observed increase (+0.4 percentage points). Overall, the matched analysis suggests relatively stable behavioral health prevalence among continuously enrolled members, with some shifts in the types of conditions identified over time.

5.3. Behavioral Health Diagnosis Rates by County

Behavioral health diagnosis prevalence in Van Buren County is compared with the remainder of the SWMBH region. Because individuals may have more than one behavioral health diagnosis, condition-specific percentages are not mutually exclusive and should not be summed.

The table below compares Van Buren County's 2025 diagnosis rates with the rest of the SWMBH region. Statistically significant differences between Van Buren County and the remainder of the region are identified using bold text, colored shading, and arrows. Conditions are ordered from highest to lowest regional prevalence.

Table 9. Behavioral Health Diagnosis Rates - Van Buren vs. Rest of Region

Percent with diagnosis (2025)

Condition	Van Buren (N=23,356)	Rest of Region (N=223,070)
Any BH Diagnosis	31.5% ↓	32.9%
Anxiety	15.4%	15.9%
Depressive	11.3% ↓	12.6%
ADHD	6.1% ↓	6.8%
Adjustment Disorder	4.3% ↓	5.7%
SUD	3.8% ↓	4.9%
Trauma-Related (PTSD)	4.7%	4.9%
Bipolar	3.0% ↓	3.5%
Schizophrenia/Psychosis	2.4%	2.5%
Autism Spectrum	2.3%	2.2%
Impulse Control/Conduct	1.2% ↓	1.8%
IDD	1.7% ↑	1.4%
Personality Disorder	1.0% ↓	1.3%
Dementia	0.9%	0.9%
OCD	0.6%	0.6%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Van Buren County had a significantly lower overall behavioral health diagnosis rate than the remainder of the SWMBH region (31.5% vs. 32.9%). Several individual conditions were also significantly less prevalent, including depressive disorders (11.3% vs. 12.6%), ADHD (6.1% vs. 6.8%), adjustment disorder (4.3% vs. 5.7%), SUD (3.8% vs. 4.9%), bipolar disorder (3.0% vs. 3.5%), impulse control/conduct disorders (1.2% vs. 1.8%), and personality disorder (1.0% vs. 1.3%).

IDD showed a different pattern and was significantly more prevalent in Van Buren County than in the remainder of the region (1.7% vs. 1.4%). Anxiety, trauma-related diagnoses, schizophrenia/psychosis, autism spectrum disorder, dementia, and OCD did not differ significantly from the rest of the region.

The generally lower documented diagnosis rates should not necessarily be interpreted as lower underlying behavioral health need. Differences may also reflect variation in population characteristics, access to care, screening and diagnostic practices, service utilization, or documentation.

5.4. Behavioral Health Conditions Demographic Comparisons

Examining behavioral health diagnoses across demographic groups helps identify populations with different patterns of behavioral health need and potential disparities in diagnosis or access to care. The following analyses compare diagnosis prevalence by age, sex, race and ethnicity, and Medicare-Medicaid dual eligibility.

5.4.1. Behavioral Health Conditions by Age Group

Behavioral health diagnosis patterns varied substantially across age groups. Overall, 24% of enrollees younger than 18 had at least one behavioral health diagnosis, compared with 36.6% of adults ages 18–64, and 34.3% of adults ages 65 or older. The most common conditions among those younger than 18 were ADHD, Anxiety, Adjustment Disorder. Among adults ages 18–64, the most common were Anxiety, Depressive, SUD, while among adults ages 65 or older, the most common were Depressive, Anxiety, Dementia.

Table 10. Behavioral Health Conditions by Age Group - Van Buren County

Percent with diagnosis (2025)

Condition	<18 (N=9,050)	18-64 (N=12,554)	65+ (N=1,752)
Any BH Diagnosis	24.0%	36.6%	34.3%
Anxiety	6.6%	21.7%	15.3%
Depressive	3.3%	16.4%	15.9%
SUD	0.3%	6.5%	2.2%
Bipolar	0.2%	5.2%	2.4%
Schizophrenia/Psychosis	0.2%	3.6%	4.3%
Personality Disorder	0.1%	1.8%	0.7%
OCD	0.2%	0.8%	0.7%
Adjustment Disorder	4.2%	4.6%	2.7%
Dementia	0.0%	0.2%	10.5%
Impulse Control/Conduct	2.0%	0.9%	0.1%
Autism Spectrum	3.3%	1.8%	0.3%
IDD	0.4%	2.6%	2.2%
Trauma-Related (PTSD)	2.9%	6.4%	2.5%
ADHD	8.3%	5.3%	0.2%

Shading reflects diagnosis rate magnitude (lighter = lower, darker = higher). No statistical testing was performed for this table.

Among children and adolescents, ADHD was the most commonly documented condition (8.3%), followed by anxiety (6.6%) and adjustment disorder (4.2%). Adults ages 18–64 had the highest rates of anxiety (21.7%), depression (16.4%), SUD (6.5%), and trauma-related diagnoses (6.4%).

Among adults age 65 and older, depression (15.9%) and anxiety (15.3%) remained common, while dementia increased sharply to 10.5%. Schizophrenia/psychosis was also somewhat more prevalent among adults age 65 and older than among younger age groups.

Overall, the age-specific patterns were consistent with different behavioral health profiles across the lifespan: ADHD and autism spectrum disorder were more concentrated among children, SUD and trauma-related diagnoses among working-age adults, and dementia among older adults.

5.4.2. Behavioral Health Conditions by Sex

Behavioral health diagnosis patterns differed by both age and sex. Overall, 33.5% of females and 29.2% of males had at least one behavioral health diagnosis in 2025. Among adults, females had substantially higher rates of anxiety (26.0% vs. 14.4%) and depression (20.3% vs. 11.2%), while adult males had higher rates of SUD (7.8% vs. 4.5%) and schizophrenia/psychosis (5.1% vs. 2.6%). Adult females also had higher rates of trauma-related diagnoses, while adult males had higher rates of autism spectrum disorder and IDD.

Among children, males had a higher overall behavioral health diagnosis rate than females (26.4% vs. 21.5%), driven in part by higher rates of ADHD (10.8% vs. 5.8%), autism spectrum disorder (4.6% vs. 2.0%), and impulse control/conduct disorders (2.6% vs. 1.3%). In contrast, anxiety and depression were more common among female children.

Table 11. Behavioral Health Conditions by Age Group and Sex - Van Buren County

Percent with diagnosis (2025)

Condition	Adult Female (N=8,047)	Adult Male (N=6,259)	Child Female (N=4,483)	Child Male (N=4,567)
Any BH Diagnosis	40.2%	31.3%	21.5%	26.4%
Anxiety	26.0%	14.4%	8.0%	5.1%
Depressive	20.3%	11.2%	4.2%	2.4%
SUD	4.5%	7.8%	0.4%	0.2%
Bipolar	5.4%	4.0%	0.3%	0.1%
Schizophrenia/Psychosis	2.6%	5.1%	0.2%	0.2%
Personality Disorder	2.0%	1.2%	0.1%	0.0%
OCD	0.9%	0.7%	0.2%	0.1%
Adjustment Disorder	5.2%	3.3%	4.5%	3.9%
Dementia	1.7%	1.2%	0.0%	0.0%
Impulse Control/Conduct	0.3%	1.3%	1.3%	2.6%
Autism Spectrum	0.6%	3.0%	2.0%	4.6%
IDD	1.9%	3.5%	0.4%	0.5%
Trauma-Related (PTSD)	7.4%	4.0%	3.6%	2.1%
ADHD	4.6%	4.7%	5.8%	10.8%

Shading reflects diagnosis rate magnitude (lighter = lower, darker = higher). No statistical testing was performed for this table.

5.4.3. Behavioral Health Conditions by Medicare-Medicaid Dual Eligibility

Comparing behavioral health diagnoses by Medicare-Medicaid dual eligibility provides insight into differences between individuals with more complex healthcare needs and those covered by Medicaid alone. In 2025, 43.7% of dual-eligible Medicaid enrollees had at least one behavioral health diagnosis, compared to 29.8% of non-dual enrollees.

Table 12. Behavioral Health Conditions by Medicare Dual Status - Van Buren County

Percent with diagnosis (2025)

Condition	Dual (N=2,859)	No (N=20,497)
Any BH Diagnosis	43.7%	29.8%
Anxiety	18.9%	14.9%
Depressive	17.5%	10.4%
SUD	4.2%	3.7%
Bipolar	6.3%	2.6%
Schizophrenia/Psychosis	8.4%	1.5%
Personality Disorder	2.0%	0.9%
OCD	1.0%	0.5%
Adjustment Disorder	3.0%	4.5%
Dementia	6.6%	0.1%
Impulse Control/Conduct	1.1%	1.2%
Autism Spectrum	2.2%	2.3%
IDD	6.9%	1.0%
Trauma-Related (PTSD)	5.4%	4.6%
ADHD	2.9%	6.5%

*Shading reflects diagnosis rate magnitude (lighter = lower, darker = higher).
No statistical testing was performed for this table.*

Dual-eligible enrollees had a substantially higher overall behavioral health diagnosis rate than non-dual enrollees (43.7% vs. 29.8%). Higher documented rates among dual-eligible members were especially apparent for schizophrenia/psychosis (8.4% vs. 1.5%), bipolar disorder (6.3% vs. 2.6%), IDD (6.9% vs. 1.0%), depression (17.5% vs. 10.4%), and dementia

(6.6% vs. 0.1%). Anxiety was also more common among dual-eligible enrollees (18.9% vs. 14.9%).

In contrast, ADHD was more common among non-dual enrollees (6.5% vs. 2.9%), and adjustment disorder was also somewhat higher in the non-dual population. These differences should be interpreted in the context of the substantially different age and disability profiles of dual and non-dual enrollees, particularly because this comparison is not age-adjusted.

5.4.4. BH Diagnosis by Race/Ethnicity

Race and ethnicity are important factors for identifying potential disparities in behavioral health diagnoses. The following table, and the race/ethnicity tables later in this report, use abbreviated column labels for the following categories: American Indian or Alaska Native (AI/AN) and Native Hawaiian or Other Pacific Islander (NH/PI). The remaining categories - White, Black or African American, Hispanic or Latino, Asian, and Other Race - are shown by their full names.

The following table summarizes behavioral health diagnosis prevalence by race and ethnicity in 2025. Because individuals may have more than one behavioral health diagnosis, condition-specific percentages within each racial/ethnic group are not mutually exclusive and should not be summed. Statistical significance was assessed using chi-square tests with Bonferroni correction.

Table 13. Behavioral Health Diagnoses by Race/Ethnicity - Van Buren

Percent with diagnosis, by race/ethnicity (2025)

Condition	AI/AN (N=353)	Asian (N=51)	Black (N=1,596)	Hispanic (N=4,358)	NH/PI (N=23)	Other (N=1,244)	White (N=15,731)
Any BH Diagnosis	39.4%	19.6%	28.3%	16.8% ↓	8.7%	24.5% ↓	36.4% ↑
Anxiety	21.0%	7.8%	10.8% ↓	7.6% ↓	4.3%	10.3% ↓	18.3% ↑
Depressive	15.3%	5.9%	8.6%	5.4% ↓	0.0%	6.9% ↓	13.5% ↑
SUD	5.7%	0.0%	3.6%	1.3% ↓	0.0%	3.2%	4.5% ↑
Bipolar	3.4%	2.0%	2.2%	0.5% ↓	0.0%	2.7%	3.8% ↑
Schizophrenia/Psychosis	3.1%	2.0%	4.1% ↑	0.6% ↓	0.0%	1.9%	2.7% ↑
Personality Disorder	0.3%	0.0%	1.2%	0.2% ↓	0.0%	0.7%	1.3% ↑
OCD	0.6%	2.0%	0.4%	0.1% ↓	0.0%	1.0%	0.7%
Adjustment Disorder	6.8%	3.9%	4.4%	2.1% ↓	0.0%	2.2% ↓	5.0% ↑
Dementia	0.3%	0.0%	0.8%	0.2% ↓	0.0%	0.9%	1.1% ↑
Impulse Control/Conduct	0.8%	2.0%	1.3%	0.3% ↓	0.0%	1.0%	1.5% ↑
Autism Spectrum	0.6%	2.0%	2.6%	0.8% ↓	0.0%	2.7%	2.7% ↑
IDD	1.1%	0.0%	2.6%	0.3% ↓	8.7%	1.8%	2.1% ↑
Trauma-Related (PTSD)	6.8%	2.0%	3.7%	1.6% ↓	0.0%	3.3%	5.8% ↑
ADHD	8.5%	0.0%	5.6%	2.1% ↓	0.0%	5.9%	7.2% ↑

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Behavioral health diagnosis prevalence varied substantially across racial and ethnic groups in Van Buren County. White enrollees had a significantly higher overall rate of any behavioral health diagnosis at 36.4%, while Hispanic or Latino enrollees (16.8%) and those classified as Other Race (24.5%) had significantly lower overall diagnosis rates. American Indian or Alaska Native enrollees had the highest observed overall rate at 39.4%, although this difference was not statistically significant.

White enrollees also had significantly higher rates across many individual conditions, including anxiety, depressive disorders, SUD, bipolar disorder, schizophrenia/psychosis, personality disorder, adjustment disorder, dementia, impulse control/conduct disorders, autism spectrum disorder, IDD, trauma-related diagnoses, and ADHD. Hispanic enrollees showed the opposite pattern, with significantly lower rates across most of these same conditions.

Black enrollees had a distinct pattern: anxiety was significantly lower, while schizophrenia/psychosis was significantly higher than in the remainder of the population. Other Race enrollees also had significantly lower rates of anxiety, depression, and adjustment disorder.

These differences should not be interpreted as direct measures of underlying behavioral health need. Diagnosis prevalence may also reflect differences in access to care, help-seeking, screening, diagnostic practices, cultural factors, and documentation. The patterns may therefore help identify areas where additional review of access and potential disparities is warranted.

Together, these findings show that behavioral health diagnosis patterns vary across demographic groups, geographic areas, and diagnosis categories within the Van Buren County Medicaid population. These differences provide important context for the chronic physical health, multimorbidity, and healthcare utilization analyses that follow.

6. Chronic Health Conditions

6.1. Overview and Methods

Chronic physical health conditions are an important contributor to healthcare utilization, quality of life, and overall healthcare costs (Centers for Disease Control and Prevention, 2026). Understanding the prevalence and distribution of chronic conditions helps identify populations with greater medical complexity, supports prevention and care management efforts, and provides context for the healthcare utilization and multimorbidity analyses presented later in this report.

This section summarizes documented chronic physical health conditions among Medicaid enrollees, trends from 2022 through 2025, and differences across demographic groups.

For this analysis, ICD-10 diagnosis codes from Medicaid service encounters between 2022 and 2025 were used to identify documented chronic conditions among the Van Buren County Medicaid population. Services funded by Medicaid Health Plans or Medicaid Fee-for-Service were included, along with PIHP/CMH-funded services containing one of the diagnoses of interest. A condition was considered present if a qualifying diagnosis appeared on an encounter during the study period, regardless of funding source, service type, diagnostic position on the claim, or number of times the diagnosis was reported.

To simplify interpretation, individual diagnosis codes were organized into broader analytic condition groups based on clinically related diseases. These groupings allow related conditions to be examined together when they share common risk factors, treatment approaches, or affected organ systems. The composite groups used in this section are:

- **Cardiac Disease:** Coronary artery disease (CAD), congestive heart failure, valvular heart disease, and other chronic ischemic heart disease.
- **Vascular Disease:** Atherosclerosis, peripheral vascular disease, stroke, and transient ischemic attack (TIA).
- **Metabolic Risk Factors:** Hypertension, diabetes, hyperlipidemia, obesity/morbid obesity, and sleep apnea.
- **GI Functional Disorder:** GERD/esophageal disorders and gastrointestinal motility disorders.
- **Chronic Pain/Migraine:** Chronic pain syndrome, migraine, fibromyalgia, and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS).
- **Social Determinants of Health (SDoH):** Housing/economic instability, social/family circumstance concerns, education/employment problems, and other psychosocial circumstances.

SDoH are included as a health-related condition grouping rather than a chronic physical health condition because social and economic circumstances can substantially influence physical and behavioral health outcomes, access to care, and treatment stability (McQueen et al., 2021).

6.2. Prevalence of Chronic Conditions

The tables in this section examine the prevalence of documented chronic health conditions among Medicaid enrollees in Van Buren County. These results represent documented diagnosis history among the 2025 Medicaid population rather than conditions newly diagnosed during the year.

Conditions are not mutually exclusive; an individual may be represented in more than one category when multiple chronic conditions are present. Percentages across conditions therefore should not be summed to estimate overall chronic disease prevalence.

The table compares Van Buren County with the remainder of the SWMBH region. Overall, 38.8% of enrollees had at least one of the chronic conditions included in this analysis. The most commonly identified conditions were Metabolic Risk Factors (24.2%), Chronic Pain/Migraine (11%), GI Functional Disorder (8.3%). Statistical significance was assessed using chi-square tests with Bonferroni correction.

