2025 Medicaid Primary Care Provider Experience Survey

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

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LIST OF ABBREVIATIONS

Abbreviation	Definition
NC Medicaid	North Carolina Medicaid Program
Ob/Gyn	Obstetrics and Gynecology
ACO	Accountable Care Organizations
VBP	Value-based payment
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 5	Fourth year of Standard Prepaid Health Plans
Wave 4	Third year of Standard Prepaid Health Plans
Wave 3	Second year of Standard Prepaid Health Plans
Wave 2	First year of Standard Prepaid Health Plans
Wave 1	Baseline year of Medicaid Primary Care Provider Experience Survey
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
BHP	Behavioral Health Provider
I/DD	Intellectual/Developmental Disabilities
MAT	Medication Assisted Treatment
Standard plans	Standard Prepaid Health Plans
TPs	Tailored Plans

EXECUTIVE SUMMARY

The North Carolina (NC) Medicaid program transitioned from predominately fee-for-service to managed care starting in 2021 through the offering of Standard Prepaid Health Plans (standard plans) 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. The 2025 survey included a companion survey of behavioral health providers (BHPs), specifically those who engage in treatment for mild to moderate depression and anxiety, severe and persistent mental illness (e.g., Bipolar Disorder, Schizophrenia, Post-traumatic stress disorder, Major depressive disorder), or substance use or addiction treatment services. Providers' experience with Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plans (TPs) are presented in the Baseline Medicaid Behavioral Health Provider Experience Survey Report.

This report describes findings from the fifth assessment of primary care provider experience with the NC Medicaid program. The survey was conducted from March 24 to June 30, 2025, representing experience with the standard plans from the fourth year of Medicaid managed care. New additions to this year's survey include questions on opioid use disorder treatment, financial and administrative challenges faced by provider organizations, and experiences with NC HealthConnex (North Carolina's statewide health information exchange). This year's survey of the fourth year into managed care is referred to as Wave 5.

The five standard plans had high rates of contracting with provider organizations. Among our respondents, contracting levels with each of the five standard plans ranged from 83.3% to 96.2%, Respondents rated their experience across fourteen domains representing dimensions of administrative and clinical functions of the plans, using a scale from "poor" (represented as 1 numerically) to "excellent" (represented as 4). **Exhibits E1** and **E2** compare the first, second, third, and fourth years of managed care for each of these domains. Mean overall ratings for the five plans ranged from 2.77 to 2.95 on the four-point scale. The largest variation remains across domains, rather than between plans on any given domain.

Overall, while many domains trend flatly, there is a notable downward trend on measures of access, including access to medical specialists, behavioral health prescribers, and behavioral health therapists. Compared to previous years the standard plans were still rated worse than a practice's largest commercial payor in all domains except for support with social determinants of health.

Although most variation remains across domains, a trend this year is changes in performance convergence across the standard plans. **Exhibit E3** compares plans across domains on the Wave 5 survey. AmeriHealth Caritas, while underperforming across the board in prior years, has made substantial improvements in provider experience across several domains, and especially in administrative domains such as timeliness to answer questions, timeliness of claims processing, prior authorizations, and customer/member support services.

Exhibit E1. Experience with administrative domains: by year after transition to standard plans

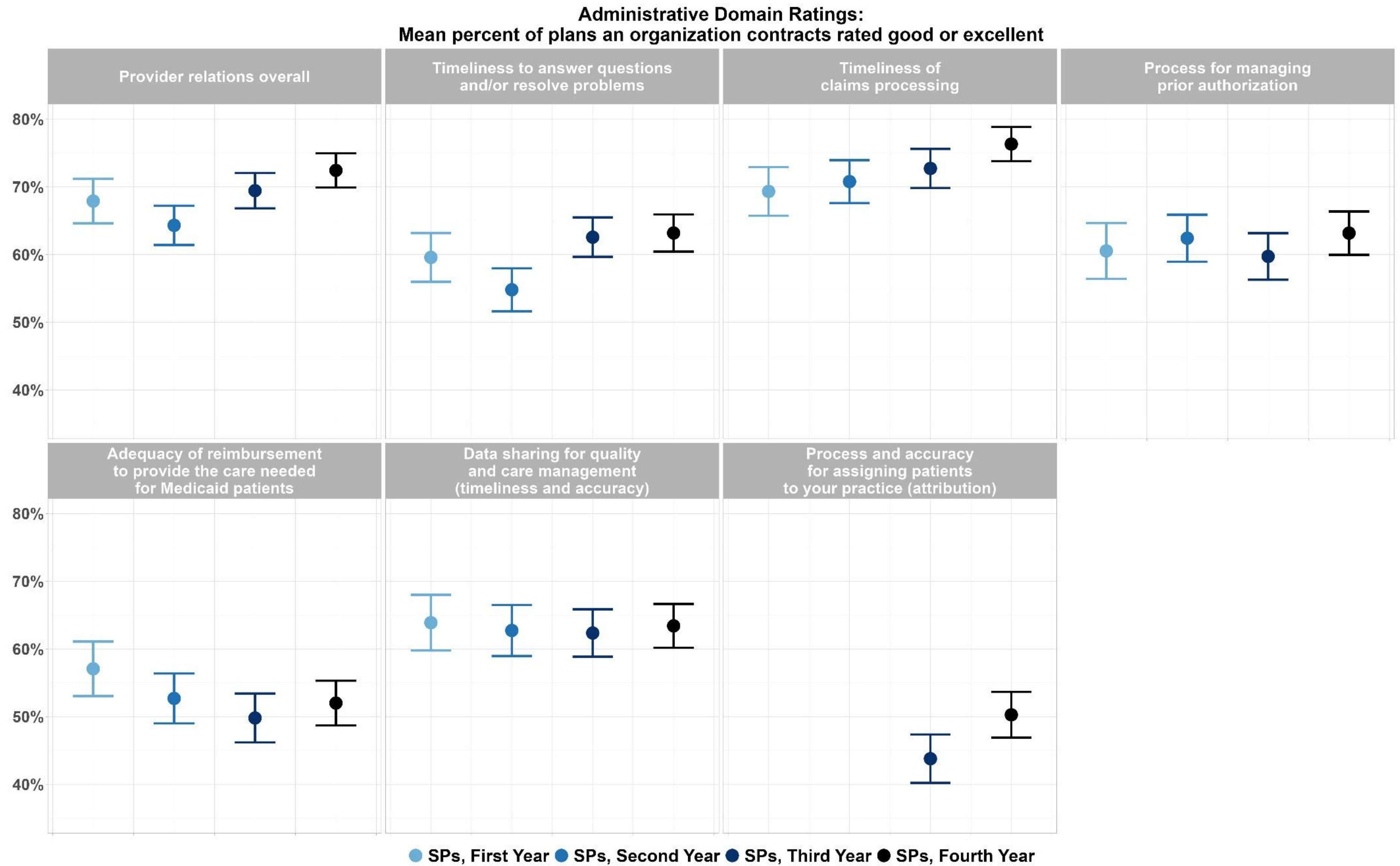


Exhibit E2. Experience with clinical domains: by year after transition to standard plans

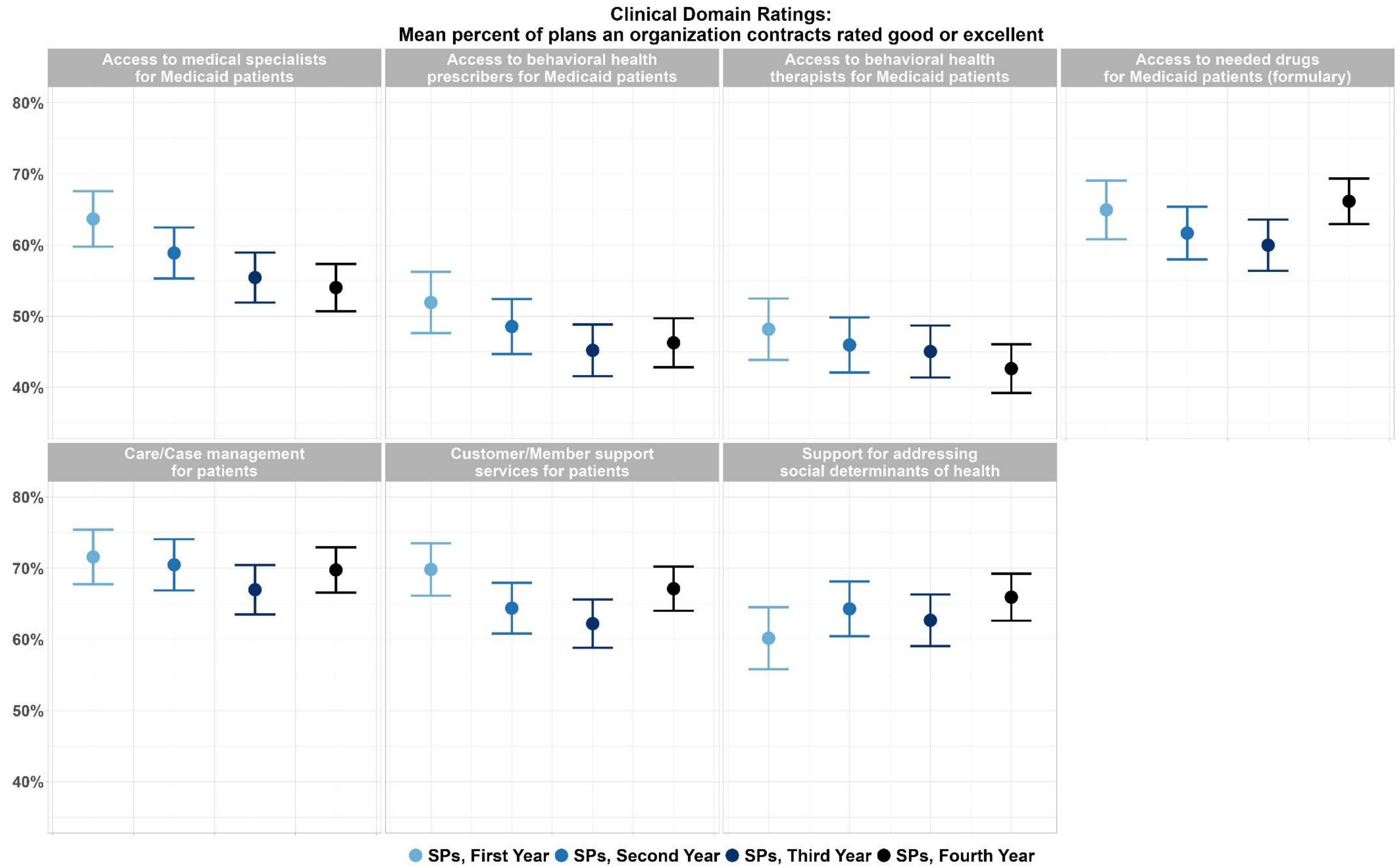


Exhibit E3. Proportion of respondents rating domain 'Good' or 'Excellent', by standard plans and largest commercial payor

	AmeriHealth Caritas	BCBSNC Healthy Blue	UnitedHealthcare	WellCare Health Plans	Carolina Complete Health	Largest Commercial Payor
Administrative						
Provider relations overall	70%	77%	69%	72%	70%	88%
Timeliness to answer questions and/or resolve problems	63%	68%	61%	62%	59%	77%
Timeliness of claims processing	74%	80%	76%	75%	72%	86%
Process for managing prior authorizations	62%	65%	64%	62%	63%	72%
Adequacy of reimbursement to provide the care needed for Medicaid	51%	51%	50%	51%	50%	76%
Data sharing for quality and care management (timeliness and accuracy)	62%	62%	65%	63%	61%	70%
Process and accuracy for assigning patients to your practice (Attribution)	48%	51%	47%	47%	48%	72%
Clinical						
Access to medical specialists for Medicaid patients	51%	58%	52%	53%	53%	85%
Access to behavioral health prescribers for Medicaid patients	43%	46%	43%	44%	44%	66%
Access to behavioral health therapists for Medicaid patients	41%	42%	42%	42%	41%	65%
Access to needed drugs for Medicaid patients (formulary)	65%	68%	65%	65%	66%	78%
Care/Case management for patients	69%	70%	69%	66%	68%	73%
Customer/Member support services for patients	65%	69%	65%	65%	65%	76%
Support for addressing social determinants of health	64%	65%	65%	63%	64%	64%

Key Findings

- Rates of contracting with each of the five available standard plans ranged from **83.3% to 96.2%**, and respondent organizations contracted with **health systems and medical groups and independent practices had an average of 4.5-4.6 plans each.**
- **Only 4.8%** of respondents report they **anticipate dropping any standard plan contracts** in the coming year.
- **Meaningful differences** compared to prior years were found in provider experience with standard plans on some key domains, as shown in Exhibits E1 and E2:
  - Plans had continued improvement in provider relations overall and timeliness of claims processing.
  - Plans have performed progressively worse each year in: adequacy of reimbursement, access to medical specialists, access to behavioral health prescribers, and access to behavioral health therapists.
- Overall, providers rated their experience with plans on clinical domains (e.g., access to specialists) worse than on administrative domains (e.g., claims processing).
- **Performance gaps between specific standard plans have narrowed**, driven mostly by the improvement of previously lagging plans:
  - While in year 3 of managed care AmeriHealth underperformed on several domains, this year their performance improved notably in provider relations overall, timeliness to answer questions and/or resolve problems, timeliness of claims processing, and customer/member support services, as shown in **Exhibit E3.** It is now largely on-par with other standard plans in terms of provider relations overall.
- Of provider organizations that did not contract with all standard plans, when asked if they anticipated adding any new standard plan PHP contracts in the coming year, **a majority (83.8%) said that they would not be adding more standard plans**.
- Standard plans performed substantively worse in all domains compared to providers' largest commercial payor on all but two domains: Care/Case management for patients and support for addressing social determinants of health (see Exhibit E3).
- **31.6% to 39.9%** of providers report having value-based payment or shared risk arrangements with standard plans**.**
- A large portion of respondents remained unclear on medical home attestation: **39.1%** of organizations responded that **they did not know what tier of medical home they attested to** with the state of North Carolina.
- Open-ended comments revealed **continued administrative burden** in sustaining multiple PHP relationships; providers report this has ultimately placed financial strain on their organizations and imposed stress on the healthcare system as more time is spent by providers and staff to resolve administrative issues.
- Similar to prior years, large provider organizations rated their experience with the health plans slightly worse than smaller provider organizations. No substantive differences in experience were found when comparing rural versus non-rural provider organizations (**see Appendix**).
- In contrast to prior years, Ob/Gyn provider organizations rated their experience with the health plans **better** than provider organizations that do not provide Ob/Gyn care (**see Appendix**).

Recommendations for the Division of Health Benefits

- Provider relations overall are as good or better compared to previous years for the majority of standard plans, indicating general improvement in provider experience, though all plans still lag behind experience with any given provider organization's largest commercial plan.
- Results indicate worsening or stagnating behavioral health and medical specialist access across all plans, suggesting that statewide approaches to improving access to these specialties may be more important than plan specific approaches. Additionally, provider reimbursement rates have been frozen since 2012, so this could also potentially impact access to behavioral health and medical specialists.
- Attribution remains one of the lowest rated domains across all plans, an issue which is corroborated with qualitative provider feedback. To better understand the challenges present, provider voices should be centered when working to improve patient assignment and attribution. Focus should be on program-wide solutions that improve accuracy of patient attribution and fix, update, or correct inaccurate attribution.
- Decreasing differential performance across plans suggests that the focus should be on domain specific statewide approaches. For underperforming domains, state and standard plans should work in tandem to identify state policies, approaches, or changes to the overall managed care program that may improve provider experience.
- While there have been some marginal improvements in standard plans performance in care/case management, experience with adequacy of reimbursement remains poor. The medical home model seeks to embed care management in practices; suggesting that there are still gains to be made in creating a more effective strategy between standard plans and practices.
- Given the comparisons with commercial plans, the state may benefit from investigating where specific state program requirements may be unnecessarily contributing to complexity or issues that generate provider dissatisfaction with Medicaid specifically. Conversely, the state may consider where it could use its contracting authority to seek improvements in Medicaid plan operations with regard to providers to improve provider experience with Medicaid plans.
- Expansion of the Collaborative Care Model is proceeding slowly. Roughly the same proportion of practices have implemented the CCM this year compared with the prior year. Practices identify several barriers to implementation, including more than 40% indicating they cannot sustain the CCM with current reimbursement. We anticipate that expansion of this effective model will stall unless reimbursement improves. Since the 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 the annual Medicaid provider survey is to assess health system and practice experience with Standard Prepaid Health Plans 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 Three Years into Managed Care (Wave 4)[1], this link for Two Years into Managed Care (Wave 3)[2], this link for One Year into Managed Care (Wave 2)[3] survey and this link for Baseline Survey (Wave 1)[4].

Objectives

The objectives of the Wave 5 survey were to:

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

The state will use the findings as one 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.

[1] https://medicaid.ncdhhs.gov/2024-nc-medicaid-provider-experience-survey-report/download?attachment
[2] https://medicaid.ncdhhs.gov/documents/reports/providerexperiencesurveywave3report/download?attachment
[3] https://medicaid.ncdhhs.gov/blog/2023/03/09/2022-medicaid-provider-experience-survey-report-released
[4] https://medicaid.ncdhhs.gov/blog/2022/08/18/baseline-medicaid-provider-experience-survey-report-released

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 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 the 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 2025 Medicaid Transformation Provider Experience Survey (Wave 5) covered the following domains, largely identical to the Wave 2, 3, and 4 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)
- Contracting with standard plans (current contracts, plans to add or drop contracts, Medical Home arrangements, etc.)
- Overall perceived effects of standard plans on practice (financial health of practice, ability to recruit and retain providers and staff)
- 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 standard plans affect the health care delivery system. Additionally, the questionnaire was built to minimize respondent burden and reduce overlap with other primary 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 organizations that provide primary care and Ob/Gyn care who met the inclusion criteria as described below. 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 and Wave 2, 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 October 2024. Data included clinician National Provider Identifiers (NPIs)in medical groups or independent practices identified with outpatient primary care and Ob/Gyn care, using the following Class of Trade classifications: Family Practice, General Practice, Geriatric Medicine, Internal Medicine, Multi-specialty practice, Ob/Gyn, Pediatric Medicine, Preventative Medicine, and Primary Care. A prior validation check in Wave 4 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.

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. In earlier waves of the survey, during the frame cleaning process 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, the Wave 3-5 sample frame was developed to include organizations that had at least fifty Medicaid claims for ambulatory care visits. This method was effective at 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 the response rate.

Overall, this resulted in conducting sample frame cleaning and outreach with a cleaner and more representative sample in Wave 3-5 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, a mistake in the data, confirmed not to be primary care and 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 by email asking to confirm their contact information and identify their preferred method of receiving the questionnaire (email or paper mail). 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 practice manager.

Data Collection

All potential respondents identified after initial frame cleaning (n=682) 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.

After initial frame cleaning, surveys were mailed. Additional frame cleaning was conducted within the context of follow-up phone calls 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 connecting to the practice and a follow-up web search included confirmation of closure. Several attempts were made to call and identify alternative contacts for these practices. Practices remained “unknown” if ineligibility could not be confirmed. The total number of practices that were eligible or with unknown status remaining in the sample was n=665.

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 redistribute the participant’s 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 March 24, 2025, and June 30, 2025. The final response rate was 62.2%. **Exhibit 1** summarizes responses for all sampled organizations. Wave 5 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 to be ineligible if it was confirmed the organization existed as a medical practice, but they did not provide primary care or Ob/Gyn services. Respondents were determined to be eligible and complete if they submitted the survey or answered 70% of essential questions. 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, did not exist, did not accept Medicaid, or had merged with another practice. This yielded an eligibility rate from the original sample frame of 90.8%. Eligibility for a small subset of potential respondents could not be determined. A response rate was calculated using the American Association for Public Opinion Research (AAPOR RR3) formula, which adjusts for unknown eligibility of respondents.[9]

Exhibit 1. Response rate & final dispositions of sample frame

Final designations	**Total Response**
	Count (%)
Completed surveys from eligible respondents	396
Refusals from eligible respondents	42
Ineligible for survey	61
Unknown eligibility	227
Duplicate	5
Total	731

Notes: response rate = (completed & eligible respondents)/ [completed & eligible respondents + refusals of eligible respondents + (Unknown eligibility × eligibility rate)] = 62.2%

To account for non-response, survey weights were developed using poststratification adjustment method. Strata were based on provider organization size and rurality. Organization size included small (1-2 providers), medium (3-9 providers), and large (10+ providers). Rurality is a binary variable based on respondent organization having any primary care or Ob/Gyn practice locations in a rural county, as defined by the population density of each county being 250 people or few per square mile.[10] To more accurately reflect the known and unknown eligibility of the sample frame, survey weights were updated to account for eligibility rates across the 6 categories based on the combination of organization size and rurality.

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 standard plans and across years.

