Medicaid Transformation Provider Experience Survey 2023

2023 Results Overview for Survey Participants

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 is 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 Prepaid Health Plans (PHPs) in the transition to Medicaid managed care. Survey findings will serve as a leading indicator for quality improvement for PHPs. This report details a general overview of findings at the end of the second 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. This year's survey was finalized in March 2023. We sampled and fielded the survey at the organizational level, given that most interactions with PHPs occur at the organizational (rather than individual clinician) level.

Survey Domains

Practice characteristics

Contacting/negotiating with PHPs

Experience with clinical and administrative factors

Overall perceived effects of PHPs on care delivery

Behavioral Health and Tailored Plans

How did you field the survey?

We used IQVIA OneKey data to identify 999 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 July 2023 from these identified organizations. Through our recruitment process using phone calls, mailings, and emails, we determined that approximately 57% of the organizations in our sample were eligible to receive the survey.

Who responded to the survey?

The table to the right summarizes overall characteristics of 346 respondent organizations. Our final response rate was 61%.

Our sample includes a diverse set of organizations, from solo practice physicians to large integrated delivery systems.

Organizational respondent overview

	Total (n = 346)
Ownership (self-reported)	
Health Systems	20 (6%)
Independent Practices/Medical Groups	326 (94%)
Size	
Small (1 – 2 physicians)	136 (39%)
Medium (3 – 9 physicians)	148 (43%)
Large (10+ physicians)	62 (18%)
Services (inclusive)	
Primary care	338 (98%)
Prenatal/Postnatal care	51 (15%)
Inpatient obstetrics care	30 (9%)

Contracting with PHPs

Rates of contracting with one of the five PHPs among surveyed provider organizations ranged from **73.3% to 97.2%.** Among medical groups and independent practices, the mean number of plans contracted with was **4.5.**

Respondents had very **similar dispositions toward each PHP**; mean overall ratings for the five PHPs (on a scale of 1 to 4, with 1 being “poor” and 4 being “excellent”) ranged from **2.52 to 2.65.**

Overall perceived effects of PHPs on care delivery

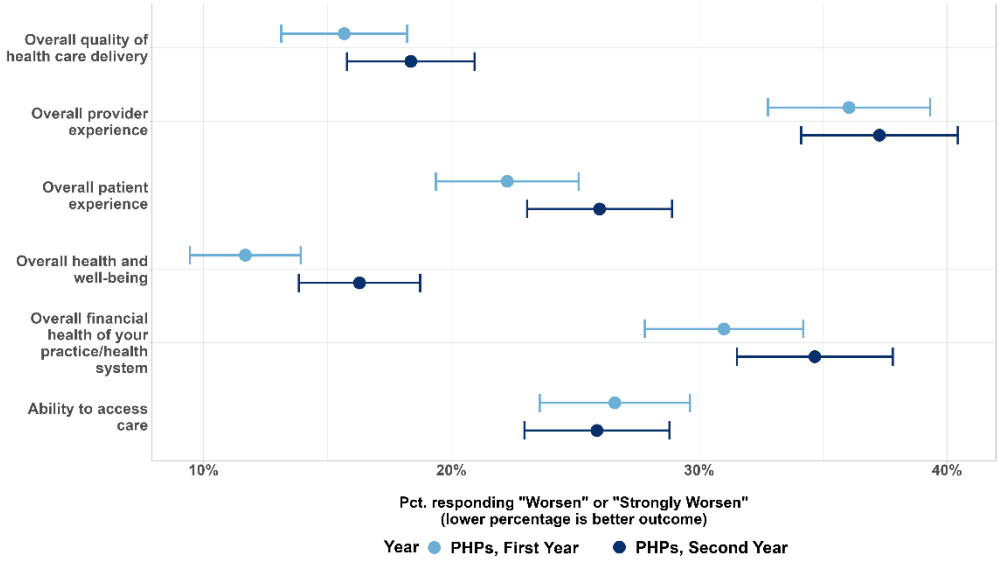
While most organizational respondents felt ambivalent about the effects of PHPs on care delivery, there was a significant increase in respondents feeling the PHPs have worsened or strongly worsened **overall health and well-being**.

Experience with clinical and administrative factors

We asked provider organizations about their experiences with each PHP on thirteen different 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.

Plans performed similarly to each other across clinical and administrative domains. **Compared with the first year into managed care, PHPs performed worse in administrative domains**. PHPs were rated worse on timeliness to answer questions and/or resolve problems, customer/member support services for patients, access to medical specialists for Medicaid patients, and access to needed drugs for Medicaid patients (formulary). Providers rated PHPs better on support for addressing social determinants of health.



Behavioral health and tailored plans

In this survey, we asked provider organizations about their approach to integration of care with behavioral health providers and their plans regarding the upcoming tailored plans. 25% of provider organizations reported that they have embedded or co-located behavioral health professionals in primary care offices. For those organizations without embedded or co-located behavioral health, the most common reasons were not enough space, unable to sustain a position with current reimbursement, burdensome administrative processes, and not enough demand from patients. 42% reported that they did not have access to a psychiatrist to support the Collaborative Care Model.

Regarding plans to contract with Behavioral Health and Intellectual/Developmental Disability Tailored Plans, 62% said yes, compared with 30% the previous year. 25% were not aware of tailored plans. These responses suggest that some primary care and Ob/Gyn practices may not understand any potential care delivery changes and resources that may become available for these populations.

To learn more about our survey results or our multi- year Medicaid transformation evaluation, contact us at : medicaideval@unc.edu