AMERIGROUP CORPORATION

Medicaid Coordinated Long-Term Care for Dual Eligibles

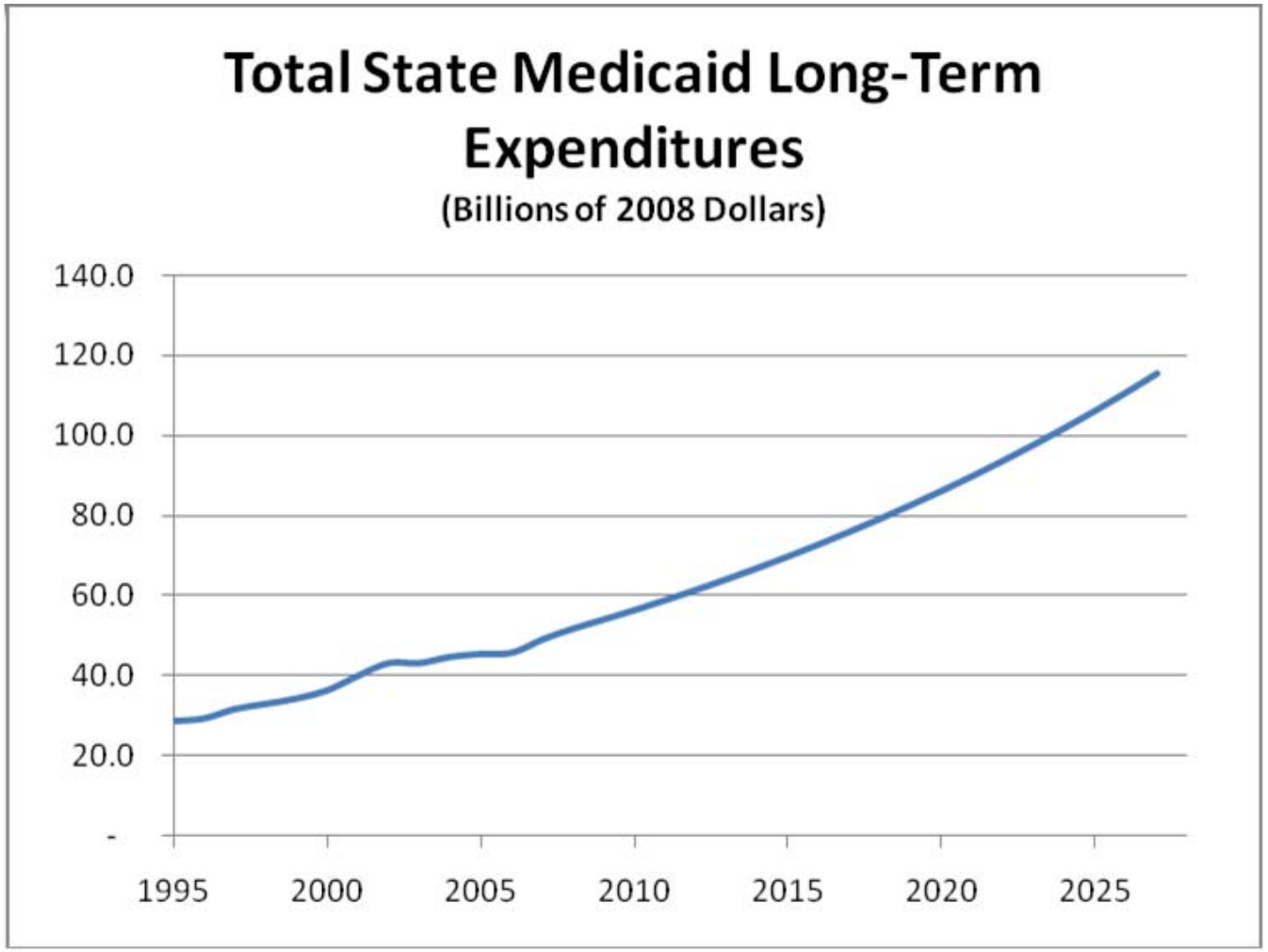
May 31, 2009

Agenda

- Problem
- Population
- Services
- State Models
- Economics
- Care Management
- Success Factors

