



Presentation to Senate Finance Committee: Subcommittee on Health and Human Resources - July 7, 2011

Jim Carlson, Chairman and Chief Executive Officer; Dick Zoretic, Executive Vice President and Chief Operating Officer; and Patrick Blair, Chief Marketing Officer

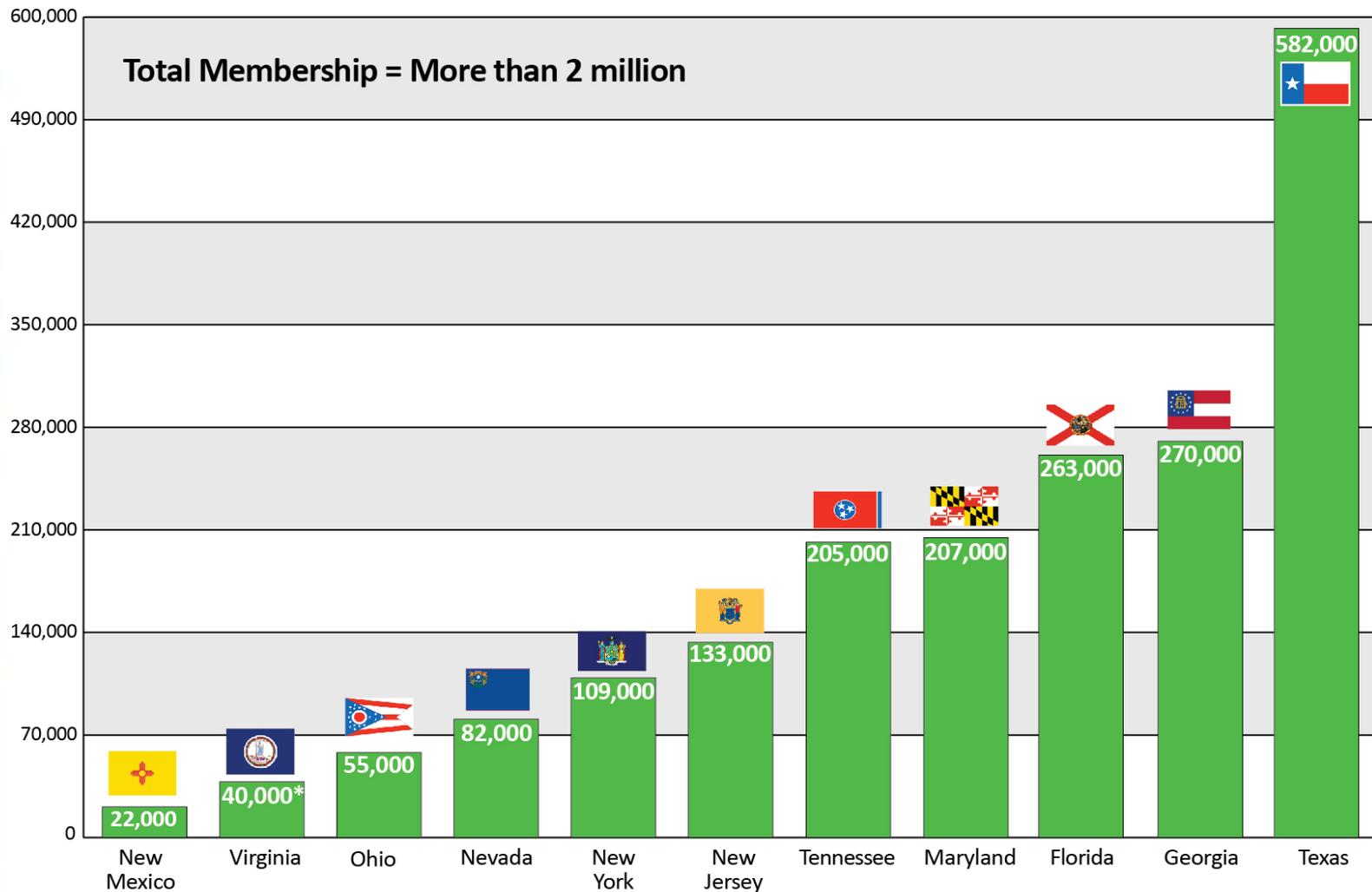
Who We Are: Amerigroup

- We meet the health care needs of financially vulnerable Americans, seniors and people with disabilities
- With more than 15 years of experience, we serve those on Medicaid, Medicare and other publicly funded health care programs
- Amerigroup is ranked No. 396 on the *Fortune* 500 list
- We have 4,624 total associates employed by Amerigroup, including 945 nurses, doctors and social workers
- Our administrative costs are less than 10 percent – quite low by broad-based industry standards. Amerigroup targets a net income range of 2.5 to 3.5 percent
- Since 1996, Amerigroup has saved taxpayers an estimated \$3 billion*

