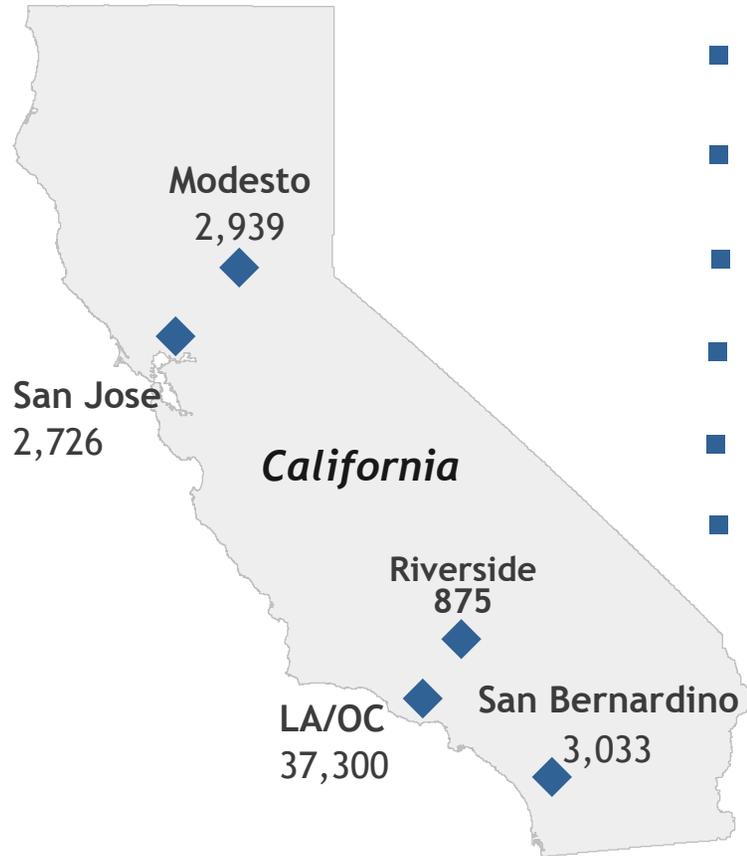


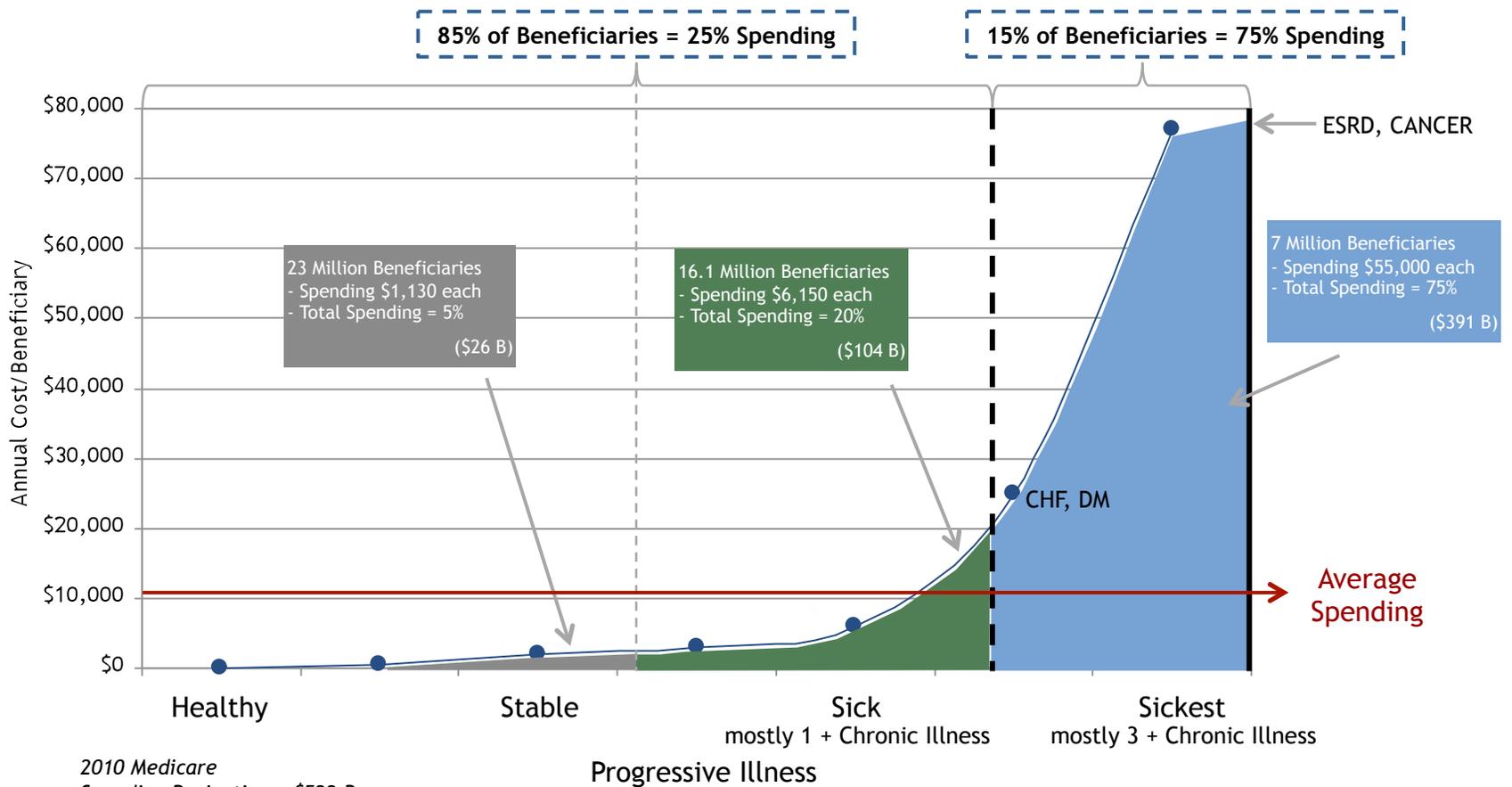
## CareMore has successfully deployed its care model



