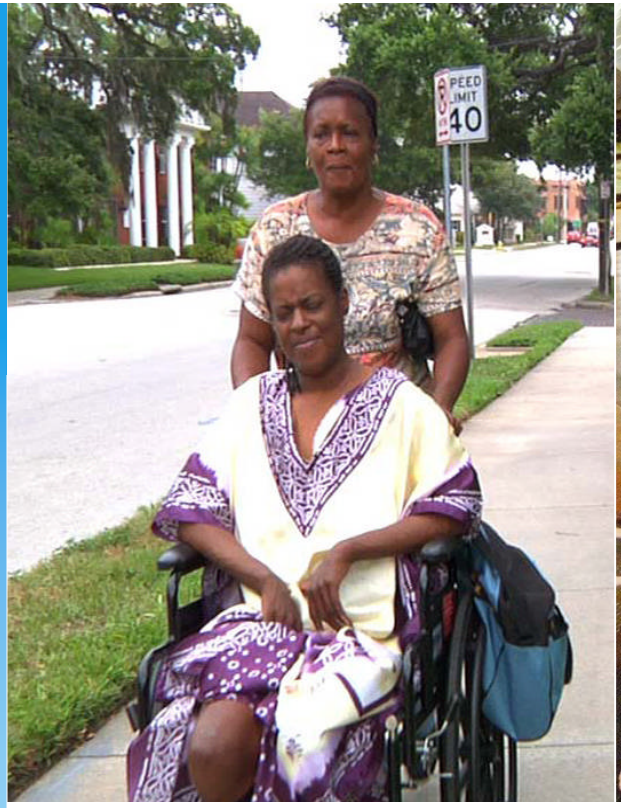

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Coordinating Long-Term Care Services: *Unrealized Potential in North Carolina*

Agenda

The Company

The Problem

The Solution

The Savings

The Roadmap

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A Different Kind of Managed Care Company

The Setting

- Government spending on financially vulnerable, disabled and aged
  - Growing at unsustainable pace
  - One of the fastest growing line items in the budget

The Company

- The industry pioneer in working with government to:
  - Control costs
  - Coordinate care
  - Achieve better quality and accountable results

The Opportunity

- Capitalize on continuing expansion of government-sponsored health insurance

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Medicaid LTC Program Challenges

- Duplication of services and programs results in waste of taxpayer dollars
- Long term care funding imbalance between nursing facility and home and community based services (HCBS)
- Programs spread over multiple agencies and departments, with less than optimal 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

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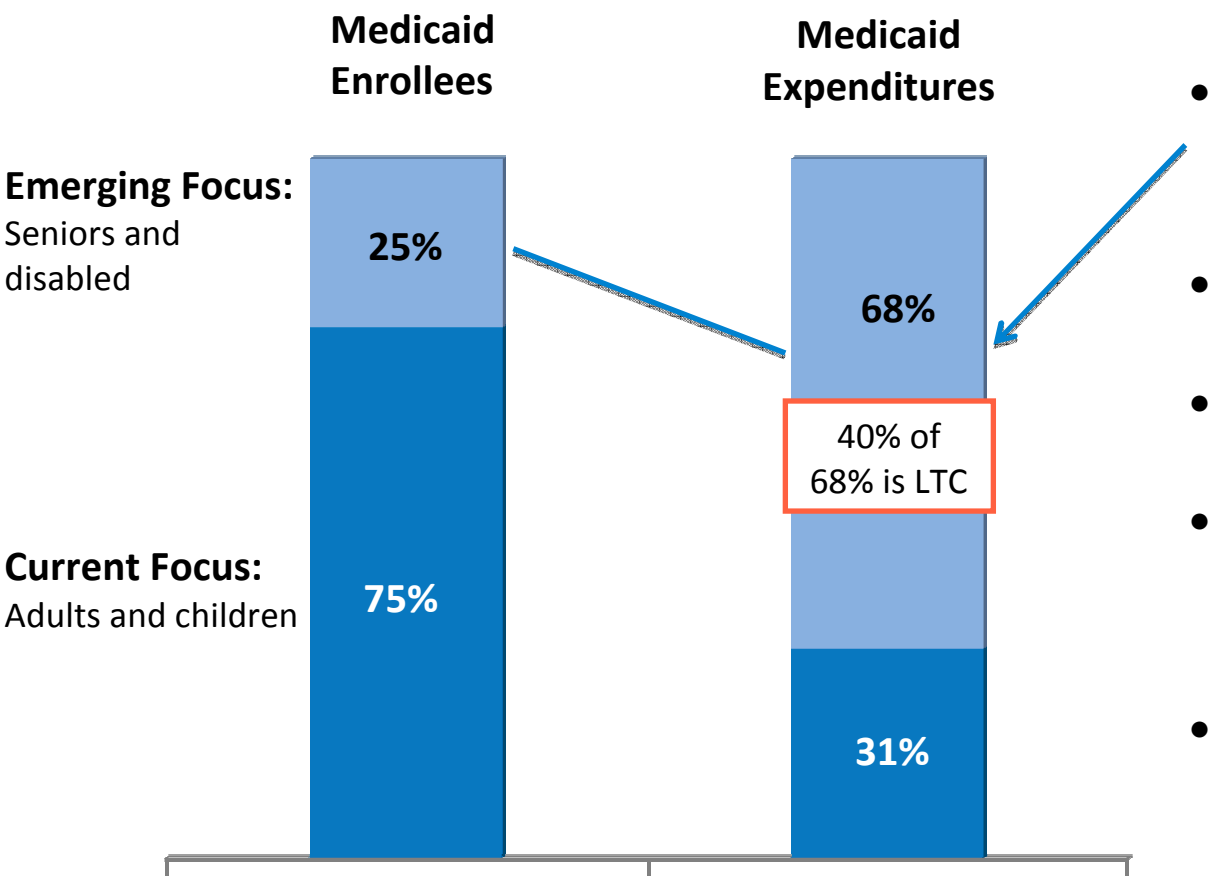
LTC Represent a Serious Challenge for States



