RESEARCH REPORT

North Carolina Medicaid’s Transition to Risk-Based Managed Care

Findings from the Preimplementation Period

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Executive Summary

The North Carolina legislature passed a law in 2015 formally directing the state’s Department of Health and Human Services (DHHS) to implement a risk-based managed care delivery system for Medicaid and the Children’s Health Insurance Program (CHIP). DHHS announced its plan for Medicaid transformation in 2018. In addition to moving from a fee-for-service (FFS) approach to a risk-based managed care approach, the plan includes measures to better integrate physical and behavioral health care delivery and address social determinants of health. In July 2021, after several delays related to the state budget process and the COVID-19 pandemic, almost 1.6 million Medicaid beneficiaries were transitioned to managed care and enrolled in prepaid health plans (PHPs), including most parents and children, pregnant women, and non-Medicare Aged, Blind, and Disabled populations.

The Urban Institute, with funding from the Kate B. Reynolds Charitable Trust, is examining North Carolina Medicaid’s transition to managed care and its effects on equitable health outcomes for North Carolinians, focusing on the effects of Medicaid transformation on access to and quality of care for children and pregnant and parenting people. This mixed-methods study includes a qualitative component consisting of interviews with key stakeholders involved in or affected by the implementation of managed care, as well as focus groups with Medicaid beneficiaries. Initial interviews and focus groups were conducted in spring and summer 2021 while preparations for the managed care launch were under way, to learn about the strengths and weaknesses of the precursor FFS system, implementation progress, and expectations of how the managed care system may affect access to and quality of care and health disparities. Data collection occurred during the PHP open enrollment period just before the launch of managed care and during the COVID-19 pandemic. As such, our findings offer a unique insight into the experiences of a broad range of Medicaid stakeholders during a transitional time for the program and an unprecedented public health crisis. Below, we summarize key findings by topic.

Perspectives on Fee-for-Service Medicaid

Most interviewees and focus group participants thought the FFS Medicaid system in North Carolina provided good access to primary care, with many noting “exceptionally high” levels of provider participation among primary care, pediatric, and obstetrician and gynecology practices. They also identified the state’s care coordination infrastructure, the Community Care of North Carolina (CCNC) network, as a major strength of the preexisting system and wondered whether the managed care
program would be able to perform this function as efficiently. Perceived weaknesses in the system included poor performance on quality measures including inequitable health outcomes; restrictive eligibility limits for low-income nonpregnant adults; limited access to dental, behavioral, and other specialty health care; a cumbersome nonemergency Medicaid transportation system; and provider shortages in rural areas, which were widely acknowledged as an issue for the state’s health care system generally and not exclusive to Medicaid.

Preventing for Managed Care

As PHPs, Medicaid officials, and health care providers prepared for the summer 2021 launch of risk-based managed care, they focused on activities related to developing provider networks, educating providers and beneficiaries about upcoming changes, and finalizing health plan contract requirements. Key informants recognized that the managed care program was designed to maintain access to care for beneficiaries and minimize administrative burdens on providers, but many anticipated initial disruptions in access and administrative hassle for providers.

The responsibility for coordinating Medicaid beneficiary care will be carried out by PHPs and, for the highest-risk patients, newly designated advanced medical homes. PHP representatives reported working with advanced medical homes to get them ready to take on care management for these members. PHPs are also responsible for screening members about social needs (e.g., housing, food, and personal safety) and taking steps to address those needs. PHP approaches to implementing this requirement vary and include incorporating the screening into the PHP health risk assessment and providing training and scripts to in-network health care providers who will be responsible for screening their patients. To support continuity of care, PHPs will honor prior authorizations issued before or during the transition period and are expected to help members switch to in-network providers in the first 90 days of enrollment while fully reimbursing out-of-network care received during this period. Informants identified this provision as particularly important for newborn care. Some PHP representatives reported that they will try to contract with members’ out-of-network providers before working with members to select new in-network providers.

The state Medicaid agency amended PHP contracts before the launch of managed care to focus on health equity. PHPs will be required to undertake performance-improvement projects focused on closing racial and ethnic disparities in access to care. While the Medicaid agency was finalizing its managed care quality monitoring strategy during the study’s data collection period, state officials shared that the measures will be familiar to providers and related to preventive care and recommended
screenings, such as well-child visits, child immunizations, and comprehensive diabetes care. Medicaid will require PHPs to collect and stratify performance data by race and ethnicity, which one stakeholder suggested would have spillover effects in their other lines of business.

**Beneficiary Communication and Assistance**

The state deployed a multipronged communications strategy to notify beneficiaries of the transition to managed care and aid with PHP enrollment. This included mailing notices to beneficiaries, developing a website with pertinent information, launching an enrollment portal online and via mobile app, and hiring an enrollment broker to manage the process, including a call center. The state expected to launch an ombudsman program in spring 2021 to be a resource and educational hub for beneficiaries. Although some informants praised the state’s effort to make information and assistance available, others shared concerns that the website was difficult to navigate (particularly the provider lookup tool) and reported technical glitches or long wait times with the enrollment broker’s call center. Focus group participants reinforced informants’ concerns, with many expressing confusion about the transition or worries about its effects on their coverage and ability to see current providers. Some also reported not having the time or information to confidently select a PHP. Parents of children with special health care needs in Medicaid expressed acute concern about the lack of information, given the various therapies and specialized services their children receive through the program.

**Influence of COVID-19**

Many informants suggested the COVID-19 pandemic put a much-needed spotlight on existing inequities in North Carolina’s health care system—mainly the disparate burden of the COVID-19 disease on some racial and ethnic minority groups—and spurred efforts to address inequities much faster than would have otherwise happened. Though COVID-19 delayed managed care implementation, state officials said this delay allowed them to focus more on addressing health disparities and noted that they continue to explore ways to advance health equity through managed care contracting. Even though state officials had more time to introduce strategies to address health inequities, the pandemic complicated and created a stressful environment for the managed care transition. Implementing managed care while adapting the Medicaid program in response to the public health emergency strained agency staff. Similarly, while health care providers were coping with increased workloads related to caring for COVID-19 patients and responding to growing mental health
and social needs, they had to find time to negotiate contracts with PHPs and prepare for enhanced care management responsibilities.

Anticipated Effects of Managed Care

We asked study participants to share their perspectives on how the shift to risk-based managed care would affect access to and experiences with care, as well as health disparities. Some worried that access to care could be negatively affected if managed care–related administrative burdens prompt providers to limit participation in the program or leave it altogether. On the other hand, informants were hopeful that the increased emphasis on social determinants of health and health disparities would improve Medicaid beneficiaries’ health and well-being. Although most focus group participants were worried about losing access to providers and services when they enrolled in a PHP, some were optimistic that access to certain services (e.g., vision and dental care) and referral processes would be streamlined under managed care.

Multiple informants suggested that risk-based managed care, and North Carolina’s Medicaid transformation more generally, would lead to community-level improvements focused on social determinants of health. They suggested the FFS model, with its focus on individual patients rather than communities, could never achieve this type of result. One interviewee characterized managed care as applying a new set of resources and tools to health inequities (e.g., the requirements for PHPs to disaggregate quality metrics data by race and ethnicity and other characteristics) and financial incentives to address disparities identified in these data.

As the Urban Institute research team continues to monitor implementation of managed care in North Carolina, we will conduct additional interviews and focus groups in 2022 to assess PHP and provider experiences with the transition, and beneficiary experiences with access to and quality of care in the new system.
North Carolina Medicaid’s Transition

North Carolina’s Medicaid program is undergoing a major transformation in how it delivers and pays for beneficiary care. This report synthesizes qualitative data from a study of the implementation of one large component of this transformation: the shift from a FFS system to a risk-based managed care delivery system for Medicaid. As background for this study and context for its findings, we begin by reviewing features of the Medicaid program and its significance for low-income North Carolinians, the state’s decision to shift to Medicaid managed care, and the transition’s potential impacts based on other states’ experiences. Box 1 introduces and defines terms frequently used throughout the report.

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BOX 1
Frequently Used Abbreviations and Definitions

AMH = Advanced Medical Homes. A program in which primary care practices manage the care of patients enrolled in Medicaid.

CCNC = Community Care of North Carolina. A care management program responsible for case management and quality improvement initiatives for primary care practices participating in Medicaid.

FFS = fee for service. A payment system in which health care providers receive payments for each service delivered to patients. Payments are dependent on quantity of care rather than quality of care.

MCO = managed care organization. A health plan that contracts with a Medicaid program to deliver care to beneficiaries.

MMC = Medicaid managed care. A system in which a Medicaid agency contracts with health plans for a set monthly (or “capitated”) payment to manage health care benefits.

