Finding a Winning Business Model in Population Health Management

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Brendan Baker – CFO, CareMore
Dr. Scott Mancuso – Senior Medical Officer, CareMore

Agenda for Today’s Discussion

• The Volume to Value Revolution – Healthcare Value Transformation and Population Health Management

• The CareMore Case Study: A Model for Population Health Management
  – The CareMore Model
  – Results
  – Lessons Learned and Keys to Success

• Q&A/Wrap-up
The Volume to Value Revolution

Healthcare value transformation and population health management

National health market tipping point in 2016/17 as more than 30% of the market shifts to value

U.S. Lives Buying Value by Funding Source
2010 - 2025

Value Market Opportunity by Funding Source
2010-2025

227M lives in 2025 (63% of total lives)

$3.7T in 2025 (70% of total spend)

The value market will grow from $232B to $3.7T by 2025
The “volume to value revolution” is building momentum

Three transformational waves are reshaping the health marketplace

WAVE 1
PATIENT-CENTERED CARE
2010-2016

WAVE 2
CONSUMER ENGAGEMENT
2014-2020

WAVE 3
SCIENCE OF PREVENTION
2018-2025
Fueling development of new patient and consumer centered business designs

**BUSINESS DESIGN**

**WAVE 1**
PATIENT-CENTERED CARE
2010-2016

**WAVE 2**
CONSUMER ENGAGEMENT
2014-2020

**WAVE 3**
SCIENCE OF PREVENTION
2018-2025

FROM
Physician-centered

Patient-focused

Transactional, isolating
Care team managed

Sick-care
Health and well-being

Inaccessible
Convenient and 24/7

Patient turnover-volume
Patient health-value

Unwarranted variation
Evidence-based standard

TO

Unlocking value throughout the population pyramid

**Population Stratification**

5%
Poly-chronic
Frail Elders
End of Life

25%
At risk for major intervention

70%
Healthy/minor issues

**Resource Consumption**

45%-50%
ED visits
Avoidable events
Readmissions

30%-35%
Higher acuity episodes than reqd.
Complications and Readmissions

20%
Unmanaged and unengaged

Opportunities for total redesign of care delivery models

Opportunities for dramatically enhanced efficiency and consistency in care delivery

Opportunities to enhance value through better access and enhanced patient engagement

Source: Blended MarketScan Commercial, Medicare FFS LDS, and representative payer Medicare data
For population health players, the top of the pyramid offers the greatest impact opportunity... this will also be most disruptive to inpatient and specialty services

<table>
<thead>
<tr>
<th>Healthy</th>
<th>Frail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy independent</td>
<td>Late state or poly-chronic</td>
</tr>
<tr>
<td>Health risk factors</td>
<td>Complex conditions</td>
</tr>
<tr>
<td>Early stage chronic</td>
<td>1+ chronic conditions that are uncontrolled or advanced</td>
</tr>
</tbody>
</table>

**Description**
- No chronic conditions and free of key risk factors
- No major chronic conditions with one or more risks
- Chronic condition that is well controlled without substantially progression
- Systemic or otherwise complex condition
- 1+ chronic conditions that are uncontrolled or advanced

**% of Population**
- 54%
- 17%
- 11%
- 13%
- 6%

**% of Cost**
- 20%
- 11%
- 8%
- 25%
- 36%

**Source:** Interstudy

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The top 5% of spenders drive 45%-50% of total medical spend

**Cumulative medical spend by member**

<table>
<thead>
<tr>
<th>Average 2012 PMPY by percentile</th>
<th>1st percentile</th>
<th>2nd percentile</th>
<th>3rd percentile</th>
<th>4th percentile</th>
<th>5th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial³</td>
<td>$128k</td>
<td>$46k</td>
<td>$32k</td>
<td>$26k</td>
<td>$21k</td>
</tr>
<tr>
<td>Medicare⁴</td>
<td>$207k</td>
<td>$119k</td>
<td>$93k</td>
<td>$78k</td>
<td>$64k</td>
</tr>
</tbody>
</table>

**Source:** Commercial Sample – MarketScan Commercial claims data; Medicare Sample – Medicare 5% sample

Note: Only those Medicare patients with both Parts A and B were included in the analysis. 1. Trended to 2012 using 7% annual inflation rate. 2. Trended to 2012 using 5% annual inflation rate; just Medicare Parts A and B, no Rx spend included.
Not all patients’ needs are identical or require equally intensive management; patient-centric care must be highly personalized.