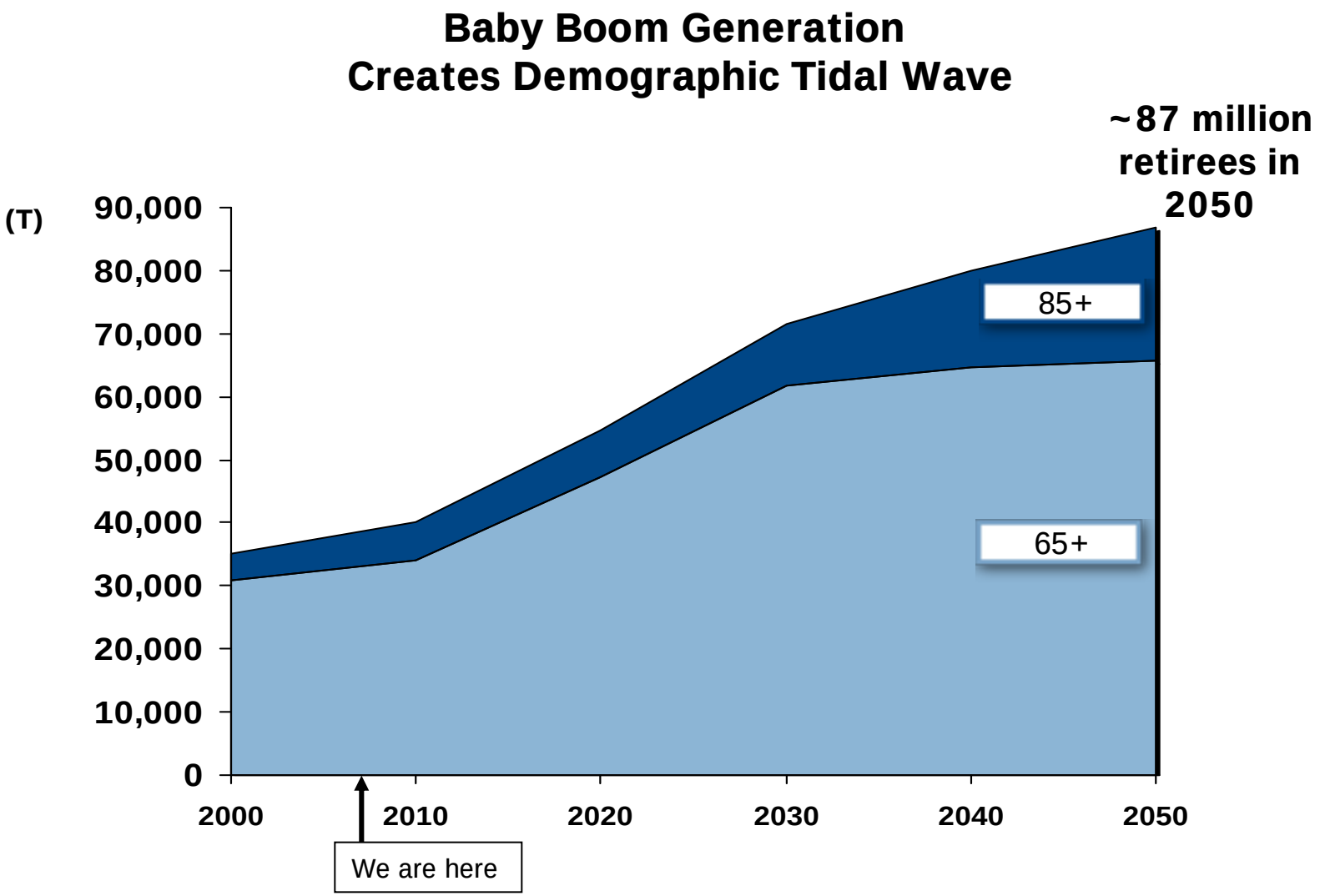


Medicaid LTC Expenditure Forecast



Data and Sources The data for this fact sheet is from the report, *State Medicaid Expenditures for Long-Term Care 2008-2027*. Paul A. London and Associates and Strategic Affairs Forecasting prepared the report in the summer of 2008. Expenditure data is for state funds, exclusive of the federal match.

The pressure on LTC costs will only continue with the coming “Tsunami” of elderly Medicaid eligibles

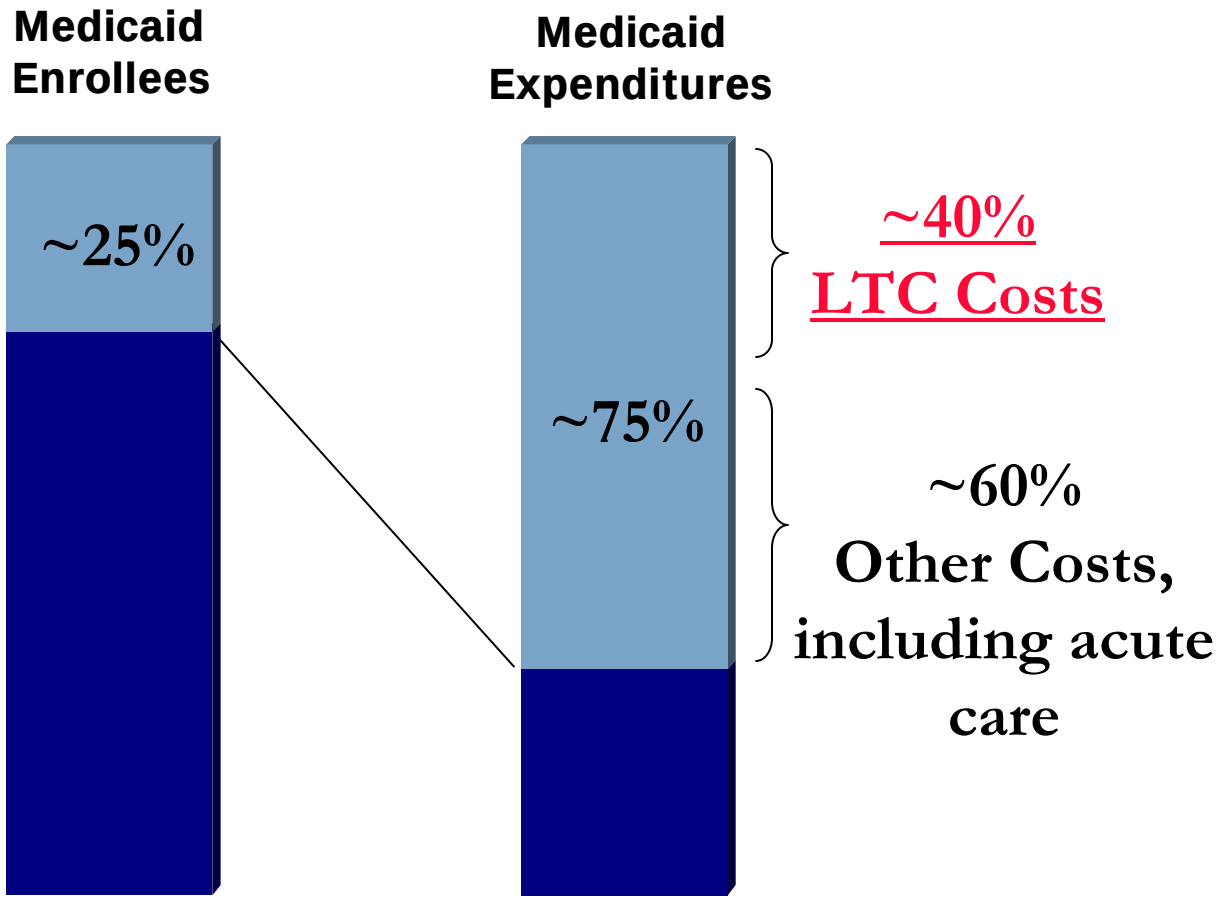


Source: US Interim Projections by Age, Sex, Race and Hispanic Origin 2004, Bureau of the Census

LTC costs for the elderly and disabled drive a significant portion of State Medicaid spending