- LTC costs represents roughly 25% of NC Medicaid spending (1)

Who are we talking about?

- Seniors with chronic disease and functional ability limitations
- Younger individuals with physical impairments and limitations
- Individuals with severe mental or emotional conditions, including mental illness (depression, schizophrenia)
- Individuals with disabling conditions such cerebral palsy, cystic fibrosis, Parkinson's disease

Note (1): Reference to distribution of LTC costs as % of total NC Medicaid costs (25%) does not include costs for intermediate care facilities and mental health facilities.

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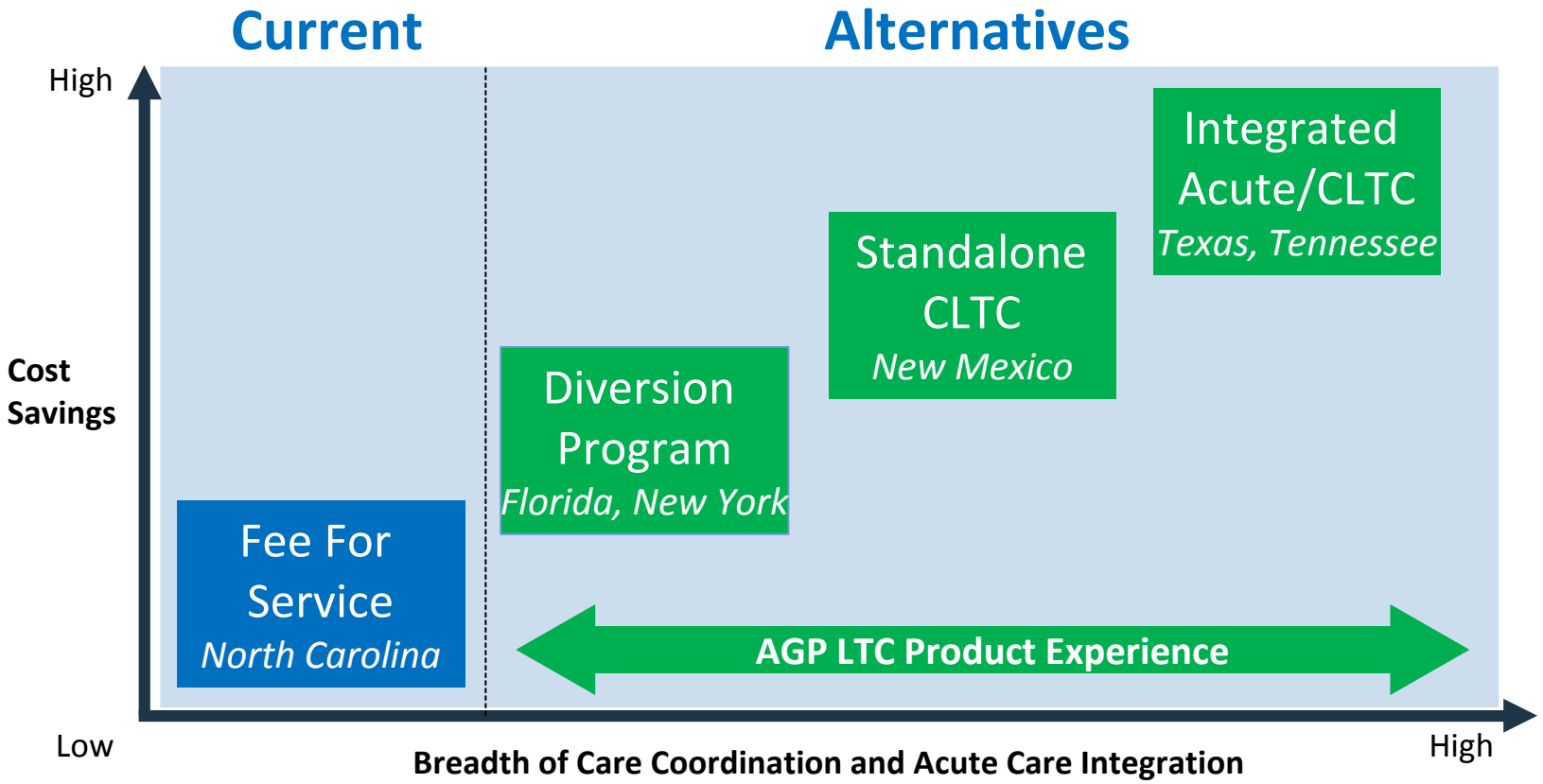
There are Different Options for Coordinating Long-Term Care Services