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 =12)	Self-Identified Medical Groups and Independent Practices (N =384)
	N (%) or Mean (SD)	N (%) or Mean (SD)
Practice Composition		
Services Provided for Patients with Medicaid		
Primary Care	11 (91.7%)	374 (97.4%)
Prenatal/Postnatal Care	9 (75%)	40 (10.4%)
Inpatient Obstetrics Care	8 (66.7%)	10 (2.6%)
Number of Providers (IQVIA-sourced)		
1-2 providers	1 (8.3%)	143 (37.2%)
3-9 providers	1 (8.3%)	162 (42.2%)
10 or more providers	10 (83.3%)	79 (20.6%)
Geography		
No Rural Practice Sites	0 (0%)	188 (49%)
Any Rural Practice Sites	12 (100%)	196 (51%)
Ownership		
Independent Medical Practice at a Single Site	0 (0%)	284 (74%)
Medical Group (multiple practices owned by a single owner)	0 (0.00%)	68 (17.7%)
Other	0 (0%)	13 (3.4%)
Part of a Clinically Integrated Network (CIN) for Medicaid work	4 (36.4%)	223 (60.6%)
Tier 3 Highest Tier of Medical Home Attestation with State (among primary care provider organizations)	4 (33.3%)	175 (45.6%)

Practice Service to Medicaid Beneficiaries		
Mean percentage of patients served that are insured by Medicaid	35.5 (18.01)	40.1 (25.72)
Limit on Percentage of Patients with Medicaid		
Yes	0 (0%)	71 (18.6%)
No	11 (91.7%)	284 (74.5%)
Unsure	1 (8.3%)	26 (6.8%)
Mean limit that practice/system places on percentage of patients with Medicaid Insurance *(if yes to above)*	NA	23.07 (25.1)
Treatments for Opioid Disorder Offered or Referred		
Buprenorphine (i.e., Subutex, Suboxone)	2 (18.2%)	58 (15.5%)
Naltrexone (i.e., Revia, Vivitrol)	1 (9.1%)	27 (7.2%)
Methadone	2 (18.2%)	21 (5.6%)
None	1 (9.1%)	232 (61.9%)
Don't Know	8 (72.7%)	76 (20.3%)
Contracting with Pre-Paid Health Plans		
Mean number of standard plans that practice/system is currently contracting with	4.58 (0.9)	4.54 (1)

Notes: Any data categories which do not add to final response n=396 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 =384) that self-identified as such and all health system respondents (unweighted n =12). All subsequent figures reported in this section are weighted.

Contracting with Standard Prepaid Health Plans

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

Exhibit 4. Provider organizations' contract arrangements with standard plans in North Carolina Medicaid in Wave 5, with Wave 2, Wave 3, and Wave 4 comparisons

For the below listed Standard Prepaid Health Plans, have you contracted with the following plans?				
PHP	**2022 Response: Yes % (N)**	**2023 Response: Yes % (N)**	**2024 Response: Yes % (N)**	**2025 Response: Yes % (N)**
AmeriHealth Caritas North Carolina	81.1% (318)	85.3% (295) *	87.4%(316)	87.0% (345)
BCBSNC Healthy Blue	94.5% (372)	97.2% (336)	96.9% (350)	96.2% (381)
UnitedHealthcare	90.9% (357)	94.5% (327) *	93.8% (338)	92.9% (368)
WellCare Health Plans	88.9% (349)	93.7% (324) *	95.1% (343)	93.8% (372)
Carolina Complete Health†	73.3% (285)	77.3% (265)	83.0% (300) *	83.3% (330)

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 standard plans contracts in the coming year

Question	Yes % (N)	No % (N)
Among provider organizations that did not contract with all standard SPs, when asked if they anticipated adding any new standard plan PHP contracts in the coming year	16.2 % (16)	83.8% (81)
When asked if they anticipated dropping any standard plan PHP contracts in the coming year	4.8% (19)	95.2% (375)

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	"Multiple, ongoing claims issues. Patient data for quality measures invalid resulting in less payment. Minimal communication from PHP provider reps to assist in resolution."
2. Patient volume	"Payer service levels and # of covered lives. State allocated 33% of our patients to [PHP name redacted] upon rollout so we signed an agreement. Since that time, covered lives has fallen significantly and service levels are poor."
3. Administrative burden	"Our practice would like to drop plans because of the burden associated with contracting with so many payors...We tried to drop plans in the past & had trouble ending our contracts. When it is time to renew contracts, we plan to only work with the plans that provide the services we expect for our patients."
4. Difficulty finding in-network specialists	"[I]t's very hard to find a specialist."

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

Does your practice/health system currently limit the percentage of patients with Medicaid that you will take?				
	2022 Response: % (N)	**2023 Response: % (N)**	**2024 Response: % (N)**	**2025 Response: % (N)**
Yes	14.7% (58)	14.8% (51)	14.8% (54)	17.9% (70)
No	78.5% (308)	78.2% (270)	78.1% (282)	75.3% (296)
Unsure	6.8% (27)	7.0% (24)	7.1% (26)	6.8% (27)

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	5.9% (22)
Tier 2	12.7% (48)
Tier 3	47.5% (178)
Don't Know	39.1% (147)
Not Applicable (exclusive)	5.2% (21)

Exhibit 9. Provider organizations' medical home contracts with standard plans in North Carolina Medicaid, from July 2024 – June 2025

PHP	Tier 1 % (N)	Tier 2 % (N)	Tier 3 % (N)	I don't know % (N)
AmeriHealth Caritas North Carolina	4.4% (14)	8.1% (26)	47% (152)	40.6% (131)
BCBSNC Healthy Blue	4.9% (17)	9.6% (34)	45.5% (161)	40.0% (142)
UnitedHealthcare	4.2% (14)	9.4% (32)	47.1% (160)	39.4% (134)
WellCare Health Plans	4.1% (14)	9.2% (32)	46.4% (161)	40.3% (140)
Carolina Complete Health	3.9% (12)	8.8% (27)	47.5% (148)	39.8% (124)

*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	"It is unknown at this time what tier we are. I think a one-on-one meeting with a representative to explain all of the different levels and what would be the most beneficial for our office and patients."
2. Additional support staff and/or resources	"We did but withdrew contract. There is not enough time in a day for private practice to do the amount of work the requested of us, or not enough staff."
3. Higher reimbursement	"We do receive some capitation payments so are possible Tier 3 AMH for at least some [standard plans] but the reimbursement is not worth the effort expected for the care of this patient population. It would take reimbursement equivalent to commercial payers at a minimum."
4. ACO/CIN contract	"As an independent practice the requirements of AMH Tier 3 are not possible without assistance from a CIN."

Exhibit 11. Provider organizations' progression to value-based payment arrangements with standard plans 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 standard plans?	
PHP	**Response: Yes % (N)**
AmeriHealth Caritas North Carolina	31.6% (115)
BCBSNC Healthy Blue	39.9% (147)
UnitedHealthcare	37.0% (136)
WellCare Health Plans	35.3% (129)
Carolina Complete Health	32.9% (117)

Exhibit 12. Provider organizations' contract arrangements with other partner organizations under value-based contracts with standard plans 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 standard plans Only**	**Other Payor Only (e.g. Medicare, Medicare Advantage, Commercial payor)**	**All Payor Types**
Evolent	2.3% (6)	*	*
Aledade	5.0% (15)	6.0% (18)	8.8% (27)
Caravan/Signify	*	*	*
A clinically integrated network (CIN)	25.4% (74)	1.9%(6)	3.7% (11)
Other entity or ACO	5.2% (12)	7.3% (18)	NA

Note: "All payor types" indicates that providers selected 'One or More Medicaid PHPs', 'Blue Premier or another commercial payor', and 'Other Payor (e.g. Medicare, Medicare Advantage)' for a given entity.
*Suppressed due to small cell sizes

Experience with Standard Prepaid Health Plans

Provider relations overall

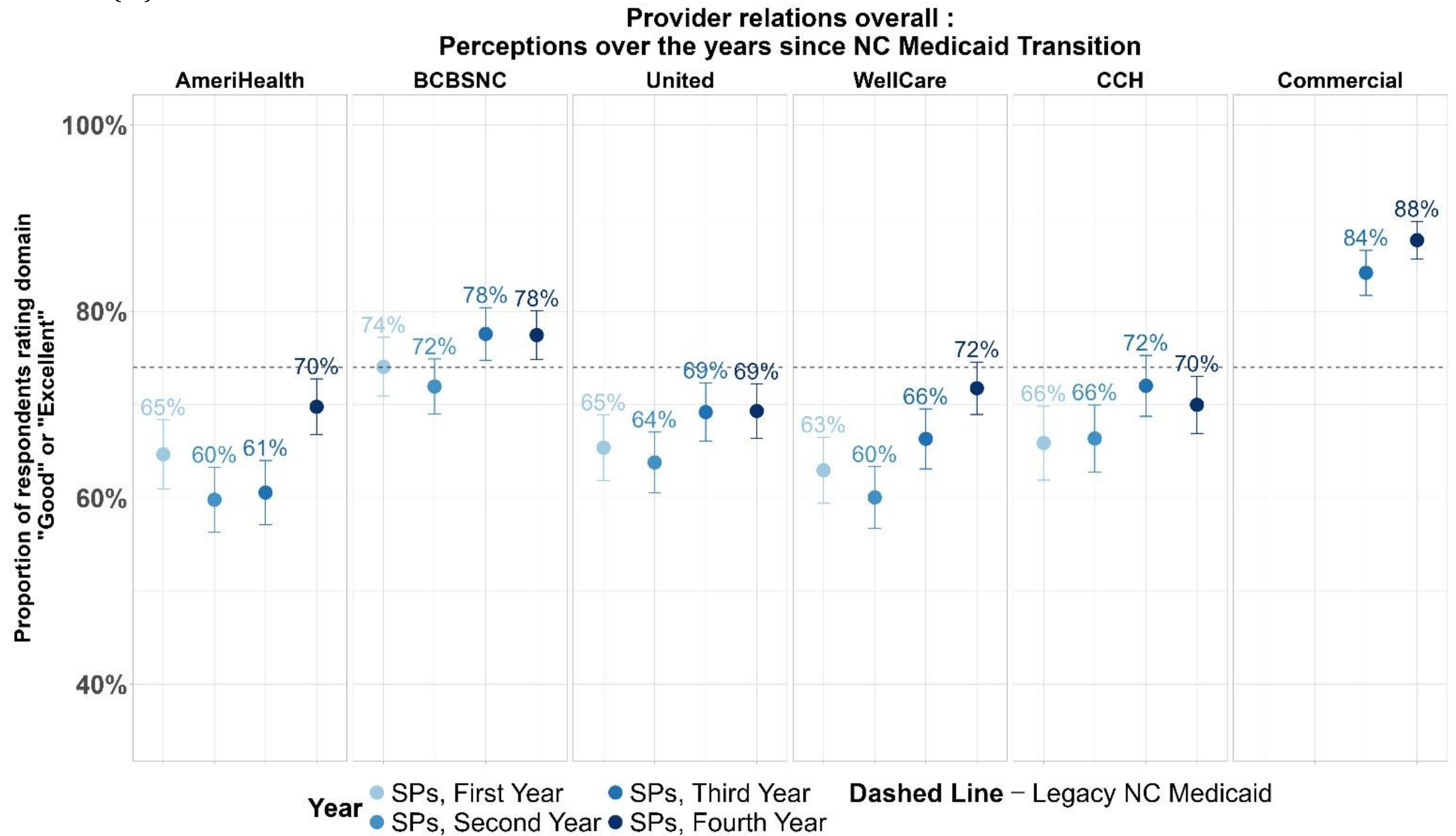
Ratings varied across standard plans in Wave 5. AmeriHealth Caritas and WellCare have had an upward trajectory in positive ratings since Wave 3. Both plans saw increases in positive ratings from provider organizations compared to prior years, achieving their highest rating in this domain since the transition to Medicaid managed care. Of note, AmeriHealth Caritas had a significant increase compared to last year. The proportion of provider organizations reporting positive experiences with BCBSNC Healthy Blue, UnitedHealthcare Community Plan, and Carolina Complete Health remained relatively stable. All standard plans had significantly lower proportion of provider organizations responding positively than commercial payors.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? *Provider Relations Overall*				
PHP	**2023 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.63 (0.03)	2.61 (0.03)	2.64 (0.03)	2.81 (0.03)
BCBSNC Healthy Blue	2.90 (0.03)	2.83 (0.03)	2.97 (0.03)	2.95 (0.02)
UnitedHealthcare	2.73 (0.03)	2.71 (0.03)	2.83(0.03)	2.77 (0.03)
WellCare Health Plans	2.68 (0.03)	2.62 (0.03)	2.77(0.03)	2.85 (0.03)
Carolina Complete Health	2.71 (0.04)	2.75 (0.03)	2.84 (0.03)	2.82 (0.03)
Largest commercial payor			3.09 (0.02)	3.14 (0.02)

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

Exhibit 14. Practice ratings for overall experience of provider organizations with standard plans, 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

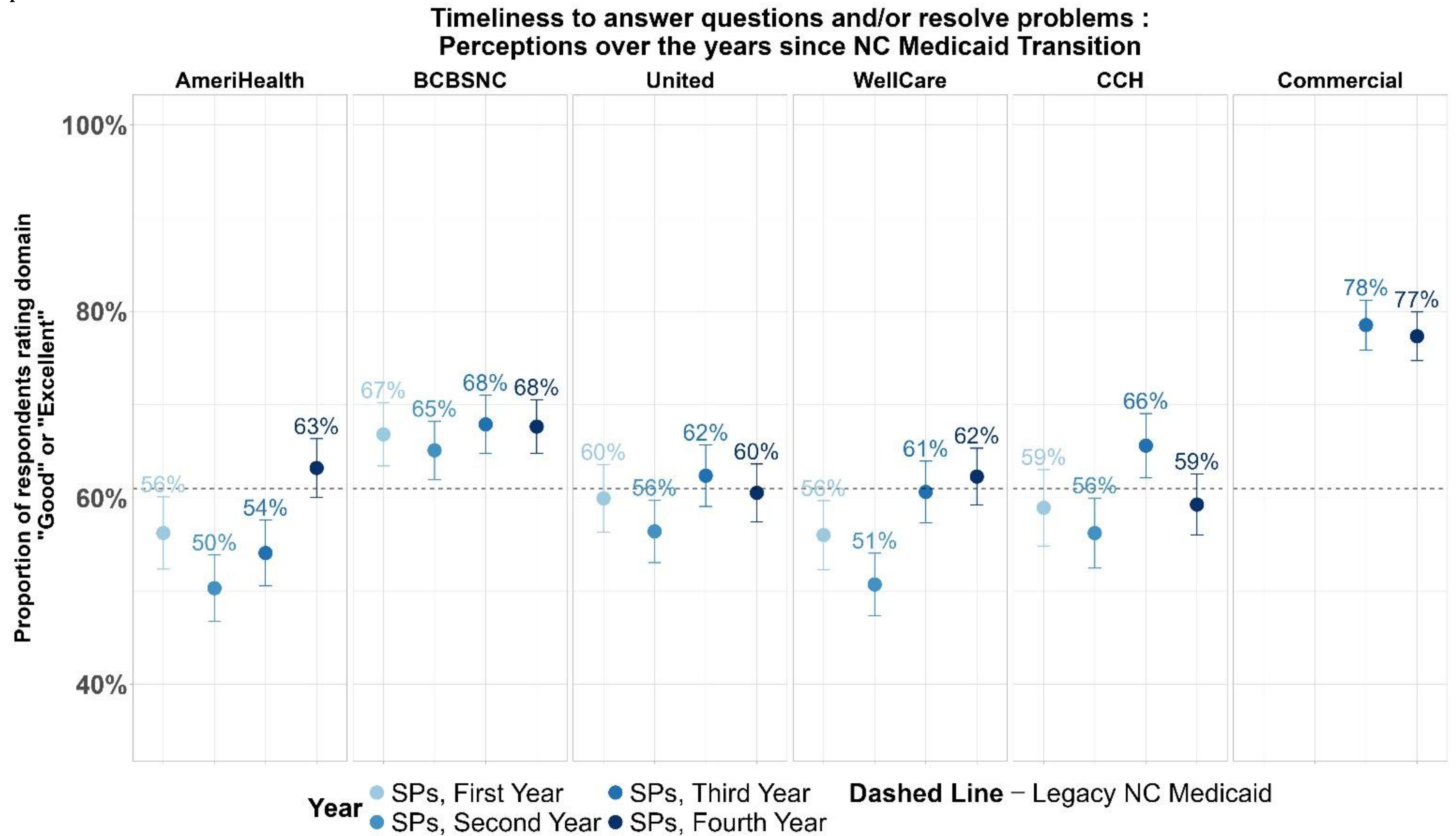
The most substantial improvement seen across plans was AmeriHealth Caritas, which had its highest rating since transition to managed care. Carolina Complete Health had less favorable performance than in the prior year. There were marginal changes in performance for BCBSNC Health Blue, WellCare and UnitedHealthcare Community Plan. All standard plans had significantly lower proportion of provider organizations responding positively than commercial payors.

Exhibit 15. Experience of provider organizations with standard plans' 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 standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? *Timeliness to answer questions and/or resolve problems*				
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.50 (0.04)	2.44 (0.03)	2.51 (0.03)	2.65 (0.03)
BCBSNC Healthy Blue	2.72 (0.03)	2.68 (0.03)	2.79 (0.03)	2.76 (0.03)
UnitedHealthcare	2.59 (0.03)	2.55 (0.03)	2.70 (0.03)	2.61 (0.03)
WellCare Health Plans	2.51 (0.04)	2.43 (0.03)	2.67 (0.03)	2.67 (0.03)
Carolina Complete Health	2.53 (0.04)	2.58 (0.04)	2.72 (0.03)	2.63 (0.03)
Largest Commercial Payor			2.95 (0.02)	2.92 (0.02)

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

Exhibit 16. Experience of provider organizations with standard plans' 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

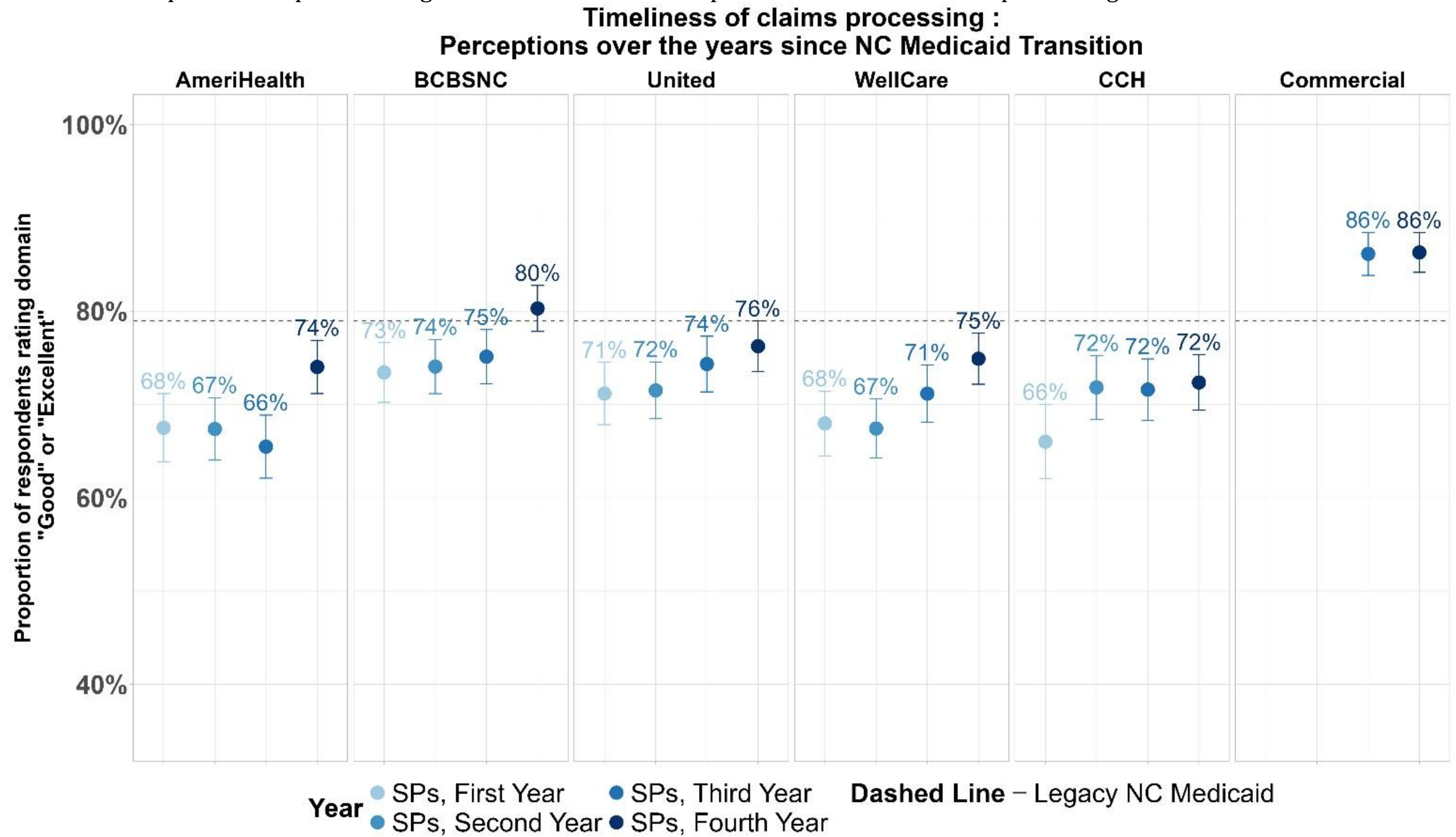
All plans had higher ratings compared to the prior year. AmeriHealth Caritas had a significant increase since Wave 4, and the largest gain. BCBSNC Healthy Blue and UnitedHealthcare Community Plan have continuously improved over four years of managed care, with BCBSNC Healthy Blue reaching a rating higher than Legacy Medicaid in Wave 5.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? *Timeliness of claims processing*				
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.71 (0.03)	2.74 (0.03)	2.71 (0.03)	2.85 (0.03)
BCBSNC Healthy Blue	2.87 (0.03)	2.87 (0.03)	2.93 (0.03)	3.01 (0.02)
UnitedHealthcare	2.81 (0.03)	2.81 (0.03)	2.90 (0.03)	2.89 (0.02)
WellCare Health Plans	2.73 (0.03)	2.73 (0.03)	2.81 (0.03)	2.88 (0.03)
Carolina Complete Health	2.70 (0.04)	2.78 (0.03)	2.85 (0.03)	2.85 (0.03)
Largest Commercial Payor			3.14 (0.02)	3.12 (0.02)