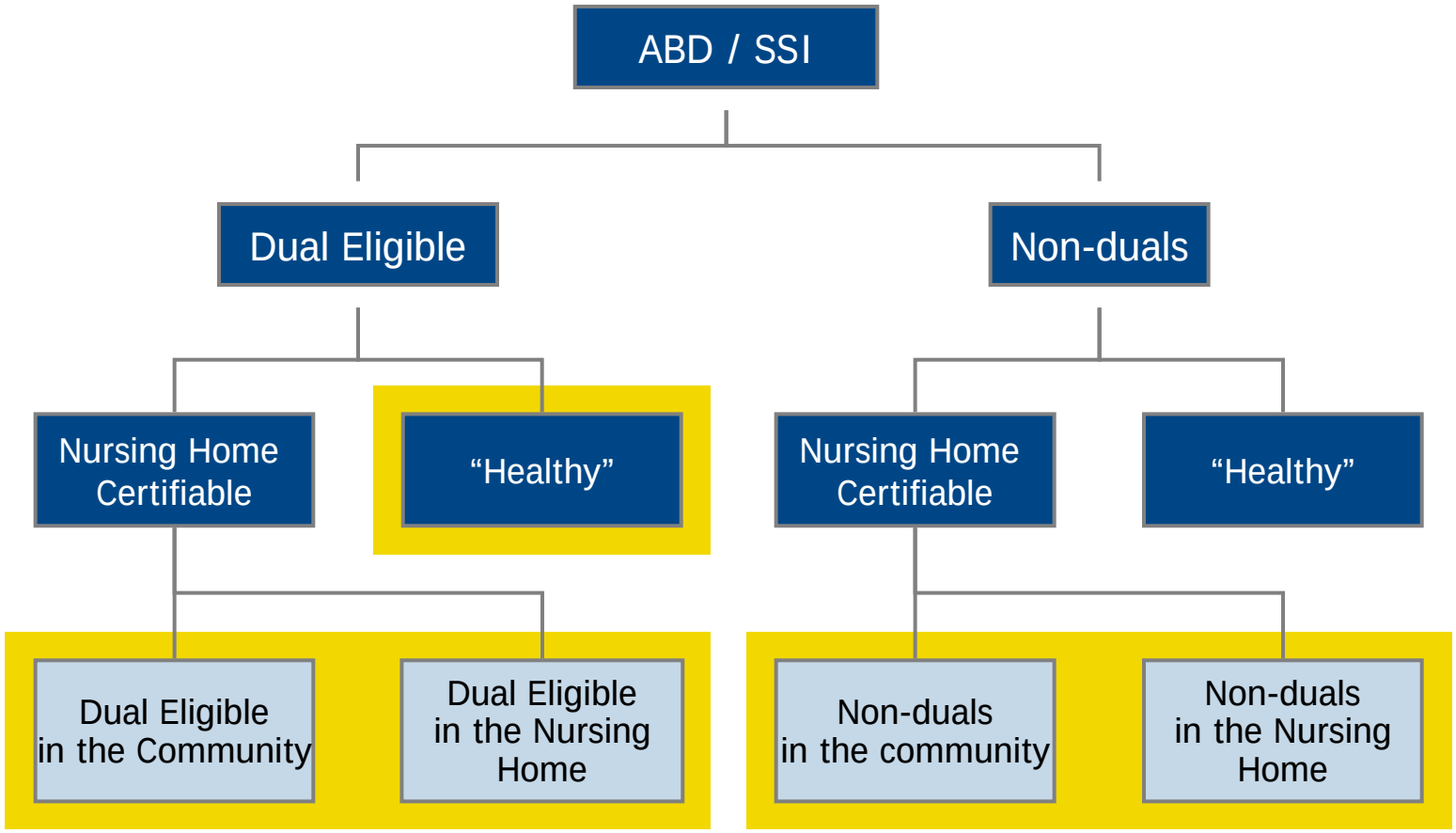
Next Wave:
Elderly and disabled

Current Wave:
Adults and children



Source: Kaiser Commission estimates based on Medicaid and the Uninsured 2003 MSIS data

Defining Coordinated LTC Populations



Typical CLTC Population

LTC recipients generally have multiple medical conditions and other needs that require support

Mental / Psychiatric Conditions (e.g. Dementia in the case of the elderly; schizophrenia; depression

