



Findings from the First Year of Medicaid Managed Care in North Carolina

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On July 1, 2021, North Carolina began the first phase of its Medicaid program overhaul by transitioning care for nearly 1.6 million Medicaid beneficiaries, including parents and children, pregnant women, and aged, blind, and disabled populations not covered by Medicare, from a fee-for-service delivery system (also known as Medicaid Direct) to risk-based managed care (NC Medicaid 2019).¹ This shift is part of a larger Medicaid Transformation initiative that aims to provide better-integrated services that address both the medical and unmet social needs of Medicaid enrollees.² The Urban Institute, with funding from the Kate B. Reynolds Charitable Trust, is studying the Medicaid managed-care transition and its impacts on access to and quality of care and disparities in health outcomes among Medicaid beneficiaries.

This brief follows up on a report from the preimplementation period that examined preparations for Medicaid managed-care implementation and beneficiaries' awareness of the upcoming changes to the Medicaid program (Allen et al. 2022). Drawing on information collected from key informants and focus groups with Medicaid beneficiaries in the winter and spring of 2022 (box 1), we document their early experiences of and perspectives on the transition to Medicaid managed care and lessons learned. Key findings from this follow-on study fall into the following categories:

- **Plan enrollment.** Key informants characterized the transition to Medicaid managed care as a success, with the majority (about 97 percent) of 1.6 million beneficiaries experiencing little to no disruptions in care. However, about 7,500 beneficiaries with complex behavioral health conditions self-enrolled in standard health plans, which were optional for these beneficiaries, and had to be reenrolled in Medicaid Direct to preserve their access to specialty behavioral health benefits. In addition, Medicaid beneficiaries with high physical health care needs reported challenges finding a plan that included all their preferred providers and needed services.

- **Provider participation and experience.** The shift to managed care may have affected access to care for some beneficiaries, largely because many providers do not seem to contract with all available health plans. Providers cite administrative burdens as their reason for limiting health plan participation, according to key informants. The overall change in the provider Medicaid participation was unknown in spring 2022, partly because of ongoing plan-provider contract negotiations.
- **Access to care.** Despite various provisions and processes to ensure continuity of care during the transition, key informants and focus group participants reported disruptions in access to nonemergency medical transportation benefits and prescription medications. Medicaid beneficiaries with high physical health care needs reported challenges accessing some services and medications, including challenges with the prior authorization process and out-of-pocket costs. Many expressly preferred Medicaid Direct over managed care.
- **Care coordination and social needs screenings.** Little information was available on the implementation of care coordination requirements or whether and how beneficiaries are screened by health plans and/or providers for unmet social needs. Key informants noted that few beneficiaries, less than 1 percent, have taken up the value-added benefits plans offer.
- **Beneficiary outreach and assistance.** Key informants and focus group participants pointed out that health plans continued to struggle with effectively communicating with and assisting Medicaid beneficiaries; for example, informants said the plans were not adequately engaging Medicaid members on their advisory committees. Key informants and focus group participants praised the newly implemented Medicaid Ombudsman program as a critical beneficiary protection.

In the remainder of this brief, we discuss these findings in more detail and conclude with policy implications from these early experiences that may inform future policy and program development in North Carolina, particularly given that the state plans to transition other high-needs populations to managed care. These findings and lessons may be of value to other states interested in implementing Medicaid managed care.

BOX 1

Methods

Between February and March 2022, we conducted eight semistructured virtual interviews with stakeholders knowledgeable about the transition to Medicaid managed care in North Carolina, including Medicaid officials, representatives from health plans and provider associations, and consumer advocates. We first identified and interviewed these informants during the initial round of data collection that took place in spring 2021. The interviews explored early experiences with Medicaid managed care, including plan enrollment, provider participation, and beneficiary access to care.

In April and May 2022, we conducted four virtual focus groups with Medicaid beneficiaries to understand their experiences getting health care and how those experiences may have changed since the implementation of Medicaid managed care. We partnered with North Carolina-based community

leaders and organizations to recruit focus group participants, including pregnant and postpartum women, adults with chronic physical health conditions, and parents or caregivers of children with complex medical needs. Thirteen adults participated in focus groups (we conducted two focus groups in English and two in Spanish), and one person participated in a one-on-one interview in English.

