SECTION B: QUALIFICATIONS AND EXPERIENCE

B.1 Indicate your organization's legal name, trade name, dba, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provider the name and address of the local representative; if none, so state.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

The Proposer must sign the Proposal Certification Statement without exception or qualification.

Organization Identification

AMERIGROUP Louisiana, Inc. (Amerigroup Louisiana) is a wholly owned subsidiary of AMERIGROUP Corporation, an organization that focuses *solely* on meeting the health care needs of financially vulnerable Americans. AMERIGROUP Corporation and our health plan subsidiaries (collectively Amerigroup) have **more than 15 years of experience providing Medicaid coordinated care services**. Amerigroup now serves approximately **2 million members nationally** through health plans in 11 states – Florida, Georgia, Maryland, Nevada, New Jersey, New Mexico, New York, Ohio, Tennessee, Texas and Virginia. Table B-1 provides the requested information about our organization.

REAL SOLUTIONS *mean* **REAL RESULTS**

Our Mission
Provide Real Solutions for members who need a little help by making the health care system work better while keeping it more affordable for taxpayers.

Table B-1. Amerigroup Louisiana Information

Requested Information	Response
Legal Name	AMERIGROUP Louisiana, Inc.
Trade Name/DBA	Amerigroup Community Care
Acronym or Other Name	None
Physical Address	3501 N. Causeway Blvd., Suite 307, Metairie, LA 70002

Requested Information	Response
Mailing Address	AMERIGROUP Louisiana, Inc. ATTN: Regulatory Services 4425 Corporation Lane, Virginia Beach, VA 23462
Telephone Number	757-490-6900
Legal Name of Parent Organization	AMERIGROUP Corporation
Form of Business	Corporation
State Where Incorporated	Louisiana
State Where Commercially Domiciled	N/A
Federal Taxpayer ID (FEIN)	26-4674149
Louisiana Taxpayer ID	1356211-001

Amerigroup offers to DHH our experience, along with qualified staff and proven, replicable processes to meet the CCN program goals and to effectively administer health care services in Louisiana.

Amerigroup shares best practices and ***Real Solutions*** to help those in publicly-funded health care programs by ensuring that these individuals enter an organized system of care and a true medical home. Amerigroup is dedicated to offering ***Real Solutions*** that improve health care access and quality for our Members, while proactively working to reduce the overall cost of care to taxpayers.

Our mission is the foundation upon which our Company was built and it is the basis for the values that guide and integrate our operations and empower our employees.

Amerigroup is guided by our ***Real Solutions*** fundamental principles:

- We improve access to care; ensuring individuals can see the right doctor at the right time.
- We improve health outcomes, one member at a time.
- We save taxpayers money by lowering health care costs and avoiding expensive emergency room use.
- We provide innovative solutions to states, physicians and members.
- We help mothers-to-be deliver healthy babies on time, reducing premature births and infant mortalities through early prenatal care and other risk-reduction strategies.
- We improve overall child health through prevention, timely immunizations and wellness programs like those combating childhood obesity.
- We help seniors and people with disabilities to live healthier, more independent lives.
- We make it easier for doctors to do their jobs.
- We keep medical costs low, while maintaining quality care.

Our long record shows that we can succeed in **helping states overcome some of their toughest health care challenges.** We deliver services to our state partners and members through a local community-based health plan model that is backed with national program knowledge and expertise. We blend our broad experience and strong national operations with local plans that are deeply rooted in the local community. This helps us to understand local health issues, as well as the provider and member environment, and to offer a knowledgeable and experienced partner to each state and community we serve.

Our unique dedication to Medicaid programs will provide DHH a **true partner with the requisite experience and resources to ensure high-quality health outcomes and improved access to care for members,** while enabling the Department to control and predict costs. We have the capabilities to meet the ever-changing needs of the populations being served by DHH. Our member-centric care management model integrates behavioral, physical and social factors into each individual member's plan of care. Our model features the early identification of needs, continuous assessment of health and a medical home approach that promotes collaboration among members, family, providers and community resources. Among our core competencies are successfully implementing new business and transitioning members to maintain their continuity of care.

Officers and Directors

Amerigroup Louisiana Officers and Directors are identified in the table that follows. All of these individuals have the same mailing address (Amerigroup Louisiana, 4425 Corporation Lane, Virginia Beach, VA 23462) and the same telephone number (757-490-6900).

Table B-2. AMERIGROUP Louisiana, Inc. – Officers and Directors

Name	Title
C. Brian Shipp	Chairman of the Board, President and Chief Executive Officer
Nicholas J. Pace	Director, Vice President and Secretary
Scott W. Anglin	Director, Vice President and Treasurer
Margaret W. Roomsburg	Vice President and Assistant Secretary
James W. Truess	Vice President and Assistant Treasurer
Karen L. Shields	Vice President and Assistant Treasurer
John E. Littel	Vice President, Government Relations
Linda K. Whitley-Taylor	Vice President

Name and address of any health professional that has at least a five percent (5%) financial interest

No health professional holds more than a five percent financial interest in Amerigroup.

CMS Form 1513 – Disclosure of Ownership and Control Interest Statement

We provide as Attachment B.1.a to this proposal a completed CMS Form 1513 – Disclosure of Ownership and Control Interest Statement, as required in the RFP. The completed form states that Amerigroup Louisiana is a wholly owned subsidiary (100 percent) of Amerigroup Corporation, a publicly traded company (NYSE: AGP).

Previous Engagements with DHH

Amerigroup Louisiana affirmatively states that we have had no contractual engagement with DHH within the past 24 months.

Proposal Certification Statement

Amerigroup Louisiana has provided a completed Proposal Certification Statement without exception or qualification, as Attachment B.1.b to this proposal.

CNC-P PROPOSAL CERTIFICATION STATEMENT
RFP # 305PUR-DHHRFP-CCN-P-MVA

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including appendices and attachments.

OFFICIAL CONTACT: DHH requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Type or Print Clearly)

Date	June 22, 2011
Official Contact Name	Pamela Perry, Vice President, Government Relations
Email Address	pperry@amerigroupcorp.com
Fax Number with Area Code	(804) 343-3895
Telephone Number	(804) 343-5130
Street Address	600 East Main Street, Suite 2020
City, State, and Zip	Richmond, VA 23219

Proposer certifies that the above information is true and grants permission to DHH to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, proposer certifies that:

1. The information contained in its response to this RFP is accurate;
2. Proposer accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP;
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP;
4. Proposer's quote is valid for at least 120 days from the date of proposal's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have seven (7) business days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. DHH has the option to waive this deadline if actions or inactions by the Department cause the delay.
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at www.epls.gov).

Authorized Signature: C. Brian Shipp

Typed or Printed Name: C. Brian Shipp

Title: President and Chief Executive Officer

Company Name: Amerigroup Louisiana, Inc.

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B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries.

Mergers and Acquisitions

Amerigroup Louisiana has not been involved in any mergers, acquisitions or sales of our organization. Additionally, we do not anticipate any such activity during the twelve (12) months following the Proposal Due Date.

Amerigroup Corporation, our parent company, has made several mergers, acquisitions and/or asset purchases over the last ten years. Relevant details regarding the transactions appear in the table below.

Table B-3. Amerigroup Mergers, Acquisitions and Asset Purchases

Effective Date	Plan Name	Market
07/01/1998	Oxford New Jersey	New Jersey
06/01/1999	Prudential	Maryland
08/01/1999	Prudential	District of Columbia
06/01/2001	PrimeHealth	Maryland
08/01/2001	Humana	Texas
01/01/2002	Methodist Care	Texas
07/01/2002	Capital Community Health Plan	District of Columbia
01/01/2003	Physicians Health Plans, Inc.	Florida
07/01/2003	St. Augustine Medicaid	Florida
01/01/2005	CarePlus, LLC	New York
11/01/2007	MMCC/TLC Health Plan	Tennessee
03/10/2010	University Health Plan	New Jersey

In addition to the specified acquisitions, Amerigroup Corporation also sold the assets of an affiliated health plan, Amerigroup Community Care of South Carolina, Inc., on March 1, 2009.

Change in Ownership

Neither Amerigroup Louisiana nor Amerigroup Corporation anticipates a change in ownership during the 12 months following the Proposal Due Date.

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B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries.

Convictions and Suspensions

Amerigroup Louisiana is an organization established for the sole purpose of serving Medicaid enrollees under the Coordinated Care Network program. Amerigroup Louisiana states affirmatively that none of its employees, agents, independent contractors or subcontractors have ever been convicted of, pled guilty to or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.

Amerigroup Louisiana's parent organization, Amerigroup Corporation, also states affirmatively that none of its employees have ever been convicted of, pled guilty to or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.

Additionally, Amerigroup Corporation states on behalf of Amerigroup Louisiana affiliate health plans in 11 states that none of its employees have ever been convicted of, pled guilty to or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.

Finally, Amerigroup Corporation states to the best of our knowledge and belief that none of its independent contractors or subcontractors have ever been convicted of, pled guilty to or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.

Amerigroup maintains a policy that prohibits hiring or contracting with individuals or entities that have been excluded or debarred from participating in federal or state health care programs or government procurement contracts. Pursuant to this policy, Amerigroup conducts screenings against the federal exclusion and debarment databases upon contracting/hiring and also performs monthly status rechecks. The Office of Business Ethics (OBE) conducts monthly screenings for all Amerigroup employees, vendors, delegated entities, Board of Directors and shareholders with greater than five percent holdings.

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B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.

Pending or Recent Litigation

There is no pending or threatened litigation against Amerigroup Louisiana.

Amerigroup Louisiana's parent corporation, Amerigroup Corporation, currently operates health plans in 11 states and it, as well as its subsidiaries, is occasionally involved in legal proceedings in the normal course of business that are not material to its business or operations. Amerigroup Corporation believes that any adverse judgment in pending or recent litigation would either be covered by insurance, has been adequately reserved for or would not have a material financial impact. We do not believe that any of the recent or pending litigation disclosed below will materially impact our ability to deliver services under the CCN contract. Amerigroup Corporation has disclosed the following material litigation items in its filings with the Securities and Exchange Commission during the previous five years:

- Hamel Toure, Individually and on Behalf of All Other Persons Similarly Situated v. AMERIGROUP Corporation and AMERIGROUP New York, LLC f/k/a Careplus, L.L.C. is a class action wage and hour claim seeking monetary damages and other relief that was filed in 2010 in the United States District Court, Eastern District of New York, Brooklyn Division. This case is currently pending. The amount of damages being sought is unknown at this time.
- Centene Corporation and University Health Plans, Inc. v. AMERIGROUP New Jersey, Inc. and AMERIGROUP Corporation was filed in 2009 in the Superior Court of New Jersey, Essex County, Chancery Division. This was a dispute pertaining to the proposed acquisition of a New Jersey health plan. This case was settled and dismissed on October 23, 2009.
- Memorial Hermann Hospital System v. AMERIGROUP Texas, Inc. was filed in 2007 in the District Court for Harris County, Texas, 333rd Judicial District. This was an alleged breach of contract dispute that was settled and dismissed on August 3, 2010.
- Illinois State Board of Investment, et al. v. AMERIGROUP Corporation, et al. was filed in 2005 in the United States District Court for the Eastern District of Virginia, Norfolk Division. This was a class action shareholder case. Settlement of the case was approved by the court in February 2007.
- United States of America ex. rel. Colleen Batty, et al. v. AMERIGROUP Illinois, Inc. and AMERIGROUP Corporation was filed in 2005 in the United States District Court for the Northern District of Illinois. The Court dismissed federal and state claims with prejudice and dismissed a wrongful discharge claim without prejudice. The wrongful discharge claim was subsequently settled and the case was dismissed on February 11, 2008.

- United States of America, ex. rel. Tyson v. AMERIGROUP Illinois, Inc. and AMERIGROUP Corporation was filed in 2002 in the United States District Court for the Northern District of Illinois and a judgment was entered against Amerigroup. In 2008, Amerigroup settled the case while on appeal for $225 million and Amerigroup entered into a Corporate Integrity Agreement with the Office of the Inspector General of the United States Department of Health and Human Services as part of the settlement.

Contact Person for Pending or Recent Litigation

Nicholas J. Pace, Esquire
Executive Vice President, General Counsel, and Secretary
Amerigroup Corporation
4425 Corporation Lane
Virginia Beach, Virginia 23462
(757) 518-3604

B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries.

Bankruptcy or Insolvency

Amerigroup Louisiana affirmatively states that we have not filed or had filed against us any bankruptcy or insolvency proceeding in the last ten years. Our parent organization, Amerigroup Corporation, and our affiliate organizations and subsidiaries, can make the same affirmation.

Amerigroup manages its cash, investments and capital structure so we are able to meet the short and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy. Amerigroup Louisiana is supported by Amerigroup Corporation, whose financial strength gives us the ability to be a dependable partner to DHH in serving Louisiana's neediest citizens. Revenues for Amerigroup Corporation increased by an average of about 24 percent a year in the past nine years, with membership growing by an average of approximately 17 percent a year during the same time across all affiliated health plans. Total revenues grew from $891 million in 2001, when Amerigroup went public, to $5.8 billion in 2010. As a publicly traded company, Amerigroup Corporation has access to capital markets and greater transparency of financial operations.

As of March 31, 2011, Amerigroup possessed approximately $2.4 billion in assets, $1.7 billion in cash and investments and approximately $1.2 billion in total shareholder's equity. Our consolidated financial reports reflect our proven fiscal soundness. Amerigroup generally maintains net worth at all of its regulated health plans at a level well above state mandates. In general our historical practice has been to capitalize our regulated subsidiaries at a level that is approximately double the state requirement. This conservatism increases our health plans' financial security and allows them to effectively manage unexpected changes in profitability while maintaining net worth above state requirements.

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B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.

Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.

Securities and Exchange Commission Form 10K and Form 10-Q

Amerigroup Louisiana is a wholly owned subsidiary of Amerigroup Corporation. Amerigroup Corporation is a publicly-traded corporation on the New York Stock Exchange under the symbol "AGP". A copy of Amerigroup Corporation's most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report for the year ending December 31, 2010, and the most recent 10-Q Quarterly Report for the quarterly period ending March 31, 2011, are provided as Attachments B.6.a and B.6.b, respectively.

Security Exchange Commission Investigations

There are no current or pending SEC investigations, civil or criminal, involving Amerigroup Corporation. Additionally, there have been no SEC investigations, civil or criminal, involving Amerigroup Corporation in the last 10 years.

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AMERIGROUP CORP (AGP)

10-K

Annual report pursuant to section 13 and 15(d)
Filed on 02/23/2011
Filed Period 12/31/2010

THOMSON REUTERS

Westlaw BUSINESS

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C.
20549

Form 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2010

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission File Number 001-31574

AMERIGROUP Corporation

(Exact name of registrant as specified in its charter)

Delaware *(State or Other Jurisdiction of Incorporation or Organization)*	**54-1739323** *(I.R.S. Employer Identification No.)*
4425 Corporation Lane, **Virginia Beach, Virginia** *(Address of principal executive offices)*	**23462** *(Zip Code)*

Registrant's telephone number, including area code:
(757) 490-6900

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $.01 par value	**New York Stock Exchange**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

As of June 30, 2010 the aggregate market value of the registrant's common stock held by non-affiliates of the registrant was $1,590,589,026.

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date.

Class	Outstanding at February 17, 2011
Common Stock, $.01 par value	**49,498,758**

Documents Incorporated by Reference

Document	Parts Into Which Incorporated
Proxy Statement for the Annual Meeting of Stockholders to be held May 12, 2011 (Proxy Statement)	**Part III**

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Forward-looking Statements

This Annual Report on Form 10-K, and other information we provide from time-to-time, contains certain "forward-looking" statements as that term is defined by Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). All statements regarding our expected future financial position, membership, results of operations or cash flows, our growth strategy, our competition, our ability to refinance our debt obligations, our ability to finance growth opportunities, our ability to respond to changes in government regulations and similar statements including, without limitation, those containing words such as "believes," "anticipates," "expects," "may," "will," "should," "estimates," "intends," "plans" and other similar expressions are forward-looking statements.

Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated in the forward-looking statements as a result of, but not limited to, the following factors:

- our inability to manage medical costs;
- our inability to operate new products and markets at expected levels, including, but not limited to, profitability, membership and targeted service standards;
- local, state and national economic conditions, including their effect on the premium rate increase process and timing of payments;
- the effect of laws and regulations governing the health care industry, including the Patient Protection and Affordable Care Act and the Health Care and Educational Reconciliation Act of 2010 and any regulations enacted thereunder;
- changes in Medicaid and Medicare payment levels and methodologies;
- increased use of services, increased cost of individual services, pandemics, epidemics, the introduction of new or costly treatments and technology, new mandated benefits, insured population characteristics and seasonal changes in the level of health care use;
- our ability to maintain and increase membership levels;
- our ability to enter into new markets or remain in our existing markets;
- changes in market interest rates or any disruptions in the credit markets;
- our ability to maintain compliance with all minimum capital requirements;
- liabilities and other claims asserted against us;
- demographic changes;
- the competitive environment in which we operate;
- the availability and terms of capital to fund acquisitions, capital improvements and maintain capitalization levels required by regulatory agencies;
- our ability to attract and retain qualified personnel;
- the unfavorable resolution of new or pending litigation; and
- catastrophes, including acts of terrorism or severe weather.

Investors should also refer to Item 1A. entitled *"Risk Factors"* for a discussion of the factors identified above and other risk factors in connection with considering any forward-looking statements. Given these risks and uncertainties, we can give no assurances that any forward-looking statements will, in fact, transpire and, therefore, caution investors not to place undue reliance on them.

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PART I.

Item 1. *Business*

Overview

We are a multi-state managed health care company focused on serving people who receive health care benefits through publicly funded health care programs, including Medicaid, Children's Health Insurance Program ("CHIP"), Medicaid expansion programs and Medicare Advantage. We believe that we are better qualified and positioned than many of our competitors to meet the unique needs of our members and the government agencies with whom we contract because of our focus solely on recipients of publicly funded health care, medical management programs and community-based education and outreach programs. We design our programs to address the particular needs of our members, for whom we facilitate access to health care benefits pursuant to agreements with applicable state and Federal government agencies. We combine medical, social and behavioral health services to help our members obtain quality health care in an efficient manner. Our success in establishing and maintaining strong relationships with government agencies, health care providers and our members has enabled us to retain existing contracts, obtain new contracts and establish and maintain a leading market position in many of the markets we serve. We continue to believe that managed health care remains the only proven mechanism that improves health outcomes for our members while helping our government customers manage the fiscal viability of their health care programs. We are dedicated to offering real solutions that improve health care access and quality for our members, while proactively working to reduce the overall cost of care to taxpayers.

We were incorporated in Delaware on December 9, 1994 as AMERICAID Community Care. Since 1994, we have expanded through negotiating contracts with various state governments, entering new markets, developing new products and through the acquisition of health plans. As of December 31, 2010, we provided an array of products to approximately 1,931,000 members in Texas, Georgia, Florida, Tennessee, Maryland, New Jersey, New York, Nevada, Ohio, Virginia and New Mexico.

Background

Publicly Funded Health Care in the United States Today

Based on U.S. Census Bureau data and estimates from the Centers for Medicare & Medicaid Services ("CMS") Office of the Actuary, it is estimated that in 2010 the United States had a population of approximately 309 million and approximately $2.6 trillion was spent on health care. According to CMS, of the total population, approximately 118 million people were covered by publicly funded health care programs. Included in this population were approximately 63 million people covered by the joint state and Federally funded Medicaid program; approximately 47 million people covered by the Federally funded Medicare program; and approximately 8 million people covered by the joint state and Federally funded CHIP program. In 2010, projected Medicare spending was $534 billion and estimated Medicaid and CHIP spending was $427 billion. Two-thirds of Medicaid funding in 2010 came from the Federal government, with the remainder coming from state governments. Approximately 51 million Americans were uninsured in 2009, as of the most recent census data.

According to CMS, prior to the passage of the Patient Protection and Affordable Care Act and the Health Care and Educational Reconciliation Act of 2010 (collectively "the Acts"), by 2014 Medicaid and CHIP spending was projected to be approximately $634 billion at its current rate of growth, with an expectation that spending under the current program would approach $896 billion by 2019. With passage of the Medicaid expansion provisions under the Acts, it is projected that Medicaid expenditures will increase an additional $455 billion through 2019. Approximately 95% of these additional costs will be paid for by the Federal government. Medicaid continues to be one of the fastest-growing and largest components of states' budgets. Medicaid spending currently represents approximately 22%, on average, of a state's budget and is growing at an average rate of 8% per year. Medicaid spending has generally surpassed other important state budget items, including education, transportation and criminal justice. Almost every state has balanced budget requirements, which means expenditures cannot exceed revenues. Macroeconomic conditions in recent years have, and are expected to continue to, put pressure on state budgets as the Medicaid eligible population increases creating more need and competing for funding with other state needs. As Medicaid consumes more and more of the states' limited dollars, states must either increase their tax

revenues or reduce their total costs. States are limited in their ability to increase their tax revenues pointing to cost reduction as the more attainable option. To reduce costs, states can either reduce funds allotted for Medicaid or spend less on other programs, such as education or transportation. As the need for these programs has not abated, state governments must find ways to control rising Medicaid costs. We believe that the most effective way to control rising Medicaid costs is through managed care.

Changing Dynamics in Medicaid

Under traditional Medicaid programs, payments were made directly to providers after delivery of care. Under this approach, recipients received care from disparate sources, as opposed to being cared for in a systematic way. As a result, care for routine needs was often accessed through emergency rooms or not at all.

The delivery of episodic health care under the traditional Medicaid program limited the ability of states to provide quality care, implement preventive measures and control health care costs. In response to rising health care costs and in an effort to ensure quality health care, the Federal government has expanded the ability of state Medicaid agencies to explore, and, in some cases, mandate the use of managed care for Medicaid beneficiaries. If Medicaid managed care is not mandatory, individuals entitled to Medicaid may choose either the traditional Medicaid program or a managed care plan, if available. According to information published by CMS, managed care enrollment among Medicaid beneficiaries in 2009 increased to 73% of all enrollees. All the markets in which we currently operate have some form of state-mandated Medicaid managed care programs in place.

We continue to believe that there are three current trends in Medicaid. First, certain states have major initiatives underway in our core business areas — soliciting bids from managed care companies to cover the Temporary Assistance for Needy Families ("TANF") and aged, blind and disabled ("ABD") populations currently in managed care, expansion of coverage under managed care, and moving existing populations into managed care for the first time.

Second, many states are moving to bring the ABD population into managed care. This population represents approximately 25% of all Medicaid beneficiaries and approximately two-thirds of all costs. While approximately 40 states have moved to bring some portion of the ABD population into managed care, a number of those states still permit enrollment to be voluntary and the remaining states still provide care to this population through the fee-for-service program. The remaining fee-for-service population represents additional potential for continued managed care growth as states explore how best to provide health benefits to this population in the most cost effective manner.

Third, the Acts, signed into law in March 2010, endeavor to provide coverage to those who are currently uninsured. The Acts provide comprehensive changes to the U.S. health care system, which will be phased in at various stages over the next several years. Among other things, the Acts are intended to provide health insurance to approximately 32 million uninsured individuals of whom approximately 20 million are expected to obtain health insurance through the expansion of the Medicaid program beginning in 2014, assuming the Acts take effect as originally enacted. Funding for the expanded coverage will initially come largely from the Federal government. As the state and Federal governments continue to explore solutions for this population, the opportunity for growth under managed care may be significant.

The Acts did not have a material effect on our results of operations, liquidity or cash flows in 2010; however, we are currently evaluating the provisions of the Acts and believe that the Acts may provide us with significant opportunities for membership growth in our existing markets and, potentially, in new markets in the future. There can be no assurance that we will realize this growth, or that this growth will be profitable.

There are numerous steps required to implement the Acts, including promulgating a substantial number of new and potentially more onerous regulations that may affect our business. Further, there is resistance to expansion at the state level, largely due to budgetary pressure. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the Federal or state level or the effect that any future legislation or regulation will have on our business or our growth opportunities. There have been a number of cases in various Federal district courts challenging the constitutionality of the Acts. Plaintiffs in the cases, which include a majority of the states, have challenged, among

other things, the constitutionality of requiring individuals to purchase health insurance, otherwise known as the individual mandate, as well as the constitutionality of requiring a state to expand its Medicaid programs. To date, no Federal district court has ruled that requiring a state to expand its Medicaid programs is unconstitutional. However, two federal district courts have ruled that the individual mandate is unconstitutional. These cases are expected to be appealed to the Federal appellate courts and it is expected that the constitutionality of the Acts will ultimately be decided by the U.S. Supreme Court. The particular case and the willingness or timing of the U.S. Supreme Court's decision to hear such case is unknown at this time, as is the ultimate outcome of the challenges to the Acts. As a result of these legal challenges, we cannot be certain that the Acts will be implemented as enacted, or whether the Acts will be substantially modified or ultimately held to be unconstitutional. We cannot predict the outcome of these court decisions or the impact the decisions could have on the opportunities and potential growth presented by the Acts.

The Acts also include the imposition of a significant new non-deductible Federal premium-based assessment and other assessments on health insurers. If this Federal premium-based assessment is imposed as enacted, and if the cost of the Federal premium-based assessment is not included in the calculation of our premium rates, or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and liquidity may be materially adversely affected.

Medicaid Program

Medicaid was established by the 1965 amendments to the Social Security Act of 1935. The amendments, known collectively as the Social Security Act of 1965, created a joint Federal-state program. Medicaid policies for eligibility, services, rates and payment are complex and vary considerably among states, and the state policies may change from time-to-time.

States are also permitted by the Federal government to seek waivers from certain requirements of the Social Security Act of 1965. Partly due to advances in the commercial health care field, states have been increasingly interested in experimenting with pilot projects and statewide initiatives to control costs and expand coverage and have done so under waivers authorized by the Social Security Act of 1965 and with the approval of the Federal government. The waivers most relevant to us are the Section 1915(b) freedom of choice waivers that enable:

- mandating Medicaid enrollment into managed care,
- utilizing a central broker for enrollment into plans,
- using cost savings to provide additional services, and
- limiting the number of providers for additional services.

Section 1915(b) waivers are approved generally for two-year periods and can be renewed on an ongoing basis if the state applies. These waivers cannot negatively impact beneficiary access or quality of care and must be cost-effective. Managed care initiatives may be state-wide and required for all classes of Medicaid eligible recipients, or may be limited to service areas and classes of recipients. All markets in which we operate have some form of state-mandated Medicaid managed care programs in place. However, under the waivers pursuant to which the mandatory programs have been implemented, there must be at least two managed care plans from which Medicaid eligible recipients may choose. If a second managed care-plan is not available, eligible recipients may choose to remain in the traditional fee-for-service program.

Many states operate under a Section 1115 demonstration waiver rather than a 1915(b) waiver. This is a more expansive form of waiver that enables the state to have a Medicaid program that is broader than typically permitted under the Social Security Act of 1965. For example, Maryland's 1115 waiver allows it to include more individuals in its managed care program than is typically allowed under Medicaid.

Medicaid, CHIP and FamilyCare Eligibles

Medicaid makes Federal matching funds available to all states for the delivery of health care benefits to eligible individuals, principally those with incomes below specified levels who meet other state-specified

requirements. Medicaid is structured to allow each state to establish its own eligibility standards, benefits package, payment rates and program administration under broad Federal guidelines.

Most states determine Medicaid eligibility thresholds by reference to other Federal financial assistance programs, including TANF and Supplementary Security Income ("SSI").

TANF provides assistance to low-income families with children and was adopted to replace the Aid to Families with Dependent Children program, more commonly known as welfare. Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Medicaid benefits were provided to recipients of TANF during the duration of their enrollment, with one additional year of coverage.

SSI is a Federal income supplement program that provides assistance to ABD individuals who have little or no income. However, states can broaden eligibility criteria. Assuming the Acts take effect as originally enacted, beginning January 1, 2014, states will be required to use modified adjusted gross income to determine eligibility for the elderly. Asset tests will no longer be used, except for individuals using long-term services and supports. For ease of reference, throughout this Form 10-K, we refer to those members who are aged, blind or disabled as ABD, as a number of states use ABD or SSI interchangeably.

CHIP, created by Federal legislation in 1997 and previously referred to as SCHIP, is a state and Federally funded program that provides health care coverage to children not otherwise covered by Medicaid or other insurance programs. CHIP enables a segment of the large uninsured population in the U.S. to receive health care benefits. States have the option of administering CHIP as a Medicaid expansion program, or administratively through their Medicaid programs, or as a freestanding program. Current enrollment in this non-entitlement program is approximately eight million children nationwide. The President signed a bill on February 4, 2009 to reauthorize and expand the CHIP program. The expanded program is expected to cover up to eleven million children by 2013, about 4 million of whom would have been otherwise uninsured, and provide an additional $32.8 billion in funding over a four and a half year period ending in 2013. The increase is paid for by a nearly $0.62 increase in the tax levied on cigarettes and allows states to expand coverage up to 300% of the Federal poverty level ("FPL") and grandfathers those states that are currently above 300% of the FPL. For states that want to expand their CHIP programs above 300% of the FPL, those states will be reimbursed at the Medicaid rate for children for amounts exceeding 300% of the FPL. The bill also allows the states an option for legal immigrant children to be covered under CHIP. The prior law required legal immigrant children to be in the country for at least five years before becoming eligible for Federal programs. CHIP will continue to be funded at an enhanced match, with the minimum Federal amount being 65%.

FamilyCare encompasses a variety of Medicaid expansion programs that have been developed in several states. For example, New Jersey's FamilyCare program is a voluntary state and Federally funded Medicaid expansion health insurance program created to help low income uninsured families, single adults and couples without dependent children obtain affordable health care coverage.

Medicare Advantage

The Social Security Act of 1965 also created the Medicare program which provides health care coverage primarily to individuals age 65 or older as well as to individuals with certain disabilities. Unlike the Federal-state partnership of Medicaid, Medicare is solely a Federal program. Medicare relies primarily on a fee-for-service delivery system in which beneficiaries receive services from any provider who accepts Medicare.

The Tax Equity and Fiscal Responsibility Act legislation of 1988 permitted the Medicare program to begin contracting with private health plans as an alternative means of delivering and managing Medicare benefits. Referred to as "Medicare risk plans", these coordinated care plans provided benefits at least comparable to those offered under the traditional fee-for-service Medicare program in exchange for a fixed monthly premium payment per enrollee from the Medicare program.

The Medicare Modernization Act of 2003 instituted the Medicare prescription drug benefit and expanded managed care for Medicare beneficiaries by renaming the program "Medicare Advantage" and allowing the establishment of new kinds of Medicare plans to provide coordinated care options for Medicare beneficiaries. Some Medicare Advantage plans focus on Medicare beneficiaries with special needs. There are three types of special

needs plans focusing on: beneficiaries who are institutionalized in long-term care facilities; dual eligibles (those who are eligible for both Medicare and Medicaid benefits); or individuals with chronic conditions.

We began serving dual eligible beneficiaries in our Texas markets in 2006 with a dual eligibles special needs plan and have since expanded to six other markets, offering Medicare plans for both dual eligibles and traditional Medicare beneficiaries. We believe that the coordination of care offered by managing both the Medicare and Medicaid benefits brings better integration of services for members and significant cost savings with increased accountability for patient care.

Medicaid Funding

The Federal government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage ("FMAP"), is determined annually by a formula that compares the state's average per capita income level with the national average per capita income level. Thus, states with higher per capita income levels are reimbursed a smaller share of their costs than states with lower per capita income levels.

The Federal government also matches administrative costs, generally about 50%, although higher percentages are paid for certain activities and functions, such as development of automated claims processing systems. Federal payments have no set limits (other than for CHIP programs), but rather are made on a matching basis. State governments pay the share of Medicaid and CHIP costs not paid by the Federal government. Some states require counties to pay part of the state's share of Medicaid costs.

As part of the American Recovery and Reinvestment Act of 2009 (the "ARRA"), enacted on February 12, 2009, states received approximately $87 billion in assistance for their Medicaid programs through a temporary increase in the FMAP match rate. Through Public Law No: 111-226 enacted on August 10, 2010, states received an additional $16.1 billion in a phased-down FMAP match rate. The funding became effective retroactively to October 1, 2008 and continues through June 30, 2011. In order to receive this additional FMAP increase, states may not reduce Medicaid eligibility levels below the eligibility levels that were in place on July 1, 2008. Furthermore, states cannot put into place procedures that make it more difficult to enroll than the procedures that were in place on July 1, 2008.

Under the ARRA, every state received a minimum FMAP increase of 6.2%. Under Public Law No: 111-226, the temporary increase in the FMAP match rate has been extended whereby the FMAP increase for each state will be reduced to 3.2% in the second quarter of Federal fiscal year 2011 and 1.2% in the third quarter of fiscal year 2011. The balance of funding is based on unemployment rates in the states. For states that have experienced an unemployment increase of 1.5% to 2.5%, the FMAP increase is 5.5% above the base state rate. For states that have experienced an unemployment increase greater than 2.5% up to 3.5%, the FMAP increase is 8.5% above the base state rate. For states that have experienced an unemployment increase greater than 3.5%, the FMAP increase is 11.5% above the base state rate.

Further, under the ARRA, if a state's unemployment rate increases during the period in which the FMAP increase is in place, a state's FMAP could potentially increase. All eleven states in which we offer health care services received adjustments in their FMAP rate in 2009 and 2010. If a state's unemployment rate decreased during this period however, the FMAP increase was not reduced prior to January 1, 2011. Additionally, states will be held harmless from any decrease in FMAP rates previously scheduled to take effect. After June 30, 2011, FMAP funding will revert to previous levels. Depending on the financial position of the states in which we do business at that time, this reduction could place additional pressure on already stressed state budgets.

During fiscal year 2010, the Federal government is estimated to have spent approximately $243 billion on Medicaid and CHIP with a corresponding state spending of approximately $184 billion. Key factors driving Medicaid spending include:

- number of eligible individuals who enroll,
- price of medical and long-term care services,
- use of covered services,

- state decisions regarding optional services and optional eligibility groups, and
- effectiveness of programs to reduce costs of providing benefits, including managed care.

Federal law establishes general rules governing how states administer their Medicaid and CHIP programs. Within those rules, states have considerable flexibility with respect to provider reimbursement and service utilization controls. Generally, state Medicaid budgets are developed and approved annually by the states' governors and legislatures. Medicaid expenditures are monitored during the year against budgeted amounts.

Medicare Funding

The Medicare program is administered by CMS and represents approximately 15% of the annual budget of the Federal government. Rising health care costs and increasing Medicare eligible populations require continual examination of available funding which may cause changes in eligibility requirements and covered benefits.

Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans' members. One of the primary directives of CMS in establishing the Medicare Advantage program was to make it more attractive to managed care plans to enroll members with higher intensity illnesses. To accomplish this, CMS implemented a risk adjusted payment system for Medicare health plans in 1997 pursuant to the Balanced Budget Act of 1997. This payment system was further modified pursuant to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. To implement the risk adjusted payment system, CMS requires that all managed care companies capture, collect and report the diagnosis code information associated with health care services received by beneficiaries to CMS on a regular basis. As of 2007, CMS had fully phased in this risk adjusted payment methodology with a model that bases the total CMS reimbursement payments on various clinical and demographic factors, including hospital inpatient diagnoses, additional diagnosis data from ambulatory treatment settings, hospital outpatient department and physician visits, gender, age and eligibility status.

Regulation

Our health care operations are regulated by numerous local, state and Federal laws and regulations. Government regulation of the provision of health care products and services varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce these rules. Changes in applicable state and Federal laws and corresponding rules may also occur periodically.

State Insurance Holding Company Regulations

Our health plan subsidiaries are generally licensed to operate as Health Maintenance Organizations ("HMOs"), except our Ohio subsidiary which is licensed as a health insuring corporation ("HIC"), and our New York subsidiary which is licensed as a Prepaid Health Services Plan ("PHSP"). Our health plan subsidiaries are regulated by the applicable state health, insurance and/or human services departments that oversee the activities of HMOs, HICs and PHSPs that provide or arrange for the provision of services to health care beneficiaries.

The process for obtaining the authorization to operate as an HMO, HIC or PHSP is lengthy and complex and requires demonstration to the regulators of the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs and complaint procedures. Each of our health plan subsidiaries must comply with applicable state financial requirements with respect to net worth, deposits, and reserves, among others. Under state HMO, HIC and PHSP statutes and state insurance laws, our health plan subsidiaries are required to file periodic financial reports and other reports about operations, including inter-company transactions. These are transactions between the regulated entity and its affiliates, including persons or entities that control the regulated entity. The regulated entity and the corporations or persons that control it constitute an insurance holding company system.

We are registered under such laws as an insurance holding company system in all of the jurisdictions in which we do business. Most states, including states in which our subsidiaries are domiciled, have laws and regulations that require regulatory approval of a change in control of an insurer or an insurer's holding company. Where such laws and regulations apply to us and our subsidiaries, there can be no effective change in control of the Company unless

the person seeking to acquire control has filed a statement containing specified information with the insurance regulators and has obtained prior approval for the proposed change from such regulators. The usual measure for a presumptive change of control pursuant to these laws is, with some variation, the acquisition of 10% or more of the voting stock of an insurance company or its parent. These laws may discourage potential acquisition proposals and may delay, deter, or prevent a change in control of the Company, including through transactions, and in particular unsolicited transactions, that some or all of our stockholders might consider to be desirable. Our health plans' compliance with state insurance holding company system requirements are subject to monitoring by state departments of insurance. Each of our health plans is subject to periodic comprehensive audits by these departments.

In addition, such laws and regulations restrict the amount of dividends that may be paid to the Company by its subsidiaries. Such laws and regulations also require prior approval by the state regulators of certain material transactions with affiliates within the holding company system, including the sale, purchase, or other transfer of assets, loans, guarantees, agreements or investments, as well as certain material transactions with persons who are not affiliates within the holding company system if the transaction exceeds regulatory thresholds.

Each of our health plans must also meet numerous criteria to secure the approval of state regulatory authorities before implementing operational changes, including the development of new product offerings and, in some states, the expansion of service areas.

In addition to regulation as an insurance holding company system, our business operations must comply with the other state laws and regulations that apply to HMOs, HICs and PHSPs, respectively, in the states in which we operate, and with laws, regulations and contractual provisions governing the respective state or Federal managed care programs, which are discussed below.

Contractual and Regulatory Compliance

Medicaid

In all the states in which we operate, we must enter into a contract with the state's Medicaid agency in order to offer managed care benefits to Medicaid eligible recipients. States generally use either a formal proposal process, reviewing many bidders, or award individual contracts to qualified applicants that apply for entry to the program. Currently Texas, Georgia, Tennessee, Nevada, Ohio and New Mexico all use competitive bidding processes, and other states in which we operate, or may operate, have done so in the past and may do so in the future.

The contractual relationship with the state is generally for a period of one- to two-years and renewable on an annual or biannual basis. The contracts with the states and regulatory provisions applicable to us generally set forth in great detail the requirements for operating in the Medicaid sector including provisions relating to: eligibility; enrollment and disenrollment processes; covered services; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education, wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems.

A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. Most health plans must also submit quarterly and annual statutory financial statements and utilization reports, as well as many other reports in accordance with individual state requirements.

Medicare

Our health plans in Florida, Maryland, New Jersey, New Mexico, New York, Tennessee, and Texas operate Medicare Advantage plans for which they contract with CMS on a calendar year basis. These contracts renew annually, and most recently were renewed for the 2011 plan year.

CMS requires that each Medicare Advantage plan meet the regulatory requirements set forth at 42 CFR 422 and the operational requirements described in the Medicare Managed Care ("MMC") Manual. The MMC Manual provides the detailed requirements that apply to our Medicare line of business including provisions related to: enrollment and disenrollment; marketing; benefits and beneficiary protections; quality assessment; relationships with providers; payment from CMS; premiums and cost-sharing; our contract with CMS; the effect of a change of ownership during the contract period; and beneficiary grievances, organization determinations, and appeals.

All of our Medicare Advantage plans include Medicare Part D prescription drug coverage; therefore, our health plans that operate Medicare Advantage plans also have Part D contracts with CMS. As Medicare Advantage Prescription Drug Plan contractors, we are also obligated to meet the requirements set forth in 42 CFR 423 and the Prescription Drug Benefit ("PDB") Manual. The PDB Manual provides the detailed requirements that apply specifically to the prescription drug benefits portion of our Medicare line of business. The PDB provides detailed requirements related to: benefits and beneficiary protections; Part D drugs and formulary requirements; marketing (included in the MMC Manual); enrollment and disenrollment guidance; quality improvement and medication therapy management; fraud, waste and abuse; coordination of benefits; and Part D grievances, coverage determinations, and appeals.

In addition to the requirements outlined above, CMS requires that each Medicare Advantage plan conduct ongoing monitoring of its internal compliance with the requirements as well as oversight of any delegated vendors.

Fraud and Abuse Laws

Our operations are subject to various state and Federal health care laws commonly referred to as "fraud and abuse" laws. Investigating and prosecuting health care fraud and abuse has become a top priority for state and Federal law enforcement entities. The funding of such law enforcement efforts has increased in the past few years and these increases are expected to continue. The focus of these efforts has been directed at providers in government funded health care programs such as Medicaid and Medicare. These regulations, and contractual requirements applicable to participants in these programs, are complex and changing.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") broadened the scope of fraud and abuse laws applicable to health care companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA establishes new enforcement mechanisms to combat fraud and abuse, including a whistleblower program. Further, HIPAA imposes civil and criminal penalties for failure to comply with the privacy and security standards set forth in the regulation. The Patient Protection and Affordable Care Act created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicare, Medicaid and CHIP. Those enhancements included mandatory licensure for all providers and site visits, fingerprinting and criminal background checks for higher risk providers. On September 23, 2010, CMS issued proposed regulations designed to implement these requirements. It is not clear at this time the degree to which managed care providers would have to comply with these new requirements, many of which resemble procedures that we already have in place.

The Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), a part of the ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations. The U.S. Department of Health and Human Services, as required by the HITECH Act, has issued interim final rules that set forth the breach notification obligations applicable to covered entities and their business associates (the "HHS Breach Notification Rule"). The various requirements of the HITECH Act and the HHS Breach Notification Rule have different compliance dates, some of which have passed and some of which will occur in the future. With respect to those requirements whose compliance dates have passed, we believe that we are in compliance with these provisions. With respect to those requirements whose compliance dates are in the future, we are reviewing our current practices and identifying those which may be impacted by upcoming regulations. It is our intention to implement these new requirements on or before the applicable compliance dates.

Violations of certain fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other Federal health care

programs and Federally funded state health programs. These laws include the Federal False Claims Act which prohibits the knowing filing of a false claim or the knowing use of false statements to obtain payment from the Federal government. Many states have false claim act statutes that closely resemble the Federal False Claims Act. If an entity is determined to have violated the Federal False Claims Act, it must pay three times the actual damages sustained by the government, plus mandatory civil penalties up to fifty thousand dollars for each separate false claim. Suits filed under the Federal False Claims Act, known as *"qui tam"* actions, can be brought by any individual on behalf of the government and such individuals (known as "relators" or, more commonly, as "whistleblowers") may share in any amounts paid by the entity to the government in fines or settlement. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the Deficit Reduction Action of 2005 ("DRA") encourages states to enact state-versions of the Federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators.

We are currently unaware of any pending or filed but unsealed *qui tam* actions against us.

In recent years, we enhanced the regulatory compliance efforts of our operations. However, with the highly technical regulatory environment and ongoing vigorous law enforcement, our compliance efforts in this area will continue to require substantial resources.

Our Approach

Unlike many managed care organizations that attempt to serve multiple populations, we currently focus on serving people who receive health care benefits through publicly funded programs. We primarily serve Medicaid populations, and the Medicare population through our Medicare Advantage product. Our success in establishing and maintaining strong relationships with governments, providers and members has enabled us to obtain new contracts and to establish a strong market position in the markets we serve. We have been able to accomplish this by operating programs that address the various needs of these constituent groups.

Government Agencies

We have been successful in bidding for contracts and implementing new products, primarily due to our ability to facilitate access to quality health care services as well as manage and reduce costs. Our education and outreach programs, our disease and medical management programs and our information systems benefit the individuals and communities we serve while providing the government with predictable costs. Our education and outreach programs are designed to decrease the use of emergency care services as the primary venue for access to health care through the provision of certain programs such as member health education seminars and system-wide, 24-hour on-call nurses. Our information systems are designed to measure and track our performance, enabling us to demonstrate the effectiveness of our programs to government agencies. While we highlight these programs and services in applying for new contracts or seeking to add new products, we believe that our ability to obtain additional contracts and expand our service areas within a state results primarily from our ability to facilitate access to quality care, while managing and reducing costs, and our customer-focused approach to working with government agencies. We believe we will also benefit from this experience when bidding for and acquiring contracts in new state markets and in future Medicare Advantage applications.

Providers

Our health care providers include hospitals, physicians and ancillary providers that provide covered medical and health care related services to our members. In each of the communities in which we operate, we have established extensive provider networks and have been successful in continuing to establish new provider relationships. We have accomplished this by working closely with physicians to help them operate efficiently, and by providing physician and patient educational programs, disease and medical management programs and other relevant information. In addition, as our membership increases within each market, we provide our physicians with a growing base of potential patients in the markets they serve. This network of providers and relationships assists us in implementing preventive care methods, managing costs and improving access to health care for members. We

believe that our experience working and contracting with Medicaid and Medicare providers will give us a competitive advantage in entering new markets. While we only directly market to or through our providers to the extent expressly permitted by applicable law, they are important in helping us attract new members and retain existing members.

Nationally, approximately 66% of Medicaid spending is directed toward hospital, physician and other acute care services, and the remaining 34% is for nursing home and other long-term care. Inpatient and emergency room utilization can be higher within the unmanaged Medicaid eligible population than among the general population because of the inability to access a primary care physician ("PCP"), leading to the postponement of treatment until acute care is required. Through our health plans, we aim to improve access to PCPs and encourage preventive care and early diagnosis and treatments, reducing inpatient and emergency room usage and thereby decreasing the total cost of care.

Members

In both enrolling new members and retaining existing members, we focus on understanding the unique needs of the Medicaid, CHIP, Medicaid expansion and Medicare Advantage populations. We have developed a system that provides our members with appropriate access to care. We supplement this care with community-based education and outreach programs designed to improve the well-being of our members. These programs not only help our members control and manage their medical care, but also decrease the incidence of emergency room care, which can be traumatic, or at a minimum, disruptive for the individual and expensive and inefficient for the health care system. We also help our members access prenatal care which improves outcomes for our members and is less costly than the potential consequences associated with inadequate prenatal care. As our presence in a market matures, these programs and other value-added services help us build and maintain membership levels.

Communities

We focus on the members we serve and the communities in which they live. Many of our employees, including our outreach staff, are a part of the communities we serve. We are active in our members' communities through education and outreach programs. We often provide programs in our members' physician offices, places of worship and community centers. Upon entering a new market, we use these programs and advertising to create brand awareness and loyalty in the community.

We believe community focus and understanding are important to attracting and retaining members. To assist in establishing our community presence in a new market, we seek to establish relationships with prestigious medical centers, children's hospitals, Federally qualified health centers, community-based organizations and advocacy groups to offer our products and programs.

Competition

Our principal competition consists of the following:

- Traditional Fee-for-Service Programs — Original unmanaged provider payment system whereby state governments pay providers directly for services provided to Medicaid and Medicare eligible beneficiaries.
- Primary Care Case Management Programs — Programs established by the states through contracts with physicians to provide primary care services to Medicaid recipients, as well as provide oversight over other services.
- Administrative Services Only Health Plans — Health plans that contract with the states to provide administrative services only ("ASO") for the traditional fee-for-service Medicaid program.
- Multi-line Commercial Health Plans — National and regional commercial managed care organizations that have Medicaid and Medicare members in addition to members in private commercial plans.
- Medicaid Health Plans — Managed care organizations that focus solely on serving people who receive health care benefits through Medicaid.

- Medicare Health Plans — Managed care organizations that focus solely on serving people who receive health care benefits through Medicare. These plans also may include Medicare Part D prescription coverage.
- Medicare Prescription Drug Plans — These plans offer Medicare beneficiaries Part D prescription drug coverage only, while members of these plans receive their medical benefits from Medicare Fee-For-Service.

We will continue to face varying levels of competition as we expand in our existing service areas and enter new markets. Changes in the business climate, including changes driven by the Acts, may cause a number of commercial managed care organizations already in our service areas to decide to enter or exit the publicly funded health care market. Some of these managed care organizations have substantially larger enrollments, greater financial and other resources and offer a broader scope of products than we do.

We compete with other managed care organizations to obtain state contracts, as well as to attract new members and retain existing members. States generally use either a formal procurement process reviewing many bidders or award individual contracts to qualified applicants that apply for entry to the program. In order to be awarded a state contract, state governments consider many factors, which include providing quality care, satisfying financial requirements, demonstrating an ability to deliver services, and establishing networks and infrastructure. People who wish to enroll in a managed health care plan or to change health care plans typically choose a plan based on the services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits.

In addition to competing for members, we compete with other managed care organizations to enter into contracts with independent physicians, physician groups and other providers. We believe the factors that providers consider in deciding whether to contract with us include potential member volume, reimbursement rates, our medical management programs, timeliness of reimbursement and administrative service capabilities.

Products

We offer a range of health care products through publicly funded programs within a care model that integrates physical and behavioral health. These products are also community-based and seek to address the social and economic issues faced by the populations we serve. The average premiums for our products vary significantly due to differences in the benefits offered and underlying medical conditions of the populations covered.

The following table sets forth the approximate number of our members who receive benefits under our products as of December 31, 2010, 2009 and 2008. Because we receive two premiums for members that are in both the Medicare Advantage and Medicaid products, these members have been counted in each product.

	December 31,		
Product	**2010**	**2009**	**2008**
TANF (Medicaid)(1)	1,373,000	1,255,000	1,095,000
CHIP(1)	271,000	259,000	253,000
ABD (Medicaid)(2)	197,000	196,000	182,000
FamilyCare (Medicaid)	71,000	63,000	40,000
Medicare Advantage	19,000	15,000	9,000
Total	1,931,000	1,788,000	1,579,000

(1) Reflects a reclassification in 2008 from CHIP to TANF to coincide with state classifications and current year presentation.
(2) Membership includes approximately 14,000 and 13,000 members each in 2010 and 2009 under an ASO contract in Texas. There were no ASO contracts in effect as of December 31, 2008.

Medical and Quality Management Programs

We provide specific disease and medical management programs designed to meet the special health care needs of our members with chronic illnesses and medical conditions, to manage excessive costs, and to improve the

overall health of our members. We integrate our members' behavioral health care with their physical health care utilizing our integrated medical management model. Members are systematically contacted and screened utilizing standardized processes. Members are stratified based on their physical, behavioral, and social needs and grouped for care management. We offer a continuum of care management including disease management, pharmacy integration, centralized telephonic case management, case management at the health plans, and field-based case management for some of our higher-risk members. These programs focus on preventing acute occurrences associated with chronic conditions by identifying at-risk members, monitoring their conditions and proactively managing their care. These disease management programs also facilitate members in the self-management of chronic disease and include asthma, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, diabetes, depression, schizophrenia and HIV/AIDS. These disease management programs attained National Committee for Quality Assurance ("NCQA") reaccreditation in 2009, which is effective through 2011.

Our Maternal-Child Services program provides health promotion, advocacy and care management for pregnant women and their newborns. Our Taking Care of Baby and Me® case management service has a major focus on the earliest identification of pregnant women, screening for risk factors, mentoring and advocating for evidenced-based clinical practices. We work with our members and providers to improve the outcomes of pregnancy through the promotion of reproductive health, access to prenatal care, access to quality care for a healthy pregnancy and delivery as well as the post-partum period and newborn care. Case managers assist members with access to transportation, prenatal vitamins, smoking cessation, breastfeeding support, the 24-hour nurse call line as well as referral to community-based home visitor programs. Essential to the success of the program is the predictive risk screening tool and survey process where members are stratified by risk grouping and begin engagement in the program.

We provide comprehensive assessment and service coordination for our long-term services and supports members. In compliance with state requirements, licensed or qualified non-licensed staff conduct service coordination for our members who receive home and community-based or institution-based services for long-term care. Comprehensive assessments are designed to assess members in multiple domains essential to the coordination of services. These domains may include physical, psychiatric, behavioral, cognitive, environmental, caregivers, functional, social, safety, and health maintenance. Based on the results of the comprehensive assessment, members participate in the development of an individualized service plan that is designed to meet goals established by the member, the service coordinator and appropriate providers. After implementation of an initial service plan, the service coordinator will perform periodic reassessments to ensure that services are being provided as planned and that service plan goals are being met. Reassessments are performed as required by state contracts and as clinically indicated. Based on the results of reassessments, service plans may be revised to meet additional new or unmet goals. In all cases, service plans are developed to promote safety and independence in the most cost efficient manner appropriate to the situation. Services are provided that are determined to meet state and contractual requirements for necessity and/or reasonableness.

We have a comprehensive quality management plan designed to improve access to cost-effective quality care. We have developed policies and procedures to ensure that the health care services arranged by our health plans meet the professional standards of care established by the industry and the medical community. These procedures include:

- Analysis of health care utilization data — We analyze the health care utilization data of the PCPs in our network in order to identify PCPs who either over utilize or under utilize health care services. We do this by comparing their utilization patterns against benchmarks based upon the utilization data of their peers. If a PCP's utilization rates vary significantly from the norm, either above or below, we meet with the provider to discuss and understand their utilization patterns, suggest opportunities for improvement and implement an ongoing monitoring program.
- Medical care satisfaction studies — We evaluate the quality and appropriateness of care provided to our health plan members by reviewing health care utilization data and responses to member and physician questionnaires and grievances.
- Clinical care oversight — Each of our health plans has a medical advisory committee comprised of physician representatives and chaired by the plan's medical director. This committee approves clinical

protocols and practice guidelines. Based on regular reviews, the medical directors who head these committees develop recommendations for improvements in the delivery of medical care.

- Quality improvement plan — A quality improvement plan is implemented in each of our health plans and is governed by a quality management committee, which is either chaired or co-chaired by the medical director of the health plan. The quality management committee is comprised of senior management at our health plans, who review and evaluate the quality of our health care services and are responsible for the development of quality improvement plans spanning both clinical quality and customer service quality. These plans are developed from provider and membership feedback, satisfaction surveys and results of action plans. Our corporate quality improvement council oversees and meets regularly with our health plan quality management committees to help ensure that we have a coordinated, quality-focused approach relating to our members and providers.

Provider Network

We facilitate access to health care services for our members generally through mutually non-exclusive contracts with PCPs, specialists, hospitals and ancillary providers. Either prior to or concurrent with being awarded a new contract, we establish a provider network in the applicable service area. As of December 31, 2010, our provider networks included approximately 110,000 physicians, including PCPs, specialists and ancillary providers, and approximately 700 hospitals.

The PCP is a critical component in care delivery, the management of costs and the attraction and retention of members. PCPs include family and general practitioners, pediatricians, internal medicine physicians, and may include obstetricians and gynecologists. These physicians provide preventive and routine health care services and are responsible for making referrals to specialists, hospitals and other providers while also providing a health care access point or "Medical Home" for our members. Health care services provided directly by PCPs include the treatment of illnesses not requiring referrals, periodic physician examinations, routine immunizations, well-child care and other preventive health care services. Specialists with whom we contract provide a broad range of physician services. While referral for these specialist services is not generally required prior to care delivery, the PCP continues to be integral to the coordination of care. Our contracts with both the PCPs and specialists usually are for two-year periods and automatically renew for successive one-year periods subject to termination by either party with or without cause upon 90 to 120 days prior written notice, except in Ohio and Tennessee, where termination may occur upon 60 days notice.

Our contracts with hospitals are usually for one- to two-year periods and automatically renew for successive one-year periods. Generally, our hospital contracts may be terminated by either party with or without cause upon 90 to 120 days prior written notice except in Ohio and Tennessee, where termination may occur upon 60 days notice. Pursuant to their contracts, each hospital is paid for all medically necessary inpatient and outpatient services and all covered emergency and medical screening services provided to members. With the exception of emergency services, most inpatient hospital services require advance approval from our medical management department. We require hospitals in our network to participate in utilization review and quality assurance programs.

We have also contracted with other ancillary providers for physical therapy, mental health and chemical dependency care, home health care, nursing home care, home-based community services, diagnostic laboratory tests, x-ray examinations, ambulance services and durable medical equipment. Additionally, we have contracted with dental vendors that provide routine dental care, vision vendors that provide routine vision services, transportation vendors where non-emergency transportation is a covered benefit and with a national pharmacy benefit manager that provides a local pharmacy network in each of our markets where these services are covered benefits.

In order to ensure the quality of our medical care providers, we credential and re-credential our providers using standards that are supported by the NCQA and that meet individual state credentialing requirements. As part of the credentialing review, we ensure that each provider in our network is eligible to participate in publicly funded health care programs. We provide feedback and evaluations on quality and medical management to them in order to improve the quality of care provided, increase their support of our programs and enhance our ability to attract and retain providers. Additionally, we include incentive payments and risk-sharing arrangements to encourage quality care and cost containment when appropriate.

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Provider Payment Methods

We periodically review the fees paid to providers and make adjustments as necessary. Generally, the contracts with providers do not allow for automatic annual increases in reimbursement levels. Among the factors generally considered in adjustments are changes to state Medicaid or Medicare fee schedules, competitive environment, current market conditions, anticipated utilization patterns and projected medical expenses. Some provider contracts are directly tied to state Medicaid or Medicare fee schedules, in which case reimbursement levels will be adjusted up or down, generally on a prospective basis, based on adjustments made by the state or CMS to the appropriate fee schedule.

The following are the various provider payment methods in place as of December 31, 2010:

Fee-for-Service. This is a reimbursement mechanism that pays providers based upon services performed. For the year ended December 31, 2010, approximately 97% of our expenses for direct health benefits were on a fee-for-service reimbursement basis, including fees paid to third-party vendors for ancillary services such as pharmacy, mental health, dental and vision benefits. The primary fee-for-service arrangements are on a maximum allowable fee schedule, per diem, case rates, percent of charges or any combination thereof. The following is a description of each of these mechanisms:

- Maximum Allowable Fee Schedule — Providers are paid the lesser of billed charges or a specified fixed payment for a covered service. The maximum allowable fee schedule is developed using, among other indicators, the state fee-for-service Medicaid program fee schedule, Medicare fee schedules, medical costs trends and market conditions.
- Per Diem and Case Rates — Hospital facility costs are typically reimbursed at negotiated per diem or case rates. Per diem rates are fixed daily rates whereas case rates vary by the diagnosis and level of care within the hospital setting. Lower rates are paid for lower intensity services, such as the delivery of a baby without complication, compared to higher rates for a neonatal intensive care unit stay for a baby born with severe developmental disabilities.
- Percent of Charges — Providers are paid an agreed-upon percent of their standard charges for covered services.

We generally pay out-of-network providers based on a state-mandated out-of-network reimbursement methodology, or in states where no such rates are mandated, based on our Company's standard out-of-network fee schedule. We do not rely on databases that attempt to calculate the "prevailing" or "usual customary and reasonable" charge for services rendered to our members.

Capitation. Some of our PCPs and specialists are paid on a fixed-fee per member basis, also known as capitation. Our arrangements with ancillary providers for vision, dental, home health, laboratory and durable medical equipment may also be capitated.

Risk-sharing arrangements. A small number of primary care arrangements also include a risk-sharing component, in which the provider takes on some financial risk for the care of the member. Under a risk-sharing arrangement, the parties conduct periodic reconciliations, generally quarterly, based on which the provider may receive a portion of the surplus, or pay a portion of the deficit, relating to the total cost of care of its assigned members. These risk-sharing arrangements include certain measures to ensure the financial solvency of the provider and to protect the member against reduced care for medically necessary services as well as to comply with state and/or Federal regulatory requirements.

Incentive arrangements. A number of arrangements, mainly relating to primary care or coordinated care for members with chronic conditions, include an incentive component in which the provider may receive a financial incentive for achieving certain performance standards relating to quality of care and cost containment. Similar to risk-sharing arrangements, these incentive arrangements include measures to protect the member against reduced care for medically necessary services.

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Outreach and Educational Programs

An important aspect of our comprehensive approach to health care delivery is our outreach and educational programs, which we administer system-wide for our providers and members. We also provide education through outreach and educational programs in churches and community centers. The programs we have developed are specifically designed to increase awareness of various diseases, conditions and methods of prevention in a manner that supports the providers, while meeting the unique needs of our members. For example, we conduct health promotion events in physicians' offices. Direct provider outreach is supported by traditional methods such as direct mail, telemarketing, television, radio and cooperative advertising with participating medical groups.

We believe that we can also increase and retain membership through outreach and education initiatives. We have a dedicated staff that actively supports and educates prospective and existing members and community organizations. Through programs such as PowerZone, a program that addresses childhood obesity, and Taking Care of Baby and Me®, a prenatal program for pregnant mothers, we promote a healthy lifestyle, safety and good nutrition to our members. In several markets, we provide value-added benefits as a means to attract and retain members. These benefits may include such things as vouchers for over-the-counter medications or free memberships to the local Boys and Girls Clubs.

We have developed specific strategies for building relationships with key community organizations, which help enhance community support for our products and improve service to our members. We regularly participate in local events and festivals and organize community health fairs to promote healthy lifestyle practices. Equally as important, our employees help support community groups by serving as board members and volunteers. In the aggregate, these activities serve to act not only as a referral channel, but also reinforce the Company brand and foster member loyalty.

Information Technology Services

The ability to capture, process, and enable access to data and translate it into meaningful information is essential to our ability to operate across a multi-state service area in a cost-effective manner. We deployed an integrated system strategy for our financial, claims, care management, encounter management and sales/marketing systems to avoid the costs associated with supporting multiple versions of similar systems and improve productivity. This approach helps to assure the integrity of our data and that consistent sources of financial, claim, provider, member and clinical information are provided across all of our health plans. We utilize our integrated system for billing, claims and encounter processing, utilization management, marketing and sales tracking, financial and management accounting, medical cost trending, reporting, planning and analysis. This integrated system also supports our internal member and provider service functions and we provide access to this information through our provider and member portals to enable self-service capabilities for our constituents. Our system is scalable and we believe it will meet our software needs to support our long-term growth strategies. In 2010, we added a new integrated workstation for our call center operations that has significantly improved efficiency and call quality. In addition, we have security systems that meet best practices and also maintain a robust business continuity plan and disaster recovery site in the event of a disruptive event.

Our Health Plans

We currently have eleven active health plan subsidiaries offering health care services. All of our contracts, except those in Georgia, New Jersey and New York, contain provisions for termination by us without cause generally upon written notice with a 30 to 180 day notification period. Our state customers also have the right to terminate these contracts. The states' termination rights vary from contract-to-contract and may include the right to terminate for convenience, upon the occurrence of an event of default, upon the occurrence of a significant change in circumstances or as a result of inadequate funding.

We serve members who receive health care benefits through our contracts with the regulatory entities in the jurisdictions in which we operate. For the year ended December 31, 2010, our Texas contract represented approximately 23% of our premium revenues and our Tennessee, Georgia and Maryland contracts represented approximately 15%, 12% and 11% of our premium revenues, respectively. The following table sets forth the approximate number of members we served in each state as of December 31, 2010, 2009 and 2008.

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Because we receive two premiums for members that are in both the Medicare Advantage and Medicaid products, these members have been counted twice in the states in which we operate Medicare Advantage plans.

Market	December 31, 2010	2009	2008
Texas[1]	559,000	505,000	455,000
Georgia	266,000	249,000	206,000
Florida	263,000	236,000	237,000
Tennessee	203,000	195,000	187,000
Maryland	202,000	194,000	169,000
New Jersey	134,000	118,000	105,000
New York	109,000	114,000	110,000
Nevada	79,000	62,000	—
Ohio	55,000	60,000	58,000
Virginia	40,000	35,000	25,000
New Mexico	21,000	20,000	11,000
South Carolina[2]	—	—	16,000
Total	1,931,000	1,788,000	1,579,000

(1) Membership includes approximately 14,000 and 13,000 members under an ASO contract as of December 31, 2010 and 2009, respectively. There was no ASO contract in effect as of December 31, 2008.
(2) The contract with South Carolina terminated March 1, 2009 concurrent with the sale of our rights under the contract.

As of December 31, 2010, each of our health plans provided managed care services through one or more of our products, as set forth below:

Market	TANF	CHIP	ABD	FamilyCare	Medicare Advantage
Texas	✓	✓	✓		✓
Georgia	✓	✓			
Florida	✓	✓	✓		✓
Tennessee	✓		✓		✓
Maryland	✓	✓	✓	✓	✓
New Jersey	✓	✓	✓	✓	✓
New York	✓	✓	✓	✓	✓
Nevada	✓	✓		✓	
Ohio	✓				
Virginia	✓	✓	✓		
New Mexico			✓		✓

Texas

Our Texas subsidiary, AMERIGROUP Texas, Inc., is licensed as an HMO and became operational in September 1996. Our current service areas include the cities of Austin, Corpus Christi, Dallas, Fort Worth, Houston and San Antonio and the surrounding counties. Our joint TANF, CHIP and ABD contract renews annually at the State's option and is effective through the contract year ending August 31, 2013. Effective January 1, 2006, AMERIGROUP Texas, Inc. began operations as a Medicare Advantage plan to offer Medicare benefits to dual eligibles that live in and around Houston, Texas. AMERIGROUP Texas, Inc. already served these members through the Texas Medicaid STAR+PLUS program and now offers these members Medicare Parts A & B benefits and the Part D drug benefit under this contract that renews annually. Effective January 1, 2008, AMERIGROUP Texas, Inc.

expanded its Medicare Advantage offerings to the Houston contiguous counties and San Antonio service areas. Each of these contracts renew annually and were most recently renewed effective for the 2011 plan year. Additionally, in June 2010, we received approval from CMS to add Tarrant County to our Medicare Advantage service areas and to expand our Medicare Advantage plans to cover traditional Medicare beneficiaries in addition to the existing special needs beneficiaries, effective January 1, 2011.

In May 2010, the Texas Health and Human Services Commission ("HHSC") announced that our Texas health plan was selected through a competitive procurement to expand health care coverage to seniors and people with disabilities in the six-county service area surrounding Fort Worth, Texas. AMERIGROUP Texas, Inc. began serving approximately 27,000 STAR+PLUS members in that service area on February 1, 2011, a portion of which were previously our members under an ASO contract. We are one of two health plans awarded this expansion contract; however, we are currently serving all STAR+PLUS members in the Fort Worth market while the other health plan completes its readiness review. If and when that second plan becomes operational, the members will be provided an opportunity to choose between health plans.

HHSC is currently drafting a request for proposal ("RFP") for the re-bid of its entire managed care program in the State of Texas. We expect the RFP to include the addition of new service areas and new product opportunities in existing service areas, resulting in a significant increase to the size and scope of the State's managed care program. We anticipate that the release of the RFP and HHSC's selection of vendors under the new contract will occur sometime in 2011 with details regarding implementation dates dependent on the timing of the award. If we are not awarded this contract through the re-bidding process, our results of operations, financial position or cash flows in future periods could be materially and adversely affected.

As of December 31, 2010, we had approximately 559,000 members in Texas. We believe that we have the largest Medicaid health plan membership of the three health plans in our Fort Worth market, the second largest Medicaid health plan membership of the three health plans in our Austin and Dallas markets, the second largest Medicaid health plan membership of the six health plans in our Houston market and the third largest Medicaid health plan membership of the three health plans in our Corpus Christi and San Antonio markets.

Georgia

Our Georgia subsidiary, AMGP Georgia Managed Care Company, Inc., is licensed as an HMO and became operational in June 2006 in the Atlanta region, and in the North, East and Southeast regions in September 2006. Our TANF and CHIP contract with the State of Georgia expires June 30, 2011, with the State's option to renew the contract for one additional one-year term. The State has notified us of its intent to renew our contract effective July 1, 2011 and to amend our existing contract to include an option to renew for two additional one-year terms.

As of December 31, 2010, we had approximately 266,000 members in Georgia. We believe we have the second largest Medicaid health plan membership of the three health plans in the regions of Georgia in which we operate.

Florida

Our Florida subsidiary, AMERIGROUP Florida, Inc., is licensed as an HMO and became operational in January 2003. The TANF contract expires August 31, 2012 and can be terminated by the health plan upon 120 days notice. Our Long-Term Care contract was renewed on September 1, 2010 and expires August 31, 2011. However, either party can terminate the contract upon 60 days notice. Currently, we are in good standing with the Department of Elder Affairs, the agency with regulatory oversight of the Long-Term Care program, and have no reason to believe that the contract will not be renewed. The reprocurement of our CHIP contract in 2010 expanded our approved service area to include Sarasota County as of January 1, 2011. The contract, executed in October 2010 extends through September 30, 2011 with the state agency's option to extend the contract term for one additional one-year period. Additionally, effective January 1, 2008, AMERIGROUP Florida, Inc. began operating a Medicare Advantage plan for eligible beneficiaries in Florida under a contract that renews annually and was most recently renewed for the 2011 plan year.

As of December 31, 2010, we had approximately 263,000 members in Florida. Our current service areas include the metropolitan areas of Miami/Fort Lauderdale, Orlando and Tampa covering fourteen counties in

Florida. We believe that we have the largest Medicaid health plan membership of the eight health plans in our Tampa market, the second largest Medicaid health plan membership of the five health plans in our Orlando market and the third largest Medicaid health plan membership of the fourteen health plans in our Miami/Fort Lauderdale markets.

Tennessee

Our Tennessee subsidiary, AMERIGROUP Tennessee, Inc., is licensed as an HMO and became operational in April 2007. Our risk contract with the State of Tennessee expires June 30, 2011, with the State's option to extend the contract on an annual basis through an executed contract amendment for a total term of no more than five years. We anticipate that the State will extend our contract effective July 1, 2011. On March 1, 2010, AMERIGROUP Tennessee, Inc. began offering long-term care services to existing members through the State's TennCare CHOICES program. The program, created as a result of the Long Term Care Community Choices Act of 2008, is an expansion program offered through amendments to existing Medicaid managed care contracts and focuses on promoting independence, choice, dignity and quality of life for long-term care Medicaid managed care recipients by offering members the option to live in their own homes while receiving long-term care and other medical services. Effective January 1, 2008, AMERIGROUP Tennessee, Inc. began operating a Medicare Advantage plan for eligible beneficiaries in Tennessee under a contract that renews annually and was most recently renewed for the 2011 plan year. Additionally, in June 2010, we received approval from CMS to add Rutherford County to our Medicare Advantage service areas and to expand our Medicare Advantage plans to cover traditional Medicare beneficiaries in addition to the existing special needs beneficiaries, effective January 1, 2011. We can give no assurance that our entry into these expanded areas will be favorable to our results of operations, financial position or cash flows in future periods.

As of December 31, 2010, we had approximately 203,000 members in Tennessee. We are one of two health plans in our Tennessee market each of which covers approximately half of the members in the Middle Tennessee region in which we operate.

Maryland

Our Maryland subsidiary, AMERIGROUP Maryland, Inc., is licensed as an HMO in Maryland and became operational in June 1999. Our contract with the State of Maryland does not have a set term and can be terminated by the State without prior notice. We can terminate our contract with Maryland by providing the State 90 days prior written notice. Effective January 1, 2007, we began operations as a Medicare Advantage plan for eligible beneficiaries in Maryland, which we expanded as of January 1, 2008 under a contract that renews annually and was most recently renewed for the 2011 plan year. Effective May 1, 2009, we expanded our product line offering to include the Primary Adult Care Program, a basic health care service for low income adults.

Our current service areas include 22 of the 24 counties in Maryland. As of December 31, 2010, we had approximately 202,000 members in Maryland. We believe that we have the largest Medicaid health plan membership of the seven health plans in our Maryland service areas.

New Jersey

Our New Jersey subsidiary, AMERIGROUP New Jersey, Inc., is licensed as an HMO and became operational in February 1996. Our contract with the State of New Jersey expires June 30, 2011, with the State's option to extend the contract on an annual basis through an executed contract amendment. We anticipate that the State will renew our contract effective July 1, 2011. Additionally, effective January 1, 2008, AMERIGROUP New Jersey, Inc. began operating a Medicare Advantage plan for eligible beneficiaries in New Jersey under a contract that renews annually and was most recently renewed for the 2011 plan year.

On March 1, 2010, AMERIGROUP New Jersey, Inc. completed the previously announced acquisition of the Medicaid contract rights and rights under certain provider agreements of University Health Plans, Inc. ("UHP") for $13.4 million.

Our current service areas include 20 of the 21 counties in New Jersey. As of December 31, 2010, we had approximately 134,000 members in our New Jersey service areas. We believe that we have the third largest Medicaid health plan membership of the four health plans in our New Jersey service areas.

New York

Our New York subsidiary, AMERIGROUP New York, LLC, formerly known as CarePlus, LLC, is licensed as a PHSP in New York. We acquired this health plan on January 1, 2005. Our current service areas include New York City and Putnam County. The State TANF, ABD and Medicaid expansion contracts had an initial term of three years (through September 30, 2008) and the State Department of Health exercised its option to extend the contract through February 28, 2011. The City TANF contract with the City Department of Health has also been extended through February 28, 2011. Amendments to further extend the State TANF, ABD and Medicaid expansion contracts and City TANF contract are pending execution, with the current contracts continuing in effect until such time a fully executed amendment is received. Our CHIP contract with the State is a five-year contract for the period January 1, 2008 through December 31, 2012. Our contract with the Department of Health under the Managed Long-Term Care Demonstration project was renewed for a three-year term through December 31, 2009, with the Department exercising its option to extend the contract through December 31, 2010. An amendment to further extend the contract through December 31, 2011 is pending execution, with the current contract continuing in effect until such time a fully executed amendment is received.

In 2010, AMERIGROUP New York, LLC entered into two additional product contracts, each effective January 1, 2010, with the State and City of New York. The Medicaid Advantage Plus contract with the State covers dual eligibles and provides for Medicare cost sharing, limited Medicaid benefits and long-term care benefits to eligible members and is effective through December 31, 2011 with an option to renew for three additional one-year terms. The Medicaid Advantage contract with the City also covers dual eligibles and provides for Medicare cost sharing and limited Medicaid benefits to eligible members and is effective through December 31, 2010 with the option to renew for four additional one-year terms. An amendment to further extend the Medicaid Advantage contract with the City through December 31, 2011 is pending execution, with the current contract continuing in effect until such time a fully executed amendment is received. Additionally, effective January 1, 2008, AMERIGROUP New York, LLC began operating a Medicare Advantage plan for eligible beneficiaries in New York under a contract that renews annually and was most recently renewed for the 2011 plan year.

As of December 31, 2010, we had approximately 109,000 members in New York. We believe we have the ninth largest Medicaid health plan membership of the twenty-one health plans in our New York service areas.

Nevada

Our Nevada subsidiary, AMERIGROUP Nevada, Inc., began serving TANF and CHIP members in February 2009 under a contract to provide Medicaid managed care services through June 30, 2012 in the urban service areas of Washoe and Clark counties. As of December 31, 2010, AMERIGROUP Nevada, Inc. served approximately 79,000 members in Nevada. We believe we have the second largest Medicaid health plan membership of the two health plans in our Nevada service areas.

Ohio

Our Ohio subsidiary, AMERIGROUP Ohio, Inc., is licensed as a HIC and began operations in September 2005 in the Cincinnati service area. Through a reprocurement process in early 2006, we were successful in retaining our Cincinnati service area and expanding to the Dayton service area, thereby serving a total of 16 counties in Ohio. In October 2009, AMERIGROUP Ohio, Inc. provided notice of intent to exit the ABD program in the Southeast Region due to the inability to obtain adequate premium rates in that product. The termination was effective as of February 1, 2010 and did not materially affect our results of operations, financial position or cash flows. AMERIGROUP Ohio, Inc. continues to provide services to members in the Southwest and West Central regions for the TANF Medicaid population. Our contract with the State of Ohio expires on June 30, 2011. We anticipate the State will renew our contract effective July 1, 2011.

As of December 31, 2010, AMERIGROUP Ohio, Inc. served approximately 55,000 members in Ohio. We believe we have the third largest Medicaid health plan membership of the four health plans in our Ohio service areas.

Virginia

Our Virginia subsidiary, AMERIGROUP Virginia, Inc., is licensed as an HMO and began operations in September 2005 serving 14 counties and independent cities in Northern Virginia. Our TANF and ABD contract and our CHIP contract, each with the Commonwealth of Virginia, expire on June 30, 2011. We anticipate the Commonwealth of Virginia will renew our contracts effective July 1, 2011. As of December 31, 2010, we had approximately 40,000 members in Virginia. We believe we have the second largest Medicaid health plan membership of the two health plans in our Northern Virginia service area.

New Mexico

Our New Mexico subsidiary, AMERIGROUP Community Care of New Mexico, Inc., is licensed as an HMO and began operations in January 2008 as a Medicare Advantage plan for eligible beneficiaries in New Mexico. The Medicare Advantage contract with CMS renews annually and was most recently renewed effective for the 2011 plan year. Additionally, in June 2010, we received approval from CMS to expand our Medicare Advantage plan to cover traditional Medicare beneficiaries in addition to the existing special needs beneficiaries, effective January 1, 2011. We can give no assurance that this expansion will be favorable to our results of operations, financial position or cash flows in future periods. In August 2008, we began serving individuals in New Mexico's Coordination of Long-Term Services ("CoLTS") program. The CoLTS contract with the State of New Mexico expires June 30, 2012.

Our statewide service area is inclusive of 33 counties organized into five service regions. As of December 31, 2010, we served approximately 21,000 members in New Mexico. We believe we have the largest CoLTS Medicaid health plan membership of the two health plans in our New Mexico service areas.

South Carolina

Our South Carolina subsidiary, AMERIGROUP Community Care of South Carolina, Inc., was licensed as an HMO and became operational in November 2007 with the TANF population, followed by a separate CHIP contract in May 2008. On March 1, 2009, we sold our rights to serve Medicaid members pursuant to the contract with the State of South Carolina and, as a result, our South Carolina subsidiary is no longer active.

Employees

As of December 31, 2010, we had approximately 4,500 employees. Our employees are not represented by a union and we have never experienced any work stoppages since our inception. We believe our overall relations with our employees are generally good.

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Executive Officers of the Company

Our executive officers, their ages and positions as of February 23, 2011, are as follows:

Name	Age	Position
James G. Carlson	58	Chairman, President and Chief Executive Officer
James W. Truess	45	Executive Vice President and Chief Financial Officer
Richard C. Zoretic	52	Executive Vice President and Chief Operating Officer
John E. Littel	46	Executive Vice President, External Relations
Mary T. McCluskey, M.D.	52	Executive Vice President and Chief Medical Officer
Nicholas J. Pace	40	Executive Vice President, General Counsel and Secretary
Margaret M. Roomsburg	51	Senior Vice President and Chief Accounting Officer
Leon A. Root, Jr.	57	Executive Vice President and Chief Information Officer
Linda K. Whitley-Taylor	47	Executive Vice President, Human Resources

James G. Carlson joined us in April of 2003 and serves as our Chairman, President and Chief Executive Officer. From April 2003 to August 2007, Mr. Carlson was our President and Chief Operating Officer. He has served on our Board of Directors since July 2007. Mr. Carlson has over 30 years of experience in health insurance, including having served as an Executive Vice President of UnitedHealth Group and President of its UnitedHealthcare business unit, which served more than 10 million members in HMO and preferred provider organization plans nationwide. Mr. Carlson also held a series of positions with increasing responsibility over 17 years with Prudential Financial, Inc.

James W. Truess joined us in July 2006 as Executive Vice President and Chief Financial Officer. Mr. Truess has worked more than 20 years in the managed care industry, including the last 13 years as a chief financial officer. Prior to joining us, from 1997 to 2006, Mr. Truess served as Chief Financial Officer and Treasurer of Group Health Cooperative, a vertically integrated health care system that coordinates care and coverage to residents of Washington State and North Idaho. Mr. Truess is a CFA charterholder.

Richard C. Zoretic joined us in September of 2003 and serves as our Executive Vice President and Chief Operating Officer. From November 2005 to August 2007, he served as Executive Vice President, Health Plan Operations; and from September 2003 to November 2005, Mr. Zoretic was our Chief Marketing Officer. Mr. Zoretic has 30 years experience in health care and insurance, having served as Senior Vice President of Network Operations and Distributions at CIGNA Dental Health. Previously, he served in a variety of leadership positions at UnitedHealthcare, including Regional Operating President of United's Mid-Atlantic operations and Senior Vice President of Corporate Sales and Marketing. Mr. Zoretic also held a series of positions with increased responsibilities over 13 years with MetLife, Inc.

John E. Littel joined us in 2001 and serves as our Executive Vice President, Government Relations. Mr. Littel has worked in a variety of positions within state and Federal governments, as well as for non-profit organizations and political campaigns. Mr. Littel served as the Deputy Secretary of Health and Human Resources for the Commonwealth of Virginia. On the Federal level, he served as the director of intergovernmental affairs for The White House's Office of National Drug Control Policy. Mr. Littel also held the position of Associate Dean and Associate Professor of Law and Government at Regent University. Mr. Littel is licensed to practice law in the State of Pennsylvania.

Mary T. McCluskey, M.D. joined us in September 2007 as Executive Vice President and Chief Medical Officer. From 1999 to 2007, Dr. McCluskey served in a variety of senior medical positions with increasing responsibility for Aetna Inc., a leading diversified health care benefits company, most recently as Chief Medical Officer, Northeast Region. Her previous positions at Aetna, Inc. included National Medical Director/Head of Clinical Cost Management and Senior Regional Medical Director, Southeast Region. Dr. McCluskey received her Doctorate of Internal Medicine from St. Louis University School of Medicine in 1986 and conducted her residency

at the Jewish Hospital/Washington University in St. Louis. She is board certified in Internal Medicine with active licenses in the states of Florida and Missouri.

Nicholas J. Pace joined us in 2006 as our Senior Vice President and Deputy General Counsel and has served as our Executive Vice President, General Counsel and Secretary since August 2010. Mr. Pace is licensed to practice law in Virginia and California. Prior to joining the Company, Mr. Pace was Assistant General Counsel with CarMax, Inc., a publicly-traded used vehicle retailer from 2003 to 2006 and a corporate and securities attorney in private practice, including with the law firm of Morrison & Foerster, LLP.

Margaret M. Roomsburg joined us in 1996 and has served as our Senior Vice President and Chief Accounting Officer since February 1, 2007. Previously, Ms. Roomsburg served as our Controller. Ms. Roomsburg has 30 years of experience in accounting and finance. Prior to joining us, Ms. Roomsburg was the Director of Finance for Value Options, Inc. Ms. Roomsburg is a certified public accountant.

Leon A. Root, Jr. joined us in May 2002 as our Senior Vice President and Chief Technology Officer and has served as our Executive Vice President and Chief Information Officer since June 2003. Prior to joining us, Mr. Root served as Chief Information Officer at Medunite, Inc., a private e-commerce company founded by Aetna Inc., Cigna Corp., PacifiCare Health Systems and five other national managed care companies. Mr. Root has over 25 years of experience in Information Technology.

Linda K. Whitley-Taylor joined us in January 2008 and serves as our Executive Vice President, Human Resources. Prior to joining us, Ms. Whitley-Taylor was Senior Vice President, Human Resources Operations with Genworth Financial, Inc., a leading global financial security company and former division of General Electric, where she was employed for 19 years.

Available Information

We file annual, quarterly and current reports, proxy statements and all amendments to these reports and other information with the U.S. Securities and Exchange Commission ("SEC"). You may read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, NE., Washington, DC 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. The SEC maintains an internet site that contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC and the address of that site is (http://www.sec.gov). We make available free of charge on or through our website at www.amerigroupcorp.com our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and all amendments to those reports as soon as reasonably practicable after such material is electronically filed with or furnished to the SEC, as well as, among other things, our Corporate Governance Principles, our Audit, Compensation and Nominating and Corporate Governance charters and our Code of Business Conduct and Ethics. Further, we will provide without charge, upon written request, a copy of our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and all amendments to those reports. Requests for copies should be addressed to Investor Relations, AMERIGROUP Corporation, 4425 Corporation Lane, Virginia Beach, VA 23462.

In accordance with New York Stock Exchange ("NYSE") Rules, on June 4, 2010, we filed the annual certification by our Chief Executive Officer certifying that he was unaware of any violation by us of the NYSE's corporate governance listing standards at the time of the certification.

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Item 1A. ***Risk Factors***

RISK FACTORS

Risks related to our business

Our inability to manage medical costs effectively could reduce our profitability.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage medical costs. Changes in health care regulations and practices, level of use of health care services, hospital costs, pharmaceutical costs, major epidemics, pandemics, such as the H1N1 virus, new medical technologies and other external factors, including general economic conditions such as inflation levels or natural disasters, are beyond our control and could reduce our ability to predict and effectively control the costs of health care services. Although we attempt to manage medical costs through a variety of techniques, including various payment methods to PCPs and other providers, advance approval for hospital services and referral requirements, medical management and quality management programs, and our information systems and reinsurance arrangements, we may not be able to manage costs effectively in the future. In addition, new products or new markets, such as our Tennessee long-term care offering, could pose new and unexpected challenges to effectively manage medical costs. It is possible that there could be an increase in the volume or value of appeals for claims previously denied and claims previously paid to out-of-network providers could be appealed and subsequently reprocessed at higher amounts. This would result in an adjustment to health benefits expense. If our costs for medical services increase, our profits could be reduced, or we may not remain profitable.

We maintain reinsurance to help protect us against individually severe or catastrophic medical claims, but we can provide no assurance that such reinsurance coverage will be adequate or available to us in the future or that the cost of such reinsurance will not limit our ability to obtain appropriate levels of coverage.

Our limited ability to accurately predict our incurred but not reported medical expenses has in the past and could in the future materially impact our reported results.

Our health benefits expense includes estimates of the cost of claims for services rendered to our members that are yet to be received, or incurred but not reported ("IBNR"). We estimate our IBNR health benefits expense based on a number of factors, including authorization data, prior claims experience, maturity of markets, complexity and mix of products and stability of provider networks. Adjustments, if necessary, are made to health benefits expense in the period during which the actual claim costs are ultimately determined or when underlying assumptions or factors used to estimate IBNR change. We cannot be sure that our current or future IBNR estimates are adequate or that any further adjustments to such IBNR estimates will not significantly harm or benefit our results of operations. Further, our inability to accurately estimate IBNR may also affect our ability to take timely corrective actions, further exacerbating the extent of the impact on our results of operations. Though we employ substantial efforts to estimate our IBNR at each reporting date, we can give no assurance that the ultimate results will not materially differ from our estimates resulting in a material increase or decrease in our health benefits expense in the period such difference is determined. New products or new markets, such as Tennessee long-term care, or significant volatility in membership enrollment and health care service utilization patterns, could pose new and unexpected challenges to effectively predict health benefits expense.

We derive a majority of our premium revenues and net income from a small number of states, in particular, the State of Texas, and if we fail to retain our contracts in those states, or if the conditions in those states change, our business and results of operations may suffer.

We earn substantially all of our revenues by serving members who receive health care benefits through contracts with the regulatory entities in the jurisdictions in which we operate. For the year ended December 31, 2010, our Texas contract represented approximately 23% of our premium revenues and our Tennessee, Georgia and Maryland contracts represented approximately 15%, 12% and 11% of our premium revenues, respectively. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly as a result of significant premium rate reductions, a loss of a material contract,

legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic or pandemic, or an unexpected increase in utilization, general economic conditions and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, or results of operations.

Some of our contracts are subject to a re-bidding or re-application process. For example, HHSC is currently drafting a RFP for the re-bid of its entire managed care program in the State of Texas. We expect the RFP to include the addition of new service areas and new product opportunities in existing service areas, resulting in a significant increase to the size and scope of the State's managed care program. We anticipate that the release of the RFP and HHSC's selection of vendors under the new contract will occur sometime in 2011 with details regarding implementation dates dependent on the timing of the award. If we lost a contract through the re-bidding process, or if an increased number of competitors were awarded contracts in a specific market, our results of operations, financial position or cash flows in future periods could be materially and adversely affected.

Changes in the number of Medicaid eligible beneficiaries, or benefits provided to Medicaid eligible beneficiaries or a change in mix of Medicaid eligible beneficiaries could cause our operating results to suffer.

Historically, the number of persons eligible to receive Medicaid benefits has increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. This pattern has proven consistent with our experience of significant membership growth during the recession that occurred during the past few years. However, during such economic downturns, state budgets can and have decreased, causing states to attempt to cut health care programs, benefits and rates. If this were to happen while our membership was increasing, our results of operations could suffer. Macroeconomic conditions in recent years have resulted in such budget challenges in the states in which we operate, placing pressures on the rate-setting process. Conversely, the number of persons eligible to receive Medicaid benefits may grow more slowly or even decline as economic conditions improve, thereby causing our operating results to suffer. In either case, in the event that the Company experiences a change in product mix to less profitable product lines, our profitability could be negatively impacted.

Receipt of inadequate or significantly delayed premiums could negatively impact our revenues, profitability and cash flows.