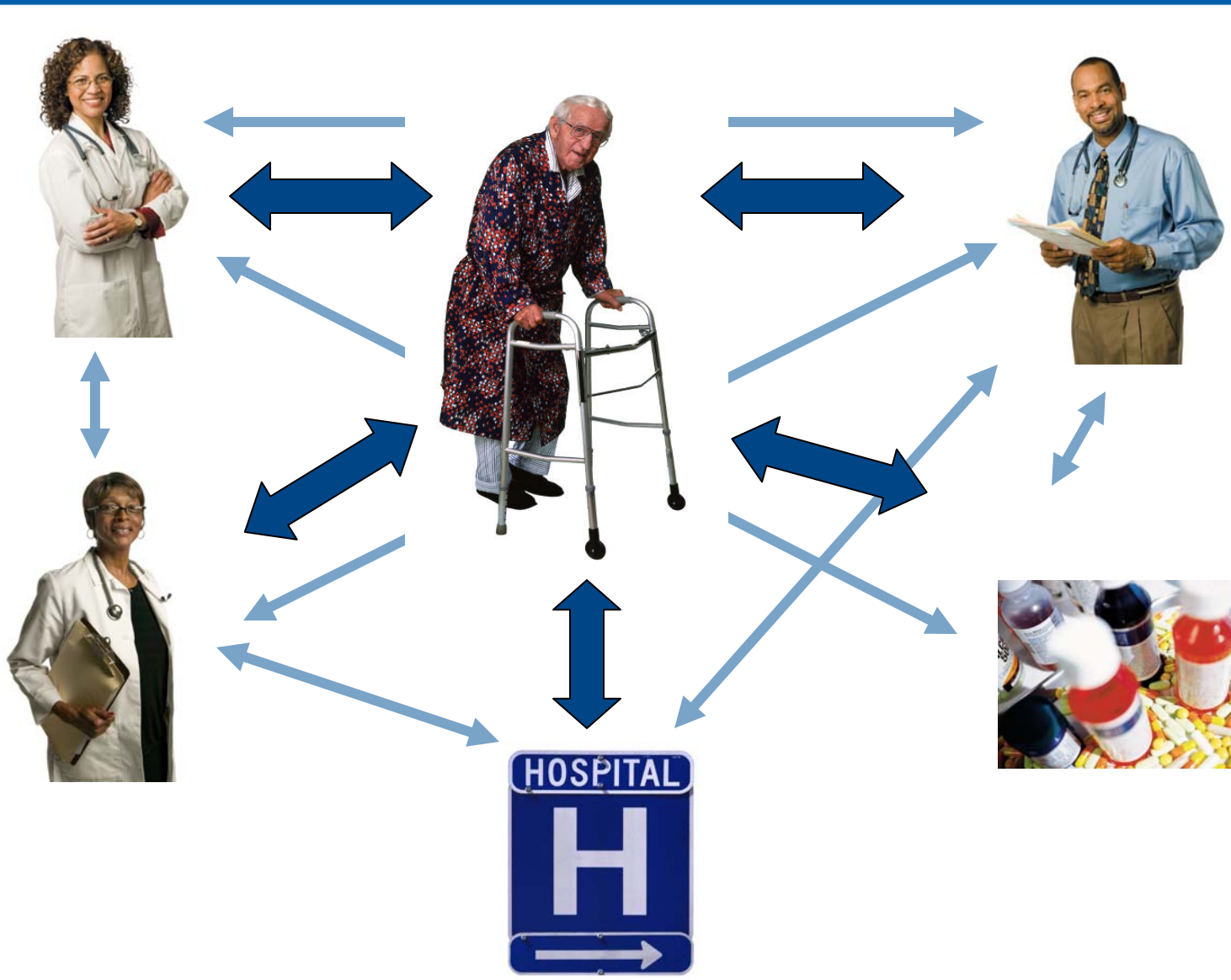
Chronic conditions (e.g. diabetes, arthritis)

Acute Care (e.g. physician services, hospitalization, ER)

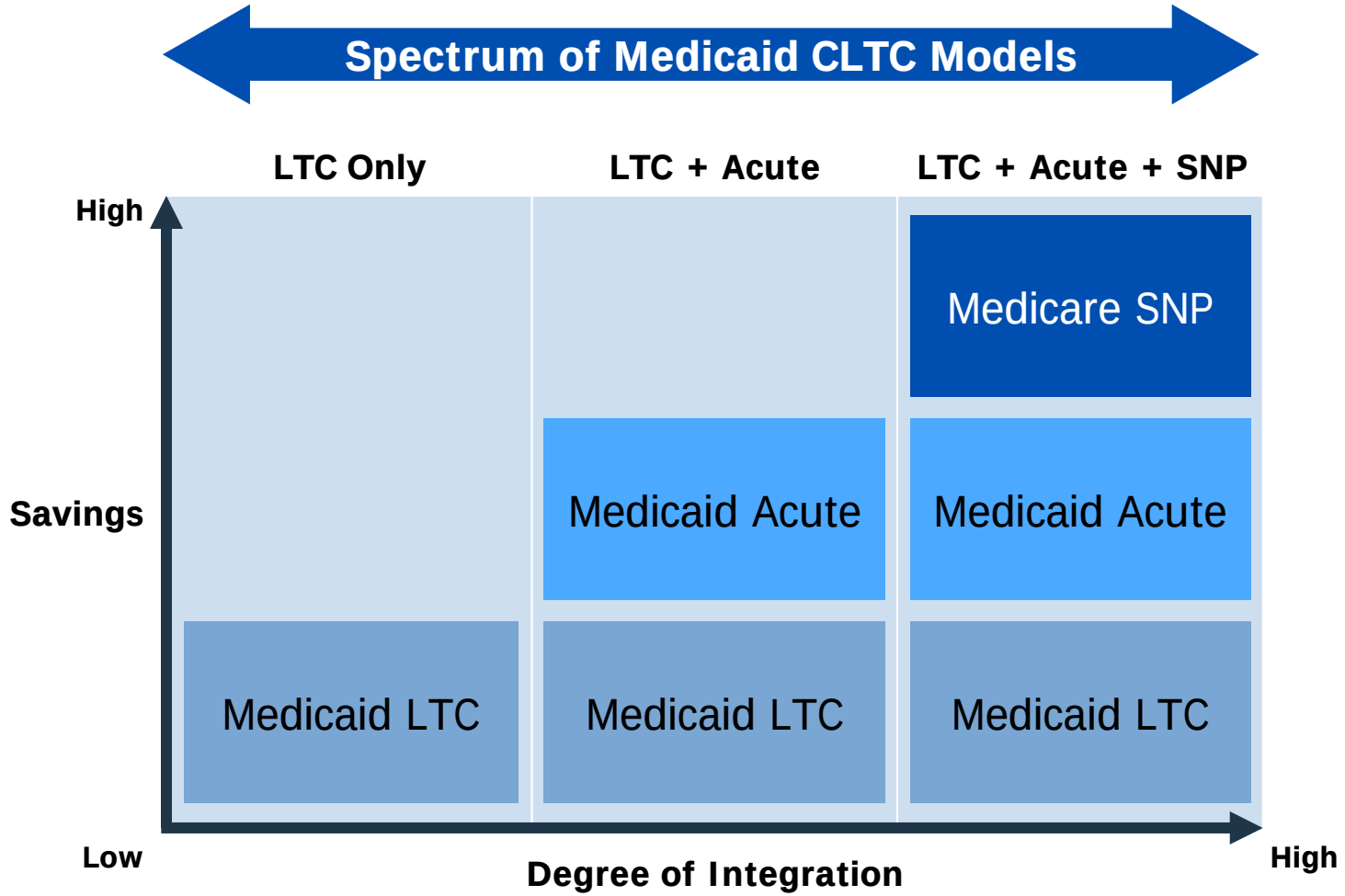
Said simply, CLTC is for people with **a limited ability to care for themselves**

