2022 Medicaid 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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EXECUTIVE SUMMARY

With the 1115 Medicaid Waiver, the North Carolina Medicaid program transitioned from predominately fee-for-service to managed care through the offering of Prepaid Health Plans (PHPs).The North Carolina Provider Experience Survey was developed to evaluate the influence of the North Carolina 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.

In this report, we describe findings from the second assessment of provider experience and satisfaction with the North Carolina Medicaid program, which was conducted from April through June 2022, representing experience with the PHPs from the first year of Medicaid managed care. We refer to this year's survey as the Medicaid Provider Experience Survey – One Year into Managed Care ("Y1MC"). Findings from the report include that the five major health plans had high rates of contracting with provider organizations. Rates of contracting with one of the five private health plans ranged from 73.3% to 94.5. Among medical groups and independent practices, the mean number of plans the organization contracts with was 4.3 (SD: 1.3).

Respondents were given the options to rate their experience in each domain on a scale from "poor" (equivalent to 1 numerically) to "excellent" (equivalent to 4). Respondents had similar dispositions toward each PHP; mean overall ratings for the five ranged from 2.56 to 2.69. In sum, the similarity in overall ratings across plans indicates that providers do not report substantial differences among the PHPs. Furthermore, plans perform similarly in a more granular analysis of thirteen separate domains of provider experience covering both clinical and administrative factors. Overall, providers rate experience with plans on clinical factors (e.g., network adequacy) worse than on administrative factors (e.g., claims processing), while qualitative comments reveal administrative burden which, providers state, have harmed patient access to care. Access to behavioral health prescribers and therapists were rated worse than all other domains, though were still rated better for PHPs than for Legacy NC Medicaid.

Across all domains, we find that large provider organizations rated their experience with the health plans worse than smaller provider organizations. In contrast, there were no differences between organizations with rural practice sites compared with those with no rural practice sites, nor were there differences between those providing inpatient obstetrics care or prenatal/postnatal care compared with those that provided solely primary care services.

Finally, as compared with the baseline measurement of provider experiences with Legacy NC Medicaid prior to implementation of the transition, PHPs as a whole performed similarly, with a few exceptions. Providers rated PHPs better than Legacy NC Medicaid on access to behavioral health prescribers and therapists. However, PHPs were rated worse than Legacy NC Medicaid on timeliness of claims processing and provider relations overall, which qualitative comments on the survey support.

Figure E1: Experience and satisfaction with administrative domains, Legacy NC Medicaid vs. Pre-Paid Health Plans

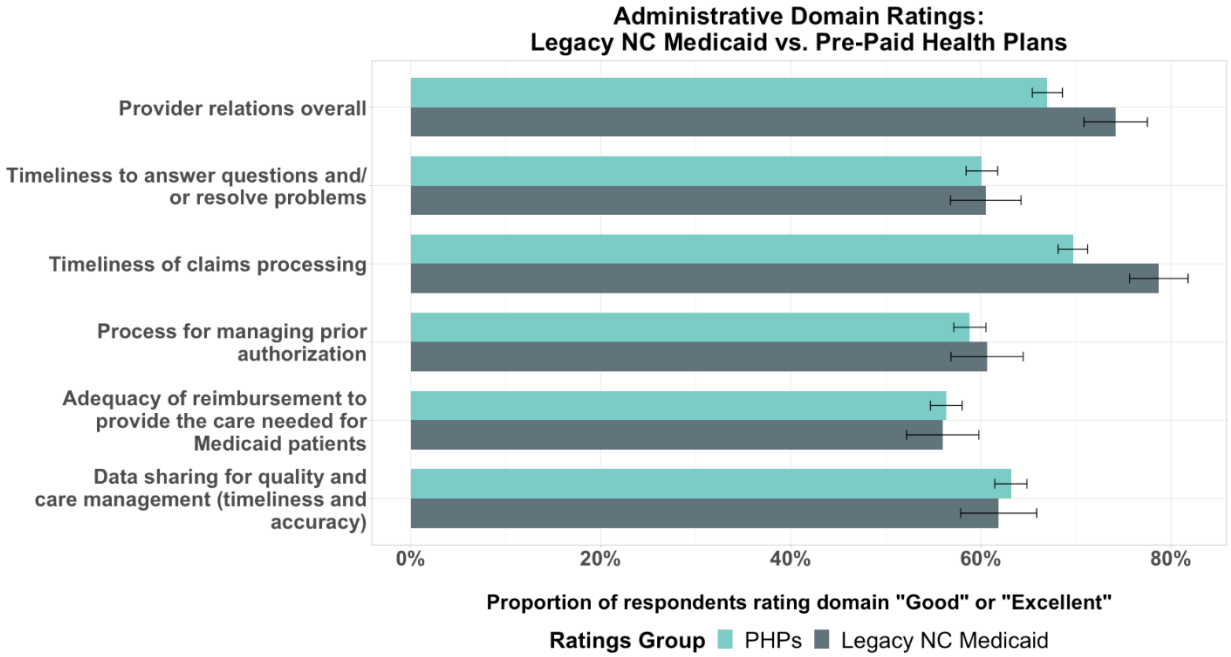
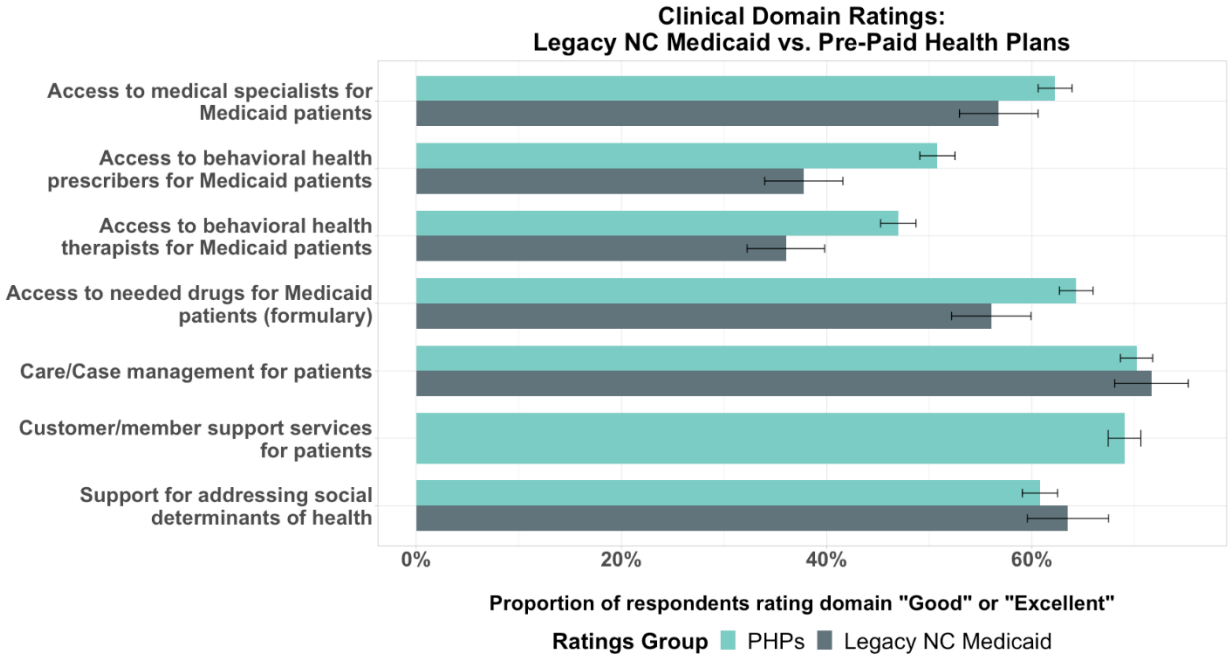


Figure E2: Experience and satisfaction with clinical domains, Legacy NC Medicaid vs. Pre-Paid Health Plans



Note: Customer/member support services for patients was only asked in the 2022 survey

Key Findings

- Rates of contracting with each of the five available PHPs ranged from **73.3% to 94.5%**, and the organizations contracted with an **average of 4.3 plans.**
- We found **small but meaningful differences** in provider experience with PHPs compared with Legacy NC Medicaid prior to the transition.
    - PHPs performed better than Legacy NC Medicaid on the following domains:
        - Access to medical specialists for Medicaid patients
        - Access to behavioral health prescribers for Medicaid patients
        - Access to behavioral health therapists for Medicaid patients
        - Access to needed drugs for Medicaid patients (formulary)
    - PHPs performed worse than Legacy NC Medicaid on the following domains:
        - Provider relations overall
        - Timeliness to answer questions and/or resolve problems
        - Timeliness of claims processing
        - Care/case management for patients
- We did **not find large, meaningful differences** between PHPs on performance domains. Overall, providers rated their experience with plans on clinical factors (e.g., network adequacy) slightly worse than on administrative factors (e.g., claims processing).
- Open-ended comments reveal **notable administrative burden** in sustaining multiple PHP relationships which providers say has ultimately harmed patient access to care and is a stress on the healthcare system more broadly.
- **Access to behavioral health prescribers and therapists** were rated substantially worse than all other domains.
- Large provider organizations rated their experience with the health plans worse than smaller provider organizations. We found no difference in experience comparing rural versus non-rural.

Recommendations for the Department of Health Benefits

- Differences between PHPs were small and not meaningful; in contrast, differences across domains were larger. Put another way, plans are generally all performing similarly on any given domain, meaning domains with poor ratings of provider experience are rated poorly for all plans, and domains with better ratings of provider experience are rated well for all plans. Therefore, the Department of Health Benefits (DHB) may find it useful to approach improvement in provider experience as a collective endeavor with all participating PHPs, rather than trying using differences between plans as a point of leverage. Improvement will likely require collective action by PHPs and possibly policy levers at DHB to improve experience.
- One domain DHB should prioritize as a target area for intervention is behavioral health. Although plans have improved provider ratings of behavioral health access over Legacy NC Medicaid, these domains were still the worst rated of all domains. Potential policy actions that may improve plan performance for behavioral health include strengthening network adequacy requirements for behavioral health; adjusting the minimum required reimbursement threshold for behavioral health providers, especially in underserved

regions; considering telehealth or technological innovations; and collecting additional data on access through things such as audit studies. Plans may also have important ideas for continuing to improve this problem, given they have achieved some success at improving over Legacy NC Medicaid. Behavioral health has proved challenging across both the private and public sector, but the health plans may be able to draw upon their experiences with contracting arrangements to collaborate with DHB to develop improvement plans.

- A second area of priority is timeliness of the claims process. This domain scored worse for the PHPs than for Legacy NC Medicaid, and numerous open-ended comments support this finding. DHB could pursue steps such as investigating provider claims of nonpayment by inviting providers to report such instances or considering regulatory levers to ensure practices are paid in a reasonable amount of time (e.g., penalties, interest). Open-ended comments suggested continued challenges in this domain is a reason practices may end participation in the Medicaid program moving forward.
- In open ended comments, providers reported a heavy administrative burden of working across five plans, each with differing processes. To reduce this burden, DHB may consider ways to standardize or encourage standardization across plans in processes, administration, and interaction with providers.

OVERVIEW

Purpose

The overall goal of this annual provider survey is to assess health system and practice experience and satisfaction with pre-paid health plans (PHPs) 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) 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 baseline annual survey, please see the report posted at this link.

Objectives

The objectives of the **baseline** survey were to:

1. Evaluate satisfaction with support for healthcare quality in the Legacy NC Medicaid program
2. Evaluate experience with the administrative process in the Legacy NC Medicaid program
3. Serve as a baseline for comparison against Pre-Paid Health Plan (PHP) performance in future years

The objectives of this Medicaid Provider Experience Survey - One Year into Managed Care **(Y1MC)** survey were to:

1. Assess changes in provider experience and satisfaction with the state's Medicaid program between the Legacy NC Medicaid program and PHPs
2. Evaluate provider experiences with each PHP
3. Understand provider contracting decisions regarding medical homes
4. Understand provider capabilities for behavioral health

The state will use findings as an 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.

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. Items were reviewed by a series of subject matter experts including faculty at the University of North Carolina at Chapel Hill as well as leaders in health system and primary care practices in North Carolina. The Carolina Survey Research Laboratory and the North Carolina Department of Health and Human Services 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 covered several broad domains. The final domains for the 2021 baseline survey were:

- Background items
  - Examples: respondent's role at the organization, contact information, organizational information, organization's Medicaid involvement
- Practice characteristics
  - Examples: type of organization, Independent Practice Association/Clinically Integrated Network participation and support, Medicaid patient population, medical home, and accountable care organization participation
- History and overall experiences working with the Medicaid program
- Overall expectations from Medicaid transformation
  - Examples: quality, cost, and patient experience
- Contracting/negotiating with PHPs
  - Examples: current contracting approach and priorities, overall experience thus far with PHPs

The questionnaire for the 2022 Medicaid Transformation Provider Experience Survey (Y1MC) covered the following domains:

- Background items
  - Examples: respondent's role at the organization, contact information, organizational information, organization's Medicaid involvement
- Practice characteristics

    - Examples: type of organization, Independent Practice Association/Clinically Integrated Network participation and support, Medicaid patient population, medical home, and accountable care organization participation
- Contracting with PHPs
    - Examples: current contracts, plans to add or drop contracts, Medical Home arrangements
- Overall perceived effects of PHPs on care delivery
    - Examples: overall health and well-being, quality of health care delivery, patient experience, provider experience
- Behavioral Health and Tailored Plans
    - Examples: co-located behavioral health professionals, Collaborative Care Model, contracting with tailored plan

These themes are intentionally broad to address the numerous ways that Medicaid and PHPs 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 were limited and skip patterns were incorporated to reduce time required to complete the questionnaire.

Sample Description

The target population for the survey was all primary care/Ob-Gyn practices and health systems in North Carolina that accept Medicaid. After deliberation and consultation in conjunction with the Department of Health Benefits (DHB), the questionnaire was administered to every organization that met our inclusion criteria (accepting Medicaid and providing primary care or Ob/Gyn care). The questionnaire was sampled and fielded at the highest organizational level, such as the health system or medical group when applicable. This decision to field the survey at the highest organizational level was based on factors such as contracting and data sharing occurring at the organizational level rather than individual or clinician levels. Thus, our sample includes a diverse set of organizations, from solo practice physicians to very large integrated delivery systems. Every medical group, independent practice, and system in our sample frame was invited to participate in the survey, a total of 1,243 potential respondents.

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 medical groups, as well as the health systems or other corporate parents that own practices. As a result, these data allow us to more

accurately identify and survey healthcare organizations and groups where Medicaid transformation and implementation 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.

The IQVIA OneKey database provides a robust set of data elements for North Carolina MD/DO, nurse practitioners, physician assistants, and health departments, as well as information about health systems and corporate parents linked with these providers sourced in December 2021. Data included all individual clinician NPIs in medical groups or independent practices identified with outpatient primary care and Ob/Gyn care, using the following Class of Trade specialties: Family Practice, General Practice, Geriatric Medicine, Internal Medicine, Multi-specialty practice, Ob/Gyn, Pediatric Medicine, Preventative Medicine, and Primary Care.

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 the first wave of the survey, we achieved a 96% match rate of individual NPIs in the IQVIA data to the NC Medicaid data. After the baseline survey, we were able to match more individual NPIs in the IQVIA data to the NC Medicaid provider file, achieving close to 100% matching NPIs. This ensured we accurately captured nearly all eligible organizations for the Medicaid Provider Experience Survey - One Year into Managed Care, or Y1MC. This resulted in an increased number of organizations to be included in the sample frame cleaning and outreach (668 in baseline vs. 1,243 in Y1MC). IQVIA data identify both the medical group or independent practice where a provider worked, as well as the owner of the group or practice, such as a larger, multi-site medical group or integrated delivery system. For sampling, medical groups and practices were rolled up to the largest organizational entity (e.g., a health system, or large medical group). This resulted in a final sample of 202 larger corporate entities (including health systems and larger medical groups) and 1,041 independent practices and medical groups, as defined by IQVIA organizational designations. All organizations from the IQVIA data that had at least one NPI and were matched to the Medicaid provider file were surveyed and further screened for organizational eligibility with sample cleaning processes (described below) and the questionnaire itself.