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

Exhibit 18. Experience of provider organizations with standard plans' 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

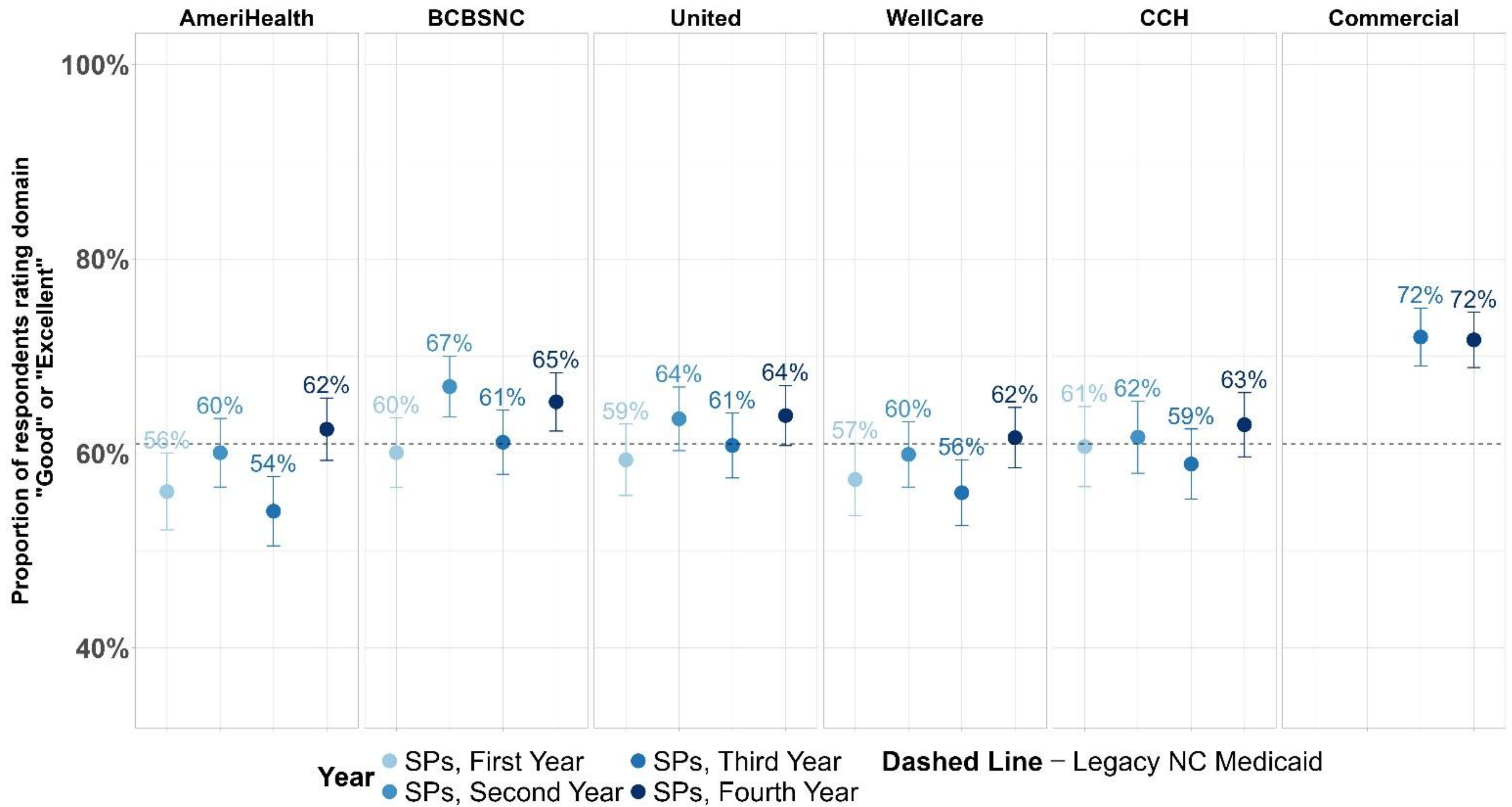
All standard plans improved in Wave 5, reaching ratings above Legacy Medicaid. This follows an across the board decrease in positive experiences between Waves 3 and 4. AmeriHealth Caritas had the biggest improvement of all the plans, performing substantially better compared to the prior year.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? *Process for managing prior authorization*				
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.52 (0.03)	2.59 (0.03)	2.51(0.03)	2.63 (0.03)
BCBSNC Healthy Blue	2.61 (0.03)	2.71 (0.03)	2.62 (0.03)	2.68 (0.02)
UnitedHealthcare	2.59 (0.03)	2.67 (0.03)	2.63 (0.03)	2.64 (0.02)
WellCare Health Plans	2.53 (0.03)	2.60 (0.03)	2.53 (0.03)	2.62 (0.02)
Carolina Complete Health	2.60 (0.03)	2.64 (0.03)	2.59 (0.03)	2.65 (0.03)
Largest Commercial Payor			2.79 (0.03)	2.8 (0.02)

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

Exhibit 20. Experience of provider organizations with standard plans' 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

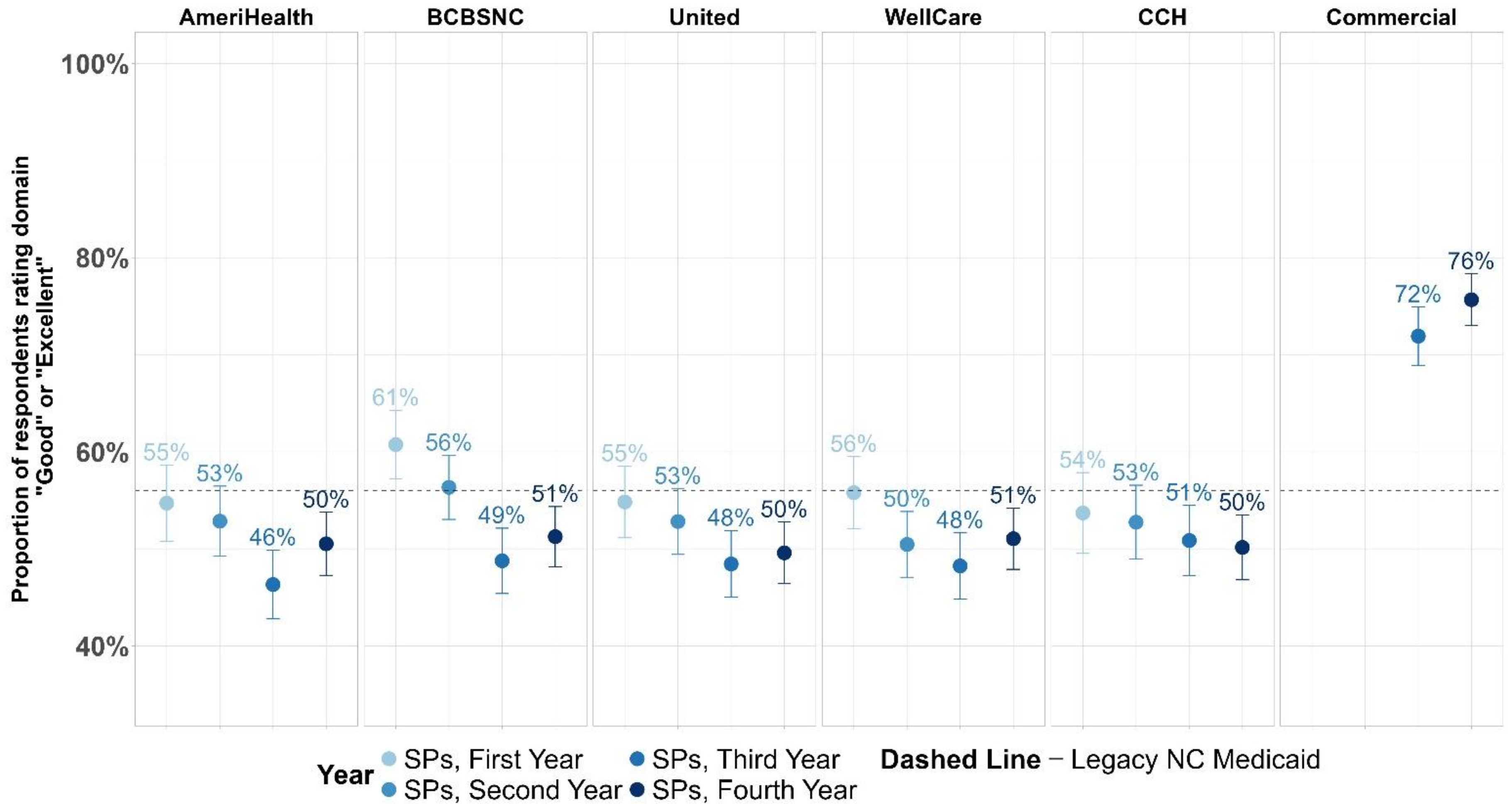
Estimates for most plans were slightly higher than previous years, but differences were not statistically significant, indicating no measurable change. Though the decrease in the Carolina Complete Health rating between Wave 4 and Wave 5 was small, ratings across years since the transition continued to decline. All standard plans had significantly lower proportion of provider organizations responding positively than commercial payors.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans 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)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.49 (0.03)	2.49 (0.03)	2.37 (0.03)	2.45 (0.03)
BCBSNC Healthy Blue	2.64 (0.03)	2.55 (0.03)	2.46 (0.03)	2.47 (0.03)
UnitedHealthcare	2.54 (0.03)	2.48 (0.03)	2.44 (0.03)	2.44 (0.03)
WellCare Health Plans	2.53 (0.03)	2.44 (0.03)	2.41 (0.03)	2.43 (0.03)
Carolina Complete Health	2.48 (0.04)	2.47 (0.04)	2.44 (0.03)	2.43 (0.03)
Largest Commercial Payor			2.86 (0.03)	2.89 (0.02)

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

Exhibit 22. Experience of provider organizations with standard plans' 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

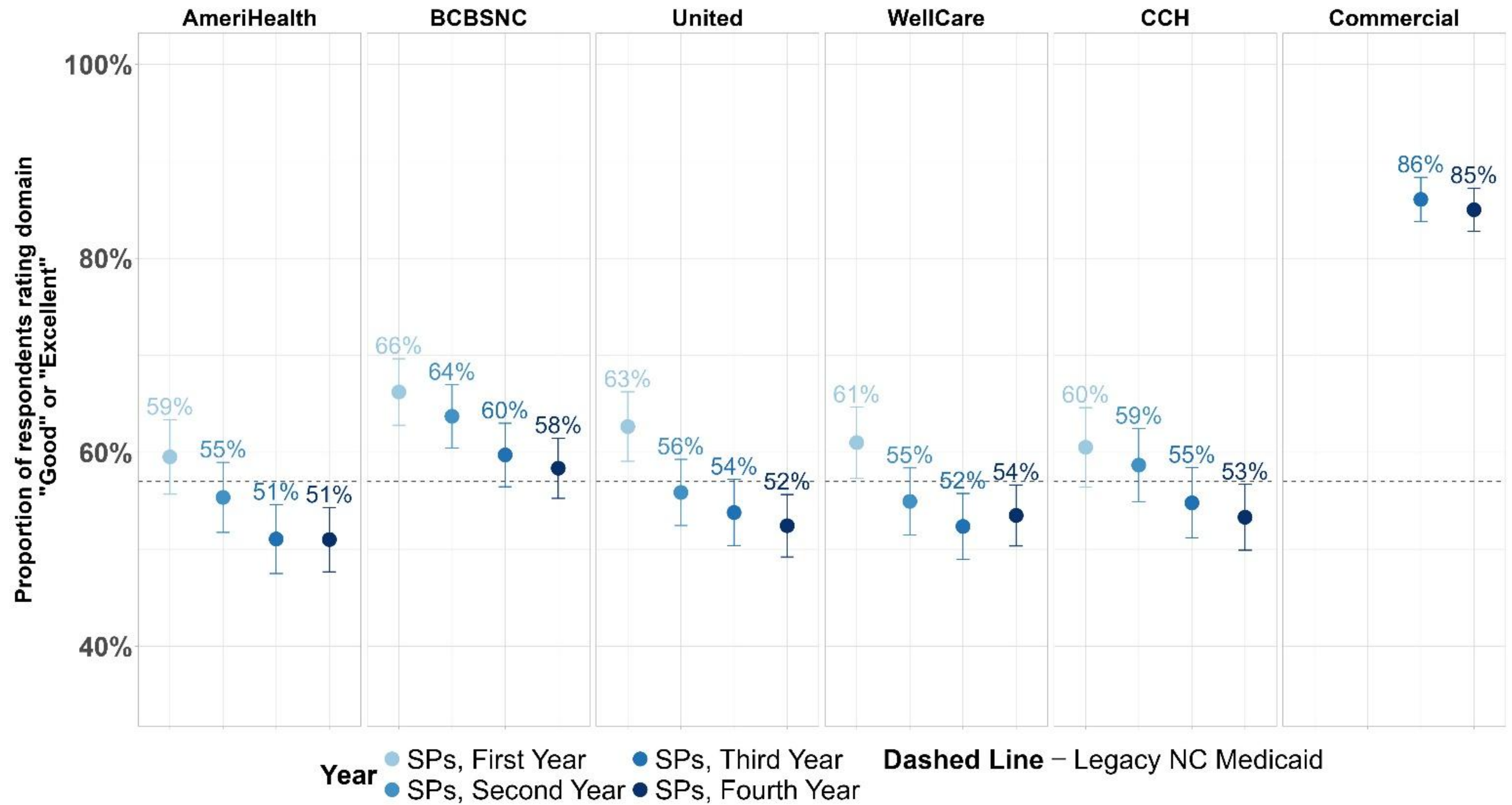
SP performance has worsened year after year since transition to managed care for BCBSNC Healthy Blue, UnitedHealthcare Community Plan, and Carolina Complete Health. All standard plans except BCBSNC Healthy Blue performed below Legacy Medicaid this year. Standard plans also performed considerably worse compared to commercial plans.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? *Access to medical specialists for Medicaid patients*				
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.58 (0.03)	2.46 (0.03)	2.41 (0.03)	2.42 (0.03)
BCBSNC Healthy Blue	2.72 (0.03)	2.63 (0.03)	2.57 (0.03)	2.57 (0.03)
UnitedHealthcare	2.65 (0.03)	2.49 (0.03)	2.46 (0.03)	2.44 (0.03)
WellCare Health Plans	2.59 (0.03)	2.47 (0.03)	2.46 (0.03)	2.47 (0.03)
Carolina Complete Health	2.60 (0.03)	2.55 (0.03)	2.50 (0.03)	2.47 (0.03)
Largest Commercial Payor			3.15 (0.02)	3.14 (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%).

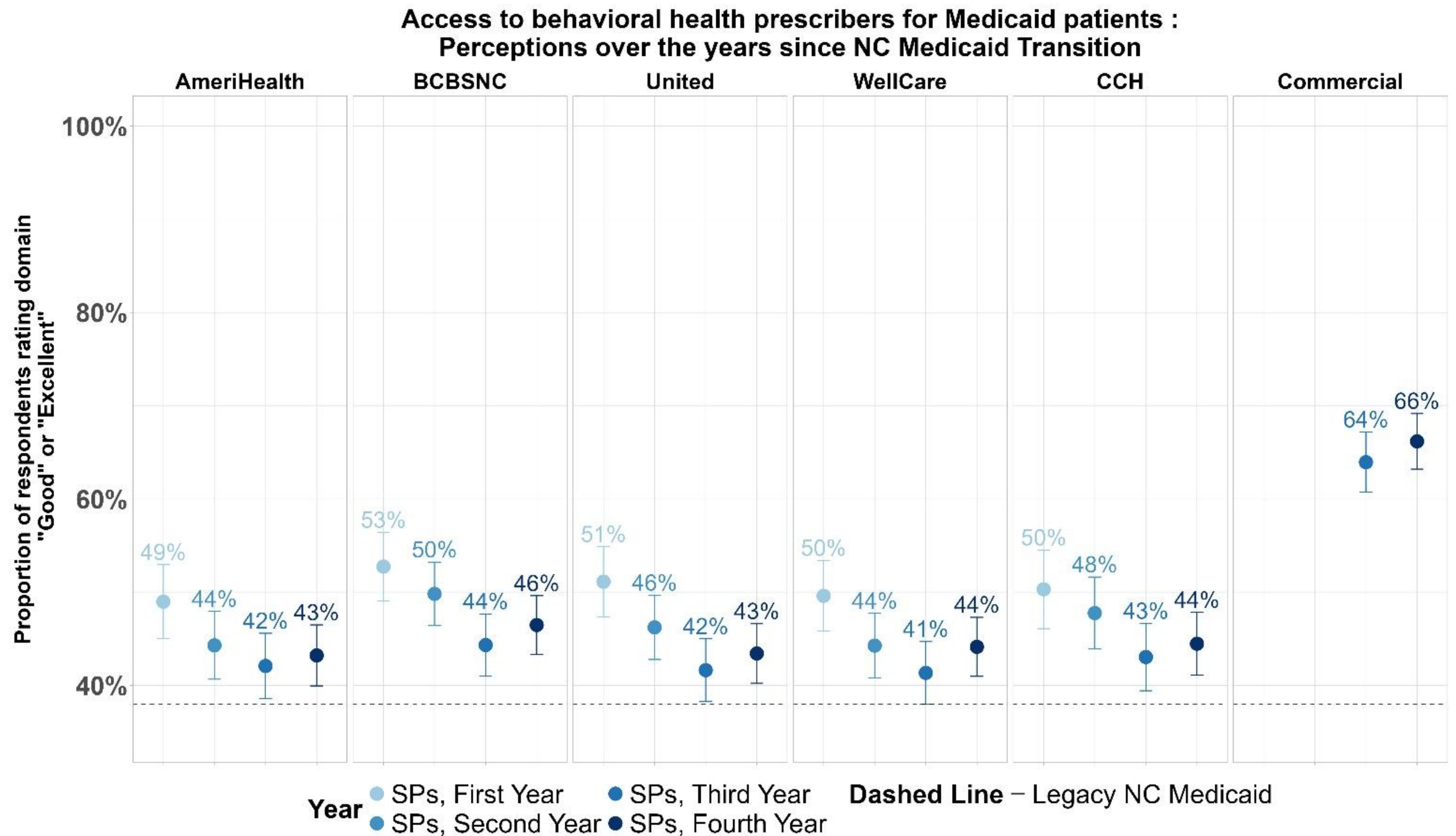
Access to behavioral health prescribers for Medicaid patients
Estimates for all plans were slightly higher than previous years, but differences were not statistically significant, indicating no measurable change.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans 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)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.36 (0.04)	2.30 (0.03)	2.24 (0.03)	2.26 (0.03)
BCBSNC Healthy Blue	2.43 (0.03)	2.39 (0.03)	2.29 (0.03)	2.34 (0.03)
UnitedHealthcare	2.40 (0.03)	2.32 (0.03)	2.23 (0.03)	2.28 (0.03)
WellCare Health Plans	2.37 (0.03)	2.31 (0.03)	2.24 (0.03)	2.28 (0.03)
Carolina Complete Health	2.39 (0.04)	2.36 (0.03)	2.29 (0.03)	2.31 (0.03)
Largest Commercial Payor			2.70 (0.03)	2.74 (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

