2024 Medicaid Provider Experience Survey

Last revised: March 5, 2025

Produced by the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill

Suggested report citation:
DeWalt DA, Rivadeneira NA, Agans R, Zadrozny S, Chen P, Lewis VA. *2024 Medicaid Provider Experience Survey.* North Carolina Medicaid 1115 Waiver Independent Evaluation. Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. March 5, 2025.

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LIST OF ABBREVIATIONS

Abbreviation	Definition
NC Medicaid	North Carolina Medicaid Program
PHP(s)	Prepaid Health Plan(s)
Ob/Gyn	Obstetrics and Gynecology
ACO	Accountable Care Organizations
TPs	Tailored Plans
SPs	Standard Plans
VBP	Value-based payment
Wave 4	Fourth survey round, representing third year of Prepaid Health Plans
BCBSNC	Blue Cross Blue Shield of North Carolina
DHHS	North Carolina Department of Health and Human Services
DHB	Division of Health Benefits
NPI	National Provider Identifier
Wave 3	Third survey round, representing second year of Prepaid Health Plans
Wave 2	Second survey round, representing first year of Prepaid Health Plans
UNC-CH	Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill
CSRL	Carolina Survey Research Laboratory
CI	Confidence Interval

EXECUTIVE SUMMARY

The North Carolina (NC) Medicaid program transitioned from predominately fee-for-service to managed care through the offering of Prepaid Health Plans (PHPs) with the 1115 Medicaid Waiver. This transition has been coined as North Carolina Medicaid Transformation. The North Carolina Provider Experience Survey was developed to evaluate the influence of NC Medicaid Transformation on primary care and obstetrics/gynecology (Ob/Gyn) practices that contract with Medicaid. It was administered across all North Carolina independent primary care practices, medical groups, and health care systems that provide primary care or Ob/Gyn care.

In this report, findings are described from the fourth assessment of provider experience with the NC Medicaid program. The survey was conducted from April 10 to June 30, 2024, representing experience with the PHPs from the third year of Medicaid managed care. As Tailored Plans (TPs) were not available during survey fielding, PHPs refer to the five Standard Plans (SPs) available at the time. New additions to this year's survey are the inclusion of experience with their largest commercial payor, questions on Accountable Care Organization (ACO) or Value Based Payment (VBP) arrangements with Medicaid and commercial payors, and questions on perceptions of Medicaid expansion. We refer to this year's survey of the third year into managed care as Wave 4.

The five PHPs had high rates of contracting with provider organizations in our study. Of our respondents, contracting levels with each of the five PHPs ranged from 83.0% to 96.9%. Respondents rated their experience across fourteen domains representing dimensions of administrative and clinical functions of the PHPs, using a scale from "poor" (equivalent to 1 numerically) to "excellent" (equivalent to 4). **Figures E1** and **E2** compare the first, second, and third years of managed care for each of these domains. Mean overall ratings for the five plans ranged from 2.50 to 2.64. Overall, in the third year of managed care, there was a notable divergence of PHP ratings within performance domains (**Table E1**). That is, providers generally rated some plans worse and some plans better on a domain (e.g., provider relations overall, timeliness to answer questions and/or resolve problems, timeliness of claims processing).

Although most variation remains across domains, an emergent trend this year is growing differential performance across the PHPs (**Table E2**). Blue Cross Blue Shield of North Carolina (BCBSNC) Healthy Blue had a higher proportion of positive provider experience across the majority of performance domains, whereas AmeriHealth Caritas was underperforming. Overall, all plans were performing worse in Wave 4 compared with the first year of managed care in at least half of the domains.

PHPs were comparatively worse than a practice's largest commercial payor by substantial margins in all domains except for support with social determinants of health. These findings indicate that provider experience with Medicaid was worse due to several factors – and not only that Medicaid may pay lower rates than private payers. Even apart from increasing reimbursement, Medicaid can likely substantially improve provider experience through improving the operations of Medicaid managed care.

Exhibit E1. Experience and satisfaction with administrative domains: by year after transition to PHPs

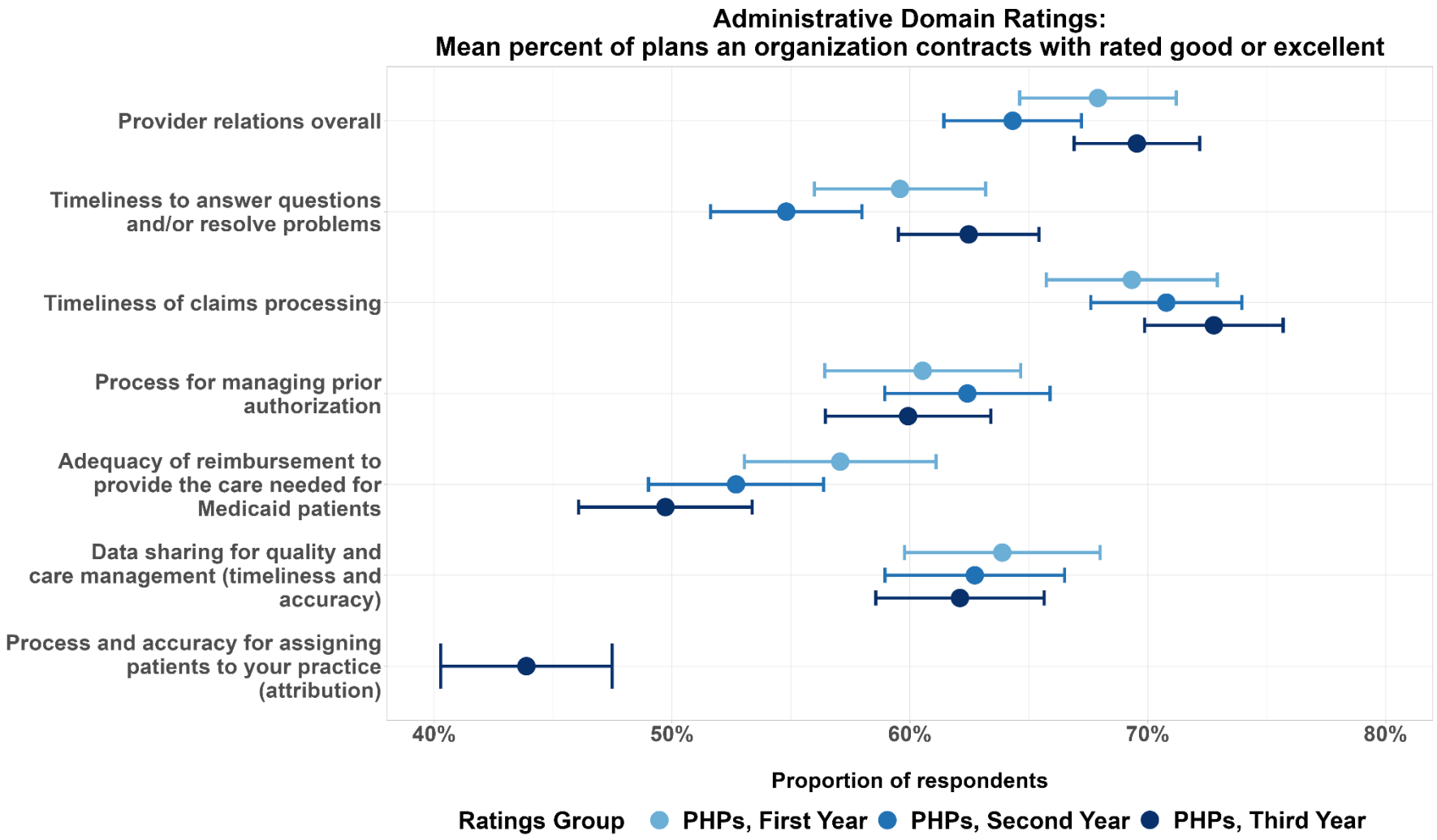


Exhibit E2. Experience and satisfaction with clinical domains: by year after transition to PHPs

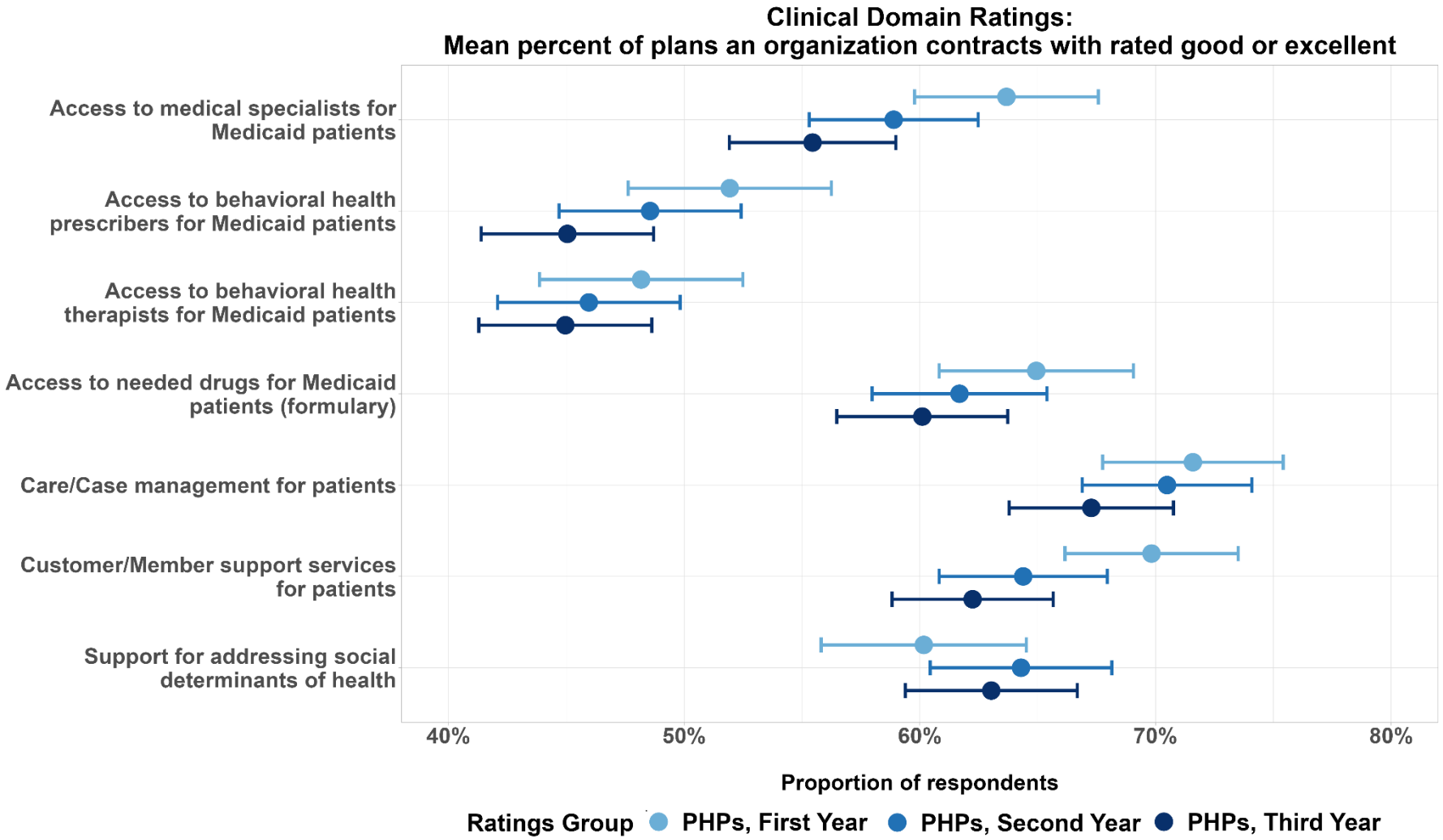


Exhibit E3. PHP differences in average predicted probabilities* of respondents rating domain 'Good' or 'Excellent', third year into managed care (Wave 4) vs first year into managed care (Wave 2)

	AmeriHealth Caritas	BCBSNC Healthy Blue	UnitedHealthcare	WellCare Health Plans	Carolina Complete Health
Provider relations overall	-4.7%‡	2.3%	2.3%	2.6%	5.1%‡
Timeliness to answer questions and/or resolve problems	-1.3%	1.2%	2.2%	5.6%‡	6.4%‡
Timeliness of claims processing	-1.1%	1.1%	2.3%	3.3%‡	4.4%‡
Process for managing prior authorizations	-0.4%	1.4%	1.7%	0.9%	-0.6%
Adequacy of reimbursement to provide the care needed for Medicaid	-7.0%‡	-10.3%‡	-4.5%‡	-5.2%‡	-0.9%
Access to medical specialists for Medicaid patients	-4.8%‡	-2.6%	-5.1%‡	-4.3%‡	-2.6%
Access to behavioral health prescribers for Medicaid patients	-4.4%	-6.7%‡	-7.1%‡	-4.6%‡	-4.8%‡
Access to behavioral health therapists for Medicaid patients	-0.2%	-0.9%	-1.5%	-0.1%	-0.1%
Access to needed drugs for Medicaid patients (formulary)	-0.1%	-0.1%	-0.1%	-0.2%	-0.1%
Care/Case management for patients	-0.1%	-0.1%	-0.1%	-0.1%	0.0%
Customer/Member support services for patients	-5.4%‡	-2.2%‡	-3.8%‡	-2.1%	-2.6%
Support for addressing social determinants of health	0.1%	0.1%	0.0%	0.1%	0.1%
Data sharing for quality and care management (timeliness and accuracy) ‡	-2.2%	-1.7%	-1.0%	-1.2%	-0.3%

*Average predicted probabilities derived from mixed effect logistic regression model, adjusting for Wave 3 and PHP
†Average predicted probabilities derived from fixed effect logistic regression model, adjusting for Wave 3 and PHP
‡Significant difference as determined by the overlap of the 95% confidence interval (CI) no more than about half the margin of error.
Orange represents significantly difference, blue significantly higher.

Exhibit E4. Proportion of respondents rating domain 'Good' or 'Excellent', by PHPs and largest commercial payor

	AmeriHealth Caritas	BCBSNC Healthy Blue	United-Healthcare	WellCare Health Plans	Carolina Complete Health	Largest Commercial Payor	Legacy Medicaid
Provider relations overall	61%	78%	69%	66%	72%	84%	74%
Timeliness to answer questions and/or resolve problems	54%	68%	62%	61%	66%	78%	61%
Timeliness of claims processing	66%	75%	74%	71%	72%	86%	79%
Process for managing prior authorizations	54%	61%	61%	56%	59%	72%	61%
Adequacy of reimbursement to provide the care needed for Medicaid	46%	49%	48%	48%	51%	72%	56%
Access to medical specialists for Medicaid patients	51%	60%	54%	52%	55%	86%	57%
Access to behavioral health prescribers for Medicaid patients	42%	44%	42%	41%	43%	64%	38%
Access to behavioral health therapists for Medicaid patients	43%	44%	42%	42%	43%	65%	36%
Access to needed drugs for Medicaid	58%	60%	60%	58%	59%	75%	56%

patients (formulary)							
Care/Case management for patients	64%	67%	66%	66%	66%	74%	72%
Customer/Member support services for patients	56%	66%	61%	59%	61%	76%	--
Support for addressing social determinants of health	59%	63%	61%	60%	61%	63%	64%
Data sharing for quality and care management (timeliness and accuracy)	59%	64%	64%	60%	60%	74%	62%
Process and accuracy for assigning patients to your practice (Attribution)	41%	44%	44%	42%	44%	70%	--

Note: 'Customer/Member support services for patients' and 'Process and accuracy for assigning patients to your practice' were not asked in 2021 Baseline Survey(Wave 1).

Key Findings

- Rates of contracting with each of the five available PHPs ranged from **83.0% to 96.9%**, and the organizations contracted with an **average of 4.6 plans.**
- **93.9%** of respondents reported they **did not anticipate dropping any standard plan PHP contracts** in the coming year.
- **Meaningful differences** were found in provider experience with PHPs overall compared to performance in prior years.
    - Domains in which some PHPs had continued improvement were provider relations overall, timeliness to answer questions and/or resolve problems, and timeliness of claims processing
    - PHPs have performed successively worse each year on the following domains: adequacy of reimbursement to provide the care needed for Medicaid patients, access to medical specialists for Medicaid patients, access to behavioral health prescribers for Medicaid patients, and access to needed drugs for Medicaid patients (formulary).
- Overall, providers rated their experience with plans on clinical domains (e.g., access to specialists) worse than on administrative domains (e.g., claims processing).
- Apart from addressing social determinants of health, PHPs performed worse in all domains compared to the largest commercial payor they contract with.
- **Large differences began to emerge** between specific PHPs on some performance domains, although some key patterns across plans emerged.
    - As noted in Exhibit E3, PHPs worsened in more domains than they improved.
    - On domains where some plans improved, the biggest gains were in provider relations overall, timeliness to answer questions and/or resolve problems, timeliness of claims processing.
    - There were larger differences between PHPs this year than the prior year, particularly for administrative domains. BCBSNC Healthy Blue rated higher in most domains and AmeriHealth Caritas underperformed compared to other PHPs.
- Rates of having value-based payment or shared risk arrangement with any of the PHPs ranged from **33.3% to 43.0%.**
- A large portion of respondents remained unclear on medical home attestation: **37.2%** of organizations providing primary care responded that they did not know what tier of medical home they attested to with the state of North Carolina.
- **73.0%** of respondents believed Medicaid expansion will either slightly or substantially increase the number of Medicaid patients in their organization.
- **44.1%** of respondents believed Medicaid expansion will either somewhat or very positively affect their organization.
- Medicaid expansion is viewed mostly favorably by providers. Most indicate that they will be seeing more patients with Medicaid and the vast majority indicate that expansion will have neutral or positive effects on their practice's health.
- Open-ended comments revealed **continued administrative burden** in sustaining multiple PHP relationships, which providers say has ultimately placed financial strain on provider

organizations, harmed patient access to care, and has imposed stress on the healthcare system more broadly.

- Large provider organizations rated their experience with the health plans worse than smaller provider organizations (**see Appendix Exhibits A1-A6**). Overall ratings for PHPs averaged 2.54 for small provider organizations (1-2 providers) and 2.38 for larger provider organizations (>=10 providers).
- No substantive differences in experience were found when comparing rural versus non-rural provider organizations (**see Appendix Exhibits A7-A12**).
- Ob/Gyn provider organizations rated their experience with the health plans worse than provider organizations that do not provide Ob/Gyn care. (**see Appendix Exhibits A13-A18**). Overall ratings for PHPs averaged 2.33 for Ob/Gyn providers and 2.50 for provider organizations that do not provide Ob/Gyn care.
- Provider perceptions of the overall Medicaid transformation trended slightly better than prior years (**Exhibit 46**), particularly patient experience. **37-45%** of providers felt the Medicaid transformation had made no difference in cost, quality, access, provider experience, and patient experience. **16-38%** believed the transformation has worsened these areas.

Recommendations for the Division of Health Benefits

- Results indicate worsening behavioral health access across all plans, suggesting that statewide approaches may be more important than plan-specific approaches.
- PHPs' performance in care/case management has declined, suggesting that providers are not valuing the current PHP approaches. The medical home model seeks to embed care management in the practices; however, practices feel that reimbursement for these services is not nearly sufficient. PHPs may want to meet with practices to understand how PHP care management services could improve, or work with practices on a sustainable model for embedding care management in the practice.
- Growing differential performance across plans suggests that the state should strategize to improve plan performance. In domains where there is differential effectiveness across plans, there is opportunity for sharing best practices as well as clarifying expectations for underperforming plans. In domains where effectiveness is similar across all plans, collaborative work between the state and PHPs could identify state policies that may improve provider experience.
- Expansion of the Collaborative Care Model is proceeding slowly. Almost exactly the same proportions of practices have implemented the CCM compared with last year. Practices identify several barriers to implementation including 50% indicating they cannot sustain CCM with current reimbursement. We anticipate that expansion of this effective model will stall unless reimbursement improves. Since CCM is felt to be cost saving (not just cost effective), greater reimbursement would be a much better investment by Medicaid than most other health care services.

OVERVIEW

Purpose

The overall goal of this annual provider survey is to assess health system and practice experience and satisfaction with prepaid health plans (PHPs) and identify opportunities for improvement. The project is an evaluation directly funded and sponsored by the North Carolina Department of Health and Human Services' (DHHS) Division of Health Benefits (DHB) and implemented at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill (UNC-CH). To access the results of the previous annual surveys, please see the report posted at this link for Two Years into Managed Care (Wave 3), this link for One Year into Managed Care (Wave 2) survey and this link for Baseline Survey (Wave 1).

Objectives

The objectives of the Wave 4 survey were to:

1. Evaluate provider experiences with each PHP
2. Assess changes in provider experience and satisfaction with the state's Medicaid program over three years of PHPs
3. Understand provider contracting decisions regarding medical homes
4. Understand provider capabilities for behavioral health

The state will use these findings as an indicator of PHP quality. Additional investigation of issues and opportunities for improvement will be carried out with other data collection methods under the waiver evaluation and include focus groups, interviews, claims, and other clinical and administrative data analyses.

METHODS

Questionnaire Development

The North Carolina Medicaid Provider Experience Questionnaire is a single instrument that was developed for practice managers, medical directors, or other organizational leaders of North Carolina systems and practices that deliver primary care to patients with Medicaid. The questionnaire was developed specifically to understand the experience of health care providers delivering primary care and obstetrics and gynecological (Ob/Gyn) care in North Carolina's transition to NC Medicaid Managed Care. During the study start-up phase, a survey working group with experience in primary care delivery, payment models, and Medicaid constructed a broad item bank based on prior surveys, relevant literature, and content expertise. The Carolina Survey Research Laboratory (CSRL) and the North Carolina Division of Health Benefits (DHB) also provided input on questionnaire development. Items determined to be outside the scope of the organizational experiences in the transition to NC Medicaid Managed Care were excluded. Items were further modified and reviewed over the course of several iterations to improve conciseness and clarity of interpretation.

The questionnaire for the 2024 Medicaid Transformation Provider Experience Survey (Wave 4) covered the following domains, largely identical to the Wave 2 and 3 surveys:

- Background items (e.g., respondent's role at the organization, contact information, organizational information, organization's Medicaid involvement)
- Practice characteristics (type of organization, Independent Practice Association/Clinically Integrated Network participation and support, Medicaid patient population, medical home, and accountable care organization participation (new to Wave 4))
- Contracting with PHPs (current contracts, plans to add or drop contracts, Medical Home arrangements, etc.)
- Overall perceived effects of PHPs on care delivery (overall health and well-being, quality of health care delivery, patient experience, provider experience, etc.)
- Perceived effects on Medicaid Expansion on practice/health system (new to Wave 4)
- Behavioral Health and Tailored Plans (co-located behavioral health professionals, Collaborative Care Model, contracting with tailored plan, etc.)

These themes are intentionally broad to address the numerous ways that Medicaid and PHPs affect the health care delivery system. Additionally, the questionnaire was built to minimize respondent burden and reduce overlap with other data collection activities. The number of questions was limited and skip patterns were incorporated to reduce the time required to complete the questionnaire.

Sample Description

The target population for the survey was all primary care and Ob/Gyn practices and health systems in North Carolina that accept Medicaid. After deliberation and consultation in conjunction with DHB, the questionnaire was administered to every organization that met the inclusion criteria (i.e., accepting Medicaid and providing primary care or Ob/Gyn care). The survey was

sampled and fielded at the highest organizational level, such as the health system or medical group when applicable.

Sample Development

Organizational and system data were obtained from the IQVIA OneKey database, a proprietary commercial database containing characteristics of providers and health care organizations in the United States. IQVIA data has been used in numerous peer-reviewed studies using claims data as well as for provider surveys.[1–8] Further information on it can be found in the Wave 1, Wave 2 and Wave 3 survey reports.