- 6500 Dual Eligibles
- Average Age: 74
- 67% at least 1 chronic condition
- 42% 2+ chronic conditions
- 1200 ESRD patients
- 1800 institutionalized patients

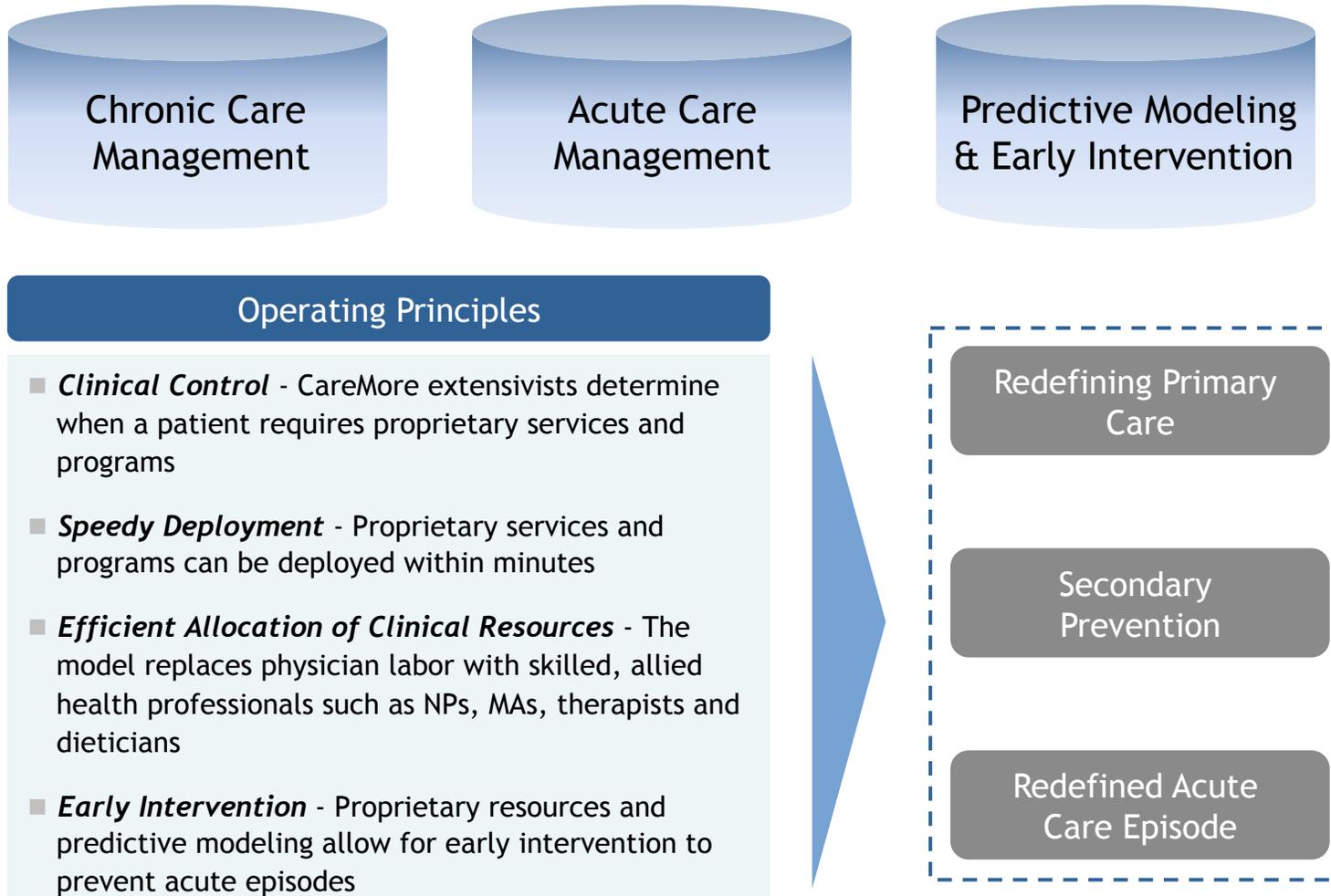
Source: Management estimates for membership for the year ending 12/31/11