Most of our revenues are generated by premiums consisting of fixed monthly payments per member. These premiums are fixed by contract and we are obligated during the contract period to facilitate access to health care services as established by the state governments. We have less control over costs related to the provision of health care services than we do over our selling, general and administrative expenses. Historically, our reported expenses related to health benefits as a percentage of premium revenue have fluctuated. For example, our expenses related to health benefits were 81.6%, 85.4% and 82.9% of our premium revenue for the years ended December 31, 2010, 2009 and 2008, respectively. If health benefits expense increases at a higher rate than premium increases, our results of operations would be impacted negatively. In addition, if there is a significant delay in our premium rate increases to offset previously incurred health benefits expense increases, our operating results, financial position and cash flows could be negatively impacted.

Premiums are contractually payable to us before or during the month for which we are obligated to provide services to our members. Our cash flow would be negatively impacted if premium payments are not made according to contract terms.

As participants in state and Federal health care programs, we are subject to extensive fraud and abuse laws which may give rise to frequent lawsuits and claims against us, and the outcome of these lawsuits and claims may have a material adverse effect on our financial position, results of operations and liquidity.

Our operations are subject to various state and Federal health care laws commonly referred to as "fraud and abuse" laws, including the Federal False Claims Act. Many states have false claims act statutes which mirror the provisions of the Federal act. The Federal False Claims Act prohibits any person from knowingly presenting, or causing to be presented to the Federal government, a false or fraudulent claim for payment. Suits filed under the Federal False Claims Act, known as *"qui tam"* actions, can be brought by any individual (known as a "relator" or, more commonly, "whistleblower") on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the DRA encourages states to enact state-versions of the Federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators.

In 2002, a former employee of our former Illinois subsidiary filed a *qui tam* action alleging that the subsidiary had submitted false claims under the Medicaid program by maintaining a scheme to discourage or avoid the enrollment into the health plan of pregnant women and other recipients with special needs. Following trial, the jury returned a verdict in favor of the relator and the court entered a judgment against the Company and its subsidiary. In August 2008, we settled this matter and paid the aggregate amount of $225.0 million as a settlement plus approximately $9.2 million to the former employee for legal fees.

Although we believe we are in substantial compliance with the health care laws applicable to our Company, we can give no assurances that we will not be subject to additional Federal False Claims Act suits in the future. Any violations of any applicable fraud and abuse laws or any Federal False Claims Act suit against us could have a material adverse effect on our financial position, results of operations and cash flows.

Failure to comply with the terms of our government contracts could negatively impact our profitability and subject us to fines, penalties and liquidated damages.

We contract with various state governmental agencies and CMS to provide managed health care services. These contracts contain certain provisions regarding data submission, provider network maintenance, quality measures, continuity of care, call center performance and other requirements specific to state and program regulations. If we fail to comply with these requirements, we may be subject to fines, penalties and liquidated damages that could impact our profitability. Additionally, we could be required to file a corrective plan of action with the state and we could be subject to fines, penalties and liquidated damages and additional corrective action measures if we did not comply with the corrective plan of action. Our failure to comply could also affect future membership enrollment levels. These limitations could negatively impact our revenues and operating results.

Changes in Medicaid or Medicare funding by the states or the Federal government could substantially reduce our profitability.

Most of our revenues come from state government Medicaid premiums. The base premium rate paid by each state differs depending on a combination of various factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix and member eligibility category. Future levels of Medicaid premium rates may be affected by continued government efforts to contain medical costs and may further be affected by state and Federal budgetary constraints. Changes to Medicaid programs could reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or health care costs under such programs. States periodically consider reducing or reallocating the amount of money they spend for Medicaid. We believe that additional reductions in Medicaid payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation in the event of the unavailability of state funds. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required.

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State governments generally are experiencing tight budgetary conditions within their Medicaid programs. Macroeconomic conditions in recent years have, and are expected to continue to, put pressure on state budgets as the Medicaid eligible population increases, creating the need and competing for funding with other state needs. We anticipate this will require government agencies with whom we contract to find funding alternatives, which may result in reductions in funding for current programs and program expansions, contraction of covered benefits, limited or no premium rate increases or premium decreases. If any state in which we operate were to decrease premiums paid to us, or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our revenues and operating results.

Additionally, a portion of our premium revenues comes from CMS through our Medicare Advantage contracts. As a consequence, our Medicare Advantage plans are dependent on Federal government funding levels. The premium rates paid to Medicare health plans are established by contract, although the rates differ depending on a combination of factors, including upper payment limits established by CMS, a member's health profile and status, age, gender, county or region, benefit mix, member eligibility categories, and the member's risk scores. Some members of Congress have proposed significant cuts in payments to Medicare Advantage plans. In addition, continuing government efforts to contain health care related expenditures, including prescription drug costs, and other Federal budgetary constraints that result in changes in the Medicare program, including with respect to funding, could lead to reductions in the amount of reimbursement, elimination of coverage for certain benefits or mandate additional benefits, and reductions in the number of persons enrolled in or eligible for Medicare, which in turn could reduce the number of beneficiaries enrolled in our health plans and have a material adverse effect on our revenues and operating results.

Lastly, CMS has conducted Risk Adjustment Data Validation ("RADV") audits to review the diagnosis code information provided by managed care companies for medical records in support of the reported diagnosis codes. These audits were performed on a sample basis across all Medicare Advantage plans. In 2009, CMS announced an expansion of these audits to include targeted or contract specific audits. These audits will cover calendar year 2009 and 2010 contract years with the intent of determining an error rate from a selected sample and extrapolating that error to determine any overpayments made to the Medicare Advantage plan. The payment error calculation methodology is currently proposed and CMS has requested comments on the proposed methodology. To date, we have not been notified that any of our Medicare Advantage plans have been selected for audit. If we are selected for audit and the payment error calculation methodology is employed as proposed, we could be subject to an assessment for overpayment of premium for the years under audit due to the inherent judgment required when reviewing medical records and those assessments could be significant.

Delays in program expansions or contract changes could negatively impact our business.

In any program start-up, expansion, or re-bid, the state's ability to manage the implementation as designed may be affected by factors beyond our control. These include political considerations, network development, contract appeals, membership assignment (allocation for members who do not self-select) and errors in the bidding process, as well as difficulties experienced by other private vendors involved in the implementation, such as enrollment brokers. Our business, particularly plans for expansion or increased membership levels, could be negatively impacted by these delays or changes.

If a state fails to renew its Federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under Federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two-year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew its mandated program or the Federal government denies the state's application for renewal, our business could suffer as a result of a likely decrease in membership.

We rely on the accuracy of eligibility lists provided by state governments, and in the case of our Medicare Advantage members, by the Federal government. Inaccuracies in those lists could negatively affect our results of operations.

Premium payments to us are based upon eligibility lists produced by government enrollment data. From time-to-time, governments require us to reimburse them for premiums paid to us based on an eligibility list that a government later determines contains individuals who were not in fact eligible for a government sponsored program, were enrolled twice in the same program or were eligible for a different premium category or a different program. Alternatively, a government could fail to pay us for members for whom we are entitled to receive payment. Our results of operations could be adversely affected as a result of such reimbursement to the government or inability to receive payments we are due if we had made related payments to providers and were unable to recoup such payments from the providers.

Our inability to operate new business opportunities at underwritten levels could have a material adverse effect on our business.

In underwriting new business opportunities we must estimate future health benefits expense. We utilize a range of information and develop numerous assumptions. The information we use can often include, but is not limited to, historical cost data, population demographics, experience from other markets, trend assumptions and other general underwriting factors. The information we utilize may be inadequate or not applicable and our assumptions may be incorrect. If our underwriting estimates are incorrect, our cost experience could be materially different than expected. If costs are higher than expected, our operating results could be adversely affected.

Our inability to maintain good relations with providers could harm our profitability or subject us to material fines, penalties or sanctions.

We contract with providers as a means to assure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, or difficulty in meeting regulatory or accreditation requirements.

Our profitability depends, in large part, upon our ability to contract on favorable terms with hospitals, physicians and other health care providers. Our provider arrangements with our primary care physicians and specialists usually are for two-year periods and automatically renew for successive one-year terms, subject to termination by us for cause based on provider conduct or other appropriate reasons. The contracts generally may be canceled by either party without cause upon 90 to 120 days prior written notice. Our contracts with hospitals are usually for one- to two-year periods and automatically renew for successive one-year periods, subject to termination for cause due to provider misconduct or other appropriate reasons. Generally, our hospital contracts may be canceled by either party without cause on 90 to 120 days prior written notice. There can be no assurance that we will be able to continue to renew such contracts or enter into new contracts enabling us to service our members profitably. We will be required to establish acceptable provider networks prior to entering new markets. Although we have established long-term relationships with many of our providers, we may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms. If we are unable to retain our current provider contracts, or enter into new provider contracts timely or on favorable terms, our profitability could be adversely affected. In some markets, certain providers, particularly hospitals, physician/hospital organizations and some specialists, may have significant market positions. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts to themselves, our profitability could be adversely affected.

Some providers that render services to our members have not entered into contracts with our health plans (out-of-network providers). In those cases, there is no pre-established understanding between the non-network provider and the health plan about the amount of compensation that is due to the provider. In some states, with respect to certain services, the amount that the health plan must pay to out-of-network providers for services provided to our members is defined by law or regulation, but in certain instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, we generally pay

out-of-network providers based on our Company's standard out-of-network fee schedule. Out-of-network providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with the health plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our financial position, results of operations or cash flows.

We are required to establish acceptable provider networks prior to entering new markets and to maintain such networks as a condition to continued operation in those markets. If we are unable to retain our current provider networks, or establish provider networks in new markets in a timely manner or on favorable terms, our profitability could be harmed. Further if we are unable to retain our current provider networks, we may be subject to material fines, penalties or sanctions from state or Federal regulatory authorities.

Our inability to integrate, manage and grow our information systems effectively could disrupt our operations.

Our operations are significantly dependent on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status and other information.

We operate our markets through integrated information technology systems for our financial, claims, care management, encounter management and sales/marketing systems. The ability to capture, process, enable local access to data and translate it into meaningful information is essential to our ability to operate across a multi-state service area in a cost efficient manner. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. Moreover, any acquisition activity requires transitions to or from, and the integration of, various information systems. We are continually upgrading and expanding our information systems capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, from operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses.

Failure of a business in a new state or market could negatively impact our results of operations.

Start-up costs associated with a new business can be substantial. For example, in order to obtain a certificate of authority and obtain a state contract in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to process claims. If we are unsuccessful in obtaining the necessary license, winning the bid to provide service or attracting members in numbers sufficient to cover our costs, the new business would fail. We also could be obligated by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or recover start-up costs. The costs associated with starting up the business could have a significant impact on our results of operations. In addition, if the new business does not operate at underwritten levels, our profitability could be adversely affected.

Difficulties in executing our acquisition strategy or integrating acquired business could adversely affect our business.

Historically, acquisitions, including the acquisition of publicly funded program contract rights and related assets of other health plans, both in our existing service areas and in new markets, have been a significant factor in our growth. Although we cannot predict our rate of growth as the result of acquisitions with complete accuracy, we believe that acquisitions similar in nature to those we have historically executed, or other acquisitions we may consider, will continue to contribute to our growth strategy. Many of the other potential purchasers of these assets have greater financial resources than we have. Furthermore, many of the sellers are interested in either (i) selling, along with their publicly funded program assets, other assets in which we do not have an interest; or (ii) selling their companies, including their liabilities, as opposed to just the assets of the ongoing business. Therefore, we cannot be sure that we will be able to complete acquisitions on terms favorable to us or that we can obtain the necessary financing for these acquisitions, particularly if the credit environment were to experience similar volatility and disruption to that over the last several years.

We are generally required to obtain regulatory approval from one or more state agencies when making these acquisitions. In the case of an acquisition of a business located in a state in which we do not currently operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire new business, we would be required to obtain additional regulatory approval if, as a result of the acquisition, we will operate in an area of the state in which we did not operate previously. There can be no assurance that we would be able to comply with these regulatory requirements for an acquisition in a timely manner, or at all.

In addition to the difficulties we may face in identifying and consummating acquisitions, we will also be required to integrate our acquisitions with our existing operations. This may include the integration of:

- additional employees who are not familiar with our operations,
- existing provider networks, which may operate on different terms than our existing networks,
- existing members, who may decide to switch to another health care provider, and
- disparate information and record keeping systems.

We may be unable to successfully identify, consummate and integrate future acquisitions, including integrating the acquired businesses on to our technology platform, or to implement our operations strategy in order to operate acquired businesses profitably. There can be no assurance that incurring expenses to acquire a business will result in the acquisition being consummated. These expenses could impact our selling, general and administrative expense ratio. If we are unable to effectively execute our acquisition strategy or integrate acquired businesses, our future growth will suffer and our results of operations could be harmed.

We are subject to competition that impacts our ability to increase our penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional fee-for-service programs, primary care case management programs and other commercial Medicaid or Medicare only health plans. Some of the health plans with which we compete have substantially larger enrollments, greater financial and other resources and offer a broader scope of products than we do.

While many states mandate health plan enrollment for Medicaid eligible participants, including all of those in which we do business, the programs are voluntary in other states. Subject to limited exceptions by Federally approved state applications, the Federal government requires that there be a choice for Medicaid recipients among managed care programs. Voluntary programs and mandated competition will impact our ability to increase our market share.

In addition, in most states in which we operate we are not allowed to market directly to potential members, and therefore, we rely on creating name brand recognition through our community-based programs. Where we have only recently entered a market or compete with health plans much larger than we are, we may be at a competitive disadvantage unless and until our community-based programs and other promotional activities create brand awareness.

Negative publicity regarding the managed care industry may harm our business and operating results.

In the past, the managed care industry and the health insurance industry in general have received negative publicity. This publicity has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. These factors may adversely affect our ability to market our services, require us to change our services and increase the regulatory burdens under which we operate, further increasing the costs of doing business and adversely affecting our operating results.

We may be subject to claims relating to professional liability, which could cause us to incur significant expenses.

Our providers and employees involved in medical care decisions may be exposed to the risk of professional liability claims. Some states have passed, or may consider passing in the future, legislation that exposes managed care organizations to liability for negligent treatment decisions by providers or benefits coverage determinations and/or legislation that eliminates the requirement that certain providers carry a minimum amount of professional liability insurance. This kind of legislation has the effect of shifting the liability for medical decisions or adverse outcomes to the managed care organization. This could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Therefore, successful professional liability claims asserted against us, our providers or our employees could adversely affect our financial condition and results of operations.

In addition, we may be subject to other litigation that may adversely affect our business or results of operations. We maintain errors and omissions insurance and such other lines of coverage as we believe are reasonable in light of our experience to date. However, this insurance may not be sufficient or available at a reasonable cost to protect us from liabilities that might adversely affect our business or results of operations. Even if any claims brought against us were unsuccessful or without merit, we would still have to defend ourselves against such claims. Any such defenses may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business, reputation and profitability.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various state and Federal laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could have a material adverse effect on our business, reputation and results of operations.

We are currently involved in litigation, and may become involved in future litigation, which may result in substantial expense and may divert our attention from our business.

In the normal course of business, we are involved in legal proceedings and, from time-to-time, we may be subject to additional legal claims of a non-routine nature. We may suffer an unfavorable outcome as a result of one or more claims, resulting in the depletion of capital to pay defense costs or the costs associated with any resolution of such matters. Depending on the costs of litigation and the amount and timing of any unfavorable resolution of claims against us, our financial position, results of operations or cash flows could be materially adversely affected.

In addition, we may be subject to securities class action litigation from time-to-time due to, among other things, the volatility of our stock price. When the market price of a stock has been volatile, regardless of whether such fluctuations are related to the operating performance of a particular company, holders of that stock have sometimes initiated securities class action litigation against such company. Any class action litigation against us could cause us to incur substantial costs, divert the time and attention of our management and other resources, or otherwise harm our business.

Acts of terrorism, natural disasters and medical epidemics could cause our business to suffer.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage health benefits expense. If an act or acts of terrorism or a natural disaster (such as a major hurricane) or a medical epidemic, such as the H1N1 pandemic in 2009, were to occur in markets in which we operate, our business could suffer. The results of terrorist acts or natural disasters could lead to higher than expected medical costs, network and information technology disruptions, and other related factors beyond our control, which would cause our business

to suffer. A widespread epidemic or pandemic in a market could cause a breakdown in the medical care delivery system which could cause our business to suffer.

Risks related to being a regulated entity

Changes in government regulations designed to protect providers and members could force us to change how we operate and could harm our business and results of operations.

Our business is extensively regulated by the states in which we operate and by the Federal government. These laws and regulations are generally intended to benefit and protect providers and health plan members rather than us and our stockholders. Changes in existing laws and rules, the enactment of new laws and rules and changing interpretations of these laws and rules could, among other things:

- force us to change how we do business,
- restrict revenue and enrollment growth,
- increase our health benefits and administrative costs,
- impose additional capital requirements, and
- increase or change our claims liability.

Regulations could limit our profits as a percentage of revenues.

Our New Jersey and Maryland subsidiaries, as well as our CHIP product in Florida, are subject to minimum medical expense levels as a percentage of premium revenue. Our Florida subsidiary is subject to minimum behavioral health expense levels as a percentage of behavioral health premium revenues. In New Jersey, Maryland and Florida, premium revenue recoupment may occur if these levels are not met. In addition, our Ohio subsidiary is subject to certain limits on administrative costs and our Virginia subsidiary is subject to a limit on profits. These regulatory requirements, changes in these requirements and additional requirements by our other regulators could limit our ability to increase or maintain our overall profits as a percentage of revenues, which could harm our operating results. We have been required, and may in the future be required, to make payments to the states as a result of not meeting these expense levels.

Additionally, we could be required to file a corrective plan of action with the states and we could be subject to fines and additional corrective action measures if we did not comply with the corrective plan of action. Our failure to comply could also affect future rate determinations and membership enrollment levels. These limitations could negatively impact our revenues and operating results.

Our Texas health plan is required to pay an experience rebate to the State of Texas in the event profits exceed established levels. We file experience rebate calculation reports with the State of Texas for this purpose. These reports are subject to audits and if the audit results in unfavorable adjustments to our filed reports, our financial position, results of operations or cash flows could be negatively impacted.

Recently enacted health care reform and the implementation of these laws could have a material adverse effect on our results of operations, financial position and liquidity. In addition, if the new non-deductible Federal premium-based assessment is imposed as enacted, or if we are unable to adjust our business model to address this new assessment, our results of operations, financial position and liquidity may be materially adversely affected.

On March 23, 2010, the President signed into law The Patient Protection and Affordable Care Act, and on March 30, 2010 the President signed into law The Health Care and Education Reconciliation Act of 2010 (the "Acts"). Implementation of these new laws varies from as early as six months from the date of enactment to as long as 2018.

There are numerous steps required to implement the Acts including, promulgating a substantial number of new and potentially more onerous regulations. Further, there is resistance to expansion at the state level, largely due to

budgetary pressure. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the Federal or state level, or the effect that any future legislation, regulation, or even the pending litigation challenging the Acts, will have on our business or our growth opportunities. There is also considerable uncertainty regarding the impact of the Acts and the other reforms on the health insurance market as a whole. In addition, we cannot predict our competitors' reactions to the changes. Although we believe the Acts will provide us with significant opportunity, the enacted reforms, as well as future regulations, legislative changes and judicial decisions, may in fact have a material adverse affect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of health care reform, or do not do so as effectively as our competitors, our business may be materially adversely affected.

The Acts include the imposition of a significant new non-deductible Federal premium-based assessment and other assessments on health insurers. If this Federal premium-based assessment is imposed as enacted, and if the cost of the Federal premium-based assessment is not included in the calculation of our premium rates, or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and liquidity may be materially adversely affected.

Changes in health care laws could reduce our profitability.

Numerous proposals relating to changes in health care laws have been introduced, some of which have been passed by Congress and the states in which we operate or may operate in the future. These include mandated medical loss ratio thresholds, Medicaid reform initiatives in Florida, as well as waivers requested by states for various elements of their programs. Changes in applicable laws and regulations are continually being considered and interpretations of existing laws and rules may also change from time-to-time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business and results of operations. Although some changes in government regulations, such as the removal of the requirements on the enrollment mix between commercial and public sector membership, have encouraged managed care participation in public sector programs, we are unable to predict whether new laws or proposals will continue to favor or hinder the growth of managed health care.

We cannot predict the outcome of these legislative or regulatory proposals, nor the effect which they might have on us. Legislation or regulations that require us to change our current manner of operation, provide additional benefits or change our contract arrangements could seriously harm our operations and financial results.

If state regulators do not approve payments of dividends, distributions or administrative fees by our subsidiaries to us, it could negatively affect our business strategy and liquidity.

We principally operate through our health plan subsidiaries. These subsidiaries are subject to state insurance holding company system and other regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. We also have administrative services agreements with our subsidiaries in which we agree to provide them with services and benefits (both tangible and intangible) in exchange for the payment of a fee. Some states limit the administrative fees which our subsidiaries may pay. For example, Maryland and Ohio limit the administrative fees paid to an affiliate to the cost of providing the services. If the regulators were to deny our subsidiaries' requests to pay dividends to us or restrict or disallow the payment of the administrative fee or not allow us to recover the costs of providing the services under our administrative services agreement or require a significant change in the timing or manner in which we recover those costs, the funds available to our Company as a whole would be limited, which could harm our ability to implement our business strategy, expand our infrastructure, improve our information technology systems, make needed capital expenditures and service our debt as well as negatively impact our liquidity.

If state regulatory agencies require a statutory capital level higher than the state regulations we may be required to make additional capital contributions.

Our operations are conducted through our wholly-owned subsidiaries, which include HMOs, one HIC and one PHSP. HMOs, HICs, and PHSPs are subject to state regulations that, among other things, require the maintenance of

minimum levels of statutory capital and the maintenance of certain financial ratios (which are referred to as risk based capital requirements), as defined by each state. Certain states also require performance bonds or letters of credit from our subsidiaries. Additionally, state regulatory agencies may require, at their discretion, individual regulated entities to maintain statutory capital levels higher than the state regulations. If this were to occur or other requirements change for one of our subsidiaries, we may be required to make additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

Failure to comply with government laws and regulations could subject us to civil and criminal penalties and limitations on our profitability.

We are subject to numerous local, state and Federal laws and regulations. Violation of the laws or regulations governing our operations could result in the imposition of sanctions, the cancellation of our contracts to provide services, or in the extreme case, the suspension or revocation of our licenses and/or exclusion from participation in state or Federal health care programs. We can give no assurance that the terms of our contracts with the states or the manner in which we are directed to comply with our state contracts is in accordance with the CMS regulations.

We may be subject to material fines or other sanctions in the future. If we became subject to material fines, or if other sanctions or other corrective actions were imposed upon us, our ability to continue to operate our business could be materially and adversely affected. From time-to-time we have been subject to sanctions as a result of violations of marketing regulations. Although we train our employees with respect to compliance with local, state and Federal laws of each of the states in which we do business, no assurance can be given that violations will not occur.

We are, or may become subject to, various state and Federal laws designed to address health care fraud and abuse, including false claims laws. State and Federal laws prohibit the submission of false claims and other acts that are considered fraudulent or abusive. The submission of claims to a state or Federal health care program for items and services that are determined to be "not provided as claimed" may lead to the imposition of civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in state and Federal funded health care programs, including the Medicaid and Medicare programs.

The DRA requires all entities that receive $5.0 million or more in annual Medicaid funds to establish specific written policies for their employees, contractors, and agents regarding various false claims-related laws and whistleblower protections under such laws as well as provisions regarding their policies and procedures for detecting and preventing fraud, waste and abuse. These requirements are conditions of receiving all future payments under the Medicaid program. We believe that we have made appropriate efforts to meet the requirements of the compliance provisions of the DRA. However, if it is determined that we have not met the requirements appropriately, we could be subject to civil penalties and/or be barred from receiving future payments under the Medicaid programs in the states in which we operate thereby materially adversely affecting our business, results of operation and financial condition.

HIPAA broadened the scope of fraud and abuse laws applicable to health care companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA establishes new enforcement mechanisms to combat fraud and abuse, including a whistleblower program. Further, HIPAA imposes civil and criminal penalties for failure to comply with the privacy and security standards set forth in the regulation. The Patient Protection and Affordable Care Act created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicare, Medicaid and CHIP. Those enhancements included mandatory licensure for all providers and site visits, fingerprinting and criminal background checks for higher risk providers. On September 23, 2010, CMS issued proposed regulations designed to implement these requirements. It is not clear at this time the degree to which managed care providers would have to comply with these new requirements.

The HITECH Act, one part of the ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations. The U.S. Department of Health and Human Services, as required by

the HITECH Act, has issued the HHS Breach Notification Rule. The various requirements of the HITECH Act and the HHS Breach Notification Rule have different compliance dates, some of which have passed and some of which will occur in the future. With respect to those requirements whose compliance dates have passed, we believe that we are in compliance with these provisions. With respect to those requirements whose compliance dates are in the future, we are reviewing our current practices and identifying those which may be impacted by upcoming regulations. It is our intention to implement these new requirements on or before the applicable compliance dates.

The Federal and state governments have and continue to enact other fraud and abuse laws as well. Our failure to comply with HIPAA or these other laws could result in criminal or civil penalties and exclusion from Medicaid or other governmental health care programs and could lead to the revocation of our licenses. These penalties or exclusions, were they to occur, would negatively impact our ability to operate our business.

Compliance with the terms and conditions of our Corporate Integrity Agreement requires significant resources and, if we fail to comply, we could be subject to penalties or excluded from participation in government health care programs, which could seriously harm our results of operations, liquidity and financial results.

In August 2008, in connection with the settlement of a *qui tam* action, we voluntarily entered into a five-year Corporate Integrity Agreement with the Office of Inspector General of the United States Department of Health and Human Services ("OIG"). The Corporate Integrity Agreement provides that we shall, among other things, keep in place and continue our current compliance program, including a corporate compliance officer and compliance officers at our health plans, a corporate compliance committee and compliance committees at our health plans, a compliance committee of our Board of Directors, a code of conduct, comprehensive compliance policies, training and monitoring, a compliance hotline, an open door policy and a disciplinary process for compliance violations. The Corporate Integrity Agreement further provides that we shall provide periodic reports to the OIG, appoint a benefits rights ombudsman responsible for addressing concerns raised by health plan members and potential enrollees and engage an independent review organization to assist us in assessing and evaluating our compliance with the requirements of the Federal health care programs and other obligations under the Corporate Integrity Agreement and retain a compliance expert to provide independent compliance counsel to our Board of Directors.

Maintaining the broad array of processes, policies, and procedures necessary to comply with the Corporate Integrity Agreement is expected to continue to require a significant portion of management's attention as well as the application of significant resources. Failing to meet the Corporate Integrity Agreement obligations could have material adverse consequences for us including monetary penalties for each instance of non-compliance. In addition, in the event of an uncured material breach or deliberate violation of the Corporate Integrity Agreement, we could be excluded from participation in Federal health care programs and/or subject to prosecution, which could seriously harm our results of operations, liquidity and financial results.

Risks related to our financial condition

Ineffective management of rapid growth or our inability to grow could negatively affect our results of operations, financial condition and business.

We have experienced rapid growth. In 2000, we had $642.6 million of premium revenue. In 2010, we had $5.8 billion in premium revenue. This increase represents a compounded annual growth rate of 24.6%. Depending on acquisitions and other opportunities, as well as macroeconomic conditions that affect membership such as those conditions experienced recently, we expect to continue to grow rapidly. Continued growth could place a significant strain on our management and on other resources. We anticipate that continued growth, if any, will require us to continue to recruit, hire, train and retain a substantial number of new and highly skilled medical, administrative, information technology, finance and other support personnel. Our ability to compete effectively depends upon our ability to implement and improve operational, financial and management information systems on a timely basis and to expand, train, motivate and manage our work force. If we continue to experience rapid growth, our personnel, systems, procedures and controls may be inadequate to support our operations, and our management may fail to anticipate adequately all demands that growth will place on our resources. In addition, due to the initial costs

incurred upon the acquisition of new businesses, rapid growth could adversely affect our short-term profitability. Our inability to manage growth effectively or our inability to grow could have a negative impact on our business, operating results and financial condition.

Our debt service obligations may adversely affect our cash flows and our increased leverage as a result of our 2.0% Convertible Senior Notes may harm our financial condition and results of operations. In addition, our 2.0% Convertible Senior Notes and our warrants sold concurrent with the 2.0% Convertible Senior Notes will be dilutive in current and future periods if the market price of our common stock exceeds certain thresholds.

As of December 31, 2010, we had $260.0 million outstanding in aggregate principal amount of 2.0% Convertible Senior Notes due May 15, 2012 ("2.0% Convertible Senior Notes"). Our debt service obligation on our 2.0% Convertible Senior Notes is approximately $5.2 million per year in cash interest payments. Additionally, under the provisions of the 2.0% Convertible Senior Notes, if the market price of our common stock exceeds $42.53 we will be obligated to settle, in cash or our shares of our common stock at our option, an amount equal to approximately $6.1 million for each dollar in share price that the market price of our common stock exceeds $42.53, or the conversion value of the 2.0% Convertible Senior Notes. In periods prior to conversion, the 2.0% Convertible Senior Notes would also have a dilutive impact to earnings if the average market price of our common stock exceeds $42.53 for the period reported. At conversion, the dilutive impact would result if the conversion value of the 2.0% Convertible Senior Notes, if any, is settled in shares of our common stock.

Under the provisions of the convertible note hedges purchased concurrent with the 2.0% Convertible Senior Notes, we are entitled to receive cash or shares of our common stock in an amount equal to the conversion value of the 2.0% Convertible Senior Notes from the counterparty to the convertible note hedges. Additionally, under the provisions of the warrant instruments sold concurrent with the 2.0% Convertible Senior Notes, if the market price of our common stock exceeds $53.77 at exercise we will be obligated to settle in shares of our common stock an amount equal to approximately $6.1 million for each dollar in share price that the market price of our common stock exceeds $53.77 resulting in a dilutive impact to our earnings. In periods prior to exercise, the warrant instruments would also have a dilutive impact to earnings if the average market price of our common stock exceeds $53.77 for the period reported.

If we are unable to generate sufficient cash to meet these obligations through proceeds from debt or equity financing, or internally generated funds, or if the counterparty to the convertible note hedges is unwilling or unable to fulfill the obligations under the hedge instruments, our ability to pursue other activities of our business may be limited and our financial condition and results of operations may be materially adversely affected.

We intend to fulfill our debt service obligations from cash generated by our operations, if any, and from our existing cash and investments. We anticipate that the principal of our 2.0% Convertible Senior Notes, which is due in May 2012, will be repaid with available cash on hand or with proceeds from debt or equity financing, or a combination thereof. If we determine that debt or equity financing is appropriate, our operations at the time we enter the credit or equity markets cannot be predicted and may cause our access to these markets to be limited. Additionally, any disruptions in the credit markets could further limit our flexibility in refinancing our 2.0% Convertible Senior Notes, planning for, or reacting to, changes in our business and industry and addressing our future capital requirements.

Our operations may not generate sufficient cash and we may be unable to access financing to enable us to service our debt. If we fail to make a debt service obligation payment, we could be in default under our 2.0% Convertible Senior Notes.

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Our investment portfolio may suffer losses from reductions in market interest rates and fluctuations in fixed income securities which could materially adversely affect our results of operations or liquidity.

As of December 31, 2010, we had total cash and investments of $1.7 billion. The following table shows the types, percentages and average Standard and Poor's ("S&P") ratings of our holdings within our investment portfolio at December 31, 2010:

	Portfolio Percentage	Average S&P Rating
Auction rate securities	1.2%	AAA
Cash, bank deposits and commercial paper	4.1%	AAA
Certificates of deposit	8.6%	AAA
Corporate bonds	13.7%	A+
Debt obligations of government sponsored entities, Federally insured corporate bonds and U.S. Treasury securities	21.6%	AAA
Money market funds	33.4%	AAA
Municipal bonds	17.4%	AA+
	100.0%	AA+

Our investment portfolio generated approximately $17.2 million, $22.4 million and $50.9 million of pre-tax income for the years ended December 31, 2010, 2009 and 2008, respectively. The performance of our investment portfolio is interest rate driven, and consequently, changes in interest rates affect our returns on, and the fair value of our portfolio. This factor or any disruptions in the credit markets could materially adversely affect our financial position, results of operations or cash flows in future periods.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our financial position, results of operations, or cash flows.

Our investment portfolio is comprised of investments classified as available-for-sale. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive income as a separate component of stockholders' equity. If we experience a decline in value and we intend to sell such security prior to maturity, or if it is likely that we will be required to sell such security prior to maturity, the security is deemed to be other-than-temporarily impaired and it is written down to fair value through a charge to earnings.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include, the length of time and the extent to which market value has been less than cost, financial condition and near term prospects of the issuer, recommendations of investment advisors and forecasts of economic, market or industry trends. This review process also entails an evaluation of the likelihood that we will hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. During the year ended December 31, 2010, we did not record any charges for other-than-temporary impairment of our available-for-sale securities. Over time, the economic and market environment may further deteriorate or provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and material other-than-temporary impairments may result in realized losses in future periods which could have an adverse effect on our financial position, results of operations, or cash flows.

Adverse credit market conditions may have a material adverse affect on our liquidity or our ability to obtain credit on acceptable terms.

The financial markets have experienced periods of volatility and disruption. Future volatility and disruption is possible and unpredictable. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, such as the principal of our 2.0% Convertible Senior Notes, pay capital expenditures or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significantly higher than in past periods depending on the market conditions and our financial position at the time we pursue additional financing.

Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms. This could restrict our ability to (i) acquire new business or enter new markets, (ii) service or refinance our existing debt, (iii) make necessary capital investments, (iv) maintain statutory net worth requirements in the states in which we do business and (v) make other expenditures necessary for the ongoing conduct of our business.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We do not own any real property. We lease office space in Virginia Beach, Virginia, where our primary headquarters, call, claims and data centers are located. We also lease real property in each of our health plan locations. We are obligated by various insurance and Medicaid regulatory authorities to have offices in the service areas where we provide managed care services.

Item 3. ***Legal Proceedings***

Employment Litigation

On November 22, 2010, a former AMERIGROUP New York, LLC marketing representative filed a putative collective and class action Complaint against AMERIGROUP Corporation and AMERIGROUP New York, LLC in the United States District Court, Eastern District of New York styled as *Hamel Toure, Individually and on Behalf of All Other Persons Similarly Situated v. AMERIGROUP CORPORATION and AMERIGROUP NEW YORK, L.L.C. f/k/a CAREPLUS, L.L.C. (Case No.: CV10-5391)*. The Complaint alleges, *inter alia*, that the plaintiff and certain other employees should have been classified as non-exempt employees under the Fair Labor Standards Act ("FLSA") and during the course of their employment should have received overtime and other compensation under the FLSA from October 22, 2007 until the entry of judgment and under the New York Labor Law from October 22, 2004 until the entry of judgment. The Complaint requests certification of the action as a class action, designation of the action as a collective action, a declaratory judgment, injunctive relief, an award of unpaid overtime compensation, an award of liquidated and/or punitive damages, prejudgment and post-judgment interest, as well as costs and attorneys' fees. At this early stage of the case, we are unable to make a reasonable estimate of the amount or range of loss that could result from an unfavorable outcome in this matter because the scope and size of the potential class has not been determined, no discovery has occurred and no specific amount of monetary damages has been alleged. We believe we have meritorious defenses to the claims against us and intend to defend ourselves vigorously.

Other Litigation

The Company is involved in various legal proceedings in the normal course of business. Based upon its evaluation of the information currently available, the Company believes that the ultimate resolution of any such proceedings will not have a material adverse effect, either individually or in the aggregate, on its financial position, results of operations or liquidity.

Item 4. ***(Removed and Reserved)***

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Part II.

Item 5. ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our common stock is listed on the New York Stock Exchange ("NYSE") under the symbol "AGP". The following table sets forth the range of high and low sales prices for our common stock for the period indicated.

	High	Low
2010		
First quarter	$ 34.52	$ 24.13
Second quarter	37.74	32.38
Third quarter	42.68	30.48
Fourth quarter	46.67	40.28

	High	Low
2009		
First quarter	$ 31.50	$ 22.26
Second quarter	32.40	25.56
Third quarter	29.01	21.34
Fourth quarter	27.49	20.87

On February 17, 2011, the last reported sales price of our common stock was $55.80 per share as reported on the NYSE. As of February 17, 2011, we had 57 shareholders of record.

We have never declared or paid any cash dividends on our common stock. We currently anticipate that we will retain any future earnings for the development and operation of our business and do not anticipate declaring or paying any cash dividends in the foreseeable future. In addition, our ability to pay dividends is dependent on receiving cash dividends from our subsidiaries. Generally, state insurance regulations limit the ability of our subsidiaries to pay dividends to us.

Under the authorization of our Board of Directors, we maintain an ongoing share repurchase program that allows us to repurchase up to $400.0 million of shares of the Company's common stock. Pursuant to this ongoing share repurchase program, we repurchased 3,748,669 shares of our common stock and placed them into treasury during the year ended December 31, 2010 at an average per share cost of $36.96 and an aggregate cost of $138.5 million. As of December 31, 2010, we had authorization to purchase up to an additional $224.3 million of common stock under the repurchase program. Stock repurchases may be made from time-to-time in the open market or in privately negotiated transactions and will be funded from unrestricted cash. We have adopted written plans pursuant to Rule 10b5-1 of the Exchange Act to effect the repurchase of a portion of shares authorized. The number of shares repurchased and the timing of the repurchases are based on the level of available cash and other factors, including market conditions, the terms of any applicable Rule 10b5-1 plans, and self-imposed blackout periods. There can be no assurances as to the exact number or aggregate value of shares that will be repurchased. The repurchase program may be suspended or discontinued at any time or from time-to-time without prior notice.

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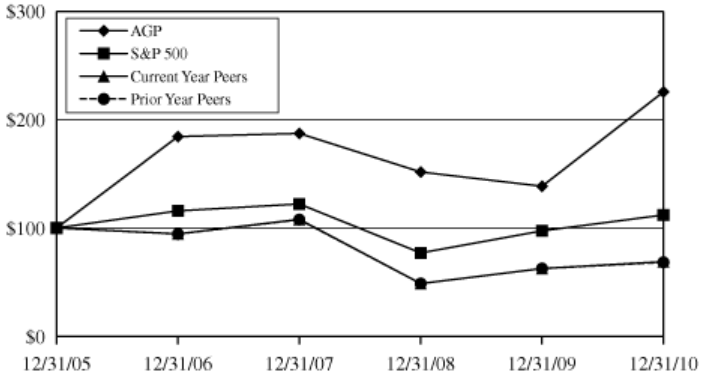
Performance Graph

The following line graph compares the cumulative total stockholder return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (the "S&P 500") and a peer group index for the period from December 31, 2005 to December 31, 2010. The graph assumes an initial investment of $100.00 in the Company's common stock and in each of the indices and includes the reinvestment of dividends paid, if any.

The Current Year Peers index consists of Aetna Inc. (AET), Centene Corp. (CNC), Cigna Corp. (CI), Coventry Health Care Inc. (CVH), Health Net Inc. (HNT), HealthSpring Inc. (HS), Humana Inc. (HUM), Magellan Health Services Inc. (MGLN), Metropolitan Health Networks Inc. (MDF), Molina Healthcare Inc. (MOH), Unitedhealth Group Inc. (UNH), Universal American Corp. (UAM), Wellcare Health Plans Inc. (WCG), and WellPoint Inc. (WLP). We revised the peer group index to include Metropolitan Health Networks Inc. and Universal American Corp. in the current year as we believe it better reflects the group of companies to which the investment community compares our performance.

In calculating the cumulative total stockholder return of the peer group index, the returns of each of the peer group companies have been weighted according to their relative stock market capitalizations.



	Value of $100 Invested Over Past 5 Years					
	12/31/05	12/31/06	12/31/07	12/31/08	12/31/09	12/31/10
AMERIGROUP Corporation	**$ 100.00**	$ 184.43	$ 187.31	$ 151.70	$ 138.54	$ 225.69
S&P 500 Index	**100.00**	115.79	122.16	76.96	97.33	111.99
Current Year Peers	**100.00**	94.55	107.94	48.66	62.57	68.88
Prior Year Peers	**100.00**	94.41	107.67	48.64	62.52	68.30

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Proceeds of Equity Securities by the Issuer and Affiliated Purchasers

Set forth below is information regarding our stock repurchases during the three months ended December 31, 2010:

Period	Total Number of Shares (or Units) Purchased	Average Price Paid per Share (or Unit)	Total Number of Shares (or Units) Purchased as Part of Publicly Announced Plans or Programs[1]	Approximate Dollar Value of Shares (or Units) that May Yet Be Purchased Under the Plans or Programs[2]
October 1 — October 31, 2010	—	$ —	—	$ 248,711,837
November 1 — November 30, 2010[3]	490,559	43.24	489,536	227,545,452
December 1 — December 31, 2010[3]	79,257	44.65	72,750	224,307,308
Total	569,816	43.44	562,286	$ 224,307,308

(1) Shares purchased during the fourth quarter of 2010 were purchased as part of our existing authorized share repurchase program. On August 18, 2010, we entered into a trading plan, in accordance with Rule 10b5-1 of the Exchange Act, to facilitate repurchases of our common stock pursuant to our ongoing share repurchase program (the "Rule 10b5-1 plan"). The Rule 10b5-1 plan effectively terminated the previous Rule 10b5-1 plan and became effective on November 2, 2010 and expires on July 31, 2012, unless terminated earlier in accordance with its terms.

(2) On September 15, 2010, our Board of Directors authorized a $200.0 million increase to the ongoing share repurchase program, bringing the total authorization to $400.0 million. The $400.0 million authorization allows us to repurchase shares of our common stock from and after August 5, 2009. No duration has been placed on the repurchase program and we reserve the right to discontinue the repurchase program at any time.

(3) Our 2009 Equity Incentive Plan allows, upon approval by the plan administrator, stock option recipients to deliver shares of unrestricted Company common stock held by the participant as payment of the exercise price and applicable withholding taxes upon the exercise of stock options or vesting of restricted stock. During November and December 2010, certain employees elected to tender 1,023 shares and 6,507 shares, respectively, to the Company in payment of related withholding taxes upon vesting of restricted stock

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Item 6. ***Selected Financial Data***

The following selected consolidated financial data should be read in conjunction with the audited Consolidated Financial Statements and accompanying notes thereto and Management's Discussion and Analysis of Financial Condition and Results of Operations appearing elsewhere in this Form 10-K. Selected financial data as of and for each of the years in the five-year period ended December 31, 2010 has been adjusted to reflect the changes resulting from adoption of new guidance related to convertible debt instruments effective January 1, 2009 and are derived from our audited Consolidated Financial Statements, which have been audited by KPMG LLP, independent registered public accounting firm. (See Note 9 to our audited Consolidated Financial Statements as of and for the year ended December 31, 2010 included in Item 8. of this Form 10-K.)

	Years Ended December 31,				
	2010	2009	2008	2007	2006
	(Dollars in thousands, except for per share data)				
Statement of Operations Data:					
Revenues:					
Premium	$ 5,783,458	$ 5,158,989	$ 4,366,359	$ 3,835,454	$ 2,788,642
Investment income and other	22,843	29,081	71,383	73,320	39,279
Total revenues	5,806,301	5,188,070	4,437,742	3,908,774	2,827,921
Expenses:					
Health benefits	4,722,106	4,407,273	3,618,261	3,216,070	2,266,017
Selling, general and administrative	452,069	394,089	435,876	377,026	315,628
Premium tax	143,896	134,277	93,757	85,218	47,100
Depreciation and amortization	35,048	34,746	37,385	31,604	25,486
Litigation settlement	—	—	234,205	—	—
Interest	16,011	16,266	20,514	18,962	608
Total expenses	5,369,130	4,986,651	4,439,998	3,728,880	2,654,839
Income (loss) before income taxes	437,171	201,419	(2,256)	179,894	173,082
Income tax expense	163,800	52,140	54,350	67,667	65,976
Net income (loss)	$ 273,371	$ 149,279	$ (56,606)	$ 112,227	$ 107,106
Basic net income (loss) per share	$ 5.52	$ 2.89	$ (1.07)	$ 2.13	$ 2.07
Weighted average number of common shares outstanding	49,522,202	51,647,267	52,816,674	52,595,503	51,863,999
Diluted net income (loss) per share	$ 5.40	$ 2.85	$ (1.07)	$ 2.08	$ 2.02
Weighted average number of common shares and dilutive potential common shares outstanding	50,608,008	52,309,268	52,816,674	53,845,829	53,082,933

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	December 31,				
	2010	2009	2008	2007	2006
	(Dollars in thousands)				
Balance Sheet Data:					
Cash and cash equivalents and short- and long-term investments	$ 1,633,118	$ 1,354,634	$ 1,337,423	$ 1,067,294	$ 776,273
Total assets	2,283,388	1,999,634	1,955,667	2,076,546	1,345,695
Long-term debt, less current portion	245,750	235,104	268,956	317,244	—
Total liabilities	1,117,751	1,015,190	1,083,008	1,134,652	577,110
Stockholders' equity	1,165,637	984,444	872,659	941,894	768,585

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

Overview

We are a multi-state managed health care company focused on serving people who receive health care benefits through publicly funded health care programs, including Medicaid, Children's Health Insurance Program ("CHIP"), Medicaid expansion programs and Medicare Advantage. We operate in one business segment with a single line of business. We were founded in December 1994 with the objective of becoming the leading managed care organization in the U.S. focused on serving people who receive these types of benefits. We believe that we are better qualified and positioned than many of our competitors to meet the unique needs of our members and the government agencies with whom we contract because of our focus solely on recipients of publicly funded health care, our medical management programs and community-based education and outreach programs. We design our programs to address the particular needs of our members, for whom we facilitate access to health care benefits pursuant to agreements with applicable state and Federal government agencies. We combine medical, social and behavioral health services to help our members obtain quality health care in an efficient manner. Our success in establishing and maintaining strong relationships with government agencies, providers and members has enabled us to obtain new contracts and to establish and maintain a leading market position in many of the markets we serve. We continue to believe that managed health care remains the only proven mechanism that improves health outcomes for our members while helping our government customers manage the fiscal viability of their health care programs. We are dedicated to offering real solutions that improve health care access and quality for our members, while proactively working to reduce the overall cost of care to taxpayers.

Summary Highlights for the Year Ended December 31, 2010

- Total revenues of $5.8 billion, an 11.9% increase over the year ended December 31, 2009;
- Membership increased by 143,000, or 8.0%, to 1,931,000 members compared to 1,788,000 members as of December 31, 2009;
- Health benefits ratio ("HBR") of 81.6% of premium revenues for the year ended December 31, 2010 compared to 85.4% for the year ended December 31, 2009;
- Selling, general and administrative expense ("SG&A") ratio of 7.8% of total revenues for the year ended December 31, 2010 compared to 7.6% for the year ended December 31, 2009;
- Cash provided by operations was $401.9 million for the year ended December 31, 2010;
- Unregulated cash and investments of $248.6 million as of December 31, 2010;
- On March 1, 2010, our Tennessee health plan began providing long-term care services to existing members under the State's newly created TennCare CHOICES program;

- On March 1, 2010, our New Jersey health plan completed the previously announced acquisition of certain assets of University Health Plans, Inc. ("UHP"). As of December 31, 2010, we served approximately 134,000 members in New Jersey;
- In May 2010, the Texas Health and Human Services Commission ("HHSC") announced that our Texas health plan was selected through a competitive procurement to expand health care coverage to seniors and people with disabilities in the six-county service area surrounding Fort Worth, Texas. AMERIGROUP Texas, Inc. began serving approximately 27,000 STAR+PLUS members in that service area on February 1, 2011, a portion of which were previously our members under an ASO contract; and
- In September 2010, our Board of Directors authorized a $200.0 million increase to our ongoing share repurchase program, bringing the total authorization to $400.0 million. During 2010, we repurchased 3,748,669 shares of our common stock for approximately $138.5 million and had remaining authorization to purchase up to an additional $224.3 million of shares as of December 31, 2010.

Similar to our experience in 2009, our results for the year ended December 31, 2010 reflect the impact of continued membership growth, which we believe is driven by the macroeconomic environment that has increased the number of Medicaid eligible individuals. Increases in premium revenue also reflect the impact of a benefit expansion to provide long-term care services to eligible members in Tennessee, the net effect of premium rate changes from the prior year related to annual contract renewals and the impact of our first quarter 2010 acquisition in New Jersey. Health benefits expense for the year ended December 31, 2010 reflects moderating cost trends for current and prior periods, the latter of which generated revisions of estimates related to prior periods.

Health Care Reform

On March 23, 2010, the Patient Protection and Affordable Care Act was signed into law and on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was signed into law (collectively, the "Acts"). The Acts provide comprehensive changes to the U.S. health care system, which will be phased in at various stages over the next several years. Among other things, the Acts are intended to provide health insurance to approximately 32 million uninsured individuals of whom approximately 20 million are expected to obtain health insurance through the expansion of the Medicaid program beginning in 2014. Funding for the expanded coverage will initially come largely from the Federal government.

The Acts did not have a material effect on our results of operations, liquidity or cash flows in 2010; however, we are currently evaluating the provisions of the Acts and believe that the Acts may provide us with significant opportunities for membership growth in our existing markets and, potentially, in new markets in the future. There can be no assurance that we will realize this growth, or that this growth will be profitable. Further, there are several pending lawsuits challenging the constitutionality of the Acts so there can be no assurance that the Acts will take effect as originally enacted or at all.

There are numerous steps required to implement the Acts, including promulgating a substantial number of new and potentially more onerous regulations that may affect our business. Further, there is resistance to expansion at the state level, largely due to budgetary pressure. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the Federal or state level, or the effect that any future legislation or regulation, or even the pending litigation challenging the Acts, will have on our business or our growth opportunities. Although we believe the Acts will provide us with significant opportunity, the enacted reforms, as well as future regulations, legislative changes and judicial decisions may in fact have a material adverse effect on our results of operations, financial position or liquidity.

The Acts also include the imposition of a significant new non-deductible Federal premium-based assessment and other assessments on health insurers. If this Federal premium-based assessment is imposed as enacted, and if the cost of the Federal premium-based assessment is not included in the calculation of our premium rates, or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and liquidity may be materially adversely affected.

Business Strategy

We have a disciplined approach to evaluating the operating performance of our existing markets to determine whether to exit or continue operating in each market. As a result, in the past we have and may in the future decide to exit certain markets if they do not meet our long-term business goals. We also periodically evaluate acquisition opportunities to determine if they align with our business strategy. We continue to believe acquisitions can be an important part of our long-term growth strategy.

Opportunities for Future Membership Growth

Medicare Advantage

In June 2010, we received approval from the Centers for Medicare & Medicaid Services ("CMS") to add Tarrant County to our Medicare Advantage service area in Texas, and to add Rutherford County to our Medicare Advantage service area in Tennessee. In addition, CMS approved expansion of our Medicare Advantage plans to cover traditional Medicare beneficiaries in addition to the existing special needs beneficiaries already covered in Texas, Tennessee and New Mexico. These approvals allowed us to begin serving Medicare members in the expanded areas effective January 1, 2011. We can give no assurance that our entry into these service areas will be favorable to our results of operations, financial position or cash flows in future periods.

Texas

In May 2010, HHSC announced that our Texas health plan was selected through a competitive procurement to expand health care coverage to seniors and people with disabilities in the six-county service area surrounding Fort Worth, Texas. AMERIGROUP Texas, Inc. began serving approximately 27,000 STAR+PLUS members in that service area on February 1, 2011, a portion of which were previously our members under an ASO contract. We are one of two health plans awarded this expansion contract; however we are currently serving all STAR+PLUS members in the Fort Worth market while the other health plan completes its readiness review. If and when that second plan becomes operational, the members will be provided the opportunity to choose between health plans.

HHSC is currently drafting a request for proposal ("RFP") for the re-bid of its entire managed care program in the State of Texas. We expect the RFP to include the addition of new service areas and new product opportunities in existing service areas, resulting in a significant increase to the size and scope of the State's managed care program. We anticipate that the release of the RFP and HHSC's selection of vendors under the new contract will occur sometime in 2011 with details regarding implementation dates dependent on the timing of the award. If we are not awarded this contract through the re-bidding process, our results of operations, financial position or cash flows in future periods could be materially and adversely affected.

Georgia

Our Temporary Assistance for Needy Families ("TANF") and CHIP contract with the State of Georgia expires June 30, 2011, with the State's option to renew the contract for one additional one-year term. The State has notified us of its intent to renew our contract effective July 1, 2011 and to amend our existing contract to include an option to renew for two additional one-year terms.

Other Market Updates

Tennessee

On March 1, 2010, our Tennessee health plan began offering long-term care services to existing members through the State's TennCare CHOICES program. The program, created as a result of the Long Term Care Community Choices Act of 2008, is an expansion program offered through amendments to existing Medicaid managed care contracts. TennCare CHOICES focuses on promoting independence, choice, dignity and quality of life for long-term care Medicaid managed care recipients by offering members the option to live in their own homes while receiving long-term care and other medical services.

New Jersey

On March 1, 2010, our New Jersey health plan completed the previously announced acquisition of the Medicaid contract rights and rights under certain provider agreements of UHP for $13.4 million. At December 31, 2010, we served approximately 134,000 members in the State of New Jersey.

Contingencies

Florida Medicaid Contract Dispute

Under the terms of the Medicaid contracts with the Florida Agency for Health Care Administration ("AHCA"), managed care organizations are required to have a process to identify members who are pregnant, or the newborns of members, so that the newborn can be enrolled as a member of the health plan as soon as possible after birth. This process is referred to as the "Unborn Activation Process."

Beginning in July 2008, AMERIGROUP Florida, Inc. received a series of letters from the Florida Office of the Inspector General ("IG") and AHCA stating that AMERIGROUP Florida, Inc. had failed to comply with the Unborn Activation Process in each and every instance during the period from July 1, 2004 through December 31, 2007 and, as a result, AHCA had paid approximately $10.6 million in Medicaid fee-for-service claims that should have been paid by AMERIGROUP Florida, Inc. The letters requested that AMERIGROUP Florida, Inc. provide documentation to evidence its compliance with the terms of the contract with AHCA with respect to the Unborn Activation Process. It is our belief that AHCA and the IG sent similar letters to the other Florida Medicaid managed care organizations during this time period.

In October 2008, AMERIGROUP Florida, Inc. submitted its response to the letters. In July 2009, AMERIGROUP Florida, Inc. received another series of letters from the IG and AHCA stating that, based on a review of the AMERIGROUP Florida, Inc.'s response, they had determined that AMERIGROUP Florida, Inc. did not comply with the Unborn Activation Process and assessed fines against AMERIGROUP Florida, Inc. in the amount of two thousand, five hundred dollars per newborn for an aggregate amount of approximately $6.0 million. The letters further reserved AHCA's right to pursue collection of the amount paid for the fee-for-service claims. AMERIGROUP Florida, Inc. appealed these findings and submitted documentation to evidence its compliance with, and performance under, the Unborn Activation Process requirements of the contract. On January 14, 2010, AMERIGROUP Florida, Inc. appealed AHCA's contract interpretation to the Florida Deputy Secretary of Medicaid that the failure to utilize the Unborn Activation Process for each and every newborn could result in fines. In February 2010, AMERIGROUP Florida, Inc. received another series of letters from the IG and AHCA revising the damages from $10.6 million to $3.2 million for the fee-for-service claims that AHCA believed they paid. The revised damages included an offset of premiums that would have been paid for the dates of service covered by the claims. The letters also included an updated fine amount which was not materially different from the prior letters.

On May 26, 2010, the Florida Deputy Secretary of Medicaid denied AMERIGROUP Florida, Inc.'s contract interpretation appeal. Following the denial, in June 2010, AMERIGROUP Florida, Inc. received another series of letters from AHCA assessing fines in the amount of two thousand, five hundred dollars per newborn for an aggregate amount of approximately $6.0 million.

As a result of discussions with the IG and AHCA, in December 2010, AMERIGROUP Florida, Inc. and AHCA entered into a confidential settlement agreement resolving and releasing all claims related to the Unborn Activation Process during the period from July 1, 2004 through December 31, 2007. The settlement, which is included in the accompanying audited Consolidated Financial Statements, was not material to our financial position, results of operations or liquidity.

Georgia Letter of Credit

Effective July 1, 2010, we renewed a collateralized irrevocable standby letter of credit, initially issued on July 1, 2009 in an aggregate principal amount of approximately $17.4 million, to meet certain obligations under our Medicaid contract in the State of Georgia through our Georgia subsidiary, AMGP Georgia Managed Care Company, Inc. The letter of credit is collateralized through cash held by AMGP Georgia Managed Care Company, Inc.

Legal Proceedings

We are involved in various legal proceedings in the normal course of business. Based upon our evaluation of the information currently available, we believe that the ultimate resolution of any such proceedings will not have a material adverse effect, either individually or in the aggregate, on our financial position, results of operations or cash flows. Additionally, we have been involved in specific litigation in the current year, the details of which are disclosed in Part I, Item 3. *Legal Proceedings*.

Discussion of Critical Accounting Policies

In the ordinary course of business, we make a number of estimates and assumptions relating to the reporting of results of operations and financial condition in the preparation of our audited Consolidated Financial Statements in conformity with U.S. generally accepted accounting principles. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances. Actual results could differ from those estimates and the differences could be significant. We believe that the following discussion addresses our critical accounting policies, which are those that are most important to the portrayal of our financial condition and results of operations and require management's most difficult, subjective and complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain.

Revenue Recognition

We generate revenues primarily from premiums and administrative services only ("ASO") fees we receive from the states in which we operate to arrange for health care services for our TANF, CHIP, aged, blind and disabled ("ABD") and FamilyCare members. We receive premiums from CMS for our Medicare Advantage members. We recognize premium and ASO fee revenue during the period in which we are obligated to provide services to our members. A fixed amount per member per month ("PMPM") is paid to us to arrange for health care services for our members pursuant to our contracts in each of our markets. These premium payments are based upon eligibility lists produced by the government agencies with whom we contract. Errors in this eligibility determination on which we rely can result in positive and negative revenue adjustments to the extent this information is adjusted by the state. Adjustments to eligibility data received from these government agencies result from retroactive application of enrollment or disenrollment of members or classification changes of members between rate categories that were not known by us in previous months due to timing of the receipt of data or errors in processing by the government agencies. These changes, while common, are not generally large. Retroactive adjustments to revenue for corrections in eligibility data are recorded in the period in which the information becomes known. We estimate the amount of outstanding retroactivity each period and adjust premium revenue accordingly, if appropriate.

In all of the states in which we operate, with the exceptions of Florida, New Mexico, Tennessee and Virginia, we are eligible to receive supplemental payments to offset the health benefits expense associated with the birth of a baby. Each state contract is specific as to what is required before payments are collectible. Upon delivery of a baby, each state is notified in accordance with contract terms. Revenue is recognized in the period that the delivery occurs and the related services are provided to our member based on our authorization system for those services. Changes in authorization and claims data used to estimate supplemental revenues can occur as a result of changes in eligibility noted above or corrections of errors in the underlying data. Adjustments to revenue for corrections to authorization and claims data are recorded in the period in which the corrections become known.

Historically, the impact of adjustments from retroactivity, changes in authorizations and changes in claims data used to estimate supplemental revenues has represented less than 1.0% of annual revenue. This results in a negligible impact on annual earnings as changes in revenue are typically accompanied by corresponding changes in the related health benefits expense. We believe this historical experience represents what is reasonably likely to occur in future periods.

Additionally, delays in annual premium rate changes require that we defer the recognition of any increases to the period in which the premium rates become final. The time lag between the effective date of the premium rate increase and the final contract can and has been delayed one quarter or more. The value of the impact can be significant in the period in which it is recognized dependent on the magnitude of the premium rate change, the membership to which it applies and the length of the delay between the effective date and the final contract date.

Estimating Health Benefits Expense and Claims Payable

Medical claims payable, representing 45.7% of our total consolidated liabilities as of December 31, 2010, consist of actual claims reported but not paid and estimates of health care services incurred but not reported ("IBNR"). Included in this liability and the corresponding health benefits expense for IBNR claims are the estimated costs of processing such claims. Health benefits expense has two main components: direct medical expenses and medically-related administrative costs. Direct medical expenses include amounts paid to hospitals, physicians and providers of ancillary services, such as laboratories and pharmacies. Medically-related administrative costs include items such as case and disease management, utilization review services, quality assurance and on-call nurses.

We have used a consistent methodology for estimating our medical expenses and medical claims payable since inception, and have refined our assumptions to take into account our maturing claims, product and market experience. Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of the estimate. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice.

In developing our medical claims payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For mature incurred months (generally the months prior to the most recent three months), we calculate completion factors using an analysis of claim adjudication patterns over the most recent 12-month period. A completion factor is an actuarial estimate, based upon historical experience, of the percentage of incurred claims during a given period that have been adjudicated as of the date of estimation. We apply the completion factors to actual claims adjudicated-to-date in order to estimate the expected amount of ultimate incurred claims for those months. Actuarial estimates of claim liabilities are determined by subtracting the actual paid claims from the estimate of ultimate incurred claims.

We do not believe that completion factors are fully credible for estimating claims incurred for the most recent two-to-three months which constitute the majority of the amount of the medical claims payable. Accordingly, we estimate health benefits expense incurred by applying observed medical cost trend factors to medical costs incurred in a more complete time period. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months for which more complete claim data is available. Assumptions for known changes in hospital authorization data, provider contracting changes, changes in benefit levels, age and gender mix of members, and seasonality are also incorporated into the most recent incurred estimates. The incurred estimates resulting from the analysis of completion factors, medical cost trend factors and other known changes are weighted together using actuarial judgment.

Many aspects of the managed care business are not predictable with consistency. These aspects include the incidences of illness or disease state (such as cardiac heart failure cases, cases of upper respiratory illness, the length and severity of the flu season, new flu strains, diabetes, the number of full-term versus premature births and the number of neonatal intensive care babies). Therefore, we must rely upon our historical experience, as continually monitored, to reflect the ever-changing mix, needs and growth of our members in our assumptions. Among the factors considered by management are changes in the level of benefits provided to members, seasonal variations in utilization, identified industry trends and changes in provider reimbursement arrangements, including changes in the percentage of reimbursements made on a capitated, as opposed to a fee-for-service, basis. These considerations are aggregated in the medical cost trend. Other external factors that may impact medical cost trends include factors such as government-mandated benefits or other regulatory changes; catastrophes and epidemics, such as the H1N1 pandemic; or increases in membership that contribute to an increase in outpatient costs. Other internal factors such as system conversions and claims processing interruptions may impact our ability to accurately establish estimates of historical completion factors or medical cost trends. Management is required to use considerable judgment in the selection of health benefits expense trends and other actuarial model inputs.

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Completion factors and medical cost trends are the most significant factors we use in developing our medical claims payable estimates. The following tables illustrate the sensitivity of these factors and the estimated potential impact on our medical claims payable estimates for those periods as of December 31, 2010:

Completion Factor (Decrease) Increase in Factor	Increase (Decrease) in Medical Claims Payable[1] (In millions)	Medical Claims Trend Increase (Decrease) in Factor	Increase (Decrease) in Medical Claims Payable[2] (In millions)
(0.75)%	$ 73.5	10.0%	$ 16.0
(0.50)%	$ 49.0	5.0%	$ 8.1
(0.25)%	$ 24.5	2.5%	$ 4.1
0.25%	$ (24.5)	(2.5)%	$ (4.1)
0.50%	$ (49.0)	(5.0)%	$ (8.1)
0.75%	$ (73.5)	(10.0)%	$ (16.0)

(1) Reflects estimated potential changes in health benefits expense and medical claims payable caused by changes in completion factors used in developing medical claims payable estimates for older periods, generally periods prior to the most recent three months.

(2) Reflects estimated potential changes in health benefits expense and medical claims payable caused by changes in medical costs trend data used in developing medical claims payable estimates for the most recent three months.

The analyses above include those outcomes that are considered reasonably likely based on our historical experience in estimating our medical claims payable.

Changes in estimates of medical claims payable are primarily the result of obtaining more complete claims information that directly correlates with the claims and provider reimbursement trends. Volatility in members' needs for medical services, provider claims submission and our payment processes often results in identifiable patterns emerging several months after the causes of deviations from assumed trends. Since our estimates are based upon PMPM claims experience, changes cannot typically be explained by any single factor, but are the result of a number of interrelated variables, all influencing the resulting experienced medical cost trend. Deviations, whether positive or negative, between actual experience and estimates used to establish the liability are recorded in the period known.

We continually monitor and adjust the medical claims payable and health benefits expense based on subsequent paid claims activity. If it is determined that our assumptions regarding medical cost trends and utilization are significantly different than actual results, our results of operations, financial position and liquidity could be impacted in future periods. Adjustments of prior year estimates may result in additional health benefits expense or a reduction of health benefits expense in the period an adjustment is made. Further, due to the considerable variability of health care costs, adjustments to medical claims payable occur each quarter and are sometimes significant as compared to the net income recorded in that quarter. Prior period development is recognized immediately upon the actuaries' judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued.

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The following table presents the components of the change in medical claims payable for the three years ended December 31 (in thousands):

	2010	2009	2008
Medical claims payable as of January 1	$ 529,036	$ 536,107	$ 541,173
Health benefits expenses incurred during the year:			
Related to current year	4,828,321	4,492,590	3,679,107
Related to prior years	(106,215)	(85,317)	(60,846)
Total incurred	4,722,106	4,407,273	3,618,261
Health benefits payments during the year:			
Related to current year	4,359,216	4,007,789	3,197,732
Related to prior years	381,251	406,555	425,595
Total payments	4,740,467	4,414,344	3,623,327
Medical claims payable as of December 31	$ 510,675	$ 529,036	$ 536,107
Current year medical claims paid as a percent of current year health benefits expenses incurred	90.3%	89.2%	86.9%
Health benefits expenses incurred related to prior years as a percent of prior year medical claims payable as of December 31	(20.1)%	(15.9)%	(11.2)%
Health benefits expenses incurred related to prior years as a percent of the prior year's health benefits expenses related to current year	(2.4)%	(2.3)%	(1.9)%

Health benefits expense incurred during the year, was reduced by approximately $106.2 million, $85.3 million and $60.8 million in the years ended December 31, 2010, 2009 and 2008, respectively, for amounts related to prior years. As noted above, the actuarial standards of practice generally require that the liabilities established for IBNR be sufficient to cover obligations under an assumption of moderately adverse conditions. We did not experience moderately adverse conditions in any of these periods. Therefore, included in the amounts related to prior years are approximately $32.2 million, $34.4 million and $37.3 million for the years ended December 31, 2010, 2009 and 2008, respectively, related to amounts included in the medical claims payable as of January 1 of each respective year in order to establish the liability at a level adequate for moderately adverse conditions.

The remaining reduction in health benefits expense incurred during the year, related to prior years, of approximately $74.0 million, $50.9 million and $23.5 million for the years ended December 31, 2010, 2009 and 2008, respectively, primarily resulted from obtaining more complete claims information for claims incurred for dates of service in the prior years. We refer to these amounts as net reserve development. We experienced lower medical trend than originally estimated due to moderating medical trends lower than previously estimated and to claims processing initiatives that yielded increased claim payment recoveries and coordination of benefits in 2010, 2009 and 2008 related to prior year dates of services for all periods. These factors also caused our actuarial estimates to include faster completion factors than were originally established. The faster completion factors contributed to the net favorable reserve development in each respective period.

Establishing the liabilities for IBNR associated with health benefits expense incurred during a year related to that current year, at a level sufficient to cover obligations under an assumption of moderately adverse conditions, will cause incurred health benefits expense for that current year to be higher than if IBNR was established without sufficiency for moderately adverse conditions. In the above table, the health benefits expense incurred during the year related to the current year includes an assumption to cover moderately adverse conditions.

Also included in medical claims payable are estimates for provider settlements due to clarification of contract terms, out-of-network reimbursement and claims payment differences, as well as amounts due to contracted providers under risk-sharing arrangements. These estimates are established through analysis of claims payment

data, contractual provisions and state or Federal regulations, as applicable. Differences in interpretation of appropriate payment levels and the methods under which these liabilities are resolved cause these estimates to be subject to revision in future periods.

Premium Deficiency Reserves

In addition to incurred but not paid claims, the liability for medical claims payable includes reserves for premium deficiencies, if appropriate. We review each state Medicaid and Federal Medicare contract under which we operate on a quarterly basis for any apparent premium deficiency. In doing so, we evaluate current medical cost trends, expected premium rate changes and termination clauses to determine our exposure to future losses, if any. Premium deficiencies are recognized when it is probable that expected claims and administrative expenses will exceed future premiums and investment income on existing medical insurance contracts. For purposes of premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. We did not have any premium deficiency reserves at December 31, 2010.

Income Taxes

We account for income taxes in accordance with current accounting guidance as prescribed under U.S. generally accepted accounting principles. On a quarterly basis, we estimate our required tax liability based on enacted tax rates, estimates of book-to-tax differences in income, and projections of income that will be earned in each taxing jurisdiction. Deferred tax assets and liabilities representing the tax effect of temporary differences between financial reporting net income and taxable income are measured at the tax rates enacted at the time the deferred tax asset or liability is recorded.

After tax returns for the applicable year are filed, the estimated tax liability is adjusted to the actual liability per the filed state and Federal tax returns. Historically, we have not experienced significant differences between our estimates of tax liability and our actual tax liability.

Similar to other companies, we sometimes face challenges from the tax authorities regarding the amount of taxes due. Positions taken on our tax returns are evaluated and benefits are recognized only if it is more likely than not that our position will be sustained on audit. Based on our evaluation of tax positions, we believe that we have appropriately accounted for potential tax exposures.

In addition, we are periodically audited by state and Federal taxing authorities and these audits can result in proposed assessments. We believe that our tax positions comply with applicable tax law and, as such, will vigorously defend these positions on audit. We believe that we have adequately provided for any reasonably foreseeable outcome related to these matters. Although the ultimate resolution of these audits may require additional tax payments, we do not anticipate any material impact to earnings.

The *qui tam* litigation settlement payment we made in 2008 had a significant impact on tax expense and the effective tax rates for 2008 and 2009 due to the fact that a portion of the settlement payment is not deductible for income tax purposes. At December 31, 2008, the estimated tax benefit associated with the *qui tam* litigation settlement payment was approximately $34.6 million. In June 2009, we recorded an additional $22.4 million tax benefit regarding the tax treatment of the *qui tam* litigation settlement under an agreement in principle with the Internal Revenue Service ("IRS") which was formalized through a pre-filing agreement with the IRS in September 2009. The pre-filing agreement program permits taxpayers to resolve tax issues in advance of filing their corporate income tax returns. We do not anticipate that there will be any further material changes to the tax benefit associated with this litigation settlement in future periods.

For further information, please reference Note 13 to our audited Consolidated Financial Statements as of and for the year ended December 31, 2010 included in Item 8. of this Form 10-K.

Investments

As of December 31, 2010, we had investments with a carrying value of $984.0 million, primarily held in marketable debt securities. Our investments are classified as available-for-sale and are recorded at fair value. We exclude gross unrealized gains and losses on available-for-sale investments from earnings and report unrealized

gains or losses, net of income tax effects, as a separate component in stockholders' equity. We continually monitor the difference between the cost and fair value of our investments. As of December 31, 2010, our investments had gross unrealized gains of $4.6 million and gross unrealized losses of $3.6 million. We evaluate investments for impairment considering the length of time and extent to which market value has been less than cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and our intent to sell the security or the likelihood that we will be required to sell the security before recovery of the entire amortized cost. For debt securities, if we intend to either sell or determine that we will more likely than not be required to sell a debt security before recovery of the entire amortized cost basis or maturity of the debt security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not more likely than not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in accumulated other comprehensive income. New information and the passage of time can change these judgments. We manage our investment portfolio to limit our exposure to any one issuer or market sector, and largely limit our investments to U.S. government and agency securities; state and municipal securities; and corporate debt obligations, substantially all of investment grade quality. As of December 31, 2010, our investments included securities with an auction reset feature ("auction rate securities") issued by student loan corporations established by various state governments. Since early 2008, auctions for these auction rate securities have failed, significantly decreasing our ability to liquidate these securities prior to maturity. As we cannot predict the timing of future successful auctions, if any, our auction rate securities are classified as available-for-sale and are carried at fair value within long-term investments. We currently believe that the net unrealized loss position that remains at December 31, 2010 on our auction rate securities portfolio is primarily due to liquidity concerns and not the creditworthiness of the underlying issuers. We currently have the intent to hold our auction rate securities to maturity, if required, or if and when market stability is restored with respect to these investments.

Goodwill and Intangible Assets

The valuation of goodwill and intangible assets at acquisition requires assumptions regarding estimated discounted cash flows and market analyses. These assumptions contain uncertainties because they require management to use judgment in selecting the assumptions and applying the market analyses to the individual acquisitions. Additionally, impairment evaluations require management to use judgment to determine if impairment of goodwill and intangible assets is apparent. We have applied a consistent methodology in both the original valuation and subsequent impairment evaluations for all goodwill and intangible assets. We do not anticipate any changes to that methodology, nor has any impairment loss resulted from our analyses other than that recognized in connection with discontinued operations in West Tennessee and the District of Columbia in 2008. Based on our analysis, we have concluded that a significant margin of fair value in excess of the carrying value of goodwill and other intangibles exists as of December 31, 2010. If the assumptions used to evaluate the value of goodwill and intangible assets change in the future, an impairment loss may be recorded and it could be material to our results of operations in the period in which the impairment loss occurs.

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Results of Operations

The following table sets forth selected operating ratios for the years ended December 31, 2010, 2009 and 2008. All ratios, with the exception of the HBR, are shown as a percentage of total revenues.

	Years Ended December 31,		
	2010	2009	2008
Premium revenue	99.6%	99.4%	98.4 %
Investment income and other	0.4	0.6	1.6
Total revenues	100.0%	100.0%	100.0 %
Health benefits expenses(1)	81.6%	85.4%	82.9 %
Selling, general and administrative expenses	7.8%	7.6%	9.8 %
Income (loss) before income taxes	7.5%	3.9%	(0.1) %
Net income (loss)	4.7%	2.9%	(1.3) %

(1) HBR is shown as a percentage of premium revenue because there is a direct relationship between the premium received and the health benefits provided.

Summarized comparative financial information for the years ended December 31, 2010, 2009 and 2008 are as follows (dollars in millions, except per share data; totals in the table below may not equal the sum of individual line items as all line items have been rounded to the nearest decimal):

	Years Ended December 31,			Years Ended December 31,		
	2010	2009	% Change 2010-2009	2009	2008	% Change 2009-2008
Revenues:						
Premium	$ 5,783.5	$ 5,159.0	12.1 %	$ 5,159.0	$ 4,366.4	18.2 %
Investment income and other	22.8	29.1	(21.5)%	29.1	71.4	(59.3)%
Total revenues	5,806.3	5,188.1	11.9 %	5,188.1	4,437.7	16.9 %
Expenses:						
Health benefits	4,722.1	4,407.3	7.1 %	4,407.3	3,618.3	21.8 %
Selling, general and administrative	452.1	394.1	14.7 %	394.1	435.9	(9.6)%
Premium tax	143.9	134.3	7.2 %	134.3	93.8	43.2 %
Depreciation and amortization	35.0	34.7	0.9 %	34.7	37.4	(7.1)%
Litigation settlement	—	—	—	—	234.2	*
Interest	16.0	16.3	(1.6)%	16.3	20.5	(20.7)%
Total expenses	5,369.1	4,986.7	7.7 %	4,986.7	4,440.0	12.3 %
Income (loss) before income taxes	437.2	201.4	117.0 %	201.4	(2.3)	*
Income tax expense	163.8	52.1	214.2 %	52.1	54.4	(4.1)%
Net income (loss)	$ 273.4	$ 149.3	83.1 %	$ 149.3	$ (56.6)	*
Diluted net income (loss) per common share	$ 5.40	$ 2.85	89.5 %	$ 2.85	$ (1.07)	*

* Not meaningful

Revenues

Premium Revenue

Premium revenue for the year ended December 31, 2010 increased $624.5 million, or 12.1%, to $5.8 billion from $5.2 billion for the year ended December 31, 2009. Premium revenue for the year ended December 31, 2009 increased $792.6 million, or 18.2%, from $4.4 billion for the year ended December 31, 2008. The increase in both periods was due in part to significant increases in full-risk membership across the majority of our existing products and markets. These membership increases are partially due to continuing high levels of unemployment and the generally adverse macroeconomic environment driving increases in the number of people eligible for publicly funded health care programs. We expect membership increases to continue into 2011 at moderating levels. Premium revenue for the year ended December 31, 2010 also increased as a result of our entry into the Tennessee TennCare CHOICES program and our acquisition of the Medicaid contract rights from UHP in the State of New Jersey, both occurring in March 2010, as well as from premium rate and mix changes. These increases were offset in part by our decision to exit the ABD program in the Southwest region of Ohio as well as the State's election to remove pharmacy coverage from the benefit package, both effective February 2010.

Premium revenue for the year ended December 31, 2009 as compared to the year ended December 31, 2008 also increased as a result of our completion of a full statewide rollout under New Mexico's Coordination of Long-Term Services ("CoLTS") program in April 2009, which began with six counties in August 2008, as well as our entry into the Nevada market in February 2009.

The following table sets forth the approximate number of members we served in each state as of December 31, 2010, 2009 and 2008. Because we receive two premiums for members that are in both the Medicare Advantage and Medicaid products, these members have been counted twice in the states where we operate Medicare Advantage plans.

	December 31,		
Market	**2010**	**2009**	**2008**
Texas[1]	559,000	505,000	455,000
Georgia	266,000	249,000	206,000
Florida	263,000	236,000	237,000
Tennessee	203,000	195,000	187,000
Maryland	202,000	194,000	169,000
New Jersey	134,000	118,000	105,000
New York	109,000	114,000	110,000
Nevada	79,000	62,000	—
Ohio	55,000	60,000	58,000
Virginia	40,000	35,000	25,000
New Mexico	21,000	20,000	11,000
South Carolina[2]	—	—	16,000
Total	1,931,000	1,788,000	1,579,000

(1) Membership includes approximately 14,000 and 13,000 members under an ASO contract as of December 31, 2010 and 2009, respectively. There was no ASO contract in effect as of December 31, 2008.

(2) The contract with South Carolina terminated March 1, 2009 concurrent with the sale of our rights under the contract.

Total membership as of December 31, 2010 increased by 143,000 members, or 8.0%, to 1,931,000 members from 1,788,000 as of December 31, 2009. Total membership as of December 31, 2009 increased by 209,000 members, or 13.2%, from 1,579,000 members as of December 31, 2008. Our risk membership as of December 31, 2010 increased by 142,000 members, or 8.0%, to 1,917,000 members from 1,775,000 as of December 31, 2009. Our

risk membership as of December 31, 2009 increased by 196,000 members, or 12.4%, from 1,579,000 as of December 31, 2008.

The increase in both periods was primarily a result of membership growth in the majority of our products and markets driven by a surge in Medicaid eligibility, which we believe was driven by high unemployment and general adverse economic conditions. Membership as of December 31, 2010 also increased as a result of our March 2010 acquisition of the Medicaid contract rights from UHP to provide services to additional members in the State of New Jersey. Membership as of December 31, 2009 also increased as a result of our entry into the Nevada market in February 2009 and the commencement of the CoLTS program in New Mexico in August 2008.

At December 31, 2010, we served members who received health care benefits through contracts with the regulatory entities in the jurisdictions in which we operate. For the year ended December 31, 2010, our Texas contract represented approximately 23% of premium revenues and our Tennessee, Georgia and Maryland contracts represented approximately 15%, 12%, and 11% of premium revenues, respectively. Our state contracts have terms that are generally one- to two-years in length, some of which contain optional renewal periods at the discretion of the individual states. Some contracts also contain a termination clause with notification periods ranging from 30 to 180 days. At the termination of these contracts, re-negotiation of terms or the requirement to enter into a re-bidding or reprocurement process is required to execute a new contract. If these contracts were not renewed on favorable terms to us, our financial position, results of operations or cash flows could be materially adversely affected.

Investment Income and Other

Our investment portfolio generated approximately $17.2 million, $22.4 million and $50.9 million in pre-tax income for the years ended December 31, 2010, 2009 and 2008, respectively. The decrease in each period is primarily a result of decreasing rates of return on fixed income securities due to current market interest rates. We anticipate that our effective yield will remain at or below the current rate as of December 31, 2010 for the foreseeable future, which will result in similar or reduced returns on our investment portfolio in future periods. The performance of our investment portfolio is interest rate driven and, consequently, changes in interest rates affect our returns on, and the fair value of, our portfolio which can materially affect our results of operations or liquidity in future periods.

Other revenue for the year ended December 31, 2010, decreased $1.1 million to $5.6 million compared to $6.7 million for the year ended December 31, 2009. Other revenue for the year ended December 31, 2009 decreased $13.8 million from $20.5 million for the year ended December 31, 2008. Included in other revenue for the year ended December 31, 2010 is a $4.0 million gain on the sale of certain trademarks. Included in other revenue for the year ended December 31, 2009 is a $5.8 million gain on the sale of the South Carolina contract rights. Included in other revenue for the year ended December 31, 2008 is the ASO revenue from the West Tennessee contract which concluded October 31, 2008.

Health Benefits Expense

Expenses relating to health benefits for the year ended December 31, 2010, increased $314.8 million, or 7.1%, to $4.7 billion compared to $4.4 billion for the year ended December 31, 2009. Our HBR decreased to 81.6% for the year ended December 31, 2010 compared to 85.4% for the prior year. The decrease in health benefits expense as it compares to premium revenue for the year ended December 31, 2010 resulted primarily from moderating cost trends for current and prior periods, the latter of which generated revisions of estimates related to prior periods. In addition, we believe a less severe winter flu season and lower utilization of health services due to severe winter weather in some of our markets favorably impacted the ratio. HBR was also favorably impacted by the net effect of premium rate changes in connection with annual contract renewals.

Expenses relating to health benefits for the year ended December 31, 2009 increased $789.0 million, or 21.8% compared to that for the year ended December 31, 2008. The HBR for the year ended December 31, 2009 was 85.4% compared to 82.9% in 2008. Our 2009 results compared to 2008 reflect an increase in the HBR primarily as a result of increased outpatient costs experienced across the majority of our markets and membership base. The surge in membership in 2009 resulted in increased utilization and intensity of services, particularly as it relates to

emergency room services, ambulatory services and physician services. Historical experience indicates that new members generally utilize more services during the first two months of enrollment. Our 2009 results also reflect a significant increase in flu-related costs directly related to the onset of a severe off-season flu outbreak associated with the H1N1 virus, which has been noted to be particularly virulent among children, pregnant women, and other high-risk populations, all of whom together represent a significant portion of our membership. Additionally, our entry into the New Mexico market, with a higher HBR due to the benefit structure of the CoLTS program, contributed to the increase in HBR overall. In total, the increases in health benefits expense exceeded growth in premium revenues, thereby negatively impacting HBR for the year ended December 31, 2009.

Selling, General and Administrative Expenses

SG&A increased $58.0 million, or 14.7%, to $452.1 million for the year ended December 31, 2010 compared to $394.1 million for the year ended December 31, 2009. Our SG&A to total revenues ratio for the year ended December 31, 2010 was 7.8% compared to 7.6% in 2009. The increase in SG&A is primarily a result of increased salary and benefits expenses due to increased variable compensation accruals as a result of our operating performance for 2010 as well as moderate wage, benefits and workforce increases over the prior year. Our SG&A ratio remained relatively stable as the increased expense levels were matched by leverage gained through increased premium revenues.

SG&A decreased $41.8 million, or 9.6%, for the year ended December 31, 2009 compared to 2008. Our SG&A to total revenues ratio for the year ended December 31, 2009 was 7.6% compared to 9.8% in 2008. The decrease in the SG&A ratio in 2009 compared to 2008 is primarily a result of reductions in salary and benefits expenses due to lower variable compensation accruals related to our operating results in 2009. The decrease in the SG&A ratio is also the result of leverage gained through an increase in premium revenue through new market expansion and existing market growth and the termination of our ASO contract in West Tennessee in October 2008.

Premium Tax Expense

Premium taxes increased $9.6 million, or 7.2%, to $143.9 million for the year ended December 31, 2010 compared to $134.3 million for the year ended December 31, 2009. The increase in premium tax expense in 2010 compared to 2009 is attributable to increased premium revenues in the State of Tennessee primarily as a result of our entry into the TennCare CHOICES program in March 2010 and a premium tax rate increase in Tennessee effective July 2009. Additionally, premium revenue growth in the majority of other markets where premium tax is levied contributed to the increase. These factors were partially offset by the termination of premium tax in the State of Georgia in October 2009 which was subsequently reinstated at a lower rate in July 2010.

Premium taxes increased $40.5 million, or 43.2%, for the year ended December 31, 2009 compared to 2008. The increase in premium tax expense in 2009 compared to 2008 is a result of the commencement of the CoLTS program in New Mexico in August 2008, entry into Nevada in February 2009, adoption of premium tax in the State of New York effective January 2009, a premium tax rate increase in Tennessee effective July 2009 and growth in premium revenues across all markets where premium tax is levied. These increases were partially offset by the suspension of premium tax in the State of Georgia in October 2009.

Litigation Settlement

On August 13, 2008, we settled a *qui tam* litigation relating to certain marketing practices of our former Illinois health plan for a cash payment of $225.0 million without any admission of wrong-doing by us, our subsidiaries or affiliates. We also paid approximately $9.2 million to the relator for legal fees. Both payments were made during the three months ended September 30, 2008. As a result, we recorded a one-time expense in the amount of $234.2 million, or $199.6 million net of the related tax effects, in the year ended December 31, 2008 and reported a net loss. In June 2009, we recorded a $22.4 million tax benefit regarding the tax treatment of the settlement under an agreement in principle with the IRS which was formalized through a pre-filing agreement with the IRS in September 2009. The pre-filing agreement program permits taxpayers to resolve tax issues in advance of filing their corporate income tax returns. We do not anticipate that there will be any further material changes to the tax benefit associated with this settlement in future periods.

Interest Expense

Interest expense was $16.0 million, $16.3 million and $20.5 million for the years ended December 31, 2010, 2009 and 2008, respectively. The decreases are the result of scheduled and voluntary payments resulting in payment in full of all outstanding balances under our previously maintained Credit Agreement which we terminated in August 2009, as well as fluctuating interest rates for previous borrowings under the Credit Agreement.

Provision for Income Taxes

Income tax expense was $163.8 million, $52.1 million and $54.4 million for the years ended December 31, 2010, 2009 and 2008, respectively. The effective tax rate for the year ended December 31, 2010 was 37.5%. The effective tax rate for the year ended December 31, 2009 was significantly decreased due to a pre-filing agreement reached with the IRS in 2009 regarding the tax treatment of the 2008 *qui tam* litigation settlement payment resulting in an additional tax benefit of $22.4 million over what was recorded in 2008. Excluding the impact of the pre-filing agreement, the effective tax rate for the year ended December 31, 2010 compared to the year ended December 31, 2009 increased as a result of increases in non-deductible expenses as well as an increase in the blended state income tax rate. Additionally, excluding the impact of the tax benefits relating to the pre-filing agreement in 2009 and the settlement payment in 2008, the effective tax rate for the year ended December 31, 2009 decreased from the year ended December 31, 2008 due to a decrease in the blended state income tax rate.

Net Income (Loss)

Net income for 2010 was $273.4 million, or $5.40 per diluted share, compared to net income of $149.3 million, or $2.85 per diluted share in 2009 and a net loss of $56.6 million, or $1.07 per diluted share in 2008. Net income increased from 2009 to 2010 primarily as a result of moderating cost trends for current and prior periods, the latter of which generated revisions of estimates related to prior periods. The increase was also a result of premium growth, primarily driven by membership growth; expansion into the TennCare CHOICES program in the State of Tennessee; premium rate and mix changes; and our acquisition of the Medicaid contract rights from UHP in the State of New Jersey; each without an equal increase in health benefits expense. Net income increased from 2008 to 2009 primarily as a result of the one-time expense recorded in 2008 in connection with the settlement of the *qui tam* litigation equal to $234.2 million before the related tax benefit.

Liquidity and Capital Resources

We manage our cash, investments and capital structure so we are able to meet the short- and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our primary sources of liquidity are cash and cash equivalents, short- and long-term investments, and cash flows from operations. As of December 31, 2010, we had cash and cash equivalents of $763.9 million, short- and long-term investments of $869.2 million and restricted investments on deposit for licensure of $114.8 million. Cash, cash equivalents, and investments which are unregulated totaled $248.6 million at December 31, 2010.

Financing Activities

Convertible Senior Notes

As of December 31, 2010, we had $260.0 million outstanding in aggregate principal amount of 2.0% Convertible Senior Notes due May 15, 2012. The 2.0% Convertible Senior Notes are governed by an Indenture dated as of March 28, 2007 (the "Indenture"). The 2.0% Convertible Senior Notes are senior unsecured obligations of the Company and rank equal in right of payment with all of our existing and future senior debt and senior to all of our subordinated debt. The 2.0% Convertible Senior Notes bear interest at a rate of 2.0% per year, payable semiannually in arrears in cash on May 15 and November 15 of each year and mature on May 15, 2012, unless earlier repurchased or converted in accordance with the Indenture.