The IQVIA OneKey database provides a robust set of data elements about North Carolina health care providers, as well as information about medical groups and health systems linked with these providers. IQVIA updates provider and organizational contact information (e.g., mailing address, phone numbers) every six months. Data used for sample development were obtained in November 2023. Data included clinician National Provider Identifiers (NPIs) in medical groups or independent practices identified with outpatient primary care and Ob/Gyn care, using these specialties: Family Practice, General Practice, Geriatric Medicine, Internal Medicine, Multi-specialty practice, Ob/Gyn, Pediatric Medicine, Preventative Medicine, and Primary Care.

Data from the IQVIA OneKey database were matched to the NC Medicaid provider file and claims data to increase confidence in captured organizations serving Medicaid patients in NC. During the frame cleaning process in earlier waves of the survey, we learned that a number of organizations in our sample frame had a very small number of Medicaid patients (e.g., sometimes a single patient). This meant that although they were technically contracted with Medicaid, they expressed to us that they were unable to answer our survey questions on experience with Medicaid. After examining the data, we developed the Wave 4 sample frame to organizations that had at least fifty Medicaid claims for ambulatory care visits. This method was effective in removing low quality data from the sample frame so the sample more accurately reflected the target population for Carolina Survey Research Lab (CSRL), resulting in greater coverage and more accurate characterization of response rate.

As an additional check on our sample frame, a random sample of 100 provider organizations from the OneKey data not identified as outpatient primary care or Ob/Gyn care were included. We used this as a validation sample to identify if there are any gaps in the provider population and improve provider representation. The validation sample confirmed that 97-98% of organizations not identified as outpatient primary care were correctly characterized, suggesting our strategy provides a valid sample with strong coverage.

Overall, this resulted in conducting sample frame cleaning and outreach with a cleaner and more representative sample in Wave 4 compared with prior waves.

Sample Frame Cleaning

The research team refined and validated the sample of potential survey respondents by ensuring that all of the practices in the sample exist and removed organizations that were closed, organizations that have been acquired by or merged into another previously identified

organization, confirmed not to be primary care and/or OB/Gyn care providers, or otherwise not operating. For large health systems, once the contact point was determined, a member of the research team contacted health system leaders with an email asking to confirm their contact information and identify their preferred method (email or mail) of receiving the questionnaire. Follow-up went to that individual or, in the case of no response, another identified individual.

For medical group and independent practice leaders, a member of the survey team contacted the practice with a phone call asking them to identify the best person to complete the questionnaire (practice manager, medical director, lead physician, or other). The team then obtained specific contact information for that person in order to mail the questionnaire. If the team was unable to verify the contact information for a specific person, the case was flagged for review. If the reviewers could not find the leader of the practice, the questionnaire was mailed to the practice address given in the IQVIA data set and addressed to the lead physician.

As part of frame cleaning, phone calls were made during data collection to non-responders to confirm eligibility. Practices were considered ineligible if they did not accept Medicaid patients or if they did not provide primary care or Ob/Gyn care. Practices were also considered ineligible if the given telephone number was no longer operating or connected to the practice and a follow-up web search could not produce an alternative telephone number or mailing address. Several attempts were made to these practices before removing them from the sample.

Data Collection

All potential respondents (n=634) received an invitation packet to participate in the survey. The packet included a letter describing the study and gave individual links to a password protected online survey hosted by Qualtrics^{XM}. Each packet also included a paper survey with a prepaid return envelope, so participants could respond either online or by mail.

Beginning 2 weeks after initial surveys were mailed, follow-up telephone calls were implemented for non-responders. For the remaining period of data collection, telephone calls were made to all non-responders to determine point of contact, verify contact information, and to resupply the participant with his or her preferred survey mode (i.e., URL link & password for an online survey, paper survey, or faxed survey). Five weeks following the initial contact, follow-up packets were mailed to all non-responders and another round of calling was done before closing the survey. Respondents who completed the questionnaire received a $30 gift card to compensate them for their time.

Final response rate

Survey responses were collected between April 10, 2024 and June 30, 2024. The final response rate was 59.4%. **Exhibit 1** summarizes responses for all sampled organizations. Wave 4 data collection considered the entire sample frame as "unknown eligibility" until their eligibility could be determined. Potential respondents who completed the eligibility screening were coded as eligible or not. Respondents were determined as ineligible if it was confirmed the organization existed as a medical practice, but they did not take Medicaid or did not provide primary care or Ob/Gyn services. Those who did not want to complete the survey were deemed refusals. Practices were removed from the sample frame if it was determined the organization was closed, not

operating as a medical practice, or did not exist. This yielded an eligibility rate from the original sample frame of 95.9%. Eligibility for a small subset of potential respondents was not able to be determined. A response rate was calculated using the American Association for Public Opinion Research (AAPOR RR4) formula that adjusts for unknown eligibility of respondents.[9]

Exhibit 1. Response rate & final dispositions of sample frame

Final designations	**Total Response Count (%)**
Completed & eligible respondents	361 (56.9%)
Refusals of eligible respondents	10 (1.6%)
Ineligible for survey	16 (2.5%)
Unknown eligibility	247 (39.0%)
Total	634

Notes: response rate = (completed & eligible respondents)/ [completed & eligible respondents + refusals of eligible respondents + (Unknown eligibility × eligibility rate)] = 59.4%

To account for non-response, survey weights were developed using the total number of PCP and Ob/Gyn NPIs per organization, as well as whether respondent organization had any primary care or Ob/Gyn practice locations in rural zip codes, as defined by the US Census rural-urban commuting area (RUCA) codes. To more accurately reflect the known and unknown eligibility of the sample frame, survey weights were updated to account for eligibility rates across the categories.

All analyses presented exclude missing data from eligible survey respondents. The finite population correction was used where applicable because the sample rate (number of survey respondents as a proportion of the target population) was large.

Experience with Health Plan Domains

Results are presented on 14 separate domains of health plan experience. Seven represent clinical categories, and seven represent administrative categories. We also use two composites representing clinical and administrative composites that were developed in collaboration with the state during Wave 2 of the survey. **Exhibit 2** lists all items and whether they were categorized as clinical or administrative**.** Where mean ratings on individual and categorized domains are provided, ratings scale ranges from 1 (Poor) to 4 (Excellent). Legacy NC Medicaid estimates are from the baseline survey conducted prior to PHP implementation. The proportion of respondents rating "Good" or "Excellent" was calculated to compare ratings between PHPs and across years. Logistic regression models were used to look at the effect of PHP and survey year on provider experience. The 13 domains for which data was available for every year of Medicaid Managed Care were analyzed. The models included fixed effects for PHP and wave, as well as their interaction term. Additionally, survey weights were included to ensure representative estimates. Models included random intercepts for provider organizations to account for multiple responses within a survey to provide more accurate estimates, with the exception of the model for the domain on

data sharing for quality and care management which did not converge so was run without these random intercepts. Post-estimation interaction contrasts analyses between PHP and survey were done to examine the difference in provider experience between plans at specific years (**Exhibit E3**). Significant differences were determined if the overlap of the 95% confidence intervals (CI) is no more than about half the margin of error (half the interval).

Exhibit 2. Categorizations of domains into administrative and clinical groups

Domain	Domain Description	Category
1	Provider relations overall	Administrative
2	Timeliness to answer questions and/or resolve problems	Administrative
3	Timeliness of claims processing	Administrative
4	Process for managing prior authorizations	Administrative
5	Adequacy of reimbursement to provide the care needed for Medicaid patients	Administrative
6	Access to medical specialists for Medicaid patients	Clinical
7	Access to behavioral health prescribers for Medicaid patients	Clinical
8	Access to behavioral health therapists for Medicaid patients	Clinical
9	Access to needed drugs for Medicaid patients (formulary)	Clinical
10	Care/Case management for patients	Clinical
11	Customer/Member support services for patients	Clinical
12	Support for addressing social determinants of health	Clinical
13	Data sharing for quality and care management (timeliness and accuracy)	Administrative
14	Process and accuracy for assigning patients to your practice (attribution)	Administrative

SURVEY RESPONDENT CHARACTERISTICS

Exhibit 3. Health system and practice characteristics for survey respondents (unweighted)

Health System and Practice Characteristics	Self-Identified Health Systems (N = 11)	Self-Identified Medical Groups and Independent Practices (N = 350)
	N (%) or Mean (SD)	N (%) or Mean (SD)
Practice Composition		
Services Provided for Patients with Medicaid		
Primary Care	10 (90.9%)	344 (98.2%)
Prenatal/Postnatal Care	9 (81.8%)	28 (8.0%)
Inpatient Obstetrics Care	8 (72.7%)	9(2.5%)
Number of Providers (IQVIA-sourced)		
1-2 providers	0 (0.0%)	112 (32.0%)
3-9 providers	0 (0.0%)	170 (48.6%)
10 or more providers	11 (100.0%)	68 (19.4%)
Geography		
No Rural Practice Sites	0 (0.0%)	165 (47.1%)
Any Rural Practice Sites	11 (100%)	185 (52.9%)
Ownership		
Independent Medical Practice at a Single Site	n/a	279 (79.7%)
Medical Group (multiple practices owned by a single owner)	n/a	66 (18.9%)
Other	n/a	5 (1.4%)
Part of a Clinically Integrated Network (CIN) for Medicaid work	8 (72.7%)	228 (65.3%)
Highest Tier of Medical Home Attestation with State (among primary care provider organizations)		
Tier 3	6 (54.6%)	166 (47.4%)
All else	5 (45.5%)	184 (52.6%)

<u>Practice Service to Medicaid Beneficiaries</u>		
Mean percentage of patients served that are insured by Medicaid	23.1 (10.0)	39.6 (24.7)
Limit on Percentage of Patients with Medicaid		
Yes	0 (0.0%)	54 (15.4%)
No	11 (100%)	270 (77.1%)
Unsure	0 (0.0%)	26 (7.4%)
Mean <u>limit</u> that practice/system places on percentage of patients with Medicaid Insurance *(if yes to above)*	n/a	25.4 (27.7)
<u>Contracting with Pre-Paid Health Plans</u>		
Mean number of PHPs that practice/system is currently contracting with	4.6 (0.9)	4.6 (0.9)

Notes: Any data categories which do not add to final response n=361 are due to item non-response.

EXPERIENCE OF PROVIDER ORGANIZATIONS

In this section, analyses represent all respondents to the survey. This includes independent medical groups and practices (unweighted n = 350) that self-identified as such and all health system respondents (unweighted n = 11). All subsequent figures reported in this section are weighted.

Contracting with Prepaid Health Plans (PHPs)

The following questions and findings are related to provider organizations' relationships with PHPs. Practices were asked to identify the standard PHPs they contracted with.

Exhibit 4. Provider organizations' contract arrangements with standard PHPs in North Carolina Medicaid in Wave 4, with Wave 2 and Wave 3 comparisons

For the below listed standard Prepaid Health Plans (PHPs), have you contracted with the following plans?			
PHP	**2022 Response: Yes N (%)**	**2023 Response: Yes N (%)**	**2024 Response: Yes N (%)**
AmeriHealth Caritas North Carolina	318 (81.1%)	295 (85.3%)*	316 (87.4%)
BCBSNC Healthy Blue	372 (94.5%)	336 (97.2%)	350 (96.9%)
UnitedHealthcare	357 (90.9%)	327 (94.5%)*	338 (93.8%)
WellCare Health Plans	349 (88.9%)	324 (93.7%)*	343 (95.1%)
Carolina Complete Health†	285 (73.3%)	265 (77.3%)	300 (83.0%)*

Note: * Significant difference from prior year as determined by the overlap of the 95% confidence interval (CI) no more than about half the margin of error. †Because Carolina Complete Health is geographically limited, they do not contract with as many providers.

Exhibit 5. Provider organizations anticipating adding or dropping PHPs contracts in the coming year

Question	Yes N (%)	No N (%)
Among provider organizations that did not contract with all standard PHPs, when asked if they anticipated adding any new standard plan PHP contracts in the coming year	13 (14.9%)	73 (85.1%)
When asked if they anticipated dropping any standard plan PHP contracts in the coming year	22 (6.1%)	338 (93.9%)

Exhibit 6. Themes of write-in responses regarding why a health system/practice is dropping PHP(s)

Themes write-in responses (from most common to least common)	Quotes
1. **Payment challenges**	"As a small practice, it is not practical not effectively contract with all PHPs. As a result we have suffered tremendous financial losses due to the different approaches plans adjudicated claims resulting in constant recoupments from some."
2. **Administrative burden**	"Administrative burden for claims issues & lack of direct provider relations representatives to assist in resolution, untimely response to Provider Ombudsman tickets, as well as value based contract incentives. Very bad issues with patient panel attribution and removal." "I only have a few patients in certain plans. Dropping those plans save time."
3. **Poor customer service**	"We are considering dropping [PHP name omitted] . They are simply too difficult to work with."
4. **Patients expressing frustration with PHPs**	"We actually dropped [PHP name omitted] in February of this year. [PHP name omitted] kept changing our patient's providers, many each month and many times to providers that were not in our practice…. Our patients were very frustrated with [PHP name omitted] as we were. "
5. **Difficulty finding in-network specialists**	"[I]t is very difficult to find specialist that take their insurance."

Exhibit 7. Provider organization responses when asked if they currently limit the percentage of patients with Medicaid that they will take

Response	N (%)
Yes	54 (14.8%)
No	282 (78.1%)
Unsure	26 (7.1%)

Medical Homes

Exhibit 8. Response of organizations providing primary care when asked what tier of medical home their provider organization attested to with the state of North Carolina (non-exclusive)

Response	N (%)
Tier 1	28 (7.6%)
Tier 2	44 (12.2%)
Tier 3	173 (47.8%)
Don't Know	134 (37.2%)
Not Applicable (exclusive)	7 (2.0%)

Exhibit 9. Provider organizations' medical home contracts with PHPs in North Carolina Medicaid, from July 2023 – June 2024

At what tier of medical home has your practice/health system contracted with each PHP in the contract year from July 2023-June 2024?				
PHP	**Tier 1 N (%)**	**Tier 2 N (%)**	**Tier 3 N (%)**	**I don't know N (%)**
AmeriHealth Caritas North Carolina	11 (3.1%)	25 (6.8%)	146 (40.4%)	125 (34.6%)
BCBSNC Healthy Blue	14 (3.9%)	31 (8.5%)	158 (43.8%)	137 (37.9%)
UnitedHealthcare	11 (3.1%)	29 (8.0%)	151 (41.9%)	139 (38.4%)
WellCare Health Plans	13 (3.3%)	28 (7.7%)	159 (43.9%)	135 (37.5%)
Carolina Complete Health	*	21 (5.8%)	135 (37.5%)	123 (34.1%)

*Suppressed due to small cell sizes

Exhibit 10. Themes of write-in responses on what would it take for their practice to contract as a Tier 3 AMH with all health plans

Themes write-in responses (from most common to least common)	**Quotes**

1. **Not sure what Tier 3 is and/or have not received any information about this**	"[A] better understanding of the Tier system. I am not familiar with the fact that we are tiered for Medicaid or what the different Tier levels entail."
2. **Additional providers and/or support staff**	"Having the staffing issues that ALL clinics are having creates an overload on those employees that are dedicated to the medical field in which we work. It's an issue that Covid created but it is ongoing today."
3. **Higher reimbursement**	"I'm not sure there is anything at this point that would make me willing to complete the amount of useless busywork being asked to create these tiers--the reimbursement incentives are, quite frankly, insulting."
4. **Less administrative burden**	"Less administrative burden, transparent for claims, faster turn around time for payment on new codes."
5. **ACO/CIN contract**	"We are contracted through an ACO and CIN, we were told we have to contract as a tier 2 AMH through our ACO."
6. **Knowledge of cost and benefit to practice**	"I don't know what that means but I would contract higher with these payers. One of the things our practice wants to do and do well is care for those with lower incomes."

Exhibit 11. Provider organizations' progression to value-based payment arrangements with standard PHPs in North Carolina Medicaid

Apart from any medical home arrangements, are you under a value-based payment arrangement (such as a shared savings, accountable care organization [ACO], or shared risk arrangement) with any of the PHPs?	
PHP	**Response: Yes N (%)**
AmeriHealth Caritas North Carolina	115 (33.3%)
BCBSNC Healthy Blue	148 (43.0%)
UnitedHealthcare	138 (40.4%)
WellCare Health Plans	130 (37.5%)
Carolina Complete Health	113(33.6%)

Exhibit 12. Provider organizations' contract arrangements with other partner organizations under value-based contracts with PHPs and other payors.

Apart from any medical home arrangements, are you contracting with any of the following organizations as part of a value-based payment arrangement (such as a shared savings, accountable care organizations [ACO], or shared risk arrangement)?			
Entity	**One or More Medicaid PHPs Only**	**Other Payor (e.g. Medicare, Medicare Advantage, Commercial payor)**	**Both Medicaid PHP(s) and Other Payor**
Evolent	*	23 (6.4%)	*
Aledade	37 (10.2%)	71 (19.7%)	22 (6.1%)
Caravan/Signify	*	17 (4.7%)	0 (0%)
A clinically integrated network (CIN)	103 (28.6%)	21 (5.8%)	19 (5.2%)
Other entity or ACO	16 (4.4%)	54 (15.0%)	11 (3.0%)

*Suppressed due to small cell sizes

Provider relations overall

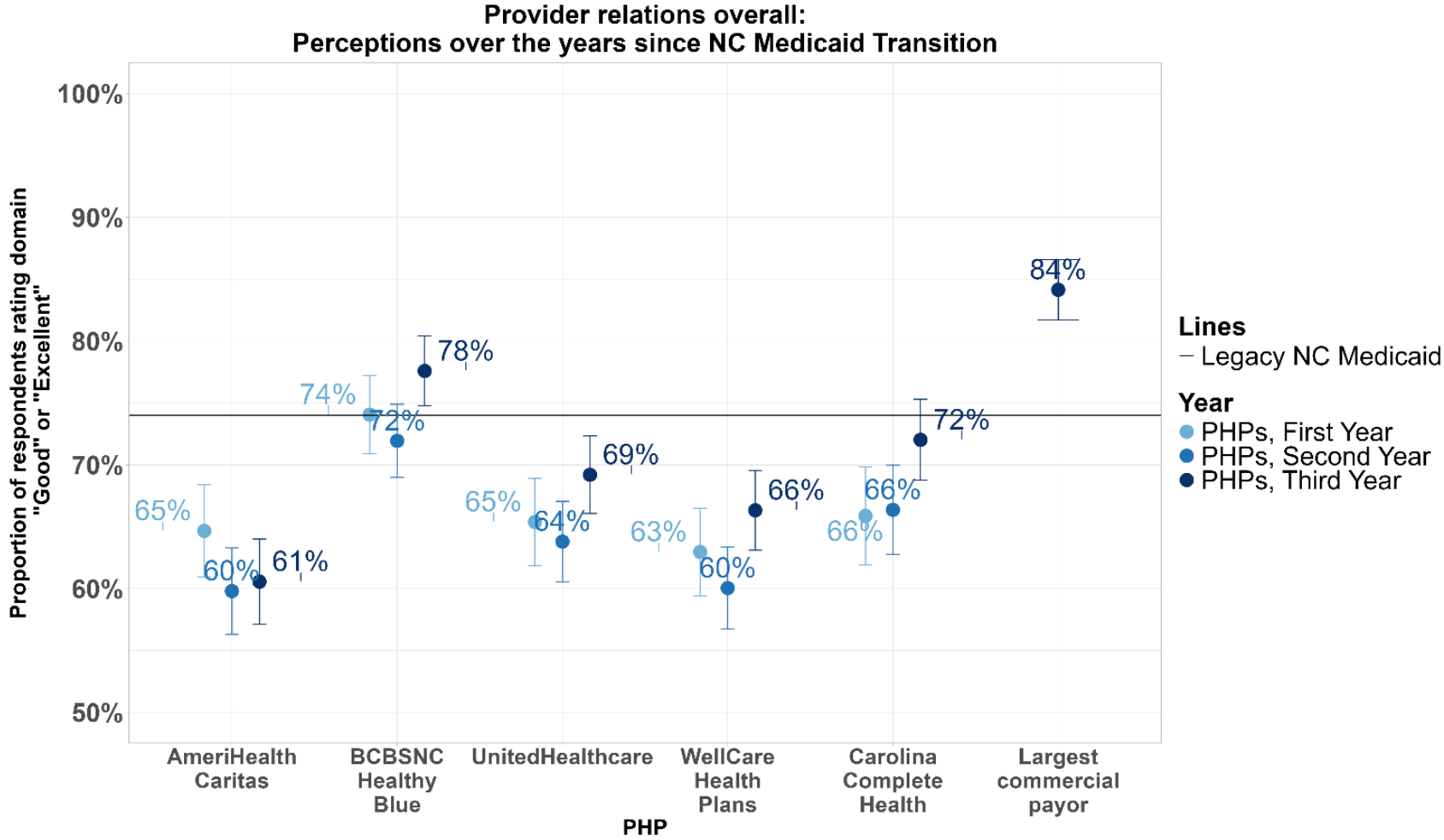
All PHPs improved in Wave 4 after low performance in Wave 3. BCBSNC Healthy Blue was the best overall performing PHP this year and the only PHP performing better than Legacy Medicaid. AmeriHealth Caritas had marginal improvement but was the lowest performing among all plans. UnitedHealthcare Community Plan, WellCare, and Carolina Complete Health improved their performance to be closer to that of Legacy Medicaid.