Table 14. Chronic Health Condition Rates - Van Buren vs. Rest of Region

Percent with condition (2025)

Condition	Van Buren (N=23,356)	Rest of Region (N=223,070)
Any Chronic Condition	38.8%	38.0%
Metabolic Risk Factors	24.2%	23.9%
Chronic Pain/Migraine	11.0% ↑	9.5%
GI Functional Disorder	8.3%	8.2%
Tobacco Use	6.1% ↓	7.3%
Asthma	5.7%	6.2%
Social Determinants of Health	3.1% ↓	4.3%
Cardiac Disease	3.8%	3.9%
COPD	3.5%	3.5%
Hypothyroidism	2.9%	2.7%
Urinary Tract Infection	2.6%	2.8%
Vascular Disease	2.5%	2.2%
Liver Disease	2.5% ↑	2.1%
Chronic Kidney Disease	2.1%	2.1%

Table 14. Chronic Health Condition Rates - Van Buren vs. Rest of Region*Percent with condition (2025)*

Condition	Van Buren (N=23,356)	Rest of Region (N=223,070)
Cancer	2.0%	1.7%
Epilepsy	1.6%	1.7%
Prediabetes	1.6%	1.5%
Traumatic Brain Injury	1.0%	1.0%
Feeding Difficulty	0.7%	0.6%
Inflammatory Bowel Disease	0.3%	0.4%
Rheumatoid Arthritis	0.3%	0.3%
Lupus/SLE	0.1%	0.2%
Multiple Sclerosis	0.2%	0.1%
Sickle Cell Disease	0.1%	0.2%
Long COVID	0.1%	0.0%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Overall chronic condition prevalence in Van Buren County was similar to the remainder of the SWMBH region, with 38.8% of enrollees having at least one documented chronic condition compared with 38.0% in the rest of the region. Metabolic Risk Factors, the most common chronic condition group, were also similar (24.2% vs. 23.9%).

Several individual conditions differed significantly. Chronic pain/migraine was more prevalent in Van Buren County (11.0% vs. 9.5%), as was liver disease (2.5% vs. 2.1%). In contrast, tobacco use was significantly lower (6.1% vs. 7.3%), as were documented Social Determinants of Health concerns (3.1% vs. 4.3%).

Most other chronic conditions were similar to the remainder of the region. These differences may reflect variation in underlying population health, risk factors, healthcare access, diagnostic practices, or documentation. Overall, Van Buren County's chronic disease burden appears broadly comparable with the region, with a few condition-specific areas that may warrant closer local review.

6.2.1. Chronic Condition Prevalence Trend (2022-2025)

Monitoring chronic condition prevalence over time helps identify changes in disease burden and may reflect shifts in population health, healthcare access, or diagnosis practices. The figure below displays annual trends in the percentage of Medicaid enrollees with at least one chronic physical health condition from 2022 through 2025.

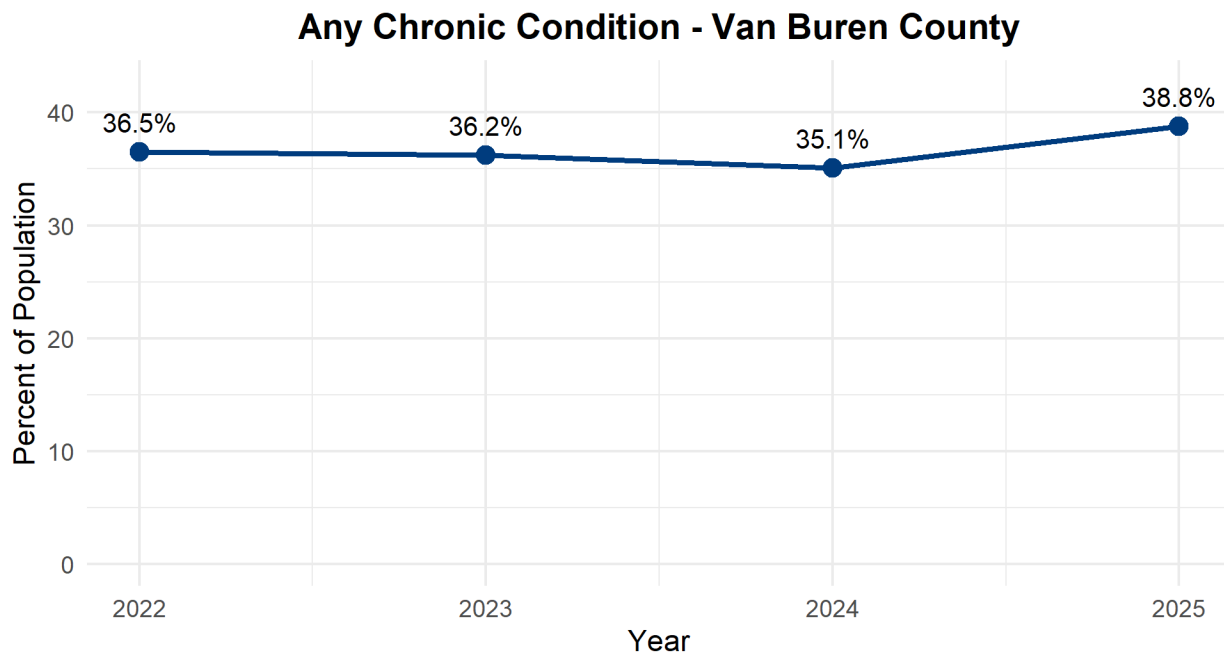


Figure 8: *Percent of population with any chronic condition studied, 2022-2025.*

Chronic condition prevalence was relatively stable from 2022 through 2024, declining slightly from 36.5% in 2022 to 35.1% in 2024 before increasing to 38.8% in 2025. This represents a notable change from the relatively flat pattern observed during the prior three years.

Changes between 2024 and 2025 were also evaluated among Medicaid enrollees active in both years using McNemar’s test with Bonferroni correction. This matched-cohort approach reduces the influence of changes in Medicaid enrollment on the year-over-year comparison. Because individuals were one year older in 2025 and had additional opportunities for conditions to be identified and documented over time, increases may occur within a continuously enrolled population. The matched comparison nevertheless provides insight into changes in the medical complexity of this population. Because the matched population differs from the full population used in the annual trend figure, the percentages below will not exactly match the 2024 and 2025 values shown above.

Table 15: Year-Over-Year Change (Chronic Conditions) - Van Buren County (N matched = 19,617)

Condition	2024 %	2025 %	Change
Any Chronic Condition	38.3%	39.6%	+1.3 ↑
Metabolic Risk Factors	23.6%	25.1%	+1.5 ↑
Chronic Pain/Migraine	11.4%	11.6%	+0.2 ↑
GI Functional Disorder	8.1%	8.5%	+0.4 ↑
Tobacco Use	6.1%	6.3%	+0.2 ↑
Asthma	5.9%	6.0%	+0.1 ↑
Cardiac Disease	3.5%	3.9%	+0.4 ↑
COPD	3.4%	3.6%	+0.2 ↑
Hypothyroidism	3.2%	3.0%	-0.2 ↓
Social Determinants of Health	2.9%	2.8%	-0.1 ↓
Vascular Disease	2.5%	2.6%	+0.1 ↑
Urinary Tract Infection	2.5%	2.6%	+0.1 ↑
Liver Disease	2.3%	2.6%	+0.3 ↑
Chronic Kidney Disease	1.9%	2.1%	+0.2 ↑
Cancer	1.7%	2.0%	+0.3 ↑
Prediabetes	1.5%	1.7%	+0.2 ↑
Epilepsy	1.7%	1.6%	-0.1 ↓
Traumatic Brain Injury	1.0%	1.0%	0
Feeding Difficulty	0.6%	0.6%	0
Inflammatory Bowel Disease	0.4%	0.4%	0
Rheumatoid Arthritis	0.3%	0.3%	0
Multiple Sclerosis	0.2%	0.2%	0
Sickle Cell Disease	0.1%	0.1%	0
Lupus/SLE	0.1%	0.1%	0
Long COVID	0.1%	0.0%	-0.1 ↓

Bold, colored Change values are statistically significant (McNemar's test, Bonferroni-corrected): red = significant increase, green = significant decrease.

The increase in documented chronic conditions remained evident within the matched Van Buren County population, with any chronic condition increasing by 1.3 percentage points, from 38.3% in 2024 to 39.6% in 2025. Metabolic Risk Factors showed the largest increase (+1.5 percentage points), with statistically significant increases also observed for cardiac disease (+0.4) and cancer (+0.3). These findings show that increases in several chronic conditions were also present among individuals enrolled in both years, supporting the broader pattern of greater and more complex healthcare needs in the 2025 population.

6.3. Chronic Conditions by Age Group

Chronic disease burden varies considerably across the lifespan, making age an important consideration when comparing condition prevalence across populations (Watson et al., 2025). In Van Buren County, 66.8% of adults age 65 and older had at least one chronic condition, compared with 47.4% of adults ages 18–64 years, and 21.3% of children younger than 18.

Table 16. Chronic Conditions by Age Group - Van Buren County

Percent with condition (2025)

Condition	<18 (N=9,050)	18-64 (N=12,554)	65+ (N=1,752)
Any Chronic Condition	21.3%	47.4%	66.8%
Cardiac Disease	0.1%	4.1%	20.4%
Vascular Disease	0.1%	2.5%	14.7%
Metabolic Risk Factors	7.3%	31.6%	58.0%
GI Functional Disorder	2.9%	11.0%	17.6%
Chronic Pain/Migraine	2.6%	15.9%	18.3%
Social Determinants of Health	3.7%	2.8%	2.8%
Asthma	5.5%	6.2%	3.9%
COPD	0.0%	3.9%	18.3%
Cancer	0.2%	2.3%	9.3%
Epilepsy	0.7%	2.3%	1.8%
Hypothyroidism	0.2%	4.0%	9.8%
Long COVID	0.0%	0.1%	0.1%
Tobacco Use	0.1%	9.5%	13.4%

Table 16. Chronic Conditions by Age Group - Van Buren County

Percent with condition (2025)

Condition	<18 (N=9,050)	18-64 (N=12,554)	65+ (N=1,752)
Prediabetes	0.2%	2.4%	3.8%
Sickle Cell Disease	0.1%	0.1%	0.1%
Traumatic Brain Injury	0.8%	1.2%	1.1%
Urinary Tract Infection	1.1%	3.2%	6.7%
Feeding Difficulty	1.7%	0.0%	0.0%
Inflammatory Bowel Disease	0.1%	0.5%	0.4%
Liver Disease	0.3%	4.1%	3.3%
Rheumatoid Arthritis	0.0%	0.4%	1.2%
Lupus/SLE	0.0%	0.2%	0.2%
Multiple Sclerosis	0.0%	0.3%	0.4%
Chronic Kidney Disease	0.2%	2.0%	12.5%

Shading reflects diagnosis rate magnitude (lighter = lower, darker = higher). No statistical testing was performed for this table.

Chronic condition burden increased substantially with age in Van Buren County. At least one chronic condition was documented for 21.3% of children, 47.4% of adults ages 18–64, and 66.8% of adults age 65 and older. Metabolic Risk Factors showed one of the strongest age-related patterns, increasing from 7.3% among children to 31.6% among adults ages 18–64 and 58.0% among adults age 65 and older.

Several other conditions also increased markedly with age. Cardiac disease, vascular disease, COPD, chronic kidney disease, cancer, hypothyroidism, and urinary tract infection were all substantially more common among adults age 65 and older. Chronic pain/migraine was also common among both working-age and older adults, affecting 15.9% and 18.3%, respectively.

In contrast, asthma and documented Social Determinants of Health showed less pronounced age-related differences, while feeding difficulty was concentrated primarily among children. Overall, older adults had the greatest chronic condition burden across most categories.

These patterns underscore the importance of age when interpreting chronic disease prevalence and suggest that older adults may require more intensive management of multiple co-occurring physical health conditions.

6.4. Chronic Conditions by Age Group and Dual Eligibility

Medicare dual eligibility provides another way to examine differences in chronic disease burden within the Medicaid population. Individuals enrolled in both Medicare and Medicaid represent a diverse population that differs in age, disability status, healthcare needs, and patterns of service use (Fox & Reichard, 2013).

The table below presents chronic condition prevalence by age group and Medicare dual eligibility status. Examining dual and non-dual populations within age groups helps distinguish differences associated with dual eligibility from patterns that may primarily reflect the older age distribution of the dual-eligible population. Statistical comparisons are made between dual-eligible and non-dual enrollees within the same adult age group.

Table 17. Chronic Conditions by Age Group and Dual Eligibility - Van Buren County

Percent with condition (2025)

Condition	Dual 18-64 (N=1,196)	Dual 65+ (N=1,663)	No <18 (N=9,050)	No 18-64 (N=11,358)	No 65+ (N=89)
Any Chronic Condition	63.3% ↑	67.0% ↑	21.3% ↓	45.8% ↑	61.8% ↑
Cardiac Disease	9.4% ↑	20.6% ↑	0.1% ↓	3.6%	16.9% ↑
Vascular Disease	6.7% ↑	14.9% ↑	0.1% ↓	2.1% ↓	10.1% ↑
Metabolic Risk Factors	48.7% ↑	58.6% ↑	7.3% ↓	29.8% ↑	47.2% ↑
GI Functional Disorder	19.1% ↑	18.0% ↑	2.9% ↓	10.2% ↑	10.1%
Chronic Pain/Migraine	25.3% ↑	18.6% ↑	2.6% ↓	15.0% ↑	12.4%
Social Determinants of Health	2.8%	2.8%	3.7% ↑	2.8%	2.2%
Asthma	8.2% ↑	4.1%	5.5%	6.0%	0.0%
COPD	8.9% ↑	18.8% ↑	0.0% ↓	3.3%	7.9%
Cancer	4.4% ↑	9.2% ↑	0.2% ↓	2.1%	11.2% ↑
Epilepsy	6.0% ↑	1.9%	0.7% ↓	1.9%	0.0%
Hypothyroidism	8.6% ↑	10.1% ↑	0.2% ↓	3.5% ↑	4.5%
Long COVID	0.1%	0.1%	0.0%	0.1%	0.0%
Tobacco Use	13.2% ↑	13.6% ↑	0.1% ↓	9.1% ↑	10.1%
Prediabetes	3.4% ↑	3.7% ↑	0.2% ↓	2.3% ↑	5.6%
Sickle Cell Disease	0.2%	0.1%	0.1%	0.1%	0.0%
Traumatic Brain Injury	1.3%	1.1%	0.8%	1.1%	2.2%

Table 17. Chronic Conditions by Age Group and Dual Eligibility - Van Buren County

Percent with condition (2025)

Condition	Dual 18-64 (N=1,196)	Dual 65+ (N=1,663)	No <18 (N=9,050)	No 18-64 (N=11,358)	No 65+ (N=89)
Urinary Tract Infection	4.2%	6.7% ↑	1.1% ↓	3.1% ↑	5.6%
Feeding Difficulty	0.1%	0.0%	1.7% ↑	0.0% ↓	0.0%
Inflammatory Bowel Disease	1.3% ↑	0.4%	0.1% ↓	0.5%	0.0%
Liver Disease	5.4% ↑	3.2%	0.3% ↓	3.9% ↑	5.6%
Rheumatoid Arthritis	0.8%	1.3% ↑	0.0% ↓	0.3%	0.0%
Lupus/SLE	0.4%	0.2%	0.0%	0.1%	0.0%
Multiple Sclerosis	1.2% ↑	0.4%	0.0% ↓	0.2%	0.0%
Chronic Kidney Disease	7.1% ↑	12.7% ↑	0.2% ↓	1.4% ↓	7.9%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Among adults ages 18–64, dual-eligible enrollees had substantially greater chronic disease burden than non-dual enrollees. Any chronic condition was documented for 63.3% of dual-eligible adults compared with 45.8% of non-dual adults in the same age group. Metabolic Risk Factors were also considerably more common among dual-eligible adults ages 18–64 (48.7% vs. 29.8%). Higher rates among dual-eligible adults were observed across many other conditions, including cardiac and vascular disease, chronic pain/migraine, COPD, chronic kidney disease, epilepsy, hypothyroidism, and tobacco use.

Among adults age 65 and older, overall chronic condition prevalence was also higher among dual-eligible enrollees (67.0% vs. 61.8%). Metabolic Risk Factors were present in 58.6% of dual-eligible older adults compared with 47.2% of non-dual older adults, while cardiac disease, vascular disease, COPD, hypothyroidism, and chronic kidney disease were also more common among dual-eligible older adults.

Overall, the age-stratified comparisons suggest that dual eligibility identifies a population with elevated chronic health needs, particularly among adults ages 18–64. Comparisons among adults age 65 and older should be interpreted cautiously because the non-dual group was very small (N=89).

6.5. Multiple Chronic Conditions by Dual Eligibility (Adults)

The number of chronic conditions present provides another measure of overall medical complexity. Individuals with multiple chronic conditions often require more intensive care management and may experience higher healthcare utilization.