Upon conversion of the 2.0% Convertible Senior Notes, we will pay cash up to the principal amount of the 2.0% Convertible Senior Notes converted. With respect to any conversion value in excess of the principal amount, we have the option to settle the excess with cash, shares of our common stock, or a combination thereof based on a daily conversion value, as defined in the Indenture. The initial conversion rate for the 2.0% Convertible Senior Notes is 23.5114 shares of common stock per one thousand dollars of principal amount of 2.0% Convertible Senior Notes, which represents a 32.5% conversion premium based on the closing price of $32.10 per share of our common stock on March 22, 2007 and is equivalent to a conversion price of approximately $42.53 per share of common stock. Consequently, under the provisions of the 2.0% Convertible Senior Notes, if the market price of our common stock exceeds $42.53 we will be obligated to settle, in cash or shares of our common stock at our option, an amount equal to approximately $6.1 million for each dollar in share price that the market price of our common stock exceeds $42.53, or the conversion value in excess of the principal amount of the 2.0% Convertible Senior Notes. In periods prior to conversion, the 2.0% Convertible Senior Notes would also have a dilutive impact to earnings if the average market price of our common stock exceeds $42.53 for the period reported. At conversion, the dilutive impact would result if the conversion value in excess of the principal amount of the 2.0% Convertible Senior Notes, if any, is settled in shares of our common stock. The conversion rate is subject to adjustment in some events but will not be adjusted for accrued interest. In addition, if a "fundamental change" occurs prior to the maturity date, we will in some cases increase the conversion rate for a holder of 2.0% Convertible Senior Notes that elects to convert their 2.0% Convertible Senior Notes in connection with such fundamental change.

Concurrent with the issuance of the 2.0% Convertible Senior Notes, we purchased convertible note hedges covering, subject to customary anti-dilution adjustments, 6,112,964 shares of our common stock. The convertible note hedges are expected to reduce the potential dilution upon conversion of the 2.0% Convertible Senior Notes in the event that the market value per share of our common stock, as measured under the convertible note hedges, at the time of exercise is greater than the strike price of the convertible note hedges. Consequently, under the provisions of the convertible note hedges, we are entitled to receive cash or shares of our common stock in an amount equal to the conversion value in excess of the principal amount of the 2.0% Convertible Senior Notes from the counterparty to the convertible note hedges.

Also concurrent with the issuance of the 2.0% Convertible Senior Notes, we sold warrants to acquire, subject to customary anti-dilution adjustments, 6,112,964 shares of our common stock at an exercise price of $53.77 per share. If the average price of our common stock during a defined period ending on or about the settlement date exceeds the exercise price of the warrants, the warrants will be settled in shares of our common stock. Consequently, under the provisions of the warrant instruments, if the market price of our common stock exceeds $53.77 at exercise we will be obligated to settle in shares of our common stock an amount equal to approximately $6.1 million for each dollar in share price that the market price of our common stock exceeds $53.77 resulting in a dilutive impact to our earnings. In periods prior to exercise, the warrant instruments would also have a dilutive impact to earnings if the average market price of our common stock exceeds $53.77 for the period reported.

The convertible note hedges and warrants are separate transactions which do not affect holders' rights under the 2.0% Convertible Senior Notes.

Universal Automatic Shelf Registration

On December 15, 2008, we filed a universal automatic shelf registration statement with the Securities and Exchange Commission which enables us to sell, in one or more public offerings, common stock, preferred stock, debt securities and other securities at prices and on terms to be determined at the time of the applicable offering. The shelf registration provides us with the flexibility to publicly offer and sell securities at times we believe market conditions make such an offering attractive. Because we are a well-known seasoned issuer, the shelf registration statement was effective upon filing. No securities have been issued under the shelf registration.

Share Repurchase Program

Under the authorization of our Board of Directors, we maintain an ongoing share repurchase program. On September 15, 2010, the Board of Directors authorized a $200.0 million increase to the ongoing share repurchase program, bringing the total authorization to $400.0 million. The $400.0 million authorization is for repurchases of

our common stock made from and after August 5, 2009. Pursuant to this ongoing share repurchase program, we repurchased 3,748,669 shares of our common stock and placed them into treasury during the year ended December 31, 2010 at an aggregate cost of $138.5 million. As of December 31, 2010, we had remaining authorization to purchase up to an additional $224.3 million of shares of the Company's common stock under the ongoing share repurchase program.

Credit Agreement

We previously maintained a Credit Agreement that provided both a secured term loan and a senior secured revolving credit facility. On July 31, 2009, we paid the remaining balance of the secured term loan. Effective August 21, 2009, we terminated the Credit Agreement and related Pledge and Security Agreement. We had no outstanding borrowings under the Credit Agreement as of the effective date of termination.

Cash and Investments

Cash provided by operations was $401.9 million for the year ended December 31, 2010 compared to $147.0 million for the year ended December 31, 2009. The increase in cash flows was primarily a result of an increase in net income due to premium revenue growth across the majority of our existing products and markets as well as moderating cost trends for current and prior periods and an increase in cash flows generated from working capital changes. Cash flows generated from working capital changes was $59.2 million for the year ended December 31, 2010 compared to cash used in operating activities for working capital changes of $55.7 million for the year ended December 31, 2009. The increase in cash provided by working capital changes primarily resulted from a net increase in cash provided through changes in accounts payable, accrued expenses, contractual refunds payable and other current liabilities of $105.7 million primarily due to fluctuations in variable compensation accruals which are directly related to our achievement of financial performance goals and changes in the experience rebate accrual under our contract with the State of Texas. The increase in cash provided by working capital changes is further attributable to variability in the timing of receipts of premium from government agencies.

Cash used in investing activities was $80.7 million for the year ended December 31, 2010 compared to $296.6 million for the year ended December 31, 2009. The decrease in cash used in investing activities is due primarily to a decrease in the net purchases of investments of $230.9 million during the year ended December 31, 2010 compared to the year ended December 31, 2009, partially offset by our acquisition of the Medicaid contract rights from UHP for $13.4 million in March 2010. We currently anticipate total capital expenditures for 2011 to be between approximately $35.0 million and $45.0 million related primarily to technological infrastructure development and enhancement of core systems to increase scalability and efficiency.

Our investment policies are designed to preserve capital, provide liquidity and maximize total return on invested assets. As of December 31, 2010, our investment portfolio consisted primarily of fixed-income securities with a weighted average maturity of approximately twenty-two months. We utilize investment vehicles such as auction rate securities, certificates of deposit, commercial paper, corporate bonds, debt securities of government sponsored entities, Federally insured corporate bonds, money market funds, municipal bonds and U.S. Treasury securities. The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their funds. The weighted average taxable equivalent yield on consolidated investments as of December 31, 2010 was approximately 0.90%. As of December 31, 2010, we had total cash and investments of approximately $1.7 billion.

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The following table shows the types, percentages and average Standard and Poor's ("S&P") ratings of our holdings within our investment portfolio at December 31, 2010:

	Portfolio Percentage	Average S&P Rating
Auction rate securities	1.2%	AAA
Cash, bank deposits and commercial paper	4.1%	AAA
Certificates of deposit	8.6%	AAA
Corporate bonds	13.7%	A+
Debt obligations of government sponsored entities, Federally insured corporate bonds and U.S. Treasury securities	21.6%	AAA
Money market funds	33.4%	AAA
Municipal bonds	17.4%	AA+
	100.0%	AA+

As of December 31, 2010, $21.3 million of our investments were comprised of auction rate securities issued by student loan corporations established by various state governments. Since early 2008, auctions for these auction rate securities have failed, significantly decreasing our ability to liquidate these securities prior to maturity. As we cannot predict the timing of future successful auctions, if any, our auction rate securities are classified as available-for-sale and are carried at fair value within long-term investments. The weighted average life of our auction rate securities portfolio, based on the final maturity, is approximately twenty-two years. We currently believe that the $1.4 million net unrealized loss position that remains at December 31, 2010 on our auction rate securities portfolio is primarily due to liquidity concerns and not the creditworthiness of the underlying issuers. We currently have the intent to hold our auction rate securities to maturity, if required, or if and when market stability is restored with respect to these investments. During the year ended December 31, 2010, certain investments in auction rate securities were sold or called for net proceeds of $39.2 million, resulting in a $0.9 million net realized gain recorded in earnings, excluding the loss on the forward contract expiration of $1.2 million related to certain sales of auction rate securities.

Cash used in financing activities was $63.3 million for the year ended December 31, 2010 compared to $107.7 million for the year ended December 31, 2009. The decrease in cash used in financing activities is primarily due to repayments during 2009 of $44.3 million of borrowings under our previously maintained Credit Agreement, which was terminated effective August 21, 2009. The decrease in cash used in financing activities was further attributable to an increase in the change in bank overdrafts of $43.4 million and an increase in proceeds from employee stock option exercises and stock purchases of $15.8 million, partially offset by an increase in repurchases of our common stock of $68.8 million.

We believe that existing cash and investment balances and cash flow from operations will be sufficient to support continuing operations, capital expenditures and our growth strategy for at least 12 months. Our debt-to-total capital ratio at December 31, 2010 was 17.4%. We utilize the debt-to-total capital ratio as a measure, among others, of our leverage and financial flexibility. We believe our current debt-to-total capital ratio allows us flexibility to access debt financing should the need or opportunity arise; however the financial markets have experienced periods of volatility and disruption. Future volatility and disruption is possible and unpredictable. In the event we need access to additional capital, our ability to obtain such capital may be limited and the cost of any such capital will depend on the market condition and our financial position at the time we pursue additional financing.

The principal of our 2.0% Convertible Senior Notes may be repaid with proceeds from debt or equity financing, existing cash and investments, or a combination thereof. If we determine that debt or equity financing is appropriate, our access to these markets may be limited as our results of operations cannot be predicted. Additionally, any disruptions in the credit markets similar to that of the recent recession could further limit our flexibility in planning for, or reacting to, changes in our business and industry and addressing our future capital requirements. Further, to the extent the counterparties to the convertible note hedges are unwilling or unable to fulfill the obligations under the convertible note hedges, our financial condition could be materially adversely affected.

Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms.

Regulatory Capital and Dividend Restrictions

Our operations are conducted through our wholly-owned subsidiaries, which include Health Maintenance Organizations ("HMOs"), one health insuring corporation ("HIC") and one Prepaid Health Services Plan ("PHSP"). HMOs, HICs and PHSPs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to their stockholders. Additionally, certain state regulatory agencies may require individual regulated entities to maintain statutory capital levels higher than the state regulations. As of December 31, 2010, we believe our subsidiaries are in compliance with all minimum statutory capital requirements. The parent company may be required to fund minimum net worth shortfalls during 2011 using unregulated cash, cash equivalents and investments. We believe, as a result, that we will continue to be in compliance with these requirements at least through the end of 2011.

The National Association of Insurance Commissioners ("NAIC") has defined risk-based capital ("RBC") standards for HMOs and other entities bearing risk for health care coverage that are designed to measure capitalization levels by comparing each company's adjusted surplus to its required surplus ("RBC ratio"). The RBC ratio is designed to reflect the risk profile of HMOs. Within certain ratio ranges, regulators have increasing authority to take action as the RBC ratio decreases. There are four levels of regulatory action, ranging from (a) requiring insurers to submit a comprehensive plan to the state insurance commissioner, to (b) requiring the state insurance commissioner to place the insurer under regulatory control. Eight of our eleven states have adopted RBC as the measure of required surplus. At December 31, 2010, our consolidated RBC ratio for these states is estimated to be over 450% which compares to the required level of 200%, the level at which regulatory action would be initiated. In the remaining states, we have approximately four times the state required surplus level.

Contractual Obligations

The following table summarizes our material contractual obligations, including both on- and off-balance sheet arrangements, and our commitments at December 31, 2010 (in thousands):

Contractual Obligations	Total	2011	2012	2013	2014	2015	Thereafter
Long-term obligations	$ 267,800	$ 5,200	$ 262,600	$ —	$ —	$ —	$ —
Operating lease obligations	77,074	15,223	13,441	8,848	7,465	6,712	25,385
Total contractual obligations	$ 344,874	$ 20,423	$ 276,041	$ 8,848	$ 7,465	$ 6,712	$ 25,385

Long-term Obligations. Long-term obligations include amounts due under our 2.0% Convertible Senior Notes which mature May 15, 2012.

Operating Lease Obligations. Our operating lease obligations are primarily for payments under non-cancelable office space leases.

Off-Balance Sheet Arrangements

We have no investments, loans or any other known contractual arrangements with special-purpose entities, variable interest entities or financial partnerships. Effective July 1, 2010, we renewed a collateralized irrevocable standby letter of credit, initially issued on July 1, 2009 in an aggregate principal amount of approximately $17.4 million, to meet certain obligations under our Medicaid contract in the State of Georgia through our Georgia subsidiary, AMGP Georgia Managed Care Company, Inc. The letter of credit is collateralized through investments

held by AMGP Georgia Managed Care Company, Inc. Additionally, certain provisions of our 2.0% Convertible Senior Notes, convertible note hedges and warrant instruments are off-balance sheet arrangements, the details of which are described in Note 9 to our audited Consolidated Financial Statements included in Item 8. of this Annual Report on Form 10-K.

Commitments

As of December 31, 2010, the Company has no commitments.

Inflation

Although health care cost inflation has stabilized in recent years, the national health care cost inflation rate still significantly exceeds the general inflation rate. We use various strategies to reduce the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted care providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk***

Our audited Consolidated Balance Sheets include a number of assets whose fair values are subject to market risk. Due to our significant investment in fixed-income investments, interest rate risk represents a market risk factor affecting our consolidated financial position. Increases and decreases in prevailing interest rates generally translate into decreases and increases in fair values of those instruments. The financial markets have experienced periods of volatility and disruption, which have impacted liquidity and valuations of many financial instruments. While we do not believe we have experienced material adverse changes in the value of our cash, cash equivalents and investments, disruptions could impact the value of these assets and other financial assets we may hold in the future. There can be no assurance that future changes in interest rates, creditworthiness of issuers, prepayment activity, liquidity available in the market and other general market conditions will not have a material adverse impact on our results of operations, liquidity, financial position or cash flows.

As of December 31, 2010, substantially all of our investments were in high quality securities that have historically exhibited good liquidity.

The fair value of our fixed-income investment portfolio is exposed to interest rate risk — the risk of loss in fair value resulting from changes in prevailing market rates of interest for similar financial instruments. However, we have the ability to hold fixed-income investments to maturity. We rely on the experience and judgment of senior management to monitor and mitigate the effects of market risk. The allocation among various types of securities is adjusted from time-to-time based on market conditions, credit conditions, tax policy, fluctuations in interest rates and other factors. In addition, we place the majority of our investments in high-quality, liquid securities and limit the amount of credit exposure to any one issuer. As of December 31, 2010, an increase of 1.0% in interest rates on securities with maturities greater than one year would reduce the fair value of our fixed-income investment portfolio by approximately $13.6 million. Conversely, a reduction of 1.0% in interest rates on securities with maturities greater than one year would increase the fair value of our fixed-income investment portfolio by approximately $12.2 million. The above changes in fair value are impacted by securities in our portfolio that have a call provision feature. We believe this fair value presentation is indicative of our market risk because it evaluates each investment based on its individual characteristics. Consequently, the fair value presentation does not assume that each investment reacts identically based on a 1.0% change in interest rates.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
AMERIGROUP Corporation:

We have audited the accompanying consolidated balance sheets of AMERIGROUP Corporation and subsidiaries (the "Company") as of December 31, 2010 and 2009, and the related consolidated statements of operations and consolidated statements of stockholders' equity and cash flows for each of the years in the three-year period ended December 31, 2010. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of AMERIGROUP Corporation and subsidiaries as of December 31, 2010 and 2009, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2010, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), AMERIGROUP Corporation and subsidiaries' internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control — Integrated Framework* , issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 23, 2011 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP
Norfolk, Virginia
February 23, 2011

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Item 8. ***Financial Statements and Supplementary Data***

AMERIGROUP Corporation And Subsidiaries

Consolidated Balance Sheets
(Dollars in thousands, except for per share data)

	December 31, 2010	December 31, 2009
ASSETS		
Current assets:		
Cash and cash equivalents	$ 763,946	$ 505,915
Short-term investments	230,007	137,523
Premium receivables	83,203	104,867
Deferred income taxes	28,063	26,361
Provider and other receivables	32,861	33,083
Prepaid expenses	13,538	8,959
Other current assets	7,083	5,274
Total current assets	1,158,701	821,982
Long-term investments	639,165	711,196
Investments on deposit for licensure	114,839	102,780
Property, equipment and software, net	96,967	101,002
Other long-term assets	13,220	13,398
Goodwill	260,496	249,276
Total assets	$2,283,388	$1,999,634
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Claims payable	$ 510,675	$ 529,036
Accounts payable	7,023	4,685
Unearned revenue	103,067	98,298
Accrued payroll and related liabilities	71,253	37,311
Accrued expenses and other	114,260	77,191
Contractual refunds payable	44,563	12,776
Total current liabilities	850,841	759,297
Long-term convertible debt	245,750	235,104
Deferred income taxes	7,393	8,430
Other long-term liabilities	13,767	12,359
Total liabilities	1,117,751	1,015,190
Commitments and contingencies (Note 10)		
Stockholders' equity:		
Common stock, $0.01 par value. Authorized 100,000,000 shares; outstanding 48,167,229 and 50,638,474 at December 31, 2010 and 2009, respectively	554	546
Additional paid-in capital	543,611	494,735
Accumulated other comprehensive income	627	1,354
Retained earnings	864,003	590,632
	1,408,795	1,087,267
Less treasury stock at cost (7,759,234 and 3,956,560 shares at December 31, 2010 and 2009, respectively)	(243,158)	(102,823)
Total stockholders' equity	1,165,637	984,444
Total liabilities and stockholders' equity	$2,283,388	$1,999,634

See accompanying notes to consolidated financial statements.

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AMERIGROUP Corporation And Subsidiaries

Consolidated Statements of Operations
(Dollars in thousands, except for per share data)

	Years Ended December 31,		
	2010	2009	2008
Revenues:			
Premium	$ 5,783,458	$ 5,158,989	$ 4,366,359
Investment income and other	22,843	29,081	71,383
Total revenues	5,806,301	5,188,070	4,437,742
Expenses:			
Health benefits	4,722,106	4,407,273	3,618,261
Selling, general and administrative	452,069	394,089	435,876
Premium tax	143,896	134,277	93,757
Depreciation and amortization	35,048	34,746	37,385
Litigation settlement	—	—	234,205
Interest	16,011	16,266	20,514
Total expenses	5,369,130	4,986,651	4,439,998
Income (loss) before income taxes	437,171	201,419	(2,256)
Income tax expense	163,800	52,140	54,350
Net income (loss)	$ 273,371	$ 149,279	$ (56,606)
Net income (loss) per share:			
Basic net income (loss) per share	$ 5.52	$ 2.89	$ (1.07)
Weighted average number of common shares outstanding	49,522,202	51,647,267	52,816,674
Diluted net income (loss) per share	$ 5.40	$ 2.85	$ (1.07)
Weighted average number of common shares and dilutive potential common shares outstanding	50,608,008	52,309,268	52,816,674

See accompanying notes to consolidated financial statements.

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AMERIGROUP Corporation And Subsidiaries

Consolidated Statements of Stockholders' Equity
(Dollars in thousands)

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Treasury Stock		Total Stockholders' Equity
	Shares	Amount				Shares	Amount	
Balances at January 1, 2008	53,129,928	$ 532	$ 444,275	$ —	$ 497,959	25,713	$ (872)	$ 941,894
Common stock issued upon exercise of stock options, vesting of restricted stock grants, and purchases under the employee stock purchase plan	725,232	7	10,241	—	—	—	—	10,248
Compensation expense related to share-based payments	—	—	10,381	—	—	—	—	10,381
Tax benefit related to share-based payments	—	—	2,034	—	—	—	—	2,034
Employee stock relinquished for payment of taxes	(18,770)	—	—	—	—	18,770	(618)	(618)
Common stock repurchases	(1,163,027)	—	—	—	—	1,163,027	(30,647)	(30,647)
Unrealized loss on available-for-sale securities, net of tax	—	—	—	(4,022)	—	—	—	(4,022)
Other	—	—	(5)	—	—	—	—	(5)
Net loss	—	—	—	—	(56,606)	—	—	(56,606)
Balances at December 31, 2008	52,673,363	539	466,926	(4,022)	441,353	1,207,510	(32,137)	872,659
Common stock issued upon exercise of stock options, vesting of restricted stock grants, and purchases under the employee stock purchase plan	714,161	7	11,034	—	—	—	—	11,041
Compensation expense related to share-based payments	—	—	15,936	—	—	—	—	15,936
Tax benefit related to share-based payments	—	—	842	—	—	—	—	842
Employee stock relinquished for payment of taxes	(24,161)	—	—	—	—	24,161	(591)	(591)
Employee stock relinquished for stock option exercises	(11,322)	—	—	—	—	11,322	(344)	(344)
Common stock repurchases	(2,713,567)	—	—	—	—	2,713,567	(69,751)	(69,751)
Unrealized gain on held-to-maturity investment portfolio at time of transfer to available-for-sale, net of tax	—	—	—	3,030	—	—	—	3,030
Unrealized gain on available-for-sale securities, net of tax	—	—	—	2,346	—	—	—	2,346
Other	—	—	(3)	—	—	—	—	(3)
Net income	—	—	—	—	149,279	—	—	149,279
Balances at December 31, 2009	50,638,474	546	494,735	1,354	590,632	3,956,560	(102,823)	984,444
Common stock issued upon exercise of stock options, vesting of restricted stock grants, and purchases under the employee stock purchase plan	1,331,429	8	26,458	—	—	—	—	26,466
Compensation expense related to share-based payments	—	—	19,635	—	—	—	—	19,635
Tax benefit related to share-based payments	—	—	3,097	—	—	—	—	3,097
Employee stock relinquished for payment of taxes	(54,005)	—	—	—	—	54,005	(1,795)	(1,795)
Common stock repurchases	(3,748,669)	—	—	—	—	3,748,669	(138,540)	(138,540)
Unrealized loss on available-for-sale securities, net of tax	—	—	—	(727)	—	—	—	(727)
Other	—	—	(314)	—	—	—	—	(314)
Net income	—	—	—	—	273,371	—	—	273,371
Balances at December 31, 2010	48,167,229	$ 554	$ 543,611	$ 627	$ 864,003	7,759,234	$(243,158)	$ 1,165,637

See accompanying notes to consolidated financial statements.

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AMERIGROUP Corporation And Subsidiaries

Consolidated Statements of Cash Flows
(Dollars in thousands)

	Years Ended December 31,		
	2010	2009	2008
Cash flows from operating activities:			
Net income (loss)	$ 273,371	$ 149,279	$ (56,606)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	35,048	34,746	37,385
Loss on disposal or abandonment of property, equipment and software	354	585	644
Deferred tax (benefit) expense	(2,262)	818	(288)
Compensation expense related to share-based payments	19,635	15,936	10,381
Convertible debt non-cash interest	10,646	9,974	9,344
Impairment of goodwill	—	—	8,808
Gain on sale of intangible assets	(4,000)	—	—
Gain on sale of contract rights	—	(5,810)	—
Other	9,219	(167)	(441)
Changes in assets and liabilities increasing (decreasing) cash flows from operations:			
Premium receivables	21,664	(18,272)	(3,655)
Prepaid expenses, provider and other receivables and other current assets	(10,818)	(2,310)	41,183
Other assets	(691)	(1,146)	788
Claims payable	(18,361)	(7,071)	(5,066)
Accounts payable, accrued expenses, contractual refunds payable and other current liabilities	61,967	(43,758)	5,557
Unearned revenue	4,769	15,710	26,651
Other long-term liabilities	1,408	(1,480)	(409)
Net cash provided by operating activities	401,949	147,034	74,276
Cash flows from investing activities:			
Proceeds from sale of trading securities	12,000	5,850	—
Purchase of trading securities	—	—	(17,850)
Proceeds from sale of available-for-sale securities	1,063,119	299,239	121,039
Purchase of available-for-sale securities	(1,104,496)	(648,670)	(78,864)
Proceeds from redemption of held-to-maturity securities	—	273,125	617,025
Purchase of held-to-maturity securities	—	(194,851)	(644,431)
Purchase of property, equipment and software	(29,463)	(29,738)	(37,034)
Proceeds from redemption of investments on deposit for licensure	86,345	72,164	68,404
Purchase of investments on deposit for licensure	(98,737)	(79,574)	(73,897)
Proceeds from sale of intangible assets	4,000	—	—
Proceeds from sale of contract rights	—	5,810	—
Purchase of contract rights and related assets	(13,420)	—	—
Purchase price adjustment received	—	—	1,500
Release of restricted investments held as collateral	—	—	351,318
Net cash (used in) provided by investing activities	(80,652)	(296,645)	307,210
Cash flows from financing activities:			
Repayment of borrowings under credit facility	—	(44,318)	(84,028)
Net increase (decrease) in bank overdrafts	40,890	(2,492)	2,192
Payment of capital lease obligations	—	—	(368)
Customer funds administered	4,821	(2,725)	(5,259)
Proceeds from exercise of stock options and employee stock purchases	26,466	10,698	10,248
Repurchase of common stock shares	(138,540)	(69,751)	(30,647)
Tax benefit related to share-based payments	3,097	842	2,034
Net cash used in financing activities	(63,266)	(107,746)	(105,828)
Net increase (decrease) in cash and cash equivalents	258,031	(257,357)	275,658
Cash and cash equivalents at beginning of year	505,915	763,272	487,614
Cash and cash equivalents at end of year	$ 763,946	$ 505,915	$ 763,272
Supplemental disclosures of cash flow information:			
Cash paid for interest	$ 5,380	$ 6,302	$ 12,832
Cash paid for income taxes	$ 169,890	$ 51,745	$ 27,977
Supplemental disclosures non-cash information:			
Employee stock relinquished for payment of taxes	$ (1,795)	$ (591)	$ (618)
Employee stock relinquished for stock option exercises	$ —	$ (344)	$ —
Transfer of held-to-maturity securities to available-for-sale securities	$ —	$ 424,237	$ —
Transfer of held-to-maturity investments on deposit to available-for-sale investments on deposit	$ —	$ 98,458	$ —
Unrealized gain on held-to-maturity portfolio at time of transfer to available-for-sale, net of tax	$ —	$ 3,030	$ —
Unrealized (loss) gain on available-for-sale securities, net of tax	$ (727)	$ 2,346	$ (4,022)

See accompanying notes to consolidated financial statements.

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AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(Dollars in thousands, except for per share data)

(1) Corporate Organization and Principles of Consolidation

(a) Corporate Organization

AMERIGROUP Corporation, a Delaware corporation, through its wholly-owned subsidiaries, is a multi-state managed health care company focused on serving people who receive health care benefits through publicly funded health care programs, including Medicaid, Children's Health Insurance Program ("CHIP"), Medicaid expansion and Medicare Advantage. AMERIGROUP Corporation and its subsidiaries are collectively referred to as "the Company".

AMERIGROUP Corporation was incorporated in 1994 and began operations of its wholly-owned subsidiaries to develop, own and operate as managed health care companies. The Company operates in one business segment with a single line of business.

(b) Principles of Consolidation

The audited Consolidated Financial Statements include the financial statements of AMERIGROUP Corporation and its wholly-owned subsidiaries. All significant intercompany balances and transactions have been eliminated in consolidation. Additionally, certain reclassifications have been made to prior year amounts on the audited Consolidated Balance Sheets to conform to the current year presentation.

(c) Use of Estimates

Management has made a number of estimates and assumptions relating to the reporting of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the audited Consolidated Financial Statements and the reported amounts of revenues and expenses during the reporting period to prepare these audited Consolidated Financial Statements in conformity with U.S. generally accepted accounting principles ("GAAP"). Actual results could differ from those estimates. As discussed in Note 2 (i), these estimates and assumptions are particularly sensitive when recording claims payable and health benefits expenses.

(2) Summary of Significant Accounting Policies and Practices

(a) Cash Equivalents

The Company considers all highly liquid investments with original maturities of three months or less to be cash equivalents. The Company had cash equivalents of $742,141 and $481,585 at December 31, 2010 and 2009, respectively. Cash equivalents at December 31, 2010 consisted of certificates of deposit, commercial paper, corporate bonds, money market funds, municipal bonds, and U.S. Treasury securities. Cash equivalents at December 31, 2009 consisted of certificates of deposit, commercial paper, corporate bonds, debt securities of government sponsored entities, money market funds and municipal bonds.

(b) Fair Value Measurements

The fair value of a financial instrument is the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The following methods and assumptions were used to estimate the fair value of each class of financial instruments:

Cash, premium receivables, provider and other receivables, prepaid expenses, other current assets, claims payable, accounts payable, unearned revenue, accrued payroll and related liabilities, accrued expenses and other current liabilities and contractual refunds payable: These financial instruments are carried at cost which approximates fair value because of the short maturities of these items.

AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

Cash equivalents, short-term investments, long-term investments, investments on deposit for licensure, cash surrender value of life insurance policies (included in other long-term assets), deferred compensation (included in other long-term liabilities) and the forward contract related to certain auction rate securities (included in other long-term assets at December 31, 2009): Fair values for these items are determined based upon quoted market prices or discounted cash flow analyses.

Convertible Senior Notes: The estimated fair value of the Company's 2.0% Convertible Senior Notes is determined based upon a quoted market price.

Additional information regarding fair value measurements is included in Note 3, *Fair Value Measurements*.

(c) Short- and Long-Term Investments and Investments on Deposit for Licensure

Short- and long-term investments and investments on deposit for licensure at December 31, 2010 and 2009 consisted of investment vehicles such as auction rate securities, certificates of deposit, commercial paper, corporate bonds, debt securities of government sponsored entities, Federally insured corporate bonds, money market funds, municipal bonds and U.S. Treasury securities. The Company considers all investments with original maturities greater than three months but less than or equal to twelve months to be short-term investments. At December 31, 2010, all of the Company's debt securities are classified as available-for-sale. Available-for-sale securities are carried at fair value with changes in fair value reported in accumulated other comprehensive income until realized through the sale or maturity of the security or at the time at which an other-than-temporary-impairment is determined.

As a condition for licensure by various state governments to operate health maintenance organizations ("HMOs"), health insuring corporations ("HICs") or prepaid health services plans ("PHSPs"), the Company is required to maintain certain funds on deposit, in specific dollar amounts based on either formulas or set amounts, with or under the control of the various departments of insurance. The Company purchases interest-bearing investments with a fair value equal to or greater than the required dollar amount. The interest that accrues on these investments is not restricted and is available for withdrawal.

Effective July 1, 2009, the Company began reporting all of the debt securities in its investment portfolio as available-for-sale, other than certain auction rate securities that were subject to a forward contract and continued to be classified as trading securities until sold in 2010. The decision to reclassify the securities as available-for-sale is intended to provide the Company with the opportunity to improve liquidity and increase investment returns through prudent investment management while providing financial flexibility in determining whether to hold those securities to maturity. Additional information regarding the reclassification of debt securities as well as additional information regarding the purchase amount, realized gains, realized losses and fair value for trading securities held at December 31, 2009 is included in Note 4, *Short- and Long-Term Investments and Investments on Deposit for Licensure*. Additional information regarding the sale of certain auction rate securities that were subject to a forward contract and continued to be classified as trading securities until sold in 2010 is included in Note 3, *Fair Value Measurements*.

(d) Property and Equipment

Property and equipment are stated at cost less accumulated depreciation and amortization. Depreciation and amortization expense on property and equipment is calculated on the straight-line method over the estimated useful lives of the assets. Leasehold improvements are amortized on the straight-line method over the shorter of the lease term or estimated useful lives of the assets. The estimated useful lives are as follows:

Leasehold improvements	3-15 years
Furniture and fixtures	7 years
Equipment	3-5 years

AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

(e) Software

Software is stated at cost less accumulated amortization. Software is amortized over its estimated useful life of three to ten years, using the straight-line method.

(f) Other assets

Other assets include cash surrender value of life insurance policies, net amortizable intangible assets acquired in business combinations, debt issuance costs, deposits, cash on deposit for payment of claims under administrative services only ("ASO") arrangements and at December 31, 2009, forward contract rights related to certain auction rate securities. Intangible assets with estimable useful lives are amortized over their respective estimated useful lives to their estimated residual values and reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable.

(g) Goodwill and Other Intangibles

Goodwill represents the excess of cost over fair value of businesses acquired. Goodwill and intangible assets acquired in a business combination and determined to have indefinite useful lives are not amortized, but instead tested for impairment at least annually. The Company performs its annual impairment review of goodwill and indefinite lived intangible assets at December 31 and when a triggering event occurs between annual impairment tests.

(h) Impairment of Long-Lived Assets

Long-lived assets, such as property and equipment and purchased intangibles subject to amortization, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized by the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be disposed of would be separately presented in the audited Consolidated Balance Sheets and reported at the lower of the carrying amount or fair value less costs to sell, and would no longer be depreciated. The assets and liabilities of a group classified as held for sale would be presented separately in the appropriate asset and liability sections of the audited Consolidated Balance Sheets. No impairment of long-lived assets was recorded in 2010, 2009 or 2008.

Goodwill is tested annually for impairment, and is tested for impairment more frequently if events and circumstances indicate that the asset might be impaired. An impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. This determination is made at the reporting unit level and consists of two steps. First, the fair value of a reporting unit is determined and compared to its carrying amount. Second, if the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation on a business acquisition. The residual fair value after this allocation is the implied fair value of the reporting unit goodwill.

(i) Claims Payable

Accrued health benefits expenses for claims associated with the provision of services to the Company's members (including hospital inpatient and outpatient services, physician services, pharmacy and other ancillary services) include amounts billed and not paid and an estimate of costs incurred for unbilled services provided. These estimates are principally based on historical payment patterns while taking into consideration variability in those patterns using actuarial techniques. In addition, claims processing costs are accrued based on an estimate of the

costs necessary to process unpaid claims. Claims payable are reviewed and adjusted periodically and, as adjustments are made, differences are included in current operations.

(j) Contractual Refunds Payable

Included in contractual refunds payable is a liability for contractual premium. Our contracts in the States of Maryland, Florida, New Jersey and Virginia contain provisions relating to the amount of profit that can be earned. Depending on the contract, these profit collars are determined based on items such as minimum medical loss ratios or underwriting gain limitations and can be based on a calendar year or a state fiscal year basis. Medical loss ratio calculations typically limit the medical expenses as a percentage of revenue to a predetermined contractual percentage. Underwriting gain limitations limit the income before taxes and investment income to a predetermined percentage. Accruals for these refunds payable are reflected as reductions to premium revenue. Any adjustment made to the estimated liability as a result of final settlement is included in current operations.

Experience rebate payable, included in contractual refunds payable, consists of estimates of amounts due under contracts with the State of Texas. These amounts are computed based on a percentage of the contract profits as defined in the contract with the State. The profitability computation includes premium revenue earned from the State less paid medical and administrative costs incurred and estimated unpaid claims payable for the applicable membership. The unpaid claims payable estimates are based on historical payment patterns using actuarial techniques. A final settlement is generally made 334 days after the contract period ends using paid claims data and is subject to audit by the State of Texas any time thereafter. Accruals for this rebate payable is reflected as a reduction in premium revenue. Any adjustment made to the experience rebate payable as a result of final settlement is included in current operations.

(k) Premium Revenue

Premium revenue is recorded based on membership and premium information from each government agency with whom the Company contracts to provide services. Premiums are due monthly and are recognized as revenue during the period in which the Company is obligated to provide services to members. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Adjustments to eligibility lists produced by the government agencies result from retroactive application of enrollment or disenrollment of members or classification changes between rate categories. The Company estimates the amount of retroactive premium owed to or from the government agencies each period and adjusts premium revenue accordingly. In all of the states in which the Company operates, except Florida, New Mexico, Tennessee and Virginia, the Company is eligible to receive supplemental payments for newborns and/or obstetric deliveries. In some states, the level of payment is determined based on the health status of the newborn. Each state contract is specific as to what is required before payments are generated. Upon delivery of a newborn, each state is notified according to the contract. Revenue is recognized in the period that the delivery occurs and the related services are provided to the Company's member. Additionally, in some states, supplemental payments are received for certain services such as high cost drugs and early childhood prevention screenings. Any amounts that have been earned and have not been received from the state by the end of the period are recorded on the balance sheet as premium receivables.

Additionally, delays in annual premium rate changes require that the Company defer the recognition of any increases to the period in which the premium rates become final. The time lag between the effective date of the premium rate increase and the final contract can and has been delayed one quarter or more. The value of the impact can be significant in the period in which it is recognized dependent on the magnitude of the premium rate change, the membership to which it applies and the length of the delay between the effective date and the final contract date.

AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

(l) Stop-Loss Coverage

Stop-loss premiums, net of recoveries, are included in health benefits expense in the accompanying audited Consolidated Statements of Operations.

(m) Stock-Based Compensation

Stock-based compensation expense related to share-based payments are recorded in accordance with GAAP, whereby it is required to measure the cost of employee services received in exchange for an award of equity instruments based on the grant date fair value of the award. The fair value of employee share options and similar instruments is estimated using option-pricing models. That cost is recognized over the period during which an employee is required to provide service in exchange for the award, which is generally quarterly over four years.

(n) Premium Tax

Taxes based on premium revenues are currently paid by all of the Company's health plan subsidiaries except in the States of Florida and Virginia. The State of Georgia repealed its premium tax levy effective October 1, 2009 which was subsequently reinstated at a lower rate in July 2010. As of December 31, 2010, premium taxes range from 1.75% to 7.50% of premium revenue or are calculated on a per member per month basis.

(o) Income Taxes

The Company accounts for income taxes using the asset and liability method. The objective of the asset and liability method is to establish deferred tax assets and liabilities for the temporary differences between the financial reporting basis and the tax basis of the Company's assets and liabilities at enacted tax rates expected to be in effect when the Company realizes such amounts. On a quarterly basis, the Company's tax liability is estimated based on enacted tax rates, estimates of book-to-tax differences in income, and projections of income that will be earned in each taxing jurisdiction.

After tax returns for the applicable year are filed, the estimated tax liability is adjusted to the actual liability per the filed state and Federal tax returns. Historically, the Company has not experienced significant differences between its estimates of tax liability and its actual tax liability.

Similar to other companies, the Company sometimes faces challenges from the tax authorities regarding the amount of taxes due. Positions taken on the tax returns are evaluated and benefits are recognized only if it is more likely than not that the position will be sustained on audit. Based on the Company's evaluation of its tax positions, it is believed that potential tax exposures have been recorded appropriately.

In addition, the Company is periodically audited by state and Federal tax authorities and these audits can result in proposed assessments. The Company believes that its tax positions comply with applicable tax law and, as such, will vigorously defend its positions on audit. The Company believes that it has adequately provided for any reasonable foreseeable outcome related to these matters. Although the ultimate resolution of these audits may require additional tax payments, it is not anticipated that any additional tax payments would have a material impact to earnings.

The *qui tam* litigation settlement payment in 2008 (see Note 13) had a significant impact on tax expense and the effective tax rates for 2009 and 2008 due to the fact that a portion of the settlement payment is not deductible for income tax purposes. At December 31, 2008, the estimated tax benefit associated with the *qui tam* settlement payment was $34,566. In 2009, the Company recorded an additional $22,449 tax benefit under a pre-filing agreement with the Internal Revenue Service ("IRS"). The pre-filing agreement program permits taxpayers to resolve tax issues in advance of filing their corporate income tax returns. The Company does not anticipate that there will be any further material changes to the tax benefit associated with this litigation settlement in future periods.

AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

(p) Net Income (Loss) Per Share

Basic net income (loss) per share has been computed by dividing net income (loss) by the weighted average number of common shares outstanding. Diluted net income (loss) per share reflects the potential dilution that could occur assuming the inclusion of dilutive potential common shares and has been computed by dividing net income (loss) by the weighted average number of common shares and dilutive potential common shares outstanding. Dilutive potential common shares include all outstanding stock options, convertible debt securities and warrants after applying the treasury stock method to the extent the potential common shares are dilutive.

(q) Recent Accounting Standards

Intangibles — Goodwill and Other

In December 2010, the Financial Accounting Standards Board ("FASB") issued new guidance related to performing the goodwill impairment test for reporting units with zero or negative carrying amounts. The new guidance eliminates an entity's ability to assert that it does not need to perform Step 2 of the goodwill impairment test based solely on the fact that a business unit's carrying amount is zero or negative. Entities will now be required to perform Step 2 of the goodwill impairment test if it is more likely than not that a goodwill impairment exists as a result of any adverse qualitative factors. The new guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Company does not anticipate that the adoption of this new guidance will materially impact its financial position, results of operations or cash flows.

Business Combinations

In December 2010, the FASB issued new guidance on business combinations to clarify that if a public entity presents comparative financial statements, the entity should disclose revenue and earnings of the combined entity as though the business combination that occurred during the current year had occurred as of the beginning of the prior annual reporting period and to include a description of the nature and amount of material, nonrecurring pro forma adjustments directly attributable to the business combination included in the reported pro forma revenue and earnings. This new guidance is effective prospectively for business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2010. Future acquisitions will be accounted for under this guidance.

(r) Risks and Uncertainties

The Company's profitability depends in large part on accurately predicting and effectively managing health benefits expense. The premium and benefit structure is continually reviewed to reflect the underlying claims experience and revised actuarial data; however, several factors could adversely affect the health benefits expense. Certain of these factors, which include changes in health care practices, cost trends, inflation, new technologies, major epidemics or pandemics, natural disasters and malpractice litigation, are beyond any health plan's control and could adversely affect the Company's ability to accurately predict and effectively control health care costs. Costs in excess of those anticipated could have a material adverse effect on the Company's results of operations.

At December 31, 2010, the Company served members who received health care benefits through contracts with the regulatory entities in the jurisdictions in which it operates. For the year ended December 31, 2010, the Texas contract represented approximately 23% of premium revenues and the Tennessee, Georgia and Maryland contracts represented approximately 15%, 12% and 11% of premium revenues, respectively. The Company's state contracts have terms that are generally one- to two-years in length, some of which contain optional renewal periods at the discretion of the individual state. Some contracts also contain a termination clause with notification periods generally ranging from 30 to 180 days. At the termination of these contracts, re-negotiation of terms or the requirement to enter into a re-bidding or reprocurement process is required to execute a new contract. If these

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Notes to Consolidated Financial Statements — (Continued)

contracts were not renewed on favorable terms to the Company, the Company's financial position, results of operations or cash flows could be materially adversely affected.

(3) Fair Value Measurements

Assets and liabilities recorded at fair value in the audited Consolidated Balance Sheets are categorized based upon a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include:

Tier Level	Tier Definition
Level 1	Observable inputs such as quoted prices in active markets.
Level 2	Inputs other than quoted prices in active markets that are either directly or indirectly observable.
Level 3	Unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

Transfers between levels, as a result of changes in the inputs used to determine fair value, are recognized as of the beginning of the reporting period in which the transfer occurs. There were no transfers between levels for the year ended December 31, 2010.

Assets

The Company's assets measured at fair value on a recurring basis at December 31, 2010 and 2009 were as follows:

		Fair Value Measurements at Reporting Date Using		
	2010	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash equivalents	$ 742,141	$ 565,418	$ 176,723	$ —
Money market funds	20,009	20,009	—	—
Available-for-sale securities:				
Auction rate securities	21,293	—	—	21,293
Certificates of deposit	13,651	—	13,651	—
Commercial paper	14,793	—	14,793	—
Corporate bonds	237,916	—	237,916	—
Debt securities of government sponsored entities	332,051	332,051	—	—
Federally insured corporate bonds	21,454	21,454	—	—
Municipal bonds	300,817	—	300,817	—
U.S. Treasury securities	21,721	21,721	—	—
Total assets measured at fair value	$ 1,725,846	$ 960,653	$ 743,900	$ 21,293

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AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

		Fair Value Measurements at Reporting Date Using		
	2009	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash equivalents	$ 481,585	$ 471,326	$ 10,259	$ —
Auction rate securities (trading)	10,835	—	—	10,835
Forward contract related to auction rate securities	1,165	—	—	1,165
Money market funds	21,978	21,978	—	—
Available-for-sale securities:				
Auction rate securities	46,003	—	—	46,003
Certificates of deposit	36,155	—	36,155	—
Commercial paper	8,992	—	8,992	—
Corporate bonds	210,163	—	210,163	—
Debt securities of government sponsored entities	382,976	382,976	—	—
Federally insured corporate bonds	47,008	47,008	—	—
Municipal bonds	165,681	—	165,681	—
U.S. Treasury securities	21,294	21,294	—	—
Total assets measured at fair value	$ 1,433,835	$ 944,582	$ 431,250	$ 58,003

For the years ended December 31, 2010 and 2009, a net unrealized loss of $1,201 and a net unrealized gain of $8,578, respectively, was recorded to accumulated other comprehensive income as a result of changes in fair value for investments classified as available-for-sale.

The following table presents the changes in the Company's assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3), for the years ended December, 31 2010 and 2009:

	2010	2009
Balance at beginning of period	$ 58,003	$ 73,654
Total net realized (losses) gains included in earnings	(290)	224
Total net unrealized gains included in other comprehensive income	2,790	2,225
Sales and calls by issuers	(39,210)	(18,100)
Balance at end of period	$ 21,293	$ 58,003

At December 31, 2010 and 2009, the Company did not elect the fair value option available under current guidance for any financial assets and liabilities that were not required to be measured at fair value.

The Company has invested in auction rate securities issued by student loan corporations established by various state governments which are reflected at fair value and included in long-term investments in the accompanying audited Consolidated Balance Sheets. The auction events for these securities failed during early 2008 and have not resumed. Therefore, the estimated fair values of these securities have been determined utilizing discounted cash flow analyses as of December 31, 2010 and 2009. These analyses consider, among other items, the creditworthiness of the issuer, the timing of the expected future cash flows, including the final maturity associated with the securities, and an assumption of when the next time the security is expected to have a successful auction. These securities were also compared, when possible, to other observable and relevant market data. As the timing of future successful auctions, if any, cannot be predicted, auction rate securities are classified as long-term.

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Notes to Consolidated Financial Statements — (Continued)

During the years ended December 31, 2010 and 2009, proceeds from the sale or call of certain investments in auction rate securities, the net realized gains and the amount of prior period net unrealized losses reclassified from accumulated other comprehensive income on a specific-identification basis were as follows (excludes the impact of the forward contract discussed below):

	December 31,	
	2010	2009
Proceeds from sale or call of auction rate securities	$ 39,210	$ 18,100
Net realized gain recorded in earnings	875	1,073
Net unrealized loss reclassified from accumulated other comprehensive income, included in realized gain above	(290)	—

During the fourth quarter of 2008, the Company entered into a forward contract with a registered broker-dealer, at no cost, which provided the Company with the ability to sell certain auction rate securities to the registered broker-dealer at par within a defined timeframe, beginning June 30, 2010. These securities were classified as trading securities because the Company did not intend to hold these securities until final maturity. Trading securities are carried at fair value with changes in fair value recorded in earnings. The value of the forward contract was estimated using a discounted cash flow analysis taking into consideration the creditworthiness of the counterparty to the agreement. The forward contract was included in other long-term assets. As of June 30, 2010, all of the remaining trading securities under the terms of this forward contract were repurchased by the broker-dealer; therefore, the forward contract expired and a realized loss of $1,165 was recorded during the year ended December 31, 2010, which was largely offset by recovery of the related auction rate securities at par.

Liabilities

The estimated fair value of the 2.0% Convertible Senior Notes is determined based upon a quoted market price. As of December 31, 2010 and 2009, the fair value of the borrowings under the 2.0% Convertible Senior Notes was $303,550 and $246,025, respectively, compared to the face value of $260,000.

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Notes to Consolidated Financial Statements — (Continued)

(4) Short- and Long-Term Investments and Investments on Deposit for Licensure

The amortized cost, gross unrealized holding gains, gross unrealized holding losses and fair value for available-for-sale short- and long-term investments and investments on deposit for licensure held at December 31, 2010 were as follows:

	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses	Fair Value
Auction rate securities, maturing in greater than ten years	$ 22,650	$ —	$ 1,357	$ 21,293
Cash equivalents, maturing within one year	306	—	—	306
Certificates of deposit, maturing within one year	13,651	—	—	13,651
Commercial paper, maturing within one year	14,797	—	4	14,793
Corporate bonds, maturing within one year	105,826	555	10	106,371
Corporate bonds, maturing between one year and five years	129,949	1,772	176	131,545
Debt securities of government sponsored entities, maturing within one year	170,209	416	—	170,625
Debt securities of government sponsored entities, maturing between one year and five years	161,684	207	465	161,426
Federally insured corporate bonds, maturing within one year	21,097	360	3	21,454
Money market funds, maturing within one year	20,009	—	—	20,009
Municipal bonds, maturing within one year	101,572	40	13	101,599
Municipal bonds, maturing between one year and five years	29,539	129	24	29,644
Municipal bonds, maturing between five years and ten years	121,547	964	1,171	121,340
Municipal bonds, maturing in greater than ten years	48,576	12	354	48,234
U.S. Treasury securities, maturing within one year	18,113	52	—	18,165
U.S. Treasury securities, maturing between one year and five years	3,479	78	1	3,556
Total	$ 983,004	$ 4,585	$ 3,578	$984,011

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Notes to Consolidated Financial Statements — (Continued)

The amortized cost, gross unrealized holding gains, gross unrealized holding losses and fair value for available-for-sale short- and long-term investments and investments on deposit for licensure held at December 31, 2009 were as follows:

	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses	Fair Value
Auction rate securities, maturing between one year and five years	$ 4,000	$ —	$ 231	$ 3,769
Auction rate securities, maturing in greater than ten years	46,150	—	3,916	42,234
Cash equivalents, maturing within one year	414	—	—	414
Certificates of deposit, maturing within one year	36,150	5	—	36,155
Commercial paper, maturing within one year	8,989	3	—	8,992
Corporate bonds, maturing within one year	45,722	627	1	46,348
Corporate bonds, maturing between one year and five years	162,017	1,897	99	163,815
Debt securities of government sponsored entities, maturing within one year	168,181	868	22	169,027
Debt securities of government sponsored entities, maturing between one year and five years	212,588	1,427	66	213,949
Federally insured corporate bonds, maturing within one year	22,040	316	—	22,356
Federally insured corporate bonds, maturing between one year and five years	24,200	459	7	24,652
Money market funds, maturing within one year	21,978	—	—	21,978
Municipal bonds, maturing within one year	22,612	18	3	22,627
Municipal bonds, maturing between one year and five years	15,271	138	6	15,403
Municipal bonds, maturing between five years and ten years	32,632	300	57	32,875
Municipal bonds, maturing in greater than ten years	94,366	415	5	94,776
U.S. Treasury securities, maturing within one year	16,189	8	13	16,184
U.S. Treasury securities, maturing between one year and five years	4,959	151	—	5,110
Total	$ 938,458	$ 6,632	$ 4,426	$940,664

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Notes to Consolidated Financial Statements — (Continued)

As of December 31, 2010, the Company had divested all of its trading securities, which consisted only of auction rate securities (see Note 3). The purchase amount, realized gains, realized losses and fair value for trading securities held at December 31, 2009 were as follows:

	Purchase Amount	Realized Gains	Realized Losses	Fair Value
2009:				
Auction rate securities, maturing in greater than ten years	$ 12,000	$ —	$ 1,165	$ 10,835

The following tables show the fair value of the Company's available-for-sale investments with unrealized losses that are not deemed to be other-than-temporarily impaired at December 31, 2010 and 2009. Investments are aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position:

	Less than 12 Months			12 Months or Greater		
	Fair Value	Gross Unrealized Holding Losses	Total Number of Securities	Fair Value	Gross Unrealized Holding Losses	Total Number of Securities
2010:						
Auction rate securities	$ —	$ —	—	$ 21,293	$ 1,357	6
Commercial paper	19,495	4	8			
Corporate bonds	71,278	186	37	—	—	—
Debt securities of government sponsored entities	86,881	465	29	—	—	—
Federally insured corporate bond	4,036	3	1	—	—	—
Municipal bonds	160,860	1,562	64	—	—	—
U.S. Treasury securities	9,564	1	3	—	—	—
Total temporarily impaired securities	$ 352,114	$ 2,221	142	$ 21,293	$ 1,357	6

	Less than 12 Months			12 Months or Greater		
	Fair Value	Gross Unrealized Holding Losses	Total Number of Securities	Fair Value	Gross Unrealized Holding Losses	Total Number of Securities
2009:						
Auction rate securities	$ —	$ —	—	$ 46,003	$ 4,147	13
Corporate bonds	40,971	100	32	—	—	—
Debt securities of government sponsored entities	44,881	88	13	—	—	—
Federally insured corporate bond	4,076	7	1	—	—	—
Municipal bonds	17,771	71	7	—	—	—
U.S. Treasury securities	9,420	13	2	—	—	—
Total temporarily impaired securities	$ 117,119	$ 279	55	$ 46,003	$ 4,147	13

The temporary declines in value at December 31, 2010 and 2009 are primarily due to fluctuations in short-term market interest rates and the lack of liquidity of auction rate securities. Auction rate securities that have been in an

unrealized loss position for greater than 12 months have experienced losses due to the lack of liquidity for these instruments, not as a result of impairment of the underlying debt securities. Additionally, the Company does not intend to sell any of these securities prior to maturity or recovery and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other-than-temporary impairment for these securities.

Effective July 1, 2009, the Company began reporting all of the debt securities in its investment portfolio as available-for-sale, other than certain auction rate securities that were subject to a forward contract and continued to be classified as trading securities until sold in 2010 (see Note 3). The change resulted in the transfer to available-for-sale of $397,369 in held-to-maturity securities and $80,761 in held-to-maturity investments on deposit, with unrealized gains of $4,648 and $464, respectively, and the transfer to available-for-sale of $26,868 in held-to-maturity securities and $17,697 in held-to-maturity investments on deposit, with unrealized losses of $193 and $54, respectively. The unrealized gains and losses, net of the related tax effects, were recorded to accumulated other comprehensive income.

(5) Property, Equipment and Software, Net

Property, equipment and software, net at December 31, 2010 and 2009 is summarized as follows:

	2010	2009
Leasehold improvements	$ 35,997	$ 33,799
Furniture and fixtures	21,742	21,169
Equipment	60,924	67,691
Software	152,987	135,036
	271,650	257,695
Less accumulated depreciation and amortization	(174,683)	(156,693)
	$ 96,967	$ 101,002

Depreciation and amortization expense on property and equipment was $12,795, $15,506 and $16,321 for the years ended December 31, 2010, 2009 and 2008, respectively. Amortization expense on software was $20,349, $16,392 and $14,255 for the years ended December 31, 2010, 2009 and 2008, respectively.

(6) Market Updates

(a) Awards and Acquisitions

Medicare Advantage

In June 2010, the Company received approval from the Centers for Medicare & Medicaid Services ("CMS") to add Tarrant County to its Medicare Advantage service area in Texas, and to add Rutherford County to its Medicare Advantage service area in Tennessee. In addition, CMS approved expansion of the Company's Medicare Advantage plans to cover traditional Medicare beneficiaries in addition to the existing special needs beneficiaries already covered in Texas, Tennessee and New Mexico. These approvals allow the Company to begin serving Medicare members in the expanded areas effective January 1, 2011.

Texas

In May 2010, the Texas Health and Human Services Commission ("HHSC") announced that the Company's Texas health plan was selected through a competitive procurement to expand health care coverage to seniors and people with disabilities in the six-county service area surrounding Fort Worth, Texas. AMERIGROUP Texas, Inc. began serving approximately 27,000 STAR+PLUS members in that service area on February 1, 2011, a portion of

which were previously the Company's members under an ASO contract. AMERIGROUP Texas, Inc. is one of two health plans awarded this expansion contract; however, AMERIGROUP Texas, Inc. is currently serving all STAR+PLUS members in the Fort Worth market while the other health plan completes its readiness review. If and when that second health plan becomes operational, the members will be provided an opportunity to choose between health plans.

Tennessee

On March 1, 2010, the Company's Tennessee health plan began offering long-term care services to existing members through the State's TennCare CHOICES program. The program, created as a result of the Long Term Care Community Choices Act of 2008, is an expansion program offered through amendments to existing Medicaid managed care contracts. TennCare CHOICES focuses on promoting independence, choice, dignity and quality of life for long-term care Medicaid managed care recipients by offering members the option to live in their own homes while receiving long-term care and other medical services.

New Jersey

On March 1, 2010, the Company's New Jersey health plan acquired the Medicaid contract rights and rights under certain provider agreements of University Health Plans, Inc. ("UHP") for strategic reasons. The purchase price of $13,420 was financed through available cash. The entire purchase price was allocated to goodwill and other intangibles, which includes $2,200 of specifically identifiable intangibles allocated to the rights to the Medicaid service contract and the assumed provider contracts. Intangible assets related to the rights to the Medicaid service contract are being amortized over a period of approximately 117 months based on a projected disenrollment rate of members in this market. Intangible assets related to the provider network are being amortized over 120 months on a straight-line basis.

(b) Pending Contractual Revisions

Texas

HHSC is currently drafting a request for proposal ("RFP") for the re-bid of its entire managed care program in the State of Texas. The Company anticipates the release of the RFP and HHSC's selection of vendors under the new contract will occur sometime in 2011 with details regarding implementation dates dependent on the timing of the award. If the Company is not awarded this contract through the re-bidding process, the Company's results of operations, financial position or cash flows in future periods could be materially and adversely affected.

Georgia

The Company's Temporary Assistance for Needy Families ("TANF") and CHIP contract between its Georgia health plan and the State of Georgia expires June 30, 2011 with the State's option to renew the contract for one additional one-year term. The State has notified the Company of its intent to renew its contract effective July 1, 2011 and to amend the Company's existing contract to include an option to renew for two additional one-year terms.

(c) Market Exits

South Carolina

The Company's South Carolina health plan was licensed as a HMO and became operational in November 2007 with the TANF population, followed by a separate CHIP contract in May 2008. On March 1, 2009, the South Carolina health plan sold its rights to serve Medicaid members pursuant to the contract with the State of South Carolina for $5,810, and recorded a gain which is included in investment income and other revenues for the year ended December 31, 2009. As a result of this transaction, the Company's South Carolina health plan does not currently serve any members. Costs recorded to discontinue operations in South Carolina were not material to the Company's results of operations, financial position or cash flows.

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Notes to Consolidated Financial Statements — (Continued)

District of Columbia

On March 10, 2008, the Company's Maryland health plan was notified that it was one of four successful bidders in the reprocurement of the District of Columbia's Medicaid managed care business for the contract period beginning May 1, 2008. On April 2, 2008, the Company's Maryland health plan elected not to participate in the District's new contract due to premium rate and programmatic concerns. Accordingly, its contract with the District of Columbia, as amended, terminated on June 30, 2008. As a result of exiting this market, the Company wrote off goodwill of $2,264 to selling, general and administrative expenses during the year ended December 31, 2008.

Tennessee

On November 1, 2007, the Company's Tennessee health plan acquired the contract rights and substantially all of the assets of Memphis Managed Care Corporation ("MMCC") including substantially all of the assets of Midsouth Health Solutions, Inc., a subsidiary of MMCC, for approximately $11,733. The purchase price was financed through available unregulated cash. The assets purchased consisted primarily of MMCC's rights to provide services through an ASO contract to the State of Tennessee for its TennCare members in the West Tennessee region. Goodwill and other intangibles totaled $9,967, which included $1,923 of specifically identifiable intangibles allocated to the rights to the ASO contract, the provider network and trademarks. The ASO contract terminated on October 31, 2008, pursuant to its terms. The Company received a purchase price adjustment that reduced the purchase price by $1,500 for early termination of the ASO contract which was recorded as an adjustment to goodwill. As a result of the early termination of the ASO contract, the Company wrote off to selling, general and administrative expenses the remaining goodwill of $71 and $6,544 during the years ended December 31, 2009 and 2008, respectively.

(7) Summary of Goodwill and Acquired Intangible Assets

The change in the carrying amount of goodwill for the year ended December 31, 2010 is as follows:

	January 1, 2010	Additions[1]	Disposals/ Impairments	December 31, 2010
Goodwill	$ 258,155	$ 11,220	$ —	$ 269,375
Accumulated impairment losses	(8,879)	—	—	(8,879)
Total	$ 249,276	$ 11,220	$ —	$ 260,496

(1) Goodwill associated with the acquisition of the Medicaid contract rights and rights under certain provider agreements of UHP on March 1, 2010.

The change in the carrying amount of goodwill for the year ended December 31, 2009 is as follows:

	January 1, 2009	Additions	Disposals/ Impairments[1]	December 31, 2009
Goodwill	$ 258,155	$ —	$ —	$ 258,155
Accumulated impairment losses	(8,808)	—	(71)	(8,879)
Total	$ 249,347	$ —	$ (71)	$ 249,276

(1) Goodwill written off related to Midsouth Health Solutions, Inc.

As a result of the Company's exit from the West Tennessee and District of Columbia markets in 2008, impairment losses of $71 and $8,808 were recorded during the years ended December 31, 2009 and 2008, respectively, related to goodwill. No impairment of goodwill was recorded in 2010.

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Other acquired intangible assets for the years ended December 31, 2010 and 2009 are as follows:

	2010		2009	
	Gross Carrying Amount	Accumulated Amortization	Gross Carrying Amount	Accumulated Amortization
Membership rights and provider contracts	$ 28,171	$ (26,106)	$ 25,971	$ (25,517)
Non-compete agreements and trademarks	946	(946)	1,596	(1,596)
	$ 29,117	$ (27,052)	$ 27,567	$ (27,113)

Amortization expense for the years ended December 31, 2010, 2009 and 2008 was $589, $404 and $2,496, respectively, and the estimated aggregate amortization expense for the five succeeding years is as follows:

	Estimated Amortization Expense
2011	$ 485
2012	365
2013	284
2014	225
2015	150

(8) Claims Payable

The following table presents the components of the change in medical claims payable for the years ended December 31:

	2010	2009	2008
Medical claims payable as of January 1	$ 529,036	$ 536,107	$ 541,173
Health benefits expenses incurred during the year:			
Related to current year	4,828,321	4,492,590	3,679,107
Related to prior years	(106,215)	(85,317)	(60,846)
Total incurred	4,722,106	4,407,273	3,618,261
Health benefits payments during the year:			
Related to current year	4,359,216	4,007,789	3,197,732
Related to prior years	381,251	406,555	425,595
Total payments	4,740,467	4,414,344	3,623,327
Medical claims payable as of December 31	$ 510,675	$ 529,036	$ 536,107
Current year medical claims paid as a percent of current year health benefits expenses incurred	90.3%	89.2%	86.9%
Health benefits expenses incurred related to prior years as a percent of prior year medical claims payable as of December 31	(20.1)%	(15.9)%	(11.2)%
Health benefits expenses incurred related to prior years as a percent of the prior year's health benefits expenses related to current year	(2.4)%	(2.3)%	(1.9)%

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Notes to Consolidated Financial Statements — (Continued)

Health benefits expense incurred during the year was reduced by approximately $106,200, $85,300 and $60,800 in the years ended December 31, 2010, 2009 and 2008, respectively, for amounts related to prior years. Actuarial standards of practice generally require that the liabilities established for accrued medical expenses be sufficient to cover obligations under an assumption of moderately adverse conditions. Moderately adverse conditions were not experienced in any of these periods. Therefore, included in the amounts related to prior years are approximately $32,200, $34,400 and $37,300 for the years ended December 31, 2010, 2009 and 2008, respectively, related to amounts included in the medical claims payable as of January 1 of each respective year in order to establish the liability at a level adequate for moderately adverse conditions.

The remaining reduction in health benefits expense incurred during the year, related to prior years, of approximately $74,000, $50,900 and $23,500 for the years ended December 31, 2010, 2009 and 2008, respectively, primarily resulted from obtaining more complete claims information for claims incurred for dates of service in the prior years. These amounts are referred to as net reserve development. We experienced lower medical trend than originally estimated due to moderating medical trends lower than previously estimated and to claims processing initiatives that yielded increased claim payment recoveries and coordination of benefits in 2010, 2009 and 2008 related to prior year dates of services for all periods. These factors also caused the actuarial estimates to include faster completion factors than were originally established. The faster completion factors contributed to the net favorable reserve development in each respective period.

(9) Long-Term Debt

Convertible Senior Notes

As of December 31, 2010, the Company had $260,000 outstanding in aggregate principal amount of 2.0% Convertible Senior Notes issued March 28, 2007 and due May 15, 2012. The carrying amount of the 2.0% Convertible Senior Notes at December 31, 2010 and 2009 was $245,750 and $235,104, respectively. The unamortized discount at December 31, 2010 and 2009 was $14,250 and $24,896, respectively. The unamortized discount at December 31, 2010 will continue to be amortized over the remaining seventeen months until maturity. In May 2007, an automatic shelf registration statement was filed on Form S-3 with the Securities and Exchange Commission covering the resale of the 2.0% Convertible Senior Notes and common stock issuable upon conversion. The 2.0% Convertible Senior Notes are governed by an Indenture dated as of March 28, 2007 (the "Indenture"). The 2.0% Convertible Senior Notes are senior unsecured obligations of the Company and rank equal in right of payment with all of its existing and future senior debt and senior to all of its subordinated debt. The 2.0% Convertible Senior Notes are effectively subordinated to all existing and future liabilities of the Company's subsidiaries and to any existing and future secured indebtedness. The 2.0% Convertible Senior Notes bear interest at a rate of 2.0% per year, payable semiannually in arrears in cash on May 15 and November 15 of each year, beginning on May 15, 2007. The 2.0% Convertible Senior Notes mature on May 15, 2012, unless earlier repurchased or converted in accordance with the Indenture.

Upon conversion of the 2.0% Convertible Senior Notes, the Company will pay cash up to the principal amount of the 2.0% Convertible Senior Notes converted. With respect to any conversion value in excess of the principal amount, the Company has the option to settle the excess with cash, shares of its common stock, or a combination thereof based on a daily conversion value, as defined in the Indenture. The initial conversion rate for the 2.0% Convertible Senior Notes is 23.5114 shares of common stock per one thousand dollars of principal amount of 2.0% Convertible Senior Notes, which represents a 32.5% conversion premium based on the closing price of $32.10 per share of the Company's common stock on March 22, 2007 and is equivalent to a conversion price of approximately $42.53 per share of common stock. Consequently, under the provisions of the 2.0% Convertible Senior Notes, if the market price of the Company's common stock exceeds $42.53, the Company will be obligated to settle, in cash or shares of its common stock at its option, an amount equal to approximately $6,100 for each dollar in share price that the market price of the Company's common stock exceeds $42.53, or the conversion value in excess of the principal amount of the 2.0% Convertible Senior Notes. In periods prior to conversion, the

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2.0% Convertible Senior Notes would also have a dilutive impact to earnings if the average market price of the Company's common stock exceeds $42.53 for the period reported. At conversion, the dilutive impact would result if the conversion value in excess of the principal amount of the 2.0% Convertible Senior Notes, if any, is settled in shares of the Company's common stock. The conversion rate is subject to adjustment in some events but will not be adjusted for accrued interest. In addition, if a "fundamental change" occurs prior to the maturity date, the Company will in some cases increase the conversion rate for a holder of the 2.0% Convertible Senior Notes that elects to convert their 2.0% Convertible Senior Notes in connection with such fundamental change.

In May 2008, the FASB issued new guidance related to convertible debt instruments which requires the proceeds from the issuance of convertible debt instruments that may be settled wholly or partially in cash upon conversion to be allocated between a liability component and an equity component in a manner reflective of the issuers' nonconvertible debt borrowing rate. The amount allocated to the equity component represents a discount to the debt, which is amortized over the period the convertible debt is expected to be outstanding as additional non-cash interest expense. The Company's adoption of this new guidance on January 1, 2009, with retrospective application to prior periods, changed the accounting treatment for its 2.0% Convertible Senior Notes. To adopt the provisions of this new guidance, the fair value of the 2.0% Convertible Senior Notes was estimated with a nonconvertible debt borrowing rate of 6.74% as of the date of issuance, as if they were issued without the conversion options. The difference between the fair value and the principal amounts of the 2.0% Convertible Senior Notes was $50,885 which was recorded as a debt discount and as a component of equity. The discount is being amortized over the expected five-year life of the 2.0% Convertible Senior Notes resulting in a non-cash increase to interest expense in historical and future periods.

The following table reflects the amortization of the debt discount (non-cash interest) component and the contractual interest (cash interest) component for the 2.0% Convertible Senior Notes for each of the years presented:

	Years Ended December 31,		
	2010	2009	2008
Interest expense:			
Non-cash interest	$ 10,646	$ 9,974	$ 9,344
Cash interest	5,200	5,200	5,200
Total interest expense	$ 15,846	$ 15,174	$ 14,544

Concurrent with the issuance of the 2.0% Convertible Senior Notes, the Company purchased convertible note hedges covering, subject to customary anti-dilution adjustments, 6,112,964 shares of its common stock. The convertible note hedges allow the Company to receive shares of its common stock and/or cash equal to the amounts of common stock and/or cash related to the conversion value in excess of the principal amount that the Company would pay to the holders of the 2.0% Convertible Senior Notes upon conversion. These convertible note hedges will generally terminate at the earlier of the maturity date of the 2.0% Convertible Senior Notes or the first day on which none of the 2.0% Convertible Senior Notes remain outstanding due to conversion or otherwise.

The convertible note hedges are expected to reduce the potential dilution upon conversion of the 2.0% Convertible Senior Notes in the event that the market value per share of the Company's common stock, as measured under the convertible note hedges, at the time of exercise is greater than the strike price of the convertible note hedges, which corresponds to the initial conversion price of the 2.0% Convertible Senior Notes and is subject to certain customary adjustments. If, however, the market value per share of the Company's common stock exceeds the strike price of the warrants (discussed below) when such warrants are exercised, the Company will be required to issue common stock. Both the convertible note hedges and warrants provide for net-share settlement at the time of any exercise for the amount that the market value of the common stock exceeds the applicable strike price.

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Notes to Consolidated Financial Statements — (Continued)

Also concurrent with the issuance of the 2.0% Convertible Senior Notes, the Company sold warrants to acquire, subject to customary anti-dilution adjustments, 6,112,964 shares of its common stock at an exercise price of $53.77 per share. If the average price of the Company's common stock during a defined period ending on or about the settlement date exceeds the exercise price of the warrants, the warrants will be settled in shares of its common stock. Consequently, under the provisions of the warrant instruments, if the market price of the Company's common stock exceeds $53.77 at exercise, the Company will be obligated to settle in shares of its common stock an amount equal to approximately $6,100 for each dollar in share price that the market price of its common stock exceeds $53.77 resulting in a dilutive impact to its earnings. In periods prior to exercise, the warrant instruments would also have a dilutive impact to earnings if the average market price of the Company's common stock exceeds $53.77 for the period reported.

The convertible note hedges and warrants are separate transactions which will not affect holders' rights under the 2.0% Convertible Senior Notes.

As of December 31, 2010, the Company's common stock was last traded at a price of $43.92 per share. Based on this value, if converted at December 31, 2010, the Company would be obligated to pay the principal of the 2.0% Convertible Senior Notes plus an amount in cash or shares equal to $8,481. An amount equal to $8,481 would be owed to the Company in cash or in shares of our common stock through the provisions of the convertible note hedges resulting in net cash outflow equal to the principal amount of the 2.0% Convertible Senior Notes. At this per share value, no shares would be delivered under the warrant instruments as the price is less than the exercise price of the warrants.

Credit and Guaranty Agreement

The Company maintained a Credit and Guaranty Agreement (the "Credit Agreement") that provided both a secured term loan and a senior secured revolving credit facility. On July 31, 2009, the Company paid the remaining balance of the secured term loan. Effective August 21, 2009, the Company terminated the Credit Agreement and related Pledge and Security Agreement. The Company had no outstanding borrowings under the Credit Agreement as of the effective date of termination.

Maturities of Long-Term Obligations

Maturities of long-term debt for future years ending December 31 are as follows:

	Principal	Interest	Total
2011	$ —	$ 5,200	$ 5,200
2012	260,000	2,600	262,600
Thereafter	—	—	—
Total debt	$ 260,000	$ 7,800	$ 267,800

(10) Commitments and Contingencies

(a) Minimum Reserve Requirements

Regulations governing the Company's managed care operations in each of its licensed subsidiaries require the applicable subsidiaries to meet certain minimum net worth requirements. Each subsidiary was in compliance with its requirements at December 31, 2010.

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(b) Professional Liability

The Company maintains professional liability coverage for certain claims which is provided by independent carriers and is subject to annual coverage limits. Professional liability policies are on a claims-made basis and must be renewed or replaced with equivalent insurance if claims incurred during its term, but asserted after its expiration, are to be insured.

(c) Lease Agreements

The Company leases office space under operating leases which expire at various dates through 2021. Future minimum payments by year and in the aggregate under all non-cancelable leases are as follows at December 31, 2010:

	Operating Leases
2011	$ 15,223
2012	13,441
2013	8,848
2014	7,465
2015	6,712
Thereafter	25,385
Total minimum lease payments	$ 77,074

These leases have various escalations, abatements and tenant improvement allowances that have been included in the total cost of each lease and amortized on a straight-line basis. Total rent expense for all office space and office equipment under non-cancelable operating leases was $17,063, $18,246 and $18,351 in 2010, 2009 and 2008, respectively, and is included in selling, general and administrative expenses in the accompanying audited Consolidated Statements of Operations. The Company had no capital lease obligations at December 31, 2010.

(d) Deferred Compensation Plans

The Company's employees have the option to participate in a deferred compensation plan sponsored by the Company. All full-time and most part-time employees of the Company and its subsidiaries may elect to participate in this plan. This plan is a defined contribution profit sharing plan under Section (401)k of the Internal Revenue Code. Participants may contribute a certain percentage of their compensation subject to maximum Federal and plan limits. The Company may elect to match a certain percentage of each employee's contributions up to specified limits. For the years ended December 31, 2010, 2009 and 2008, the matching contributions under the plan were $4,758, $4,486 and $3,649, respectively.

Certain employees have the option to participate in a non-qualified deferred compensation plan sponsored by the Company. Participants may contribute a percentage of their income subject to maximum plan limits. The Company does not match any employee contributions; however, the Company's obligation to the employee is equal to the employees' deferrals plus or minus any return on investment the employee earns through self-selected investment allocations. Included in other long-term liabilities at December 31, 2010 and 2009, respectively was $6,612 and $6,178 related to this plan.

Certain employees are eligible for a long-term cash incentive award designed to retain key executives. Each eligible participant is assigned a cash target, the payment of which is deferred for three years. The amount of the target is dependent upon the participant's performance against individual major job objectives in the first year of the program. The target award amount is funded over the three-year period, with the funding at the discretion of the Compensation Committee of the Board of Directors. An executive is eligible for payment of a long-term incentive

award earned in any one year only if the executive remains employed with the Company and is in good standing on the date the payment is made following the third year of the three-year period. The expense recorded for the long-term cash incentive awards was $7,051, $3,192 and $5,232 in 2010, 2009 and 2008, respectively. The related current portion of the liability of $5,835 and $5,722 at December 31, 2010 and 2009, respectively, is included in accrued payroll and related liabilities for the amounts due under the 2008 plan payable in 2011. The related long-term portion of the liability of $6,464 and $5,392 at December 31, 2010 and 2009, respectively, is included in other long-term liabilities.

(e) Florida Medicaid Contract Dispute

Under the terms of the Medicaid contracts with the Florida Agency for Health Care Administration ("AHCA"), managed care organizations are required to have a process to identify members who are pregnant, or the newborns of members, so that the newborn can be enrolled as a member of the health plan as soon as possible after birth. This process is referred to as the "Unborn Activation Process."

Beginning in July 2008, AMERIGROUP Florida, Inc. received a series of letters from the Florida Office of the Inspector General ("IG") and AHCA stating that AMERIGROUP Florida, Inc. had failed to comply with the Unborn Activation Process in each and every instance during the period from July 1, 2004 through December 31, 2007 and, as a result, AHCA had paid approximately $10,600 in Medicaid fee-for-service claims that should have been paid by AMERIGROUP Florida, Inc. The letters requested that AMERIGROUP Florida, Inc. provide documentation to evidence its compliance with the terms of the contract with AHCA with respect to the Unborn Activation Process.

In October 2008, AMERIGROUP Florida, Inc. submitted its response to the letters. In July 2009, the Company received another series of letters from the IG and AHCA stating that, based on a review of the AMERIGROUP Florida, Inc.'s response, they had determined that AMERIGROUP Florida, Inc. did not comply with the Unborn Activation Process and assessed fines against AMERIGROUP Florida, Inc. in the amount of two thousand, five hundred dollars per newborn for an aggregate amount of approximately $6,000. The letters further reserved AHCA's right to pursue collection of the amount paid for the fee-for-service claims. AMERIGROUP Florida, Inc. appealed these findings and submitted documentation to evidence its compliance with, and performance under, the Unborn Activation Process requirements of the contract. On January 14, 2010, AMERIGROUP Florida, Inc. appealed AHCA's contract interpretation to the Florida Deputy Secretary of Medicaid that the failure to utilize the Unborn Activation Process for each and every newborn could result in fines. In February 2010, AMERIGROUP Florida, Inc. received another series of letters from the IG and AHCA revising the damages from $10,600 to $3,200 for the fee-for-service claims that AHCA believed they paid. The revised damages include an offset of premiums that would have been paid for the dates of service covered by the claims. The letters also included an updated fine amount which was not materially different from the prior letters.

On May 26, 2010, the Florida Deputy Secretary of Medicaid denied AMERIGROUP Florida, Inc.'s contract interpretation appeal. Following the denial, in June 2010, AMERIGROUP Florida, Inc. received another series of letters from AHCA assessing fines in the amount of two thousand, five hundred dollars per newborn for an aggregate amount of approximately $6,000.

In December 2010, AMERIGROUP Florida, Inc. and AHCA entered into a confidential settlement agreement resolving and releasing all claims related to the Unborn Activation Process during the period from July 1, 2004 through December 31, 2007. The settlement was not material to the Company's financial position, results of operations or liquidity.

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(f) Letter of Credit

Effective July 1, 2010, the Company renewed a collateralized irrevocable standby letter of credit, initially issued on July 1, 2009 in an aggregate principal amount of approximately $17,400, to meet certain obligations under its Medicaid contract in the State of Georgia through its Georgia subsidiary, AMGP Georgia Managed Care Company, Inc. The letter of credit is collateralized through investments held by AMGP Georgia Managed Care Company, Inc.

(g) Legal Proceedings

Employment Litigation

On November 22, 2010, a former AMERIGROUP New York, LLC marketing representative filed a putative collective and class action Complaint against AMERIGROUP Corporation and AMERIGROUP New York, LLC in the United States District Court, Eastern District of New York styled as *Hamel Toure, Individually and on Behalf of All Other Persons Similarly Situated v. AMERIGROUP CORPORATION and AMERIGROUP NEW YORK, L.L.C. f/k/a CAREPLUS, L.L.C. (Case No.: CV10-5391)*. The Complaint alleges, *inter alia*, that the plaintiff and certain other employees should have been classified as non-exempt employees under the Fair Labor Standards Act ("FLSA") and during the course of their employment should have received overtime and other compensation under the FLSA from October 22, 2007 until the entry of judgment and under the New York Labor Law from October 22, 2004 until the entry of judgment. The Complaint requests certification of the action as a class action, designation of the action as a collective action, a declaratory judgment, injunctive relief, an award of unpaid overtime compensation, an award of liquidated and/or punitive damages, prejudgment and post-judgment interest, as well as costs and attorneys' fees. At this early stage of the case, the Company is unable to make a reasonable estimate of the amount or range of loss that could result from an unfavorable outcome in this matter because the scope and size of the potential class has not been determined, no discovery has occurred and no specific amount of monetary damages has been alleged. The Company believes it has meritorious defenses to the claims against it and intends to defend itself vigorously.

Memorial Hermann Litigation

On July 29, 2010, AMERIGROUP Texas, Inc. and Memorial Hermann Hospital System ("Memorial Hermann") entered into a confidential settlement agreement resolving and releasing all claims related to various cases filed in the District Court of Harris County, Texas by Memorial Hermann against AMERIGROUP Texas, Inc. in 2007, 2009 and 2010 alleging breach of contract for failure to pay claims in accordance with the contract between the parties and *quantum meriut*. The cases sought aggregate damages of approximately $41,400 plus interest, statutory damages and legal fees. The settlement was not material to the Company's financial position, results of operations or liquidity.

Litigation Settlement

On August 13, 2008, the Company settled a *qui tam* litigation relating to certain marketing practices of its former Illinois health plan for a cash payment of $225,000 without any admission of wrong-doing by the Company, its subsidiaries or affiliates. The Company also paid approximately $9,205 to the relator for legal fees. Both payments were made during the three months ended September 30, 2008. As a result, a one-time expense in the amount of $234,205, or $199,638 net of the related tax effects, was recorded in the year ended December 31, 2008 resulting in a net loss for the year. In June 2009, the Company recorded a $22,449 tax benefit regarding the tax treatment of the settlement under an agreement in principle with the IRS which was formalized through a pre-filing agreement with the IRS in September 2009. The pre-filing agreement program permits taxpayers to resolve tax issues in advance of filing their corporate income tax returns. The Company does not anticipate that there will be any further material changes to the tax benefit associated with this settlement in future periods.

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Other Litigation

Additionally, the Company is involved in various other legal proceedings in the normal course of business. Based upon its evaluation of the information currently available, the Company believes that the ultimate resolution of any such proceedings will not have a material adverse effect, either individually or in the aggregate, on its financial position, results of operations or cash flows.

(11) Stock Option Plan

In May 2009, the Company's shareholders adopted and approved the Company's 2009 Equity Incentive Plan (the "2009 Plan"), which provides for the granting of stock options, restricted stock, restricted stock units, stock appreciation rights, stock bonuses and other stock-based awards to employees and directors. The Company reserved for issuance a maximum of 3,635,000 shares of common stock under the 2009 Plan. In addition, shares remaining available for issuance under previous plans are available under the 2009 Plan. Under all plans, an option's maximum term is ten years. As of December 31, 2010, the Company had a total 2,934,801 shares available for issuance under the 2009 Plan.

Stock option activity during the year ended December 31, 2010 was as follows:

	Shares	Weighted-Average Exercise Price	Aggregate Intrinsic Value	Weighted-Average Remaining Contractual Term (Years)
Outstanding at December 31, 2009	5,306,012	$ 27.95		
Granted	104,413	37.49		
Exercised	(1,101,866)	23.75		
Expired	(72,840)	30.89		
Forfeited	(68,725)	29.74		
Outstanding at December 31, 2010	4,166,994	$ 29.09	$ 61,781	3.88
Exercisable as of December 31, 2010	2,954,760	$ 29.53	$ 42,529	3.42

The fair value of each option grant is estimated on the date of grant using the Black-Scholes-Merton option-pricing model with the following weighted average assumptions for the year ended December 31, 2010, 2009 and 2008:

	Years Ended December 31,		
	2010	2009	2008
Expected volatility	46.88%-47.65%	47.28%-48.94%	43.25%-46.65%
Weighted-average stock price volatility	47.53%	48.89%	44.95%
Expected option life	1.63-5.50 years	2.42-5.56 years	1.14-7.00 years
Risk-free interest rate	0.64%-2.45%	0.60%-2.73%	1.67%-3.36%
Dividend yield	None	None	None

Assumptions used in estimating the fair value at date of grant were based on the following:

i. the expected life of each award granted was calculated using the "simplified method", which uses the vesting period, generally quarterly over four years, and the option term, generally seven years, to calculate the expected life of the option;

ii. expected volatility is based on historical volatility levels, which the Company believes is indicative of future levels; and

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iii. the risk-free interest rate is based on the implied yield currently available on U.S. Treasury zero coupon issues with a remaining term equal to the expected life.

The Company employs the simplified method to estimate the expected life of each award due to the significant volatility in the market price of its common stock which has created exercise patterns that the Company does not believe are indicative of future activity.

The weighted average fair value per share of options granted during the years ended December 31, 2010, 2009 and 2008 was $16.13, $13.80 and $11.79, respectively. The total fair value of options vested during the years ended December 31, 2010, 2009 and 2008 was $7,674, $8,148 and $6,324, respectively. The following table provides information related to options exercised during the years ended December 31, 2010, 2009, and 2008:

	Years Ended December 31,		
	2010	2009	2008
Cash received upon exercise of options	$ 26,466	$ 10,698	$ 10,248
Related tax benefit realized	3,097	842	2,034

Total intrinsic value of options exercised was $16,817, $5,036 and $6,970, for the years ended December 31, 2010, 2009 and 2008, respectively.

Non-vested restricted stock for the twelve months ended December 31, 2010 is summarized below:

	Shares	Weighted-Average Grant Date Fair Value
Non-vested balance at December 31, 2009	533,018	$ 29.89
Granted	920,837	30.82
Vested	(194,127)	30.02
Forfeited	(30,746)	32.21
Non-vested balance at December 31, 2010	1,228,982	$ 30.49

Non-vested restricted stock includes grants conditioned upon service and/or performance based vesting. Service-based awards generally vest annually over a period of four years contingent only on the employees' continued employment. Performance based awards contain a vesting condition based upon the extent of achievement of certain goals relating to the Company's earnings per share in the grant year. The total number of shares that may vest is determined upon the earnings per share for the grant year with the determined number of shares then vesting annually over the following three and a third years. Performance based awards represent 62,329 shares of outstanding non-vested restricted stock awards.

As of December 31, 2010, there was $40,061 of total unrecognized compensation cost related to non-vested share-based compensation arrangements, which is expected to be recognized over a weighted average period of 1.77 years.

(12) Employee Stock Purchase Plan

On February 15, 2001, the Board of Directors approved and the Company adopted an Employee Stock Purchase Plan. All employees are eligible to participate except those employees who have been employed by the Company less than 90 days, whose customary employment is less than 20 hours per week or any employee who owns five percent or more of the Company's common stock. Eligible employees may join the plan every six months. Purchases of common stock are priced at the lower of the stock price less 15% on the first day or the last day of the six-month period. The Company has reserved for issuance 1,200,000 shares of common stock and has issued 88,343, 97,332, and 104,238 shares under the Employee Stock Purchase Plan in 2010, 2009, and 2008, respectively.

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As of December 31, 2010 a total of 421,536 shares were available for issuance under the Employee Stock Purchase Plan.

The fair value of the employees' purchase rights granted in each of the six month offering periods during 2010, 2009 and 2008 was estimated on the date of grant using the Black-Scholes-Merton option-pricing model with the following weighted average assumptions:

	Six Month Offering Periods Ending					
	December 31, 2010	June 30, 2010	December 31, 2009	June 30, 2009	December 31, 2008	June 30, 2008
Expected volatility	47.44%	48.10%	48.83%	47.32%	44.27%	43.28%
Expected term	6 months	6 months	6 months	6 months	6 months	6 months
Risk-free interest rate	0.22%	0.20%	0.35%	0.27%	2.17%	3.49%
Divided yield	None	None	None	None	None	None

The per share fair value of those purchase rights granted in each of the six month offering periods during 2010, 2009 and 2008 were as follows:

	Six Month Offering Periods Ending					
	December 31, 2010	June 30, 2010	December 31, 2009	June 30, 2009	December 31, 2008	June 30, 2008
Grant-date fair value	$ 9.20	$ 7.69	$ 7.71	$ 8.36	$ 5.74	$ 10.00

(13) Income Taxes

Total income taxes for the years ended December 31, 2010, 2009 and 2008 were allocated as follows:

	Years Ended December 31,		
	2010	2009	2008
Income taxes from continuing operations	$163,800	$52,140	$54,350
Stockholders' equity, tax benefit related to share-based payments	(3,097)	(842)	(2,034)
Stockholders' equity, tax expense related to unrealized gain on held-to-maturity investment portfolio at time of transfer to available-for-sale	—	1,835	—
Stockholders' equity, tax (benefit) expense related to unrealized (loss) gain on available-for-sale securities	(476)	1,369	(2,350)
	$160,227	$54,502	$49,966

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AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

Income tax expense from continuing operations for the years ended December 31, 2010, 2009 and 2008 consists of the following:

	Current	Deferred	Total
Year ended December 31, 2010:			
U.S. Federal	$ 151,953	$ (2,642)	$ 149,311
State and local	14,109	380	14,489
	$ 166,062	$ (2,262)	$ 163,800
Year ended December 31, 2009:			
U.S. Federal	$ 48,532	$ 86	$ 48,618
State and local	2,790	732	3,522
	$ 51,322	$ 818	$ 52,140
Year ended December 31, 2008:			
U.S. Federal	$ 46,445	$ (555)	$ 45,890
State and local	8,193	267	8,460
	$ 54,638	$ (288)	$ 54,350

Income tax expense from continuing operations differed from the amounts computed by applying the statutory U.S. Federal income tax rate to income before income taxes as a result of the following:

	Years Ended December 31,					
	2010		2009		2008	
	Amount	%	Amount	%	Amount	%
Tax expense (benefit) at statutory rate	$ 153,010	35.0	$ 70,496	35.0	$ (789)	35.0
Increase in income taxes resulting from:						
State and local income taxes, net of Federal income tax effect	9,418	2.2	2,549	1.3	5,620	(249.1)
Qui tam settlement payment, net non-deductible amount	—	—	—	—	48,724	(2,160.0)
Effect of non-deductible expenses and other, net	1,372	0.3	1,544	0.7	795	(35.3)
Decrease in income taxes resulting from:						
IRS pre-filing agreement on *qui tam* settlement	—	—	(22,449)	(11.1)	—	—
Total income tax expense	$ 163,800	37.5	$ 52,140	25.9	$ 54,350	(2,409.4)

The effective tax rate is based on expected taxable income, statutory tax rates, and estimated permanent book-to-tax differences. Filed income tax returns are periodically audited by state and Federal authorities for compliance with applicable state and Federal tax laws. The effective tax rate is computed taking into account changes in facts and circumstances, including progress of audits, developments in case law and other applicable authority, and emerging legislation.