- **Health care services (such as physician, hospital or nursing care)**
- **Personal care (assistance with daily activities such as dressing, bathing, taking medication)**
- **Social services (such as getting meals delivered at home, assistance with utility bills, home safety modifications)**

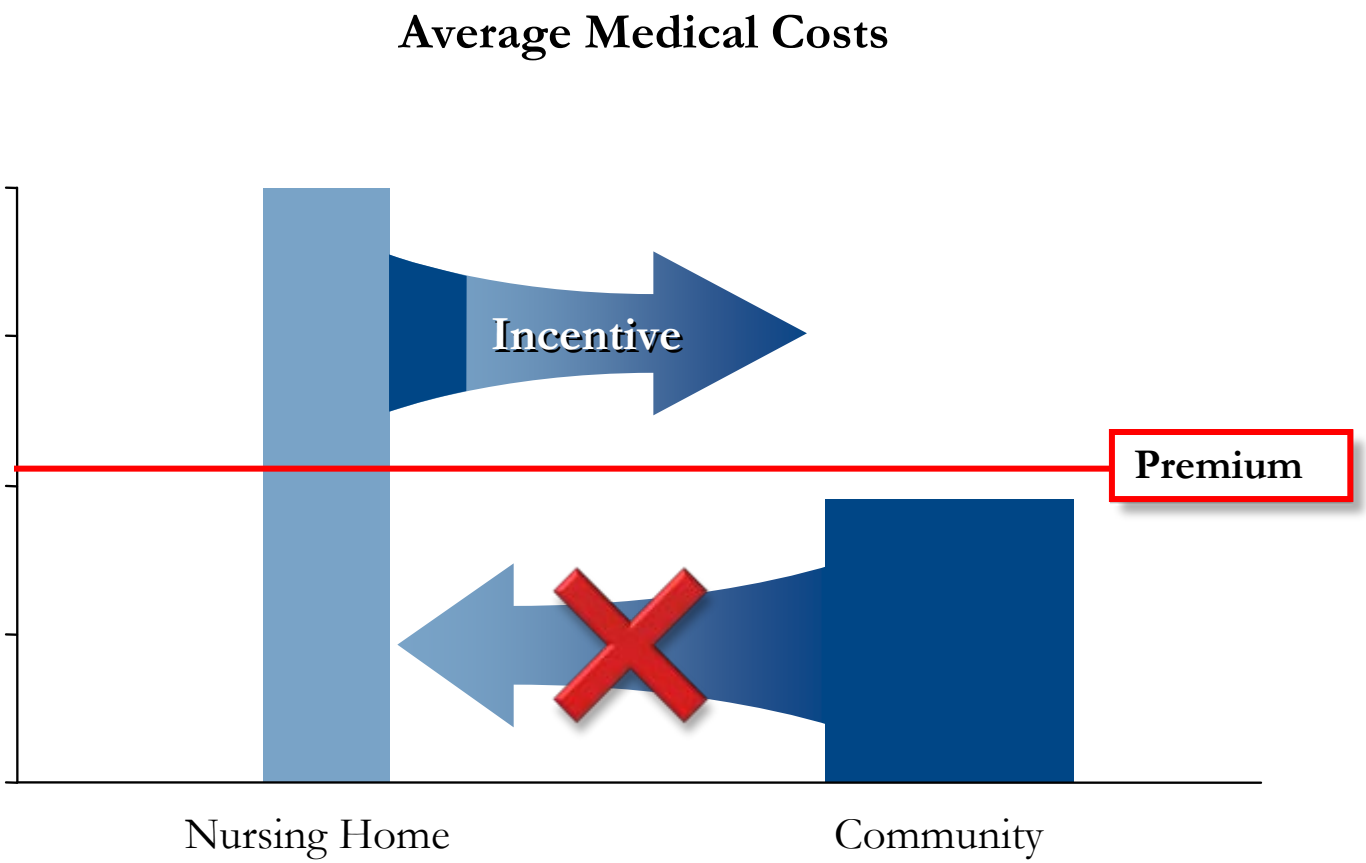
LTC recipients are faced with a challenging web of services and relationships to manage