Exhibit 13. Provider ratings of PHPs regarding provider relations overall, ranges from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Provider Relations Overall***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.63 (0.03)	2.61 (0.03)	2.64 (0.03)
BCBSNC Healthy Blue	2.90 (0.03)	2.83 (0.03)	2.97 (0.03)
UnitedHealthcare	2.73 (0.03)	2.71 (0.03)	2.83(0.03)
WellCare Health Plans	2.68 (0.03)	2.62 (0.03)	2.77(0.03)
Carolina Complete Health	2.71 (0.04)	2.75 (0.03)	2.84 (0.03)
Largest commercial payor			3.09 (0.02)

Notes: Legacy NC Medicaid mean (standard error) : 2.93 (0.03)

Exhibit 14. Practice ratings for overall satisfaction of provider organizations with PHPs, with 95% Confidence Intervals (CI)



Legacy NC Medicaid 95% CI of respondents rating domain "Good" or "Excellent" : (71%-78%)

Timeliness to answer questions and/or resolve problems

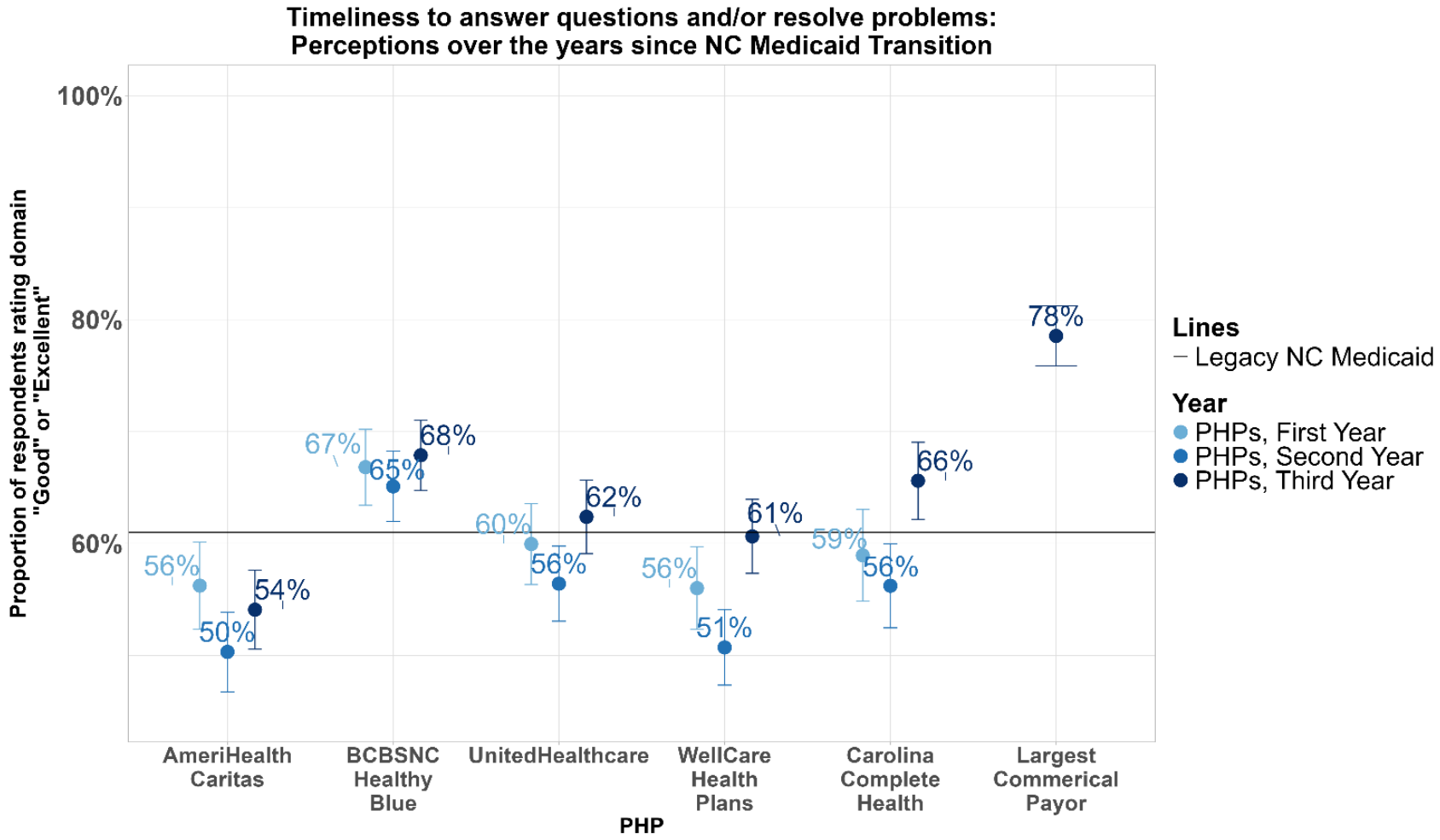
PHPs performed better in Wave 4 compared to a low performance in Wave 3. WellCare and Carolina Complete Health made substantial improvements from the prior year. BCBSNC Healthy Blue remained the highest rated plan. AmeriHealth Caritas lagged behind the other PHPs and performed worse than Legacy Medicaid.

Exhibit 15. Experience of provider organizations with PHPs' timeliness to answer questions and/or resolve problems, ranges from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Timeliness to answer questions and/or resolve problems***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.50 (0.04)	2.44 (0.03)	2.51 (0.03)
BCBSNC Healthy Blue	2.72 (0.03)	2.68 (0.03)	2.79 (0.03)
UnitedHealthcare	2.59 (0.03)	2.55 (0.03)	2.70 (0.03)
WellCare Health Plans	2.51 (0.04)	2.43 (0.03)	2.67 (0.03)
Carolina Complete Health	2.53 (0.04)	2.58 (0.04)	2.72 (0.03)
Largest Commercial Payor			2.95 (0.02)

Notes: Legacy NC Medicaid mean (standard error): 2.65 (0.04).

Exhibit 16. Experience of provider organizations with PHPs' timeliness to answer questions and/or resolve problems, with 95% CI



Legacy NC Medicaid 95% CI of respondents rating domain "Good" or "Excellent" : (57%-64%).

Timeliness of claims processing

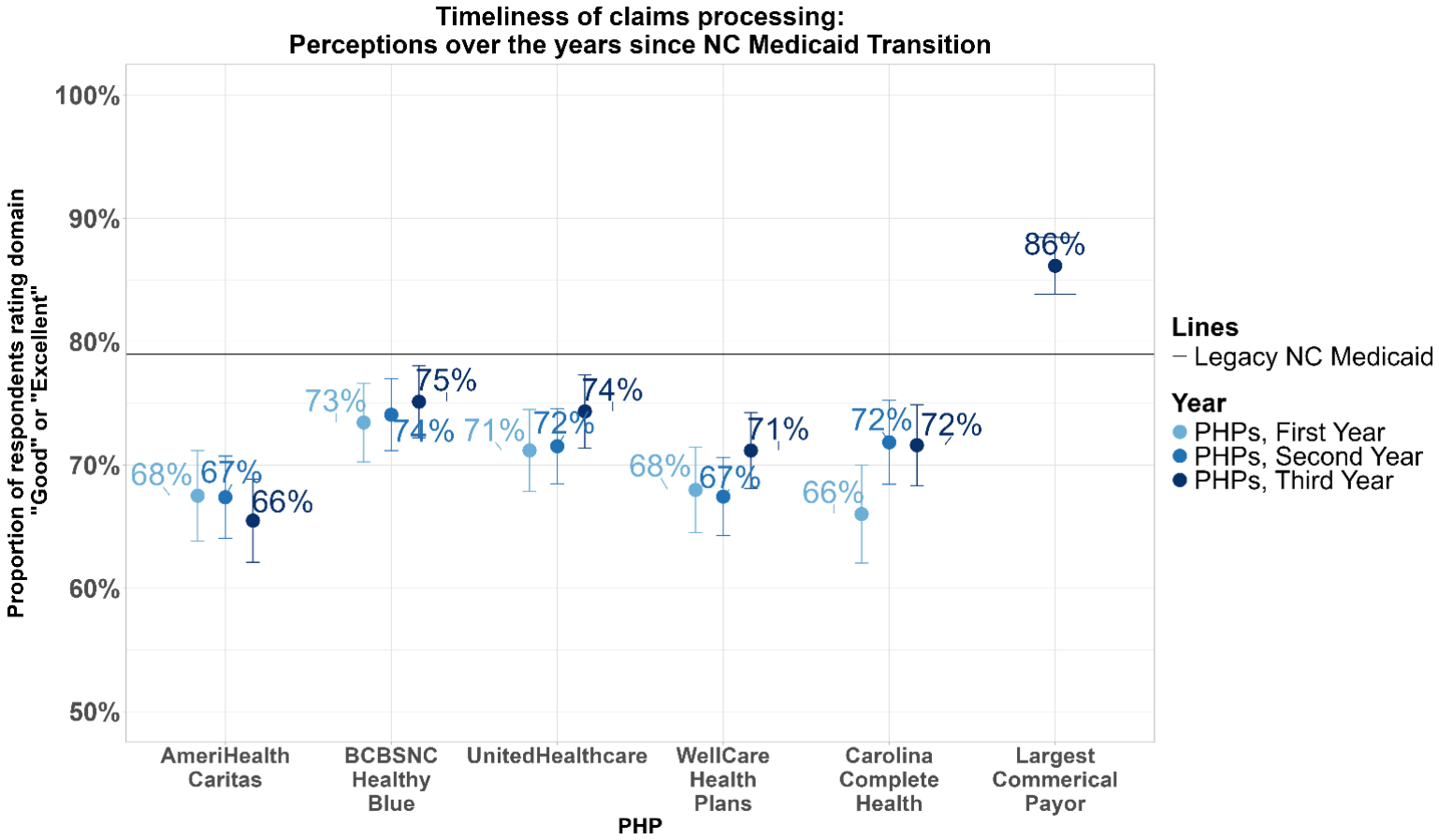
For most PHPs, timeliness of claims processing remained stable or slightly improved from Wave 3. The exception was AmeriHealth Caritas, which generally performed worse than other plans and slightly worsened in Wave 4. All PHPs were performing worse than Legacy Medicaid and commercial plans.

Exhibit 17. Experience of provider organizations with PHPs' timeliness of claims processing, ranges from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Timeliness of claims processing***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.71 (0.03)	2.74 (0.03)	2.71 (0.03)
BCBSNC Healthy Blue	2.87 (0.03)	2.87 (0.03)	2.93 (0.03)
UnitedHealthcare	2.81 (0.03)	2.81 (0.03)	2.90 (0.03)
WellCare Health Plans	2.73 (0.03)	2.73 (0.03)	2.81 (0.03)
Carolina Complete Health	2.70 (0.04)	2.78 (0.03)	2.85 (0.03)
Largest Commercial Payor			3.14 (0.02)

Notes: Legacy NC Medicaid mean (standard error): 3.05 (0.03).

Exhibit 18. Experience of provider organizations with PHPs' timeliness of claims processing, with 95% CI



Legacy NC Medicaid 95% CI of respondents rating domain "Good" or "Excellent" : (76%-82%).

Process for managing prior authorizations

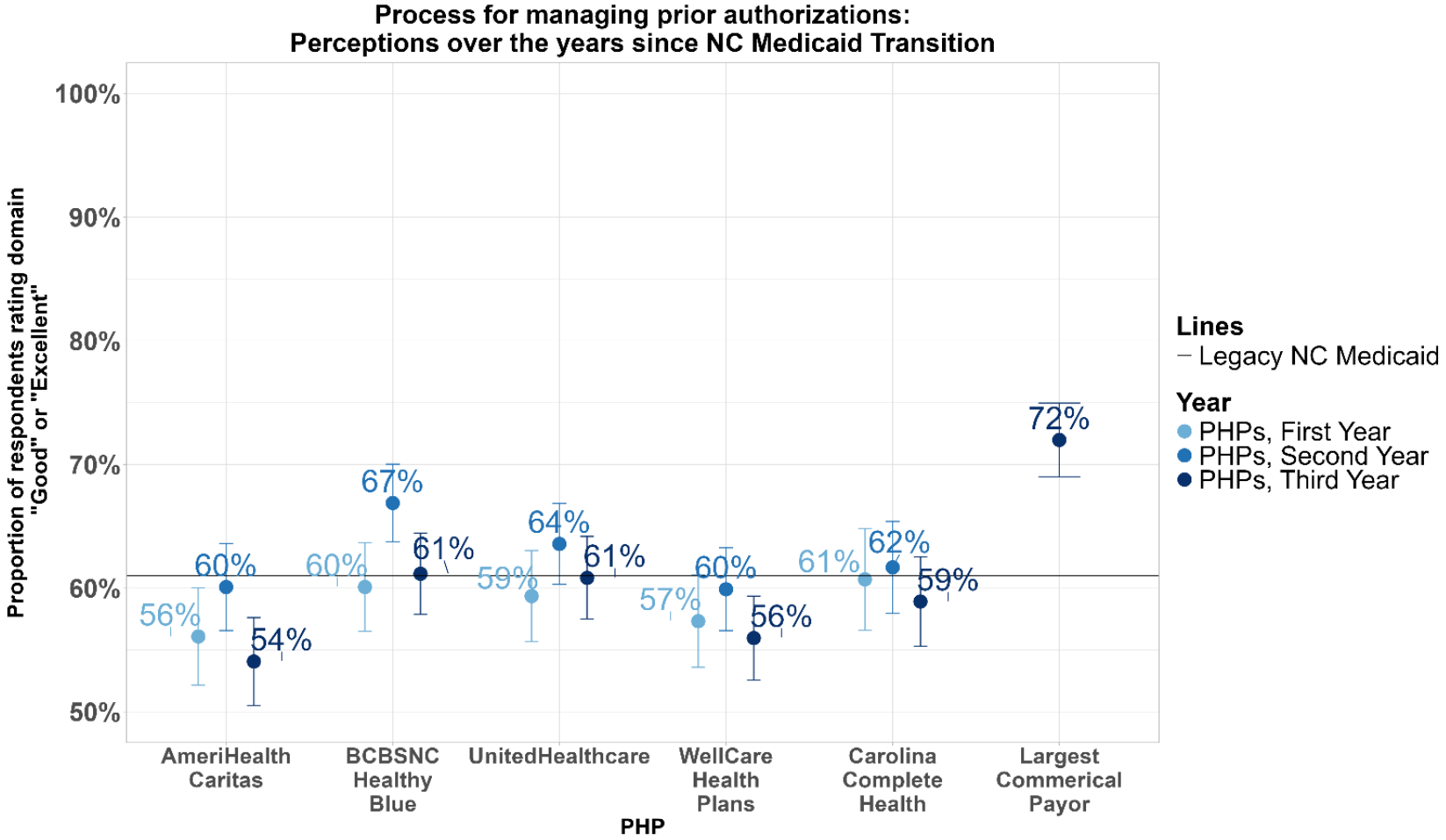
PHPs performed worse in Wave 4 compared to Wave 3. There were substantial differences across the plans, with BCBSNC Healthy Blue and UnitedHealthcare Community Health Plan being the best performing plans.

Exhibit 19. Experience of provider organizations with PHPs' process for managing prior authorization, ranging from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Process for managing prior authorization***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.52 (0.03)	2.59 (0.03)	2.51(0.03)
BCBSNC Healthy Blue	2.61 (0.03)	2.71 (0.03)	2.62 (0.03)
UnitedHealthcare	2.59 (0.03)	2.67 (0.03)	2.63 (0.03)
WellCare Health Plans	2.53 (0.03)	2.60 (0.03)	2.53 (0.03)
Carolina Complete Health	2.60 (0.03)	2.64 (0.03)	2.59 (0.03)
Largest Commercial Payor			2.79 (0.03)

Notes: Legacy NC Medicaid mean (standard error) : 2.60 (0.03)

Exhibit 20. Experience of provider organizations with PHPs' process for managing prior authorization, with 95% CI



Legacy NC Medicaid 95% CI of respondents rating domain "Good" or "Excellent" : (57%-64%).

Adequacy of reimbursement to provide the care needed for Medicaid patients

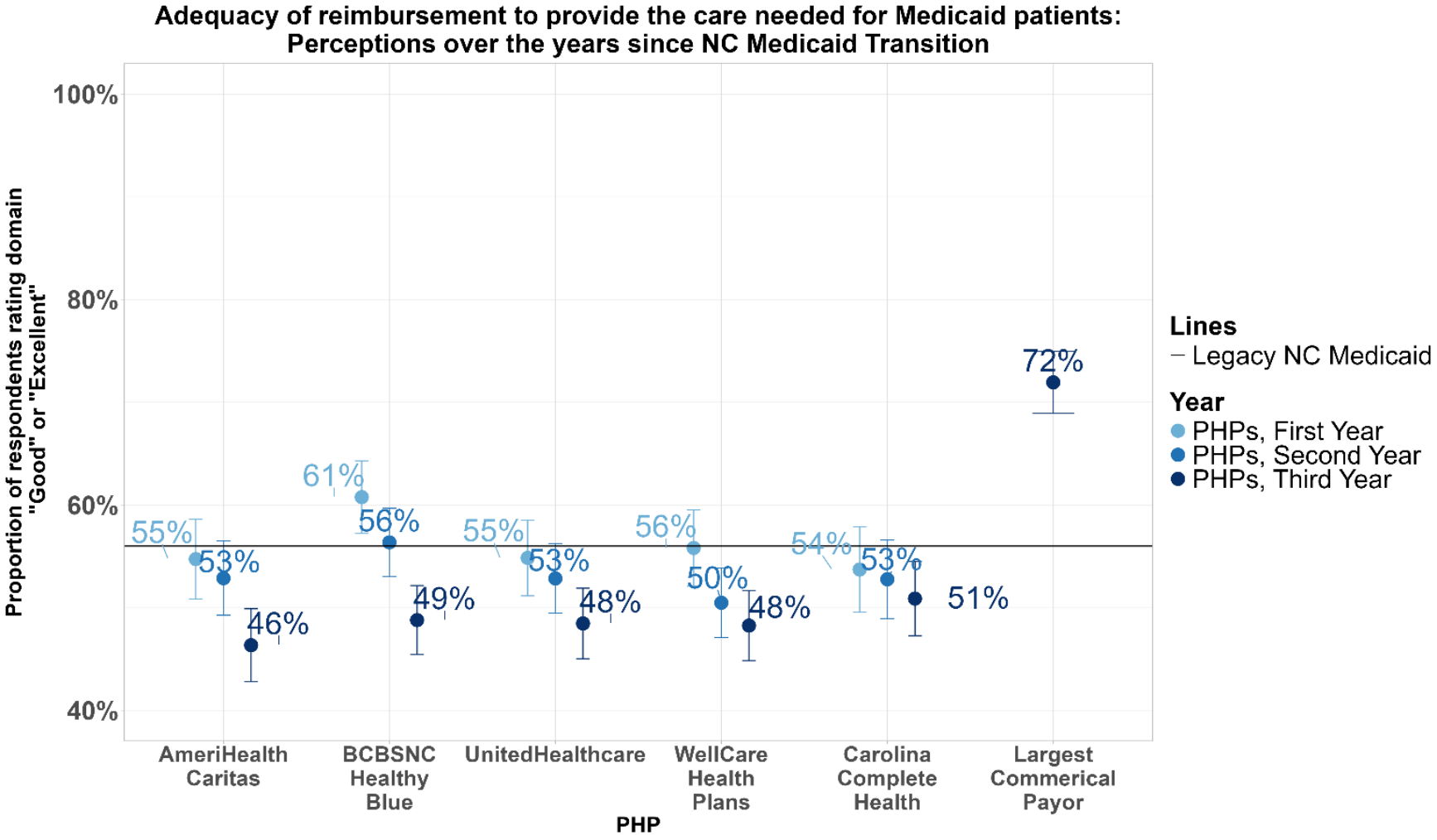
PHP performance has worsened year after year since the transition to managed care. There was no considerable variation across plans. All plans were performing worse than Legacy Medicaid. PHPs also performed considerably worse compared to commercial plans.

Exhibit 21. Experience of provider organizations with PHPs' reimbursement to provide the care needed for Medicaid patients, ranging from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Adequacy of reimbursement to provide the care needed for Medicaid patients***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.49 (0.03)	2.49 (0.03)	2.37 (0.03)
BCBSNC Healthy Blue	2.64 (0.03)	2.55 (0.03)	2.46 (0.03)
UnitedHealthcare	2.54 (0.03)	2.48 (0.03)	2.44 (0.03)
WellCare Health Plans	2.53 (0.03)	2.44 (0.03)	2.41 (0.03)
Carolina Complete Health	2.48 (0.04)	2.47 (0.04)	2.44 (0.03)
Largest Commercial Payor			2.86 (0.03)

Notes: Legacy NC Medicaid mean (standard error) : 2.51 (0.04).

Exhibit 22. Experience of provider organizations with PHPs' reimbursement to provide the care needed for Medicaid patients, with 95% CI



Legacy NC Medicaid 95% CI of respondents rating domain "Good" or "Excellent" : (52%-60%).

Access to medical specialists for Medicaid patients

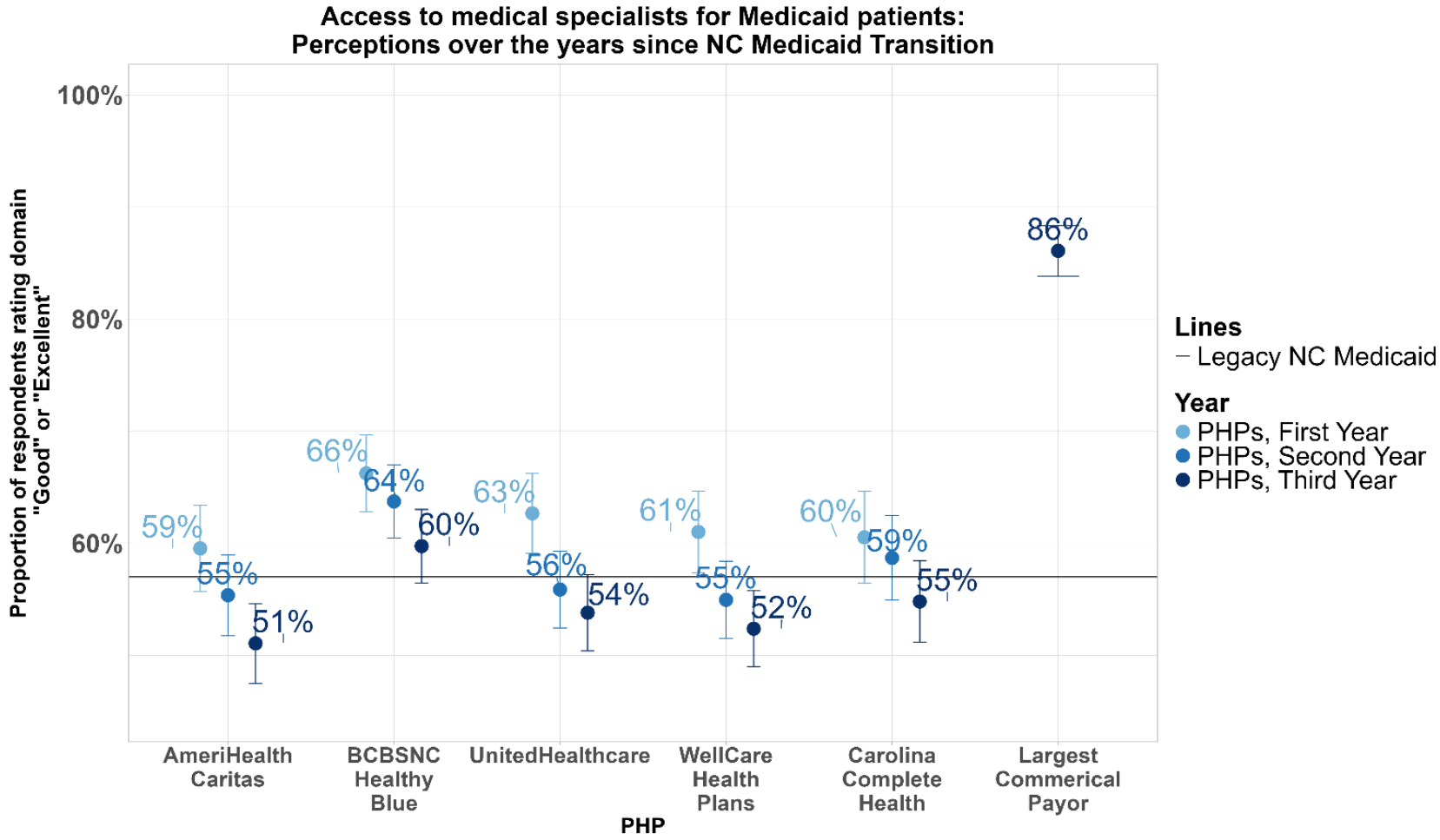
PHP performance has worsened year after year since the transition to managed care. BCBSNC Healthy Blue was the best performing plan, though the differences between PHPs were small. AmeriHealth Caritas was the lowest performing plan and saw the largest decline in performance from the prior year. All PHPs except BCBSNC Healthy Blue performed below Legacy Medicaid this year. PHPs also performed considerably worse compared to commercial plans.

Exhibit 23. Experience of provider organizations with access to medical specialists for Medicaid patients, ranging from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Access to medical specialists for Medicaid patients***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.58 (0.03)	2.46 (0.03)	2.41 (0.03)
BCBSNC Healthy Blue	2.72 (0.03)	2.63 (0.03)	2.57 (0.03)
UnitedHealthcare	2.65 (0.03)	2.49 (0.03)	2.46 (0.03)
WellCare Health Plans	2.59 (0.03)	2.47 (0.03)	2.46 (0.03)
Carolina Complete Health	2.60 (0.03)	2.55 (0.03)	2.50 (0.03)
Largest Commercial Payor			3.15 (0.02)

Notes: Legacy NC Medicaid mean (standard error): 2.53 (0.03).

