Baseline Medicaid Behavioral Health Provider Experience Survey Report

September 2026

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

Suggested citation: Hughes PM, Thomas KC, Zadrozny S, Lewis V, deWalt D, Bergmire D, Holmes GM. Baseline Medicaid behavioral health provider experience survey report, prepared for North Carolina Medicaid, July, 2026.

Table of Contents

EXECUTIVE SUMMARY

With the provision of the 1115 Medicaid Waiver, the North Carolina (NC) Medicaid program transitioned from a predominately fee-for-service model to managed care through the offering of Prepaid Health Plans (PHPs). In addition to the standard PHPs (also referred to as Standard Plans or SPs) available to most NC Medicaid beneficiaries, a set of Tailored Plans (TPs) were created specific to children and adults with behavioral health needs defined as serious mental illnesses, substance use disorders, or intellectual/developmental disabilities. SPs began covering about three-fifths of Medicaid beneficiaries on July 1, 2021; the TPs launched July 1, 2024 and cover about 1% of NC Medicaid's beneficiaries. For additional information about primary care providers' experiences with NC Medicaid Standard Plans in 2025, please view the report here.

To evaluate the influence of the NC Medicaid transformation on outpatient behavioral health care practices that contract with NC Medicaid Tailored Plans, the North Carolina Behavioral Health Provider Experience Survey was developed and administered across all North Carolina behavioral health care practices or their corporate parent. This survey builds on the framework established by the ongoing North Carolina Primary Care Provider Experience Survey, which provides a similar assessment of primary care providers and their experiences with Standard Plans. The sample included all eligible behavioral health organizations in NC that contract with NC Medicaid (final sample n = 117). Stratified analyses were conducted to draw comparisons between 1) small/medium practices (less than 10 health professionals) versus large practices (10 or more health professionals) and 2) rural versus non-rural organizations.

This report describes findings from the baseline assessment of provider experience and satisfaction in the first year of contracting with TPs. The baseline assessment will serve as a comparison against TP performance in future years. Most questions asked the provider to report on their satisfaction and experiences with each TP with which they contract. For purposes of comparison, participants were also asked about their largest commercial payor for the practice. On average, behavioral health organizations rated their overall experience with TPs as Excellent or Good, with all plans performing as well as the largest commercial payor across most measures. TPs generally fared better than the largest commercial payor for case management (mean ratings 2.72-2.89 vs 2.59, respectively) and addressing social determinants of health (mean ratings 2.72-2.80 vs 2.44, respectively). However, compared to the largest commercial payor, TPs fared worse on access to medical specialists (mean ratings 2.75-2.91 vs 2.96, respectively). Scores for reimbursement adequacy were lower among three of the four TPs (mean ratings 2.70-2.80) compared to the largest commercial payor (mean rating 2.86), with one TP slightly surpassing the commercial payor (mean rating 2.88). Free-text responses regarding satisfaction and experiences with the TPs included themes of Communication, Reimbursement and Billing, Impact on Patients, Credentialling, and Case Management.

Compared to large organizations, small/medium organizations were more satisfied with TPs regarding the adequacy of reimbursement (mean ratings 2.88 vs 2.69, respectively), access for medical specialists (mean ratings 2.92 vs 2.74, respectively), access to therapists (mean ratings 3.10 vs 2.87, respectively), access to all drugs (mean ratings 3.04 vs 2.92, respectively), access to psychotropic drugs (mean ratings 3.09 vs 2.89, respectively), support for addressing social determinants (mean ratings 2.73 vs 2.59, respectively), and the bidirectional flow of information with specialty care (mean ratings 2.90 vs 2.67, respectively). Small/medium organizations were also more satisfied with the TPs overall and, more specifically, the clinical domain; however, while the scores for small/medium organizations are statistically significantly higher, we caution that the majority of these differences are quite small and identifying the policy significance may require additional data. These differences should be monitored for consistency over time.

Compared to organizations and practices with no rural locations, those with rural locations were less satisfied with the bidirectional flow of information with specialty care (mean ratings 2.72 vs 2.84, respectively). Additionally, rural organizations were less satisfied with the clinical domain of this survey (i.e., survey items related to the delivery of care such as access to specialists, medications, case management, and supports, mean ratings 2.81 vs 2.91, respectively), though no additional components of the clinical domain were significantly different. We believe this may be explained, in part, by two differences approaching significance: satisfaction with access to therapists (mean ratings 2.94 vs 3.03, respectively) and access to psychotropic medications (mean ratings 2.94 vs 3.03, respectively); however, we would recommend caution in interpreting the overall clinical domain difference as meaningful at this time. These differences should be monitored over time to identify emerging trends.

Overall, the results suggest that the TPs have been well received by behavioral health organizations and are relatively comparable to commercial plans in terms of organization satisfaction. Although TPs are in their infancy, one notable area where TPs appeared to underperform relative to commercial payors was access to medical specialists, suggesting policy revisions designed to improve access may improve satisfaction overall. Interestingly, while most of the TPs scored lower than commercial plans on reimbursement, open-ended responses suggested that this difference may be less about reimbursement rates and more about the challenges of getting claims approved. In particular, efforts to simplify billing for Physician Associates may yield notable improvements in satisfaction with the plans. There were a myriad of measures for which small and medium organizations were more satisfied with the TPs than large organizations. This is possibly a reflection of different baseline needs from organizations with fewer resources for which the TPs may be filling gaps in resources for small/medium organizations that larger organizations may not have (e.g., providing case managers). Alternatively, the shift to TPs may have modified processes in a way that makes it easier to contract with Medicaid for small/medium organizations who may not have the dedicated billing staff typical of a larger organization. However, these different experiences by organization size

should be examined further in future surveys before strong conclusions can be made. A detailed summary of provider satisfaction and experience for health systems and behavioral health care practices overall, as well as stratified by rural versus non-rural practices and small versus non-small practices, follows. To review the Discussion, Implications, and Conclusions from these findings, please click here.

OVERVIEW

Purpose

The overall goal of this annual behavioral health provider survey is to assess health system and practice experience and satisfaction with North Carolina's (NC) Medicaid Tailored Plans (TPs) launch as a component of the larger transition to managed care. The project is an evaluation directly funded and sponsored by the North Carolina Department of Health and Human Services (DHHS) and implemented at the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill (UNC-CH).

Objectives

The objectives of the baseline Behavioral Health Provider survey were to:

1. Evaluate provider experiences with each specific Tailored Plan
2. Compare provider experiences between TPs and their largest commercial payor
3. Compare differences in provider experiences between provider types and geographies
4. Describe provider plans for continued contracting with TPs
5. Understand provider experiences with North Carolina's Health Information Exchange (HIE)

The state intends to use these findings as an indicator of TP quality. However, performance on the provider survey does not affect payments by the state. Additional investigation of issues and opportunities for improvement will be carried out with other data collection methods (i.e., focus groups, interviews, claims analyses) under the broader 1115 managed care waiver evaluation.

METHODS

Questionnaire Development

The North Carolina Medicaid Behavioral Health 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 behavioral health care to patients with Medicaid. This questionnaire was adapted from the ongoing Primary Care Provider Experience Questionnaire to specifically understand the experience of behavioral health care providers delivering care in North Carolina's transition to Medicaid managed care. Using the Primary Care survey as a guide, a survey working group with experience in behavioral health care delivery, payment models, and Medicaid revised existing questions and developed new items as necessary. The Carolina Survey Research Laboratory and NC DHHS also provided input on questionnaire development. Items from the ongoing Primary Care Provider Experience Questionnaire determined to be outside the scope of the organizational experiences in the launch of the NC Medicaid TPs were excluded. Items were further modified and reviewed over the course of several iterations to improve conciseness and clarity of interpretation.

The questionnaire covers several key areas. The following are the final topical areas for the Year 1 survey:

- Respondent Characteristics and Inclusion Criteria (e.g., respondent's role at the organization, contact information, organizational information, organization's Medicaid involvement)
- Practice characteristics (e.g., type of organization, Independent Practice Association/Clinically Integrated Network participation and support, Medicaid patient population, medical home, and accountable care organization participation)
- Overall experiences working with the Medicaid program (e.g., differences between experiences with Medicaid and commercial plans)
- Contracting with TPs (e.g., current contracting plans, overall experience thus far with TPs)

These domains were intentionally broad to address the numerous ways that NC Medicaid and TPs affect the health care delivery system. In order to minimize respondent burden and reduce overlap with other primary data collection activities, we limited the length of the instrument in terms of the number of questions and took other steps, such as incorporating skip patterns in the design, to reduce the length of time required to complete the questionnaire. The behavioral health survey took approximately 10 to 15 minutes for respondents to complete. For the small (n = 21) subset of healthcare organizations (e.g., hospital systems, large multispecialty organizations) with co-located primary care and behavioral health, the behavioral health questionnaire was included

as an addition to the primary care survey, in which case survey completion was estimated to be 18 to 25 minutes.

Sample Description

Using the Primary Care survey as a guide for administering surveys with an organization-based sample, the questionnaire was fielded at the highest organizational level (i.e., the health system or provider group when applicable). Most interactions with the TPs, such as contracting decisions and data sharing, occur at the organizational (rather than individual clinician) level. Thus, our sample includes a diverse set of organizations, from small practices to very large integrated delivery systems, providing outpatient behavioral health care, with at least 50 Medicaid claims in 2024. Every provider group, independent practice, and system in our sample frame that was affiliated with an organization was summarized at the organization level and the organization was invited to participate in the survey (261 organizations).

Given the complex patchwork of providers that deliver behavioral health care, there were 1,297 behavioral health providers who billed Medicaid in 2024 but could not be linked to a clinic or healthcare organization (i.e., unaffiliated providers). We examined a multitude of these unaffiliated individuals and believe this group to largely consist of solo providers who are practicing independently without a support staff (e.g., a clinical psychologist practicing from their home). Given that these individuals are unaffiliated with a health care business and predominantly without support staff, we believe this to be a provider population substantially different from the identified organizations and for whom billing insurance is quite burdensome; as such, we do not anticipate that this group will be significantly involved in contracting with Medicaid TPs and therefore excluded them from our primary sample. We attempted to survey a random sample of the unaffiliated providers (301 of the 1,297 identified providers); however, we received responses from only a few individuals and therefore do not include them in the sample.

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 uses multiple data sources to regularly update their roster of providers and organizations, based on manual web searches, telephone verification, and information received from the AMA, National Plan and Provider Enumeration System (NPPES), the Drug Enforcement Agency (DEA) registration files, state licensing agencies, and drug distribution data non-retail shipping addresses. IQVIA data has been used in numerous peer-reviewed studies using claims data as well as for provider surveys.[1–8]

IQVIA OneKey links individual clinicians with practices and provider groups, as well as the health systems or other corporate parents that own practices. As a result, this data allows us to more

accurately identify and survey healthcare organizations and groups where Medicaid transformation and implementation decisions (e.g., contracting decisions) are made. Additionally, IQVIA updates provider and organizational contact information (e.g., mailing address, phone numbers) every six months. This ensures survey data collection efforts are more effective, especially through a multi-year surveying effort.

From IQVIA, we obtained a robust set of data elements for all North Carolina psychologists, social workers, counselors, MD/DOs, nurse practitioners, physician assistants, and health departments, as well as information about health systems and corporate parents linked with these providers regardless of if they contracted with NC Medicaid. We requested data for all national provider index (NPI) numbers associated with individual clinicians in provider groups or independent practices identified with outpatient primary care or behavioral health care, using the following Class of Trade specialties: Behavioral Health, Addiction Medicine, Family Practice, General Practice, Geriatric Medicine, Internal Medicine, Multi-specialty practice, Pediatric Medicine, Preventative Medicine, and Primary Care. Our initial data request was intentionally broad to account for the diverse healthcare settings in which providers deliver behavioral health services.

To increase confidence that we were capturing the universe of organizations which may serve NC Medicaid beneficiaries receiving behavioral health services, we matched NPIs from the IQVIA OneKey database to the North Carolina Medicaid provider file and claims to identify all providers who billed Medicaid for behavioral health visits. To focus our sample further on providers likely to be contracted with TPs, we only included providers who had a professional taxonomy code indicating that they are a behavioral health provider (counselors, psychiatric mental health nurse practitioners, psychiatrists, psychologists, and social workers). For this first round of the survey, we were able to match 69.7% of individual NPIs in the NC Medicaid provider file to the IQVIA data. Of those, 34.9% were not affiliated with an organization or practice in the IQVIA data.

We chose to survey all organizations from the IQVIA data that had at least one NPI which we could match to the Medicaid provider file, billed for at least 50 outpatient behavioral health visits in the last year, and had a Class of Trade of Behavioral Health or Addiction Medicine. Finally, we further screened organizational eligibility with sample-cleaning processes (described below) and the questionnaire itself. IQVIA data identified both 1) the provider group or independent practice where a provider worked and 2) any multi-site provider group or integrated delivery system that owns the group or practice. For sampling, provider groups and practices were rolled up to the largest organizational entity (e.g., a health system, or large provider group). This resulted in a final sample of 104 larger corporate entities (including health systems and large provider groups) and 157 small/medium practices and provider groups, as defined by the number of NPIs associated with the organization (small/medium: 1-9 providers; large: 10 or more providers). All behavioral health care practices (n=261) that met inclusion criteria were invited to participate.

Sample Frame Cleaning

We used a multi-pronged approach to identify appropriate individual or collaborative survey respondents at different types of organizations identified in the sample frame. Larger health systems with co-located primary care and behavioral health (n = 21; 8.4% of the sample) were identified early in the process, given that they would receive both the primary care and behavioral health provider surveys. For these large health systems, we used a more personalized frame cleaning process in addition to the standard approach described below, wherein a senior member of the research team contacted health system leaders with a personal email to confirm the survey was received by someone with relevant expertise and to encourage follow-up. If no response to the email was received after 1 week, the research team identified a new health system contact and repeated the above process until a contact was reached. If no contact was reached after 3 attempts, the organization-level contact was used for the mailing.

For all group practices, callers from Carolina Survey Research Lab (CSRL) contacted the practice with a phone call asking them to identify the best person to complete the questionnaire (practice manager, medical director, or other). The team then obtained specific contact information for that person to mail the questionnaire. If the team was unable to verify the contact information for a specific person, the case was flagged for review. The calling supervisor reviewed by calling again and searching online for additional contact names and searching for additional phone numbers. If the supervisor was unsuccessful, reviewed contacts were flagged for discussion with project staff and classified as unknown if ultimately no contact was made and the address provided by IQVIA was used for the mailing, addressed to the "Clinical Director". All practices had updated contact information for the practice address, either from calling, or if no updated contact information was identified from the address given in the IQVIA data set. Confirmation of contact information associated with email and organization-level phone call attempts counted in **Table A.**

Table A. Sample frame cleaning via email & phone to identify correct respondent.

Organization	**Small /Medium Practices (1-9 Providers) (n=157)**	**Large Practices (10+ Providers) (n= 104)**
	Count (%)	**Count (%)**
Reached	100 (64%)	91 (88%)
Not Reached	57 (36%)	13 (12%)
Call Attempts (organization-level)		
1-3	59 (38%)	56 (54%)
4-9	37 (24%)	34 (33%)
10-15	16 (10%)	8 (8%)

Outreach

Surveys were initially distributed by mail to all organizations and individuals with contact information who were not identified as ineligible or whose practice was not closed during the frame cleaning stage. After the initial survey distribution by mail, multi-modal follow-up with non-respondents for survey completion was done by phone, email, and additional mailings by all mechanisms available based on original contact information from IQVIA and updated contact information obtained by CSRL during frame cleaning. For all contacts, after Frame Cleaning, multi-modal follow-up by mail and phone was done for non-respondents as seen in **Table B1**. Respondents were called 1-2 times per week until reaching a final disposition (completed, refusal, number out of order, unknown, or ineligible), up to 15 times. If after 4 weeks, the survey was unfinished (i.e., not started or partially completed), a second survey package and return envelope were mailed. For all mailed survey packages that were returned to sender, CSRL staff investigated the practice to find additional contact information or if the practice had closed or merged. For contacts where an email was provided during frame cleaning, respondents were emailed an electronic link to the survey, with reminders twice per week (Tuesdays and Fridays) until completed or until the survey closed (**Table B2**).