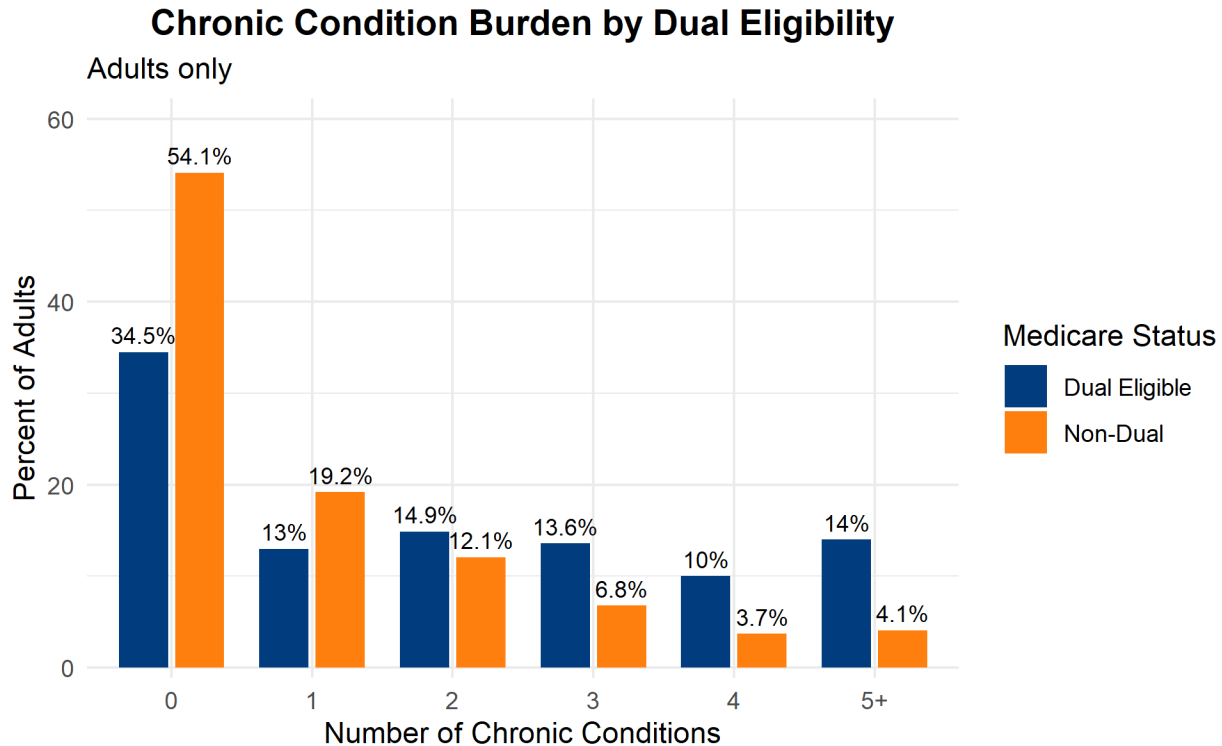


Figure 9: *Percent of adult enrollees by number of chronic conditions, by Medicare dual eligibility status.*

Dual-eligible adults had a greater chronic condition burden than non-dual adults. While 54.1% of non-dual adults had none of the chronic conditions included in this analysis, only 34.5% of dual-eligible adults had no identified chronic conditions. Differences became more pronounced at higher levels of complexity: 14% of dual-eligible adults had five or more chronic conditions, compared with 4.1% of non-dual adults. Dual-eligible adults were also more likely to have three or four chronic conditions.

These findings reinforce that dual-eligible adults represent a population with greater medical complexity and may warrant greater emphasis on care coordination and management of multiple co-occurring conditions.

6.6. Chronic Conditions by Behavioral Health Diagnosis Group

Physical and behavioral health conditions frequently occur together, and examining chronic disease prevalence across behavioral health populations can help identify groups with greater combined medical and behavioral health needs.

The following tables compare chronic condition prevalence across the primary behavioral health diagnosis groups defined earlier in this report. Individuals without an identified behavioral health diagnosis are included as a comparison group. Because chronic condition prevalence differs substantially by age, results are presented separately for children and adolescents and for adults. This stratification allows behavioral health groups to be compared within more similar age ranges and reduces the influence of age-related differences in chronic disease burden.

Table 18. Chronic Conditions by BH Diagnosis Group - Adults*Percent with condition among enrollees age 18 and older (2025)*

Condition	No BH Diagnosis (N=9,114)	IDD (N=278)	Mild/Moderate MI (N=3,154)	Other (N=212)	SMI/SED (N=1,116)	SUD (N=432)
Any Chronic Condition	35.5% ↓	64.7% ↑	78.2% ↑	81.6% ↑	72.3% ↑	61.8% ↑
Cardiac Disease	4.6% ↓	4.0%	8.7% ↑	21.2% ↑	7.6%	9.3%
Vascular Disease	2.6% ↓	4.3%	6.4% ↑	20.3% ↑	5.8%	3.0%
Metabolic Risk Factors	24.2% ↓	40.3%	56.0% ↑	67.9% ↑	53.3% ↑	39.1%
GI Functional Disorder	6.2% ↓	20.5% ↑	22.3% ↑	21.7% ↑	22.9% ↑	15.7%
Chronic Pain/Migraine	9.5% ↓	11.5%	32.8% ↑	13.7%	25.6% ↑	17.6%
Social Determinants of Health	1.3% ↓	5.8%	5.1% ↑	4.2%	6.3% ↑	5.8% ↑
Asthma	3.1% ↓	7.2%	11.9% ↑	5.7%	11.2% ↑	7.6%
COPD	3.8% ↓	1.1%	9.0% ↑	13.2% ↑	10.4% ↑	7.6%
Cancer	2.5% ↓	1.4%	4.9% ↑	6.1%	3.7%	3.2%
Epilepsy	1.0% ↓	14.4% ↑	2.9%	7.5% ↑	5.5% ↑	3.5%
Hypothyroidism	2.4% ↓	9.7% ↑	8.7% ↑	14.2% ↑	9.6% ↑	3.2%
Long COVID	0.1%	0.0%	0.2%	0.0%	0.1%	0.0%
Tobacco Use	6.1% ↓	2.2% ↓	17.5% ↑	11.3%	17.5% ↑	19.9% ↑
Prediabetes	1.8% ↓	4.0%	4.4% ↑	1.4%	3.9%	1.9%
Sickle Cell Disease	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Traumatic Brain Injury	0.6% ↓	2.5%	1.8% ↑	5.7% ↑	2.6% ↑	2.1%
Urinary Tract Infection	2.2% ↓	6.1%	5.8% ↑	12.7% ↑	6.9% ↑	3.7%
Feeding Difficulty	0.0%	0.4%	0.1%	0.0%	0.0%	0.0%
Inflammatory Bowel Disease	0.3% ↓	0.7%	1.1% ↑	0.0%	0.7%	0.7%
Liver Disease	2.4% ↓	2.2%	6.9% ↑	4.2%	6.2% ↑	11.1% ↑
Rheumatoid Arthritis	0.3% ↓	0.4%	1.0% ↑	0.9%	0.7%	0.2%
Lupus/SLE	0.1%	0.0%	0.3%	0.5%	0.1%	0.0%
Multiple Sclerosis	0.2% ↓	0.0%	0.7% ↑	0.5%	0.4%	0.5%
Chronic Kidney Disease	2.5% ↓	2.2%	4.4% ↑	12.7% ↑	5.0%	2.5%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Among adults, chronic condition prevalence was substantially higher across all behavioral health diagnosis groups than among adults without a behavioral health diagnosis. Any chronic condition was documented for 35.5% of adults with no behavioral health diagnosis, compared with 61.8% to 81.6% across the behavioral health groups.

Adults in the Other diagnosis group had the highest overall chronic condition prevalence at 81.6%, including particularly high rates of Metabolic Risk Factors (67.9%), cardiac disease (21.2%), vascular disease (20.3%), and chronic kidney disease (12.7%). Adults with Mild/Moderate MI and SMI/SED also showed broad elevations across many chronic physical health conditions. Mild/Moderate MI was especially notable for chronic pain/migraine (32.8%), while SMI/SED showed elevated chronic pain/migraine (25.6%), GI functional disorders (22.9%), tobacco use (17.5%), and several other conditions.

The SUD group also had substantial chronic health burden, with 61.8% having at least one chronic condition and particularly high tobacco use (19.9%) and liver disease (11.1%). Overall, these findings reinforce the substantial overlap between behavioral and physical health needs among adults in Van Buren County.

Table 19. Chronic Conditions by BH Diagnosis Group - Children and Adolescents*Percent with condition among enrollees under age 18 (2025)*

Condition	No BH Diagnosis (N=6,881)	IDD (N=205)	Mild/Moderate MI (N=1,128)	Other (N=622)	SMI/SED (N=214)
Any Chronic Condition	16.7% ↓	42.4% ↑	37.7% ↑	31.5% ↑	35.5% ↑
Cardiac Disease	0.1%	1.0%	0.2%	0.8% ↑	0.0%
Vascular Disease	0.0%	0.5%	0.1%	0.3%	0.0%
Metabolic Risk Factors	5.7% ↓	15.6% ↑	12.5% ↑	10.8%	13.6%
GI Functional Disorder	1.8% ↓	9.8% ↑	5.2% ↑	8.0% ↑	1.4%
Chronic Pain/Migraine	1.9% ↓	4.9%	6.7% ↑	1.3%	5.1%
Social Determinants of Health	2.3% ↓	4.9%	8.5% ↑	6.8% ↑	13.1% ↑
Asthma	4.3% ↓	11.7% ↑	9.1% ↑	8.0%	8.4%
COPD	0.0%	0.0%	0.1%	0.0%	0.5%
Cancer	0.1%	1.0%	0.2%	0.5%	0.0%
Epilepsy	0.4% ↓	6.8% ↑	0.5%	1.6%	1.4%
Hypothyroidism	0.1%	1.0%	0.4%	0.5%	0.0%
Long COVID	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓
Tobacco Use	0.0% ↓	0.0%	0.6% ↑	0.0%	0.5%
Prediabetes	0.1%	1.0%	0.4%	0.3%	0.5%
Sickle Cell Disease	0.1%	0.0%	0.0%	0.2%	0.0%
Traumatic Brain Injury	0.6% ↓	0.0%	1.7%	1.6%	1.4%
Urinary Tract Infection	0.7% ↓	2.9%	1.7%	2.1%	3.7%
Feeding Difficulty	1.1% ↓	10.7% ↑	1.0%	6.3% ↑	0.9%
Inflammatory Bowel Disease	0.0%	0.0%	0.3%	0.0%	0.0%
Liver Disease	0.2%	0.5%	0.7%	0.5%	0.0%
Rheumatoid Arthritis	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓
Lupus/SLE	0.0%	0.5%	0.0%	0.0%	0.0%
Multiple Sclerosis	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓
Chronic Kidney Disease	0.1%	1.5% ↑	0.3%	0.3%	0.0%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

A similar pattern of behavioral and physical health overlap was observed among children and adolescents. Those without a behavioral health diagnosis had the lowest overall chronic condition prevalence at 16.7%, while prevalence ranged from 31.5% to 42.4% across the behavioral health groups.

Children in the IDD group had the highest overall chronic condition prevalence at 42.4%, with notably elevated rates of Metabolic Risk Factors (15.6%), asthma (11.7%), epilepsy (6.8%), feeding difficulty (10.7%), and GI functional disorders (9.8%). Children with Mild/Moderate MI also showed broad elevations, including chronic pain/migraine, Social Determinants of Health, asthma, and GI functional disorders.

The SMI/SED group was distinguished by a particularly high rate of documented Social Determinants of Health concerns at 13.1%, while the Other group also showed elevated feeding difficulty and GI functional disorders. Overall, these findings indicate substantial overlap between behavioral and physical health needs among children and adolescents and support integrated approaches that address behavioral, chronic physical, and social health needs together.

6.7. Chronic Conditions by Race/Ethnicity

The table below examines chronic condition prevalence across race and ethnicity groups to identify differences in diagnosed chronic disease burden within the Medicaid population. Differences observed across groups may reflect a combination of underlying health risk, social and environmental conditions, access to healthcare, healthcare utilization, and differences in opportunities for conditions to be diagnosed. Statistical significance was assessed using chi-square tests with Bonferroni correction.

Table 20. Chronic Conditions by Race/Ethnicity - Van Buren County*Percent with condition (2025)*

Condition	AI/AN (N=353)	Asian (N=51)	Black (N=1,596)	Hispanic (N=4,358)	NH/PI (N=23)	Other (N=1,244)	White (N=15,731)
Any Chronic Condition	44.8%	25.5%	39.7%	28.5% ↓	17.4%	28.1% ↓	42.3% ↑
Cardiac Disease	3.4%	2.0%	4.4%	0.8% ↓	0.0%	2.5%	4.7% ↑
Vascular Disease	2.0%	2.0%	2.5%	0.7% ↓	0.0%	1.4%	3.0% ↑
Metabolic Risk Factors	30.9%	13.7%	24.6%	17.5% ↓	8.7%	15.2% ↓	26.6% ↑
GI Functional Disorder	8.8%	11.8%	8.0%	4.1% ↓	0.0%	5.6%	9.8% ↑
Chronic Pain/Migraine	13.0%	3.9%	10.4%	5.5% ↓	4.3%	4.6% ↓	13.0% ↑
Social Determinants of Health	1.7%	0.0%	2.8%	3.1%	0.0%	3.9%	3.2%
Asthma	5.4%	2.0%	8.5% ↑	4.0% ↓	0.0%	4.0%	6.1%
COPD	3.7%	0.0%	2.8%	0.1% ↓	0.0%	1.6%	4.6% ↑
Cancer	2.0%	0.0%	1.6%	0.6% ↓	4.3%	1.4%	2.5% ↑
Epilepsy	1.7%	2.0%	1.7%	0.5% ↓	4.3%	2.1%	1.9% ↑
Hypothyroidism	4.0%	0.0%	1.7%	1.4% ↓	0.0%	1.6%	3.6% ↑
Long COVID	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%
Tobacco Use	9.6%	2.0%	6.4%	1.3% ↓	4.3%	3.1% ↓	7.6% ↑
Prediabetes	1.7%	2.0%	2.1%	1.2%	0.0%	1.1%	1.8%
Sickle Cell Disease	0.0%	0.0%	0.6% ↑	0.1%	0.0%	0.2%	0.0% ↓
Traumatic Brain Injury	0.6%	0.0%	1.1%	0.8%	0.0%	0.4%	1.1%
Urinary Tract Infection	3.1%	3.9%	2.4%	1.8% ↓	0.0%	1.0% ↓	3.0% ↑
Feeding Difficulty	0.3%	0.0%	0.4%	0.6%	0.0%	1.4%	0.7%
Inflammatory Bowel Disease	0.0%	0.0%	0.4%	0.1%	0.0%	0.1%	0.4%
Liver Disease	3.4%	3.9%	1.9%	1.7% ↓	0.0%	1.8%	2.9% ↑
Rheumatoid Arthritis	0.0%	0.0%	0.3%	0.2%	0.0%	0.2%	0.3%
Lupus/SLE	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.1%
Multiple Sclerosis	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.3%
Chronic Kidney Disease	1.1%	3.9%	2.4%	0.9% ↓	0.0%	1.4%	2.4% ↑

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Chronic condition prevalence varied across racial and ethnic groups in Van Buren County. White enrollees had a significantly higher overall prevalence of any chronic condition at 42.3%, while Hispanic or Latino enrollees (28.5%) and those classified as Other Race (28.1%) had significantly lower overall prevalence. American Indian or Alaska Native enrollees had the highest observed overall rate at 44.8%, although this difference was not statistically significant.

White enrollees also had significantly higher rates across several individual conditions, including cardiac disease, vascular disease, Metabolic Risk Factors, GI functional disorders, chronic pain/migraine, COPD, cancer, tobacco use, urinary tract infection, liver disease, and chronic kidney disease. Hispanic enrollees showed the opposite pattern, with significantly lower rates across many of these same conditions. Other Race enrollees also had significantly lower rates of Metabolic Risk Factors, chronic pain/migraine, tobacco use, and urinary tract infection.

Black enrollees had a different condition-specific profile, with significantly higher rates of asthma and sickle cell disease despite no significant difference in overall chronic condition prevalence. These patterns may reflect differences in underlying health risk, environmental and social conditions, healthcare access and utilization, and opportunities for conditions to be identified and documented. Lower documented prevalence should therefore not be interpreted as lower health need without additional context.

6.8. Chronic Conditions and Inpatient (IP) Hospitalization Risk

Chronic conditions are associated not only with disease burden but also with healthcare utilization. The following analyses examine the relationship between chronic conditions and inpatient hospitalization during 2025.

Inpatient utilization increased substantially as the number of chronic conditions increased. Individuals with no identified chronic conditions averaged approximately 0.2 inpatient days during 2025, while average inpatient days generally rose with each additional condition.

The increase became particularly pronounced at higher levels of multimorbidity, exceeding 10 average inpatient days among individuals with seven chronic conditions and reaching approximately 15 to 24 days among those with nine to eleven conditions. Although the pattern is not perfectly linear at every condition count, it demonstrates a strong overall relationship between greater chronic disease burden and use of inpatient care.

The highest chronic-condition counts may represent relatively small numbers of enrollees, so the individual values at the far end of the distribution should be interpreted cautiously. The broader pattern, however, indicates substantially greater inpatient utilization among individuals with multiple co-occurring chronic conditions.

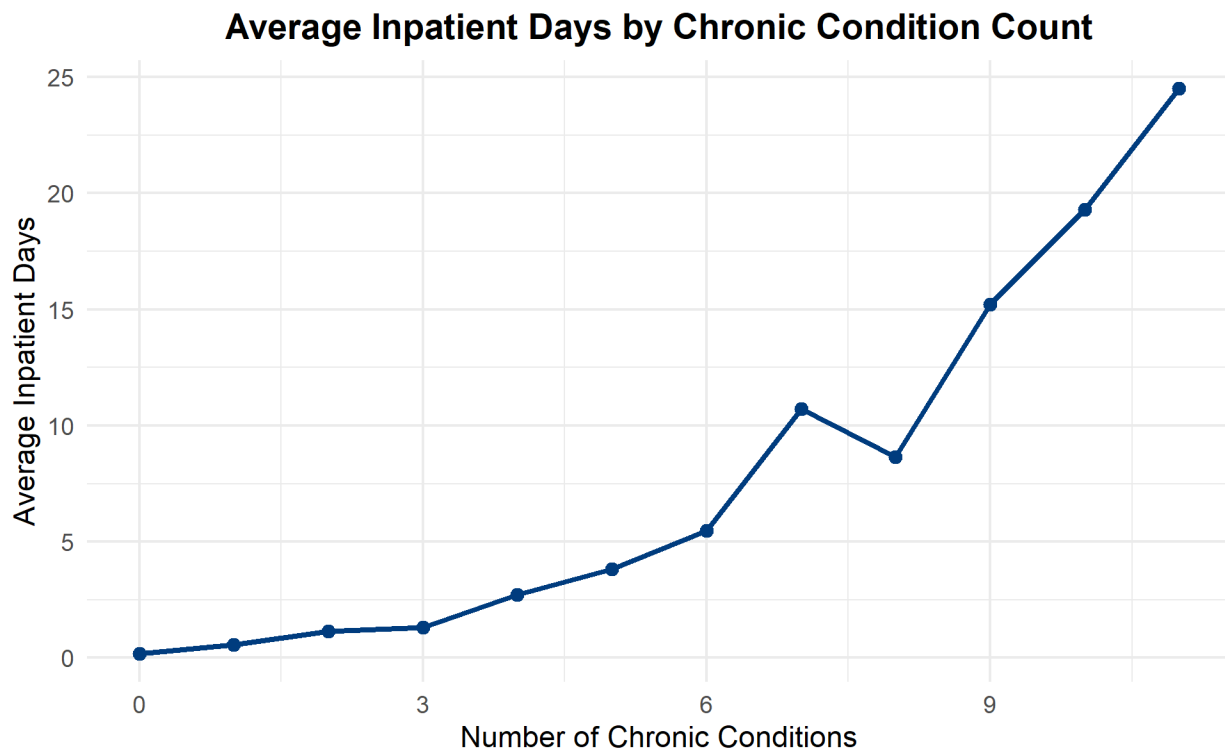


Figure 10: Average number of inpatient days among Medicaid enrollees, by total number of chronic conditions.