Exhibit 24. Experience of provider organizations with access to medical specialists for Medicaid patients, with 95% CI



Legacy NC Medicaid 95% CI of respondents rating domain “Good” or “Excellent” : (53%-61%).

Access to behavioral health prescribers for Medicaid patients

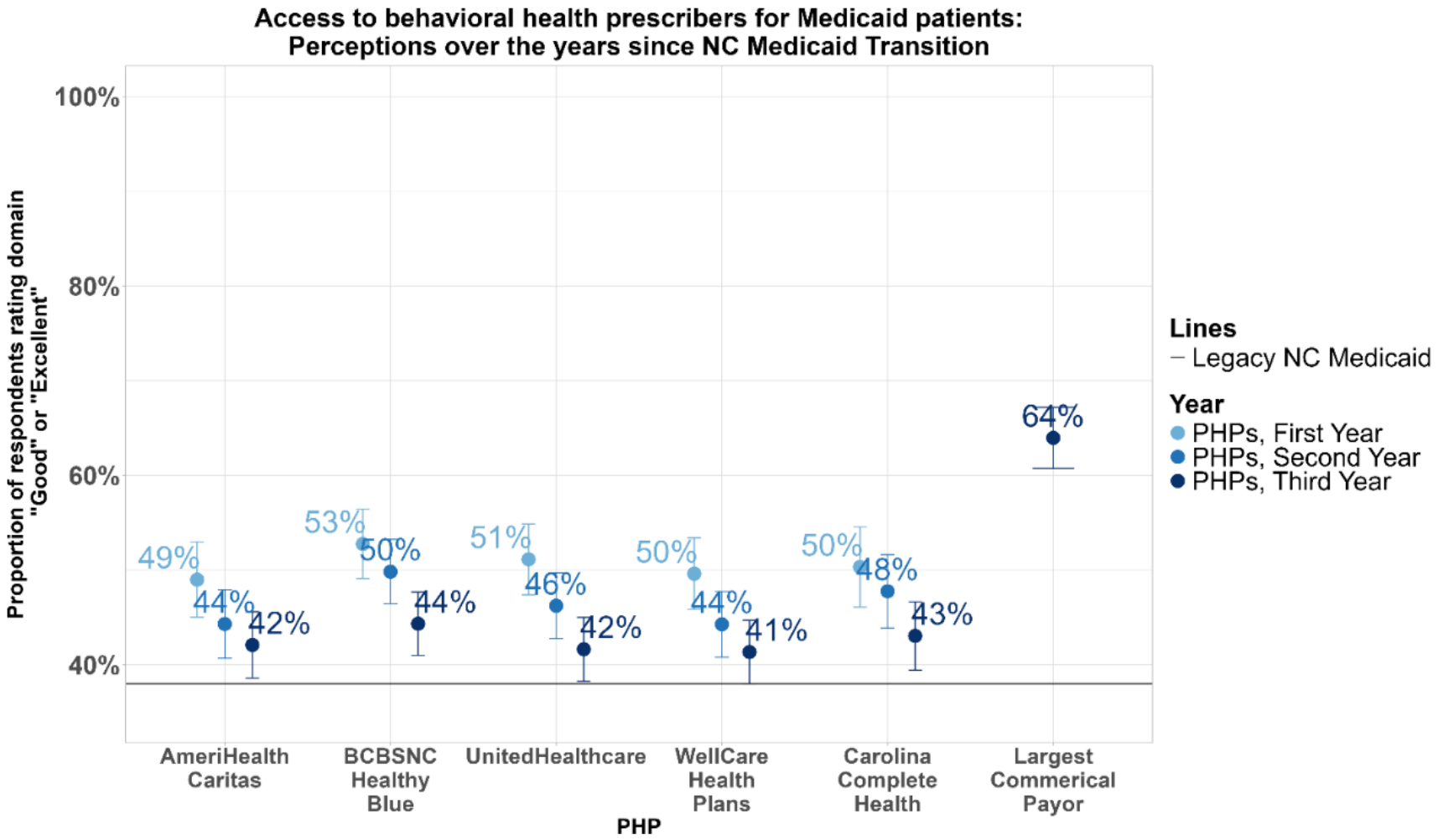
PHP performance has worsened year after year since the transition to managed care. There were no appreciable differences between plans. All PHPs performed better than Legacy Medicaid in Wave 4. However, PHPs performed considerably worse compared to commercial plans.

Exhibit 25. Experience of provider organizations with access to behavioral health prescribers (e.g., psychiatrists, psychiatric nurse practitioners, or physician assistants) for Medicaid patients, ranging from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Access to behavioral health prescribers (e.g., psychiatrists, psychiatric nurse practitioners, or physician assistants) for Medicaid patients***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.36 (0.04)	2.30 (0.03)	2.24 (0.03)
BCBSNC Healthy Blue	2.43 (0.03)	2.39 (0.03)	2.29 (0.03)
UnitedHealthcare	2.40 (0.03)	2.32 (0.03)	2.23 (0.03)
WellCare Health Plans	2.37 (0.03)	2.31 (0.03)	2.24 (0.03)
Carolina Complete Health	2.39 (0.04)	2.36 (0.03)	2.29 (0.03)
Largest Commercial Payor			2.70 (0.03)

Notes: Legacy NC Medicaid mean (standard error): 2.15 (0.04).

Exhibit 26. Experience of provider organizations with access to behavioral health prescribers (e.g., psychiatrists, psychiatric nurse practitioners, or physician assistants) for Medicaid patients, with 95% CI



Legacy NC Medicaid 95% CI of respondents rating domain “Good” or “Excellent” : (34%-42%).

Access to behavioral health therapists for Medicaid patients

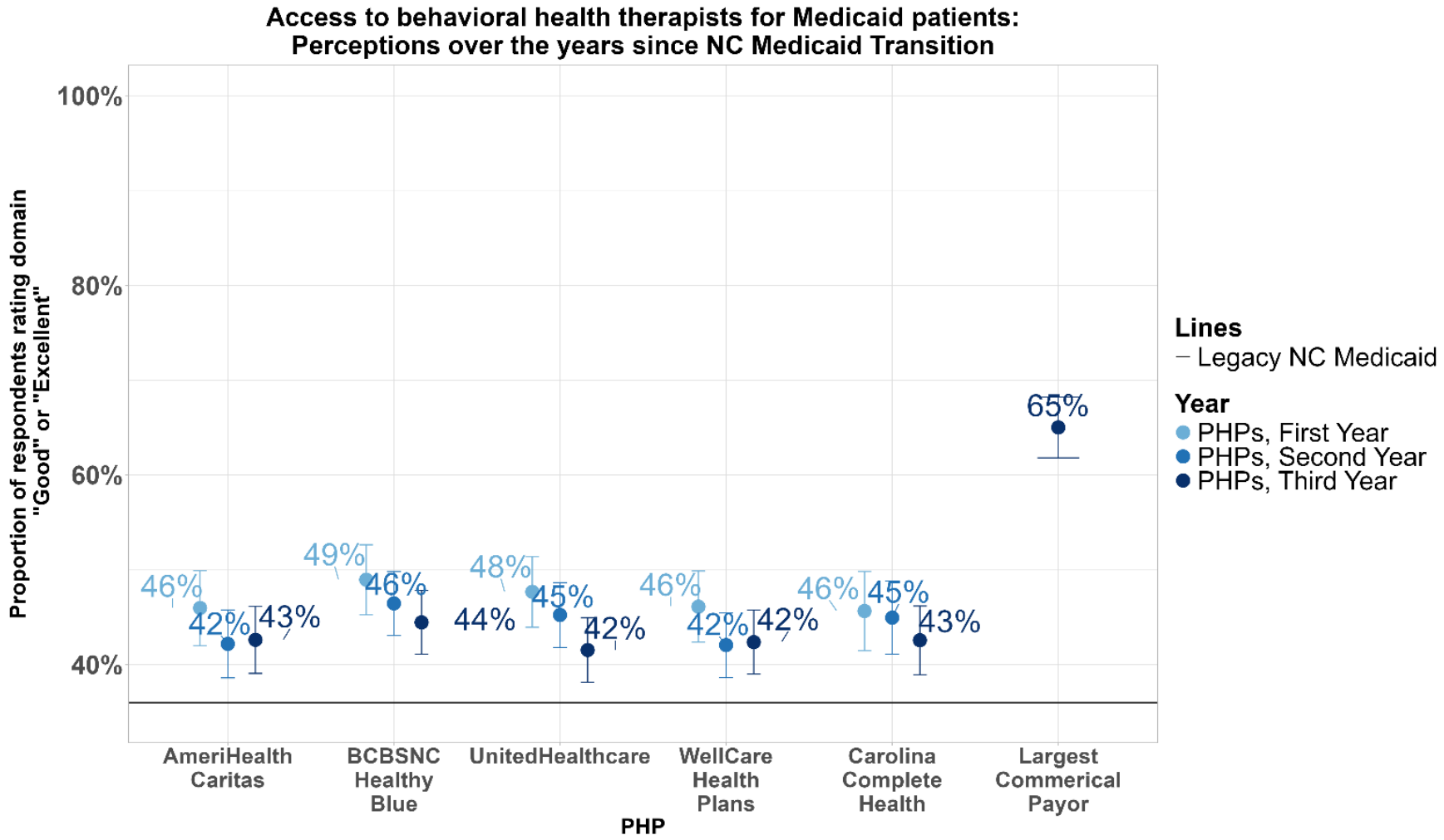
In Wave 4, AmeriHealth Caritas and WellCare showed slight improvement from the previous year. BCBSNC Healthy Blue, UnitedHealthcare Community Plan, and Carolina Complete had slightly worsening performance. All PHPs performed better than Legacy Medicaid this year. PHPs performed considerably worse compared to commercial plans.

Exhibit 27. Experience of provider organizations with access to behavioral health therapists for Medicaid patients, ranging from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Access to behavioral health therapists for Medicaid patients***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.32 (0.04)	2.27 (0.03)	2.26 (0.03)
BCBSNC Healthy Blue	2.38 (0.03)	2.33 (0.03)	2.30 (0.03)
UnitedHealthcare	2.36 (0.03)	2.28 (0.03)	2.24 (0.03)
WellCare Health Plans	2.31 (0.03)	2.27 (0.03)	2.26 (0.03)
Carolina Complete Health	2.32 (0.04)	2.32(0.03)	2.27 (0.03)
Largest Commercial Payor			2.7 (0.03)

Notes: Legacy NC Medicaid mean (standard error) : 2.16 (0.04).

Exhibit 28. Experience of provider organizations with access to behavioral health therapists for Medicaid patients, with 95% CI



Legacy NC Medicaid 95% CI of respondents rating domain “Good” or “Excellent” : (32%-40%).

Access to needed drugs for Medicaid patients (formulary)

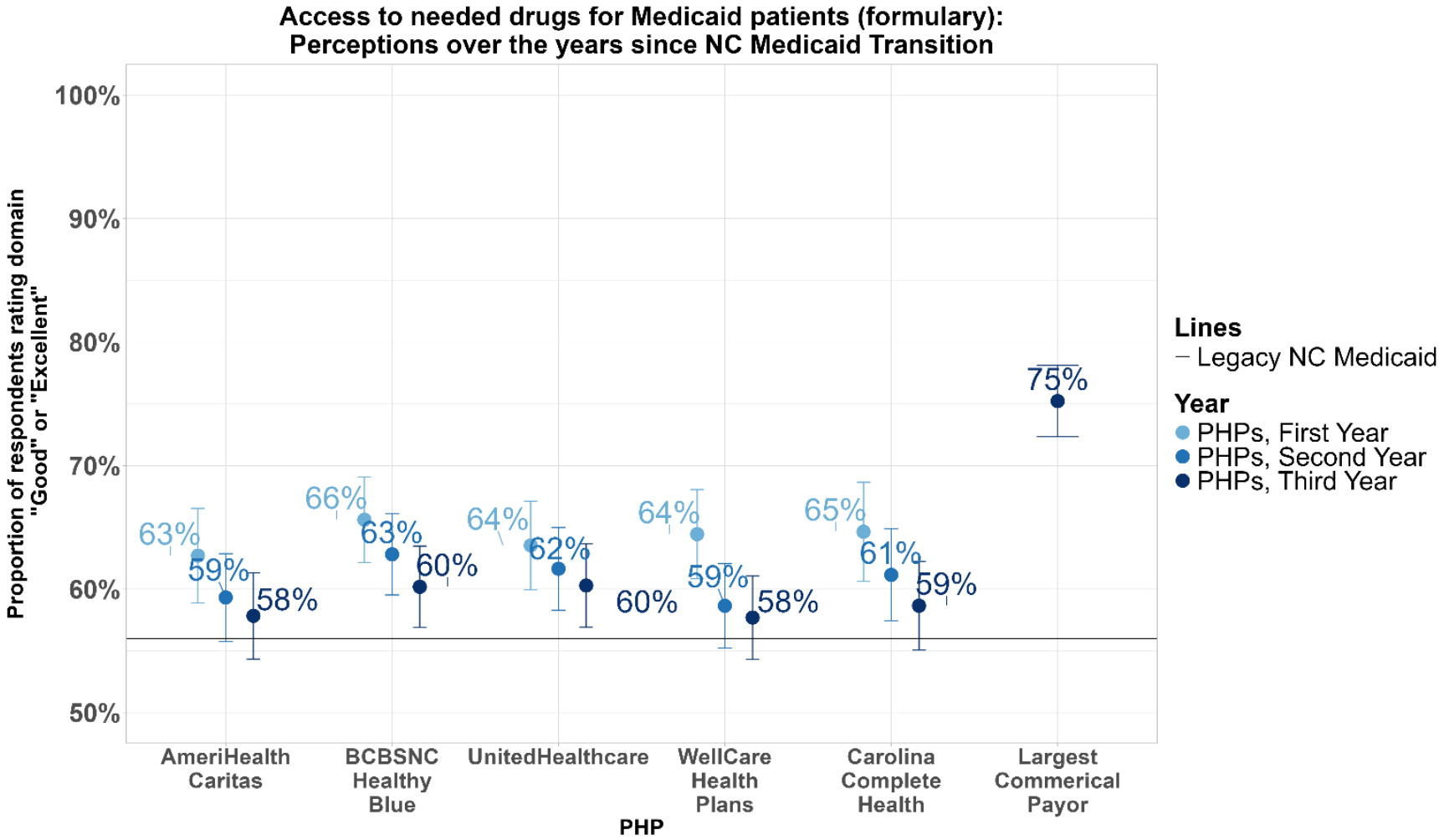
PHP performance has worsened year after year since the transition to managed care. There were no appreciable differences between plans, but PHPs performed more closely to Legacy Medicaid level than in prior years. PHPs also performed considerably worse compared to the commercial plan

Exhibit 29. Experience of provider organizations with access to needed drugs for Medicaid patients (formulary), ranging from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Access to needed drugs for Medicaid patients (formulary)***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.63 (0.03)	2.60 (0.03)	2.55 (0.03)
BCBSNC Healthy Blue	2.67 (0.03)	2.65 (0.02)	2.61 (0.03)
UnitedHealthcare	2.64 (0.03)	2.62 (0.03)	2.59 (0.03)
WellCare Health Plans	2.62 (0.03)	2.59 (0.03)	2.57 (0.03)
Carolina Complete Health	2.66 (0.03)	2.62 (0.03)	2.58 (0.03)
Largest Commercial Payor			2.87 (0.02)

Notes: Legacy NC Medicaid mean (standard error) : 2.54 (0.03)

Exhibit 30. Experience of provider organizations with access to needed drugs for Medicaid patients (formulary), with 95% CI



Legacy NC Medicaid 95% CI of respondents rating domain "Good" or "Excellent" : (52%-60%).

Care/Case management for patients

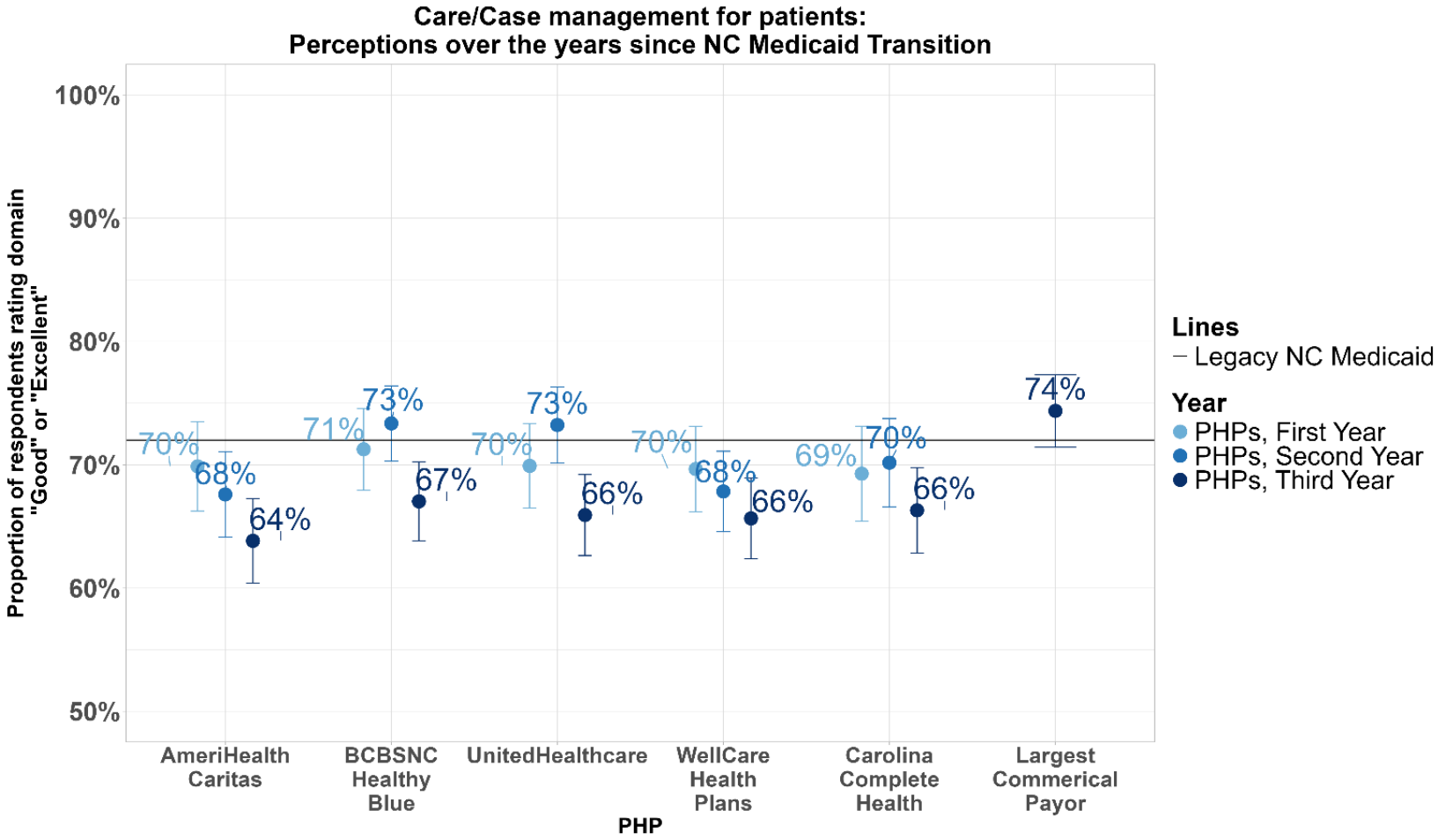
PHPs performed worse in Wave 4 compared to prior years. There were no appreciable differences between plans. BCBSNC Healthy Blue, UnitedHealthcare Community Plan, and Carolina Complete Health had a decline in performance in Wave 4 compared to prior years. PHPs performed worse than Legacy Medicaid.

Exhibit 31. Experience of provider organizations with care/case management for your patients, ranges from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Care/case management for your patients***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.75 (0.03)	2.71 (0.03)	2.66 (0.03)
BCBSNC Healthy Blue	2.80 (0.03)	2.78 (0.03)	2.73 (0.03)
UnitedHealthcare	2.78 (0.03)	2.78 (0.03)	2.71 (0.03)
WellCare Health Plans	2.75 (0.03)	2.70 (0.03)	2.69(0.03)
Carolina Complete Health	2.77 (0.03)	2.76 (0.03)	2.71 (0.03)
Largest Commercial Payor			2.85 (0.02)

Notes: Legacy NC Medicaid mean (standard error) : 2.83 (0.03).

Exhibit 32. Experience of provider organizations with care/case management for your patients, with 95% CI



Legacy NC Medicaid 95% CI of respondents rating domain “Good” or “Excellent” : (68%-75%).

Customer/Member support services for patients

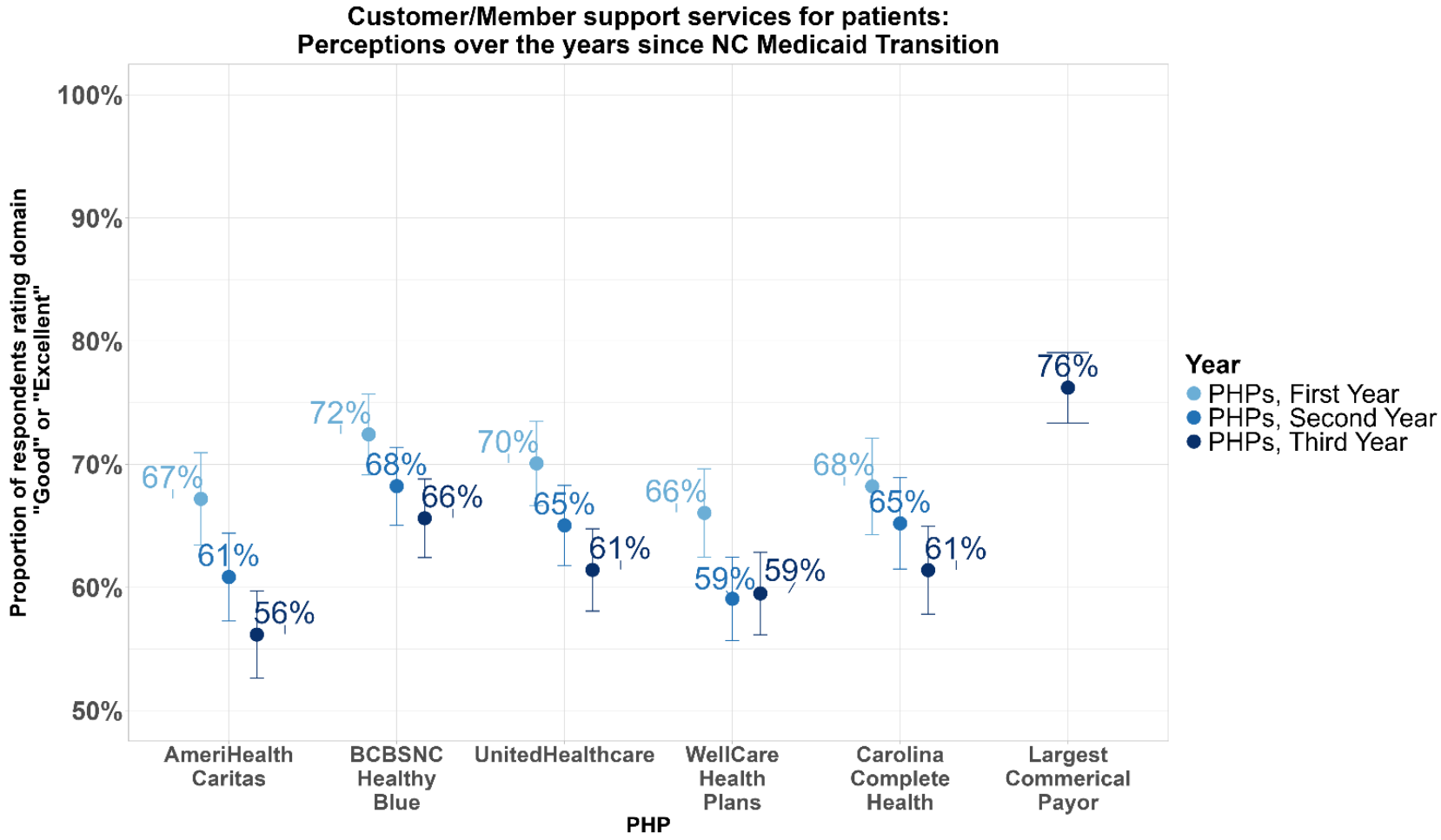
PHP performance has worsened over time since the transition to managed care. BCBSNC Healthy Blue performed the best and AmeriHealth Caritas the worst with the other plans in between.