The higher match rate in the second wave (Y1MC) yielded a larger total population we reached out to with surveys. The additional organizations included in the sample frame were largely very small organizations (e.g., a single NPI, such as a solo practice), mainly because large practices and health care systems are already represented in our data, so additional matched NPIs at those do not yield additional organizations to survey; in contrast, solo practice NPIs are all added to our sample. However, through the sample frame cleaning process (described below), we determined most of the additional sample of tiny practices were not eligible for the survey; for example, many were not operating as practices, or represent measurement error in the IQVIA data. These practices were deemed as ineligible and excluded from the sample.

Sample Frame Cleaning

The term “sample frame cleaning” refers to the research team’s process of refining and validating the sample of potential survey respondents, such as ensuring that all of the practices in the sample

exist, and removing practices that are closed or a mistake in the data. A multi-pronged approach was used to identify appropriate individual survey respondents at different types of organizations identified in the sample frame. IQVIA's size and corporate parent designations were used to parse the 59 larger medical groups and health systems (4.8% of the sample) as they would require a more deliberate approach. These were separated from the rest of the sample for a more targeted frame cleaning process.

For large health systems, once the contact point was determined, a member of the research team contacted health system leaders with an email asking to confirm their contact information and identify their preferred method (email or mail) of receiving the questionnaire. If no response was received after three business days, a member of the research team contacted the health system leader with a phone call to confirm their contact information and identify their preferred method (email or mail) of receiving the questionnaire. If no response was received within one week, the research team identified a new health system contact and repeated the above process.

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 lead physician.

As part of frame cleaning, phone calls were made 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 removed from the sampling frame if the given telephone was no longer operating or connecting to the practice and a follow up web search could not produce an alternative telephone number or mailing address for a given practice. Several attempts were made to these practices before removing them from the sample.

Data Collection

All potential respondents (n=1,243) 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. Email invitations were also sent at this time to all respondents who participated in last year's survey and had provided an email address.

Follow-up packets were mailed to all non-responders three weeks later, at which time follow-up telephone calls were implemented. 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 resupply the participant with his or her preferred survey mode (i.e., URL link & password for an online survey, paper survey or faxed survey). Respondents who completed the questionnaire will receive a $30 gift card to compensate them for their time.

Final response rate

Survey responses were collected between April 13, 2022, and July 29, 2022. The final response rate was 50.2%. **Table A** summarizes response for all sampled organizations. Potential respondents were removed from the sample frame if we determined the potential respondent organization was closed, not operating as a medical practice, or did not exist. Respondents were determined as ineligible if we confirmed the organization existed as a medical practice, but they did not take Medicaid or did not provide primary care or Ob/Gyn services. This yielded an eligibility rate from the original sample frame was 62.9%. For a small subset of our potential respondents, we were unable to determine eligibility. We calculated a response rate using the American Association for Public Opinion Research (AAPOR RR4) formula that adjusts for unknown eligibility of respondents.[9]

Table A. Response rate & final dispositions of sample frame.

Final designations	**Total Response**
	Count (%)
Completed & eligible respondents	394 (31.6%)
Refusals of eligible respondents	353 (28.4%)
Ineligible for survey	285 (22.9%)
Unknown eligibility	58 (4.7%)
Not operating as practices	154 (12.4%)
Total	**1,243**

To account for non-response, survey weights were developed using the total number of PCP and Ob/Gyn NPIs per organization, as well as whether respondent organization had any primary care or Ob/Gyn practice locations in rural zip codes, as defined by the US Census rural-urban commuting area (RUCA) codes.

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

Health Plan Experience Domains

In this report, results are presented in 13 individual domains of health plan services. Factor analysis was performed to provide summary assessments of the individual domain items. The factor analysis indicated the 13 items to be unidimensional. Due to their unidimensional nature, we combined them into one overall summary score. Two subscales were created and defined as clinical and administrative as a clear delineation of categories between domains was established. **Table B** lists all items and whether they were categorized as clinical or administrative**.** Where

mean ratings on individual and categorized domains are provided, our ratings scale ranges from 1 (poor) to 4 (excellent). Please note that Legacy NC Medicaid estimates are from the baseline survey.

Table B: 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

SURVEY RESPONDENT CHARACTERISTICS

Table 1. Health system and practice characteristics for survey respondents (unweighted)

Health System and Practice Characteristics	Self-Identified Health Systems (N = 14)	Self-Identified Medical Groups and Independent Practices (N = 380)
	N (%) or Mean (SD)	N (%) or Mean (SD)
Respondent		
Role of Respondent		
Practice Manager	2 (14.3%)	255 (67.1%)
Medical Director	1 (7.1%)	25 (6.6%)
Other	11 (78.6%)	99 (26.1%)
Practice Composition		
Services Provided for Patients with Medicaid		
Primary Care	14 (100.0%)	371 (97.6%)
Prenatal/Postnatal Care	10 (71.4%)	32 (8.4%)
Inpatient Obstetrics Care	11 (78.6%)	12 (3.2%)
Number of Providers (IQVIA-sourced)		
1-2 providers	0 (0.0%)	261 (68.7%)
3-9 providers	1 (7.1%)	95 (25.0%)
10 or more providers	13 (92.9%)	24 (6.3%)
Geography		
No Rural Practice Sites (NCRC)	2 (14.3%)	192 (50.5%)
Any Rural Practice Sites (NCRC)	12 (85.7%)	188 (49.5%)
Ownership		
Independent Medical Practice at a Single Site	n/a	300 (79.0%)
Medical Group (multiple practices owned by a single owner)	n/a	44 (11.6%)
Other	n/a	36 (9.5%)
Part of a Clinically Integrated Network (CIN) for Medicaid work	7 (50.0%)	222 (58.6%)

Highest Tier of Medical Home Attestation with State (among primary care provider organizations)		
Tier 3	7 (50.0%)	199 (53.6%)
All else	7 (50.0%)	172 (46.4%)
Participation in an Accountable Care Organization (ACO) with any payor	8 (57.1%)	141 (37.7%)
<u>Practice Service to Medicaid Beneficiaries</u>		
Percentage of patients served that are insured by Medicaid	16.25 (9.94)	35.20 (25.54)
Limit on Percentage of Patients with Medicaid		
Yes	0 (0.0%)	58 (15.3%)
No	14 (100.0%)	295 (77.8%)
Unsure	0 (0.0%)	26 (6.9%)
Mean <u>limit</u> that practice/system places on percentage of patients with Medicaid Insurance *(if yes to above)*	n/a	15.1 (19.1)
<u>Contracting with Pre-Paid Health Plans</u>		
Number of PHPs that practice/system is currently contracting with	4.4 (1.0)	4.3 (1.3)

Notes: Any data categories which do not add to our final response n=394 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 = 380) that self-identified as such and all health system respondents (unweighted n = 14). All subsequent figures reported in this section are weighted.

Contracting with Prepaid Health Plans (PHPs)

The following questions and findings are related to provider organizations' relationships with PHPs. We asked practices to identify the standard PHPs that they contracted with.

Table 2. Provider organizations' contract arrangements with standard PHPs in North Carolina Medicaid

For the below listed standard Prepaid Health Plans (PHPs), have you contracted with the following plans?	
PHP	**Response: Yes N (%)**
Ameri-Health Caritas North Carolina	318 (81.1%)
BCBSNC Healthy Blue	372 (94.5%)
United Health Care	357 (90.9%)
WellCare Health Plans	349 (88.9%)
Carolina Complete Health*	285 (73.3%)

Note: *Because Carolina Complete Health is geographically limited, they do not contract with as many providers. Among providers that have practices in the Carolina Complete Health regions, they contract with 86.3%.

Among provider organizations that did not contract with all standard PHPs, when asked if they anticipated adding any new standard plan PHP contracts in the coming year, practices reported as follows:

- 20 (14.7%) Yes
- 113 (85.3%) No

When asked if they anticipated dropping any standard plan PHP contracts in the coming year, provider organizations reported as follows:

- 43 (11.0%) Yes
- 349 (89.0%) No

Write-in responses: If you answered NO to any of the options in the first two questions on the previous page, can you comment on why your health system/practice has not contracted with or is not planning to contract with that health plan?

Themes write-in responses (from most common to least common)

- Plan not offered in area or had no patients with that plan (e.g., lack of need)
- Plan did not respond to our communication efforts
    - Quote: "We have had an extremely hard time getting contracted with any of the Prepaid care plans, therefore the doctor has not got paid for a lot of his time spent with patients ever since the move from Medicaid. It has been a huge headache, trying to find the answers and what we need to do, to get contracted, sending emails, calling for help, spending A LOT of time on this process and STILL not contracted, so STILL not getting paid."
- Too many options
    - Did not want to have a lot to keep up with right at the beginning; wanted to see how things would pan out first
    - Quote: "In order to keep it simple, we chose only one plan"
    - There were too many plans and websites were overwhelming
    - Quote: "Patients and staff are confused. Concern about admin burden"
- Problems
    - Payment challenges
        - Quote: "IF we were to drop an insurance contract with one of the insurance companies, it would be [PHP name omitted] due to issues trying to receive payment EOBs from the payspan website. I have reached out to payspan numerous times and have yet to have any issues resolved."
        - Quote: "[PHP name omitted] is not paying us properly. They deny stating the ID# can't be found and I have had to refile claim after claim. Fax claims from 2021 that have not been paid. It has been a nightmare. But on their website the patient comes up with their ID# as active patient. Then it denies stating member ID can't be found…only 1 girl files the claims."
        - Quote: "[PHP name omitted] is much more complicated to participate with as an integrated mental health practice because the mental health claims all get sent to their mental health subsidiary, [PHP name omitted]. Going from one computer claims system (Medicaid Direct) to the multiple PHP computer system was predicted to be difficult- and it still is, we still have claims that are not paying correctly [x] months later. They are working on it, there has been progress, but bottom line we have MUCH more administrative hassle to get paid than we used to."
        - Quote: "I continue to have problems with getting paid when Medicaid is 2nd. I have [talked to] provider relations so many times with no results. The issues are many."
        - Lack of coverage and denials for necessary tests and procedures
        - Decrease in reimbursement – e.g., "reimbursement reliability," "practice lost revenue during the transition process"
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        - Decrease in reimbursement – e.g., "reimbursement reliability," "practice lost revenue during the transition process"

    - Unable to reach agreement due to PHPs tying other objectives to Medicaid contracts/performance items
    - Administrative burden/customer service
        - Quote: "We have had nothing but trouble with this program. We will add no more and are considering opting out completely. This has been a nightmare."
        - Quote: "The five PHPs we are already contracted with are causing enough pain and turmoil. We will NOT be adding to that situation." [regarding tailored plans]
    - Lack of PHP presence pre go-live date
- Not taking new Medicaid patients

When asked if their provider organization currently limits the percentage of patients with Medicaid that they will take, they responded as follows:

- 58 (14.7%) Yes
- 308 (78.5%) No
- 27 (6.8%) Unsure

Medical Homes

When asked what tier of medical home their provider organization attested to with the state of North Carolina (non-exclusive), organizations providing primary care reported as follows:

- 17 (6.4%) Tier 1
- 56 (20.8%) Tier 2
- 206 (76.2%) Tier 3
- 115 (29.8%) Not Applicable (exclusive)

Note: We recommend interpreting these numbers with caution due to unusually high rate of "Not Applicable" responses.

Table 3: Provider organizations' medical home contracts with PHPs in North Carolina Medicaid, from July 2021 – June 2022

PHP	Tier 1 N (%)	Tier 2 N (%)	Tier 3 N (%)	Not Applicable N (%)
Ameri-Health Caritas North Carolina	11 (2.8%)	32 (8.1%)	182 (46.1%)	169 (43.0%)
BCBSNC Healthy Blue	14 (3.6%)	47 (12.0%)	187 (47.6%)	145 (36.9%)
United Health Care	12 (3.0%)	43 (11.0%)	187 (47.5%)	152 (38.5%)

WellCare Health Plans	14 (3.6%)	39 (10.0%)	190 (48.3%)	150 (38.2%)
Carolina Complete Health[1]	*	32 (8.0%)	155 (39.3%)	200 (50.7%)

*Suppressed due to small cell sizes

Note: We recommend interpreting these figures with caution, as there was an unusually high rate of "Not Applicable" responses

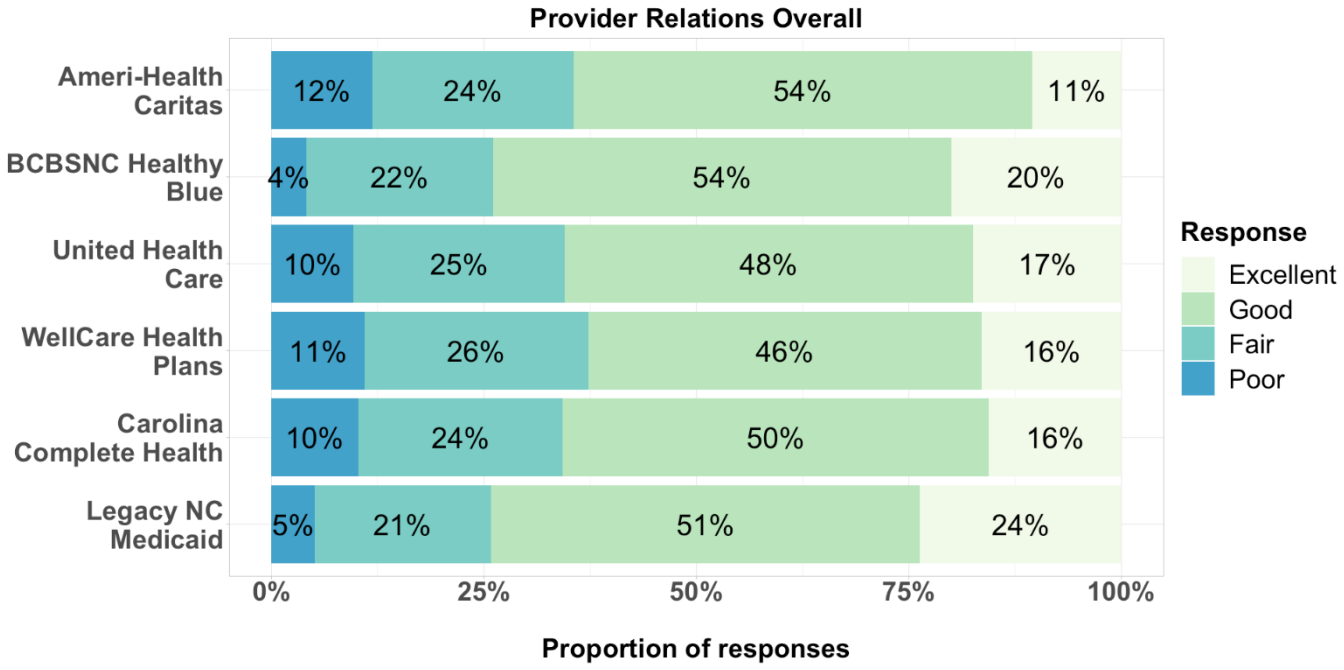
Satisfaction with Prepaid Health Plans (PHPs)

Table 4. Overall satisfaction of provider organizations with PHPs

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Provider Relations Overall*	
PHP	**Mean (Standard Error)**
Ameri-Health Caritas North Carolina	2.63 (0.03)
BCBSNC Healthy Blue	2.90 (0.03)
United Health Care	2.73 (0.03)
WellCare Health Plans	2.68 (0.03)
Carolina Complete Health	2.71 (0.04)
Legacy NC Medicaid (i.e., prior to transition to PHPs)	2.93 (0.03)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey.