There are a wide-range of CLTC models

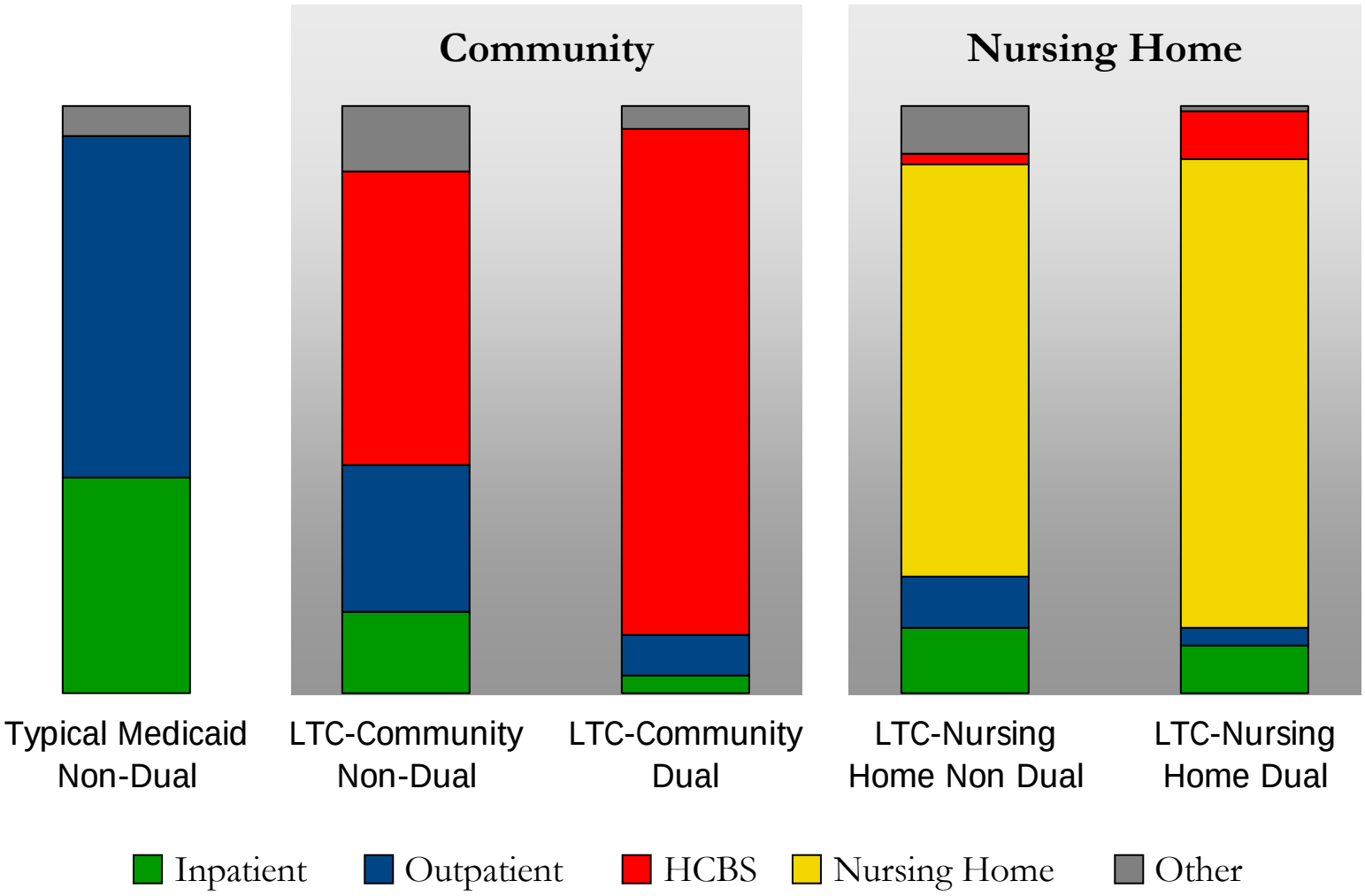


Enabling Independence is the Recipe for Success in CLTC



Maintaining the appropriate distribution between nursing home and community members is critical to success

CLTC Medical Cost Drivers are Different

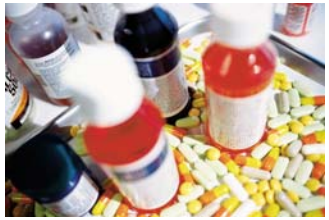


What are the key features of CLTC ?

- An organized system of care that:
  - **identifies those members in need**
  - **makes sure health care and other support services are delivered in a timely fashion**
- A **Service Coordinator / Care Manager is** assigned to those Medicaid members in need of special attention due to their health status.
- Medical oversight through the **Service Coordinator** to **coordinate care and appointments, transportation, and home services where necessary.**
- Coordination of the members' LTC needs as well as their acute care needs.

CLTC programs provide greater oversight and coordination of a LTC recipient's needs

Care Coordinator



It is critical to have a robust CLTC Care Management Model that assesses an individual's unique needs

AMERIGROUP's Model

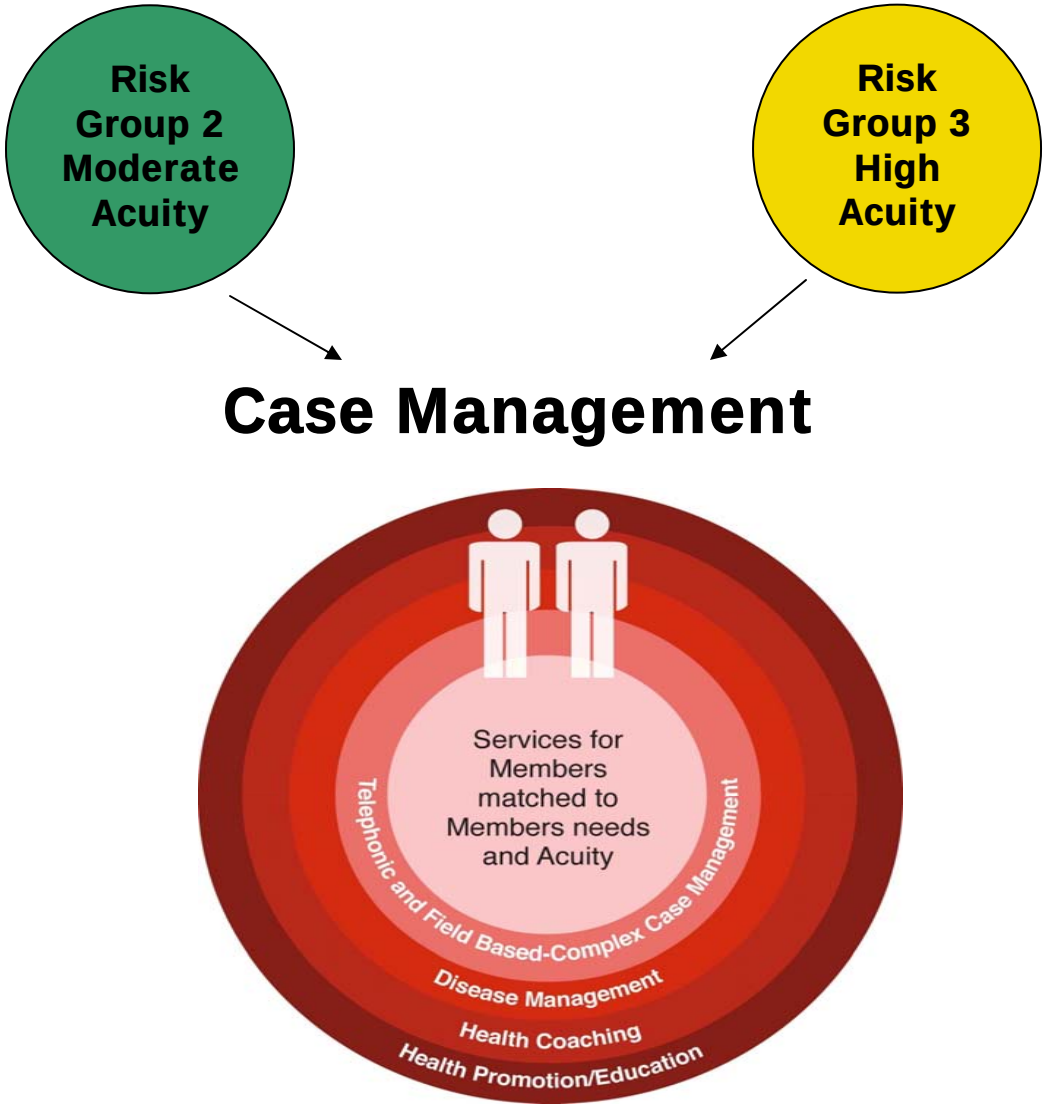
Evaluate Status of Individual & Prioritize for Treatment in 3 Groups