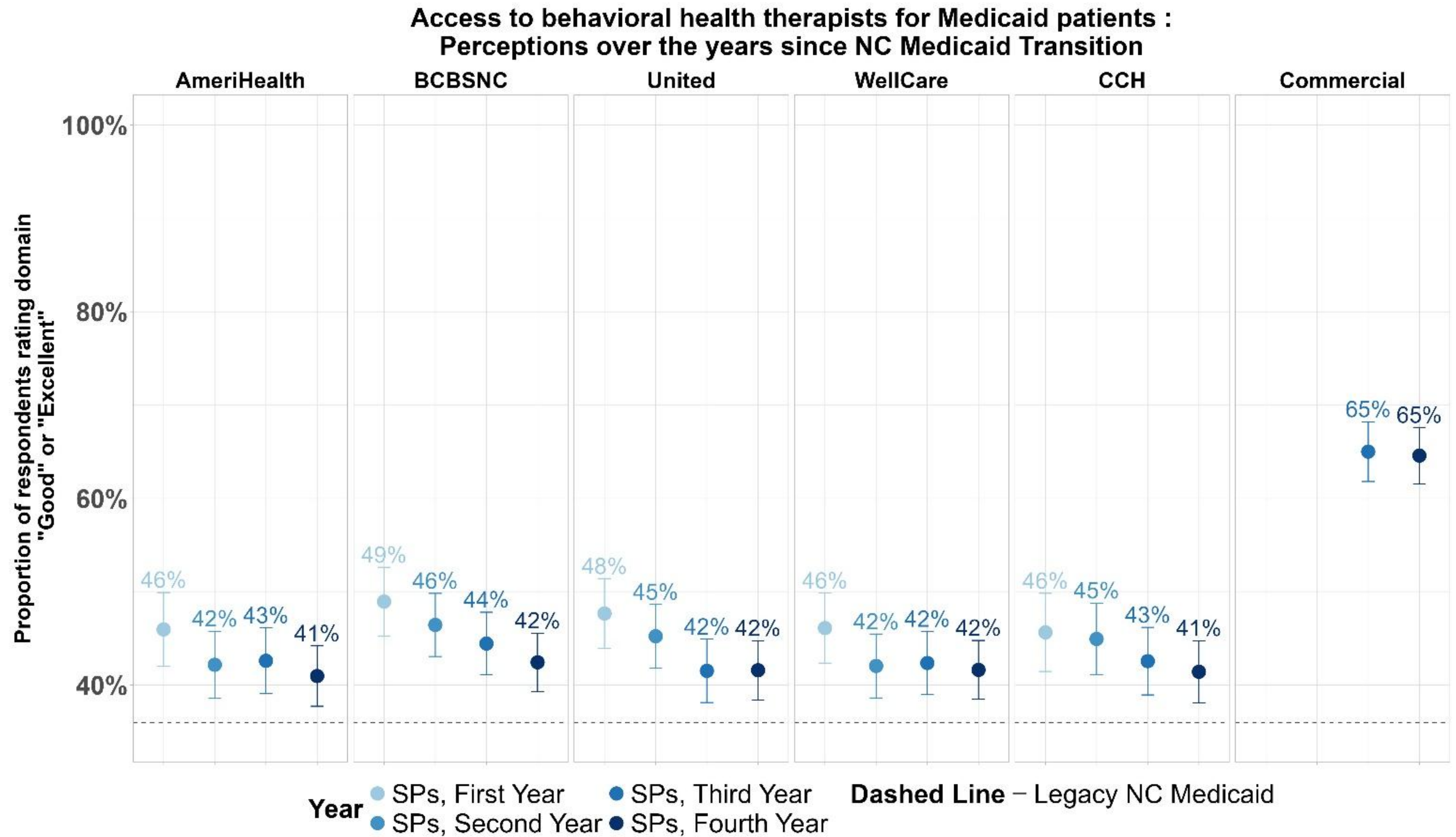
There were minimal changes in SP performance from the prior year. Performance ratings have remained stable for UnitedHealthcare Community Plan and WellCare. Performance by BCBSNC Healthy Blue and Carolina Complete Health has continually worsened over time. All standard plans still performed better than Legacy Medicaid. Standard plans performed considerably worse compared to commercial plans.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? *Access to behavioral health therapists for Medicaid patients*				
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.32 (0.04)	2.27 (0.03)	2.26 (0.03)	2.24 (0.03)
BCBSNC Healthy Blue	2.38 (0.03)	2.33 (0.03)	2.30 (0.03)	2.29 (0.03)
UnitedHealthcare	2.36 (0.03)	2.28 (0.03)	2.24 (0.03)	2.26 (0.03)
WellCare Health Plans	2.31 (0.03)	2.27 (0.03)	2.26 (0.03)	2.25 (0.03)
Carolina Complete Health	2.32 (0.04)	2.32(0.03)	2.27 (0.03)	2.28 (0.03)
Largest Commercial Payor			2.7 (0.03)	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)

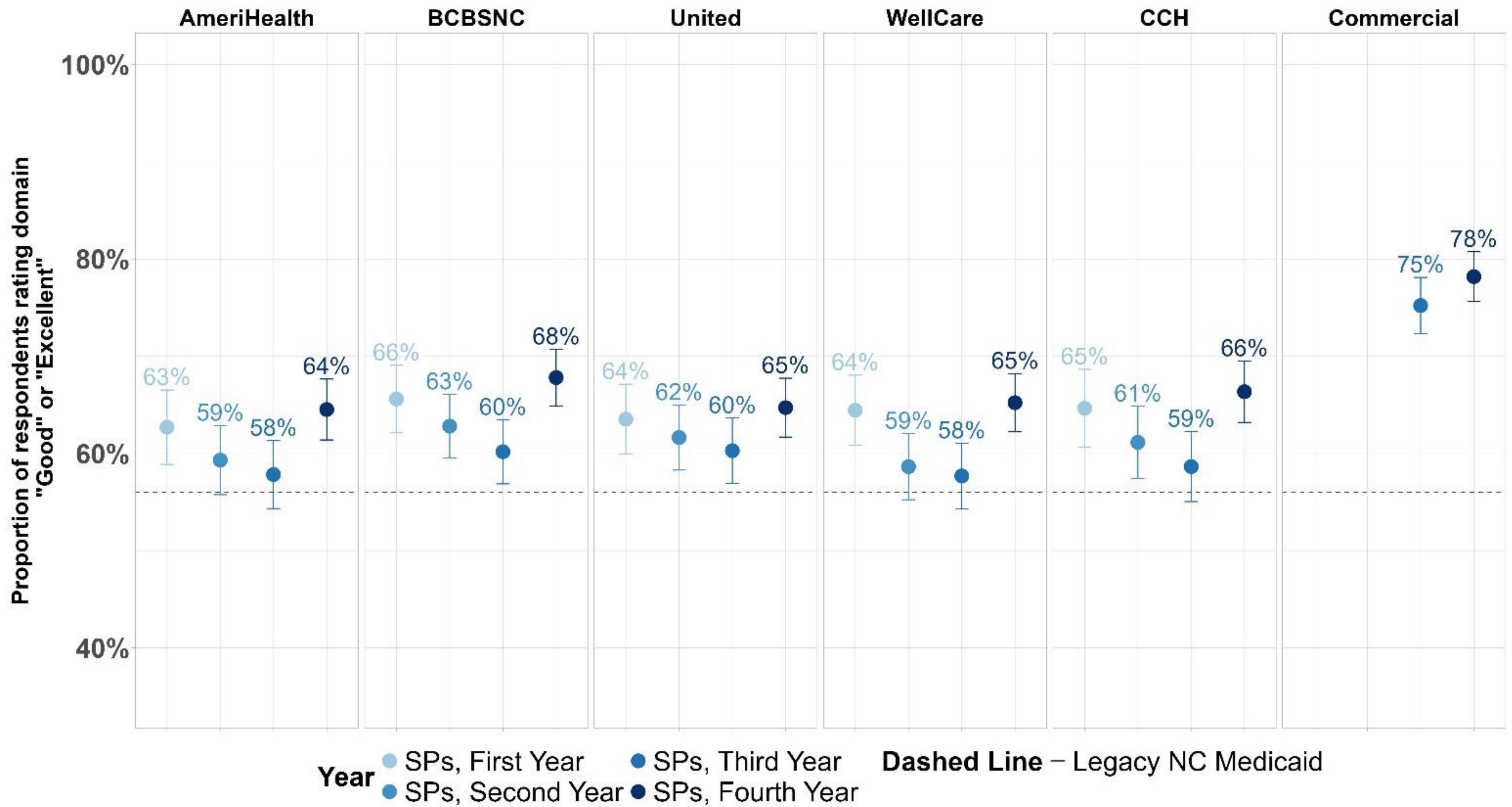
All standard plans performed substantively better in Wave 5 compared to the prior year, reversing the downward trend since the transition to managed care. UnitedHealthcare Community Plan had the smallest gain in performance of the plans.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? *Access to needed drugs for Medicaid patients (formulary)*				
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.63 (0.03)	2.60 (0.03)	2.55 (0.03)	2.67 (0.03)
BCBSNC Healthy Blue	2.67 (0.03)	2.65 (0.02)	2.61 (0.03)	2.72 (0.02)
UnitedHealthcare	2.64 (0.03)	2.62 (0.03)	2.59 (0.03)	2.66 (0.02)
WellCare Health Plans	2.62 (0.03)	2.59 (0.03)	2.57 (0.03)	2.67 (0.02)
Carolina Complete Health	2.66 (0.03)	2.62 (0.03)	2.58 (0.03)	2.69 (0.03)
Largest Commercial Payor			2.87 (0.02)	2.89 (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

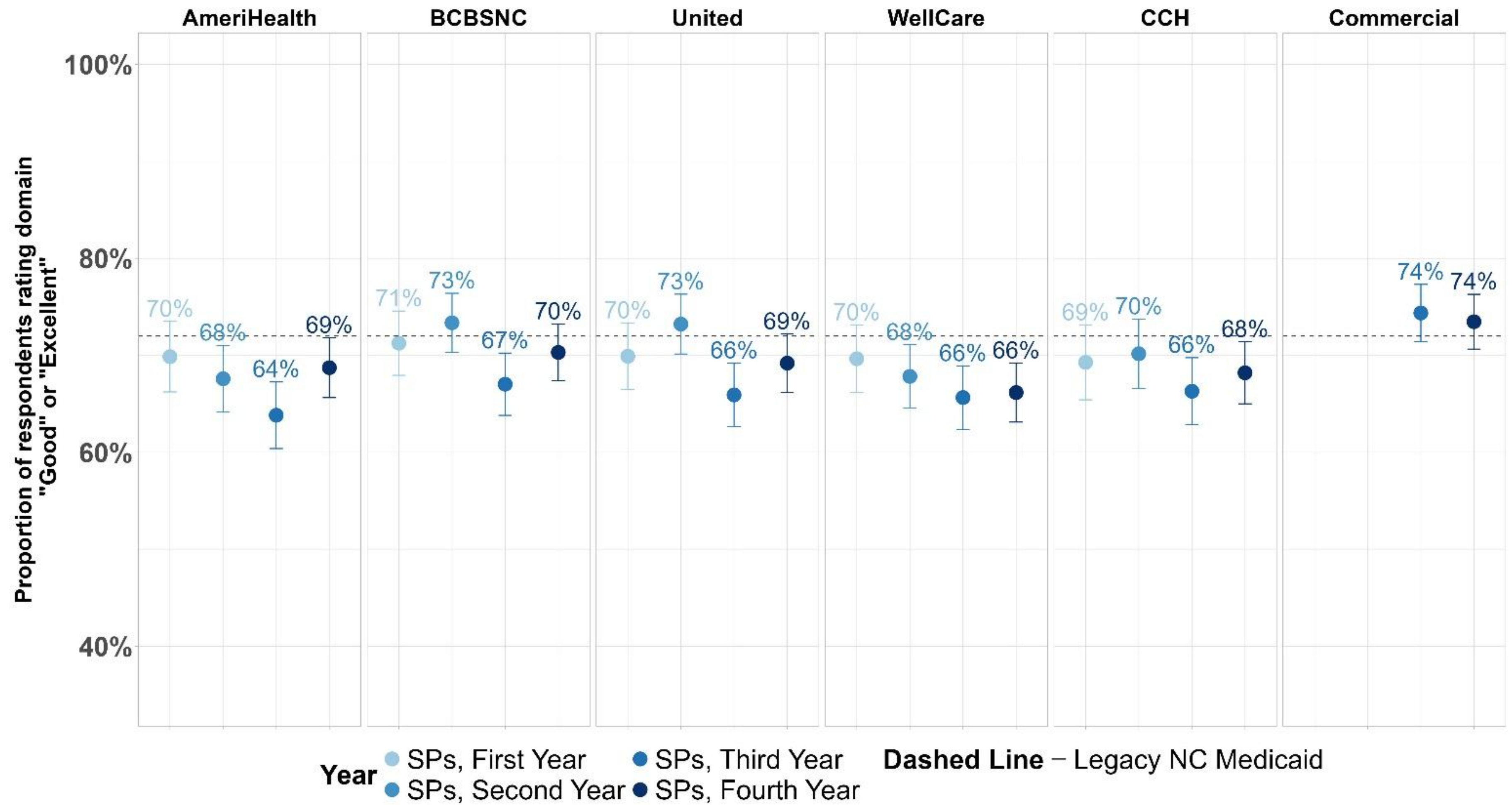
There were minimal changes in SP performance from the prior year. There were no appreciable differences between plans. However, standard plans performed worse than Legacy Medicaid.

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 standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? ***Care/case management for your patients***				
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.75 (0.03)	2.71 (0.03)	2.66 (0.03)	2.77 (0.03)
BCBSNC Healthy Blue	2.80 (0.03)	2.78 (0.03)	2.73 (0.03)	2.8 (0.02)
UnitedHealthcare	2.78 (0.03)	2.78 (0.03)	2.71 (0.03)	2.76 (0.02)
WellCare Health Plans	2.75 (0.03)	2.70 (0.03)	2.69(0.03)	2.73 (0.02)
Carolina Complete Health	2.77 (0.03)	2.76 (0.03)	2.71 (0.03)	2.76 (0.03)
Largest Commercial Payor			2.85 (0.02)	2.8 (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

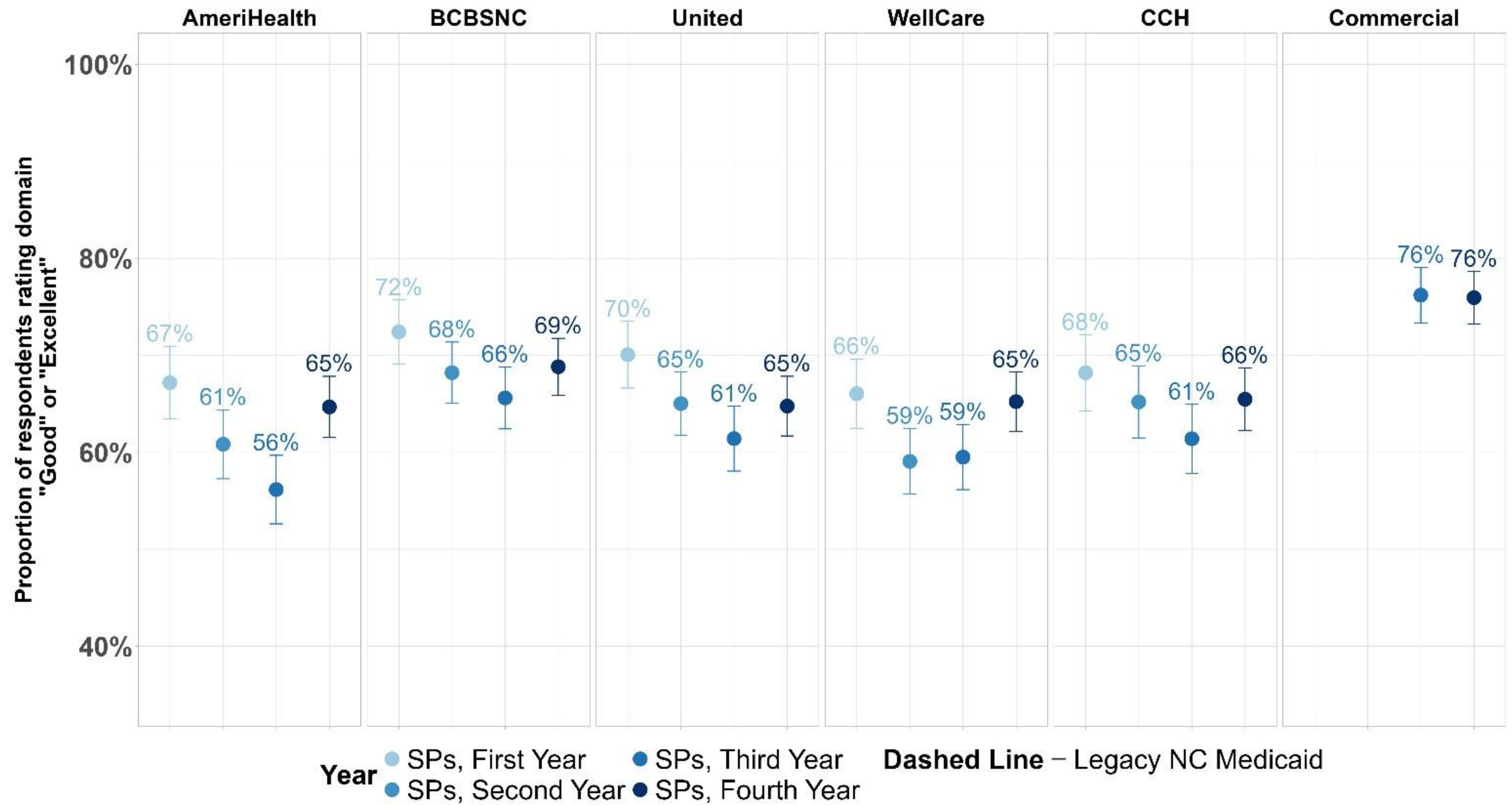
All standard plans performed better in Wave 5 compared to the prior year, with some being large enough to be statistically significant differences. This change reverses the downward trend seen for AmeriHealth, BCBSNC Healthy Blue, UnitedHealthcare Community Plan, and Carolina Complete Health since transition to managed care. AmeriHealth Caritas had the biggest improvement among the standard plans. Performance was comparable across standard plans.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? *Customer/member support services for patients*				
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.72 (0.03)	2.61 (0.03)	2.56 (0.03)	2.66 (0.03)
BCBSNC Healthy Blue	2.82 (0.03)	2.72 (0.03)	2.70 (0.03)	2.73 (0.02)
UnitedHealthcare	2.75 (0.03)	2.67 (0.03)	2.66 (0.03)	2.66 (0.03)
WellCare Health Plans	2.69 (0.03)	2.56 (0.03)	2.62 (0.03)	2.65 (0.03)
Carolina Complete Health	2.74 (0.03)	2.68 (0.03)	2.64 (0.03)	2.69 (0.03)
Largest Commercial Payor			2.87 (0.02)	2.84 (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

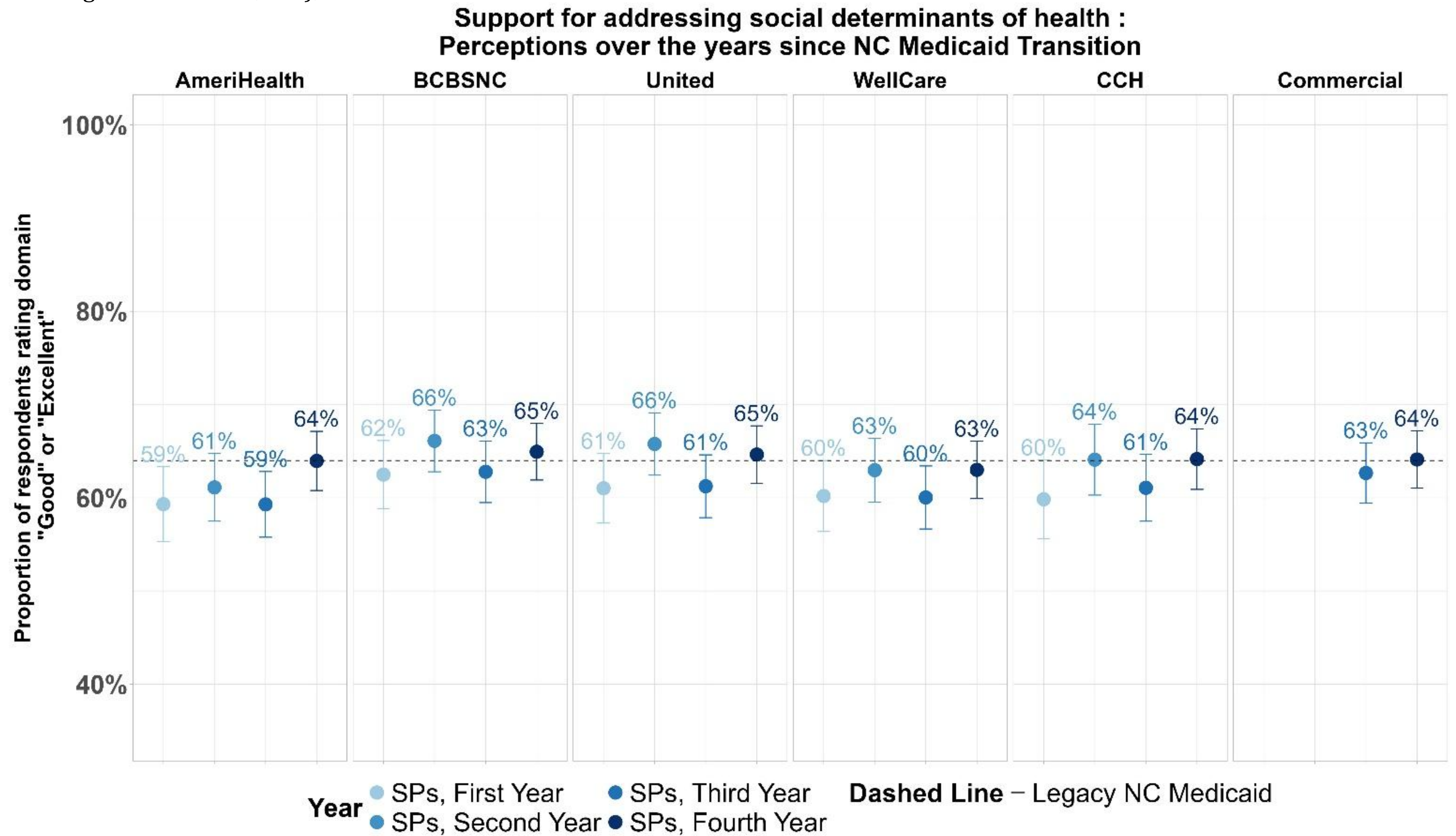
All standard plans performed better in Wave 5 than in the prior year. There were no appreciable differences across standard plans. Standard plans performed as well as commercial plans.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans 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)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.61 (0.03)	2.58 (0.03)	2.59 (0.03)	2.65 (0.03)
BCBSNC Healthy Blue	2.67 (0.03)	2.66 (0.03)	2.64 (0.03)	2.68 (0.03)
UnitedHealthcare	2.64 (0.03)	2.66 (0.03)	2.63 (0.03)	2.67 (0.03)
WellCare Health Plans	2.60 (0.03)	2.60 (0.03)	2.60 (0.03)	2.65 (0.03)
Carolina Complete Health	2.61 (0.03)	2.63 (0.03)	2.61 (0.03)	2.66 (0.03)
Largest Commercial Payor			2.66 (0.03)	2.64 (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%).