Patient Stratification:

- **Healthy**
  - No chronic conditions/ risk factors
  - Normal BMI, non-smoker

- **At Risk**
  - No major chronic conditions, 1+ risks
  - Hypertension, high cholesterol, obesity

- **Early Stage Chronic**
  - Chronic condition is well controlled, little progression
  - Diabetes, Asthma, CAD

- **Late Stage/ Polychronic**
  - Uncontrolled, advanced or multiple chronic conditions
  - Advanced chronics (top 10% of spend), CHF, ESRD

- **Complex Condition**
  - Systemic or otherwise complex conditions
  - Cancer, multiple sclerosis, cystic fibrosis

- **End of Life**
  - Terminally ill patients nearing the last 12 weeks of life

The population health manager will stratify patients to determine the type and level of care needed to best treat them...

Care Delivery:

- Few PCP activities, more health plan mgmt
- Significant PCP management and care coordination
- Specialists utilized to assist in diagnosis and formulate treatment plans, rather than in maintenance of care

... and channel resources accordingly

Active management of the patients has the potential to significantly impact both outcomes and costs of care... in short, the total approach to care

<table>
<thead>
<tr>
<th>Procedural</th>
<th>Acute manifestation</th>
<th>Chronic</th>
<th>Complex/polychronic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representative Condition</td>
<td>Appendixis</td>
<td>Trauma</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>% of Total Spend</td>
<td>0.5%</td>
<td>2.2%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Active Management Impact</td>
<td>N/A</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Patient engagement</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Health risk assessment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>24/7 virtual access</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Genetic testing / biomarkers</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Remote monitoring</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Integrated treatment plan</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medication management</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Early intervention</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Care coordination</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Post-acute management</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Behavioral health integration</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Palliative / pain mgmt. integration</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Health and wellness education</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Nutrition support</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Fitness support</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Social engagement / social media</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Home / environmental review</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Clinical Efficiency</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Reduction in low value activities</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Shift to spend on prevention</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Net Ability to Impact: Low | Low/Med | Med | Med | High | High | High | High | High | High | High |
This has significant implications for sites and types of service

<table>
<thead>
<tr>
<th>Current fee for service silos</th>
<th>Primary Care</th>
<th>Specialists</th>
<th>Emergency</th>
<th>Ambulatory</th>
<th>Hospital</th>
<th>Post-Acute</th>
<th>R(x)</th>
</tr>
</thead>
</table>

Integrated episode, condition and disease ecosystems

Population health and condition management

Concentration
Low
High

Participating in an integrated, patient-centric care delivery ecosystem will be a paradigm shift for many of today’s independent-minded physician practitioners

**Today’s Care Model**

My patients are those who make appointments with me.

Care is determined by today’s problem and time available today.

Care varies by scheduled time and memory or skill of the doctor.

Patients are largely responsible for coordinating their own care, including visits to specialists.

It’s up to the patient to tell us what happened to him/her.

**Patient-Centric Model**

Our patients are those who are registered in our medical home and we take accountability for optimizing their health status in a cost efficient manner.

Care is managed with a proactive plan to meet patients’ needs without visits.

Care is standardized according to evidence-based guidelines and measured on quality, patient experience and cost.

A team of professionals coordinates every patient’s care and accepts responsibility for meeting care needs and obtaining positive outcomes.

We track tests and consultations, and follow-up after ED and hospital visits, and in doing so reduce recidivism (readmissions, ER visits, episode condition flare ups, etc).
Retailers, payers and wellness companies are increasingly focusing on the bottom of the pyramid while providers dominate the top... for now

Top-down vs. bottom-up competition for lives

In a value-based world, providers have a range of options of where to play for value