PHP = prepaid health plan. A term used to describe health plans that contract with North Carolina’s Medicaid program to deliver managed care.

PMPM = per member, per month. A set payment amount paid monthly to health plans or providers.
Medicaid in North Carolina

North Carolina Medicaid and Children’s Health Insurance Program (CHIP) are important sources of health insurance coverage for North Carolina residents, particularly for children and pregnant people. In July 2021, NC Medicaid covered nearly 2.5 million North Carolinians, and with CHIP, the number rose to 2.6 million.¹ Medicaid beneficiaries represent nearly a quarter of North Carolina’s 10.5 million residents, and include 1.4 million children (Centers for Medicare & Medicaid Services, n.d.).² People younger than 18 make up 21.9 percent of the total North Carolina population but represent 50 percent of Medicaid beneficiaries.³ In 2019, North Carolina Medicaid paid for 49,201 live births (or 41.4 percent of all live births in the state) and covered an average of 20,812 pregnant women in each month of the same year.⁴ Box 2 shows additional information on eligibility for Medicaid.

BOX 2
North Carolina Medicaid/CHIP Eligibility at a Glance

North Carolina has not expanded Medicaid under the Affordable Care Act (ACA). In North Carolina, a person may be eligible for Medicaid if they are 65 or older, blind or disabled, infants and children younger than 21, pregnant, caretakers of children younger than 18, in need of long-term care, or Medicare recipients. Each of these categories has additional income and resource limits. Pregnant people and children have no limits on resources but must meet certain income thresholds. Lawfully present immigrants are subject to a five-year waiting period before they can qualify for Medicaid coverage, with exceptions for lawfully residing pregnant women and children. Undocumented immigrants are eligible for Medicaid coverage of emergency medical services only.

As of 2021, the following thresholds applied to each category:

- **Children from birth to age 5**
  - Medicaid covers this population up to 211 percent of the federal poverty level

- **Children ages 6 to 18**
  - Medicaid covers this population up to 133 percent of the federal poverty level
  - CHIP covers this population up to 211 percent of the federal poverty level

- **Pregnant people**
  - Medicaid covers this population up to 196 percent of the federal poverty level
  - Coverage lasts through pregnancy and for 12 months postpartum⁵

- **Caretakers of children younger than 18 and children ages 19 and 20**
» Medicaid covers this population up to 34 percent of the federal poverty level
» Eligible people in this category must be below the resource limit of $3,000

North Carolina enacted legislation to use the state option provided under the American Rescue Plan Act of 2021 to seek federal approval to extend Medicaid coverage for pregnant people for up to one year postpartum at the same income threshold. The state plans to use a state plan amendment or Section 1115 waiver demonstration for this extension.


Medicaid is also an important source of coverage for racial and ethnic groups in the state. About 22 percent of North Carolinians identify as non-Hispanic Black, and 10 percent identify as Hispanic/Latinx, but these populations are overrepresented in Medicaid, with 38 percent of Medicaid enrollees identifying as Black (regardless of Hispanic/Latinx ethnicity) and 14 percent of enrollees identifying as Hispanic/Latinx (NC Medicaid 2020b).5 Eight percent of North Carolina’s population in 2018 were foreign-born, and between 2016 and 2020, 21.5 percent of North Carolinians ages 5 and older spoke a language other than English (NC Medicaid 2020b).6 The disproportionate Black and Hispanic/Latinx shares in NC Medicaid can be partially explained by the low-income status of many families of color; though Black and Hispanic/Latinx adults participate in the labor market at similar rates as white people, they are disproportionately represented in low-wage jobs without access to employer-sponsored health insurance (BLS 2019).7

Additionally, evidence shows that people of color experience disparities in health access and outcomes. Consistent evidence across multiple national surveys of health indicate that Black children in Medicaid have less access to care than white children in Medicaid: Black children are 25 percent less likely than white children to have visited a specialist in the past year, even when controlling for health status and related factors (Kenney, Coyer, and Anderson 2013). Hispanic/Latinx children in Medicaid face similar health disparities, though those disparities decrease slightly when controlling for other factors, such as income, citizenship, education, and geographic location (Kenney, Coyer, and Anderson 2013). Additionally, studies frequently find that Black people, American Indian and Alaska Native people, and other people of color are more likely than white people to report discrimination in health
care and that this discrimination has negative consequences on their health outcomes and access to care (Grady and Edgar 2003; Pascoe and Smart Richman 2009; Stepanikova and Oates 2017).

North Carolina’s Shift to Managed Care

North Carolina is one of the last states to transition to risk-based managed care in its Medicaid program: 38 other states and the District of Columbia have already done so. Under risk-based managed care, a state Medicaid program pays managed care organizations (MCOs) a fixed payment (typically on a per member per month, or PMPM, basis), and MCOs administer benefits and bear financial risk for the costs of health care services for Medicaid beneficiaries enrolled in their health plans. MCOs develop provider networks, pay out claims, and usually coordinate and arrange beneficiaries’ care. Studies have demonstrated both the positive and negative impacts of Medicaid managed care on cost, quality of care, and access to care (Franco Montoya, Chehal, and Adams 2020), but the transition period may be a particularly vulnerable time as beneficiaries choose or are assigned to MCOs that may have a different provider network than the state’s FFS Medicaid plan and thus may cause disruptions in care, at least temporarily.

Since the 1990s, North Carolina’s Medicaid program has provided care management services to most enrollees through its primary care case management (PCCM) program Carolina ACCESS, which provides primary care practices a nominal PMPM fee to coordinate patient care (Centers for Medicare & Medicaid Services 2014). The Medicaid program also operates the enhanced care management program Community Care of North Carolina (CCNC), which consists of 14 provider networks across the state that receive PMPM payments to provide case management and lead data analysis and quality improvement initiatives for primary care practices participating in the PCCM program (North Carolina Institute of Medicine 2018). CCNC manages several population-specific care coordination programs, including Care Coordination for Children, for young children with special health care needs and other conditions, and Pregnancy Medical Home, designed to improve access to high-quality prenatal care (North Carolina Institute of Medicine 2018). The Pregnancy Medical Home program helped practices link their management data with claims, vital records, and quality data to help providers understand patients’ specific needs and outcomes. The program included trusted nurse coordinators who supported quality improvement in each participating practice and provided bidirectional communication between individual practices and the statewide program. Several independent evaluations of the CCNC program found that the program improved quality of care and reduced health care costs (North Carolina Institute of Medicine 2018).
Growing Medicaid costs in the early 2010s prompted state legislators to consider revamping the program. In 2013, North Carolina’s Republican governor, Pat McCrory, proposed to overhaul the Medicaid system, including a transition to risk-based managed care, which the Republican-majority state legislature supported. Amid concerns from advocacy groups about budget cuts and privatization, a law passed in 2015 formally directing the DHHS to shift the Medicaid and CHIP programs from an FFS PCCM delivery system to risk-based managed care. In 2018, the new DHHS secretary, Mandy Cohen, appointed by Democratic governor Roy Cooper, announced the department’s plan for Medicaid transformation. Unlike other preceding plans, this plan included details about integrating medical and mental health care and proposed a Section 1115 demonstration waiver to address social determinants of health. A budget impasse in the state legislature in November 2019 postponed Medicaid transformation until February 2020, and then the COVID-19 pandemic prompted further delays. After months of uncertainty, North Carolina lawmakers passed the DHHS budget in June 2020, which included an official launch date for Medicaid transformation of July 1, 2021.

As part of the development of the Medicaid managed care (MMC) transition planning in 2019, DHHS selected bids from five managed care companies to offer prepaid health plans and to manage beneficiary care. AmeriHealth Caritas North Carolina, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, and WellCare of North Carolina are providing state plans, and Carolina Complete Health is offering plans in 41 counties in the state’s central and western regions.

North Carolina Medicaid transformation also includes a health plan administered by the Eastern Band of Cherokee Indians (EBCI), referred to as the tribal option. Federal law prohibits states from requiring American Indian and Alaska Native populations to enroll in managed care unless the managed care entity is an Indian managed care entity (i.e., operated by the Indian Health Service or tribal organization).Reportedly, this rule prompted Medicaid to work with the Cherokee Indian Hospital Authority to create the EBCI tribal option, the country’s first Indian managed care entity. The EBCI tribal option is a robust primary care case management program to care for federally recognized tribal members and other individuals eligible to receive Indian Health Services who live in or near Cherokee, Graham, Haywood, Jackson, and Swain Counties (all in managed care Region 1). Unlike with PHPs, claims for patients enrolled in the EBCI tribal option will continue to be paid directly by Medicaid on a FFS basis.