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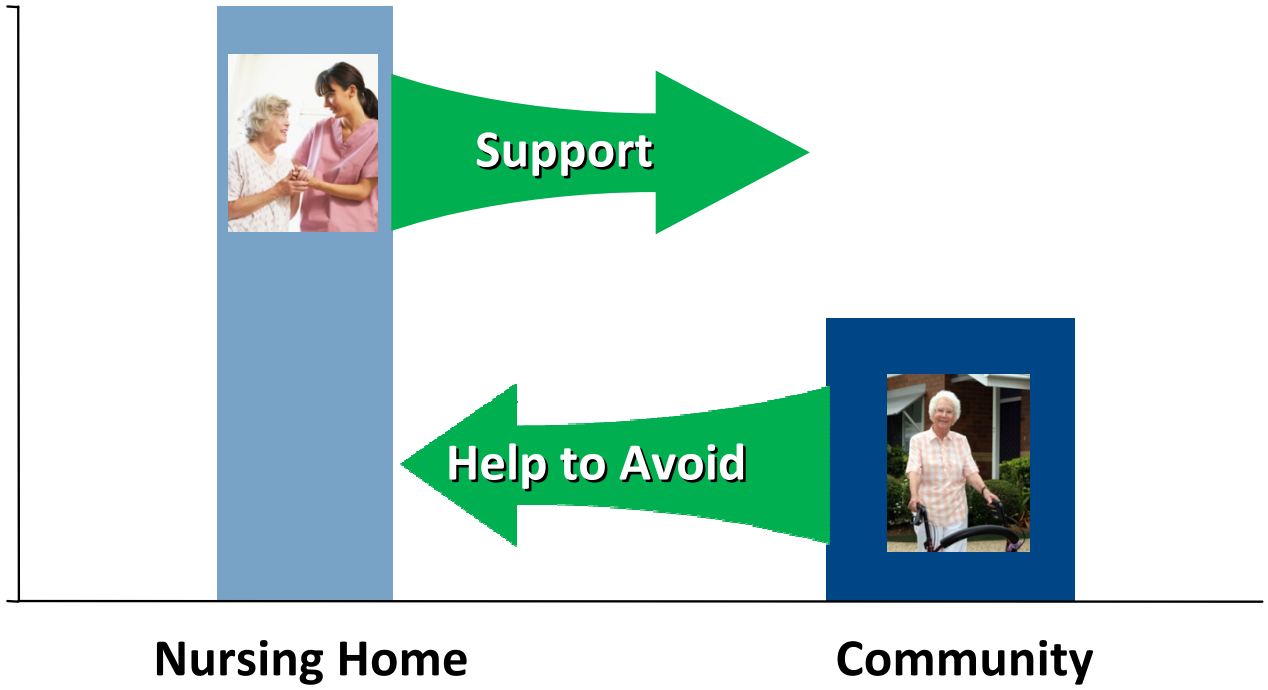
Community Independence is the Goal of Coordinated Long Term Care (CLTC) Programs



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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 ER, inpatient, outpatient and Rx utilization *(savings would be realized by CCNC program)*

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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 healthcare across all settings including transitional care management (hospital<=>skilled nursing<=>rehab<=>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

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What Coordinated Care Could Save the State

Assumes 12 calendar months of savings under a state-wide capitated full-risk model

Savings Drivers	Estimated Savings (in millions)
Divert unnecessary skilled nursing facility stays that can lead to long-term institutionalization	$8 – 11
Reintegrate low acuity nursing home residents safely back into the community	$10 - 13
Reduce trend of nursing home admissions among those living in the community	$4 - 7
Sub-Total Estimated LTC Savings	**$22 - $31**
Reduce unnecessary ER, inpatient, outpatient and Rx utilization *(potential incremental financial benefit to CCNC program)*	$8 - 10
Total Estimated, Annualized Savings Potential	**$30 - $41**

Source: Amerigroup internal analysis based on FY2008 CMS report 64 data.

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Results: Win / Win for all Stakeholders

- Rebalances LTC funding, allowing the state to serve more people with existing funds while saving tax payer money
- Extends and empowers community independence of NC 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 home and community based services
- Individuals are liberated from institutional settings to community and home settings of their choice

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How Do We Get There From Here?

- Define short and long-term program design framework *(populations, regions, services, timing, budget)*
- Conduct detailed savings analysis based on latest state data
- Determine funding model
  - Fee-based (temporary bridge to full risk---state maintains insurance risk)
  - Full risk (managed care organization assumes insurance risk)
- Engage stakeholders (advocates, providers, state agencies, health plans)
- Implement Program
  - Start with fee-based funding model Sept 2011 (expedited 2 vendor contracting)
  - Convert to full risk funding model 2012 (contingent on CMS approval timing)
- Achieve Savings
  - Savings begin 2nd quarter 2012

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