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AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and deferred tax liabilities at December 31, 2010 and 2009 are presented below:

	December 31, 2010	December 31, 2009
Deferred tax assets:		
Estimated claims incurred but not reported, a portion of which is deductible as paid for tax purposes	$ 4,945	$ 4,867
Vacation, bonus, stock compensation and other accruals, deductible as paid for tax purposes	27,182	25,093
Accounts receivable allowances, deductible as written off for tax purposes	7,532	6,896
Start-up costs, deductible in future periods for tax purposes	382	413
Unearned revenue, a portion of which is includible in income as received for tax purposes	8,257	7,343
Convertible bonds	583	603
State net operating loss/credit carryforwards, deductible in future periods for tax purposes	—	322
Gross deferred tax assets	48,881	45,537
Deferred tax liabilities:		
Goodwill, due to timing differences in book and tax amortization	(5,500)	(4,774)
Unrealized gains on investments	(377)	(854)
Property, equipment and software, due to timing differences in book and tax depreciation	(20,060)	(19,902)
Deductible prepaid expenses and other	(2,274)	(2,076)
Gross deferred tax liabilities	(28,211)	(27,606)
Net deferred tax asset	$ 20,670	$ 17,931

To assess the recoverability of deferred tax assets, the Company considers whether it is more likely than not that deferred tax assets will be realized. In making this determination, the scheduled reversal of deferred tax liabilities and whether projected future taxable income is sufficient to permit deduction of the deferred tax assets are taken into account. Based on the reversal of deferred tax liabilities, the level of historical taxable income and projections for future taxable income, the Company believes it is more likely than not that it will fully realize the benefits of the gross deferred tax assets of $48,881.

Income tax payable was $2,643 and $8,938 at December 31, 2010 and December 31, 2009, respectively, and is included in accrued expenses and other current liabilities.

The Company is subject to U.S. Federal income tax, as well as income taxes in multiple state jurisdictions. Substantially all U.S. Federal income tax matters have been concluded for years through 2006. Substantially all material state matters have been concluded for years through 2006.

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AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

The following table presents a reconciliation of the beginning and ending amount of unrecognized tax benefits as follows:

	Amount
Balance at January 1, 2009	$ 952
Additions based on tax positions for current year	—
Additions for tax positions of prior years	56
Reductions for tax positions of prior years	(126)
Settlements	—
Balance at December 31, 2009	882
Additions based on tax positions for current year	—
Additions for tax positions of prior years	—
Reductions for tax positions of prior years	(125)
Settlements	—
Balance at December 31, 2010	$ 757

Of the total $757 of unrecognized tax benefits, $491, net of the Federal benefit on state issues, represents the total amount of tax benefits that, if recognized, would reduce the annual effective rate. The Company recognizes interest and any penalties accrued related to unrecognized tax benefits in income tax expense. Potential interest of $4 was accrued relating to these unrecognized tax benefits during 2010. As of December 31, 2010, the Company has recorded a liability for potential gross interest of $323.

(14) Share Repurchase Program

Under the authorization of the Company's Board of Directors, the Company maintains an ongoing share repurchase program. On September 15, 2010, the Board of Directors authorized a $200,000 increase to the ongoing share repurchase program, bringing the total authorization to $400,000. The $400,000 authorization is for repurchases of the Company's common stock made from and after August 5, 2009. Pursuant to this ongoing share repurchase program, the Company repurchased 3,748,669 shares of its common stock and placed them into treasury during the year ended December 31, 2010 at an aggregate cost of $138,540. As of December 31, 2010, the Company had remaining authorization to purchase up to an additional $224,307 of shares of its common stock under the ongoing share repurchase program.

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AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

(15) Earnings Per Share

The following table sets forth the calculation of basic and diluted net income (loss) per share:

	Years Ended December 31,		
	2010	2009	2008
Basic net income (loss) per share:			
Net income (loss)	$ 273,371	$ 149,279	$ (56,606)
Weighted-average number of common shares outstanding	49,522,202	51,647,267	52,816,674
Basic net income (loss) per share	$ 5.52	$ 2.89	$ (1.07)
Diluted net income (loss) per share:			
Net income (loss)	$ 273,371	$ 149,279	$ (56,606)
Weighted-average number of common shares outstanding	49,522,202	51,647,267	52,816,674
Dilutive effect of stock options and non-vested stock awards (as determined by applying the treasury stock method)	1,085,806	662,001	—
Weighted-average number of common shares and dilutive potential common shares outstanding	50,608,008	52,309,268	52,816,674
Diluted net income (loss) per share	$ 5.40	$ 2.85	$ (1.07)

Potential common stock equivalents representing 895,899 shares, 2,676,447 shares, and 3,351,807 shares for the years ended December 31, 2010, 2009 and 2008, respectively, were not included in the computation of diluted net income (loss) per share because to do so would have been anti-dilutive.

The shares issuable upon the conversion of the Company's 2.0% Convertible Senior Notes due May 15, 2012, which were issued effective March 28, 2007 in an aggregate principle amount of $260,000 (see Note 9), were not included in the computation of diluted net income (loss) per share for the years ended December 31, 2010, 2009 and 2008 because to do so would have been anti-dilutive.

The Company's warrants to purchase shares of its common stock, sold on March 28, 2007 and April 9, 2007 (see Note 9), were not included in the computation of diluted net income (loss) per share for the years ended December 31, 2010, 2009 and 2008 because to do so would have been anti-dilutive.

(16) Quarterly Financial Data (unaudited)

	Three Months Ended			
2010	March 31	June 30	September 30	December 31
Premium revenues	$ 1,366,767	$ 1,428,879	$ 1,489,884	$ 1,497,928
Health benefits expenses	1,141,572	1,176,445	1,199,706	1,204,383
Selling, general and administrative expenses	117,423	108,189	106,815	119,642
Income before income taxes	68,482	106,783	135,338	126,568
Net income	42,182	67,213	84,348	79,628
Diluted net income per share	0.82	1.31	1.68	1.59
Weighted-average number of common shares and dilutive potential common shares outstanding	51,226,435	51,318,044	50,197,740	49,924,608

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AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

2009	Three Months Ended March 31	June 30	September 30	December 31
Premium revenues	$ 1,217,447	$ 1,284,890	$ 1,298,969	$ 1,357,683
Health benefits expenses	1,019,303	1,103,213	1,136,391	1,148,366
Selling, general and administrative expenses	110,375	96,285	82,238	105,191
Income before income taxes	59,434	43,374	34,949	63,662
Net income	36,909	49,599	22,549	40,222
Diluted net income per share	0.69	0.94	0.43	0.79
Weighted-average number of common shares and dilutive potential common shares outstanding	53,424,802	53,029,943	51,920,745	51,069,265

(17) Comprehensive Earnings

Differences between net income (loss) and total comprehensive income (loss) resulted from net unrealized gains (losses) on the investment portfolio as follows:

	Years Ended December 31, 2010	2009	2008
Net income (loss)	$ 273,371	$ 149,279	$ (56,606)
Other comprehensive income (loss):			
Unrealized gains on held-to-maturity investment portfolio at time of transfer to available-for-sale, net of tax	—	3,030	—
Unrealized (losses) gains on available-for-sale securities, net of tax	(727)	2,346	(4,022)
Total change	(727)	5,376	(4,022)
Comprehensive income (loss)	$ 272,644	$ 154,655	$ (60,628)

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AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

(18) Parent Financial Statements

The following parent only condensed financial information reflects the financial condition, results of operations and cash flows of AMERIGROUP Corporation.

CONDENSED BALANCE SHEETS

	December 31, 2010	December 31, 2009
	(Dollars in thousands)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 62,189	$ 58,326
Short-term investments	54,895	52,765
Due from affiliates	34,397	26,076
Deferred income taxes	8,445	7,975
Prepaid expenses and other	13,611	12,928
Total current assets	173,537	158,070
Long-term investments	131,523	120,886
Investment in subsidiaries	1,128,535	934,838
Property, equipment and software, net of accumulated depreciation of $145,375 and $131,280 at December 31, 2010 and 2009, respectively	84,428	84,035
Deferred income taxes	20,074	11,278
Other long-term assets	10,734	12,525
Total assets	$1,548,831	$1,321,632
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable	$ 10,713	$ 7,144
Accrued payroll and related liabilities	71,254	37,311
Accrued expenses and other	36,479	38,891
Total current liabilities	118,446	83,346
Long-term convertible debt	245,750	235,104
Deferred income taxes	5,231	6,379
Other long-term liabilities	13,767	12,359
Total liabilities	383,194	337,188
Stockholders' equity:		
Common stock, $0.01 par value. Authorized 100,000,000 shares; outstanding 48,167,229 and 50,638,474 at December 31, 2010 and 2009, respectively	554	546
Additional paid-in-capital	543,611	494,735
Accumulated other comprehensive income	627	1,354
Retained earnings	864,003	590,632
	1,408,795	1,087,267
Less treasury stock at cost (7,759,234 and 3,956,560 shares at December 31, 2010 and 2009, respectively)	(243,158)	(102,823)
Total stockholders' equity	1,165,637	984,444
Total liabilities and stockholders' equity	$1,548,831	$1,321,632

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AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

CONDENSED STATEMENTS OF OPERATIONS

	Years Ended December 31,		
	2010	2009	2008
	(Dollars in thousands, except for per share data)		
Revenues:			
Service fees from subsidiaries	$ 416,447	$ 368,379	$ 291,350
Investment income and other	4,208	2,476	15,309
Total revenues	420,655	370,855	306,659
Expenses:			
Selling, general and administrative	321,367	262,684	228,155
Depreciation and amortization	28,375	27,256	27,626
Litigation settlement	—	—	234,205
Interest	15,871	16,225	19,382
Total expenses	365,613	306,165	509,368
Income (loss) before income taxes and equity earnings in subsidiaries	55,042	64,690	(202,709)
Income tax (expense) benefit	(24,155)	(465)	20,855
Equity earnings in subsidiaries	242,484	85,054	125,248
Net income (loss)	$ 273,371	$ 149,279	$ (56,606)
Net income (loss) per share:			
Basic net income (loss) per share	$ 5.52	$ 2.89	$ (1.07)
Weighted average number of shares outstanding	49,522,202	51,647,267	52,816,674
Diluted net income (loss) per share	$ 5.40	$ 2.85	$ (1.07)
Weighted average number of common shares and dilutive potential common shares outstanding	50,608,008	52,309,268	52,816,674

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AMERIGROUP Corporation And Subsidiaries

Notes to Consolidated Financial Statements — (Continued)

CONDENSED STATEMENTS OF CASH FLOWS

	Years Ended December 31,		
	2010	2009	2008
	(Dollars in thousands)		
Cash flows from operating activities:			
Net income (loss)	$ 273,371	$ 149,279	$ (56,606)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:			
Equity earnings in subsidiaries	(242,484)	(85,054)	(125,248)
Depreciation and amortization	28,375	27,256	27,626
Loss on disposal or abandonment of property, equipment and software	361	121	402
Deferred tax (benefit) expense	(9,937)	(9,467)	195
Compensation expense related to share-based payments	19,635	15,936	10,381
Convertible debt non-cash interest	10,646	9,974	9,344
Gain on sale of contract rights	—	(5,810)	—
Other	(152)	(2,763)	(384)
Changes in assets and liabilities (decreasing) increasing cash flows from operations:			
Prepaid expenses and other current assets	(683)	(2,397)	23,064
Other assets	(689)	(1,146)	795
Accounts payable, accrued expenses and other current liabilities	32,990	(28,215)	17,498
Other long-term liabilities	1,408	(1,480)	(409)
Net cash provided by (used in) operating activities	112,841	66,234	(93,342)
Cash flows from investing activities:			
(Purchases of) proceeds from sale of securities, net	(14,541)	(115,115)	71,980
Purchase of property, equipment and software	(27,814)	(24,656)	(29,321)
Contributions made to subsidiaries	(11,012)	(70,104)	(87,390)
Dividends received from subsidiaries	61,687	71,700	70,151
Proceeds from sale of contract rights	—	5,810	—
Release of restricted investments held as collateral	—	—	351,318
Net cash provided by (used in) investing activities	8,320	(132,365)	376,738
Cash flows from financing activities:			
Change in due to and due from subsidiaries, net	(8,321)	(29,140)	1,989
Repayment of borrowings under credit facility	—	(44,318)	(84,028)
Payment of capital lease obligations	—	—	(368)
Proceeds from exercise of stock options and employee stock purchases	26,466	10,698	10,248
Repurchase of common stock shares	(138,540)	(69,751)	(30,647)
Tax benefit related to share-based payments	3,097	842	2,034
Net cash used in financing activities	(117,298)	(131,669)	(100,772)
Net increase (decrease) in cash and cash equivalents	3,863	(197,800)	182,624
Cash and cash equivalents at beginning of year	58,326	256,126	73,502
Cash and cash equivalents at end of year	$ 62,189	$ 58,326	$ 256,126

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Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures***

(a) *Evaluation of Disclosure Controls and Procedures.*

Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, has evaluated the effectiveness of our disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), as of the end of the period covered by this report. Based on such evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that, as of the end of such period, our disclosure controls and procedures are effective in recording, processing, summarizing and reporting, on a timely basis, information required to be disclosed by us in the reports that we file or submit under the Exchange Act and are effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure.

(b) *Internal Control over Financial Reporting.*

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

The management of AMERIGROUP Corporation is responsible for establishing and maintaining adequate internal control over financial reporting. Internal control over financial reporting is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act as a process designed by, or under the supervision of, the Company's principal executive and principal financial officers and effected by the Company's Board of Directors, management and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles.

The management of AMERIGROUP Corporation assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2010. In making this assessment, we used the criteria established in *Internal Control — Integrated Framework* set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). Based on our assessment, we have concluded that, as of December 31, 2010, the Company's internal control over financial reporting was effective based on those criteria.

AMERIGROUP Corporation's independent registered public accounting firm has issued an audit report on the effectiveness of the Company's internal control over financial reporting as of December 31, 2010. That report has been included herein.

(c) *Changes in Internal Controls*

During the year ended December 31, 2010, in connection with our evaluation of internal control over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act of 2002, we concluded there were no changes in our internal control procedures that materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

(d) *Other*

Our internal control over financial reporting includes policies and procedures that:

- pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the Company;
- provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with U.S. generally accepted accounting principles, and that receipts and

expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and

- provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the audited Consolidated Financial Statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Projections of any evaluation of effectiveness to future periods are subject to the risks that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Item 9B. ***Other Information***

On February 17, 2011, AMERIGROUP Texas, Inc. received an executed amendment to the Health & Human Services Commission Agreement for Health Services to the STAR, STAR+PLUS, CHIP and CHIP Perinatal programs expiring August 31, 2013. The amendment, among other things, revises capitation rates effective March 1, 2011 through the August 31, 2011 rate period.

The foregoing description does not purport to be a complete statement of the parties' rights and obligations under the contract or the amendment thereto.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
AMERIGROUP Corporation:

We have audited AMERIGROUP Corporation and subsidiaries' internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). AMERIGROUP Corporation and subsidiaries' management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the AMERIGROUP Corporation and subsidiaries' internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, AMERIGROUP Corporation and subsidiaries' maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of AMERIGROUP Corporation and subsidiaries' as of December 31, 2010 and 2009, and the related consolidated statements of operations and consolidated statements of stockholders' equity and cash flows for each of the years in the three-year period ended December 31, 2010, and our report dated February 23, 2011 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP
Norfolk, Virginia
February 23, 2011

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Part III.

Item 10. ***Directors, Executive Officers and Corporate Governance***

The information regarding directors is incorporated herein by reference from the section entitled "Proposal #1: Election of Directors" in the Proxy Statement.

The information regarding Executive Officers is contained in Part I of this Report under the caption "Executive Officers of the Company."

There are no family relationships among any of our directors or executive officers.

The information regarding compliance with Section 16(a) of the Exchange Act is incorporated herein by reference from the section entitled "Section 16(a) Beneficial Ownership Reporting Compliance" of our definitive Proxy Statement (the "Proxy Statement") to be filed pursuant to Regulation 14A of the Exchange Act, as amended, for our Annual Meeting of Stockholders to be held on Thursday, May 12, 2011. The Proxy Statement will be filed within 120 days after the end of our fiscal year ended December 31, 2010.

The information regarding the Company's Code of Business Conduct and Ethics is incorporated herein by reference from the sections entitled "Corporate Governance" in the Proxy Statement.

The information regarding the Company's procedures by which security holders may recommend nominees to the Company's Board of Directors is incorporated herein by reference from the sections entitled "Questions and Answers About the Proxy Materials and our Annual Meeting of Stockholders" in the Proxy Statement.

The information regarding the members of the Audit Committee and the determination of an audit committee financial expert is incorporated herein by reference from the sections entitled "Information About our Board of Directors and Committees" in the Proxy Statement.

Item 11. ***Executive Compensation***

Information regarding executive compensation is incorporated herein by reference from the sections entitled "Compensation Discussion and Analysis", "Compensation Committee Report" and "Compensation of Directors" in the Proxy Statement. The Compensation Committee Report shall be deemed furnished with this Form 10-K, and shall not be "filed" for purposes of Section 18 of the Exchange Act, nor shall it be deemed incorporated by reference in any filing under the Securities Act of 1933, as amended, or the Exchange Act.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information regarding security ownership of certain beneficial owners and management and securities authorized for issuance under equity compensation plans is incorporated herein by reference from the sections entitled "Security Ownership of Certain Beneficial Owners and Management" in the Proxy Statement.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information regarding certain relationships and related transactions is incorporated herein by reference from the section entitled "Certain Relationships and Related Transactions" in the Proxy Statement.

Item 14. ***Principal Accountant Fees and Services***

Information regarding principal accountant fees and services is incorporated herein by reference from the section entitled "Proposal #2: Ratification of the Selection of Independent Registered Public Accounting Firm" in the Proxy Statement.

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Part IV.

Item 15. ***Exhibits and Financial Statement Schedules***

(a)(1) *Financial Statements.*

The following financial statements appear on the pages listed, herein:

Report of Independent Registered Public Accounting Firm	65
Consolidated Balance Sheets as of December 31, 2010 and 2009	66
Consolidated Statements of Operations for the years ended December 31, 2010, 2009 and 2008	67
Consolidated Statements of Stockholders' Equity for the years ended December 31, 2010, 2009 and 2008	68
Consolidated Statements of Cash Flows for the years ended December 31, 2010, 2009 and 2008	69
Notes to Consolidated Financial Statements	70

(a)(2) *Financial Statement Schedules.*

None.

(b) *Exhibits.*

The exhibits listed on the accompanying Exhibit Index immediately following the Signatures page are incorporated by reference into this report.

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Signatures

Pursuant to the requirements of Section 13 or 15(d) of the Securities Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, in the City of Virginia Beach, Commonwealth of Virginia, on February 23, 2011.

AMERIGROUP Corporation

By: /s/ James W. Truess
Name: James W. Truess
Title: Chief Financial Officer and Executive Vice President

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signatures	Title	Date
/s/ James G. Carlson James G. Carlson	Chairman, Chief Executive Officer and President	February 23, 2011
/s/ James W. Truess James W. Truess	Chief Financial Officer and Executive Vice President	February 23, 2011
/s/ Margaret M. Roomsburg Margaret M. Roomsburg	Chief Accounting Officer and Senior Vice President	February 23, 2011
/s/ Thomas E. Capps Thomas E. Capps	Director	February 23, 2011
/s/ Jeffrey B. Child Jeffrey B. Child	Director	February 23, 2011
/s/ Emerson U. Fullwood Emerson U. Fullwood	Director	February 23, 2011
/s/ Kay Coles James Kay Coles James	Director	February 23, 2011
/s/ William J. McBride William J. McBride	Director	February 23, 2011
/s/ Hala Moddelmog Hala Moddelmog	Director	February 23, 2011
/s/ Joseph W. Prueher Joseph W. Prueher	Director	February 23, 2011

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Signatures	Title	Date
/s/ Uwe E. Reinhardt, Ph.D. Uwe E. Reinhardt, Ph.D.	Director	February 23, 2011
/s/ Richard D. Shirk Richard D. Shirk	Director	February 23, 2011
/s/ John W. Snow John W. Snow	Director	February 23, 2011

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EXHIBIT INDEX

The following exhibits, which are furnished with this annual report or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Annual Report on Form 10-K contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement.

The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Annual Report on Form 10-K not misleading.

Exhibit Number	Description
3.1	Amended and Restated Certificate of Incorporation of the Company (incorporated by reference to exhibit 3.1 to our Registration Statement on Form S-3 (No. 333-108831) filed on July 3, 2000).
3.2	Amended and Restated By-Laws of the Company (incorporated by reference to exhibit 3.1 to our Current Report on Form 8-K filed on February 14, 2008).
4.1	Form of share certificate for common stock (incorporated by reference to exhibit 3.3 to our Registration Statement on Form S-1 (No. 333-347410) filed on July 24, 2000).
4.2	Indenture related to the 2.0% Convertible Senior Notes due 2012 dated March 28, 2007, between AMERIGROUP Corporation and The Bank of New York, as trustee (including the form of 2.0% Convertible Senior Note due 2012) (incorporated by reference to exhibit 4.1 to our Current Report on Form 8-K filed on April 2, 2007).
4.3	Registration Rights Agreement dated March 28, 2007, between AMERIGROUP Corporation, Goldman Sachs, & Co., as representative of the initial purchasers (incorporated by reference to exhibit 4.2 to our Current Report on Form 8-K filed on April 2, 2007).
10.1	Retirement and Employment Agreement by and between AMERIGROUP Corporation and Stanley F. Baldwin, dated August 4, 2009 (incorporated by reference to exhibit 10.3 to our Current Report on Form 8-K filed on August 10, 2009).
10.2	Confirmation, Re Convertible Note Hedge Transaction, dated March 22, 2007 between AMERIGROUP Corporation and Wells Fargo Bank, National Association (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed April 3, 2007).
10.3	Confirmation, Re Issuer Warrant Transaction, dated March 22, 2007 between AMERIGROUP Corporation and Wells Fargo Bank, National Association (incorporated by reference to exhibit 10.2 to our Current Report on Form 8-K filed April 3, 2007).
10.4	Amendment to Confirmation, Re Issuer Warrant Transaction, dated April 3, 2007 between AMERIGROUP Corporation and Wells Fargo Bank, National Association (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed April 9, 2007).
10.5	AMERIGROUP Corporation Amended and Restated Form 2007 Cash Incentive Plan dated November 6, 2008, (incorporated by reference to exhibit 10.2 to our Current Report on Form 8-K filed on November 12, 2008).
10.6	Amendment to AMERIGROUP Corporation 2009 Equity Incentive Plan dated August 5, 2009, (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed on August 10, 2009).
10.7	Form 2008 AMERIGROUP Corporation Severance Plan (incorporated by reference to exhibit 10.6 to our Current Report on Form 8-K filed on November 12, 2008).
10.7.1	Amendment to the AMERIGROUP Corporation Severance Plan (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed on May 4, 2009).

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Exhibit Number	Description
10.8	Form of Officer and Director Indemnification Agreement (incorporated by reference to exhibit 10.16 to our Registration Statement on Form S-1 (No. 333-37410) filed on June 26, 2000).
10.9	Form of Employee Non-compete, Nondisclosure and Developments Agreement (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed on February 23, 2005).
10.10	Form of Incentive Stock Option Agreement (2009 Equity Incentive Plan); (incorporated by reference to exhibit 10.2 to our Current Report on Form 8-K, filed on May 4, 2009).
10.11	Form of Nonqualified Stock Option Agreement (2009 Equity Incentive Plan); (incorporated by reference to exhibit 10.3 to our Current Report on Form 8-K filed on May 4, 2009).
10.12	Form of Restricted Stock Agreement (2009 Equity Incentive Plan); (incorporated by reference to exhibit 10.4 to our Current Report on Form 8-K filed on May 4, 2009).
10.13	Form of Stock Appreciation Rights Agreement (2009 Equity Incentive Plan); (incorporated by reference to exhibit 10.5 to our Current Report Form 8-K filed on May 4, 2009).
10.14	Form of Restricted Stock Unit Agreement (2009 Equity Incentive Plan); (incorporated by reference to exhibit 10.1 to our Current Report Form 8-K filed on February 15, 2011).
10.15	AMERIGROUP Corporation Amended and Restated Form 2005 Executive Deferred Compensation Plan between AMERIGROUP Corporation and Executive Associates dated May 15, 2010, (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed on May 18, 2010).
10.16	AMERIGROUP Corporation Amended and Restated Form 2005 Non-Employee Director Deferred Compensation Plan between AMERIGROUP Corporation and Non-Executive Associates dated May 15, 2010, (incorporated by reference to exhibit 10.2 to our Current Report on Form 8-K filed on May 18, 2010).
10.17	Employment Agreement of James G. Carlson dated January 16, 2008 (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed on January 18, 2008).
10.17.1	Amendment No. 1 to Executive Employment Agreement dated November 6, 2008 between AMERIGROUP Corporation and James G. Carlson (incorporated by reference to exhibit 10.5 to our Current Report on Form 8-K filed on November 12, 2008).
10.17.2	Amendment No. 2 to Executive Employment Agreement dated August 4, 2009 between AMERIGROUP Corporation and James G. Carlson (incorporated by reference to exhibit 10.2 to our Current Report on Form 8-K filed on August 10, 2009).
10.18	Noncompetition Agreement for James G. Carlson dated January 16, 2008 (incorporated by reference to exhibit 10.2 to our Current Report on Form 8-K filed on January 18, 2008).
10.19	Amendment No. 3, Amended and Restated Contract between the Georgia Department of Community Health and AMERIGROUP Georgia Managed Care Company, Inc. for the provision of HMO services to Georgia Families for the period from July 1, 2008 through June 30, 2009, (incorporated by reference to Exhibit 10.4 to our Quarterly Report on Form 10-Q filed on October 28, 2008).
10.19.1	Amendment No. 4 between the Georgia Department of Community Health and AMGP Georgia Managed Care Company, Inc. for the provision of HMO services to Georgia Families for the period from July 1, 2008 through June 30, 2009, (incorporated by reference to Exhibit 10.5 to our Quarterly Report on Form 10-Q filed on October 28, 2008).
*10.19.2	Amendment No. 5 between Georgia Department of Community Health and AMGP Georgia Managed Care Company, Inc. for the provision of HMO services to Georgia Families for the period from July 1, 2008 through June 30, 2009, (incorporated by reference to Exhibit 10.6 to our Quarterly Report on Form 10-Q filed on October 28, 2008).
*10.19.3	Amendment No. 7 between Georgia Department of Community Health and AMGP Georgia Managed Care Company, Inc. for the provision of HMO services to Georgia Families for the period from July 1, 2009 through June 30, 2010, (incorporated by reference to Exhibit 10.3 to our Quarterly Report on Form 10-Q filed on November 4, 2009).

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Exhibit Number	Description
*10.19.4	Amendment No. 9 between Georgia Department of Community Health and AMGP Georgia Managed Care Company, Inc. for the provision of HMO services to Georgia Families for the period from July 1, 2010 through June 30, 2011, filed herewith.
*10.20	Health & Human Services Commission Uniform Managed Care Contract covering all service areas and products in which the subsidiary has agreed to participate, effective September 1, 2006 (incorporated by reference to exhibit 10.32.9 to our Quarterly Report on Form 10-Q filed on November 14, 2006).
*10.20.1	Amendment, effective September 1, 2007, to the Health & Human Services Commission Agreement for Health Services to the STAR, STAR+PLUS, CHIP, and CHIP Perinatal, programs in the Bexar, Dallas, Harris, Nueces, Tarrant and Travis Service Delivery Areas effectively extending the contract through August 31, 2008 (incorporated by reference to Exhibit 10.35.10 to our Quarterly Report on Form 10-Q filed on November 2, 2007).
*10.20.2	Amendment effective September 1, 2008, to the Health & Human Services Commission Agreement for Health Services to the STAR, STAR+PLUS, CHIP, and CHIP Perinatal programs effectively extending the contract through August 31, 2010, (incorporated by reference to Exhibit 10.1 to our Quarterly Report on Form 10-Q filed on October 28, 2008).
*10.20.3	Amendment effective March 1, 2009, to the Health & Human Services Commission Agreement for Health Services to the STAR, STAR +PLUS, CHIP, and CHIP Perinatal programs expiring August 31, 2010, (incorporated by reference to Exhibit 10.1 to our Quarterly Report on Form 10-Q filed on May 5, 2009).
*10.20.4	Amendment effective September 1, 2009, to the Health & Human Services Commission Agreement for Health Services to the STAR, STAR+PLUS, CHIP, and CHIP Perinatal programs in the Bexar, Dallas, Harris, Nueces, Tarrant, and Travis Service Delivery Areas expiring August 31, 2010, (incorporated by reference to Exhibit 10.2 to our Quarterly Report on Form 10-Q filed on November 4, 2009).
*10.20.5	Amendment effective September 1, 2010, to the Health & Human Services Commission Agreement for Health Services to the STAR, STAR+PLUS, CHIP, and CHIP Perinatal programs in the Bexar, Dallas, Harris, Nueces, Tarrant, and Travis Service Delivery Areas effectively extending the contract through August 31, 2013, (incorporated by reference to Exhibit 10.1 to our Quarterly Report on Form 10-Q filed on November 3, 2010).
*10.20.6	Amendment effective December 1, 2010, to the Health & Human Services Commission Agreement for Health Services to the STAR, STAR+PLUS, CHIP, and CHIP Perinatal programs in the Bexar, Dallas, Harris, Nueces, Tarrant, and Travis Service Delivery Areas expiring August 31, 2013, filed herewith.
*10.20.7	Amendment effective March 1, 2011, to the Health & Human Services Commission Agreement for Health Services to the STAR, STAR +PLUS, CHIP, and CHIP Perinatal programs in the Bexar, Dallas, Harris, Nueces, Tarrant, and Travis Service Delivery Areas expiring August 31, 2013, filed herewith.
10.21	Contractor Risk Agreement between the State of Tennessee and AMERIGROUP Tennessee, Inc. effective August 15, 2006, (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed on August 21, 2006).
10.21.1	Amendment No. 3 to Contract Risk Agreement between the State of Tennessee and AMERIGROUP Tennessee, Inc. effective July 1, 2008, (incorporated by reference to exhibit 10.8 to our Quarterly Report on Form 10-Q filed on July 29, 2008).
10.21.2	Amendment No. 4 to Contract Risk Agreement between the State of Tennessee and AMERIGROUP Tennessee, Inc. effective September 1, 2009, (incorporated by reference to exhibit 10.4 to our Quarterly Report on Form 10-Q filed on November 4, 2009).
10.21.3	Amendment to Amendment No. 4 to Contract Risk Agreement between the State of Tennessee and AMERIGROUP Tennessee, Inc. effective July 1, 2009, (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed on December 30, 2009).

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Exhibit Number	Description
10.21.4	Amendment No. 5 to Contract Risk Agreement between the State of Tennessee and AMERIGROUP Tennessee, Inc. effective March 1, 2010, (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed on May 26, 2010).
10.22	Settlement Agreement dated as of August 13, 2008, by and among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General of the Department of Health and Human Services; the State of Illinois acting through the Office of the Illinois Attorney General; Cleveland A. Tyson; AMERIGROUP Corporation; and AMERIGROUP Illinois, Inc. (incorporated by reference to Exhibit 10.1 to our Current Report on Form 8-K filed on August 14, 2008).
10.23	AMERIGROUP Corporation Amended and Restated Change in Control Benefit Policy dated November 6, 2008 (incorporated by reference to Exhibit 10.3 to our Current Report on Form 8-K filed on November 12, 2008).
10.24	AMERIGROUP Corporation Corporate Integrity Agreement (incorporated by reference to Exhibit 10.2 to our Current Report on Form 8-K filed on August 14, 2008).
12.1	Computation of Ratio of Earnings to Fixed Charges
14.1	AMERIGROUP Corporation Amended and Restated Code of Business Conduct and Ethics (incorporated by reference to Exhibit 14.1 to our Current Report on Form 8-K filed on August 10, 2009).
21.1	List of Subsidiaries
23.1	Consent of KPMG LLP, Independent Registered Public Accounting Firm, with respect to financial statements of the registrant.
31.1	Certification of Chief Executive Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002, dated February 23, 2011.
31.2	Certification of Chief Financial Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002, dated February 23, 2011.
32	Certification of Chief Executive Officer and Chief Financial Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002, dated February 23, 2011.
**101.INS	XBRL Instance Document.
**101.SCH	XBRL Taxonomy Extension Schema Document.
**101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
**101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
**101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
**101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

* The Company has requested confidential treatment of the redacted portions of this exhibit pursuant to Rule 24b-2, under the Securities Exchange Act of 1934, as amended, and has separately filed a complete copy of this exhibit with the Securities and Exchange Commission.

** In accordance with Rule 406T of Regulation S-T, the information in these exhibits is furnished and deemed not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, is deemed not filed for purposes of Section 18 of the Exchange Act of 1934, and otherwise is not subject to liability under these sections and shall not be incorporated by reference into any registration statement or other document filed under the Securities Act of 1933, as amended, except as expressly set forth by specific reference in such filing.

Exhibit 10.19.4

AMENDMENT #9 TO CONTRACT NO. 0652 BETWEEN
GEORGIA DEPARTMENT OF COMMUNITY HEALTH AND
AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.

This Amendment is between the Georgia Department of Community Health (hereinafter referred to as "DCH" or the "Department") and Amerigroup Georgia Managed Care Company, Inc. (hereinafter referred to as "Contractor") and is made effective this ___ day of _____, 2010 (hereinafter referred to as the "Effective Date"). Other than the changes, modifications and additions specifically articulated in this Amendment #9 to Contract # 0652, RFP#41900-001-0000000027, the original Contract shall remain in effect and binding on and against DCH and Contractor. Unless expressly modified or added in this Amendment #9 the terms and conditions of the original Contract are expressly incorporated into this Amendment #9 as if completely restated herein.

WHEREAS, DCH and Contractor executed a contract for the provision of services to members of the Georgia Families Program;

WHEREAS, DCH pays Contractor a per member per month capitation rate for each Georgia Families member enrolled in the Contractor's plan;

WHEREAS, DCH has sought permission from the Centers for Medicare and Medicaid Services (hereinafter referred to as "CMS") to revise the capitation rates payable to Contractor for State Fiscal Year 2011; and

WHEREAS, pursuant to **Section 32.0, *Amendments in Writing,*** DCH and Contractor desire to amend the above-referenced Contract by adding additional funding as set forth below.

NOW THEREFORE, for and in consideration of the mutual promises of the Parties, the terms, provisions and conditions of this Amendment and other good and valuable consideration, the sufficiency of which is hereby acknowledged, DCH and Contractor hereby agree as follows:

I. Upon receiving written notice from CMS indicating that agency's approval of the revised capitation rates, the parties shall delete the current ***Attachment H, Capitation Payment***, in its entirety and replace it with the new ***Attachment H, Capitation Payment*** contained at Exhibit 1 to this Amendment.

II. DCH and Contractor agree that they have assumed an obligation to perform the covenants, agreements, duties and obligations of the Contract, as modified and amended herein, and agree to abide by all the provisions, terms and conditions contained in the Contract as modified and amended.

III. This Amendment shall be binding and inure to the benefit of the parties hereto, their heirs, representatives, successors and assigns. Whenever the provisions of this Amendment and the Contract are in conflict, the provisions of this Amendment shall take precedence and control.

IV. It is understood by the Parties hereto that, if any part, term, or provision of this Amendment or this entire Amendment is held to be illegal or in conflict with any law of this State, then DCH, at its sole option, may enforce the remaining unaffected portions or provisions of this Amendment or of the Contract and the rights and obligations of the parties shall be construed and enforced as if the Contract or Amendment did not contain the particular part, term or provision held to be invalid.

V. This Amendment shall become effective as stated herein and shall remain effective for so long as the Contract is in effect.

VI. This Amendment shall be construed in accordance with the laws of the State of Georgia.

VIII. All other terms and conditions contained in the Contract and any amendment thereto, not amended by this Amendment, shall remain in full force and effect.

- SIGNATURES ON THE FOLLOWING PAGE-

SIGNATURE PAGE

IN WITNESS WHEREOF, DCH and Contractor, through their authorized officers and agents, have caused this Amendment to be executed on their behalf as of the date indicated.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

/s/ Clyde L. Reese, III — 9/23/10
Clyde L. Reese, III, Esq. Commissioner — Date

/s/ Jerry Dubberly — 9/23/10
Jerry Dubberly, Medicaid Division Chief — Date

AMERIGROUP

BY: /s/ Tunde Sotunde, M.D. — 09/16/2010
*SIGNATURE — Date

Tunde Sotunde, M.D.
Please Print/Type Name Here

AFFIX CORPORATE SEAL HERE
(Corporations without a seal, attach a Certificate of Corporate Resolution)

ATTEST: /s/ Nicholas J. Pace
**SIGNATURE

Director, Vice President and Secretary
TITLE

---

* Must be President, Vice President, CEO or Other Authorized Officer

** Must be Corporate Secretary

EXHIBIT 1

CONFIDENTIAL — NOT FOR CIRCULATION **ATTACHMENT H**

Attachment H is a table displaying the contracted rates by rate cell for each contracted region. These rates will be the basis for calculating capitation payments in each contracted Region.

(The table is displayed on the following page.)

************REDACTED************

Exhibit 10.20.6

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-R

Part 1: Parties to the Contract:

This Contract Amendment (the "Amendment") is between the Texas Health and Human Services Commission (HHSC), an administrative agency within the executive department of the State of Texas, having its principal office at 4900 North Lamar Boulevard, Austin, Texas 78751, and Amerigroup Texas, Inc. (HMO) a corporation organized under the laws of the State of Texas, having its principal place of business at: 2505 N. Highway 360, Suite 300, Grand Prairie, Texas 75050. HHSC and HMO may be referred to in this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their original contract, HHSC contract number 529-06-0280-00002 (the "Contract") as set forth herein. The Parties agree that the terms of the Contract will remain in effect and continue to govern except to the extent modified in this Amendment.

This Amendment is executed by the Parties in accordance with the authority granted in Attachment A to the HHSC Managed Care Contract document, "HHSC Uniform Managed Care Contract Terms & Conditions," Article 8, "Amendments and Modifications."

Part 2: Effective Date of Amendment:	**Part 3: Contract Expiration Date**	**Part 4: Operational Start Date:**
December 1, 2010	August 31, 2013	STAR and CHIP HMOs: September 1, 2006 STAR+PLUS HMOs: February 1, 2007 CHIP Perinatal HMOs: January 1, 2007

Part 5: Project Managers:

HHSC:

Scott Schalchlin
Director, Health Plan Operations
11209 Metric Boulevard, Building H
Austin, Texas 78758
Phone: 512-491-1866
Fax: 512-491-1969

HMO:

Aileen McCormick
Amerigroup Texas, Inc.
3800 Buffalo Speedway, Suite 400
Houston, Texas 77098
Phone: 713-218-5101
Fax: 713-218-8692

E-mail: amccorm@amerigroupcorp.com

Part 6: Deliver Legal Notices to:

HHSC:

General Counsel
4900 North Lamar Boulevard, 4th Floor
Austin, Texas 78751
Fax: 512-424-6586

HMO:

Amerigroup Texas, Inc.
3800 Buffalo Speedway, Suite 400
Houston, Texas 77098
Fax: 713-218-8692

Part 7: HMO Programs and Service Areas:

This Contract applies to the following HHSC HMO Programs and Service Areas *(check all that apply)*. All references in the Contract Attachments to HMO Programs or Service Areas that are not checked are superfluous and do not apply to the HMO.

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-R

☑ **Medicaid STAR HMO Program**

Service Areas:

☐ Bexar
☑ Dallas
☐ El Paso
☑ Harris
☐ Lubbock
☑ Nueces
☑ Tarrant
☑ Travis

See Attachment B-6, "Map of Counties with HMO Program Service Areas," for listing of counties included within the STAR Service Areas.

☑ **Medicaid STAR+PLUS HMO Program**

Service Areas:

☑ Bexar
☑ Harris
☐ Nueces
☑ Travis

See Attachment B-6.1, "Map of Counties with STAR+PLUS HMO Program Service Areas," for listing of counties included within the STAR +PLUS Service Areas.

☑ **CHIP HMO Program**

Core Service Areas:

☐ Bexar
☑ Dallas
☐ El Paso
☑ Harris
☐ Lubbock
☑ Nueces
☑ Tarrant
☐ Travis
☐ Webb

Optional Service Areas:

☐ Bexar
☐ El Paso
☐ Harris
☐ Lubbock
☐ Nueces
☐ Travis

See Attachment B-6, "Map of Counties with HMO Program Service Areas," for listing of counties included within the CHIP Core Service Areas and CHIP Optional Service Areas.

☑ **CHIP Perinatal Program**

Core Service Areas:

☐ Bexar
☐ Dallas
☐ El Paso
☐ Harris
☐ Lubbock
☐ Nueces
☑ Tarrant
☐ Travis

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-R

Optional Service Areas:

☐ Bexar ☐ Lubbock
☐ El Paso ☐ Nueces
☐ Harris ☐ Travis

See Attachment B-6.2, "Map of Counties with CHIP Perinatal HMO Program Service Areas," for a list of counties included within the CHIP Perinatal Service Areas.

Part 8: Payment

Part 8 of the HHSC Managed Care Contract document, "Payment," is modified to add the capitation rates for Rate Period 5.

☑ **Medicaid STAR HMO PROGRAM**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the STAR Program. The following Rate Cells and Capitation Rates will apply to Rate Period 5:

******REDACTED******

STAR SSI Administrative Fee: HHSC will pay STAR HMO a monthly Administrative fee of ******REDACTED****** per SSI Beneficiary who voluntarily enrolls in HMO in accordance with Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10.

Delivery Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Delivery Supplemental Payment for the STAR Program.

Bariatric Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Bariatric Supplemental Payment for the STAR Program.

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-R

☑ **Medicaid STAR+PLUS HMO Program**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the STAR+PLUS Program. The following Rate Cells and Capitation Rates will apply to Rate Period 5:

******REDACTED******

Bariatric Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Bariatric Supplemental Payment for the STAR+PLUS Program.

☑ **CHIP HMO PROGRAM**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the CHIP Program. The following Rate Cells and Capitation Rates will apply to Rate Period 5:

******REDACTED******

Delivery Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Delivery Supplemental Payment for the CHIP Program. The CHIP Delivery Supplemental Payment is ********REDACTED******** for all Service Areas.

☑ **CHIP Perinatal Program**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the CHIP Perinatal Program.

******REDACTED******

Delivery Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Delivery Supplemental Payment for the CHIP Perinatal Program. The CHIP Perinatal Delivery Supplemental Payment is ********REDACTED******** for Perinates between 186% and 200% of the Federal Poverty Level for all Service Areas.

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-R

Part 9: Contract Attachments:

Modifications to Part 9 of the HHSC Managed Care Contract document, "Contract Attachments," are italicized below:

A: HHSC Uniform Managed Care Contract Terms & Conditions — *Version 1.16 is replaced with Version 1.17*

B: Scope of Work/Performance Measures — *Version 1.16 is replaced with Version 1.17 for all attachments, except if noted.*

- B-1: HHSC RFP 529-04-272, Sections 6-9
- B-2: Covered Services
  - B-2.1 STAR+PLUS Covered Services
  - B-2.2 CHIP Perinatal Program Covered Services
- B-3: Value-added Services
  - B-3.1 STAR+PLUS Value-added Services
  - B-3.2 CHIP Perinatal Program Value-added Services
- B-4: Performance Improvement Goals
  - B-4.1 SFY 2008 Performance Improvement Goals
- B-5: Deliverables/Liquidated Damages Matrix
- B-6: Map of Counties with STAR and CHIP HMO Program Service Areas
  - B-6.1 STAR+PLUS Service Areas
  - B-6.2 CHIP Perinatal Program Service Areas
- B-7: STAR+PLUS Attendant Care Enhanced Payment Methodology

C: HMO's Proposal and Related Documents

- C-1: HMO's Proposal
- C-2: HMO Supplemental Responses
- C-3: Agreed Modifications to HMO's Proposal

Part 10: Special Provision for Nueces Service Area

Attachment A, Section 10.04 is amended to include sub-part (b) as follows:

(b) In addition to the reasons set forth in Section 10.04(a), the Parties expressly understand and agree that HHSC may, at any time, unilaterally adjust the Rate Period 2 STAR Program Capitation Rates for the Nueces Service Area. HHSC is entitled to unilaterally adjust such rates, prospectively and/or retrospectively, if it determines that: (1) the cumulative Rate Period 2 Encounter Data for all HMOs in the Nueces Service Area does not support the Capitation Rates; or (2) economic factors in the Nueces Service Area significantly and measurably impact providers or the delivery of Covered Services to Members. For adjustments made pursuant to this Section 10.04(b), HHSC will provide written notice at least ten (10) Business Days before: (1) the effective date of a prospective adjustment; (2) offsetting Capitation Payments to recover retrospective adjustments. Any adjustments to the Rate Period 2 Capitation Rates must meet the actuarial soundness requirements of Attachment A, Section 10.03, "Certification of Capitation Rates."

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-R

Part 11: Signatures:

The Parties have executed this Contract Amendment in their capacities as stated below with authority to bind their organizations on the dates set forth by their signatures. By signing this Amendment, the Parties expressly understand and agree that this Amendment is hereby made part of the Contract as though it were set out word for word in the Contract.

Texas Health and Human Services Commission	**Amerigroup Texas, Inc.**
/s/ Charles E. Bell, M.D.	/s/ Aileen McCormick
Charles E. Bell, M.D.	By: Aileen McCormick
Deputy Executive Commissioner for Health Services	Title: President and CEO
Date: 11/5/10	Date: October 13, 2010

Exhibit 10.20.7

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-S

Part 1: Parties to the Contract:

This Contract Amendment (the "Amendment") is between the Texas Health and Human Services Commission (HHSC), an administrative agency within the executive department of the State of Texas, having its principal office at 4900 North Lamar Boulevard, Austin, Texas 78751, and Amerigroup Texas, Inc. (HMO) a corporation organized under the laws of the State of Texas, having its principal place of business at: 3800 Buffalo Speedway, Suite 400, Houston, Texas 77098. HHSC and HMO may be referred to in this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their original contract, HHSC contract number 529-06-0280-00002 (the "Contract") as set forth herein. The Parties agree that the terms of the Contract will remain in effect and continue to govern except to the extent modified in this Amendment.

This Amendment is executed by the Parties in accordance with the authority granted in Attachment A to the HHSC Managed Care Contract document, "HHSC Uniform Managed Care Contract Terms & Conditions," Article 8, "Amendments and Modifications."

Part 2: Effective Date of Amendment:	**Part 3: Contract Expiration Date**	**Part 4: Operational Start Date:**
March 1, 2011	August 31, 2013	STAR and CHIP HMOs: September 1, 2006 STAR+PLUS HMOs: February 1, 2007 CHIP Perinatal HMOs: January 1, 2007

Part 5: Project Managers:

HHSC:

Scott Schalchlin
Director, Health Plan Operations
11209 Metric Boulevard, Building H
Austin, Texas 78758
Phone: 512-491-1866
Fax: 512-491-1969

HMO:

Aileen McCormick
Amerigroup Texas, Inc.
3800 Buffalo Speedway, Suite 400
Houston, Texas 77098
Phone: 713-218-5101
Fax: 713-218-8692

E-mail: amccorm@amerigroupcorp.com

Part 6: Deliver Legal Notices to:

HHSC:

General Counsel
4900 North Lamar Boulevard, 4th Floor
Austin, Texas 78751
Fax: 512-424-6586

HMO:

Amerigroup Texas, Inc.
3800 Buffalo Speedway, Suite 400
Houston, Texas 77098
Fax: 713-218-8692

Part 7: HMO Programs and Service Areas:

This Contract applies to the following HHSC HMO Programs and Service Areas *(check all that apply)*. All references in the Contract Attachments to HMO Programs or Service Areas that are not checked are superfluous and do not apply to the HMO.

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-S

☑ **Medicaid STAR HMO Program**

Service Areas:

☐ Bexar
☑ Dallas
☐ El Paso
☑ Harris
☐ Lubbock
☑ Nueces
☑ Tarrant
☑ Travis

See Attachment B-6, "Map of Counties with HMO Program Service Areas," for listing of counties included within the STAR Service Areas.

☑ **Medicaid STAR+PLUS HMO Program**

Service Areas:

☑ Bexar
☑ Harris
☐ Nueces
☑ Travis

See Attachment B-6.1, "Map of Counties with STAR+PLUS HMO Program Service Areas," for listing of counties included within the STAR +PLUS Service Areas.

☑ **CHIP HMO Program**

Core Service Areas:

☐ Bexar
☑ Dallas
☐ El Paso
☑ Harris
☐ Lubbock
☑ Nueces
☑ Tarrant
☐ Travis

Optional Service Areas:

☐ Bexar
☐ El Paso
☐ Harris
☐ Lubbock
☐ Nueces
☐ Travis

See Attachment B-6, "Map of Counties with HMO Program Service Areas," for listing of counties included within the CHIP Core Service Areas and CHIP Optional Service Areas.

☑ **CHIP Perinatal Program**

Core Service Areas:

☐ Bexar
☐ Dallas
☐ El Paso
☐ Harris
☐ Lubbock
☐ Nueces
☑ Tarrant
☐ Travis

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-S

Optional Service Areas:

☐ Bexar ☐ Lubbock
☐ El Paso ☐ Nueces
☐ Harris ☐ Travis

See Attachment B-6.2, "Map of Counties with CHIP Perinatal HMO Program Service Areas," for a list of counties included within the CHIP Perinatal Service Areas.

Part 8: Payment

Part 8 of the HHSC Managed Care Contract document, "Payment," is modified to add the capitation rates for Rate Period 5.

☑ **Medicaid STAR HMO PROGRAM**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the STAR Program. The following Rate Cells and Capitation Rates will apply to Rate Period 5:

******REDACTED******

STAR SSI Administrative Fee: HHSC will pay STAR HMO a monthly Administrative fee of ******REDACTED****** per SSI Beneficiary who voluntarily enrolls in HMO in accordance with Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10.

Delivery Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Delivery Supplemental Payment for the STAR Program.

Bariatric Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Bariatric Supplemental Payment for the STAR Program.

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-S

☑ **Medicaid STAR+PLUS HMO Program**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the STAR+PLUS Program. The following Rate Cells and Capitation Rates will apply to Rate Period 5:

******REDACTED******

Bariatric Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Bariatric Supplemental Payment for the STAR+PLUS Program.

☑ **CHIP HMO PROGRAM**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the CHIP Program. The following Rate Cells and Capitation Rates will apply to Rate Period 5:

******REDACTED******

Delivery Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Delivery Supplemental Payment for the CHIP Program. The CHIP Delivery Supplemental Payment is ********REDACTED******** for all Service Areas.

☑ **CHIP Perinatal Program**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the CHIP Perinatal Program.

******REDACTED******

Delivery Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Delivery Supplemental Payment for the CHIP Perinatal Program. The CHIP Perinatal Delivery Supplemental Payment is ********REDACTED******** for Perinates between 186% and 200% of the Federal Poverty Level for all Service Areas.

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-S

Part 9: Contract Attachments:

Modifications to Part 9 of the HHSC Managed Care Contract document, "Contract Attachments," are italicized below:

A: HHSC Uniform Managed Care Contract Terms & Conditions — *Version 1.17 is replaced with Version 1.18*

B: Scope of Work/Performance Measures — *Version 1.17 is replaced with Version 1.18 for all attachments, except if noted.*

- B-1: HHSC RFP 529-04-272, Sections 6-9
- B-2: Covered Services
  - B-2.1 STAR+PLUS Covered Services
  - B-2.2 CHIP Perinatal Program Covered Services
- B-3: Value-added Services
  - B-3.1 STAR+PLUS Value-added Services
  - B-3.2 CHIP Perinatal Program Value-added Services
- B-4: Performance Improvement Goals
  - B-4.1 SFY 2008 Performance Improvement Goals
- B-5: Deliverables/Liquidated Damages Matrix
- B-6: Map of Counties with STAR and CHIP HMO Program Service Areas
  - B-6.1 STAR+PLUS Service Areas
  - B-6.2 CHIP Perinatal Program Service Areas
- B-7: STAR+PLUS Attendant Care Enhanced Payment Methodology

C: HMO's Proposal and Related Documents

- C-1: HMO's Proposal
- C-2: HMO Supplemental Responses
- C-3: Agreed Modifications to HMO's Proposal

Part 10: Special Provision for Nueces Service Area

Attachment A, Section 10.04 is amended to include sub-part (b) as follows:

(b) In addition to the reasons set forth in Section 10.04(a), the Parties expressly understand and agree that HHSC may, at any time, unilaterally adjust the Rate Period 2 STAR Program Capitation Rates for the Nueces Service Area. HHSC is entitled to unilaterally adjust such rates, prospectively and/or retrospectively, if it determines that: (1) the cumulative Rate Period 2 Encounter Data for all HMOs in the Nueces Service Area does not support the Capitation Rates; or (2) economic factors in the Nueces Service Area significantly and measurably impact providers or the delivery of Covered Services to Members. For adjustments made pursuant to this Section 10.04(b), HHSC will provide written notice at least ten (10) Business Days before: (1) the effective date of a prospective adjustment; (2) offsetting Capitation Payments to recover retrospective adjustments. Any adjustments to the Rate Period 2 Capitation Rates must meet the actuarial soundness requirements of Attachment A, Section 10.03, "Certification of Capitation Rates."

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: HHSC Managed Care Contract HHSC Contract No. 529-06-0280-00002-S

Part 11: Signatures:

The Parties have executed this Contract Amendment in their capacities as stated below with authority to bind their organizations on the dates set forth by their signatures. By signing this Amendment, the Parties expressly understand and agree that this Amendment is hereby made part of the Contract as though it were set out word for word in the Contract.

Taxas Health and Human Services Commission

/s/ Charles E. Bell, M.D.
Charles E. Bell, M.D.
Deputy Executive Commisssioner for Health Services
Date: 2/8/11

Amerigroup Texas, Inc.

/s/ Aileen McCormick
By: Aileen McCormick
Title: President and CEO
Date: January 19, 2011

Exhibit 12.1

	Years Ended December 31,				
	2010	2009	2008	2007	2006
Earnings:					
Income (loss) before income taxes	$ 437,171	$ 201,419	$ (2,256)	$ 179,894	$ 173,082
Add: fixed charges	22,569	24,414	30,439	27,287	5,020
Total earnings	$ 459,740	$ 225,833	$ 28,183	$ 207,181	$ 178,102
Fixed charges:					
Interest expensed	$ 16,011	$ 16,266	$ 20,514	$ 18,962	$ 608
Amortization of debt issuance cost	1,315	2,444	4,313	3,410	508
Interest component of rental payments (1)	5,243	5,704	5,612	4,915	3,904
Total fixed charges	$ 22,569	$ 24,414	$ 30,439	$ 27,287	$ 5,020
Ratio of earnings to fixed charges	20.4	9.3	0.9	7.6	35.5
Total additional earnings required to achieve 1:1 coverage ratio of fixed charges	$ —	$ —	$ 2,089	$ —	$ —

(1) Estimated at 33% of rental expense as a reasonable approximation of the interest factor.

Exhibit 21.1

List of Subsidiary Corporations

AMERIGROUP Corporation

The Registrant owns and controls the following subsidiary corporations:

Entity	State of Incorporation	Incorporation Date
AMERIBRIDGE, Inc.	Florida*	8/8/2007
AMERIGROUP California, Inc.	California*	3/5/2002
AMERIGROUP Colorado, Inc.	Colorado*	1/13/2005
Amerigroup Community Care of Arizona, Inc.	Arizona*	8/7/2002
AMERIGROUP Community Care of Mississippi, Inc.	Mississippi*	2/27/2009
AMERIGROUP Community Care of New Mexico, Inc.	New Mexico	12/6/2004
AMERIGROUP Community Care of South Carolina, Inc.	South Carolina*	10/24/2003
AMERIGROUP Connecticut, Inc.	Connecticut*	3/5/2002
AMERIGROUP Delaware, Inc.	Delaware*	3/1/2002
AMERIGROUP Florida, Inc.	Florida	12/31/2002
AMERIGROUP Hawaii, Inc.	Hawaii*	11/9/2007
AMERIGROUP Health Solutions, Inc.	Delaware*	8/31/2007
AMERIGROUP Indiana, Inc.	Indiana*	3/4/2002
AMERIGROUP Louisiana, Inc.	Louisiana*	3/25/2009
AMERIGROUP Maine, Inc.	Maine*	7/16/2010
AMERIGROUP Maryland, Inc.	Maryland	1/7/2009
AMERIGROUP Massachusetts, Inc.	Massachusetts*	3/5/2002
AMERIGROUP Michigan, Inc.	Michigan*	4/1/2002
AMERIGROUP Nevada, Inc.	Nevada	8/11/2005
AMERIGROUP New Jersey, Inc.	New Jersey	4/3/1995
AMERIGROUP New York, LLC	New York	10/10/1995
AMERIGROUP Ohio, Inc.	Ohio	3/8/2002
AMERIGROUP Pennsylvania, Inc.	Pennsylvania*	3/5/2002
AMERIGROUP Puerto Rico, Inc.	Puerto Rico*	3/13/2002
AMERIGROUP Tennessee, Inc.	Tennessee	4/23/2006
AMERIGROUP Texas, Inc.	Texas	6/19/1995
AMERIGROUP Virginia, Inc.	Virginia	8/30/2004
AMERIGROUP Washington, Inc.	Washington*	9/13/2010
AMERIGROUP Wisconsin, Inc.	Wisconsin*	4/2/2002
AMERIVANTAGE, Inc.	Delaware*	1/16/2004
AMGP Georgia Managed Care Company, Inc.	Georgia	6/11/2003
AMGP Georgia, Inc.	Georgia*	11/8/2002
PHP Holdings, Inc.	Florida	3/30/1995

* non-active

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

The Board of Directors AMERIGROUP Corporation:

We consent to the incorporation by reference in Registration Statement No. 333-37410 on post-effective amendment No. 1 to Form S-1, in the Registration Statement No. 333-109134 on Form S-8, in the Registration Statement No. 333-125033 on Form S-8, in the Registration Statement No. 333-159024 on Form S-8, in the Registration Statement No. 333-143197 on Form S-3, and in the Registration Statement No. 333-156134 on Form S-3 of AMERIGROUP Corporation of our reports dated February 23, 2011, with respect to the consolidated balance sheets of AMERIGROUP Corporation and subsidiaries as of December 31, 2010 and 2009, and the related consolidated statements of operations and consolidated statements of stockholders' equity and cash flows for each of the years in the three-year period ended December 31, 2010, and the effectiveness of internal control over financial reporting as of December 31, 2010, which reports appear in the December 31, 2010 annual report on Form 10-K of AMERIGROUP Corporation.

Norfolk, Virginia February 23, 2011

Exhibit 31.1

CERTIFICATION
OF
CHIEF EXECUTIVE OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, James G. Carlson, Chairman, President and Chief Executive Officer of AMERIGROUP Corporation, certify that:

1. I have reviewed this Annual Report on Form 10-K for the year ended December 31, 2010 of AMERIGROUP Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a- 15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's fourth fiscal quarter that

has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 23, 2011

/s/ JAMES G. CARLSON
James G. Carlson
Chairman, President and Chief Executive Officer

Exhibit 31.2

CERTIFICATION
OF
CHIEF FINANCIAL OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, James W. Truess, Executive Vice President and Chief Financial Officer of AMERIGROUP Corporation, certify that:

1. I have reviewed this Annual Report on Form 10-K for the year ended December 31, 2010 of AMERIGROUP Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a- 15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's fourth fiscal quarter that

has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 23, 2011

/s/ JAMES W. TRUESS
James W. Truess
Executive Vice President and Chief Financial Officer

Exhibit 32

CERTIFICATION OF CEO AND CFO
PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of AMERIGROUP Corporation (the "Company") on Form 10-K for the year ended December 31, 2010 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), James G. Carlson, as Chief Executive Officer of the Company, hereby certifies to the best of his knowledge, and James W. Truess, as Chief Financial Officer (principal financial officer) of the Company, hereby certifies to the best of his knowledge, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

/s/ JAMES G. CARLSON
James G. Carlson
Chairman, President and Chief Executive Officer
Date: February 23, 2011

/s/ JAMES W. TRUESS
James W. Truess
Executive Vice President and Chief Financial Officer
Date: February 23, 2011

This certification accompanies this Report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended.

AMERIGROUP CORP (AGP)

10-Q

Quarterly report pursuant to sections 13 or 15(d)
Filed on 05/03/2011
Filed Period 03/31/2011

THOMSON REUTERS

Westlaw BUSINESS

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the quarterly period ended March 31, 2011

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission File Number 001-31574

AMERIGROUP Corporation

(Exact name of registrant as specified in its charter)

Delaware *(State or Other Jurisdiction of Incorporation or Organization)*	**54-1739323** *(I.R.S. Employer Identification No.)*
4425 Corporation Lane, Virginia Beach, VA *(Address of principal executive offices)*	**23462** *(Zip Code)*

Registrant's telephone number, including area code:
(757) 490-6900

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

As of April 29, 2011, there were 49,603,017 shares outstanding of the Company's common stock, par value $0.01 per share.

AMERIGROUPCorporation and Subsidiaries

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Part I. Financial Information

Item 1. ***Financial Statements***

AMERIGROUP Corporation and Subsidiaries

Condensed Consolidated Balance Sheets
(Dollars in thousands, except per share data)
(Unaudited)

	March 31, 2011	December 31, 2010
ASSETS		
Current assets:		
Cash and cash equivalents	$ 601,950	$ 763,946
Short-term investments	307,072	230,007
Premium receivables	110,315	83,203
Deferred income taxes	27,952	28,063
Provider and other receivables	27,109	32,861
Prepaid expenses	25,198	13,538
Other current assets	9,227	7,083
Total current assets	1,108,823	1,158,701
Long-term investments	807,260	639,165
Investments on deposit for licensure	119,158	114,839
Property, equipment and software, net of accumulated depreciation of $182,713 and $174,683 at March 31, 2011 and December 31, 2010, respectively	99,074	96,967
Other long-term assets	14,050	13,220
Goodwill	260,496	260,496
Total assets	$2,408,861	$ 2,283,388
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Claims payable	$ 539,767	$ 510,675
Bank overdrafts	64,404	40,890
Unearned revenue	100,231	103,067
Accrued payroll and related liabilities	46,871	71,253
Contractual refunds payable	51,645	44,563
Accounts payable, accrued expenses and other	105,310	80,393
Total current liabilities	908,228	850,841
Long-term convertible debt	248,591	245,750
Deferred income taxes	7,146	7,393
Other long-term liabilities	12,296	13,767
Total liabilities	1,176,261	1,117,751
Stockholders' equity:		
Common stock, $0.01 par value. Authorized 100,000,000 shares; outstanding 48,272,578 and 48,167,229 at March 31, 2011 and December 31, 2010, respectively	560	554
Additional paid-in capital	566,361	543,611
Accumulated other comprehensive income	27	627
Retained earnings	934,480	864,003
	1,501,428	1,408,795
Less treasury stock at cost (8,214,445 and 7,759,234 shares at March 31, 2011 and December 31, 2010, respectively)	(268,828)	(243,158)
Total stockholders' equity	1,232,600	1,165,637
Total liabilities and stockholders' equity	$2,408,861	$ 2,283,388

See accompanying notes to condensed consolidated financial statements.

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AMERIGROUP Corporation and Subsidiaries

Condensed Consolidated Income Statements
(Dollars in thousands, except per share data)
(Unaudited)

	Three Months Ended March 31,	
	2011	2010
Revenues:		
Premium	$ 1,535,795	$ 1,366,767
Investment income and other	4,120	4,882
Total revenues	1,539,915	1,371,649
Expenses:		
Health benefits	1,256,962	1,141,572
Selling, general and administrative	116,459	117,423
Premium tax	40,448	31,472
Depreciation and amortization	9,090	8,710
Interest	4,179	3,990
Total expenses	1,427,138	1,303,167
Income before income taxes	112,777	68,482
Income tax expense	42,300	26,300
Net income	$ 70,477	$ 42,182
Net income per share:		
Basic net income per share	$ 1.46	$ 0.83
Weighted average number of common shares outstanding	48,265,104	50,550,754
Diluted net income per share	$ 1.37	$ 0.82
Weighted average number of common shares and dilutive potential common shares outstanding	51,534,794	51,226,435

See accompanying notes to condensed consolidated financial statements.

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AMERIGROUP Corporation and Subsidiaries

Condensed Consolidated Statement of Stockholders' Equity
Three Months Ended March 31, 2011
(Dollars in thousands)
(Unaudited)

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings	Treasury Stock		Total Stockholders' Equity
	Shares	Amount				Shares	Amount	
Balances at January 1, 2011	48,167,229	$ 554	$543,611	$ 627	$864,003	7,759,234	$(243,158)	$1,165,637
Common stock issued upon exercise of stock options and vesting of restricted stock grants	560,560	6	15,169	—	—	—	—	15,175
Compensation expense related to share-based payments	—	—	4,856	—	—	—	—	4,856
Tax benefit related to share-based payments	—	—	2,725	—	—	—	—	2,725
Employee stock relinquished for payment of taxes	(14,883)	—	—	—	—	14,883	(878)	(878)
Common stock repurchases	(440,328)	—	—	—	—	440,328	(24,792)	(24,792)
Unrealized loss on available-for-sale securities, net of tax	—	—	—	(600)	—	—	—	(600)
Net income	—	—	—	—	70,477	—	—	70,477
Balances at March 31, 2011	48,272,578	$ 560	$566,361	$ 27	$934,480	8,214,445	$(268,828)	$1,232,600

See accompanying notes to condensed consolidated financial statements.

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AMERIGROUP Corporation and Subsidiaries
Condensed Consolidated Statements of Cash Flows
(Dollars in thousands)
(Unaudited)

	Three Months Ended March 31, 2011	Three Months Ended March 31, 2010
Cash flows from operating activities:		
Net income	$ 70,477	$ 42,182
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Depreciation and amortization	9,090	8,710
Loss on disposal or abandonment of property, equipment and software	159	8
Deferred tax expense (benefit)	227	(821)
Compensation expense related to share-based payments	4,856	4,427
Convertible debt non-cash interest	2,841	2,661
Other	3,451	1,903
Changes in assets and liabilities (decreasing) increasing cash flows from operations:		
Premium receivables	(27,112)	(44,041)
Prepaid expenses, provider and other receivables and other current assets	(9,873)	(15,567)
Other assets	(1,296)	(783)
Claims payable	29,092	20,184
Accounts payable, accrued expenses, contractual refunds payable and other current liabilities	5,917	28,949
Unearned revenue	(2,836)	(51,172)
Other long-term liabilities	(1,471)	(3,489)
Net cash provided by (used in) operating activities	83,522	(6,849)
Cash flows from investing activities:		
Proceeds from sale of trading securities	—	2,950
Proceeds from sale of available-for-sale securities	199,843	213,793
Purchase of available-for-sale securities	(449,244)	(248,224)
Proceeds from redemption of investments on deposit for licensure	22,685	18,315
Purchase of investments on deposit for licensure	(27,177)	(21,481)
Purchase of property, equipment and software	(10,890)	(6,435)
Purchase of contract rights and related assets	—	(13,420)
Net cash used in investing activities	(264,783)	(54,502)
Cash flows from financing activities:		
Net increase in bank overdrafts	23,514	—
Customer funds administered	2,643	1,611
Proceeds from exercise of stock options	15,175	1,852
Repurchase of common stock shares	(24,792)	(6,982)
Tax benefit related to share-based payments	2,725	139
Net cash provided by (used in) financing activities	19,265	(3,380)
Net decrease in cash and cash equivalents	(161,996)	(64,731)
Cash and cash equivalents at beginning of period	763,946	505,915
Cash and cash equivalents at end of period	$ 601,950	$ 441,184
Supplemental disclosures of non-cash information:		
Employee stock relinquished for payment of taxes	$ (878)	$ (700)
Unrealized (loss) gain on available-for-sale securities, net of tax	$ (600)	$ 242

See accompanying notes to condensed consolidated financial statements.

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AMERIGROUP Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements
(Dollars in thousands, except per share data)
(Unaudited)

1. Interim Financial Reporting

Basis of Presentation

The accompanying Condensed Consolidated Financial Statements as of March 31, 2011 and for the three months ended March 31, 2011 and 2010 of AMERIGROUP Corporation and its subsidiaries (the "Company"), are unaudited and reflect all adjustments, consisting only of normal recurring adjustments, which are, in the opinion of management, necessary for a fair presentation of the Company's financial position at March 31, 2011 and operating results for the interim periods ended March 31, 2011 and 2010. The December 31, 2010 Condensed Consolidated Balance Sheet was derived from the audited consolidated financial statements as of that date. Certain reclassifications have been made to prior year amounts to conform to the current year presentation.

The Condensed Consolidated Financial Statements should be read in conjunction with the audited consolidated financial statements and accompanying notes thereto and management's discussion and analysis of financial condition and results of operations for the year ended December 31, 2010 contained in the Company's Annual Report on Form 10-K filed with the Securities and Exchange Commission ("SEC") on February 23, 2011. The results of operations for the three months ended March 31, 2011 are not necessarily indicative of the results to be expected for the entire year ending December 31, 2011.

2. Earnings per Share

Basic net income per common share is computed by dividing net income by the weighted average number of shares of common stock outstanding. Diluted net income per common share is computed by dividing net income by the weighted average number of shares of common stock outstanding plus other potentially dilutive securities. Restricted shares and restricted share units subject to performance and/or market conditions are only included in the calculation of diluted net income per common share calculations if all of the necessary performance and/or market conditions have been satisfied and the impact is not anti-dilutive. All potential dilutive securities are determined by applying the treasury stock method. The following table sets forth the calculations of basic and diluted net income per share:

	Three Months Ended March 31,	
	2011	2010
Basic net income per share:		
Net income	$ 70,477	$ 42,182
Weighted average number of common shares outstanding	48,265,104	50,550,754
Basic net income per share	$ 1.46	$ 0.83
Diluted net income per share:		
Net income	$ 70,477	$ 42,182
Weighted average number of common shares outstanding	48,265,104	50,550,754
Dilutive effect of stock options and non-vested stock awards	1,823,865	675,681
Dilutive effect of assumed conversion of the 2.0% Convertible Senior Notes	1,351,908	—
Dilutive effect of warrants	93,917	—
Weighted average number of common shares and dilutive potential common shares outstanding	51,534,794	51,226,435
Diluted net income per share	$ 1.37	$ 0.82

AMERIGROUP Corporation and Subsidiaries

Notes to Condensed Consolidated Financial Statements — (Continued)

Potential common stock equivalents representing 13,682 shares and 2,801,645 shares for the three months ended March 31, 2011 and 2010, respectively, were not included in the computation of diluted net income per share because to do so would have been anti-dilutive.

The shares issuable upon conversion of the Company's 2.0% Convertible Senior Notes (the "2.0% Convertible Senior Notes") due May 15, 2012 which were issued effective March 28, 2007 in the aggregate principal amount of $260,000 (See Note 8) were not included in the computation of diluted net income per share for the three months ended March 31, 2010 because to do so would have been anti-dilutive.

The Company's warrants to purchase shares of its common stock sold on March 28, 2007 and April 9, 2007 (See Note 8) were not included in the computation of diluted net income per share for the three months ended March 31, 2010 because to do so would have been anti-dilutive.

3. Fair Value Measurements

The fair value of a financial instrument is the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The following methods and assumptions were used to estimate the fair value of each class of financial instruments:

Cash, premium receivables, provider and other receivables, prepaid expenses, other current assets, claims payable, bank overdrafts, unearned revenue, accrued payroll and related liabilities, contractual refunds payable and accounts payable, accrued expenses and other current liabilities: The fair value of these financial instruments approximates the historical cost because of the short maturity of these items.

Cash equivalents, short-term investments, long-term investments (other than auction rate securities), investments on deposit for licensure, cash surrender value of life insurance policies (included in other long-term assets), long-term convertible debt, deferred compensation (included in other long-term liabilities): Fair value for these items is determined based upon quoted market prices.

Auction rate securities (included in long-term investments) and the forward contract related to certain auction rate securities (included in other long-term assets at March 31, 2010): Fair value for these items is determined based upon discounted cash flow analyses.

Assets and liabilities recorded at fair value in the Condensed Consolidated Balance Sheets are categorized based upon a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include:

Level 1 — Observable inputs such as quoted prices in active markets: The Company's Level 1 securities consist of money market funds, debt securities of government sponsored entities, Federally insured corporate bonds and U.S. Treasury securities. Level 1 securities are classified as short-term investments, long-term investments and investments on deposit for licensure in the accompanying Condensed Consolidated Balance Sheets. These securities are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Inputs other than quoted prices in active markets that are either directly or indirectly observable: The Company's Level 2 securities consist of certificates of deposit, commercial paper, corporate bonds and municipal bonds and are classified as short-term investments, long-term investments and investments on deposit for licensure in the accompanying Condensed Consolidated Balance Sheets. The Company's investments in securities classified as Level 2 are traded frequently though not necessarily daily. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions: The Company's Level 3 securities consist of auction rate securities issued by

AMERIGROUP Corporation and Subsidiaries

Notes to Condensed Consolidated Financial Statements — (Continued)

student loan corporations established by various state governments. The auction events for these securities failed during early 2008 and have not resumed. Therefore, the estimated fair values of these securities have been determined utilizing an income approach, specifically discounted cash flow analyses. These analyses consider among other items, the creditworthiness of the issuer, the timing of the expected future cash flows, including the final maturity associated with the securities, and an assumption of when the next time the security is expected to have a successful auction. These securities were also compared, when possible, to other observable and relevant market data. As the timing of future successful auctions, if any, cannot be predicted, available-for-sale auction rate securities are classified as long-term investments in the accompanying Condensed Consolidated Balance Sheets.

Transfers between levels, as a result of changes in the inputs used to determine fair value, are recognized as of the beginning of the reporting period in which the transfer occurs. There were no transfers between levels for the periods ended March 31, 2011 and December 31, 2010.

Assets

The Company's assets measured at fair value on a recurring basis at March 31, 2011 were as follows:

		Fair Value Measurements at Reporting Date Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash equivalents:				
Certificates of deposit	$ 140,313	$ —	$ 140,313	$ —
Commercial paper	23,302	—	23,302	—
Debt securities of government sponsored entities	82,996	82,996	—	—
Money market funds	364,087	364,087	—	—
Available-for-sale securities:				
Auction rate securities	17,394	—	—	17,394
Certificates of deposit	13,153	—	13,153	—
Commercial paper	4,494	—	4,494	—
Corporate bonds	300,704	—	300,704	—
Debt securities of government sponsored entities	434,896	434,896	—	—
Federally insured corporate bonds	21,350	21,350	—	—
Municipal bonds	387,322	—	387,322	—
U.S. Treasury securities	31,638	31,638	—	—
Total assets measured at fair value	$ 1,821,649	$ 934,967	$ 869,288	$ 17,394

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AMERIGROUP Corporation and Subsidiaries

Notes to Condensed Consolidated Financial Statements — (Continued)

The Company's assets measured at fair value on a recurring basis at December 31, 2010 were as follows:

		Fair Value Measurements at Reporting Date Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash equivalents:				
Certificates of deposit	$ 137,215	$ —	$ 137,215	$ —
Commercial paper	34,742	—	34,742	—
Corporate bonds	1,002	—	1,002	—
Money market funds	584,427	584,427	—	—
Municipal bonds	3,764	—	3,764	—
U.S. Treasury securities	1,000	1,000	—	—
Available-for-sale securities:				
Auction rate securities	21,293	—	—	21,293
Certificates of deposit	13,651	—	13,651	—
Commercial paper	14,793	—	14,793	—
Corporate bonds	237,916	—	237,916	—
Debt securities of government sponsored entities	332,051	332,051	—	—
Federally insured corporate bonds	21,454	21,454	—	—
Municipal bonds	300,817	—	300,817	—
U.S. Treasury securities	21,721	21,721	—	—
Total assets measured at fair value	$ 1,725,846	$ 960,653	$ 743,900	$ 21,293

The following table presents the changes in the Company's assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the periods ended March 31, 2011 and December 31, 2010:

	Three Months Ended March 31, 2011	Twelve Months Ended December 31, 2010
Balance at beginning of period	$ 21,293	$ 58,003
Total net realized loss included in earnings	—	(290)
Total net unrealized gain included in other comprehensive income	326	2,790
Sales	—	(12,000)
Calls by issuers	(4,225)	(27,210)
Balance at end of period	$ 17,394	$ 21,293

At March 31, 2011 and December 31, 2010, the Company did not elect the fair value option available under current guidance for any financial assets and liabilities that were not required to be measured at fair value.

AMERIGROUP Corporation and Subsidiaries

Notes to Condensed Consolidated Financial Statements — (Continued)

During the three months ended March 31, 2011 and 2010, proceeds from the sale or call of certain investments in auction rate securities, the net realized gains and the amount of prior period net unrealized losses reclassified from accumulated other comprehensive income on a specific-identification basis were as follows (excludes the impact of the forward contract discussed below):

	Three Months Ended March 31,	
	2011	2010
Proceeds from sale or call of auction rate securities	$ 4,225	$ 7,870
Net realized gain recorded in earnings	—	201
Net unrealized loss reclassified from accumulated other comprehensive income, included in realized gain above	—	(80)

During the fourth quarter of 2008, the Company entered into a forward contract with a registered broker-dealer, at no cost, which provided the Company with the ability to sell certain auction rate securities to the registered broker-dealer at par within a defined timeframe, beginning June 30, 2010. These securities were classified as trading securities because the Company did not intend to hold these securities until final maturity. Trading securities are carried at fair value with changes in fair value recorded in earnings. The value of the forward contract was estimated using a discounted cash flow analysis taking into consideration the creditworthiness of the counterparty to the agreement. The forward contract was included in other long-term assets. As of June 30, 2010, all of the remaining trading securities under the terms of this forward contract were repurchased by the broker-dealer; therefore, the forward contract expired. For the three months ended March 31, 2010, a gross realized gain of $281 was recorded to earnings relating to these trading securities. As the trading securities increased in value for the three months ended March 31, 2010, a corresponding decrease in fair value of $280 for the forward contract was recorded to earnings.

Liabilities

The 2.0% Convertible Senior Notes are carried at cost plus the value of the accrued discount in the accompanying Condensed Consolidated Balance Sheets, or $248,591 and $245,750 as of March 31, 2011 and December 31, 2010, respectively. The estimated fair value of the 2.0% Convertible Senior Notes is determined based upon a quoted market price. As of March 31, 2011 and December 31, 2010, the fair value of the borrowings under the 2.0% Convertible Senior Notes was $389,025 and $303,550, respectively, compared to the face value of $260,000.

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AMERIGROUP Corporation and Subsidiaries

Notes to Condensed Consolidated Financial Statements — (Continued)

4. Short- and Long-Term Investments and Investments on Deposit for Licensure

The amortized cost, gross unrealized holding gains, gross unrealized holding losses and fair value for available-for-sale short- and long-term investments and investments on deposit for licensure held at March 31, 2011 were as follows:

	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses	Fair Value
Auction rate securities, maturing in greater than ten years	$ 18,425	$ —	$ 1,031	$ 17,394
Cash equivalents, maturing within one year	346	—	—	346
Certificates of deposit, maturing within one year	13,153	—	—	13,153
Commercial paper, maturing within one year	4,495	—	1	4,494
Corporate bonds, maturing within one year	102,024	511	14	102,521
Corporate bonds, maturing between one year and five years	196,965	1,558	340	198,183
Debt securities of government sponsored entities, maturing within one year	221,039	280	11	221,308
Debt securities of government sponsored entities, maturing between one year and five years	206,788	131	711	206,208
Debt securities of government sponsored entities, maturing between five years and ten years	7,388	—	8	7,380
Federally insured corporate bonds, maturing within one year	21,072	279	1	21,350
Money market funds, maturing within one year	22,193	—	—	22,193
Municipal bonds, maturing within one year	137,802	57	1	137,858
Municipal bonds, maturing between one year and five years	22,572	202	9	22,765
Municipal bonds, maturing between five years and ten years	159,166	902	1,852	158,216
Municipal bonds, maturing in greater than ten years	68,472	291	280	68,483
U.S. Treasury securities, maturing within one year	30,625	6	—	30,631
U.S. Treasury securities, maturing between one year and five years	921	86	—	1,007
Total	$1,233,446	$ 4,303	$ 4,259	$1,233,490

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AMERIGROUP Corporation and Subsidiaries

Notes to Condensed Consolidated Financial Statements — (Continued)

The amortized cost, gross unrealized holding gains, gross unrealized holding losses and fair value for available-for-sale short- and long-term investments and investments on deposit for licensure held at December 31, 2010 were as follows:

	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses	Fair Value
Auction rate securities, maturing in greater than ten years	$ 22,650	$ —	$ 1,357	$ 21,293
Cash equivalents, maturing within one year	306	—	—	306
Certificates of deposit, maturing within one year	13,651	—	—	13,651
Commercial paper, maturing within one year	14,797	—	4	14,793
Corporate bonds, maturing within one year	105,826	555	10	106,371
Corporate bonds, maturing between one year and five years	129,949	1,772	176	131,545
Debt securities of government sponsored entities, maturing within one year	170,209	416	—	170,625
Debt securities of government sponsored entities, maturing between one year and five years	161,684	207	465	161,426
Federally insured corporate bonds, maturing within one year	21,097	360	3	21,454
Money market funds, maturing within one year	20,009	—	—	20,009
Municipal bonds, maturing within one year	101,572	40	13	101,599
Municipal bonds, maturing between one year and five years	29,539	129	24	29,644
Municipal bonds, maturing between five years and ten years	121,547	964	1,171	121,340
Municipal bonds, maturing in greater than ten years	48,576	12	354	48,234
U.S. Treasury securities, maturing within one year	18,113	52	—	18,165
U.S. Treasury securities, maturing between one year and five years	3,479	78	1	3,556
Total	$983,004	$ 4,585	$ 3,578	$984,011

For the three months ended March 31, 2011 and 2010, a net unrealized loss of $963 and a net unrealized gain of $472, respectively, was recorded to accumulated other comprehensive income as a result of changes in fair value for investments classified as available-for-sale.

AMERIGROUP Corporation and Subsidiaries

Notes to Condensed Consolidated Financial Statements — (Continued)

The following table shows the fair value of the Company's available-for-sale investments with unrealized losses that are not deemed to be other-than-temporarily impaired at March 31, 2011. Investments are aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position:

	Less than 12 Months			12 Months or Greater		
	Fair Value	Gross Unrealized Holding Losses	Total Number of Securities	Fair Value	Gross Unrealized Holding Losses	Total Number of Securities
March 31, 2011:						
Auction rate securities	$ —	$ —	—	$ 17,394	$ 1,031	5
Commercial paper	1,995	1	1	—	—	—
Corporate bonds	137,639	354	53	—	—	—
Debt securities of government sponsored entities	204,254	730	50	—	—	—
Federally insured corporate bond	4,028	1	1	—	—	—
Municipal bonds	135,592	2,142	53	—	—	—
Total temporarily impaired securities	$ 483,508	$ 3,228	158	$ 17,394	$ 1,031	5

The temporary declines in value at March 31, 2011 are primarily due to fluctuations in short-term market interest rates and the lack of liquidity of auction rate securities. Auction rate securities that have been in an unrealized loss position for greater than 12 months have experienced losses due to the lack of liquidity for these instruments, not as a result of impairment of the underlying debt securities. Additionally, the Company does not intend to sell these securities prior to maturity or recovery and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other-than-temporary impairment for these securities.

5. Market Updates

Pending Contractual Revisions

Texas

In April 2011, the Texas Health and Human Services Commission ("HHSC") issued a request for proposal for the re-bid of the Medicaid and Children's Health Insurance Program ("CHIP") Managed Care Services Contract. Proposals are due in May 2011 and the Company anticipates a contract award date during the latter half of the year with an operational start date in early 2012. If the Company is not awarded this contract or if the level of the Company's business in Texas is reduced through the re-bidding process, the Company's results of operations, financial position or cash flows in future periods could be materially and adversely affected.

Georgia

The Company's Temporary Assistance for Needy Families and CHIP contract between its Georgia health plan and the State of Georgia expires June 30, 2011 with the State's option to renew the contract for one additional one-year term. The State has notified the Company of its intent to renew its contract effective July 1, 2011 and to amend the Company's existing contract to include one additional year and one additional option to renew for a one-year term for an ultimate potential contract term ending on June 30, 2014 at the outermost. Additionally, the State has indicated its intent to reprocure the contract through a competitive bidding process sometime prior to this contract termination.

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AMERIGROUP Corporation and Subsidiaries

Notes to Condensed Consolidated Financial Statements — (Continued)

Other Market Updates

Texas

In February 2011, the Company's Texas health plan began serving aged, blind and disabled ("ABD") members in the six-county service area surrounding Forth Worth, Texas through an expansion contract awarded by HHSC. As of March 31, 2011, approximately 29,000 members were served by the Company's Texas health plan under this contract. Previously, the Company served approximately 14,000 ABD members in the Dallas and Fort Worth areas under an administrative services only contract that terminated on January 31, 2011.

6. Summary of Goodwill and Acquired Intangible Assets

On March 1, 2010, the Company's New Jersey health plan acquired the Medicaid contract rights and rights under certain provider agreements of University Health Plans, Inc. for strategic reasons. The purchase price of $13,420 was financed through available cash. The entire purchase price was allocated to goodwill and other intangibles, which includes $2,200 of specifically identifiable intangibles allocated to the rights to the Medicaid service contract and the assumed provider contracts.

Other acquired intangible assets, included in other long-term assets in the accompanying Condensed Consolidated Balance Sheets, at March 31, 2011 and December 31, 2010 are as follows:

	March 31, 2011		December 31, 2010	
	Gross Carrying Amount	Accumulated Amortization	Gross Carrying Amount	Accumulated Amortization
Membership rights and provider contracts	$ 28,171	$ (26,243)	$ 28,171	$ (26,106)
Non-compete agreements and trademarks	946	(946)	946	(946)
	$ 29,117	$ (27,189)	$ 29,117	$ (27,052)

7. Claims Payable

The following table presents the components of the change in claims payable for the periods presented:

	Three Months Ended March 31, 2011	Twelve Months Ended December 31, 2010
Claims payable, beginning of period	$ 510,675	$ 529,036
Health benefits expense incurred during the period:		
Related to current year	1,307,566	4,828,321
Related to prior years	(50,604)	(106,215)
Total incurred	1,256,962	4,722,106
Health benefits payments during the period:		
Related to current year	900,625	4,359,216
Related to prior years	327,245	381,251
Total payments	1,227,870	4,740,467
Claims payable, end of period	$ 539,767	$ 510,675

Health benefits expense incurred during both periods was reduced for amounts related to prior years. The amounts related to prior years include the impact of amounts previously included in the liability to establish it at a

level sufficient under moderately adverse conditions that were not needed and the reduction in health benefits expense due to revisions to prior estimates.

8. Convertible Senior Notes

As of March 31, 2011, the Company had $260,000 outstanding in aggregate principal amount of 2.0% Convertible Senior Notes issued March 28, 2007 and due May 15, 2012, the carrying amount of which was $248,591 and $245,750 as of March 31, 2011 and December 31, 2010, respectively. The unamortized discount of $11,409 at March 31, 2011, will continue to be amortized over the remaining fourteen months until maturity.

Upon conversion of the 2.0% Convertible Senior Notes, the Company will pay cash up to the principal amount of the 2.0% Convertible Senior Notes converted. With respect to any conversion value in excess of the principal amount, the Company has the option to settle the excess with cash, shares of its common stock, or a combination thereof based on a daily conversion value, as defined in the Indenture. The initial conversion rate for the 2.0% Convertible Senior Notes is 23.5114 shares of common stock per one thousand dollars of principal amount of 2.0% Convertible Senior Notes, which represents a 32.5% conversion premium based on the closing price of $32.10 per share of the Company's common stock on March 22, 2007 and is equivalent to a conversion price of approximately $42.53 per share of common stock. Consequently, under the provisions of the 2.0% Convertible Senior Notes, if the market price of the Company's common stock exceeds $42.53, the Company will be obligated to settle, in cash or shares of its common stock at its option, an amount equal to approximately $6,100 for each dollar in share price that the market price of the Company's common stock exceeds $42.53, or the conversion value in excess of the principal amount of the 2.0% Convertible Senior Notes. In periods prior to conversion, the 2.0% Convertible Senior Notes would also have a dilutive impact to earnings if the average market price of the Company's common stock exceeds $42.53 for the period reported. As of March 31, 2011, the 2.0% Convertible Senior Notes had a dilutive impact to earnings per share as the average market price of the Company's common stock for the three months ended March 31, 2011 of $54.61 exceeded the conversion price of $42.53.

