NC MEDICAID MANAGED CARE QUALITATIVE EVALUATION

Results from the Medicaid Managed Care Launch Year 1 – Provider Perspectives

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➢ What is the NC Medicaid Managed Care Qualitative Evaluation?

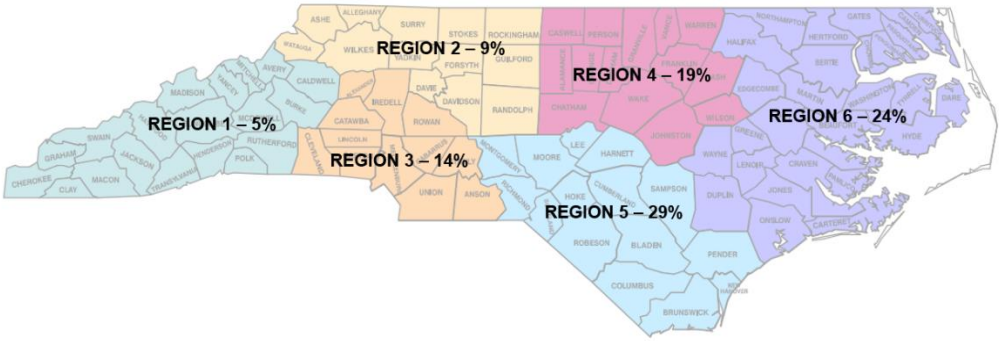
Qualitative interviews with organizational stakeholders (e.g., physician practices and health systems) are part of a larger multi-year evaluation of North Carolina Medicaid's transition from fee for service to Medicaid Managed Care under the 1115 demonstration waiver. The interviews provide a detailed account of organizational experiences during the first year of Medicaid Managed Care, November 2021 to October 31, 2022.

➢ How were interviews conducted?

We identified potential interviewees from multiple sources, including data from Medicaid provider files and publicly available information (e.g., the Department of Health and Human Services website). We sampled by organization/practice type (e.g., health system, independent practices), provider specialty type (primary care, pediatrics, etc.), and geographic location (Regions 1 to 6).

We conducted phone and email outreach to 139 health systems, health care practices, and local health departments and completed interviews with representatives of 26 of them. At each organization, we interviewed one or more representatives who could provide details of the transition to Medicaid Managed Care. Interviews were conducted between March and July 2022.

➢ Who participated in the interviews?



Participant Characteristics (Total participants = 41; total organizations represented = 26)	First interview	Repeat interview	Total
Specialty			
Internal Medicine/ Family Medicine	4	1	5
Pediatrics	4	5	9
*OBGYN**	0	0	0
Role			
Admin only	12	8	20
Leadership	9	3	12
Provider + admin	4	2	6
Provider only	2	1	3

**We reached out to 18 independent Obstetric practices. They were either unavailable or did not respond.*

Topics Covered During the Health System and Health Care Practice Interviews


Experience working with PHPs


Advanced Medical Home Status


Referrals


Member Assignment


Tailored Plan Implementation


Recommendations

Experience working with Prepaid health plans (PHPs)

Of the 26 participating health systems and practices, 14 had contracted with all five, 5 with four, and 4 with three PHPs. Three had contracted with two or fewer PHPs.

Participants reported mixed experiences in working with PHPs. Common factors that the participants considered were responsiveness, claim processing, reworking denials, and ease of using the website.

Concerns about working with the PHPs

- Timely communication with the PHPs to resolve issues
- Inconsistency in claim-filing requirements, e.g., modifiers
- Number of denials and incorrect payments
- Duration for which claims can be filed retrospectively
- Increased need for prior authorizations
- Access to timely and accurate data
- Coverage of services
- Administrative burden contributing to staff burnout

"The people we started out with, with the managed care plans, are no longer working for the managed care plans, or they've been moved to a different department. You can't get questions answered. You have to email people with questions. And you still, half the time, that doesn't get answered." (Administrator, large pediatric practice)

When asked about the decision to contract with the PHPs in the future, over half said they would likely continue to contract with the same number of PHPs. Most others reported considering contracting with fewer PHPs next year based on their experience.

Advanced Medical Home Status

18 of the participating independent practices and health systems had a Tier 3 advanced medical home status, of which 11 contracted with a Clinically Integrated Network (CIN), and 5 had an in-house care management infrastructure. Participants were highly satisfied with the care management through CIN partnerships.

Member Assignment

An overwhelming majority of participants described initial challenges with auto-assignment to a primary care provider, which improved over time. The concerns included:

- Access to member assignment lists
- Correcting member assignment
- Attribution of performance to primary care providers for wrongly assigned members
- Loss of revenue

"They did not produce their lists so that we could reconcile with our internal list and take out those patients assigned to our practice that we had not seen in a year. It was hard for—it took time for us to actually get that list and manipulate it." (Director of Revenue, FQHC)

Referrals to Specialists

Mental health services were identified as the ones most impacted. Other specialties impacted included cardiology, gastroenterology, and dermatology.

Behavioral Health and Intellectual/Developmental Disability Tailored Plans

12 of the participating practices and health systems were unsure about their participation in the BH/IDD tailored plans, and 4 had no intention to participate due to their experience of implementing Standard Plans. 6 were either gathering information or had contracts underway.

Recommendations

- Clear guidance from the state
  - Promote transparency in the accountability of PHPs
- More Resources
  - Member education
  - Workforce for care coordination
- Structural
  - Timely and accurate member lists
  - Data on quality metrics
  - Standardized processes across PHPs
  - Well-trained PHP representatives/liaisons
- Delay the implementation of the BH/IDD tailored plans