Exhibit 33. Experience of provider organizations with customer/member support services for their patients, ranging from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Customer/member support services for patients***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.72 (0.03)	2.61 (0.03)	2.56 (0.03)
BCBSNC Healthy Blue	2.82 (0.03)	2.72 (0.03)	2.70 (0.03)
UnitedHealthcare	2.75 (0.03)	2.67 (0.03)	2.66 (0.03)
WellCare Health Plans	2.69 (0.03)	2.56 (0.03)	2.62 (0.03)
Carolina Complete Health	2.74 (0.03)	2.68 (0.03)	2.64 (0.03)
Largest Commercial Payor			2.87 (0.02)

Notes: This question was not asked in 2021 Baseline Survey

Exhibit 34. Experience of provider organizations with customer/member support services for their patients, with 95% CI



Notes: Not asked in Baseline Survey.

Support for addressing social determinants of health

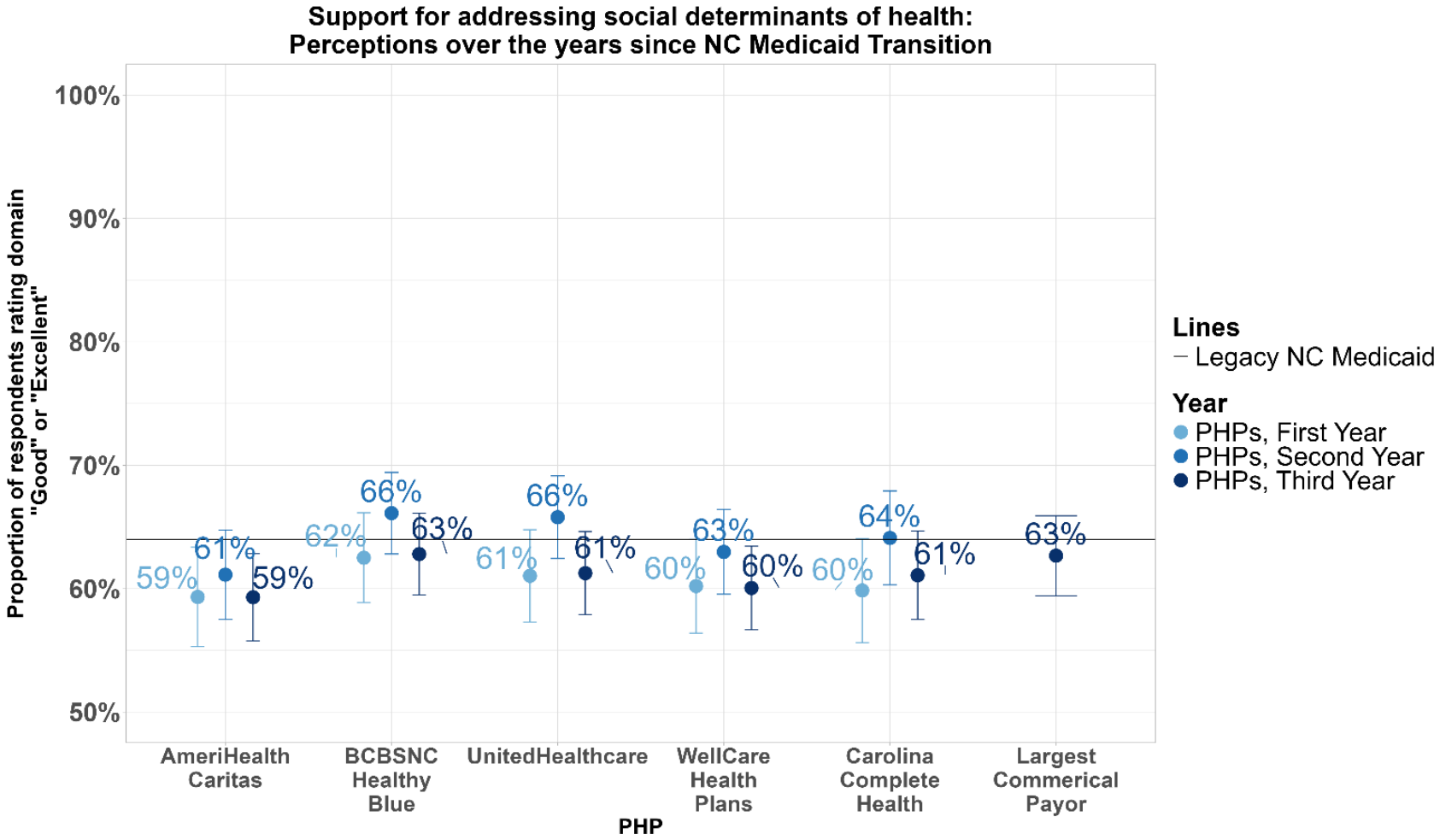
There were no appreciable differences over time or across PHPs. PHPs performed as well as commercial plans and similar to Legacy Medicaid.

Exhibit 35. Experience of provider organizations with support for addressing social determinants of health (food, education, housing, access to care, etc.), ranging from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Support for addressing social determinants of health (food, education, housing, access to care, etc.)***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.61 (0.03)	2.58 (0.03)	2.59 (0.03)
BCBSNC Healthy Blue	2.67 (0.03)	2.66 (0.03)	2.64 (0.03)
UnitedHealthcare	2.64 (0.03)	2.66 (0.03)	2.63 (0.03)
WellCare Health Plans	2.60 (0.03)	2.60 (0.03)	2.60 (0.03)
Carolina Complete Health	2.61 (0.03)	2.63 (0.03)	2.61 (0.03)
Largest Commercial Payor			2.66 (0.03)

Notes: Legacy NC Medicaid mean (standard error) : 2.68 (0.04).

Exhibit 36. Experience of provider organizations with support for addressing social determinants of health (food, education, housing, access to care, etc.), with 95% CI



Legacy NC Medicaid 95% CI of respondents rating domain “Good” or “Excellent” : (60%-67%).

Data sharing for quality and care management (timeliness and accuracy)

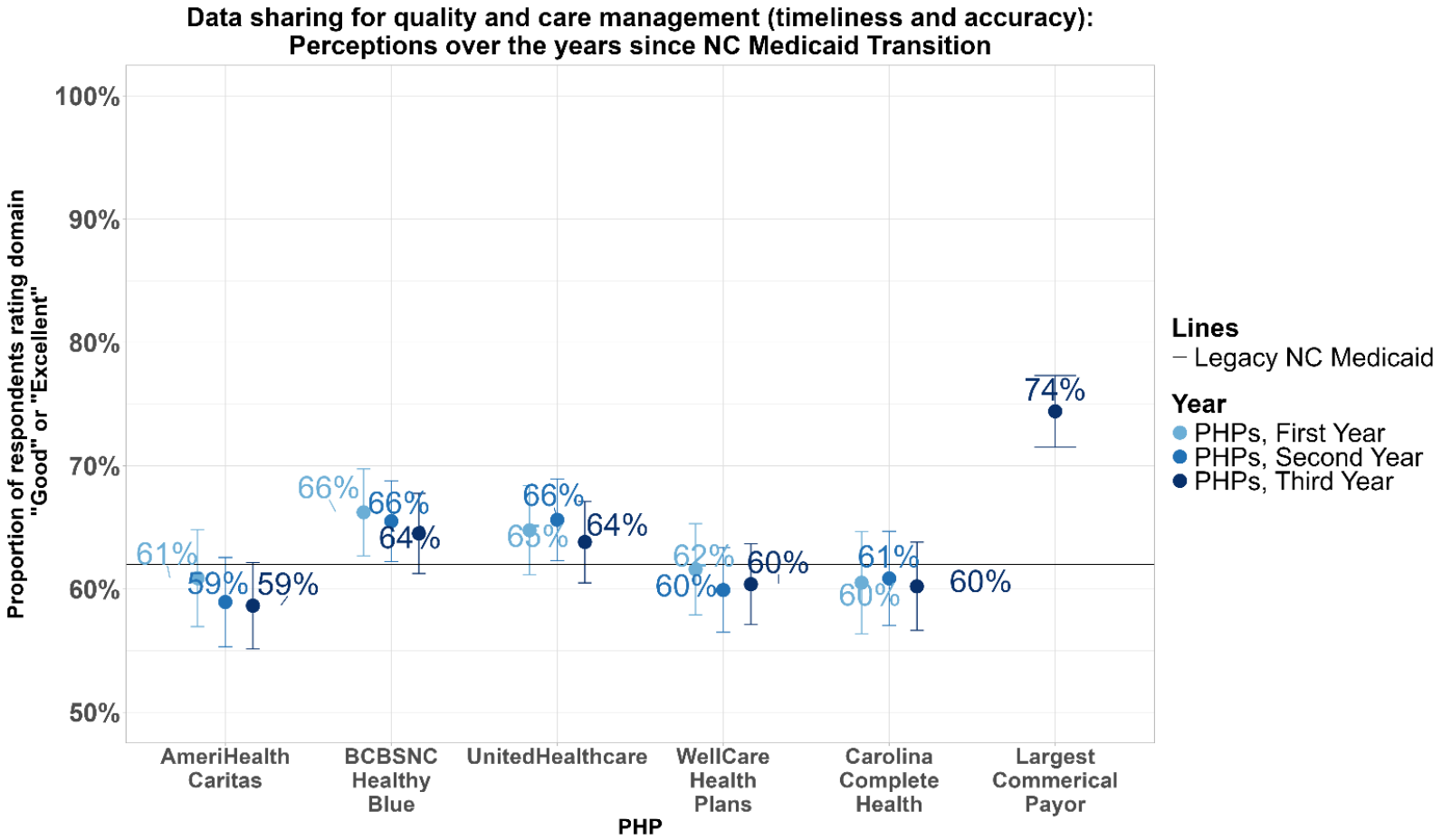
There were no appreciable differences in performance by PHPs over time. BCBSNC Healthy Blue and UnitedHealthcare Community Plan were the better performing plans in Wave 4, though differences across plans were small. PHPs performed considerably worse compared to commercial plans.

Exhibit 37. Experience of provider organizations with data sharing for quality and care management (timeliness and accuracy), ranging from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Data sharing for quality and care management (timeliness and accuracy)***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	2.57 (0.03)	2.55 (0.03)	2.57 (0.03)
BCBSNC Healthy Blue	2.69 (0.03)	2.67 (0.03)	2.68 (0.03)
UnitedHealthcare	2.68 (0.03)	2.67 (0.03)	2.68 (0.03)
WellCare Health Plans	2.57 (0.03)	2.58 (0.03)	2.62 (0.03)
Carolina Complete Health	2.60 (0.03)	2.60 (0.03)	2.63 (0.03)
Largest Commercial Payor			2.83 (0.03)

Notes: Legacy NC Medicaid mean (standard error) : 2.62 (0.04) .

Exhibit 38. Experience of provider organizations with data sharing for quality and care management (timeliness and accuracy), with 95% CI



Legacy NC Medicaid proportion (95% CI) of respondents rating domain “Good” or “Excellent” : 62% (58%-66%).

Process and accuracy for assigning patients to your practice (attribution)

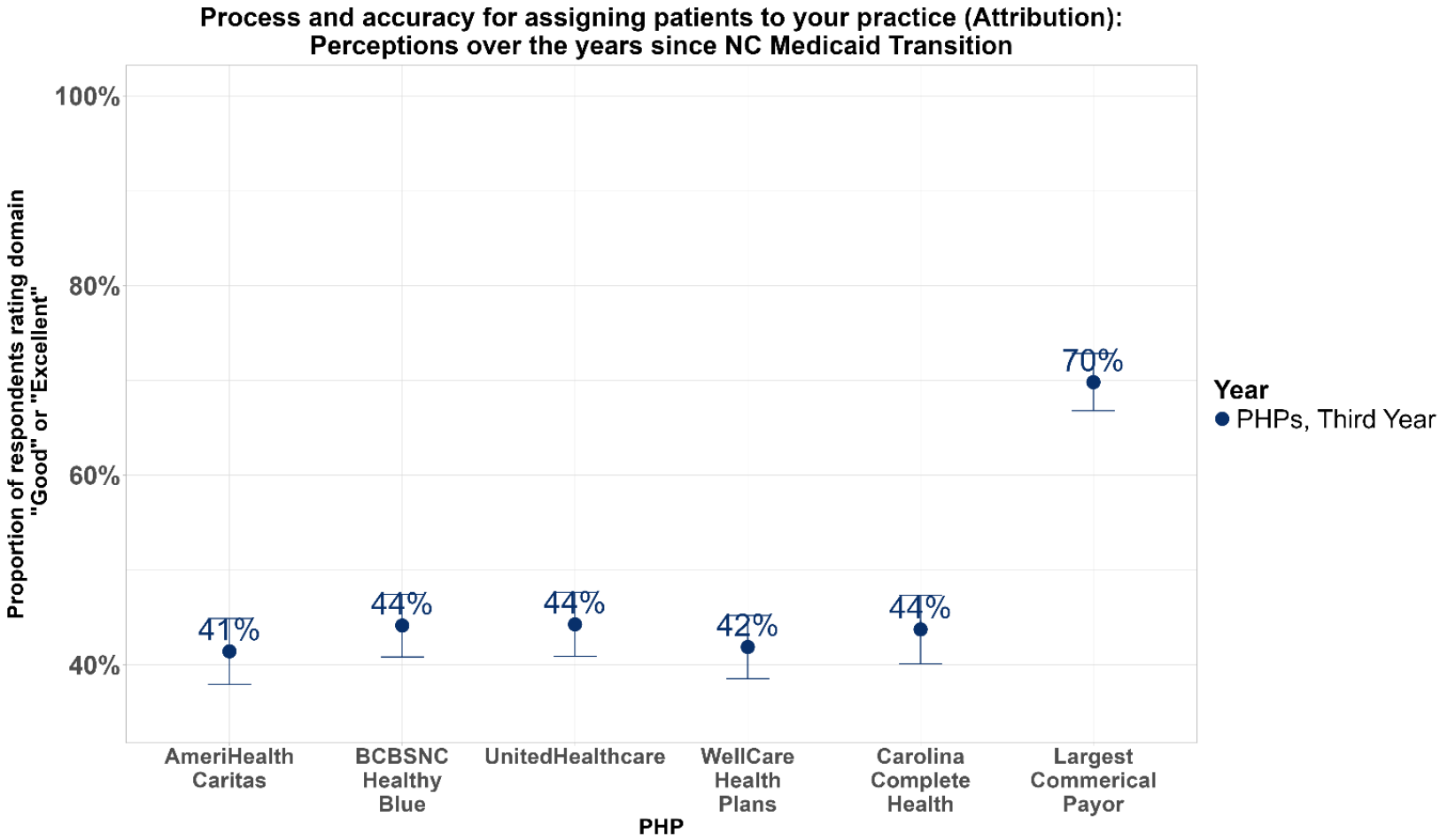
Provider organizations were asked about their experience with patient attribution for the first time in Wave 4. All PHPs had low performance, with little difference across plans. PHPs performed considerably worse compared to commercial plans.

Exhibit 39. Experience of provider organizations with data sharing for process and accuracy for assigning patients to your practice (attribution), ranging from 1 (poor) to 4 (excellent)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? ***Process and accuracy for assigning patients to your practice (attribution)***			
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**
AmeriHealth Caritas North Carolina	--	--	2.20 (0.03)
BCBSNC Healthy Blue	--	--	2.27 (0.03)
UnitedHealthcare	--	--	2.27 (0.03)
WellCare Health Plans	--	--	2.20 (0.03)
Carolina Complete Health	--	--	2.26 (0.04)
Largest Commercial Payor			2.79 (0.03)

Notes: Question was not asked Waves 1-3 .

Exhibit 40. Experience of provider organizations with data sharing process and accuracy for assigning patients to your practice (attribution), with 95% CI



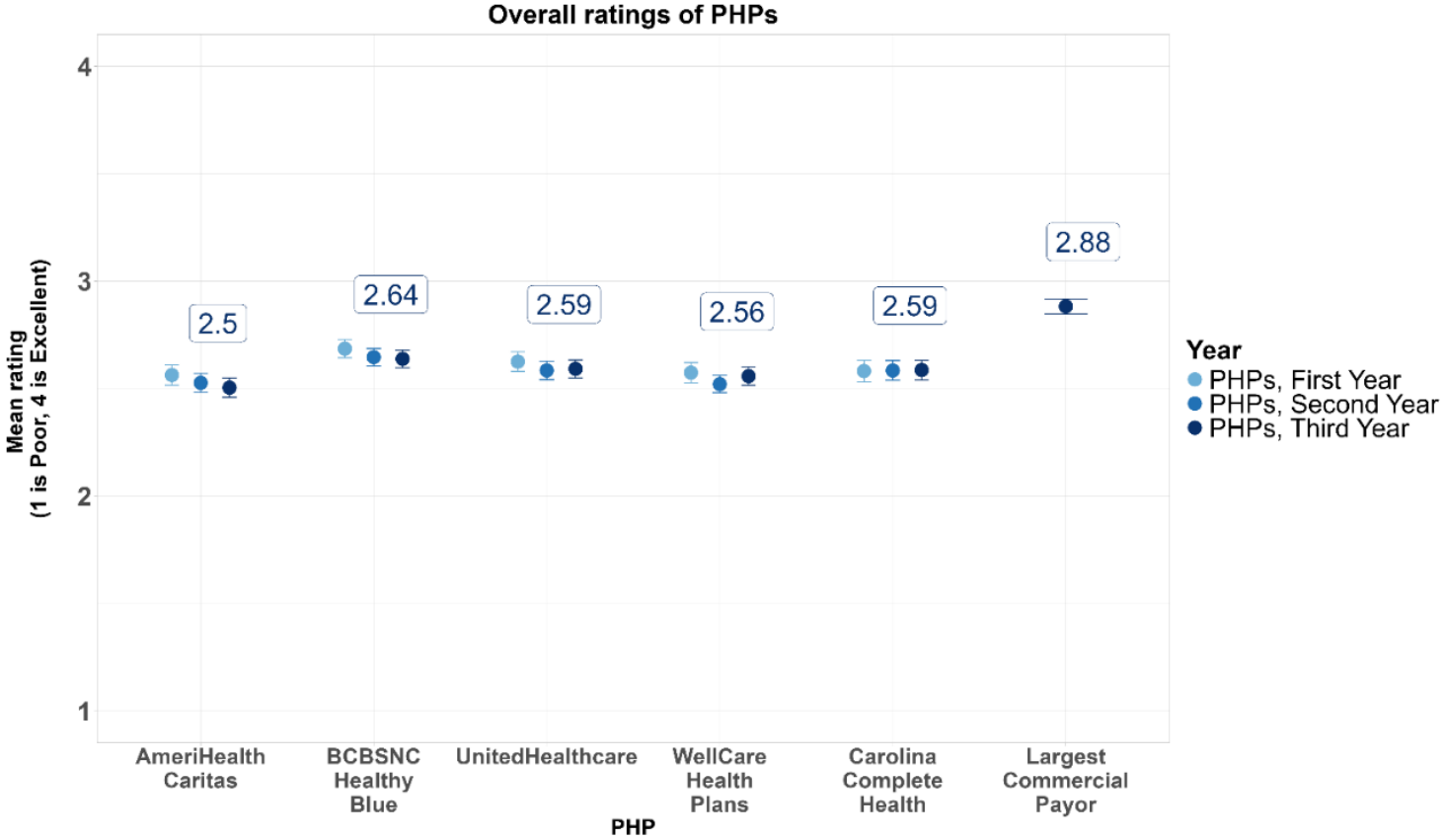
Notes: Not asked in Waves 1-3.

The ratings scale in this section ranges from 1 (poor) to 4 (excellent).

Overall ratings of PHPs

Overall, BCBSNC Healthy Blue had the highest overall rating of all PHPs in Wave 4; AmeriHealth Caritas had the lowest. Though the PHPs had no appreciable differences over time, AmeriHealth Caritas has been performing worse compared to other plans. PHPs were rated considerably worse than commercial plans.

Exhibit 41. All Domains: Mean ratings and 95% CI of PHPs across three years of managed care

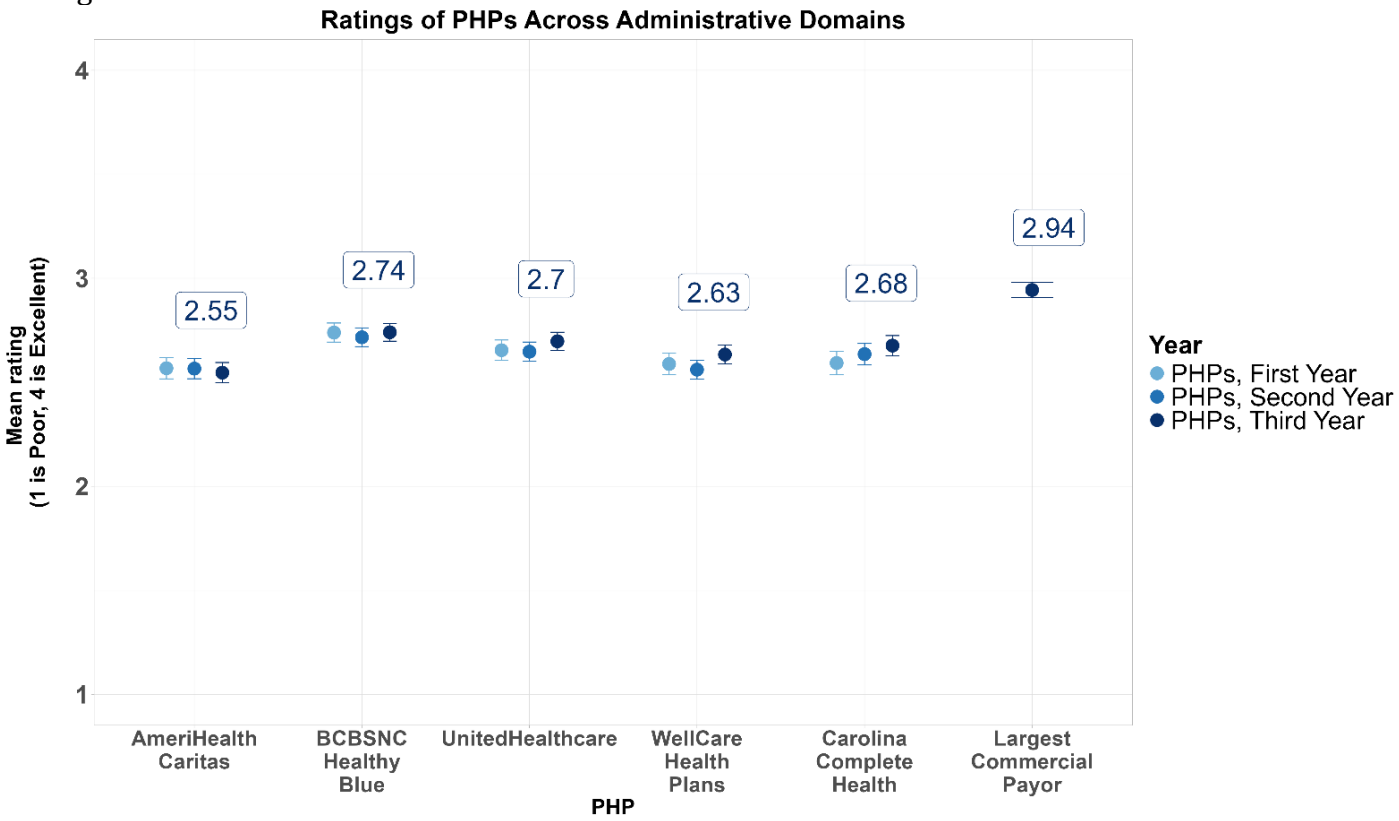


Notes: Data label reports Wave 4 mean. To allow for multiyear comparison, process and accuracy for assigning patients to your practice (attribution) is not included in Wave 4 estimate.