Table B1. Organization-level survey follow-up by mail and calling

	Small /Medium Practices (1-9 Providers) (n=157)	**Large Practices (10+ Providers) (n= 104)**
	Count (%)	**Count (%)**
Mailing Waves, counts of organizations receiving a mailing		
Initial Mailing (full packet)	153 (97%)	98 (94%)
2nd wave (full packet)	120 (76%)	55 (53%)
3rd wave (postcard)	105 (67%)	38 (37%)
Call Attempts (organization-level)		
1-3	42 (27%)	43 (41%)
4-9	93 (59%)	54 (52%)
10-15	11 (7%)	4 (4%)

Table B2. Organization-level survey follow-up by email

	n=261
Emails obtained	
Initial Email	119 (46%)
Email Follow-up Attempts	
1-3 Email Follow-ups	96 (37%)
4-6 Email Follow-ups	93 (36%)

Final response rate

Survey responses were collected between April 9 and July 4, 2025. **Table C** summarizes response for all organizations sampled.

Table C. Response Rate & Final Dispositions of Sample Frame

Final designations	**Total Response**
	Count (%)
Completed Respondents	117 (44.83)
Refusals	12 (4.6)
Ineligible	44 (16.86)
Duplicates	6 (2.3)
Unknown eligibility	82 (31.42)
Total	261 (100)

We calculated a final response rate using the third American Association for Public Opinion Research (AAPOR) formula that adjusts for unknown eligibility of respondents,[9] which was **61.53%.** To account for non-response, we developed survey weights that used the total size of behavioral health NPIs per organization, as well as whether respondent organizations had any practice locations in rural counties, as defined by North Carolina Rural Center county data.[10]

The following analyses exclude all missing data from eligible survey respondents. We used the finite population correction where applicable because the sample rate (total respondents as a proportion of the entire population of respondents) was large.

SURVEY RESPONDENT CHARACTERISTICS

Table 1. Organization characteristics for survey respondents (unweighted)

Organization Characteristics	Small / Medium Organizations (N=69)	Large Organizations (N=48)
	N (%) or Mean (SD)	N (%) or Mean (SD)
Respondent		
Role of Respondent		
Practice Director	33 (47.8)	21 (43.8)
Medical Director	6 (8.7)	1 (2.1)
Other (e.g., CEO, Practice Owner, Billing Manager)	30 (43.5)	26 (54.2)
Organization Composition		
Services Provided for Patients with Medicaid		
Treatment for mild/moderate depression/anxiety	52 (75.4)	45 (93.8)
Specialty behavioral health care for severe/persistent mental illness	59 (85.5)	44 (91.7)
Substance use or addiction treatment services	45 (65.2)	30 (62.5)
Mean Number of Total Behavioral Health Providers†	14.8 (32.0)	27.6 (30.6)
Geography		
No Rural Sites (NCRC)	48 (65.6)	33 (68.8)
Any Rural Sites (NCRC)	21 (30.4)	15 (31.3)
Ownership		
Independent Medical Practice at a Single Site	22 (31.9)	3 (6.3)
Provider Group (multiple practices owned by a single owner)	45 (65.2)	38 (79.2)
Health Systems	0 (0.0)	6 (12.5)
Health Department	0 (0.0)	1 (2.1)
Missing	2 (2.9)	0 (0)
FQHC Designation	7 (10.1)	1 (2.1)
CMHC Designation	12 (17.4)	4 (8.3)

Part of an Accountable Care Organization (ACO) or Clinically Integrated Network (CIN) for Medicaid work		
Evolent	5 (7.3)	1 (2.1)
Aledade	3 (4.4)	1 (2.1)
Caravan	3 (4.4)	1 (2.1)
CIN	7 (10.2)	9 (18.8)
Other ACOs	4 (5.8)	4 (8.3)
<u>Service to Medicaid Beneficiaries</u>		
Mean estimated percentage of health system/practice patients with Medicaid	63.7 (22.9)	56.3 (28.9)
Does the Organization Limit the Percentage of Patients with Medicaid?		
Yes	4 (5.8)	2 (4.17)
No	59 (85.5)	41 (85.4)
Unsure	4 (5.8)	5 (10.4)
Did Not Answer	2 (2.9)	0 (0)
Mean <u>limit</u> that practice/system places on percentage of patients with Medicaid insurance *(if yes to above)*	18 (13.11) N = 3	15 (0.0) N = 1
Support services patients can be offered or receive referrals for:		
Supported Employment (vocational services)	17 (24.6)	19 (39.6)
Assertive Community Treatment (ACT)	27 (39.1)	23 (47.9)
Integrated dual-disorder treatment	44 (63.8)	34 (70.8)
Family psychoeducation	31 (44.9)	24 (50.0)
Illness Management and Recovery (IMR)	22 (31.9)	12 (25.0)
Medications for Opioid Use Disorder patients can be offered or receive referrals for:		
Buprenorphine	36 (52.2)	18 (37.5)
Naltrexone	24 (34.8)	13 (27.1)
Methadone	12 (17.4)	14 (29.2)
None of the above	18 (26.1)	16 (33.3)

I don't know	9 (13.0)	9 (18.8)
Does your organization provide tailored care management services (i.e., a certified care management agency)?		
Yes	16 (23.2)	9 (18.8)
No	30 (43.5)	24 (50.0)
Unsure	21 (30.4)	14 (29.2)
Did Not Answer	2 (2.9)	1 (2.1)
What do you believe is the ideal situation for care management?		
Embedded in Individual Practices	19 (27.5)	12 (25.0)
Provided by Health System or CIN	6 (8.7)	8 (16.7)
Provided by PHPs or TPs	17 (24.6)	9 (18.8)
Unsure	20 (29.0)	15 (31.3)
Other	3 (4.4)	2 (4.2)
Did Not Answer	4 (5.8)	2 (4.2)

†Organization size was determined by the total number of behavioral health providers with NPI numbers identified in our data sources, whereas the survey asks respondents to provide an estimated number of behavioral health providers, potentially including some without an NPI number. Mean behavioral health providers of 14.6 indicates that respondents defined behavioral health clinical providers more broadly than captured by NPIs.

Table 2. Organizational Well-Being and Experience with Health Information Exchange (unweighted)

Organizational Well-Being & Health Information Exchange	**Small / Medium Organizations (N=69)**	**Large Organizations (N=48)**
	N (%)	**N (%)**
Organizational Well-Being		
Overall financial health of your practice		
Excellent	19 (27.5)	8 (16.7)
Good	33 (47.8)	29 (60.4)
Fair	11 (15.9)	9 (18.8)
Poor	2 (2.9)	0 (0.0)
Did Not Answer	4 (5.8)	2 (4.2)
Ability to recruit primary care providers		
Excellent	11 (15.9)	8 (16.7)
Good	21 (30.4)	23 (47.9)
Fair	26 (37.7)	10 (20.8)

Poor	5 (7.3)	4 (8.3)
Did Not Answer	6 (8.7)	3 (6.3)
Ability to recruit to fill staff openings		
Excellent	13 (18.8)	9 (18.8)
Good	24 (34.8)	22 (45.8)
Fair	22 (31.9)	13 (27.1)
Poor	5 (7.3)	2 (4.2)
Did Not Answer	5 (7.3)	2 (4.2)
Ability to retain primary care providers		
Excellent	17 (24.6)	12 (25.0)
Good	27 (39.1)	17 (35.4)
Fair	12 (17.4)	11 (22.9)
Poor	3 (4.4)	3 (6.3)
Did Not Answer	10 (14.5)	5 (10.4)
Ability to retain staff		
Excellent	21 (30.4)	10 (20.8)
Good	33 (47.8)	26 (54.2)
Fair	11 (15.9)	9 (18.8)
Poor	0 (0.0)	1 (2.1)
Did Not Answer	4 (5.8)	2 (4.2)
Ability to make referrals		
Excellent	26 (37.7)	11 (22.9)
Good	33 (47.8)	25 (52.1)
Fair	5 (7.3)	10 (20.8)
Poor	1 (1.5)	0 (0.0)
Did Not Answer	4 (5.8)	2 (4.2)
NC HealthConnex (Health Information Exchange/HIE)		
Is your practice connected to NC HealthConnex?		
Yes	25 (36.2)	20 (41.7)
No	18 (26.1)	10 (20.8)
Unsure	23 (33.3)	17 (35.4)
Did Not Answer	3 (4.4)	1 (2.1)
How does the HIE change the process of sharing quality measure data with Medicaid Prepaid Health Plans?		
Improves a lot	8 (11.6)	4 (8.3)
Improves a little	4 (5.8)	4 (8.3)
No change	13 (18.8)	12 (25.0)
Worsens a little	0 (0.0)	0 (0.0)
Worsens a lot	0 (0.0)	0 (0.0)
Did Not Answer /Not connected to the HIE	44 (63.8)	28 (58.3)

Does the HIE allow you to access social determinants of health screening data about your patients?		
Yes, all of the time	5 (7.3)	4 (8.3)
Yes, some of the time	5 (7.3)	5 (10.4)
No	8 (11.6)	3 (6.3)
I don't know	7 (10.1)	8 (16.7)
Did Not Answer /Not connected to the HIE	44 (63.8)	28 (58.3)

OVERALL PROVIDER EXPERIENCE

Contracting with Tailored Plans (TPs)

The following questions and findings are related to provider organizations' relationships with TPs. Results are weighted – organizations have been rounded to the nearest whole number (e.g., 1.1 = 1) and percentages may not sum to 100 due to rounding.

Table 3. Provider organizations' contract arrangements with Tailored Plans in North Carolina Medicaid

For the below listed Tailored Plans (TPs), have you contracted with the following plans?	
TP	**Response: Yes N (%)**
Alliance Health	72 (61.6)
Partners Health Management	76 (65.3)
Trillium Health Resources	92 (78.4)
Vaya Health	88 (75.6)

Tailored Plans are regionally defined, and it is possible that not every responding provider organization has practice location(s) in all TP regions. These geographic parameters directly influence rates of contracting among providers with Tailored Plans. Among provider organizations that did not contract with *all* TPs (N=2), when asked if they anticipated adding any new TP contracts in the coming year, one said no and one was missing.

When asked if they anticipated dropping any Tailored Plan contracts in the coming year, provider organizations reported as follows:

- Yes: 4 (3.4%)
- No: 111 (96.6%)

Of the four respondents who indicated they were dropping a Tailored Plan, two provided additional information about why. One of the two stated that their organization had discontinued their care management program in 2024, while the other cited concerns about MCOs favoring certain providers.

Satisfaction with Tailored Plans (TPs)

Table 4. Overall satisfaction of provider organizations with TPs

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? ***Provider Relations Overall***	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	3.21 (0.06)
Partners Health Management	3.33 (0.06)
Trillium Health Resources	3.11 (0.05)
Vaya Health	3.15 (0.05)
Largest Commercial Payor	3.04 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 1. Distribution of respondent ratings of provider relations overall by TP

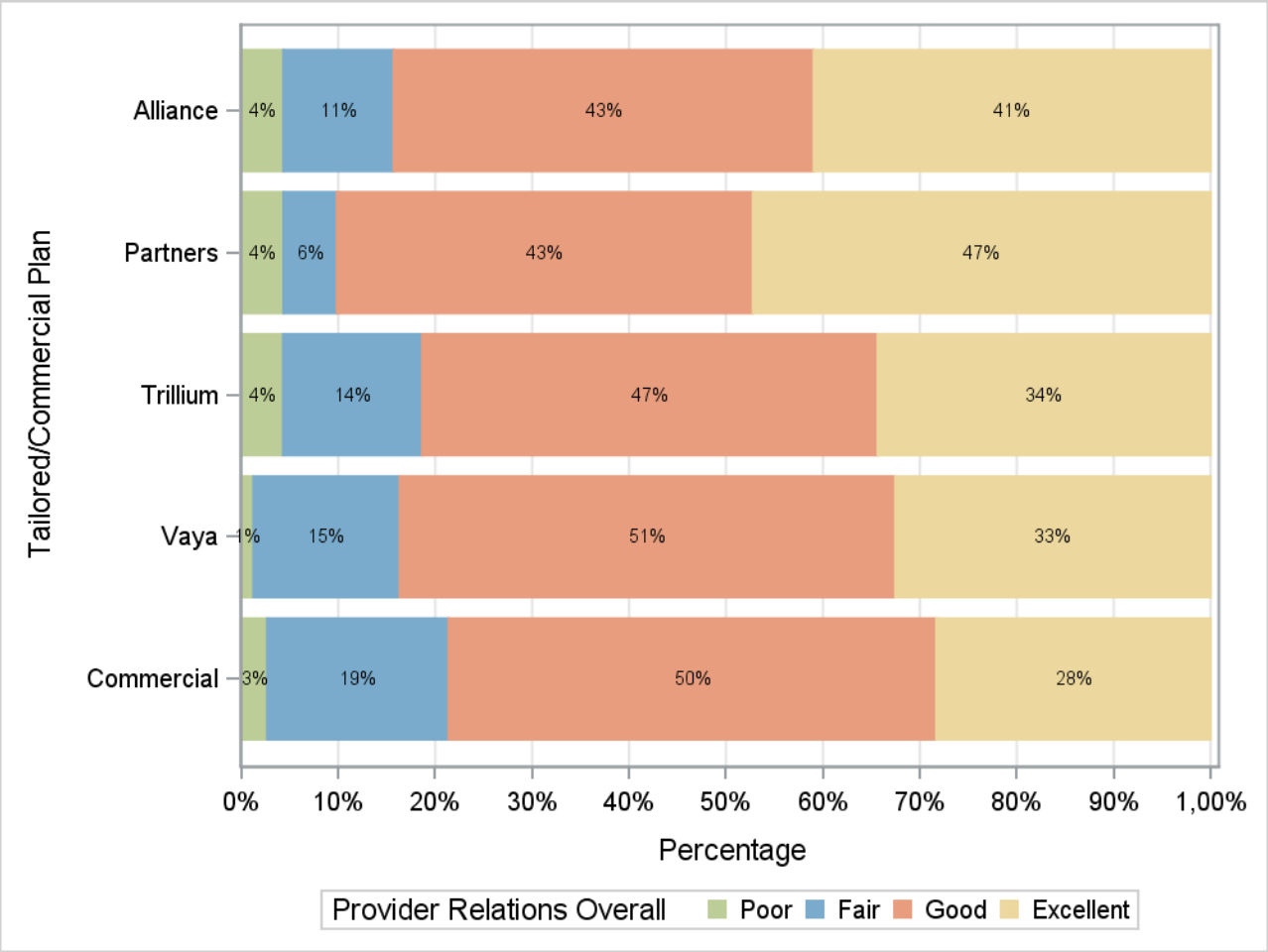


Table 5. Satisfaction of provider organizations with TPs' timeliness to answer questions and/or resolve problems

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Timeliness to Answer Questions/Resolve Problems*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	3.04 (0.06)
Partners Health Management	3.18 (0.06)
Trillium Health Resources	2.91 (0.06)
Vaya Health	3.07 (0.05)
Largest Commercial Payor	2.90 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 2. Distribution of respondent ratings of timeliness to answer questions and/or resolve problems by TP