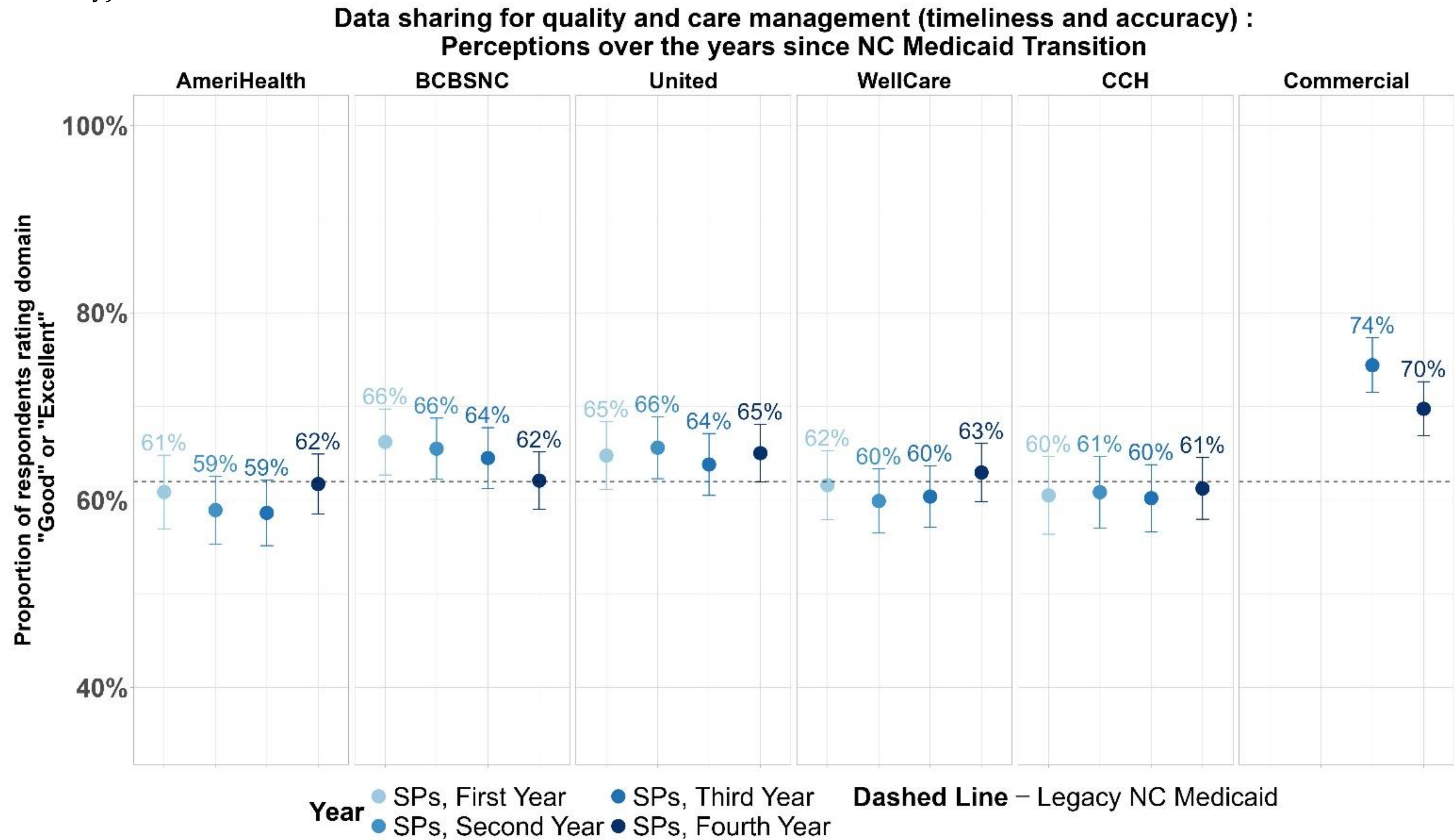
Data sharing for quality and care management (timeliness and accuracy)
Performance improved or remained stable for all plans except BCBSNC Healthy Blue. However, improvements were small. BCBSNC Healthy Blue's performance continues to worsen over time. There were no appreciable differences in performance across standard plans over time.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? *Data sharing for quality and care management (timeliness and accuracy)*				
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	2.57 (0.03)	2.55 (0.03)	2.57 (0.03)	2.62 (0.03)
BCBSNC Healthy Blue	2.69 (0.03)	2.67 (0.03)	2.68 (0.03)	2.66 (0.03)
UnitedHealthcare	2.68 (0.03)	2.67 (0.03)	2.68 (0.03)	2.69 (0.03)
WellCare Health Plans	2.57 (0.03)	2.58 (0.03)	2.62 (0.03)	2.66 (0.03)
Carolina Complete Health	2.60 (0.03)	2.60 (0.03)	2.63 (0.03)	2.66 (0.03)
Largest Commercial Payor			2.83 (0.03)	2.77 (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)

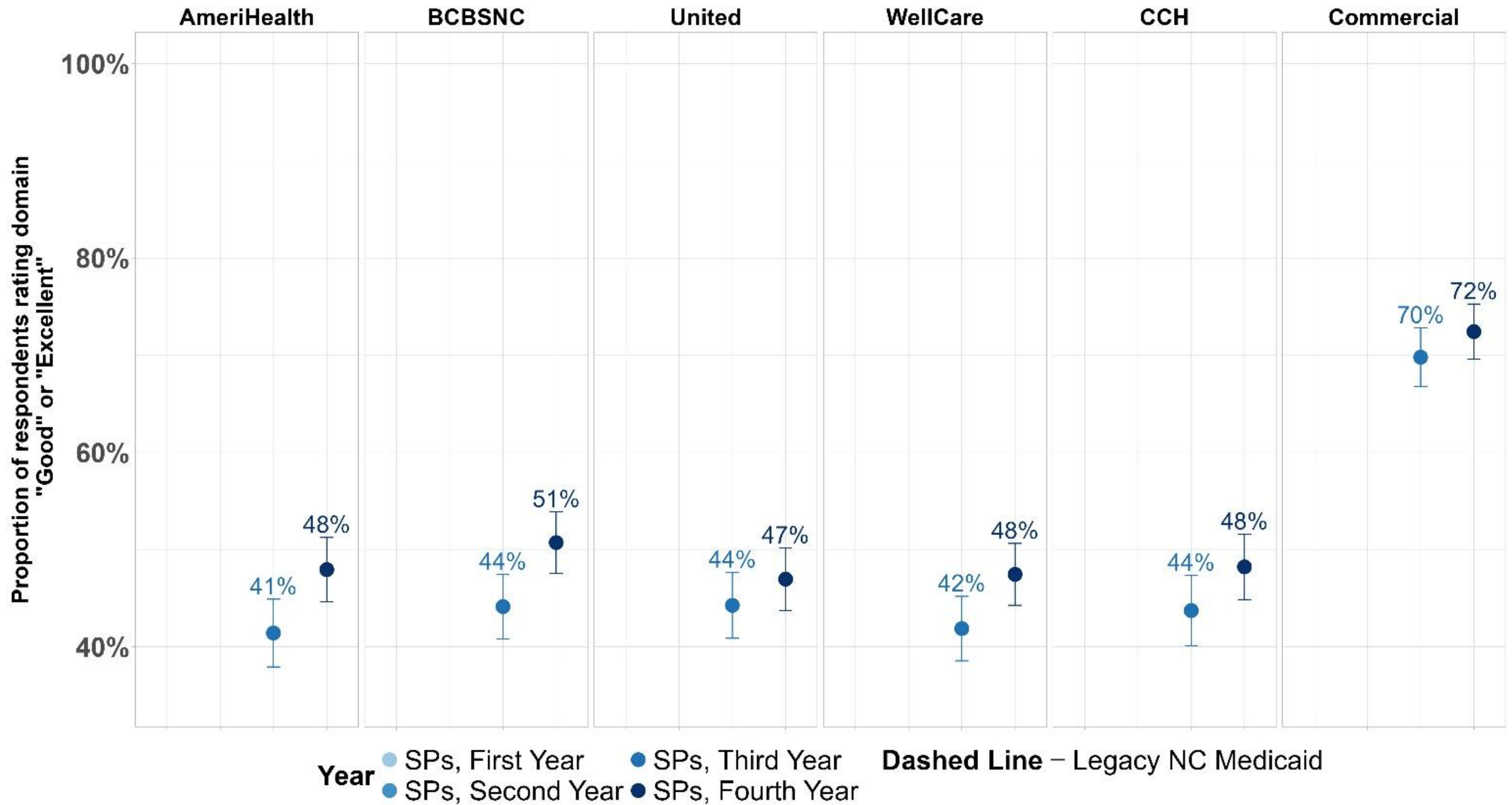
All standard plans had improved performance compared to last year, with little difference across plans. AmeriHealth and BCBSNC Healthy Blue had substantial improvements. Standard plans performed considerably worse compared to commercial plans.

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

Based on your practice's/health system's experience with standard plans, how would you describe your overall experience for the following factors for each of the standard plans you are contracting with? *Process and accuracy for assigning patients to your practice (attribution)*				
PHP	**2022 Mean (SE)**	**2023 Mean (SE)**	**2024 Mean (SE)**	**2025 Mean (SE)**
AmeriHealth Caritas North Carolina	--	--	2.20 (0.03)	2.3 (0.03)
BCBSNC Healthy Blue	--	--	2.27 (0.03)	2.36 (0.03)
UnitedHealthcare	--	--	2.27 (0.03)	2.29 (0.03)
WellCare Health Plans	--	--	2.20 (0.03)	2.29 (0.03)
Carolina Complete Health	--	--	2.26 (0.04)	2.31 (0.03)
Largest Commercial Payor			2.79 (0.03)	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.

Composite Experience with Standard Prepaid Health Plans

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

Overall ratings of standard plans

Overall, BCBSNC Healthy Blue had the highest overall rating of all standard plans in Wave 5; AmeriHealth Caritas had the lowest. Though the standard plans have no appreciable differences over time, AmeriHealth Caritas has been performing worse compared to other plans. Standard plans were rated considerably worse than commercial plans.

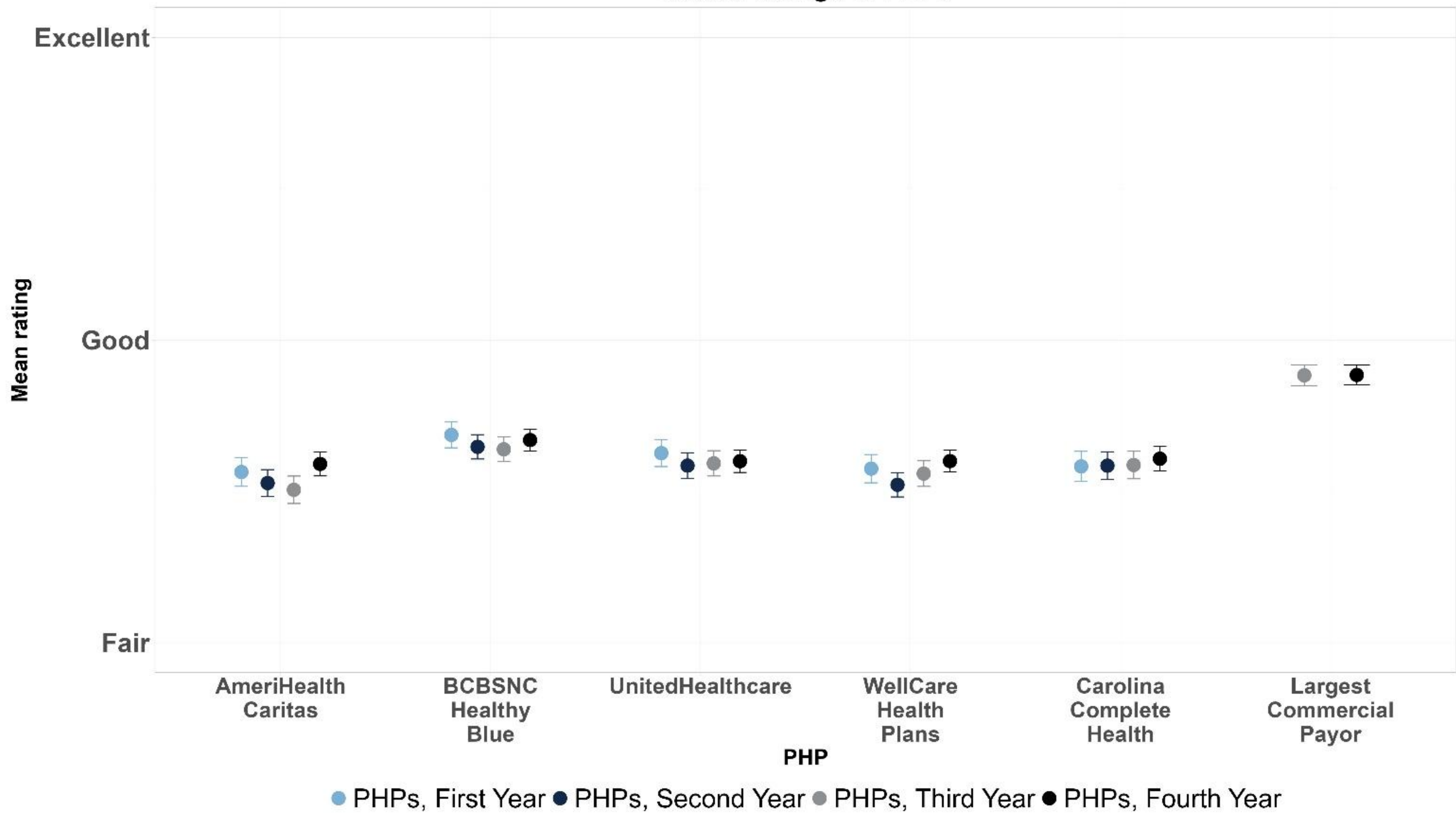
Ratings of standard plans across administrative domains

Across administrative domains, 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, though AmeriHealth has made substantial improvements in Wave 5. Standard plans were rated considerably worse in administrative domains than commercial plans.

Ratings of standard plans across clinical domains

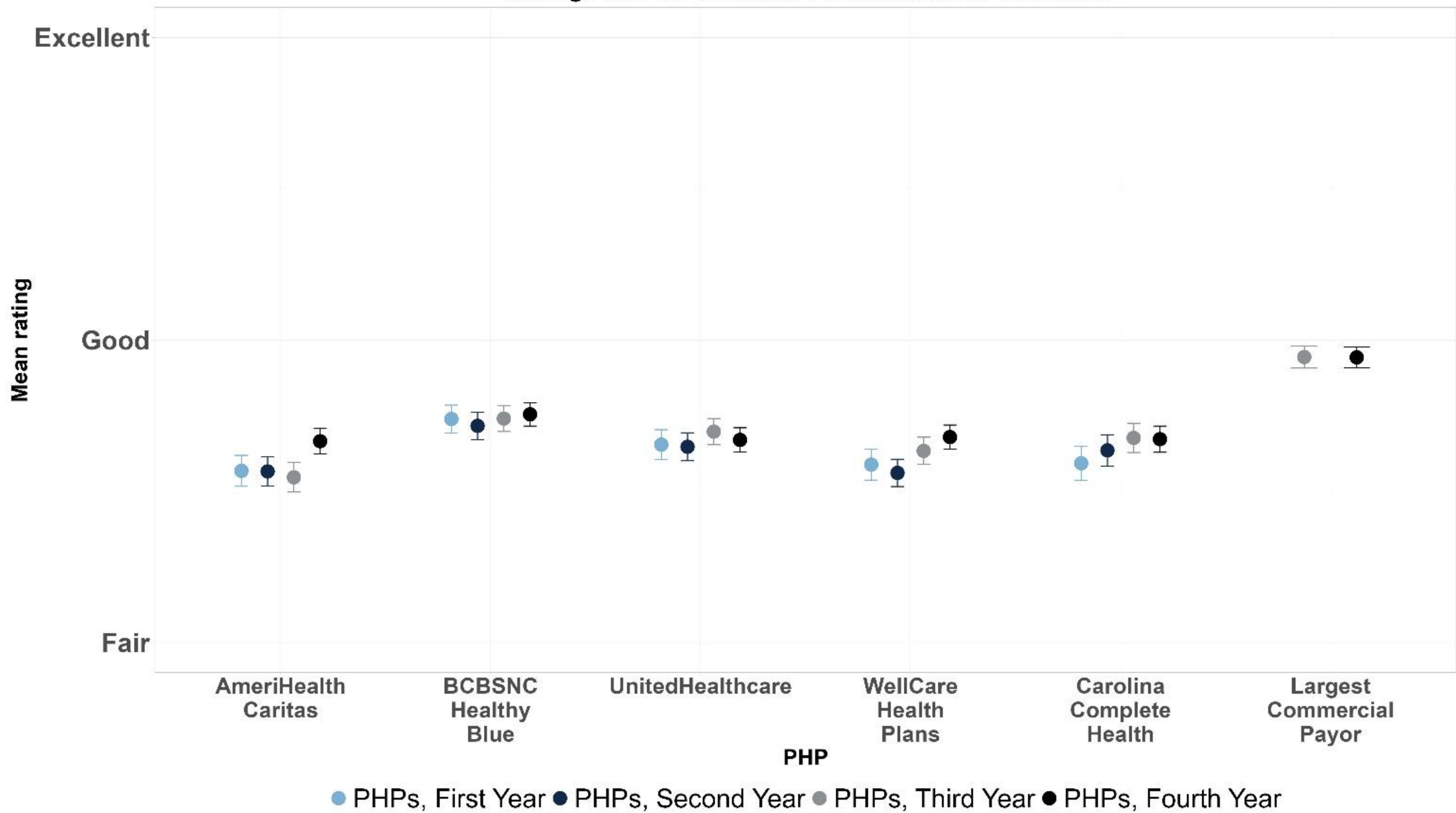
Across clinical domains, most standard plans are getting worse year after year, though all seem to be potentially reversing this trend in Wave 5. There were no appreciable differences between plans in Wave 5. All plans were rated lower in clinical domains than in administrative domains. Standard plans were rated considerably worse than commercial plans.