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



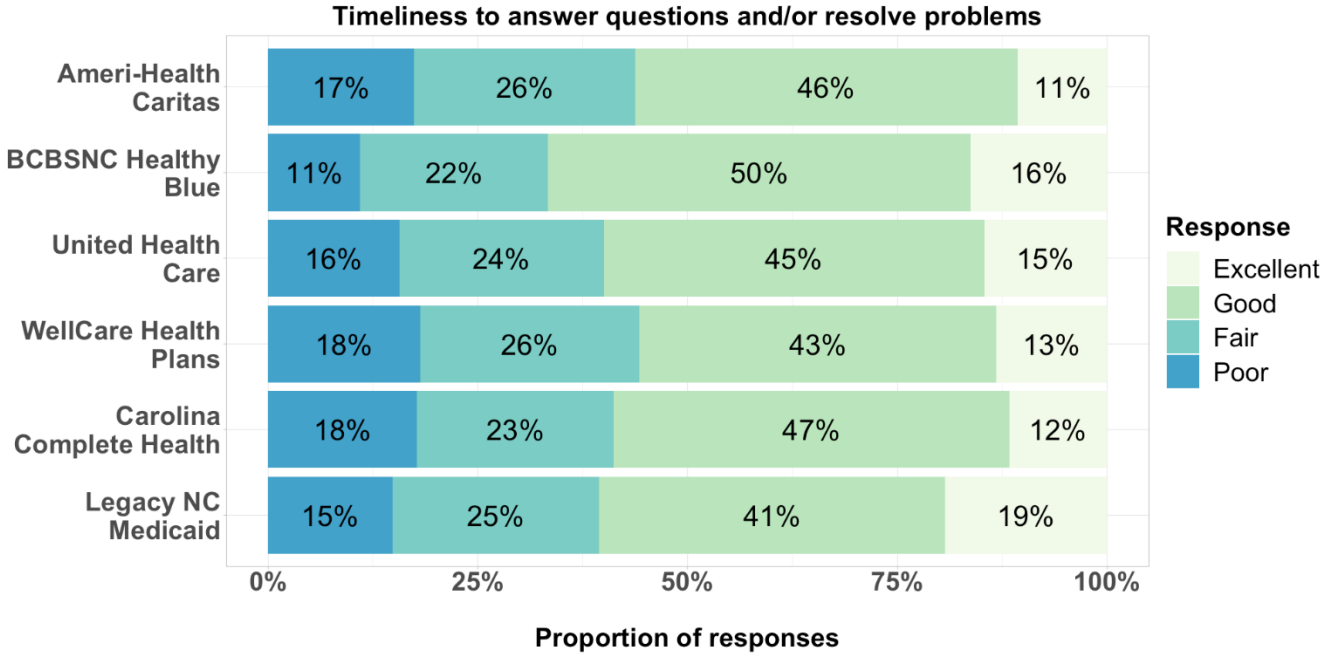
Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

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

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Timeliness to answer questions and/or resolve problems*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.50 (0.04)
BCBSNC Healthy Blue	2.72 (0.03)
United Health Care	2.59 (0.03)
WellCare Health Plans	2.51 (0.04)
Carolina Complete Health	2.53 (0.04)
Legacy NC Medicaid (i.e., prior to transition to PHPs)	2.65 (0.04)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

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



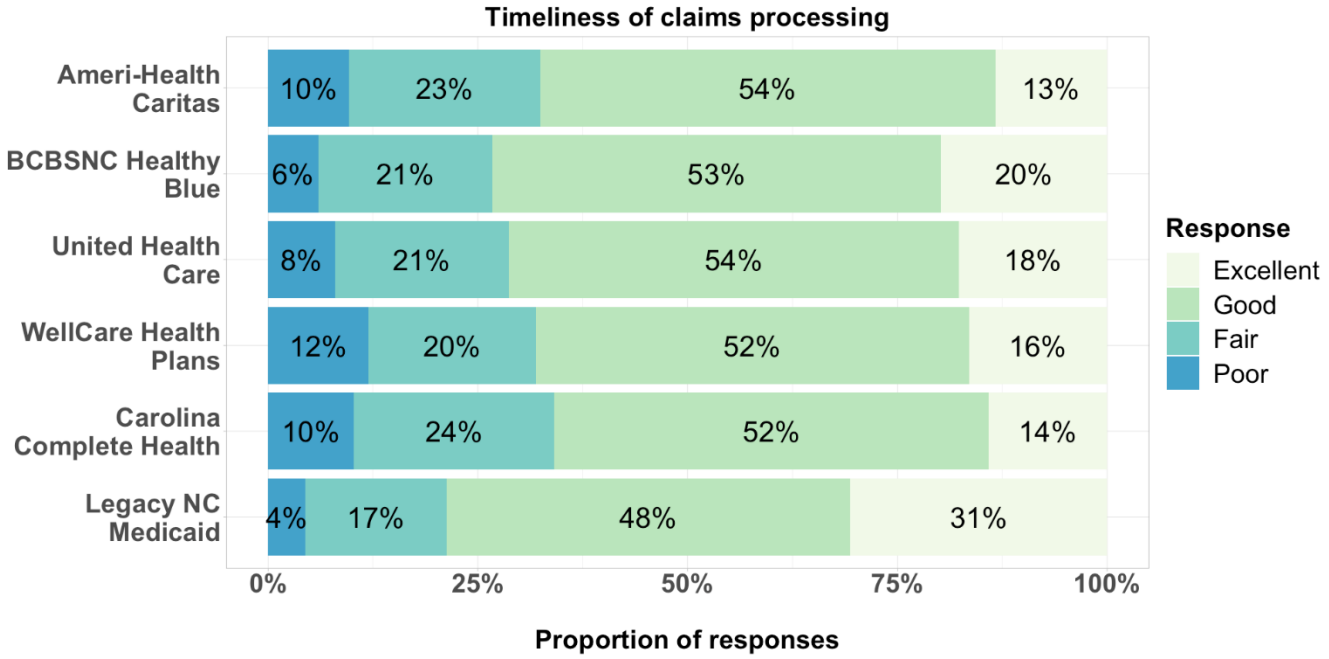
Notes: Legacy NC Medicaid estimates are from our wave 1 baseline survey.

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

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Timeliness of claims processing*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.71 (0.03)
BCBSNC Healthy Blue	2.87 (0.03)
United Health Care	2.81 (0.03)
WellCare Health Plans	2.73 (0.03)
Carolina Complete Health	2.70 (0.04)
Legacy NC Medicaid (i.e., prior to transition to PHPs)	3.05 (0.03)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

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



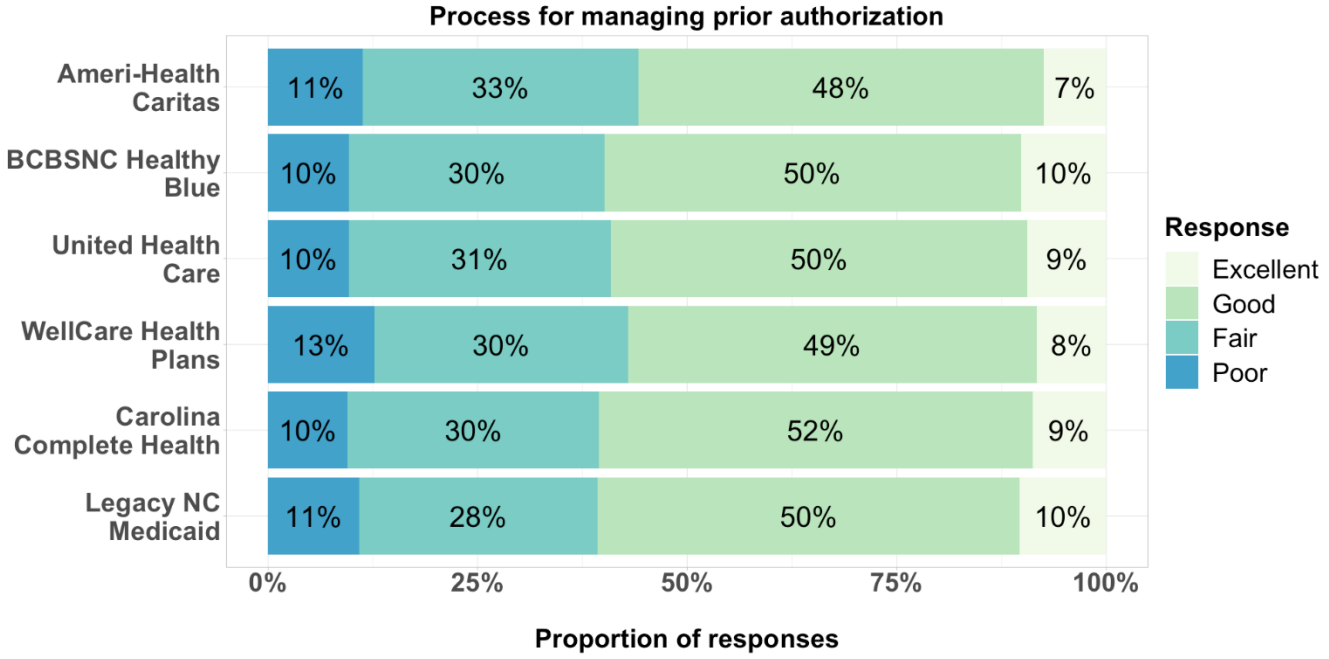
Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

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

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Process for managing prior authorization*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.52 (0.03)
BCBSNC Healthy Blue	2.61 (0.03)
United Health Care	2.59 (0.03)
WellCare Health Plans	2.53 (0.03)
Carolina Complete Health	2.60 (0.03)
Legacy NC Medicaid (i.e., prior to transition to PHPs)	2.60 (0.03)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

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



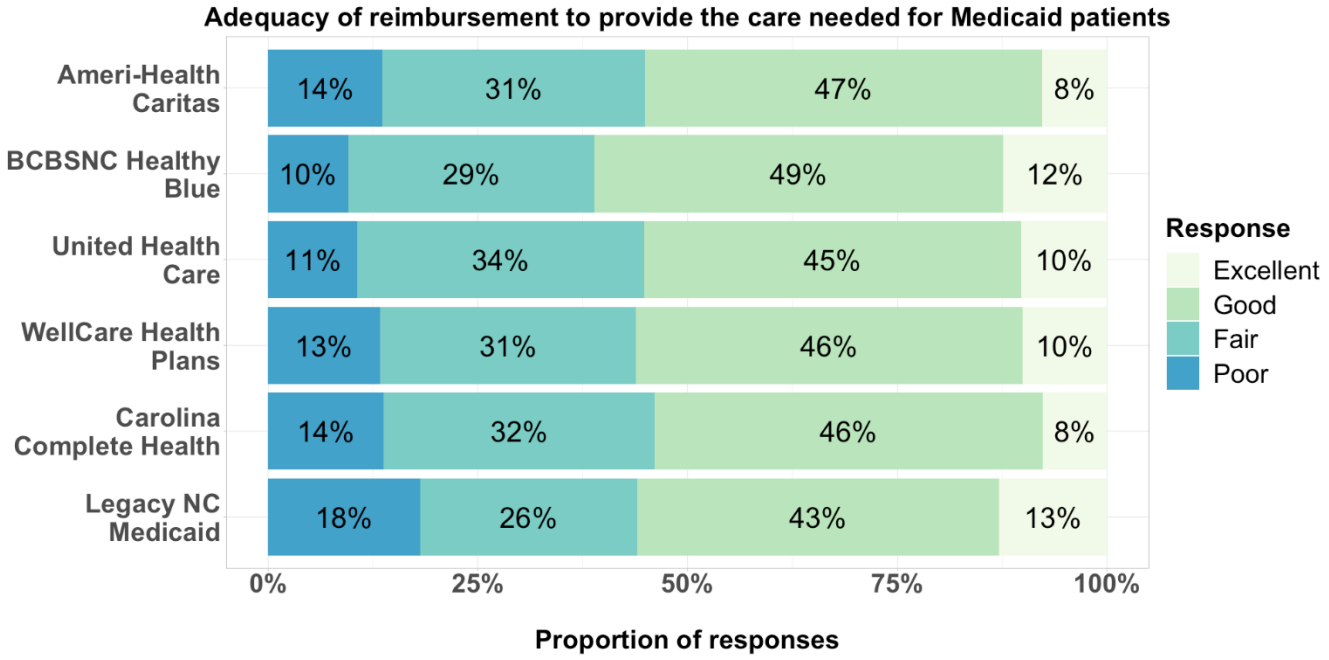
Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

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

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Adequacy of reimbursement to provide the care needed for Medicaid patients*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.49 (0.03)
BCBSNC Healthy Blue	2.64 (0.03)
United Health Care	2.54 (0.03)
WellCare Health Plans	2.53 (0.03)
Carolina Complete Health	2.48 (0.04)
Legacy NC Medicaid (i.e., prior to transition to PHPs)	2.51 (0.04)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

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



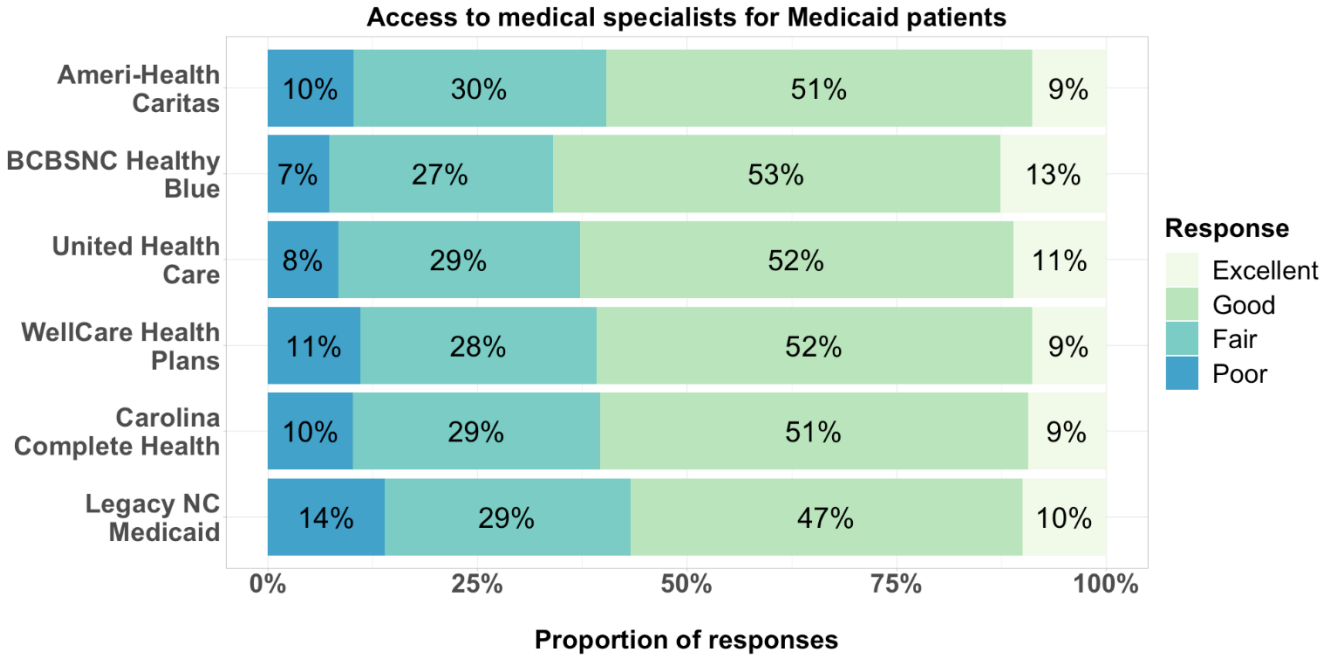
Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

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

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Access to medical specialists for Medicaid patients*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.58 (0.03)
BCBSNC Healthy Blue	2.72 (0.03)
United Health Care	2.65 (0.03)
WellCare Health Plans	2.59 (0.03)
Carolina Complete Health	2.60 (0.03)
Legacy NC Medicaid (i.e. prior to transition to PHPs)	2.53 (0.03)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