To identify which chronic conditions were most strongly and independently associated with inpatient hospitalization, a multivariable logistic regression model was used, predicting any inpatient hospitalization in 2025 from all conditions studied simultaneously. This approach estimates the association between each condition and hospitalization while accounting for the other conditions included in the model (LaValley, 2008).

Results are reported as adjusted odds ratios (ORs). An odds ratio greater than 1 indicates higher odds of hospitalization among individuals with the condition, while an odds ratio below 1 indicates lower odds, after accounting for the other conditions in the model.

Because very large samples can produce statistically significant results even when differences are small, statistical significance should be considered alongside the magnitude of the observed association (Peeters, 2016). For this reason, the table emphasizes conditions with **meaningfully large** associations (odds ratios greater than 1.5 or less than 0.67) rather than relying solely on statistical significance. These thresholds help distinguish conditions that may have greater practical importance for understanding hospitalization risk.

Table 21: Chronic Conditions Associated with Inpatient Hospitalization - Van Buren County			
Condition	Odds Ratio	95% CI	p-value
Sickle Cell Disease	33.51	(14.00 - 85.39)	<0.001
Social Determinants of Health	5.10	(4.24 - 6.11)	<0.001
Feeding Difficulty	4.85	(3.29 - 7.04)	<0.001
Urinary Tract Infection	3.50	(2.86 - 4.27)	<0.001
Liver Disease	2.43	(1.96 - 2.99)	<0.001
Cardiac Disease	2.32	(1.92 - 2.80)	<0.001
Epilepsy	2.21	(1.68 - 2.89)	<0.001
Traumatic Brain Injury	2.06	(1.43 - 2.91)	<0.001
GI Functional Disorder	2.02	(1.75 - 2.32)	<0.001
Tobacco Use	1.89	(1.60 - 2.22)	<0.001
Vascular Disease	1.77	(1.42 - 2.20)	<0.001
Rheumatoid Arthritis	1.76	(0.94 - 3.19)	0.068
Chronic Kidney Disease	1.73	(1.36 - 2.20)	<0.001
Lupus/SLE	1.67	(0.51 - 4.93)	0.377

Table 21: Chronic Conditions Associated with Inpatient Hospitalization - Van Buren County

Condition	Odds Ratio	95% CI	p-value
Metabolic Risk Factors	1.65	(1.46 - 1.87)	<0.001
Cancer	1.61	(1.25 - 2.05)	<0.001
COPD	1.50	(1.22 - 1.84)	<0.001
Hypothyroidism	1.24	(0.99 - 1.55)	0.058
Inflammatory Bowel Disease	1.23	(0.64 - 2.25)	0.513
Asthma	0.90	(0.74 - 1.09)	0.292
Chronic Pain/Migraine	0.81	(0.70 - 0.94)	0.007
Prediabetes	0.77	(0.56 - 1.05)	0.113
Multiple Sclerosis	0.66	(0.19 - 1.75)	0.453
Long COVID	0.23	(0.01 - 1.56)	0.207

Multivariable logistic regression predicting any inpatient hospitalization in 2025, adjusting for all conditions listed simultaneously. OR > 1 indicates increased odds of hospitalization. Bold/colored rows have a meaningfully large odds ratio (>1.5 or <0.67), not just a significant p-value.

Several chronic conditions remained strongly associated with inpatient hospitalization after accounting for the other conditions included in the model. Sickle cell disease had the strongest association, with 33.51 times the odds of hospitalization compared with individuals without the condition, holding the other modeled conditions constant. Documented Social Determinants of Health and feeding difficulty were also strongly associated with hospitalization, with adjusted odds ratios of 5.10 and 4.85, respectively.

Other conditions with meaningfully elevated and statistically significant hospitalization odds included urinary tract infection (OR 3.50), liver disease (2.43), cardiac disease (2.32), epilepsy (2.21), traumatic brain injury (2.06), GI functional disorders (2.02), tobacco use (1.89), vascular disease (1.77), chronic kidney disease (1.73), Metabolic Risk Factors (1.65), and cancer (1.61). These findings indicate that hospitalization risk is associated with a broad range of medical and social health needs rather than a single disease category.

The association observed for Social Determinants of Health is particularly notable. Although SDoH diagnoses do not represent a chronic physical disease, they were associated with more than five times the adjusted odds of hospitalization, suggesting that documented social and economic needs may be important markers of individuals at elevated risk for acute healthcare utilization.

The very large odds ratio for sickle cell disease should be interpreted alongside the wide confidence interval (14.00–85.39), which suggests greater uncertainty around the exact

magnitude of the association. Similarly, some conditions with large odds ratios, such as rheumatoid arthritis, lupus/SLE, multiple sclerosis, and Long COVID, were not statistically significant and should not be interpreted as established independent associations in this model.

While individual conditions provide useful information about hospitalization risk, the preceding analyses also demonstrate the importance of overall disease burden. Many Medicaid enrollees experience multiple chronic and behavioral health conditions simultaneously. Examining these conditions together provides a more complete picture of health complexity and its relationship with healthcare utilization than considering individual diagnoses in isolation.

7. Inpatient and Emergency Department Utilization

Emergency department visits and inpatient hospitalizations represent some of the most intensive forms of healthcare utilization. Examining these patterns helps identify populations with greater healthcare needs and may highlight opportunities for prevention, care coordination, and earlier intervention. This section summarizes inpatient and emergency department utilization during 2025 and examines how utilization varies by age and behavioral health diagnosis group.

7.1. Overview and Methods

Medicaid inpatient and emergency department (ED) encounters during 2025 were analyzed to assess patterns of acute healthcare utilization in Van Buren County. The analysis included PIHP- and CMH-funded behavioral health inpatient services, including behavioral health state inpatient services, as well as acute medical inpatient and ED services funded by Medicaid Health Plans and Medicaid Fee-for-Service.

ED visits and medical inpatient days with a primary substance use service diagnosis were not available for this report because of 42 CFR Part 2 privacy protections. As a result, ED and medical inpatient utilization among individuals with substance use disorders is underrepresented in the analyses that follow.

For this analysis, an ED visit or inpatient day was classified as behavioral when the principal service diagnosis associated with the claim was behavioral and as medical when it was not. If multiple ED claims were billed on the same day and included both behavioral and medical principal service diagnoses, the visit was counted in both categories.

7.2. Overall Utilization

The following summary provides an overview of medical and behavioral health ED and inpatient utilization during 2025. Percentages represent the proportion of enrollees with at least one visit or inpatient day, while averages reflect utilization across the full Medicaid population, including individuals with no utilization during the year.

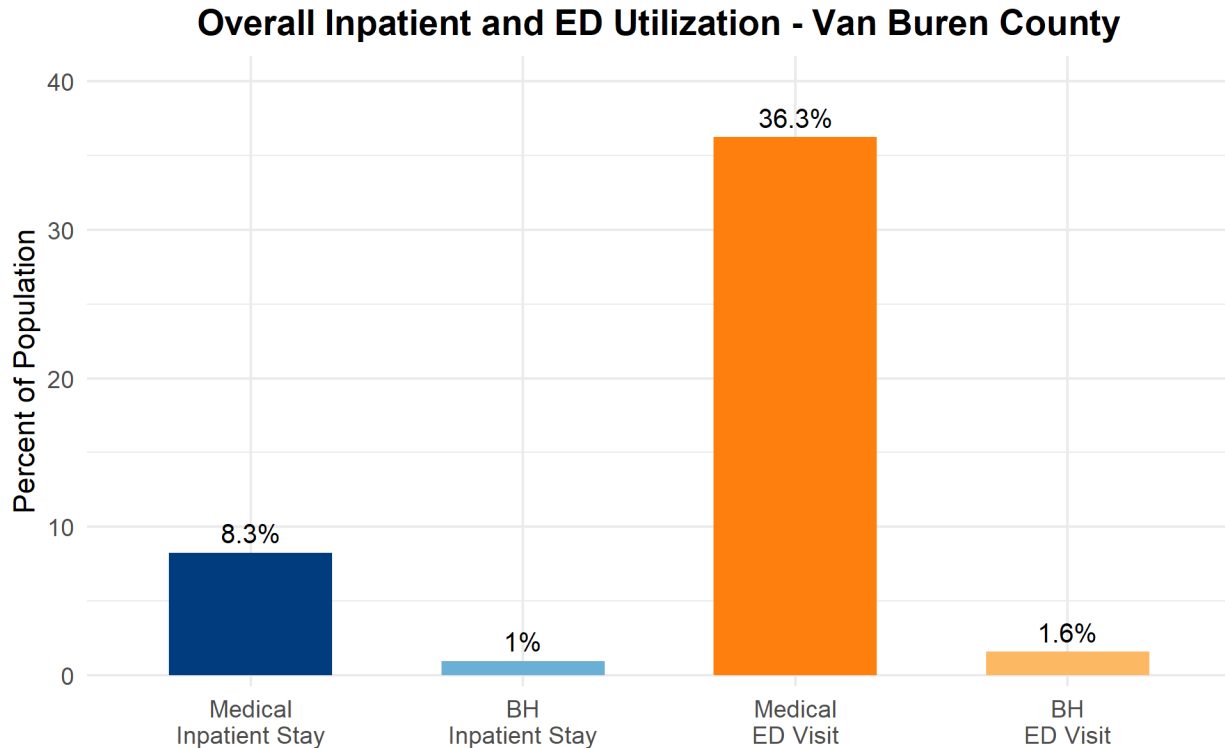


Figure 11: *Percent of Medicaid enrollees with at least one inpatient stay or emergency department visit, by service type, 2025.*

Medical emergency department use was the most common form of acute-care utilization, with 36.3% of enrollees having at least one medical ED visit during 2025. In comparison, 8.3% had at least one medical inpatient day, 1.6% had a behavioral health ED visit, and 1% had a behavioral health inpatient day. Across the full Medicaid population, enrollees averaged 2.14 medical ED visits and 0.07 behavioral health ED visits, along with 8.48 medical inpatient days and 1.78 behavioral health inpatient days.

7.3. Utilization by Age

Patterns of healthcare utilization vary across the lifespan as healthcare needs change with age. The following figures compare average medical and behavioral health ED visits and inpatient days across age groups during 2025.

7.3.1. Emergency Department Visits

The figure below compares average medical and behavioral health ED visits per enrollee across age groups.

Average BH and Medical ED Visits per Person by Age Group

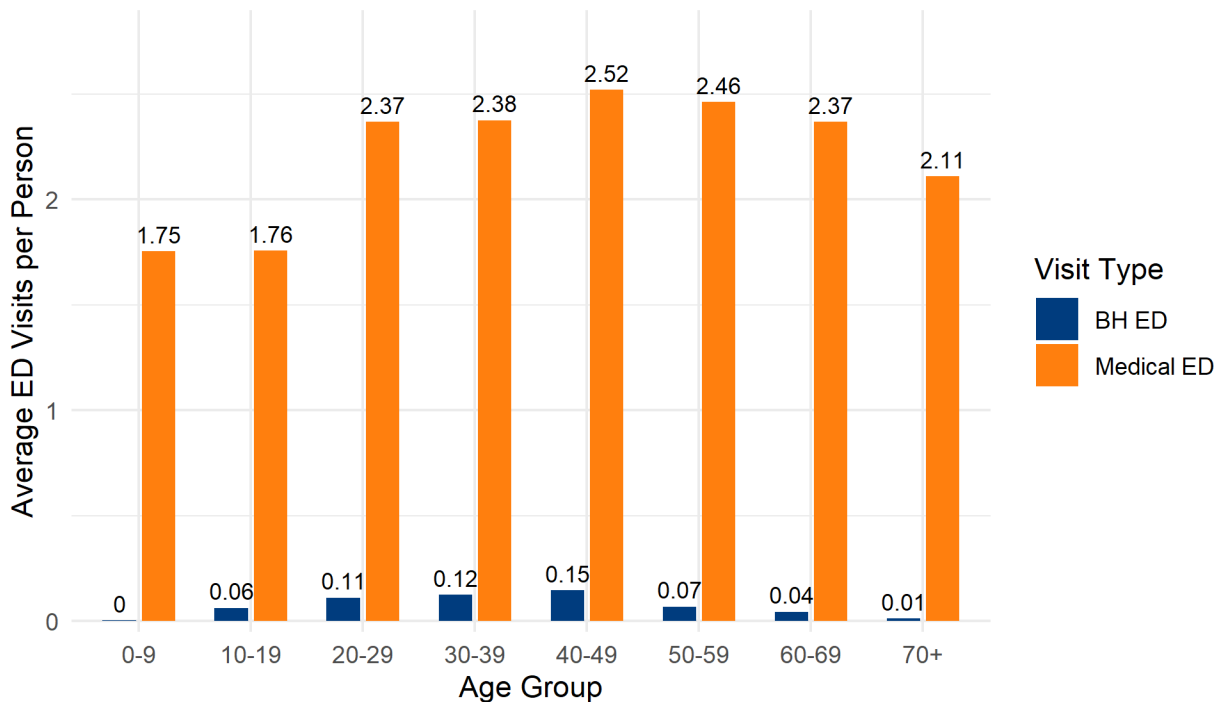


Figure 12: Average number of ED visits per Medicaid enrollee stratified by age group and visit type.

Medical ED utilization increased from childhood into middle adulthood, rising from 1.75 visits per person among ages 0–9 to a peak of 2.52 among ages 40–49. Utilization then declined gradually with age, reaching 2.11 visits per person among adults age 70 and older.

Behavioral health ED utilization was much lower overall and followed a different age pattern. Average BH ED visits increased from adolescence through early and middle adulthood, peaking among ages 40–49 at 0.15 visits per person, before declining in the older age groups.

Overall, medical ED use was highest across working-age adults, while behavioral health ED use was concentrated more narrowly in adulthood and remained substantially lower than medical ED utilization across all age groups.

7.3.2. Inpatient Utilization

The figure below compares average medical and behavioral health inpatient days per enrollee across age groups.

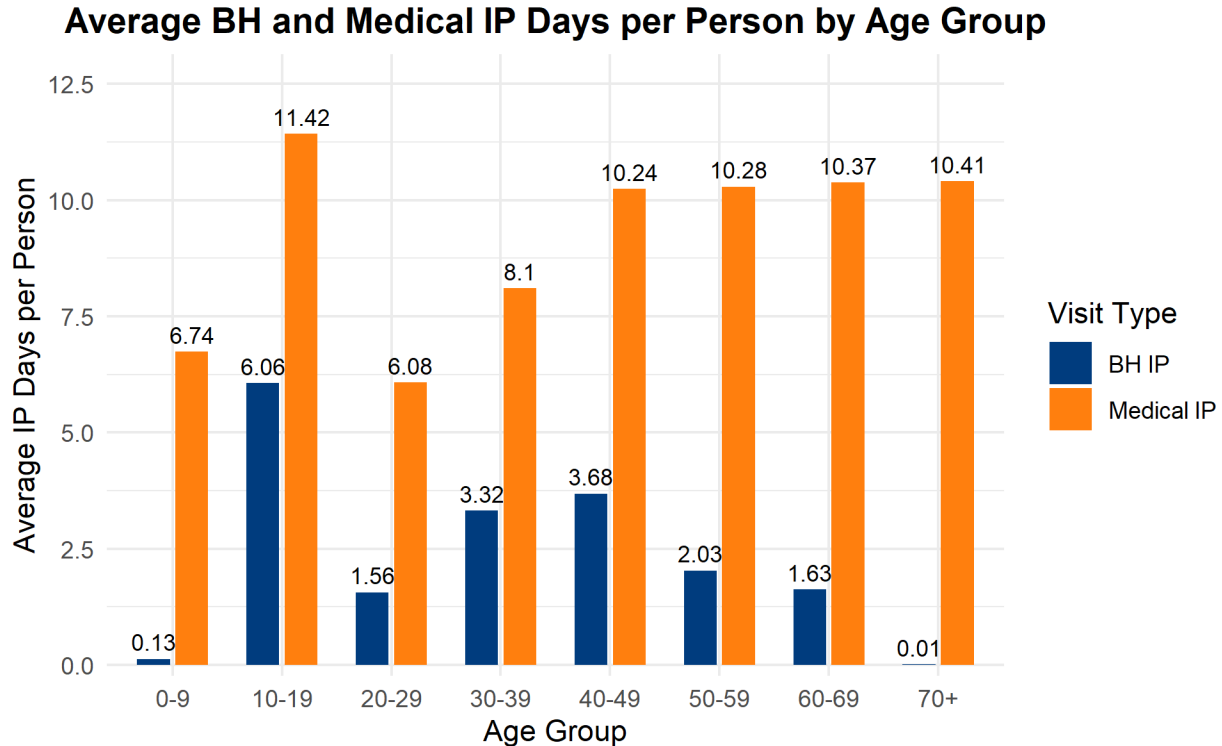


Figure 13: Average number of IP days per Medicaid enrollee stratified by age group and stay type.