*Reden & Anders Formula



Who We Are: Amerigroup Membership



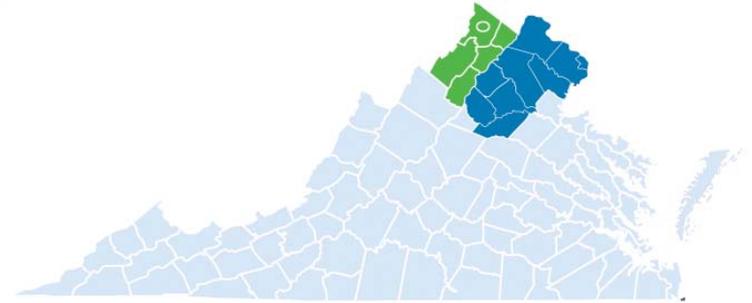
*Amerigroup Virginia membership as of 6/1/2011.

Who We Serve

- We focus on the conditions most prevalent among the populations we serve:
 - Moms and kids
 - Seniors
 - People with disabilities
- Accordingly, four areas are of particular interest:
 1. Prenatal care for pregnant women to ensure healthy babies
 2. Reduction and prevention of childhood obesity
 3. Home- and Community-Based Services (HCBS) for independent living
 4. Diversion of members from emergency room care



Amerigroup in Virginia



Amerigroup Virginia serves more than 40,000 members in the Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), expanded Medicaid and Supplemental Security Income/Aged, Blind and Disabled (SSI/ABD) programs in 20 cities and counties* in Virginia.

- Amerigroup employs 1,895 associates who live in Virginia
- The Company's estimated economic impact on Hampton Roads since 1994 is \$3.2 billion**
- Amerigroup Virginia's network includes 6,037 providers and 17 hospitals
- Amerigroup paid an estimated \$8.6 million in taxes in the state of Virginia in 2010***

*Includes approved expansion into Northwest region as of Sept. 1, 2011

**Source: "The Economic Impact of Amerigroup Corporation on Hampton Roads," Dr. James Koch; Reden & Anders formula

***Including corporate income, personal property, real estate, use and unemployment taxes





Benefits of Medicaid Public-Private Partnerships

Benefits of Medicaid Public-Private Partnerships

As a Medicaid managed care organization we:

1. Increase access to care

Managed care increases access to primary care and use of preventive services while lowering costs

2. Yield cost savings

By collaborating with doctors, hospitals and other providers to ensure beneficiaries receive proactive health services and supports, managed care reduces the incidence of acute episodes of care, improves the quality of life and reduces overall burden on the taxpayers

3. Achieve quality improvements

Managed care achieves quality improvements by adhering to quality standards and monitoring procedures; no comparable standards or procedures are required in Fee-For-Service (FFS) arrangements

Benefits of Medicaid Public-Private Partnerships

4. Medicaid health plans provide budget stability and savings

- Provide budget certainty and lower cost trends
- Offer an opportunity for state governments to stretch their Medicaid dollars