Another hallmark of North Carolina’s transition to MMC is its approach to improving the social determinants of health for Medicaid beneficiaries. The Centers for Medicare & Medicaid Services (CMS) approved a Section 1115 demonstration waiver in 2018 to provide financing for a new Healthy Opportunities Pilot program that allows NC Medicaid to use up to $650 million to address specific...
social needs of Medicaid beneficiaries that are tied to overall health and health outcomes (Hinton et al. 2019). This enhanced case management model will allow Medicaid to pay for safe and healthy housing, groceries, transportation, and other urgent needs (NC Medicaid 2021b). All PHPs and the EBCI must screen enrollees to assess their nonmedical needs and connect them to appropriate community resources. In 2019, North Carolina launched an online platform for social services, NCCARE360, to allow health care and social services providers and insurers to make referrals to services, stay connected about whether beneficiaries’ social needs are being met, and track outcomes (Hinton et al. 2019; Thomas and Ferguson 2019).

As of July 1, 2021, almost 1.6 million Medicaid beneficiaries were transitioned to managed care and enrolled in PHPs, including most parents and children, pregnant women, and non-Medicare Aged, Blind, and Disabled populations (NC Medicaid 2019). Some groups of Medicaid enrollees are excluded from managed care and will continue to receive care through the FFS system, also known as Medicaid Direct in North Carolina, including groups who qualify for family planning services, those who have extensive medical needs, those who partially qualify for Medicare, and people enrolled in the Program of All-Inclusive Care for the Elderly (NC Medicaid 2019). Finally, the state has temporarily delayed the transition to Medicaid managed care for some beneficiaries with behavioral health conditions and other groups, such as dually eligible Medicare and Medicaid beneficiaries. Specifically, beneficiaries who have significant behavioral health needs and intellectual or developmental disabilities will be enrolled in tailored plans as of December 1, 2022, though these groups are free to enroll in a PHP in the first phase of the transition if they chose (NC Medicaid 2021a). But beneficiaries with behavioral health needs who chose to enroll in a PHP may lose some benefits that are currently covered in Medicaid Direct (NC Medicaid 2021a).

Effects of Medicaid Managed Care: Lessons from Other States

The transition to risk-based managed care has the potential to improve or worsen access to and quality of care among Medicaid beneficiaries, or to improve or exacerbate health care disparities. Although managed care presents opportunities for increased care management and care coordination at lower cost to Medicaid, the way incentives are structured in managed care programs often prompt concerns that MCOs will ration services to maximize profit. Other states’ experiences with transitioning to MMC have produced mixed results in terms of access to and quality of care and impacts on health care costs. Systematic reviews of literature from managed care implementation both pre- and post-ACA
indicate that access improvements for beneficiaries under MMC is state-specific (Franco Montoya, Chehal, and Adams 2020; Sparer 2012). Studies from California, New York, and Wisconsin find improved rates of having a usual source of care, reductions in emergency department visits, and fewer admissions for ambulatory care-sensitive conditions (Bindman et al. 2005; Levinson and Ullman 1998; Sisk et al. 1996). Oregon’s coordinated care organization model was associated with reduced costs and improved access to and quality of care, but results were mixed depending on the comparison state (Franco Montoya, Chehal, and Adams 2020). A 2012 literature review concluded that although Medicaid managed care is unlikely to significantly lower costs, it can provide more “predictability and stability in Medicaid expenditures” (Sparer 2012). A more recent analysis concluded that some states have reduced Medicaid costs by implementing managed care, particularly for high-risk populations, but notes cost savings and predictability may be specific to state policies or health plan activities and not generalizable to Medicaid managed care itself (Franco Montoya, Chehal, and Adams 2020). National studies generally have not found improved access to care under managed care, and the results of between-state studies are mixed (Franco Montyoa, Chehal, and Adams 2020; Greene, Blustein, and Remler 2005; Herring and Adams 2011).

Key lessons of the Medicaid managed care transitions in the 1990s—when many state programs made this shift—point to special considerations for children and pregnant people enrolled in Medicaid. During the transition from FFS to managed care, preserving doctor-patient relationships is especially important, as is protecting traditional safety net providers and enrollees with complex (and often high-cost) physical and mental health service needs and oversight of efficiency and quality standards (Freund and Lewit 1993).

A study examining maternal outcomes among women enrolled in Medicaid found that MMC has not been associated with a higher risk of potentially avoidable maternity complications, which suggests access to prenatal care of “reasonable quality” (Laditka et al. 2004). No differences in potential avoidable maternity complications were detected between urban and rural mothers enrolled in Medicaid, but adjusted risks of complications were higher for Black mothers than for white mothers enrolled in Medicaid in four out of five studied states (Laditka et al. 2004). Another study from the same period found MMC to have virtually no causal effects on prenatal care use, birthing outcomes, and cesarean section (Kaestner, Dubay, and Kenney 2002). More recent findings from Pennsylvania’s Medicaid program showed the adoption of MMC resulted in fewer preventable complications, especially for more severely ill new parents (Hu, Chou, and Deily 2015), though national results are still mixed (Franco Montoya, Chehal, and Adams 2020). An analysis comparing access to prenatal care
before and after the managed care transition found that the Oregon coordinated care model increased rates of timely prenatal care (Oakley et al. 2017).

Medicaid managed care has been found to have modest or neutral effects on children’s health outcomes and access to care (Franco Montoya, Chehal, and Adams 2020). An early study of MMC transitions in the late 1990s indicates that increases in MMC enrollment among children are associated with less emergency room use, more outpatient visits, and fewer hospitalizations, but at the same time, MMC is associated with higher rates of delaying care and lower satisfaction with care (Baker and Afendulis 2005). A national study of state changes to MMC since 2000 found that for 17 states, as MMC enrollment increased, children’s receipt of preventive services also increased, while six states had a negative association between MMC and preventive care access (Kusma, Cartland, and Davis 2021). One study found that children with Type 1 diabetes enrolled in Medicaid managed care were significantly less likely to be readmitted to a hospital within 90 days of discharge than non–managed care Medicaid enrollees (Healy-Collier et al. 2016).

**Purpose of This Study**

The Urban Institute, with funding from the Kate B. Reynolds Charitable Trust, is examining North Carolina Medicaid’s transition to managed care and its effects on equitable health outcomes for North Carolinians, focusing on how Medicaid transformation affects access to and quality of care for pregnant and parenting women and children. The study includes two quantitative analyses to build a foundation for measuring effects of Medicaid reforms on health outcomes for childbearing women and children. Both analyses will describe each population’s health before the managed care transition, including racial and geographic disparities in access to and quality of care, and health outcomes. Establishing these baselines will allow researchers to measure the effects of North Carolina’s managed care transition going forward.

The study also has a qualitative component consisting of interviews with key stakeholders involved in or affected by the implementation of managed care, as well as focus groups with Medicaid beneficiaries. This report summarizes findings from qualitative data collected in spring and summer 2021, while preparations for the managed care launch were under way, to learn about the strengths and weaknesses of the precursor FFS system, implementation progress, and expectations of how the managed care system may affect access to and quality of care and health disparities.
Methods

We began the study in October 2020 by conducting a scan of published peer-reviewed literature examining previous state Medicaid program experiences with shifting from an FFS system to a risk-based managed care system. Topics we examined included the impacts of Medicaid managed care implementation on access to care, quality of care, health care outcomes, and health disparities. We also focused on identifying studies that examine these topics for children and for pregnant and parenting people enrolled in Medicaid.

Between March and June 2021, we conducted semistructured virtual interviews with stakeholders involved in or affected by Medicaid transformation in North Carolina. We identified interviewees through professional networks and recommendations of the study’s project officer and other local stakeholders. We interviewed 23 people from 15 organizations, including representatives from the Medicaid program, prepaid health plans, consumer advocacy organizations, health care provider associations, community health centers, and statewide care collaboratives. Interviews explored the transition to managed care, beneficiary enrollment and outreach, anticipated changes to service delivery, anticipated impacts of managed care on beneficiary access and quality of care, and COVID-19 and other contextual factors.

To capture a range of perspectives and experiences, we conducted virtual focus groups with Medicaid beneficiaries and parents or caregivers of Medicaid beneficiaries in May and June 2021, focusing on pregnant or postpartum people, and parents or caregivers of children with special health care needs (i.e., chronic physical and/or behavioral health conditions). We selected these populations because of their higher likelihood of frequent engagement with health care services and mandatory transition to managed care, though children with significant behavioral health care needs had an option to enroll in a PHP or stay in the FFS system (NC Medicaid 2021a).