The majority (92 percent) of Medicaid beneficiaries who participated in focus groups identified as female and almost two-thirds (62 percent) were between ages 25 and 44. Slightly more than half of focus group participants (54 percent) identified as Hispanic/Latino and primarily spoke Spanish at home. Almost a quarter of participants (23 percent) identified as African American/Black and 15 percent identified as white. More than half of focus group participants (53 percent) came from urban counties, and the other half was split equally between suburban and rural counties.^a

The research team recorded, transcribed, and, as applicable, translated to English all interviews and focus group discussions and analyzed them to identify key insights and common themes. We interviewed and held focus groups with a relatively small number of stakeholders and beneficiaries and selected participants through a nonrandom convenience sample. Consequently, some important perspectives may not be captured and other perspectives may be overrepresented. In particular, our findings may not capture the experiences of Medicaid beneficiaries who did not have access to video technology to participate in focus groups. Our findings and conclusions should therefore be interpreted with these limitations in mind.

Note: ^a Thirteen of the 14 focus group participants self-reported their demographic information via an online survey. Participants were a nonrandom convenience sample, and the demographic characteristics of focus group participants do not reflect the demographics of the overall Medicaid population in the state. Rural status was determined using the [NC Rural Center](#) definition of rurality based on population density as of the 2020 Census.

Plan Enrollment

Key informants reported that plan selection and autoenrollment went as expected; that is, a few Medicaid beneficiaries selected a plan on their own during open enrollment and most were autoenrolled. State officials and health plan representatives considered the autoenrollment process a success considering that the majority (about 97 percent) of the 1.6 million people who transitioned to managed care were able to keep the same primary care providers they saw before the transition. A health plan representative thought the autoenrollment process was particularly sensitive to keeping families enrolled in one plan and with one primary care provider. A state official credited the smooth autoenrollment process to the agency's thoughtful approach to and extensive refinement and testing of the autoassignment algorithm, including relying on claims data to match members to primary care providers with whom they already had a relationship.

Nevertheless, the autoenrollment formula was not perfect; state officials and other informants said they anticipated some challenges with the process. For example, one informant reported problems with newborns being assigned to a different health plan than older siblings. Medicaid beneficiaries had 90 days after the managed-care launch to switch plans, and the period was later extended by another month to provide additional time for beneficiaries to make changes. Consumer advocates and provider representatives noted this extended flexibility to switch plans was greatly needed because of ineffective communication about the managed-care transition, which resulted in some beneficiaries

only finding out they were enrolled in a health plan when they sought an appointment with their doctors. Key informants reported that beneficiaries most commonly changed plans because their preferred providers were not in their first plan's network. Medicaid beneficiaries who participated in our focus groups corroborated that access to preferred providers was the main reason they had changed or would consider changing health plans.

A state official said the criteria for switching health plans are broad so beneficiaries or their health care providers can request changes to plan enrollment at any time if needed. The decision to allow for more flexibility in switching plans was partly driven by confusion among beneficiaries who have significant behavioral health needs and are therefore eligible for tailored behavioral health plans, which are specialized managed-care plans for beneficiaries with significant behavioral health needs slated to roll out on April 1, 2023.³ According to many key informants, the information about the transition to managed care was sufficiently complex and confusing that about 7,500 people with behavioral health needs selected enrollment in a standard health plan (which was optional for this population) and lost access to some of the services currently available only in Medicaid Direct (but will be available in tailored behavioral health plans). Consumer advocates reported sounding an alarm about this issue in the early days of the managed-care launch, which led the Medicaid agency to reach out to affected beneficiaries and transfer them back to Medicaid Direct.