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



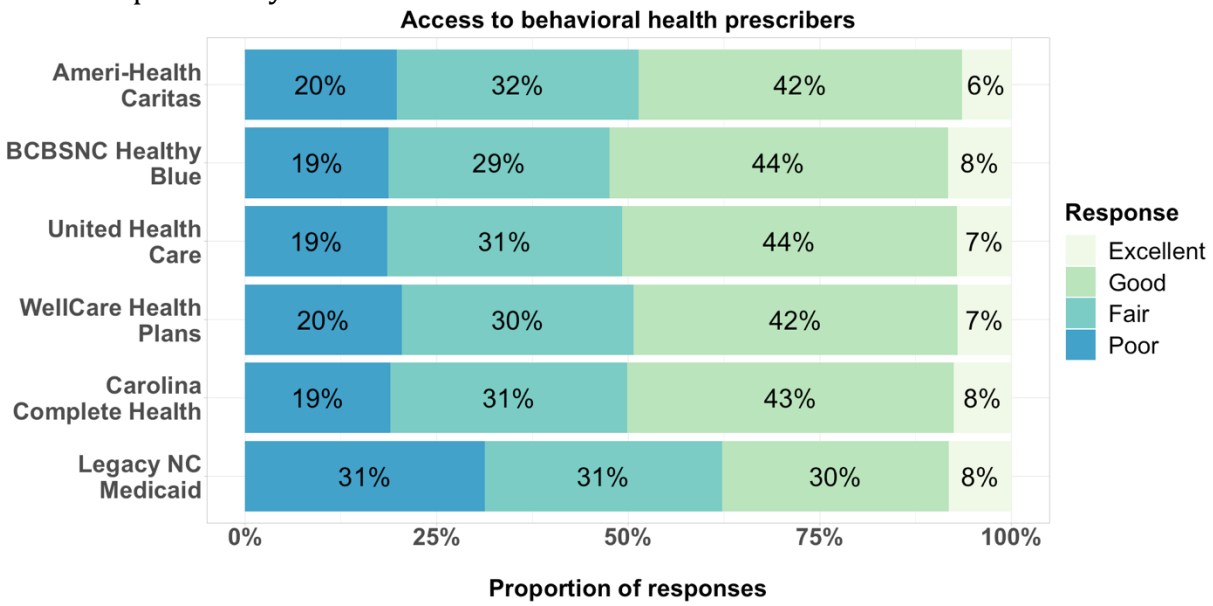
Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

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

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Access to behavioral health prescribers (e.g., psychiatrists, psychiatric nurse practitioners, or physician assistants) for Medicaid patients*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.36 (0.04)
BCBSNC Healthy Blue	2.43 (0.03)
United Health Care	2.40 (0.03)
WellCare Health Plans	2.37 (0.03)
Carolina Complete Health	2.39 (0.04)
Legacy NC Medicaid (i.e. prior to transition to PHPs)	2.15 (0.04)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

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



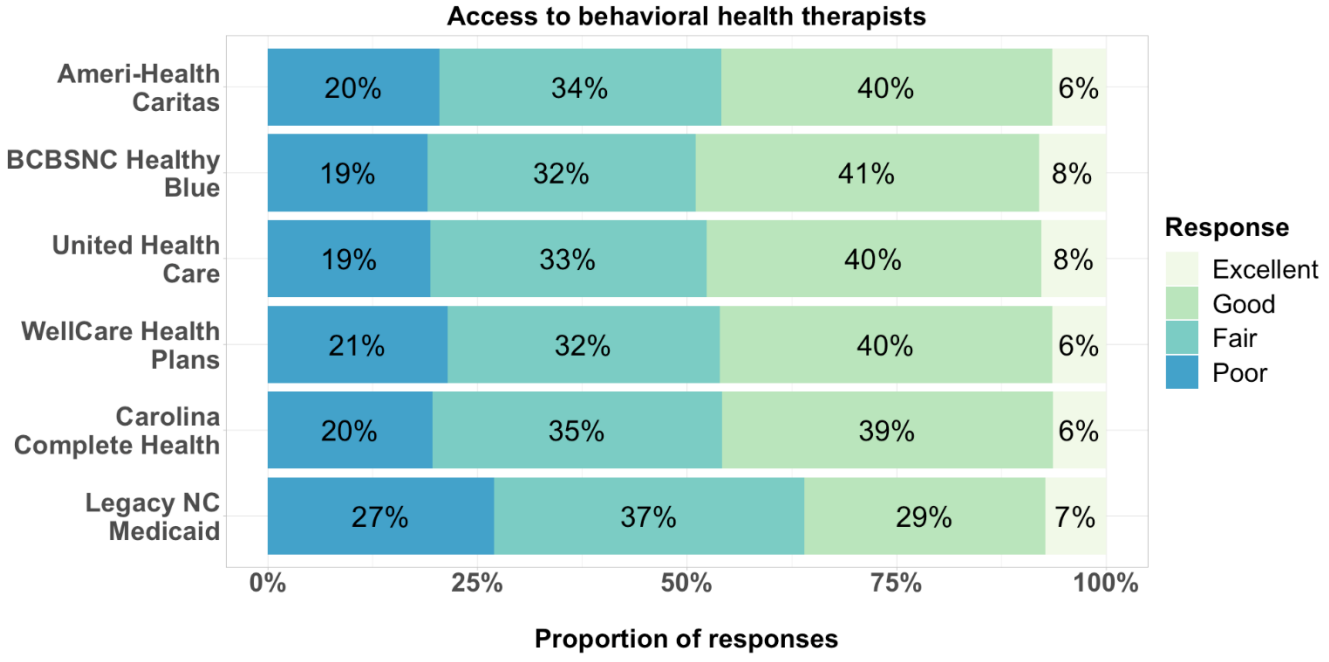
Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

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

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Access to behavioral health therapists for Medicaid patients*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.32 (0.04)
BCBSNC Healthy Blue	2.38 (0.03)
United Health Care	2.36 (0.03)
WellCare Health Plans	2.31 (0.03)
Carolina Complete Health	2.32 (0.04)
Legacy NC Medicaid (i.e., prior to transition to PHPs)	2.16 (0.04)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

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



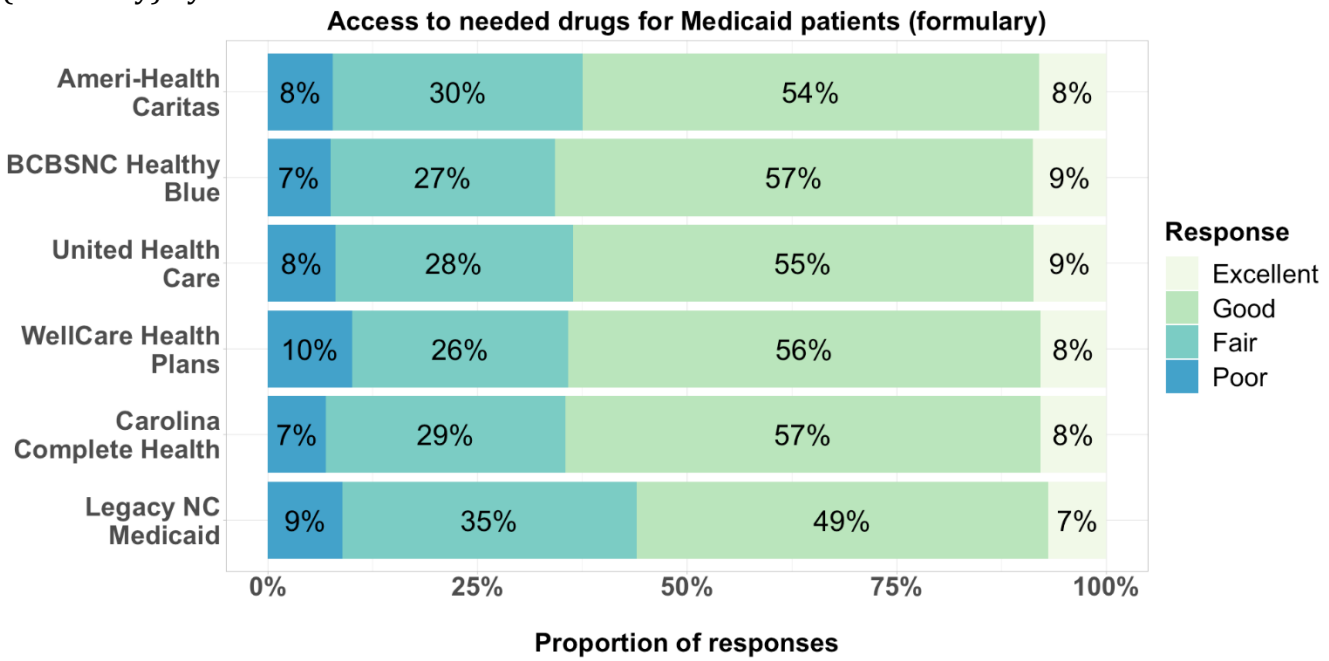
Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

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

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Access to needed drugs for Medicaid patients (formulary)*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.63 (0.03)
BCBSNC Healthy Blue	2.67 (0.03)
United Health Care	2.64 (0.03)
WellCare Health Plans	2.62 (0.03)
Carolina Complete Health	2.66 (0.03)
Legacy NC Medicaid (i.e., prior to transition to PHPs)	2.54 (0.03)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

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



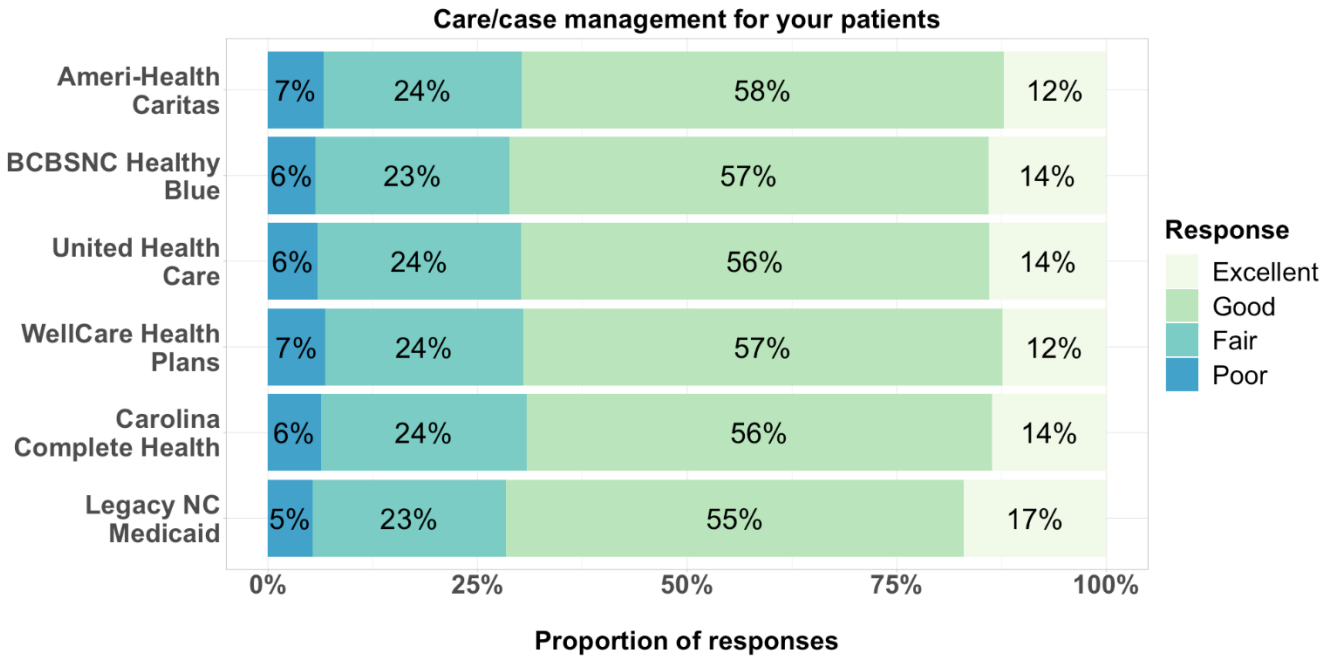
Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

Table 13. Satisfaction of provider organizations with care/case management for your patients

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Care/case management for your patients*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.75 (0.03)
BCBSNC Healthy Blue	2.80 (0.03)
United Health Care	2.78 (0.03)
WellCare Health Plans	2.75 (0.03)
Carolina Complete Health	2.77 (0.03)
Legacy NC Medicaid (i.e., prior to transition to PHPs)	2.83 (0.03)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

Figure 10. Distribution of respondent ratings of care/case management for Medicaid patients by PHP



Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

Table 14. Satisfaction of provider organizations with customer/member support services for their patients

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Customer/member support services for patients*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.72 (0.03)
BCBSNC Healthy Blue	2.82 (0.03)
United Health Care	2.75 (0.03)
WellCare Health Plans	2.69 (0.03)
Carolina Complete Health	2.74 (0.03)
Legacy NC Medicaid (i.e. prior to transition to PHPs)	N/A*

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021. *Not asked on the baseline survey prior to the Medicaid transition to managed care

Figure 11. Distribution of respondent ratings of customer/member support services for Medicaid patients by PHP

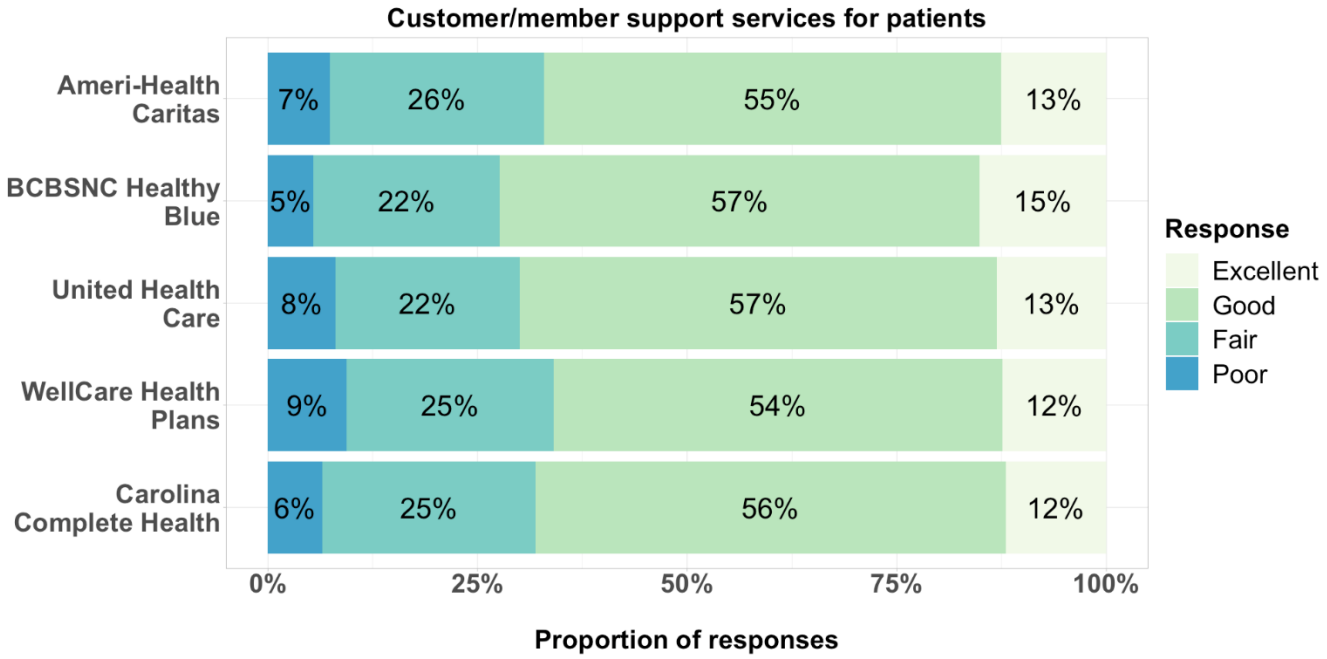
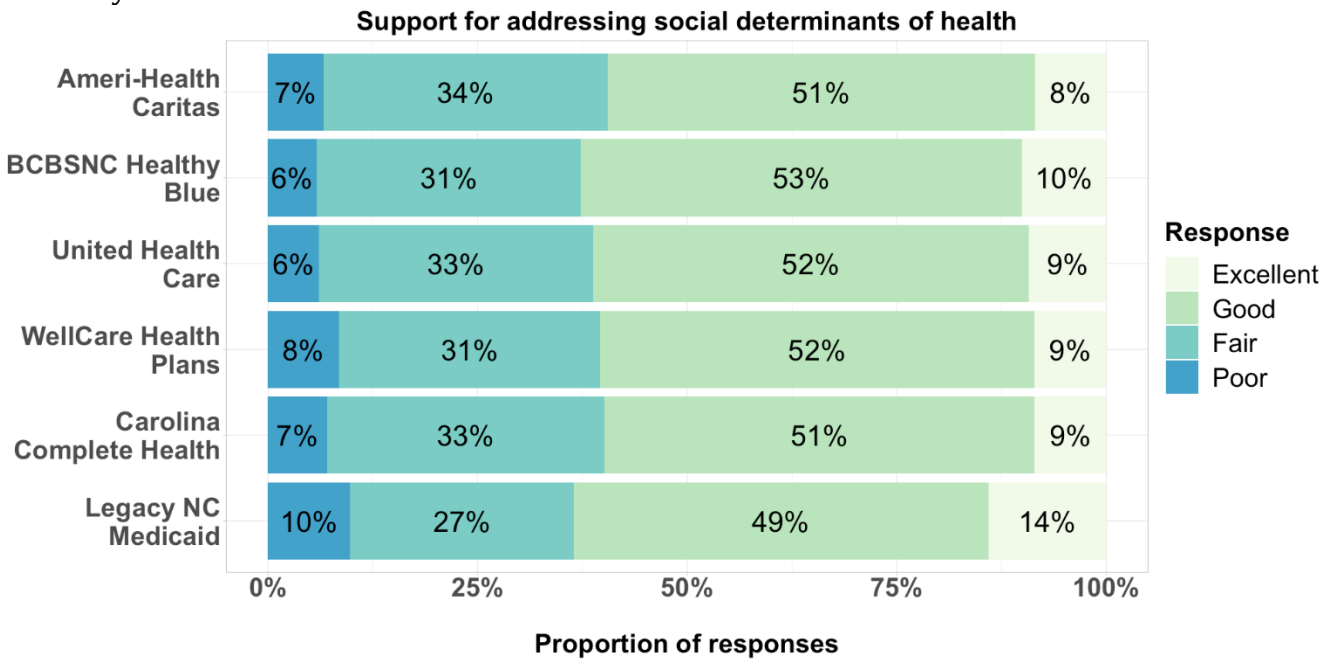