Risk Group 1 Low Acuity

Risk Group 2 Moderate Acuity

Risk Group 3 High Acuity

The Care Management Model should focus special attention on individuals with the greatest needs



CLTC requires a different focus than traditional acute care management models

Diagnosis Driven

Function Driven

Hospital Care

- Patient function is incidental acute clinical needs
- Patient discharged when clinical needs do not require hospital intensity

Post-Acute Care

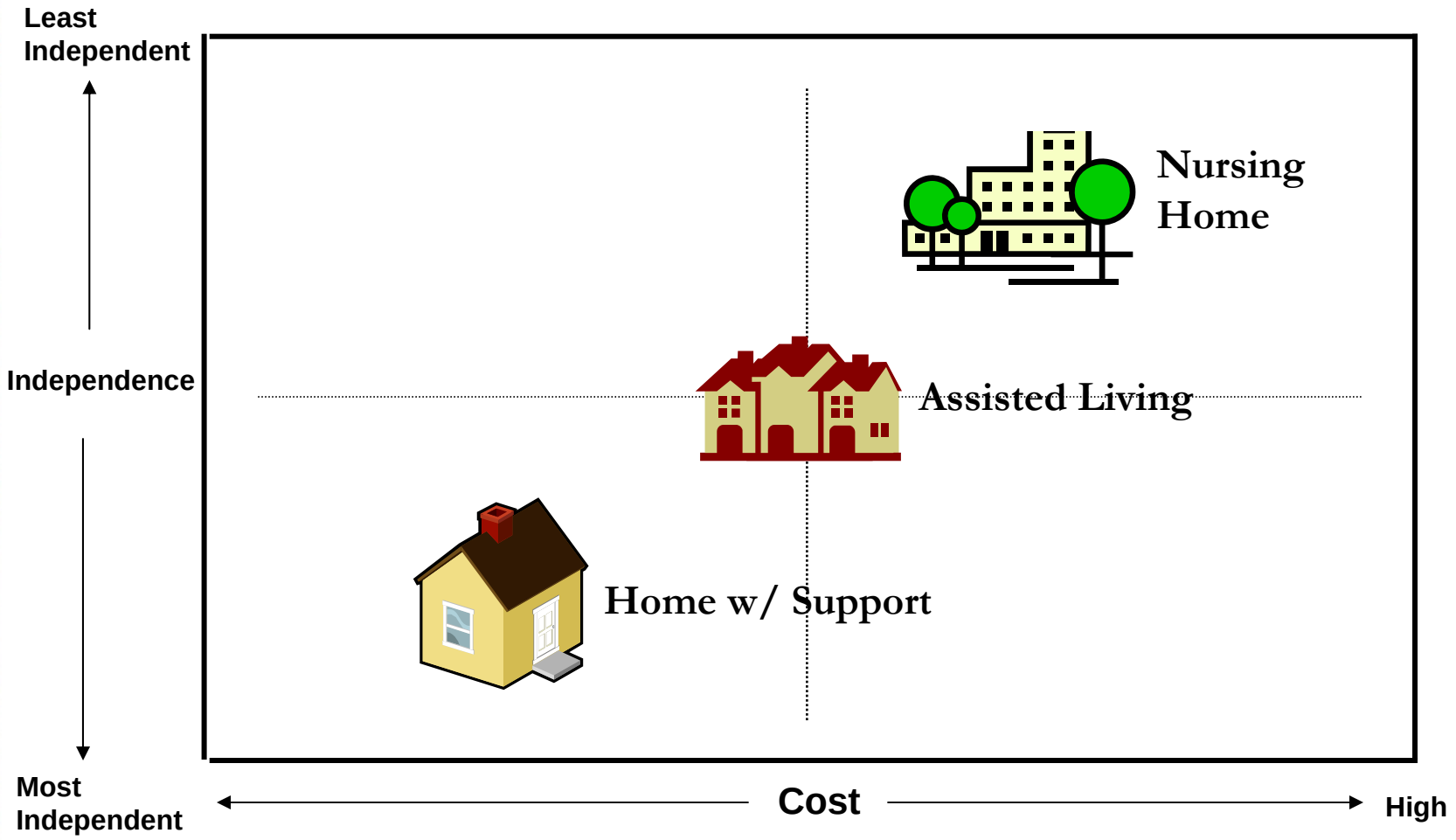
- Focus on ability to regain functional ability
- Patient is discharged when functionally able to care for themselves

Community

- Ensure safe living situation
- Maintain community independence
- Coordinate home and community-based services (HCBS)