<table>
<thead>
<tr>
<th>Pop’n Health Mgr.</th>
<th>Condition Manager</th>
<th>Episode Manager</th>
<th>FFS Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pop Health Mgr.</td>
<td>A superior holistic patient experience that delivers better outcomes, lower cost through engagement and care coordination</td>
<td>An EBM care experience that engages/stears complex &amp; chronic patients to cost &amp; quality endpoints</td>
<td>A comprehensive care experience oriented to deliver a high quality outcome at a defined price point</td>
</tr>
<tr>
<td>Place</td>
<td>Risk adjusted, PMPM reimbursement with performance incentives</td>
<td>Risk adjusted, PMPM reimbursement with performance incentives</td>
<td>Risk adjusted bundled payment</td>
</tr>
<tr>
<td>Price</td>
<td>Distribution options: • Direct to market (ER, Indiv.) • ACO • Traditional Payer</td>
<td>Distribution options: • Pop’n Hlth. Mgr. • ACO • Traditional payer</td>
<td>Distribution options: • Condition Mgr. • Pop’n Hlth. Mgr. • ACO • Traditional payer</td>
</tr>
<tr>
<td>Promotion</td>
<td>Patient experience, outcomes and value-oriented branding Sub-brand of Payer, ACO</td>
<td>Patient experience, outcomes and value-oriented branding</td>
<td>Patient experience, outcomes and value-oriented branding</td>
</tr>
</tbody>
</table>
OUR CHALLENGE

Healthcare is an industry where any tough-minded insider will convince you that “more than a third of the healthcare dollar is wasted today”

A GLIMPSE OF OPPORTUNITY

Over the last decade, quiet innovators have invented and refined new care models for every patient population across the country.

They have two things in common: 25% better outcomes, 20% lower costs
IGNITING THE REVOLUTION

Any one of them will tell you exactly the same thing – **they are just getting started** – their stories have richly informed our roadmap – helping us understand the **change that is already underway**

POTENTIAL

It is an industry that has **more new value growth potential than any other industry in the world**, including technology
MOMENTUM

The sleeping healthcare giant is waking up. We are at a most unique time in the history of the healthcare marketplace.

Is there anything more important?

- Patient safety, wellbeing and dignity
- Healthcare access for millions of Americans
- U.S. social and economic stability
- Medicare/Medicaid solvency
- Employer sponsored health benefits market
- U.S. industry cost and productivity competitiveness
- U.S. leadership role in global healthcare marketplace
CareMore Case Study: A Model for Population Health Management

The CareMore Model
Healthcare cost and quality problems are concentrated....not widespread

- 45% of Beneficiaries = 25% Spending
- 15% of Beneficiaries = 75% Spending

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

23 Million Beneficiaries
Spending $1,100 each
Total Spending = 5%
($23 B)

16.1 Million Beneficiaries
Spending $6,150 each
Total Spending = 20%
($104 B)

7 Million Beneficiaries
Spending $55,000 each
Total Spending = 75%
($391 B)

Average Spending

The essentials of CareMore’s model

**Operating Principles**

- **Clinical Control** - CareMore extensivists determine when a patient requires proprietary services and programs
- **Speedy Deployment** - Proprietary services and programs can be deployed within minutes
- **Efficient Allocation of Clinical Resources** - The model replaces physician labor with skilled, allied health professionals such as NPs, MAs, therapists and dieticians
- **Early Intervention** - Proprietary resources and predictive modeling allow for early intervention to prevent acute episodes

Redefining Primary Care
Secondary Prevention
Redefined Acute Care Episode
CareMore solution – new model of care