Table 15. Satisfaction of provider organizations with support for addressing social determinants of health (food, education, housing, access to care, etc.)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Support for addressing social determinants of health (food, education, housing, access to care, etc.)*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.61 (0.03)
BCBSNC Healthy Blue	2.67 (0.03)
United Health Care	2.64 (0.03)
WellCare Health Plans	2.60 (0.03)
Carolina Complete Health	2.61 (0.03)
Legacy NC Medicaid (i.e., prior to transition to PHPs)	2.68 (0.04)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

Figure 12. Distribution of respondent ratings of support for addressing social determinants of health by PHP



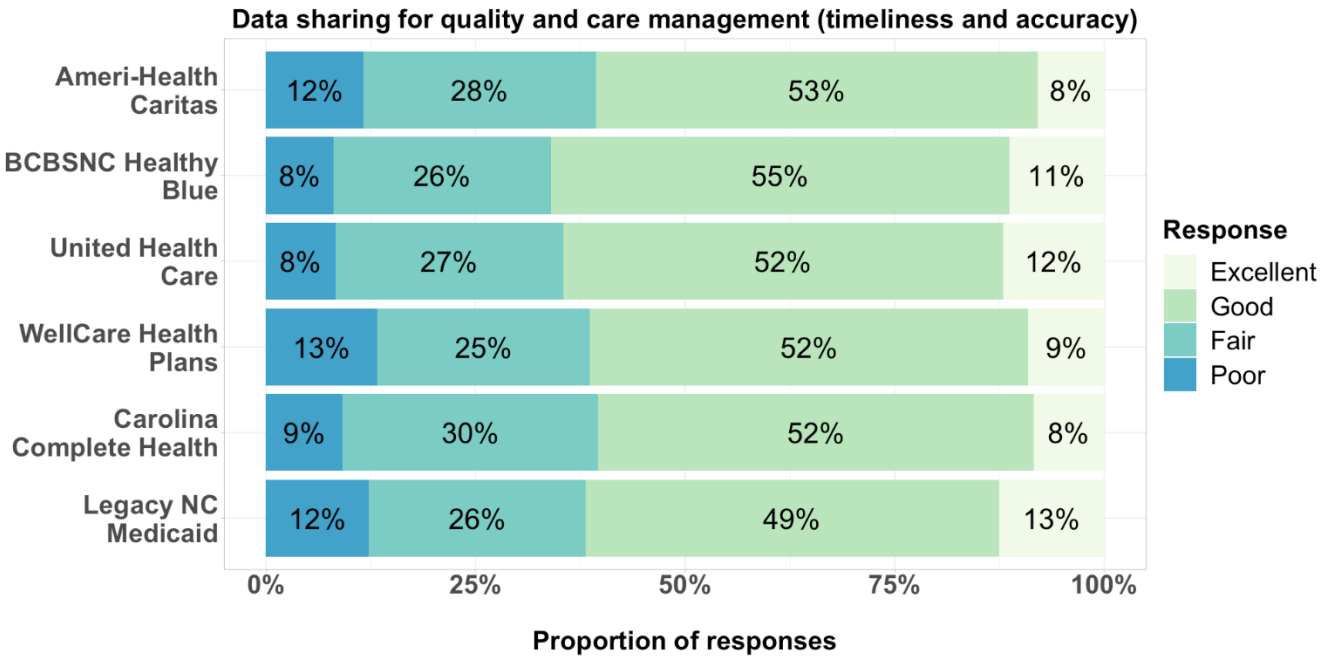
Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

Table 16. Satisfaction of provider organizations with data sharing for quality and care management (timeliness and accuracy)

Based on your practice's/health system's experience with PHPs, how would you describe your overall experience for the following factors for each of the PHPs you are contracting with? *Data sharing for quality and care management (timeliness and accuracy)*	
PHP	**Mean (SE)**
Ameri-Health Caritas North Carolina	2.57 (0.03)
BCBSNC Healthy Blue	2.69 (0.03)
United Health Care	2.68 (0.03)
WellCare Health Plans	2.57 (0.03)
Carolina Complete Health	2.60 (0.03)
Legacy NC Medicaid (i.e., prior to transition to PHPs)	2.62 (0.04)

Notes: Ratings scale ranges from 1 (poor) to 4 (excellent). Legacy NC Medicaid estimates are from the baseline survey in 2021.

Figure 13. Distribution of respondent ratings of data sharing for quality and care management by PHP



Notes: Legacy NC Medicaid estimates are from the baseline survey in 2021.

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

Figure 14: Overall summary ratings of PHPs across all domains

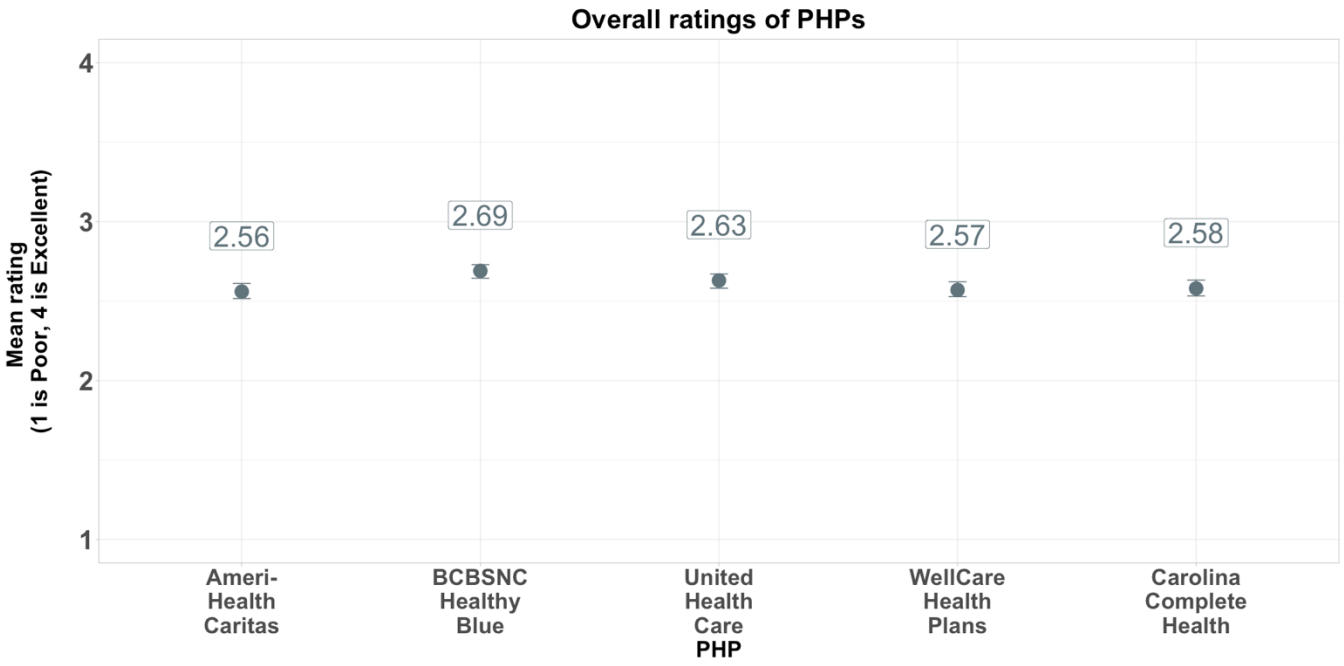


Figure 15: Composite ratings of PHPs across administrative domains

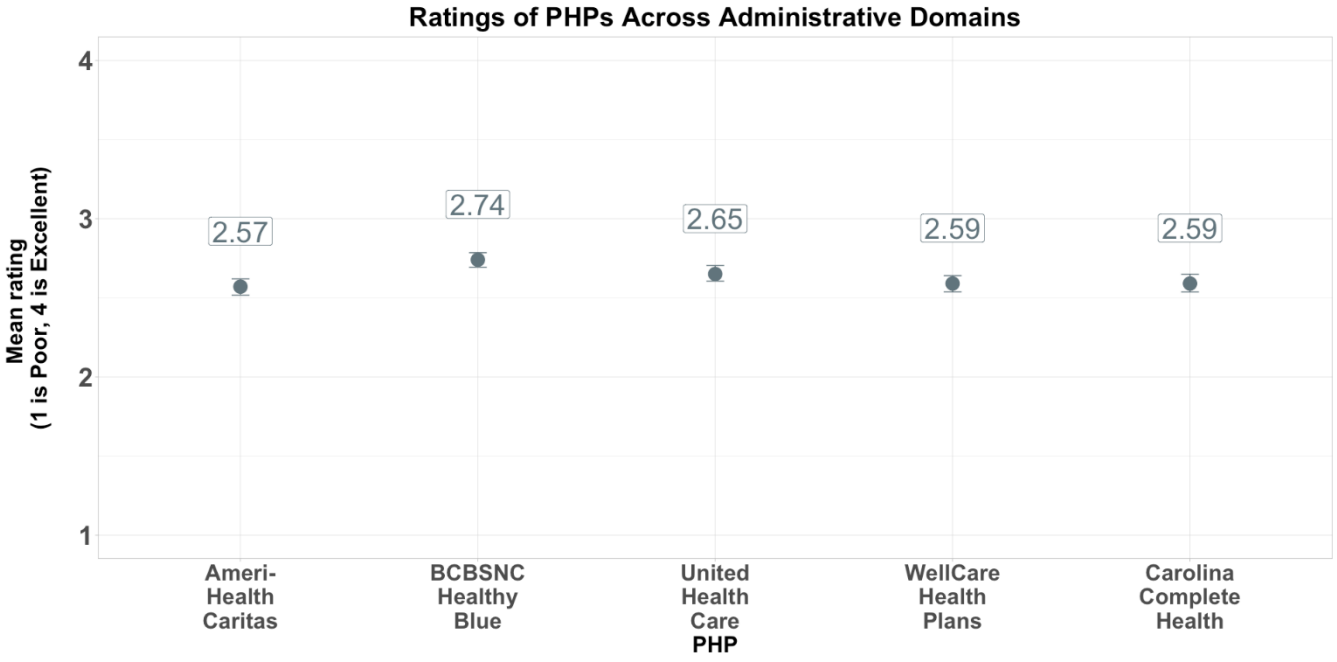


Figure 16: Composite ratings of PHPs across clinical domains

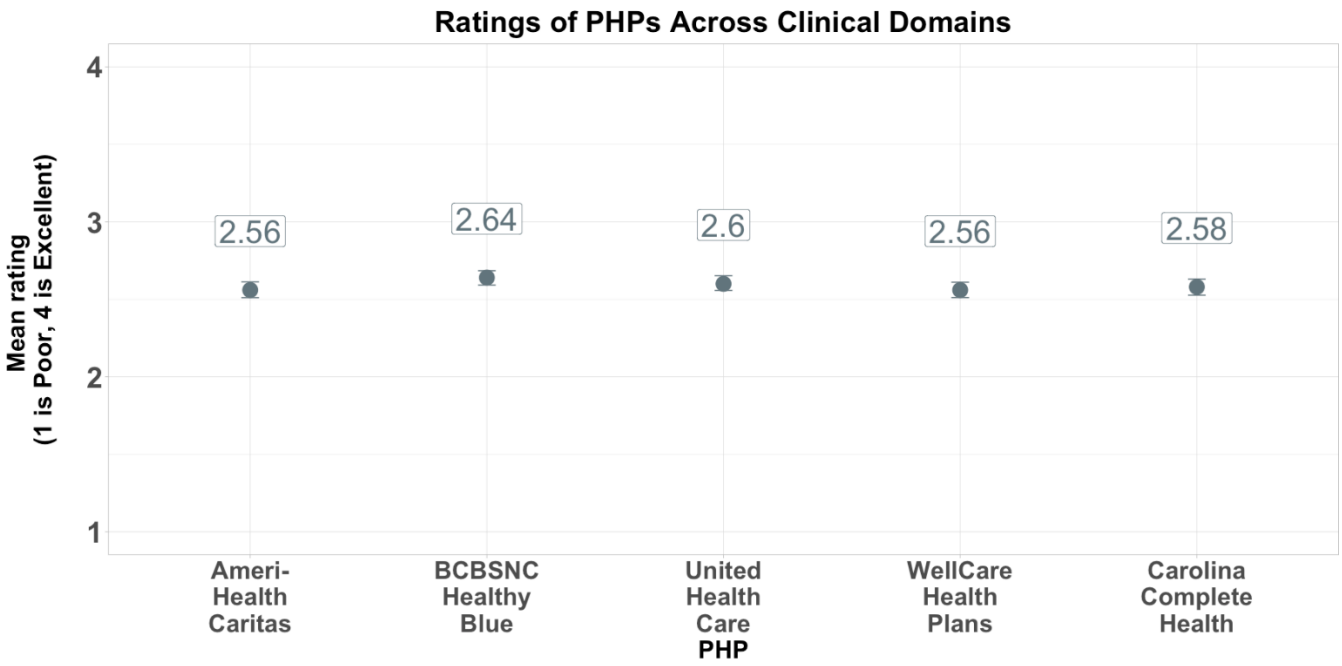


Figure 17a: Experience and satisfaction with administrative domains, Legacy NC Medicaid vs. Pre-Paid Health Plans