# Healthcare cost and quality problems are concentrated...not widespread



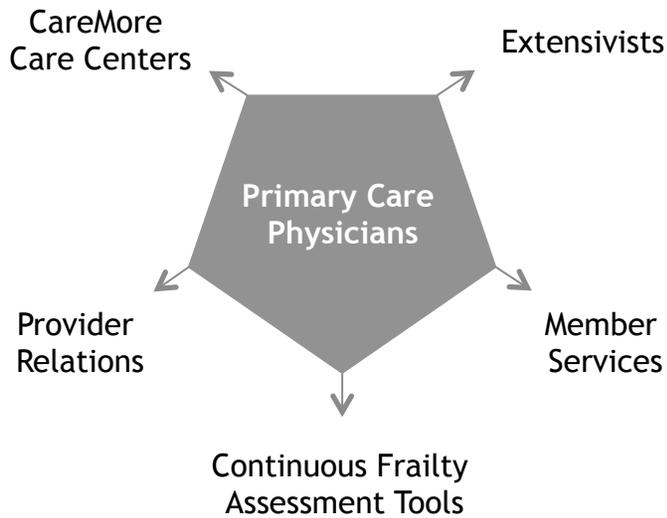
2010 Medicare  
Spending Projection = \$522 B  
46 Million Beneficiaries  
Spending Per Beneficiary = \$11,347

## The essentials of CareMore's model



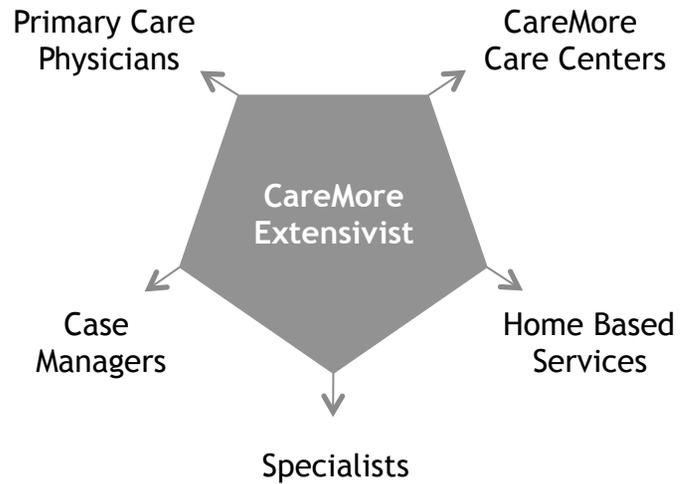
# CareMore's system functions in parallel with community physicians