CareMore model allows for efficient allocation of clinical resources

<table>
<thead>
<tr>
<th>Extensivists</th>
<th>Nurse Practitioners</th>
<th>Case Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Conduct pre-operative exams</td>
<td>• Chronic Care</td>
<td>• Acute Episodes</td>
</tr>
<tr>
<td>• Manage patient hospitalization decision</td>
<td>• Conduct annual health risk assessments and create care plans</td>
<td>• Take “ownership” of patient at point of admission</td>
</tr>
<tr>
<td>• Take control of entire inpatient stay, including specialist consultation,</td>
<td>• Micro-manage chronic conditions and lead interdisciplinary teams specific to a</td>
<td>• Prepare patient and family for discharge</td>
</tr>
<tr>
<td>diagnostics, PCP communication, family communication</td>
<td>patient’s needs</td>
<td>• Dispatch all services necessary to avoid readmission</td>
</tr>
<tr>
<td>• Create and manage discharge plan</td>
<td>• Provide all wound care (diabetic, ulcerative, post-surgical)</td>
<td>• Long Term Management</td>
</tr>
<tr>
<td>• Retain lead physician role during Skilled Nursing stay</td>
<td>• Staff all home wireless monitoring systems</td>
<td>• “Own” patient for remainder of life</td>
</tr>
<tr>
<td>• Follow patients on an out-patient basis until acute episode or frailty</td>
<td>• Available for 24/7 telephonic patient consultation</td>
<td>• Dispatch home-based services</td>
</tr>
<tr>
<td>resolves</td>
<td>• Frailty and Palliative Care</td>
<td>• Facilitate CCC and other necessary skills</td>
</tr>
<tr>
<td>• Manage high-risk outpatient events, such as fall prevention programs,</td>
<td>• Primary care provider and case manager for home-bound patients</td>
<td>• Facilitate transportation and other social services</td>
</tr>
<tr>
<td>dementia evaluations, transplant evaluations, bariatric surgery evaluations</td>
<td>• Assume primary clinical role for palliative care patients</td>
<td></td>
</tr>
<tr>
<td>• Create transition to palliative care and end-of-life teams as appropriate</td>
<td>• Institutional/Custodial/Assisted Living Residents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Make weekly visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Become first point of contact for facilities and family for ALL care needs</td>
<td></td>
</tr>
</tbody>
</table>
The CareMore model allows for predictive modeling and early intervention

**Predictive Model / Early Intervention**

- **Healthy Start – initial evaluation**
  - Close to 80% of members have an appointment within first 30 days of enrollment
  - 23% referred to a chronic care program
  - 42% referred to a prevention or other support program
  - 18% diagnosed with depression
  - 3% diagnosed with diabetes for the first time

- **Healthy Journey – ongoing evaluation**
  - 70% of SNP members undergo annual assessment
  - 100% update to care plan, medication plan, coding

- **Johns Hopkins predictive modeling software**

- **CARS – identifies sick patients through software**

- **Ascender – predictive modeling tool identifies targets based on claims data**
  - Monthly run of claims, RX, lab data, age correlated to identify 5% most at-risk members
  - 72% plugged into appropriate chronic care or frailty program

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**CareMore’s information engine**
Results of the CareMore Model

CareMore model produces superior results

- Superior clinical outcomes
- Low costs
- Unique competitive marketing and sales advantage
- Unique primary care value proposition
- Superior revenue realization
- Replicable and deployable model
The CareMore model produces dramatically improved outcomes for several costly chronic diseases and conditions

<table>
<thead>
<tr>
<th>Disease</th>
<th>Status quo</th>
<th>CareMore Redesign</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Half of all ESRD Admissions were the result of either poor hygiene, poor diabetic control or vascular access limitations. Only 1 in 10 visits resulted in an admission.</td>
<td>Established an insulin &quot;start&quot; and insulin &quot;camps&quot;. At the &quot;start&quot; day, patient is trained in all aspects of self-administration of insulin. At &quot;camps&quot;, patients are brought to the center for a full day to observe all of their behaviors and monitor glucose levels at all points of self care. A personal nutrition counselor was assigned.</td>
<td>Average HbA1c for those attending our diabetic clinic is 7.08, with 7.0 being considered good control. Patients in the clinic are referred for poor control.</td>
</tr>
<tr>
<td>ESRD</td>
<td>PCPs were not collecting daily weights, a leading indicator of change of condition. Self-reported weights were inaccurate. PCPs were not adequately responsive to immediate care needs of patients who require intervention within a few hours of onset of symptoms.</td>
<td>Established a dedicated case manager and nurse practitioner who receive referrals from centers in lieu of ER referral. Primary/preventive care is provided and all patients are in the diabetic management program, receiving monthly preventive access line inspection visit, if needed, cleaning.</td>
<td>50% reduction in hospital admission rate in 3 months. 60% fewer admissions than the national average.</td>
</tr>
<tr>
<td>CHF</td>
<td>Status quo</td>
<td>Status quo</td>
<td>30% reduction in hospital admission rate in 3 months.</td>
</tr>
</tbody>
</table>

**System Failure**

70% of hypertensive patients do not have adequate blood pressure control. This leads to increased stroke and other cardiovascular events. A majority of PCPs do not monitor blood pressure frequently as it is inaccurate. Equipped patients with labile HTN with wireless blood pressure cuff. CareMore NPs monitor blood pressure & make appropriate changes according to JNC guideline.