The focus group participants who switched health plans complained that the process was difficult to navigate and assistance was hard to come by. Participants with high physical health needs (or those with children who have complex medical needs) who regularly see multiple specialists or need additional services such as physical therapy reported that it was stressful, challenging, and time consuming to ensure all their preferred providers and services were covered under the same plan. Some families with multiple children with varying health care needs ended up with their children being enrolled in different health plans to ensure the kids could continue seeing their preferred providers, which focus group participants characterized as a hassle for families to manage. Several participants who had high physical health care needs or who had children with complex medical needs reported going back to Medicaid Direct on their own or at their provider's request, though at least one person reported being switched from a health plan to Medicaid Direct by the Medicaid agency. This suggests that not only people with significant behavioral health needs but also those with complex physical health conditions may require more tailored health benefits and specialized health plans and more robust support in understanding and accessing benefits.

Provider Participation and Experiences

In the months leading up to the managed-care transition, key stakeholders commonly articulated that the transition would negatively affect access to care (Allen et al. 2022). More specifically, some key informants worried that fewer providers would participate in Medicaid because of the perceived administrative hassle of contracting with multiple entities. No data were readily available at the time of our spring 2022 interviews to assess the extent to which provider participation in Medicaid may have changed following managed-care implementation. Several informants pointed out that managed-care

networks were still evolving as plans continued to conduct outreach to and negotiate with providers. However, anecdotal evidence suggests many providers have chosen to contract with some but not all available health plans in their areas (four out of five health plans are statewide). Though key informants thought provider participation in Medicaid was still high, some speculated that practices were limiting the number of plans they contract with to reduce administrative burdens, and those with smaller Medicaid panels may have decided to opt out of contracting with a Medicaid managed-care plan altogether.

Key informants noted that because providers' contracting with available health plans was uneven, access to care for some Medicaid-covered services or in some geographic areas may have worsened. These informants noted that provider shortages were most common in behavioral health care, pediatric specialties, and therapies such as occupational and speech therapy and for most provider types in rural areas. However, key informants also acknowledged that shortages in these specialties and rural areas existed even before the managed-care transition. Several focus group participants reported difficulty finding new primary care providers who were both covered under their plan and taking new Medicaid patients. Furthermore, some participants shared that getting specialty care was more difficult after the transition. For example, some participants were referred to specialists who were out of network. This required them to find another specialist in network and resulted in delayed care because specialists tend to have long wait times for visits.

State officials reported that several health plans requested exceptions from network adequacy standards, but about half of those requests were denied. Health plans reportedly engaged in ongoing efforts to bolster their networks, but negotiations with large provider groups and dominant systems were sometimes prolonged. A health plan representative described proactive outreach to and negotiations with providers; for example, if a member sought out-of-network care, the health plan would immediately engage the provider with a contract offer to ensure the member had access to needed services in network. According to several key informants, at least one major health system had not contracted with a Medicaid health plan as of spring 2022.

Providers' early experiences with Medicaid managed care seem to have aligned with concerns they vocalized before the managed-care launch, namely worries about administrative hassles and delays in payments. According to several key informants, once managed care was implemented providers voiced frustration about additional hassle related to differences among health plans in coding and billing systems and in prior authorization for services (e.g., each plan has different services that require prior authorization). Challenges with denied or delayed claims processing have also been reported. A state official said that a claims data analysis showed payments were not flowing to providers as expected. Health plan representatives reported the payment issues were largely caused by administrative errors, such as missing taxonomies or incorrect provider information, and that health plans prioritized speedy resolution of claims disputes. One key informant noted that these issues are not surprising considering the variation among the data systems and in how data flows across health plans and the Medicaid agency. The informant suggested that more work could have gone into integrating the systems and streamlining processes during the preimplementation period.

Access to Care

In describing what aided continuity of care during the managed-care transition, several informants pointed out the “out-of-network” period, 90 days immediately after implementation during which beneficiaries could receive services from their usual providers regardless of whether a provider was in the beneficiary’s new health plan network. This included requirements for plans to honor prior authorizations issued before or during the transition period and to fully reimburse care received out of network during this period. These provisions were designed to ensure beneficiaries could get needed care even while they were looking for a new provider or switching plans. Despite the state’s efforts to ensure continuity of care, several beneficiaries who participated in our focus groups reported they were either turned away from a provider who was out of network or were charged for services.