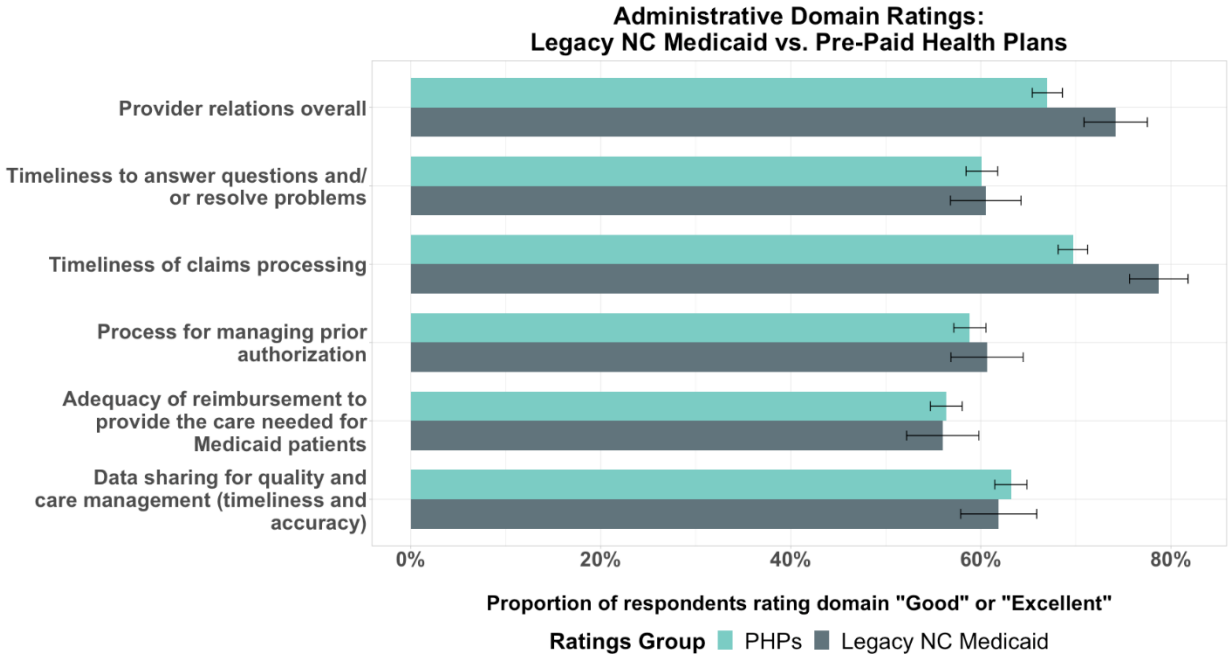
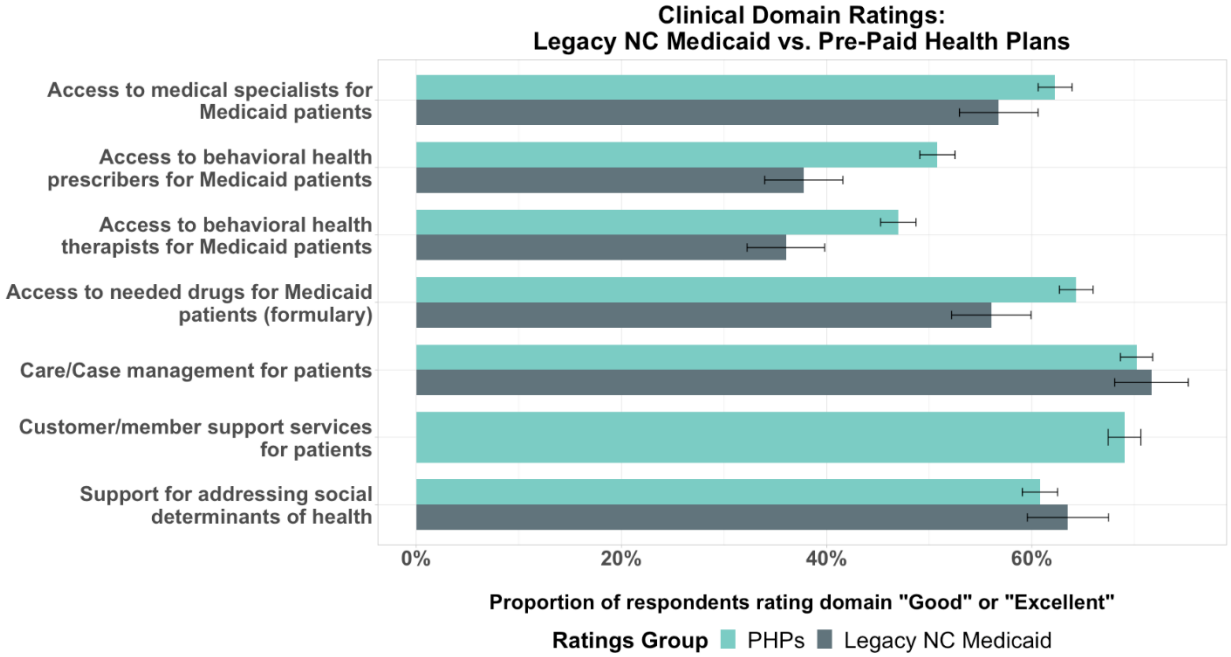


Figure 17b: Experience and satisfaction with clinical domains, Legacy NC Medicaid vs. Pre-Paid Health Plans

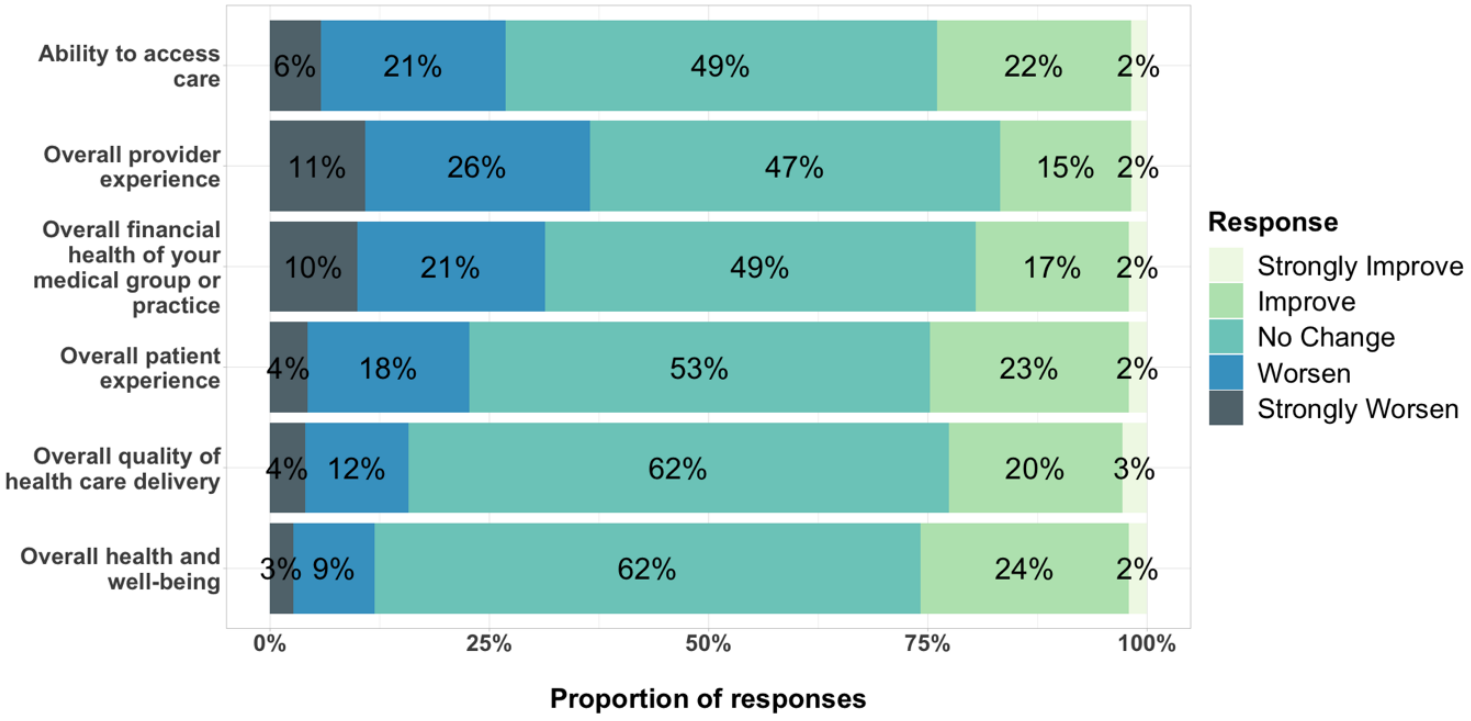


Note: Customer/member support services for patients was only asked in the 2022 survey

Table 17: Provider organizations' feelings on how PHPs have affected various aspects of health care delivery in North Carolina

Item	Strongly Improve N (%)	Improve N (%)	No Change N (%)	Worsen N (%)	Strongly Worsen N (%)
Overall health and well-being	8 (2.1%)	92 (23.6%)	242 (62.5%)	36 (9.2%)	10 (2.7%)
Overall quality of health care delivery	11 (2.8%)	77 (19.7%)	239 (61.6%)	46 (11.9%)	15 (4.0%)
Overall patient experience	8 (2.1%)	87 (22.8%)	204 (52.5%)	71 (18.3%)	17 (4.3%)
Overall financial health of your medical group or practice	8 (2.1%)	67 (17.3%)	191 (49.2%)	84 (21.5%)	38 (9.9%)
Overall provider experience	7 (1.8%)	58 (14.8%)	182 (46.9%)	100 (25.7%)	42 (10.8%)
Ability to access care	7 (1.8%)	86 (22.1%)	191 (49.1%)	82 (21.2%)	22 (5.8%)

Figure 18: Distribution of respondent ratings regarding how PHPs have affected various aspects of health care delivery in North Carolina



When asked how their provider organization feels PHPs have affected per capita total cost of care to the state Medicaid program, organizations reported as follows:

- 41 (10.9%) Increase substantially
- 86 (22.7%) Increase slightly
- 196 (51.5%) No change
- 45 (11.9%) Decrease slightly
- 12 (3.1%) Decrease substantially

Provider Organizations' Approach to Behavioral Health and Tailored Plans

When asked whether their provider organization had embedded or co-located behavioral health professionals in its primary care office(s), organizations reported as follows:

- 67 (17.3%) Yes, in all offices
- 26 (6.7%) Yes, in some offices
- 296 (76.0%) No

Write-in responses: Please select all the reasons that your practice/health system does not have embedded or co-located behavioral health professionals in its primary care office(s): - Other (please specify)

Themes write-in responses (from most common to least common)

- Shortage of behavioral health professionals (e.g., especially behavioral health providers who want this type of job) and trouble retaining qualified staff
- Have preferred referral locations/relationships
- Solo/small practice that manages uncomplicated depression/anxiety patients inhouse and refers others out
- Not enough patient volume to trigger need for integrated behavioral health
- Not enough space to house embedded behavioral health services
- Have not thought about it since changes to Medicaid came in the middle of a pandemic
- Have not evaluated this option or no one has discussed in concrete terms
- Not interested in this option (e.g., does not fit business model)
- Low reimbursement in rural area
- Practice leadership is nearing retirement age
- Planning on doing this with more space or new practice which is still growing
- Quote: "Payment by our LME isn't sufficient to allow us to hire additional providers. Our current program produces a substantial loss every year, but we continue to maintain it despite the loss. Our LME, [name redacted], is not interested in working with us to help alleviate this loss."

When asked whether their provider organization used the Collaborative Care Model (CCM) in their primary care office(s) (and were provided a definition of the CCM), organizations reported as follows:

- 53 (13.7%) I don't know what the Collaborative Care Model is
- 54 (14.0%) Yes, in all offices
- 14 (3.7%) Yes, in some offices
- 265 (68.6%) No

Table 18: 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 (%)	We do not have access to a psychiatrist to support collaborative care 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 = 294)	138 (47.3%)	109 (37.5%)	98 (33.5%)	92 (31.4%)	N/A
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 = 263)	108 (40.9%)	91 (34.4%)	87 (33.2%)	77 (29.4%)	116 (44.1%)

When asked whether their provider organization was planning to contract with Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans (starting in December 2022), organizations reported as follows:

- 116 (29.9%) Yes
- 74 (18.9%) No
- 199 (51.3%) I don't know about Tailored Plans

Write-in responses: Please select all reasons why your practice/health system does not use the Collaborative Care Model in its primary care office(s): - Other (please specify)

Themes write-in responses (from most common to least common)

- Private and/or specialty and/or independent office
- No interest or not necessary (e.g., “no one has asked”)
- Have not investigated further because of lack of space to house additional service providers
- Unable to find behavioral health providers that will take any of the five health plans
- Unable to find reliable behavioral health providers with good communication between the practice and the patient
- Behavioral health services should be integrated into the primary care needs of the patient in their holistic approach to care
- In the process of getting this started
- Not sure what a Collaborative Care Model is and/or have not received any information about this
- Prepaid Health Plans do not provide coverage
- Have had embedded integrated behavioral health for a long time; their limitation is everyone’s lack of psychiatrists

STRATIFIED EXPERIENCE OF PROVIDER ORGANIZATIONS

In this section, we provide several stratifications of the provider satisfaction domains that are presented across all participating organizations in the previous section. Primarily, we provide 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. We group the domains presented in the previous section into two categories, administrative domains and clinical domains.

Stratified Experience Ratings: Size of Provider Organization

Table 19: Mean ratings of PHPs across all domains, stratified by provider organization size

Overall ratings for PHPs stratified by size			
PHP	**Small Provider Organizations (n = 267) Mean (SE)**	**Medium Provider Organizations (n = 88) Mean (SE)**	**Large Provider Organizations (n = 39) Mean (SE)**
Ameri-Health Caritas North Carolina	2.62 (0.03)	2.49 (0.04)	2.41 (0.07)
BCBSNC Healthy Blue	2.74 (0.03)	2.60 (0.04)	2.50 (0.06)
United Health Care	2.69 (0.03)	2.53 (0.04)	2.44 (0.06)
WellCare Health Plans	2.65 (0.03)	2.45 (0.04)	2.36 (0.06)
Carolina Complete Health	2.64 (0.03)	2.50 (0.05)	2.44 (0.05)

Figure 19: Mean ratings of PHPs across all domains, stratified by provider organization size

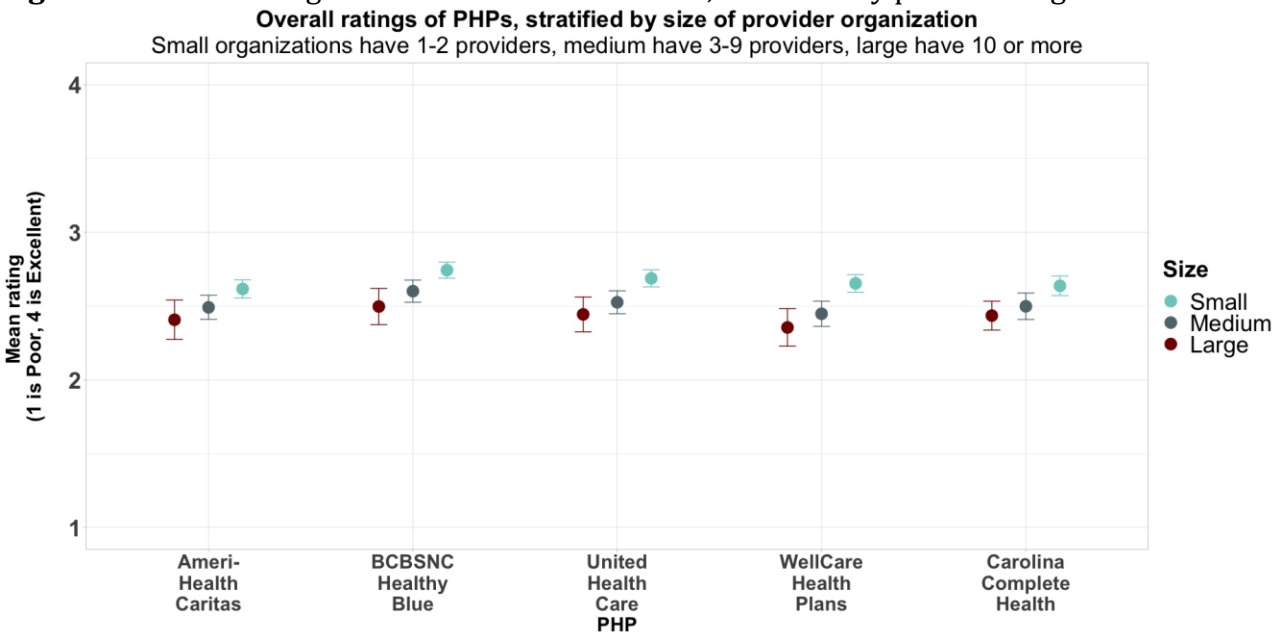


Table 20: Mean ratings of PHPs across administrative domains, stratified by provider organization size

Administrative ratings for PHPs stratified by size			
PHP	**Small Provider Organizations (n = 267) Mean (SE)**	**Medium Provider Organizations (n = 88) Mean (SE)**	**Large Provider Organizations (n = 39) Mean (SE)**
Ameri-Health Caritas North Carolina	2.64 (0.03)	2.50 (0.05)	2.30 (0.08)
BCBSNC Healthy Blue	2.80 (0.03)	2.67 (0.04)	2.49 (0.07)
United Health Care	2.72 (0.03)	2.58 (0.04)	2.41 (0.06)
WellCare Health Plans	2.68 (0.03)	2.47 (0.05)	2.27 (0.07)
Carolina Complete Health	2.65 (0.04)	2.52 (0.05)	2.38 (0.06)

Figure 20: Mean ratings of PHPs across administrative domains, stratified by provider organization size