We partnered with community-based organizations in North Carolina, including a community health center, a home visiting program, and a child advocacy nonprofit organization, to recruit community residents for six 90-minute focus groups. We conducted two focus groups in Spanish and four in English. Thirty-nine adults participated in beneficiary focus groups, and 1 person participated in a one-on-one interview. Table 1 shows basic characteristics of beneficiary focus group participants and the interviewee. Many focus group participants lived in or around Charlotte, Raleigh, and Durham, North Carolina’s largest cities. Others hailed from more rural areas of Davie and Nash Counties and the smaller cities of Winston-Salem and Burlington. Focus group moderators used a semistructured
question guide that included such topics as beneficiaries’ experiences with the current FFS system, awareness and knowledge of the Medicaid managed care transition, PHP selection and enrollment, and concerns and hopes for Medicaid managed care.

**TABLE 1**
Demographic Characteristics of Focus Group Participants, May through June 2021

<table>
<thead>
<tr>
<th>Demographic characteristic</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Sex</td>
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<tr>
<td>Female</td>
<td>96.2%</td>
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<tr>
<td>Male</td>
<td>3.8%</td>
</tr>
<tr>
<td>Age</td>
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</tr>
<tr>
<td>25–34</td>
<td>38.5%</td>
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<tr>
<td>35–44</td>
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<tr>
<td>65–74</td>
<td>3.8%</td>
</tr>
<tr>
<td>Race or ethnicity</td>
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</tr>
<tr>
<td>Hispanic/Latino</td>
<td>53.8%</td>
</tr>
<tr>
<td>Black/African American</td>
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<tr>
<td>White</td>
<td>15.4%</td>
</tr>
<tr>
<td>More than one race</td>
<td>3.8%</td>
</tr>
<tr>
<td>Rurality of county of residence&lt;sup&gt;a&lt;/sup&gt;</td>
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</tr>
<tr>
<td>Urban</td>
<td>61.5%</td>
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<tr>
<td>Suburban</td>
<td>23.1%</td>
</tr>
<tr>
<td>Rural</td>
<td>7.7%</td>
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<tr>
<td>Not reported</td>
<td>7.7%</td>
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<tr>
<td>Primary language spoken at home</td>
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<tr>
<td>Spanish</td>
<td>53.8%</td>
</tr>
<tr>
<td>English</td>
<td>46.2%</td>
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<tr>
<td>Medicaid beneficiary status</td>
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<td>They are the Medicaid beneficiary</td>
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</tr>
<tr>
<td>Their child is the Medicaid beneficiary</td>
<td>57.7%</td>
</tr>
<tr>
<td>Both they and their child are beneficiaries</td>
<td>26.9%</td>
</tr>
<tr>
<td>Sample size</td>
<td>26 participants</td>
</tr>
</tbody>
</table>

**Source:** Focus group discussions from May through June 2021.

**Note:** Participants were a nonrandom convenience sample, and the demographic characteristics of focus group participants do not reflect demographics of the overall Medicaid population.


The research team recorded, transcribed, and translated to English all interviews and focus group discussions as applicable and analyzed them to identify key insights and common themes.

Our qualitative data collection occurred during the PHP open enrollment period just before NC Medicaid Managed Care launched and during the COVID-19 pandemic. As such, our findings offer
unique insight into Medicaid beneficiaries’ experiences and an unprecedented public health crisis. Virtual interviews and focus groups allowed us to conveniently reach Medicaid beneficiaries without risking participants’ safety during the pandemic. Our findings may not capture the experiences of Medicaid beneficiaries who did not have access to video technology to participate in these focus groups. Additionally, our findings may not capture any emerging circumstances related to Medicaid transformation that occurred following our data collection period. We interviewed and held focus groups with a small number of stakeholders, and as such, we may not have captured some important perspectives. All participants were a nonrandom convenience sample. For all these reasons, our findings may not represent perspectives and experiences of all stakeholders and beneficiaries involved in or affected by the managed care transition.
Findings

The following section summarizes our findings from stakeholder interviews and Medicaid beneficiary focus groups. We first describe study participants’ perspectives on NC Medicaid’s preexisting FFS delivery system and then summarize how stakeholders were preparing for the program’s transition to risk-based managed care and the beneficiary experience just before the change. We conclude by reviewing participants’ expectations for how the shift to managed care might influence access to care, health outcomes, and health equity among Medicaid enrollees.

Perspectives on NC Medicaid’s Fee-for-Service Delivery System

Key informants and focus group participants agreed that Medicaid was a fundamental safety net program that provided critical health care services to many low-income North Carolinians. Informants emphasized that high levels of provider participation and enhanced care coordination (primarily through CCNC) were hallmarks of the program. But most study participants also acknowledged there were gaps, inefficiencies, and inequities in the system because of limited accountability for outcomes.

Most Key Informants Described Very Good Access to Care

Most informants viewed the FFS Medicaid system in North Carolina as providing very good access to primary care, largely because of “exceptionally high” levels of provider participation among primary care, pediatric, and obstetrician and gynecology practices. In describing the state’s especially high rate of provider participation, several interviewees pointed out that Medicaid pays relatively well. Medicaid reimbursement rates are 100 percent of the Medicare fee schedule in North Carolina, and primary care practices qualify for the above-described PMPM payments for care management. One informant said Medicaid has been an “excellent program” that has helped millions of North Carolina residents gain access to medical, dental, behavioral health, and other specialist care. When comparing the FFS system with a managed care approach, another informant highlighted the simplicity of access to care under the FFS approach, noting that beneficiaries did not have to worry about whether a provider was in a health plan’s network and could access care from any provider that accepted Medicaid.

Similarly, most beneficiaries who participated in our focus groups reported overall satisfaction with the FFS Medicaid program, highlighting that it was an important resource. They expressed gratitude for
the program and the access to health care it provided. Some highlighted that, without Medicaid coverage, they could not have afforded care for themselves or their children.

But informants and focus group participants pointed out weaknesses in the Medicaid program. Some interviewees lamented the program's restrictive eligibility limits, especially for low-income (nonpregnant) adults, given that North Carolina has not yet adopted the ACA's Medicaid expansion. Others identified barriers to care in Medicaid, including limited access to specialty care, provider shortages in rural areas, and transportation barriers. According to our interviewees, access to specialty care, such as dental and behavioral health care, is limited because these providers participate in Medicaid at lower rates, and those who do participate often limit the number of Medicaid patients they see. Furthermore, some interviewees said access to care in rural areas can be dire, with some North Carolina counties having limited or no access even to primary care in Medicaid. One interviewee said about 20 counties do not have a pediatrician who accepts Medicaid. Lastly, a few interviewees described limited public transportation options in much of the state and cumbersome administration of the nonemergency Medicaid transportation (NEMT) system. For example, the NEMT benefit provides bus passes that have limited value without sufficient public transportation options. Buses may also not be accessible for people with mobility challenges. Furthermore, the NEMT van service is designed so beneficiaries might need to spend all day traveling to and from their medical appointments because vans pick up and drop off multiple people in each trip.

Medicaid beneficiaries who participated in our focus groups described some negative experiences with Medicaid, including how access challenges affect them. Multiple participants spoke about long waits for appointments with specialists and traveling for several hours to see a provider who accepts Medicaid. Some participants highlighted coverage gaps, noting that dental and vision services were not adequately covered (if at all), and coverage for some specific therapies or medical equipment for children with special health care needs was not comprehensive enough. One parent said they receive medical supplies for their child on a less frequent schedule than the manufacturer recommends, and another had to wait many months for a specialized bed for their child. Other parents felt that Medicaid did not cover enough services to help their child get better (e.g., coverage was limited to only 15 minutes of therapy as opposed to a full hour). Participants who were parents or caregivers of children with special health care needs had more concerns about Medicaid coverage than others in the focus groups. Parents and caregivers spoke about challenges finding behavioral health care providers for their children and said that the in-home assistance they received was of poor quality, which they linked to low reimbursement rates for home health workers. Lastly, multiple beneficiaries reported that the perceived stigma associated with Medicaid made them feel uneasy being enrolled.
Medicaid's Care Coordination Infrastructure Was Also a Major Strength

Several informants felt that the state’s existing infrastructure for coordinating care, namely the CCNC network, was a major strength of the FFS system and wondered whether the managed care program would be able to perform this function as efficiently. One interviewee noted that CCNC’s pregnancy medical home program was available in every county, with about 95 percent of the state’s obstetric providers participating. A provider described the program as something that is “a really special and somewhat unique part of the mechanics of the [Medicaid] system right now.”