Ratings of PHPs across administrative domains

Across administrative domains, UnitedHealthcare Community Plan, WellCare, and Carolina Complete Health have improved their ratings over time. BCBSNC Healthy Blue and AmeriHealth Caritas have been the highest and lowest performing plans in all years of managed care, respectively. PHPs were rated considerably worse in administrative domains than commercial plans.

Exhibit 42. Administrative Domains: Mean ratings and 95% CI of PHPs across three years of managed care

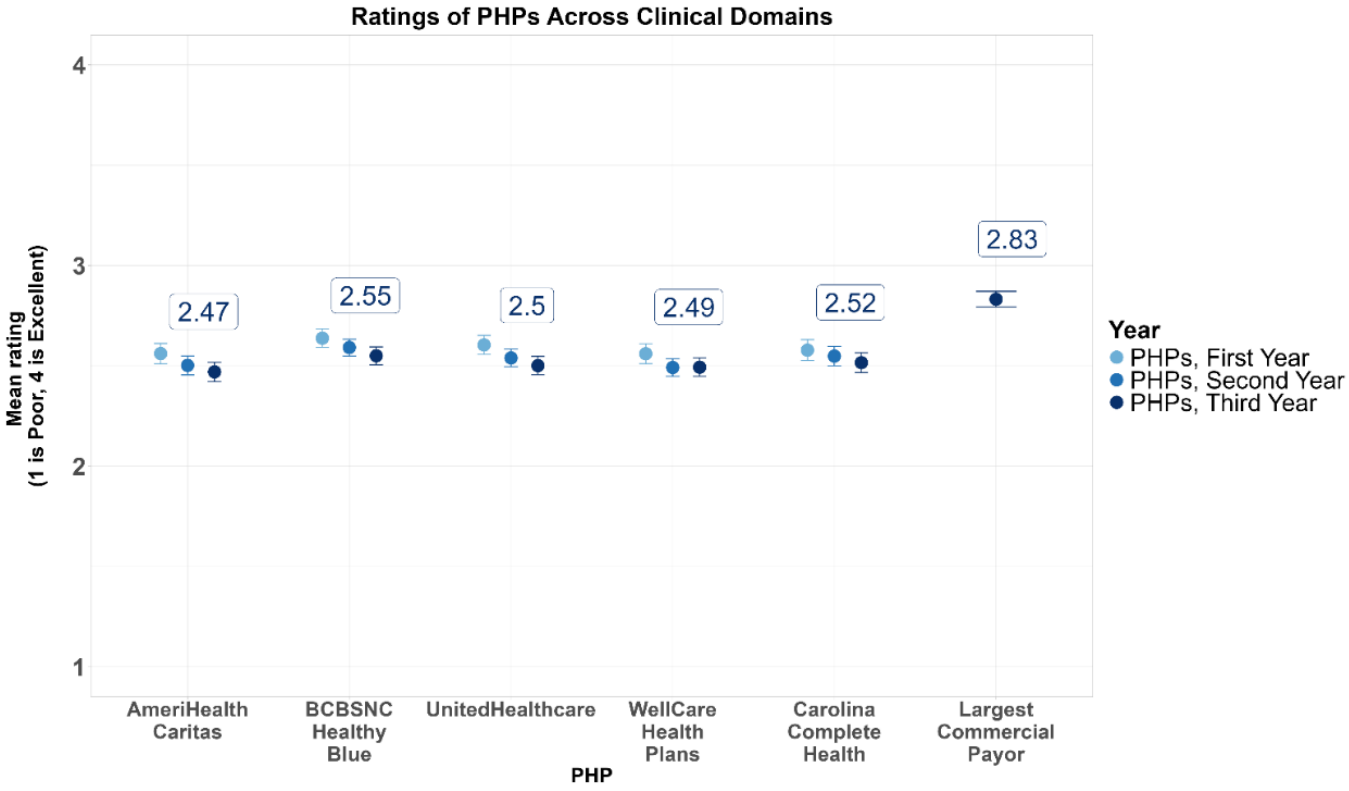


Notes: Data label reports Wave 4 mean. To allow for multiyear comparison, process and accuracy for assigning patients to your practice (attribution) is not included in Wave 4 estimate

Ratings of PHPs across clinical domains

Across clinical domains, most PHPs have worsened over time. The exception is WellCare, which did not have a change in performance between Wave 3 and Wave 4. There were no appreciable differences between plans in Wave 4. All plans were rated lower in clinical domains than in administrative domains. PHPs were rated considerably worse than commercial plans.

Exhibit 43. Clinical Domains: Mean ratings and 95% CI of PHPs across three years of managed care

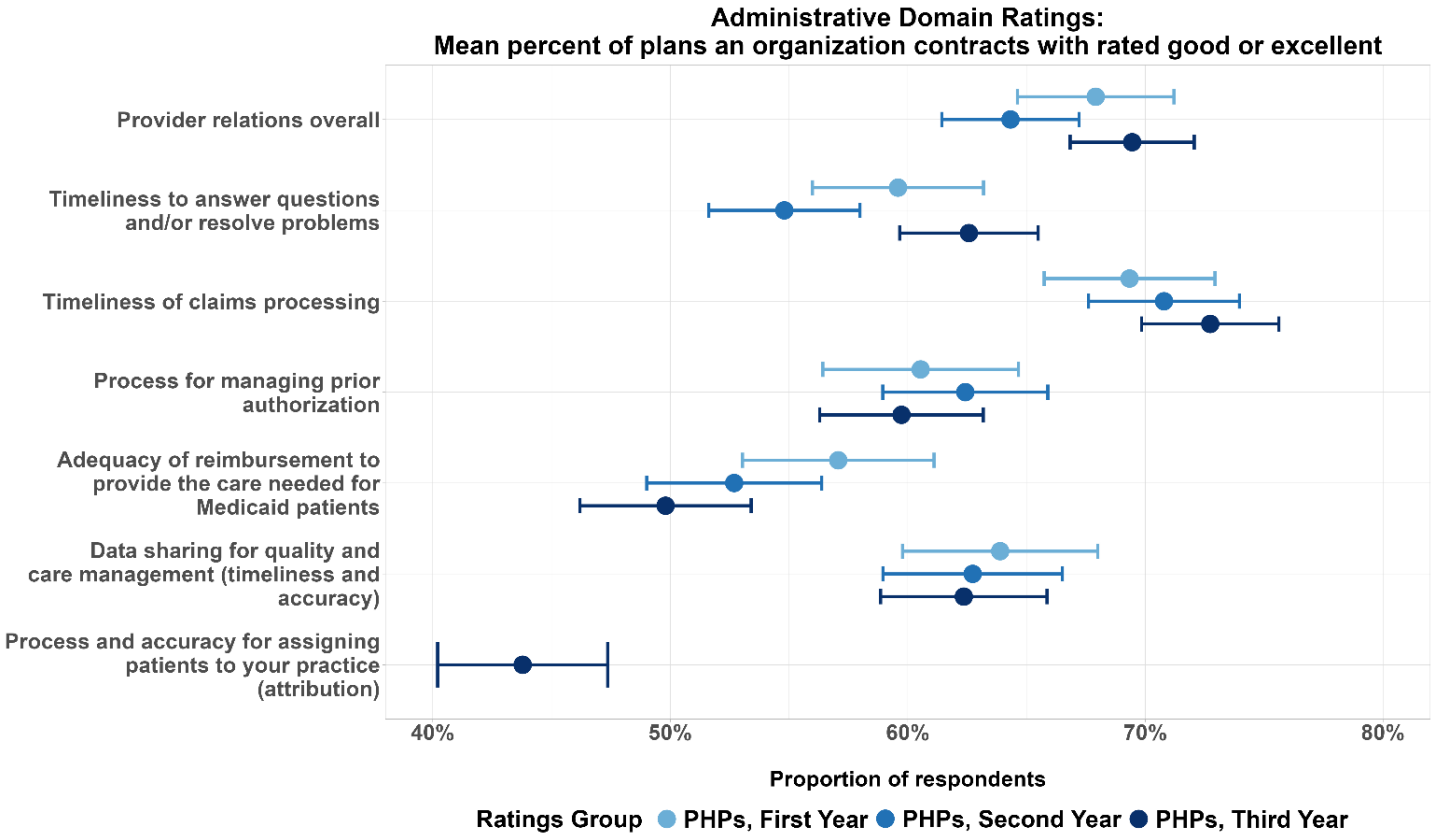


Note: Data label reports Wave 4 mean

Experience: Three years of Medicaid managed care

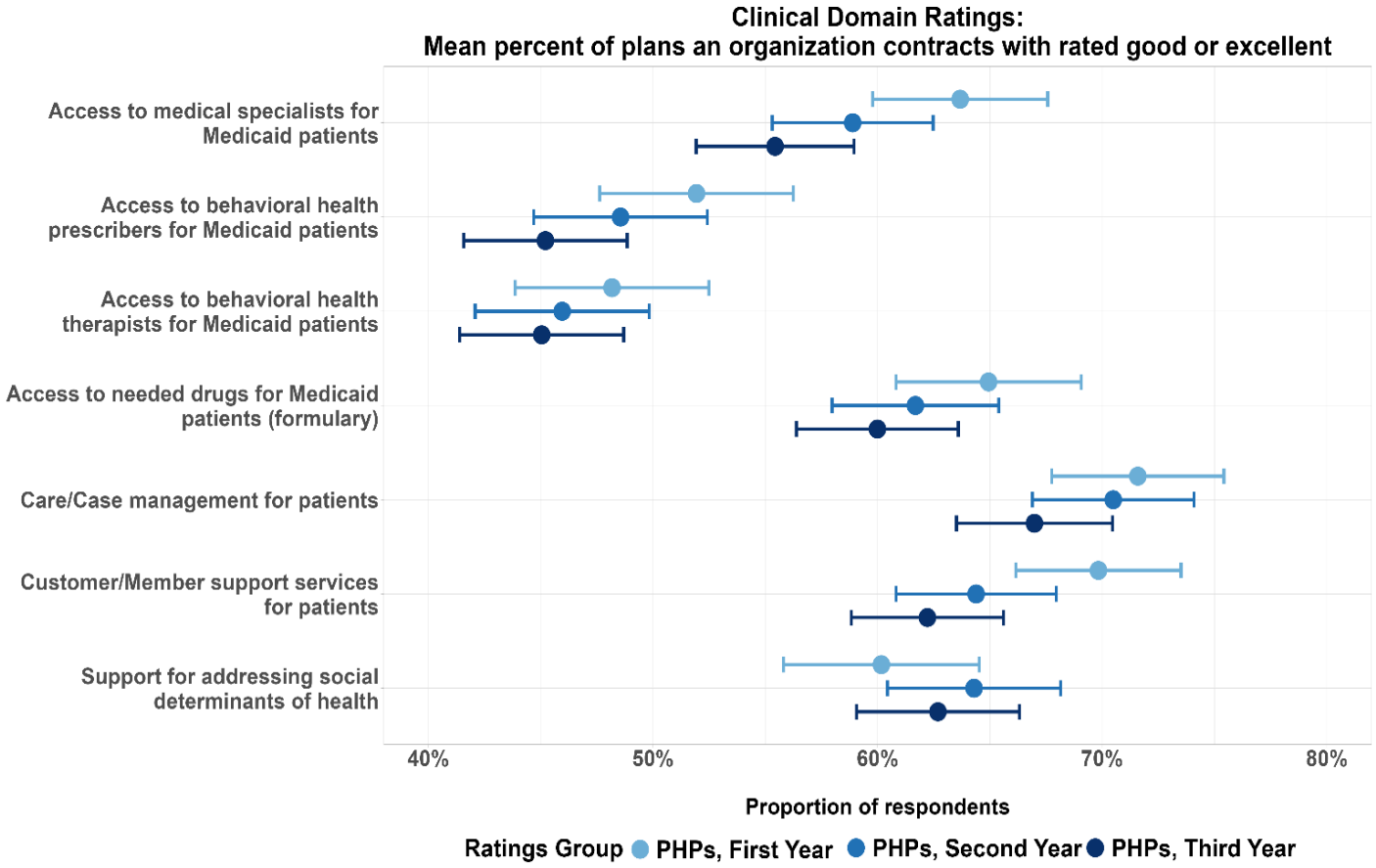
In the following exhibits, we combine the data across PHPs to estimate an overall performance of the PHPs together. This can be viewed as providers' overall experience. Overall, there were slight improvements in provider relations, timeliness to answer questions, and timeliness of claims processing. There was slight worsening in prior authorization, adequacy of reimbursement, and data sharing. Attribution was much worse than other domains and is an important sticking point. Poor attribution makes it harder for practices to agree to value-based contracts because they are being held accountable for patients they do not provide care for.

Exhibit 44a. Experience with administrative domains, by year after transition to PHPs



Among the clinical domains, there was worsening over time for all domains except for support for addressing social determinants of health. This broad worsening of experience likely reflects a general problem for Medicaid policy. Medicaid will need to work closely with PHPs and the provider community to understand how to turn this around. Policy approaches could include incentives and accountability standards for improvements in each of these areas as well as increasing minimum reimbursement rates particularly for access to medical and behavioral health specialists.

Exhibit 44b. Experience with clinical domains, by year after transition to PHPs



Perceptions of Overall Medicaid Transition to PHPs

Overall, most provider organizations felt that PHPs have not changed various aspects of health care delivery. Fewer providers responded that PHPs worsened or strongly worsened health care delivery compared to prior years. However, there was considerable worsening compared to the prior year in overall patient experience, overall health and well being, and overall financial health of practice/health system. Although we have identified several areas for improvement, this result suggests that providers have less nostalgia for Legacy Medicaid compared to prior years.

Exhibit 45. Provider organizations' feelings on how PHPs have affected various aspects of health care delivery in North Carolina.

Item	Strongly Improve N (%)	Improve N (%)	No Change N (%)	Worsen N (%)	Strongly Worsen N (%)
Overall health and well-being	23 (6.5%)	133 (37.0%)	161 (45.0%)	33 (9.3%)	8 (2.2%)
Overall quality of health care delivery	20 (5.7%)	130 (36.1%)	159 (44.3%)	35 (9.7%)	15 (4.2%)
Overall patient experience	17 (4.8%)	121 (33.8%)	152 (42.4%)	55 (15.2%)	13 (3.7%)
Overall financial health of your medical group or practice	17 (4.8%)	96 (26.9%)	147 (41.0%)	70 (19.7%)	27 (7.6%)
Overall provider experience	17 (4.8%)	87 (24.2%)	141 (39.2%)	80 (22.3%)	34 (9.5%)
Ability to access care	25 (7.0%)	114 (32.2%)	132 (37.2%)	65 (18.2%)	19 (5.4%)

Exhibit 46. Proportion of respondents' ratings that PHPs have worsened or strongly worsened various aspects of health care delivery in North Carolina , by year after transition to PHPs

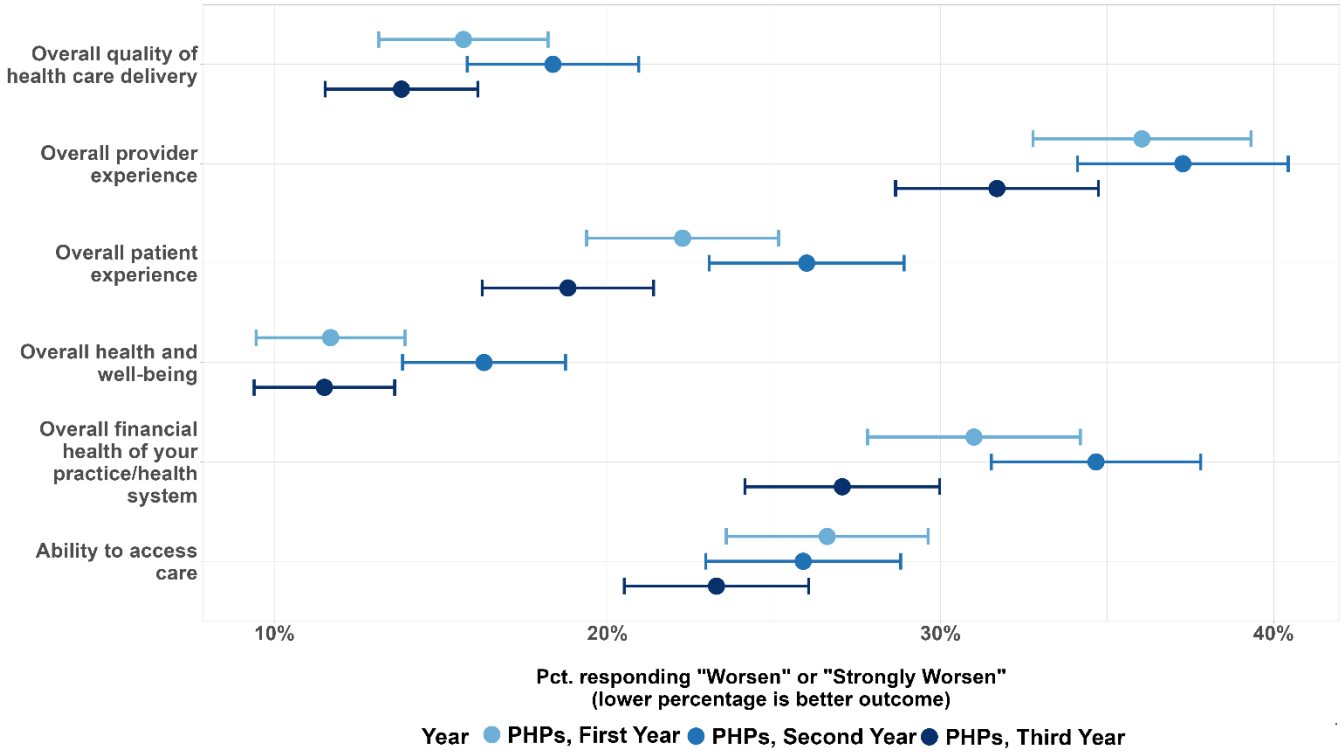


Exhibit 47. Responses when asked how provider organization feel PHPs have affected per capita total cost of care to the state Medicaid program

Item	N(%)
Increase substantially	49 (14.1 %)
Increase slightly	131 (37.4 %)
No change	129 (36.8 %)
Decrease slightly	33 (9.4 %)
Decrease substantially	8 (2.3 %)

Perceptions of Medicaid Expansion

Smaller practices perceived Medicaid expansion more favorably than medium and large practices, suggesting that expansion is helping smaller practices most. Rural practices had a slightly less positive view of how Medicaid expansion affects the health of their practice. From write-in responses, it appears this may be due to lack of personnel to handle the additional number of patients. Non-rural sites may have easier access to personnel to expand capacity.

Exhibit 48. Responses when asked how the provider organization feels Medicaid expansion will affect the number of Medicaid patients in their practice/health system

Item	N(%)
Increase substantially	94 (24.9 %)
Increase slightly	172 (48.1%)
No change	89(24.9 %)
Decrease slightly	2(0.01 %)
Decrease substantially	1 (< 0.01 %)

Exhibit 49. Responses when asked how the provider organization thinks Medicaid expansion will affect their practice/health system

Item	N (%)
Very positive change	49 (13.5 %)
Somewhat positive change	110 (30.6 %)
No change	146 (40.8 %)
Somewhat negative change	41 (11.5 %)
Very negative change	13 (3.6 %)

Exhibit 50. Provider organizations' feelings on how Medicaid expansion will affect their practice/health system, stratified by size

Item	Small Provider Organizations (n = 115) N (%)	Medium Provider Organizations * (n = 160) N (%)	Large Provider Organizations (n = 86) N (%)
Very positive change	16 (14.1%)	16 (10.1%)	16 (19.0%)
Somewhat positive change	39 (34.2%)	49 (31.0%)	22 (25.1%)
No change	46 (40.2%)	70 (44.2%)	30 (35.3%)
Somewhat negative change	7 (6.3%)	20 (12.4%)	14 (16.8%)
Very negative change	6 (5.3%)	4 (2.3%)	3 (3.8%)

Notes: Small =1-2 providers, medium 3-9, large >=10. *Analysis of variance test demonstrates mean response for medium size organizations is significantly lower than small organizations.

Exhibit 51. Provider organizations' feelings on Medicaid expansion will affect their practice/health system, stratified by rurality

Item	Has rural practice site* (n = 186) N (%)	Does not have rural practice site (n = 176) N(%)
Very positive change	19 (10.4%)	29 (16.8%)
Somewhat positive change	53 (28.8%)	56 (32.6%)
No change	82 (44.4%)	64 (37.0%)
Somewhat negative change	22 (11.8%)	19 (11.2%)
Very negative change	9 (4.6%)	4 (2.5%)

Note: *Analysis of variance test demonstrates mean response for organizations with rural practice is significantly lower than practices with no rural practice

Exhibit 52. Write-in responses: Please comment on how Medicaid expansion will have a positive or negative effect on your practice

Themes write-in responses (from most common to least common)	Quote
Positive effect	
1. **Increases patient volume**	"I think that it will be a positive change as it will bring more patients to the practice increasing the practice revenue."
2. **Patients having greater access to care**	"There are no negatives. We are finding these patients largely more complex and in need of many services, but we are happy to dig in and help connect them to every available resource."
3. **Reducing financial harm to patients**	"Less financial burden on patients wanting to schedule."
Negative effect	
1. **Administrative burden**	"It has increased the volume of patients. However, the mandates of paperwork for care gaps and requirements for keeping track of patient's annual wellness exams, closing care gaps are becoming more of a burden of the practice as some patients are non-complaint. This is something we keep stressing to the

	insurance companies as we are held liable for the disconnect with the patients."
2. Reimbursement concerns	"It just means more patients we have to get poorly reimbursed for who still need and deserve the high-quality medical care we provide."
3. Not having enough providers to meet higher demand/ unable to meet care needs	"We are a small, single provider rural office. We have not been able to limit our panel sizes and will not be able to accommodate many new unknown patients."
4. Increase in appointment no-shows	"[W]e cannot charge a No Show fee to this group for the missed appointments -which means missed revenue for the clinic."

The results show almost exactly the same proportion of practices using the Collaborative Care Model (CCM) and that substantial barriers remain. In particular, practices do not have psychiatrists to support the model, and reimbursement is not sufficient to cover the costs of the model. These are clear policy targets for the state.