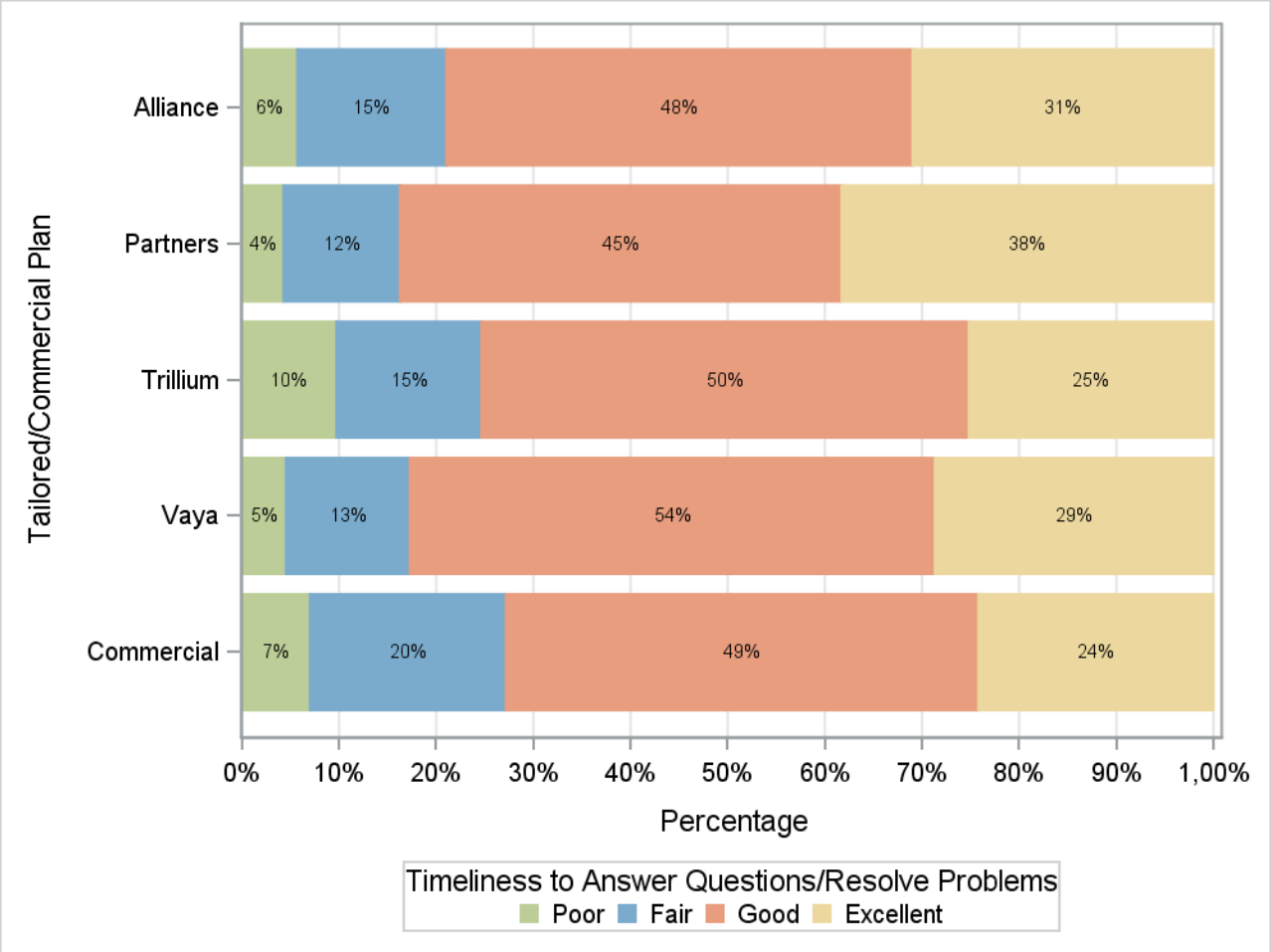


Table 6. Satisfaction of provider organizations with TPs' timeliness of claims processing

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Timeliness of Claims Processing*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	3.24 (0.05)
Partners Health Management	3.22 (0.05)
Trillium Health Resources	3.04 (0.06)
Vaya Health	3.2 (0.05)
Largest Commercial Payor	3.15 (0.04)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 3. Distribution of respondent ratings of timeliness of claims processing by TP

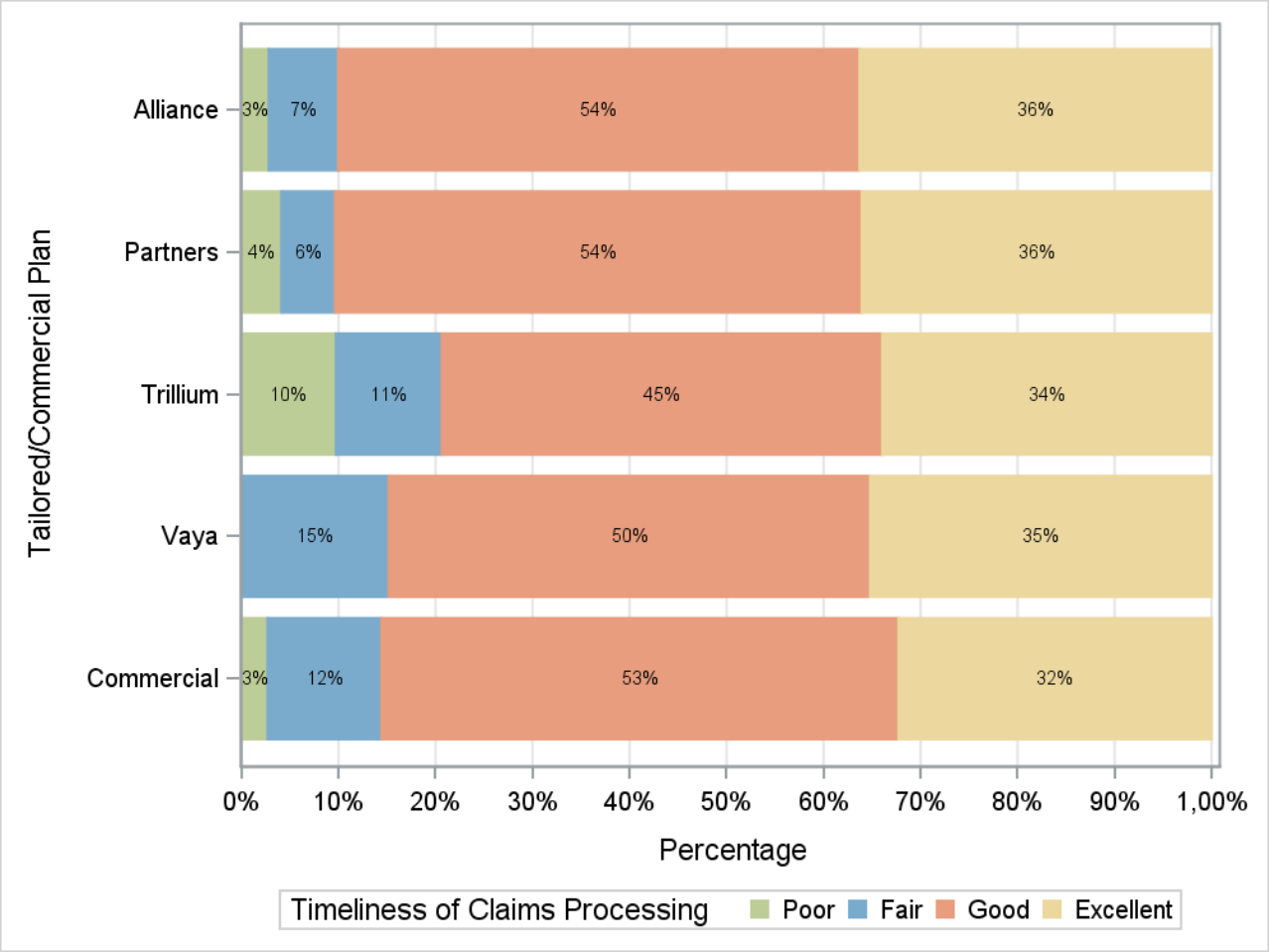


Table 7. Satisfaction of provider organizations with TPs' process for managing prior authorization

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Process for Managing Prior Authorization*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	3.07 (0.06)
Partners Health Management	3.15 (0.05)
Trillium Health Resources	2.97 (0.06)
Vaya Health	3.06 (0.05)
Largest Commercial Payor	2.91 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 4. Distribution of respondent ratings of process for managing prior authorization by TP

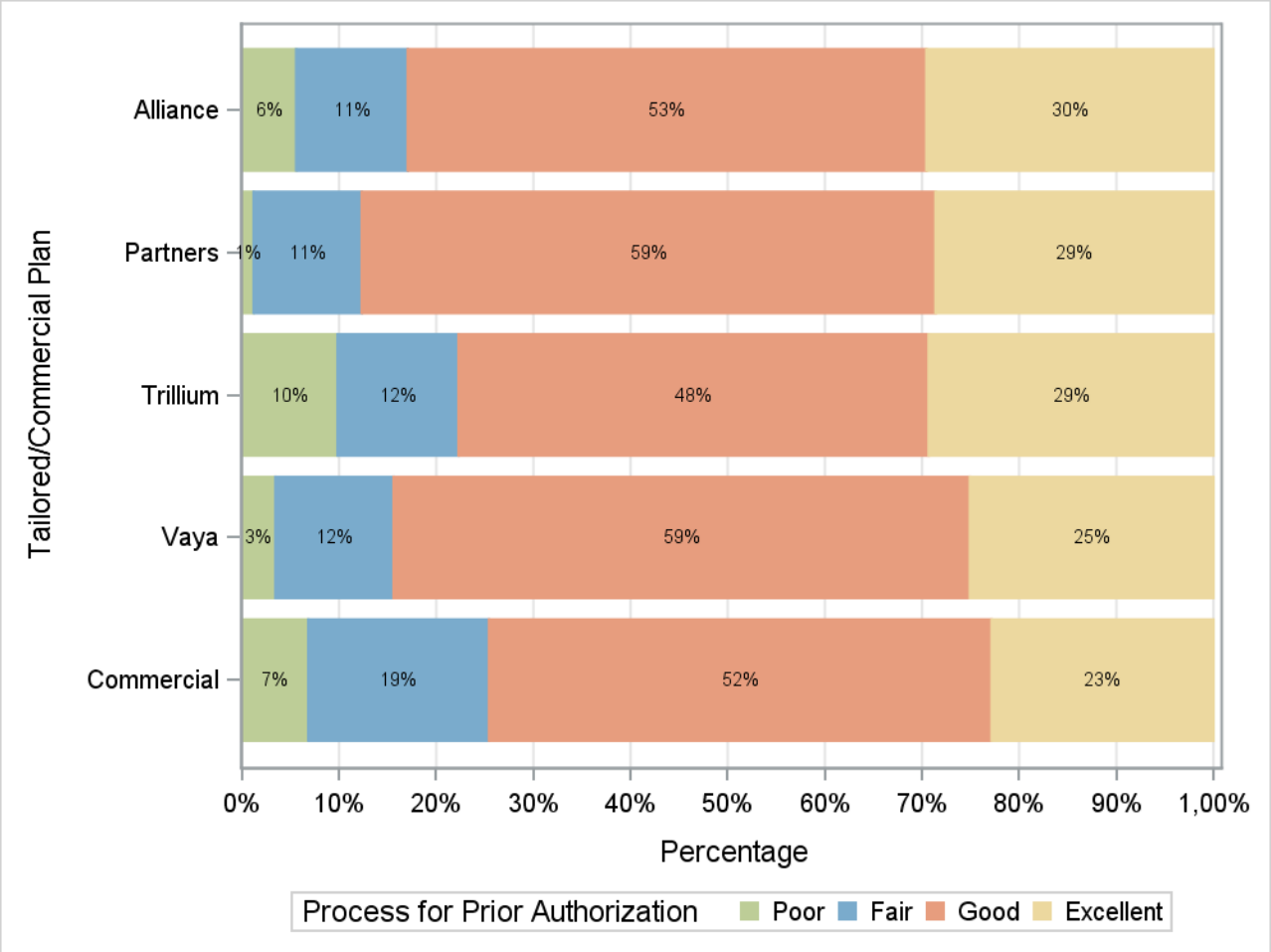


Table 8. Satisfaction of provider organizations with TPs' reimbursement to provide the care needed for Medicaid patients

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Adequacy of Reimbursement to Provide the Care Needed for Medicaid Patients*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	2.77 (0.06)
Partners Health Management	2.80 (0.06)
Trillium Health Resources	2.70 (0.06)
Vaya Health	2.88 (0.05)
Largest Commercial Payor	2.86 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 5. Distribution of respondent ratings of adequacy of reimbursement to provide the care needed for Medicaid patients by TP

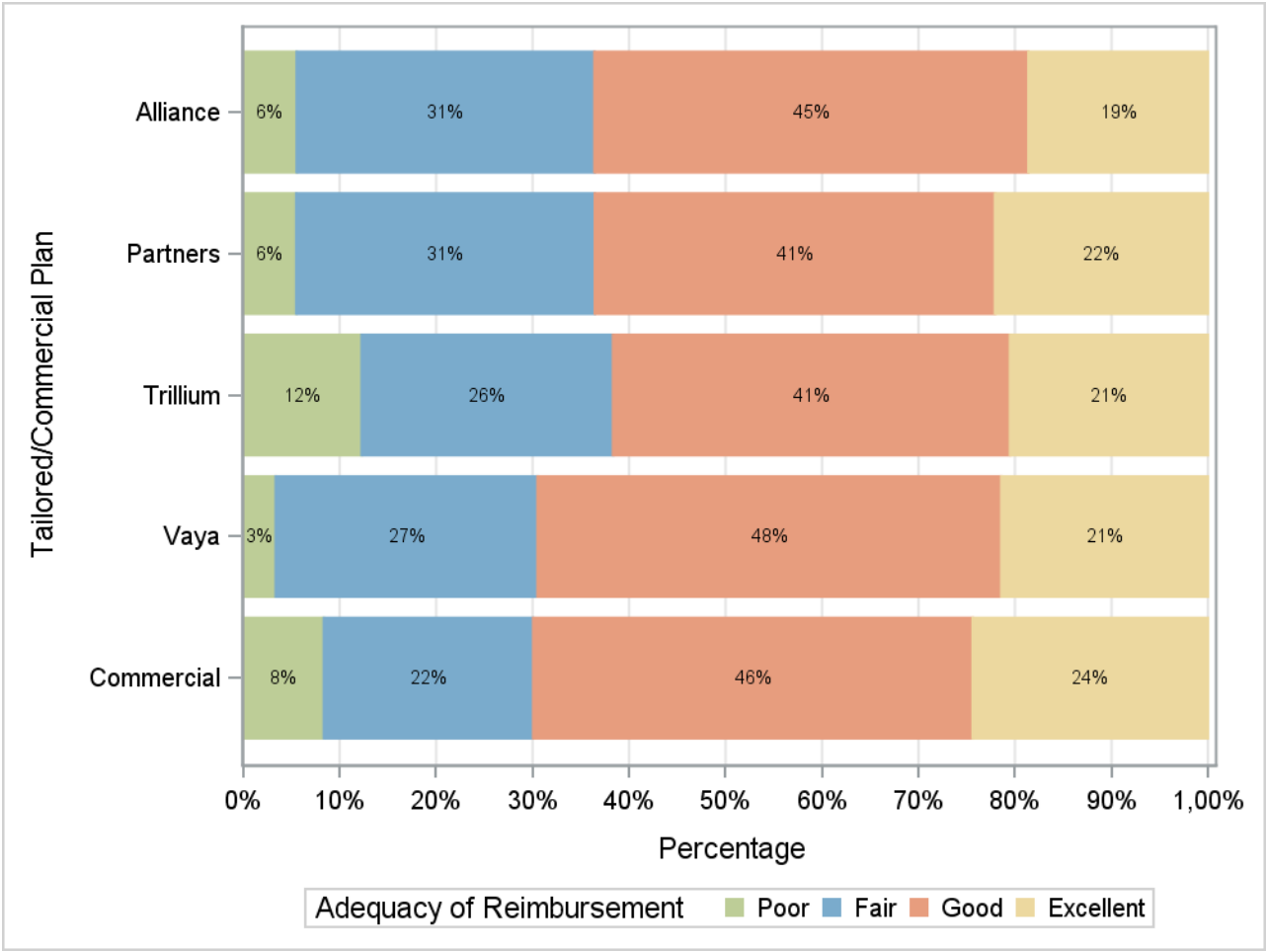


Table 9. Satisfaction of provider organizations with access to medical specialists for Medicaid patients

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Access to Medical Specialists for Medicaid Patients*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	2.79 (0.07)
Partners Health Management	2.91 (0.06)
Trillium Health Resources	2.75 (0.06)
Vaya Health	2.81 (0.05)
Largest Commercial Payor	2.96 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 6. Distribution of respondent ratings of access to medical specialists for Medicaid patients by TP