Recognizing that networks remain fluid as health plans continue negotiations with providers, beneficiaries were able to access out-of-network providers even after the initial transition period, though this required prior approval from their plans. If a plan approves prior authorization for out-of-network care, patients should not face any costs. Though most focus group participants avoided seeing out-of-network providers or were unaware that they could, several participants reported getting out-of-network care either because they had a strong relationship and comfort level with a certain provider or because the provider was the only specialist in the area to treat their condition. However, these focus group participants encountered issues getting prior authorization approval and having their treatment paid for. Some beneficiaries reported that it took several months of constant follow-up with the health plan to get approval to see an out-of-network provider. Others had to pay for out-of-network care themselves and at the time of the focus group discussion were still trying to get their respective plans to reimburse them for the expenses.

New prior authorization requirements were another source of challenge and frustration for both providers and many beneficiaries. For example, beneficiaries expressed that prior authorization for specialists, therapies, and some medicine is now required under managed care, whereas it was not previously needed with Medicaid Direct. Another beneficiary stated that it was “confusing” to work on prior authorizations, because the communication channels between providers and health plans were not effective. Key informants also described the appeals process for a prior authorization as burdensome and lengthy, with inadequate communication from health plans during the process. A provider representative described considerable confusion and uncertainty among providers about which services may be approved or denied and why. For example, the same service may be denied one week but approved the following week.

Multiple informants indicated that at the start of the transition, there were pharmacy benefit issues where data, such as protected information, diagnoses, claims data, or member eligibility, were not properly transferred from Medicaid to health plans. This resulted in some beneficiaries not being able to fill their prescriptions or having to pay out of pocket for their medications. Indeed, several focus group participants reported having to pay for prescriptions they or their children routinely take. State officials reported the pharmacy data glitch was quickly fixed. However, at least one focus group participant

reported struggling to get their health plan to cover medication their child had been taking for years. When asked about other changes in access to care and services under managed care, some beneficiaries said they experienced longer wait times for appointments with doctors, which was reportedly not the case for Medicaid Direct.

Though most focus group participants reported they were able to get the care they need while enrolled in health plans, some had to go through additional hoops like getting prior authorizations and waiting months to get approvals for services. Overall, many beneficiaries who experienced challenges and delays in care, particularly those who had complex care needs or had children with high medical needs, preferred Medicaid Direct over managed care. As one beneficiary said, “Everything was covered and simple [under Medicaid Direct]. Primary care physicians could give referrals and you could go to see your specialist. Now you have to find whether referred providers are covered in your plan. With Medicaid Direct, it was easy to get dental and vision care too.” Additionally, some participants reported that with health plans they have a new worry that services they or their children need will be denied. Some wondered why the state decided to implement a more complex system when Medicaid Direct was working well in their experience.

Beneficiaries also expressed concern about the overall quality of care in Medicaid. Focus groups participants thought the quality of care available to Medicaid recipients was poorer than the care available to people who are privately insured. Many participants reported experiencing discrimination and being made to feel inferior by both their doctors and front-office staff. These experiences discouraged them from being proactive about their health. This has not changed with the implementation of Medicaid managed care and is an ongoing issue, according to focus group participants.

One of the larger problems interviewees and beneficiaries noted about the transition’s effect on access to care and services was the poor nonemergency medical transportation (NEMT) service. Health plans are now responsible for contracting with transportation brokers to coordinate NEMT services. However, informants reported that health plans have struggled to provide adequate NEMT benefits. Several informants expressed that NEMT services were not properly established at the beginning of the transition and instances of late or no pickups were numerous, which, as a state official put it, “created risk for the people we served.” There were also challenges with contracting transportation vendors in rural areas, which tend to have limited public transportation options and fewer providers. These challenges required residents to travel longer distances to access care. Informants also reported issues with finding vendors that could effectively transport patients who have special needs, such as those who require stretchers to be transported. One informant stated that the current NEMT service “is not a good model generally” in eliminating barriers to care and could contribute to health inequities by exacerbating transportation difficulties rather than ameliorating them.