- 48% of patients had >10mmHg drop in blood pressure
- Patients with SBP>160 or higher had average SBP drop of 23 mmHg
- Patients with SBP b/n 150-160 had average SBP drop of 19mmHg

Diabetic amputation rate for CareMore members is 60% less than the national average. Designed a wound clinic, staffed with wound-certified CareMore NPs. PCPs have inadequate time/resources to deal with diabetic wounds, which results in specialty referrals to delay treatment, increases cost and, if delayed, increases chance of amputation.

Early diagnosis and then intervention at CareMore’s mental health centers (19% of screened) All new CareMore members receive a comprehensive health exam that includes PHQ-9 & dementia screen. Depression is a undertigated problem in seniors. Undertigated depression leads to a myriad of health problems and costs including ER visits & unnecessary tests.

---

The CareMore model produces dramatically improved outcomes for several costly chronic diseases and conditions (cont’d)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Status quo</th>
<th>CareMore Redesign</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke Prevention</td>
<td>System Failure</td>
<td>CareMore Redesign</td>
<td>Stroke Prevention</td>
</tr>
<tr>
<td>Amputations</td>
<td>System Failure</td>
<td>CareMore Redesign</td>
<td>Amputations</td>
</tr>
<tr>
<td>Depression</td>
<td>System Failure</td>
<td>CareMore Redesign</td>
<td>Depression</td>
</tr>
</tbody>
</table>

Stroke Prevention

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The CareMore model produces dramatically improved clinical outcomes for several costly chronic diseases and conditions (cont’d)

<table>
<thead>
<tr>
<th>Wounds</th>
<th>Institutional</th>
<th>CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status quo</td>
<td>Status quo</td>
<td>Status quo</td>
</tr>
<tr>
<td>Inactivity and some staffing issues (one monthly visit/60 days); lack of primary care or facilities resulted in wound development or exacerbation (for example bed sores)</td>
<td>Patients in institutional settings were being hospitalized at a rate of 5 times the general populations for treatable conditions, largely because nursing homes do not have skilled clinical staff to make timely interventions</td>
<td>A small fraction of the Medicare population are hospitalized 5 times per year because of lack of home-based or social support resulting in falls, malnutrition, dehydration. Most live alone and suffer from dementia or other mental illnesses.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CareMore Redesign</th>
<th>CareMore Redesign</th>
<th>CareMore Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deployed home care teams in 13 nursing homes weekly to proactively tend to skin or create early intervention in patients likely to develop wounds</td>
<td>CareMore sends a nurse practitioner to the nursing home once a week to keep patients stabilized. If an acute event emerges, an NP is available 24/7 for telephonic consultation and in-person visits as needed</td>
<td>CareMore assembled a team of clinical social workers, mental health professionals, lawyers, physicians and NPs to assume a home-based multi-disciplinary care approach for these patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Result</th>
<th>Result</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only one new wound developed in over three years and more than 600 patients</td>
<td>Preventive intervention resulted in reduction in bedsores and reduction in falls. Hospital admission rates are 80% less than national norm</td>
<td>Reduced hospital and SNF admissions by 60%. Resulted in placement rate of &gt;30% for participants</td>
</tr>
</tbody>
</table>

**Superior clinical outcomes**

<table>
<thead>
<tr>
<th>ALOS</th>
<th>Bed days /1,000</th>
<th>Admit Rate /1000</th>
<th>Readmission Rate</th>
<th>% Deaths in Hospice1</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.8</td>
<td>1,052</td>
<td>280</td>
<td>14.7%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Note: Information above is based on data from January to December 2012
1-Excludes ESRD
Differentiated results in managing care for chronic and the frail and elderly

### Revenue and member acuity

#### Grand Total - Revenue and HCC by Raf Score (CY 11)

![Graph showing revenue and HCC by Raf Score](image)

- % of MM
- Revenue PMPM
- HCC PMPM

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### Primary care physician value proposition

**Increase PCP Compensation**
- Medicare FFS pays the PCP $79 per visit (CPT code 99213) -- an average of $569 patient/year (assuming 7.2 patient visits a year)
- CareMore guarantees the PCP $569 ($47 PMPM) but visits are only 4.5 per year and we pay $126 per visit or 159% of Medicare

**Increases PCP Schedule Capacity**
- CareMore clinicians and programs relieve PCPs of their most complex chronically ill and frail patients
- Increases PCP capacity by 30% to 40% -- can add more patients to increase pay