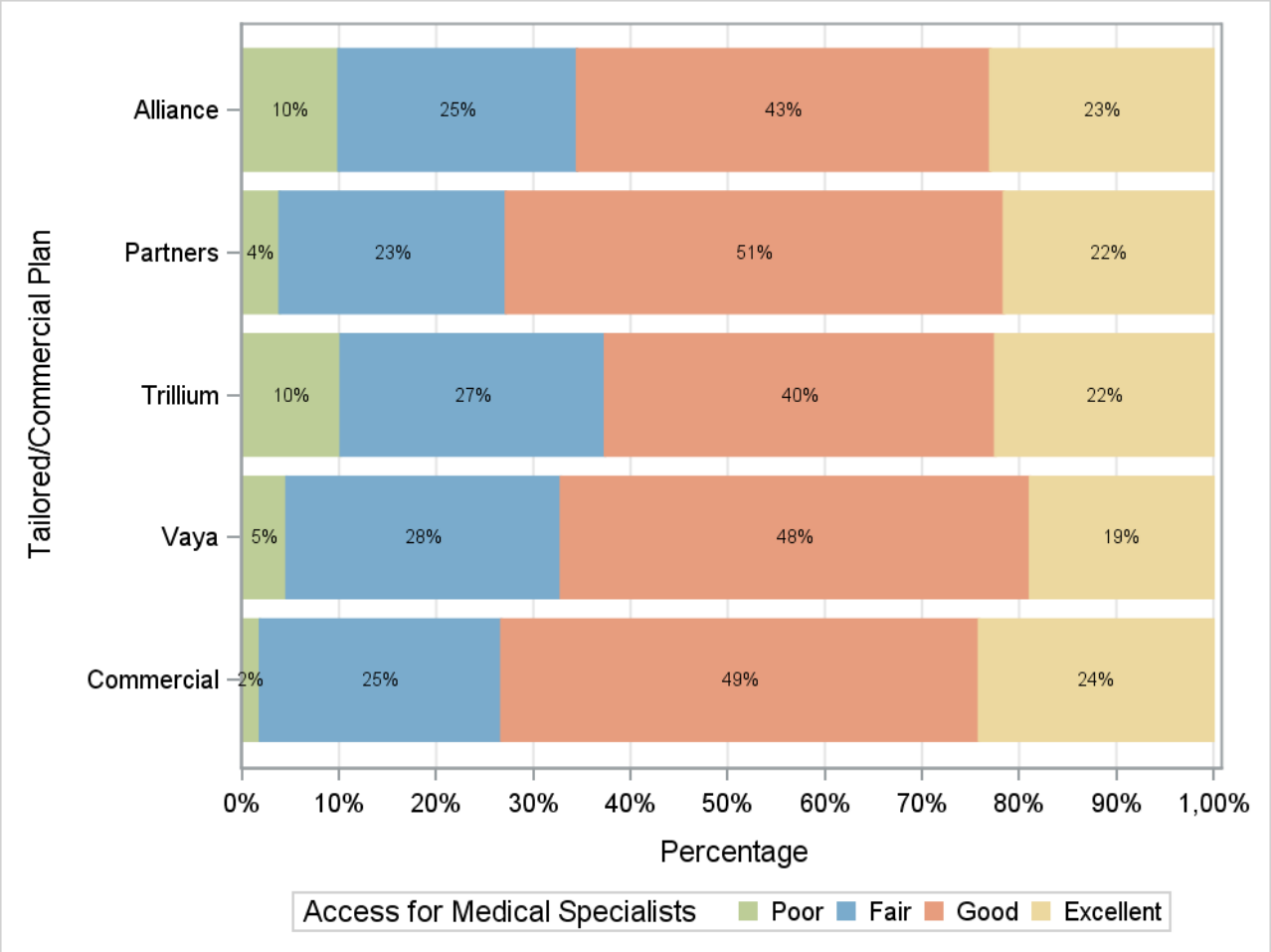


Table 10. Satisfaction of provider organizations with access to behavioral health prescribers (e.g., psychiatrists, psychiatric nurse practitioners, or physician assistants) for Medicaid patients

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Access to Behavioral Health Prescribers for Medicaid Patients*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	3.11 (0.05)
Partners Health Management	3.12 (0.05)
Trillium Health Resources	2.96 (0.05)
Vaya Health	3.09 (0.05)
Largest Commercial Payor	3.03 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 7. Distribution of respondent ratings of access to behavioral health prescribers for Medicaid patients by TP

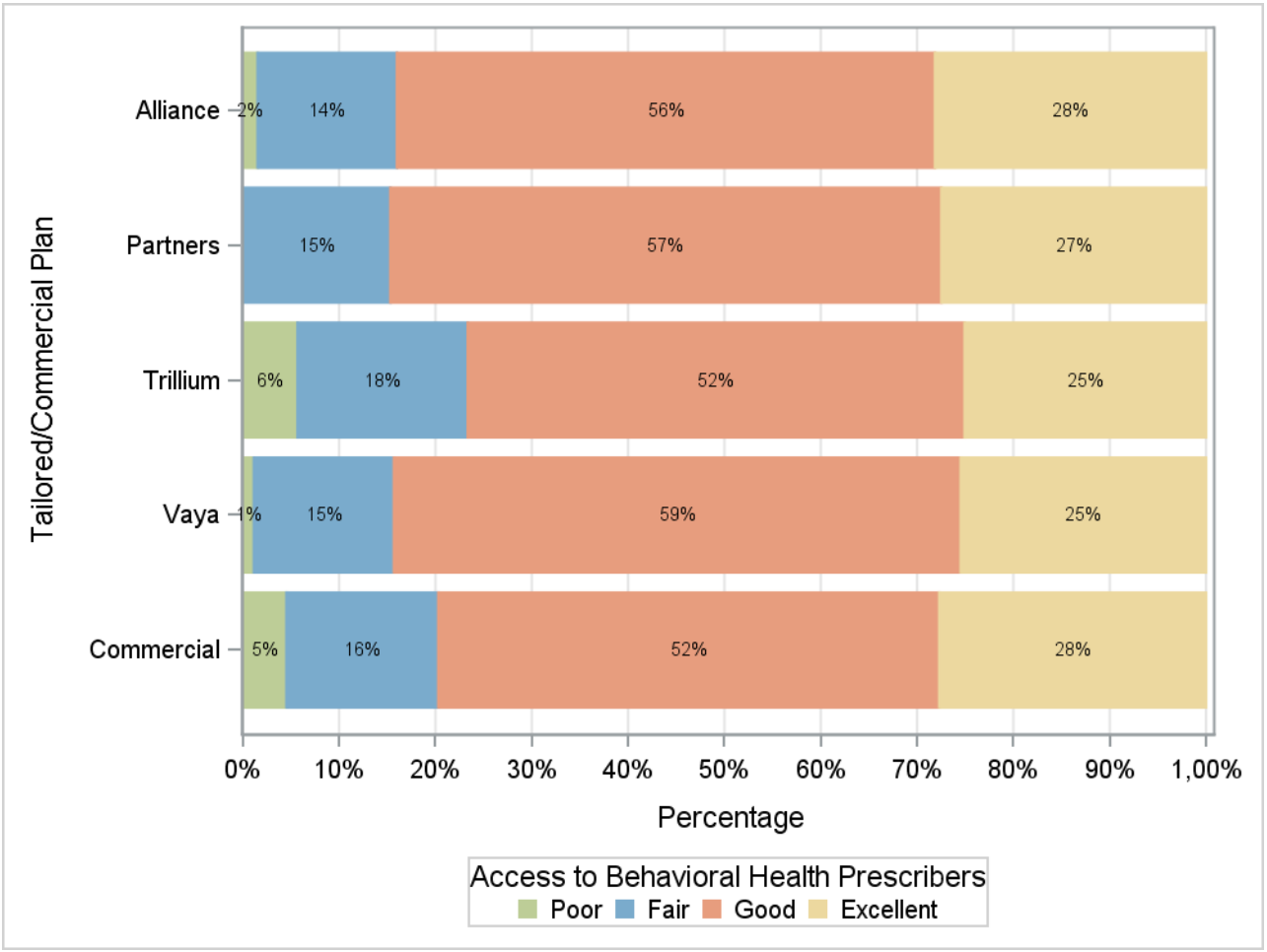


Table 11. Satisfaction of provider organizations with access to behavioral health therapists for Medicaid patients

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Access to Behavioral Health Therapists for Medicaid Patients*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	3.01 (0.06)
Partners Health Management	3.01 (0.05)
Trillium Health Resources	3.00 (0.05)
Vaya Health	2.98 (0.05)
Largest Commercial Payor	3.03 (0.04)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 8. Distribution of respondent ratings of access to behavioral health therapists for Medicaid patients by TP

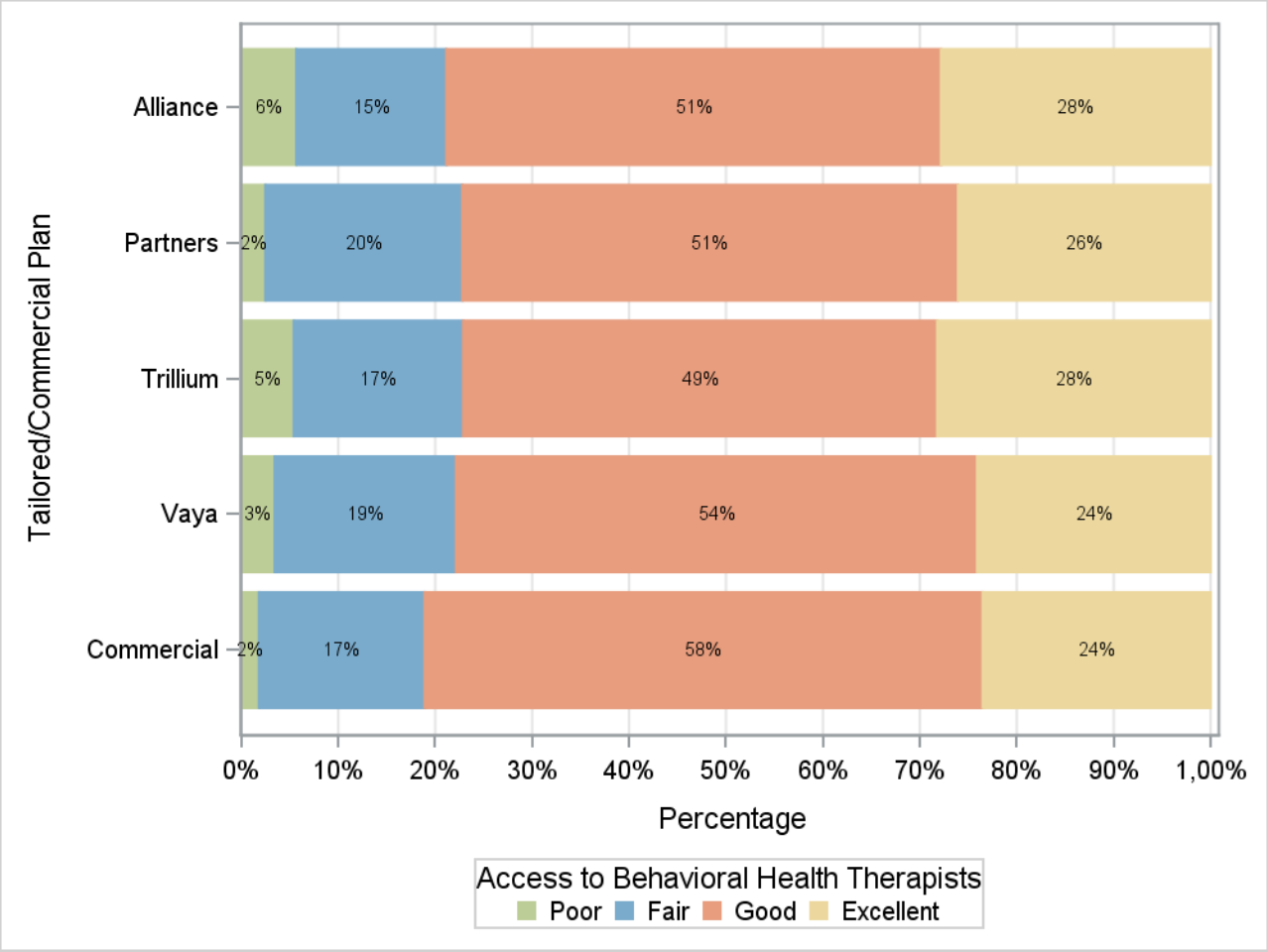


Table 12. Satisfaction of provider organizations with access to needed drugs for Medicaid patients (formulary)

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Access to Needed Drugs for Medicaid Patients*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	3.02 (0.05)
Partners Health Management	3.02 (0.04)
Trillium Health Resources	2.91 (0.05)
Vaya Health	3.01 (0.04)
Largest Commercial Payor	3.01 (0.04)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 9. Distribution of respondent ratings of access to all needed drugs (formulary) for Medicaid patients by TP

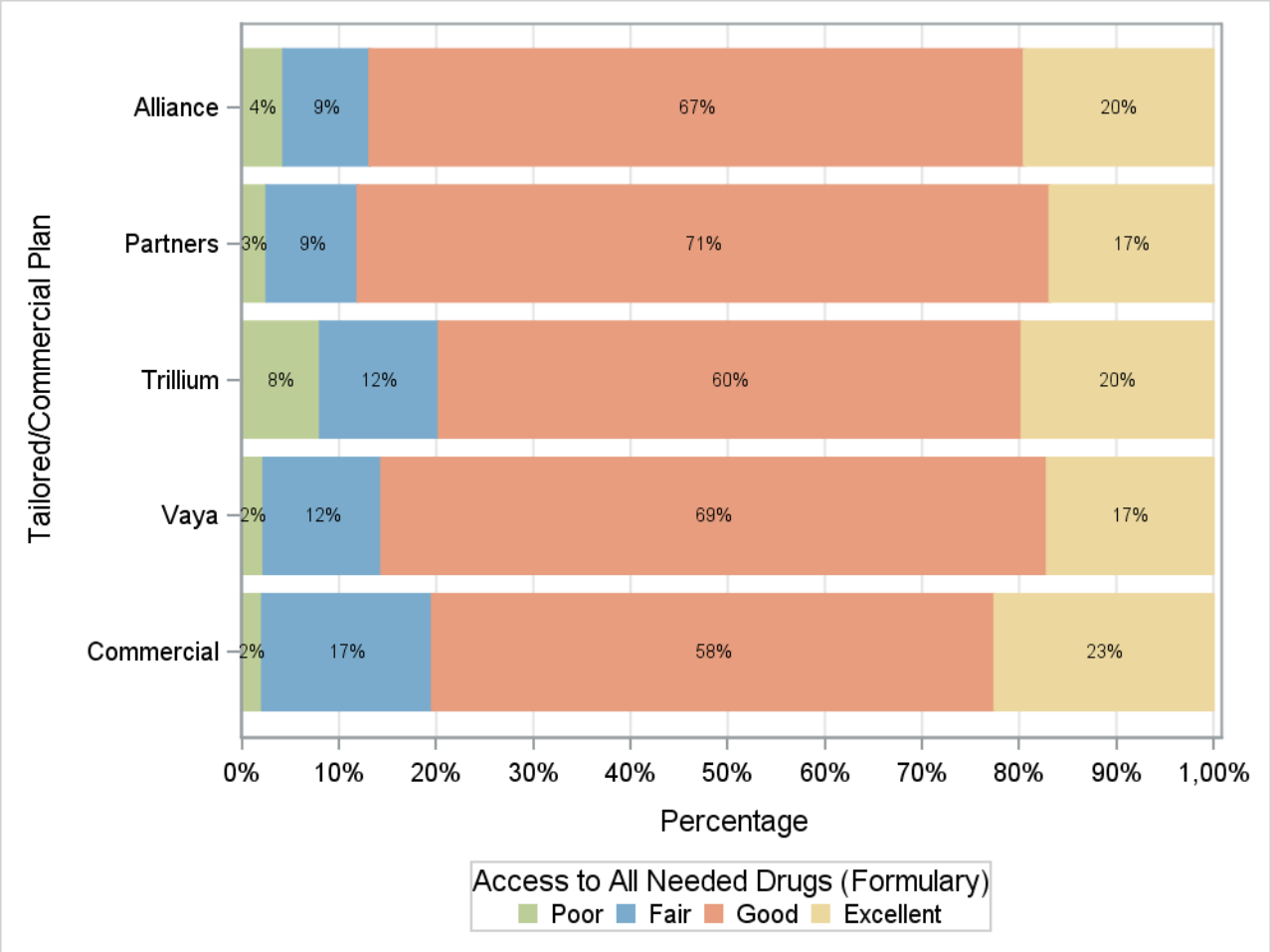


Table 13. Satisfaction of provider organizations with access to needed psychotropic medications (formulary) for your patients