Beneficiaries had mixed reviews of the NEMT service. Several experienced difficulties getting NEMT services to and from the hospital or a provider’s office and reported needing to instead ask their family members who may or may not have been available. One participant expressed that it was harder to get transportation services under a health plan than under Medicaid Direct. Multiple beneficiaries

did not know about covered transportation benefits. However, a few beneficiaries were able to access transportation services under managed care and had good experiences.

Coordinated Care and Social Services

According to several key informants, care management needs are high among Medicaid beneficiaries; around 74 to 80 percent of beneficiaries are assigned to tier 3 advanced medical homes for care coordination, whereas 20 to 26 percent are managed by health plans. The state dictates advanced medical home care coordination requirements, and health plans are ultimately responsible for ensuring members receive appropriate care management. One informant said plans are effective in setting up care management once people are enrolled, but they speculated that the plans were not proactive in reaching out to their members to ensure they are actually receiving services after the care management link has been established. Another informant similarly stated that Medicaid's risk-stratification process is not transparent; it is not clear how beneficiaries are assigned to care coordination and how they receive it. Provider representatives were not aware of any concerns or issues among their members regarding care coordination. None of the focus group participants recalled receiving a call or other communications from their health plans or providers about care coordination. Health plans are reportedly required to delegate the care management of people with high needs, such as women with high-risk pregnancies or children with complex medical needs, to local health departments within the first three years of managed-care implementation. One health plan representative noticed that health departments in their network are falling short of meeting the need and reported that this is becoming an important gap for the health plan to fill.

A new requirement for health plans is identifying and addressing social determinants of health such as food assistance, housing assistance, and intimate partner violence. Though screening for unmet social needs is reportedly a priority for the state and among plans, little information was available in spring 2022 about the extent to which and how screenings are being conducted or whether plans and providers are using [NCCARE360](#), an online platform, to connect members to resources. A state official noted that social needs screening was still being phased in. Only one health plan representative reported that members are being screened for unmet social needs as part of the plan's health risk assessment; this plan's screenings are reportedly being conducted by care coordinators. Two big areas of unmet need that surfaced early in implementation were housing and food insecurity, according to multiple informants. Among beneficiaries who participated in our focus groups, most reported being screened for social needs by their providers. When asked what they think about being screened for social needs, one participant expressed, "I feel comfortable answering them. I know that if I do need these services, then I can access them easily." Other participants described that the availability of these services was a great comfort to new mothers, and knowing these resources exist made them feel supported. However, one participant was also apprehensive about whether health care providers had the capacity or knowledge to provide substantial help, considering that community resources are already limited and health care providers may not have connections to local social service providers. Other participants were wary about the quality of food provided through these services.

One of the new features of Medicaid managed care is value-added benefits, which are additional services or perks outside of what is traditionally covered. Each plan has a list of value-added services offered, which can include, for example, wellness programs or meal deliveries, and the services offered vary by plan. Value-added benefits are “one of the biggest areas of opportunity to improve health,” according to one informant. For example, all health plans offered financial incentives to members who received their COVID-19 vaccines.⁴ However, uptake is relatively low across all plans; one informant stated that fewer than 1 percent of Medicaid members across all plans have used value-added benefits. Among focus group participants, most were unaware of any value-added services in their plans. The beneficiaries who did know about them stated that health plans did not promote them well and that coverage specifics were unclear. One participant chose their health plan specifically because it offered incentives for tutoring and school supplies, which they found helpful.

Beneficiary Outreach and Assistance

The state implemented a multipronged communications and outreach strategy to inform Medicaid beneficiaries about the shift to managed care and encouraged them to select a health plan on their own during open enrollment. This involved contracting with an enrollment broker to manage outreach and assistance, including mailing notices to beneficiaries, developing a website with pertinent information, launching an online enrollment portal, and staffing a call center. Key informants acknowledged these efforts were not as effective as they could have been in reaching people and clearly communicating important information and action steps. Among Medicaid beneficiaries who participated in focus groups, those who selected a plan on their own shared that it was challenging to pick a health plan during open enrollment because the information packets did not include detailed information about plan features, the provider information tools did not work well, and the information about covered services was difficult to find and too vague.