Concurrent with the issuance of the 2.0% Convertible Senior Notes, the Company purchased convertible note hedges covering, subject to customary anti-dilution adjustments, 6,112,964 shares of its common stock. The convertible note hedges allow the Company to receive shares of its common stock and/or cash equal to the amounts of common stock and/or cash related to the excess conversion value that the Company would pay to the holders of the 2.0% Convertible Senior Notes upon conversion. The convertible note hedges are expected to reduce the potential dilution upon conversion of the 2.0% Convertible Senior Notes in the event that the market value per share of the Company's common stock, as measured under the convertible note hedges, at the time of exercise is greater than the strike price of the convertible note hedges, which corresponds to the initial conversion price of the 2.0% Convertible Senior Notes and is subject to certain customary adjustments. If, however, the market value per share of the Company's common stock exceeds the strike price of the warrants (discussed below) when such warrants are exercised, the Company will be required to issue common stock. Both the convertible note hedges and warrants provide for net-share settlement at the time of any exercise for the amount that the market value of the common stock exceeds the applicable strike price.

Also concurrent with the issuance of the 2.0% Convertible Senior Notes, the Company sold warrants to acquire, subject to customary anti-dilution adjustments, 6,112,964 shares of its common stock at an exercise price of $53.77 per share. If the average market price of the Company's common stock during a defined period ending on or about the settlement date exceeds the exercise price of the warrants, the warrants will be settled in shares of its common stock. Consequently, under the provisions of the warrant instruments, if the market price of the Company's common stock exceeds $53.77 at exercise, the Company will be obligated to settle in shares of its common stock an amount equal to approximately $6,100 for each dollar that the market price of its common stock exceeds $53.77 resulting in a dilutive impact to its earnings. As of March 31, 2011, the warrant instruments had a dilutive impact to earnings per share as the average market price of the Company's common stock for the three months ended March 31, 2011 of $54.61 exceeded the $53.77 exercise price of the warrants.

AMERIGROUP Corporation and Subsidiaries

Notes to Condensed Consolidated Financial Statements — (Continued)

The convertible note hedges and warrants are separate transactions which will not affect holders' rights under the 2.0% Convertible Senior Notes.

As of March 31, 2011, the Company's common stock was last traded at a price of $64.25 per share. Based on this value, if converted at March 31, 2011, the Company would have been obligated to pay the principal of the 2.0% Convertible Senior Notes plus an amount in cash or shares equal to $132,758. An amount equal to $132,758 would be owed to the Company in cash or in shares of its common stock through the provisions of the convertible note hedges resulting in net cash outflow equal to the principal amount of the 2.0% Convertible Senior Notes. At this per share value, the Company would be required to deliver approximately $64,064 in shares of the Company's common stock under the warrant instruments or approximately 997,000 shares of its common stock at that price per share.

9. Commitments and Contingencies

Florida Premium Recoupment

On March 14, 2011, AMERIGROUP Florida, Inc. received written notices (the "Notices") from the Florida Agency for Health Care Administration ("AHCA") regarding an audit, conducted by a third party, of Medicaid claims paid under contracts between AHCA and Florida Medicaid managed care organizations for the period October 1, 2008 through December 31, 2010. The Notices claim that AHCA paid premium to AMERIGROUP Florida, Inc. for members who were not eligible to be enrolled in the Medicaid program at the time AHCA and other State agencies enrolled these purportedly ineligible members. The Notices also seek recoupment of premium payments to AMERIGROUP Florida, Inc. attributable to the purportedly ineligible members in the amount of $2,900. The Notices relate to two Florida counties and the Company believes that it may receive similar notices for other counties in which it operates or has operated in Florida.

The Company is evaluating its appeal rights and believes that it has substantial defenses to the claims asserted in the Notices for premium recoupment. The accompanying Condensed Consolidated Financial Statements reflect the Company's best estimate of its liability for the claims set forth in the Notices as of March 31, 2011. However, the Company is unable to estimate the amount or nature of any potential claims for premium recoupment in the other Florida counties in which it operates or has operated because the Company has not received a notice from AHCA or the third party audit firm for such claims. As a result, there can be no assurances that the ultimate outcome of this matter will not have a material adverse effect on the Company's financial position, results of operations or cash flows.

Letter of Credit

Effective July 1, 2010, the Company renewed a collateralized irrevocable standby letter of credit, initially issued on July 1, 2009, in an aggregate principal amount of approximately $17,400, to meet certain obligations under its Medicaid contract in the State of Georgia through its Georgia subsidiary, AMGP Georgia Managed Care Company, Inc. The letter of credit is collateralized through investments held by AMGP Georgia Managed Care Company, Inc.

Legal Proceedings

Employment Litigation

On November 22, 2010, a former AMERIGROUP New York, LLC marketing representative filed a putative collective and class action Complaint against AMERIGROUP Corporation and AMERIGROUP New York, LLC in the United States District Court, Eastern District of New York styled as *Hamel Toure, Individually and on Behalf of All Other Persons Similarly Situated v. AMERIGROUP CORPORATION and AMERIGROUP NEW YORK, L.L.C. f/k/a CAREPLUS, L.L.C. (Case No.: CV10-5391)*. The Complaint alleges, *inter alia*, that the plaintiff and certain other employees should have been classified as non-exempt employees under the Fair Labor Standards Act ("FLSA") and during the course of their employment should have received overtime and other compensation under

the FLSA from October 22, 2007 until the entry of judgment and under the New York Labor Law from October 22, 2004 until the entry of judgment. The Complaint requests certification of the action as a class action, designation of the action as a collective action, a declaratory judgment, injunctive relief, an award of unpaid overtime compensation, an award of liquidated and/or punitive damages, pre-judgment and post-judgment interest, as well as costs and attorneys' fees. The plaintiff recently amended the Complaint to include a nationwide collective/class action on behalf of other similarly situated former and current associates who have worked as marketing representatives for any subsidiary health plan of the Company during the time period from November 2007 to the present.

In addition, the Company recently learned that a Complaint making substantially the same allegations as the *Toure* case has been filed in the United States District Court, Eastern District of New York. The case is styled as *Andrea Burch, individually and on behalf of all others similarly situated v. AMERIGROUP CORP., d/b/a AMERIGROUP; AMERIGROUP NEW YORK, LLC, d/b/a AMERIGROUP (Case No.: CV11-1895).*

At this early stage of the aforementioned cases, the Company is unable to make a reasonable estimate of the amount or range of loss that could result from an unfavorable outcome because the scope and size of the potential class has not been determined, no discovery has occurred and no specific amount of monetary damages has been alleged. The Company believes it has meritorious defenses to the claims against it and intends to defend itself vigorously.

Other Litigation

The Company is involved in various other legal proceedings in the normal course of business. Based upon its evaluation of the information currently available, the Company believes that the ultimate resolution of any such proceedings will not have a material adverse effect, either individually or in the aggregate, on its financial position, results of operations or cash flows.

10. Share Repurchase Program

The Board of Directors authorized the repurchase of up to $400,000 of shares of the Company's common stock under the Company's ongoing share repurchase program on August 5, 2009. Pursuant to this share repurchase program, the Company repurchased and placed into treasury 440,328 shares of its common stock at an aggregate cost of $24,792 during the three months ended March 31, 2011. As of March 31, 2011, the Company had remaining authorization to purchase up to an additional $199,515 of shares of its common stock under the share repurchase program.

11. Long-Term Incentive Plan

In March 2011, under the terms of existing compensation plans, the Company granted performance-based restricted stock units and performance-based cash awards to certain of its senior executives. These awards are earned based upon the Company's performance against pre-established targets, including return on equity, net income margin and revenue growth over the three-year performance period. In addition to the performance conditions, these awards also include a market condition, which under certain performance conditions, may ultimately impact the number of restricted stock units and total cash awarded. The market condition is satisfied if the Company's total shareholder return is above the median total shareholder return of the Company's peer group as determined by the Compensation Committee of the Board of Directors (See Part II, Item 5. of the Company's Annual Report on Form 10-K filed with the SEC on February 23, 2011 for a list of the companies that comprise the Company's peer group.) Under the terms of the awards, participants have the ability to earn between 0% — 200% of their target award based upon the attainment of performance and/or market conditions as defined.

Performance-based restricted stock units are classified as equity awards. The fair value of the awards subject to the market condition is calculated using a Monte Carlo valuation model. Expense associated with the performance-based restricted stock units subject to the market condition is recognized regardless of whether the market condition

AMERIGROUP Corporation and Subsidiaries

Notes to Condensed Consolidated Financial Statements — (Continued)

is met. A target of 77,828 performance-based restricted stock units were granted with the ability for participants to earn 0 to 155,656 units.

The following details of performance-based restricted stock units outstanding as of March 31, 2011 are provided based on current assumptions of future performance:

	Shares	Weighted - Average Grant Date Fair Value
Outstanding units at January 1, 2011	—	—
Granted at target level	77,828	$ 58.83
Adjustments above/(below) target level	—	—
Expired	—	—
Forfeited	—	—
Outstanding units at March 31, 2011	77,828	$ 58.83
Vested units at March 31, 2011	—	
Unvested units at March 31, 2011	77,828	
Unrecognized compensation expense	$ 4,943,105	
Weighted average remaining period (years)	2.92	

Performance-based cash awards are classified as liability awards because they are settled in cash. The fair value of the performance-based cash liability is re-evaluated using the Monte Carlo valuation model at each reporting date. A target of $4,515 performance-based cash awards were granted with the ability for participants to earn $0 to $9,030.

Expense for both the performance-based restricted stock units and the performance-based cash is recognized based on the total expected award and the period elapsed as of each reporting date. For the three months ended March 31, 2011, a total of $470 was recognized related to grants of performance-based restricted stock units and performance-based cash.

12. Comprehensive Earnings

Differences between net income and total comprehensive income resulted from net unrealized (losses) gains on the investment portfolio as follows:

	Three Months Ended March 31, 2011	Three Months Ended March 31, 2010
Net income	$ 70,477	$ 42,182
Other comprehensive income:		
Unrealized (loss) gain on available-for-sale securities, net of tax	(600)	242
Comprehensive income	$ 69,877	$ 42,424

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

Forward-looking Statements

This Quarterly Report on Form 10-Q, and other information we provide from time-to-time, contains certain "forward-looking" statements as that term is defined by Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). All statements regarding our expected future financial position, membership, results of operations or cash flows, our growth strategy, our competition, our ability to refinance our debt obligations, our ability to finance growth opportunities, our ability to respond to changes in government regulations and similar statements including, without limitation, those containing words such as "believes," "anticipates," "expects," "may," "will," "should," "estimates," "intends," "plans" and other similar expressions are forward-looking statements.

Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated in the forward-looking statements as a result of, but not limited to, the following factors:

- our inability to manage medical costs;
- our inability to operate new products and markets at expected levels, including, but not limited to, profitability, membership and targeted service standards;
- local, state and national economic conditions, including their effect on the premium rate increase process and timing of payments;
- the effect of laws and regulations governing the healthcare industry, including the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 and any regulations enacted thereunder;
- changes in Medicaid and Medicare payment levels and methodologies;
- increased use of services, increased cost of individual services, pandemics, epidemics, the introduction of new or costly treatments and technology, new mandated benefits, insured population characteristics and seasonal changes in the level of healthcare use;
- our ability to maintain and increase membership levels;
- our ability to enter into new markets or remain in our existing markets;
- changes in market interest rates or any disruptions in the credit markets;
- our ability to maintain compliance with all minimum capital requirements;
- liabilities and other claims asserted against us;
- demographic changes;
- the competitive environment in which we operate;
- the availability and terms of capital to fund acquisitions, capital improvements and maintain capitalization levels required by regulatory agencies;
- our ability to attract and retain qualified personnel;
- the unfavorable resolution of new or pending litigation; and
- catastrophes, including acts of terrorism or severe weather.

Investors should also refer to our Annual Report on Form 10-K for the year ended December 31, 2010, filed with the Securities and Exchange Commission ("SEC") on February 23, 2011 for a discussion of risk factors. Given these risks and uncertainties, we can give no assurances that any forward-looking statements will, in fact, transpire, and therefore caution investors not to place undue reliance on them.

Overview

We are a multi-state managed healthcare company focused on serving people who receive healthcare benefits through publicly funded healthcare programs, including Medicaid, Children's Health Insurance Program ("CHIP"), Medicaid expansion programs and Medicare Advantage. We believe that we are better qualified and positioned than many of our competitors to meet the unique needs of our members and the government agencies with whom we contract because of our focus solely on recipients of publicly funded healthcare, medical management programs and community-based education and outreach programs. We design our programs to address the particular needs of our members, for whom we facilitate access to healthcare benefits pursuant to agreements with applicable state and Federal government agencies. We combine medical, social and behavioral health services to help our members obtain quality healthcare in an efficient manner. Our success in establishing and maintaining strong relationships with government agencies, healthcare providers and our members has enabled us to retain existing contracts, obtain new contracts and establish and maintain a leading market position in many of the markets we serve. We continue to believe that managed healthcare remains the only proven mechanism that improves health outcomes for our members while helping our government customers manage the fiscal viability of their healthcare programs. We are dedicated to offering real solutions that improve healthcare access and quality for our members, while proactively working to reduce the overall cost of care to taxpayers.

Summary highlights of our first quarter of 2011 include:

- Membership increased by 104,000 members, or 5.6%, to 1,967,000 members as of March 31, 2011 compared to 1,863,000 members as of March 31, 2010;
- Total revenues of $1.5 billion for the first quarter of 2011, a 12.3% increase over the first quarter of 2010;
- Health benefits ratio ("HBR") of 81.8% of premium revenues for the first quarter of 2011 compared to 83.5% in the first quarter of 2010;
- Selling, general and administrative expense ("SG&A") ratio of 7.6% of total revenues for the first quarter of 2011 compared to 8.6% in the first quarter of 2010;
- Cash provided by operations was $83.5 million for the three months ended March 31, 2011;
- Unregulated cash and investments of $268.9 million as of March 31, 2011;
- We repurchased 440,328 shares of common stock for approximately $24.8 million during the first quarter of 2011; and
- On February 1, 2011 we began providing managed healthcare services to STAR+PLUS members under an expansion contract in the six-county service area surrounding Forth Worth, Texas.

Our results for the three months ended March 31, 2011 reflect the impact of modest membership growth. Additionally, increases in premium revenue reflect the impact of a full period of a benefit expansion to provide long-term care services to eligible members in Tennessee which began in March 2010, the net effect of premium rate changes from the prior year and the impact of a contract award through competitive procurement to expand healthcare coverage to seniors and people with disabilities in the six-county service area surrounding Forth Worth, Texas. Health benefits expense for the three months ended March 31, 2011 reflects moderating cost trends for current and prior periods, the latter of which generated favorable development related to prior periods.

Health Care Reform

On March 23, 2010, the Patient Protection and Affordable Care Act was signed into law and on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was signed into law (collectively, the "Acts"). The Acts provide comprehensive changes to the U.S. healthcare system, which will be phased in at various stages over the next several years. Among other things, the Acts are intended to provide health insurance to approximately 32 million uninsured individuals of whom approximately 20 million are expected to obtain health insurance through the expansion of the Medicaid program beginning in 2014. Funding for the expanded coverage will initially come largely from the Federal government.

To date, the Acts have not had a material effect on our results of operations, liquidity or cash flows; however, we continue to evaluate the provisions of the Acts and believe that the Acts may provide us with significant opportunities for membership growth in our existing markets and, potentially, in new markets in the future. There can be no assurance that we will realize this growth, or that this growth will be profitable. Further, there are several pending lawsuits challenging the constitutionality of the Acts so there can be no assurance that the Acts will take effect as originally enacted or at all.

There are numerous steps required to implement the Acts, including promulgating a substantial number of new and potentially more onerous regulations that may affect our business. Further, there has been resistance to expansion at the state level, largely due to budgetary pressure. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the Federal or state level, or the effect that any future legislation or regulation, or the pending litigation challenging the Acts, will have on our business or our growth opportunities. Although we believe the Acts will provide us with significant opportunity, the enacted reforms, as well as future regulations, legislative changes and judicial decisions may in fact have a material adverse effect on our results of operations, financial position or liquidity.

The Acts also include the imposition of a significant new non-deductible Federal premium-based assessment and other assessments on health insurers. If this Federal premium-based assessment is imposed as enacted, and if the cost of the Federal premium-based assessment is not included in the calculation of our premium rates, or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position or liquidity may be materially adversely affected.

Pending Contractual Revisions

Texas

In April 2011, the Texas Health and Human Services Commission ("HHSC") issued a request for proposal for the re-bid of the Medicaid and CHIP Managed Care Services Contract. Proposals are due in May 2011 and we anticipate a contract award date during the latter half of the year with an operational start date in early 2012. If we are not awarded this contract or if the level of our business in Texas is reduced through the re-bidding process, our results of operations, financial position or cash flows in future periods could be materially and adversely affected.

Georgia

Our Temporary Assistance for Needy Families ("TANF") and CHIP contract with the State of Georgia expires June 30, 2011, with the State's option to renew the contract for one additional one-year term. The State has notified us of its intent to renew our contract effective July 1, 2011 and to amend our existing contract to include one additional year and one additional option to renew for a one-year term for an ultimate potential contract term ending on June 30, 2014 at the outermost. Additionally, the State has indicated its intent to reprocure the contract through a competitive bidding process sometime prior to this contract termination. If we are not awarded this contract through the re-bidding process, our results of operations, financial position or cash flows in future periods could be materially and adversely affected.

Other Market Updates

Texas

In February 2011, we began serving aged, blind and disabled ("ABD") members in the six-county service area surrounding Forth Worth, Texas through an expansion contract awarded by HHSC. As of March 31, 2011, approximately 29,000 members were served by our Texas health plan under this contract. Previously, we served approximately 14,000 ABD members in the Dallas and Fort Worth areas under an administrative services only ("ASO") contract that terminated on January 31, 2011.

Contingencies

Florida Premium Recoupment

On March 14, 2011, AMERIGROUP Florida, Inc. received written notices (the "Notices") from the Florida Agency for Health Care Administration ("AHCA") regarding an audit, conducted by a third party, of Medicaid claims paid under contracts between AHCA and Florida Medicaid managed care organizations for the period October 1, 2008 through December 31, 2010. The Notices claim that AHCA paid premium to AMERIGROUP Florida, Inc. for members who were not eligible to be enrolled in the Medicaid program at the time AHCA and other State agencies enrolled these purportedly ineligible members. The Notices also seek recoupment of premium payments to AMERIGROUP Florida, Inc. attributable to the purportedly ineligible members in the amount of $2.9 million. The Notices relate to two Florida counties and we believe that we may receive similar notices for other counties in which we operate or have operated in Florida. Further, we believe that the other Florida Medicaid managed care organizations have received similar notices for this time period.

We are evaluating our appeal rights and believe that we have substantial defenses to the claims asserted in the Notices for premium recoupment. The accompanying Condensed Consolidated Financial Statements reflect our best estimate of our liability for the claims set forth in the Notices as of March 31, 2011. However, we are unable to estimate the amount or nature of any potential claims for premium recoupment in the other Florida counties in which we operate or have operated because we have not received a notice from AHCA or the third party audit firm for such claims. As a result, there can be no assurances that the ultimate outcome of this matter will not have a material adverse effect on our financial position, results of operations or cash flows.

Georgia Letter of Credit

Effective July 1, 2010, we renewed a collateralized irrevocable standby letter of credit, initially issued on July 1, 2009, in an aggregate principal amount of approximately $17.4 million, to meet certain obligations under our Medicaid contract in the State of Georgia through our Georgia subsidiary, AMGP Georgia Managed Care Company, Inc. The letter of credit is collateralized through cash held by AMGP Georgia Managed Care Company, Inc.

Employment Litigation

On November 22, 2010, a former AMERIGROUP New York, LLC marketing representative filed a putative collective and class action Complaint against AMERIGROUP Corporation and AMERIGROUP New York, LLC in the United States District Court, Eastern District of New York styled as *Hamel Toure, Individually and on Behalf of All Other Persons Similarly Situated v. AMERIGROUP CORPORATION and AMERIGROUP NEW YORK, L.L.C. f/k/a CAREPLUS, L.L.C. (Case No.: CV10-5391)*. The Complaint alleges, *inter alia*, that the plaintiff and certain other employees should have been classified as non-exempt employees under the Fair Labor Standards Act ("FLSA") and during the course of their employment should have received overtime and other compensation under the FLSA from October 22, 2007 until the entry of judgment and under the New York Labor Law from October 22, 2004 until the entry of judgment. The Complaint requests certification of the action as a class action, designation of the action as a collective action, a declaratory judgment, injunctive relief, an award of unpaid overtime compensation, an award of liquidated and/or punitive damages, pre-judgment and post-judgment interest, as well as costs and attorneys' fees. The plaintiff recently amended the Complaint to include a nationwide collective/class action on behalf of other similarly situated former and current associates who have worked as marketing representatives for any of our subsidiary health plans during the time period from November 2007 to the present.

In addition, we recently learned that a Complaint making substantially the same allegations as the *Toure* case has been filed in the United States District Court, Eastern District of New York. The case is styled as *Andrea Burch, individually and on behalf of all others similarly situated v. AMERIGROUP CORP., d/b/a AMERIGROUP; AMERIGROUP NEW YORK, LLC, d/b/a AMERIGROUP (Case No.: CV11-1895).*

At this early stage of the aforementioned cases, we are unable to make a reasonable estimate of the amount or range of loss that could result from an unfavorable outcome because the scope and size of the potential class has not been determined, no discovery has occurred and no specific amount of monetary damages has been alleged. We believe we have meritorious defenses to the claims against us and intend to defend ourselves vigorously.

Results of Operations

The following table sets forth selected operating ratios for the three months ended March 31, 2011 and 2010. All ratios, with the exception of the HBR, are shown as a percentage of total revenues:

	Three Months Ended March 31,	
	2011	2010
Premium revenue	99.7%	99.6%
Investment income and other	0.3	0.4
Total revenues	100.0%	100.0%
Health benefits(1)	81.8%	83.5%
Selling, general and administrative expenses	7.6%	8.6%
Income before income taxes	7.3%	5.0%
Net income	4.6%	3.1%

(1) The HBR is shown as a percentage of premium revenue because there is a direct relationship between the premium received and the health benefits provided.

Three Months Ended March 31, 2011 Compared to Three Months Ended March 31, 2010

Summarized comparative financial information for the three months ended March 31, 2011 and 2010 is as follows (dollars in millions, except per share data; totals in the table below may not equal the sum of individual line items as all line items have been rounded to the nearest decimal):

	Three Months Ended March 31,		
	2011	2010	% Change 2011-2010
Revenues:			
Premium	$ 1,535.8	$ 1,366.8	12.4
Investment income and other	4.1	4.9	(15.6)
Total revenues	1,539.9	1,371.6	12.3
Expenses:			
Health benefits	1,257.0	1,141.6	10.1
Selling, general and administrative	116.5	117.4	(0.8)
Premium tax	40.4	31.5	28.5
Depreciation and amortization	9.1	8.7	4.4
Interest	4.2	4.0	4.7
Total expenses	1,427.1	1,303.2	9.5
Income before income taxes	112.8	68.5	64.7
Income tax expense	42.3	26.3	60.8
Net income	$ 70.5	$ 42.2	67.1
Diluted net income per share	$ 1.37	$ 0.82	67.1

Premium Revenue

Premium revenue for the three months ended March 31, 2011 increased $169.0 million, or 12.4%, to $1.5 billion from $1.4 billion for the three months ended March 31, 2010. The increase was due in part to increases in full-risk membership across the majority of our existing products and markets, most significantly in the State of Texas. These membership increases are partially due to continuing high levels of unemployment and the generally

adverse macroeconomic environment driving increases in the number of people eligible for publicly funded healthcare programs. In addition, premium revenue increased as a result of our entry into the Tennessee TennCare CHOICES program in March 2010, premium rate and mix changes and our Texas expansion into the Forth Worth STAR+PLUS program on February 1, 2011.

Membership

The following table sets forth the approximate number of members we served in each state as of March 31, 2011 and 2010. Because we receive two premiums for members that are in both the Medicare Advantage and Medicaid products, these members have been counted twice in the states where we operate Medicare Advantage plans.

	March 31,	
	2011	2010
Texas[1]	582,000	510,000
Georgia	270,000	250,000
Florida	263,000	250,000
Maryland	207,000	197,000
Tennessee	205,000	202,000
New Jersey	133,000	158,000
New York	109,000	113,000
Nevada	82,000	69,000
Ohio	55,000	56,000
Virginia	39,000	37,000
New Mexico	22,000	21,000
Total	1,967,000	1,863,000

(1) Membership includes approximately 13,000 ABD members under an ASO contract as of March 31, 2010. This contract terminated January 31, 2011.

As of March 31, 2011, we served approximately 1,967,000 members, reflecting an increase of approximately 104,000 members, or 5.6%, compared to March 31, 2010. The increase is primarily a result of membership growth in the majority of our products and markets driven by a surge in Medicaid eligibility, which we believe was driven by continuing high levels of unemployment and general adverse economic conditions in addition to the impact of the expansion in the Forth Worth, Texas STAR+PLUS program on February 1, 2011. This growth was partially offset by contraction in our New Jersey health plan as a result of changes in our provider network causing member selection of our health plan to decrease.

The following table sets forth the approximate number of our members who receive benefits under our products as of March 31, 2011 and 2010. Because we receive two premiums for members that are in both the Medicare Advantage and Medicaid products, these members have been counted in each product.

	March 31,	
Product	2011	2010
TANF (Medicaid)	1,394,000	1,309,000
CHIP	268,000	269,000
ABD (Medicaid)[1]	215,000	197,000
FamilyCare (Medicaid)	72,000	72,000
Medicare Advantage	18,000	16,000
Total	1,967,000	1,863,000

(1) Membership includes approximately 13,000 members under an ASO contract in Texas as of March 31, 2010. This contract terminated January 31, 2011.

Investment income and other revenue

Investment income and other revenue was $4.1 million and $4.9 million for the three months ended March 31, 2011 and 2010, respectively.

Our investment portfolio is comprised of fixed income securities and cash and cash equivalents, which generated investment income totaling $3.9 million for the three months ended March 31, 2011 compared to $4.2 million for the three months ended March 31, 2010. The decrease in investment income is primarily a result of decreased rates of return on fixed income securities due to current market interest rates. Our effective yield could remain at or below the current rate as of March 31, 2011 for the foreseeable future, which would result in similar or reduced returns on our investment portfolio in future periods. The performance of our investment portfolio is interest rate driven and, consequently, changes in interest rates affect our returns on, and the fair value of, our portfolio which can materially affect our results of operations or liquidity in future periods.

Other revenue decreased from $0.7 million for the three months ended March 31, 2010 to $0.2 million for the three months ended March 31, 2011 due to the termination of the ASO contract in the Dallas and Fort Worth service areas of Texas on January 31, 2011.

Health benefits expenses

Expenses relating to health benefits for the three months ended March 31, 2011 increased $115.4 million, or 10.1%, to $1.3 billion compared to $1.1 billion for the three months ended March 31, 2010. Our HBR decreased to 81.8% for the three months ended March 31, 2011 compared to 83.5% for the same period of the prior year. The decrease in health benefits expense as it relates to premium revenue resulted primarily from moderating cost trends for current and prior periods, the latter of which generated favorable development related to prior periods. HBR was also favorably impacted by the net effect of premium rate changes in connection with annual contract renewals.

The following table presents the components of the change in claims payable for the periods presented (in thousands):

	Three Months Ended March 31, 2011	Twelve Months Ended December 31, 2010
Claims payable, beginning of period	$ 510,675	$ 529,036
Health benefits expense incurred during the period:		
Related to current year	1,307,566	4,828,321
Related to prior years	(50,604)	(106,215)
Total incurred	1,256,962	4,722,106
Health benefits payments during the period:		
Related to current year	900,625	4,359,216
Related to prior years	327,245	381,251
Total payments	1,227,870	4,740,467
Claims payable, end of period	$ 539,767	$ 510,675

Health benefits expense incurred during both periods were reduced for amounts related to prior years. The amounts related to prior years include the impact of amounts previously included in the liability to establish it at a level sufficient under moderately adverse conditions that were not needed and the reduction in health benefits expense due to revisions to prior estimates.

Selling, general and administrative expenses

SG&A for the three months ended March 31, 2011 and 2010 was $116.5 million and $117.4 million, respectively. Our SG&A to total revenues ratio was 7.6% for the three months ended March 31, 2011 compared to 8.6% for the three months ended March, 31, 2010. The decrease in the SG&A ratio is primarily the result of leverage gained through an increase in premium revenue due to existing market growth, our entry into the Tennessee TennCare CHOICES program in March 2010, premium rate and mix changes and our Texas expansion into the Forth Worth STAR+PLUS program on February 1, 2011.

Premium tax expense

Premium taxes were $40.4 million and $31.5 million for the three months ended March 31, 2011 and March 31, 2010, respectively. The increase in premium tax expense for the three months ended March 31, 2011 compared to the three months ended March 31, 2010 is primarily due to the termination of premium tax in the State of Georgia in October 2009 which was subsequently reinstated at a lower rate in July 2010 as well as increased premium revenues in the State of Tennessee primarily as a result of our entry into the TennCare CHOICES program in March 2010. Additionally, premium revenue growth in the majority of the other markets where premium tax is levied contributed to the increase.

Provision for income taxes

Income tax expense for the three months ended March 31, 2011 was $42.3 million with an effective tax rate of 37.5% compared to $26.3 million of income tax expense with an effective tax rate of 38.4% for the three months ended March 31, 2010. The change in the effective tax rate for the three months ended March 31, 2011 as compared to the three months ended March 31, 2010 is primarily attributable to a decrease in the blended state income tax rate.

Net income

Net income for the three months ended March 31, 2011 was $70.5 million, or $1.37 per diluted share, compared to net income of $42.2 million, or $0.82 per diluted share for the three months ended March 31, 2010. The increase in net income is primarily attributable to an increase in premium revenue as a result of existing market growth, our entry into the Tennessee TennCare CHOICES program in March 2010, premium rate and mix changes and our Texas expansion into the Forth Worth STAR+PLUS program on February 1, 2011. The increase was also a result of moderating cost trends for current and prior periods, the latter of which generated favorable development related to prior periods.

Liquidity and Capital Resources

We manage our cash, investments and capital structure so we are able to meet the short- and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our primary sources of liquidity are cash and cash equivalents, short- and long-term investments, and cash flows from operations. As of March 31, 2011, we had cash and cash equivalents of $602.0 million, short- and long-term investments of $1.1 billion and restricted investments on deposit for licensure of $119.2 million. Cash, cash equivalents, and investments which are unregulated totaled $268.9 million at March 31, 2011.

Universal Automatic Shelf Registration

On December 15, 2008, we filed a universal automatic shelf registration statement with the SEC which enables us to sell, in one or more public offerings, common stock, preferred stock, debt securities and other securities at prices and on terms to be determined at the time of the applicable offering. The shelf registration provides us with the flexibility to publicly offer and sell securities at times we believe market conditions make such an offering attractive. Because we are a well-known seasoned issuer, the shelf registration statement was effective upon filing. No securities have been issued under the shelf registration.

Share Repurchase Program

Under the authorization of our Board of Directors on August 5, 2009, we maintain a share repurchase program that allows us to repurchase up to $400.0 million shares of our common stock. Pursuant to this share repurchase program, we repurchased and placed into treasury 440,328 shares of our common stock at an aggregate cost of $24.8 million during the three months ended March 31, 2011. As of March 31, 2011, we had remaining authorization to purchase up to an additional $199.5 million of shares of our common stock under the share repurchase program.

Cash and Investments

Cash provided by operations was $83.5 million for the three months ended March 31, 2011 compared to cash used in operations of $6.8 million for the three months ended March 31, 2010. The increase in cash flows was primarily a result of an increase in cash flows generated from working capital changes of $56.8 million and an increase in net income of $28.3 million. Cash used in operating activities for working capital changes was $4.8 million for the three months ended March 31, 2011 compared to $61.6 million for the three months ended March 31, 2010. The decrease in cash used in operating activities for working capital changes primarily resulted from increased cash flows from routine changes in the timing of receipts of premium from government agencies of $65.3 million and variability in claims payable, which is impacted by growth in our markets offset by increased claims processing speeds, of $8.9 million. These increases were partially offset by a net decrease in cash provided through changes in accounts payable, accrued expenses, contractual refunds payable and other current liabilities of $23.0 million due primarily to fluctuations in variable compensation accruals, which are directly related to our attainment of financial performance goals, offset by an increase in cash provided through changes in income tax accruals.

Cash used in investing activities was $264.8 million for the three months ended March 31, 2011 compared to $54.5 million for the three months ended March 31, 2010. The increase in cash used in investing activities of $210.3 million is due primarily to an increase in the net purchases of investments of $219.2 million during the three months ended March 31, 2011 compared to the three months ended March 31, 2010, partially offset by the impact of our New Jersey health plan's acquisition of the Medicaid contracts rights from University Health Plans, Inc. for $13.4 million in March 2010 not recurring. We currently anticipate total capital expenditures for 2011 to be between approximately $35.0 million and $45.0 million related primarily to technological infrastructure development and enhancement of core systems to increase scalability and efficiency. For the three months ended March 31, 2011, total capital expenditures were $10.9 million.

Our investment policies are designed to preserve capital, provide liquidity and maximize total return on invested assets. As of March 31, 2011, our investment portfolio consisted primarily of fixed-income securities with a weighted average maturity of approximately twenty-two months. We utilize investment vehicles such as auction rate securities, certificates of deposit, commercial paper, corporate bonds, debt securities of government sponsored entities, Federally insured corporate bonds, money market funds, municipal bonds and U.S. Treasury securities. The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their funds. The weighted average taxable equivalent yield on consolidated investments as of March 31, 2011 was approximately 1.1%. As of March 31, 2011, we had total cash and investments of approximately $1.8 billion.

The following table shows the types, percentages and average Standard and Poor's ("S&P") ratings of our holdings within our investment portfolio at March 31, 2011:

	Portfolio Percentage	Average S&P Rating
Auction rate securities	0.9%	AAA
Cash, bank deposits and commercial paper	2.3%	AAA
Certificates of deposit	8.4%	AAA
Corporate bonds	16.4%	A+
Debt securities of government sponsored entities, Federally insured corporate bonds and U.S. Treasury securities	31.1%	AAA
Money market funds	19.8%	AAA
Municipal bonds	21.1%	AA+
	100.0%	AA+

As of March 31, 2011, $17.4 million of our investments were comprised of securities with an auction reset feature ("auction rate securities") issued by student loan corporations established by various state governments. Since early 2008, auctions for these auction rate securities have failed, significantly decreasing our ability to liquidate these securities prior to maturity. As we cannot predict the timing of future successful auctions, if any, our auction rate securities are classified as available-for-sale and are carried at fair value within long-term investments. The weighted average life of our auction rate securities portfolio, based on the final maturity, is approximately twenty-three years. We currently believe that the $1.0 million net unrealized loss position that remains at March 31, 2011 on our auction rate securities portfolio is primarily due to liquidity concerns and not the creditworthiness of the underlying issuers. We currently have the intent to hold our auction rate securities to maturity, if required, or if and when market stability is restored with respect to these investments. During the three months ended March 31, 2011, certain investments in auction rate securities were called at par for net proceeds of $4.2 million.

Cash provided by financing activities was $19.3 million for the three months ended March 31, 2011, compared to cash used in financing activities of $3.4 million for the three months ended March 31, 2010. The increase in cash flows from financing activities is due primarily to an increase in the change in bank overdrafts of $23.5 million and an increase in proceeds from employee stock option exercises of $13.3 million offset by an increase in repurchases of our common stock of $17.8 million.

We believe that existing cash and investment balances and cash flows from operations will be sufficient to support continuing operations, capital expenditures and our growth strategy for at least 12 months. Our debt-to-total capital ratio at March 31, 2011 was 16.8%. We utilize the debt-to-total capital ratio as a measure, among others, of our leverage and financial flexibility. We believe our current debt-to-total capital ratio allows us flexibility to access debt financing should the need or opportunity arise; however, the financial markets have experienced periods of volatility and disruption from time-to-time. Future volatility and disruption is possible and unpredictable. In the event we need to access additional capital, our ability to obtain such capital may be limited and the cost of any such capital will depend on the market condition and our financial position at the time we pursue additional financing.

Convertible Senior Notes

As of March 31, 2011, we had $260.0 million outstanding in aggregate principal amount of 2.0% Convertible Senior Notes (the "2.0% Convertible Senior Notes") due May 15, 2012. The 2.0% Convertible Senior Notes are governed by an Indenture dated as of March 28, 2007 (the "Indenture"). The 2.0% Convertible Senior Notes are senior unsecured obligations of the Company and rank equal in right of payment with all of our existing and future senior debt and senior to all of our subordinated debt. The 2.0% Convertible Senior Notes bear interest at a rate of 2.0% per year, payable semiannually in arrears in cash on May 15 and November 15 of each year and mature on May 15, 2012, unless earlier repurchased or converted in accordance with the Indenture.

Upon conversion of the 2.0% Convertible Senior Notes, we will pay cash up to the principal amount of the 2.0% Convertible Senior Notes converted. With respect to any conversion value in excess of the principal amount,

we have the option to settle the excess with cash, shares of our common stock, or a combination thereof based on a daily conversion value, as defined in the Indenture. The initial conversion rate for the 2.0% Convertible Senior Notes is 23.5114 shares of common stock per one thousand dollars of principal amount of 2.0% Convertible Senior Notes, which represents a 32.5% conversion premium based on the closing price of $32.10 per share of our common stock on March 22, 2007 and is equivalent to a conversion price of approximately $42.53 per share of common stock. Consequently, under the provisions of the 2.0% Convertible Senior Notes, if the market price of our common stock exceeds $42.53 we will be obligated to settle, in cash or shares of our common stock at our option, an amount equal to approximately $6.1 million for each dollar in share price that the market price of our common stock exceeds $42.53, or the conversion value in excess of the principal amount of the 2.0% Convertible Senior Notes. In periods prior to conversion, the 2.0% Convertible Senior Notes would also have a dilutive impact to earnings if the average market price of our common stock exceeds $42.53 for the period reported. At conversion, the dilutive impact would result if the conversion value in excess of the principal amount of the 2.0% Convertible Senior Notes, if any, is settled in shares of our common stock. The conversion rate is subject to adjustment in some events but will not be adjusted for accrued interest. In addition, if a "fundamental change" occurs prior to the maturity date, we will in some cases increase the conversion rate for a holder of 2.0% Convertible Senior Notes that elects to convert their 2.0% Convertible Senior Notes in connection with such fundamental change. As of March 31, 2011, the 2.0% Convertible Senior Notes had a dilutive impact to earnings per share as the average market price of our common stock for the three months ended March 31, 2011 of $54.61 exceeded the conversion price of $42.53.

Concurrent with the issuance of the 2.0% Convertible Senior Notes, we purchased convertible note hedges covering, subject to customary anti-dilution adjustments, 6,112,964 shares of our common stock. The convertible note hedges are expected to reduce the potential dilution upon conversion of the 2.0% Convertible Senior Notes in the event that the market value per share of our common stock, as measured under the convertible note hedges, at the time of exercise is greater than the strike price of the convertible note hedges. Consequently, under the provisions of the convertible note hedges, we are entitled to receive cash or shares of our common stock in an amount equal to the conversion value in excess of the principal amount of the 2.0% Convertible Senior Notes from the counterparty to the convertible note hedges.

Also concurrent with the issuance of the 2.0% Convertible Senior Notes, we sold warrants to acquire, subject to customary anti-dilution adjustments, 6,112,964 shares of our common stock at an exercise price of $53.77 per share. If the average market price of our common stock during a defined period ending on or about the settlement date exceeds the exercise price of the warrants, the warrants will be settled in shares of our common stock. Consequently, under the provisions of the warrant instruments, if the market price of our common stock exceeds $53.77 at exercise we will be obligated to settle in shares of our common stock an amount equal to approximately $6.1 million for each dollar that the market price of our common stock exceeds $53.77 resulting in a dilutive impact to our earnings. As of March 31, 2011, the warrant instruments had a dilutive impact to earnings per share as the average market price of our common stock for the three months ended March 31, 2011 of $54.61 exceeded the $53.77 exercise price of the warrants.

The convertible note hedges and warrants are separate transactions which do not affect holders' rights under the 2.0% Convertible Senior Notes.

As of March 31, 2011, our common stock was last traded at a price of $64.25 per share. Based on this value, if converted at March 31, 2011, we would have been obligated to pay the principal of the 2.0% Convertible Senior Notes plus an amount in cash or shares equal to $132.8 million. An amount equal to $132.8 million would be owed to us in cash or in shares of our common stock through the provisions of the convertible note hedges resulting in net cash outflow equal to the principal amount of the 2.0% Convertible Senior Notes. At this per share value, we would be required to deliver approximately $64.1 million in shares of our common stock under the warrant instruments or approximately 997,000 shares of our common stock at that price per share.

The principal of our 2.0% Convertible Senior Notes may be repaid with proceeds from debt or equity financing, existing unregulated cash and investments, or a combination thereof. If we determine that debt or equity financing is appropriate, our access to these markets may be limited as our results of operations cannot be predicted. Additionally, any disruptions in the credit markets similar to that of the recent recession could further limit our flexibility in planning for, or reacting to, changes in our business and industry and addressing our future capital

requirements. Further, to the extent the counterparties to the convertible note hedges are unwilling or unable to fulfill the obligations under the convertible note hedges, our financial condition could be materially adversely affected.

Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, as well as lenders' perception of our long- or short-term financial prospects. On March 30, 2011, as a result of our improved financial flexibility, growing operational scale and associated strong cash-flow generation capacity, Standard and Poor's Ratings Services raised its counterparty credit and senior debt ratings on the Company from BB to BB+.

Similarly, our access to additional financing may be impaired if regulatory authorities or rating agencies take negative actions against us or if lenders develop a negative perception of our long- or short-term financial prospects. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all.

Regulatory Capital and Dividend Restrictions

Our operations are conducted through our wholly-owned subsidiaries, which include Health Maintenance Organizations ("HMOs"), one health insuring corporation ("HIC") and one Prepaid Health Services Plan ("PHSP"). HMOs, HICs and PHSPs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to their stockholders. Additionally, certain state regulatory agencies may require individual regulated entities to maintain statutory capital levels higher than the state regulations. As of March 31, 2011, we believe our subsidiaries are in compliance with all minimum statutory capital requirements. The parent company may be required to fund minimum net worth shortfalls or choose to increase capital at its subsidiary health plans during the remainder of 2011 using unregulated cash, cash equivalents, investments or a combination thereof. We believe, as a result, that we will continue to be in compliance with these requirements at least through the end of 2011.

The National Association of Insurance Commissioners ("NAIC") has defined risk-based capital ("RBC") standards for HMOs and other entities bearing risk for healthcare coverage that are designed to measure capitalization levels by comparing each company's adjusted surplus to its required surplus ("RBC ratio"). The RBC ratio is designed to reflect the risk profile of HMOs. Within certain ratio ranges, regulators have increasing authority to take action as the RBC ratio decreases. There are four levels of regulatory action, ranging from (a) requiring insurers to submit a comprehensive plan to the state insurance commissioner, to (b) requiring the state insurance commissioner to place the insurer under regulatory control. Eight of our eleven states have adopted RBC as the measure of required surplus. At March 31, 2011, our RBC ratio in each of these states exceeded the requirement thresholds at which regulatory action would be initiated. Although not all states had adopted these rules at March 31, 2011, at that date, each of our active health plans had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules.

Item 3. ***Quantitative and Qualitative Disclosures About Market Risk***

Our Condensed Consolidated Balance Sheets include a number of assets whose fair values are subject to market risk. Due to our significant investment in fixed-income investments, interest rate risk represents a market risk factor affecting our consolidated financial position. Increases and decreases in prevailing interest rates generally translate into decreases and increases in fair values of those instruments. The financial markets have experienced periods of volatility and disruption, which have impacted liquidity and valuations of many financial instruments. While we do not believe we have experienced material adverse changes in the value of our cash equivalents and investments, disruptions could impact the value of these assets and other financial assets we may hold in the future. There can be no assurance that future changes in interest rates, creditworthiness of issuers, prepayment activity, liquidity available in the market and other general market conditions will not have a material adverse impact on our results of operations, liquidity, financial position or cash flows.

As of March 31, 2011, substantially all of our investments were in high quality securities that have historically exhibited good liquidity.

The fair value of our fixed-income investment portfolio is exposed to interest rate risk — the risk of loss in fair value resulting from changes in prevailing market rates of interest for similar financial instruments. However, we have the ability to hold fixed-income investments to maturity. We rely on the experience and judgment of senior management to monitor and mitigate the effects of market risk. The allocation among various types of securities is adjusted from time-to-time based on market conditions, credit conditions, tax policy, fluctuations in interest rates and other factors. In addition, we place the majority of our investments in high-quality, liquid securities and limit the amount of credit exposure to any one issuer. As of March 31, 2011, an increase of 1% in interest rates on securities with maturities greater than one year would reduce the fair value of our fixed-income investment portfolio by approximately $22.2 million. Conversely, a reduction of 1% in interest rates on securities with maturities greater than one year would increase the fair value of our fixed-income investment portfolio by approximately $19.8 million. The above changes in fair value are impacted by securities in our portfolio that have a call provision feature. We believe this fair value presentation is indicative of our market risk because it evaluates each investment based on its individual characteristics. Consequently, the fair value presentation does not assume that each investment reacts identically based on a 1% change in interest rates.

Item 4. ***Controls and Procedures***

(a) *Evaluation of Disclosure Controls and Procedures.* Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, has evaluated the effectiveness of our disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended) as of the end of the period covered by this report. Based on such evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that, as of the end of such period, our disclosure controls and procedures are effective in recording, processing, summarizing and reporting, on a timely basis, information required to be disclosed by us in the reports that we file or submit under the Exchange Act and are effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure.

(b) *Changes in Internal Controls over Financial Reporting.* During the first quarter of 2011, in connection with our evaluation of internal control over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act of 2002, we concluded there were no changes in our internal control procedures that materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Part II. Other Information

Item 1. ***Legal Proceedings***

The information required under this Item 1 of Part II is contained in Item 1 of Part I of this Quarterly Report on Form 10-Q in Note 9 to the Condensed Consolidated Financial Statements, and such information is incorporated herein by reference in this Item 1 of Part II.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition and results of operations and you should carefully consider them. There has been no material change in our risk factors as previously disclosed in Part I., Item 1.A., Risk Factors, of the Company's Annual Report on Form 10-K for the year ended December 31, 2010 as filed with the SEC on February 23, 2011.

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Item 2. ***Unregistered Sales of Equity Securities and Use of Proceeds***

Set forth below is information regarding the Company's stock repurchases during the three months ended March 31, 2011:

Period	Total Number of Shares (or Units) Purchased (#)	Average Price Paid per Share (or Unit) ($)	Total Number of Shares (or Units) Purchased as Part of Publicly Announced Plans or Programs[1] (#)	Approximate Dollar Value of Shares (or Units) that May Yet Be Purchased Under the Plans or Programs[2] ($)
January 1 — January 31, 2011	63,541	47.20	63,541	221,308,127
February 1 — February 28, 2011	122,124	57.34	122,124	214,305,965
March 1 — March 31, 2011[3]	269,546	58.13	254,663	199,515,246
Total	455,211	56.39	440,328	199,515,246

(1) Shares purchased during the first quarter of 2011 were purchased as part of our existing authorized share repurchase program pursuant to Rule 10b5-1 of the Exchange Act as well as in open market purchases as permitted by Rule 10b5-18 of the Exchange Act. On March 8, 2011, we entered into a trading plan in accordance with Rule 10b5-1 of the Exchange Act, to facilitate repurchases of our common stock pursuant to our ongoing share repurchase program (the "Rule 10b5-1 plan"). The Rule 10b5-1 plan effectively terminated the previous Rule 10b5-1 plan and became effective on May 3, 2011 and expires on May 1, 2013, unless terminated earlier in accordance with its terms.

(2) The ongoing share repurchase program authorized by the Board of Directors allows us to repurchase up to $400.0 million shares of our common stock from and after August 5, 2009. No duration has been placed on the repurchase program and we reserve the right to discontinue the repurchase program at any time.

(3) Our 2009 Equity Incentive Plan allows, upon approval by the plan administrator, stock option recipients to deliver shares of unrestricted Company common stock held by the participant as payment of the exercise price and applicable withholding taxes upon the exercise of stock options or vesting of restricted stock. During March 2011, certain employees elected to tender 14,883 shares to the Company in payment of related withholding taxes upon vesting of restricted stock.

Item 3. ***Defaults Upon Senior Securities***

None.

Item 4. ***(Removed and Reserved)***

Item 5. ***Other Information***

None.

Item 6. ***Exhibits***

The exhibits listed on the accompanying Exhibit Index immediately following the Signatures page are incorporated by reference into this report.

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Signatures

Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this Report to be signed on its behalf by the undersigned thereunto duly authorized.

AMERIGROUP Corporation

By: /s/ James G. Carlson
James G. Carlson
Chairman, Chief Executive Officer and President

Date: May 3, 2011

AMERIGROUP Corporation

By: /s/ James W. Truess
James W. Truess
Chief Financial Officer and Executive Vice President

Date: May 3, 2011

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EXHIBITS

Exhibits.

The following exhibits, which are furnished with this Quarterly Report on Form 10-Q or incorporated herein by reference, are filed as part of this Quarterly Report on Form 10-Q.

The agreements included or incorporated by reference as exhibits to this Quarterly Report on Form 10-Q contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement.

The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Quarterly Report on Form 10-Q not misleading.

Exhibit Number	Description
3.1	Amended and Restated Certificate of Incorporation (incorporated by reference to exhibit 3.1 to our Amendment No. 2 to our Registration Statement on Form S-3 (No. 333-108831) filed on October 9, 2003).
3.2	Amended and Restated By-Laws of the Company (incorporated by reference to exhibit 3.1 to our Current Report on Form 8-K filed on February 14, 2008).
4.1	Form of share certificate for common stock (incorporated by reference to exhibit 3.3 to our Amendment No. 3 to our Registration Statement on Form S-1 (No. 333-347410) filed on July 24, 2000).
4.2	Indenture related to the 2.0% Convertible Senior Notes due 2012 dated March 28, 2007, between AMERIGROUP Corporation and The Bank of New York, as trustee (including the form of 2.0% Convertible Senior Note due 2012) (incorporated by reference to exhibit 4.1 to our Current Report on Form 8-K filed on April 3, 2007).
4.3	Registration Rights Agreement dated March 28, 2007, between AMERIGROUP Corporation, Goldman Sachs, & Co., as representative of the initial purchasers (incorporated by reference to exhibit 4.2 to our Current Report on Form 8-K filed on April 3, 2007).
10.1	Amendment to the AMERIGROUP Corporation Severance Plan (incorporated by reference to exhibit 10.1 to our Current Report on Form 8-K filed on April 1, 2011).
10.2	Amendment No. 3 to Employment Agreement between AMERIGROUP Corporation and James G. Carlson (incorporated by reference to exhibit 10.2 to our Current Report on Form 8-K filed on April 1, 2011).
31.1	Certification of Chief Executive Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002, dated May 3, 2011.
31.2	Certification of Chief Financial Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002, dated May 3, 2011.
32	Certification of Chief Executive Officer and Chief Financial Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002, dated May 3, 2011.
*101.INS	XBRL Instance Document
*101.SCH	XBRL Taxonomy Extension Schema Document
*101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
*101.DEF	XBRL Taxonomy Extension Definition Linkbase Document

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Exhibit Number	Description
*101.LAB	XBRL Taxonomy Extension Label Linkbase Document
*101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

* In accordance with Rule 406T of Regulation S-T, the information in these exhibits is furnished and deemed not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, is deemed not filed for purposes of Section 18 of the Exchange Act of 1934, and otherwise is not subject to liability under these sections and shall not be incorporated by reference into any registration statement or other document filed under the Securities Act of 1933, as amended, except as expressly set forth by specific reference in such filing.

Exhibit 31.1

CERTIFICATION
OF
CHIEF EXECUTIVE OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, James G. Carlson, Chairman, Chief Executive Officer and President of AMERIGROUP Corporation, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q for the three month period ended March 31, 2011 of AMERIGROUP Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the periods covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a- 15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter

that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 3, 2011

/s/ JAMES G. CARLSON
James G. Carlson
Chairman, Chief Executive Officer and President

Exhibit 31.2

CERTIFICATION
OF
CHIEF FINANCIAL OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, James W. Truess, Chief Financial Officer and Executive Vice President of AMERIGROUP Corporation, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q for the three month period ended March 31, 2011 of AMERIGROUP Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the periods covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a- 15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter

that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 3, 2011

/s/ JAMES W. TRUESS
James W. Truess
Chief Financial Officer and Executive Vice President

Exhibit 32

CERTIFICATION OF CEO AND CFO
PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of AMERIGROUP Corporation (the "Company") on Form 10-Q for the three month period ended March 31, 2011 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), James G. Carlson, as Chief Executive Officer of the Company, hereby certifies to the best of his knowledge, and James W. Truess, as Chief Financial Officer (principal financial officer) of the Company, hereby certifies to the best of his knowledge, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JAMES G. CARLSON
James G. Carlson
Chairman, Chief Executive Officer and President
Date: May 3, 2011

/s/ JAMES W. TRUESS
James W. Truess
Chief Financial Officer and Executive Vice President
Date: May 3, 2011

This certification accompanies this Report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed "filed" by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended.

B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

Parent Organization Financial Reports

Amerigroup Louisiana is a wholly owned subsidiary of Amerigroup Corporation. See the response to Section B.6 and its attachments for the required financial reports for Amerigroup Corporation. Information regarding the parent organization begins on page 100 of the SEC Form 10K. As the financial reports reflect, Amerigroup Corporation is a strong, fiscally sound and financially well-managed organization. Our solid financial backing demonstrates the ability to be a long-term partner to DHH for the CCN program.

Further, as required, a statement signed by an authorized representative of Amerigroup Corporation is provided as Attachment B.7.a to unconditionally guarantee performance by the proposing organization, Amerigroup Louisiana.

Amerigroup Louisiana is supported by Amerigroup Corporation, whose financial strength gives us the ability to be a dependable partner to DHH in serving Louisiana's neediest citizens. Revenues for Amerigroup Corporation increased by an average of about 24 percent a year in the past nine years, with membership growing by an average of approximately 17 percent a year during the same time across all affiliated health plans. Total revenues grew from $891 million in 2001, when Amerigroup went public, to $5.8 billion in 2010. As a publicly traded company, Amerigroup Corporation has access to capital markets and greater transparency of financial operations.

Figure B-1. Amerigroup's Membership Increase 2004-2010

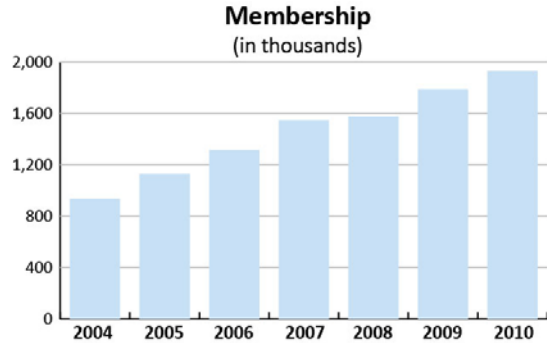
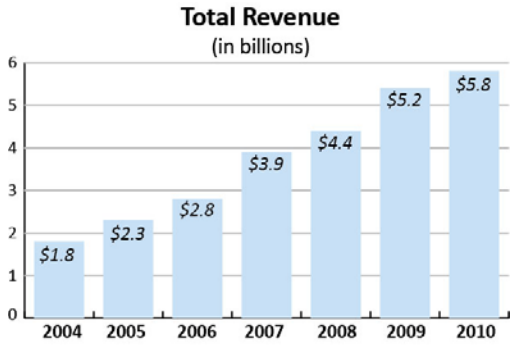


Figure B-2. Amerigroup's Revenue 2004-2010



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Amerigroup RealSolutions in healthcare

Amerigroup Corporation Performance Guarantee

Amerigroup Corporation will unconditionally guarantee performance by Amerigroup Louisiana, Inc. of each and every obligation, warranty, covenant, term and condition of the Contract.

Scott Anglin
Senior Vice President & Treasurer, Amerigroup Corporation
Date: 6/9/14

4425 Corporation Lane
Virginia Beach, Virginia 23462
757.490.6900

www.amerigroupcorp.com

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B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries.

Amerigroup Louisiana is a wholly owned subsidiary of Amerigroup Corporation, an organization that focuses *solely* on meeting the health care needs of financially vulnerable Americans.

Amerigroup's ***Real Solutions*** for Louisiana include a comprehensive approach to support DHH in launching a statewide Coordinated Care Network program. Each of our Solutions is highlighted below.

- **A Louisiana-based Community Health Plan** backed by our national experience and expertise addressing the health care challenges of individuals enrolled in public programs.
- **Targeted Programs and Strategies to Support Care Management** and drive better health care outcomes consistent with the DHH goals.
- **Innovative Program Solutions** that we will bring to Louisiana to address your most challenging health care issues.
- **A Culture of Compliance and Ethics** is embedded in the roots of our organization as a company dedicated to public programs. We ensure the State, and all of our state partners, that all Amerigroup employees receive compliance training and understand – from the top down –Amerigroup's commitment to ethical behavior in all of our actions.

Number of Employees

Amerigroup offers an experienced organization with a local heart. Based on similar health plans operating under various programs in 11 states, we estimate that Amerigroup Louisiana will employ a minimum of 69 full-time equivalent employees throughout the state in servicing this Contract. We also estimate that 98 full-time equivalent corporate employees will support the health plan in Louisiana. This team will use standardized systems and processes to administer core functions like implementation, information technology, claims, enrollment, financial analysis and reporting. Our business and core information processes will be supported by a single integrated coordinated care platform that combines enrollment, premium reconciliation, claims processing, customer service and reporting.

We have built and refined our care management model, tools, processes and systems over 15 years with experience gained operating and growing Medicaid programs in 11 states. **The centerpiece of our approach is a community-based model that pairs local expertise and relationships with national resources and best practices.** Amerigroup Louisiana will include Louisiana-based employees including clinical care management, provider relations and health education and outreach employees. Hired from within the communities we will serve, our employees will have relationships with the provider community and community-based organizations, and knowledge of the local health care infrastructure.

We are aware of the language in Section 4.2 of the RFP **specifying positions that should be located in Louisiana and the requirement for state licensure for some of the positions.** We are fully committed to assuring that the employees we will recruit and hire for the Louisiana-based team upon Contract award

will be of the same caliber and meet the same high standards in place for other Amerigroup health plans.

Client Base

Amerigroup Louisiana was formed with the sole purpose of serving the residents of Louisiana.

Location of Offices

Amerigroup Louisiana has established an office in Louisiana at 3501 N. Causeway Boulevard, Suite 307, in Metairie, LA, and will evaluate additional office locations and needs upon Contract award. The table below demonstrates our commitment to the communities we serve and identifies the location of Amerigroup offices across the nation.

Amerigroup Organization Chart

We provide organizational charts, as Attachment A at the end of this question, to illustrate the reporting relationships of the individuals who will support the administration of the Louisiana Contract.

Parent Organization

Amerigroup Corporation is a Delaware corporation founded and incorporated in 1994. The Company began developing operations of our wholly-owned subsidiaries in 1995 and our first health plans started serving Medicaid members in 1996.

Amerigroup Corporation and its health plan subsidiaries (collectively, Amerigroup) have more than 15 years of experience in Medicaid managed care. Our record reflects that we can help states to meet tough health care challenges. We are committed to ensuring high-quality health outcomes and improved access to care for members while enabling our state partners to control and predict costs. Amerigroup serves approximately 2 million members nationally through health plans in 11 states – Florida, Georgia, Maryland, Nevada, New Jersey, New Mexico, New York, Ohio, Tennessee, Texas and Virginia.

Number of Employees

Amerigroup currently employs 4,624 individuals in 48 offices across the nation.

In addition to the new Louisiana-based staff, we will draw from the experience of Amerigroup employees serving other states in the region to share subject matter expertise and best practices. Amerigroup Louisiana will have corporate resources who have demonstrated implementation success in a wide variety of markets. The result for Louisiana will be a team of experts who understand both the requirements and needs of the Louisiana CCN *and* managed care implementation and delivery.

Client Base

Amerigroup's affiliate health plans across the country serve approximately 2 million members through a variety of public programs, including Medicaid, Medicare and the Children's Health Insurance Program (CHIP). Out 11 clients are listed in Table B-4, which also shows the types of members served by each of our health plans.

Table B-4. Amerigroup Serves Approximately 2 Million Members

Market	TANF	CHIP	ABD	Acute	Behavioral Health (BH)	Rx	Vision	Dental	Members Served
Florida	✓	✓	✓	✓	✓	✓	✓	✓(1)	***263,000***
Georgia	✓	✓		✓	✓	✓	✓	✓	***270,000***
Maryland	✓	✓	✓(2)	✓	✓(3)	✓	✓	v	***207,000***
New Jersey	✓	✓	✓	✓	✓(4)	✓	✓	✓	***133,000***
New Mexico			✓	✓	✓(5)	✓	✓	✓	***22,000***
New York	✓	✓	✓	✓	✓	✓(6)	✓	✓	***109,000***
Nevada	✓	✓		✓	✓	✓	✓	✓	***82,000***
Ohio	✓	✓		✓	✓(7)	(8)	✓	✓	***55,000***
Tennessee	✓		✓	✓	✓		✓	✓	***205,000***
Texas	✓	✓	✓	✓	✓		✓	✓	***582,000***
Virginia	✓	✓	✓	✓	✓	✓	✓		***39,000***

1. *Long-term care members only*
2. *Individuals 65 years or older are excluded from managed care*
3. *Specialty mental health is not covered by Amerigroup. Amerigroup benefit includes (a) mental health provided by a Primary Care Physician (PCP) and (b) substance abuse*
4. *Provided through state except for Division of Developmental Disabilities members*
5. *Provided through state unless provided by Amerigroup network providers*
6. *For Child Health Plus members only*
7. *Provided through State except for members who are unwilling or unable to access services through publicly funded community BH system*
8. *Not currently covered by Amerigroup. Previously covered until 2/1/10 and will be covered again effective 10/1/11*

Our local, community-based, managed care model is based on national program knowledge and expertise developed throughout our 15-year history. Our health plans share best practices to support and further improve innovation and program development for our customers.

Location of Offices

Table B-5. Amerigroup Corporation Offices

AMERIGROUP Corporation		
Office Name	**Address**	**Telephone**
Virginia – Home Office	4425 Corporation Lane Virginia Beach, VA 23462	757-490-6900 Main Phone 757-473-2737 Direct Dial + Extension
Virginia – Home Office II	4433 Corporation Lane Virginia Beach, VA 23462	757-490-6900 Main Phone 757-473-2737 Direct Dial + Extension
Support Center I	1300 Amerigroup Way Virginia Beach, VA 23464	757-490-6900 Main Phone 757-473-2737 Direct Dial + Extension
Support Center II	1330 Amerigroup Way Virginia Beach, VA 23464	757-490-6900 Main Phone 757-473-2737 Direct Dial + Extension
Richmond Office	600 East Main Street Suite 2020 Richmond, VA 23219	804-343-3890 Main Phone 804-343-3895 Main Fax

Table B-6. Amerigroup Florida Offices

AMERIGROUP Florida, Inc.		
Office Name	**Address**	**Telephone**
Tampa Office (Main Office)	4200 West Cypress Street Suite 900 Tampa, FL 33607	813-830-6900 866-588-4761 Main Fax
Miami Lakes Office	14750 NW 77th Court Suite 225 Miami Lakes, FL 33016	305-512-7000 Main Phone 305-512-5507 Main Fax
Orlando Office	2290 Lucien Way Suite 210 Maitland, FL 32751	407-622-7960 407-647-1710 Main Fax
Boca Raton Office	621 NW 53rd Street Suite 175 Boca Raton, FL 33487	561-750-8866 800-950-7679 Toll-Free 561-750-6293 Main Fax
Stuart Office	900 East Ocean Blvd. Suites D232 and D130 Stuart, FL 34994	772-600-2678 Main Phone

Table B-7. Amerigroup Georgia Offices

AMERIGROUP Georgia Managed Care Company, Inc.		
Office Name	**Address**	**Telephone**
Atlanta Office	303 Perimeter Center North, Suite 400 Atlanta, GA 30346	678-587-4840 Main Phone 770-604-9330 Main Fax
Savannah Office	7001 Chatham Center Drive Suite 2400 Savannah, GA 31405	912-235-4470 Main Phone 912-236-1617 Main Fax
Augusta Office	621 Northwest Frontage Road Suite 310 Augusta, GA 30907	706-868-4401 Main Phone 706-447-2860 Main Fax

Table B-8. Amerigroup Maryland Office

AMERIGROUP Maryland, Inc.		
Office Name	**Address**	**Telephone**
Hanover Office	7550 Teague Road Suite 500 Hanover, MD 21076	410-859-5800 Main Phone 410-981-4010 Main Fax

Table B-9. Amerigroup Nevada Office

AMERIGROUP Nevada, Inc.		
Office Name	**Address**	**Telephone**
Las Vegas Office	7251 W. Lake Mead Boulevard Suite 104 Las Vegas, NV 89128	702-228-1308 Main Phone 702-360-0755 Main Fax

Table B-10. Amerigroup New Jersey Office

AMERIGROUP New Jersey, Inc.		
Office Name	**Address**	**Telephone**
Edison Office	399 Thornall Street Suite 900 Edison, NJ 08837	732-452-6000 Main Phone 732-906-2021 Main Fax

Table B-11. Amerigroup New Mexico Office

AMERIGROUP Community Care of New Mexico, Inc.		
Office Name	**Address**	**Telephone**
Albuquerque Office	6565 Americas Parkway NE Suite 110 Albuquerque, NM 87110	505-875-4320 Main Phone 505-884-0921 Main Fax

Table B-12. Amerigroup New York Office

AMERIGROUP New York, LLC		
Office Name	**Address**	**Telephone**
New York Office	360 W 31st Street, 5th Floor New York, NY 10001	212-563-5570 Main Phone 212-563-5975 Main Fax

Table B-13. Amerigroup Ohio Office

AMERIGROUP Ohio, Inc.		
Office Name	**Address**	**Telephone**
Cincinnati Office	10123 Alliance Road Suites 140 and 320 Cincinnati, OH 45242	513-733-2300 Main Phone 513-733-0516 Main Fax

Table B-14. Amerigroup Tennessee Office

AMERIGROUP Tennessee, Inc.		
Office Name	**Address**	**Telephone**
Nashville Office	22 Century Boulevard Suite 310 Nashville, TN 37214	615-231-6065 Main Phone 615-883-5218 Main Fax

Table B-15. Amerigroup Texas Offices

AMERIGROUP Texas, Inc.		
Office Name	**Address**	**Telephone**
Dallas/Fort Worth Office	2505 North Highway 360 Suite 300 Grand Prairie, TX. 75050	817-861-7700 Main Phone 817-548-7125 Main Fax
Houston Office	3800 Buffalo Speedway Suite 400 Houston, TX 77098	713-218-5100 Main Phone 713-218-8692 Main Fax
Austin Office	823 Congress Avenue Suite 400 Austin, TX 78701	512-382-4970 Main Phone 512-382-4965 Main Fax
Corpus Christi Office	5656 South Staples Street Suite 312 Corpus Christi, TX 78411	361-994-5500 Main Phone 361-906-1826 Main Fax
San Antonio Office	4400 Piedras Drive South Suite 100 San Antonio, TX 78228	210-737-5700 Main Phone 210-736-9631 Main Fax

Table B-16. Amerigroup Virginia Office

Amerigroup Virginia, Inc.		
Office Name	**Address**	**Telephone**
Northern Virginia Plan Office	2815 Hartland Road Suites 200 and 140 Falls Church, VA 22043	703-286-3976 Main Phone 703-286-3994 Main Fax

Affiliates and Subsidiaries

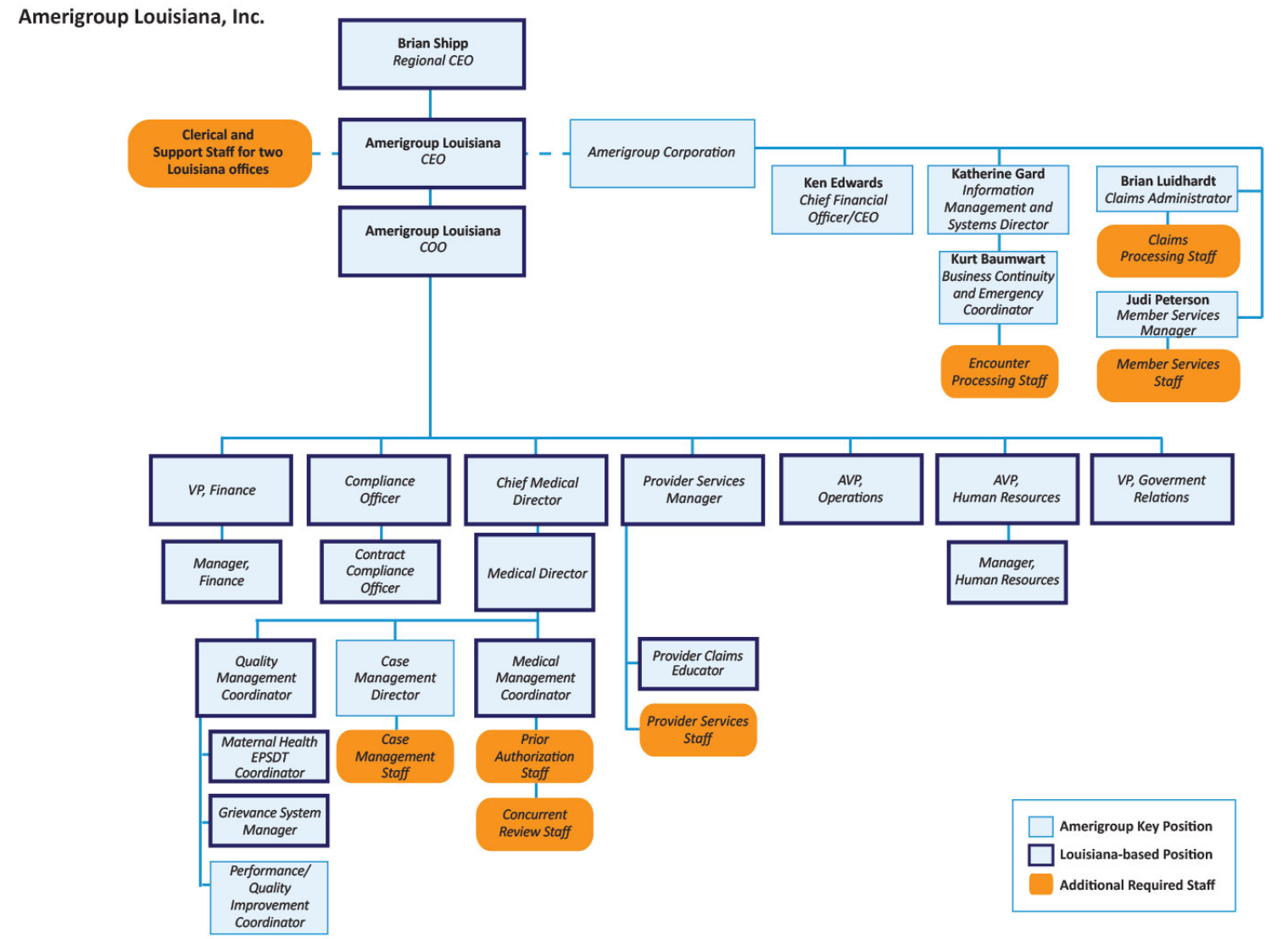
Amerigroup Louisiana currently has 11 operational affiliate health plans, each of which is wholly-owned by Amerigroup Corporation, including:

- AMERIGROUP Florida, Inc.
- AMERIGROUP Georgia Managed Care Company, Inc.
- AMERIGROUP Maryland, Inc.
- AMERIGROUP Nevada, Inc.
- AMERIGROUP New Jersey, Inc.
- AMERIGROUP Community Care of New Mexico, Inc.
- AMERIGROUP New York, LLC
- AMERIGROUP Ohio, Inc.
- AMERIGROUP Tennessee, Inc.
- AMERIGROUP Texas, Inc.
- AMERIGROUP Virginia, Inc.

Amerigroup Organization Chart

As required, we have provided as Attachment B.8.a at the end of this question, an organizational chart showing the structure and lines of responsibility and authority within the Amerigroup Corporation and its subsidiary health plans.

Attachment B.8.a
Chart A: Amerigroup Louisiana Organizational Chart



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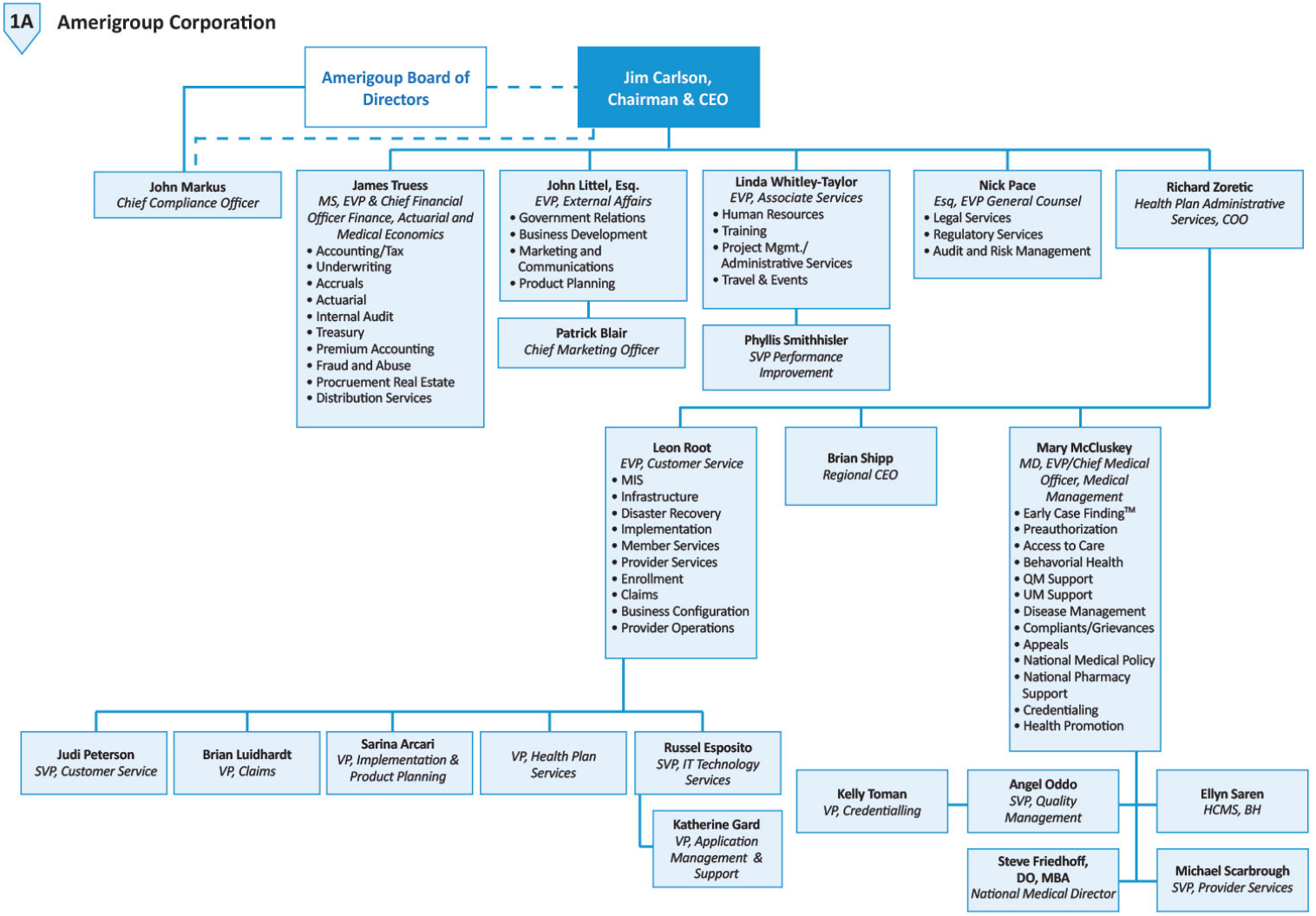
Attachment B.8.b
Amerigroup Corporation Organizational Chart



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B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.

Louisiana Medicaid CCN Project Team

Amerigroup has mastered the key components of **integrating a disciplined and formal implementation with Project Team that carries out the responsibilities of the Contract.** Our expertise in this area comes from more than 15 years of operating Medicaid-specific health plans

REAL SOLUTIONS *mean* REAL RESULTS

To launch the program, we will blend our highly skilled team of leaders with the Louisiana-based personnel, who will bring regional relationships and understanding of unique, local health care challenges.

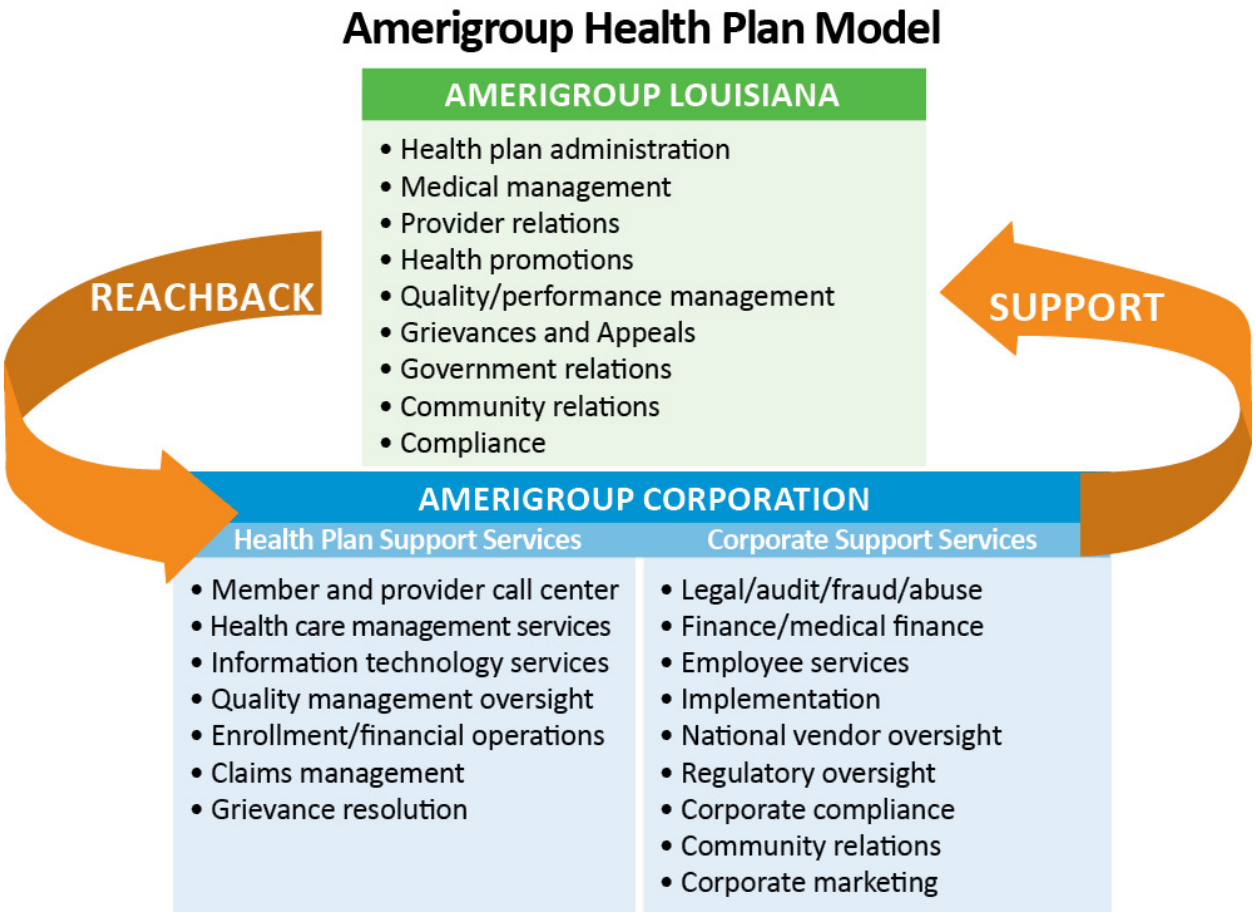
Our Louisiana Project Team, detailed in Section B.10 and identified in Figure B-4, an organizational chart, at the end of this question, includes existing experienced leaders from our cooperate organization to represent the caliber of employees we will continue to recruit and hire for the Louisiana-based team upon Contract award. This experienced Team ensures clear communication, smooth integration and ongoing maintenance activities for your Contract across all Amerigroup teams, processes and systems.

Amerigroup has already begun our search for qualified candidates for the health plan positions, including the key positions we will base in Louisiana. At the onset, the Amerigroup Louisiana Project Team will be managed by Brian Shipp, who will serve as the President and CEO of Amerigroup Louisiana until a **local leader with commensurate experience** is hired.

As the organizational chart illustrates, the Louisiana CEO will be supported by both local and corporate resources. Based on our experience with other affiliate plans, Amerigroup projects that we will have **100 local and 131 corporate Full-Time Equivalent (FTE) employees** in support of Louisiana health plan operations by the end of 2012. These professionals, with reachback to and support from Amerigroup Corporation's Health Plan Support Services and Corporate Support Services, will maintain accountability for the administration of the Louisiana program. As illustrated in our model for Louisiana, shown in Figure B-3, many key functions of the health plan will be held at the local level.

A key benefit to our model is the depth of corporate reach back available to the health plan. In addition to the support the health plan will receive from Amerigroup Corporation, our health plans regularly share both best practices and lessons learned in regional and national meetings.

Figure B-3. Amerigroup's Health Plan Model for Louisiana



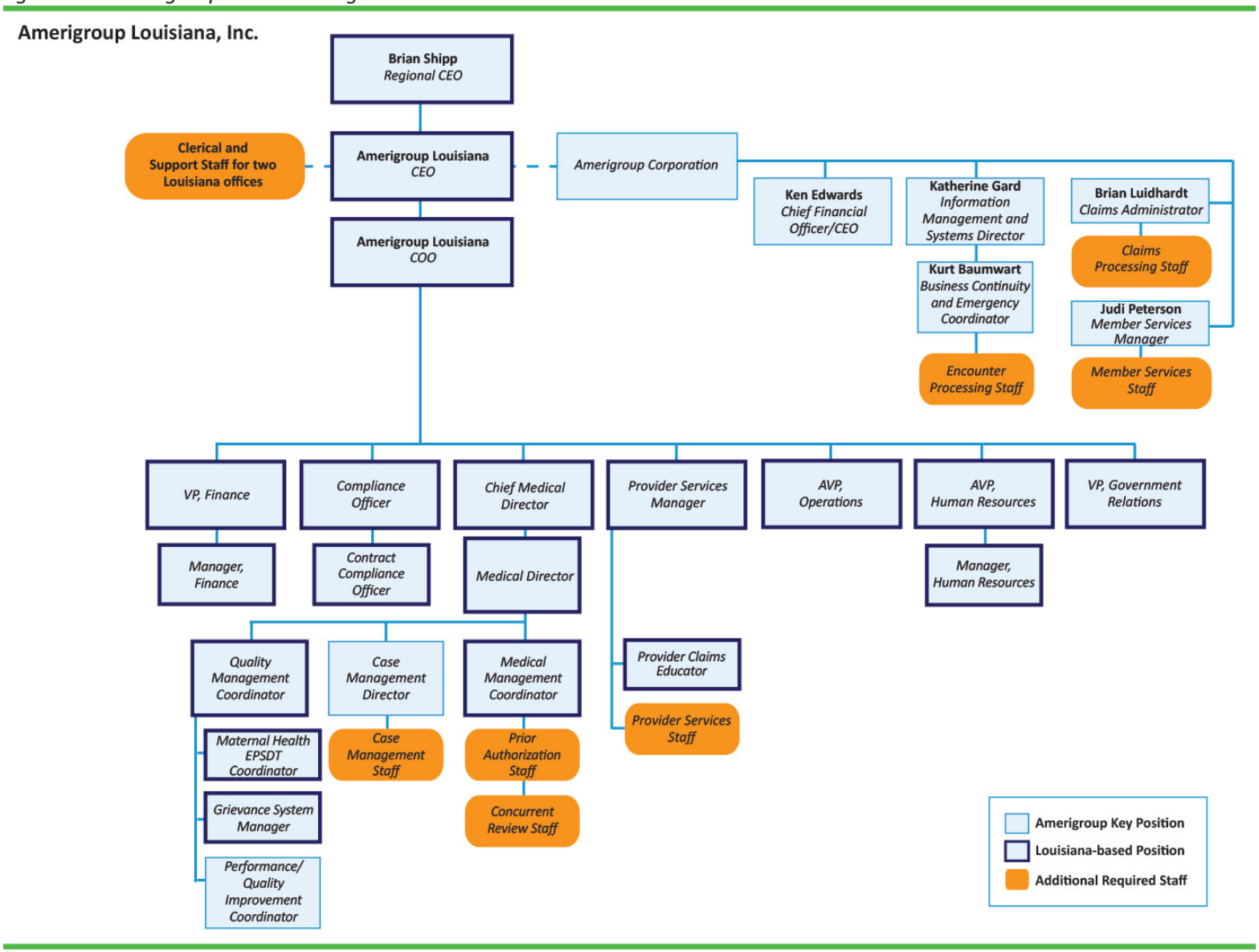
Proposed Geographic Service Areas

Amerigroup Louisiana is submitting a proposal to serve all three Geographic Service Areas (GSAs) in the State.

The Implementation Project Management Team will be responsible for activities in all three GSAs. As DHH has staggered implementation for the three GSAs, our Team will structure its activities to match the implementation schedule.

One Project Team will serve all three GSAs.

Figure B-4. Amerigroup Louisiana Organizational Chart



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B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.

If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.

While our vision for and dedication to a world-class service experience begins with our Implementation Project Management Team, the health plan staff, which will be composed of a combination of Louisiana-based staff and corporate employees, will perform the duties of the Contract. Amerigroup, through our 82 implementation over more than 15 years, has developed a **model in which we pair the key employees of our new health plans with a corporate mentor to ensure that the transition from the implementation phase to operations is a smooth and seamless one.**

REAL SOLUTIONS *mean* **REAL RESULTS**

When we begin serving plan members, we will have filled all of the health plan positions with locally based staff who meet Amerigroup's stringent employment prescreening and training requirements.

As we blend our highly skilled team of leaders with local staff members who will bring regional relationships and understanding of unique, local health care challenges, we ensure DHH the right combination of personnel to meet the needs of the State and of our potential Louisiana members.

As we hire, train and monitor Louisiana-based staff, our Corporate Operations Team has the responsibility to transition the Louisiana personnel and assist them as they successfully manage the ongoing administration and operation of the Contract. Through this model, our Louisiana CCN members will benefit from the administrative efficiencies offered by a national organization that centralizes certain services in support of each local health plan.

Key Staff

The Operations Team that will transition and mentor the Amerigroup Louisiana employees, who will be hired upon Contract award, is presented in Table B-17. As the table clearly shows, these staff members have many years of experience that will assure successful program operation. None of the personnel named is a current or former Louisiana state employee.

Table B-17. Key Amerigroup Staff Supporting Louisiana Program Operations

RFP Function	Name and Amerigroup Title of Project Team Member/Corporate Mentor	Years of Experience
Administrator/CEO/COO	C. Brian Shipp *Regional CEO*	15
Medical Director/CMO	Stephen Friedhoff, M.D. *Medical Director*	17
Chief Financial Officer/CFO	Ken Edwards *Vice President, Finance*	19
Compliance Officer	John Markus, *Chief Compliance Officer*	25
Contract Compliance Officer	Sharon Brumley *Senior Vice President, Regulatory Services*	26
Grievance System Manager	Kristen Younkins *Director, Compliance and Accreditation*	10
Business Continuity Planning and Emergency Coordinator	Kurt Baumwart *Director, Service Continuity*	11
Quality Management Coordinator	Angel Oddo *Senior Vice President, Quality Management*	10
Performance/Quality Improvement Manager	Phyllis Smithhisler *Senior Vice President, Business Improvement*	30
Maternal Health/EPSDT Coordinator	Bobbie Tabor *Manager, EPSDT*	14
Medical Management Coordinator	Ellyn Saren *Senior Vice President, Healthcare Management*	18
Provider Services Manager	Michael Scarbrough, *Senior Vice President, Healthcare Delivery Systems*	20
Member Services Manager	Judi Peterson *Senior Vice President, Customer Care Organization*	15
Claims Administrator	Brian Luidhardt *Vice President, Claims*	10
Provider Claims Educator	Leigh A. Davison *Vice President, Health Plan Operations*	25
Case Management Administrator/Manager	Sandy Orsulak *Associate Vice President, Healthcare Management Services*	11
Information Management and System Director	Katherine Gard *Vice President, ITS Implementation*	26

Position Qualifications and Resumes of Key Staff

On the following pages, we have included position qualifications and resumes for the Key Staff identified in Table B-17. These individuals will support the initial administration of the Louisiana program for Amerigroup. Figure B-5, an organizational chart that shows the lines of responsibility, follows the final resume.

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POSITION QUALIFICATIONS

Administrator/CEO/COO

Position Description

Leads strategic planning and development of the health plan's business plan; performs quarterly reviews and course corrections. Oversees resulting health plan budgeting and financials, including management of medical expenses, management of administrative expenses (local, direct and indirect), financial reports delivered to the state, capital budget planning and management.