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Access to Needed Psychotropic Medications for Your Patients*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	3.06 (0.05)
Partners Health Management	3.01 (0.05)
Trillium Health Resources	2.93 (0.06)
Vaya Health	3.00 (0.04)
Largest Commercial Payor	3.04 (0.04)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 10. Distribution of respondent ratings of access for needed psychotropic medications (formulary) for Medicaid patients by TP

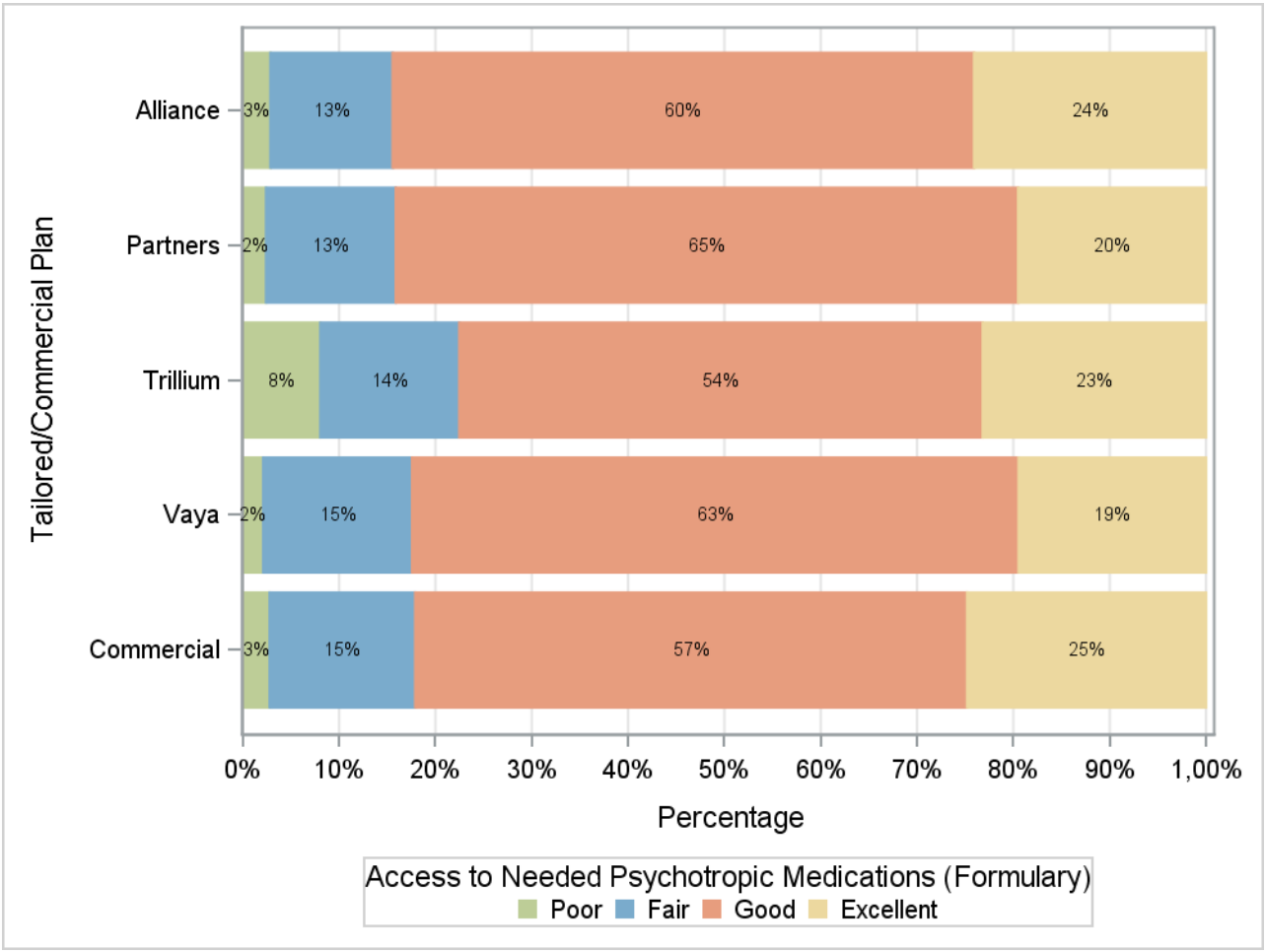


Table 14. Satisfaction of provider organizations with care/case management for your patients

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? ***Care/Case Management for Your Patients***	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	2.89 (0.06)
Partners Health Management	2.82 (0.06)
Trillium Health Resources	2.72 (0.06)
Vaya Health	2.75 (0.06)
Largest Commercial Payor	2.59 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 11. Distribution of respondent ratings of care/case management for Medicaid patients by TP

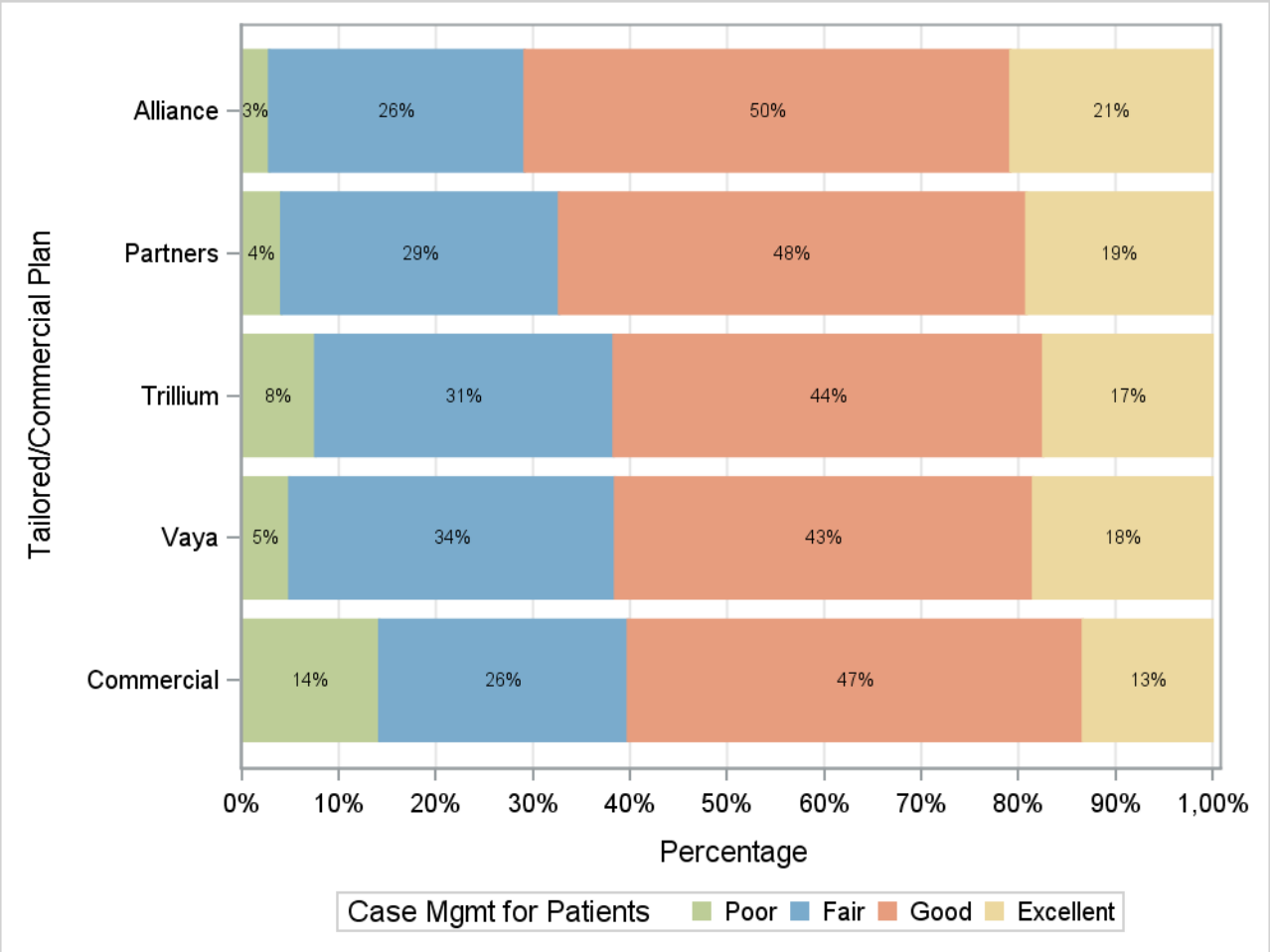


Table 15. Satisfaction of provider organizations with customer/member support services for their patients

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Customer/Member Support Services for Your Patients*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	3.09 (0.05)
Partners Health Management	2.97 (0.05)
Trillium Health Resources	2.92 (0.05)
Vaya Health	2.96 (0.05)
Largest Commercial Payor	2.90 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 12. Distribution of respondent ratings of customer/member support services for Medicaid patients by TP

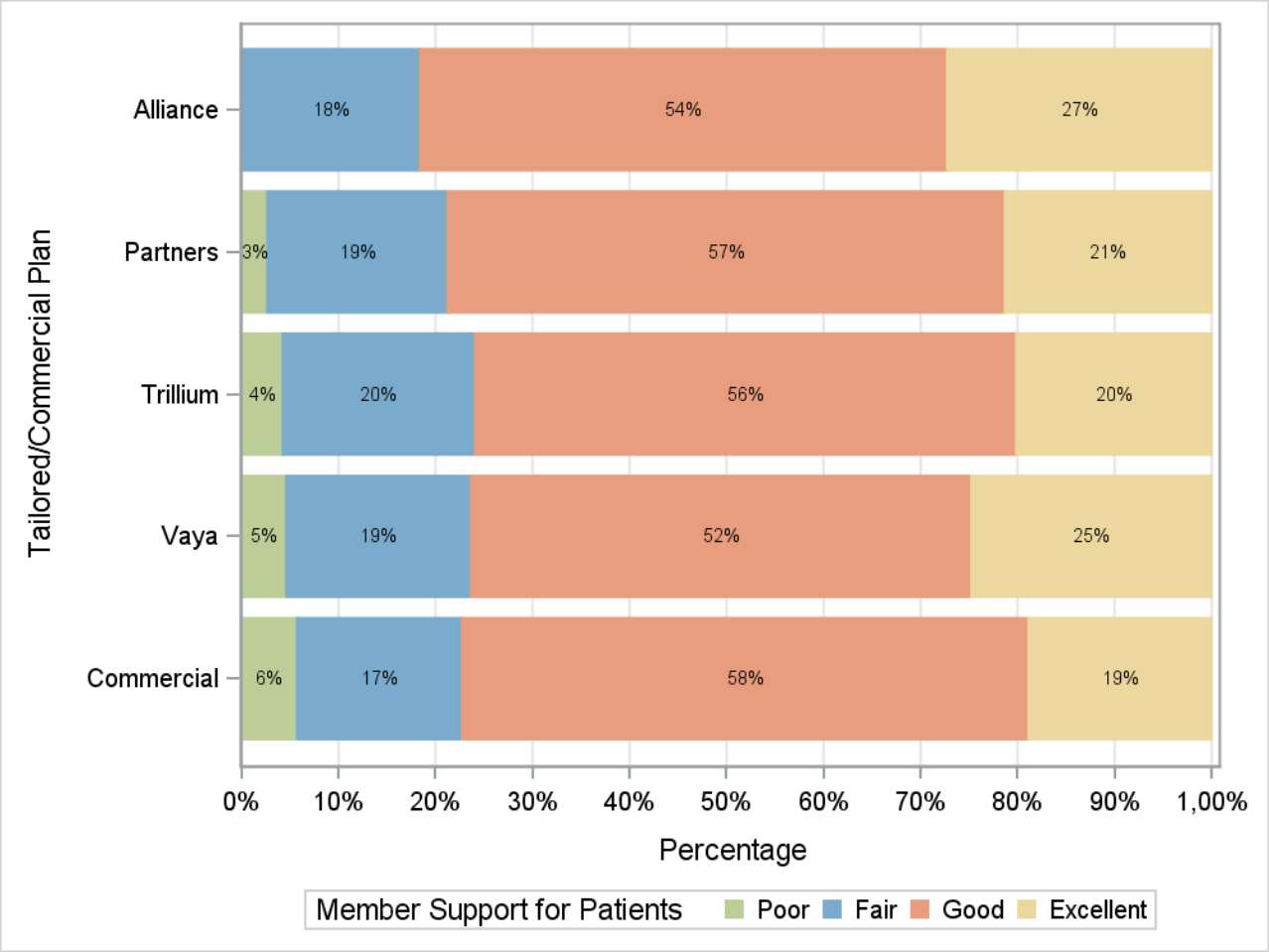


Table 16. Satisfaction of provider organizations with support for addressing social determinants of health (food, education, housing, access to care, etc.)

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Support for Addressing Social Determinants of Health*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	2.80 (0.06)
Partners Health Management	2.75 (0.06)
Trillium Health Resources	2.72 (0.06)
Vaya Health	2.76 (0.06)
Largest Commercial Payor	2.44 (0.06)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 13. Distribution of respondent ratings of support for addressing social determinants of health by TP

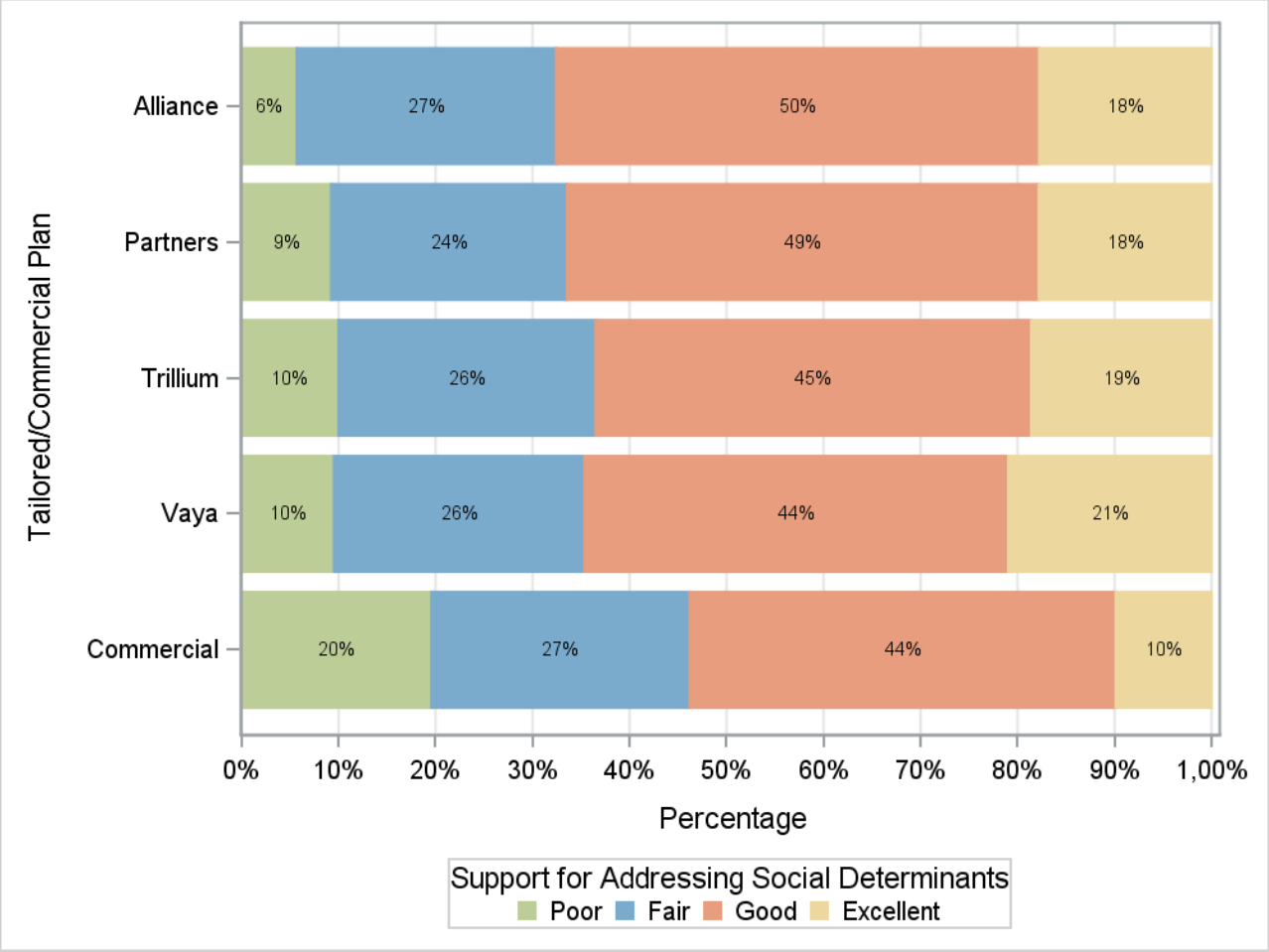


Table 17. Satisfaction of provider organizations with data sharing for quality and care management (timeliness and accuracy)