Exhibit 41. All Domains: Mean ratings and 95% CI of standard plans across four years of managed care



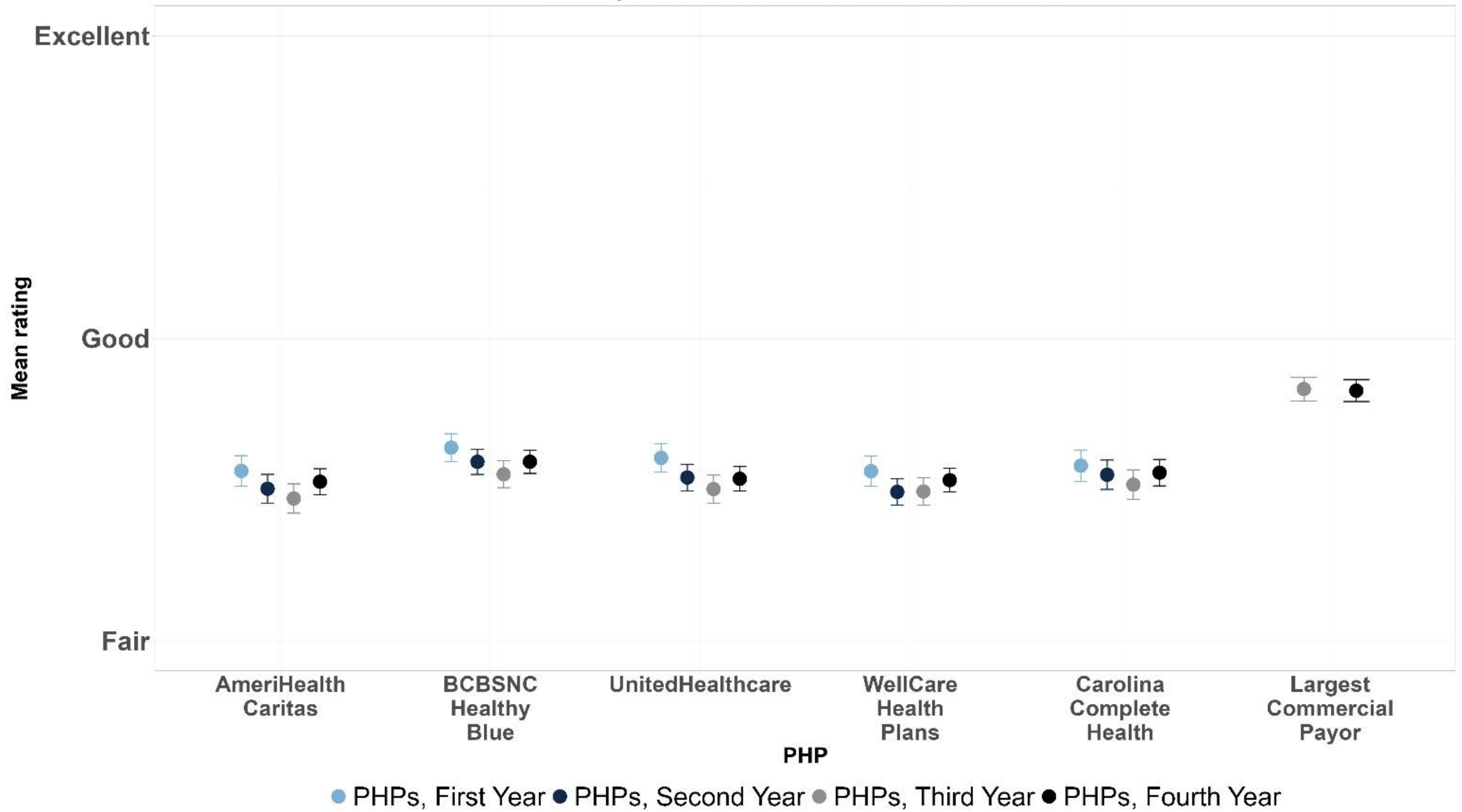
Notes: Data label reports Wave 4 mean. To allow for multiyear comparison, process and accuracy for assigning patients to your practice (attribution) is not included in Wave 4 estimate.

Exhibit 42. Administrative Domains: Mean ratings and 95% CI of standard plans across four 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

Exhibit 43. Clinical Domains: Mean ratings and 95% CI of standard plans across four years of managed care



Note: Data label reports Wave 4 mean

Experience: Four years of Medicaid managed care

In the following exhibits, we combine the data across standard plans to estimate their overall performance together. This can be viewed as providers' overall experience. Overall, we see slight improvements in provider relations, timeliness of claims processing, and process and accuracy for assigning patients to practices (attribution). No categories substantially worsened from the previous wave. Attribution is much worse than other domains and is an important sticking point, though it appears to be improving. Responses to open ended questions revealed inaccurate attribution as an obstacle for providers to meet their performance metrics and the difficulty of resolving attribution issues adding to administrative strain. The majority of clinical domains, except formulary and support services, appear to have stagnated or worsened over time. The two exceptions mentioned are the only ones to have confidence intervals that do not overlap the previous year's point estimates.

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

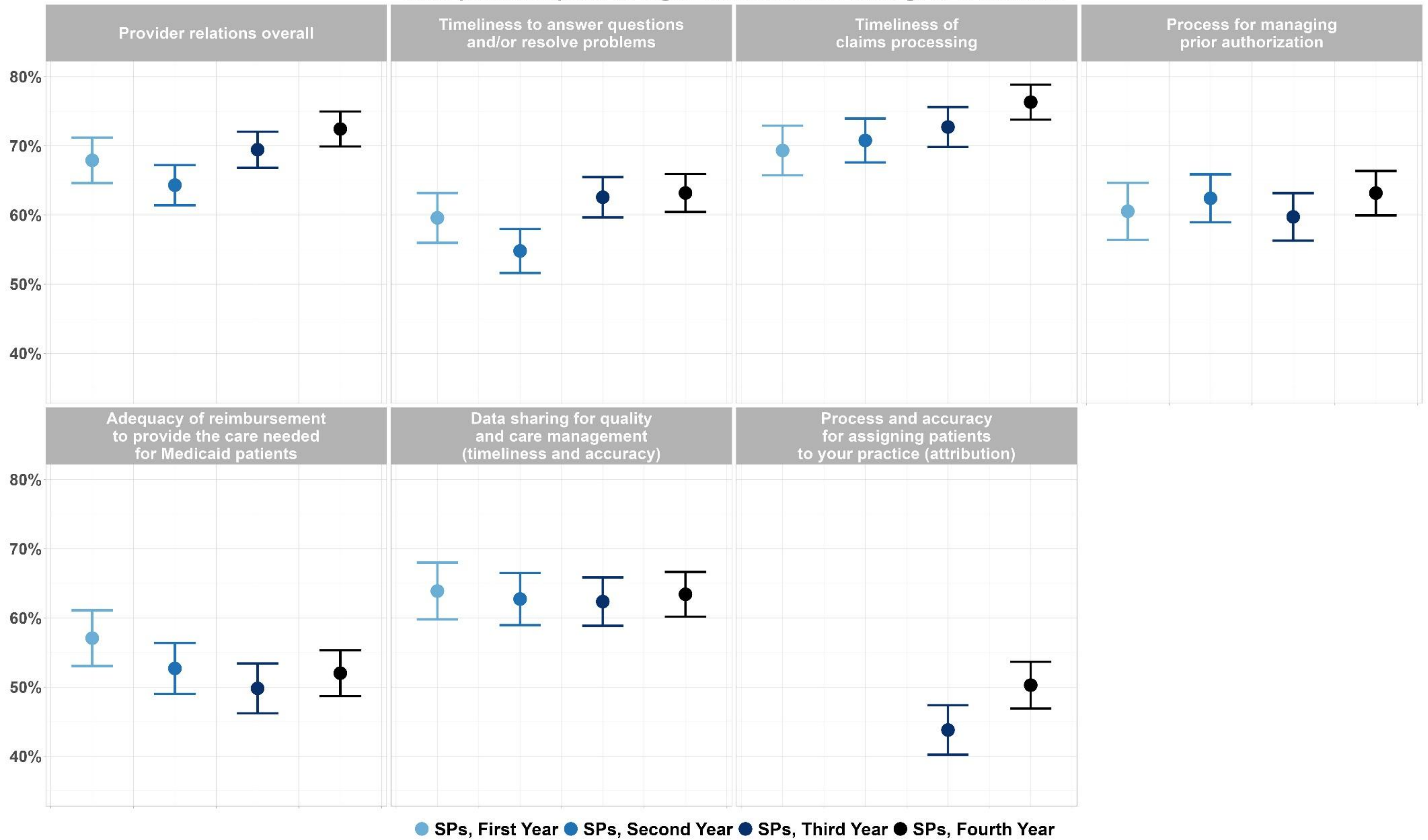
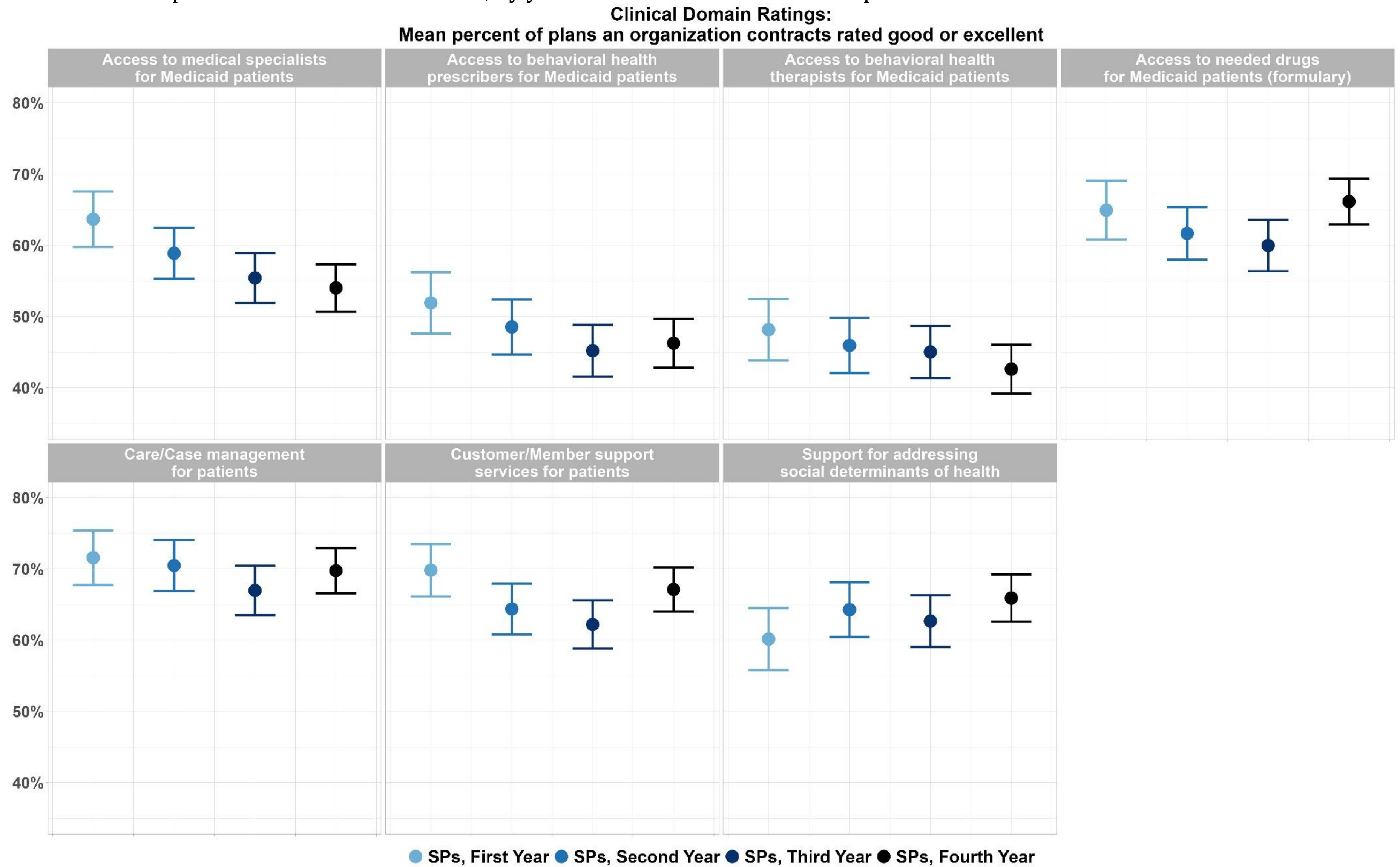
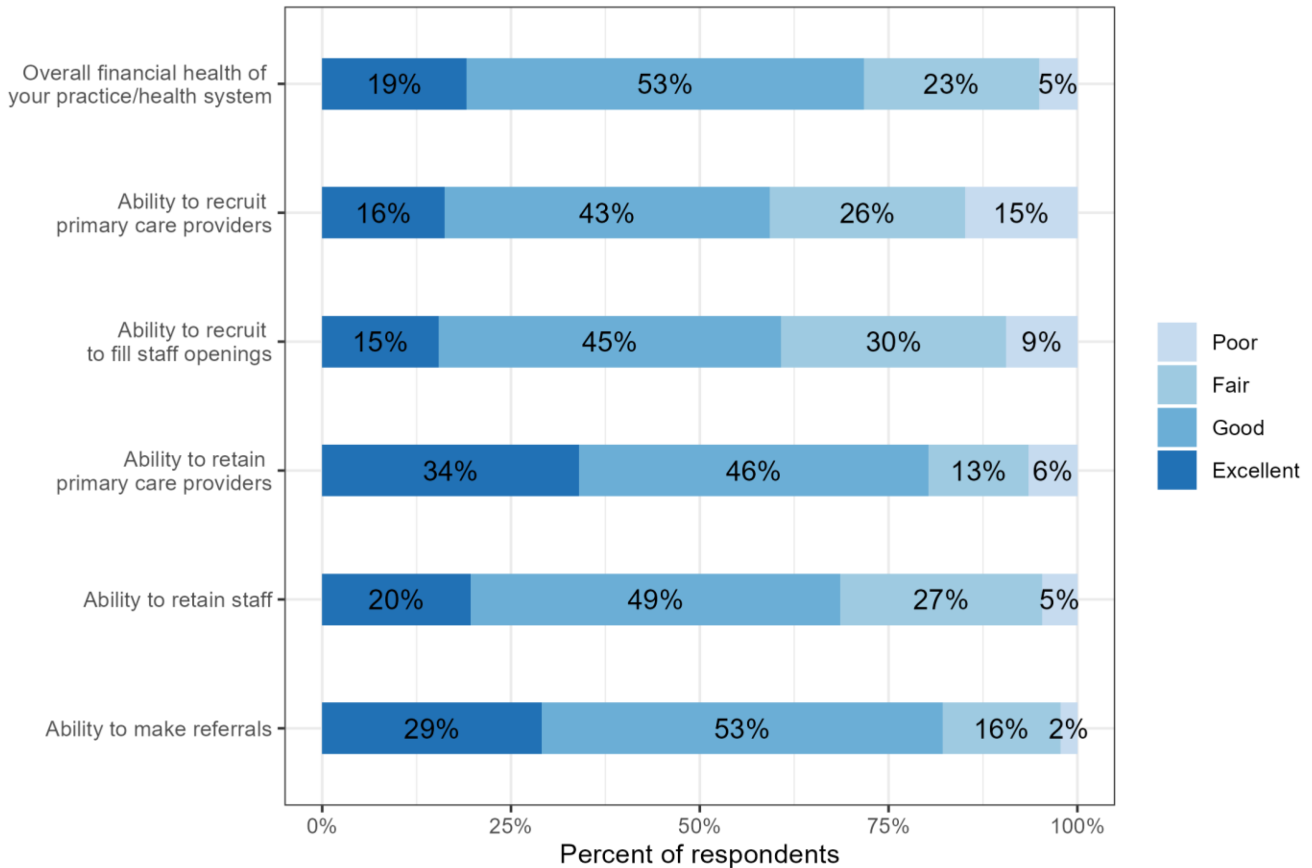


Exhibit 44b. Experience with clinical domains, by year after transition to standard plans



When asked about the financial health of their organization and of staffing retention, a large majority of providers responded favorably (good or excellent). Areas in which a larger portion of providers rated either fair or poor were the ability to recruit primary care providers and the ability to fill staff openings.

Exhibit 45. Practice/health system ratings on operational, financial, and staffing challenges



A third of provider organizations think case management would ideally be embedded in individual practices. Another 30% of provider organizations are unsure how case management should be situated. The most common response for a specific option than what was listed was a combination of CIN involvement and individual practices or with PHPs.

Exhibit 46. Ideal situation for care management for practice/health system

Item	% (N)
Embedded in individual practices	33.9% (128)
Provided by health system or clinically integrated network (not embedded in individual practices)	20.5% (77)
Provided by PHPs	11.5% (43)
Unsure	30.8% (117)
Other	3.4% (13)

Note: 18 NA values not included in denominator

The results show almost exactly the same proportion of practices using the Collaborative Care Model (CCM) and substantial barriers remain. Particularly, practices identified a lack of behavioral health professionals, not having enough space in the office to support one, and reimbursement not being sufficient to cover the costs of the model. These are clear policy targets for the state.

Exhibit 47. Presence of embedded or co-located behavioral health among provider organizations

Item	% (N)
Yes, in all offices	19.8% (73)
Yes, in some offices	8.4% (31)
No	71.8% (265)

Note: 27 NA values not included in denominator

Exhibit 48. 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
2. Not enough funding and/or resources
3. Not interested in this option
4. Have preferred referral locations/relationships
5. Considering it or in the process of getting this started

Exhibit 49. Use of Collaborative Care Model among provider organizations

Item	% (N)
Yes, in all offices	17.2% (62)
Yes, in some offices	2.7% (10)
No	68.9% (251)
I don't know what the Collaborative Care Model	11.1% (40)

Note: 33 NA values not included in denominator

Exhibit 50. 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)
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 = 296)	53.7% (149)	42.8% (119)	22.8% (63)	31.8% (88)
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 = 261)	40% (101)	43.3% (109)	24.6% (62)	35.1% (89)

Note: 19 NA values not included in denominator for top row, 8 NA values not included in denominator for bottom row

Exhibit 51. 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. Considering it or in the process of getting this started
2. Lack of funding
3. Unfamiliar with model/ Does not know of potential benefits
4. Shortage of behavioral health professionals
5. Have preferred referral locations/relationships
6. Not interested in option

Experience with Health Information Exchanges

The majority of provider organizations (70.5%) reported being connected to NC HealthConnex (North Carolina's statewide health information exchange). Of these provider organizations that reported using NC HealthConnex, an overwhelming preponderance report neutral to positive experience with the program (98.8%). However, only a minority (42.9%) reported that NC HealthConnex improved their access to social determinants of health screening data.

Exhibit 52. Provider organizations' responses when asked whether their practice/medical group or system was connected to NC HealthConnex (North Carolina's statewide health information exchange)

Item	% (N)
Yes	70.5% (270)
No	11.3% (43)
Unsure	18.2% (70)

Note: 13 NA values not included in denominator

Exhibit 53. Provider organizations' responses when asked how the HIE changed the process of sharing quality measure data with Medicaid Standard Prepaid Health Plans

Item	% (N)
Improves a lot	21.8% (58)
Improves a little	24.1% (64)
No Change	52.9% (140)
Worsens a little	0.8% (2)
Worsens a lot	0.3% (1)

Note: 132 NA values not included in denominator

Exhibit 54. Provider organizations' responses when asked whether the HIE allowed them to access social determinants of health screening data about your patients

Item	% (N)
Yes, all of the time	9.7% (26)
Yes, some of the time	33.2% (88)
No	20.5% (54)
I don't know	36.6% (97)

Note: 131 NA values not included in denominator

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

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

- **Patient Attribution.** Many provider organizations report incorrect patient attribution and the process to correct attribution lists being a significant administrative burden. Organizations have described patients also having difficulty with standard plans changing their primary care provider. A frequently cited issue is an organization being assigned patients when they are no longer accepting new patients and/or at capacity. Ultimately, issues with attribution are impacting providers' ability to process claims and to report on required quality measures.

  Quote: "[PHP name omitted] has been fairly good with attribution issues, however, I feel they could be better. [PHP name omitted] is terrible with attribution issues. We are told we have to wait a year for a patient to circle off of our list. That is unacceptable. Why should we have to wait a year to have a patient removed once they are identified as not coming to our practice. This affects care gap closures and our bonus money we receive from the plan. Very UNFAIR!"
- **Payment challenges.** Many provider organizations report issues with reimbursement. Cited payment challenges include issues with Coordination of Benefits and accuracy of payments. Some provider organizations cited that high administrative burden for the low reimbursement of standard plans is a major challenge for their practice. A specific issue that was mentioned was communication issues with standard plans and not knowing who to contact for resolution.

  Quote: "Rather than going to one place to take care of things we have to consistently do extra work having the 5 PHP's… Physician/provider burnout is going to peak soon if payments do not increase. The cost of doing business, exceeds the reimbursements we receive and it is not fair to the patients or the providers to have to see 25-30 patients to just keep the lights on."
- **Network adequacy.** Provider organizations have described the administrative burden of referrals, as few specialists accept standard plans. Difficulties in finding in-network providers further delays patient care.