## Non-Frail Population



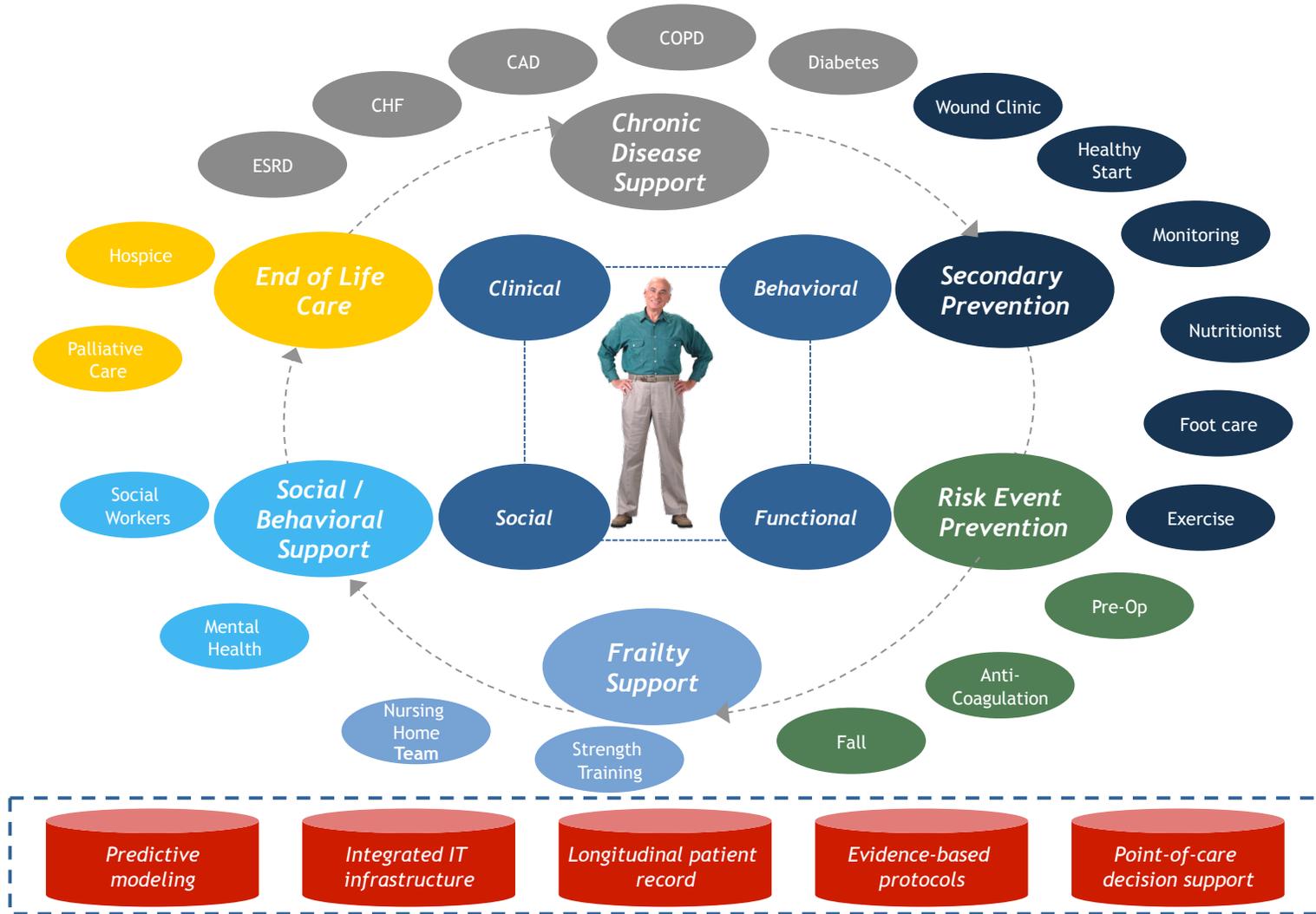
- Close monitoring of non-frail members to proactively identify at-risk members and aggressive management of chronic conditions to prolong the onset of frailty

## Frail & Chronically Ill Population



- Intensive management of frail and chronically ill members, identified through predictive models, data scans, PCP referrals or member self-identification

# CareMore solution - new model of care



## A day in the life

### On an average business day, CareMore...

- Sees 620 patients in our Care Centers for follow-up and chronic care management
- Provides more than 1,917 rides to patients to and from points of care
- Makes 56 post-discharge calls to our members
- Sees more than 51 new members to assess health, arrange and document personal care plans
- Visits 20 homes to provide social and behavioral support
- Engages 5 families in end-of-life/hospice planning
- Provides 671 strength and exercise training sessions
- Makes 220 care visits to patients residing in nursing homes/assisted living
- Reads 777 blood pressures from monitors in the homes of hypertensive patients
- Reads 750 weights from monitors in the homes of chronic heart failure patients
- Sees 70 behavioral visits, largely for depression
- Cuts toenails for 105 patients at the CCC

Note: Data as of 11/12/10

## Considerations for Dual Eligible Demo

### A CARE MODEL (NOT A NETWORK) MATTERS MOST

- Access
- Solutions for Compliance
- FULL Integration

### HIGHER QUALITY CARE IS LOWER COST

### MEASURE CLINICAL OUTCOMES, NOT PROCESS

- Incidence of Stroke, Amputations, Infections, Falls, etc.
- Admission and Readmission Rates
- Impact of Mental Health Support