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Data Sharing Quality and Care Management (Timeliness and Accuracy)*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	2.91 (0.06)
Partners Health Management	2.89 (0.06)
Trillium Health Resources	2.81 (0.05)
Vaya Health	2.78 (0.05)
Largest Commercial Payor	2.73 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 14. Distribution of respondent ratings of data sharing for quality and care management by TP

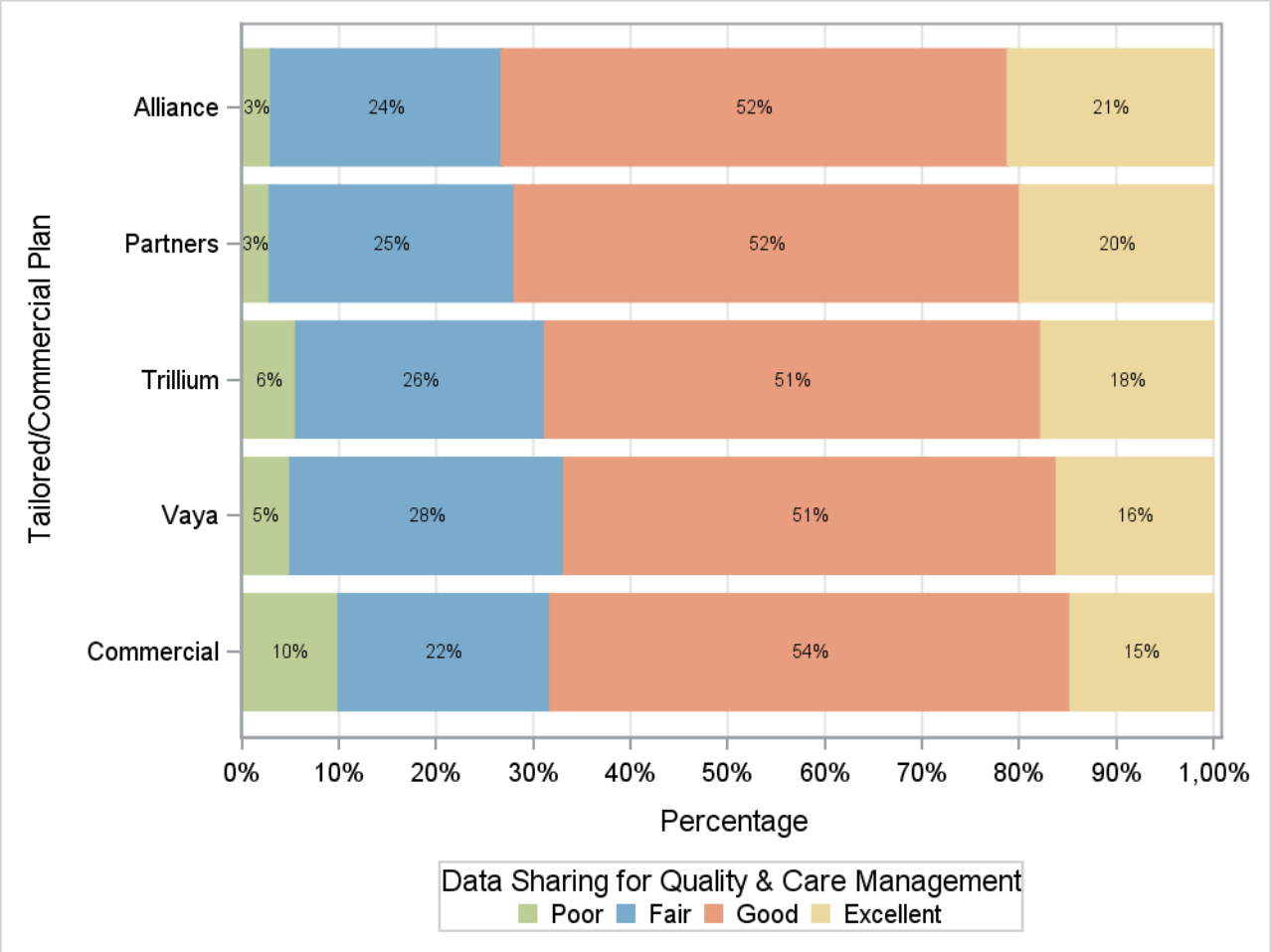


Table 18. Satisfaction of provider organizations process and accuracy for assigning patients to your practice (attribution)

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Process and Accuracy for Assigning Patients to Your Practice (Attribution)*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	2.89 (0.06)
Partners Health Management	2.96 (0.05)
Trillium Health Resources	2.87 (0.05)
Vaya Health	2.89 (0.05)
Largest Commercial Payor	2.84 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 15. Distribution of respondent ratings of process and accuracy for assigning patients to your practice (attribution) by TP

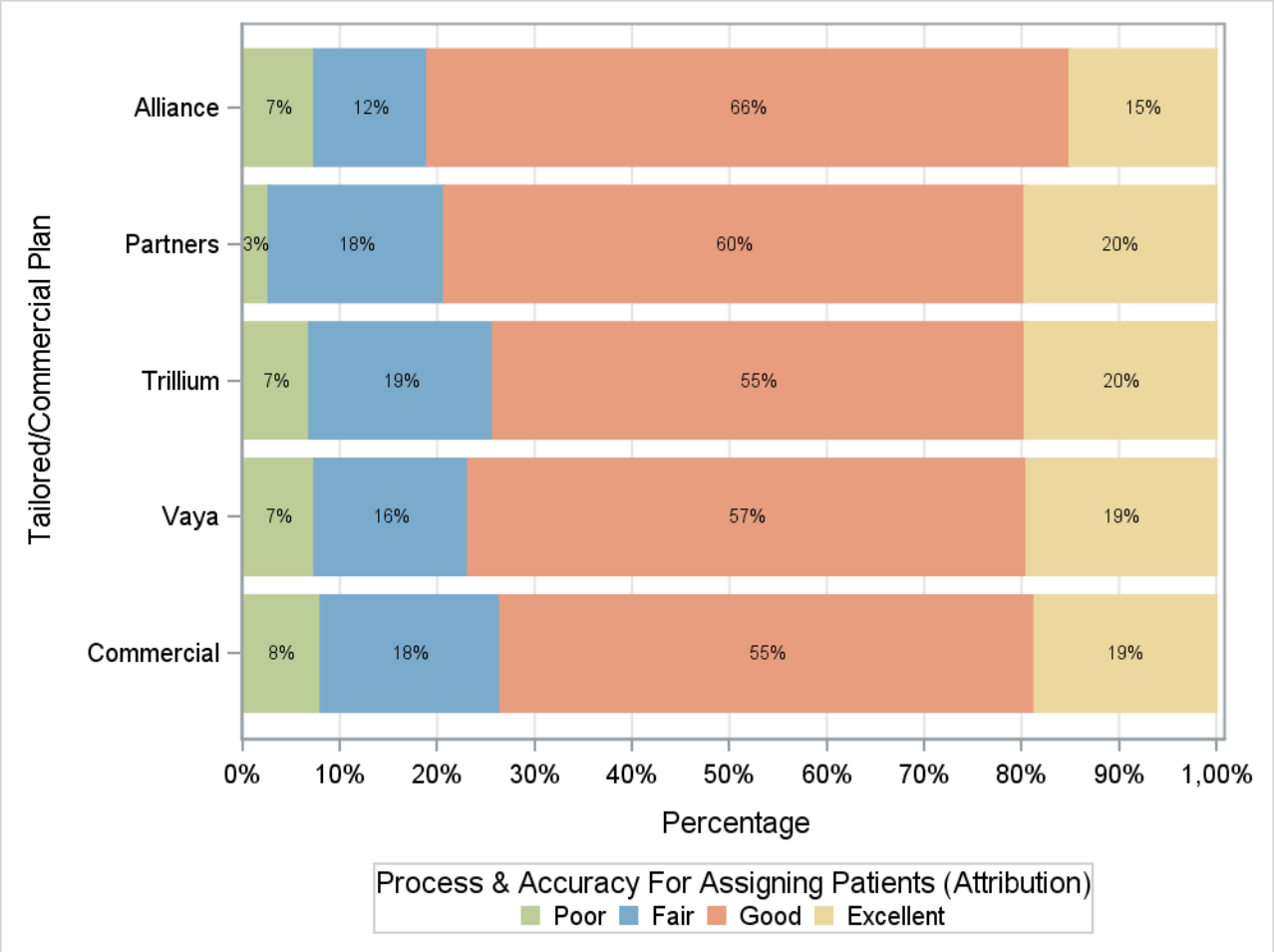


Table 19. Satisfaction of provider organizations with bidirectional flow of information with specialty care practices

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Bidirectional Flow of Information with Specialty Care*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	2.79 (0.06)
Partners Health Management	2.87 (0.06)
Trillium Health Resources	2.79 (0.06)
Vaya Health	2.81 (0.06)
Largest Commercial Payor	2.78 (0.04)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 16. Distribution of respondent ratings of bidirectional flow of information with specialty care practices by TP

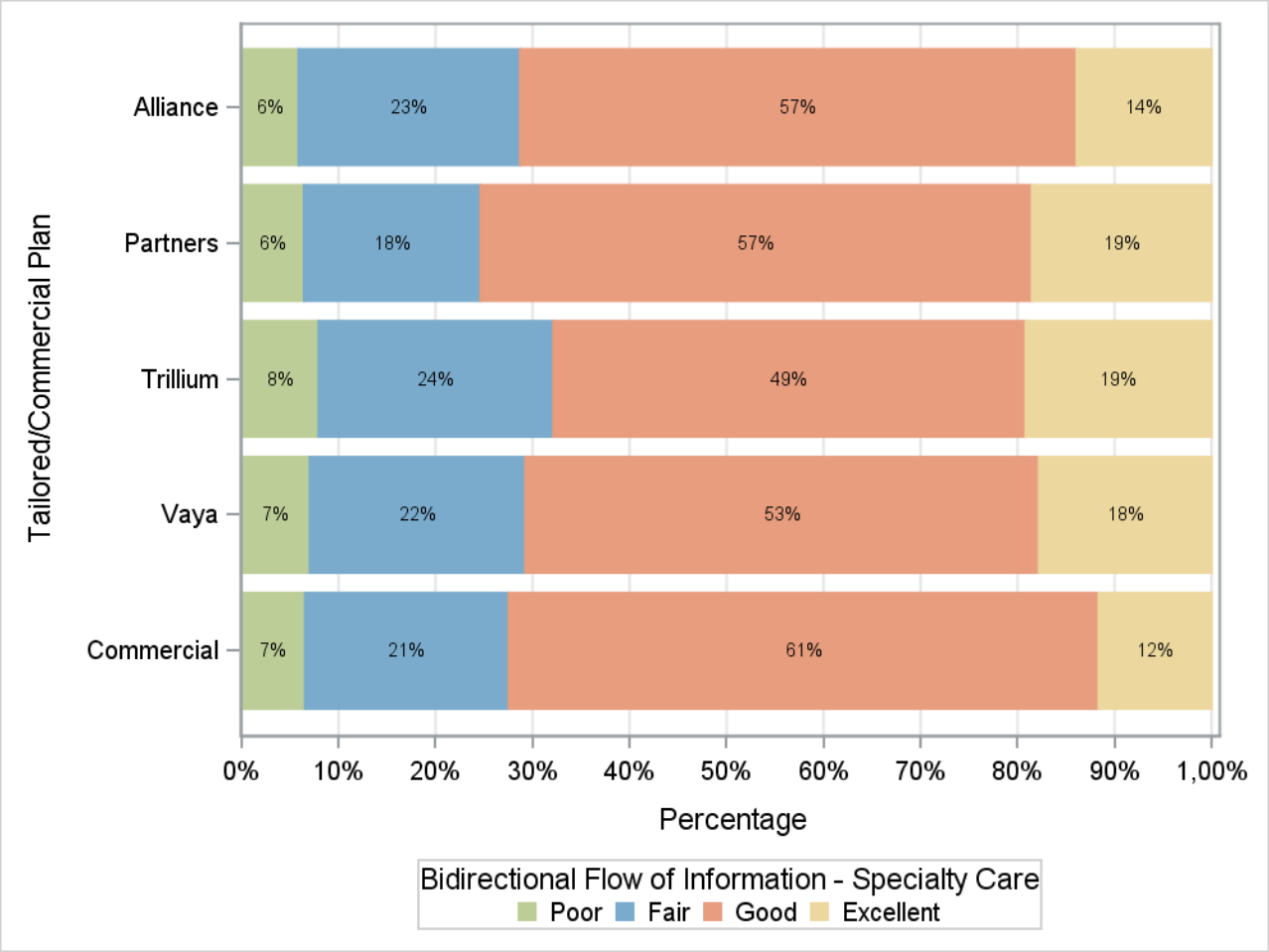
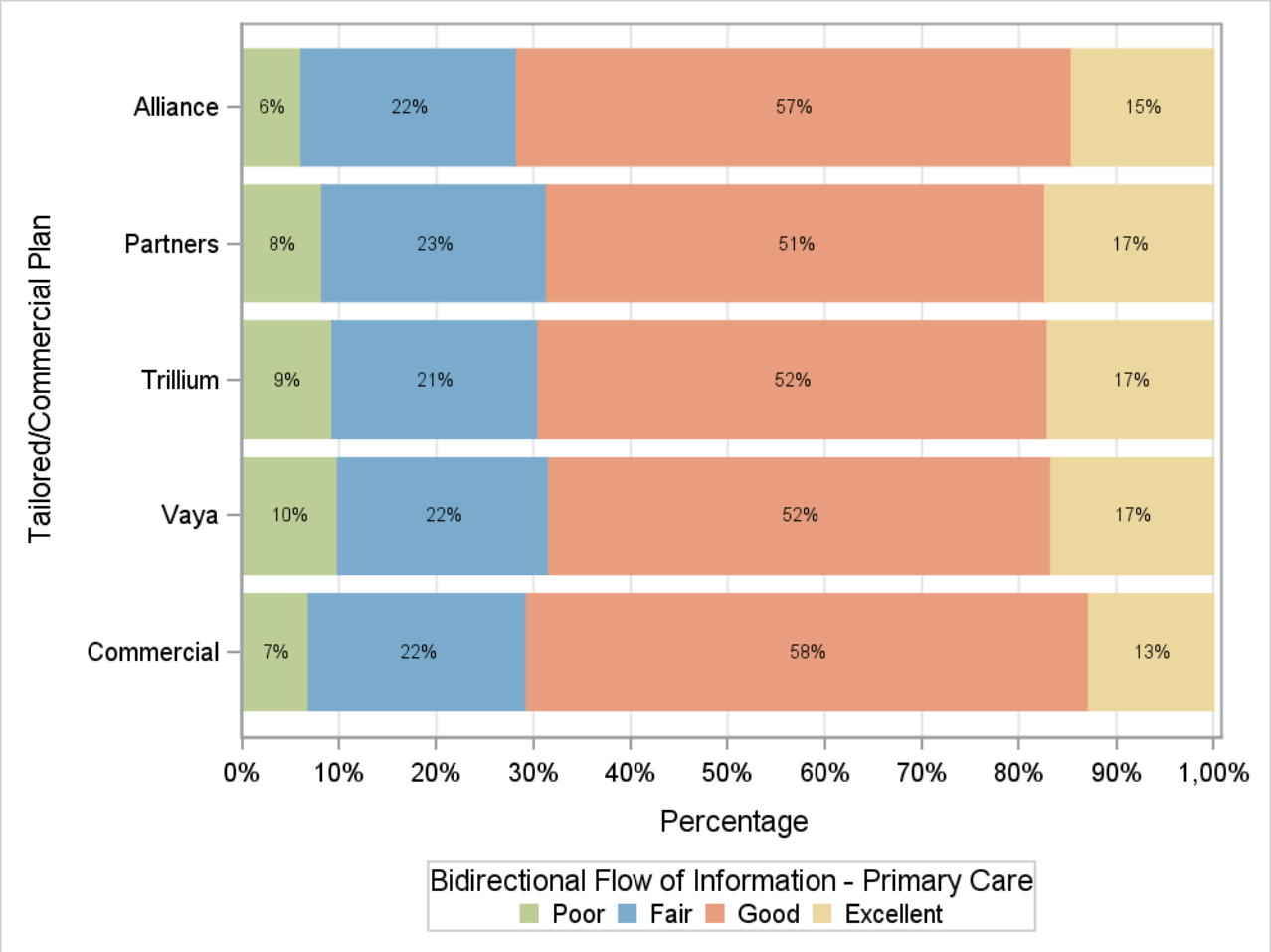