Develops and manages key State regulatory and legislative relationships and processes, including premium rates, covered populations, eligibility, benefit design, networks, administrative requirements, and new products. Actively participates in the political and legislative processes, and provide overarching leadership and direction relative to contract negotiations with the State.

C. BRIAN SHIPP

Regional Chief Executive Officer (CEO)

Summary of Experience

C. Brian Shipp, Regional CEO for Amerigroup Corporation and mentor for the CEO for the Louisiana plan, has been with our company for three years. He possesses 15 years of executive leadership experience for managed care organizations.

Experience

Regional Chief Executive Officer, Amerigroup Community Care, Tennessee Health Plan (2007 -present)

- Managed implementation of the Amerigroup entry into the TennCare program representing 185,000 new members and more than 14,000 new provider contracts; oversaw and led approximately 250 staff involved with implementation

President and Chief Executive Officer, UnitedHealthcare, Mid-South (UHC) (2005-2006)

- Led integration of separate health plan operations in Arkansas and Tennessee while serving as CEO of this new combined region while at United Healthcare; oversaw a staff of more than 150 associates for a business representing over $500 million in revenue

President and Chief Executive Officer, UnitedHealthcare of Arkansas (1999-2004)

- Five health plans in the Southeast region of UHC went through a systems conversion in 1999 and experienced near operating collapse due to claim issues with conversion; while serving as a business unit CEO, led a cross functional operations team to resolve claims, service and operations issues across the region; approximately 100 staff members involved with project

Academic Background and Professional Certifications

- **Wharton School, Executive Management Program for Chief Executive Officers**, University of Pennsylvania, Philadelphia, PA
- **Bachelor of Arts in Communications/Minor Marketing,** University of Alabama, Tuscaloosa, AL
- Professional Licenses: Series 7 Securities and Series 3 Commodities and Futures
- Center for Creative Leadership, “Leadership at the Peak” Series completed

POSITION QUALIFICATIONS

Medical Director/CMO

Position Description

The Medical Director oversees all medical care for Amerigroup products and services and the health care needs of the membership and serves as the principal medical manager and policy advisor to the company and health plan CEO or COO. This position is accountable for and provides professional leadership and direction to the utilization/cost management and clinical quality management functions. Works collaboratively with other plan functions that interface with medical management, such as provider relations, member services, benefits and claims management. Reports all issues of clinical quality management to the health plan CEO or COO, the Board and the Amerigroup Chief Medical Officer (CMO).

Primary Responsibilities

- Responsible and accountable to the CEO, COO and the Board for managing health plan medical costs and assuring appropriate health care delivery for Amerigroup health plans, products and services; reports to the CEO or COO of the Health Plan; has a dotted line relationship to the corporate Chief Medical Officer
- Designs and implements health plan medical policies, goals and objectives
- Assures plan conformance with legal and regulatory requirements; interacts with regulatory agencies
- Provides reports and updates as required in the Quality Management Program description, the annual work Plan and Amerigroup policy and procedures to various plan committees, the health plan CEO and corporate Medical Affairs
- Supports URAC and NCQA accreditation activities; prepares for site visits and responds to accrediting and regulatory agency feedback; Supports pre-admission review, utilization management, and concurrent and retrospective review process
- Participates in risk management, claim adjudication, pharmacy utilization management, catastrophic case review, outreach programs, HEDIS reporting, site visit review coordination, triage, nutrition service review, provider orientation, credentialing, provider profiling, etc.
- Chairs (or delegates leadership of) the Medical Advisory Committees of the health plan which include but are not limited to the Peer Review Subcommittee and the Credentialing Subcommittee of the Quality Management Committee
- Participates in the development of strategic planning for existing and expanding business; recommends changes in program content in concurrence with changing markets and technologies
- Ensures the Utilization Management Program is available on a 24-hour basis to respond to authorization requests for emergency and urgent services and is available at a minimum during normal working hours for inquiries and authorization requests for non-urgent health care services
- The medical director must ensure that a covered person enrolled in the Plan is permitted to:
    - Choose or change a primary care physician from among participating providers in the provider network
    - When appropriate, choose a specialist from among participating network providers following an authorized referral if required by the carrier and subject to the ability of the specialist to accept new patients

STEPHEN G. FRIEDHOFF, M.D.

Medical Director

Summary of Experience

Stephen Friedhoff, Amerigroup Corporation's National Medical Director and mentor to the Louisiana health plan Medical Director, has professional experience that spans 17 years of medical practice and medical management for large managed health care companies.

Experience

SVP, National Medical Director, Amerigroup Corporation (2008 - present)

- National Medical Director for a 1.9 million member, 11 state managed care organization dedicated to caring for the financially vulnerable, disabled, and seniors through publicly funded programs
- Direct reports include SVP Pharmacy, VP Clinical Operations, VP Reimbursement Policy, and VP Provider Billing Integrity with additional oversight of clinical call center and corporate credentialing

Regional Medical Director, Independence Blue Cross/AmeriHealth, Philadelphia, PA/Mount Laurel, NJ (2002-2008)

Regional Medical Director, June 2007-September 2008

- Lead department of more than 50 medical directors, nurses and support staff with overall responsibility for population health and wellness, care management, quality management and pharmacy for NJ region

Senior Medical Director (2006-2007); Medical Director (2002-2006)

- Lead Medical Director for NJ region; primary responsibilities include Quality Management, Network Management and Utilization Management for southern NJ region of AmeriHealth-NJ and Independence Blue Cross (IBC) Family of Companies; mentored local Medical Directors
- Lead Medical Director for provider profiling of both PCPs and specialists

Medical Director, Health Net of the Northeast (formerly Qualmed Health Plans), Philadelphia, PA (2000-2002)

- Responsible for all aspects of medical management and provider relations; sole Medical Director responsible for PA plan and one of three Medical Directors
- Lead Medical Director for Pennsylvania Network Management department, including assessment of network adequacy, new technologies and primary provider physician liaison
- Primary Medical Director for claims resolution issues in NJ and PA

Academic Background and Professional Certifications

- **Doctor of Medicine,** University of Medicine and Dentistry of New Jersey-New Jersey Medical School, Newark, NJ
- **Bachelor of Science,** Rensselaer Polytechnic Institute, Troy, NY, Graduated Summa Cum Laude
- America's Health Insurance Plans (AHIP) Certified Health Insurance Executive, 2005
- Alpha Omega Alpha (medical honor society), 1990
- Diplomate, National Board of Medical Examiners, 1992
- Diplomate, American Board of Family Practice, 1994 (recertified 2000, 2006)
- Diplomate, American Academy of Family Physicians, 1994
- Society of Teachers of Family Medicine, 1994
- Licensure: NJ (active), PA (inactive), FL (active), LA (active)

POSITION QUALIFICATIONS

Chief Financial Officer/CFO

Position Description

The Finance Officer is responsible for owning, managing and driving the budgeting, forecasting and financial analysis functions of the health plan to ensure achievement of membership, premium, medical expense, gross margin, and local SG&A goals on a quarterly and annual basis. Major activities owned include the annual budget, quarterly forecasts, financial statement analysis and interpretation, ownership of the ACT process to maximize gross margin, and participation in the premium rate-setting process. The Officer will work collaboratively with health plan and corporate management in all areas of responsibility to ensure the organization is focused on current results versus budget, current financial performance trends and the identification and execution of initiatives to properly manage revenue, medical, gross margin, and SG&A to plan.

Primary Responsibilities

- Owns top-line medical expense and local/direct SG&A portions of annual budget process and quarterly forecasts:
    - Drives process with health plan leadership in conjunction with CEO/COO
    - Conducts/coordinates all analysis required for membership, premium yield, medical expense and local/direct admin. by product
    - Provides all required files to corporate Finance departments within required time frames
- Full participation in monthly operational meetings, financial statement meetings and medical accrual meetings
- Owns the ACT program and ensures its success for the health plan in achieving revenue, medical and gross margin targets on a quarterly and annual basis according to budget/forecast
- Conducts and manages all required analysis for the ACT program
- Fully engages with other Plans and corporate departments to identify, define and use standard tools and analytical approaches, including use of common data sets; interaction with Medical Finance, Finance, Medical Management, Claims, Cost Containment, Provider Service Operations and Premium Reconciliation is expected
- Monitors monthly cost containment activity, including investigation and resolution of adverse changes in collection activity
    - Provides direction to Cost Containment Unit for additional expense savings opportunities not taken
- Monitors monthly claims production, including investigation and resolution of adverse changes in production statistics and their impact on medical accrual estimates
- Monitors monthly supplemental revenue collections such as Maternity kick payments, Newborn kick payment and reimbursable drugs, including investigation and resolution of adverse changes in collection activity
- Monitors, analyzes and reports any variances for local and direct administration expenses
- Identifies and drives opportunities for savings with Plan leadership on a monthly basis
- Works with Actuarial to understand key drivers of the premium development for each product
- Identifies and monitors the assumptions and issues in the rate methodology that drive financial success including trend, populations covered, benefits covered, unit cost assumptions, risk adjustment, birth rates, newborn enrollment rules, special populations (e.g., AIDS/HIV), utilization assumptions and program changes

KEN EDWARDS

Vice President, Finance

Summary of Experience

Ken Edwards, Vice President of Finance for the Tennessee health plan and Finance Officer mentor for the Louisiana plan, has been with our company for four years. He possesses 19 years of leadership experience in finance and audit functions and has proven health care experience in all aspects of corporate and operational financial management, including Medicare/Medicaid reimbursement, income taxes, cost containment and employee benefit plan design.

Experience

Vice President, Finance, Amerigroup of Tennessee (2007 - present)

Chief Financial Officer, Care Plus (a Humana subsidiary) (2005-2006)

- Responsible for market finance and provider contracting for a 60,000 Medicare lives health plan and ten provider clinics that included pharmacy retail and mail order operation for pharmaceutical distribution

Assistant Corporate Controller, Humana (2004-2005)

- Reporting to the Corporate Controller, responsible for directing six controllers with controller responsibility for all of Humana's health plan markets, including Puerto Rico; responsible for all budgeting, financial reporting and operational analysis for all health plan markets

Senior Vice President of Finance, Divestiture Consultant, VP of Finance, Health Net, Inc. (1998 to 2003)

- Assembled and supervised entirely new financial and administrative management team, including department heads of legal and regulatory affairs, provider contracting, human resources, accounting, financial planning and analysis, billing and enrollment, actuarial services and underwriting
- Coordinated all financial interaction with the Florida Department of Insurance (DOI); eliminated over $3 million per year in administrative costs; obtained above-market rate increases on all commercial lines of business from the DOI
- Rewrote provider risk contracts and redesigned the related financial reporting to eliminate settlement disputes
- Headed Health Net's effort to divest the Florida health plan, with the sale closing in August 2001
- Remained with Health Net after the sale to manage financial settlements with the buyer (including a post-sale performance guarantee) and indemnified provider and litigation matters and to assist with other Health Net divestiture matters

Academic Background and Professional Certifications

- **Master of Business Administration,** The University of Alabama, Tuscaloosa, Alabama
  Bachelor of Science, Commerce & Business Administration, The University of Alabama, Tuscaloosa, Alabama, Majored in Accounting, Minored in Mathematics

POSITION QUALIFICATIONS

Compliance Officer

Position Description

Independently manages the regulatory services program of the States' contract; supports the plan's compliance with the regulatory and contractual obligations of state and federal regulatory bodies; serves as a liaison with State regulators; serves as the primary communication vehicle for educating corporate and health plan management staff on regulatory/contractual requirements, operational or implementation issues, and recommended actions to develop or support compliant activity by active management of the full spectrum of the market's regulatory activities required for successful "go-live" or ongoing operations; manages the day-to-day activities of assigned team members.

Primary Responsibilities

- Develop and manage the regulatory services program of multiple operational markets or a single market that is complex in its business operations; lead activities in support of Amerigroup's understanding of and compliance with federal and state regulatory requirements and contractual obligations that Amerigroup is subject to as a licensed Managed Care Organization and state contractor
- Operate as the internal subject matter expert (SME) in the education of health plan and corporate staff on market and product specific regulatory and contractual requirements; provide key stakeholders with information and resource tools to promote informed and strategic decision-making and planning
- Serves as primary company representative for state regulatory agencies and personnel
- Research and document operational requirements, developing and/or maintaining customer-focused resource tools for the purpose of associate education, executive decision-making, and compliance assessments (i.e., State Requirements Grids, reporting grids, *Alerts,* Contract Summaries and SharePoint work sites)
- Research and document licensing requirements and subsequently manage the preparation, submission and timely approval process of the initial licensure and certification applications, acquisition documents, or renewal filings necessary for market entry or ongoing operations (Certificate of Authority, Service Area Expansions, Form A Approval, HMO Certification, Third Party Administrator, Utilization Review Agent)
    - Ensure regulatory requirements are defined
    - Identify/attain agreement on business owner accountability for deliverables
    - Develop and direct document tracking system and monitoring plans
    - Review application content for compliance with state specific requirements
    - Project manages all application submissions through the regulatory approval process
- Lead/co-lead the review, preparation and submission of desktop audit and readiness review materials required for new contract implementations or scheduled operational audits
    - Actively participate in audit preparations and on-site regulatory agency reviews
- Lead the review, assessment, communication and understanding of new or revised state regulations, legislation, state Medicaid contracts and other state issued guidance material
- Serve as Regulatory SME in the development of request for proposal related activities
- Oversee regulatory filings of marketing/advertising materials, member correspondence, outreach programs and other collateral documents and items

JOHN MARKUS

Chief Compliance Officer

Summary of Experience

John Markus, Counsel and Interim Compliance Officer, has professional experience spanning over 20 years and an extensive executive management background in the health care industry focusing on regulatory compliance, pursuing legislative changes and designing and implementing state and federal programs.

Experience

Interim Compliance Officer, Amerigroup Corporation, Virginia Beach, VA (December 2010 - Present)

- Responsible for oversight of regulatory compliance of Medicaid and Medicare managed care plans in 11 states
- Lead the Office of Business Ethics and manage a Corporate Compliance Agreement with the U.S. Office of Inspector General

Of Counsel, Balch & Bingham, LLP, Birmingham, AL (2007 - Present)

- National health care practice focusing on regulatory compliance, reimbursement, and compliance program design and evaluation for providers and managed care organizations

Executive Vice President and Chief Compliance Officer, HealthSouth Corporation, Birmingham, AL (2004 - 2007)

- Designed and implemented a new internal regulatory compliance program for a $3.0 billion, 30,000-employee health care company operating through several hundred inpatient and outpatient rehabilitation hospitals and clinics, ambulatory surgery centers, and diagnostic imaging facilities
- Developed a comprehensive regulatory compliance risk assessment and remediation program utilizing a system of focused management controls and audit processes

Senior Vice President – Corporate Compliance, Fresenius Medical Care – North America, Lexington, MA (1999 - 2004)

- Designed and managed a regulatory turn-around at the nation's largest integrated provider of renal products and services with annual revenues of approximately $4 billion following a $480 million settlement of federal fraud allegations against a predecessor company; compliance program covered 28,000 employees at more than 1,000 locations engaged in dialysis services, products manufacturing, and clinical laboratory testing
- Managed government affairs functions, including development of a full risk End Stage Renal Disease demonstration program in partnership with CMS

Vice President, Corporate Compliance, Oxford Health Plans, Norwalk, CT (1998 - 1999)

- Designed and implemented a comprehensive state and federal regulatory compliance program
- Helped resolve pre-existing regulatory issues with the New York State Departments of Insurance and Public Health and with the federal Medicare program

Academic Background and Professional Certifications

- **Doctor of Jurisprudence**, American University, Washington, DC
- **Master of Business Administration**, University of Chicago, Chicago, Illinois
- **Bachelor of Arts,** Princeton University, Princeton, New Jersey

POSITION QUALIFICATIONS

Grievance System Manager

Position Description

The Director, Clinical Quality Compliance is responsible in conjunction with the AVP of Accreditation and HEDIS for ensuring corporate and health plan compliance with the Accreditation Standards of the National Committee for Quality Assurance (NCQA), state, federal and regulatory standards (inclusive of Delegation Standards) as they apply to clinical quality management as well as engagement with the organizations vendor oversight committee/processes. Accountability includes training new health plans, serving as a consultant to new health plans or for health plans with resource gaps as well as the mechanics for ensuring quality accrediting and regulatory compliance enterprise wide. The Director is responsible for collaborating with the health plans to ensure successful integration of accreditation compliance and delegation oversight activities with the standards of each health plan's External Quality Review Organization (EQRO) and Centers for Medicare & Medicaid Services (CMS) standards.

Primary Responsibilities

- Collaborates with health plans to ensure Accreditation and Delegation Oversight Standards are appropriately integrated with EQRO and CMS standards to maintain NCQA compliance; provides subject matter expertise (consultant) and makes recommendations regarding reconciling EQRO and CMS requirements with NCQA Standards; includes ability to conduct gap analysis (includes Compliance 360) and recommendations, development of project and action plans
- Performs NCQA Gap Analysis at appropriate intervals for health plans preparing for NCQA Accreditation Surveys; provides written recommendations for 100% compliance; assists health plans in navigating corporate processes for creating, updating and publishing documents
- Performs (Collateral Materials Approval Process) CMAP reviews of documents used as evidence for NCQA surveys and provides appropriate written information and feedback to ensure NCQA and Delegation Oversight compliance
- Coordinates delegation and vendor oversight activities with the corporate Vendor Selection Oversight Committee (VSOC), and attends scheduled VSOC meetings; performs onsite and desktop delegation oversight assessments of delegated entities, prepares and presents reports of findings, and monitors corrective action plans (CAP)
- Monitors corporate and health plans for potential or actual accreditation and delegation risks and provides timely and accurate documentation of risks through appropriate leadership channels; provides leadership and direction in resolving or mitigating the identified issues
- Develops presentations for corporate and health plan audiences to provide education regarding NCQA Accreditation Standards and Delegation Oversight Standards; creates standardized tools and programs specific to accreditation/delegation education for health plans and maintains up to date expertise and knowledge on all NCQA activities and standards
- Other duties as assigned

KRISTEN T. YOUNKINS

Director, Compliance and Accreditation

Summary of Experience

Kristen Younkins joined Amerigroup with 10 years of leadership experience within the managed care industry where she spent several years as a Senior Quality Improvement Specialist leading and coordinating various Quality Assurance audits and later moved into management where she developed and implemented HEDIS processes in 14 states for Anthem Blue Cross and Blue Shield.

Experience

***Corporate Director, Compliance and Accreditation,* Amerigroup Corporation, Virginia Beach, VA (February 2011 - Present)**

- Oversee and support corporate appeals process for 11 Amerigroup markets
- Oversee and support corporate complaint process for 11 Amerigroup markets
- Act as an internal consultant to Amerigroup markets to assist with adherence to NCQA Standards and Guidelines

Program Manager, Enterprise Quality, State Sponsored Business, Anthem Blue Cross and Blue Shield Virginia Beach, VA (May 2010 - February 2011)

- Manage the end to end HEDIS process for the Anthem Enterprise Medicaid line of business in 14 states, including hiring, training, data collection, data abstraction, official HEDIS Audits, and analysis
- Coordinate, and assure company adherence to, state-specific HEDIS and other quality-related regulations for the Enterprise Medicaid products

Senior Health Information Consultant, Anthem Blue Cross and Blue Shield Virginia Beach, VA (September 2007 – May 2010)

- Annually develop, implement and manage the HEDIS (Health Information Data and Information Set) Project for the Commercial, Medicaid and Medicare products in Virginia, including leading a team of over 20 nurses and administrative associates to collect, review and record member medical record health information
- Effectively communicate the purpose and importance of the HEDIS project to provider offices in order to obtain medical records in a timely manner

Senior Quality Improvement Specialist, Anthem Blue Cross and Blue Shield Richmond, VA (May 2001 – September 2007)

- Supported the Quality Improvement Department in the writing and updating of QI policies and procedures, as well as the corporate Quality Improvement Work Plan, Program, and annual QI Program Evaluation
- Provided business knowledge to appropriate areas of the company regarding opportunities for improvement as well as compliance to various regulatory and accrediting standards
- Performed bi-monthly UM denial and appeal file audits to assure maintained compliance to state regulations and NCQA Standards

Academic Background and Professional Certifications

- **Bachelor of Science, Health Services Administration,** James Madison University, Harrisonburg, VA
- Earned Six Sigma Green Belt Technical Certification

POSITION QUALIFICATIONS

Business Continuity Planning and Emergency Coordinator

Position Description

Manages and responsible for overseeing all aspects of Amerigroup's Continuous Business Operations (CBO) with emphasis on the management of the company's Business Continuity and Recovery Plan (BCRP), and Emergency Management Plan (EMP), including planning exercises, conducting training and overseeing testing of Plan components. Serves as an Emergency or Disaster Coordinator in the case of an actual business interruption and documents the Consolidated Action Plan (CAP) used to manage the activities related to restoring normal operations in addition to the Incident Report (IR). Responsible for Infrastructure Services' network and application access administration functions in compliance with ITS Security Policies and Procedures. Responsible for ITIL best practices oversights and alignments for Infrastructure Services to include, Service Management, Service Delivery, Service Support and Service Continuity. This position is considered essential to operations and will be required to be available during any emergency. Additionally, the incumbent will be required to maintain an on-call status.

Primary Responsibilities

- Maintains Amerigroup's BCRP and EMP, working with key stake holders throughout the organization, ensuring that the plans are accurately maintained and reflect current Amerigroup operations
- Advises the Disaster Recovery (DR) Leader (CIO) and DR Coordinator (SVP/VP, Infrastructure Services) of ongoing changes to the BCRP and/or EMP and recommends strategic changes to business continuity and recovery strategies in support of an expanding and changing environment supporting Amerigroup operations
- Oversees and reviews results from scheduled tests of key components of the BCRP and EMP, including operational and system tests to demonstrate Amerigroup readiness and disaster preparedness
- Conducts exercises as scheduled to ensure recoverability of critical functions in an emergency situation; exercises are to be conducted as directed by the BCRP Steering Committee
- Develops a Consolidated Action Plan (CAP) in the event of an actual emergency or disaster and serve as the central resource in managing activities in support of the Recovery Leadership Team (RLT) during an actual emergency or disaster incident
- Documents all incidents using Disaster Incident Report (DIR) and conducts debriefing sessions to collect lessons learned and identify opportunities to improve processes, documentation, and management related to the BCRP and EMP
- Participates in internal and external audits related to Amerigroup's ability to recovery from an emergency or disaster incident
- Creates materials for exercises and/or training in support of associate education concerning all aspects of service continuity
- Ensures Infrastructure Services network and application account administration is in compliance with ITS Security Policies and Procedures
- Ensures Infrastructure Services Service Management, Service Delivery and Service Support functions are in alignment with ITIL best practices
- Acts as a management focal point for the department in ensuring the timeliness and accuracy in communication information corporately pertaining to all Infrastructure Services activities and initiatives that may impact IT service continuity

KURT BAUMWART

Director, Service Continuity

Summary of Experience

Possessing over 10 years of management and IT expertise, Kurt Baumwart joined Amerigroup as an expert in contingency planning and recovery strategy and has been with our company for six years handling all aspects of Business Continuity and coordinating emergency management and disaster recovery plans.

Experience

Director, Service Continuity, Amerigroup Corporation, Virginia Beach, VA (2005 - Present)

- Responsible for all aspects of Business Continuity and Disaster Recovery planning, including plan preparation and maintenance, coordination of scheduled BC/DR exercises, vendor negotiations, and recovery strategies; all plans are maintained in the **SunGard** planning product – **LDRPS**
- Renegotiated multiple contracts related to Business Continuity to consolidate the agreements and improve preparedness
- Revised and updated the Business Continuity/Disaster Recovery plans
- Coordinated numerous Disaster Recovery and Work Area Recovery exercises

Security and Business Continuity Administrator, BENEFITFOCUS.COM, INC., Mount Pleasant, SC (2005)

- Responsible for planning and coordination of business resilience and compliance activities, including contingency planning and security policy/procedures
- Developed a business continuity and recovery strategy
- Updated and revised the business continuity plan
- Updated policies and procedures for HIPAA compliance

IS Director, Global Infrastructure Services, KEMET Electronics Corporation, Simpsonville, SC (2002 - 2004)

- Responsible for global IS support for manufacturing, distribution, and sales facilities, including Business Continuity, network infrastructure, server infrastructure, voice communications, desktop services, and computer operations/technical services (mainframe, midrange, Unix, etc.)
- Upgraded the desktop environment to Windows 2000, deploying the Office application suite

Senior IS Manager, KEMET Electronics Corporation, Simpsonville, SC (1999 - 2000)

- Responsibilities included network infrastructure, server infrastructure, voice communications, desktop services, computer operations/technical services, help desk, and disaster recovery

Academic Background and Professional Certifications

- **Master of Business Administration**, East Carolina University, Greenville, NC
- **Bachelor of Science in Business Administration**, East Carolina University, Greenville, NC

POSITION QUALIFICATIONS

Contract Compliance Officer

Position Description

Independently manages the regulatory services program of the States' contract; supports the plan's compliance with the regulatory and contractual obligations of state and federal regulatory bodies; serves as a liaison with State regulators; serves as the primary communication vehicle for educating corporate and health plan management staff on regulatory/contractual requirements, operational or implementation issues, and recommended actions to develop or support compliant activity by active management of the full spectrum of the market's regulatory activities required for successful "go-live" or ongoing operations; manages the day-to-day activities of assigned team members.

Primary Responsibilities

- Develop and manage the regulatory services program of multiple operational markets or a single market that is complex in its business operations; lead activities in support of Amerigroup's understanding of and compliance with federal and state regulatory requirements and contractual obligations that Amerigroup is subject to as a licensed Managed Care Organization and state contractor
- Operate as the internal subject matter expert (SME) in the education of health plan and corporate staff on market and product specific regulatory and contractual requirements; provide key stakeholders with information and resource tools to promote informed and strategic decision-making and planning
- Serves as primary company representative for state regulatory agencies and personnel –
- Research and document operational requirements, developing and/or maintaining customer-focused resource tools for the purpose of associate education, executive decision-making, and compliance assessments (i.e., State Requirements Grids, reporting grids, *Alerts,* Contract Summaries and SharePoint work sites)
- Research and document licensing requirements and subsequently manage the preparation, submission and timely approval process of the initial licensure and certification applications, acquisition documents, or renewal filings necessary for market entry or ongoing operations (Certificate of Authority, Service Area Expansions, Form A Approval, HMO Certification, Third Party Administrator, Utilization Review Agent)
- Lead/co-lead the review, preparation and submission of desktop audit and readiness review materials required for new contract implementations or scheduled operational audits
    - Actively participate in audit preparations and on-site regulatory agency reviews
- Lead the review, assessment, communication and understanding of new or revised state regulations, legislation, state Medicaid contracts and other state issued guidance material
- Serve as Regulatory Services SME in the development of request for proposal related activities
- Oversee regulatory filings of marketing/advertising materials, member correspondence, outreach programs and other collateral documents and items –
    - Review and assess collateral documents for compliance with market or product
    - Specific guidelines as a primary reviewer in the Collateral Material Approval Process; and
- Negotiate approvals by state regulatory liaisons as may be necessary

SHARON BRUMLEY

Senior Vice President, Regulatory Services

Summary of Experience

Sharon Brumley, Senior Vice President of Regulatory Services and mentor for Louisiana's plan for 12 years with a total of 25 years management experience within the managed care industry, including regulatory services; operational compliance; market development and start-up activity; legislative policy assessment; risk identification, mitigation, and policy and procedure management. A subject matter expert in federal HMO and Medicaid regulations with a proven track record for developing talent and identifying and implementing initiatives that improve department and organizational effectiveness.

Experience

Senior Vice President, Regulatory Services *(previously Vice President, Associate Vice President, Director and Manager),* Amerigroup Corporation, Virginia Beach, Virginia (1999 - present)

- Responsible for leading the activities of multiple business units focused on ensuring business requirements are identified and ensuring activities support and promote company-wide compliance with the regulatory and contractual obligations of multiple state and federal regulatory bodies
- Established and manages centralized Regulatory Services, Policy/Procedure Management, Business Development and Operational Compliance departments overseeing:
  - 36 associates
  - 2011 annual budget of $3.5M
  - 21 product contracts
  - 33 oversight agencies
- Leads continuum of regulatory activities in support of the company's growth initiatives and implementation activities resulting in licensures and state approvals for market entry and operations into 10 additional states since 2002 and establishing an effective replicable regulatory services focus valued by state agency administrators and health plan management
- Implemented an end-to-end regulatory compliance process to communicate, track, monitor and measure company-wide activities associated with regulatory agency communications and requirements that provides the company with a mechanism to monitor and manage changes to the operational environment and mitigate risk of non-compliant activity
- Developed a 28-hour training program for department new hires focused on introducing and/or building knowledge of the managed care industry, Amerigroup, and the regulatory services department, with several of the department's program components now incorporated into the company's orientation program for all newly hired associates
- Initiated the development and ongoing maintenance of 75+ summary documents that outline business requirements in Amerigroup markets, resulting in user-friendly educational tools that promote a greater level of understanding of and compliance with contractual and regulatory requirements across the company
- Implemented the federal Medicaid Managed Care Rule company-wide, created resource tools highlighting Rule components and variances from then-current contractual requirements and operational processes; direct partnership with State Agency administrators in Illinois, Texas, Florida and the District of Columbia influenced final regulations and contract provisions

Academic Background and Professional Certifications

- **Master of Science, Management,** Southern Nazarene University, Tulsa, Oklahoma
- **Bachelor of Science, Sociology,** University of Tulsa, Tulsa, Oklahoma

POSITION QUALIFICATIONS

Quality Management Coordinator

Position Description

Responsible, in conjunction with the Chief Medical Officer or his designee, for developing, coordinating, and implementing clinical quality initiatives within the health plan. This includes establishing indicators for monitoring and evaluating the quality and appropriateness of care/service, assessing for continuous improvement in monitored indicator activities, monitoring member satisfaction, and directing initiatives for improvement and evaluating the effectiveness of interventions across the continuum of care to members. Maintains liaison for clinical quality initiatives with state and federal regulatory agencies and collaborates with Government Relations leaders to meet external quality information needs. Provides operational leadership for Health Employer Data Information Sets (HEDIS) reporting, member/provider satisfaction surveying, appeals processing, Quality Management (QM) scorecard reporting, HIPAA privacy compliance, and QM new business development. Works to establish and promote a culture of operational excellence.

Primary Responsibilities

- Provides leadership for implementation of the comprehensive Clinical QM Program for the State's plan to meet the demographic and epidemiological needs of the population served
- Promotes understanding, communication and coordination of the Clinical QM Program
- Oversees the QM Scorecard reporting, including analyzing validity of Clinical QM data/reports from a clinical perspective
- Provides leadership for the development, implementation and evaluation of Clinical Quality improvement action plans for clinical quality improvement activities
- Oversees the member complaint process, privacy compliance process, and centralized appeal process
- Provides leadership for the member/provider satisfaction survey process
- Oversees HEDIS reporting and provides leadership to the development and realization of action plans to achieve target improvement goals
- Supports the health plans' External Quality Review Organization (EQRO) state audit processes
- Oversees and provides leadership for the companywide Quality Improvement Council (QIC)
- Provides supervision and leadership to QM representation in new business activities (RFP responses, new market/product development, and state contract changes etc.)
- Provides organizational leadership to comply with National Committee for Quality Assurance (NCQA) standards, or other accrediting bodies such as URAC and AAAHC
- Provides leadership and makes recommendations for provider recredentialing in the areas of medical record reviews, Clinical Quality indicators, performance and quality of care actions
- Assures compliance with Commonwealth and federal quality improvement/assurance requirements
- Collaborates with Government Relations and external communication leaders to meet the QM information needs of customers
- Oversees delegated services QM auditing including ensuing evaluations/recommendations for improvement
- Develops the annual operating and capital budgets for the health plan to sufficiently meet departmental needs and ensures that department stays within budget and accounts for variances

ANGEL A. ODDO, RN, BSN, MPM

Senior Vice President, Business Improvement

Summary of Experience

Prior to joining Amerigroup last year, Ms. Oddo was Vice President of Quality and Health Services for Coventry HealthCare, Inc. where she maintained oversight of quality, utilization, case and disease management activities for populations in Western Pennsylvania, Northwestern Pennsylvania, Ohio, West Virginia and Delaware. She possesses more than 10 years of leadership experience with managed health care organizations, holds a Bachelor's degree in nursing from Penn State University and holds a Master's degree in Public Management from Carnegie Mellon University.

Experience

***Senior Vice President,* Quality Management, (2010 - present)**

- Develops and implements the comprehensive corporate Quality Management Program to meet the needs of served populations
- Promotes corporate-wide understanding, communication and coordination of the quality management program
- Trends quality data and develops aggregate and individual plan reports as indicated; Analyzes validity of data/reports
- Coordinates development, implementation and evaluation of continuous quality improvement action plans for improvement activities
- Participates in reporting of HEDIS and coordinates improvement action plans
- Coordinates state regulatory quality reporting for the dental plan
- Provides support for provider re-credentialing
- Assures compliance with state and federal quality improvement requirements
- Prepares plan staff for successful State and internal audits

***Vice President,* Quality Health Services and Quality, Health America, Inc./Coventry Health Care, Inc., Pittsburgh, PA (2002-2010)**

- Oversaw all utilization and case management activities in Western Pennsylvania, Northwestern Pennsylvania and Ohio for commercial and Medicare lines of business, inclusive of meeting all regulatory and accrediting oversight requirements
- Held statewide accountability for the Quality Improvement Department, inclusive of disease management, prevention and credentialing

***Chief Operating Officer*, Vale-U-Health, Belle Vernon, PA (1999-2002)**

- Managed operational components in credentialing, quality, utilization review, case and disease management, customer service/claims adjudication and regulatory
- Served on the Board of Directors and facilitated the care management committee

Academic Background and Professional Certifications

- **Master in Public Management**, Carnegie Mellon University — The H. John Heinz III School of Public Policy and Management: Concentration in Health Systems, Pittsburgh, PA, *Graduated with Distinction*
- **Bachelor of Science in Nursing**, Penn State University, University Park, PA, *Graduated with Honors*

POSITION QUALIFICATIONS

Performance/Quality Improvement Coordinator

Position Description

Responsible for advancing Amerigroup's mission and strategic imperatives by establishing strategic plans and objectives in regards to the organization's business improvement efforts, including ownership of Amerigroup's Work Out™ process. Accountable for improving organizational effectiveness, cost management and quality through new strategies, a variety of tools, partnership initiatives, and technology. Provide vision, direction and oversight to Amerigroup's process improvement team for maximum customer (internal and external) satisfaction.

Primary Responsibilities

- Serve as a change agent by stimulating communication and institutionalizing agreed upon improvements through collaborative efforts and Work Out™
- Drives the culture of data driven problem solving
- Works collaboratively across Health Plans and Home office to functional areas to drive best practices for sustained improvements
- Sets the priorities/projects for process improvement based on the voice of leaders, associates and customers
- Liaison with Leadership Team/Health Plans on process rigor
- Coaches team on tool application/methodology
- Sets the strategy for customer centric vision (in collaboration with the business leaders) to reduce business operations through the appropriate tools and methodology while enhancing the overall customer satisfaction
- Collaborates with business leaders to develop project deployment strategy, goals and priorities
- Provides a comprehensive communication plan around team accountabilities/activities/projects and outcomes
- Identify key customer satisfaction metrics to drive sustainable improvements
- Facilitate the use of ongoing company Listening Tours, both process and outcomes
- Select, develop and evaluate staff to ensure the efficient operation of the function
- Act as liaison and company resource on Work Out™ philosophy/actions
- Perform other duties as assigned

PHYLLIS SMITHHISLER

Senior Vice President, Business Improvement

Summary of Experience

Phyllis Smithhisler has more than 30 years of business improvement and management experience in the health care industry focusing on identifying improvement opportunities; corporate reengineering to reduce costs; marketing research; claims processing and budget management.

Experience

Senior Vice President, Business Improvement, Amerigroup Corporation, Virginia Beach, VA (June 2010 - Present)

- Responsible for providing internal consulting services to all areas of the company that will result in improved business results
    - Responsible for identifying improvement opportunities
    - Responsible for identifying appropriate improvement methodology
    - Responsible for coordinating improvement implementation

Senior Vice President, Claims Operations, Amerigroup Corporation, Virginia Beach, VA (March 2006 - June 2010)

- Responsible for the Claims Operations functions for 16 Health Plans in 11 states with 1.8M covered lives in the Medicaid and Medicare programs

Vice President, Business Process Outsourcing Operations, ASI (AmisysSynertech Inc.), Harrisburg, PA (May 2003 - March 2006)

- Responsible for the Mailroom, Data Capture, Enrollment, Claims Processing, and Customer Services Operations for over 3 million members

Vice President, Overpayment Operations, Primax Recoveries Inc., Westlake Village, CA (October 2000 - May 2003)

- Responsible for the Investigation, Identification and Recovery of Coordination of Benefit and Contractual Overpayments for Managed Care Clients

Vice President, Product Support, McKesson HBOC (AMISYS), Rockville, MD (July 1997 - October 2000)

- Responsible for the support for 111 customers using the AMISYS software product

Director, Marketing, Blue Cross and Blue Shield of the National Capital Area, Washington, D.C. (July 1994 - September 1995)

- Directed the marketing research, marketing strategic planning, product portfolio development and product maintenance functions

Academic Background and Professional Certifications

- Northwestern, J.L. Kellogg Graduate School of Management
- Blue Cross and Blue Shield National Management Development Institute - 1991
- The George Washington University, School of Business and Public Management, Executive Development - 1991

POSITION QUALIFICATIONS

Maternal Health/EPSDT Coordinator

Position Description

This position provides support to health plan for EPSDT initiatives and state reporting initiatives.

Primary Responsibilities

- Maintains the EPSDT Data Mart periodicity and immunization schedules and CPT code mapping for all markets
- Supplies ad-hoc reporting and predefined reports training as needed
- Work with state agencies and internal IT department to ensure implementation of immunization and lead registries, ensuring all data received is captured appropriately in the Amerigroup EPSDT Data Mart
- Manages corporate outreach mailing efforts for EPSDT using an outside vendor
- Maintain medical record databases

BOBBIE TABOR

Manager, EPSDT

Summary of Experience

Bobbie Tabor, EPSDT Manager and EPSDT Coordinator mentor for the Louisiana plan, has been with our company for 14 years. She also possessed many years of experience in service and support coordination before joining Amerigroup.

Experience

EPSDT Manager, Amerigroup Corporation, Virginia Beach, VA (2010 - present)

- Maintains the EPSDT Data Mart periodicity and immunization schedules and CPT code mapping for all markets
- Supplies ad-hoc reporting and predefined reports training as needed
- Work with state agencies and internal IT department to ensure implementation of immunization and lead registries, ensuring all data received is captured appropriately in the Amerigroup EPSDT Data Mart
- Manages corporate outreach mailing efforts for EPSDT using an outside vendor
- Maintain medical record databases

Project Coordinator-Quality Management, Amerigroup Corporation, Virginia Beach, VA (2002-2010)

- Initiate provider satisfaction survey project according to defined time frames and deliverables; interface with health plans and appropriate corporate staff to ensure survey approval by designated internal and external review bodies; serve as primary contact and facilitator between the survey vendor, corporate Provider Relations, Quality Management and the health plans; provide final review of survey reports prior to distribution; serve as subject matter expert for survey process and results
- Initiate survey project according to defined timeframes and deliverables; interface with health plans, corporate staff, external review bodies (as needed) and survey vendor to ensure compliance; coordination of time frames and deliverables; manage defined accountabilities and results reporting packages, presentations and work plans; serve as subject matter expert for survey process and results
- QM Scorecards: maintained the QM Scorecards for all markets, tracking key indicators across the company on a monthly basis; included variance reporting and quarterly charting; developed and maintained QM Scorecard roll-up reporting, including monthly and rolling 12-month reports; developed and maintained SLA reporting, tracking performance variances on a quarterly basis

Project Specialist–Quality Management, Amerigroup Corporation, Virginia Beach, VA (2000-2002)

- Organize, support, assist and carry out Quality Management projects to support health plan and Corporate functions
- Development of presentations
- Planning and execution of Quality Week activities on a yearly basis
- Organized Performance Improvement training company-wide
- Created & maintained HEDIS Diaries; duties related to REALExcellence; updated & maintained organizational charts for corporate & health plans needed for NCQA/HEDIS tracking processes

Academic Background and Professional Certifications

Attended Radford University – Radford, VA

POSITION QUALIFICATIONS

Medical Management Coordinator

Position Description

This position collaborates with other executives at the highest level of the company including regional market CEOs, health plan CEOs and COOs, the CMO, the CIO, and the Clinical leadership in the company as well as external business partners. This position requires a strong proven ability to lead, with strong functional skills in clinical operations, business process engineering and business planning, and the development of operational strategy and implementation plans to include workflows, as well as key performance metrics to achieve effective, efficient, and replicable clinical processes. Experience includes a blend of strategic and operational experience with effective communications and a strong background in the healthcare industry, as well as a strong background in clinical operations. Essential responsibilities also include overall leadership and management of the HCMS area.

Primary Responsibilities

- Provides overall leadership for designing, developing, and implementing the company's integrated Medical Management program to meet the demographic and epidemiological needs of the populations/products services
- Directs and promotes leadership for individual departments within the HCMS division
- Overall leader for the specialized functional and technical delivery of the utilization/care management process, including the development of programmatic solutions to include training, clinical criteria, P&Ps and clinical program descriptions
- Overall leadership for new system implementation to support utilization management/care management
- Provides leadership for the management of the clinical component of the PreCert Process
- Leadership in the development and implementation of AGP new Clinical programs

ELLYN S. SAREN, LCSW

Senior Vice President, Healthcare Management

Summary of Experience

Ms. Saren has more than 18 years of managed healthcare experience, with a primary focus on programs serving the Medicaid populations. Her experience spans behavioral health and managed care operations, utilization management, case management, program development and implementations. She has provided collaboration at the request of multiple state agencies regarding the behavioral health needs of their respective consumers. She also has experience in direct service delivery across the public delivery system including Community Mental Health Centers, State Hospitals, and several other community-based agencies.

Experience

Senior Vice President, Health Care Management Services, AMERIGROUP Corporation (2005 - present)

- Responsible for the management of Behavioral Health, Disease Management, and Clinical Operations
- Ensures an integrated healthcare management model (behavioral health and physical health) is rolled out to all the Health Plans and supports the company's care coordination and utilization programs

Vice President, HealthCare Management Services, AMERIGROUP Corporation (2002 – 2005)

- Responsibility for overall corporate medical management operations and behavioral health program operations that cover 800,000 lives

Vice President of Medical Management ValueOptions, Norfolk, VA (2001 – 2005)

- Developed and implemented a companywide communication plan for medical management initiatives

Vice President of Clinical Programming, FHC Health Systems, Norfolk, Virginia (1998 – 2000)

- Oversight of the clinical operations for all of First Home Care, a provider of community-based mental health and case management services for children, youth, adults, and families

Vice President, Implementation, ValueOptions FHC Health Systems, Norfolk, Virginia (1997 – 1998)

- Coordinated all implementation activities between business development executives, client representatives, provider partners, corporate and/or regional operations staff, benefit plan enrollees, network and/or associate providers to service newly awarded business

Vice President, Norfolk Operations, ValueOptions, Norfolk, VA (1996 – 1997)

- Oversight of the clinical and fiscal operations of the Norfolk Service Center, managing 350,000 covered commercial and Medicaid lives

Academic Background and Professional Certifications

- **Master of Social Work**, Yeshiva University, Wurzweiler School of Social Work, New York, NY
- **Bachelor of Arts in Psychology**, Columbia University, Barnard College, New York, NY, Graduated Cum Laude
- Licensed Clinical Social Worker

POSITION QUALIFICATIONS

Provider Services Manager

Position Description

Lead all aspects of Provider Network Management to include provider network strategy, contracting, provider relations and operations to support provider service, network development, provider education and product and market expansions. Responsibilities include the strategic analysis and negotiations for network management, including organizational management, complex contracting and contracting efforts. Provider Network Management includes all aspects of interaction with claim centers, Business Solutions, Health Care Management Systems, Quality Improvement and National Service Center operations. Will also work closely with the State or regulatory partners to achieve high levels of compliance and customer satisfaction. It is further expected this leadership position is a key part of the health plan leadership team supporting important operational and leadership aspects of the health plan.

Primary Responsibilities

- Responsible for managing and improving network management operations to achieve or exceed performance standards/budgets
- Leads the development of provider network business plans, strategies and goals
- Responsible for hiring, developing, training and retaining high-quality, productive employees
- Develops and manages provider contracting efforts and partnerships to achieve quality, cost management, and strategic business development objectives
- Assists the CEO/COO with aspects of local and State government relationships including dealing with regulators as necessary to establish and continue effective working relationships
- Effectively represent Amerigroup in interaction and negotiation with the provider network
- Collaborate with health plan senior management to identify and align provider contracting efforts with the goals and objectives of the plan and Amerigroup
- Lead or assist in the development of provider network related earnings improvement initiatives
- Lead the execution of provider network business plans, strategies and goals
- Monitor local market trends relative to provider contracting, reimbursement and service, make recommendations to modify current processes and lead or assist with implementing changes when necessary
- Responsible for managing required regulatory compliance for provider networks
- Liaison to home office personnel to ensure that provider credentialing, maintenance and reimbursement is properly maintained

MICHAEL SCARBROUGH

Senior Vice President, Healthcare Delivery Systems

Summary of Experience

Michael Scarbrough came to Amerigroup with more than 20 years of health care experience, 17 of those years working with managed Medicaid programs. He is also been engaged in negotiating provider contracts and leading multiple implementations across several markets for various products.

Experience

Senior Vice-President, Health Care Delivery Systems, Amerigroup Corporation, Virginia Beach, VA (2011 to present)

- National responsibility for all provider related activities in the company, including national provider relations and contracting, network development and provider operations
- Leads national provider collaboration initiative execution and medical home program implementation across eight markets and over 800 physicians; leads development of new and innovative relationships, servicing and reimbursement models to further the goals of our provider collaboration program
- Support all rovider related aspects of new market implementations

Chief Operating Officer, Amerigroup Tennessee, Inc., Nashville, TN (2008-2010)

- Responsible for all operations of health plan, including provider relations and network contracting, health care management services, long term care, quality, and health plan operations
- Led successful NCQA accreditation effort that resulted in a commendable level of accreditation

Chief Operating Officer, TLC Family Care Healthplan, Memphis, TN (1999-2007)

- Initially recruited to improve the provider network and provider contracts aimed at stabilizing the financials of the company after a $9.5 million re-investment by ownership; financial performance improvement resulted in re-payment of all invested capital; part of small executive team that managed a controlled auction sale of TLC's assets to Amerigroup Corporation
- Obtained NCQA accreditation level of excellent for three years
- Operational oversight of all health plan operations, including provider relations and contracting, information systems and corporate administration

Manager, Government Programs and Manager, Provider Relations and Contracting, Prudential Healthcare, Memphis, TN (1993-1995; 1997-1999)

- Negotiated all provider contracts and implemented six different provider networks for various products including HMO, POS, PPO and Medicaid
- Provider Relations and contracting activities in three states (Tennessee, Mississippi, and Arkansas), including hospital, physician, ancillary, behavioral health and risk sharing agreements

Academic Background and Professional Certifications

- **Bachelor of Science**, Health Administration with Management Concentration, Warren National University
- Six-Sigma Green Belt Certification (Juran Institute Trained Master Black Belt)
- Health Insurance Association of America (HIAA), currently known as AHIP, professional designation of Managed HealthCare Professional (MHP)

POSITION QUALIFICATIONS

Member Services Manager

Position Description

Leads the organizational strategy, execution, performance and compliance of the customer service units across multiple sites, ensuring the integration of technology and personnel to meet our clients' evolving needs. Provides executive leadership to entire customer care organization and participates in the overall business planning for the company.

Primary Responsibilities

- Accountable for the implementation of strategies that integrate technology and personnel into a blended contact center environment to meet the evolving needs of our clients, members and providers
- Accountable for recruitment, training, development and production of staff; local service delivery; implementation of agreed upon, globally developed policies and practices; and quality outcomes
- Responsible for identification of continuous improvement ideas and to play a lead role in local implementations for process improvements
- Responsible for implementation of agreed upon, strategic planning processes for the National Contact Center (NCC) that are driven by and support the overall mission, goals and business objectives of the organization
- Accountable for management and development of staff members who manage operations in one of the three call center locations, as well as dotted-line leadership of any ancillary NCC support functions
- Responsible for communication and coordination of business objectives/outcomes with senior management
- Employs state-of-the-art technology to reduce costs and increase productivity
- Responsible for the accountability of salary and expense budgets
- Responsible for leading re-engineering and other organizational improvement activities
- Accountable for ensuring cross-functional coordination/communications/service relationships and creating a positive working relationship with critical matrix functions (e.g., Claims, IT, Medical Management)
- Accountable for ensuring operations complies with governing local, state and federal regulations

JUDI PETERSON

Senior Vice President, Customer Care Organization

Summary of Experience

Judi Peterson, Senior Vice President in our National Contact Center, has been with our company for three years and will have oversight of member services for Louisiana's program. She possesses 15 years of experience in management, process improvement and project analysis for managed care organizations. Judi is thoroughly familiar with program requirements and practices, and her team is dedicated to bringing only the highest level of customer service to your plan members.

Experience

Senior Vice President – National Contact Center (NCC), Amerigroup Corporation (2007 - present), Tampa, FL

- Manages inbound and outbound call center operations in three Member and Provider Service Call Center locations (Tampa, FL; Nashville, TN and Virginia Beach, VA)
- Leads team of call center support professionals who serve as liaisons between the call center and the IT/Telephony team and manage technical projects that support the call center
- Responsible for the Call Center and Claims quality assurance function

Director of Process Improvement – Enterprise Provider Services, WellPoint/Anthem, Inc., Louisville, KY (2006-2007)

- Developed, implemented and monitored call center strategic initiatives and project activities for enterprise call centers totaling 1,500 agents (14 onshore and three offshore centers)
- Executive Sponsor of three major corporate priorities: Standard Customer Service Desktop, Enhanced Self-Service and Call Center Consolidation

Director - Business Integration, Enterprise Customer Service, WellPoint/Anthem, Inc., Louisville, KY (2005-2006)

- Directed implementation of large program to outsource more than 20,000 calls a month to offshore vendors resulting in 25% improvement in service levels and an expected five-year Net Present Value to exceed $19 million

Project Manager/Business Analyst – Operations, WellPoint/Anthem, Inc., Mason, OH (2001-2003)

- Managed claims process improvement projects, including Claims Complaint Reduction and Coordination of Benefits (COB)

Manager – Business Process Improvement, Blue Cross Blue Shield Of Michigan, Detroit, MI (1998-2000)

- Managed integration of customer service and claims operations of four Health Maintenance Organizations to a common technology platform and standardized processes

Academic Background and Professional Certifications

- **Bachelor of Business Administration**, Western Michigan University, Kalamazoo, MI
  Majored in Health Care Administration; Minored in Health Education
- Completed Business Process Improvement Training and became certified to facilitate Daimler-Chrysler Process Improvement Workshops
- Project Management Professional (PMP), Project Management Institute

POSITION QUALIFICATIONS

Claims Administrator

Position Description

Provides leadership and direction for administrative and support functions, including application development and oversight, quality assurance and training, defect reduction initiatives and process improvements as they relate to claims operations; oversees new business/product activity as it relates to claims due diligence and implementation; responsible for planning, implementing and controlling the strategies and programs of the Claims department to ensure efficient operations, customer satisfaction and quality service with emphasis on defect reduction; ensures business processes and results demonstrate adherence and compliance with federal/state/regulatory standards and procedures while meeting company goals and objectives.

Primary Responsibilities

- Interfaces with and builds internal and external relationships to ensure superior service; works with business partners such as the health plans, providers, and internal departments
- Manages, controls, directs and takes corrective action with specific strategies to ensure overall performance meets federal, State and regulatory requirements
- Evaluates the Claims operations to develop and implement specific improvement programs to correct deficiencies in order to meet specific service standards
- Maintains responsibility for meeting all cost, quality and performance objectives that strengthen the company's ability to manage SG&A expenses and supports the medical expense objectives to ensure the corporation meets its financial goals
- Supports the strategic planning process for the Claims department that supports the overall mission and financial goals of the organization
- Manages and monitors departmental budget, and controls expenses by ensuring adequate departmental controls and prudent oversight of discretionary expenses
- Develops and implements new, more efficient or cost effective methods or those required by changes in the business environment as it relates to claims processing
- Participates in activities related to corporate mergers and acquisitions to ensure successful transition of core business functions
- Responsible for compliance with all Sarbanes-Oxley controls/compliance; responsible for process controls across multiple platforms

BRIAN LUIDHARDT

Vice President, Claims

Summary of Experience

Brian Luidhardt, Vice President of Claims, has been with our company for 4 years. He possesses 10 years of leadership experience in claims management, quality improvement and membership enrollment and billing.

Experience

Vice President, Claims, Amerigroup Corporation (2006 - present)

- Oversees all claims processing operations for Amerigroup
- Manages controls, directs, and takes corrective action with specific strategies to ensure overall performance meets federal, state, and regulatory requirements

Director, Group Services, UnitedHealth Group (2003–2006)

- Managed the loading of eligibility and billing of customers

Director, Production Quality Council, UnitedHealth Group (2002–2003)

- Facilitated quality improvement initiatives
- Completed Six Sigma Black Belt Training

Director, Production Center, UnitedHealth Group, (2001–2002)

- Managed the claims center

Academic Background and Professional Certifications

- **Bachelor's Degree in Data Processing**, Columbus Business University, Columbus, OH
- Attended Uniprise Leadership Academy
- Completed Six Sigma Black Belt Training – Conducted by ASQ

POSITION QUALIFICATIONS

Provider Claims Educator

Position Description

Assists the Health Plan President and CEO in the fiscal and operational management of the Health Plan. Serves as the liaison to all Virginia Beach support services. Have local responsibility for network development, provider partnerships, provider relations, and quality management programs, performance management/improvement, budgets, complaints and appeals, monthly financials, and reporting. Responsible for identifying, developing and implementing best practices and coordinating implementation of Health Plan initiatives. Work collaboratively with Health Plan Services, HP SME's and Home Office SME's.

Primary Responsibilities

- Establish objectives and annual goals in conjunction with the Health Plan CEO/COO, Health Plan Operations, and AMERIGROUP key initiatives
- Facilitate Plan requirements with Corporate initiatives; promote Plan concerns and enhance communications between respective business owners
- Analyze, evaluate and implement best practices
- Support Plan Executive Management teams by monitoring plan performance; analyze for gaps and opportunities for OpEx
- Manage assigned projects including the development of business processes, workflows and training programs to assist the Health Plans in improving their Operational Excellence
- Provide leadership for Health Plan Operational Excellence programs
- Develop and implement tools for monitoring and evaluating performance objectives
- Coordinate implementation of Health Plan initiatives
- Recognizes and utilizes appropriate channels for communication, encourages two-way communication with Plan and Home Office staff to participate in creative program development resulting in improved efficiency and enhanced job performance
- Serves as the liaison to all support services, Claims, Enrollment, MPS, Finance, Business Control, Med/Finance, Regulatory Compliance, IT, etc., in Virginia Beach. Participates in cross-company operational activities on an ad hoc (e.g., Service Center Audits) and ongoing (e.g., MOR; QOR) basis
- Develops and manages provider contracts and partnerships to achieve quality, cost management, and strategic business development objectives; develops and negotiates strategic provider contracts on behalf of the Plan
- Responsible for and leads the Plans performance management/earnings improvement activities; assists in developing policy and programs to achieve business results through effective financial management
- Assists CEO with development of the Plan's annual administrative, medical, and capital budget process
- Assists CEO with management of monthly reporting and review of financials/accruals
- Appeals Grievances: Responsible for the Plan's complaint, appeals, pended claims, and claims research functions
- Other Duties as Assigned

LEIGH A. DAVISON

Vice President, Health Plan Operations

Summary of Experience

Over 18 years experience in the health care industry both in the private and public sectors with a proven track record in expanding, developing and maintaining provider networks and health plan operations. In addition, experience in integration of multiple business areas, staffing, transition and mergers. Effective and motivational team leader, able to inspire excellence, operates within budget targets and provides outstanding client service.

Experience

Vice President, Operations, Amerigroup Corporation, New Mexico (November 2009 – Present)

- Responsible for supporting the CEO and COO with the overall operations of the health plan for the State of New Mexico
- Act as a liaison with the corporate team to ensure health plan is supported with all functional areas as needed (claims, customer service, enrollment, encounter submission, audits and compliance, regulatory, IT, contract loading, etc.

Associate Vice President, Operations, Amerigroup Corporation, Georgia (January 2006 – November 2009)

- Responsible for supporting the CEO and COO with the overall operations of the health plan for the State of Georgia representing over 235,000 members throughout the state
- Monitor health plan operations quality reporting and ensure all state requirements and SOX controls are being met

Associate Vice President, Provider Services, Amerigroup Corporation, Virginia Beach, VA (February 2005 – January 2006)

- Management and oversight of all provider communications, collateral materials and website applications for the largest Managed Medicaid Company in the country with over 1.2 million members in 10 states representing 431 hospitals and 52,000 providers
- Responsible for the development and implementation of provider relations/provider advocacy quality and enhancement programs, policies and processes
- Developed and executed the communication strategy for the claims system conversion to Facets which included the rollout of ERA/EFT functionality

Senior Project Manager/Business Project Program Manager, Aetna Inc., Alpharetta, GA (August 2002 – February 2005)

- Served as the Chief of Staff to the Head of Select Accounts, who was responsible for the profit and loss of small and mid size groups across the country; this was the largest growing segment within the company with an operating income of $139.8M and over 900K members
- Responsible for the management and oversight of budget expenses totaling over $11 Million

Academic Background and Professional Certifications

Bachelor of Business Administration, Georgia College, Milledgeville, Georgia
Majored in Marketing

POSITION QUALIFICATIONS

Case Management Administrator/Manager

Position Description

The Case Management Administrator manages the utilization / care management process ensuring delivery of essential services that effectively address the total health care needs of the State's plan members.

Primary Responsibilities

- Implements and manages health care management, utilization, cost and quality objectives in accordance with the goals of Amerigroup's mission, vision and values, the needs of the health plan, federal and state regulatory requirements, and NCQA standards
- Collaborates with the peers to ensure a seamless interface between HCMS and Medical Management
- Identifies opportunities to improve the customer service and quality outcomes for members
- Collaborates with peers to initiate innovative health care pilots to improve the overall HCMS/medical management program
- Interfaces with other departments to ensure the complete integration of behavioral health and physical health
- Overseas the development of medical management policies, procedures, and guidelines
- Ensures implementation and continued compliance by providing updates on specific medical management standards to staff
- Assists in developing clinical management guidelines, including conducting literature search to identify "evidenced-based" management; identifying changes in practice which may require updating of guidelines; developing draft guidelines as directed; identifying local providers experienced in treating patients; coordinating physician advisory groups
- Evaluates programs quarterly
- Supports and participates in quality initiatives and activities including clinical indicators reporting, focus studies and HEDIS reporting
- Ensures compliance with State reporting on utilization management activities for accuracy

SANDY ORSULAK, BSN, RN

Associate Vice President, Healthcare Management Services

Summary of Experience

Sandy Orsulak, Associate Vice President of Health Care Management Services in Maryland and Case Management Director Mentor for the State plan, has been with our company for 11 years. Her professional experience spans nearly 15 years in the health care industry. She offers extensive experience in program development, case management process, claims and cost containment.

Experience

Associate Vice President Health Care Management Services, Amerigroup Corporation (2008 - present)

- Improved timeliness of review completion for all incoming referrals by redesigning the Prior Authorization program
- Increased staff accountability, productivity and ability to identify opportunities for improvement by developing tools to monitor productivity and track cost savings
- Wrote and revised departmental policies and procedures to meet regulatory requirements
- Assisted in developing competency-based orientation program for staff by leading a multidisciplinary project team
- Co-developed internal corporate-wide certification program for licensed staff
- Developed and managed a new case management program that targeted high cost utilizers; have reduced readmissions from 100 days to less than 10 per month
- Identified value added vendors who partnered with Amerigroup on special projects for NICU, Pediatric and the Special Needs Population
- Developed and implemented a co-managed enhanced medical home/guided care model with key providers in the community that has improved both quality and access to care for all markets

Director Health Care Management Services, Amerigroup (2002-2008)

- Developed strategic cost saving initiatives that supported an overall reduction in inpatient admissions by 50%
- Provided leadership to 35 associates and oversight to multiple delegations
- Developed external contracts and innovative programs that resulted in a reduction in administrative costs
- Assisted with development of corporate case management standards in accordance with NCQA requirements
- Implemented a global case management program that has been identified as a corporate best practice
- Developed policies, procedures and department programs according to regulatory requirements
- Maintained a less than 2% turnover rate by implementing an open management style

Academic Background and Professional Certifications

- **Bachelors of Science in Nursing**, Villa Julie College, Stevenson, MD
- **Associates of Science Nursing**, Anne Arundel Community College, School of Nursing, Arnold, MD
- **Bachelors of Art in Business Administration & MBA**, University of Maryland University College, Adelphi, MD (in progress, anticipated graduation 2011)
- **Licensed:** RN, Maryland

POSITION QUALIFICATIONS

Information Management and System Director

Position Description

Responsible for the delivery of system functionality and data interface development and integration for all growth initiatives. Lead team of ITS subject matter experts (SMEs) serving as the internal ITS SME and external technical liaison to government partners and vendors in implementation growth initiatives to include due diligence, acquisitions, new market development, existing market expansion, new product implementation, and RFP responses. Propose contracting language edits for contracts with customers (e.g., states) and partners (e.g., vendors). Review contracts and other state source documents to identify the gap to Amerigroup's current environment and identify requirements for implementation. Provide leadership across the implementations working closely in the matrix team with implementation peers and a focus on Customer Service. Coordinate and lead interface testing with government partners and vendors for implementation growth initiatives. Use data analysis skills to analyze data and identify issues and validate test and production files throughout an implementation. Provide department leadership and management and initiatives, budget, planning, strategy, and tools input.

Primary Responsibilities

- Leader of department strategy for successful execution of simultaneous, multiple projects utilizing exceptional organization and analytic skills along with technical expertise and corporate knowledge; ensure information systems updates are properly planned, developed, tested, documented, and implemented within budget, meeting quality standards and scheduled time lines
- Work collaboratively with ITS to ensure applications, infrastructure, and data systems are aligned with state contractual requirements
- Provide leadership of complex and large implementation projects utilizing subject matter expertise and exceptional organization and management skills
- Provide leadership within cross-functional teams to define requirements and solutions and ensure successful completion of projects with seamless integration in all functional areas
- Ensure assigned projects are properly planned, developed, tested, documented, and implemented following quality standards and scheduled timelines
- Understand data modeling concepts (e.g., the Entity-Relationship model) and their application: entities and tables, relations and constraints, attribute data types and column data types; able to perform complex queries and simple data base updates
- Participate in RFP activities for potential vendor product/service; provide RFP language, specifically ITS language, and assess existing vendor relationships to include but not limited to: benchmark vendor performance, reduce risk of vendor nonperformance, produce early problem resolution, perform risk assessment, evaluate vendor's strategic direction, and monitor vendor compliance through implementation
- Participate on due diligence teams as the subject matter expert for ITS
- Monitor ITS departmental project status and elevates risks to senior management as appropriate
- Manage and develop departmental staff to support the volume of projects in the new business implementation portfolio; identify resource needs, hiring, evaluation, and development of project staff inside and outside the department
- Lead the development and continuous improvement of Amerigroup implementation strategies
- Negotiate contract language on state and vendor contracts

KATHERINE GARD

Vice President, ITS Implementation

Summary of Experience

Katherine Gard, Vice President – ITS Implementation, leads the technical component of new business/growth implementations and has been with our organization for 10 years. Ms. Gard has over 26 years of Information Systems experience in areas such as software development and maintenance, network administration and support, and systems recovery. In her current role, she has led the technical implementation of nine new markets through bid/startup (primarily) and acquisition as well as growth initiatives in all existing markets.

Experience

Vice President, ITS Implementation, Amerigroup Corporation, Virginia Beach, VA (2008 - present)

- Responsibilities include ITS leadership and management for growth initiatives with a focus on external technical liaison responsibilities as well as budget and project management

Associate Vice President, ITS Implementation, Amerigroup Corporation, Virginia Beach, VA (2002–2008)

- Responsibilities consisted of ITS leadership and management for the company's growth initiatives, which included budget and project management responsibilities

Director, Information Technology Services, Amerigroup Corporation (2001-2002)

- Responsible for a team of business analysts providing application analysis, requirements gathering, and testing support to Amerigroup functional business units

Information Systems Consultant, Metro Information Service (1998-2001)

- Developed a business recovery plan for the critical business processes and associated automated systems identified in the Business Impact Analysis, reviewed, revised and customized security awareness training for clients based on the results of a Risk Analysis and updated and customized policies and procedures according to State guidelines

President, Gard Technical Solutions, Inc. (1997-1998)

- Provided support services for an automated vending machine controller application written in C using an Informix database on a SCO UNIX platform; installed and configured SCO UNIX, Informix, and Red Hat Linux; manipulated the database with Informix's ISQL interface; and developed Word Basic programs to manipulate and automate the data for the final production of an extensive reference guide

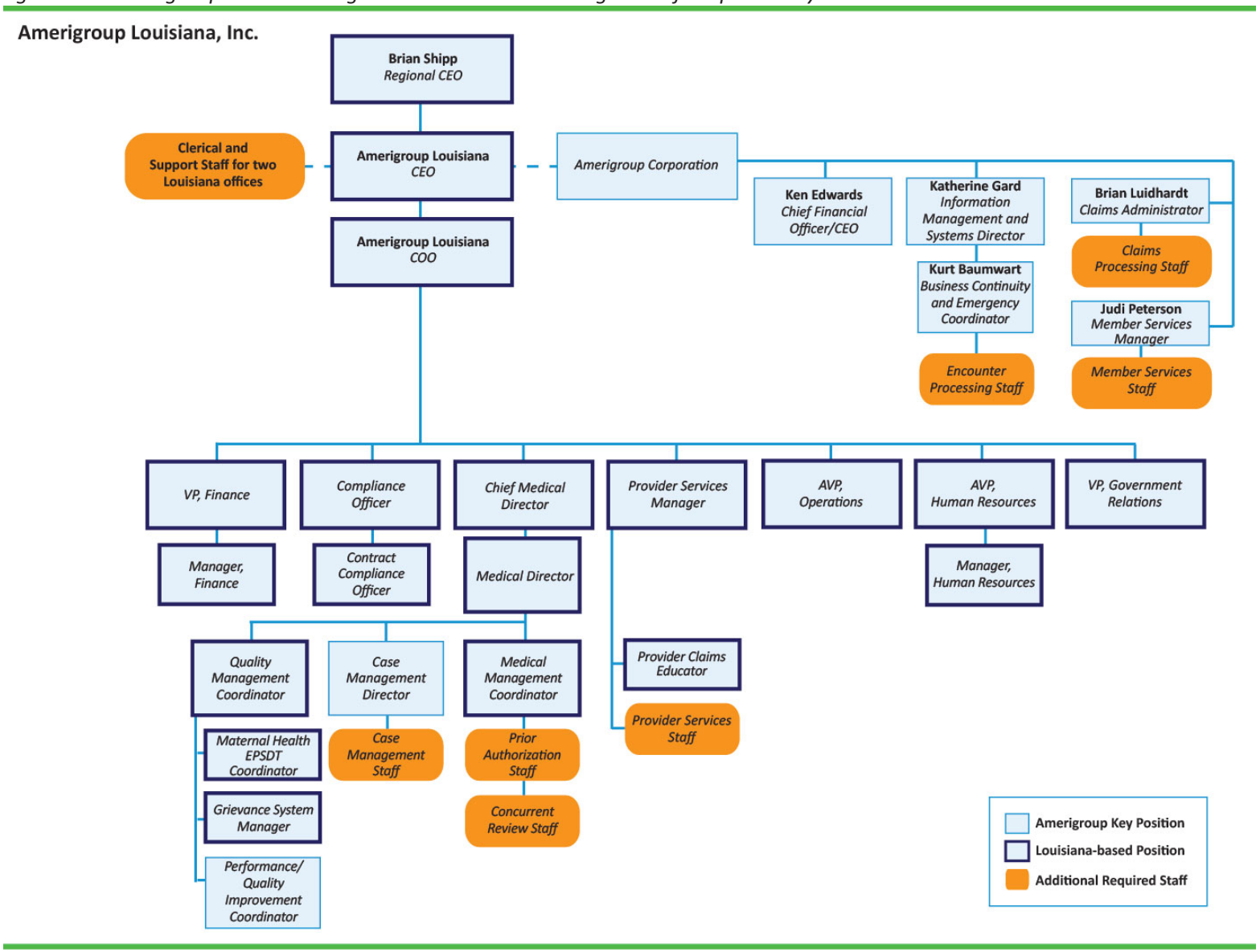
Senior System Engineer, ANADAC Inc. (1996 – 1997)

- Participated in the development in Visual Basic 4.0 and used an OLE interface to Watermark, created design and development documentation based on the project proposal and client interviews conducted for functional understanding

Academic Background and Professional Certifications

Bachelors in Mathematics and Computer Science, Virginia Wesleyan College, Virginia Beach, VA

Figure B-5. Amerigroup Louisiana Organizational Chart showing lines of Responsibility



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Position Qualifications of Additional Personnel

In addition to the position qualifications and resumes of Key Staff identified in Table B-17, we have included position qualification of other personnel as required in the RFP.

POSITION QUALIFICATIONS

Prior Authorization Staff

Position Description

The Manager of Prior Authorization Assistants is responsible for day to day operations of the Preauthorization Assistants at the National Contact Center (NCC). The Manager provides oversight in the planning, implementing and evaluating current processes including operational statistics and service standards for Amerigroup members to ensure high quality, cost effective care. The Preauthorization Assistant Manager is responsible for providing clinical, management and leadership expertise in the oversight of the associates and supervisors that are performing preauthorization services.

Primary Responsibilities

- Direct, daily supervision of the pre-authorization assistant department
- Responsible for the daily performance of department to meet corporate service levels
- Ensures that department is adequately staffed at all times; alters daily assignments as needed to ensure coverage is adequate and identifies need for additional staffing based on performance
- Manages departmental projects as assigned, including staff assignments, and reporting
- Reviews monthly incentive results, validates accuracy meets all associated timelines and discusses outliers with supervisors
- Assists with ensuring departmental spending is within budget as applicable
- Reviews and provides feedback on training documents and assists in development as assigned
- Provides assistance to supervisors concerning policy questions and criteria Communicates effectively to support company changes including sending documents alerting departments of new or urgent information
- Assists the AVP, Director of Clinical Support, and the Medical Managers in both the Virginia Beach and Tampa operations in identifying areas targeted for improvement processes, developing medical management policy, procedure and guidelines, and researching alternatives
- Responsible for the monitoring of time and attendance and the implementation of disciplinary processes
- Completes all PRISM entries/approvals within designated timelines
- Works with Work Force Management to ensure adequate coverage is available at all times
- Responsible for insuring teams' adherence to all policies and procedures delineated by Associate Service, and for implementing disciplinary processes when they are not followed including developing action plans
- Work with the Call Coaches to insure optimal levels of performance and elevate calls for dispute resolution
- Arranges 1-1 meetings with direct reports and attends the supervisor's team meetings periodically
- Actively promotes and participates in the education of associates within and outside the NCC
- Ensures consistent application of all company and NCC policies and elevates issues to appropriate contact
- Completes performance appraisals in allotted time; reviews departmental appraisals and ensures consistent application of scoring guidelines; creates development plan for associates and assists with setting departmental standards
- Provides education to providers concerning Amerigroup policies to improve quality and appropriateness of care

- Maintain adequate reporting to assure compliance with all departmental standards and policies; performs required data entry into the NCC database
- Monitors CMS and takes action when service levels decrease; monitors aux usage and addresses misuse
- Participates in internal and external quality review activities as requested
- Actively develops and maintains optimal working relationship with the health plans; proactively sets up meetings, when needed, to facilitate efficient working relationships
- Functions as department representative and participates in cross-departmental activities as assigned or deemed necessary
- Other duties as assigned

Education and Experience

Education

- 2-year college degree or equivalent work experience
  Preferred: Healthcare Degree
- LPN preferred
- Case management or utilization review experience
- Call Center experience

Years and Type of Experience

Required:

- 3-5 years clinical experience
- Previous management/supervisory experience or 1-2 years experience within the clinical area at Amerigroup having demonstrated leadership ability within project management or other equivalent assignment

POSITION QUALIFICATIONS

Concurrent Review Staff

Position Description

Assure that the delivery of healthcare services is available, accessible, timely and medically necessary. Act as a patient advocate, seeking and coordinating creative solutions to patients' health care needs without compromising quality outcomes.

Provides professional guidance to lower level RN & LVN Utilization Managers, and provides expert guidance and leadership within the area of Utilization review.

Primary Responsibilities

- Using discretion and independent judgment, coordinate the delivery of quality patient care by:
    - Demonstrating expertise in nursing care and effectiveness of utilization management for patients of varying complexity through:
        - Advanced problem solving techniques
        - In-depth understanding of liability issues for utilization management activities
        - Strong knowledge of community resources, as well as, state and federal initiatives regarding member disability
    - Assessing clinical information to ensure appropriate utilization of resources and quality care
        - Understands the physical and psychological characteristics of illnesses and wellness
        - Identifies cases with potential for high risk complications
        - Acts as an advocate for an individual's health care needs
        - Evaluates quality of necessary medical services, identifies cases that would benefit from alternative care, and recommends opportunities to maximize cost effectiveness
        - Assures that coverage is available to provide continuity in coordinating and/or managing requests for members needs
        - Adheres to the UM process, criteria and the application of the criterion
        - Performs on-site and/or telephonic review of acute and sub-acute services
        - Predicts and plans for patient's needs from pre-admission, through acute and sub-acute care and post-discharge, in collaboration with the member
    - Collaborating with the member's treating physician(s), ancillary providers, and family/care givers, utilizing a multi-disciplinary approach to problem identification, communication and negotiation to develop long/short-range goals
    - Assuring treatment plan is followed
    - Developing discharge plan for all facility admissions
- Consistently supports the compliance program by maintaining the privacy and confidentiality of information, protecting the assets of the organization, acting with ethics and integrity, reporting non compliance, and adhering to applicable federal, state and local laws and regulations, accreditation and licenser requirements (if applicable), and AMERIGROUP's policies and procedures
- Act as preceptor for area of specialty
- Takes on special projects/additional tasks along with an existing caseload

- Lead Subject Matter Expert/Team Leader for Area, Region or Product; coordinate all activities and provide updates/information to local department leadership
- Responsible for leading, reporting, and completing assigned projects/special tasks
- Other duties as assigned

Education and Experience

Education

Required:

- Bachelor's degree in nursing or related field

Preferred:

- Graduate of an accredited school of nursing

Years and Type of Experience

Required:

- 5-10 years experience in health care, case management, or discharge planning
- Minimum of three years utilization review experience

Preferred:

- Experience working on the community level and with community agencies

Specific Technical Skills

Required:

- Excellent verbal and written communication skills
- Strong decision making skills
- Advanced problem solving skills
- Demonstrated competency working with Milliman and/or Interqual criteria
- Proficiency with MS Office, Word, & Excel

Preferred:

- Proficiency with Facets software

Certifications or Licensures

Required:

- RN required with current license
- CPUR (Certified Professional utilization Review)
- Must possess valid driver's license and daily access to reliable motor vehicle

POSITION QUALIFICATIONS

Clerical and Support Staff

Position Description

Provides administrative/management support to senior executive level. Ensure proper function of the CCN's operation. Performs a variety of complicated tasks where a wide degree of creativity and latitude is expected and thereby relieving the executive of administrative type functions.

Primary Responsibilities

- Manages executive schedule, appointments, updates, and deletions to executive schedule determining priority of meetings; promotes time management for executive and their schedule; coordinates with personal schedule and family commitments
- Assists in meeting planning and preparation work, i.e., drafting agendas, minutes, and information on meetings
- Prepares draft documents/reports/correspondence for signature or review from dictation, handwritten notes, or on own
- Opens, annotates, reviews, and processes incoming mail/email, determining what mail to forward
- Coordinates travel with others and ensures time is utilized during travel
- Plans and schedules all travel based on minimum guidelines
- Prepares presentation material and provides guidance on format and layout for other administrators within the department
- Prepares supply orders
- Acts as an administrative resource to others in department
- Prepares request for capital expenditures
- Directs copies and faxes activities to others
- Assists in design of electronic file systems and maintains electronic and paper files
- Prepares weekly time sheets, prepares new hire, security, temporary and other paperwork needed
- Assists with corporate projects
- Provides financial report support
- Manages phones, screens calls, assists callers, and redirects calls as needed
- Maintains contacts for executive
- Prepares expense reports from receipts and schedule
- Provides training to Administrative Assistants when needed
- May supervise other administrative associates
- Other duties as requested or assigned

Education and Experience

Education

Required:

- High School or equivalent with two years additional education

Years and Type of Experience

Required:

- Minimum of 6 years experience as administrative support to a senior level executive(s)

Specific Technical Skills

Required:

- Word, Outlook, PowerPoint, and Excel required with testing scores of 90% or better on overall skills with at least 5 years progressive utilization of software in a business environment
- Ability to exercise judgment and maintain confidentiality
- Excellent organization skills, ability to set priorities and work under pressure with changing deadlines
- Excellent proofing skills with strong attention to detail
- Must provide documents that are error free
- Excellent verbal and written communication skills and maintains a professional demeanor
- Practices good telephone etiquette skills, customer service and communication skills
- Ability to multi-task while maintaining quality and meeting deadlines
- Ability to operate a multi-line phone and other media devices

Preferred:

- Experience using Visio in the work environment to develop flow charts, organizational charts, etc.

Certifications or Licensures

Required:

- None

Physical Requirements

The physical requirements described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- Must be able to operate general office equipment including but not limited to: computers, phones, and related media and information devices
- Ability to communicate both in person and/or by phone

POSITION QUALIFICATIONS

Provider Services Staff

Position Description

Serves as liaison to providers (including physicians, hospitals, and/or ancillary providers) and internal departments at the health plans. Responsible for performing activities designed to establish and maintain positive and productive relationships with AMERIGROUP network providers for Medicaid and in some markets, Medicare products. These activities include responding to inquiries from providers regarding benefits, claim resolution, appeal status and authorization or referral information. Also, may be responsible for recruiting providers to ensure network access and service adequacy. May perform position requirements in the field or telephonically, as appropriate.

Primary Responsibilities

- Track and respond to in-person, telephonic, and written inquiries from providers and document all contacts in appropriate system per Plan (i.e. Sales force)
- Ensures that provider relationships with the Plan are positive and productive for both parties
- Works with providers to understand issues/concerns; identifies root cause of problems and trends and participates in developing solutions; works with provider's staff and AMERIGROUP staff (local and/or corporate) to resolve the issue and monitor recurrence
- Collaborates with local and corporate staff as necessary to ensure that completed applications are processed, contracts are executed and all providers are credentialed in a timely manner
- Analyzes network for adequacy in addressing members' medical needs and assists in the identification and recruitment of key providers where network gaps or needs exist
- Organizes and prepares information required to support the network development process
- Conducts onsite or telephonic provider education, orientations, and provider servicing visits to ensure providers are well-acquainted with AMERIGROUP benefits, policies, and procedures
- Provides expertise and assistance with guidelines relative to provider billing and payment consistent with AMERIGROUP policies and procedures
- Provides follow up and intervention relating to provider complaints, thereby ensuring that the complaint process is appropriately handled and within established timeframes
- Participates in meetings, as necessary, regarding provider reimbursement issues and network development activities
- Participates in earnings improvement opportunities or management initiatives, as appropriate and achieves business objectives relating to the provider network
- Performs other duties and special projects as assigned

Education and Experience

Education

Required:

- BA/BS degree preferred or equivalent experience

Years and Type of Experience

Required:

- 3-5 years of managed care experience, preferably in a Medicaid environment

Specific Technical Skills

Required:

- Proficiency with Microsoft computer software applications including Outlook, Word, and Excel
- Claims experience/knowledge of medical coding
- Strong telephonic and customer service skills

Preferred:

- Experience using Sales force CRM

Certifications or Licensures

Required:

- Valid Driver's License

Other

Required:

- Excellent verbal and written communication skills
- Detail-oriented
- Ability to handle multiple tasks in a fast paced environment
- Must be service oriented and able to identify and resolve problems
- Appreciation of cultural diversity and sensitivity toward target population

Physical Requirements

- Must be able to operate a computer, telephone and fax machine
- Must be able to travel locally
- Must be able to operate a motor vehicle
- Must be able to conduct and participate in meetings

POSITION QUALIFICATIONS

Member Services Staff

Position Description

Serves as liaison to providers (including physicians, hospitals, and/or ancillary providers) and internal departments at the health plans. Responsible for performing activities designed to establish and maintain positive and productive relationships with AMERIGROUP network providers for Medicaid and in some markets, Medicare products. These activities include responding to inquiries from providers regarding benefits, claim resolution, appeal status and authorization or referral information. Also, may be responsible for recruiting providers to ensure network access and service adequacy. May perform position requirements in the field or telephonically, as appropriate.

Primary Responsibilities

- Track and respond to in-person, telephonic, and written inquiries from providers and document all contacts in appropriate system per Plan (i.e. Sales force)
- Ensures that provider relationships with the Plan are positive and productive for both parties
- Works with providers to understand issues/concerns; identifies root cause of problems and trends and participates in developing solutions; works with provider's staff and AMERIGROUP staff (local and/or corporate) to resolve the issue and monitor recurrence
- Collaborates with local and corporate staff as necessary to ensure that completed applications are processed, contracts are executed and all providers are credentialed in a timely manner
- Analyzes network for adequacy in addressing members' medical needs and assists in the identification and recruitment of key providers where network gaps or needs exist
- Organizes and prepares information required to support the network development process
- Conducts onsite or telephonic provider education, orientations, and provider servicing visits to ensure providers are well-acquainted with AMERIGROUP benefits, policies, and procedures
- Provides expertise and assistance with guidelines relative to provider billing and payment consistent with AMERIGROUP policies and procedures
- Provides follow up and intervention relating to provider complaints, thereby ensuring that the complaint process is appropriately handled and within established timeframes
- Participates in standing meetings, as necessary, regarding provider reimbursement issues and network development activities
- Participates in earnings improvement opportunities or management initiatives, as appropriate and achieves business objectives relating to the provider network
- Performs other duties and special projects as assigned

Education and Experience

Education

Required:

- BA/BS degree preferred or equivalent experience

Years and Type of Experience

Required:

- 3-5 years of managed care experience, preferably in a Medicaid environment

Specific Technical Skills

Required:

- Proficiency with Microsoft computer software applications including Outlook, Word, and Excel
- Claims experience/knowledge of medical coding
- Strong telephonic and customer service skills

Preferred:

- Experience using Sales force CRM

Certifications or Licensures

Required:

- Valid Driver's License

Other

Required:

- Excellent verbal and written communication skills
- Detail-oriented
- Ability to handle multiple tasks in a fast paced environment
- Must be service oriented and able to identify and resolve problems
- Appreciation of cultural diversity and sensitivity toward target population

Physical Requirements

- Must be able to operate a computer, telephone and fax machine
- Must be able to travel locally
- Must be able to operate a motor vehicle
- Must be able to conduct and participate in meetings

POSITION QUALIFICATIONS

Case Management Staff

Position Description

Provide comprehensive integrated case management for members with complex needs and/or catastrophic illness or injury to insure cost effective and efficient utilization of health services. Act as a patient advocate, seeking and coordinating creative solutions to patients' health care needs without compromising quality of outcomes. Sr. Case Managers may be specifically geared to certain disease management, for example, high-risk maternity, asthma, HIV or behavioral health CI3 management, while maintaining an overall focus on holistic management of the person.

Provides professional expertise as appropriate to lower level RN & LVN Case Managers and provides expert guidance and leadership within the area of specialty.

Primary Responsibilities

- Using discretion and independent judgment, coordinate the delivery of quality patient care by:
  - Demonstrating expertise in nursing care and effectiveness of case management for patients of varying complexity through:
    - Advanced problem solving techniques
    - In-depth understanding of liability issues for case management activities
    - Strong knowledge of community resources, as well as, state and federal initiatives regarding member disability
  - Assessing clinical information to develop treatment plans and expected outcomes
    - Understands the physical and psychological characteristics of illnesses and wellness
    - Identifies cases with potential for high risk complications
    - Acts as an advocate for an individual's health care needs
    - Evaluates quality of necessary medical services, identifies cases that would benefit from alternative care, and recommends opportunities to maximize cost effectiveness
  - Collaborating with the member's treating physician(s), ancillary providers, and family/care givers, utilizing a multi-disciplinary approach to problem identification, communication and negotiation to develop long/short-range goals
  - Assuring the treatment plan is followed
  - Provide case management and/or disease management services to members, as identified by the health plan's CI3 list
- Consistently support compliance program by maintaining the privacy and confidentiality of information, protecting the assets of the organization, acting with ethics and integrity, reporting non compliance, and adhering to applicable federal, state and local laws and regulations, accreditation and licenser requirements (if applicable), and AMERIGROUP's policies and procedures
- Act as preceptor for area of specialty
- Takes on special projects/additional tasks along with an existing case management caseload
- Is responsible for leading, reporting, and completing an assigned project /special task
- Lead Subject Matter Expert/Team Leader for Region or Product; coordinate all activities and provide updates/information to local department leadership
- Other Duties as Assigned

Education and Experience

Required:

- Bachelor's degree in nursing or related field
- Graduate of an accredited school of nursing

Years and Type of Experience

Required:

- 5-10 years experience in health care, case management or discharge planning
- Minimum of three years case management experience

Preferred:

- Experience working on the community level and with community agencies preferred

Specific Technical Skills

Required:

- Excellent verbal and written communication skills
- Strong decision making skills
- Advanced problem solving skills
- Proficiency with MS Office, Word, & Excel

Preferred:

- Proficiency with Facets and Case Management software

Certifications or Licensure

Required:

- Current RN state license required
- Certified Case Manager
- Internal Candidates - successful completion of Intermediate or Expert Level AGP Case Management Certification
- External Candidates – successful completion of Intermediate or Expert Level AGP Case Management Certification within 6 months of hire
- Must possess a valid driver's license and access to a motor vehicle

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B.11 Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than $100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.

In addition, as part of the response to this item, for each major subcontractor that is not your organization's parent organization, affiliate, or subsidiary, restate and respond to items B.1 through B.7, B10 and B.16 through B.27.

If the major subcontractor is your organization's parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B11; note, however, responses to various other items in Section B must include information on your organization's parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization's parent organization, affiliate, or subsidiary.

Major Subcontractors

Amerigroup Louisiana will use several major subcontractors to support its administrative and service delivery responsibilities for the Louisiana Medicaid CCN Program. Our affiliate health plans have a long and successful history with many of the subcontractors included in this proposal. We carefully select our subcontractors and are confident of their ability to provide high caliber services and supports to Louisiana CCN members.

We propose to subcontract with the following organizations:

- Amerigroup Corporation
- Connextions, Inc.
- eyeQuest
- Health Management Systems
- LogistiCare Solutions, LLC
- Verity HealthNet, LLC

Tables B-18 through B-23 provide details on our subcontractor organizations and respond to the required Section B items for subcontractors. In addition to the subcontractors identified, upon CCN award, we plan to competitively procure the services of a subcontractor to provide utilization management services for high tech radiology services.

Oversight of Subcontractor Performance

Amerigroup will enter into contractual agreements with our vendors that include all terms and conditions specified in Section 7, Section 23 and Appendix O of the CCN RFP. We will maintain oversight of and accept full responsibility for subcontractor performance**. Vendor oversight is maintained through our proven Vendor Selection and Oversight Committee (VSOC) that is currently used by the 11 Amerigroup health plans.** The VSOC is an interdisciplinary team of employees from corporate departments who manage subcontractors and monitor delegated activities. The Louisiana Compliance Officer will participate in the VSOC to ensure DHH requirements are understood by the subcontractors and that appropriate actions are taken as necessary to assure compliance. VSOC functions include:

- Assuring subcontractor requirements with federal and state program integrity requirements
- Reviewing periodic management reports
- Conducting readiness reviews and annual on-site audits of delegated services
- Facilitating quarterly joint operations meetings between Amerigroup and each subcontractor to discuss, monitor and review performance metrics and to follow up regarding any corrective action plans and discussion between the health plan and the delegate in reference to any other issues
- Monitoring the subcontractor's financial stability

Subcontractors delivering health care services are also monitored locally through our Medical Advisory Committee as well as at the corporate level through VSOC.