- **Claims denials and processes for resolution.** Many provider organizations report overall dissatisfaction with the claims process. A commonly reported issue is resolving denied claims and the lack of a standardized process to resolve claims. Existing issues with communication with standard plans to resolve issues is making it difficult to reprocess claims.

- **Frustration and administrative burden of dealing with many standard plans.** Many organizations commented on continuous administrative burden and stress on their staff since transition to managed care.

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

- **Patient care.** Providers are concerned about the added burden to their patients navigating a complex system. Many provider organizations expressed the need for the standard plans to share more information with their patients regarding their benefits. Specific examples given are more information regarding transportation, food insecurity and other social determinants of health.

- **Burden on small and/or rural providers.** Small practices or those who work in rural areas note the difficulties contracting with standard plans have on their staff. These challenges have had an impact on their ability to retain clinical and administrative staff and overall patient care.

    Quote. "We are a small, independent family practice with the doctor and only three staff members. It is hard for the practice to handle changes such as the transition to managed care and need support from Medicaid. I believe that we should offer to care for Medicaid patients but it is hard to do."

DISCUSSION

This report presents provider experience at the end of the fourth year of NC Medicaid Managed Care. The results of the Wave 5 survey demonstrate some stagnation overall in reported provider experience. In terms of overall relations, most standard plans remain on par or worse than Legacy Medicaid for the majority of administrative and clinical domains. Domains which did see some improvement, such as timeliness to answer questions (Exhibit 16), are still at or below Legacy Medicaid levels for most plans. Other domains which have shown improvement such as access to formulary (Exhibit 30) have returned to pre-transition rates but did not exceed them. Domains which had fallen in previous years such as access to medical specialists (Exhibit 24) and behavioral health prescribers (Exhibit 26) remain low, although behavioral health access remains slightly higher than Legacy Medicaid.

Important differences were noted when comparing Wave 5 results between individual standard plans. Whereas in Wave 4 it seemed that there was separation occurring between plans, the improvements in AmeriHealth Caritas across several domains mean that for Wave 5 on most domains the plans are more similar than different. For example, in provider relations overall (Exhibit 14), while BCBSNC Healthy Blue still performs best, the remaining plans are all within 3 percentage points of one another and statistically not distinguishable from one another. Similar trends can be seen for timeliness to answer questions (Exhibit 16) and timeliness of claims processing (Exhibit 18), where plans excluding BCBSNC Healthy Blue are within a few percentage points of one another. Other domains such as adequacy of reimbursement (Exhibit 22) or access to behavioral health prescribers (Exhibit 26) have all plans within a percentage point difference of one another. A similar trend bears out in the remaining domains, where either *all* plans are within a few percentage points of one another, or BCBSNC Healthy Blue outperforms, with the remaining plans within a few percentage points of one another. Similarly, differences across types of providers (e.g. large vs. small practices) were dwarfed by differences across domains; put another way, the issues that are the biggest problem for small provider organizations are the same as the issues for large organizations.

Cross plan similarity indicates that the state may want to focus more on underperforming domains rather than focusing on underperforming plans. Domains such as adequacy of reimbursement, access to medical specialists, access to behavioral health prescribers, access to behavioral health therapists, and process and accuracy of attribution all have near or below 50% experience ratings from providers. Policy approaches to address these problem domains 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.

Wave 5 was the second time providers were asked to rate their experience with their largest commercial payor. With the exception of care/case management and support for addressing social determinants of health, the standard plans continue to perform considerably worse compared with the largest commercial provider. Providers report worse experiences with Medicaid plans across the vast majority of domains, in some cases by as much as 20 percentage points or more on domains such as access to specialty care. This suggests that it is not only reimbursement rates, but a number of other factors, that lead to worse experiences compared with commercial plans. Data

on NC HealthConnex indicates that the majority of provider organizations (70.5%) report being connected. Connected providers viewed the service favorably, with a vast majority (98.8%) indicating neutral to positive experience with the program.

In summary, this report shows the continued stagnation of provider experiences working with standard plans. Combining the quantitative results and the open-ended 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. Attribution remains a significant problem area as well. Write in comments highlight the financial strain from low reimbursement, delayed payments, and recoupments. Statewide efforts to address domain specific standard plan performance will be important to preserving access to and quality of care for patients with NC Medicaid.

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APPENDIX

Stratified Experience of Provider Organizations

This section presents several stratifications of the provider experience 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 standard plans across all domains, stratified by provider organization size

Overall ratings for standard plans stratified by size			
PHP	**Small Provider Organizations (n = 149) Mean (SE)**	**Medium Provider Organizations (n = 151) Mean (SE)**	**Large Provider Organizations (n = 95) Mean (SE)**
AmeriHealth Caritas North Carolina	2.63 (0.04)	2.5 (0.03)	2.58 (0.04)
BCBSNC Healthy Blue	2.71 (0.03)	2.57 (0.03)	2.68 (0.03)
UnitedHealthcare	2.62 (0.03)	2.55 (0.03)	2.56 (0.04)
WellCare Health Plans	2.61 (0.03)	2.51 (0.03)	2.62 (0.03)
Carolina Complete Health	2.63 (0.04)	2.52 (0.03)	2.63 (0.04)
Largest Commercial Payor	2.89 (0.03)	2.87 (0.03)	2.87 (0.03)

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

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

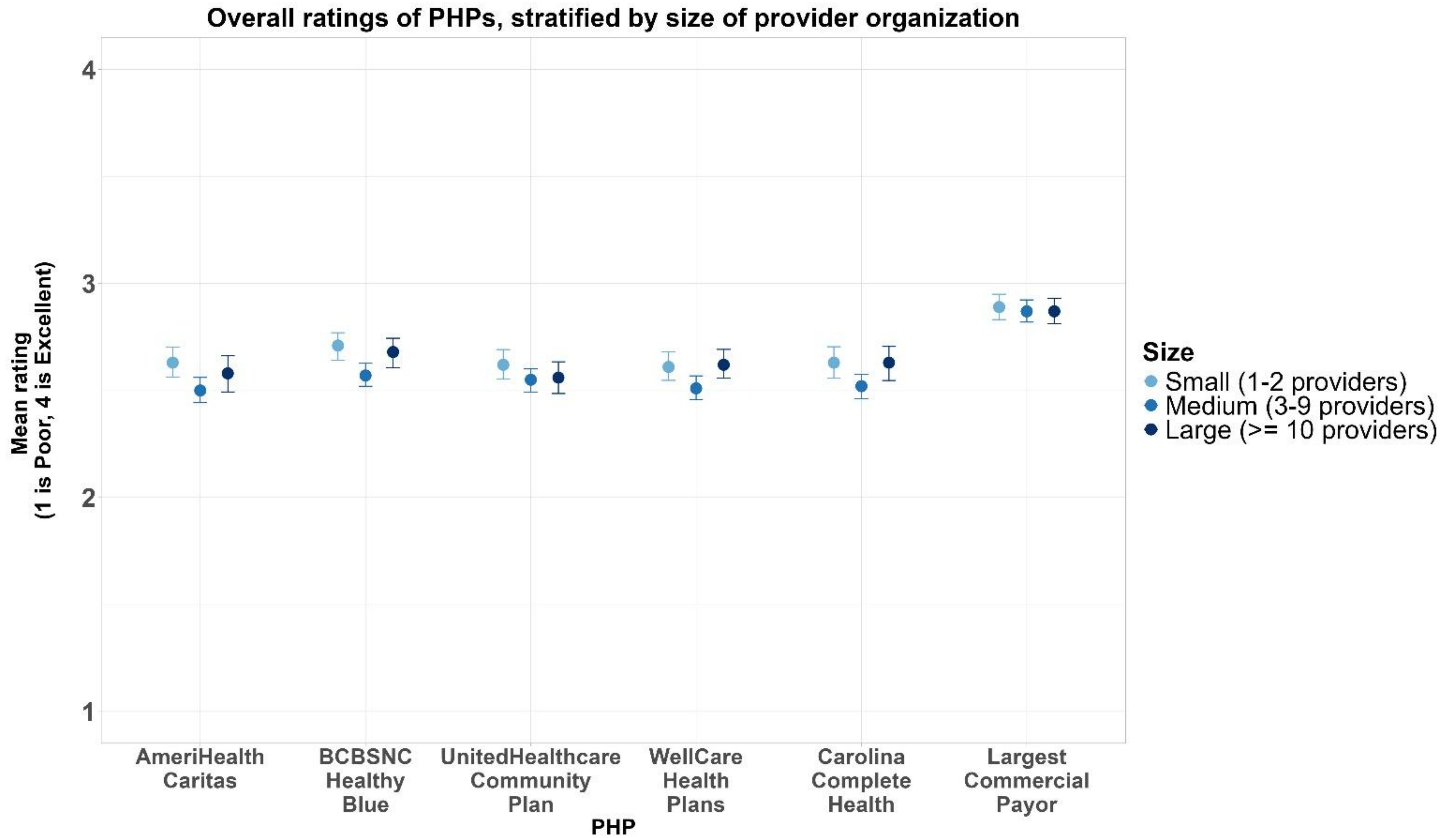


Exhibit A3. Mean ratings of standard plans across administrative domains, stratified by provider organization size

Administrative ratings for standard plans stratified by size			
PHP	**Small Provider Organizations (n = 149) Mean (SE)**	**Medium Provider Organizations (n = 151) Mean (SE)**	**Large Provider Organizations (n = 95) Mean (SE)**
AmeriHealth Caritas North Carolina	2.67 (0.04)	2.56 (0.03)	2.61 (0.04)
BCBSNC Healthy Blue	2.77 (0.03)	2.63 (0.03)	2.69 (0.04)
UnitedHealthcare	2.67 (0.04)	2.6 (0.03)	2.58 (0.04)
WellCare Health Plans	2.67 (0.04)	2.57 (0.03)	2.64 (0.04)
Carolina Complete Health	2.68 (0.04)	2.57 (0.03)	2.61 (0.04)
Largest Commercial Payor	2.92 (0.03)	2.93 (0.03)	2.92 (0.03)

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

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

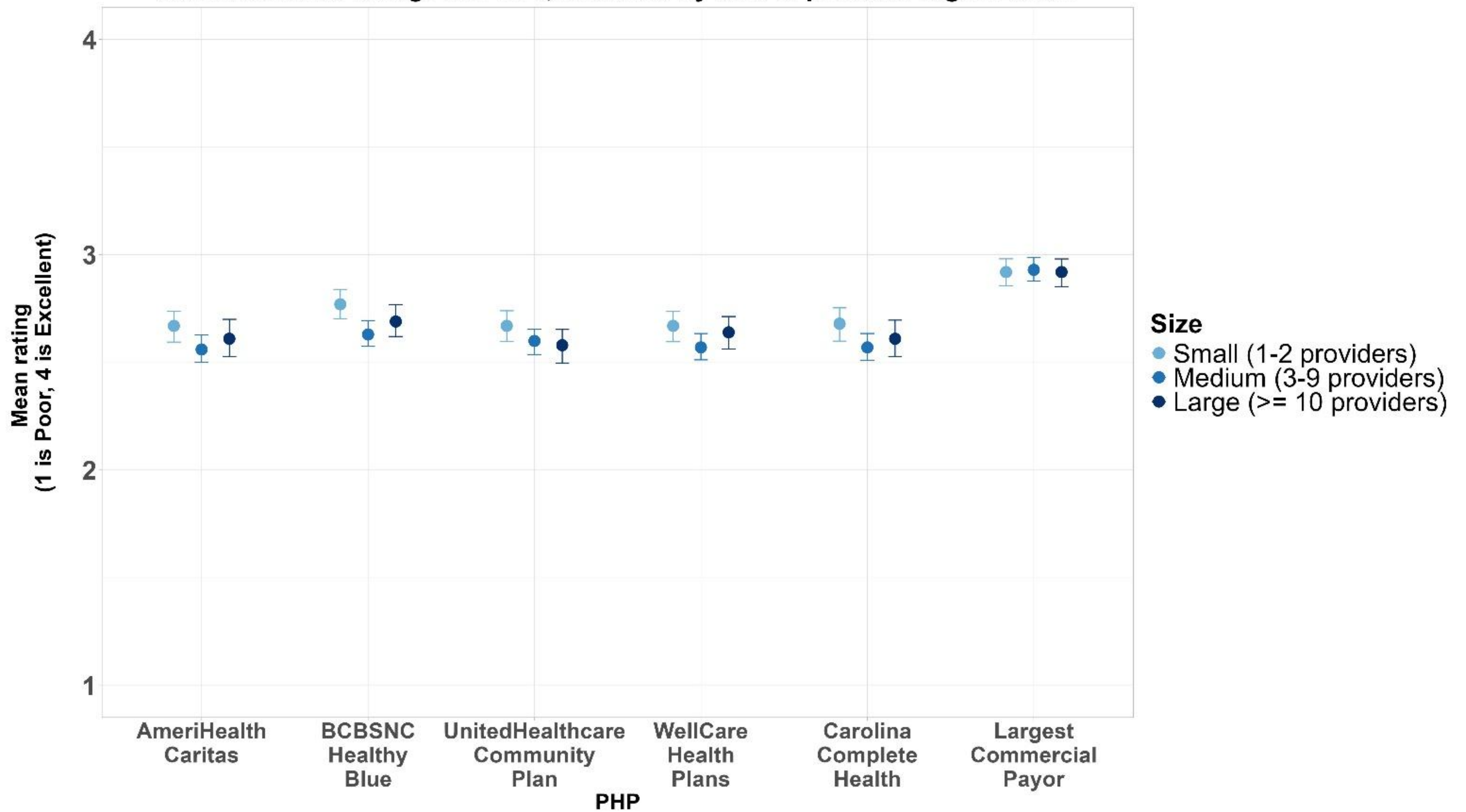
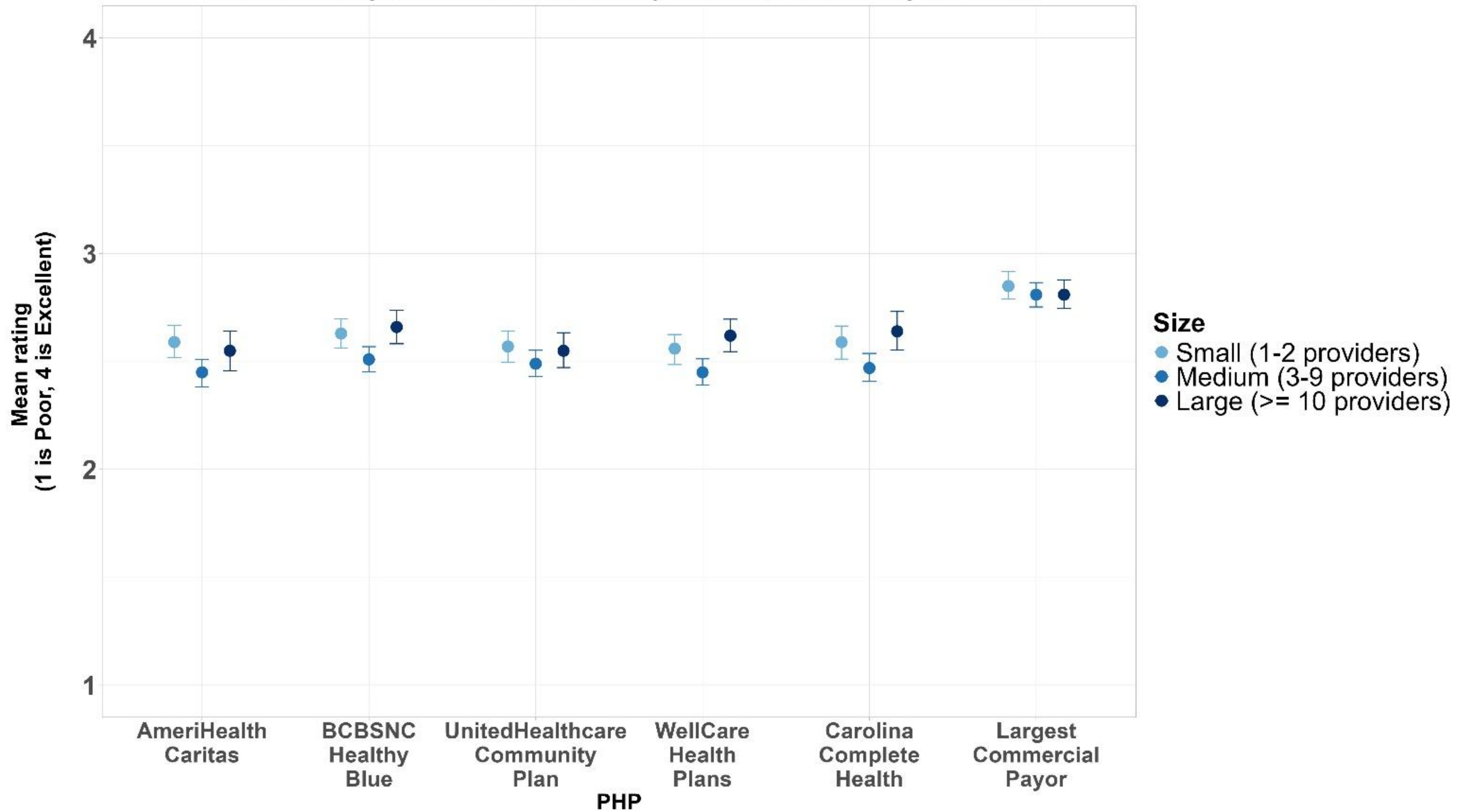


Exhibit A5. Mean ratings of standard plans across clinical domains, stratified by provider organization size

Clinical ratings for standard plans stratified by size			
PHP	**Small Provider Organizations (n = 149)** **Mean (SE)**	**Medium Provider Organizations (n = 151)** **Mean (SE)**	**Large Provider Organizations (n = 95)** **Mean (SE)**
AmeriHealth Caritas North Carolina	2.59 (0.04)	2.45 (0.03)	2.55 (0.05)
BCBSNC Healthy Blue	2.63 (0.03)	2.51 (0.03)	2.66 (0.04)
UnitedHealthcare	2.57 (0.04)	2.49 (0.03)	2.55 (0.04)
WellCare Health Plans	2.56 (0.04)	2.45 (0.03)	2.62 (0.04)
Carolina Complete Health	2.59 (0.04)	2.47 (0.03)	2.64 (0.05)
Largest Commercial Payor	2.85 (0.03)	2.81 (0.03)	2.81 (0.03)

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

Exhibit A6. Mean ratings of standard plans 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 standard plans across all domains, stratified by rurality of provider organization

Overall ratings for standard plans stratified by rurality		
PHP	**Has rural practice site (n =204) Mean (SE)**	**Does not have rural practice site (n = 192) Mean (SE)**
AmeriHealth Caritas North Carolina	2.59 (0.03)	2.55 (0.03)
BCBSNC Healthy Blue	2.66 (0.03)	2.64 (0.03)
UnitedHealthcare	2.6 (0.03)	2.56 (0.03)
WellCare Health Plans	2.56 (0.03)	2.6 (0.03)
Carolina Complete Health	2.61 (0.03)	2.57 (0.03)
Largest Commercial Payor	2.85 (0.02)	2.91 (0.02)