Medical inpatient utilization varied across age groups rather than increasing steadily with age. The highest average number of medical inpatient days was observed among adolescents ages 10–19 at 11.42 days per person. Utilization was lower among adults ages 20–29, then increased again and remained relatively high from ages 40 through 70+, at approximately 10 days per person.

Behavioral health inpatient utilization followed a different pattern. Adolescents ages 10–19 had the highest average at 6.06 days per person, while utilization was also elevated among adults ages 30–49, reaching 3.68 days among ages 40–49. Behavioral health inpatient days then declined with age and were nearly zero among adults age 70 and older.

Overall, adolescents stand out as a particularly high-utilization group for both medical and behavioral health inpatient care, while behavioral health inpatient use remains concentrated more heavily in adolescence and middle adulthood.

7.4. Utilization Among Individuals with Behavioral Health Diagnoses

The following analyses examine medical and behavioral health utilization across the primary behavioral health diagnosis groups defined earlier in this report. Trends from 2022 through 2025 show average utilization per enrollee over time, while 2025 age-stratified comparisons help account for differences in age distribution across behavioral health populations.

For the age-stratified comparisons, each behavioral health diagnosis group is compared with enrollees in the same age bracket who had no behavioral health diagnosis. Ratios above 1 indicate higher average utilization than the same-age no-BH-diagnosis comparison group, while ratios below 1 indicate lower utilization.

7.4.1. Medical Emergency Department Visits

The figure and table below show average medical ED visits per enrollee by primary behavioral health diagnosis group from 2022 through 2025. The figure highlights changes over time, while the accompanying table provides the annual values and uses shading to make differences across groups easier to identify.

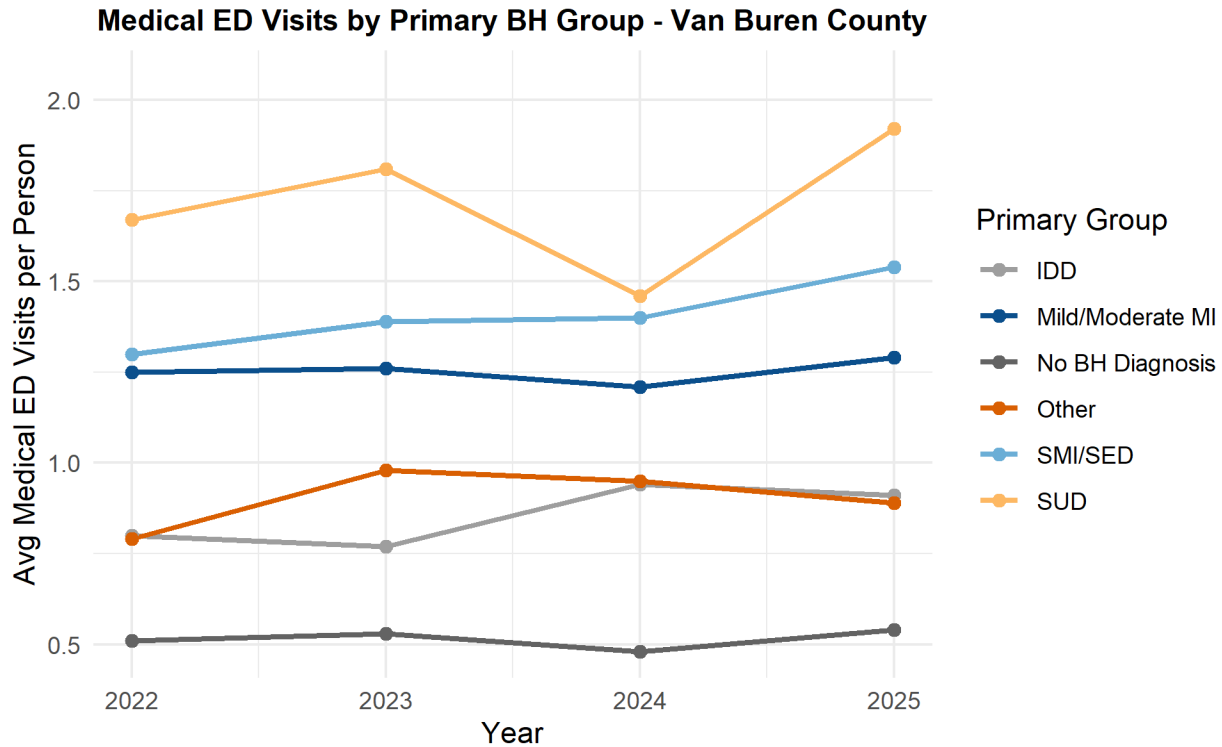


Figure 14: Average medical ED visits per person by primary BH group, 2022-2025.

Table 22. Average Medical ED Visits by Primary BH Group and Year - Van Buren County

Average visits per person, 2022-2025

Primary BH Group	2022	2023	2024	2025
IDD	0.80	0.77	0.94	0.91
Mild/Moderate MI	1.25	1.26	1.21	1.29
No BH Diagnosis	0.51	0.53	0.48	0.54
Other	0.79	0.98	0.95	0.89
SMI/SED	1.30	1.39	1.40	1.54
SUD	1.67	1.81	1.46	1.92

Medical ED utilization was consistently higher among enrollees with behavioral health diagnoses than among those with no behavioral health diagnosis. In 2025, individuals with SUD had the highest average medical ED utilization at 1.92 visits per person, followed by SMI/SED at 1.54 and Mild/Moderate MI at 1.29. Enrollees with no behavioral health diagnosis averaged 0.54 medical ED visits per person.

SMI/SED remained persistently elevated across the four-year period and increased from 1.30 visits per person in 2022 to 1.54 in 2025. SUD also remained the highest-utilization group overall, although its pattern was more variable, rising to 1.81 visits in 2023, declining to 1.46 in 2024, and then increasing to 1.92 in 2025. The remaining behavioral health groups showed smaller year-to-year changes.

The following table presents age-stratified risk ratios for having at least one medical ED visit in 2025, comparing each behavioral health diagnosis group with enrollees in the same age bracket who had no behavioral health diagnosis.

Table 23. Risk Ratios for Medical ED Visits - Van Buren County

Risk of 1+ medical ED visits compared with individuals with no BH diagnosis, by age bracket (2025)

Age Bracket	IDD	Mild/Moderate MI	Other	SMI/SED	SUD
0-9	1.24	1.21	1.28	1.37	N/A
10-19	1.41	1.53	1.34	1.97	3.83
20-29	1.41	1.90	1.63	2.13	2.25
30-39	1.25	1.73	0.88	1.68	1.99
40-49	1.04	1.61	1.41	1.66	1.80
50-59	0.81	1.91	0.50	1.85	2.11
60-69	1.77	1.79	1.25	1.70	2.37
70+	0.93	1.99	1.80	1.78	1.87

Risk ratio compares the proportion with at least one utilization event with the same-age No BH Diagnosis group. "N/A" indicates the reference group's risk was 0, so a risk ratio could not be calculated.

The elevated medical ED utilization observed among behavioral health populations remained evident when comparing the likelihood of any ED use within the same age groups. SUD and SMI/SED showed some of the highest relative risks across most age brackets. Among adolescents ages 10–19, individuals with SUD were 3.83 times as likely to have at least one medical ED visit as same-age enrollees without a behavioral health diagnosis, while those with SMI/SED were 1.97 times as likely. Elevated risk persisted throughout adulthood. SUD remained among the highest-risk groups across nearly every adult age bracket, with relative risks ranging from 1.80 to 2.37. SMI/SED was also consistently elevated, while Mild/Moderate MI showed roughly 1.6 to 2.0 times the risk across most adult age groups.

Overall, these age-stratified comparisons indicate that higher medical ED utilization among behavioral health populations is not explained by age alone. The especially high adolescent SUD risk ratio should be interpreted alongside subgroup size and the underlying reference-group event rate, since low baseline utilization can produce large relative differences.

Medical ED utilization among individuals with SUD should be interpreted cautiously because ED services with a primary substance use diagnosis are not fully represented in the available data due to 42 CFR Part 2 restrictions.

7.4.2. Behavioral Health Emergency Department Visits

The figure and table below show average behavioral health ED visits per enrollee by primary behavioral health diagnosis group from 2022 through 2025. The figure highlights changes over time, while the accompanying table provides the annual values and uses shading to make differences across groups easier to identify.

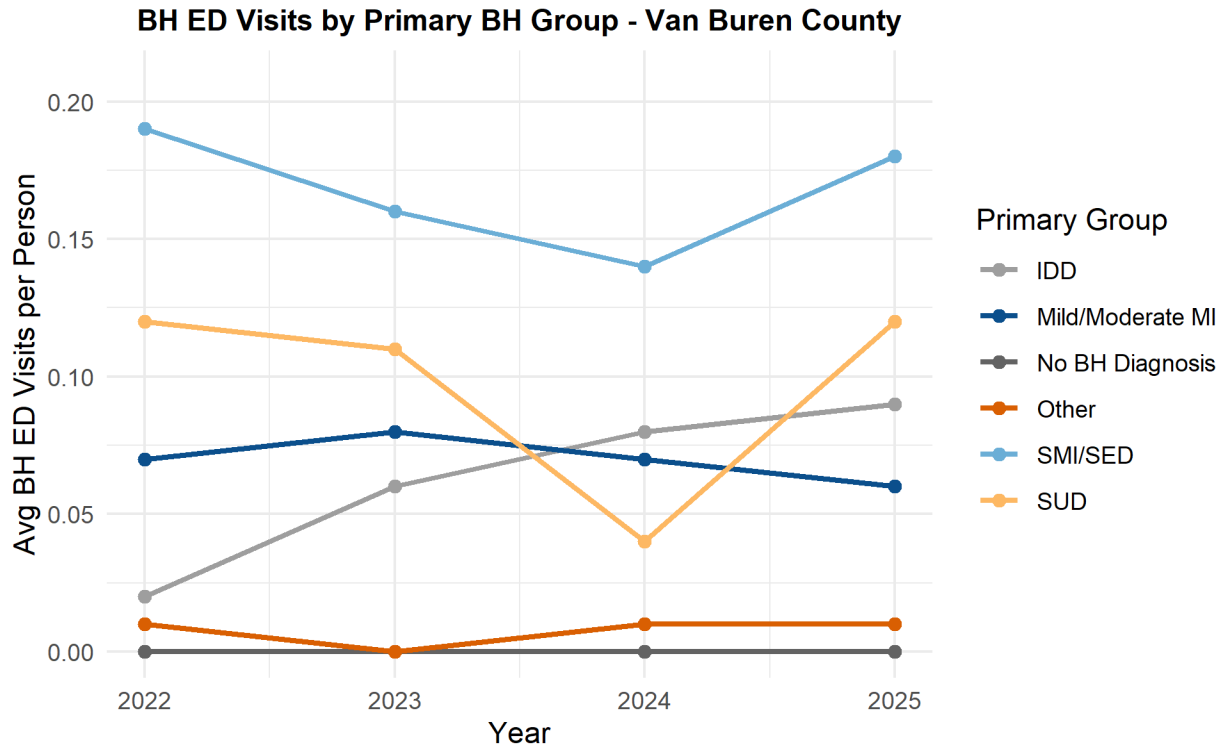


Figure 15: Average BH ED visits per person by primary BH group, 2022-2025.

Table 24. Average BH ED Visits by Primary BH Group and Year - Van Buren County

Average visits per person, 2022-2025

Primary BH Group	2022	2023	2024	2025
IDD	0.02	0.06	0.08	0.09
Mild/Moderate MI	0.07	0.08	0.07	0.06
No BH Diagnosis	0.00	0.00	0.00	0.00
Other	0.01	0.00	0.01	0.01
SMI/SED	0.19	0.16	0.14	0.18
SUD	0.12	0.11	0.04	0.12

Behavioral health ED utilization was concentrated primarily among individuals with SMI/SED and SUD. In 2025, the SMI/SED group had the highest average behavioral health ED utilization at 0.18 visits per enrollee, followed by SUD at 0.12. Utilization was substantially lower among the remaining behavioral health groups and was near zero among individuals without a behavioral health diagnosis.

SMI/SED remained the highest-utilization group throughout the study period, declining from 0.19 visits per enrollee in 2022 to 0.14 in 2024 before increasing to 0.18 in 2025. SUD showed a similar rebound, falling to 0.04 visits per enrollee in 2024 before returning to 0.12 in 2025. IDD also increased gradually from 0.02 visits per enrollee in 2022 to 0.09 in 2025, although utilization remained below the SMI/SED and SUD groups.

The following table further breaks down 2025 average utilization by age bracket to examine whether differences across primary behavioral health groups are consistent across age groups.

Table 25. Average BH ED Visits by Age Bracket and Primary BH Group - Van Buren County

Average visits per person, by age bracket (2025)

Age Bracket	IDD	Mild/Moderate MI	No BH Diagnosis	Other	SMI/SED	SUD
0-9	0.00	0.01	0.00	0.00	0.00	
10-19	0.01	0.06	0.00	0.00	0.16	0.00
20-29	0.16	0.08	0.00	0.17	0.26	0.06
30-39	0.09	0.08	0.00	0.00	0.23	0.21
40-49	0.43	0.07	0.00	0.00	0.30	0.10
50-59	0.04	0.05	0.00	0.00	0.08	0.13
60-69	0.05	0.03	0.00	0.04	0.09	0.04
70+	0.00	0.01	0.00	0.01	0.01	0.00

Age-specific patterns show that behavioral health ED utilization varied across both age and diagnosis group. SMI/SED was elevated across much of adolescence and adulthood, with the highest average in that group observed among ages 40–49 at 0.30 visits per person.

SUD-related behavioral health ED utilization was concentrated primarily among working-age adults, peaking among ages 30–39 at 0.21 visits per person. IDD showed a distinct pattern, with the highest average behavioral health ED utilization in the table among ages 40–49 at 0.43 visits per person, although utilization was much lower in most other age brackets.

Overall, crisis-oriented behavioral health ED use was concentrated in selected age and diagnosis groups rather than following a uniform pattern across the lifespan. SMI/SED remained broadly elevated, while IDD and SUD showed more age-specific peaks.

7.4.3. Medical Inpatient Utilization

The figure and table below show average medical inpatient days per enrollee by primary behavioral health diagnosis group from 2022 through 2025. The figure highlights changes over time, while the accompanying table provides the annual values and uses shading to make differences across groups easier to identify.

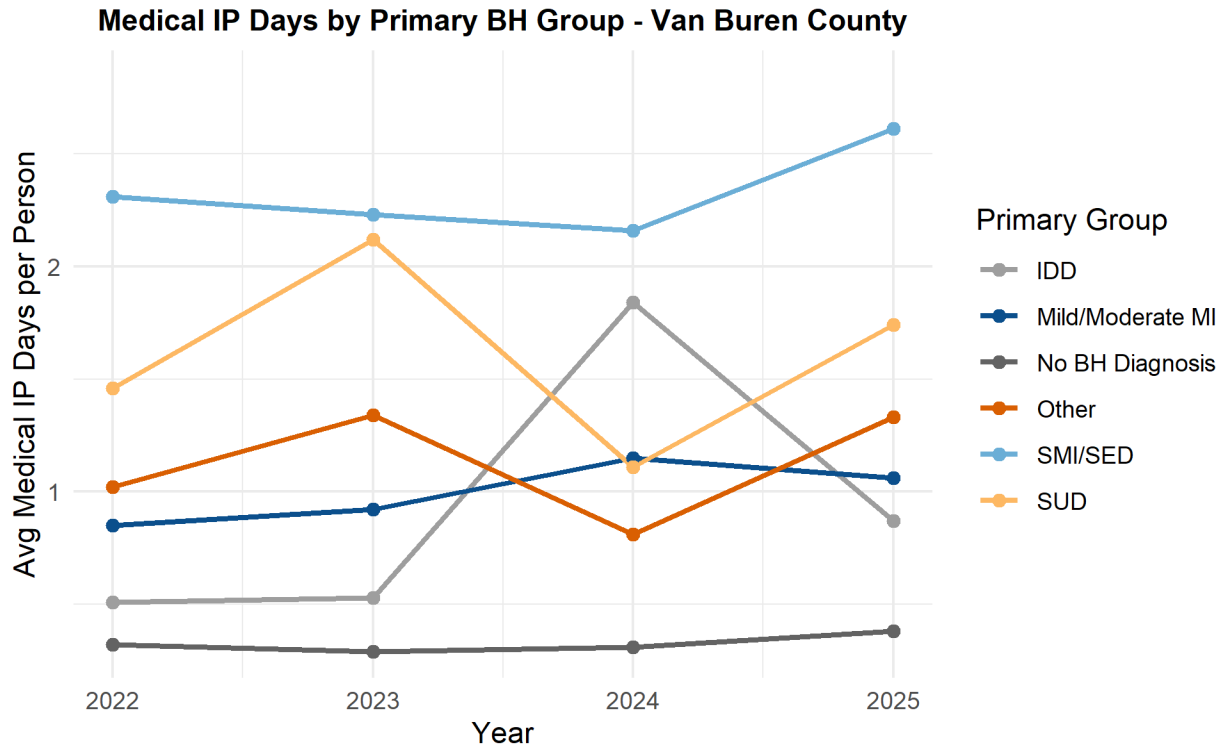


Figure 16: Average medical inpatient days per person by primary BH group, 2022-2025.