Exhibit 53. Presence of embedded or co-located behavioral health among provider organizations

Item	N (%)
Yes, in all offices	63 (18.1%)
Yes, in some offices	30 (8.6%)
No	257 (73.4%)

Exhibit 54. Themes of write-in responses for other reasons practice/health system does not have embedded or co-located behavioral health professionals in its primary care office(s)

Themes write-in responses (from most common to least common)
1. Shortage of behavioral health professionals (e.g., especially behavioral health providers who want this type of job)
2. Have preferred referral locations/relationships
3. Solo practice that does not have space or need to house embedded behavioral health services
4. Not enough funding
5. Unsure about this option
6. Not interested in this option
7. Planning on doing this with more space or new practice which is still growing
8. Not enough patient volume to trigger need for integrated behavioral health

Exhibit 55. Use of Collaborative Care Model among provider organizations

Item	N (%)
Yes, in all offices	60 (17.0%)
Yes, in some offices	13 (3.7%)
No	234 (66.5%)
I don't know what the Collaborative Care Model	45 (12.8%)

Exhibit 56. Provider organizations' reasons for not having an embedded or co-located behavioral health professional or not using the Collaborative Care Model in its primary care office(s)

Item	Not enough space in the office(s) N (%)	Unable to sustain a position with current reimbursement N (%)	Not enough demand among our patients N (%)	Administrative processes are too burdensome N (%)	We do not have access to a psychiatrist to support collaborative care N (%)
If your provider organization does not have an embedded or co-located behavioral health professional, please select all reasons why your organization does not (N eligible = 287)	146 (52.8%)	136 (49.3%)	70 (25.2%)	84 (30.4%)	N/A
If your provider organization does not use the Collaborative Care Model in its primary care office(s), please select all reasons why your organization does not use it (N eligible = 247)	105 (43.0%)	118 (48.5%)	70 (28.6%)	88 (36.2%)	112 (45.7%)

Exhibit 57. Themes of write-in responses for other reasons why practice/health system does not use the Collaborative Care Model in its primary care office(s)

Themes write-in responses (from most common to least common)
1. Not interested
2. Shortage of behavioral health professionals
3. Have embedded behavioral health professional
4. Have preferred referral locations/relationships
5. Considering it or in the process of getting this started

Exhibit 58. Provider organizations' responses when asked whether they were planning to contract with Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans (starting in 2024):

North Carolina will launch Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans in 2024. Is your health care organization planning to contract with Tailored Plans?			
Response	**2022 N (%)**	**2023 N (%)**	**2024 N (%)**
Yes	116 (29.9%)	211 (61.6%)	230 (64.4%)
No	74 (18.9%)	46 (13.4%)	52 (14.6%)
I don't know about Tailored Plans	199 (51.3%)	86 (25%)	75 (21.0%)

Notes: At the time this survey was written, Tailored Plans were expected to launch sometime in 2024.

Major Themes of Open-ended Comments: Experiences Working with Prepaid Health Plans

Question wording: *Below, please provide any comments or additional areas that are important about your experience with the Prepaid Health Plans. It is helpful if you mention specific PHPs. Your responses are anonymous to the state and the health plans.*

- **Patient Attribution.** Many provider organizations reported incorrect patient attribution and the process to correct attribution lists being a significant administrative burden. Organizations have described patients falling outside their parameters on NC Tracks being attributed to their practice. A frequently cited issue with organization being assigned patients outside practice age range limits (e.g., patients over age 21 being attributed to pediatric practice, newborns being assigned to adult internal medicine clinic). Ultimately, issues with attribution are impacting providers' ability to process claims and to report on required quality measures.

  Quote: "The inability to remove patients attributed to our practice in error has made the entire Medicaid transformation frustrating and greatly affects the efficacy of the program. It makes it almost impossible for practices to focus on methods of improving health care delivery because we are so focused on trying to determine legitimate patient lists. There has to be a solution to help both patient and practices overcome this challenge."

- **Payment challenges.** Many provider organizations reported issues with reimbursement. Some organizations said that payment challenges were the reason why they dropped certain PHPs. Some FHQCs report not being reimbursed at the correct rate and issues to resolve such errors. A specific issue that was mentioned by organizations is difficulty in getting payment for services for newborns who are auto-enrolled in a PHP that they do not contract with.

  Quote: "Newborns don't get entered in NCTracks usually until a week after birth, sometimes longer… They have to see a provider within 2-3 days of discharge from the hospital. If [omitted PHP name] is the state selected health plan, we won't know until it's loaded in NCTracks. Our providers are unknowingly seeing them for free because [omitted PHP name] is has gotten smart and assigned all these newborns another PCP so they don't have to pay us anything. We are writing off thousands of dollars.**"**

- **Claims denials and processes for resolution.** Many provider organizations reported overall dissatisfaction with the claims process. A commonly reported issue is resolving denied claims. Existing issues with timeliness resolving problems with PHPs is making it difficult to reprocess claims.

  Quote: "[Omitted PHP name] - Repeatedly deny claims with the reason that the NPI is wrong, yet it is not. It takes months to appeal, and each claim must have a separate appeal. The employee time involved it this process is not cost effective."

Frustration and administrative burden of dealing with many PHPs. Many provider organizations who responded expressed general dissatisfaction with the PHPs and cited

issues with billing processes, incentive programs, and quality measures across PHPs, inaccurate rates/unsatisfactory payment, responsiveness to requests. Many organizations commented on the continuous administrative burden and stress on their staff since transition to managed care.

> **Quote**: "I believe that all of the plans should have the same benefits as traditional Medicaid. Giving someone a ride to the office, but not approving their medicine, labs, or referrals is insane."

Other open-ended comments

Question wording: *OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how North Carolina providers are experiencing the shift to Medicaid managed care, along with any anticipated or encountered issues in the transformation.*

Additional themes in write-in responses

- **Tailored Plan rollout.** Organizations shared apprehension that the program is continuing without resolving issues with the pre-existing infrastructure (e.g., attribution, member support). Some providers expressed concern about the administrative burden that tailored plans will add to their practice.
    - **Quote**: "Tailored plans will likely be a major problem for all providers. The processes are unclear, the plans do not seem prepared, and providers are simply burned out and overburdened with all the new / constantly changing rules tied to just the 5 PHPs. "
- **Medicaid reimbursement is not enough to cover costs.** Organizations facing higher costs from administrative burden do not believe that they are financially able to continue to accept Medicaid patients based on Medicaid reimbursement.

    Quote: "Privatized PHPs materially hamper payment systems, including through pre-authorization, denials and appeals, assignment, and overall fidelity with DHB's fee schedule. It's difficult to improve health outcomes when services are unpaid."

- **Patient care.** Providers are concerned about the added burden to their patients navigating a complex system. Ultimately, many organizations expressed concerns about the impact of the transition on patients' ability to access needed care.
    - **Quote:** "This has been a burdensome change for providers and patients. It has been confusing for patients and we feel things should go back to all patients being Medicaid direct."

DISCUSSION

This report presents provider experience at the end of the third year of NC Medicaid Managed Care. The results of the Wave 4 survey demonstrate overall worsening of provider experience and marginal change in provider confidence that NC Medicaid Managed Care will improve care and reduce costs. Compared to Legacy Medicaid, the PHPs were, on average, performing worse in most clinical and administrative domains. Adequacy of reimbursement continues to be a challenge as provider experience has worsened over time. Domains in which PHPs' performance in prior years of managed care was rated higher than Legacy Medicaid, such as access to behavioral health prescribers (**Exhibit 26**) and access to formulary (**Exhibit 30**), have worsened over time and are falling back to levels seen in the year prior to transition to managed care. Domains in which PHP performance was roughly comparable to legacy Medicaid in prior years of managed care have fallen below pre-transition rate. Examples of this trend include adequacy of reimbursement (**Exhibit 22**) and case/care management (**Exhibit 32**).

When comparing provider experience with PHPs in aggregate in Wave 4 versus prior waves, there are emergent trends. Overall, PHPs were improving in answering questions and/or resolving problems and support for addressing social determinants of health. Unfortunately, there was significant worsening in access to medical specialists (**Exhibit 24**), access to behavioral health prescribers (**Exhibit 26**), and customer/member support services for patients (**Exhibit 34**).

Important differences were noted when comparing Wave 4 results between individual PHPs. BCBSNC Healthy Blue is the higher performing plan in most domains. Conversely, AmeriHealth Caritas was performing worse than all other PHPs in most domains. An example in which the performance between the two is apparent is provider relations overall, in which the percentage of positive experience with BCBSNC Healthy Blue is 17% higher than AmeriHealth Caritas (**Exhibit 14**). Among the domains in which there was minimal PHP difference, all plans were rated low on patient attribution.

Differences between PHPs within domains are apparent. Over time, provider relations overall improved for all PHPs other than AmeriHealth Caritas, with Carolina Complete Health having the most significant improvement in this measure. The trend for timeliness to answer questions, and claims processing was similar, with AmeriHealth Caritas worsening over time in contrast to all other PHPs. WellCare Health Plans and Carolina Compete Health saw standout improvements in these categories. Another aspect in which we see differences across plans is the improvement with respect to Legacy Medicaid. UnitedHealthcare Community Plan, WellCare Health Plans, and Carolina Complete Health have all improved on timeliness to answer questions and/or resolving problems to be at or above Legacy Medicaid.

Wave 4 was the first time providers were asked to rate their experience with their largest commercial payor. With the exception of care/case management support for addressing social determinants of health, the PHPs performed considerably worse compared to the largest commercial provider. The range included no difference between commercial payor vs. BCBSNC Healthy Blue for addressing social determinants of health to a 35% difference between commercial payor vs. AmeriHealth Caritas for access to medical specialists. Not only did providers

report lower satisfaction with Medicaid reimbursement rates, they also reported lower satisfaction across most other domains. This suggests that it is not only reimbursement, but other factors that led to worse experience compared with commercial plans.

This evaluation has identified areas of concern. The percentage of providers with positive PHP experience on reimbursement and patient attribution is less than 50% (**Exhibit 40**). Common themes in open ended comments, such as nonpayment and frustration with the inability to directly correct attribution lists ,support these quantitative findings. The downward trend in process for managing prior authorizations, access to behavioral health prescribers, access to formulary, and care/case management highlights the potential for complete reversal of improvement since Medicaid transition. Although claims processing improved for most plans, after 3 years of managed care it is still below Legacy Medicaid.

Medicaid expansion appears to be a bright spot for a majority of practices in the state. Practices are seeing more Medicaid patients and the vast majority reported positive or neutral effects on the health of their business. Smaller practices were more likely to report positive effects than medium or large practices suggesting that expansion is particularly good for them.

In summary, this report shows the continued worsening of provider experiences working with PHPs. Combining the quantitative results and the qualitative comments from practices, it appears that low reimbursement and difficulties in finding in-network specialists and behavioral health prescribers are creating significant burdens on practices. Qualitative comments highlight the financial strain on small and rural practices. Statewide efforts to address PHP performance will be important to preserving access to and quality of care for patients with NC Medicaid.

Recommendations for the Division of Health Benefits

- Results indicate worsening behavioral health access across all plans suggesting that statewide approaches may be more important than plan specific approaches.
- PHPs performance in care/case management has declined suggesting that providers are not valuing the current PHP approaches. The medical home model seeks to embed care management in the practices, however practices feel that reimbursement for these services is not nearly sufficient. Creating a more effective strategy between PHPs and practices could be beneficial for all.
- Growing differential performance across plans suggests that the state should strategize to improve plan performance. In domains where there is differential effectiveness across plans, there is opportunity for sharing best practices as well as clarifying expectations for underperforming plans. In domains where effectiveness is similar across all plans, collaborative work between the state and PHPs could identify state policies that may improve provider experience.
- Expansion of the Collaborative Care Model is proceeding slowly. Almost exactly the same proportions of practices have implemented the CCM compared with last year. Practices identify several barriers to implementation including 50% indicating they cannot sustain

CCM with current reimbursement. We anticipate that expansion of this effective model will stall unless reimbursement improves. Since CCM is felt to be cost saving (not just cost effective), greater reimbursement would be a much better investment by Medicaid than most other health care services.

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APPENDIX

Stratified Experience of Provider Organizations

This section presents several stratifications of the provider satisfaction domains that are presented across all participating organizations in the previous section. Primarily, there are three stratifications: (1) Small provider organizations (1-2 providers) versus medium-sized provider organizations (3-9 providers) versus large provider organizations (10+ providers), (2) Provider organizations with rural practice sites versus those with no rural practice sites, and (3) Provider organizations that provide Ob/Gyn care versus those who only provide primary care. The domains presented in the previous section are grouped into two categories, administrative domains and clinical domains.

Stratified Experience Ratings: Size of Provider Organization

Exhibit A1. Mean ratings of PHPs across all domains, stratified by provider organization size

Overall ratings for PHPs stratified by size			
PHP	**Small Provider Organizations (n = 114) Mean (SE)**	**Medium Provider Organizations (n = 160) Mean (SE)**	**Large Provider Organizations (n = 86) Mean (SE)**
AmeriHealth Caritas North Carolina	2.54 (0.04)	2.50 (0.03)	2.38 (0.05)
BCBSNC Healthy Blue	2.71 (0.04)	2.60 (0.03)	2.51 (0.04)
UnitedHealthcare	2.67 (0.04)	2.54 (0.03)	2.49 (0.05)
WellCare Health Plans	2.64 (0.04)	2.51 (0.03)	2.43 (0.05)
Carolina Complete Health	2.67 (0.04)	2.56 (0.03)	2.44 (0.05)
Largest Commercial Payor	2.97 (0.04)	2.89(0.02)	2.73 (0.04)

Notes: Small =1-2 providers, medium 3-9, large >=10.

Exhibit A2. Mean ratings of PHPs across all domains, stratified by provider organization size

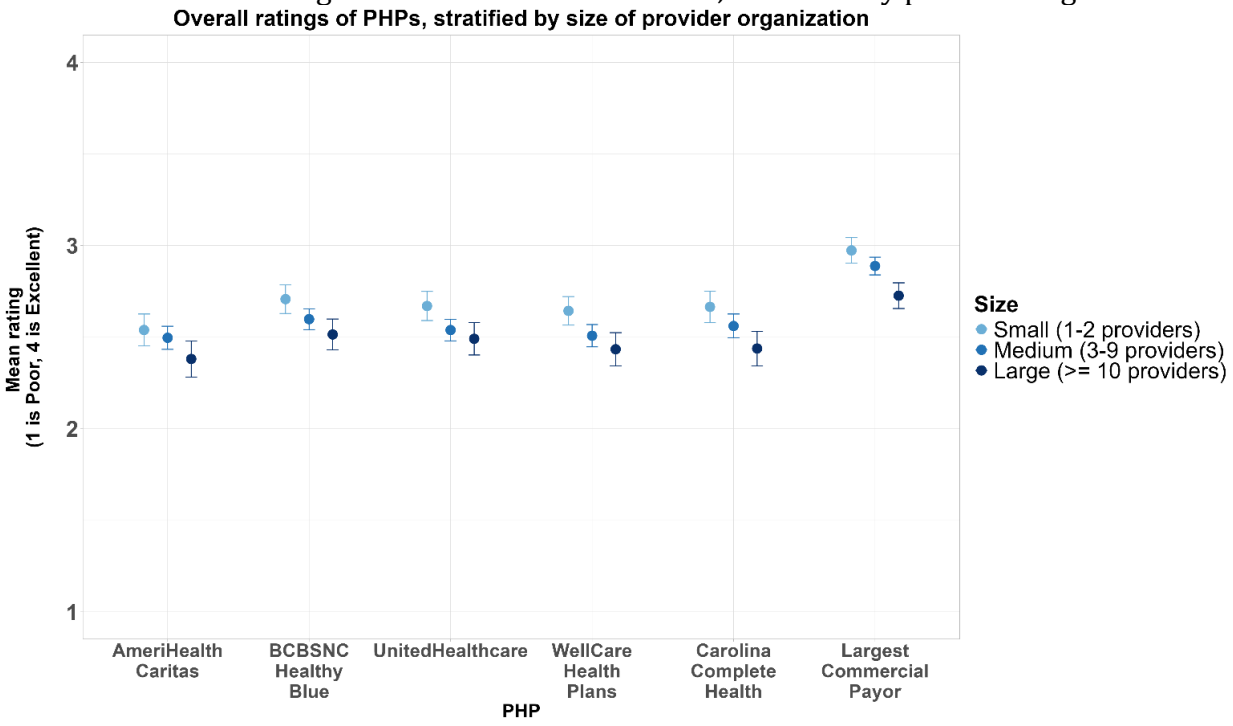


Exhibit A3. Mean ratings of PHPs across administrative domains, stratified by provider organization size

Administrative ratings for PHPs stratified by size			
PHP	**Small Provider Organizations (n = 115) Mean (SE)**	**Medium Provider Organizations (n = 160) Mean (SE)**	**Large Provider Organizations (n = 86) Mean (SE)**
AmeriHealth Caritas North Carolina	2.57 (0.05)	2.54 (0.03)	2.32 (0.05)
BCBSNC Healthy Blue	2.80 (0.04)	2.68 (0.03)	2.50 (0.05)
UnitedHealthcare	2.77 (0.04)	2.60 (0.03)	2.52 (0.05)
WellCare Health Plans	2.72 (0.04)	2.55 (0.03)	2.41 (0.05)
Carolina Complete Health	2.76 (0.04)	2.63 (0.03)	2.41 (0.05)
Largest Commercial Payor	3.02 (0.04)	2.97 (0.03)	2.71 (0.04)

Notes: Small =1-2 providers, medium 3-9, large >=10.

Exhibit A4 . Mean ratings of PHPs across administrative domains, stratified by provider organization size

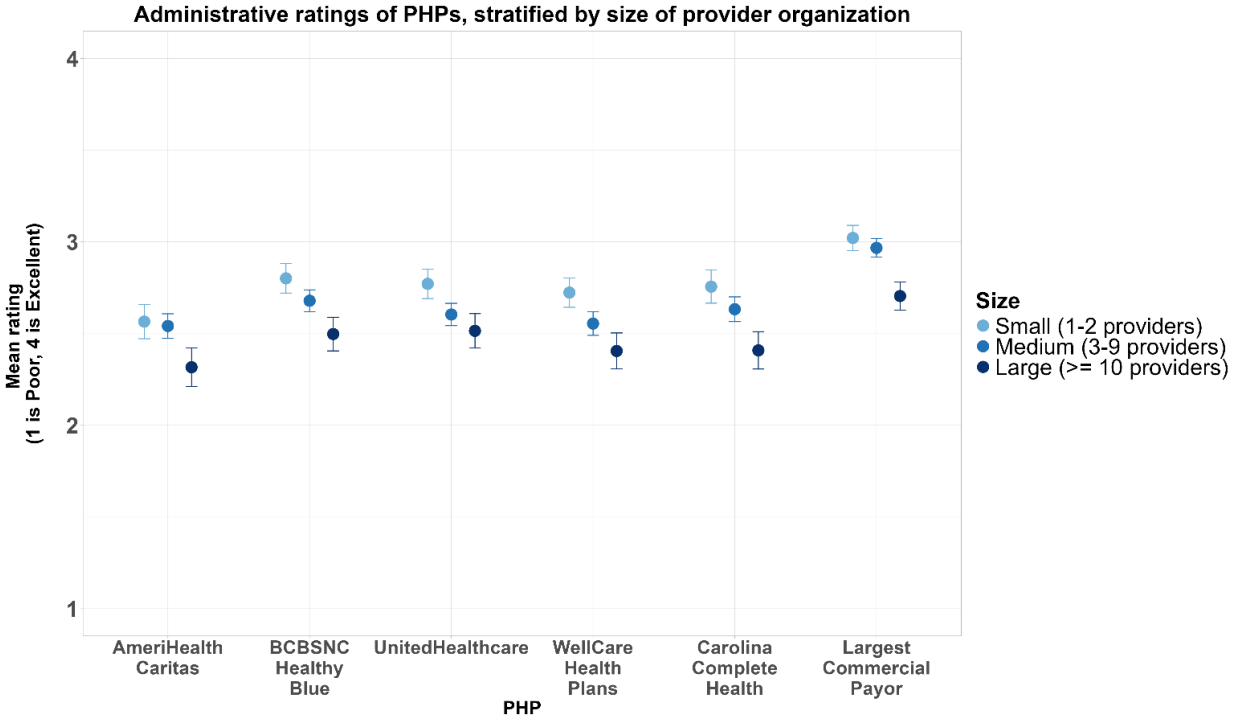
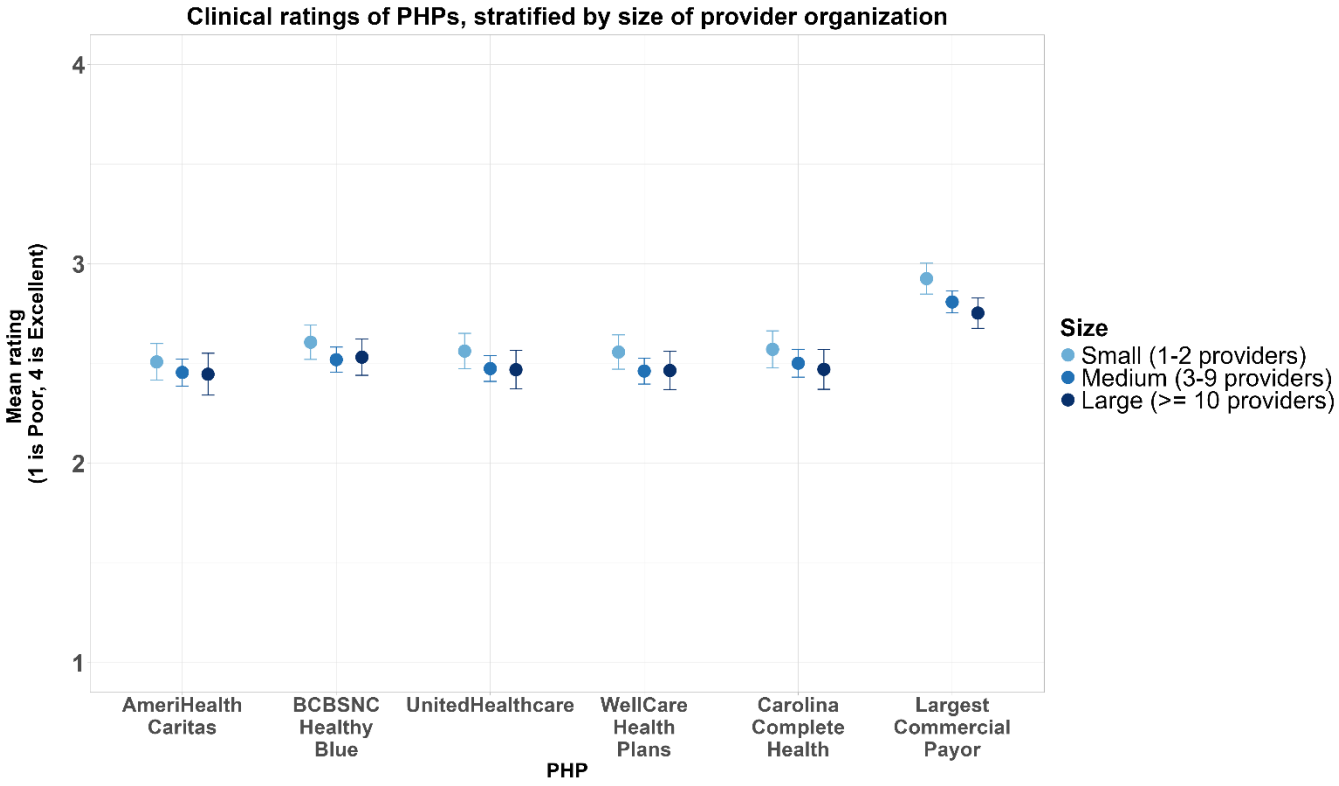


Exhibit A5. Mean ratings of PHPs across clinical domains, stratified by provider organization size

Clinical ratings for PHPs stratified by size			
PHP	**Small Provider Organizations (n = 115) Mean (SE)**	**Medium Provider Organizations (n = 160) Mean (SE)**	**Large Provider Organizations (n = 86) Mean (SE)**
AmeriHealth Caritas North Carolina	2.51 (0.05)	2.46 (0.03)	2.45 (0.05)
BCBSNC Healthy Blue	2.61 (0.04)	2.52 (0.03)	2.53 (0.05)
UnitedHealthcare	2.56 (0.05)	2.48 (0.03)	2.47 (0.05)
WellCare Health Plans	2.56 (0.04)	2.46 (0.03)	2.47 (0.05)
Carolina Complete Health	2.57 (0.05)	2.50 (0.04)	2.47 (0.05)
Largest Commercial Payor	2.93 (0.04)	2.81 (0.03)	2.75 (0.04)

Notes: Small =1-2 providers, medium 3-9, large >=10.