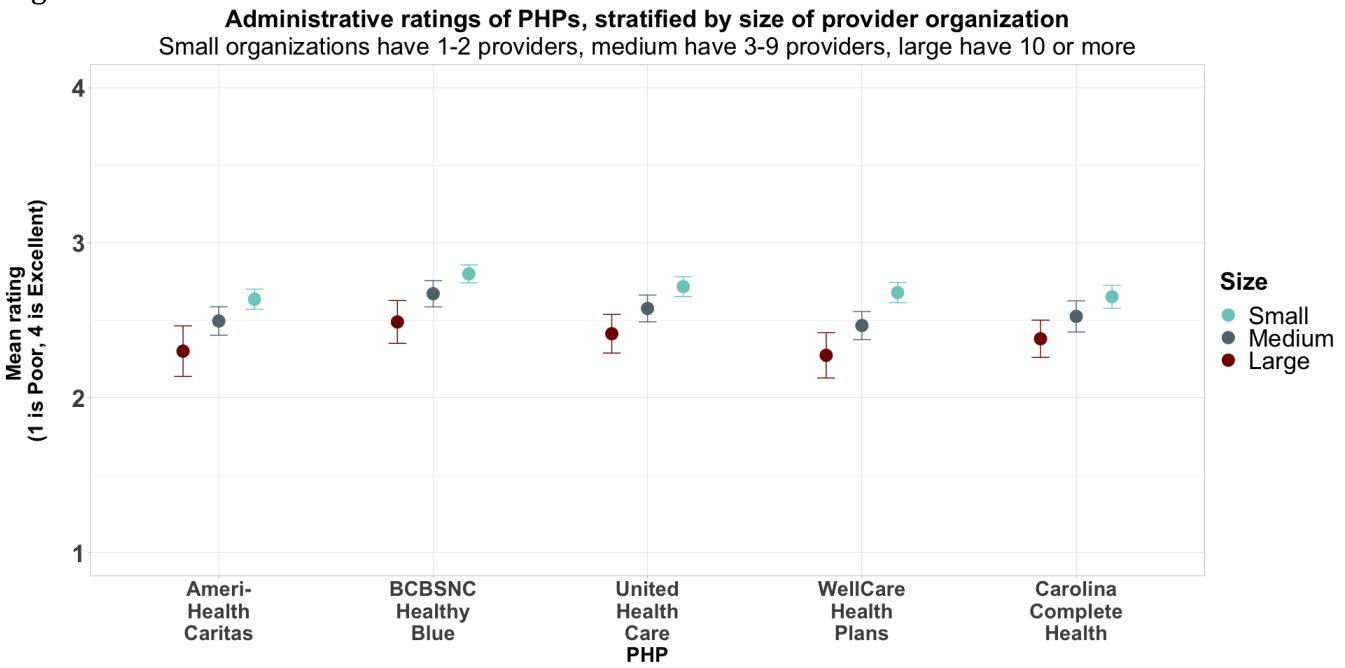
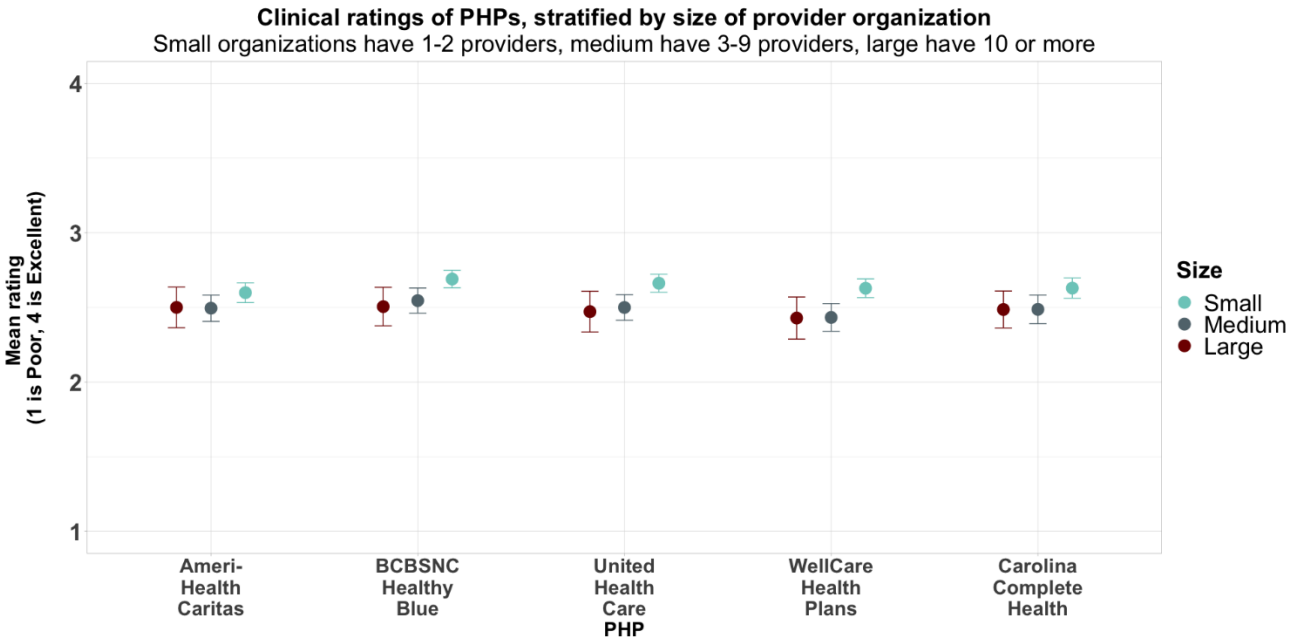


Table 21: Mean ratings of PHPs across clinical domains, stratified by provider organization size

Clinical ratings for PHPs stratified by size			
PHP	**Small Provider Organizations (n = 267) Mean (SE)**	**Medium Provider Organizations (n = 88) Mean (SE)**	**Large Provider Organizations (n = 39) Mean (SE)**
Ameri-Health Caritas North Carolina	2.60 (0.03)	2.49 (0.04)	2.50 (0.07)
BCBSNC Healthy Blue	2.69 (0.03)	2.55 (0.04)	2.51 (0.07)
United Health Care	2.66 (0.03)	2.50 (0.04)	2.47 (0.07)
WellCare Health Plans	2.63 (0.03)	2.43 (0.05)	2.43 (0.07)
Carolina Complete Health	2.63 (0.03)	2.49 (0.05)	2.49 (0.06)

Figure 21: Mean ratings of PHPs 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

Table 22: Mean ratings of PHPs across administrative domains with 95% confidence intervals, stratified by rurality of provider organization

Composite (overall) ratings for PHPs stratified by rurality		
PHP	**Has rural practice site (n = 192) Mean (SE)**	**Does not have rural practice site (n = 202) Mean (SE)**
Ameri-Health Caritas North Carolina	2.54 (0.03)	2.59 (0.04)
BCBSNC Healthy Blue	2.68 (0.03)	2.70 (0.03)
United Health Care	2.63 (0.03)	2.62 (0.03)
WellCare Health Plans	2.54 (0.03)	2.61 (0.04)
Carolina Complete Health	2.56 (0.03)	2.60 (0.04)

Figure 22: Mean ratings of PHPs across all domains with 95% confidence intervals, stratified by rurality of provider organization

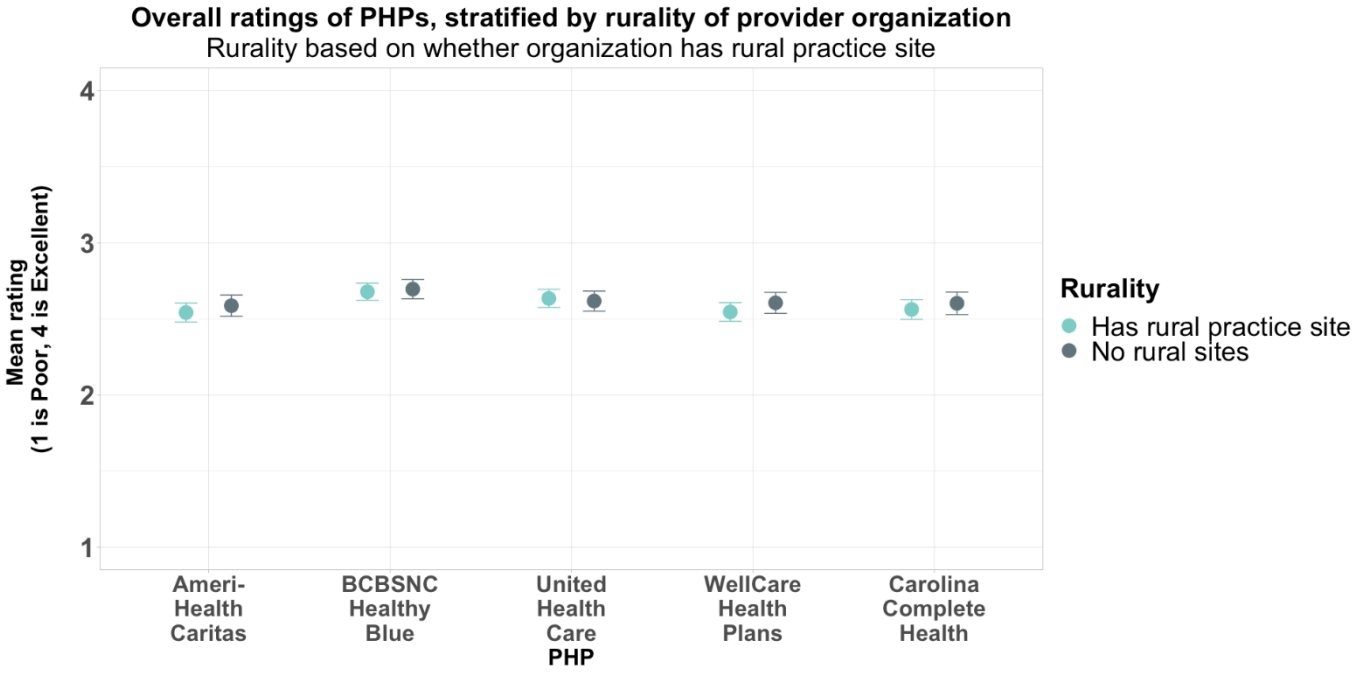


Table 23: Mean ratings of PHPs across administrative domains with 95% confidence intervals, stratified by rurality of provider organization

Administrative ratings for PHPs stratified by rurality		
PHP	**Has rural practice site (n = 192) Mean (SE)**	**Does not have rural practice site (n = 202) Mean (SE)**
Ameri-Health Caritas North Carolina	2.53 (0.04)	2.60 (0.04)
BCBSNC Healthy Blue	2.71 (0.03)	2.76 (0.03)
United Health Care	2.64 (0.03)	2.66 (0.04)
WellCare Health Plans	2.54 (0.03)	2.63 (0.04)
Carolina Complete Health	2.56 (0.04)	2.62 (0.04)

Figure 23: Mean ratings of PHPs across administrative domains with 95% confidence intervals, stratified by rurality of provider organization

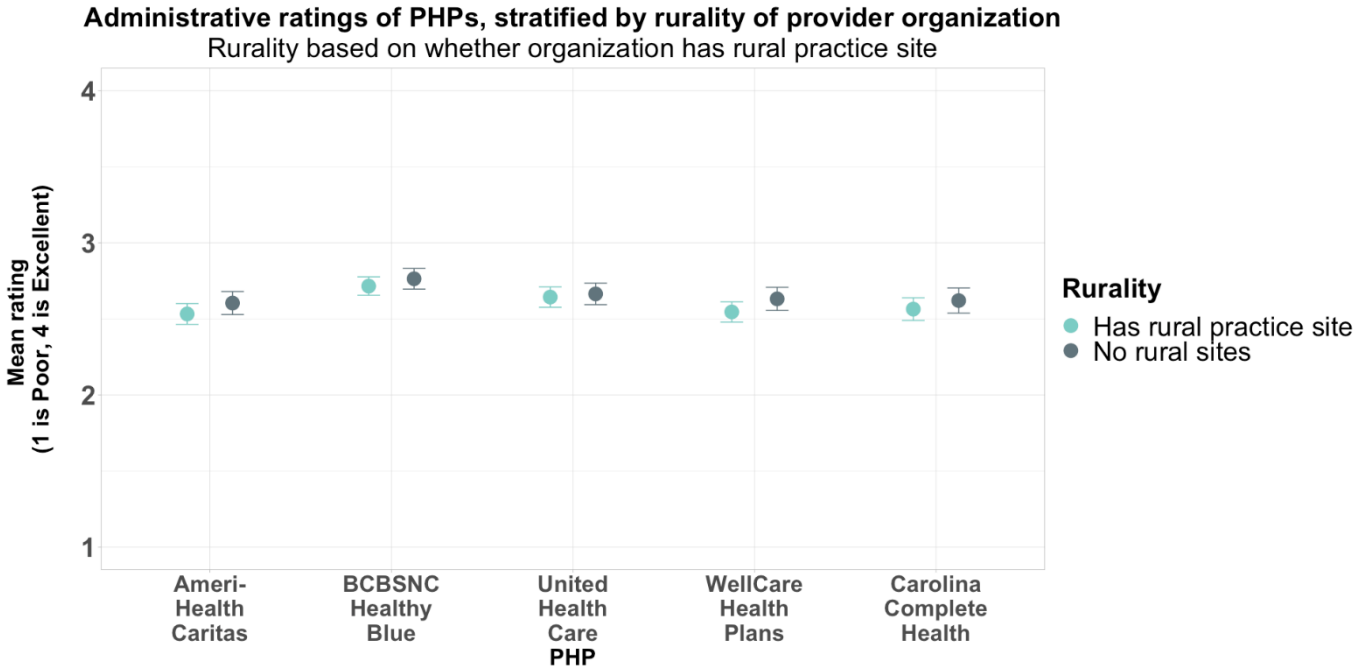
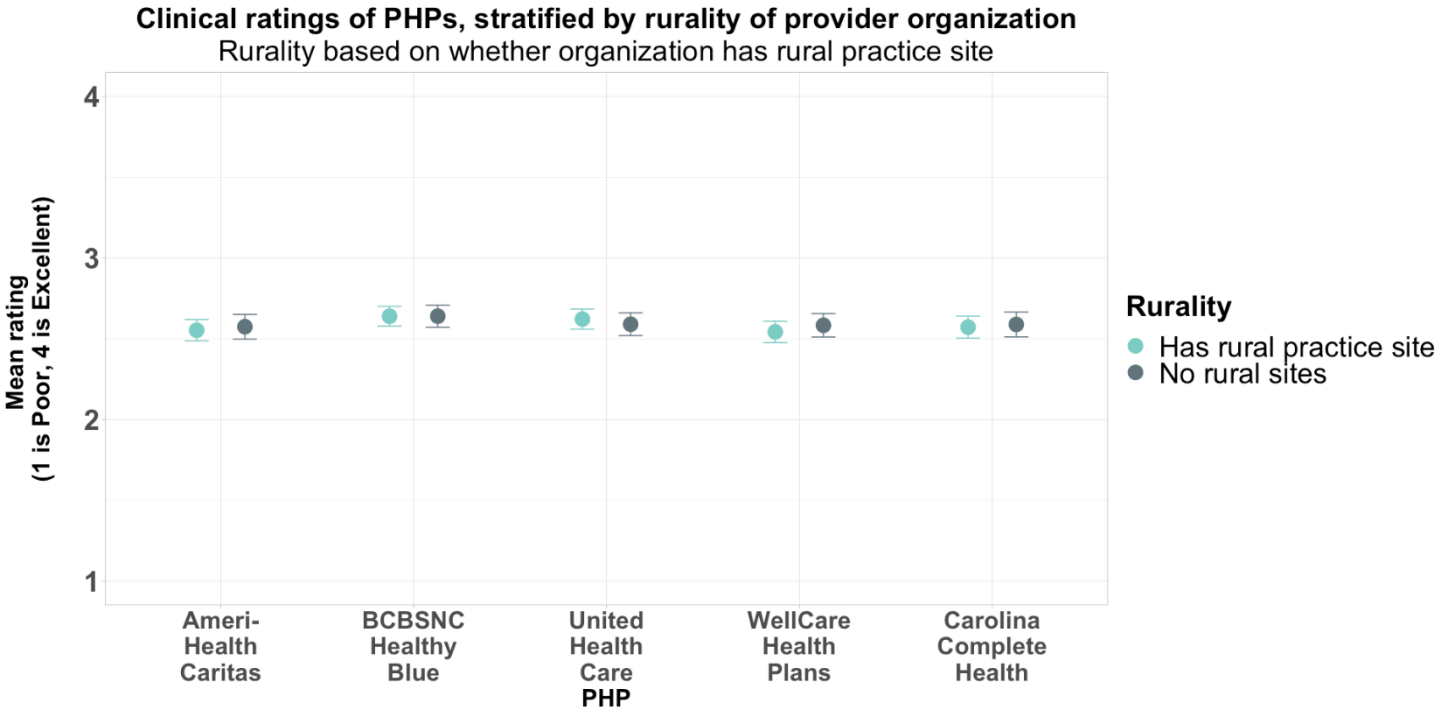