Some informants felt CCNC care management was akin to a value-based care approach in that there was a PMPM fee structure for enhanced care coordination for both the CCNC and primary care providers who participate in the network. But several interviewees noted the PMPM payments were not tied to outcomes and lacked incentives for providers to deliver high-quality and timely care, ultimately leading to calls for greater accountability through a managed care system. One informant stated, “The legislature wanted more stability and predictability in the Medicaid budget, and they weren’t getting that through CCNC.”

Focus group participants reported no experience with care coordination. This may be because care coordination is integrated into routine primary care in a way beneficiaries do not recognize as extra unique service. But when we asked about assistance with navigating different services and scheduling appointments among a group of parents of young children with special health care needs who appeared to qualify for enhanced care coordination, the participants could not recall receiving such services, and some said they would welcome it.

Health Inequities Existed across the FFS System

According to informants, North Carolina Medicaid has historically not performed well on general quality measures, which some said was because of limited provider accountability for outcomes. As one informant put it, “Nobody’s feet were held to the fire,” and other informants agreed there was always room for improvement. Beyond the health care access inequities for rural beneficiaries, informants observed several racial and ethnic inequities in the FFS system. For example, state officials identified some prior authorization requirements, which can be administratively burdensome for providers and a barrier to care for patients, as biased against racial and ethnic minority groups when the requirements targeted conditions that people in these groups are more likely to have, such as sickle cell disease or diabetes.
Other interviewees cited recent North Carolina–specific analyses documenting disparities in Medicaid; one study found that Black and American Indian and Alaska Native children receive less dental care than white children, and another study showed worse birth outcomes for babies born to Black and American Indian and Alaska Native mothers than for babies born to white and Hispanic/Latinx mothers (Menard 2021). Another interviewee mentioned that a recent analysis of coverage continuity in Medicaid found that Hispanic/Latinx children were more likely to have gaps in coverage relative to other racial and ethnic groups, which this informant believed could be related to language barriers (Benzing and Dong 2021).

In our focus groups with Spanish-speaking parents of Medicaid-enrolled children with special health care needs, participants described challenges finding providers who speak Spanish and receiving Spanish-language information about available programs and supports for their children. One participant stated, “We feel like the Hispanic community is less included and wanted in these programs [for kids with special health care needs] than other mothers. There isn’t enough information out there [in Spanish].”

Preparations for Medicaid Managed Care Implementation

During our interviews, most informants working within the health care system (e.g., PHPs, Medicaid officials, and health care providers) were preparing for the managed care launch and were focused on activities related to developing provider networks, educating providers and beneficiaries about upcoming changes, and finalizing health plan contract requirements. Informants noted that even though the managed care program was designed to maintain access to care for beneficiaries and minimize administrative burdens on providers, many anticipated that at least initially, there would be disruptions in access and administrative hassle for providers. Though the state and its contractors made efforts to notify beneficiaries about the transition to PHPs and assist them, several informants worried that the information was not accessible and comprehensible, which was largely the experience of Medicaid beneficiaries who participated in our focus groups. Lastly, although the COVID-19 pandemic prompted a more intentional focus among state officials and PHPs on addressing health inequities through managed care, informants noted that the rollout of managed care during a pandemic posed a considerable strain on everyone involved.
Building Provider Networks Was a Key Focus for PHPs

Several stakeholders, particularly representatives of the state Medicaid office and prepaid health plans, stressed that much of their focus in preparing for the managed care transition was on building provider networks to preserve access to care by achieving high provider participation rates. State officials reported that PHPs were also keeping provider diversity in mind and aiming to recruit practices with physicians and staff of color into their networks so “that people [patients] are able to see folks [providers] that look like them.” With respect to provider recruitment, one PHP representative shared that their plan’s outreach and communications strategy to the provider community includes a description of the added benefits and value to the patients that the plan offers, as well as highlighting the plan’s expertise with care management and assistance they would provide to practices to link patients to social services (which is a new expectation under managed care). Other informants mentioned that providing more integrated services to patients, including behavioral health care and social services, and getting paid for value and care outcomes were potential benefits of Medicaid managed care in North Carolina. But providers generally noted that the care management services PHPs will provide under managed care are the same as those that providers have already been responsible for under Medicaid’s PCCM-FFS system.

One state official noted that negotiations between PHPs and providers can lead to tensions. For example, a state official said that a health plan would claim, “Well, the service provider group is not willing to participate with us,” but the provider group would respond saying, “What’s happened is that the health plan is not willing to offer something that’s reasonable for us to participate.” PHP representatives reported that it was easy to contract with primary care providers and specialists that have traditionally participated in Medicaid, but negotiating with some subspecialty, outpatient, and hospital systems has been harder, likely because they have more leverage. Nevertheless, the PHPs that participated in this study were confident they would be able to contract with all the major health and hospital systems to meet the state Medicaid program’s network adequacy standards. One PHP representative explained that even though all contracts may not be in place by July 1 (the official launch of the Medicaid managed care in North Carolina), the outreach and negotiations with practices will be an ongoing process to try to ensure all members enrolled in their plan can see providers with whom they have existing relationships. The Eastern Band of Cherokee Indians plan representative shared that contracting with primary care providers has been a smooth process, particularly because providers in the EBCI network will continue to be reimbursed directly by the Medicaid agency, and as such, providers did not expect to see any administrative changes around billing or payment processes.
Overall, providers discussed the shift to risk-based managed care in terms of its administrative challenges, with limited optimism about its potential benefits. Provider representatives felt that contract negotiations with health plans were difficult. In some cases, providers would sign contracts even before all the specifics were ironed out, including payment rates. But the general perception across our interviews was that provider payment rates would not be lower under managed care than they had been in the FFS system. Informants indicated that smaller practices, independent provider groups, rural providers, and those seeing patients with high social needs would be the least prepared to handle the transition to Medicaid managed care, especially compared with larger providers and those affiliated with major health care systems or hospitals. One interviewee speculated that small practices may end up affiliating with a clinically integrated network to tap into the contract negotiating expertise as well as data and care management infrastructure.

Besides contract negotiations, providers reported many other concerns about the upcoming shift to Medicaid managed care. A top concern related to possible delays in claims processing and payments, which commonly occur when benefit administration changes hands. Providers also worried that problems with beneficiary PHP enrollment could result in the loss of their primary care patient panels. More specifically, the common online Medicaid PHP provider search tool was not working well, and informants reported that it often included incorrect provider information. This made it difficult for patients to select a plan their current primary care provider accepted, which could prompt them to choose another (and result in a PCP losing a patient on their panel). We also heard concerns that patients who were autoenrolled in a plan were not necessarily assigned to a plan that included their primary care provider. Providers shared that such issues could lead to reduced access to care for beneficiaries. Furthermore, some obstetrician and gynecology providers thought they may be at risk of out-of-network (and therefore lower) reimbursement if they cared for a patient’s newborn during the postpartum period, if that newborn ultimately ended up enrolled in a different PHP than the birthing parent.

Furthermore, we heard concerns about additional administrative complexity, such as prior authorization and reporting requirements. According to one interviewee, some providers feared that managed care plans will try to make a profit by restricting access to services such as through a greater emphasis on utilization management. Another interviewee said specialty providers were worried about new prior authorization requirements, and NEMT providers thought there may be additional driver’s certification requirements under managed care. But state officials and several PHP representatives assured us that the rules around prior authorization will not be different from the FFS system. Multiple provider representatives expressed concern that the transition will lead to a short-term focus on the administrative tasks of setting up reimbursement relationships, collecting required data, and reporting
metrics at the expense of providing high-quality patient care. As a representative of one provider organization put it,

At the end of the day...we need to have the financial resources going towards patient care and not administrative costs. And what managed care is potentially going to do is going to cause more administrative costs, and that’s going to mean our already scarce resources now are going to have to go towards the administrators. That’s gonna pull money away from direct care.

The state provider associations, including some we interviewed for the study, were highly involved in the transition and making sure members’ concerns were being elevated and members were being educated about what the shift to risk-based managed care means. Overall, informants agreed the Medicaid agency made a great effort to address provider concerns and confusion, including by producing webinars and holding regular meetings with providers to give updates about the transformation progress and answer questions. Moreover, the state took steps to incorporate input from providers into policy. For example, the above-mentioned concerns about panel assignment led the state to change the auto-assignment algorithm to better match beneficiaries with their current providers. Even so, state officials acknowledged errors were still likely, and beneficiaries may be switching providers and plans in the first few weeks of managed care implementation. Additionally, the PHP leadership had been meeting for more than a year before managed care implementation to work on aligning some policies and processes (e.g., prior authorization forms) across the plans to minimize the burden on providers. Perhaps because of the Medicaid agency and PHP’s efforts around provider engagement and collaboration before the implementation period, informants generally indicated that they expected contracting and payment concerns to resolve themselves after the initial transition period, or the first 90 days after the managed care launch.