Exhibit A6. Mean ratings of PHPs across clinical domains, stratified by provider organization size



Stratified Experience Ratings: Provider organizations with a rural practice site vs. provider organizations without a rural practice site

Exhibit A7. Mean ratings of PHPs across all domains, stratified by rurality of provider organization

Overall ratings for PHPs stratified by rurality		
PHP	**Has rural practice site (n = 186) Mean (SE)**	**Does not have rural practice site (n = 176) Mean (SE)**
AmeriHealth Caritas North Carolina	2.46 (0.03)	2.51 (0.03)
BCBSNC Healthy Blue	2.61 (0.03)	2.62 (0.03)
UnitedHealthcare	2.58 (0.03)	2.56 (0.03)
WellCare Health Plans	2.51 (0.03)	2.56 (0.03)
Carolina Complete Health	2.55 (0.03)	2.58 (0.03)
Largest Commercial Payor	2.84 (0.02)	2.91 (0.02)

Exhibit A8. Mean ratings of PHPs across all domains with 95% confidence intervals, stratified by rurality of provider organization

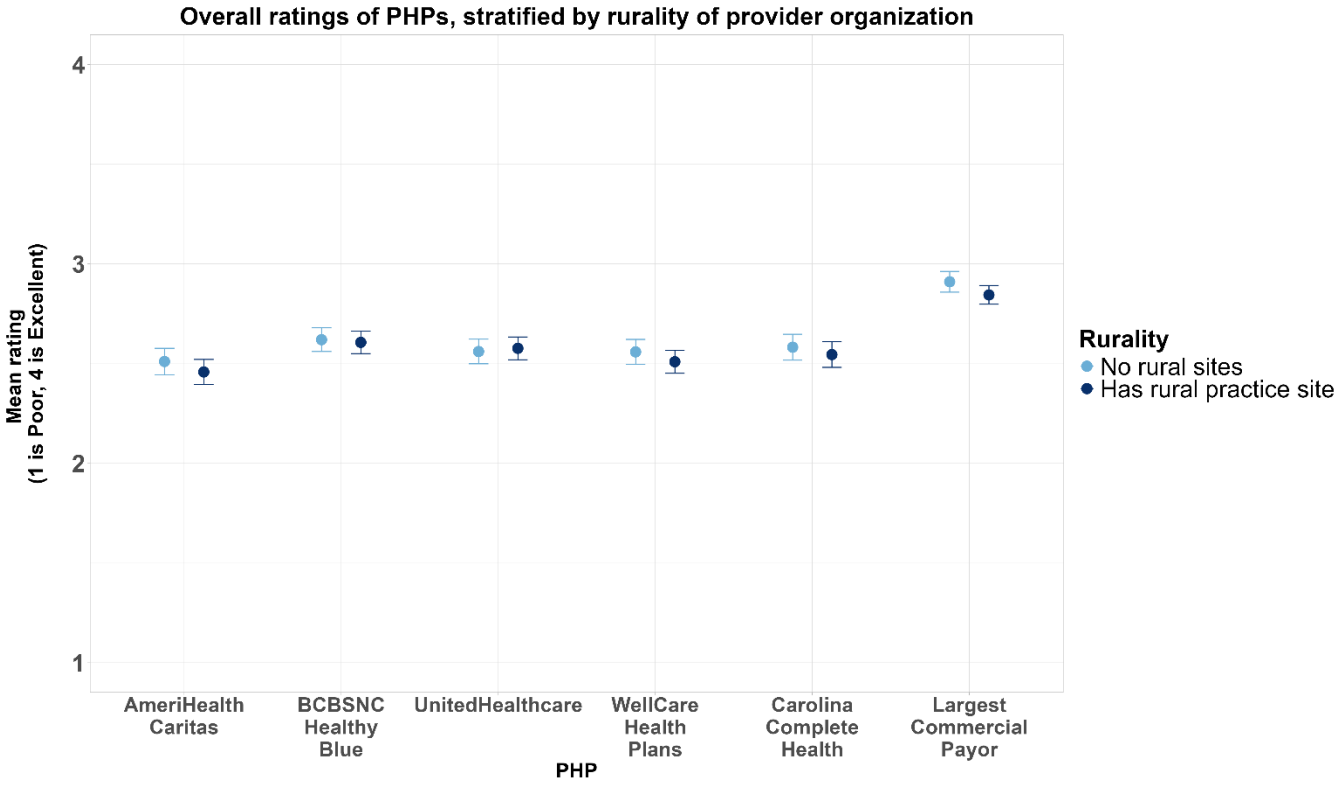


Exhibit A9. Mean ratings of PHPs across administrative domains, stratified by rurality of provider organization

Administrative ratings for PHPs stratified by rurality		
PHP	**Has rural practice site (n = 186) Mean (SE)**	**Does not have rural practice site (n = 175) Mean (SE)**
AmeriHealth Caritas North Carolina	2.46 (0.03)	2.54 (0.04)
BCBSNC Healthy Blue	2.65 (0.03)	2.70 (0.03)
UnitedHealthcare	2.62 (0.03)	2.65 (0.03)
WellCare Health Plans	2.54 (0.03)	2.61 (0.03)
Carolina Complete Health	2.58 (0.03)	2.65 (0.04)
Largest Commercial Payor	2.89 (0.02)	2.96 (0.03)

Exhibit A10. Mean ratings of PHPs across administrative domains with 95% confidence intervals, stratified by rurality of provider organization

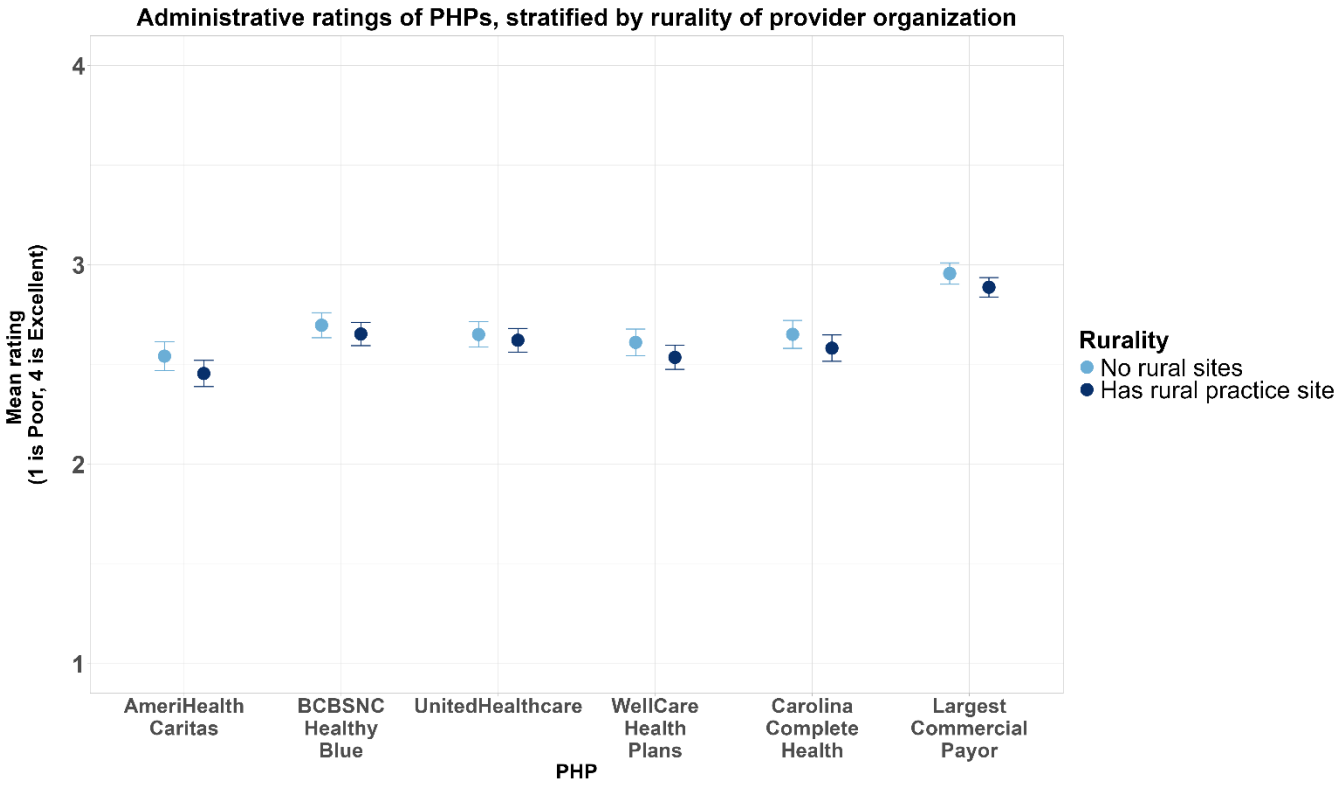
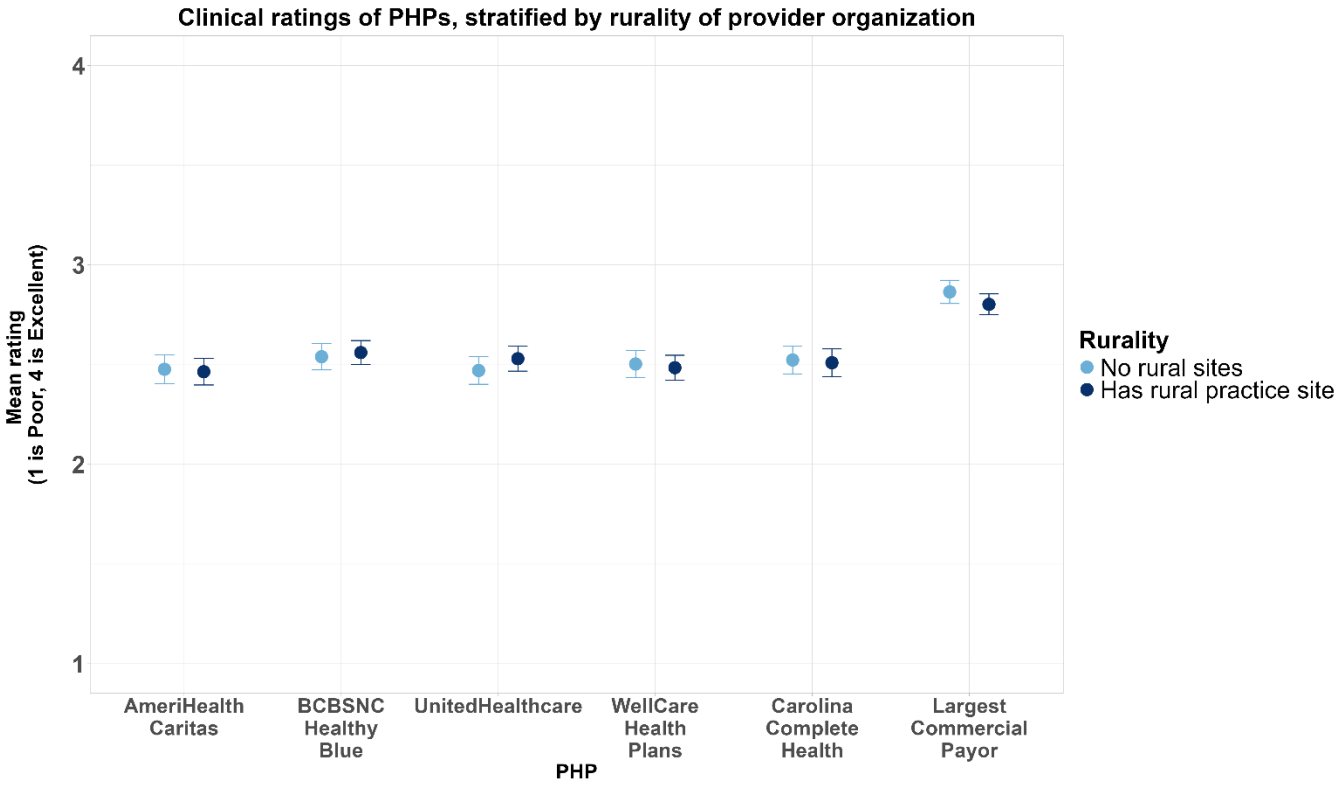


Exhibit A11. Mean ratings of PHPs across clinical domains, stratified by rurality of provider organization

Clinical ratings for PHPs stratified by rurality		
PHP	**Has rural practice site (n = 186) Mean (SE)**	**Does not have rural practice site (n = 176) Mean (SE)**
AmeriHealth Caritas North Carolina	2.46 (0.03)	2.48 (0.04)
BCBSNC Healthy Blue	2.56 (0.03)	2.54 (0.03)
UnitedHealthcare	2.53 (0.03)	2.47 (0.04)
WellCare Health Plans	2.48 (0.03)	2.50 (0.03)
Carolina Complete Health	2.51 (0.04)	2.52 (0.04)
Largest Commercial Payor	2.80 (0.03)	2.86 (0.03)

Exhibit A12. Mean ratings of PHPs across clinical domains with 95% confidence intervals, stratified by rurality of provider organization



Stratified Experience Ratings: Provider organizations that provide Ob/Gyn care versus those who provide only primary care

Exhibit A13 . Mean ratings of PHPs across all domains, stratified by whether the organization provides Ob/Gyn care

Overall ratings for PHPs stratified by provision of Ob/Gyn care		
PHP	**Provides Ob/Gyn care (n = 37) Mean (SE)**	**Does not provide Ob/Gyn care (n = 324) Mean (SE)**
AmeriHealth Caritas North Carolina	2.33 (0.06)	2.50 (0.03)
BCBSNC Healthy Blue	2.45 (0.06)	2.63 (0.02)
UnitedHealthcare	2.45 (0.06)	2.58 (0.02)
WellCare Health Plans	2.38 (0.06)	2.55 (0.02)
Carolina Complete Health	2.40 (0.07)	2.58 (0.02)
Largest Commercial Payor	2.68 (0.05)	2.90 (0.02)

Exhibit A14 . Mean ratings of PHPs across all domains with 95% confidence intervals, stratified by whether the provider organization provides Ob/Gyn care

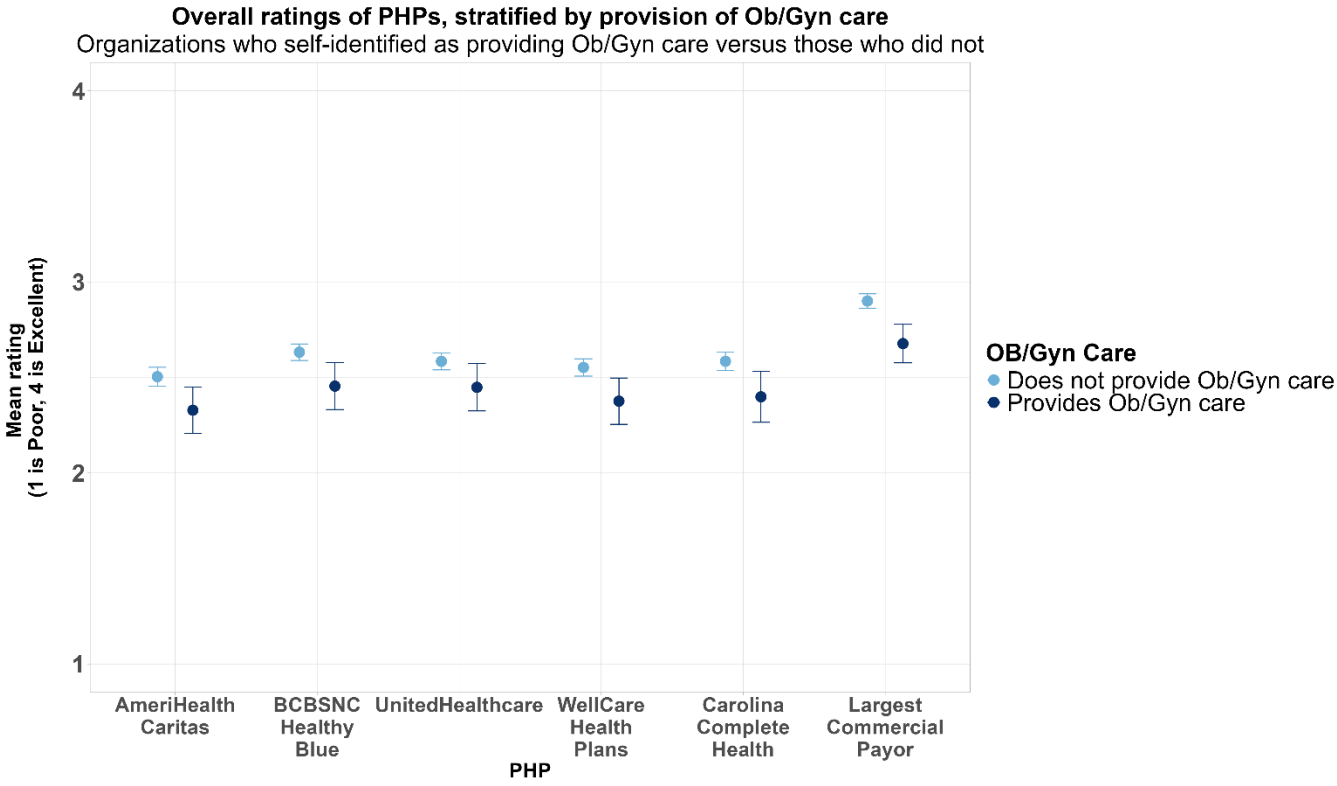


Exhibit A15 . Mean ratings of PHPs across administrative domains, stratified by whether the organization provides Ob/Gyn care

Administrative ratings for PHPs stratified by provision of Ob/Gyn care		
PHP	**Provides Ob/Gyn care (n = 37) Mean (SE)**	**Does not provide Ob/Gyn care (n = 324) Mean (SE)**
AmeriHealth Caritas North Carolina	2.23 (0.06)	2.53 (0.03)
BCBSNC Healthy Blue	2.42 (0.07)	2.70 (0.02)
UnitedHealthcare	2.43 (0.07)	2.66 (0.02)
WellCare Health Plans	2.32 (0.06)	2.60 (0.02)
Carolina Complete Health	2.40 (0.07)	2.64 (0.03)
Largest Commercial Payor	2.68 (0.05)	2.95 (0.02)

Exhibit A16 . Mean ratings of PHPs across administrative domains with 95% confidence intervals, stratified by whether the provider organization provides Ob/Gyn care

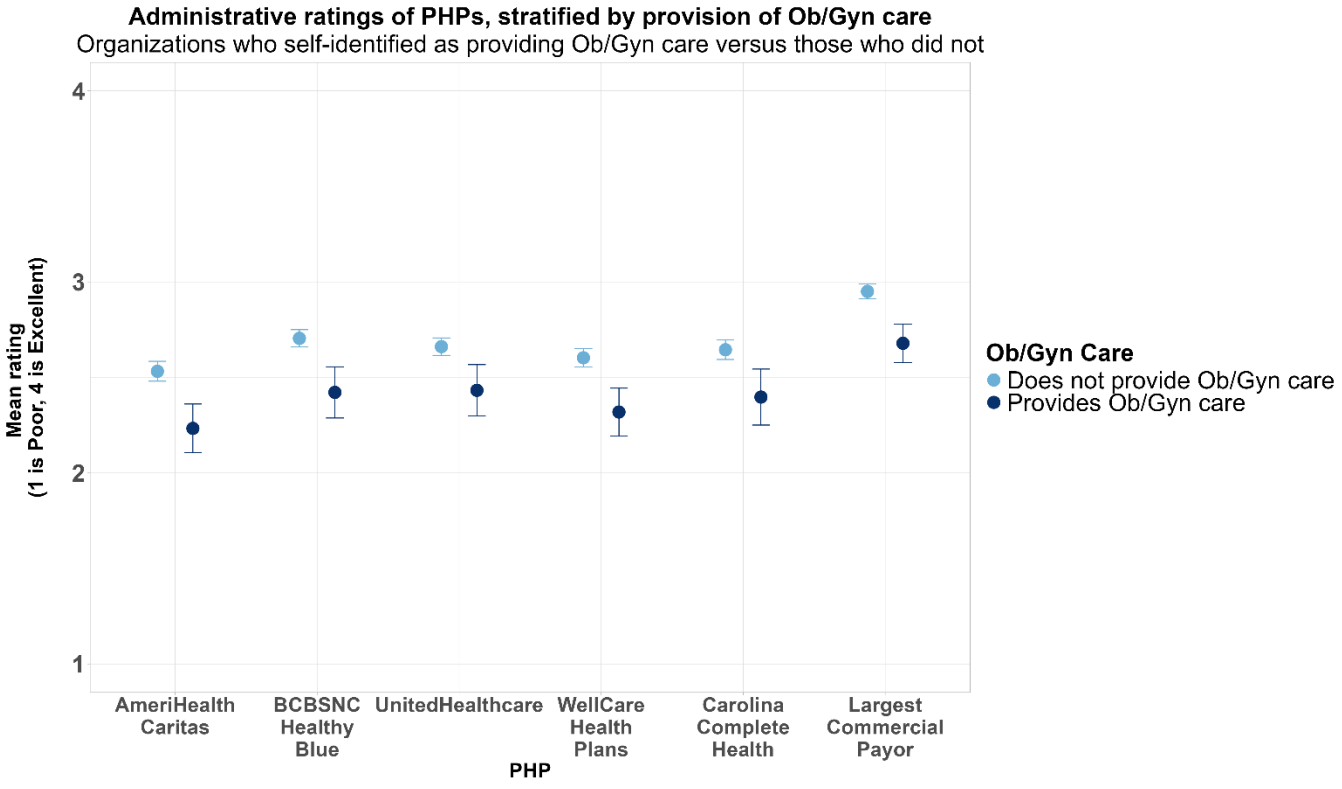


Exhibit A17. Mean ratings of PHPs across clinical domains, stratified by whether the organization provides Ob/Gyn care

Clinical ratings for PHPs stratified by provision of Ob/Gyn care		
PHP	**Provides Ob/Gyn care (n = 37) Mean (SE)**	**Does not provide Ob/Gyn care (n = 324) Mean (SE)**
AmeriHealth Caritas North Carolina	2.42 (0.06)	2.48 (0.03)
BCBSNC Healthy Blue	2.49 (0.06)	2.56 (0.02)
UnitedHealthcare	2.46 (0.07)	2.51 (0.03)
WellCare Health Plans	2.43 (0.07)	2.50 (0.02)
Carolina Complete Health	2.40 (0.07)	2.53 (0.03)
Largest Commercial Payor	2.67(0.06)	2.85 (0.02)

Exhibit A18. Mean ratings of PHPs across clinical domains with 95% confidence intervals, stratified by whether the provider organization provides Ob/Gyn care