Table 26. Average Medical IP Days by Primary BH Group and Year - Van Buren County

Average days per person, 2022-2025

Primary BH Group	2022	2023	2024	2025
IDD	0.51	0.53	1.84	0.87
Mild/Moderate MI	0.85	0.92	1.15	1.06
No BH Diagnosis	0.32	0.29	0.31	0.38
Other	1.02	1.34	0.81	1.33
SMI/SED	2.31	2.23	2.16	2.61
SUD	1.46	2.12	1.11	1.74

Medical inpatient utilization was consistently higher among enrollees with behavioral health diagnoses than among those without a behavioral health diagnosis. In 2025, individuals with SMI/SED had the highest average medical inpatient utilization at 2.61 days per enrollee, followed by SUD at 1.74 days. Individuals without a behavioral health diagnosis averaged 0.38 medical inpatient days.

SMI/SED remained the highest-utilization group throughout the study period, declining from 2.31 days per enrollee in 2022 to 2.16 in 2024 before increasing to 2.61 in 2025. SUD also remained elevated but showed more year-to-year variability, peaking at 2.12 days in 2023, falling to 1.11 in 2024, and then increasing to 1.74 in 2025.

The IDD group showed a notable one-year spike in 2024 at 1.84 days per enrollee before declining to 0.87 in 2025, while the remaining groups were comparatively lower and more stable.

The following table presents age-stratified risk ratios for having any medical inpatient utilization in 2025, comparing each behavioral health diagnosis group with enrollees in the same age bracket who had no behavioral health diagnosis.

Table 27. Risk Ratios for Medical Inpatient Utilization - Van Buren County

Compared to individuals with no BH diagnosis, by age bracket (2025)

Age Bracket	IDD	Mild/Moderate MI	Other	SMI/SED	SUD
0-9	0.53	0.12	0.32	0.16	N/A
10-19	6.04	5.37	3.70	19.58	0.00
20-29	0.28	2.45	1.74	2.91	1.05
30-39	1.80	1.84	1.57	2.67	1.78
40-49	1.95	2.97	3.32	5.89	5.74
50-59	1.36	2.79	0.00	3.27	4.36
60-69	1.24	2.69	3.06	3.57	4.85
70+	0.84	2.67	2.19	2.35	5.06

Risk ratio compares the proportion with at least one utilization event with the same-age No BH Diagnosis group. "N/A" indicates the reference group's risk was 0, so a risk ratio could not be calculated.

The higher medical inpatient utilization observed among behavioral health populations remained evident when comparing the likelihood of any inpatient use within the same age groups. SMI/SED was associated with elevated hospitalization risk across nearly all adolescent and adult age brackets, with a particularly large relative risk among ages 10–19 at 19.58 compared with same-age enrollees without a behavioral health diagnosis.

Elevated risk persisted throughout adulthood. SUD showed especially high relative risks beginning in middle adulthood, including 5.74 among ages 40–49, 4.36 among ages 50–59, 4.85 among ages 60–69, and 5.06 among adults age 70 and older. Mild/Moderate MI was also consistently elevated across most adult age groups.

Overall, these age-stratified comparisons indicate that higher medical inpatient utilization among behavioral health populations is not explained by age alone. Very large risk ratios in groups with low baseline hospitalization rates should be interpreted alongside the underlying utilization rates, as relatively small absolute differences can produce large relative differences.

7.4.4. Behavioral Health Inpatient Utilization

The figure and table below show average behavioral health inpatient days per enrollee by primary behavioral health diagnosis group from 2022 through 2025. The figure highlights changes over time, while the accompanying table provides the annual values and uses shading to make differences across groups easier to identify.

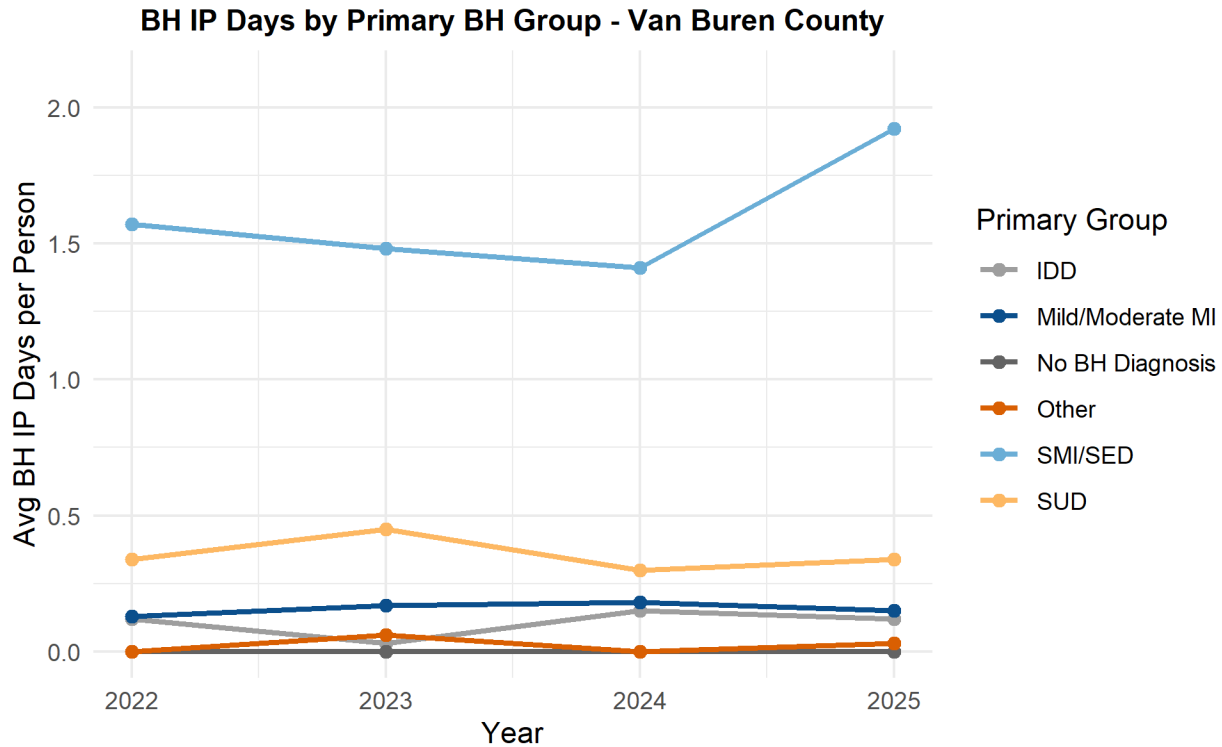


Figure 17: Average BH inpatient days per person by primary BH group, 2022-2025.

Table 28. Average BH IP Days by Primary BH Group and Year - Van Buren County

Average days per person, 2022-2025

Primary BH Group	2022	2023	2024	2025
IDD	0.12	0.03	0.15	0.12
Mild/Moderate MI	0.13	0.17	0.18	0.15
No BH Diagnosis	0.00	0.00	0.00	0.00
Other	0.00	0.06	0.00	0.03
SMI/SED	1.57	1.48	1.41	1.92
SUD	0.34	0.45	0.30	0.34

Behavioral health inpatient utilization was most heavily concentrated among individuals with SMI/SED throughout the study period. Average behavioral health inpatient days in this group declined slightly from 1.57 days per enrollee in 2022 to 1.41 in 2024 before increasing substantially to 1.92 in 2025.

SUD had the second-highest utilization in 2025 at 0.34 days per enrollee, although its pattern was relatively stable overall, ranging from 0.30 to 0.45 days across the four years. Utilization remained much lower among the IDD, Mild/Moderate MI, and Other groups and was near zero among individuals without a behavioral health diagnosis.

Overall, the 2025 increase in SMI/SED inpatient utilization stands out as the most notable change in this table and reinforces the concentration of behavioral health inpatient use among individuals with more severe or complex behavioral health needs.

The following table breaks the 2025 average down further by age bracket, to show whether the relationship between primary BH group and BH inpatient utilization holds consistently across age groups.

Table 29. Average BH IP Days by Age Bracket and Primary BH Group - Van Buren County

Average days per person, by age bracket (2025)

Age Bracket	IDD	Mild/Moderate MI	No BH Diagnosis	Other	SMI/SED	SUD
0-9	0.35	0.06	0.00	0.00	0.00	
10-19	0.00	0.18	0.00	0.00	1.96	0.00
20-29	0.00	0.21	0.00	0.73	1.85	0.00
30-39	0.12	0.18	0.00	0.00	2.31	0.53
40-49	0.00	0.15	0.00	0.00	2.38	0.24
50-59	0.27	0.14	0.00	0.00	1.57	0.58
60-69	0.00	0.09	0.00	0.00	2.60	0.18
70+	0.00	0.01	0.00	0.00	0.00	0.00

SMI/SED had the highest average behavioral health inpatient utilization across most adolescent and adult age groups. Utilization was elevated beginning in adolescence and remained high through much of adulthood, with the highest average observed among ages 60–69 at 2.60 days per person. SMI/SED utilization was also particularly high among ages 30–49, ranging from 2.31 to 2.38 days per person.

SUD-related behavioral health inpatient utilization was concentrated among working-age adults, with the highest averages observed among ages 50–59 (0.58 days) and 30–39 (0.53 days). Other notable age-specific patterns included 0.73 inpatient days among ages 20–29 in the Other group and 0.35 days among children ages 0–9 in the IDD group.

7.5. Medical Emergency Department and Hospital Utilization by Type of Behavioral Health Diagnosis

The analyses above compare utilization across the broader primary behavioral health diagnosis groups used throughout this report. The following figure provides a more detailed view by examining the most common specific behavioral health diagnosis categories.

Average medical ED visits and medical inpatient days are shown together to illustrate how patterns of acute medical utilization differ across behavioral health diagnoses. Diagnosis categories appearing farther to the right have higher average medical ED utilization, while those appearing higher on the figure have higher average medical inpatient utilization.

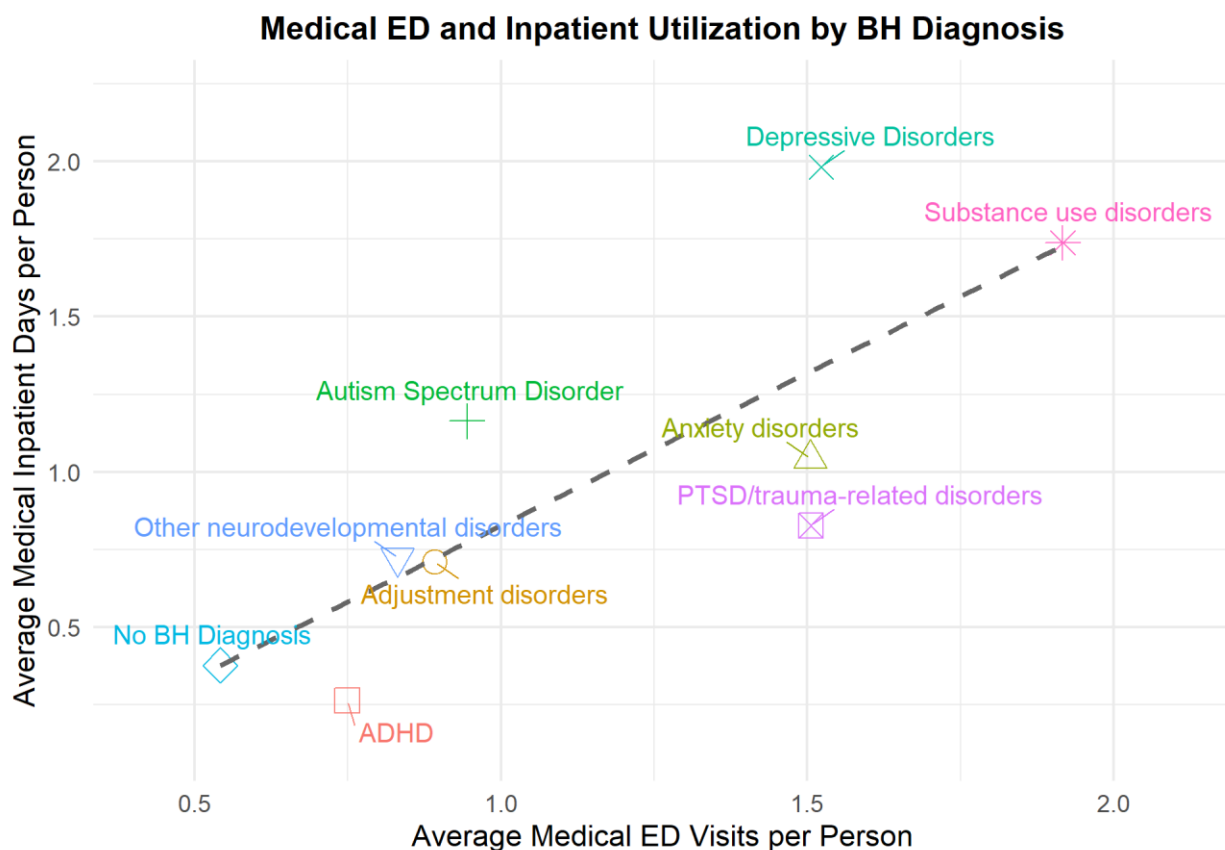


Figure 18: Average medical ED visits and inpatient days per Medicaid enrollee among the most common behavioral health diagnosis categories.

Acute medical utilization differed substantially across specific behavioral health diagnosis categories. Substance use disorders had the highest average medical ED utilization at approximately 1.9 visits per person and also showed high inpatient utilization at about 1.7 days per person. Depressive disorders had the highest average medical inpatient utilization at approximately 2.0 days per person, with medical ED utilization also elevated.

The figure also shows that higher medical ED utilization does not always correspond directly with higher inpatient utilization. Autism spectrum disorder, for example, had comparatively moderate ED use but relatively high inpatient utilization, while trauma-related diagnoses showed relatively high ED utilization with lower inpatient use. Anxiety disorders fell between these patterns, with elevated ED use but more moderate inpatient utilization.

These differences suggest that specific behavioral health conditions may be associated with distinct patterns of acute medical need and may require different approaches to care coordination and prevention. Medical ED and inpatient utilization among individuals with substance use disorders may be underrepresented because services with a primary substance use diagnosis are not fully available in the data.

Together, these analyses demonstrate that healthcare utilization varies substantially across behavioral health populations. Differences are evident in both emergency department and inpatient use and persist across multiple years and age groups. The consistently elevated utilization observed among populations with SMI/SED, SUD, and several specific serious behavioral health diagnoses reinforces the importance of integrated medical and behavioral health care, care coordination, and strategies aimed at reducing avoidable acute-care use.

8. Multimorbidity and Hospitalization Risk

8.1. Overview and Methodology

Individuals with multiple chronic and behavioral health conditions often have more complex healthcare needs, making care coordination, resource planning, and prevention efforts more challenging (Skou et al., 2022). Understanding which conditions commonly occur together can help identify groups of individuals with similar healthcare needs and support more targeted interventions.

To better understand these patterns, this report uses **latent class analysis (LCA)**. LCA is a statistical method used to identify unobserved groups within a population based on patterns across multiple observed characteristics (Sinha et al., 2021). Rather than examining one diagnosis at a time, LCA considers an individual's broader pattern of chronic and behavioral health conditions and groups people with similar profiles together. Unlike approaches that require disease combinations to be defined in advance, LCA identifies these patterns directly from the data. LCA has been used in healthcare research to identify patterns of multimorbidity and examine differences in healthcare utilization across the resulting groups (Whitson et al., 2016).

The analysis was conducted once at the regional level using all SWMBH Medicaid enrollees who were ever diagnosed with at least one condition of interest between 2022 and 2025. Based on the overall patterns of co-occurring conditions, six distinct multimorbidity classes were identified:

- **Low Diagnosis Complexity** - Few diagnosed chronic or behavioral health conditions, with no condition strongly elevated relative to the other classes.
- **Metabolic Health Complexity** - Predominantly characterized by metabolic syndrome, with modest elevations in related chronic conditions such as cardiac disease, chronic kidney disease, prediabetes, and tobacco use.
- **Anxiety and Depressive Disorders** - Primarily characterized by elevated anxiety and depressive disorders, with some additional behavioral health conditions but comparatively lower chronic physical health burden.
- **High Chronic Complexity** - Multiple co-occurring chronic physical health conditions, including metabolic, cardiovascular, gastrointestinal, respiratory, kidney, liver, vascular, and chronic pain-related conditions.
- **Neurodevelopmental Disorders & IDD** - Predominantly characterized by ADHD, other neurodevelopmental conditions, impulse control or conduct disorders, and intellectual/developmental disabilities.
- **Complex Behavioral Health** - Multiple co-occurring behavioral health conditions, including anxiety, depression, PTSD, bipolar disorder, substance use disorders, schizophrenia or psychosis, personality disorders, and related conditions.

Every enrollee in the ever-diagnosed 2022–2025 population was assigned to the single class that best matched their overall pattern of diagnoses. Because class assignment was

based on diagnoses accumulated over the full four-year period, the classes represent longer-term health profiles rather than an individual's health status during 2025 alone.

Once each enrollee was assigned to a multimorbidity class, the classes were examined to better understand how common each health profile was within the population and whether different profiles were associated with differences in healthcare utilization. Rather than focusing on individual diagnoses, the following analyses compare groups of individuals with similar overall patterns of chronic and behavioral health conditions.

8.2. Multimorbidity Class Diagnosis Profiles

The figure below illustrates the diagnosis patterns that distinguish the six multimorbidity classes. Each cell represents the estimated probability that an enrollee assigned to a class had a particular chronic or behavioral health condition. Darker shading and higher percentages indicate that the condition was more characteristic of that class. These probabilities describe the profile of each class and should not be interpreted as the percentage of the full Medicaid population with the condition.

The multimorbidity classes and diagnosis profiles shown here were developed using the full SWMBH regional population. The same regional class definitions were then applied in each county report, allowing class distributions and outcomes to be compared consistently across the region. The figure is therefore identical across the regional and county reports, while the class distribution and utilization results that follow are specific to Van Buren County.

