Critical Assumptions of Environment for Enterprise Structure Planning

1. The current Medicaid revenue stream to Networks and N3CN ($112M) will end with N3CN contract termination in July 2019. There will be a small "residual" contract negotiated by DHB/DMA with CCNC for carved out Medicaid populations not attributed to Prepaid Health Plans which will result in providing less than ¼ of current revenue.

2. CCNC/Networks will need to decide on this Enterprise Structure on a timeline that allows the organizations to form and become operational by 7/2019.

3. The Networks and the Central Office will need to markedly decrease overhead and operating expenses to remain viable. Current 'overhead' expense is approximately $24M for networks and central office and will need to be reduced by at least 50% to $8 - $12M. The Networks and Central Office may decrease overhead by designing consolidated corporate services (e.g. finance, payroll, HR, benefits), clinical functions (e.g. consolidating call center functions), and operational functions (e.g. managing health department contracts). The Networks and Central Office will need to achieve operational efficiencies in their clinical services by committing to standardized workflows and staffing ratios. Networks will take risk/reward on outcomes related to care management activity.

4. Revenue replacement will primarily come from contracting with 3 MCOs for Medicaid complex care management. We will aim to contract with 1 MCO on a broad range of clinical programs as a 'most favored nation' partner. This may account for 60% of revenue replacement. Medicare Advantage, CPC+, the BCBSNC exchange population, the uninsured, and the Duals are other possible revenue streams.

5. Networks and CCNC will transition to a structure that demands efficiencies in process, systems, staffing ratios and overhead while maintaining a local presence.

6. While overhead will need to decrease, CCNC and Networks will need to support CCNC program differentiators at the central and community/local level to distinguish us from competitors. Local presence includes clinical and operational leadership and staff at the local level that can sustain partnerships necessary to drive CCNC clinical programs (care management, provider services). Networks will collaborate with health care delivery systems which will begin to address social determinants of care as they take risk for a given portion of a community population. Health systems will be contracting with Networks to access community resources as they begin screening patients for social determinants of care. Patient referrals will be made to Networks to access resources.