**PHPs Were Also Preparing to Meet Various Contract Requirements**

We also explored activities health plans were engaging in to implement new infrastructure and processes and meet specific expectations as defined in the managed care contracts, including coordinating enrollees’ care, addressing social determinants of health, ensuring care transitions during the implementation period, and addressing health disparities.

**COORDINATING AND MANAGING CARE**

The state’s PCCM (Carolina ACCESS) program will be phased out as part of the transition to risk-based managed care. CCNC will continue, on a smaller scale, to provide care management to independent providers who are part of North Carolina’s clinically integrated network, but much of the responsibility for coordinating Medicaid beneficiary care will fall on Advanced Medical Homes (AMHs), which build on
Carolina ACCESS. PHP representatives reported working with AMHs to get them ready to take on care management for their members. In addition, the state Medicaid agency was offering enhanced PMPM payments, or “glidepath payments,” to AMH practices in the three months before Medicaid managed care implementation to build out capacity. In particular, multiple interviewees said data exchange between PHPs and AMHs required additional investments in infrastructure and ongoing monitoring and adjustments to get the data flowing correctly. Provider representatives noted that even though practices were interested in becoming a level 3 AMH because of higher reimbursement for care management, some practices dropped out because of the amount of work required to meet expectations (box 3).

BOX 3
The Advanced Medical Home Program

Under the North Carolina Medicaid managed care program, PHPs are primarily responsible for care management in coordination with primary care practices who participate in the AMH program. The AMH program’s tiered structure designates practices based on their capacity to deliver care management. Tier 1 and Tier 2 practices are expected to meet the same basic requirements and be eligible for the same nominal fees of between $1 and $3 per member per month established under the PCCM Carolina ACCESS program, such as providing 24/7 access to medical advice and services, refer to other providers, and provide interpretation to non-English speakers. For practices designated as Tier 1 or Tier 2, PHPs will retain primary responsibility for care management in close coordination with practices.

In contrast, Tier 3 practices assume primary responsibility for care management, by either directly delivering care management to beneficiaries or contracting with other care management entities. Practices designated as Tier 3 must meet Tier 1 and Tier 2 requirements and stratify all patients based on risk and develop care plans and provide care management to high-risk patients. Additionally, Tier 3 practices must provide transitional care management to patients after an emergency department visit or hospital stay and demonstrate capacity to exchange real-time data with emergency departments and hospitals and receive claims data. To compensate practices for taking on additional responsibility, Tier 3 practices will be eligible for additional PMPM fees and performance incentive payments.


ADDRESSING SOCIAL DETERMINANTS OF HEALTH

In addition to traditional coordination of medical services, a new requirement for managed care plans is to identify and coordinate services for members’ unmet health-related social needs. The expectation is that all PHPs and providers in their networks will screen members about their social needs and address those needs, including by working with the NCCARE360 platform to link members to available community resources. Plans are taking different approaches to implementing this requirement. One PHP representative reported that screening for social needs will be incorporated into its health risk assessment questionnaire. Another plan representative shared that providers in their network will be primarily responsible for screening patients for social needs but that the plan will provide scripts and training. A different plan representative talked about tying pay for performance payments to screening for social needs to encourage providers to conduct the screenings. But plans also acknowledged that a common concern and source of resistance from providers when complying with screenings is the fear of not being able to address an identified need. One informant said, “A lot of providers have been cautious about depression screening, intrapersonal violence screening...like, Okay, what if I get a yes?” To that end, NCCARE360 will not only link people with unmet needs to available resources but allow the state to monitor where the gaps are, according to one interviewee.

SUPPORTING CONTINUITY OF CARE

The state agency and PHPs also planned for how to make the initial transition period as smooth as possible, as some fluidity in enrollee plan and provider assignment was expected. The state publicized its goal that no Medicaid beneficiary should experience disruptions in care and no provider should experience delays in payment. In fact, several informants mentioned how the secretary of health and human services said that “patients will be seen and providers will be paid on day 1 [of the launch].” To support continuity of care, the state asked PHPs to honor prior authorizations issued before or during the transition period. Furthermore, PHPs are expected to help members transition from out-of-network to in-network providers in the first 90 days of enrollment but must fully reimburse care received out of network during this period. Several informants remarked that this provision is particularly important for newborn care; providers can continue to provide services to newborns for the first 90 days and get fully paid while their PHP enrollment and usual source of care is being established. Some PHP interviewees told us they will attempt to first reach out to out-of-network providers their members are seeing to contract with them before they ask members to find new providers.
ADDRESSING HEALTH DISPARITIES

NC Medicaid’s health transformation process, and the shift to risk-based managed care, has emphasized addressing health disparities. The state amended PHP contracts in the months before the managed care launch to include a greater health equity focus. PHPs will be required to undertake performance improvement projects focused on closing racial and ethnic disparities in access to care. The Medicaid agency was still finalizing its managed care quality monitoring strategy during our interviews in 2021, but state officials said the measures will be familiar to providers and related to preventive care and recommended screenings, such as well-child visits, child immunizations, and comprehensive diabetes care (table 2). The EBCI representative commented that the state was “generous and accommodating” when selecting measures for the tribal option that were aligned with measures providers had been historically tracking.

To address disparities, PHPs will be required to collect and report performance data on selected measures by various demographic and socioeconomic characteristics, such as race and ethnicity, age, gender, and locality. If an analysis of disaggregated data shows disparities of more than 10 percent, the PHPs will be required to address them. In addition, plans will be subject to withholds of a portion of their capitated PMPM payment based on their performance on a set of priority metrics, starting in contract year three. One PHP representative said the plan is developing concrete incentives for all providers who meet performance measures, though because of the Healthcare Effectiveness Data and Information Set measure construction that requires a period of continuous enrollment, the quality incentives will not be available to providers until 2022. Another plan representative thought Medicaid’s requirement to collect and stratify performance data by race and ethnicity and address disparities would have spillover effects in their other lines of business.
### TABLE 2
Quality Measures Required for Reporting by PHPs and AMHs

<table>
<thead>
<tr>
<th>Measure</th>
<th>Abbreviation</th>
<th>Required for PHPs</th>
<th>Required for AMHs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child and adolescent well-care visits</td>
<td>WCV</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Childhood immunization status (combination 10)</td>
<td>CIS</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Immunization for adolescents (combination 2)</td>
<td>IMA</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Total eligible people receiving at least one initial or periodic screen (federal fiscal year)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Use of first-line psychosocial care for children and adolescents on antipsychotics</td>
<td>APP</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Well-child visits for the first 30 months of life</td>
<td>W30</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Adult measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>CCS</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Chlamydia screening in women (total rate)</td>
<td>CHL</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Comprehensive diabetes care: Hemoglobin A1C poor control &gt; 9.0%</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Controlling high blood pressure</td>
<td>CBP</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Flu vaccinations for adults</td>
<td>FVA, FVO</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Medical assistance with smoking and tobacco use cessation</td>
<td>MSC</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Follow-up after hospitalization for mental illness</td>
<td>FUH</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Screening for depression and follow-up plan</td>
<td>CDF</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Use of opioids at high dosage in persons without cancer</td>
<td>OHD</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Use of opioids from multiple providers in persons without cancer</td>
<td>OMP</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Concurrent use of prescription opioids and benzodiazepines</td>
<td>COB</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Plan all-cause readmissions: Observed versus expected ratio</td>
<td>PCR</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Total cost of care</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Rate of screening for unmet resource needs</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Maternal measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low birth weight</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prenatal and postnatal care</td>
<td>PPC</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Rate of screening for pregnancy risk</td>
<td></td>
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<td></td>
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</table>


Notes: AMH = advanced medical home; PHP = prepaid health plans. PHPs are the standard plans administered by managed care organizations for Medicaid beneficiaries.

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**The State Used Multiple Strategies to Educate and Assist Beneficiaries**

The state deployed a multipronged communications strategy to notify beneficiaries of the transition to managed care and to help with PHP enrollment. This communication included mailing notices to beneficiaries, developing a website with pertinent information, launching an enrollment portal online and via mobile app, and hiring an enrollment broker to manage the process, which included staffing a call center. In addition, the state was working to launch an ombudsman program to go live in April to be a resource and educational hub for beneficiaries to help them navigate changes and resolve any issues.
with the managed care system. Some interviewees felt the state did a good job making information and assistance available, particularly considering pandemic-related disruptions. But informants also identified problems and concerns. Several thought the website was difficult to navigate even for people with strong computer and literacy skills. Another interviewee reported that the provider lookup tool on the website (i.e., to find whether specific providers were included in a plan network) was difficult to use. Another said they had heard about technology glitches where calls intended for the enrollment broker were being routed to a health plan customer center instead.