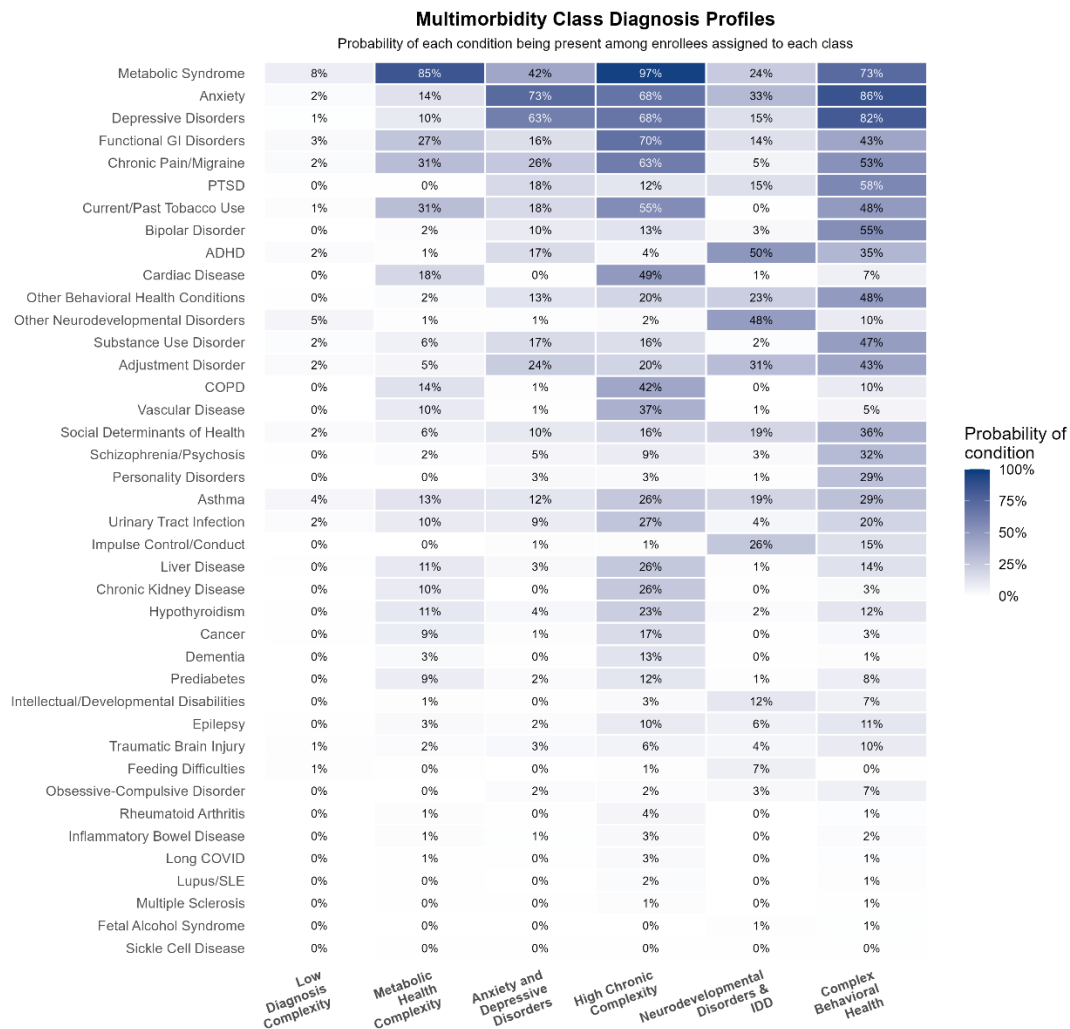


Figure 19: Estimated probability of each condition being present within each regionally defined multimorbidity class.

The six classes reflect distinct patterns of physical and behavioral health complexity. Low Diagnosis Complexity is characterized by relatively low probabilities across nearly all conditions, while Metabolic Health Complexity is dominated by metabolic syndrome and related chronic conditions. Anxiety and Depressive Disorders is distinguished primarily by anxiety and depression with comparatively lower physical health burden. High Chronic Complexity shows broad elevation across multiple physical health conditions, particularly metabolic, cardiac, gastrointestinal, respiratory, kidney, liver, and pain-related diagnoses. Neurodevelopmental Disorders & IDD is characterized by ADHD, other neurodevelopmental conditions, impulse control/conduct disorders, and IDD, while Complex Behavioral Health shows the broadest concentration of co-occurring behavioral health diagnoses, including anxiety, depression, PTSD, bipolar disorder, SUD, schizophrenia/psychosis, and personality disorder.

8.3. Class Distribution and Utilization

The following table summarizes the distribution of multimorbidity classes within the ever-diagnosed Medicaid population and compares emergency department utilization and inpatient utilization across classes. Together, these measures illustrate how overall health complexity is associated with healthcare utilization.

Table 30: Multimorbidity Class Distribution and Utilization - Van Buren County				
Multimorbidity Class	N	% of Population	ED per 1,000	IP per 1,000
Low Diagnosis Complexity	20,569	57.4%	385.3	293.9
Metabolic Health Complexity	4,530	12.6%	842.7	1,013.1
Anxiety and Depressive Disorders	5,306	14.8%	896.8	504.4
High Chronic Complexity	2,246	6.3%	1,956.8	2,939.4
Neurodevelopmental Disorders & IDD	1,950	5.4%	780.7	877.9
Complex Behavioral Health	1,211	3.4%	2,663.8	3,179.1

Ever-diagnosed population, 2022-2025. Utilization rates are annualized averages across each person's active years.

Most individuals in the ever-diagnosed population were classified as Low Diagnosis Complexity (57.4%), followed by Anxiety and Depressive Disorders (14.8%) and Metabolic Health Complexity (12.6%). The more complex classes represented substantially smaller portions of the population. Despite their smaller size, Complex Behavioral Health and High Chronic Complexity had markedly higher acute-care utilization than the other multimorbidity groups. Together, these two classes represented only 9.7% of the ever-diagnosed population but had the highest ED and inpatient utilization rates.

Complex Behavioral Health had the highest ED utilization at 2,663.8 visits per 1,000 person-years and the highest inpatient utilization at 3,179.1 per 1,000 person-years. High Chronic Complexity was similarly elevated, with 1,956.8 ED visits and 2,939.4 inpatient events per 1,000 person-years.

The following figure provides a visual summary of the distribution of multimorbidity classes within the Medicaid population.

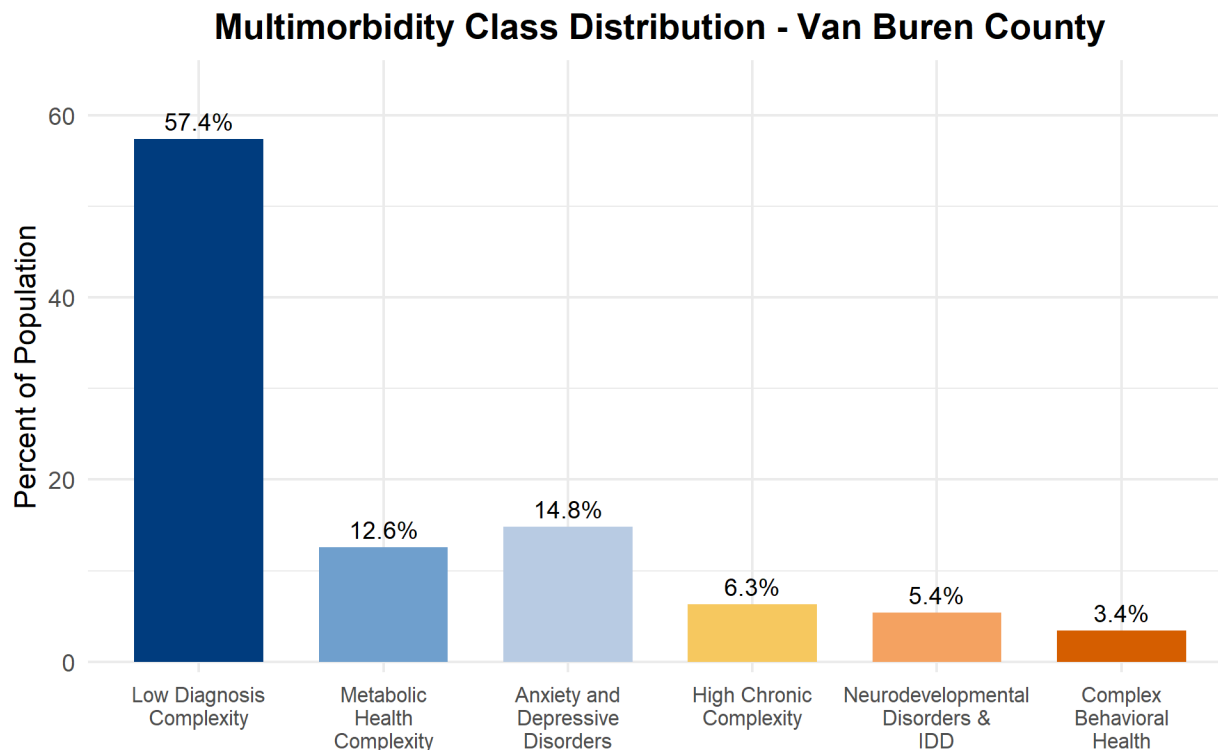


Figure 20: *Percent of the ever-diagnosed population in each multimorbidity class.*

Most individuals in the ever-diagnosed population were classified as Low Diagnosis Complexity (57.4%), followed by Anxiety and Depressive Disorders (14.8%) and Metabolic Health Complexity (12.6%). The more complex classes represented smaller shares of the population, including High Chronic Complexity at 6.3%, Neurodevelopmental Disorders & IDD at 5.4%, and Complex Behavioral Health at 3.4%.

Despite their smaller size, the Complex Behavioral Health and High Chronic Complexity classes may represent particularly important populations for intensive care coordination, transitions-of-care interventions, and strategies addressing co-occurring behavioral and physical health needs because of their high acute-care utilization.

Comparing emergency department and inpatient utilization across multimorbidity classes helps identify which health profiles are associated with the greatest use of acute healthcare services. The following figure presents annualized utilization rates for each class.

ED and IP Utilization by Multimorbidity Class - Van Buren County

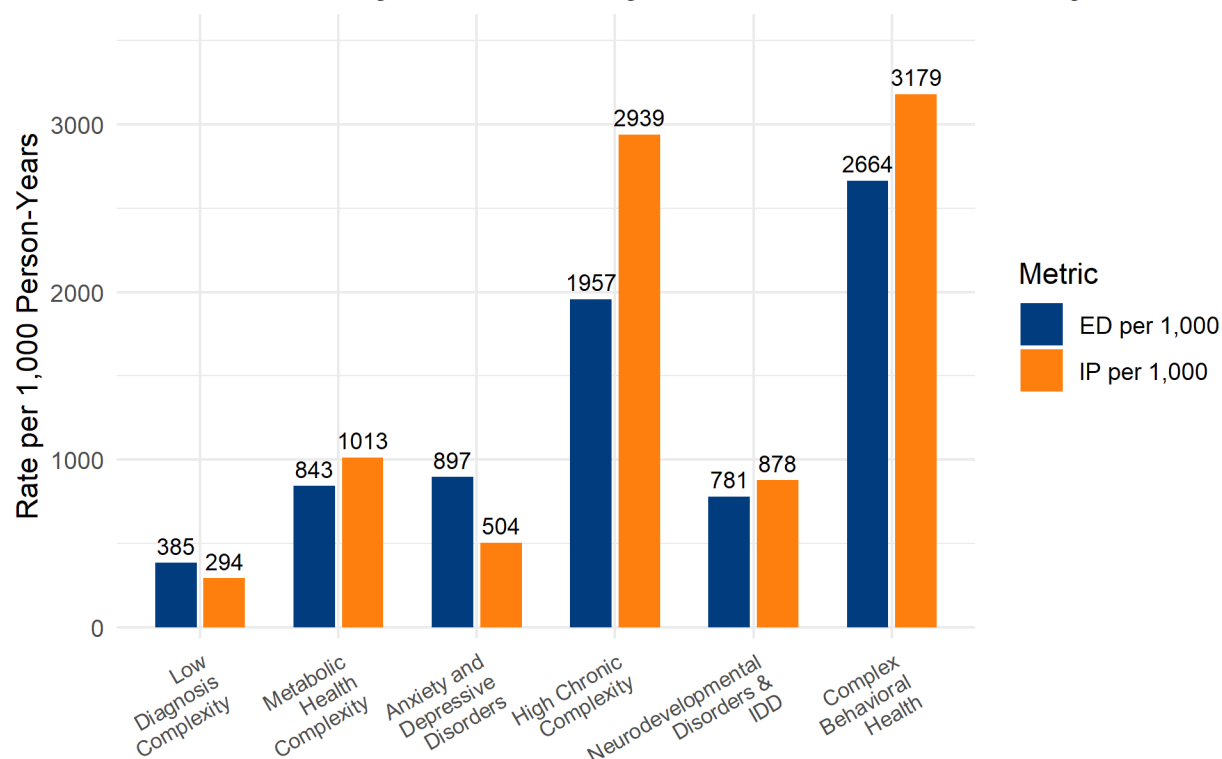


Figure 21: Average ED and IP utilization rates per 1,000 person-years, by multimorbidity class.

Acute-care utilization varied substantially across multimorbidity classes. Complex Behavioral Health had the highest ED utilization at 2,664 visits per 1,000 person-years and the highest inpatient utilization at 3,179 per 1,000 person-years. High Chronic Complexity was similarly elevated, with 1,957 ED visits and 2,939 inpatient events per 1,000 person-years.

The remaining classes had substantially lower acute-care utilization. Metabolic Health Complexity had 843 ED visits and 1,013 inpatient events per 1,000 person-years, while Neurodevelopmental Disorders & IDD had 781 and 878, respectively. Anxiety and Depressive Disorders showed a different pattern, with ED utilization (897 per 1,000) exceeding inpatient utilization (504 per 1,000).

Overall, the findings identify Complex Behavioral Health and High Chronic Complexity as particularly high-utilization populations while also showing that different multimorbidity profiles are associated with distinct patterns of ED and inpatient use.

9. Healthcare Quality and Medication Monitoring

9.1. Disease Management Metrics

Monitoring adherence to evidence-based clinical guidelines helps identify opportunities to improve healthcare quality and prevent avoidable complications. This section summarizes selected adult disease management measures reported through the Relias Population Performance platform. These measures evaluate whether eligible Medicaid enrollees received recommended monitoring or treatment for selected conditions.

Measure direction varies across the analyses in this section. For disease management measures, higher percentages generally indicate better adherence to recommended care. Medication utilization rates are descriptive and do not have an inherently favorable direction. For pharmacy quality indicators, lower triggering rates are generally preferable because higher rates indicate that a greater proportion of individuals met criteria for a situation warranting clinical review. Specific interpretation guidance is provided with each analysis. Individuals dually eligible for Medicare and Medicaid are excluded because complete Medicare claims were not available for this analysis.

Table 31. Adult Disease Management Metric Completion - Van Buren County

Percent completed, 2025

Metric ID	Quality Metric	SWMBH	Van Buren
343	Presence of at least 84 days of continuous treatment with an Antidepressant medication	62.7%	63.1%
515	Adherence to Mood Stabilizer medications for individuals with bipolar disorder	55.6%	58.3%

Van Buren County performed slightly above the SWMBH regional rate on both adult disease management measures. Continuous antidepressant treatment was completed for 63.1% of eligible adults compared with 62.7% regionally. Adherence to mood stabilizer medications among individuals with bipolar disorder was 58.3% in Van Buren County compared with 55.6% across the SWMBH region.

The difference was modest for antidepressant continuity but somewhat more pronounced for mood stabilizer adherence, suggesting comparatively stronger performance in Van Buren County on both measures, particularly adherence to mood stabilizer treatment.

9.2. Behavioral Pharmacy Analysis

Medication use and medication management are important components of behavioral healthcare quality. The following analyses summarize behavioral health medication utilization, pharmacy quality indicators, and associations between pharmacy quality indicators and hospitalization among adults and children.

9.2.1. Adults

9.2.1.1. Adult General Behavioral Pharmacy Use Data

The following table summarizes behavioral health medication utilization among adults in 2025 and compares Van Buren County with the overall SWMBH region. Medication utilization rates are descriptive and should not be interpreted as measures in which a higher or lower percentage necessarily represents better performance. Differences may reflect variation in diagnoses, clinical need, prescribing practices, or other population characteristics.

Table 32. Adult Behavioral Health Medication Utilization - Van Buren County

<i>Percent utilizing, 2025</i>		
Medication Class	SWMBH	Van Buren
Opioids	4.2%	5.1%
Insomnia Agents	3.0%	2.8%
ADHD: Stimulants	2.8%	2.3%
Antipsychotics	5.5%	5.2%
Antidepressants	14.5%	14.1%
Antidepressants: SSRIs	8.7%	8.3%
Mood Stabilizers	2.7%	2.6%
Benzodiazepines	3.4%	3.7%
ADHD Medication	3.3%	2.8%
Antidepressants: TCAs	1.2%	1.4%

Antidepressants were the most commonly utilized behavioral health medication class among adults in Van Buren County, with 14.1% receiving an antidepressant and 8.3% receiving an SSRI. Antipsychotics were used by 5.2% of adults, while opioids were used by 5.1%. Benzodiazepines were used by 3.7%, ADHD medications by 2.8%, and mood stabilizers by 2.6%.