Table 20. Satisfaction of provider organizations with bidirectional flow of information with primary care practices

How would you describe your overall experience for the following factors for each of the plans you are contracting with as well as your largest commercial payor? *Bidirectional Flow of Information with Primary Care*	
TP	**Mean (SE)**
Tailored Plans	
Alliance Health	2.80 (0.06)
Partners Health Management	2.78 (0.06)
Trillium Health Resources	2.77 (0.06)
Vaya Health	2.75 (0.06)
Largest Commercial Payor	2.77 (0.05)

Notes: Ratings scale ranges from 1 (Poor) to 4 (Excellent).

Figure 17. Distribution of respondent ratings of bidirectional flow of information with primary care practices by TP



Summary of Satisfaction with Tailored Plans (TPs)

The ratings scale in this section ranges from 1 (Poor) to 4 (Excellent).

Figure 18: Overall summary ratings of TPs (average across all satisfaction questions).

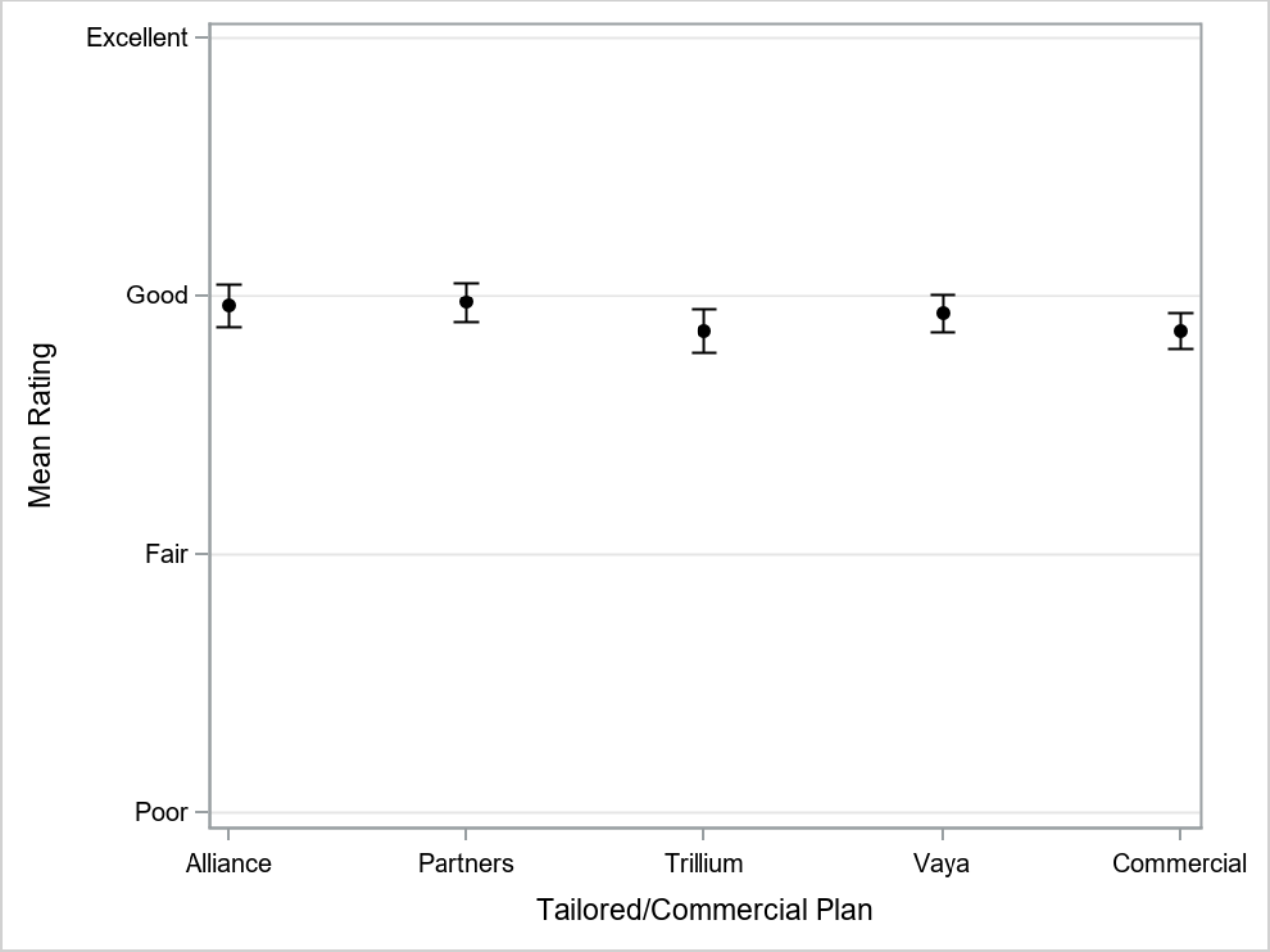
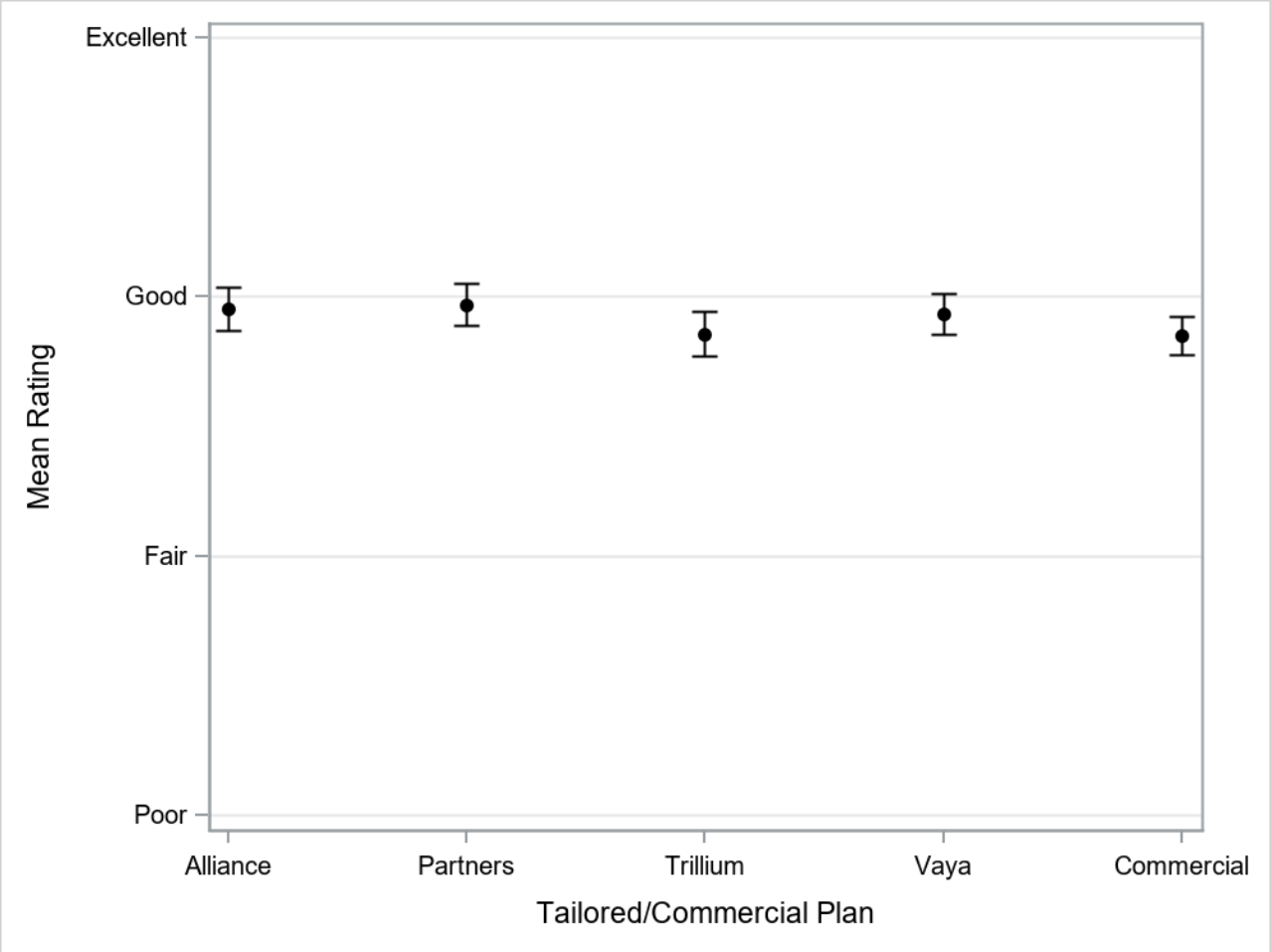
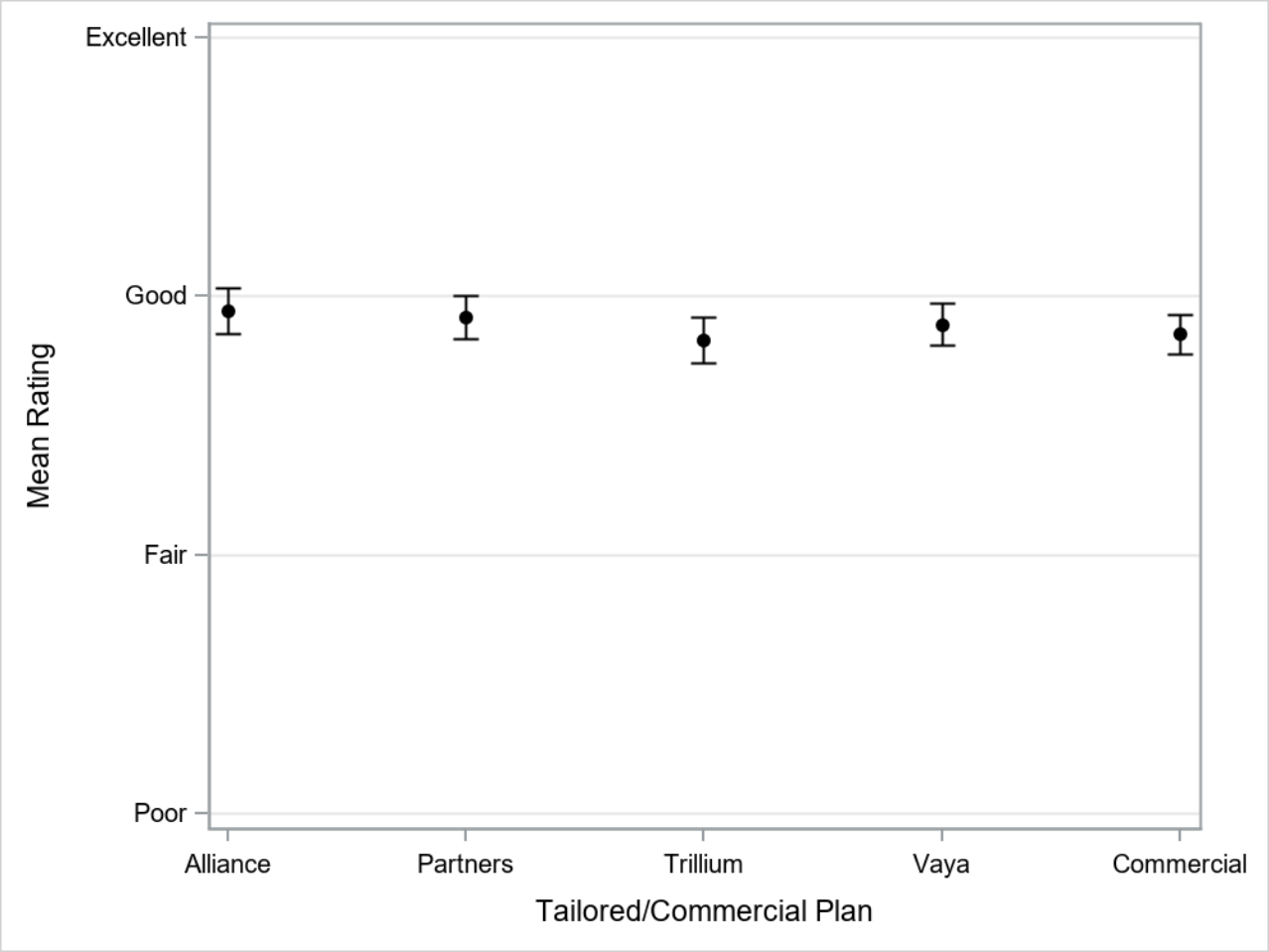


Figure 19: Composite (average) ratings of TPs across administrative domains



The administrative domain score is the average overall response across the following items: Timeliness to Answer Questions/Resolve Problems, Timeliness of Claims Processing, Process for Prior Authorization, Adequacy of Reimbursement, Member Support for Patients, Data Sharing for Quality & Care Management, Process & Accuracy For Assigning Patients (Attribution), Bidirectional Flow of Information with Specialty Care, and Bidirectional Flow of Information with Primary Care.

Figure 20: Composite (average) ratings of TPs across clinical domains



The clinical domain score is the average overall response across the following items: Access for Medical Specialists, Access to Behavioral Health Prescribers, Access to Behavioral Health Therapists, Access to All Needed Drugs (Formulary), Access to Needed Psychotropic Medications (Formulary), Case Management for Patients, Member Support for Patients, and Support for Addressing Social Determinants.

Open-Ended Findings:

Participants were invited to provide any additional comments they would like to share following the completion of the satisfaction questions. A total of 51 participants provided additional comments grouped thematically below:

Communication – Several organizations described good communication with the TPs, sharing that "[The TPs] are responsive and answer my questions in a timely manner," and that the TPs have been "a lot more helpful and communicative compared to Standard plans and Commercial plans." One respondent also highlighted the role of the Practice Transformation Specialists for making

"informed operational decisions that ensures timely access and service delivery overall." However, other organizations cited challenges in communication with the TPs. For some, communication was limited: "only certain providers in certain areas get support" and "it seems like the TPs are less responsive to some questions." Others felt there was too much communication from the TPs: "The bombardment of communications from the plans...can be overwhelming, and they are all marked 'URGENT' erroneously."