Regarding mailers, one informant heard that beneficiaries who were supposed to be exempt from managed care enrollment had received notices in error, causing undue stress. Others suggested that standard mail communication was problematic because housing instability for low-income residents has been exacerbated by the pandemic and because mailed notices were available only in English and Spanish.

Overall, our conversations with focus group participants reinforced informants’ concerns about beneficiaries’ awareness and understanding of the implications of the transition from an FFS model to risk-based managed care. Many focus group participants expressed confusion about the transition and concern about how it would affect their coverage and ability to see current providers, and some suggested they did not have the time or information to feel comfortable with their plan selection. Most beneficiaries reported receiving a letter from the Medicaid program about an upcoming change, but the notice only raised more questions and, for some, anxiety or fear. Beneficiaries sought out more information either by calling enrollment brokers, consulting with trusted health care providers, or speaking with other beneficiaries. Still, some could not meet with their doctor or get in touch with an enrollment broker (which they related to overloaded call centers) in time to select a plan. One beneficiary explained,

I received a letter in the mail saying that I need to pick the plan by a certain date, and I was not given any other information as to what was the difference between the plans or if my providers accepted certain plans.... I just picked the plan because I needed to pick one before the date.... I don’t feel like we were given the adequate information to pick the best plan for my daughter.

Parents with children who had special health care needs expressed concern about the lack of information, particularly for the additional therapies and specialized services their children required, and whether they were covered under a given plan. These parents reported an overall lack of understanding from enrollment brokers, health care professionals, and social service providers and administrators about how this change would affect their children. One parent whose child was exempt from mandatory PHP enrollment because of their health needs (but was still eligible to enroll in managed care on a voluntary basis) called the enrollment broker call line to test their knowledge in this
area. Recounting that experience, the participant reported feeling like the enrollment broker relayed inaccurate information by suggesting there would be no negative consequences to choosing a PHP instead of remaining in FFS Medicaid. The participant was troubled that the broker did not seem aware that the PHP would not cover several specialized services their child currently receives under FFS Medicaid.

The state Medicaid agency asked provider organizations, community-based organizations, and other entities to spread the word and help beneficiaries understand the transformation and plan selection. The agency developed informational materials and flyers for providers and other entities to educate them about managed care so they could effectively assist Medicaid members. One informant noted that some providers were more adept at assisting Medicaid patients, particularly practices that already had in-house insurance enrollment navigators. PHPs also conducted their own marketing within the bounds of what is allowable. One plan representative reported deploying a community-engagement team to work with community-based and faith-based organizations in notifying Medicaid members about managed care. But one interviewee representing a consumer advocacy group was concerned that PHPs were reaching out to community-based organizations merely a few weeks before managed care officially launched.

With respect to open enrollment and proactive plan selection by beneficiaries, several informants referenced experiences from other states’ shifts to Medicaid managed care, which suggest that only 10 to 15 percent of Medicaid beneficiaries select a plan on their own and the remainder are autoenrolled. Although most informants believed North Carolina’s experience would be similar, some thought the share of beneficiaries self-selecting plans may have been even lower because the transition had already been postponed once before (so beneficiaries may be skeptical about whether it was actually going to happen this time) and because of stress and other pandemic-related pressures. Indeed, the EBCI representative told us that only about 25 tribal members self-enrolled in the tribal option or one of the PHPs, and more than 3,600 were autoenrolled.

Overall, we heard varying experiences from beneficiaries in the focus groups: some had enrolled in a plan, some had been enrolled automatically, some were unsure about whether to enroll in a plan, and some did not know about the change. Most participants reported hesitancy because of an overall lack of information needed to make the right choice for their family. Several people reported calling their provider to ask which PHPs the provider contracts with but said providers often could not answer that question. Focus group participants highlighted that it was stressful and time-consuming for parents, particularly those whose children see multiple providers, to call all of them and try to figure out which
plan covers the largest proportion of their current providers. One focus group participant expressed frustration with the selection process:

I had to do so much work and call so many times; it was hard to get information, and the information I received was confusing.... The call lines are rushing us and want us off the line. They told me to call other numbers and then [the people answering] those numbers told me that all the plans are the same.

Many beneficiaries said the available resources were confusing and not easy to understand. Additionally, participants highlighted a need for hands-on assistance through the plan selection and enrollment process. A few people mentioned receiving help from a nurse, and having that support was instrumental for answering questions about enrollment, even though some still had unresolved questions. Additionally, multiple beneficiaries reported enrolling in one plan but receiving correspondence from the Medicaid program that they were enrolled in a different plan.

Informants believed that beneficiaries who actively enrolled in a plan chose it primarily based on whether their preferred provider was included in network rather than based on extra perks the plans offered, such as over-the-counter pharmacy gift cards or gym memberships. Beneficiaries who participated in our focus groups largely confirmed that their primary criterion for plan selection was whether their current provider(s) were covered under the plan. Only a few focus group participants thought the plans’ extra perks were helpful. One person picked her plan because it offered chiropractor coverage. One soon-to-be mother noted that she would randomly select a plan for her child because none of the perks or benefits offered in a given plan would benefit her newborn. Another focus group participant said,

I thought it was a little disconcerting to have that list of all the perks. That, to me, was like a real distraction. I know that it was supposed to be a benefit, but I just saw so many families trying to decide on the insurance they were going to choose based on whether or not they were going to get a gift card. I just thought it was...I don’t know...I had a problem with that.

The Pandemic Affected Medicaid Transformation Design and Implementation

Many informants suggested the COVID-19 pandemic put a much-needed spotlight on existing inequities in North Carolina’s health care system, mainly COVID-19’s disparate burden on communities of color, and spurred efforts to address inequities much faster than would have otherwise happened. State officials shared that the Medicaid agency took a closer look at policies that may perpetuate inequities and took steps to address them. For example, the agency removed prior authorization requirements from several services and prescriptions for conditions that were disproportionately prevalent among people of color. During the pandemic, the agency also vastly expanded telehealth and...
allowed phone appointments to qualify as telehealth for coverage and reimbursement purposes, in response to concerns about inequitable access to video technology and broadband among, for example, immigrant families and families in rural areas. The agency also began piloting a program to pay primary care providers for screening patients for unmet social needs during the pandemic.

Though the pandemic delayed managed care implementation, state officials said this delay allowed them to incorporate a greater focus on addressing health disparities and noted that they continue to explore ways to advance health equity through managed care contracting. Proposed provisions include alternative payment methodologies (e.g., higher PMPM payments to providers serving marginalized populations) and requirements to better engage Medicaid beneficiaries in program design and implementation, implement culturally effective care practices, and include diverse representation on PHP oversight bodies. One interviewee said they were proud of the efforts the Medicaid agency took to apply a health equity lens to the transformation and PHP contractual requirements, noting that this probably would not have happened so quickly without the urgency the pandemic caused.

Even with the silver lining of having more time to introduce strategies to address health inequities, the pandemic complicated and created a stressful environment for the managed care transition. Implementing managed care while adapting the Medicaid program in response to the public health emergency strained agency staff. Similarly, while health care providers were coping with increased workloads caring for COVID-19 patients and responding to growing mental health and social needs, they had to find time to negotiate contracts with PHPs and prepare for enhanced care management responsibilities. One informant speculated that some providers who were overextended by the COVID-19 response may have been less willing to contract with multiple plans. In terms of the beneficiary experience, some informants suggested that direct face-to-face engagement and hands-on assistance would help beneficiaries understand the transition and how it affects them, but the need for social distancing during the pandemic limited this type of personal outreach.

Perspectives on How Managed Care Would Change Medicaid

We asked key informants and focus group participants to share their concerns about and hopes for how the Medicaid managed care transition would affect access to and experiences with care, as well as health disparities. Some worried that access to care could be negatively affected if managed care–related administrative burdens prompt providers to limit participation in the program or leave it
altogether. On the other hand, informants were hopeful that the increased emphasis on social determinants of health and health disparities would improve Medicaid enrollees’ health and well-being.