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

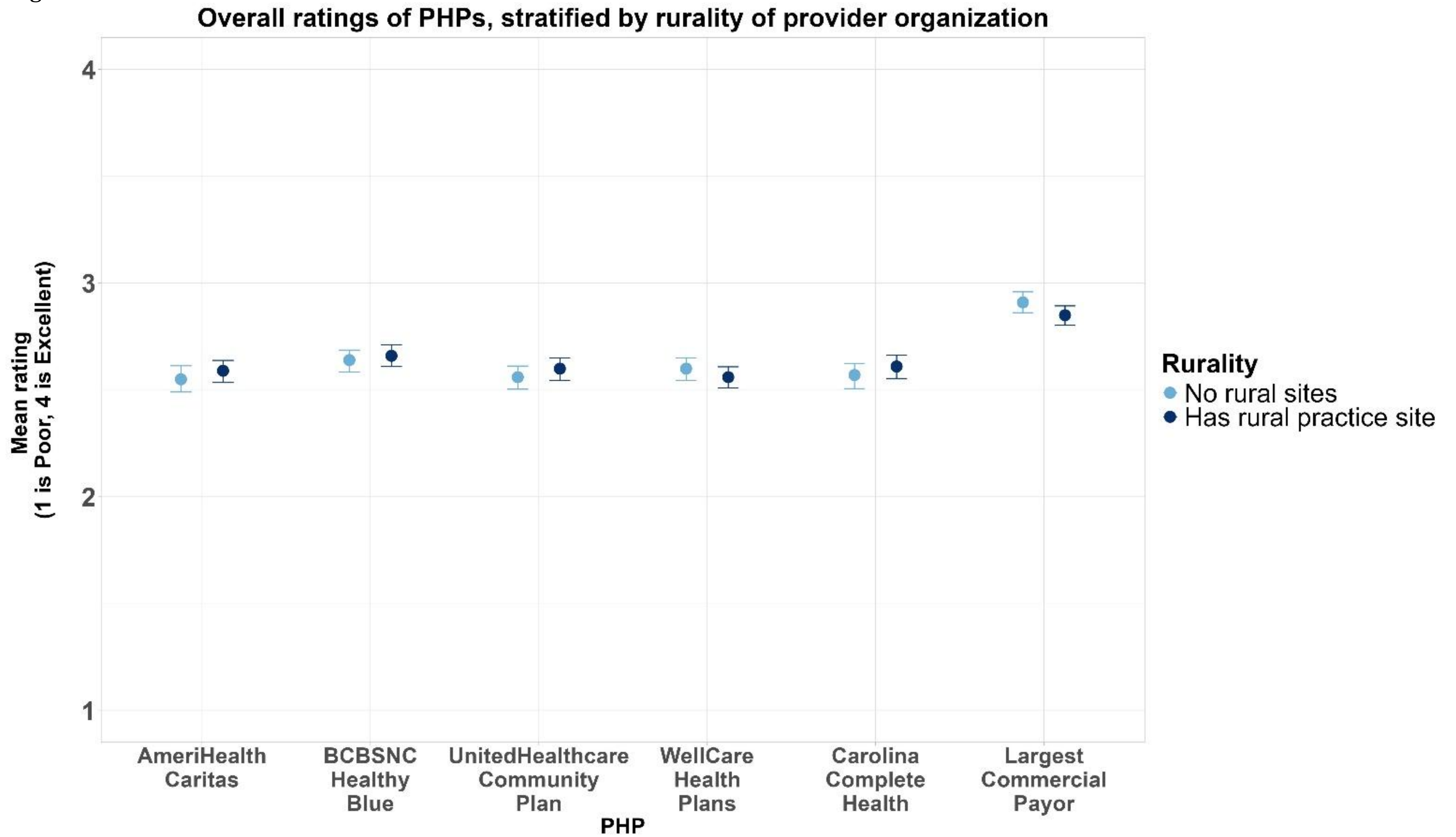


Exhibit A9. Mean ratings of standard plans across administrative domains, stratified by rurality of provider organization

Administrative ratings for standard plans stratified by rurality		
PHP	**Has rural practice site (n = 204) Mean (SE)**	**Does not have rural practice site (n = 192) Mean (SE)**
AmeriHealth Caritas North Carolina	2.64 (0.03)	2.59 (0.03)
BCBSNC Healthy Blue	2.72 (0.03)	2.68 (0.03)
UnitedHealthcare	2.65 (0.03)	2.59 (0.03)
WellCare Health Plans	2.6 (0.03)	2.65 (0.03)
Carolina Complete Health	2.64 (0.03)	2.61 (0.03)
Largest Commercial Payor	2.91 (0.02)	2.94 (0.03)

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

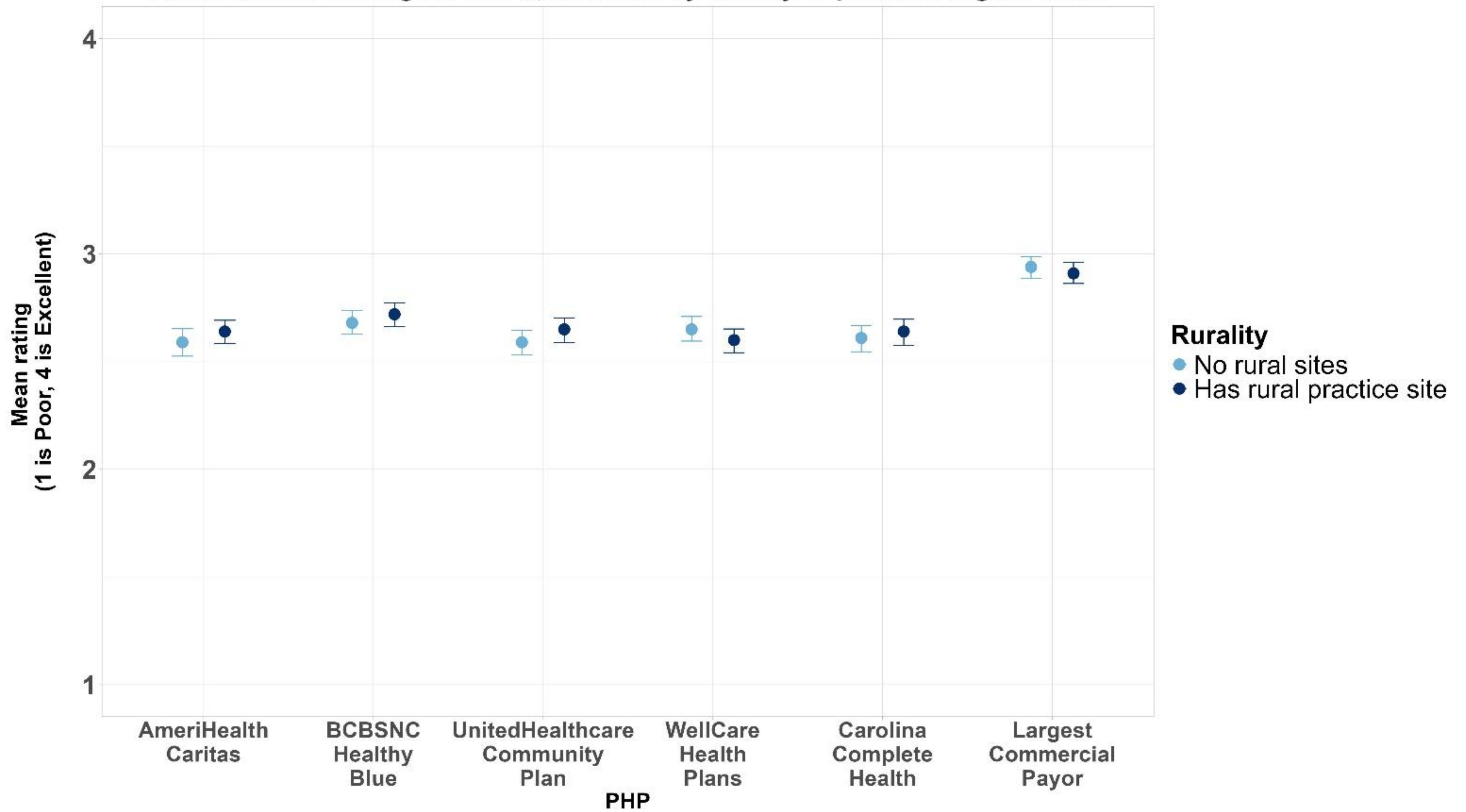
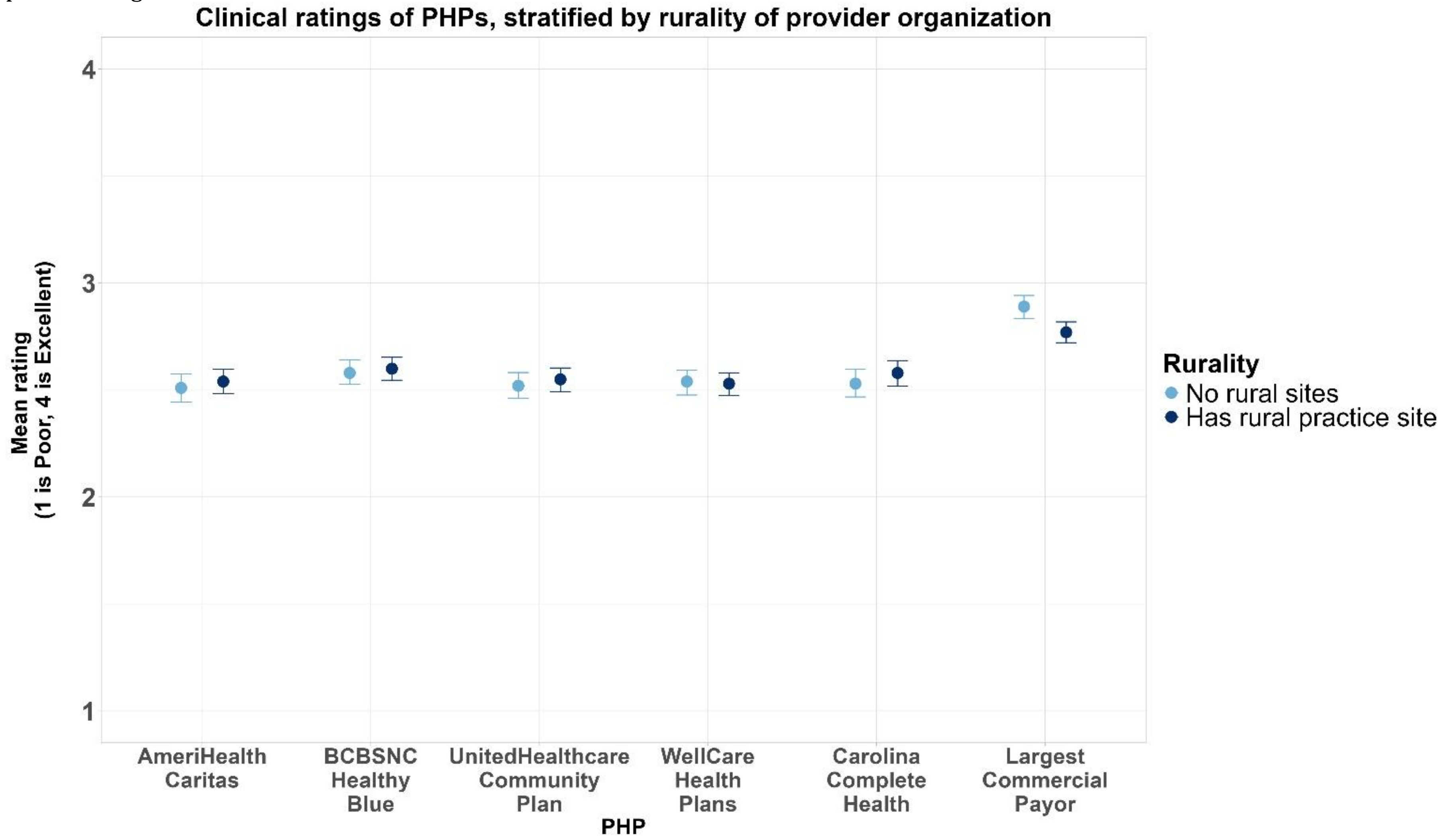


Exhibit A11. Mean ratings of standard plans across clinical domains, stratified by rurality of provider organization

Clinical ratings for standard plans stratified by rurality		
PHP	**Has rural practice site (n = 204) Mean (SE)**	**Does not have rural practice site (n = 192) Mean (SE)**
AmeriHealth Caritas North Carolina	2.54 (0.03)	2.51 (0.03)
BCBSNC Healthy Blue	2.6 (0.03)	2.58 (0.03)
UnitedHealthcare	2.55 (0.03)	2.52 (0.03)
WellCare Health Plans	2.53 (0.03)	2.54 (0.03)
Carolina Complete Health	2.58 (0.03)	2.53 (0.03)
Largest Commercial Payor	2.77 (0.02)	2.89 (0.03)

Exhibit A12. Mean ratings of standard plans 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 standard plans across all domains, stratified by whether the organization provides Ob/Gyn care

Overall ratings for standard plans stratified by provision of Ob/Gyn care		
PHP	**Provides Ob/Gyn care (n = 49) Mean (SE)**	**Does not provide Ob/Gyn care (n = 347) Mean (SE)**
AmeriHealth Caritas North Carolina	2.71 (0.05)	2.55 (0.02)
BCBSNC Healthy Blue	2.77 (0.05)	2.63 (0.02)
UnitedHealthcare	2.7 (0.05)	2.56 (0.02)
WellCare Health Plans	2.71 (0.05)	2.56 (0.02)
Carolina Complete Health	2.67 (0.05)	2.57 (0.02)
Largest Commercial Payor	2.89 (0.04)	2.88 (0.02)

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

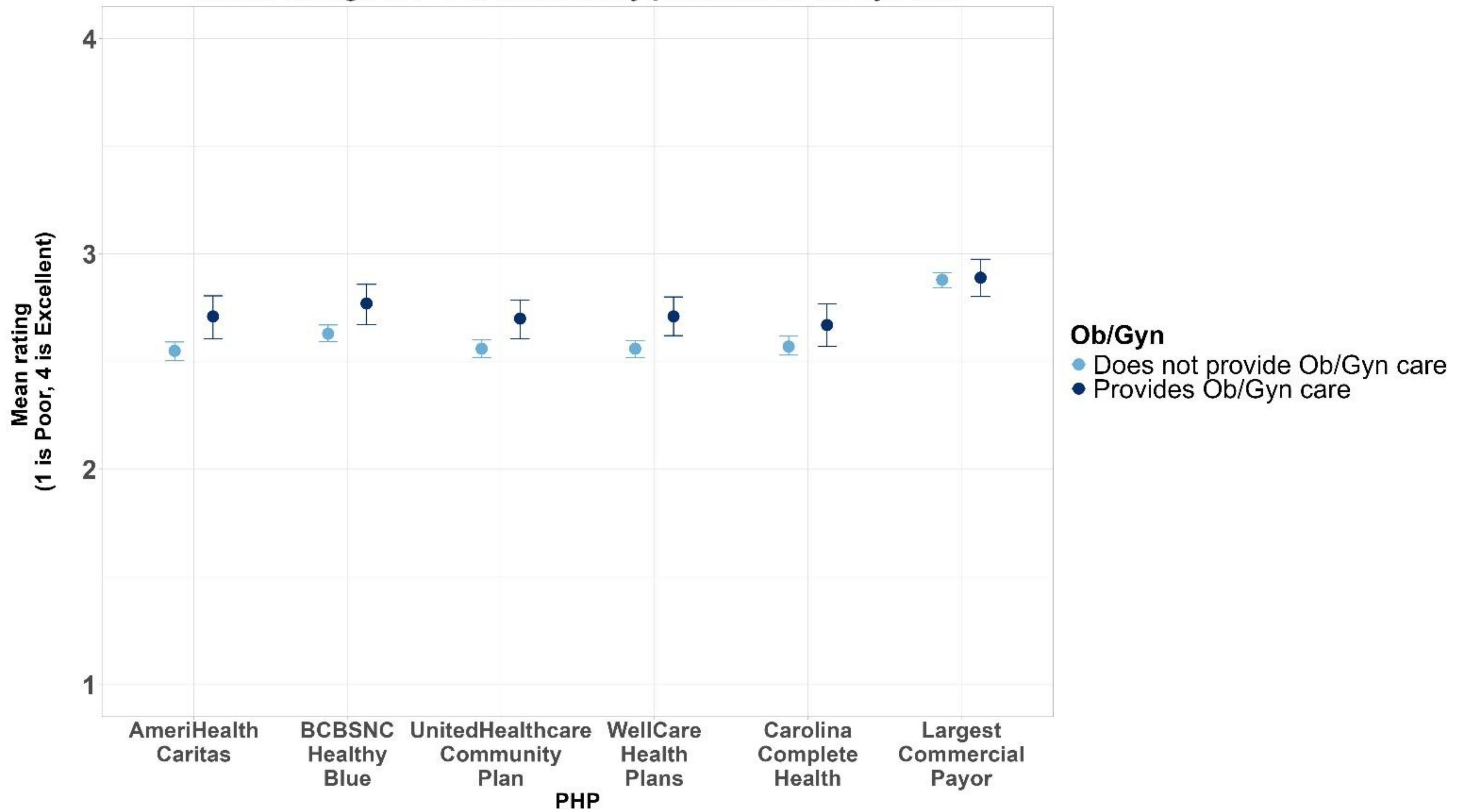


Exhibit A15. Mean ratings of standard plans across administrative domains, stratified by whether the organization provides Ob/Gyn care

Administrative ratings for standard plans stratified by provision of Ob/Gyn care		
PHP	**Provides Ob/Gyn care (n = 49) Mean (SE)**	**Does not provide Ob/Gyn care (n = 347) Mean (SE)**
AmeriHealth Caritas North Carolina	2.69 (0.05)	2.6 (0.02)
BCBSNC Healthy Blue	2.75 (0.05)	2.69 (0.02)
UnitedHealthcare	2.67 (0.05)	2.61 (0.02)
WellCare Health Plans	2.68 (0.05)	2.62 (0.02)
Carolina Complete Health	2.61 (0.05)	2.62 (0.02)
Largest Commercial Payor	2.9 (0.05)	2.93 (0.02)

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

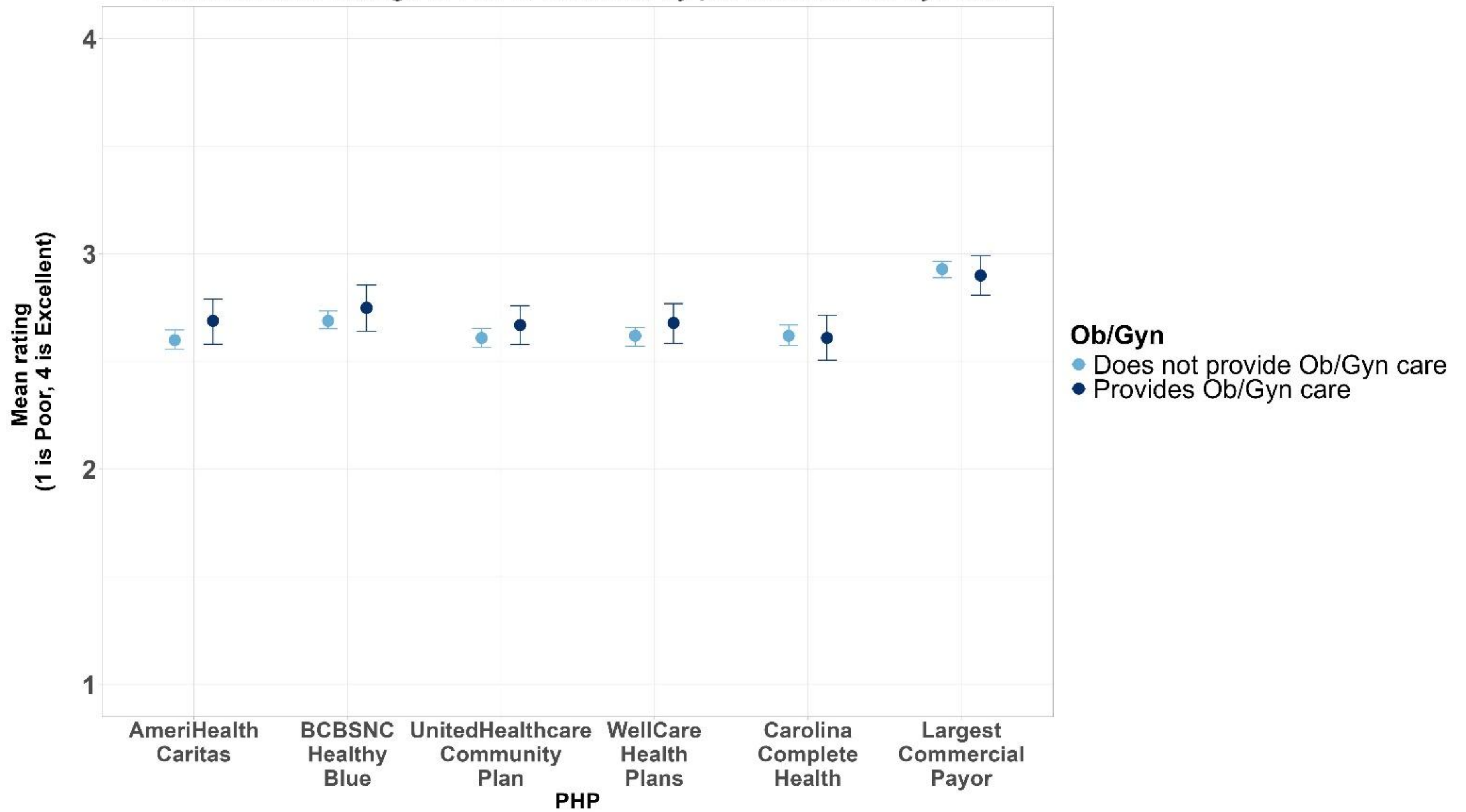


Exhibit A17. Mean ratings of standard plans across clinical domains, stratified by whether the organization provides Ob/Gyn care

Clinical ratings for standard plans stratified by provision of Ob/Gyn care		
PHP	**Provides Ob/Gyn care (n = 49) Mean (SE)**	**Does not provide Ob/Gyn care (n = 347) Mean (SE)**
AmeriHealth Caritas North Carolina	2.76 (0.06)	2.49 (0.02)
BCBSNC Healthy Blue	2.81 (0.05)	2.56 (0.02)
UnitedHealthcare	2.77 (0.05)	2.5 (0.02)
WellCare Health Plans	2.77 (0.05)	2.5 (0.02)
Carolina Complete Health	2.76 (0.06)	2.53 (0.02)
Largest Commercial Payor	2.88 (0.05)	2.82 (0.02)

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