5. Accountability and integrity program

This past year, we helped save our state partners \$70.4 million*

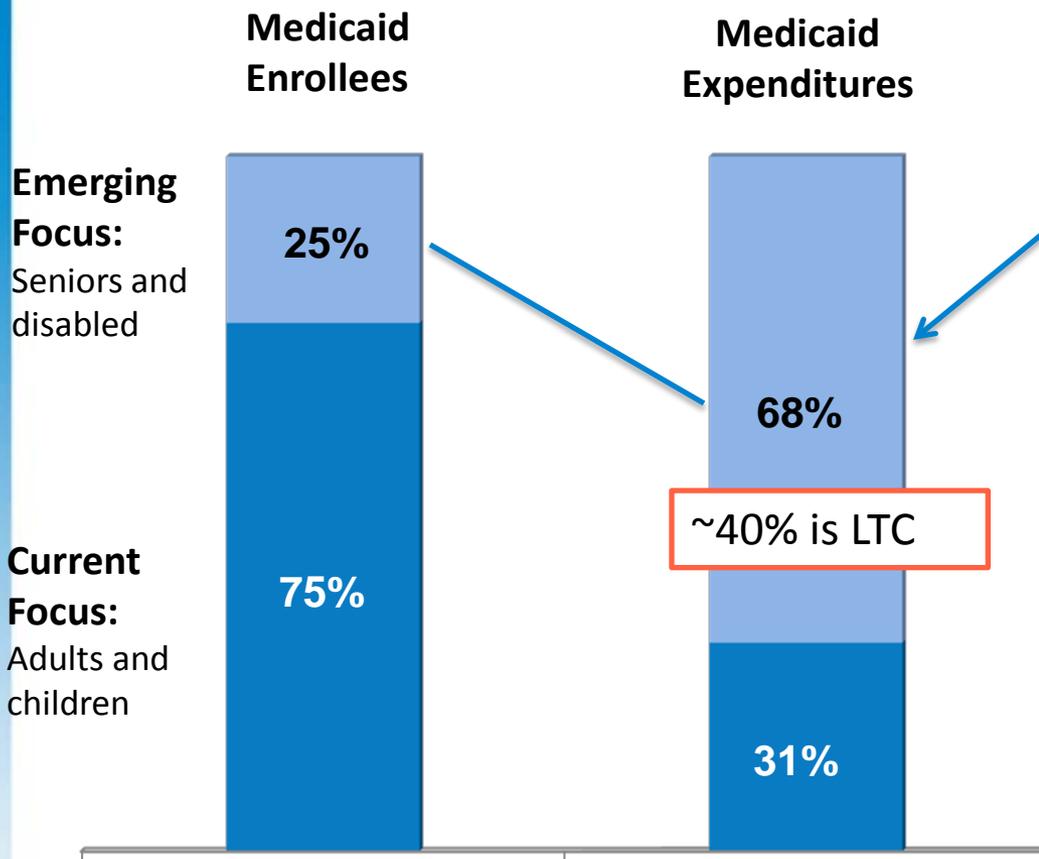
6. Beyond cost savings, health plans partner collaboratively with health care providers and ensure quality of care for beneficiaries

* Reden & Anders formula



Coordinating Long-Term Care (LTC) Services: Unrealized Potential in Virginia

LTC Represent a Serious Challenge for States



Individuals With LTC Needs

- Seniors with chronic disease and functional ability limitations (that is, dual eligibles)
- Individuals with physical disabilities like blindness and spinal cord injuries
- Individuals with severe mental health or emotional conditions, such as depression and schizophrenia
- Individuals with disabling conditions, such cerebral palsy, cystic fibrosis and Parkinson's disease

We Have Deep Coordinated LTC Experience

Note: Membership represents only clients who meet a NF Level of Care

- 1998 – Texas (5,737 LTC clients)
- 2003 – Florida (2,539)
- 2005 – New York (1,062)
- 2008 – New Mexico (11,380)
- 2010 – Tennessee (4,789)

*In addition to more than 25,000 LTC clients, Amerigroup serves the acute care needs of an additional 200,000 seniors and people with disabilities across eight states.**