Reimbursement & Billing – A few organizations expressed their displeasure with the current reimbursement rates, with one stating that the TPs are "not competitive with commercial insurance." However, one area of concern that was raised by several organizations was difficulty receiving reimbursement for services, particularly by Physician Assistants (also known as Physician Associates or PAs). One organization shared that "PAs at our practice are mental health providers and it is burdensome to have to change the insurance on each claim based on who [the patient] saw that day," while another shared similar challenges: "[The TP] refuses to process many of our claims (but not all) for the PA-C [Physician Assistant provider] taxonomy, stating that it must go to physical health, even though we are credentialed as Behavioral Health." Other organizations expressed more general frustration with claims denials, including one organization which stated that, "we received a 40-page remittance advice from [TP] with only 3 claims paid and the rest denied."

Impact on Patients – Several organizations discussed the perceived impact of the TPs for their patients. For example, one organization expressed gratitude for the TPs, stating, "thank you for helping us help the community." Others were less positive, stating, "I am not convinced the value [for patients] is better now," and "[TP credentialing problems] caused several patients to be lost to care as a result."

Credentialling – Challenges arising during the credentialling process, especially an inability to get credentialed, was cited as an ongoing barrier to some providers, stating, "We have been unable to get credentialed [in order to work with TP], despite our best efforts."

Case Management – Organizations identified case management as an area for improvement, noting that they experienced "very high turnover in case managers" and "case management is sometimes hard to get on the phone" as a result.

PRACTICE SPECIFIC COMPARISONS: SMALL/MEDIUM PRACTICES (1-9 PROVIDER) VERSUS LARGE PRACTICES (10+ PROVIDERS)

In this section, analyses are stratified by practice size to compare the experiences of small and medium practices (unweighted n = 69) to those of larger practices and health systems (unweighted n = 48). We present **means** and **standard errors** in this section, as well as *t*-test results to detect a significant difference in means.

Contracting with Tailored Plans (TPs)

The following questions and findings are related to provider organizations' relationships with TPs. Results are weighted – organization counts have been rounded to the nearest whole number (e.g., 1.1 = 1; 1.5 = 2) and percentages may not sum to 100 due to rounding.

Table 21. Provider organizations' contract arrangements with Tailored Plans in North Carolina Medicaid

For the below listed Tailored Plans (TPs), have you contracted with the following plans?		
TP	**Small/Medium Practices (1-9 Providers) N (%)**	**Large Practices (10+ Providers) N (%)**
Alliance Health	40 (55.8)	32 (70.8)
Partners Health Management	46 (64.4)	30 (66.8)
Trillium Health Resources	56 (78.2)	35 (78.8)
Vaya Health	53 (73.2)	36 (79.3)

Table 22. Satisfaction of provider organizations with Tailored Plans in North Carolina stratified by practice size. For all items, scales range from 1 (Poor) to 4 (Excellent)., with higher scores indicating greater satisfaction.

How would you describe your overall experience for the following factors for each of the plans you are contracting with?			
	Small/Med Practices (1-9 Providers) Mean (SE)	**Large Practices (10+ Providers) Mean (SE)**	***P*-value**
Provider Relations Overall	3.13 (0.03)	3.19 (0.03)	*.216*
Timeliness to Answer Questions/Resolve Problems	3.00 (0.03)	3.02 (0.04)	*.733*
Timeliness of Claims Processing	3.18 (0.03)	3.14 (0.03)	*.413*
Process for Prior Authorization	3.02 (0.03)	3.02 (0.04)	*.878*
Adequacy of Reimbursement	2.88 (0.04)	2.69 (0.04)	*<.001**
Access for Medical Specialists	2.92 (0.03)	2.74 (0.04)	*<.001**
Access to Behavioral Health Prescribers	3.07 (0.03)	3.03 (0.03)	*.335*
Access to Behavioral Health Therapists	3.10 (0.03)	2.87 (0.03)	*<.001**
Access to All Needed Drugs (Formulary)	3.04 (0.03)	2.92 (0.03)	*.004**
Access to Needed Psychotropic Medications (Formulary)	3.09 (0.03)	2.89 (0.03)	*<.001**
Case Management for Patients	2.78 (0.04)	2.68 (0.04)	*.060*
Member Support for Patients	3.00 (0.03)	2.91 (0.03)	*.058*
Support for Addressing Social Determinants	2.74 (0.04)	2.59 (0.04)	*.008**
Data Sharing for Quality & Care Management	2.82 (0.03)	2.8 (0.03)	*.667*
Process & Accuracy For Assigning Patients (Attribution)	2.89 (0.03)	2.88 (0.03)	*.866*
Bidirectional Flow of Information - Specialty Care	2.90 (0.03)	2.67 (0.04)	*<.001**
Bidirectional Flow of Information - Primary Care	2.80 (0.03)	2.72 (0.04)	*.113*
Domains			
Overall	2.95 (0.02)	2.86 (0.02)	*.008**
Administrative	2.93 (0.03)	2.86 (0.02)	*.054*
Clinical	2.93 (0.03)	2.81 (0.03)	*.002**

Yellow row shading and '*' denote statistical significance at $p<.05$

Open-Ended Results Stratified by Practice Size:

Participants were invited to provide any additional comments they would like to share following the completion of the satisfaction questions. When themes identified in the main analysis were stratified by practice size, they were evenly distributed across small/medium and large practices except for the "impact on patients" and the "credentialing" themes. In both cases, small/medium

practices accounted for the bulk of comments documenting concerns about negative impacts on patients and challenges related to credentialing.

PRACTICE SPECIFIC COMPARISONS: RESPONDENTS WITH A RURAL PRESENCE VERSUS NO RURAL PRESENCE

In this section, a respondent is defined as having a rural presence if **any** of its practice locations are rural as defined by the North Carolina Rural Center (NCRC) designated via county (unweighted n = 36). Non-rural practices are those organizations which do not have any NCRC-defined rural practices (unweighted n = 81). We present **means** and **standard errors** in this section, as well as *t*-test results to detect a significant difference in means.

Table 23. Provider organizations' contract arrangements with Tailored Plans in North Carolina Medicaid stratified by Rural Presence

For the below listed Tailored Plans (TPs), have you contracted with the following plans?		
TP	**Rural Practices N (%)**	**Non-Rural Practices N (%)**
Alliance Health	18 (45.5)	54 (69.5)
Partners Health Management	19 (48.4)	58 (73.7)
Trillium Health Resources	33 (85.2)	59 (75.1)
Vaya Health	23 (60.5)	65 (83.0)

Table 24. Satisfaction of provider organizations with Tailored Plans in North Carolina stratified by Rural Presence. For all items, scales range from 1 (Poor) to 4 (Excellent)., with higher scores indicating greater satisfaction.

How would you describe your overall experience for the following factors for each of the plans you are contracting with?			
	Rural Practices Mean (SE)	**Non-Rural Practices Mean (SE)**	***P*-value**
Provider Relations Overall	3.13 (0.04)	3.16 (0.03)	*.547*
Timeliness to Answer Questions/Resolve Problems	3.02 (0.04)	3 (0.03)	*.800*
Timeliness of Claims Processing	3.19 (0.04)	3.15 (0.03)	*.513*
Process for Prior Authorization	3.03 (0.05)	3.02 (0.03)	*.788*
Adequacy of Reimbursement	2.74 (0.05)	2.83 (0.03)	*.116*
Access for Medical Specialists	2.88 (0.05)	2.83 (0.03)	*.3893*
Access to Behavioral Health Prescribers	3.02 (0.04)	3.07 (0.03)	*.266*
Access to Behavioral Health Therapists	2.94 (0.04)	3.03 (0.03)	*.055*
Access to All Needed Drugs (Formulary)	2.99 (0.04)	2.99 (0.02)	*.970*
Access to Needed Psychotropic Medications (Formulary)	2.94 (0.05)	3.03 (0.02)	*.091*
Case Management for Patients	2.71 (0.05)	2.75 (0.03)	*.397*
Member Support for Patients	3.02 (0.04)	2.94 (0.03)	*.060*
Support for Addressing Social Determinants	2.65 (0.05)	2.69 (0.03)	*.504*
Data Sharing for Quality & Care Management	2.77 (0.05)	2.83 (0.03)	*.276*
Process & Accuracy For Assigning Patients (Attribution)	2.83 (0.04)	2.91 (0.03)	*.113*
Bidirectional Flow of Information - Specialty Care	2.72 (0.05)	2.84 (0.03)	*.018**
Bidirectional Flow of Information - Primary Care	2.73 (0.05)	2.79 (0.03)	*.242*
Domains			
Overall	2.89 (0.03)	2.92 (0.02)	*.338*
Administrative	2.89 (0.03)	2.91 (0.02)	*.562*
Clinical	2.81 (0.04)	2.91 (0.02)	*.022**

Yellow row shading and '*' denote statistical significance at $p<.05$

Open-Ended Results Stratified by Rural Presence:

Participants were invited to provide any additional comments they would like to share following the completion of the satisfaction questions. When themes identified in the main analysis were stratified by rural presence, they were evenly distributed across organizations with and without a rural presence, suggesting no clear patterns.

DISCUSSION

North Carolina's 1115 Medicaid Waiver launched Tailored Plans for individuals with behavioral health needs such as serious mental illnesses, substance use disorders, or intellectual/developmental disabilities in July 2024. The North Carolina Behavioral Health Provider Experience Survey was administered between April 9 and July 4, 2025. Respondents were behavioral health organizations in North Carolina that contract with North Carolina Medicaid (n = 117). The survey captured provider experience and satisfaction in the first year of contracting with the Tailored Plans.

Behavioral health organizations rated their overall experience with Tailored Plans as Excellent or Good, with all plans performing as well as the largest commercial payor across most measures. For example, Tailored Plans performed better than the largest commercial payor for case management and addressing social determinants of health, whereas Tailored Plans performed worse than the largest commercial payor on access to medical specialists, and three of the four Tailored Plans were rated worse on reimbursement adequacy. Additionally, small and medium behavioral health organizations were more satisfied with the Tailored Plans than large behavioral health organizations. For example, small and medium behavioral health organizations rated their experience with Tailored Plans more highly than large organizations regarding the adequacy of reimbursement, access for medical specialists and to therapists, access to all drugs and to psychotropic drugs specifically, support for addressing social determinants, and the bidirectional flow of information with specialty care. Conversely, organizations with rural locations were less satisfied with the Tailored Plans than organizations in no rural locations with regard to the bidirectional flow of information with specialty care and to the clinical domain overall. Other comparisons were not significantly different.

These findings reflect the experiences of North Carolina behavioral health organizations that contract with North Carolina Medicaid 8-12 months after the launch of North Carolina's Tailored Plans under the state's 1115 Medicaid Waiver. The positive overall experiences reported with the Tailored Plans speak to the quality of and access to guidance offered by the state to support adoption and work out any unanticipated issues. The positive experiences reported by small and medium organizations in particular speak to the value of the Waiver design and that Tailored Plans may fill gaps in resources of such organizations such as case managers and billing staff.

While Tailored Plans are in their infancy, there were three early areas identified as potential areas of improvement. First, respondent organizations explained in open-ended responses that there were challenges getting claims approved. Developing billing and claims adjudication protocols that have all necessary detail and helping behavioral health organizations identify where they can find those details may help to improve this rating. Second, organizations with rural locations rated the bidirectional flow of information with specialty care lower than those with no rural locations. This challenge may reflect the gaps in personnel resources such as case managers, billing and administrative support staff mentioned above that Tailored Plans are well-positioned to fill. Behavioral health organizations and Tailored Plans may need more time to work out the shifts in communication responsibilities that could overcome this information challenge. Altogether, it appears that the first two challenges identified may be factors related

to early implementation rather than core problems with Waiver and Tailored Plan design. Finally, access to specialists was noted as the third challenge, a widespread issue not limited to Tailored Plans.

Implications

The findings reported here highlight the overall satisfaction of behavioral health organizations for the 1115 North Carolina Waiver Tailored Plans for people with serious mental illnesses, substance use disorders, or intellectual/developmental disabilities. While findings do not suggest areas requiring Waiver and Tailored Plan redesign, a few issues warrant attention to smooth out implementation. Refining billing and claims adjudication processes may go a long way to increasing satisfaction with billing, bidirectional flow of information, and ultimately access to services. The state is likely already aware of such problem areas. Small group listening sessions with behavioral health organization staff responsible for billing and information flow, particularly those with rural locations, may highlight some unanticipated roadblocks. Small multi-stakeholder workgroups are a fruitful strategy to work out solutions. Ultimately, the state may enjoy long-term behavioral health organization support for the 1115 Waiver Tailored Plans if they hold the course and work out the remaining bumps with implementation.

Conclusions

Following the launch of Tailored Plans, the North Carolina Behavioral Health Provider Experience Survey captured baseline provider experience and satisfaction in the first year of contracting with the Tailored Plans. Findings reflect overall satisfaction of behavioral health organizations for the Tailored Plans. The positive overall experiences reported with the Tailored Plans speak to the quality of and access to guidance offered by the state to support adoption and work out any unanticipated issues. The positive experiences reported by small and medium organizations in particular, speak to the value of the Waiver design and Tailored Plans for behavioral health organizations and their clients with serious mental illnesses, substance use disorders, or intellectual/developmental disabilities. There were three areas identified for possible improvement: challenges getting claims approved, bidirectional flow of information, and access to specialists. However, the first two of these challenges appear related to early implementation rather than core problems with Waiver and Tailored Plan design. It seems likely that refining billing and claims adjudication processes may go a long way to increasing satisfaction with billing and bidirectional flow of information. In contrast, access to specialists is a widespread problem beyond Waiver and Tailored Plan design. Altogether, the Tailored Plans of North Carolina's 1115 Medicaid Waiver are working well for behavioral health organizations serving high-need populations of people with serious mental illnesses, substance use disorders, or intellectual/developmental disabilities. The successful implementation of these uniquely structured health plans is a huge accomplishment for NC Medicaid, the Tailored Plans, providers, and the patients they serve.

REFERENCES

1. Agency for Healthcare Research and Quality. *Compendium of U.S. Health Systems, 2018.*; 2019. https://www.ahrq.gov/chsp/data-resources/compendium-2018.html

2. Furukawa MF, Machta RM, Barrett KA, et al. Landscape of Health Systems in the United States. *Med Care Res Rev*. Published online 2019:1077558718823130.

3. Cohen GR, Jones DJ, Heeringa J, et al. Leveraging Diverse Data Sources to Identify and Describe U.S. Health Care Delivery Systems. *EGEMs Gener Evid Methods Improve Patient Outcomes*. 2017;5(3):9. doi:10.5334/egems.200

4. Machta RM, D Reschovsky J, Jones DJ, Kimmey L, Furukawa MF, Rich EC. Health system integration with physician specialties varies across markets and system types. *Health Serv Res*. 2020;55 Suppl 3:1062-1072. doi:10.1111/1475-6773.13584

5. Fisher ES, Shortell SM, O'Malley AJ, et al. Financial Integration's Impact On Care Delivery And Payment Reforms: A Survey Of Hospitals And Physician Practices. *Health Aff (Millwood)*. 2020;39(8):1302-1311. doi:10.1377/hlthaff.2019.01813

6. Colla C, Yang W, Mainor AJ, et al. Organizational integration, practice capabilities, and outcomes in clinically complex medicare beneficiaries. *Health Serv Res*. 2020;55(S3):1085-1097. doi:https://doi.org/10.1111/1475-6773.13580

7. Casalino LP, Wu FM, Ryan AM, et al. Independent Practice Associations And Physician-Hospital Organizations Can Improve Care Management For Smaller Practices. *Health Aff (Millwood)*. 2013;32(8):1376-1382. doi:10.1377/hlthaff.2013.0205

8. Spivack SB, Murray GF, Rodriguez HP, Lewis VA. Avoiding Medicaid: Characteristics Of Primary Care Practices With No Medicaid Revenue. *Health Aff (Millwood)*. 2021;40(1):98-104. doi:10.1377/hlthaff.2020.00100

9. The American Association for Public Opinion Research. *Standard Definitions: Final Dispositions of Case COdes and Outcome Rates for Surveys. 9th Edition.* AAPOR; 2016.

10. North Carolina Rural Center. How We Define Rural. December 22, 2025. https://www.ncruralcenter.org/how-we-define-rural/