**Better Patient Care**
- More resources used to support the PCP funded by CareMore prepayment

CareMore programs provide the PCP with resources that enable better clinical care

- Medical Home (CCC)
- Chronic programs
- Preventative care programs
- Technology
- Communications tools

Unique PCP value proposition has served CareMore well in new markets
High touch and rapid engagement result in superior coding accuracy

**Coding Advantages**
- We touch the patient
- We employ and train clinicians
- We control coding

**Results**
- Low HCC Payment Error Rate
  - 2.34 payment error rate at 99% confidence

- High Chronic Patient recoding
  - 87%

- Significant Year 1 RAF Improvement
  - 25%

---

Model will help CareMore achieve superior STAR ratings

**2014 Star Rating: 4.0**

- Control of HEDIS Data/Events
- Direct input into members’ care experience

- 2013 Star 3.5 Total Score
- 2014 Star 4.0 Total Score
**Example of partner medical group performance**

<table>
<thead>
<tr>
<th>Year Ending 12/31/12</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Member Months</td>
<td>23,819</td>
</tr>
<tr>
<td>Revenue</td>
<td>$1,319.06</td>
</tr>
<tr>
<td>Part C RAF</td>
<td>1.34</td>
</tr>
<tr>
<td>Professional</td>
<td>$207.78</td>
</tr>
<tr>
<td>Institutional</td>
<td>$344.23</td>
</tr>
<tr>
<td>Inpatient Acute</td>
<td></td>
</tr>
<tr>
<td>Acute Admits PTMPY</td>
<td>202.52</td>
</tr>
<tr>
<td>Acute Days PTMPY</td>
<td>703.19</td>
</tr>
<tr>
<td>Acute ALOS</td>
<td>3.47</td>
</tr>
<tr>
<td>Pharmacy Costs</td>
<td>$117.60</td>
</tr>
<tr>
<td>Generic %</td>
<td>86.64%</td>
</tr>
<tr>
<td>Total Supplemental</td>
<td>$186.15</td>
</tr>
<tr>
<td>Provider Performance Bonus</td>
<td>$13.42</td>
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<tr>
<td>Risk Share Expense</td>
<td>$57.75</td>
</tr>
<tr>
<td>Health Care Cost PMPM</td>
<td>$855.77</td>
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<tr>
<td>Gross Margin PMPM</td>
<td>$463.29</td>
</tr>
<tr>
<td>MLR</td>
<td>64.9%</td>
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<tr>
<td>SG&amp;A</td>
<td>$143.86</td>
</tr>
<tr>
<td>EBIT</td>
<td>$319.43</td>
</tr>
</tbody>
</table>

**CareMore Expansion Process & Keys to Success**
CareMore’s market deployment model produces superior results

- Select highly penetrated MA markets to leverage established demand - Better Product
- Superior value proposition to Members: Best benefits in the markets
- Superior value proposition to PCPs: both payment and capacity
- Market share movement for Hospital Partners, lower costs per admission
- SNP provide 12 month marketing and targeted sub populations of seniors
- CCC provides for efficient sales, high touch service, and manageable expansion

1,500 members per neighborhood to B/E
30 to 50 PCPs per neighborhood
15 month to positive operating cash flow
24 months to profitability
Target 35% ROI
Year 2 lift in revenue due to Healthy Start improvement of HCC=25%

CareMore has developed a repeatable and scalable new market entry process

### Market Research
- Target high MA penetration

### Network Strategy
- Neighborhood identification

### Provider Contracting
- PCP=GMP
- Specialists=FFS
- Hospitals=Per diems

### Operational Transition
- Market Leadership
- Centralized Services

### Care Center Development
- Standardization in clinical systems, training and protocols

### Expansion Financial Modeling
- Integration of actuarial, operational and clinical leadership
- Target 35% ROI

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Primary Keys to Success

• Provider partner buy-in and cooperation
• Superior benefits and sales execution
• Accurate risk score coding
• CMS Star rating – CHAPS, HEDIS, HOS, Etc.
• Chronic disease management = low admits/k
• Appropriate acute & post acute care = low ALOS & readmissions
• Superior information fosters appropriate network adjustments
• Generic Rx substitution

Q&A / Wrap-up