We monitor the performance of our affiliate subcontractors as well. Amerigroup health plans, through the local Oversight Steering Committee, routinely monitor the performance of all affiliate subcontractors (such as Amerigroup Corporation). A Louisiana Oversight Steering Committee will be established to focus on the Louisiana Amerigroup CCN. Quarterly summaries of the following will be submitted to the Louisiana Oversight Committee for review:

- Service-level standards and reports
- Overview of fraud and abuse activity
- Quality initiatives related to medical programs, along with HEDIS scores
- Quarterly outreach initiatives conducted and planned for the following quarter

Amerigroup Corporation

Amerigroup Corporation, our parent company, will provide several services and supports for the Louisiana CCN. We provide these services to our affiliates in 11 other states. Our team of experts shares their knowledge and best practices to efficiently deliver the following services:

- Enrollment
- Preauthorization
- Disease Management
- Member and Provider Services (telephonic, IVR and web-based methods)
- Network Development
- Claims Processing
- Management Information Systems
- Premium Collection
- Finance, Actuarial and Medical Economics
- Legal and Regulatory Services Support
- Managed Care Services
- Provider Credentialing
- Corporate Associate Services
- Planning and Development

Amerigroup Corporation provides these services to all 11 of our affiliate plans, which are located in Florida, Georgia, Maryland, New Jersey, New Mexico, New York, Nevada, Ohio, Tennessee, Texas and Virginia.

Table B-18. Amerigroup Corporation

Major Subcontractor: Amerigroup Corporation		
B.1 General Information		
1. Legal Names, including d/b/as: Amerigroup Corporation		
B.8 Affiliate Organizational Description		
Number of Employees: 4,624 individuals in 48 offices across the nation.		
Client Base: Our affiliate health plans operate in 11 states throughout the country that serve approximately 2 million members through a variety of public programs, including Medicaid, CHIP and Medicare.		
Location of Offices		
Office Name	**Address**	**Telephone**
Virginia – Home Office	4425 Corporation Lane Virginia Beach, VA 23462	757-490-6900 Main Phone 757-473-2737 Direct Dial + Extension
Virginia – Home Office II	4433 Corporation Lane Virginia Beach, VA 23462	757-490-6900 Main Phone 757-473-2737 Direct Dial + Extension
Support Center I	1300 Amerigroup Way Virginia Beach, VA 23464	757-490-6900 Main Phone 757-473-2737 Direct Dial + Extension

Major Subcontractor: Amerigroup Corporation		
Support Center II	1330 Amerigroup Way Virginia Beach, VA 23464	757-490-6900 Main Phone 757-473-2737 Direct Dial + Extension
Richmond Office	600 East Main Street Suite 2020 Richmond, VA 23219	804-343-3890 Main Phone 804-343-3895 Main Fax

Organizational Chart

Please refer to Attachment A at the end of Question B.8 for an organizational chart that illustrates the reporting relationships of the Amerigroup Corporation employees who will support the administration of the Louisiana Contract.

B.9 Narrative Description of your Louisiana Medicaid CCN Project Team

Louisiana Medicaid CCN Project Team:

Our Louisiana Project Team, includes existing experienced leaders from our cooperate organization to represent the caliber of employees we will continue to recruit and hire for the Louisiana-based team upon Contract award. This experienced Team ensures clear communication, smooth integration and ongoing maintenance activities for your Contract across all Amerigroup teams, processes and systems.

Amerigroup has already begun our search for qualified candidates for the health plan positions, including the key positions we will base in Louisiana. At the onset, the Amerigroup Louisiana Project Team will be managed by Brian Shipp, who will serve as the President and CEO of Amerigroup Louisiana until a **local leader with commensurate experience** is hired.

As the organizational chart illustrates, the Louisiana CEO will be supported by both local and corporate resources. Based on our experience with other affiliate plans, Amerigroup projects that we will have **100 local and 131 corporate full-time equivalent (FTE) employees** in support of Louisiana health plan operations by the end of 2012. These professionals, with reachback to and support from Amerigroup Corporation's Health Plan Support Services and Corporate Support Services, will maintain accountability for the administration of the Louisiana program. As illustrated in our model for Louisiana, shown in many key functions of the health plan will be held at the local level, including: health plan administration, medical management, provider relations, health promotions, quality/performance management, grievances and appeals, government relations, community relations and more. **A key benefit to our model** is the depth of corporate reach back available to the health plan. In addition to the support the health plan will receive from Amerigroup Corporation, our health plans regularly share both best practices and lessons learned in regional and national meetings.

Key Members of the Amerigroup Louisiana CCN Program Implementation Project Team

A complete list of our full Implementation Team can be found in Table C-3 of Section C.

Name	Functional Area
Sarina Arcari	Vice President, Implementation & Product Planning/Implementation Lead
Jack Young	Legal
Mark Wilson	Regulatory Services

Major Subcontractor: Amerigroup Corporation	
Melissa Kubilus	Marketing Services
Jay Jump	eBusiness
Joan Finnegan	Enrollment
Roy Faircloth	Member Call Center
William Dixey	Healthcare Delivery Services (Network Development)
James Piekut	Medical Finance
Stephanie Walker	Human Resources
Matthew Scott	Claims Operations/Testing
Mike Bowers	Health Plan Services
Sarah Aldana	Healthcare Management Services
Jen Yun	Corporate Real Estate/Procurement
Katherine Gard	Technology Services/Security & Compliance Architecture
Scott Young	Behavioral Health
Organizational Chart: Please refer to Attachment B.8.a at the end of Question B.8, which illustrates the allocation of resources in the Project Team Organization Chart.	
GSA Coverage: We are submitting a proposal to serve all three GSAs in the State. The Implementation Project Management Team will be responsible for activities in all three GSAs. As DHH has staggered implementation for the three GSAs, our Team will structure its activities to match the implementation schedule. A full implementation plan is included in Section C as Attachment C.2.a.	

Connextions, Inc.

Connextions will provide services in support of a *Nurse HelpLine* for members that will be available 24 hours a day, 7 days a week. The Company provides these services to all 11 of our affiliate health plans which are located in Florida, Georgia, Maryland, New Jersey, New Mexico, New York, Nevada, Ohio, Tennessee, Texas and Virginia.

Table B-19. Nurse HelpLine

Major Subcontractor: Connextions Inc. - Nurse HelpLine		
B.1 General Information		
1. Legal Names, including d/b/as: Connextions, Inc.		
2. Contact Information		
2a. Physical address: 3600 eCommerce Pl. Orlando, FL 32808	**2b. Mailing address:** 3600 eCommerce Pl. Orlando, FL 32808	
2c. Telephone: 407-926-2411	**2d. CEO:** Jack LeFort	
3. Relationship: ☐ **Affiliate** ☒ **Unrelated Third Party**		
4. Affiliate Information Not Applicable		
5. Type of ownership: Private Equity Majority Ownership **Name of ultimate owner/parent:** Majority ownership: New Mountain Capital, Inc.		
6. Business Status (all that apply): ☐ Sole proprietor ☐ Partnership ☒ Corporate ☒ For-profit ☐ Non-profit ☒ Privately-owned ☐ Listed on a stock exchange		
7. List of Officers, Directors and Partners		
7a. Name	**7b. Mailing address:**	**7c. Telephone**
Jack LeFort, CEO and Chairman	3600 eCommerce Pl. Orlando, FL 32808	407-926-2411
Steven Auerback, President	Same as above	
Todd Baxter, EVP Consumer Solutions		
Yvonne Daugherty, VP Marketing		
Rob Panepinto, Managing Director, Cleint Practice		
Leslie Pecci, EVP National Carrier Solutions		
Albert Prast CIO/CTO		
Jeanneen Coleman Watson, SVP Exchange Solutions		
7d. Health Professionals with at least 5% interest in subcontractor: None		
8. Federal Taxpayer Identification Number: 59-3684411		
9. Louisiana Taxpayer Identification Number: Using Federal identification number		

Major Subcontractor: Connextions Inc. - Nurse HelpLine	
10 a. State of incorporation and domicile **Incorporated:** Florida **Commercially domiciled:** Florida	**10b. If out-of-state, name and address of local representative** There is no local representative
11. Has Organization been engaged by DHH within the past 24 months? If Yes indicate contract numbers and description. No, Connextions has not been engaged by DHH within the past 24 months.	
12. Is the subcontractor providing services for Amerigroup in other states? Yes, Connextions provides services to Amerigroup plans in 11 states: FL, GA, MD, NJ, NM, NY, NV, Oh, TN, TX and VA	
B.2 Mergers and Acquisitions **Have there been any mergers, acquisitions, or sales of your organization within the last 10 years? If so, provide details. Is a change in ownership anticipated during the 12 months following the Proposal Due Date? Include parent organization, affiliates and subsidiaries.** Connextions' partnership with New Mountain Capital took place in 2006. This partnership has provided Connextions with access to capital and management that has supported continued expansion and growth in the healthcare market. In 2007, Connextions acquired bConnected. The bConnected Consumer Engagement Platform is the key lifeblood of the value they drive for their clients in the Exchange and Carrier marketplaces. In 2010, Connextions acquired HealthCare for 1, a leading quoting/enrollment platform in the Individual market. The platform, integrated into bConnected's Consumer Engagement Platform, added to bConnected's existing quoting and enrollment capabilities.	
B.3 Felonies, Health Care Related Offenses, Debarment or Suspensions by Federal or State Government Connextions employees, agents, independent contractors or subcontractors have never been convicted of, pled guilty to or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.	
B. 4 Pending or Recent Litigation Connextions Inc. has not been engaged in litigation pertinent to the services contemplated by the parties.	
B.5 Bankruptcy or Insolvency in the last ten years? If yes, provide explanation. Include your organization's parent organization, affiliates, and subsidiaries. Connextions has never filed chapter 11 or 13 bankruptcy.	
B.6. If publicly-traded, submit most recent United States Security Exchange Commission Form 10K and the most recent 10-Q Quarterly report. This does not apply to Connextions, as it is a privately held company.	
B.7. Financial Background	
a. If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner. Connextions is privately held, owned by its management team and New Mountain Capital. New Mountain owns approximately 75% of the company, with the remaining 25% controlled by the Connextions management team. See Attachment B.11.a at the end of this response for Connextion's	

Major Subcontractor: Connextions Inc. - Nurse HelpLine

statement regarding their financial disclosure policy.

b. Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

See Attachment B.11.b at the end of this response for a signed performance guarantee.

B.10 Key Personnel Information

No personnel working on this initiative is a current or former Louisiana state employee. Resumes and position descriptions are attached. See Attachment B.11.c.

B.16 Has the Organization had publicly funded managed care contracts for Medicaid, Medicare or CHIP within the last five years?

See Attachment B.11.d at the end of this response.

B.17 and B.18 Contract Terminations or Non-Renewals

Has subcontractor had a managed care contract terminated or not renewed in the last 5 years?

☐ Yes ☒ No

As is referenced below, the greatest factors for clients ending their relationship with Connextions has been to move the program offshore to reduce costs or the elimination of the program entirely. The terminations also reflect Connextions' strategic focus on the healthcare market as the two largest terminations in terms of seats, were in Connextions' Commercial Division.

Client	Reason for Termination
Sprint	Moved offshore
SanDisk	Moved offshore
Extend Health	Migrated services internally
Colonial Penn	Exited PFFS Medicare market
Oakland's Children's Hospital	Ended nurse program

B.19 Ratings (Current and Going Back 3 Years) from AM Best Company, The Street.com Inc. and Standard and Poor's – if applicable.

Connextions has not participated in any of the rating reports listed above.

B.20 Breach of Contract to Provide Physical Health Services within the Past 5 years?

Connextions has never been found in breach of contract.

B.21 - B.24 Accreditation

Is subcontractor currently, or has it ever sought, NCQA accreditation?	Currently accredited?
☐ Yes ☒ No	☐ Yes ☒ No No other questions are applicable since vendor is not NCQA accredited.

B.25 Regulatory Actions and Monetary and Non-monetary Sanctions imposed by Government regulatory entity in the last 5 years?

Connextions has never had any regulatory action or sanction imposed by any federal or state regulatory entity against its organization.

B.26 Criminal and/or Civil Investigations by a government entity in the last 5 years?

Connextions is not currently the subject of any criminal or civil investigation, nor has it been in the last five years.

B.27 Subcontractor References

A statement provided by Connextions regarding references is included as Attachment B.11.e. Due to confidentiality agreements with a majority of their clients, they have only provided one reference.

eyeQuest

eyeQuest will provide vision services for Amerigroup Louisiana's CCN members. eyeQuest provides these services for Amerigroup's health plan in Nevada.

Table B-20 eyeQuest Vision Services

Major Subcontractor: eyeQuest Vision Services		
B.1 General Information		
1. Legal Names, including d/b/a: DentaQuest LLC, d/b/a eyeQuest		
2. Contact Information		
2a. Physical address: 465 Medford St., Boston, MA 02129	**2b. Mailing address:** 465 Medford St., Boston, MA 02129	
2c. Telephone: (800) 417-7140	**2d. CEO:** Fay Donohue	
3. Relationship: ☐ **Affiliate** ☒ **Unrelated Third Party**		
4. Affiliate Information: Not Applicable		
5. Name of ultimate owner/parent: Dental Service of Massachusetts, Inc.		
6. Business Status (all that apply): ☐ Sole proprietor ☒ Limited Liability Company ☐ Corporation ☒ For-profit ☐ Non-profit ☐ Privately-owned ☐ Listed on a stock exchange		
7. List of Officers, Directors and Partners		
7a. Name	**7b. Mailing address:**	**7c. Telephone**
Fay Donohue, President and CEO	465 Medford St., Boston, MA 02129	(800) 417-7140
Jim Collins, Treasurer	Same as above	
Myra Green, Secretary		
7d. Health Professionals with at least 5% interest in subcontractor: None.		
8. Federal Taxpayer Identification Number: 45-0510673		
9. Louisiana Taxpayer Identification Number: Uses Federal Taxpayer ID		
10 a. State of incorporation and domicile Incorporated in Delaware Domiciled in Massachusetts	**10 b. If out-of-state, name and address of local representative** Not Applicable	
11. Has Organization been engaged by DHH within the past 24 months? If Yes, indicate contract numbers and description. DentaQuest has not been engaged by DHH within the past 24 months.		
12. Is the subcontractor providing services for Amerigroup in other states? Yes, DentaQuest provides services for Amerigroup in Nevada.		
B.2 Mergers and Acquisitions **Have there been any mergers, acquisitions, or sales of your organization within the last 10 years? If so, provide details. Is a change in ownership anticipated during the 12 months following the Proposal Due Date? Include parent organization, affiliates and subsidiaries.** DentaQuest, LLC, f/k/a Doral Dental USA, LLC, was established in 1993 for the sole purpose of administering dental benefits within the government sector. In 2001, DentaQuest Ventures, Inc. acquired Consumer Dental Care in Maryland. In 2004, DentaQuest Ventures, Inc. ("DentaQuest") acquired Doral. In 2008, DentaQuest, LLC acquired Health Care Atlantic, Inc., a Florida based company. On January 1, 2011, DentaQuest Ventures, LLC, DentaQuest's sole member, merged with DentaQuest, LLC. This consolidation was completed in an effort to streamline the DentaQuest corporate structure.		

Major Subcontractor: eyeQuest Vision Services
B.3 Felonies, Health Care Related Offenses, Debarment or Suspensions by Federal or State Government Neither DentaQuest, its parent organization, affiliates or subsidiaries, nor any of their employees, agents, independent contractors, or subcontractors, have been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.
B. 4 Pending or Recent Litigation There have been a small number of actions brought against the DentaQuest and its affiliates in the last five years. In general, these actions have involved payment disputes with providers or vendors in the ordinary course of business. None of this litigation has involved allegations that the proposer has failed to provide timely, adequate or quality health services to program members. No actions brought against the parent organization, Dental Service of Massachusetts.
B.5 Bankruptcy or Insolvency in the last ten years? If yes, provide explanation. Include your organization's parent organization, affiliates, and subsidiaries. Neither DentaQuest nor its parent company, affiliates or subsidiaries has filed (or had filed against it) any bankruptcy or insolvency proceeding, or undergone the appointment of a receiver, trustee or assignee for the benefit of creditors in the last ten years.
B.6. If publicly-traded, submit most recent United States Security Exchange Commission Form 10K and the most recent 10-Q Quarterly report. Not applicable – DentaQuest is not a publicly traded company.
B.7. Financial Background
a. If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner. See Attachment B.11.f at the end of this section for the most recent financial statement for Dental Services of Massachusetts, Inc., which is DentaQuest's ultimate parent organization.
b. Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract. See Attachment B.11.g for a signed statement from Dental Services of Massachusetts, Inc., unconditionally guaranteeing DentaQuest's performance of each and every obligation, warranty, covenant, term and condition of the Contract.
B.10 Key Personnel Information A summary resume of key personnel is available as Attachment B.11.h. Key personnel in DentaQuest's account team will continue to be accessible for the duration of the Contract to provide timely response to any administrative concern or inquiry. All of DentaQuest's key staff members are full-time employees, with the exception of the optometric and ophthalmology consultants. The three consultants provide service to DentaQuest on an as-needed basis. Each of the vision consultants maintains a professional practice in his/her respective field. None of DentaQuest's personnel or vision consultants is a current or former Louisiana state employee.

Major Subcontractor: eyeQuest Vision Services

B.16 Please submit an Excel file for all publicly funded managed care contracts for Medicaid, Medicare or CHIP within the last five years?

See Attachment B.11.i for contracts that include Medicaid, CHIP and Medicare clients. DentaQuest administers benefit programs for more than 10,000 groups ranging from large multi-state employers to state employer groups, unions, and municipalities. They are, however, contractually bound to protect the full privacy of their accounts. Their commercial business contracts specifically preclude them from releasing the specific account names and associated information requested.

B.17 and B.18 Contract Terminations or Non-Renewals

Has subcontractor had a managed care contract terminated or not renewed in the last 5 years?

☐ Yes ☒ No

DentaQuest has not had a managed care contract terminated or not renewed. The managed care contracts terminated or not renewed of affiliates of DentaQuest are outlined in the chart below. DentaQuest experienced positive growth last year and has every expectation that this trend will continue into 2011 and 2012.

Beginning membership as of 1/1/10 was 12,167,260.
Ending membership as of 12/31/10 was 12,859,922.

Party Involved	Contract Start and Duration	Issues and Corrective Action	Termination or Non-Renewal
Amerigroup	9/1/2005 to 12/31/2010	DentaQuest had a longstanding relationship with Amerigroup. In 2010 Amerigroup made the business decision to offer dental services through their own organization on a private label basis. This decision puts Amerigroup and DentaQuest in direct competition on certain bidding opportunities. There were no corrective action plans issued related to the cause of the termination or non-renewal. **The termination did not include EyeQuest.**	Termination
State of Tennessee	10/1/2002 to 9/30/2010	DentaQuest was the dental benefits administrator for the State of Tennessee from 2002 through 2010. During that time, DentaQuest significantly increased the size of the provider network and the number of children accessing dental care. Additionally, we assisted TennCare in meeting the requirements of the *John. B Consent Decree* and the *Grier Revised Consent Decree* related to member access and contested denials. Tennessee issued an RFP in 2010. DentaQuest responded to the RFP and scored highest in the technical portion of the RFP. However another dental vendor quoted the contract at a lower rate, resulting in that dental vendor being awarded the contract.	Non-renewal

Major Subcontractor: eyeQuest Vision Services			
		There were no corrective action plans issued related to the cause of the termination or non-renewal.	
Passport, KY	11/1/1997-7/31/2009	DentaQuest successfully managed the Passport dental program for 10 years. During this timeframe, Passport renewed DentaQuest's contract through RFP numerous times. In 2009 Passport issued another RFP to which DentaQuest responded. DentaQuest lost the RFP and was not retained as the vendor. There were no formal scores released. There were no corrective action plans issued related to the cause of the termination or non-renewal.	Non-renewal
UPMC	1/1/2001-12/31/2009	DentaQuest served as the dental and vision administrator for UPMC, for eight and four years respectively. DentaQuest misjudged the operational infrastructure and levels of staffing necessary to administer two distinct ancillary lines of business. As a result, DentaQuest's ability to meet client expectations was compromised. DentaQuest has since revamped its vision program and implemented a robust operational and IT platform. There were no corrective action plans issued that were related to the cause of the termination or non-renewal.	Termination
Prestige	12/1/2008-10/31/2010	DentaQuest served as the dental administrator for Prestige to two years. During this time there were multiple staff changes. In 2010 DentaQuest received a termination without cause notice from Prestige. We inquired into the reason. They assured us that there were no business issues. No corrective action was taken.	Termination

B.19 Ratings (Current and Going Back 3 Years) from AM Best Company, The Street.com Inc. and Standard and Poor's – if applicable.
Not applicable to DentaQuest.

B.20 Breach of Contract to Provide Physical Health Services within the Past 5 years?
DentaQuest, its parent organization, affiliates or subsidiaries have not been notified by a contracting party to be in breach of contract.

B. 21 - B.24 Accreditation

Is subcontractor currently, or has it ever sought, NCQA accreditation? ☐ Yes ☒ No	**Currently accredited?** ☐ Yes ☒ No **B.22 – B.23 are not applicable to vendor since they do not have NCQA accreditation.**

Major Subcontractor: eyeQuest Vision Services
B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report. DentaQuest is audited by one of its managed care vision clients on an annual basis, typically in the third quarter. Credentialing, claims, grievance and appeals, and utilization management functions are audited. The client completes a comprehensive review of the program through review of annual documents and policies/procedures. The client requests numerous samples that provide a comprehensive description of DentaQuest's processes. For example in preparing the claim samples, eyeQuest would be expected to provide an end to end trail of documentation – original provider claim, system screen shots, provider EOBs, member denial letters (if applicable), copies of canceled checks or confirmation of EFT payments, and bank statements documenting release of payment. This review would document appropriate payment to providers: timeliness of payments, interest obligations (if applicable), validation of Medicaid payments, etc. The client reviews each step of the process very comprehensively to ensure eyeQuest complies with contract requirements, NCQA, and regulatory requirements as applicable. DentaQuest was audited by the above-mentioned managed care client in September, 2010. **The client does not share final audit scoring with DentaQuest.**
B. 25 Regulatory Actions and Monetary and Non-monetary Sanctions imposed by Government regulatory entity in the last 5 years? DentaQuest discloses the following: 1. Atlantic Dental, Inc. (now known as DentaQuest of Florida, Inc.), a subsidiary of DentaQuest, was the subject of Florida Office of Insurance Regulation Case No. 94186-08 regarding network and product compliance. A consent order dated August 5, 2008 required Atlantic Dental, Inc. to pay an administrative penalty totaling $13,000. Atlantic Dental, Inc. has since resolved the areas of noncompliance. 2. DentaQuest Dental Plan of Wisconsin, Inc., a subsidiary of DentaQuest, was subject to two forfeitures in the past two years. The first was a failure to respond to a written request which resulted in a forfeiture of $500.00 (Legal File 08-C31460, 7/15/08). The second alleged a failure to comply with a previous examination order, resulting in a forfeiture of $25,000 (Legal File 09-C32601, 5/13/10). This company is in the process of being dissolved. 3. On July 9, 2010, the Nevada Division of Insurance fined DentaQuest, LLC, a licensed Nevada third party administrator, $500.00 for failure to file its July 2009 third party administrator annual report.
B. 26 Criminal and/or Civil Investigations by a government entity in the last 5 years?
Neither DentaQuest nor its parent company, affiliates and subsidiaries has been any civil or criminal investigations in the last five years.
B. 27 Subcontractor References The required reference documents for Verity are provided in sealed envelopes as Attachment B.11.j.

Health Management Systems

Health Management Systems (HMS) will assist the health plan with both cost avoidance and post-payment recovery activities. HMS will utilize its significant data repository of health insurance information from more than 150 health insurance organizations as well as telephonic and online verification tools that facilitate prompt confirmation of other health insurance, both relative to new coverage and changes or terminations in coverage. HMS will prepare and submit claims to recover payments from liable third parties when insurance coverage is discovered after providers have been paid.

HMS currently provides these services to 10 of its affiliate plans which are located in Florida, Georgia, Maryland, New Mexico, New York, Nevada, Ohio, Tennessee, Texas and Virginia.

Table B-21. Health Management Systems

Major Subcontractor: Health Management Systems		
B.1 General Information		
1. Legal Names, including d/b/as: Health Management Systems, Inc.		
2. Contact Information		
2a. Physical address: 401 Park Avenue South, New York, NY 10016	**2b. Mailing address:** 401 Park Avenue South, Fl 11 New York, NY 10016	
2c. Telephone: 212-857-5000	**2d.** Bill Lucia, CEO	
3. Relationship: ☐ **Affiliate** ☒ **Unrelated Third Party**		
4. Affiliate Information: Not Applicable		
5. Type of ownership: Corporate **Name of ultimate owner/parent:** HMS Holding Corporation		
6. Business Status (all that apply): ☐ Sole proprietor ☐ Partnership ☒ Corporation ☒ For-profit ☐ Non-profit ☐ Privately-owned ☐ Listed on a stock exchange		
7. List of Officers, Directors and Partners		
7a. Name	**7b. Mailing address:**	**7c. Telephone**
Bill Lucia, President and CEO	401 Park Avenue South Fl 11 New York, NY 10016	212-857-5000
Walter Hosp, SVP and CFP	Same as above	
Sean Curtin, Executive Vice President, Operations		
Christina Dragonetti, Executive Vice President, Corporate Development		
Edith Marshall, General Counsel		
Cynthia Nustad, SVP and Chief Information Officer		
Maria Perrin, Executive Vice President, Government Markets		

Major Subcontractor: Health Management Systems	
David Schmid, Vice President of Human Resources	
7d. Health Professionals with at least 5% interest in subcontractor: None	
8. Federal Taxpayer Identification Number: 13-277043	
9. Louisiana Taxpayer Identification Number: Operates under federal taxpayer number.	
10a. State of incorporation and domicile **Incorporated:** New York **Commercially domiciled:** New York	**10b. If out-of-state, name and address of local representative** No local representative
11. Has Organization been engaged by DHH within the past 24 months? If Yes indicate contract numbers and description. Yes, we have been engaged by DDHH within the past 24 months. **Agency:** Louisiana Department of Health and Hospitals **Project:** Third Party Liability **Contract Status:** Effective 07/01/08-06/30/11 **Agency:** Louisiana Department of Health and Hospitals **Project:** Home Community Worker Services (HCWS) sub to Postlethwaite & Netterville) **Contract Status:** Effective 07/01/10-06/30/11	
12. Is the subcontractor providing services for Amerigroup in other states? Yes, HMS provides services to Amerigroup plans in 10 states: FL, GA, MD, NM, NY, NV, Oh, TN, TX and VA.	
B.2 Mergers and Acquisitions	
a. Have there been any mergers, acquisitions, or sales of your organization within the last 10 years? If so, provide details. HMS, Inc. has not merged, been acquired, or sold in the past ten years.	
b. Is a change in ownership anticipated during the 12 months following the Proposal Due Date? Include parent organization, affiliates and subsidiaries. No change in ownership is anticipated during the 12 months following the proposal due date.	
B.3 Felonies, Health Care Related Offenses, Debarment or Suspensions by Federal or State Government No employees, agents, independent contractors or subcontractors have ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.	
B.4 Pending or Recent Litigation **Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.**	

Major Subcontractor: Health Management Systems

As a publicly traded company, the parent company of HMS Inc. regularly discloses litigation of all of its subsidiaries on a regular basis, leading to more transparency and less risk to their clients. In addition to the pending and closed cases listed below, from time to time, HMS may be party to administrative lawsuits tied to employee-related matters (e.g., wrongful termination). These have no material impact on HMS or its ability to provide continued service to its clients.

Note that we interpret the reference to HMS being "involved" in litigation to extend only to lawsuits in which HMS is a named party or real party in interest to the suit. Thus we have not included cases where HMS is involved in the capacity as a recipient of third party discovery, witness, consultant, or otherwise as an agent or contractor working with, for, or on behalf of a government entity.

Litigation in which HMS has been involved during the past five years:
Pending Cases

- ***HMS, Inc. v. Sagebrush Solutions, LLC.***
  Complaint filed January 4, 2011
  US District Court for the Northern District of Texas
  CIVIL ACTION NO. 3:11-cv-00016-F
  This is an action brought by HMS against its former subcontractor, alleging breach of contract, tortuous interference with contracts between HMS and other clients, and unlawful retention of confidential data. A Preliminary Injunction has been entered (on HMS's motion) against the defendant subcontractor, and HMS plans to prepare and file a motion for Summary Judgment as soon as possible.

- **Sagebrush Solutions, LLC v. Health Management Systems, Inc. and CareSource Management Group**
  U.S. District Court for the Northern District of Texas, Dallas Division. Civil Action No. 3:11-cv-00182-F Complaint filed November 9, 2010 in the District Court of Dallas County Texas, I-162nd Judicial District as Case No. DC-10-14642; HMS was served January 21, 2011. The case was subsequently removed to federal district court.

  Plaintiff, a former subcontractor of HMS, asserts claims against HMS and HMS's client Medicaid Managed Care Organization (MMCO) for payment under a breach of contract and quantum meruit theory. The MMCO's motion to be dismissed from the suit for lack of personal jurisdiction is currently pending; and following resolution of that motion, HMS plans to move for dismissal and/or summary judgment.

- **Nicholson v. Cincinnati Children's Hospital Medical Center, et al.**
  Date filed 02/27/2009
  U.S.D.C. Southern District of Ohio (Cincinnati)
  Case # 1:09-cv-00137-MRB
  Personal injury, medical malpractice claim filed against hospital and staff for treatment of a minor child. Plaintiff also named HMS as a Defendant, alleging that HMS co-ordinates the benefits and lien interests regarding Medicaid on behalf of the State government, and would therefore be the entity asserting and/or resolving claims or liens regarding Medicaid payments. No relief is sought directly against HMS. HMS has not yet been formally served, and has therefore not been required to enter an appearance with the Court to date.

Major Subcontractor: Health Management Systems

Cases Resolved During Past 5 years

- **Jamesia A. Boyce v. Health Management Systems, Inc., et al.**
  Date served: 08/03/2010
  U.S. District Court for the Western District of North Carolina
  Case # 5:10-CV-00098

  First named Defendant: North Carolina Department of Health And Human Services
  Challenge to Medicaid State Agency's construction of State Statute relating to liens on funds obtained by the estates of Medicaid recipients through litigation or settlement of tort (e.g., wrongful death) claims. The plaintiff sought, among other relief, an injunction blocking HMS from performing its contract with the North Carolina Medicaid agency in a manner consistent with the State's construction of its own laws. The State Medicaid agency and HMS moved for dismissal of the case; and the plaintiff responded by filing a voluntary dismissal of the case on February 7, 2011.

- **Causey v. Public Consulting Group, et al.//Arizona Healthcare Cost Containment System v. Causey**
  Superior Court of the State of Arizona, Maricopa County
  No. CV2008-003949

  In April 2010, in conjunction with an estate recovery project performed in the State of Arizona, a disbarred attorney who had been sued by the State, joined HMS and another contractor into the suit as additional party defendants, asserting claims of negligence and breach of contract based on the prior conduct of a business entity whose assets had been acquired by HMS. The case was settled and dismissed in March 2010.

- **Dunham and Bromhall v. State of Florida, et al.**
  Circuit Court of the Second Judicial Circuit in and For Leon County, Florida Civil Division
  Case No. 37 2009 CA 003720

  This claim brought in 2009 against the State of Florida, its Medicaid Agency, and certain Medicaid officials by Estate attorneys who alleged a State obligation to return monies previously recovered on behalf of State Medicaid. The plaintiffs contended that a recent federal Court decision had retroactive effect and entitled them to relief from the State, and initially named HMS as a defendant due to its status as a contractual agent of the State. All claims against HMS were dismissed in December, 2009 during a preliminary phase of the litigation.

- **Rafael Valenzuela, MD v. Texas Medicaid & Healthcare Partnership, et al.**
  Date filed April 28, 2008
  District Court of Dallas County Texas, 116th District
  Case No. DC-08-04657

  In April 2008, a Medicaid provider filed a lawsuit in the 116th District Court of Dallas County, Texas against the Texas Medicaid Healthcare Partnership (TMHP) and each of its members,

Major Subcontractor: Health Management Systems

including HMS, claiming that the provider's Medicaid certification had been improperly revoked. HMS entered into a nominal settlement to avoid the costs of litigation, and obtained dismissal of the claims against it in May 2009.

- **USA ex rel. Hixson, et al. v. Health Management Systems, Inc., et al.**
  Complaint originally filed 10/9/07
  U.S. District Court for the Southern District of Iowa
  Case # 4:07-cv-00465-JAJ-RAW
  8th Cir. App. No. 09-3439

  This Qui Tam case was brought against HMS, ACS State Healthcare, LLC, and two Iowa State Medicaid officials under the federal False Claims Act, alleging HMS's involvement in false claims allegedly made by the State Medicaid Agency. On July 30, 2010, the 8th Circuit Court of Appeals upheld the decisions of the U.S. District Court for the Southern District of Iowa (Orders of 9/21/09 and 11/12/09) dismissing the case for failure to state a viable claim.

- **Estate of Anthony J. Suskovich v. Anthem Health Plans of Virginia, Inc., et al.**
  Date filed 3/13/06
  U.S.D.C. Southern District of Indiana (Indianapolis)
  Case # 1:06-cv-00425-SEB-JMS
  US Court of Appeals for the 7th Circuit, Appeal No. 08-01070

  The Estate of Mr. Suskovich claimed he was misclassified as an independent contractor, as opposed to an employee, and therefore was subject to levies and fines by the Indiana Department of Revenue and Federal Internal Revenue Service, and was denied receipt of certain non-wage benefits. HMS was one of a group of so-called "Wellpoint Defendants" (Employers) named in the case. Summary Judgment was granted to the Employers in January 2009, and the District Court opinion was affirmed in appellate proceedings.

- **Davis & Associates, Inc. v. District of Columbia, et al.**
  Date filed 5/24/06
  U.S.D.C. District of Columbia
  Case # 1:06-cv-00972-GK

  This Complaint was brought by a former subcontractor of HMS, alleging Civil Rights violations by the District of Columbia government and demanding recompense of $268,000,000. No relief was sought directly against HMS, however, and HMS filed a Motion to Dismiss, which was granted on 8/16/2007.

- **United States of America v. Kinney, et al.**
  Date filed 11/29/06
  Date of final Order of Foreclosure (Default Judgment) 05/11/07
  U.S.D.C. Northern District of Iowa (Western Division)
  Case # 5:06-cv-04098-DEO

Major Subcontractor: Health Management Systems

This case involved a real property, foreclosure complaint filed against the Estate of Patricia Kinney, Capital One Services and the Iowa Estate Recovery Program (doing business as Iowa Department of Human Services), among others. HMS was not a real party in interest, although it was named as a Defendant in the case with a "quasi" interest in the property subject to foreclosure, as a result of its contractual and agency relationship with the Iowa Estate recovery Program.

B.5 Bankruptcy or Insolvency in the last ten years? If yes, provide explanation. Include your organization's parent organization, affiliates, and subsidiaries.

HMS has not filed (or had filed against HMS) any bankruptcy or insolvency proceeding, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

B.6 If publicly-traded, submit most recent United States Security Exchange Commission Form 10K and the most recent 10-Q Quarterly report.

See Attachment B.11.k for a statement that HMS Inc.'s financial results are reported together with those of its parent company, HMS Holdings Corp.

B.7 Financial Background

a. If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

HMS Holdings Corp has provided audited financial statements for Fiscal Year 2010. See attachment B.11.l.

b. Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

See attachment B.11.m

B.10 Key Personnel Information

No personnel working on this initiative is a current or former Louisiana state employee. Resumes are provided in Attachment B.11.n.

B.16 Has the Organization had publicly funded managed care contracts for Medicaid, Medicare or CHIP within the last five years?

HMS provides a variety of cost containment and program integrity services to over 75% of Medicaid managed care participants, including TANF, ABD, Duals, and CHIP enrollees. Due to confidentiality agreements with these clients, we are not able to disclose specific information relating to managed care contracts. See Atthachment B.11.o.

B.17 and B.18 Contract Terminations or Non-Renewals

Has subcontractor had a managed care contract terminated or not renewed in the last 5 years?

☐ Yes ☒ No

Description of Issues	Parties Involved	Address of primary terminating party	Phone number of primary terminating party	Corrective actions to prevent recurrence of issue
None				

Major Subcontractor: Health Management Systems	
B.19 Ratings (Current and Going Back 3 Years) from AM Best Company, The Street.com Inc. and Standard and Poor's – if applicable. Not Applicable to HMS	
B.20 Breach of Contract to Provide Physical Health Services within the Past 5 years? Not Applicable	
B.21 - B.24 Accreditation	
Is subcontractor currently, or has it ever sought, NCQA accreditation? ☐ Yes ☒ No	**Currently accredited?** ☐ Yes ☒ No The rest of the questions in B.21-24 do not apply as HMS is not accredited by NCQA.
B.25 Regulatory Actions and Monetary and Non-monetary Sanctions imposed by Government regulatory entity in the last 5 years? HMS has never been sanctioned by any federal or state regulatory entity.	
B.26 Criminal and/or Civil Investigations by a government entity in the last 5 years? HMS is the not the subject of any criminal or civil investigation by any federal or state regulatory entity.	
B.27 Subcontractor References The required reference documents for Health Management Systems will be provided in sealed envelopes with the Amerigroup Louisiana, Inc RFP response. Please see Attachment B.11.p	

LogistiCare

LogistiCare will arrange for non-emergency medical transportation for members, assuring appropriate utilization and the most appropriate and cost effective mode of transportation is made available on a timely basis. LogistiCare currently provides these services to three of our affiliate plans which are located in Florida, Ohio and Virginia.

Table B-22. Non Emergency Transportation

Major Subcontractor: LogistiCare – Non Emergency Transportation		
B.1 General Information		
1. Legal Names, including d/b/as: LogistiCare Solutions LLC , D/B/as LogistiCare		
2. Contact Information		
2a. Physical address: 1275 Peachtree Street NE, 6th Floor, Atlanta GA 30309	**2b. Mailing address:** 1275 Peachtree Street NE, 6th Floor, Atlanta GA 30309	
2c. Telephone: 404-888-5800	**2d. CEO:** Herman Schwarz	
3. Relationship: ☐ **Affiliate** ☒ **Unrelated Third Party**		
4. Affiliate Information Not Applicable		
5. Type of ownership: Wholly owned subsidiary of a publicly traded company. **Name of ultimate owner/parent:** Majority ownership: Providence Service Corporation a publicly traded company		
6. Business Status (all that apply): ☐ Sole proprietor ☒ Limited Liability Company ☐ Corporation ☒ For-profit ☐ Non-profit ☐ Privately-owned ☐ Listed on a stock exchange		
7. List of Officers, Directors and Partners		
7a. Name	**7b. Mailing address:**	**7c. Telephone**
Providence Service Corporation, Sole Member	64 E. Broadway, Tucson, AZ 85701	(520) 747-6600
Herman Schwarz, CEO	1275 Peachtree Street NE, 6th Floor, Atlanta GA 30309	404-888-5800
7d. Health Professionals with at least 5% interest in subcontractor: None		
8. Federal Taxpayer Identification Number: 58-2491253		
9. Louisiana Taxpayer Identification Number: Operates under the federal taxpayer ID		
10a. State of incorporation and domicile **Incorporated:** Delaware **Commercially domiciled:** Georgia	**10b. If out-of-state, name and address of local representative, if none state so.** No representative in the State of Louisiana at this time	
11. Has Organization been engaged by DHH within the past 24 months? If Yes indicate contract numbers and description. No, LogistiCare has not been engaged by DHH in the past 24 months.		
12. Yes, LogistiCare provides services to Amerigroup plans in three states: FL, OH, and VA.		
B.2 Mergers and Acquisitions		
a. Have there been any mergers, acquisitions, or sales of your organization within the last 10 years? If so, provide details. In December 2007, LogistiCare Solutions, LLC, through the acquisition of its holding companies Charter		

Major Subcontractor: LogistiCare – Non Emergency Transportation

LCI Corporation and LogistiCare, Inc., was acquired by The Providence Service Corporation. Previous to the acquisition by Providence, LogistiCare was a privately held company. In 2004, LogistiCare became the wholly owned subsidiary of the holding company, Charter LCI Corporation, which was formed and owned by a group of private venture capital investment groups.

b. Is a change in ownership anticipated during the 12 months following the Proposal Due Date? Include parent organization, affiliates and subsidiaries.

No change of ownership is anticipated during the next 12 months for LogistiCare, its parent organization, affiliates or subsidiaries.

B.3 Felonies, Health Care Related Offenses, Debarment or Suspensions by Federal or State Government

None of the employees, agents, independent contractors or subcontractors of LogistiCare Solutions or of The Providence Service Corporation or its affiliates and subsidiaries, have been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health-care related offense or have ever been debarred or suspended by any federal or state governmental body.

B.4 Pending or Recent Litigation

According to available records, the following is a list of all pending litigation or actions involving LogistiCare or its subsidiaries. As a broker of passenger transportation services, LogistiCare often becomes a named party in claims and litigation arising when passengers claim injuries from traffic accidents or other incidents occurring during the course of transportation. LogistiCare is typically defended as an additional insured under the contracted transportation provider's insurance policies, with little or no direct involvement, or financial contribution by LogistiCare. The damages in these cases are typically unspecified monetary damages. Unless otherwise noted, the following cases arose from vehicle accidents or passenger incidents involving subcontracted transportation companies.

LogistiCare is neither currently under any government investigation, nor are there any government lawsuits pending against the company.

For further information or to discuss pending or recent litigation, contact Chinta Gaston, General Counsel, at 434-295-2397, or Melanie Winskie Crowe, Associate General Counsel, at 404-888-5800, ext. 419.

Pending Litigation

- Davis, Carla Shantell v. Alton Kenny Davis and The Guardian Ambulance Service, Inc., and LogistiCare Solutions, LLC, Circuit Court of Wythe County, Virginia, Case No. CL 08-129.
- DeJesus, Brenda ppa Nathaniel Martinez, a minor, v. Autumn Transportation, Inc., LogistiCare, Inc., Yvonne Davidson, The Greater Hartford Academy of Mathematics and Sciences aka CREC, and City of Hartford, Superior Court of Connecticut, Judicial District of Hartford, Case No. unknown at this time.
- Dunston-Sisco, Cynthia and Saleem Sisco v. LogistiCare, LogistiCare Solutions, LLC, Marco & Peter Auto Transit, Marco Peter Transit Company, Nabil Massad aka Nabil Mossad, Marco Peter Cab Co., and John Doe, Court of Common Pleas, Philadelphia County, Pennsylvania, Case No. 110204576.
- GEM Ambulance, LLC v. LogistiCare Solutions, LLC, United States District Court, District of New Jersey, Case No. 3:33-av-00001 (trademark dispute).
- Graham, Albert et al. v. Elizabeth Mosley, individually and dba Mosley's Transportation and/or dba

Major Subcontractor: LogistiCare – Non Emergency Transportation

LogistiCare of MS, and LogistiCare Solutions, LLC, Circuit Court of Hinds County, Mississippi, Case No. 251-11-100CIV.

- Holman, Geraldine v. LogistiCare Solutions, LLC, Nevada Medical Transportation, Inc., Does 1-10, and Roe Corporations 1-10, United States District Court, District of Nevada, Case No. 2:10-cv-00169HDM-PAL.
- Marrero, Roberto, Eduardo Gomez, Roberto Ricardo, Mario Jarquin, Lazaro Merchan, Orlando Valdes, Danoy Lopez, Marisabel Alvarez vs. LogistiCare Solutions, LLC and Red Top Transportation, Inc., US District Court, Southern District of Florida, FL Case # 09-CV-205661.
- Maxwell, Brenda v. Logisticare Solutions, LLC, In the First Judicial District of Pennsylvania Court of Common Pleas of Philadelphia Co., PA. June 2010 Term Case No. CV 100603262.
- Miles, Deborah v. LogistiCare Transportation, Court of Common Pleas, Philadelphia County, PA Case No. 002199.
- Nicholson, Vivienne v. LogistiCare, Inc., Court of Common Pleas, Philadelphia County, PA. Case No. 090403969.
- Nitschke, Rhonda as personal representative of the estate of Joyce F. Nitschke, deceased, v. Roger Pipins, LogistiCare Solutions, LLC, and Soonerride, District Court of Garfield County, Oklahoma, Case No. CJ-2010-435-02.
- Orr, Ruth Ann v. Philadelphia Coach Limo, Inc., LogistiCare Solutions, LLC, Knightbrook Insurance Co., American Service Insurance Co., Inc., and American Country Insurance Co., Court of Common Pleas, Philadelphia County, Pennsylvania, Case No. 02930.
- Ramos, Yaziel, PPA by Luz Texidor, next friend, v. Katiria Figueroa, Double A Transportation, Inc., Laidlaw Transit, Inc., and LogistiCare Solutions, LLC, Superior Court Judicial District of Hartford, CT, Case No. HHD-CV-09.
- Rivera, Ines v. LogistiCare, Court of Common Pleas, Philadelphia County, Civil Trial Division Case no: 100303854 March term #3854.
- Robinson, Nakia, individually and as parent and natural guardian of Maurice Deas, and Maurice Deas, in his own right, v. Judith Dill, Charles Vinson, Marco-Peter, Inc., and LogistiCare Solutions, Inc., Court of Common Pleas, Philadelphia County, PA. Case No.101102512.
- Rose, Frances J. v. Patricia Pendleton, Elsie White d/b/a White's Medicaid Transit, and LogistiCare Solutions, LLC, Circuit Court of the County of Amherst, VA Case No. CL10007771-00.
- State Farm v. Deanna Myers, as legal guardian and next friend of Danielle Nichole Myers, Logisticare, Inc., Kenneth Johnson, Dondi Johnson, In the Superior Court of Fulton County, GA. Case No. 2010-CV-188726.
- Sifers, Chana L. v. Clayton W. Strickland et al., including LogistiCare Solutions, LLC, District Court of Oklahoma County, OK Case No. CJ-2011-2504.
- Smitherman, Mary v. LogistiCare Solutions, LLC, Court of Common Pleas, Philadelphia County, PA. Case No. 101102856.
- Torna, Francisco v. Wing Transportation Corp., G&M Transportation, Inc., Gilberto Martin, Dolores Martin, LogistiCare Solutions, LLC, and Red Top Transportation, Inc., US District Court, Southern

Major Subcontractor: LogistiCare – Non Emergency Transportation

District of Florida, Case # 09-CV-20869. (employment issue)

- Vann, Glenda G. v. Compass Transit, LLC, Logisticare Solutions, LLC, Quest Diagnostics Clinical Laboratories, Inc., and Lab One, Inc. d/b/a Quest Diagnostics, District Court of Comanchee County, OK. Case No. CJ-2010-990. (driver dispute)
- Wells Pullens, Carolyn Sue, Elizabeth Ann Wells Hoggatt, James Hillary Wells, and John Curtis Wells v. B&M Transport Solutions, Inc., LogistiCare Solutions, LLC, and Covenant Health & Rehab of Picayune, LLC, Circuit Court of Pearl River County, MS, Case No. 2010-1112H.

Closed Litigation

According to available records, the following is a list of all closed litigation within the past five years. As a broker of passenger transportation services, LogistiCare often becomes a named party in claims and litigation arising when passengers claim injuries from traffic accidents or other incidents occurring during the course of transportation. LogistiCare is typically defended as an additional insured under the contracted transportation provider's insurance policies, with little or no direct involvement, or financial contribution by LogistiCare. Unless otherwise noted, the following cases arose from vehicle accidents or passenger incidents involving subcontracted transportation companies.

- ABC Taxi v. LogistiCare Solutions, LLC, Arizona Justice Court, Pima County, Case No. CV09015096. (contract dispute)
- Alberto, Rafael v. Martinez Transportation, Inc. and LogistiCare, Inc., United States District Court Southern District of Florida Case No. 08-CV-20322. (FLSA)
- Albritton, Ruby v. LogistiCare Solutions, LLC, et al., Fulton County State Court, Georgia GA, Case No. 06VS097839.
- Andrews, Charlotte v. LogistiCare Solutions, LLC and Divine Transportation and Jane Doe, Circuit Court of Fairfax County, Virginia Case No. 2008-4980.
- Bartlett, Maisha v. Ronald Mayo, LogistiCare & Battles Transportation, Superior Court for the District of Columbia. Case No. 2006 CA 001500 B.
- Bivins, Joseph Lee and Paulette Ross as Administratrix of the Estate of Jennifer Bivins deceased v. Rosewood Nursing Center, Inc., Sterling Healthcare, Inc. Starship Transportation, Inc., LogistiCare Solutions, LLC, Dialysis Treatment Centers of Macon, LLC and Davita, Inc. and John Does I-V, In the Superior Court of Bibb County State of Georgia, Case No. 08CV49041.
- Bobrick, Paul v. Logisticare Transportation Services, John Doe's 1 to 15, Superior Court of California, County of Los Angeles Case No. VC048696.
- Cooper, Louis v. Logisticare Solutions, LLC, Mimi Transportation Services & Manor Care, Inc., Circuit Court for the City of Alexandria, VA Case No. 07002870.
- Corey, Delores v. Logisticare Solutions LLC, Veolia Transportation Services Inc; Veolia Transportation Inc; ATC/Vancom, Inc. and Keya Lewis In the State Court of Chatham County. Case No. CA0903126.
- Cromwell, Helen v. LogistiCare Solutions, LLC, FAME Transportation, et al., District Court, Clark County, Nevada, Case No. A576171.
- Cronin, Rona v. Edward Ernest Brown and LogistiCare Solutions, LLC, Circuit Court of Fairfax

Major Subcontractor: LogistiCare – Non Emergency Transportation

County, At Law No.218321.

- Cronin-Fisher, Kathleen v. Edward Ernest Brown and LogistiCare Solutions LLC, Circuit Court of Fairfax County Case No. 20078218.
- Davis, Elliot F., Jr. v. Alicia Chapman, New Community Corporation, and Leslie Leonor v. LogistiCare, Superior Court of New Jersey, Law Division, Essex County, Case No. ESX-L- 5081-10.
- Doe, Jane v. LogistiCare Solutions, LLC, WMATA, MV Public Transportation dba MV Transport, Regency Cab, Challenger Transportation, Inc. & Mohammad Sarrami Foroosnani, Circuit Court for Montgomery County Case #279800-CV & Superior Court of the District of Columbia, DC Case No. 2006 CA 003171 B.
- Doe, Jane by her Next of Friend and Conservator of Estate, Madeleine Lemieux & Quinn v. Yemi Talabi, Clarence Hendricks, Laidlaw Transit, Inc., and LogistiCare Solutions, LLC, Superior Court Judicial District of Hartford Case No. CV 07 5009974.
- Doe, Mary, PPA for Jane Doe v. Gerald Terry, Jason Hylton, Metropolitan Livery, Inc. d/b/a Metro Taxi and LogistiCare Solutions, LLC, Superior Court J.D. of Waterbury at Waterbury Case No. CV-08-5008897-S.
- Duboise, Estate of Frank Vincent (deceased) v. Sinai Plaza Nursing Rehabilitation Center; Hebrew Home Sinai, Inc. DOS Health Care, Inc. Logisticare Solutions, LLC & Red Top Transportation, Circuit Court of the Eleventh Judicial Circuit in and for Miami-Dade County, Florida Case No. 08-20346CA20.
- Duncan, Chantal v. City of Philadelphia, Nabil Habib Mossad t/a Marco & Peter Auto Transit, Marco & Peter Auto Transit, LogistiCare of Philadelphia & Arrow Plumbing & Drain Cleaning Company, Court of Common Pleas, Philadelphia County, July Term, 2009. Case no. 0907004559-000112.
- Erhardt, Ronald E. v. Keith Jewell d/b/a Magic Transportation, LogistiCare Solutions, LLC and a/k/a and d/b/a LogistiCare of Kentucky, Jefferson County Circuit Court Division III. Case No. 06CI 09705.
- Exectrans & Courier Service, LLC v. LogistiCare Solutions, LLC, In the Frederick Co General District Court. Case No. GV09-2187. (contract dispute)
- Fisher, Joseph v. Edward Ernest Brown and LogistiCare Solutions LLC, Circuit Court of Fairfax County Case No. 20053293.
- Ford, Antwanette R. v. Nicholas B. Gates, Eastern Express, Inc., Marshall Gray, Rodney Preslar and Robin Preslar d/b/a S&T Transit, and LogistiCare Solutions, LLC, Circuit Court of Dunklin County, MO Division I Case No. 06DUCC00120.
- Ford, Rosie, Lakishuire Ford and Francis Coney, aunt and next friend for the benefit of Diquan Gordon v. Nicholas B. Gates, Eastern Express, Inc., Marshall Gray, Rodney Preslar, d/b/a S & T Transit and LogistiCare Solutions, LLC, Dunklin County Circuit Court of Missouri Division I Case No. 06- DUCC00046.
- Gant, Melba on behalf of Gregory Welcome, a minor, as his mother & natural guardian v. Marco Peter Auto Transit, LogistiCare, Inc. & George E. & Susan L. Holtz, In the Court of Common Pleas Philadelphia County CA Arbitration No. 3397 September 2008. (LogistiCare affiliate)

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- Garcia, William vs. LogistiCare, Eleventh Judicial Circuit Court, Dade County, FL Case No. 23336CA32 (employment issue).
- Garnett, Corey & Mary, individually and as husband and wife v. Vegas Western Cab, Inc., a Nevada Corporation, LogistiCare Solutions, LLC, a Delaware Corporation, doing business in Nevada, Doe Cab Driver 1-5 and Roe Corporations 1-5, District Court of Clark County, Nevada Case No. A54113.
- Gateway Insurance Company v. Regency Cab, Inc., Jane Doe, Logisticare Solutions, LLC and Mohammad Sarrami Forosnani, In the U.S. District Court of Maryland (Baltimore), Case No. 1:06-cv-03278-AMD.
- Godoy, Alice v. LogistiCare, Inc., LogistiCare Solutions, LLC, et al., In the Superior Court of California, County of Riverside, Indio Branch, Case No. Inc Case No. 081797.
- Havener, Richard L., Jr. v. Oklahoma Transit Authority, Inc. d/b/a Excel Lift Services, Inc. and LogistiCare Solutions, LLC, District Court in and for Creek County, Sapulpa Division, OK Case No. CJ-2007-740.
- Hicks, Gwendolyn v. LogistiCare Solutions, LLC R/A Glory Transportation Services, Inc. Debra Olagumju & Emanuel Olagumju individually, Warrant in Debt. In the Richmond General District Court, Virginia. Case No. 069853.
- Horne, Larry, as Personal Representative of the Estate of Gertrude Horne v. Robert B. Smalls, BCD Rural Transportation Management Association and LogistiCare Solutions, LLC, Court of Common Pleas for the Ninth Judicial Circuit, Case No. 2008-CP-08-0026.
- Jackson, Ericka and Namonsha Jackson, a minor by and through her mother and next friend, Ericka Jackson, v. James McNally and LogistiCare Solutions, LLC, Circuit Court of Sunflower County, MS, Case No. 2010-386.
- Jackson, Willard M. v. David Anthony Peterson and LogistiCare Solutions, LLC, Circuit Court for Prince George's County, Case # CAL07-09409.
- Keaser, Bessie v. Art of Life, Inc., LogistiCare Solutions, LLC, and Milton Brown, Court of Common Pleas of Philadelphia County, Case No. 001011.
- Kulb, Florence v. LogistiCare, Inc., LogistiCare Solutions, LLC, Valery Grenader, and Philadelphia Coach, Inc., Court of Common Pleas, Philadelphia County, PA, Case No. 090502313.
- Lamb, Lori Ann, Administrator of the Estate of Doris Ann Lamb, Deceased v. Life Stride, Inc dba Vernice Worldwide Transport Services and Victor Rojas, Jr. and Arnida B. Lamont dba Lamont & Wade Associates and Louis Wade, dba Lamont & Wade Associates and LogistiCare Solutions, LLC, Circuit Court for the City of Staunton, VA Case No.790CL07000225-00.
- Laroche, Marie v. Logisticare Solutions, Inc. et al., Prince Georges County Circuit Court Civil Action No CAL 06-20683.
- Lewis, Bernetta L. v. Heritage Transportation, LLC and Mildred Frasier and Logisticare Solutions LLC, State of South Carolina, County of Richland, In the Court of Common Pleas C/A No. 2008-CP-40-07472. (contract dispute)
- Lifestar Response of Alabama, Inc. v. LogistiCare Solutions, LLC, Fulton County Magistrate Court,

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GA, Case No. 08MS087496. (contract dispute)

- Lincoln General Insurance Co. v. Metropolitan Livery, Inc., LogistiCare Solutions, LLC, Mary Doe, & Jane Doe, Superior Court, J.D. of Hartford, CT.
- Marberry, Lillian v. St. Joseph's/Candler Health System, Inc., TF&S Transport, Inc., Doris Pons Transport, LLC, LogistiCare, Inc. & John Doe's (1-5), Superior Court of Chatham County State of Georgia Case No. 07-0558 FR. (LogistiCare affiliate)
- Mazelis, Joel Phillip & Stillson, Jeanne v. LogistiCare Solutions, LLC, Challenger Transportation, Inc. WMATA, Luc Gilbert Bitjad & Jose A. Chicas, Circuit Court of Montgomery County Maryland, Case No. 295185-V.
- McFarland, Brian, individually and as administrator of the Estate of Brenda McFarland, v. Logisticare Solutions, LLC, James H. Autry d/b/a First Choice Transport, We Care Transportation, Inc., Davita, Inc., ABC Corp. 1-5, and John Does 1-5, In the State Court of Clayton County, Georgia, Civil Action File No. 2008EV005131A.
- Meriweather, Hattie v. Ebou Colley, individually and d/b/a Louisville Care Medical Transport, LogistiCare Solutions, LLC d/b/a Louisville Care Medical Transport and the Parkway Extended Care Center, Inc., Jefferson Circuit Court Division IX Case No. 07CI005886.
- Mills, Robert v. LogistiCare, et al., Miami-Dade County Circuit Court, FL Case # 06-9100-CA-08.
- Miqueo, Alba, as parent, natural guardian and next friend of the Estate of minor, Johnathan Miqueo, deceased v. Pediatric Network Holding Corp. d/b/a Children's Rehab Network, Red Top Transportation, Inc. and A Ride Transportation Services, Inc., Circuit Court of the 11th Judicial Circuit in and for Miami-Dade County, FL General Jurisdiction Division Case No. 06-11986CA27. (LogistiCare affiliate)
- Mora, Hernan, et al vs. Nico's Transportation and LogistiCare, US District Court, Southern District of Florida Case No. 08-20184-CIV. (FLSA)
- Mujica, Georgina v. Jose M. Mendia & LogistiCare, Circuit Court in & for Miami-Dade County, Florida, Case No. 08-32791CA04.
- Myers, Deanna S., as legal guardian and next friend of Danielle Nichole Myers v. LogistiCare, Inc., Kenneth Johnson, and Dondi Johnson, State Court of Fulton County, Georgia, Civil Action No. 10EV009332A.
- Nautilus Insurance Company v. Regency Cab, Inc., Jane Doe, Logisticare Solutions, LLC and Mohammad Sarrami Forosnani, In the U.S. District Court of Maryland (Baltimore), Case No. 1:06-cv-03088-AMP.
- Nicholson, Vivienne v. LogistiCare, Inc., Court of Common Pleas, Philadelphia County, PA. Case No. 090403969. (LogistiCare affiliate)
- Outlaw, Raymond v. LogistiCare Solutions, LLC, a foreign Limited Liability Company; and DOE'S 1-10, District Court, Clark County, Nevada, Case No. A581369 XIII.
- Pearson, David C t/a E&H Transportation v. LogistiCare Solutions, LLC, In the Circuit Court for Montgomery Cp., MD Civil No. 305001-V. (contract dispute)
- Pee Dee Regional Transportation Authority v. The SC Procurement Review Panel, SC Department of

Major Subcontractor: LogistiCare – Non Emergency Transportation

Health and Human Services, SC Procurement Materials Management Office and Logisticare Solutions, LLC, In the Court of Common Pleas Fifth Judicial District Civil Action No. 2007 – CP-40-01589. (bid protest)

- Perez, Sylvia v. LogistiCare and Transit Aide, Inc., Court of Common Pleas of Philadelphia County, Trial Division #002391.
- Pierreville, Jean v. Logisticare Solutions, LLC and/or HealthTrans, Inc., Mark Imburt, and Parkway Regional Medical Center Auxillary, Inc., Broward County Circuit Court –17th Judicial Circuit Case No. 06002932.
- Puentes, Adrian PPA Solangel Santos et al v. Specialty Transportation, Inc. and LogistiCare, Inc., Charter LCI, Inc. and Providence Service Corporation, State of Connecticut, Hartford Superior Court, Ref 108611.(LogistiCare affiliate)
- Ray, Carolyn v. Nicholas B. Gates, Eastern Express, Inc., Marshall Gray, Rodney Preslare and Robin Preslare d/b/a S&T Transit, and LogistiCare Solutions, Circuit Court of Dunklin County, Missouri Division I Case No. 07DU-CC00108.
- Regions Bank of Little Rock, as Administrator for the Estate of Gerald Paul, deceased, v. Janice R. Smithwick, LogistiCare Solutions, LLC, KST Watts & Co., LLC d/b/a KST Watts Transportation Company, and Shakendra "Cookie" Montgomery, In the Circuit Court of Pulaski County, Arkansas. Case No. CV-09-1909.
- Rodriquez, Delores v. Red Top Transportation, Inc., In the Circuit Court of the 11th Judicial Circuit and for Miami-Dade County, Florida Case No. 07-46900CA01(2). (LogistiCare affiliate)
- Rush, Gloria v. American Medical Transportation & LogistiCare Solutions, LLC, Circuit County Court of the City of St. Louis, MO Division XX Case No. 0622CC05534.
- Sanders, Kenneth & Drusilla v. Logisticare Corporate Headquarters, In the Magistrate Court of Fulton County, Georgia. Case No. 1:10-CV-00158-CAP. (miscellaneous tort, not auto)
- Sanneet, Inc. d/b/a Broad and Diamond BP v. LogistiCare Solutions, LLC a/d/b/a LogistiCare, Transit Aide, Inc. and Allstate Transportation Company, Inc., Court of Common Pleas Philadelphia County, Pennsylvania, Case No. 001732. (contract dispute)
- Serrano, Caroline, ppa Alfred Serrano, & Alfred Serrano v. City of Hartford, City of Hartford Board of Education, Specialty Transportation, Inc., & LogistiCare Solutions, LLC, Superior Court, Judicial District of Hartford at Hartford, Case No. CV-09-5030801-S.
- Steele, Faye v. Allied Medical Transport, Inc. a/k/a and d/b/a Allied Medical Transportation Services, Inc. and Allied Charter Tours, Inc. and Health Trans, Inc. and LogistiCare Solutions, LLC, 17th Judicial Circuit in and for Broward County Circuit Case No. 06-725-CACE 14.
- Stevenson, Charlene v. Bolivar County Council on Aging, Inc. LogistiCare Solutions, Inc., and John Does 1-4, Circuit Court of the First Judicial District of Hinds County, Mississippi. CA No. 251-09-1049CIV.
- The Hanover Insurance Co. v. Deanna Myers, as legal guardian and next friend of Danielle Nichole Myers, Logisticare, Inc., Kenneth Johnson, Dondi Johnson, & State Farm Mutual Automobile Insurance Company, In the Superior Court of Fulton County, Georgia. Case No. 2010-CV-188143.

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- Tubilla, Evangeline & State Farm Insurance v. Ortez Glass, Logisticare Solutions, et al., District Court of Maryland for Prince George's County, Case No. 050200035392006.
- Valdez, Ada & Eduardo Valdez v. Miguel A Golondrino & Red Top Transportation, Inc., Circuit Court of the 11th Judicial Circuit in and for Miami-Dade County, FL Case No. 06-22803-CA-30. (LogistiCare affiliate)
- Vasquez, Gloria v. Nevada Medical Transportation, Inc.; DOE DRIVER, individually, DOE EMPLOYEES, individually, and in their Official Capacity as Employees of Nevada Medical Transportation, Inc.; LogistiCare Solutions, Inc. d/b/a LogistiCare, Inc.; DOES I through X; and ROE CORPORATIONS I through X, Inclusive, In the District Court of Clark County, Nevada. Case No. A-09-595577-CV.
- Wagner, Christian P. v. Advanced Vehicle Systems, Inc., Coach USA, Inc., Miami-Beach Transportation Management Association, Inc., Electric Transit Vehicle Institute, Inc., and Red Top Transportation, Inc., In the Circuit Court of the 11th Judicial Circuit in and for Miami-Dade County, FL Case No. 02-30406CA31.
- Ward, Alice vs. LogistiCare Solutions, LLC, Rauf L. Hassain, Zohair Mohammed, M & Z, Inc., University Health Systems A/K/A The University of Virginia Medical Center, Maha A. Elobeid, Raouf El Hasson & M and Z Transportation, Inc., Circuit Court for the city of- Charlottesville, VA Case No. 06-364.
- Waters, Debra L. c/o D&K Transportation v. Logisticare Solutions, LLC, In the Justice of the Peace Court of Delaware and for Kent County Court No. 16. CA No. JP16-08-005887. (contract dispute)
- Western World Insurance Co., Inc. v. Regency Cab, Inc., Jane Doe, Logisticare Solutions, LLC and Mohammad Sarrami Forosnani, In the U.S. District Court of Maryland (Baltimore), Case No. 1:07-cv-00601-AMD.
- White, Geraldine C. v. Transit Aide, Inc. , Bill Black, John Daniels, LogistiCare, Inc., LogistiCare Solutions, LLC., and Best Transit, Inc., Court of Common Pleas of Philadelphia County Trial Division, Case No. 000825.
- Williams, Anthony v. Joyce Mary Jones, Grace Transportation, Inc., et al. including LogistiCare Solutions, LLC, County Court of Coahoma County, Mississippi, Cause No,14-CO-08-0112.
- Williams, Georgia v. USA Medical Transportation and LogistiCare Solutions, LLC, Superior Court of California, County of Los Angeles, Case No. YC061524.
- Williams, Guy v. David M. Peterson, Keystone Quality Transport, Resources for Human Development, LogistiCare Solutions, LLC, City of Philadelphia, & SEPTA, In the Court of Common Pleas, Philadelphia County, First Judicial District, Civil Division, Case No. 09110 3329.
- WMATA v. Deepak K. Gautem and LogistiCare, Inc., Circuit Court for Montgomery County, Maryland Case No. 293800-V. (LogistiCare affiliate)
- Woodruff, Luther v. Deepak K. Gautem, LogistiCare, Inc., LogistiCare Solutions, LLC & Challenger Transportation, Circuit Court for Montgomery County, Maryland, Case No. 296302–V.

American Arbitration Association Matters:

- K.A.&M. Enterprise, LLC v. LogistiCare Solutions, LLC, Oklahoma American Arbitration Association Case Number: 71 125 M 00098 10 (contract dispute).

Major Subcontractor: LogistiCare – Non Emergency Transportation

- PMT, Inc v. LogistiCare Solutions, LLC, Mississippi American Arbitration Association Case No. 69 125 Y 00499 08 (contract dispute).
- TLC Healthcare Services v. Logisticare Solutions, LLC, Ohio American Arbitration Association Case No. 53 193 00773 09. (contract dispute)

B.5 Bankruptcy or Insolvency in the last ten years? If yes, provide explanation. Include your organization's parent organization, affiliates, and subsidiaries.
Neither Logisticare nor its parent company, affiliates or subsidiaries has filed (or had filed against it) any bankruptcy or insolvency proceeding, or undergone the appointment of a receiver, trustee or assignee for the benefit of creditors in the last ten years.

B.6 If publicly-traded, submit most recent United States Security Exchange Commission Form 10K and the most recent 10-Q Quarterly report.
LogistiCare is not a publicly-traded company; therefore, this requirement is not applicable.

B.7 Financial Background

a. If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

Please see Attachment B.11.q for 2010 and 2009 Audited Providence Service Corporation 10-K Annual Report and for Form 10-Q March Financial report

b. Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

Please see Appendix B.11.r for representative's statement.

B.10 Key Personnel Information – Roster and Resumes of key staff assigned to perform duties or services
See Attachment B.11.s.

B.16 In Excel format, identify your organization's publicly funded managed care contracts for Medicaid, Medicare or CHIP within the last five years.
See Attachment B.11.t for an Excel file of publicly funded managed care contracts.

B.17 Contract Terminations or Non-Renewals

Has subcontractor had a managed care contract terminated or not renewed in the last 5 years?
☒ Yes ☐ No

LogistiCare has not had a contract terminated for cause. The customer retention rate is 90 percent across state contracts over the past 21 years. Also note, Providence Service Corporation's Social Services business has not lost or terminated any material or significant contracts within the past five years.

B.18 Corrective Action Associated with Contract Termination or Non-Renewal
Not applicable. No contract was terminated/non-renewed based on LogistiCare's performance.

Major Subcontractor: LogistiCare – Non Emergency Transportation				
B.19 Ratings (Current and Going Back 3 Years) from AM Best Company, The Street.com Inc. and Standard and Poor's – if applicable.				
Rating Agency	**2011**	**2010**	**2009**	**2008**
S&P	NR	B-	B-	B-
Moody's	B2	B2	B2	B2

B.20 Breach of Contract to Provide Physical Health Services within the Past 5 years?
Not applicable

B.21 - B.24 Accreditation

B.21a Is subcontractor currently, or has it ever sought, NCQA or URAC accreditation? ☒ Yes URAC ☐ No Note, NEMT brokers are not eligible for NCQA accreditation.	**B.21b Currently accredited?** ☒ Yes URAC ☐ No LogistiCare passed the March 2011 URAC audit with a score of 97.

B.22 Has the subcontractor's accreditation status in any state ever been adjusted down, suspended or revoked?
LogistiCare has never had its accreditation status adjusted down, suspended or revoked in any state for any reason.

B.23 If NCQA accredited, include a copy of the applicable NCQA report cards.
Not applicable.

B.24 If applicable, provide a copy of the most recent EQRO Review.
Not applicable.

B.25 Regulatory Actions and Monetary and Non-monetary Sanctions imposed by Government regulatory entity in the last 5 years?
None.

B.26 Criminal and/or Civil Investigations by a government entity in the last 5 years?
In 2007, a local office of the Department of Labor in Miami, Florida, questioned the classification of four employees in LogistiCare's Miami office. LogistiCare voluntarily reclassified those employees from exempt to hourly. There was no finding that LogistiCare had violated any law.

B.27 Subcontractor References
The required reference documents for LogistiCare will be provided in sealed envelopes with the Amerigroup Louisiana, Inc RFP response. Please see Attachment B.11.u.

Verity HealthNet LLC (Verity)

Verity will manage the GSA B Amerigroup Louisiana network of participating providers by identifying, securing and overseeing contracts with providers that meet the network adequacy guidelines defined by DHH. Verity will also maintain electronic provider demographic data and provider reimbursement terms. The subcontractor will maintain provider information in a format mutually agreed upon and consistent with data elements required by DHH. Verity does not contract with Amerigroup in other markets.

Table B-23 Contracted Provider Network

Major Subcontractor: Verity HealthNet – Contracted Provider Network		
B.1 General Information		
1. Legal Names, including d/b/as: Verity HealthNet, LLC. d/b/as Verity		
2. Contact Information		
2a. Physical address: 8490 Picardy Ave, Ste 600, Baton Rouge, LA 70809	**2b. Mailing address:** Box 83578, Baton Rouge, LA 70884-3578	
2c. Telephone: 225-819-1135	**2d. CEO:** Joseph Bonsignore	
3. Relationship: ☐ **Affiliate** ☒ **Unrelated Third Party**		
4. Affiliate Information: Not Applicable		
5. Name of ultimate owner/parent: General Healthy System		
6. Business Status (all that apply): ☐ Sole proprietor ☒ Limited Liability Company ☐ Corporation ☒ For-profit ☐ Non-profit ☒ Privately-owned ☐ Listed on a stock exchange		
7. List of Officers, Directors and Partners		
7a. Name	**7b. Mailing address:**	**7c. Telephone**
Joseph Bonsignore, President and 50% Member	PO Box 83578, Baton Rouge, LA 70884-3578	225-819-1135
Verity Health Accounts Management Services, Inc. 50% Member	8585 Picardy Avenue, Baton Rouge, LA 70809	225-237-1540
7d. Health Professionals with at least 5% interest in subcontractor: None.		
8. Federal Taxpayer Identification Number: 45-0510673		
9. Louisiana Taxpayer Identification Number: Uses Federal Taxpayer ID		
10a. State of incorporation and domicile Verity is a Louisiana based LLC and is domiciled in Louisiana.	**10b. If out-of-state, name and address of local representative** - Not Applicable	
11. Has Organization been engaged by DHH within the past 24 months? If Yes, indicate contract numbers and description. Verity has not been engaged by DHH within the past 24 months.		
12. Is the subcontractor providing services for Amerigroup in other states? No.		

Major Subcontractor: Verity HealthNet – Contracted Provider Network
B.2 Mergers and Acquisitions **a. Have there been any mergers, acquisitions, or sales of your organization within the last 10 years? If so, provide details.** Verity has had no mergers, acquisitions, or sales of the organization within the last ten years.
b. Is a change in ownership anticipated during the 12 months following the Proposal Due Date? Include parent organization, affiliates and subsidiaries. No change of ownership is anticipated during the 12 months following the Proposal Due Date.
B.3 Felonies, Health Care Related Offenses, Debarment or Suspensions by Federal or State Government No employee, agent, independent contractor or subcontractor of Verity has ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or has ever been debarred or suspended by any federal or state governmental body.
B.4 Pending or Recent Litigation
There is no pending or recent litigation against Verity.
B.5 Bankruptcy or Insolvency in the last ten years? If yes, provide explanation. Include your organization's parent organization, affiliates, and subsidiaries. Verity has not filed any filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee or assignee for the benefit of creditors.
B.6 If publicly-traded, submit most recent United States Security Exchange Commission Form 10K and the most recent 10-Q Quarterly report. Not applicable to Verity.
B.7 Financial Background
a. If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner. Not applicable, as Verity is an LLC with participating members and as such, has no parent company.
b. Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract. With no parent company, no such statement is included; however, Verity has provided a signed statement that they will unconditionally guarantee their own performance and every obligation, warranty, covenant, term and condition of the Contract. This is included as Attachment B.11.v.
B.10 Key Personnel Information A summary resume of key personnel is available as Attachment B.11.w.
B.16 Please submit an Excel file for all publicly funded managed care contracts for Medicaid, Medicare or CHIP within the last five years? No publicly funded contracts. All contracts are for access to Verity's contracted provider network. See detail below.

Major Subcontractor: Verity HealthNet – Contracted Provider Network					
Name	**Duration of Contract**	**Population Type**	**Number of Members**	**Contact Name**	**Phone Numbers**
LSU System Health Plan	July 2007 to Present	28,000	Commercial	Jennifer Christian	(225) 578-7438
Baton Rouge General Medical Center	May 2002 to Present	3,800	Commercial	Stacey Nolan	(225) 237-1555
LSU Student Health Insurance	January 2009 to Present	2,500	Commercial	Shelby Conway	(225) 578-8410
Lafayette General Medical Center	January 2004 to Present	2,100	Commercial	Don Authement	(337) 289-8624
Louisiana Health Plan	July 2005 to Present	1,700	Commercial	Leah Barron	(225) 926-6717
Assurant Health	March 2006 to Present	1,200	Commercial	Corinna Novak	(414) 299-6320
Louisiana Police Jury Association	January 2003 to Present	1,000	Commercial	Yvette Murphy	(504) 888-3555
Chitimacha Employee Health Plan	January 2004 to Present	900	Commercial	Charles Dupuy	(337) 923-4343
Iberia Medical Center	January 2004 to Present	700	Commercial	Stephanie Kirk	(337) 374-7107
IBEW Local 995	January 2005 to Present	650	Commercial	K.E. Russell	(225) 927-6340

B.17 and B.18 Contract Terminations or Non-Renewals

Has subcontractor had a managed care contract terminated or not renewed in the last 5 years?

☐ Yes ☒ No

Description of Issues	Parties Involved	Address of primary terminating party	Phone number of primary terminating party	Corrective actions to prevent recurrence of issue

Verity has not had any contract terminated or not renewed within the past five years.

B.19 Ratings (Current and Going Back 3 Years) from AM Best Company, The Street.com Inc. and Standard and Poor's – if applicable.

Not applicable to Verity.

B.20 Breach of Contract to Provide Physical Health Services within the Past 5 years?

Not applicable to Verity.

B.21 - B.24 Accreditation

Is subcontractor currently, or has it ever sought, NCQA accreditation?	**Currently accredited?**
☐ Yes ☒ No	☐ Yes ☒ No Since the vendor is not accredited they do not answer the other questions in this section.

Major Subcontractor: Verity HealthNet – Contracted Provider Network
B.25 Regulatory Actions and Monetary and Non-monetary Sanctions imposed by Government regulatory entity in the last 5 years?
Not applicable to Verity.
B.26 Criminal and/or Civil Investigations by a government entity in the last 5 years?
Not applicable to Verity.
B.27 Subcontractor References The required reference documents for Verity will be provided in sealed envelopes with the Amerigroup Louisiana, Inc RFP response. Please see Attachment B.11.x

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To Whom It May Concern:

Financial Disclosure Policy

New Mountain Capital ("New Mountain") is the majority owner of Connextions, Inc. ("CNX"). New Mountain does not allow its financial information to be disclosed by CNX to any third party. CNX is an experienced health business process outsourcer ("BPO") with over 100,000,000 in annual revenues, over 10 years providing health BPO services to various clients, and insurance equal to or better than its industry peers. These circumstances have allowed clients and entities of all kinds to find comfort in using the financial information of CNX itself in considering us for their needs.

Please contact me using the below information should you have questions regarding the foregoing.

Regards,

Stephen B. Kaplan
SVP & General Counsel

3600 ECOMMERCE PLACE 407.926.2400 MAIN
ORLANDO, FL 32808 877.772.6868 TOLL FREE
WWW.CONNEXTIONS.COM 407.926.2402 FAX

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Connextions, Inc. Performance Guarantee

Connextions, Inc. ("CNX") will continue to perform all of its duties and obligations under the Standard Support Agreement for Member Services, by and between CNX and multiple subsidiaries of Amerigroup Corporation (the "Parties"), having an Activation Date of April 1, 2006, as amended from time to time by the Parties (the "Contract") in accordance with the provisions set forth in the Contract.

Regards,

Stephen B. Kaplan
SVP & General Counsel
Connextions, Inc.

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CONNEXTIONS KEY PERSONNEL RESUMES

STEVEN AUERBACH

President

Summary of Experience

Steven Auerbach has walked several miles in the shoes of our clients, and has lived and breathed operational and service excellence for the majority of his career – at some of the largest healthcare organizations in the world (UnitedHealth Group, Aetna and CIGNA). He was brought onto the Connextions team to infuse both our internal and our client organizations with the best practices that he has successfully implemented. Steven brings more than 20 years of executive experience to his role as President of Connextions. He previously served as Executive Vice President of Operations at UnitedHealth Group (NYSE:UHG), where he oversaw 15,000 professionals providing service to more than 25 million consumers and 650,000 physicians. He also oversaw domestic and international call centers, claims processing, quality assurance, training, capacity planning, sales and marketing systems, and Internet/self-serve portal solutions.

JEANNEEN WATSON

Senior Vice President – Select Health and Exchange Solutions

Summary of Experience

Jeanneen and her teams live by her mission to drive superior growth and performance for their clients – every day, and with every interaction. She has 'walked the talk' in organizations just like the ones her teams are serving – so she knows what's needed to drive to their goals. She is the executive leader of the Select Health Division, and has top-to-bottom accountability for each of her division's clients – from operations, IT, training and quality to KPI performance. Her clients include leading insurance carriers, medical centers of excellence and pharmacy benefits managers. Her confident, take-charge demeanor has contributed to her 20 year record of building and sustaining sales, retention, member and provider service, account management and support teams. Previously, she was an AVP with Amerigroup, where she developed a team to handle claims, customer service and telesales for Medicare Advantage and long-term care insurance products. Before that, she was National Director of Telesales and Member Retention for UnitedHealthcare's Medicare and Retiree Business where she man-aged internal Medicare Advantage telesales and Member Retention teams for multiple sites as well as a large sales staff.

JON CREWS

Operations Director

Summary of Experience

As a client advocate and operations leader, Jon Crews is responsible for managing relationships and ensuring satisfaction of Connextions healthcare clients. He works in partnership with one of Connextions' largest healthcare clients and maintains one of the highest levels of agent tenure. He supports client needs through people, operations improvement and cost reductions in support of their expanding products and business needs. He has also served providing leadership to several key clients supporting AEP seasonal projects where he served clients from an operations and management perspective. He oversaw the implementation of one of Connextions' premiere healthcare clients, leading a team of more than 150 licensed agents and managers. He is a results driven leader with an extensive background in call center management and expertise in customer retention. His management background includes direct responsibility for operations, enrollment and demand publishing business lines for multi-client, multi-site centers with responsibility for more than 500 referral specialists.
In his 15-year service operations career, he has consistently delivered superior performance results for premiere corporations including Verizon, Morgan Stanley Dean Witter, Medical Mutual of Ohio, Solvay Pharmaceuticals, CVS Caremark, Barnes and Noble, among others.

POSITION QUALIFICATIONS

Operations Manager

Position Description

Due to new site expansion and explosive growth Connextions has an immediate opening for a Call Center Operations Manager- Healthcare Client Relations.

Primary Responsibilities

- Ensures attainment of internal and external key performance indictors on a daily, weekly and monthly basis.
- Provides leadership and guidance to assigned Supervisors to ensure the Connextions team develops and executes tactical business plans.
- Is responsible for daily analysis of business and client results to ensure Connextions and their clients' business objectives are met.
- Is responsible for staffing and hiring of all assigned operations positions.
- Is responsible for the smooth implementation of all change control in the Operations department.
- Provides daily analysis of results for all assigned Connextions and client processes and is responsible for making recommendations on program enhancements to appropriate Account Management and Operations leadership.
- Is responsible for evaluating process flows and service delivery through continuous quality management.
- Educates, motivates, leads, guides and directs all assigned Supervisors and representatives. Monitors calls and provides feedback to Supervisors and Representatives based on observations.
- Monitors and tracks employees for progress against internal and external objectives.
- Has P&L responsibility for assigned clients ensuring attainment of revenue and cost budgets

POSITION QUALIFICATIONS

Health Advocate

Position Description

The Health Advocate provides first-line support to members calling in on behalf of the Nurse Triage Line. The Health Advocate (HA) provides a general intake process on the call to gather member information, review the reason for the call and obtain general demographical information. In the event the call is a medical related call which would require the support a clinical staff member, the HA will transfer the call to the clinical staff member. The HA will also transfer calls back to member services departments and provides general information for those calls which are non-clinical in nature.

Primary Responsibilities

- Take inbound calls members who are in need of clinical and non-clinical support.
- Perform general intake process on the calls to obtain a general description of the reason for the call and gather demographical information
- Transfer members to various departments within the client environment
- Communicate to callers with good listening skills, genuine warmth and attitude of helpfulness.
- Continual learning about the clients and their services.
- Correct data entry for tracking and reporting.

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Connextions' Publicly Funded Managed Care Contracts for Medicaid/ CHIP

Trade Name	Scope of Work	Duration of the Contract	Contact Name	Contact Phone Number	Number of Members	Population Types (i.e. TANF, ABD, Duals, CHIP)	Annual Contract Payments	Subcontractors Y/N
Large Regional Health Plan	24 x 7 Nurse Triage Services	Started 2004, no end date, renews yearly	Due to client confidentiality we cannot release this information.	Due to client confidentiality we cannot release this information.	422,800	MEDICAID in 15 counties in the state of PA	confidential	CNX does not subcontract any work to a third party.
Amerigroup	24 x 7 Nurse Triage Services	Started 2004, no end date, renews yearly	Victoria Mitchell	757-473-2737	2,500,000	11 states, MEDICAID, MEDICARE	confidential	CNX does not subcontract any work to a third party.

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To Whom It May Concern:

Client Referrals

Pursuant to your request, Connextions, Inc. ("CNX") attempted to reach out to some representative clients for references. However, many of our clients have policies which forbid disclosure of vendor relationships to third parties and/or providing references concerning such vendors. As a result, we were unable to comply with your references request.

CNX is an experienced health business process outsourcer ("BPO") with over 100,000,000 in annual revenues, over 10 years providing health BPO services to various clients, and insurance equal to or better than its industry peers. These circumstances have allowed clients and entities of all kinds to find comfort in considering us for their needs.

Please contact me using the below information should you have questions regarding the foregoing.

Regards,

Stephen B. Kaplan
SVP & General Counsel

3600 ECOMMERCE PLACE 407.926.2400 MAIN
ORLANDO, FL 32808 877.772.6868 TOLL FREE
WWW.CONNEXTIONS.COM 407.926.2402 FAX

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Connextions References

Please see Attachment B.11.e in our **ORIGINAL** proposal for sealed envelopes containing completed reference questionnaires for Connextions.

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Dental Service of Massachusetts, Inc.

Consolidated Financial Statements
December 31, 2010 and 2009

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December 31, 2010 and 2009

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Report of Independent Auditors

To the Board of Directors of
Dental Service of Massachusetts, Inc.:

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of income, equity and cash flow present fairly, in all material respects, the financial position of Dental Service of Massachusetts, Inc. and Subsidiaries ("the Company") at December 31, 2010 and 2009, and the results of their operations and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

PricewaterhouseCoopers LLP

April 12, 2011

PricewaterhouseCoopers LLP, 125 High Street, Boston, MA 02110
T: (617) 530 5300, F: (617) 530 5001, www.pwc.com/us

Dental Service of Massachusetts, Inc.
Consolidated Balance Sheets
December 31, 2010 and 2009

(in thousands)	2010	2009
Assets		
Cash and cash equivalents	$ 56,800	$ 37,397
Investments at fair value	224,852	235,525
Accrued investment income	1,752	1,800
Receivables from customers, net of allowance for uncollectible premium amounts of $809 and $1,550		
Premium	11,539	7,551
Cost reimbursement	60,858	65,237
Receivable for open trades	556	2,411
Deferred tax asset	3,493	1,376
Prepaid expenses and other	4,380	5,207
Federal and state tax receivables	3,863	886
Total current assets	368,093	357,390
Premises and equipment, net of accumulated depreciation	63,650	53,819
Goodwill and intangibles, net of accumulated amortization	114,408	116,427
Restricted cash and securities on deposit	30,460	13,485
Noncurrent deferred tax asset	866	1,461
Total assets	$ 577,477	$ 542,582
Liabilities and Unrestricted Net Assets		
Reserves for		
Claims payable	$ 54,128	$ 49,327
Claim adjustment expenses	1,277	1,193
Group experience refunds	7,171	5,644
Total reserves	62,576	56,164
Advance deposits	45,836	45,797
Deferred revenue	7,575	6,855
Accounts payable and accrued expenses	18,116	28,277
Payable for open trades	3,449	4,122
Current portion of long-term debt	-	2,449
Total current liabilities	137,552	143,664
Long-term debt	124,915	132,929
Interest rate swap liability	2,063	3,478
Deferred tax liability	18,979	12,037
Deferred rent	212	369
Deferred stock compensation	769	-
Long-term commitment to purchase software	1,455	2,183
Total liabilities	285,945	294,660
Unrestricted net assets		
Operating net assets	274,868	238,379
Unrealized depreciation of interest rate swap liability	(1,217)	(2,052)
Unrealized appreciation of investments	17,881	11,595
Total unrestricted net assets	291,532	247,922
Total liabilities and unrestricted net assets	$ 577,477	$ 542,582

The accompanying notes are an integral part of these consolidated financial statements.

Dental Service of Massachusetts, Inc.
Consolidated Statements of Income and Changes in Net Assets
Years Ended December 31, 2010 and 2009

(in thousands)	2010	2009
Revenues		
Premiums	$ 458,608	$ 440,756
Management service fees	112,078	113,107
	570,686	553,863
Investment income, net	12,310	3,504
Total revenues	582,996	557,367
Claims incurred	369,169	353,991
Selling, general and administrative expenses	142,899	131,043
Depreciation and amortization	12,514	12,791
Impairment of software	4	47
Interest expense	6,060	7,041
Charitable contributions	11,165	10,363
Total expenses	541,811	515,276
Excess of income over expenses, before income taxes	41,185	42,091
Provision for income taxes	4,696	6,750
Net income	36,489	35,341
Change in unrealized depreciation of interest rate swap liability	835	1,049
Change in net unrealized appreciation of investments	6,286	24,858
Total change in unrestricted net assets	43,610	61,248
Unrestricted net assets, beginning of year	247,922	186,674
Unrestricted net assets, end of year	$ 291,532	$ 247,922

The accompanying notes are an integral part of these consolidated financial statements.