Compared with the SWMBH region overall, Van Buren County had somewhat higher utilization of opioids (5.1% vs. 4.2%), benzodiazepines (3.7% vs. 3.4%), and TCAs (1.4% vs. 1.2%). In contrast, utilization of antidepressants, SSRIs, antipsychotics, ADHD medications, stimulants, insomnia agents, and mood stabilizers was slightly lower than the regional rate. Overall, adult medication utilization in Van Buren County was broadly similar to the regional pattern, with opioid use standing out as the clearest area of higher utilization.

9.2.1.2. Adult Quality Indicator Triggering Rates

Pharmacy quality indicators identify medication-related situations that may warrant additional clinical review. For these measures, lower triggering rates are generally preferable because a higher percentage indicates that more individuals met the criteria for a potential medication-management concern. Triggering an indicator does not, however, confirm inappropriate care for any individual.

Table 33. Adult Pharmacy Quality Indicator Triggering Rates - Van Buren County

Percent triggered, 2025

Metric ID	Quality Metric	SWMBH	Van Buren
214	Failure to Refill Antipsychotic Medication	11.2%	9.3%
217	Use of four or more psychotropic medications for 60 or more days	3.5%	7.8%
231	Use of Opioids and Benzodiazepines for 30 or More Days	35.3%	51.5%
283	Multiple prescribers of the same class of psychotropic medications for 45 or more days	3.9%	5.0%

Among adults in Van Buren County, the most common pharmacy quality indicator was concurrent use of opioids and benzodiazepines for 30 or more days, which triggered for 51.5% of the population evaluated for that measure. Use of four or more psychotropic medications for 60 or more days triggered for 7.8%, multiple prescribers of the same psychotropic medication class for 45 or more days triggered for 5.0%, and failure to refill antipsychotic medication triggered for 9.3%.

Compared with the SWMBH regional population, Van Buren County had substantially higher triggering rates for concurrent opioid and benzodiazepine use (51.5% vs. 35.3%) and use of four or more psychotropic medications (7.8% vs. 3.5%). The multiple-prescriber indicator was also somewhat higher (5.0% vs. 3.9%). In contrast, failure to refill antipsychotic medication was lower in Van Buren County (9.3% vs. 11.2%).

These patterns may identify areas for additional clinical review or medication-management monitoring, particularly concurrent opioid and benzodiazepine use and psychotropic polypharmacy. A higher triggering rate, however, should not be interpreted on its own as evidence of inappropriate prescribing or care without additional clinical context.

9.2.1.3. Adult Hospitalization Rates by Quality Indicator

The following table compares hospitalization rates among adults with and without each pharmacy quality indicator. Rates are expressed per 100 individuals, and relative risks compare each quality indicator group with adults who triggered no pharmacy quality indicators.

Table 34. Adult Hospitalization Rates by Pharmacy Quality Indicator - Van Buren County

Hospitalizations per 100, with risk ratio vs. no QIs triggered (2025)

Metric ID	Quality Indicator	N	% of Population	Total / 100	RR - Total	BH / 100	RR - BH	Non-BH / 100	RR - Non-BH
1	No QIs Triggered	10,574	95.0%	8.6	Ref.	0.7	Ref.	7.9	Ref.
2	1+ QIs Triggered	557	5.0%	40.0	4.67 ↑	7.0	10.14 ↑	33.0	4.19 ↑
515	Adherence to Mood Stabilizer medications for individuals with bipolar disorder	30	0.3%	33.3	3.89 ↑	16.7	24.19 ↑	16.7	2.12 ↑
231	Use of opioids and benzodiazepines for 30 or more days	47	0.4%	19.1	2.23 ↑	2.1	3.04 ↑	17.0	2.16 ↑
343	Presence of at least 84 days of continuous treatment with an Antidepressant medication	154	1.4%	18.8	2.20 ↑	8.4	12.17 ↑	10.4	1.32 ↑
214	Failure to refill antipsychotic medication within 30 days of the prescription ending	52	0.5%	26.9	3.14 ↑	5.8	8.40 ↑	21.2	2.69 ↑
217	Use of four or more psychotropic medications for 60 or more days	110	1.0%	24.5	2.86 ↑	10.9	15.79 ↑	13.6	1.73 ↑
283	Multiple prescribers of the same class of psychotropic medications for 45 or more days	84	0.8%	58.3	6.81 ↑	21.4	31.00 ↑	36.9	4.69 ↑

Shading with an arrow identifies meaningfully elevated (red ↑, RR > 1.20) or lower (green ↓, RR < 0.83) risk ratios. "Ref." indicates the no-QI reference group.

Adults who triggered at least one pharmacy quality indicator experienced substantially higher hospitalization rates than those who triggered none. Individuals with one or more indicators had 40.0 hospitalizations per 100 people, compared with 8.6 per 100 among adults with no indicators, corresponding to 4.67 times the overall hospitalization risk. Elevated risk was observed for both behavioral health and non-behavioral health hospitalizations.

Several individual indicators were also associated with markedly elevated hospitalization risk. Multiple prescribers of the same psychotropic medication class showed the strongest overall association, with 58.3 hospitalizations per 100 and 6.81 times the overall hospitalization risk of the reference population. It was also associated with the highest

behavioral health hospitalization risk at 31.00 times the reference level and 4.69 times the non-behavioral health hospitalization risk.

Use of four or more psychotropic medications and the mood stabilizer adherence indicator were also strongly associated with behavioral health hospitalization, with risk ratios of 15.79 and 24.19, respectively. Continuous antidepressant treatment and failure to refill antipsychotic medication were similarly associated with elevated behavioral health hospitalization risk. Concurrent opioid and benzodiazepine use showed a more moderate pattern, with 2.23 times the overall hospitalization risk and elevated risk for both behavioral health and non-behavioral health hospitalization.

These findings do not establish that medication-related indicators caused hospitalization. Rather, the indicators may identify individuals with greater clinical complexity, medication-management challenges, or care-coordination needs who are also at elevated risk for acute-care utilization. Several individual indicator groups were relatively small, so particularly large risk ratios should be interpreted alongside the underlying hospitalization rates and group sizes.

9.2.2. Children and Adolescents

The same pharmacy analyses were performed for children and adolescents. Because medication recommendations and quality indicators differ between pediatric and adult populations, separate results are presented below.

9.2.2.1. Child General Behavioral Pharmacy Use Data

The following table summarizes behavioral health medication utilization among children and adolescents. As with the adult analysis, medication utilization rates are descriptive and do not have an inherently favorable higher or lower direction.

Table 35. Pediatric Behavioral Health Medication Utilization - Van Buren County

Percent utilizing, 2025

Medication Class	SWMBH	Van Buren
Opioids	0.4%	0.4%
Insomnia Agents	0.5%	0.5%
ADHD: Stimulants	5.4%	4.7%
Antipsychotics	1.6%	1.4%
Antidepressants	3.1%	3.1%
Antidepressants: SSRIs	2.6%	2.6%
Mood Stabilizers	0.6%	0.5%
Benzodiazepines	0.3%	0.3%
ADHD Medication	6.1%	5.2%
Antidepressants: TCAs	0.2%	0.2%

ADHD medications were the most commonly utilized behavioral health medication class among children and adolescents in Van Buren County, with 5.2% receiving an ADHD medication and 4.7% receiving a stimulant. Antidepressants were used by 3.1% of the pediatric population, including 2.6% receiving an SSRI, while antipsychotics were used by 1.4%.

Compared with the SWMBH region overall, pediatric medication utilization in Van Buren County was generally similar. ADHD medications and stimulants were somewhat lower (5.2% vs. 6.1% and 4.7% vs. 5.4%, respectively), as were antipsychotics (1.4% vs. 1.6%) and mood stabilizers (0.5% vs. 0.6%). Antidepressants, SSRIs, opioids, insomnia agents, benzodiazepines, and TCAs were essentially the same as the regional rates.

9.2.2.2. Child Quality Indicator Triggering Rates

Pediatric pharmacy quality indicators identify medication-related situations that may warrant additional clinical review. Lower triggering rates are generally preferable for each of the indicators presented below; however, triggering an indicator does not by itself indicate inappropriate prescribing or care.

Table 36. Pediatric Pharmacy Quality Indicator Triggering Rates - Van Buren County

Percent triggered, 2025

Metric ID	Quality Metric	SWMBH	Van Buren
214	Failure to Refill Antipsychotic Medication	10.0%	3.6%
283	Multiple prescribers of the same class of psychotropic medications for 45 or more days	1.6%	3.6%
301	Use of Antipsychotic Medication for Member Under the Age of 18 Diagnosed with ADHD	49.8%	52.4%

Pediatric pharmacy quality indicator triggering rates varied substantially by measure. The most common indicator in Van Buren County was antipsychotic use among children diagnosed with ADHD, which triggered for 52.4% of the eligible population. Multiple prescribers of the same psychotropic medication class triggered for 3.6%, while failure to refill antipsychotic medication triggered for 3.6%.

Compared with the SWMBH region, Van Buren County had a substantially lower rate of failure to refill antipsychotic medication (3.6% vs. 10.0%). In contrast, the multiple-prescriber indicator was higher (3.6% vs. 1.6%), as was antipsychotic use among children diagnosed with ADHD (52.4% vs. 49.8%).

These indicators identify situations that may warrant additional clinical review but should not be interpreted on their own as evidence of inappropriate prescribing or care without additional clinical context.

9.2.2.3. Child Hospitalization Rates by Quality Indicator

The following table compares hospitalization rates across pediatric pharmacy quality indicator groups using the same methodology described for adults.

Table 37. Pediatric Hospitalization Rates by Pharmacy Quality Indicator - Van Buren County

Hospitalizations per 100, with risk ratio vs. no QIs triggered (2025)

Metric ID	Quality Indicator	N	% of Population	Total / 100	RR - Total	BH / 100	RR - BH	Non-BH / 100	RR - Non-BH
1	No QIs Triggered	7,577	98.9%	3.9	Ref.	0.2	Ref.	3.7	Ref.
2	1+ QIs Triggered	86	1.1%	11.6	2.97 ↑	3.5	18.94 ↑	8.1	2.18 ↑
283	Multiple prescribers of the same class of psychotropic medications for 45 or more days	16	0.2%	25.0	6.40 ↑	12.5	67.65 ↑	12.5	3.36 ↑
214	Failure to refill antipsychotic medication within 30 days of the prescription ending (any diagnosis)	4	0.1%	25.0	6.40 ↑	0.0	0.00 ↓	25.0	6.72 ↑
301	Use of Antipsychotic Medication for Member Under the Age of 18 Diagnosed with ADHD	58	0.8%	6.9	1.77 ↑	0.0	0.00 ↓	6.9	1.85 ↑

Shading with an arrow identifies meaningfully elevated (red ↑, RR > 1.20) or lower (green ↓, RR < 0.83) risk ratios. "Ref." indicates the no-QI reference group.

Children and adolescents who triggered at least one pharmacy quality indicator had higher hospitalization rates than those who triggered none. The overall hospitalization rate was 11.6 per 100 among children with one or more indicators compared with 3.9 per 100 among those with none, corresponding to 2.97 times the overall hospitalization risk. Elevated risk was observed for both behavioral health and non-behavioral health hospitalization.

Multiple prescribers of the same psychotropic medication class showed the strongest behavioral health hospitalization pattern. Among the 16 children triggering this indicator, the overall hospitalization rate was 25.0 per 100, with 12.5 behavioral health hospitalizations per 100 and a behavioral health risk ratio of 67.65 compared with children triggering no indicators.

Failure to refill antipsychotic medication was also associated with a high overall hospitalization rate of 25.0 per 100, although this group included only four children. No behavioral health hospitalizations were observed in this group; the elevated overall risk was driven by non-behavioral health hospitalization, which was 6.72 times the reference level. Antipsychotic use among children diagnosed with ADHD showed a more modest increase in overall hospitalization risk (RR 1.77) and was also driven by non-behavioral health hospitalization.

These results should be interpreted cautiously because several pediatric indicator groups were very small and the behavioral health hospitalization rate in the reference group was only 0.2 per 100. Small group sizes and low baseline rates can produce very large relative risk estimates. Across adults and children in Van Buren County, pharmacy quality indicators identified relatively small populations with elevated hospitalization risk, although the type and strength of association varied substantially by indicator. These findings do not establish that medication-related concerns caused hospitalization but may help identify individuals with greater clinical complexity or care-coordination needs.

Together, these quality measures provide additional context regarding medication management, adherence to recommended care, and populations that may benefit from further clinical review. They complement the diagnosis, utilization, and multimorbidity presented earlier in the report.

10. Conclusion

This Population Health Analysis brings together demographic, behavioral health, chronic physical health, healthcare utilization, multimorbidity, and healthcare quality information to provide a broad view of the health needs of Medicaid enrollees in Van Buren County. Examining these areas together demonstrates that population health needs are not defined by individual diagnoses alone; behavioral, physical, social, and service-use patterns frequently overlap and are associated with substantially different levels of healthcare utilization and support need.

The 2025 population should be interpreted in the context of a changing Medicaid enrollment profile. Total enrollment declined substantially from 2024, while the percentage of enrollees receiving at least one Medicaid service increased from 78.6% to 82.1%. Behavioral health diagnosis prevalence increased in the full annual population but remained largely stable among members enrolled in both 2024 and 2025, suggesting that population turnover contributed to the observed change. Chronic condition prevalence showed a different pattern, with increases remaining evident in the matched population and particularly notable growth in Metabolic Risk Factors.

Several findings point to populations with overlapping behavioral and physical health needs. Chronic condition prevalence was substantially higher among individuals with behavioral health diagnoses, while dual-eligible adults showed greater chronic disease burden than non-dual adults within the same broad age groups. Increasing chronic-condition burden was also strongly associated with inpatient utilization, and documented Social Determinants of Health emerged as an important marker of hospitalization risk. Together, these findings reinforce the value of care approaches that consider medical, behavioral, and social needs concurrently.

Acute-care utilization was particularly concentrated among individuals with more complex health profiles. SMI/SED and SUD populations experienced elevated medical ED and inpatient utilization across many age groups, while the Complex Behavioral Health and High Chronic Complexity multimorbidity classes had the highest overall acute-care utilization. These patterns suggest that individuals with severe behavioral health needs or substantial chronic disease burden may be especially important populations for care coordination, crisis prevention, transitions of care, and integrated physical and behavioral health strategies.

Healthcare quality and pharmacy analyses identify additional opportunities for focused review. Van Buren County performed slightly above the regional rate on the adult disease-management measures examined, while elevated triggering rates for concurrent opioid and benzodiazepine use, psychotropic polypharmacy, and multiple prescribers identify medication-management patterns that may warrant further clinical review. The strong associations between several pharmacy quality indicators and hospitalization suggest that these measures may also help identify individuals with greater clinical complexity or care-coordination needs.

Overall, the findings support a population health approach that distinguishes between different forms of complexity rather than treating high need as a single category. Priorities

for continued monitoring and analysis include individuals with SMI/SED or complex behavioral health needs, members with high chronic disease burden or documented social needs, dual-eligible adults with elevated medical complexity, and medication-management quality indicators associated with hospitalization. Findings should be interpreted alongside local knowledge of service availability, access to care, population characteristics, and documentation practices; observed differences and associations can identify areas for attention but do not, by themselves, establish why those patterns occurred.

11. References

Atella, V., Piano Mortari, A., Kopinska, J., Belotti, F., Cricelli, C., Lapi, F., & Fontana, L. (2019). Trends in age-related disease burden and healthcare utilization. *Aging Cell*, 18(1), e12861. <https://doi.org/10.1111/accel.12861>

Centers for Disease Control and Prevention. (2026). *About chronic diseases*. <https://www.cdc.gov/chronic-disease/about/index.html>

Fox, M. H., & Reichard, A. (2013). Disability, health, and multiple chronic conditions among people eligible for both medicare and medicaid, 2005–2010. *Preventing Chronic Disease*, 10, E157. <https://doi.org/10.5888/pcd10.130064>

LaValley, M. P. (2008). Logistic regression. *Circulation*, 117(18), 2395–2399. <https://doi.org/10.1161/CIRCULATIONAHA.106.682658>

McQueen, A., Li, L., Herrick, C. J., Verdecias, N., Brown, D. S., Broussard, D. J., Smith, R. E., & Kreuter, M. (2021). Social needs, chronic conditions, and health care utilization among medicaid beneficiaries. *Population Health Management*, 24(6), 681–690. <https://doi.org/10.1089/pop.2021.0065>

Peeters, M. J. (2016). Practical significance: Moving beyond statistical significance. *Currents in Pharmacy Teaching and Learning*, 8(1), 83–89. <https://doi.org/10.1016/j.cptl.2015.09.001>

Sinha, P., Calfee, C. S., & Delucchi, K. L. (2021). Practitioner’s guide to latent class analysis: Methodological considerations and common pitfalls. *Critical Care Medicine*, 49(1), e63–e79. <https://doi.org/10.1097/CCM.0000000000004710>

Skou, S. T., Mair, F. S., Fortin, M., Guthrie, B., Nunes, B. P., Miranda, J. J., Boyd, C. M., Pati, S., Mtenga, S., & Smith, S. M. (2022). Multimorbidity. *Nature Reviews Disease Primers*, 8(1), 48. <https://doi.org/10.1038/s41572-022-00376-4>

Watson, K. B., Wiltz, J. L., Nhim, K., Kaufmann, R. B., Thomas, C. W., & Greenlund, K. J. (2025). Trends in multiple chronic conditions among US adults, by life stage, behavioral risk factor surveillance system, 2013–2023. *Preventing Chronic Disease*, 22, E15. <https://doi.org/10.5888/pcd22.240539>

Whitson, H. E., Johnson, K. S., Sloane, R., Cigolle, C. T., Pieper, C. F., Landerman, L., & Hastings, S. N. (2016). Identifying patterns of multimorbidity in older Americans: Application of latent class analysis. *Journal of the American Geriatrics Society*, 64(8), 1668–1673. <https://doi.org/10.1111/jgs.14201>