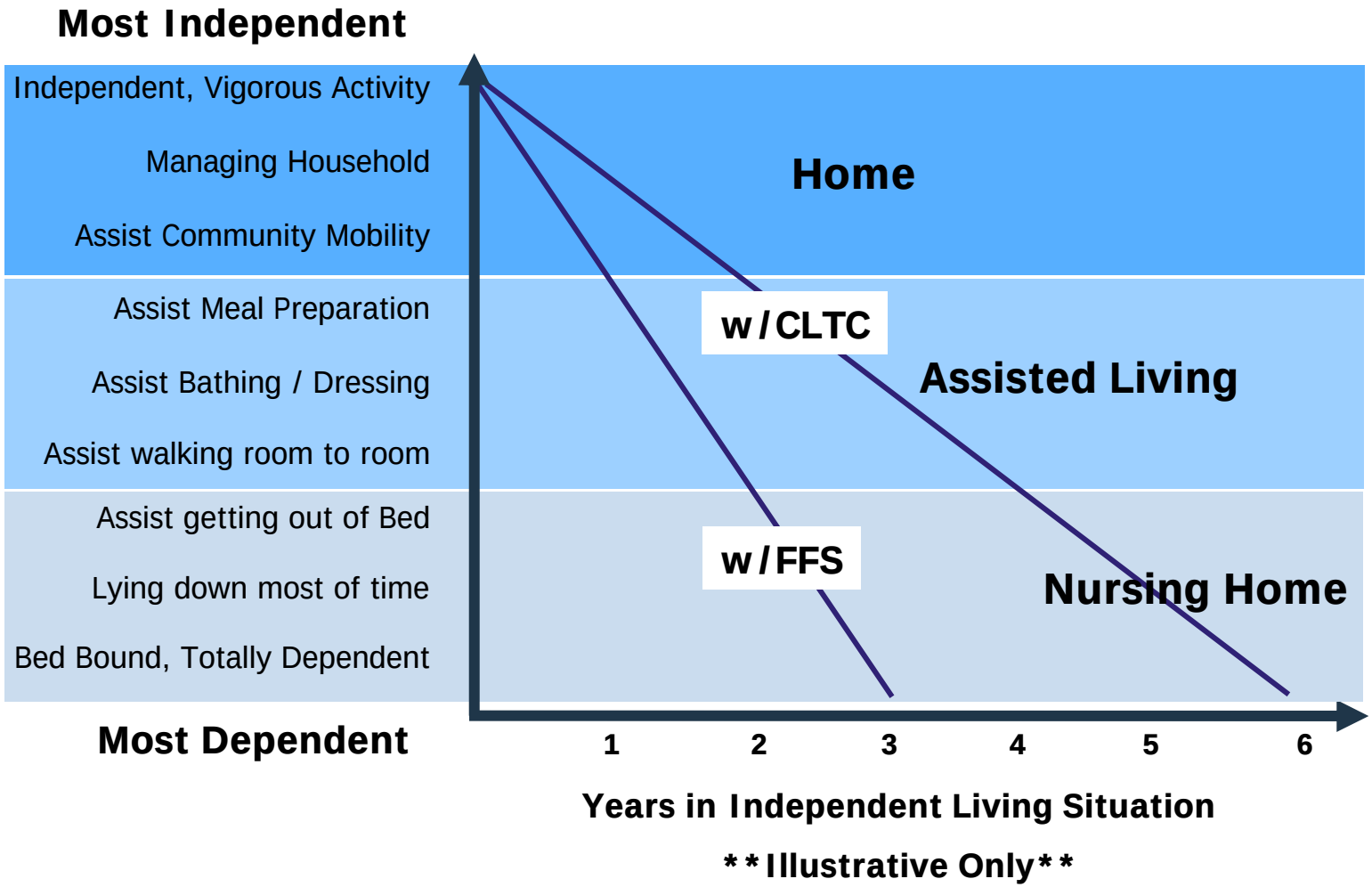
Source: Adapted with permission from SeniorMetrix, 2008

The settings with the most independence are also the least costly and the most preferred by individuals



Source: MetLife Market Survey of Nursing Home and Assisted Living Costs, October 2007
Source: Cost of home care assumes 4 hrs / day of home attendant care.

CLTC can delay costly, restrictive premature institutionalization



AGP CLTC Experience

- Texas Star+Plus
- Florida Nursing Home Diversion
- New York Managed Long Term Care
- New Mexico CoLTS
- Tennessee Community Choices (under development)

Marketing and Outreach Approach

- Launch outreach strategy simultaneously with government relations, provider relations and community development strategy.
- Multi-pronged strategy focused on influencers:
  - State agency staff
  - Advocates
  - Community-based organizations
  - Providers
  - Legislators
- Broad-based approach to maximize membership
  - Trade organizations
  - Age-based organizations
  - Physical disability agencies
  - Developmental disability agencies
  - Behavioral health disability agencies
  - Disease-specific organizations

Implementation Success Drivers

- Multi-dimensional stakeholder relations strategy (e.g. Executive Branch, Legislative Branch, Advocates, Providers)
- Ability to influence the program development
- Standardized, HIPAA compliant billing processes for home and community providers in place prior to the program development
- Subject matter expert participation in a broad variety of meetings through the development and implementation process
- Extended and extensive readiness review process
- Dedicated core implementation team that held the organization accountable for internalizing program requirements

Common CLTC Implementation Challenges

- Network development
  - Contracting for HCBS is not the same as traditional acute care network development
  - Requires deep knowledge of current Medicaid FFS reimbursement methodology and history
- Provider contract set-up and testing
  - Adjudicating out-of-network provider claims "like Medicaid FFS"
  - Managing the backlog of provider contracts as go-live approaches
- Delays in defining member cohorts and rates
  - Delays product configuration, premium forecasts (e.g. rate cell mix) and budgets
- Frail/elderly care coordination model
  - Recruitment of specialized multi-disciplinary teams
  - Utilization assumptions, staffing ratios, field v. telephonic care coordination balance
- Readiness reviews
  - "What doesn't kill you, makes you stronger."

Special Network Considerations

- Wide-range of provider types that must be contracted
- Evaluate the use of contractors to increase the reach of the plan:
  - Physician home visits, nursing home management
  - Wound care contractors may be needed based on incidence of condition
  - Adult day care as a substitution for more expensive care
  - Assistance with risk assessments, rehab screening and medical necessity
- Create "extensivist" models wherever possible to include:
  - House calls
  - Urgent Care
  - Telemedicine
- Contract local public health resources to build on their care / disease management activities

Preferred Program Design for Maximum Value

- Mandatory enrollment
- Limit to two MCOs
- Use contract amendment v. procurement if possible
- Include all nursing home certifiable (NHC) and those “at risk” of becoming NHC
- Include Duals and Non-Duals
- Include Rx (non-duals) and BH
- Include acute care for Non-Duals
- New Program Replaces Existing Waivers
- Blended rate for community and NF