**Stakeholders Shared Concerns about Reduced Access to Care**

Many interviewees feared that the added complexity of interacting with five health plans instead of one Medicaid agency could erode access to health care, as some providers may elect to contract with some but not all five PHPs. Most informants were optimistic that providers would eventually join all five networks, but several interviewees, including provider representatives, thought some providers with limited Medicaid panels may stop accepting Medicaid completely rather than contract with a plan. A representative from a provider organization explained,

> My fear is that it’s very complicated [and] practices are being asked to do a lot.... As it becomes harder, some practices may say, “You know, I’m done.” And we’re definitely hearing that. I get calls from practices saying, are we really going live July 1, because I need to start letting my Medicaid patients [know] I’m not going to see them anymore.

When asked about their expectations of how the transition to managed care would affect their health care, beneficiaries who participated in our focus groups articulated considerable uncertainty about what the change would bring, but access concerns loomed large. Many beneficiaries were unsure whether their current providers would be under their selected plan or wondered whether and how they might continue seeing an out-of-network provider after the transition. These concerns were especially relevant for parents of children with special health care needs, many of whom described existing relationships with multiple specialists in addition to their child’s primary care provider. One person noted that her provider’s race and gender made her feel comfortable, and she did not want to change her provider for that reason:

> I like my son’s doctor.... You don’t have too many Black doctors out there, and she’s a Black woman, and I like her. So, that’s the only thing I’m afraid of, oh I have to go to a whole other doctor, and he has to get comfortable with her.

Most beneficiaries who participated in our focus groups were skeptical about their ability to retain their current services, but a few were hopeful about the change, expressing optimism that their access to certain services and referral processes would be streamlined. They wondered whether they might be able to access services not covered under Medicaid Direct, such as vision and dental, or get referrals quicker. But another focus group participant worried that the introduction of so many new plans might create disruptions to established referral networks, making it difficult for providers to know where to refer children.
Some beneficiaries, particularly those who have children with special health care needs, also had doubts or concerns about whether the new plans would cover prescription medications and other services (e.g., physical, occupational, and behavioral therapies) and durable medical equipment (DME). One person noted that she works with two DME medical supply companies to get equipment for her daughter and was concerned about finding a plan that covers all her providers and the DME suppliers. One parent noted, and others agreed, that the Medicaid program understands the needs of people with disabilities and worried that the PHPs would not. A few people also worried about whether the new plans would cover prescriptions.

Some parents and caregivers also voiced concerns about getting prior authorization for services. They had not had trouble getting authorization from Medicaid in the past for services such as genetic testing, and they did not know whether the new plans would have stricter authorization requirements:

> My concern is am I going to have to fight with another insurance company now?... Now [are needed services] going to have to be scrutinized so much that the process will be delayed, you’ll go without services, or you might get a bill or, you know, something else that you didn’t normally?

Additionally, a few focus group participants felt the PHPs might behave more like private insurance plans and, for example, require copays. Though not common across all groups, a few participants described feeling stigmatized because they had Medicaid coverage and did not think this would change when PHPs were involved. One person said,

> I think that stigma is still going to be there because although we have had the options to pick UnitedHealthcare or Blue Cross Blue Shield, [there is still] a difference in the names, so I feel like once they see the names they think, oh, this is Medicaid, you know, so I feel like, it’s not worse, not better.

At least one informant pointed out that the new ombudsman program being implemented as part of the Medicaid transformation initiative will have a positive impact on beneficiaries because this program is designed to help them navigate the new managed care system and resolve problems accessing care and covered benefits.

**Informants Were Cautiously Optimistic about New Approaches to Care Coordination and Management**

Although PHPs must offer enhanced care management services, we heard a mix of provider perspectives about whether such services will go beyond those they already provide their patients under the FFS system. One provider representative concluded, "A lot of things that Medicaid managed care is bringing to the table are the things that our [provider] members are already doing; it’s just going
to enhance what they do." Another provider was more optimistic: "I think some of the prepaid health plans may, in fact, offer more care management above and beyond what the program's been able to do at this point."

But several informants thought that many providers, including maternal care providers, were confused about how care would be coordinated absent CCNC. For perinatal care specifically, providers expressed concern about losing the pregnancy medical home program, and several interviewees found it difficult to envision PHPs as providing the same level of care coordination and attention to pregnant and postpartum women. Although PHPs will be responsible for continuing the care management for pregnant women and at-risk children (DHHS 2018), one interviewee shared, "It's a little bit hard for me to imagine how national insurance companies can get that same touch...and get to know the community. I don't want to sound negative, but it's hard for me to imagine that touch statewide."

**Key Informants Were Hopeful That Medicaid Managed Care Would Improve Health Outcomes and Help Address Inequities**

Provider representatives consistently shared that, once implemented, the transition to Medicaid managed care would not change the way they provide day-to-day patient care. This was partly because of provider confidence that the same services covered now under FFS Medicaid will continue to be covered under managed care. Many of this study's interviewees, including providers, expressed hope that the transition to managed care could eventually improve health outcomes. One provider highlighted the increased emphasis on quality metrics, noting that in the FFS system, quality improvement depends on individual provider interest and initiative, but when quality metrics and monitoring are written into managed care contracts, all providers in the network must become more proactive about investing in the infrastructure to improve quality.

Providers also saw an opportunity in managed care for more and better integration of behavioral health services with physical health care. And multiple informants thought the transition could support community-level improvements focused on social determinants of health. They suggested that the FFS model, with its focus on individual patients rather than communities, would never be able to achieve this type of result. State officials and other informants expressed similar hopes that enhanced care coordination that focuses on identifying and addressing Medicaid enrollees' unmet social needs will improve health outcomes.

Some informants thought North Carolina's Medicaid transformation could address inequities. One interviewee characterized managed care as applying new resources and tools to address health
inequities (e.g., requirements for PHPs to disaggregate quality metrics data by race and ethnicity, and financial incentives to address disparities the plans identify in the data). Another interviewee was worried that even though addressing inequities was good, the plan for accomplishing this goal was too lofty and “lacking some of the pragmatic, more concrete...actual steps.” Yet another informant expressed concern that having PHPs compete with one another for patients by offering additional perks and services would lead to increased inequity in access among Medicaid beneficiaries across plans:

It seems like there's a competition between all of the PHPs as to who's going to have the best services. And instead of, let's make sure that everyone with Medicaid in North Carolina has equal opportunity and equal access to all services by privatizing Medicaid, we have taken that away and allowed for competition.
Conclusion

In the months leading up to North Carolina Medicaid’s transition to a risk-based managed care delivery system, key stakeholders, including state Medicaid officials, provider associations, and consumer advocacy groups worked to ensure the infrastructure, policies, and resources were in place to support a smooth transition to the new delivery system for both providers and beneficiaries. Our findings indicate that as with any major system change, there were some implementation challenges, including concerns about providers’ capacity to contract with PHPs and difficulties reaching out to and assisting beneficiaries with open enrollment. Medicaid beneficiaries who participated in our focus groups reported some confusion and uncertainty about the upcoming changes, and some experienced difficulties navigating plan selection and enrollment.

To some extent, study participants attributed implementation challenges to the pandemic, which strained staff at the Medicaid agency, health plans, and provider practices, who had to simultaneously respond to the pandemic and manage preparations for the managed care transition. But many informants pointed out that the racial and ethnic health disparities evident during the pandemic forced a more intentional focus on health equity and how Medicaid policies may perpetuate disparities. They viewed the managed care contracting process as an opportunity to address health disparities in North Carolina in a way that had not been done before.

Stakeholders and focus group participants shared perspectives on how the shift to risk-based managed care may affect access to care and health outcomes. Across the board, many were worried that perceived administrative hassles associated with contracting with multiple plans may discourage providers from participating in Medicaid and thereby erode access to care. But some study participants also hoped the accountability for outcomes and the focus on addressing social determinants of health and reducing health inequities in the managed care program would improve health and well-being and reduce health disparities among beneficiaries.

As we continue to monitor implementation of managed care in North Carolina, we will conduct additional interviews and beneficiary focus groups in the first year of risk-based managed care to assess PHPs’ and providers’ experiences with the transition and beneficiaries’ experiences with access to and quality of care.
Notes


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11 Dube, “Primary Care Case Management.”


15 Tosmic, “The North Carolina Experiment.”

16 Tosmic, “The North Carolina Experiment.”


25 See the website for the EBCI tribal option at https://ebcitribaloption.com/.


29 We conducted an individual interview in lieu of a focus group because only one beneficiary was recruited for that group. We used the focus group moderator guide to ask the participant the same questions they would have been asked in a focus group.


32 See the website for NCCARE360 at https://nccare360.org/.

33 The quality performance plan was released in June 2021. See DHHS (2021).

34 Race categories include American Indian/Alaska Native, Asian/Pacific Islander, Black, and white. Ethnicity categories are Hispanic/Latinx, non-Hispanic/Latinx other. See NC Medicaid (2020b).

References


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