

Medicaid Transformation Provider Experience Survey 2025

2025 Results Overview for Survey Participants

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

► What is the Medicaid Transformation Provider Experience Survey?

Administered among organizations providing primary care and/or Ob/Gyn services to Medicaid patients in North Carolina, this survey was part of a larger multi-year evaluation effort of NC's Medicaid transformation.

The survey provides a snapshot of organizational experiences, contracting, and satisfaction with Standard Plans (SPs) in the transition to Medicaid managed care. Survey findings will serve as a leading indicator for quality improvement for SPs. This report details a general overview of findings at the end of the third year of managed care.

► How did you develop the survey?

This year's survey built on the initial instrument developed in consultation with clinicians, health system/practice leaders, and stakeholders from NC Department of Health Human Services in the fall of 2020. The survey was sampled and fielded at the organizational level, given that most interactions with SPs occur at the organizational (rather than individual clinician) level.



► How did you field the survey?

The survey used IQVIA OneKey data to identify 731 unique organizations providing primary care and Ob/Gyn services in North Carolina, using Medicaid provider data to confirm the sample.

Survey responses were collected between March and June 2025 from these identified organizations. Through the recruitment process using phone calls, mailings, and emails, it was determined that approximately 90.8% of the organizations in the sample were eligible to receive the survey.

► Who responded to the survey?

The table to the right summarizes overall characteristics of 396 respondent organizations. The final response rate was 62.2%. The sample included a diverse set of organizations, from solo practice physicians to large integrated delivery systems.

Organizational respondent overview

Total (n=396)	
Ownership (self-reported)	N (%)
Health Systems	12 (3.0%)
Medical Groups/Independent Practices	384 (97%)
Size	
Small (1-2 providers)	144 (36.4%)
Medium (3-9 providers)	163 (41.2%)
Large (10+ providers)	89 (22.3%)
Services (Inclusive)	
Primary Care	385 (97.2%)
Prenatal/Postnatal Care	49 (12.4%)
Inpatient Obstetrics Care	18 (4.5%)

► Contracting with SPs

Rates of contracting with one of the five SPs among surveyed provider organizations ranged from **83.3% to 96.2%**. Among medical groups and independent practices, the mean number of plans contracted with was **4.54**.

► Experience with clinical and administrative factors

The survey asked provider organizations about their experiences with each PHP on thirteen factors, split into clinical and administrative domains.

Clinical factors included items like access to specialists, behavioral health prescribers, and formulary, while examples of **administrative factors** included timeliness of claims processing, timeliness to answer questions and/or resolve problems, and adequacy of reimbursement.

Meaningful differences were found in provider experience across SPs compared to performance in prior years. **Compared with the first three years into managed care, SPs still performed worse in clinical domains but better in administrative domains.** SPs were rated better on overall relations, and timeliness of claims processing, but worse on reimbursement, access to medical specialists, access to behavioral health prescribers, and access to behavioral health therapists. Emergent trends in overall performance also appeared between SPs, with convergence occurring between plans driven mostly by the improvement of previously lagging plans such as AmeriHealth.

► Behavioral health and tailored plans

In this survey, provider organizations were asked about their approach to integration of care with behavioral health providers and their plans regarding the upcoming tailored plans. Around 28% of provider organizations reported embedding or co-locating behavioral health professionals in primary care offices. For PCP and/or Ob/Gyn organizations without embedded or co-located behavioral health, the most common reasons were having a shortage of behavioral health professionals, having preferred referral locations/relationships, insufficient space, insufficient funding, and insufficient reimbursement.

► Commercial Payers, Value Based Payment (VBP), Health Information Exchanges

The 2025 survey included questions on provider experience with their largest commercial payer, whether providers had VBP arrangements (shared savings, accountable care organization, or shared risk arrangement), and added questions on Health Information Exchanges. SPs were rated comparatively worse than a practice's largest commercial payer by substantial margins in all domains except for support with social determinants of health and care/case management. These findings indicate that Medicaid is performing worse than commercial payers in terms of administrative and clinical processes, suggesting that low reimbursements account for only some of the provider's concerns. Rates of having value-based payment arrangements with any PHP were low, ranging from 31.6% to 39.9%. Health Information Exchange participation was broadly popular, with 70.5% of practices reporting being connected to NC HealthConnex, and 98.8% of practices reporting neutral to positive experience with the program.