Table 24: Mean ratings of PHPs across clinical domains with 95% confidence intervals, stratified by rurality of provider organization

Clinical ratings for PHPs stratified by rurality		
PHP	**Has rural practice site (n = 192) Mean (SE)**	**Does not have rural practice site (n = 202) Mean (SE)**
Ameri-Health Caritas North Carolina	2.55 (0.03)	2.57 (0.04)
BCBSNC Healthy Blue	2.64 (0.03)	2.64 (0.03)
United Health Care	2.62 (0.03)	2.59 (0.04)
WellCare Health Plans	2.54 (0.03)	2.58 (0.04)
Carolina Complete Health	2.57 (0.03)	2.59 (0.04)

Figure 24: Mean ratings of PHPs 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

Table 25: Mean ratings of PHPs across all domains, stratified by whether the organization provides Ob/Gyn care

Composite (overall) ratings for PHPs stratified by provision of Ob/Gyn care		
PHP	**Provides Ob/Gyn care (n = 43) Mean (SE)**	**Does not provide Ob/Gyn care (n = 348) Mean (SE)**
Ameri-Health Caritas North Carolina	2.51 (0.07)	2.57 (0.03)
BCBSNC Healthy Blue	2.57 (0.06)	2.70 (0.02)
United Health Care	2.48 (0.07)	2.65 (0.02)
WellCare Health Plans	2.45 (0.07)	2.59 (0.03)
Carolina Complete Health	2.59 (0.08)	2.58 (0.03)

Figure 25: Mean ratings of PHPs across all domains with 95% confidence intervals, stratified by whether the provider organization provides Ob/Gyn care

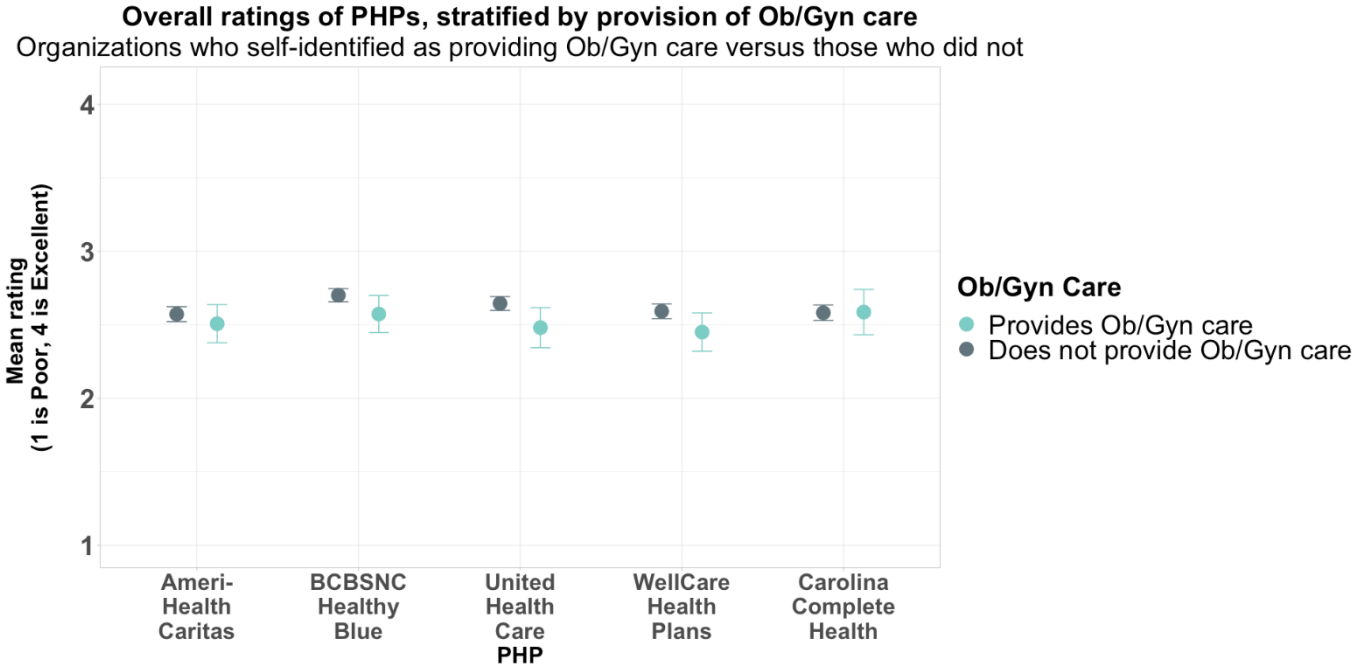


Table 26: Mean ratings of PHPs across administrative domains, stratified by whether the organization provides Ob/Gyn care

Administrative ratings for PHPs stratified by provision of Ob/Gyn care		
PHP	**Provides Ob/Gyn care (n = 43) Mean (SE)**	**Does not provide Ob/Gyn care (n = 348) Mean (SE)**
Ameri-Health Caritas North Carolina	2.37 (0.07)	2.60 (0.03)
BCBSNC Healthy Blue	2.49 (0.07)	2.77 (0.02)
United Health Care	2.39 (0.07)	2.69 (0.03)
WellCare Health Plans	2.33 (0.07)	2.62 (0.03)
Carolina Complete Health	2.50 (0.09)	2.60 (0.03)

Figure 26: Mean ratings of PHPs across administrative domains with 95% confidence intervals, stratified by whether the provider organization provides Ob/Gyn care

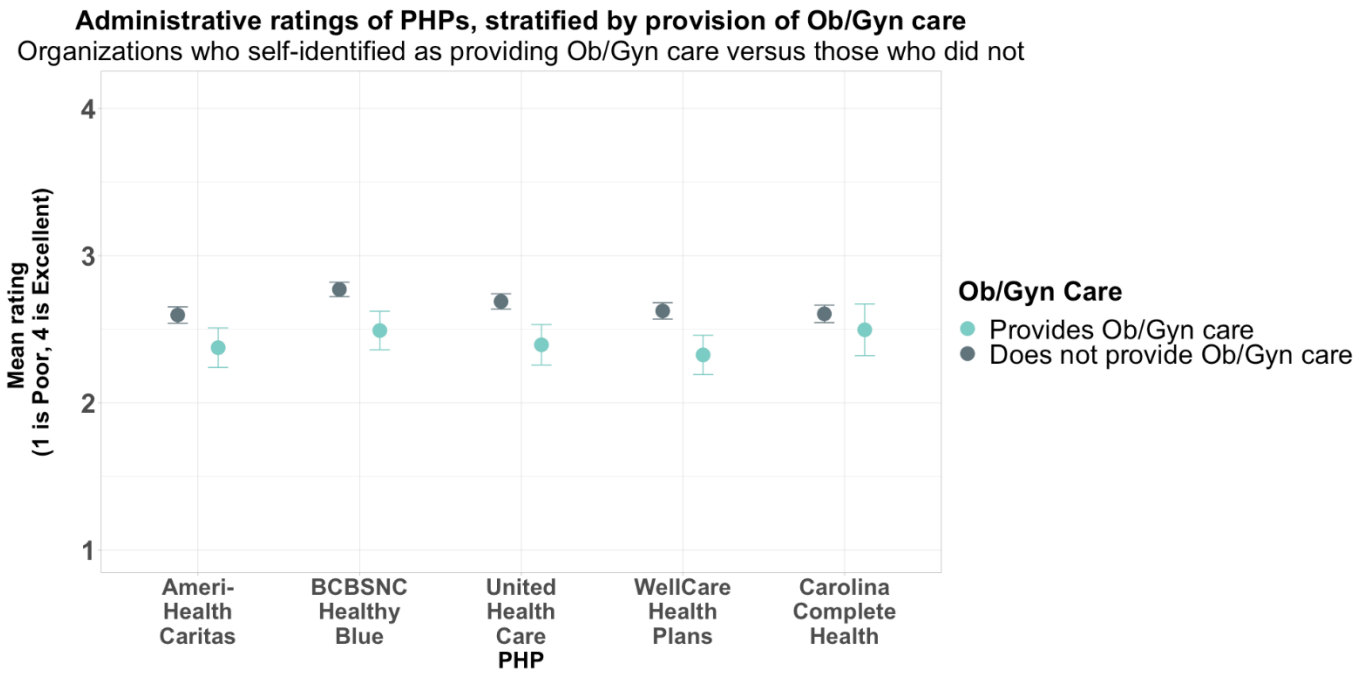
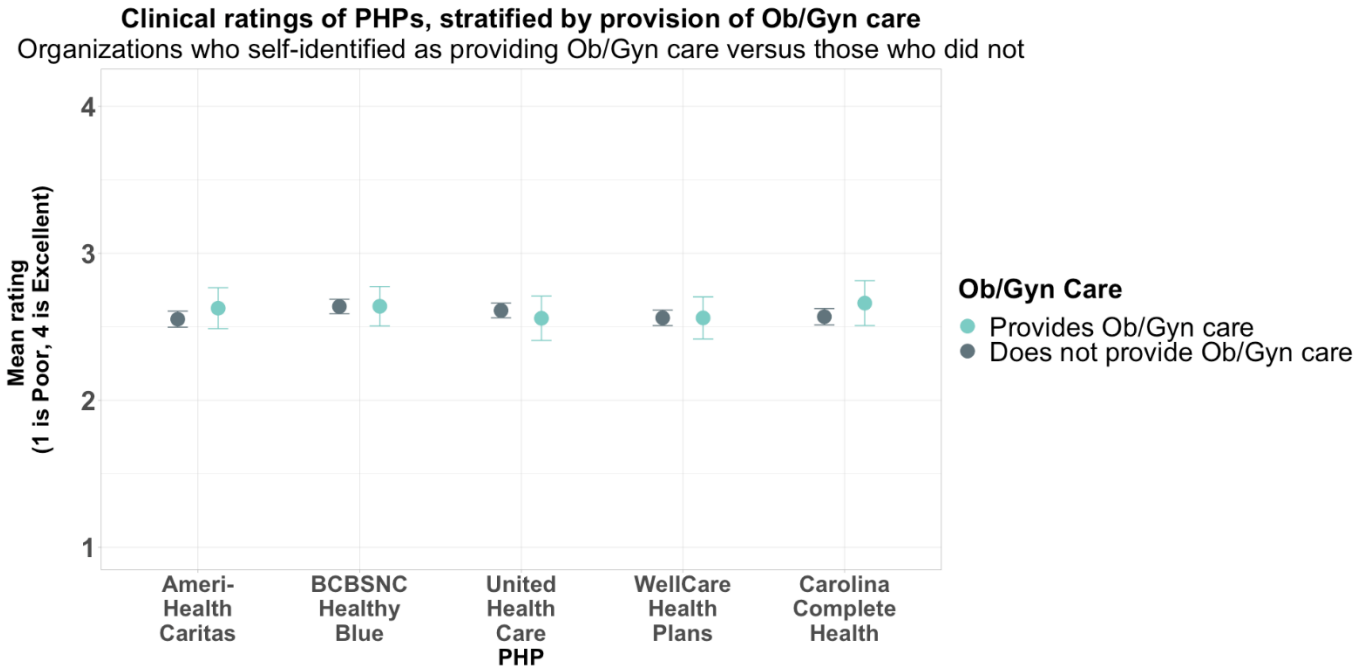


Table 27: Mean ratings of PHPs across clinical domains, stratified by whether the organization provides Ob/Gyn care

Clinical ratings for PHPs stratified by provision of Ob/Gyn care		
PHP	**Provides Ob/Gyn care (n = 43) Mean (SE)**	**Does not provide Ob/Gyn care (n = 348) Mean (SE)**
Ameri-Health Caritas North Carolina	2.63 (0.07)	2.55 (0.03)
BCBSNC Healthy Blue	2.64 (0.07)	2.64 (0.02)
United Health Care	2.56 (0.08)	2.61 (0.03)
WellCare Health Plans	2.56 (0.07)	2.56 (0.03)
Carolina Complete Health	2.66 (0.08)	2.57 (0.03)

Figure 27: Mean ratings of PHPs across clinical domains with 95% confidence intervals, stratified by whether the provider organization provides Ob/Gyn care



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

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

- **Expectations versus reality.** Overall, many organizations reflected a mismatch between what they had been told about the transition – that these plans would function like Legacy NC Medicaid – and reality. Some organizations noted that the beginning of the transformation was challenging and that things have generally been improving.
- **Frustration and administrative burden.** Many provider organizations who responded expressed general dissatisfaction with the PHPs and cited issues with delinquent claims processing, taxonomy challenges, inaccurate rates/unsatisfactory payment, and responsiveness. Many organizations commented on the increase of administrative burden and stress on their staff (e.g., one organization said their administrative time has more than quadrupled, for example).
    - **Changes to claims timeline.** A handful of provider organizations cited that Legacy NC Medicaid had timely filing up to one year and the PHPs only provide 120 days for filing, which has led to unpaid claims. Another cited that they had claims issues with all five PHPs that have taken months to get resolved. Others stated they still have not been paid by any PHPs.
    - **Burdensome prior authorization.** A few provider organizations stated that prior authorization processes routinely add extra layers of effort which often seem unnecessary and time-consuming.
    - **High PHP turnover & Medicaid expertise.** A few organizations noted high turnover across the PHPs, which has led to open and unresolved items and increased staff frustration with the transition. Additionally, PHP staff are also responsible for other products, so their time to devote to Medicaid is limited.
- **Verifying enrollment/patient cards.** Provider organizations noted the challenges that arise when a patient presents to the clinic with a different PCP listed on the card, and they can't obtain an authorization or change the PCP – provider organizations are unable to be paid for their services, even in the cases of acute illness.
    - **Quote:** "The LMEs were a huge mistake. No one cares about the patient but us and it is increasingly difficult to take care of Medicaid kids! The administration work we are up against now is impossible."

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

- **Tough transition.** Providers miss prior Legacy Medicaid system. In the initial year, provider organizations note immense administrative stress and lost revenue. Health departments and FQHCs both qualitatively express concerns about their ability to provide care in our survey.
- **Advancing to next steps.** The program is continuing to advance to next steps without resolving issues with the pre-existing infrastructure (e.g., the move to tailored plans is a cited example). Some providers note that they will only contract with tailored plans if they can get the standard plans performing correctly.
    - Quote: "I am EXTREMELY nervous about the new tailored plans for BH/ID patients. These patients change addresses frequently without notifying us, change phone numbers frequently without notifying us, are often severely schizophrenic and cannot keep up with their appointments, much less their insurance plan. Changing their plans to a new entity will be an administrative burden, requiring us to visit NC Tracks and search their current plans FOR EVERY VISIT. We have enough to do as it is, and Medicaid keeps adding more."
- **Impacting specialists and other services.** Some respondents noted that the transition has hampered certain aspects of care like referrals to specialists. One provider organization said that their community was losing providers, like speech therapists, because they had not been paid since July 1, 2021.
- **Time lapse between state intervention and PHP implementation.** One organization noted that the time lapse for when the state makes rules and PHPs implement needs work – only two of the five PHPs made the PMPM payment update to AMH practices in January, and the others recouped the payments later. Providers note PHPs should be made to forfeit any overpayment made to providers after a certain amount of time.
- **Recommendations.** Recommendations offered include assigning a single point-of-contact for clinics; getting attribution lists and PMPM monthly payments correct; centralizing verification of Medicaid eligibility; standardization amidst plans of policy numbers; consistent language being used between PHPs (e.g., care gap vs. AUBP); better system to reassign patients that have left/been dismissed from practice; more practical ways to limit/open/manage patient numbers; proactive monthly meetings between representatives and clinics to answer questions and address clinic concerns; patient education efforts.
- **Patient care.** Ultimately, many organizations expressed concerns about the impact of the transition on patients' ability to access needed care.

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