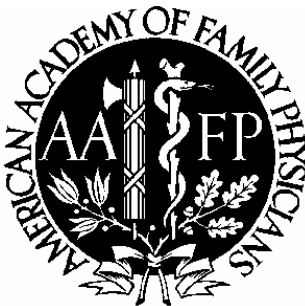


The Transferability of Community Care of North Carolina: A Provider-Led Strategy for Delivering Cost-Effective Primary Care to Medicaid Beneficiaries

Implications and Opportunities for Family Physicians

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The Transferability of *Community Care of North Carolina*: Implications and Opportunities for Family Physicians

Community Care of North Carolina (CCNC) is a patient care management program consisting of 15 local networks and more than 3,000 primary care physicians that has demonstrated significant cost savings, improved health outcomes, and increased access to care for almost 700,000 Medicaid beneficiaries. Originating as an expanded primary care case management program, CCNC has become a proven model of community-based, integrated care coordination that applies a range of tools such as disease and population management, quality improvement, and guidelines for evidence-based practice.

The CCNC program demonstrates that when primary care physicians formally share responsibility for a patient population—with the assistance and cooperation of staff, other community providers, state government, and patients—positive behavior change will occur. Physicians participating in CCNC report their Medicaid patients receive overall better care—and caring for Medicaid patients is more desirable—particularly because of the:

- Added services of case managers.
- Opportunity to participate in development/application of evidence-based clinical guidelines.
- Added per patient per month care management fee and enhanced Medicaid fee-for-service payment (95% of the Medicare fee schedule).

Nationwide, family medicine is in a unique position to improve quality and lower the cost of care delivered to Medicaid patients by advocating that states re-design their Medicaid care management programs based on this proven CCNC model. States continue to struggle to find ways to improve their Medicaid programs, and state legislatures are demanding greater accountability and a reduction in spending for high cost programs such as Medicaid.

Family physicians must provide states the guidance and leadership to design successful programs to accomplish these goals. **In each state, family medicine is charged to accomplish the following:**

1. Identify and support a visionary leader(s) who can articulate a statewide redesign of the health care system that incorporates innovations in clinical care and public health to lower costs and improve quality, access and health outcomes for Medicaid beneficiaries.
2. Communicate the necessity of creating true local public/private partnerships that bring together all key area healthcare and social service providers, or face control by ‘outside forces.’
3. The importance of local control and physician leadership in building sustained community care systems must be ‘sold’ to health care provider groups, Medicaid officials, and state legislators.
4. Help create a new system of shared state-local responsibility to develop tools needed to manage the Medicaid population, including new incentives that better align state and community goals with desired outcomes. Such a system should include financial and technical support from state government and private sources.
5. Make the primary focus for improving care quality on population management and the development/application of evidence-based clinical guidelines.