Informants highlighted that the COVID-19 pandemic complicated outreach to Medicaid beneficiaries, but they also noted that some critical community-based partners were not actively involved in the beneficiary education and enrollment assistance efforts, including front-desk staff at provider offices and staff in the local offices of the Division of Social Services. According to one informant, people go to local Division of Social Services offices to enroll in Medicaid and other benefits, and therefore these offices should be better funded and staffed to support outreach to beneficiaries. Another informant noted the enrollment broker could have coordinated with the NC Navigator Consortium of health insurance navigators, which is a vast network of people and organizations across the state that have established relationships with community members. Reportedly, Medicaid informational webinars hosted by the enrollment broker were sparsely attended compared with webinars hosted by Legal Aid and other local organizations. Several informants encouraged the state and health plans to leverage all available community-based partnerships in beneficiary engagement. In particular, informants reported that health plans are struggling to recruit Medicaid beneficiaries to participate in health equity councils and thought that trusted community-based organizations could help facilitate that engagement.

According to informants, the content of communications from the state Medicaid agency, health plans, and providers to beneficiaries has gradually shifted from raising awareness about managed care to problem-solving and providing answers to common questions and issues. State officials stated that the systems created to escalate problems through different channels have been working well. For example, the state relied on well-established communication channels among the Medicaid agency, the enrollment broker, providers, and health plans to identify and address beneficiary challenges. The agency created a tiered process for responding to concerns, which allowed care access issues that could result in member harm to be escalated and addressed quickly. One informant observed increased collaboration among different health plans to resolve commonly experienced issues. Another informant shared that the level of coordination across health plans is unprecedented and unique to North Carolina and credited the state agency for facilitating early engagement and good working relationships among all parties.

Though beneficiaries have multiple avenues for seeking help, including contacting the Medicaid office, enrollment broker, health plan customer services, or their providers, one key informant noted that it may be unclear to beneficiaries which point of contact is the most appropriate. Focus group participants reported long wait times and multiple transfers when calling the Medicaid or health plan help lines. Additionally, they reported that enrollment broker and health plan representatives did not always know how to help resolve basic issues ranging from reporting a new address or changing the assigned provider on a membership card to verifying that a certain provider was in network or that a certain service was covered. Among participants whose primary language is Spanish, the challenges of getting accurate information and assistance were compounded by limited language access and a lack of professional translation and interpretation services. Key informants reported that access to information and help in languages other than English and Spanish were even more limited.

As part of the shift to managed care, the state created the [NC Medicaid Ombudsman](#) as an additional education and assistance resource for beneficiaries. According to some informants, the Ombudsman was effective in helping beneficiaries who were unable to get a resolution to their issues via traditional communications channels. The most common issues the Ombudsman handled include assisting beneficiaries with changing health plans or primary care providers, accessing transportation and pharmacy benefits, and seeking authorization of needed care and services from health plans. Both key informants and focus group participants who worked with the Ombudsman praised the initiative as valuable and efficient in representing beneficiaries and resolving problems. Several informants said the Ombudsman collaborated effectively with both the Medicaid agency and health plans to elevate common issues and help find practical solutions.

Lessons Learned

When reflecting on early lessons from the Medicaid managed-care transition in North Carolina, key informants and focus group participants offered the following ideas for state officials and others responsible for designing, implementing, and overseeing health system transformation:

- **Learn how managed care works.** One health plan representative encouraged state agencies to learn the ins and outs of the managed-care delivery model and how it differs from the fee-for-service system to facilitate a smoother transition. For example, North Carolina reportedly did not have a list of CPT (Current Procedural Terminology) codes to provide to health plans so they could easily learn what services were covered under the program.
- **Take time to plan and be flexible.** Key informants spoke positively about the many years of planning that went into developing the managed-care program and the willingness of state officials to go back to the drawing board when new challenges and priorities emerged during the pandemic. For example, the state developed requirements for plans to measure and address disparities in outcomes, a decision prompted by the large racial and ethnic disparities in COVID-19 infection rates during the pandemic.
- **Integrate data systems.** Contracting with five entities to deliver health care also means a more complicated data system, with each plan using different technology platforms and processes. Informants highlighted that it has been challenging to get all the systems to “talk” to each other and emphasized the need for more streamlined and integrated systems to facilitate the flow of data and information.
- **Ensure provider participation and access to care.** State officials and multiple key informants stressed that provider engagement and participation in health plans were integral to successful managed-care implementation. The Medicaid agency played a key role in facilitating relationships between health plans and provider groups without interfering in contract negotiations. In addition, the state encouraged plans to work together to align administrative processes across plans where possible to minimize the administrative burden on providers.
- **Effectively engage key partners.** Many key informants highlighted that the Medicaid agency was intentional and effective in providing timely information about transition activities. They also effectively solicited feedback and input from health plans and provider groups during regular convenings and via open communication channels. Informants felt the state was particularly successful in facilitating partnerships and collaboration across health plans.
- **Identify the most effective ways to reach Medicaid beneficiaries.** Key informants and focus group participants offered several suggestions to improve beneficiary communications, including partnering with community-based organizations, enhancing training for help center staff, and ensuring adequate and high-quality interpretation and translation services. Some informants suggested surveying and engaging beneficiaries in developing communication materials. The focus group participants reported they would like more opportunities for one-on-one or small-group conversations where they can ask questions.

Conclusions

A major change in how health care is delivered and paid for is bound to be rocky, especially during an unprecedented public health emergency such as the pandemic. Many informants interviewed for this

study believed that given the scale and complexity of the system and the large number of players interacting, the transition has been relatively smooth for most providers and beneficiaries. Though key managed-care program provisions such as enhanced care coordination, emphasis on addressing beneficiaries' unmet social needs, and efforts to close racial and ethnic disparities in health outcomes are still being rolled out, many informants were hopeful that, in time, the shift to Medicaid managed care will result in better and more-equitable outcomes for people served by the program. However, some providers and beneficiaries seemed skeptical that the move to Medicaid managed care was necessary.

Discussions with Medicaid enrollees clearly indicated that people with complex family situations and high medical needs, and in particular those with limited English proficiency, experienced challenges with understanding what the managed-care transition meant for them, selecting health plans, finding in-network providers, accessing needed services, and, in some instances, even paying for out-of-pocket costs. Compared with Medicaid Direct, Medicaid managed care is a more complicated system to navigate for both providers and beneficiaries. These early experiences indicate that more support is required to fully meet the needs of people with complex medical needs and the providers who serve them. This is especially important to keep in mind given that the state is planning to roll out the tailored behavioral health plans and to transition other vulnerable populations (such as children in foster care) to managed care in the years ahead. In particular, outreach, education, and assistance to Medicaid beneficiaries, including in languages other than English, should remain a high priority.

Notes

- ¹ North Carolina Department of Health and Human Services, "NC Medicaid Managed Care to Launch Statewide on July 1," news release, June 30, 2021, <https://www.ncdhhs.gov/news/press-releases/2021/06/30/nc-medicaid-managed-care-launch-statewide-july-1>.
- ² "Healthy Opportunities and Medicaid Transformation," North Carolina Department of Health and Human Services, accessed October 17, 2022, <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots/healthy-opportunities-and-medicaid-transformation>.
- ³ North Carolina Department of Health and Human Services, "NCDHHS Delays Medicaid Managed Care Tailored Plans," news release, September 29, 2022, <https://www.ncdhhs.gov/news/press-releases/2022/09/29/ncdhhs-delays-medicaid-managed-care-tailored-plans>.
- ⁴ "SPECIAL BULLETIN COVID-19 #236: Vaccine Incentives and Value-Added Services for NC Medicaid Managed Care Standard Plan Members," NC Medicaid blog, North Carolina Department of Health and Human Services, March 4, 2022, <https://medicaid.ncdhhs.gov/blog/2022/03/04/special-bulletin-covid-19-236-vaccine-incentives-and-value-added-services-nc-medicaid-managed-care>.

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