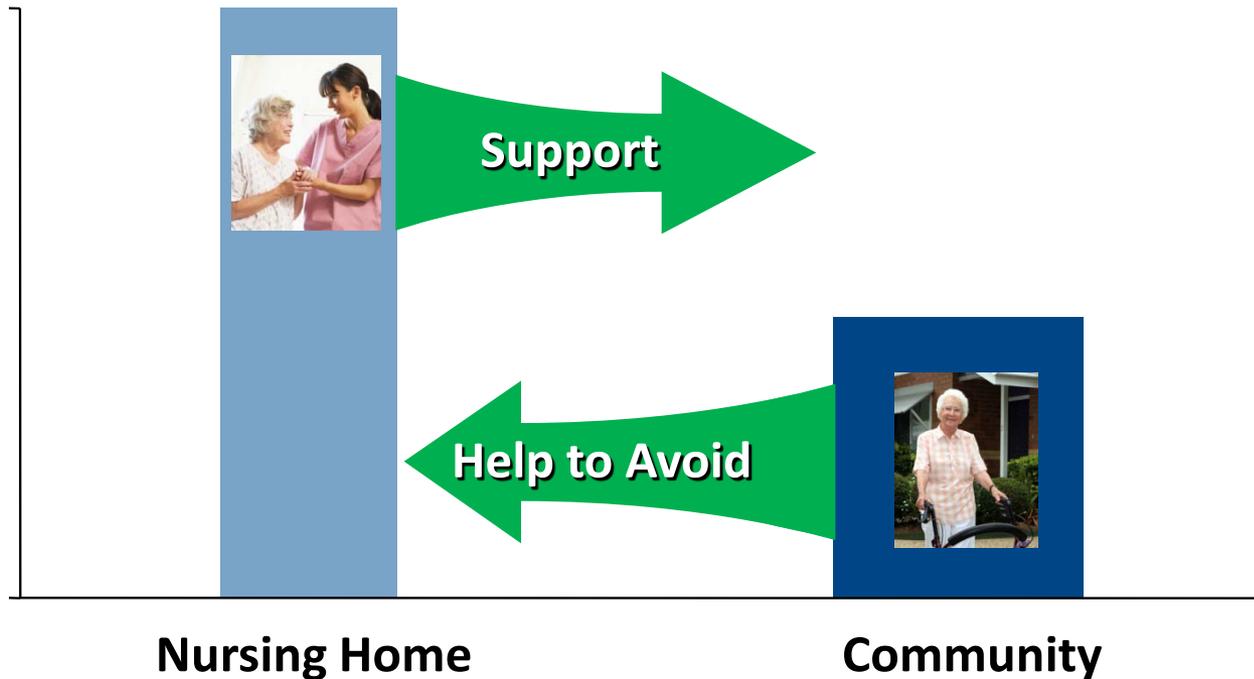
* Note: Includes approximately 20,000 Medicare members



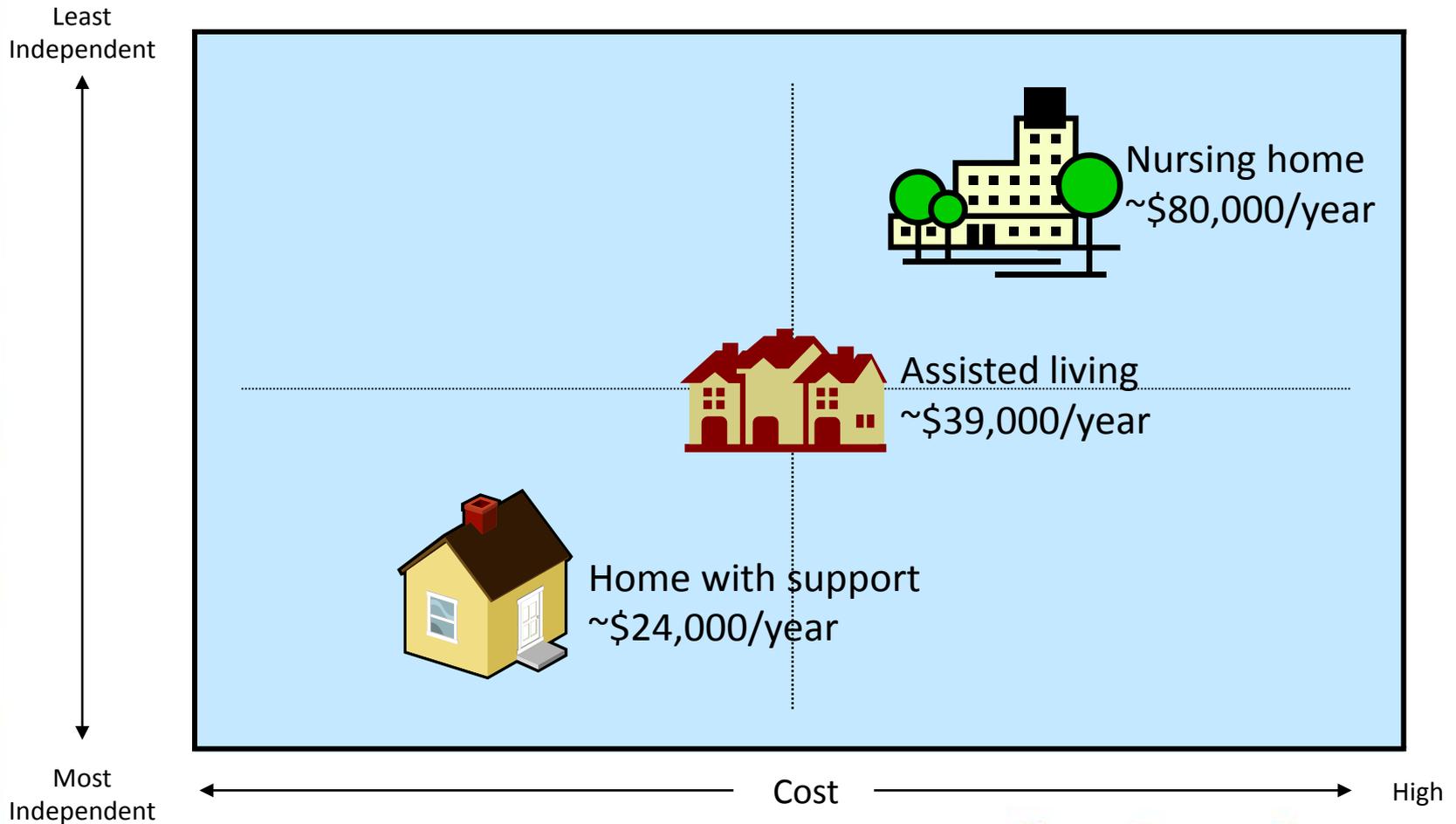
Medicaid LTC Program Challenges

- Duplication of services and programs results in waste of taxpayer dollars
- LTC funding imbalance between nursing facility and HCBS
- Programs spread over multiple agencies and departments, with limited coordination or communication between them
- Severe lack of coordinated care management (hospital<=>post acute<=>home and community<=>mental health facilities)
- Lack of information about available services
- System complexity prevents easy navigation through system

Community Independence is the Goal of Coordinated LTC Programs



LTC Options Cost Comparison



Source: MetLife, "Market Survey of Nursing Home and Assisted Living Costs," October 2010

What We Do

- Reduce overlapping services among different providers
- Divert unnecessary skilled nursing facility stays that can lead to long-term institutionalization
- Reintegrate low-acuity nursing home residents safely back into the community
- Reduce trend of nursing home admissions among those living in the community
- Reduce unnecessary emergency room, inpatient, outpatient and prescription utilization



How We Do It

- Perform individualized assessments and develop service plans to ensure necessity of services and to identify any unmet medical or social needs
- Coordinate health care across all settings, including transitional care management (hospital \leftrightarrow skilled nursing \leftrightarrow rehab \leftrightarrow home)
- Coordinate with social service agencies (e.g., local departments of health and social services)
- Ensure a single point of contact for clients and caregivers
- Ensure awareness of low-cost, high-value community resources
- Ensure strong quality oversight (right service, right place, right time, right level of care)
- Reduce fraud and abuse of program resources

Key Components of Service Coordination

- **Initial Assessment** - Standardized, electronic, comprehensive assessment of the individual's goals; capacities; physical, cognitive and behavioral health conditions; and strengths of the individual, family and/or caregiver
- **Service Plan** - Standardized process of using data from the assessment to establish a member-centric service plan meeting the needs and goals identified by the member
- **Service Coordination** - Coordination of the diverse aspects of member care throughout the acute and postacute health care continuum to achieve the highest quality and most cost-effective outcomes
- **Transitional Care Management** - Organized system of care coordination based on Eric Coleman's Care Transitions Model that views transitional care as a set of actions designed to ensure the coordination and continuity of health care as members transfer between different locations or different levels of care within the same setting

Program Quality Measurement

- Program efficiency in containing costs
- Program optimizes community inclusion
- Client access to services
- Client-centered service planning and delivery
- Provider access and capabilities
- Client safety, outcomes, satisfaction and well-being

Results: Win-Win for All Stakeholders

- Rebalances LTC funding, allowing the state to serve more people with existing funds while saving taxpayer money
- Extends and empowers community independence of Medicaid recipients at lower cost
- Decreases fragmentation and improves care coordination
- Increase options and choices for those in need of LTC and their families
- Expands access to HCBS
- Liberates individuals from institutional settings to community and home settings of their choice

Questions and Answers

Panelists:

- Dick Zoretic, EVP and Chief Operating Officer
- Dr. Mary McCluskey, Chief Medical Officer
- Patrick Blair, Chief Marketing Officer
- Pete Haytaian, Regional CEO
- Dr. Kit Gorton, Amerigroup Virginia CEO