Dental Service of Massachusetts, Inc.
Consolidated Statements of Cash Flows
Years Ended December 31, 2010 and 2009

(in thousands)	2010	2009
Reconciliation of change in net assets to net cash provided by operating activities		
Net income	$ 36,489	$ 35,341
Adjustments to reconcile change in net income to net cash provided by operating activities		
Net realized gains	(5,034)	(405)
Deferred income taxes	5,420	3,150
Impairment of investments	(82)	5,143
Depreciation	10,495	9,885
Amortization of intangibles	2,019	2,906
Amortization of bank fees	987	987
Impairment of software	4	47
Provisions for uncollectible items	741	582
Net accretion/amortization of investments	1,022	13
Changes in operating assets and liabilities		
Accrued investment income	48	330
Receivables from customers	(351)	(11,312)
Open trades	1,183	(2,474)
Other assets	5,189	(10,435)
Income taxes payable/receivable	(2,978)	(1,017)
Deferred stock compensation	769	-
Reserve for unpaid claims and group experience refunds	6,412	(273)
Advance deposits and deferred revenue	4,364	9,937
Accounts payable and accrued expenses	(11,046)	(8,817)
Net cash provided by operating activities	55,651	33,588
Cash flows from investing activities		
Purchases of investment securities	(258,888)	(132,232)
Proceeds from maturities of investments	18,970	950
Proceeds from sale of investments	235,452	132,348
Capital expenditures	(20,333)	(22,995)
Net cash used in investing activities	(24,799)	(21,929)
Cash flows from financing activities		
Repayment of debt	(11,449)	(28,060)
Proceeds from borrowings	-	8,000
Net cash used in financing activities	(11,449)	(20,060)
Net increase in cash and cash equivalents	19,403	(8,401)
Cash and cash equivalents, beginning of year	37,397	45,798
Cash and cash equivalents, end of year	$ 56,800	$ 37,397
Supplemental information		
Taxes paid	$ 2,911	$ 4,771
Interest paid	5,118	9,048

The accompanying notes are an integral part of these consolidated financial statements.

Dental Service of Massachusetts, Inc.
Notes to Consolidated Financial Statements
December 31, 2010 and 2009

1. Operations

Dental Service of Massachusetts, Inc. (the "Company") is a not-for-profit dental service corporation incorporated under Chapter 176E of the Massachusetts General Laws to provide dental insurance to Massachusetts groups and individuals.

During 2001, DentaQuest Ventures, Inc. ("DentaQuest Ventures") was established as a subsidiary of the Company. DentaQuest Ventures is operated on a for-profit basis and was created to acquire and administer dental insurance businesses outside Massachusetts.

In October 2001, DentaQuest Ventures acquired DentaQuest Mid-Atlantic, Inc. (“DQ Mid-Atlantic”) f/k/a Consumer Dental Corp., DentaQuest Virginia, Inc. (“DQ Virginia”) f/k/a Consumer Dental Care of Virginia, Inc., and DentaQuest Management, Inc. (“DQ Management”) f/k/a CDC Management, Inc. (collectively "Mid-Atlantic").

On April 2, 2004, DentaQuest Ventures acquired substantially all of the assets of DentaQuest, LLC (“DQ, LLC”) f/k/a Doral Dental USA, LLC, including certain of its subsidiaries for approximately $114 million. DQ, LLC was a third-party administrator of government dental benefits. The acquisition was financed with long-term debt of $75 million and existing cash.

On January 9, 2006, DentaQuest Ventures completed a tax reorganization which established DentaQuest Group, Inc., f/k/a DentaQuest, Inc., ("DentaQuest") as the ultimate parent entity in the DentaQuest group of companies. This reorganization preserved all interests and rights of the Company and did not change the ownership percentage or control of DentaQuest Ventures. DentaQuest Ventures, Inc. was converted into DentaQuest Ventures, LLC ("DQV LLC") which now holds the Service Agreement with the Company.

On May 8, 2008 DQ, LLC acquired the stock of Healthcare Atlantic, Inc. and its subsidiaries ("HCA").

The Company has a wholly-owned subsidiary, DSM Investments, Inc. ("DSM Investments"), which was established as a holding company. DSM Investments has two wholly owned subsidiaries, DSM Insurance Services, Inc. ("DSMIS") and DentaQuest Oral Health Center, Inc., f/k/a Dental Health Center, Inc. ("DQOHC"), both of which conduct activities that do not come under the provisions of Chapter 176E and are both operated on a for-profit basis.

The Company and DSMIS share facilities and the services of certain members of management. DQOHC is a dental clinic, located in Westborough, Massachusetts. Its activities focus on treating the causes and risk factors of dental disease.

In February 2000, the Company formed DentaQuest Foundation, Inc. (the "Foundation") f/k/a Oral Health Foundation, Inc. under Chapter 180 of the General Laws of The Commonwealth of Massachusetts. The Company is the sole corporate member of the Foundation. The Foundation is exempt from federal tax under Section 501 (c)(3) of the Internal Revenue Code. The DentaQuest Foundation supports and promotes oral health. It is a partner and collaborator in communities across the United States by connecting key stakeholders, raising awareness of oral health issues, and supporting solutions. Cumulative contributions to the Foundation by the Company were $87,298,000 as of December 31, 2010 and $79,315,000 at December 31, 2009. The Foundation made donation payments of $3,712,000 and $3,994,000 for the years ended December 31, 2010 and December 31, 2009, respectively. The financial results of the Foundation were not consolidated into the Company at December 31, 2010 and December 31, 2009, as the Company does not have an economic interest in

Dental Service of Massachusetts, Inc.
Notes to Consolidated Financial Statements
December 31, 2010 and 2009

the Foundation and a majority of members of the Board of Directors of the Foundation are not members of the Board of Directors of the Company. The Company contributes to the Foundation for the sole purpose of helping the Foundation fulfill its mission.

In October 2006, the Company formed DentaQuest Institute, Inc. (the "Institute"), f/k/a Catalyst Institute, Inc. under Chapter 180 of the General Laws of The Commonwealth of Massachusetts. The Company is the sole corporate member of the Institute. The Institute is exempt from federal tax under Section 501 (c)(3) of the Internal Revenue Code. The mission of the Institute is to gather, analyze and disseminate data and information to improve the quality of oral health delivery systems; to gather, analyze and disseminate data and information on innovative dental technologies, techniques and service delivery models; to create, test and promote models of preventive dental care and oral disease management; to educate and train oral health professionals and related personnel in innovative technologies, techniques and improved oral health care delivery systems; and to make grants to facilitate the forgoing activities. As with the Foundation, the results of the Institute are not consolidated with the Company's results as of December 31, 2010 and December 31, 2009 as the Company does not have an economic interest in the Institute, and the majority of the Board of Directors of the Institute are not members of the Board of Directors of the Company. The Company contributes to the Institute for the sole purpose of helping the Institute fulfill its mission. Cumulative contributions to the Institute by the Company were $9,802,000 as of December 31, 2010 and $7,100,000 as of December 31, 2009.

During 2010, the Company’s subsidiaries, DQV, LLC and DQ, LLC donated services valued at $270,000 and $210,000 to the Foundation and the Institute, respectively.

Effective December 31, 2010, HCA was dissolved. All remaining assets and liabilities were absorbed by DQ, LLC, who assumed the role of the Company’s Parent.

2. Significant Accounting Policies

The following is a summary of the significant accounting policies followed by the Company.

Basis of Presentation
The Company's financial statements have been prepared on the basis of accounting principles generally accepted in the United States of America ("GAAP"). These principles differ in certain respects from Statutory Accounting Practices ("SAP"), which the Company uses to report to the Division of Insurance of The Commonwealth of Massachusetts. A reconciliation of the statutory basis net income and statutory basis net worth to the excess of income over expenses and unrestricted net assets as determined in accordance with GAAP is set forth in Note 17.

Management Estimates
The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Principles of Consolidation
The accompanying consolidated financial statements include the accounts of the Company and the consolidated accounts of its subsidiaries as of December 31, 2010 and 2009 and for the years ended December 31, 2010 and 2009. All intercompany accounts and transactions have been eliminated in consolidation.

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Cash and Cash Equivalents
Cash and cash equivalents include short-term money market instruments with an original maturity of ninety days or less at the date of acquisition. Cash and cash equivalents are carried at cost, which approximates fair value. Legally restricted cash balances are included in noncurrent assets.

Restricted Cash and Securities on Deposit
The Company maintains certain restricted cash and securities to meet the requirements of state regulatory agencies. These securities are classified as investments, are considered as available-for-sale and are carried at fair market value.

Concentration of Credit Risk
As of December 31, 2010 and 2009, the Company had $22,422,000 and $1,539,000, respectively, in money market funds with a single financial institution. The Company has not experienced any credit losses with respect to its cash equivalents and believes the credit risk to be negligible. The Company and its subsidiaries maintain cash balances at three banks and cash accounts are insured by the Federal Deposit Insurance Corporation up to $250,000.

Concentration of credit risk was considered, but there were no single customers who exceeded the threshold of 10% of revenue. Management believes the risks associated with the loss of any one contract are mitigated by the existence of a competitive environment within a wide geographical area.

Investments
The Company records investments in equity and debt securities at fair value, using quoted market prices. Debt and equity securities that experience declines in value are regularly evaluated for other than temporary impairments. The decision on whether to record other-than-temporary impairments is determined in part by our assessment of the financial condition and prospects of a particular issuer, recoverability of the particular security as well as management's assertion of its intention to sell the security, and if it is more likely than not that the securities will be sold before recovery. For such securities, realized losses are recorded to reduce amortized cost. Realized gains and losses are included as investment income using the specific identification cost method.

Impairment of Long-Lived Assets
The Company periodically evaluates the recoverability of long-lived assets whenever events and changes in circumstances indicate that the carrying amount of an asset may not be fully recoverable. When indicators of impairment are present, the carrying values of the assets are evaluated in relation to the operating performance and future undiscounted cash flows of the underlying business. The net book value of the underlying asset is adjusted to fair value if the sum of the expected discounted cash flows is less than book value. Fair values are based on estimates of market prices and assumptions concerning the amount and timing of estimated future cash flows and assumed discount rates, reflecting varying degrees of perceived risk. Impairment charges recorded during any of the periods presented are described in Note 3 and Note 4.

Premium Revenue Recognition
The Company earns revenue from short duration contracts for which the Company bears the underwriting risk. Premiums are billed in advance of the coverage month and recognized as revenue at the commencement of the coverage month. Costs of acquiring and renewing business are charged to expense as incurred.

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Management Services Revenue Recognition
Management service revenues are derived from arrangements to provide claims adjudication services and other administrative and management services for dental plans. Revenue for services is earned as services are rendered.

The Company does not incur underwriting risk associated with the cost reimbursement business. Cost reimbursement business is billed monthly, on a level monthly fee, or paid claims basis, using a one-month lag.

Global revenues are derived from separate contractual arrangements whereby the Company acts as an intermediary that performs claim adjudication and administrative services for a fixed fee. Revenue for services is earned as services are rendered.

Deferred Revenue
Deferred revenue represents the unearned portion of premiums received in advance for dental service to be provided to members in the future.

Accounts Receivable
Accounts receivable are stated at net realizable value.

Allowance for Doubtful Accounts
The Company maintains an allowance for doubtful accounts to provide for the estimated amount of accounts receivable that may not be collected. The allowance is based upon an assessment of customer creditworthiness, historical payment experience and the age of outstanding receivables.

Premises and Equipment
Premises and equipment are stated at cost less accumulated depreciation. Computer hardware, purchased software, and internally developed software are capitalized. Expenditures for maintenance and repairs are charged to operations as incurred. Depreciation is determined on a straight-line basis, and begins when the asset is placed in service. The estimated useful lives are as follows:

	Estimated Useful Life
Building and building improvements	39 years
Leasehold improvements	7-15 years
Office furniture and equipment	5-10 years
Computer hardware	3-7 years
Computer software	3-7 years

As assets are retired or sold, the related cost and accumulated depreciation are removed from the accounts and any resulting gain or loss is credited or charged to operations.

Capitalized Software for Internal Use
The Company accounts for the costs of software acquired or internally developed or modified to meet the Company's internal needs. Accordingly, internal and external costs incurred during the applications development stage are capitalized and costs incurred during the preliminary project and post implementation stages are expensed in accordance with ASC 350 guidance.

Goodwill and Intangible Assets
Amortizable intangible assets include the costs of acquired member lists and software from the acquisition of Mid-Atlantic, customer contracts, trade names, and non-compete agreements from the acquisition of DQ, LLC and HCA, and a software agreement from the acquisition of DQ, LLC.

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Amortization of these assets began on the date these intangibles were acquired.

Mid-Atlantic member lists and software and DQ, LLC trade names and software agreements are amortized on a straight-line basis. DQ, LLC customer contracts and non-compete agreements are amortized based on the projected cash flows. HCA customer contracts, trade names and non-compete agreements are amortized on a straight-line basis.

All goodwill and other indefinite-lived intangible assets, and agreements, including those acquired before initial application of the standard, are not amortized but are tested for impairment at least annually. The Company has determined that there is no goodwill impairment at December 31, 2010 and 2009.

In addition, the Company continually evaluates whether events and circumstances have occurred that indicate the remaining estimated useful life of long-lived assets may warrant revision or that the remaining balance may not be recoverable. The Company records any reduction in the value of long-lived assets when such adjustments are known.

Stock-Based Compensation
The Board of Directors of DentaQuest Group, Inc. f/k/a DentaQuest Inc., a wholly owned subsidiary of the Company established the Phantom Stock Option Plan (the "Plan") effective January 1, 2008. Under the Plan the Board of DentaQuest Group, Inc. may issue phantom stock options ("PSO's") to certain eligible employees. A PSO represents a unit of value under the Plan and a maximum of 2,500,000 PSO's may be granted. All PSO's vest over a five year period and are granted with an exercise price based on the fair value of the Company on the grant date. The fair value is calculated annually and is approved by the Board of Directors of the Company. Upon vesting active participants receive a cash payment equal to the gain in value of their vested PSO's. The Plan was amended and restated as of January 1, 2009 to allow for post-vesting growth of the after-tax gain.

The Phantom Stock Unit Plan of DentaQuest Group, Inc. (the “New Plan”) was established by the Board of Directors of DentaQuest Group, Inc., effective as of January 1, 2009. Under the New Plan the Board of DentaQuest Group, Inc. may issue restricted phantom stock units (“RSUs”) to certain eligible employees. An RSU is the unit of participation in this Plan and a maximum of 2,500,000 RSU’s may be granted. All RSU’s vest over a five year period and are granted with a fair value equal to the proportionate fair value of the Company on the date of grant. The fair value is calculated annually and is approved by the Board of Directors of the Company. Upon vesting, active participants receive a cash payment equal to the current fair value of their vested RSU’s. The New Plan was amended and restated as of May 1, 2010 to permit discretionary grants of RSU’s by the Plan Administrator.

The Company accounts for its stock-based compensation as liability classified awards in accordance with ASC 718. Total stock-based employee compensation expense included in the Company's consolidated statements of income was $769,000 and $0 for the years ended December 31, 2010 and 2009, respectively.

Claims Payable
Reserves for unpaid claims include reported and incurred but not reported claims, which are estimated using the Company's accumulated statistical data, adjusted for current experience. These estimates are continually reviewed and updated and any resulting adjustments are reflected in current operating results. Correspondingly, receivables are recorded for these amounts for which the Company will be reimbursed by the covered groups and are included in receivables from customers - cost reimbursement.

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The unpaid claims balance also includes the provider liability pool, which comprises advance payments received from global contracts for future claims, plus reserves for unpaid claims including incurred but not reported claims, which are estimated using the Company's accumulated statistical data, adjusted for current experience. Favorable development in the provider liability pool is taken into operating results when appropriate based on contractual terms. These estimates are continually reviewed and updated and any resulting adjustments are reflected in current operating results

Group Experience Refunds
The liability for group experience refunds for eligible groups is determined using individual group experience and accumulated statistical data.

Income Taxes
The Company, as a 501(c)(4) entity under the Internal Revenue Code, is exempt from both federal and state income taxes although it is required to file annual informational returns. The Company's for-profit subsidiaries are subject to both federal and state income taxes. DentaQuest Group, Inc. files a federal consolidated income tax return.

Deferred income taxes and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The deferred income tax expense or benefit generally represents the net change in deferred income tax assets and liabilities during the year. The current income tax expense represents the consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. Valuation allowances are provided, if based upon the weight of the available evidence, it is more likely than not that some or all of the deferred tax assets will not be realized.

In June, 2006, the FASB issued authoritative guidance which clarifies the accounting for uncertain tax positions. This interpretation requires that the Company recognize in its financial statements the impact of a tax position if that position is more likely than not to be sustained on audit based on the technical merits of the position. The Company elected to defer the application of the application of this authoritative guidance as allowed until its fiscal year beginning after December 15, 2008. Effective January 1, 2009, the Company adopted this guidance. Upon adoption, there were no material changes in liability for unrecognized benefits (see Note 11).

Commitments and Contingencies
In conducting its activities, the Company from time to time is subject to various claims and also has claims against others. In management's opinion, the ultimate resolution of such claims would not have a material effect on the financial position of the Company.

Reclassification
Certain prior year amounts have been reclassified to conform to current year presentation.

Recent Accounting Pronouncements

Accounting Standards Codification
The Financial Accounting Standards Board (FASB) has established the Accounting Standards Codification (Codification or ASC) as the single source of authoritative accounting guidance effective for reporting in the third quarter of 2009. Therefore, the Company will use the Codification section or description when referring to GAAP except for very recent guidance that has not yet been incorporated into the Codification.

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Other-Than-Temporary Impairments
On April 1, 2009, the Company adopted the FASB's updated guidance for evaluating whether impairment is other than temporary for fixed maturities with declines in fair value below amortized cost (ASC 320). It requires assessing the Company's intent to sell or whether it is more likely than not that the Company will be required to sell such fixed maturities before their values recover. If so, an impairment loss is recognized in net income for the excess of the amortized cost over fair value. The Company must also determine if it does not expect to recover the amortized cost of fixed maturities with declines in fair value (even if it does not intend to sell or will not be required to sell these fixed maturities). In this case, the credit portion of the impairment loss is recognized in net income and the noncredit portion of an impairment loss is recognized in a separate component of unrestricted net assets.

Fair Value Measurements
In the third quarter of 2009, the FASB issued guidance on measuring the fair value of liabilities and for investments in certain entities to provide a practical alternative under certain conditions to determine the fair value of these investments using their net asset value or its equivalent. There were no material effects on the Company's Consolidated Financial Statements at adoption during 2009.

Derivatives and Hedging Disclosure
Effective January 1, 2009, the Company expanded its disclosure on derivatives and hedging activities to comply with the FASB's updated guidance (ASC 815) that requires the Company to disclose the purpose for using derivative instruments, their accounting treatment and related effects on financial condition, results of operations and liquidity. See Note 7 for information on the Company's hedging instrument including these additional required disclosures.

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3. Investments

At December 31, 2010 and 2009, the cost, fair values and gross unrealized gains and losses in restricted investment and investments are as follows:

(in thousands)

	2010				
	Amortized Cost/Cost	Impairment	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Restricted debt securities	$ 17,429	$ -	$ 9	$ (10)	$ 17,428
U.S. Treasury and obligations of U.S. government, corporations and agencies	94,834	-	4,186	(401)	98,619
Industrial and miscellaneous	69,666	(874)	3,386	(268)	71,910
Total debt securities	181,929	(874)	7,581	(679)	187,957
Equity securities	43,922	(879)	10,921	-	53,964
Preferred stocks	349	(52)	63	(1)	359
	$ 226,200	$ (1,805)	$ 18,565	$ (680)	$ 242,280

	2009				
	Amortized Cost/Cost	Impairment	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Restricted debt securities	$ 2,083	$ -	$ -	$ -	$ 2,083
U.S. Treasury and obligations of U.S. government, corporations and agencies	99,181	(16)	3,847	(731)	102,281
Industrial and miscellaneous	82,888	(1,553)	4,342	(319)	85,358
Total debt securities	184,152	(1,569)	8,189	(1,050)	189,722
Equity securities	47,000	(3,867)	4,480	(56)	47,557
Preferred stocks	350	(53)	37	(5)	329
	$ 231,502	$ (5,489)	$ 12,706	$ (1,111)	$ 237,608

The Company uses the market approach technique to value its financial instruments and there were no changes in valuation techniques during the twelve months ended December 31, 2010. The Company's financial assets and liabilities are primarily comprised of investments in money market funds, mutual funds holding publicly traded securities, and an interest rate swap.

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Assets and liabilities carried at fair value are to be classified and disclosed in one of the following three categories:

Level 1: Quoted market prices in active markets for identical assets or liabilities that the Company has the ability to access

Level 2: Observable market based inputs or unobservable inputs that are corroborated by market data such as quoted prices, interest rates, and yield curves.

Level 3: Inputs are unobservable data points that are not corroborated by market data.

(in thousands)

Description	December 31, 2010	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Investments	$ 224,852	$ 57,372	$ 167,480	
Restricted investments	17,428	17,428	-	-
Subtotal Investments	242,280	74,800	167,480	
Cash equivalent	22,421	22,421	-	-
Total assets	$ 264,701	$ 97,221	$ 167,480	$ -
Liabilities				
Interest rate swap	2,063		2,063	-
Total Liabilities	$ 2,063	$ -	$ 2,063	$ -

Cash equivalents measured at fair value of $22,421,000 are included in cash and cash equivalents of $56,800,000 on the balance sheet. The cash equivalent holdings consist of short-term money market holdings. Restricted investments measured at fair value of $17,428,000 are included as restricted cash and securities on deposit of $30,460,000 on the balance sheet. The restricted investment holdings consist of United States Treasury Notes.

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(in thousands) **Description**	**December 31, 2009**	**Quoted Prices in Active Markets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Assets				
Investments	$ 235,525	$ 55,429	$ 132,539	$ 47,557
Restricted investments	2,083	2,083	-	-
Subtotal Investments	237,608	57,512	132,539	47,557
Cash equivalent	1,551	1,551	-	-
Total assets	$ 239,159	$ 59,063	$ 132,539	$ 47,557
Liabilities				
Interest rate swap	3,478		3,478	-
Total Liabilities	$ 3,478	$ -	$ 3,478	$ -

Cash equivalents measured at fair value of $1,551,000 are included in cash and cash equivalents of $37,397,000 on the balance sheet. The cash equivalent holdings consist of short-term money market holdings. Restricted investments measured at fair value of $2,083,000 are included as restricted cash and securities on deposit of $13,485,000 on the balance sheet. The restricted investment holdings consist of United States Treasury Notes.

Investments Level 3 Rollforward
(in millions)

Balance at January 1, 2010	$ 47,557
Purchases	23,098
Sales	(22,693)
Realized gains and losses	(496)
Change in unrealized gains and losses	6,498
Transfer to Level 2	(53,964)
Balance at December 31, 2010	$ -
Balance at January 1, 2009	$ 26,602
Purchases	17,348
Sales	(6,960)
Realized gains and losses	(2,008)
Total impairment losses included in earnings	(2,990)
Change in unrealized gains and losses	15,565
Balance at December 31, 2009	$ 47,557

During 2010, all common stock investment holdings were transferred from Level 3 to Level 2 classification due to management's determination that significant observable inputs exist to support the valuation of such holdings.

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The amortized cost and fair value of debt securities at December 31, 2010, by contractual maturity, are shown below. Actual maturities will differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

(in thousands)	Amortized Cost	Fair Value
Due in one year or less	$ 21,503	$ 21,513
Due after one year through five years	62,754	65,911
Due after five years through ten years	43,375	44,955
Due after ten years	53,423	55,578
	$ 181,055	$ 187,957

Unrealized Holding Losses

Management believes that the gross unrealized losses reflected on the Company's fixed income portfolio as of December 31, 2010 were primarily the result of increases in market interest rates from the time of acquisition to the current period. These decreases in value are viewed as being temporary as the Company has the intent and ability to retain such investments for a period of time sufficient to allow for any anticipated recovery in fair value.

(in thousands)		Under 12 Months	Over 12 Months	Total
Debt Securities				
Number of positions		130	2	132
Fair value		$ 39,969	$ 141	$ 40,110
Cost		40,641	148	40,789
	Unrealized loss	$ (672)	$ (7)	$ (679)
Preferred Stocks				
Number of positions			1	1
Fair value		$ -	$ 119	$ 119
Cost		-	120	120
	Unrealized loss	$ -	$ (1)	$ (1)
Total				
Number of positions		130	3	133
Fair value		$ 39,969	$ 260	$ 40,229
Cost		40,641	268	40,909
	Unrealized loss	$ (672)	$ (8)	$ (680)

Proceeds from the sale of investments during 2010 and 2009 were $235,452,000 and $132,348,000, respectively. Gross gains of $6,435,000 and $3,379,000 and gross losses of $822,000 and $936,000 were realized on sales of debt securities during 2010 and 2009, respectively. Gross gains of $198,000 and $1,000 and gross losses of $695,000 and $2,038,000 were realized on sales of equity securities during 2010 and 2009, respectively. The calculation of the gain or loss on the sale of marketable securities is based on specific identification at the time of sale. The Company had realized losses of $82,000 and $5,143,000 in 2010 and 2009 due to the impairment of securities that were determined to be other than temporary.

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Net investment income for 2010 and 2009 consisted of the following:

(in thousands)	2010	2009
Interest and dividend income	$ 8,747	$ 8,714
Investment expenses	(1,471)	(473)
Net realized gains	5,116	406
Net realized losses on impairments	(82)	(5,143)
	$ 12,310	$ 3,504

4. Premises and Equipment

The estimated useful lives cost and accumulated depreciation of premises and equipment at December 31 are as follows:

(in thousands)	Lives	2010	2009
Land		$ 504	$ 504
Building and building improvements	39 years	3,337	3,080
Office furniture and equipment	5-10 years	6,315	6,094
Computer hardware	3-7 years	14,805	13,602
Computer software	3-7 years	51,085	22,795
Leasehold improvements	7-15 years	7,914	7,172
Internal use software in development		21,272	31,659
		$ 105,232	$ 84,906
Less: Accumulated depreciation		(41,582)	(31,087)
		$ 63,650	$ 53,819

The Company recorded depreciation expense of $10,495,000 and $9,885,000 for the years ended December 31, 2010 and 2009, respectively.

The Company recorded an impairment charge of $4,000 and $47,000 during 2010 and 2009, respectively, in connection with the capitalized development of software for internal use.

The Company entered into a commitment to purchase software for an online self service portal in the amount of $3,638,000 as of December 31, 2008. The Company will pay $61,000 in monthly installments over a five year period. The Company made payments of $728,000 for the years ended December 31, 2009 and 2010, respectively. In addition, the Company has committed to ancillary maintenance and hosting fees for ten years. The Company will pay a minimum of $72,000 in monthly installments over this 10 year period, expensed as incurred. The Company has the option to terminate the contract for reasonable cause. If the Company terminates without reasonable cause after going live with the portal, the Company is liable for the full installments.

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5. Goodwill and Intangibles

Goodwill and intangible assets consist of the following at December 31:

(in thousands)	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Average Useful Life
December 31, 2010				
Goodwill	$ 102,490	$ -	$ 102,490	
Customer contracts (DQ, LLC)	34,780	(25,833)	8,947	10 years
Customer contracts (Mid Atlantic)	4,110	(2,547)	1,563	15 years
Customers under partner agreement (Mid Atlantic)	900	(360)	540	10 years
Trade Names (DQ, LLC)	2,150	(2,150)	-	6 years
Noncompete agreements (DQ, LLC)	2,960	(2,092)	868	5 years
Software agreements (DQ, LLC)	1,500	(1,500)	-	5 years
	$ 148,890	$ (34,482)	$ 114,408	
December 31, 2009				
Goodwill	$ 102,490	$ -	$ 102,490	
Customer contracts (DQ, LLC)	34,780	(24,613)	10,167	10 years
Customer contracts (Mid Atlantic)	4,110	(2,270)	1,840	15 years
Customers under partner agreement (Mid Atlantic)	900	(270)	630	10 years
Trade names (DQ, LLC)	2,150	(2,090)	60	9 years
Noncompete agreements (DQ, LLC)	2,960	(1,720)	1,240	5 years
Software agreements (DQ, LLC)	1,500	(1,500)		5 years
	$ 148,890	$ (32,463)	$ 116,427	

Goodwill represents the excess of purchase price over the estimated fair value of net assets from acquisitions of Mid-Atlantic, DQ, LLC and HCA in the amounts of $3,676,000, $73,106,000 and $25,708,000, respectively. The Company accounted for the acquisitions in accordance with ASC 350. The Company does not amortize its goodwill and reviews goodwill annually for impairment. Based on the Company's review, there was no impairment of goodwill at December 31, 2010 and 2009.

The gross carrying value of goodwill and other intangibles of $108,792,000 is deductible for tax purposes at December 31, 2010 and 2009.

The acquisition of HCA in 2008 was considered nondeductible for tax purposes.

Intangible assets acquired in the business combinations are separately identified. Mid-Atlantic member lists exist as a result of the purchase of Mid-Atlantic and are being amortized over fifteen years. The intangible for customers under a Mid-Atlantic partner agreement was previously considered non-amortizable as the agreement is at-will, with no economic determinable life. Effective December 31, 2006, this intangible was considered to have a definite useful life and is to be amortized over the next ten years consistent with the remaining useful life of the other Mid-Atlantic customer contracts.

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Amortization expense associated with these intangible assets in 2010 and 2009 was $2,019,000 and $2,906,000, respectively. Amortization over the next five years for these intangible assets is expected to be as follows:

(in thousands)

Year Ending December 31,	
2011	$ 1,960
2012	1,960
2013	1,712
2014	1,588
2015	1,588
Thereafter	3,110
	$ 11,918

6. Accounts Payable and Accrued Expenses

(in thousands)	December 31, 2010	December 31, 2009
Accrued salaries, pension and bonus	$ 8,145	$ 6,913
Trade payables	1,828	2,011
Overdraft	-	11,793
Loan interest payable	157	287
Commitment to purchase software - current	728	728
Legal settlement	96	105
Commissions	1,463	1,127
Other accrued expenses	5,699	5,313
	$ 18,116	$ 28,277

7. Debt

Long-Term debt consist(s) of the following at December 31:

(in thousands)	2010	2009
Credit agreement	$ 126,000	$ 135,000
Note payable to bank	-	2,449
Total long-term debt	126,000	137,449
Less current portion		
Note payable to bank	-	2,449
Total current debt	-	2,449
Deferred bank fees	(1,085)	(2,071)
Long-term debt, noncurrent position	$ 124,915	$ 132,929

On February 2, 2007, DQV, LLC and its subsidiary DentaQuest, LLC ("DQ, LLC") f/k/a Doral Dental USA, LLC (the "Co-Borrowers") and DentaQuest Group, Inc. (as Parent Guarantor) entered into a Credit Agreement with a group of lenders consisting of a $200,000,000 revolving credit facility and, together with all of the subsidiaries of DentaQuest Group, Inc., a Guarantee and Collateral Agreement (together with the Credit Agreement, the "Credit Facility"). Substantially all of the assets of the Parent

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Guarantor, the Co-Borrowers and their subsidiaries were pledged as collateral against any borrowings under the Credit Agreement. Upon closing of the Credit Facility, DQV LLC borrowed $140,000,000 and purchased the outstanding interest of an outside investor for $110,000,000.

In July 2008, the Company became a party to the Credit Agreement, as amended, and to the Guarantee and Collateral Agreement, as amended. Under the amended Credit Facility, the Company became a guarantor of the obligations of the Co-Borrowers and pledged certain assets as security for such obligations. The assets pledged by the Company excluded (a) all cash and cash equivalents other than proceeds of the pledged assets, (b) its investment portfolio, other than equity capital stock or debt of its subsidiaries or proceeds thereof; (c) any property (other than information technology systems) and intellectual property; (d) any membership interests in the Foundation or the DentaQuest Institute (a nonprofit tax-exempt organization), and (e) any interest in the Company's Service Marks License Agreement with the Delta Dental Plan Association and licenses thereunder.

In June 2009, the Company invested an additional $15,000,000 in DentaQuest. These funds were used to pay down outstanding debt under the Credit Facility. During 2009, the Company borrowed an additional $8,000,000 to provide additional cash for operations.

Borrowings under the Credit Agreement bear variable interest, either at the London Interbank Offered Rate (LIBOR) or Prime, plus a margin depending on the consolidated leverage ratio as of the last quarter end. The margin at December 31, 2010 and 2009 was 1.25% and 1.50% for LIBOR, respectively and 1.25% and .50% for Prime, respectively. In certain circumstances, including additional drawing or conversion of the existing loan to other types of loans allowed under the Credit Agreement, the Company has the option to reset interest rates periodically at either LIBOR or Prime.

The Credit Facility provides for a commitment fee on the unused line of credit. The fee is a percentage based upon the leverage ratio as of the last quarter end applied to the amount of the unused line. At December 31, 2010 and 2009, the commitment fee was 0.25% and 0.30%, respectively.

The Credit Facility contains various restrictive covenants relating to the leverage and fixed charge coverage ratios, as well as restrictions on the amount of payments for capital expenditures, acquisitions, dividends and certain other transactions. As of December 31, 2010 and 2009, the Company and its subsidiaries were in compliance with the terms of the Credit Agreement.

The maturity date of the Credit Agreement is the earlier of February 2012 or the date DQ, LLC terminates the Credit Agreement with appropriate notice and repayment.

In March 2007, DQV, LLC and DQ, LLC entered into a partial interest rate swap agreement ("Swap Agreement") with the Lenders. Under the Swap Agreement, a declining notional amount starting at $75 million (54% of the initial balance of the term loan) was converted from variable one month LIBOR to a fixed rate of 5.09% until February 16, 2012. The notional amount decreases annually by $10 million on March 16th of each year. At December 31, 2010 and 2009 the value of the Swap Agreement was a liability of $2,063,000 and $3,478,000, respectively. The Swap Agreement was recorded at fair value with the resulting changes recognized in unrestricted net assets.

Dental Service of Massachusetts, Inc.
Notes to Consolidated Financial Statements
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The contractual annual maturities of long-term debt as of December 31, 2010 were as follows:

(in thousands)

Year Ending December 31,	
2011	$ -
2012	126,000
2013	-
2014	-
2015	-
	$ 126,000

8. Liability for Unpaid Claims

Activity in the liability for unpaid claims is summarized as follows:

(in thousands)	**2010**	**2009**
Balance at beginning of year	$ 49,327	$ 46,344
Incurred related to		
Current year - insured plans	371,228	353,999
Prior year - insured plans	(2,059)	(8)
	369,169	353,991
Current year - ASO contracts	460,982	444,892
Prior year - ASO contracts	(1,642)	609
	459,340	445,501
	828,509	799,492
Paid related to		
Current year - insured plans	344,747	334,689
Prior year - insured plans	17,933	22,487
	362,680	357,176
Current year - ASO contracts	435,112	417,189
Prior year - ASO contracts	25,916	22,144
	461,028	439,333
	823,708	796,509
Balance at end of year	$ 54,128	$ 49,327

Reserves decreased $2,059,000 in 2010 and $8,000 in 2009, as a result of changes in estimates of incurred claims in prior years. Total liability for insured plans was $27,002,000 and $19,422,000 at December 31, 2010 and 2009, respectively. Included in this reserve is approximately $26,074,000 and $27,776,000 as of December 31, 2010 and 2009, respectively, for estimated unpaid claims on cost reimbursement business. In 2009, the Company recorded a reserve of $2,128,000 for contracts with estimated premium deficiencies. During 2010, $1,078,000 in premium deficiencies was released.

Dental Service of Massachusetts, Inc.
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During 2010 and 2009, the reserve for unpaid claims adjustment expenses increased by $83,000 and $133,000, respectively.

9. Related Party Transactions

On May 8, 2002, DQV, LLC entered into a Service Agreement with the Company whereby DQV, LLC provided services to market sell and administer all of the Company's dental benefits as well as all business support services including without limitation disaster recovery programs. Under the Service Agreement, as amended on July 1, 2008, the Company compensated DQV, LLC based on the business services provided by DentaQuest using a cost and cost-plus methodology. Business services provided at cost include general support services such as information technology, accounting, human resources and credentialing of providers. Business services provided at cost-plus include services specific and exclusive to the operation of the Company and its insurance business, such as executive, sales and marketing, underwriting and enrollment of members and claims processing.

Effective October 1, 2010, DQV, LLC assigned the Service Agreement to DQ, LLC. The Company incurred $13,588,000 in management fees for the period October 1, 2010 through December 31, 2010. The management fee payable outstanding at December 31, 2010 and 2009 was $5,685,000 and $0, respectively. As specified in the Service Agreement, DQV, LLC maintained a deposit of $4,500,000 at December 31, 2010 and 2009, representing one month of the estimated annual service fee. Fees from DSM were $52,305,201 and $51,247,905 during 2010 and 2009, respectively.

In November 2006, the Company entered into a subcontract with its affiliate DQ, LLC which provides dental third party administrator ("TPA") services, under a Massachusetts Medicaid dental program on behalf of the Company. Administrative service fees to DQ, LLC amounted to $7,227,000 in 2010 and $6,895,000 in 2009 and are presented as part of general administrative expenses.

During 2010 and 2009, DentaQuest transferred, at cost, capitalized software amounting to $10,324,000 and $12,412,000 to the Company.

On February 4, 2010, the State of Florida, Office of Insurance Regulation issued a consent order requiring that the Company's subsidiary, DentaQuest of Florida, Inc. ("DQ Florida") make a deposit of $5,785,000 into a restricted account with the State of Florida Treasury Cash Deposit Trust Fund to satisfy certain of its statutory obligations with regard to the pledge of its assets under the Credit Facility. The deposited funds are not subject to the asset pledge under the Credit Facility. The Company funded this subsidiary through a $4,200,000 note issued by DQ Florida on February 23, 2010.

In February, 2010, DentaQuest Mid-Atlantic, Inc., a subsidiary of the Company, reached an agreement with the Maryland Insurance Administration to address the impact of the pledge of its assets under the Credit Facility on its statutory surplus by depositing a total of $3,720,000 in approved securities with the Maryland State Treasurer to secure its statutory obligations. The deposited funds are held in a restricted account not subject to the asset pledge under the Credit Facility.

In September, 2010, DentaQuest Virginia, Inc., a subsidiary of the Company, received approval from the Virginia Bureau of Insurance to increase the amount of its statutory deposit with the Treasurer of Virginia from $328,000 to a total of $1,930,000 in order to increase the percentage of its assets not subject to pledge under the Credit Facility to the level required by Virginia Insurance laws. The deposited funds are held in a restricted account not subject to the asset pledge under the Credit Facility. The Company funded this subsidiary through a $550,000 note issued by DentaQuest Virginia, Inc.

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Notes to Consolidated Financial Statements
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On May 14, 2010, the State of Texas, Commissioner of Insurance issued a consent order requiring that the Company's subsidiary DentaQuest USA Insurance Company, Inc., make a deposit of $7,100,000 into a restricted account with the Comptroller of Public Accounts for the State of Texas to satisfy certain of its statutory obligations with regard to the pledge of assets. The deposited funds are not subject to the asset pledge under the Credit Facility. The Company funded this subsidiary through a $4,200,000 note issued by DentaQuest USA Insurance Company, Inc., on May 18, 2010.

10. Retirement Plan

DentaQuest sponsors a discretionary contribution retirement plan for all of its employees (the "Retirement Plan"). All employees of the Company who have attained the age of 18 and have completed one year and 1,000 hours of service are eligible to participate in the Retirement Plan as of the last day of the month following the fulfillment of the eligibility requirements. Discretionary contributions are determined by the Board of Directors of DentaQuest. Contributions vest over a three year graduated vesting period. For the years ended December 31, 2010 and 2009, the Company recorded a discretionary contribution of $1,833,000 and $2,267,000 respectively.

The retirement plan also includes an employee 401(k) contribution, whereby employees are entitled to contribute each year up to 60% of their eligible compensation or the IRS maximum, whichever is lower.

In 2009, DentaQuest changed the Company matching contribution to a Safe Harbor formula match. The match is 100% on the first 4% of a participant's contribution and vests immediately. These matching contributions amounted to $1,610,000 and $1,534,000 for the years ended December 31, 2010 and 2009 respectively.

11. Income Taxes

The components of income tax expense were as follows for the years ended:

(in thousands)		December 31, 2010	December 31, 2009
Current			
Federal		$ (484)	$ 3,115
State		272	485
	Total Current Provision	(212)	3,600
Deferred provision		4,908	3,150
	Total Provision	$ 4,696	$ 6,750

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The reconciliation of the federal statutory rate to the effective rate is as follows:

	2010	2009
Federal tax rate	35.0%	35.0%
State income taxes, net of federal income tax benefit	2.0	2.2
Tax exempt entity income	(27.7)	(21.1)
Nondeductible expenses	0.6	0.4
Other	1.5	(0.5)
	11.4%	16.0%

The components of net deferred tax assets (liabilities) were as follows as of:

	December 31,	
(in thousands)	2010	2009
Goodwill and other intangibles	$ (12,315)	$ (10,103)
Claims payable	3,602	1,136
Fixed assets	(7,428)	(1,933)
Net operating losses	1,604	1,290
Interest rate swap liability	866	1,461
Other	421	239
Total deferred tax liability	(13,250)	(7,910)
Valuation allowance	(1,369)	(1,290)
	$ (14,619)	$ (9,200)

DSM Investments had federal net operating loss carryforwards of approximately $3,340,000 and $2,948,000 as of December 31, 2010 and 2009, respectively. These net operating losses will expire between 2021 through 2028. DentaQuest had state net operating loss carryforwards of approximately $2,756,000 as of December 31, 2010. These net operating losses will begin to expire in 2015. Management has concluded that the DSM Investments operating results do not presently support an assertion that ultimate realization is more likely than not; therefore a valuation allowance has been established for the tax benefits of all net operating loss carryforwards. Management has concluded that the DentaQuest operating results presently support an assertion that ultimate realization is more likely than not; therefore no valuation allowance has been established for the tax benefits of all net operating loss carryforwards.

The Company adopted the authoritative guidance on accounting for and disclosure of uncertainty in tax positions on January 1, 2009, which required the Company to determine whether a tax position of the Company is more likely than not to be sustained upon examination, including resolution of any related appeals of litigation processes, based on the technical merits of the position. For tax positions meeting the more likely than not threshold, the tax amount recognized in the financial statements is reduced the largest benefit that has a greater than fifty percent likelihood of being realized upon the ultimate settlement with the relevant taxing authority. The Company has determined that adoption of the authoritative guidance did not have a material effect on the consolidated financial statements.

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The Company accrues interest and penalties that may be assessed by the taxing authorities on any underpayment of tax. Interest and penalties are included in income tax expense on the Statement of Income and Retained Earnings.

The Company files tax returns as prescribed by the tax laws of the jurisdictions in which it operates. In the normal course of business the Company is subject to examination by federal and state jurisdictions, where applicable.

Below is a table of the earliest tax years that remain subject to examination by major jurisdictions:

Jurisdiction	Earliest Tax Year Subject to Examination
U.S. Federal	2007
State of New York	2007
State of Massachusetts	2007
State of Illinois	2004

All the years including and subsequent to the above years remain open to examination by the taxing authorities. The resolution of tax matters is not expected to have a material effect on the Company's consolidated financial statements.

12. Phantom Stock Plan

The fair value of granted phantom stock options ("PSO's") is calculated annually and is approved by the Board of Directors of the Company. All PSO's vest over a five year period and are granted with an exercise price equal to the fair value on the grant date. A total of 582,642 and 689,969 PSO's were granted in 2010 and 2009, respectively. As of December 31, 2010 and 2009, the total amount of PSO's outstanding was 1,188,794 and 789,020, respectively.

Upon vesting each active participant receives a cash payment equal to the gain in their vested PSO's or equal to the Fair Value of their vested RSU's. Beginning with grants made in 2009, the New Plan gave all active participants the option to elect to defer the receipt of cash payment upon vesting for a period of one year or more or upon separation of employment. In 2010 three active participants elected to defer receipt of cash payment for periods ranging from 4 to 5 years and three active participants elected to defer cash payment until separation from employment. During 2009 five active participants elected to defer receipt of cash payment for periods ranging from 2 to 12 years and seven active participants elected to defer cash payment until separation from employment. At December 31, 2010 249,502 PSO's with an average exercise price of $20.34 and 7,397 RSU's were covered by deferral elections.

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Phantom stock option plan activity is as follows:

	Number of Options	Weighted Average Exercise Price
Outstanding, December 31, 2009	789,020	$ 22.48
Granted	582,642	18.64
Canceled	(41,168)	21.81
Exchanged	(141,700)	28.74
Outstanding, December 31, 2010	1,188,794	$ 19.87

The following table summarizes information about the options outstanding at December 31, 2010:

Number Outstanding	Weighted Average Remaining Life	Weighted Average Exercise Price
1,188,794	2.6 years	$ 19.87

At December 31, 2010, the strike price of all options issued was higher than fair value.

The following table summarizes information about the restricted stock units outstanding at December 31, 2010.

Number Outstanding	Weighted Average Remaining Life	Weighted Average Exercise Price
125,494	2.2 years	$ -

13. Lease Obligations

The Company entered into a 15-year lease in May 1997 for its facility in Boston. This lease was subsequently amended on January 21, 1999. On May 1, 2002, the Company assigned its lease and all of its collective rights, titles and interest to DentaQuest Ventures, Inc. At the time of the assignment, the Company agreed to pay $641,000 for a portion of the deferred rent which is included in other noncurrent assets. DentaQuest will pay all of the deferred rent which is included in other noncurrent assets. DentaQuest will perform all of the obligations under the amended lease as of the effective date of the assignment. Under the terms of the assignment, the Company remains liable for the performance of all terms, covenants and conditions of the amended lease should DentaQuest fail to perform any of the covenants or conditions contained in the amended lease. On May 1, 2002, DentaQuest subleased 7.57% (6,000 square feet) of its leased premises to the Company.

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On March 1, 2007, the Company entered into a ten year lease to operate an expanded Oral Health Center facility and to house the DentaQuest Institute in Westborough, Massachusetts. The square footage of the facility is 12,000 square feet. The Company is committed to pay for operating expenses and real estate taxes, which amounted to $73,000 and $71,000 for the years ended December 31, 2010 and 2009, respectively. The Company has guaranteed the lease on behalf of the DentaQuest Oral Health Center.

The Company's subsidiaries lease office space at facilities in Wisconsin, Maryland, Florida and South Carolina. These leases expire in 2011, 2011, 2014 and 2015, respectively. The rent for 2010 was $179,000, $186,000, $276,000 and $67,000 respectively. The rent for 2009 was $179,000, $181,000, $276,000 and $0 for Wisconsin, Maryland, Florida and South Carolina, respectively.

The Company records rent expense on a straight-line basis over the life of leases. Total rent expense is $2,857,000 and $2,701,000 for the years ended December 31, 2010 and 2009, respectively.

As of December 31, 2010, total future minimum lease payments under its operating leases for the years ended December 31 were as follows:

(in thousands)

2011	$ 2,315
2012	2,146
2013	482
2014	468
2015	132
Thereafter	158
	$ 5,701

14. Statutory Surplus and Dividend Availability

The Company's insurance subsidiaries DentaQuest Mid-Atlantic, Inc., DentaQuest Virginia, Inc., DentaQuest USA Insurance Company, Inc. and DentaQuest of Wisconsin, Inc. and DentaQuest of Florida, Inc. are required to file financial statements with state insurance regulatory departments. The accounting principles prescribed or permitted for these financial statements differ in certain respects from accounting principles generally accepted in the United States of America. The Company's insurance subsidiaries met the required minimum capital and surplus requirements on December 31, 2010 and 2009, respectively. On a statutory accounting basis, capital and surplus of the Company's insurance subsidiaries aggregated $22,539,000 and $17,237,000 at December 31, 2010 and 2009, respectively. The Company complies with all regulatory requirements to the extent that dividends require approval of state insurance regulators.

15. Restricted Deposits

Substantially all of the assets of the Company’s subsidiaries were pledged as collateral against any borrowings under the Credit Agreement (see Note 7). Due to the pledging of assets, the Company’s subsidiaries that hold insurance licenses were required to make deposits with the regulatory bodies of the respective states in which their licenses were held.

The Company’s subsidiary DentaQuest USA Insurance Company, Inc. is required to maintain a deposit of securities with the Treasurer of the State of Texas. The required deposit is equal to 90% of cash and short-term investments held by a subsidiary of the Company. The total required deposit as

Dental Service of Massachusetts, Inc.
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of December 31, 2010 amounted to $12,258,000. The Company held $12,430,000 on deposit with the Treasurer of the State of Texas.

The Company's subsidiary, DentaQuest of Florida Inc. is required to maintain a $5,785,000 with the Florida Treasury Cash Deposit Trust Fund Regulation in accordance with a consent order issued by the Florida Office of Insurance Regulation.

The Company's subsidiary, DentaQuest Virginia Inc. is required to maintain a deposit of $1,930,000 with the Treasurer of Virginia in accordance with an agreement with the Virginia Bureau of Insurance.

In accordance with a consent order from the Maryland Insurance Administration, the Company's subsidiary DentaQuest Mid-Atlantic Inc. is required to maintain a deposit of $3,720,000 with the Maryland State Treasurer as of December 31, 2010. The required deposit is determined based on the total liabilities and Risk-Based Capital ("RBC") of DentaQuest Mid-Atlantic, Inc.

In accordance with a consent order from the Commissioner of Insurance of the State of Wisconsin, the Company's subsidiary DentaQuest Dental Plan of Wisconsin, Inc. is required to maintain a deposit of $250,000 with the Wisconsin State Treasurer.

Other subsidiaries of the Company are required to maintain restricted cash deposits in accordance with various state regulations and contracts. These other restricted cash deposits aggregated $6,320,000 and $8,577,000 as of December 31, 2010 and 2009, respectively.

16. Legal Proceedings

In the normal course of business, the Company is subject to various contingent liabilities such as market conduct examinations or guaranty fund assessments. Management does not anticipate any significant unaccrued claims or costs to result from any known or existing contingencies as of December 31, 2010 and December 31, 2009.

In February, 2006, DQV and DQ LLC (formerly known as Doral USA, LLC) and its subsidiary DentaQuest IPA of New York, LLC ("DQ IPA NY," formerly known as Doral Dental IPA of New York) were served with a class action lawsuit, styled DiTolla v. Doral Dental IPA of New York, et al., filed in the Supreme Court of the State of New York. The action was brought by a dentist alleging breach of contract and fiduciary duty to plaintiff and a class of dentists from 1995 to 2005. The complaint seeks an accounting of funds but does not include any claims for monetary damages. On October 24, 2008, the defendant filed a motion to dismiss the complaint for failure to state a claim for relief on March 26, 2009; the Court denied the Defendant's motion to dismiss. The Court entered a scheduling order requiring that all discoveries be completed by September 30, 2010. A trial date has not been set. DQ, LLC believes that, under the Asset Purchase Agreement dated as of January 19, 2004 related to the acquisition of DQ, LLC by DQV, the former owners of DQ, LLC and certain other indemnifying parties are obligated to assume the defense of that action and indemnify DQV for all losses incurred in connection therewith.

Dental Service of Massachusetts, Inc.
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17. Reconciliation of Statutory Basis to Generally Accepted Accounting Principles (GAAP)

A reconciliation of net income for the years ended December 31, 2010 and 2009 and net worth at December 31, 2010 and 2009 determined on a statutory basis to those amounts determined in accordance with GAAP is a follows:

(in thousands)	**2010**	**2009**
Statutory basis - net income	$ 33,010	$ 25,782
Adjustments to capital and surplus		
Equity in consolidated income of DentaQuest	3,956	9912
Equity in consolidated loss of DSM Investments, Inc.	(704)	(500)
Nonadmitted assets of DSM, Inc.		
Allowance for uncollectible receivables	295	(173)
Administrative fee on cost reimbursement	(68)	320
GAAP basis - net income	$ 36,489	$ 35,341
Statutory basis - net worth	$ 96,613	$ 188,280
Nonadmitted assets		
Receivable balances over 90 days	1,912	780
Premises and equipment, net	42,032	10,033
Software in development	16,522	24,699
Intercompany debt	8,726	3,300
Goodwill and intangibles	38,328	6,147
Prepaid and other	10,838	3,073
Equity in DSM Investments, Inc.	1,338	2,042
Deferred bank fees	1,084	2,071
Other adjustments		
Allowance for uncollectible receivables	(323)	(533)
Administrative fee on cost reimbursement	1,668	1,736
Amortization of goodwill	66,699	-
Net unrealized gains on debt securities	6,095	6,294
GAAP basis - Unrestricted net assets	$ 291,532	$ 247,922

Risk-Based Capital
Risk-based capital ("RBC") is the minimum level of capital deemed necessary for a managed care organization based upon the type of assets held and business written, calculated in accordance with the managed care organizations RBC formula that was adopted by the NAIC. If a company's Total Adjusted Capital falls below RBC, the Insurance Commissioner is required to take actions considered necessary to protect policyholders and creditors. The Company has total adjusted capital sufficient to meet the required level.

18. Subsequent Event

Effective January 1, 2011 DQV, LLC merged with and into DQ, LLC in a statutory merger. DQ, LLC is the surviving legal entity. Pursuant to the merger, all of the assets and liabilities of DQV, LLC have been assumed by DQ, LLC.

dsm

Dental Service of Massachusetts, Inc. Performance Guarantee

Dental Service of Massachusetts, Inc. will unconditionally guarantee performance by DentaQuest, LLC of each and every obligation, warranty, covenant, term and condition of the Contract.

Myra J. Green
Secretary, Dental Service of Massachusetts, Inc.
Date: June 9, 2011

465 Medford Street
Boston, MA 02129-1454
Telephone: 617.886.1611
800.451.1249
Facsimile: 617.886.1612

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SUBCONTRACTOR RESUMES FOR EYEQUEST

STEVE POLLOCK, JD

Chief Operating Officer

Summary of Experience

Steve Pollock was recently named DentaQuest's chief operating officer (COO). Steve is located in Mequon, WI and is responsible for the success of DentaQuest's government business unit. Prior to his role as COO, Steve served as the president of DentaQuest, a position he has held since 2004.

He began his career at DentaQuest in 1999, serving in various roles including executive vice president, vice president of market development, and chief operating officer. His broad range of experience prepared him to assume the presidency in a rapidly evolving healthcare marketplace. Under his leadership, membership, revenue, EBITDA and value has grown dramatically. His teams increased membership in benefits programs 280% over four years, representing an increased income for the company of more than $80 million. He has led the company through change and advancement with good people practices, innovative technology, and efficient processes.

Steve's leadership style is collaborative, empowering his team members to take risks, embrace change and drive the business with solid results. Steve is proud of his people development record, which demonstrates outstanding commitment, more than 98% retention, and consistent advancement.

Prior to joining DentaQuest, Steve worked with Medical Mutual of Ohio, the largest insurer in Ohio representing more than 1.5 million members. He designed a unique network for dental, vision, behavioral care, hospitals and physicians in the state. He negotiated and implemented Medicaid global capitation contract, which produced an annual savings of more than $4 million dollars.

From 1995-1997, Steve was an associate at Medimetrix Group in Cleveland, Ohio, a national health care consulting firm focused on structuring and implementing managed care initiatives in the private and public sectors. In this capacity, Steve developed a plan to establish and operate a wholly-owned insurance company to distribute Medicaid, SCHIP and Medicare products. This organization represents more than 600,000 members and consistently receives the highest quality scores.

Steve currently serves on the Board of Directors for Oral Health America (OHA), a national organization dedicated to improving oral health.

Academic Background and Professional Certifications

- J.D degree from the University of Wisconsin Law School.
- Certified Public Account in the state of Ohio

CARL MOROFF, OD

Chief Vision Officer

Summary of Experience

Dr. Moroff is a vision care veteran with more than 35 years experience in the eyecare field. Carl oversees the company's vision care program operations, quality assurance, brand management and marketing, and new business development. Dr. Moroff has been in this position since 2009. Dr. Moroff is a licensed optometrist and has the clinical knowledge to oversee all operations and ensure optimal patient care is rendered.

Dr. Moroff's career spans three decades and includes over 20 years as the executive vice president and chief operating quality officer at Davis Vision, Inc. At Davis Vision, he spearheaded the managed vision care operation with over $250 million in sales and an 89-store retail optical chain. The retail name included Empire Vision Centers, Davis Vision, Cambridge Eye Doctors, Vision World and Total Vision.

Key Responsibilities

- **Operations:** Dr. Moroff works with the vision director to manage all operational functions for the vision program. He maintains a close working relationship with internal departments, as well as external vendors who provide products and services that are essential to the success of delivering vision benefits.
- **Client relationships:** Dr. Moroff guides clients through critical contracting, compliance, financial and operational business issues. Dr. Moroff is also responsible for fostering strong working relationships with potential business partners.
- **Network development**: Dr. Moroff and the director of provider services work together to create and execute the network development strategy. Dr. Moroff is experienced at recruiting and maintaining compliant vision networks.
- **Leadership:** Dr. Moroff is responsible for overseeing a team of day-to-day operations staff dedicated to the vision program, including client services, call center, network and the vision consultants.

Academic Background and Professional Certifications

- Doctor of Optometry 1976 - Massachusetts College of Optometry
- Bachelor of Science 1972 - SUNY at New Paltz
- Candidate for Masters of Public Administration
- Long Island University-C.W. Post Campus, Old Westbury, NY
- **Optometric Licenses:**
  New York License Number 3473
  Massachusetts License Number 2582

KEVIN MILLER

Market Director

Summary of Experience

As market director for Louisiana, Kevin is responsible for ensuring network adequacy and marketability, reviewing contractual agreements with clients and overseeing the response to member issues. Kevin has been part of the DentaQuest team since 2008.

Kevin is focused on meeting AmeriHealth Mercy's high service expectations. He believes that all concerns need to be validated and addressed in a timely manner. He makes himself accessible to his clients and approaches all issues with a problem-solving attitude.

Kevin was an integral part of the success of two of DentaQuest's largest clients, including the State of Tennessee. He served as the liaison between the client and DentaQuest's internal resources to ensure the program ran running efficiently. Under Kevin's guidance, the Tennessee program has become a national model.

Before joining DentaQuest, Kevin worked in the sales field. He was responsible for securing and retaining a considerable client base totaling $10 million in company revenue. He was the direct interface between the client and the organization in a five-state region.

Key Responsibilities

- Network management: Ensuring network adequacy and marketability for the states under her direction
- Contractual review: Oversees contract details to ensure compliance and client satisfaction
- Client contact and response: Involvement in providing timely solutions to member issues and building relationships with clients.

Academic Background and Professional Certifications

- Bachelor of Science degree in business communications from Abilene Christian University, Abilene, TX.

KAREN LEMANCZYK

Manager, Credentialing

Summary of Experience

Karen Lemanczyk is the credentialing manager, a position she has held since 2007. Karen oversees a staff of credentialing specialists. She prepares documentation for credentialing committee and ensures accurate and timely credentialing of providers in accordance with requirements for DentaQuest's 23 markets.

Karen has more than 20 years of healthcare industry experience. She has held leadership responsibilities in hospitals, clinics, long term care facilities, inpatient, rehab and pediatric units, and rehabilitation agencies. She possesses proven expertise in achieving and maintaining compliance with regulatory agencies.

Key Responsibilities

- ***Credentialing management***: Karen directs credentialing and re-credentialing of providers in accordance with requirements (NCQA, CMS, etc.)
- ***Auditing***: Karen performs delegated credentialing audits as needed, and ensures all applications and site reviews are tracked
- ***Leadership***: Karen manages teams of provider data analysts and credentialing specialists. These teams are organized in a manor to ensure efficient workflow and complete understanding of market requirements.
- ***Reporting***: Karen ensures reports are prepared accurately and on a timely basis for internal and external use.

Academic Background and Professional Certifications

- Bachelor of Science Physical Therapy from Marquette University, Milwaukee, Wisconsin
- Certified by the National Association of Medical Staff Services and is a Certified Provider Credentialing Specialist

JEAN RAMSEY, MD, MPH, FAAO

Ophthalmology Consultant

Summary of Experience

Dr. Ramsey serves as an in-house expert for all aspects of ophthalmological claims authorization or denial, based on medical necessity and eligibility, in accordance to contract language. Jean has been a consultant with DentaQuest since 2010.

Dr. Ramsey currently holds a position as an associate professor of ophthalmology and pediatrics at Boston University School of Medicine. She is highly regarded in the field of ophthalmology and has held numerous instructor and professorship positions since 1994.

Dr. Ramsey is also active in several professional societies, including Alpha Omega Alpha, American Academy of Ophthalmology, American Academy of Pediatrics, American Association of Pediatric Ophthalmology and Strabismus, American Public Health Association, Massachusetts Medical Society, Massachusetts Society of Eye Physicians and Surgeons, The Association for Research in Vision and Ophthalmology and Women in Ophthalmology.

Key Responsibilities

- ***Medical prior approvals:*** Authorizes or denies ophthalmological cases by interpreting benefits as outlined in market contracts
- ***Committee representation:*** Serves on professional committees, including the Quality Assurance, Credentialing and Peer Review committees, to review, approve, restrict, or deny potential providers for the panel
- ***Network liaison:*** Conducts provider site visits and record reviews when necessary

Academic Background and Professional Certifications

- MHP, Maternal and Child Health, Boston University School of Public Health
- Fellowship, Pediatric Ophthalmology, New England Medical Center, Boston, MA
- Chief Residency, Pediatric Ophthalmology, New England Medical Center, Boston, MA
- Residency, Ophthalmology, New England Medical Center, Boston, MA
- Internship, Internal Medicine, Salem Hospital, Salem, MA
- MD, Medicine, Boston University School of Medicine
- Pre-Med, Salem State College
- Pre-Med, Boston University, Metropolitan College
- BA, Psychology, Emmanuel College

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A. Client name B. Name, title, telephone and email address		C. Contract size, average monthly lives and annual revenues		D. Capitated or non-capitated payments	E. Contract start date and duration	F. Worked performed by DentaQuest as prime contractor or subcontractor	G. Description of scope of work and covered population	
AZ	**Maricopa Managed Care Systems Medicaid** Ms. Mary Consie Network Development Manager 2701 E. Elvira Road Tucson, AZ 85756; 2502 E. University Drive Phoenix, AZ 85034 mconsie@uph.org 602-344-8389	57,447	Proprietary information	Non-capitated (ASO)	4/1/04 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid & Medicare
CA	**BC Life (County Medical Services Program)** Mr. Murphy Duckett Development Network Management 5153-B Camino Ruiz, CACN02-02, Camarillo, CA 93012 Murphy.Duckett@wellpoint.com 805-384-3929	46,054	Proprietary information	Non-capitated (ASO)	10/1/2005 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
DC	**Chartered Health Plan** Mr. James Christian Vice President for Network Services 1025 15th St. NW Washington DC 20005 christian@chartered-health.com (202) 216-2304	110,476	Proprietary information	Non-capitated (ASO)	7/1/10 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Member Services	Medicaid and Alliance
DC	**United HealthCare Community Plan** Ms. Marcia Jones Chief Operating Officer 1225 I Street, NW, Ste 510 Washington DC 20005 Marcia.jones@uhc.com (202) 218 - 7880	57,284	Proprietary information	Non-capitated (ASO)	5/1/2008 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid and Alliance
DC	**Department of Health (Healthy Smiles)** Ms. Colleen Sonosky Associate Director 825 N. Capitol St., NE, 6th Flr Washington DC 20002 colleen.sonosky@dc.gov (202) 442 - 5913	46,292	Proprietary information	Non-capitated (ASO)	10/16/2008 through present	DentaQuest is the Prime Contractor.	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid

A. Client name B. Name, title, telephone and email address		C. Contract size, average monthly lives and annual revenues		D. Capitated or non-capitated payments	E. Contract start date and duration	F. Worked performed by DentaQuest as prime contractor or subcontractor	G. Description of scope of work and covered population	
FL	**Children's Medicaid/AHCA** Ms. Margaret Cavendish Medical Healthcare Program Analyst Agency for Healthcare Administration, 2727 Mahan Drive, Mail Stop #50, Tallahassee, FL 32308 cavendim@ahca.myflorida.com 850-488-9287	185,317	Proprietary information	Capitated	7/1/2004 through Present	DentaQuest is the Prime Contractor.	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicaid
FL	**CarePlus Health Plan** Ms. Ana Bazo Account Executive, Ancillary Networks 11430 NW 20th Street, Suite 300, Doral, FL 33172 Ana.Bazo@careplus-hp.com 305-441-9400	14,423	Proprietary information	Capitated	01/01/2003 through present	DentaQuest is the Prime Contractor.	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicaid
FL	**CarePlus Health Plan** Ms. Ana Bazo Account Executive, Ancillary Networks 11430 NW 20th Street, Suite 300, Doral, FL 33172 Ana.Bazo@careplus-hp.com 305-441-9400	39,070	Proprietary information	Capitated	01/01/2003 through present	DentaQuest is the Prime Contractor.	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicare
FL	**Better Health** Ms. Vicky Camero Chief Compliance Officer 12905 SW 42nd Street, Suite 211, Miami, FL 33175 vcamero@simplyhealthcareplans.com 305-408-5700	31,120	Proprietary information	Capitated	4/1/10 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicaid
FL	**Florida Healthy Kids** Ms. Jennifer Kiser-Lloyd Director of External Affairs 661 East Jefferson Street, Floor 2, Tallahassee, FL 32301 lloydj@healthykids.org 850-701-6108	122,811	Proprietary information	Capitated	2001 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	SCHIP

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FL	**Humana** Ms. Stephanie Steele Lrg Practice/Ancillary Executive 3501 SW 160th Avenue, Miramar, FL 33027 ssteele@humana.com 305-626-5693	5,797	Proprietary information	Capitated	9/1/2006 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicaid
FL	**JMH-Medicare** Ms. Jan Crespo Director, Network Services 155 South Miami Avenue, Suite 110, Miami, FL 33130 jan.crespo@jhsmiami.org 786-466-8238	2,448	Proprietary information	Capitated	01/01/2010 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare
FL	**JMH-Medicaid** Ms. Jan Crespo Director, Network Services 155 South Miami Avenue, Suite 110 Miami, FL 33130 jan.crespo@jhsmiami.org 786-466-8238	15,497	Proprietary information	Capitated	4/1/2009 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
FL	**JMH-SFCCN** Ms. Jan Crespo Director, Network Services 155 South Miami Avenue, Suite 110 Miami, FL 33130 jan.crespo@jhsmiami.org 786-466-8238	3,237	Proprietary information	Non-capitated (ASO)	4/1/09 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
FL	**JMH-Health and Wellness** Ms. Margarita Rams-Gonzalez Disease State Manager 155 South Miami Avenue, Suite 110 Miami, FL 33130 mrams-gonzalez@jhsmiami.org 305-575-3794	20,417	Proprietary information	Capitated	1/1/06 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Customer Service, Information Services, Network Development, Provider Services, Reporting	Discount Plan

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FL	**Molina** Dr. Jose E. Perez Chief Medical Officer 8300 N.W. 33rd Street, Suite 400 Miami, FL 33122 Jose.Perez@molinahealthcare.com 305 908-3512	66,221	Proprietary information	Non-capitated (ASO)	11/01/08 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicaid
FL	**WellCare** Mr. Jay Howell New Market Development Specialist 8735 Henderson Road, Ren 4, Floor 2 Tampa, FL 33634 Jay.Howell@wellcare.com 813-206-6036	17,134	Proprietary information	Non-capitated (ASO)	9/1/2005 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicare
FL	**Medica** Ms. Maria Eugenia Duran Director of Network Development 4000 Ponce De Leon Boulevard, Suite 650 Coral Gables, FL 33146 Meduran@medicaplans.com 305-460-0624	5,948	Proprietary information	Capitated	12/12/09 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicaid
FL	**Medica** Ms. Maria Eugenia Duran Director of Network Development 4000 Ponce De Leon Boulevard, Suite 650 Coral Gables, FL 33146 Meduran@medicaplans.com 305-460-0624	33,545	Proprietary information	Capitated	12/12/09 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicare
FL	**ILS** Ms. Laure Hope Regional Director of Operations 5201 Blue Lagoon Drive, Suite 270 Miami, FL 33126 lhope@ilshealth.com 727-937-4845	1,403	Proprietary information	Capitated	10/1/2006 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicaid

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FL	**Simply Healthcare** Ms. Vicky Camero Chief Compliance Officer PO Box 830010 Miami, FL 33283 vcamero@simplyhealthcareplans.com 305-408-5700	4,519	Proprietary information	Non-capitated (ASO)	6/1/10 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Services, Reporting, Quality Improvement, Utilization Management	Medicaid
GA	**Centene/Peach State** Mr. Patrick Healy Chief Executive Officer 3200 Highlands Parkway SE Smyrna, GA 30082 phealy@centene.com 678-556-2330	302,838	Proprietary information	Capitated	6/1/2009 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid, CHIP
GA	**WellCare** Mr. Mike Minor Chief Operating Officer 211 Perimeter Center Parkway, Suite 800 Atlanta, GA 30346 michael.minor@wellcare.com 678-327-0976	561,341	Proprietary information	Non-capitated (ASO)	6/1/2006 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid, CHIP
GA	**WellCare** Mr. Mike Minor Chief Operating Officer 211 Perimeter Center Parkway, Suite 800 Atlanta, GA 30346 michael.minor@wellcare.com 678-327-0976	8,522	Proprietary information	Capitated	6/1/2006 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare
ID	**Blue Cross of Idaho - Idaho Smiles** Ms. Jeanie Phillips 3000 East Pine Ave. Meridian, ID 83642 jphillips@bcidaho.com 208-387-6837	210,684	Proprietary information	Capitated	9/1/07 to present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	Medicaid

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ID	**BCI-SNP ID-Medicare** Ms. Jeanie Phillips 3000 East Pine Ave. Meridian, ID 83642 jphillips@bcidaho.com 208-387-6837	641	Proprietary information	Capitated	5/1/2011 to present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	Medicare
IL	**State of Illinois Department of Healthcare and Family Services** Ms. Deborah Saunders 607 East Adams 4th Floor Springfield, IL 62701 deborah.saunders@illinois.gov 217-557-5438	2,689,709	Proprietary information	Non-capitated (ASO)	3/1/1999 to present	DentaQuest is the Prime Contractor.	Claims Processing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	Medicaid, SCHIP
IL	**Aetna-IL** Mr. Steve Pace 1 So Wacker Drive, 12th Floor Chicago, IL 60606 PaceS2@AETNA.com 801-766-0870	558	Proprietary information	Capitated	5/1/2011 to present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	
IL	**IlliniCare** Ms. Melissa Dannenberg 999 Oakmont Plaza Drive Westmont, IL 60559 mdannenberg@centene.com 312-576-9983	125	Proprietary information	Capitated	5/1/2011 to present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	
IL	**WellCare-Harmony Health Plan** Mr. Jay Howell 8735 Henderson Road Ren 4, Floor 2 Tampa, FL 33634 Jay.Howell@wellcare.com 813-206-6036	31,568	Proprietary information	Capitated	1/1/2011 to present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid

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IL	**WellCare-IL** Mr. Jay Howell 8735 Henderson Road Ren 4, Floor 2 Tampa, FL 33634 Jay.Howell@wellcare.com 813-206-6036	9,908	Proprietary information	Capitated	1/1/2011 to present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare
MA	**Centene/CeltiCare** Ms. Susan Kohler Vice President, Compliance & Regulatory Affairs 1380 Soldiers Field Road, Ste 300 Brighton, MA 02135 SKOHLER@CENTENE.COM 617-779-5103	2,662	Proprietary information	Non-capitated (ASO)	7/1/2009 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
MA	**Senior Whole Health** Mr. Michael Snyder Directory, Contracts and Vendor Management 58 Charles Street, Suite 2 Cambridge, MA 02141 msnyder@seniorwholehealth.com 860-214-3922	7,223	Proprietary information	Non-capitated (ASO)	1/1/2007 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare
MA	**Neighborhood Health Plan** Mr. Stephen Cairns Director of Network Development and Vendor Relations 253 Summer Street Boston, MA 02210 stephen_Cairns@nhp.org 617-772-5710	19,594	Proprietary information	Capitated	10/1/2006 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
MA	**Boston Medical Center** Ms. Rosemary Ajoku Senior Director of Operations Two Copley Place, Suite 600 Boston, MA 02116 Rosemary.Ajoku@bmchp.org 617-748-6280	25,416	Proprietary information	Non-capitated (ASO)	10/1/2006 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid

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MA	**Network Health** Mr. Paul Burke Senior Director, Network Management 101 Station Landing, 4th Floor Medford, MA 02155 paul.burke@network-health.org 781-393-3503	19,955	Proprietary information	Non-capitated (ASO)	9/1/06 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
MA	**State of Massachusetts - MassHealth Dental Program** Priscilla Portis 600 Washington St. Boston, MA 02111 priscilla.portis@state.ma.us 617-348-5573	1,276,935	Proprietary information	Non-capitated (ASO)	2/1/2007 to present	DentaQuest is the Prime Contractor.	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	Medicaid
MD	**Amerigroup** Ms. Kathleen King Manager, National Contracts 4425 Corporation Lane Virginia Beach, VA 23462 kking02@amerigroupcorp.com 757-321-3542	51,169	Proprietary information	Non-capitated (ASO)	8/1/2004 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare
MD	**Coventry** Ms. Iris Rudman Senior Provider Contracting Specialist 6310 Hillside Ct, Ste. 100 Columbia, MD 21046 ihrudman@cvty.com 866-212-5305	5,732	Proprietary information	Non-capitated (ASO)	9/1/2003 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
MD	**Bravo Health** Ms. Angela Kallas Director, Corporate Contracting 3601 O'Donnell Street Baltimore MD 21224 angela.kallas@bravohealth.com 443-573-9183	11,239	Proprietary information	Non-capitated (ASO)	3/15/07 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare

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MD	**Maryland Physicians Care** Ms. Linda Dietsch Director, Compliance 509 Progress Dr. Linthicum, MD 21090 linda.dietsch@aetna.com 410-907-4052	50,721	Proprietary information	Non-capitated (ASO)	6/1/1997 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid Adult and PAC
MD	**Priority Partners** Ms. Gitu Mirchandani Network Manager, Dept of Provider Relations 6704 Curtis Ct. Glen Burnie, MD 21060 gmirchanda@jhhc.com 410-424-4634	62,756	Proprietary information	Non-capitated (ASO)	7/1/2001 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
MD	**United HealthCare** Mr. Pierre Gerald Director, Provider Client Management 6095 Marshalee Dr., Ste. 200 Elkridge, MD 21075 Pierre_gerald@uhc.com 410-379-3477	48,475	Proprietary information	Capitated	7/1/09 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid Adult and PAC
MD	**MD State Medicaid Dental Program - MD Healthy Smiles** Susan Tucke 201 W. Preston St. Baltimore, MD 21201 tuckers@dhmh.state.md.us 410-767-1431	690,636	Proprietary information	Non-capitated (ASO)	7/1/09 to present	DentaQuest is the Prime Contractor.	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	Medicaid, SCHIP
MN	**South Country Health Alliance** Ms. Leota Lind Chief Operating Officer 110 West Fremont Street Owatonna, MN 55060 Llind@mnscha.org 507-444-7772	24,524	Proprietary information	Non-capitated (ASO)	10/1/05 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid

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MN	**Ucare** Ms. Laurie Dean Senior Vice President for Operations PO Box 52 Minneapolis, MN 55440-0052 ldean@ucare.org (612) 676-3370	127,594	Proprietary information	Non-capitated (ASO)	1/1/2001 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
MN	**Ucare** Ms. Laurie Dean Senior Vice President for Operations PO Box 52 Minneapolis, MN 55440-0052 ldean@ucare.org (612) 676-3370 Senior Vice President for Operations	52,486	Proprietary information	Non-capitated (ASO)	1/1/08 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare Advantage
MO	**Blue Cross Blue Shield of Kansas City** Ms. Judy Brennan Director of State Programs One Pershing Square; 2301 Main Street Kansas City MO 64108 judy.brennan@bluekc.com 816-395-2421	30,633	Proprietary information	Capitated	3/1/1996 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
MO	**HealthCare USA** Mr. Gene Poisson Vice President of Network Management 10 S. Broadway, Ste 1200 St. Louis MO 63102 gjpoisson@cvty.com 314-444-7914	186,195	Proprietary information	Non-capitated (ASO)	9/1/1997 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Provider Services, Information Services, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
MO	**MissouriCare** Mr. Anthony Gutierrez Chief Operations Officer 2404 Forum Blvd Columbia, MO 65203 GutierrezA1@aetna.com 573-441-2134	45,707	Proprietary information	Non-capitated (ASO)	9/1/2008 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid

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MO	**Molina** Ms. Christine Cybulski Manager, Delegation Oversight 12400 Olive Blvd, Ste 100 St. Louis MO 63141 christine.cybulski@molinahealthcare.com 314-819-5162	79,955	Proprietary information	Capitated	4/1/2010 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
MO	**WellCare-Harmony Health Plan** Jay Howell 8735 Henderson Road Ren 4, Floor 2 Tampa, FL 33634 Jay.Howell@wellcare.com 813-206-6036	13,645	Proprietary information	Capitated	1/1/2011 to present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
NJ	**Healthfirst, Inc** Ms. Susan Kwon Director of Ancillary Programs 25 Broadway New York, NY 10004 SKwon@Healthfirst.org 212-801-1505	21,691	Proprietary information	Non-capitated (ASO)	1/1/08 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
NJ	**Healthfirst, Inc** Ms. Susan Kwon Director of Ancillary Programs 25 Broadway New York, NY 10004 SKwon@Healthfirst.org 212-801-1505	5,141	Proprietary information	Non-capitated (ASO)	1/1/08 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare
NM	**Amerigroup** Ms. Laura Hopkins Chief Operating Officer 6565 America's Parkway Suite 110 Albuquerque, NM 87110 lhopkins@amerigroup.com 505-875-4375	21,760	Proprietary information	Non-capitated (ASO)	2/1/2009 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid/ Medicare

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NM	**BlueSalud** Ms. Karen Smoot Senior Director Network Development 5701 Balloon Fiesta Parkway Albuquerque, NM 87125 karen_smoot@bcbsnm.com 505-816-2163	23,365	Proprietary information	Non-capitated (ASO)	10/1/08 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
NM	**Lovelace** Mr. Steve DeSaulniers Medicaid Program Manager 4101 Indian School RD NE Albuquerque, NM 87111 Steve.desaulniers@lovelace.com 505-816-6626	79,471	Proprietary information	Non-capitated (ASO)	7/1/1997 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
NM	**Molina** Mr. Lynn Allen Chief Operating Officer 8801 Horizon Blvd NE Albuquerque, NM 87113 lynn.allen@molinahealthcare.com 505-348-0270	234,514	Proprietary information	Non-capitated (ASO)	2/1/1997 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
NM	**Presbyterian** Ms. Cathy Candelaria Sub Contract Administrator 2501 Buena Vista SE Albuquerque, NM 87106 Ccadeal@phs.org 505-923-5970	156,826	Proprietary information	Non-capitated (ASO)	7/1/1997 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
NY	**Empire** Ms. Kim Fragale Network Manager 11 Corporate Woods Blvd Albany, NY 12211 Sean.Grady@empireblue.com 512-318-8829	63,132	Proprietary information	Capitated	8/1/99 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	CHIP

A. Client name B. Name, title, telephone and email address		C. Contract size, average monthly lives and annual revenues		D. Capitated or non-capitated payments	E. Contract start date and duration	F. Worked performed by DentaQuest as prime contractor or subcontractor	G. Description of scope of work and covered population	
NY	**Fidelis** Mr. Matt Heuston Vendor Oversight Specialist 8 Southwoods Blvd Albany, NY 12211 mheuston@fideliscare.org 518-445-3928	578,072	Proprietary information	Non-capitated (ASO)	1/1/2001 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid, Medicare, CHP and FHP
NY	**Healthfirst, Inc.** Ms. Susan Kwon Director of Ancillary Programs 25 Broadway New York, NY 10004 SKwon@Healthfirst.org 212-801-1505	473,766	Proprietary information	Non-capitated (ASO)	3/1/2004 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare
NY	**Managed Heatlh, Inc.** Ms. Susan Kwon Director of Ancillary Programs 25 Broadway New York, NY 10004 SKwon@Healthfirst.org 212-801-1505	92,596	Proprietary information	Non-capitated (ASO)	5/1/04 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
NY	**MetroPlus Health Plan** Mr. Joseph Dicks Contracting Manager 160 Water Street New York, NY 10038 DICKSJ@nychhc.org 212-908-8893	53,022	Proprietary information	Non-capitated (ASO)	4/1/2004 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	CHIP
NY	**MetroPlus Health Plan** Mr. Joseph Dicks Contracting Manager 160 Water Street New York, NY 10038 DICKSJ@nychhc.org 212-908-8893	4,740	Proprietary information	Non-capitated (ASO)	4/1/2004 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare

A. Client name B. Name, title, telephone and email address		C. Contract size, average monthly lives and annual revenues		D. Capitated or non-capitated payments	E. Contract start date and duration	F. Worked performed by DentaQuest as prime contractor or subcontractor	G. Description of scope of work and covered population	
NY	**Neighborhood Health Plan** Mr. Steve Bory Chief Executive Officer 521 5th Avenue New York, NY 10175 sbory@royalhc.com 212-808-4775 x109	204,543	Proprietary information	Capitated	3/1/10 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid, CHP, and FHP
NY	**Senior Whole Health** Mr. Michael Snyder Directory, Contracts and Vendor Management 58 Charles Street, Suite 2 Cambridge, MA 02141 msnyder@seniorwholehealth.com 860-214-3922	781	Proprietary information	Non-capitated (ASO)	1/1/08 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare Advantage
OH	**Buckeye Community Health Plan** Mr. Jay Avner Manager, Contracting 4665 Cornell Road, Suite 300 Cincinnati, OH 45241 javner@centene.com 866-246-4356 x24555	158,348	Proprietary information	Non-capitated (ASO)	1/1/2004 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
OH	**Molina** Ms. Jill Schnees Delegation Manager 8101 N. High St. Columbus, OH 43235 Jill.Schnees@molinahealthcare.com 800-357-0146 x 214317	233,875	Proprietary information	Non-capitated (ASO)	10/1/2005 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
OH	**United HealthCare Community Plan** Mr. Jeff Corzine Executive Director 9200 Worthington Rd, 3rd Floor Westerville, OH 43082 jeffrey.corzine@uhc.com 614-410-7952	110,633	Proprietary information	Non-capitated (ASO)	10/1/2005 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid

A. Client name B. Name, title, telephone and email address		C. Contract size, average monthly lives and annual revenues		D. Capitated or non-capitated payments	E. Contract start date and duration	F. Worked performed by DentaQuest as prime contractor or subcontractor	G. Description of scope of work and covered population	
OH	**Wellcare** Ms. Karen Desotell Manager, Network Management 6060 Rockside Woods Blvd # 3000 Independence, OH 44131 karen.desotell@wellcare.com 216-901-4154	101,310	Proprietary information	Non-capitated (ASO)	12/1/2006 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
PA	**Bravo Health** Ms. Angela Kallas Director, Corporate Contracting 3601 O'Donnell Street Baltimore MD 21224 angela.kallas@bravohealth.com 443-573-9183	50,749	Proprietary information	Capitated	3/15/07 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare
PA	**Health Partners** Mr. Malik Haynes Manager of Specialty Programs 901 Market Street Ste 500 Philadelphia, PA 19107 mhaynes@healthpart.com 215-991-4246	168,015	Proprietary information	Non-capitated (ASO)	8/30/1996 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
PA	**Health Partners (KidzPartners)** Mr. Malik Haynes Manager of Specialty Programs 901 Market Street Ste 500 Philadelphia, PA 19107 mhaynes@healthpart.com 215-991-4246	2,389	Proprietary information	Non-capitated (ASO)	8/30/1996 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	CHIP
PA	**Amerihealth** Mr. Vincent Gordon Associate Vice President, Contracting 200 Stevens Drive Philadelphia, PA 19113 vgo@kmhp.com 215-863-5615	107,688	Proprietary information	Non-capitated (ASO)	2/1/2001 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid

A. Client name B. Name, title, telephone and email address		C. Contract size, average monthly lives and annual revenues		D. Capitated or non-capitated payments	E. Contract start date and duration	F. Worked performed by DentaQuest as prime contractor or subcontractor	G. Description of scope of work and covered population	
PA	**Keystone** Mr. Vincent Gordon Associate Vice President, Contracting 200 Stevens Drive Philadelphia, PA 19113 vgo@kmhp.com 215-863-5615	311,856	Proprietary information	Non-capitated (ASO)	2/1/2001 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
PA	**Aetna Better Health** Mr. Michael McGarrigle Chief Operating Officer 2000 Market Street Ste 850 Philadelphia, PA 19103 McgarrigleM@AETNA.com 215-282-3504	50,380	Proprietary information	Capitated	4/1/10 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
PA	**Aetna Better Health** Mr. Michael McGarrigle Chief Operating Officer 2000 Market Street Ste 850 Philadelphia, PA 19103 McgarrigleM@AETNA.com 215-282-3504	28,634	Proprietary information	Capitated	4/1/10 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare
PA	**CoventryCares** Ms. Karen Hinson Contract Analyst 3721 TecPort Drive PO Box 67103 Harrisburg PA 17106 khinson@cvty.com 717-526-2721	16,384	Proprietary information	Capitated	4/1/10 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
PA	**Geisinger** Mr. Jason T. Renne Director, Provider Network Development 100 North Academy Avenue Danville, PA 17822 jtrenne@thehealthplan.com 570-271-5555	6,554	Proprietary information	Capitated		DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	CHIP

A. Client name B. Name, title, telephone and email address		C. Contract size, average monthly lives and annual revenues		D. Capitated or non-capitated payments	E. Contract start date and duration	F. Worked performed by DentaQuest as prime contractor or subcontractor	G. Description of scope of work and covered population	
SC	**WellPoint/Blue Choice** Mr. Scott Graves Senior Director 4101 Percival Road Columbia, SC, 29229 scott.graves@bluechoicesc.com 803-382-5114	6,000	Proprietary information	Non-capitated (ASO)	07/1/10 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
SC	**State of SC Healthy Connections Dental Program** Ms. Beverly Hamilton 1801 Main Street Columbia, SC 29202 hamiltbv@scdhhs.gov 803-898-4502	700,000	Proprietary information	Non-capitated (ASO)	8/1/10 to present	DentaQuest is the Prime Contractor.	Claims Processing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	Medicaid
TN	**CoverKids Dental Program** Ms. Stephanie Dickerson 2600 WRS TN Tower 312 Rosa L. Parks Ave. Nashville, TN 37243 stephanie.k.dickerson@state.tn.us 615-253-8572	45,264	Proprietary information	Capitated	2/1/08 to present	DentaQuest is the Prime Contractor.	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	SCHIP
UT	**Utah Department of Health** Ms. Heidi Petersen 288 North 1460 West P.O. Box 144102 Salt Lake City, UT 84114 heidipeterson@utah.gov 801-538-6806	11,000	Proprietary information	Capitated	7/1/2010 to present	DentaQuest is the Prime Contractor.	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	SCHIP
VA	**State of Virginia - Department of Medical Assistance Services- Smiles for Children** Mr. Daniel Plain 600 East Broad St., Suite 1300, 11th Floor Richmond, VA 23219 daniel.plain@dmas.virginia.gov 804-786-1567	887,613	Proprietary information	Non-capitated (ASO)	7/1/2005 to present	DentaQuest is the Prime Contractor.	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management, Utilization Review	Medicaid & SCHIP

A. Client name B. Name, title, telephone and email address		C. Contract size, average monthly lives and annual revenues		D. Capitated or non-capitated payments	E. Contract start date and duration	F. Worked performed by DentaQuest as prime contractor or subcontractor	G. Description of scope of work and covered population	
WI	**Molina Healthcare of Wisconsin** Mr. Stephen Harris President 2400 S 102nd St, West Allis, WI 53227 stephen.harris@molinahealthcare.com 414-847-1765	36,623	Proprietary information	Capitated	8/1/10 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
WI	**Managed Health Services (Centene)** Mr. Paul Sabin Vice President, Network Management & Development 10700 W. Research Dr., Suite 300 Milwaukee, WI 53226 psabin@centene.com 414-773-4153	3,972	Proprietary information	Capitated	8/1/10 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicaid
WI	**Ucare** Ms. Laurie Dean Senior Vice President for Operations PO Box 52 Minneapolis, MN 55440-0052 ldean@ucare.org 612-676-3370	2,206	Proprietary information	Non-capitated (ASO)	1/1/08 through present	DentaQuest is Subcontractor. Contract is with Managed Care Company	Claims Processing, Credentialing, Customer Service, Information Services, Member Outreach, Network Development, Provider Relations, Reporting, Quality Improvement, Utilization Management	Medicare Advantage

eyeQuest References

Please see Attachment B.11.j in our **ORIGINAL** proposal for sealed envelopes containing completed reference questionnaires for eyeQuest.

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Health Management Systems, Inc. Financial Reports

Health Management Systems, Inc. 's financial results are reported together with those of its parent company, HMS Holdings Corp, included as Attachment B.11.l.

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HMS • Holdings • Corp.

2010 Annual Report

HMS • Holdings • Corp.

Dear Shareholders,

By any measure, 2010 was the best year in the Company's history. Revenue was up 32.1% over 2009, and GAAP EPS increased 29.4% over the full year to $1.41. This success demonstrates our ability to both introduce innovative new products and services and enter new markets. Meanwhile, our underlying core business continues to grow. We are also pleased that our diversification strategy has increased our ability to sustain significant growth in revenue and EPS and to build an even stronger foundation for our future.

Another critical measure of our success is the financial impact we've had on our clients. I'm happy to report that in 2010 we recovered $1.8 billion dollars for our clients in cash collections back to their programs. In addition, we saved our clients a record $4.0 billion dollars through the prevention of erroneous payments. Clearly, we have a growing impact on our nation's healthcare system.

The Affordable Care Act is now law and we observe that many states are preparing to comply with the new regulations. We see continued growth of the Medicaid program, even in advance of 2014, the year in which Medicaid eligibility rules change and the number of citizens covered by this program grows to an anticipated 85 million. And the identification, prevention and recovery of fraud, waste and abuse—looking at how payments are made as a way to curb rising costs—remains a significant point of focus for the federal government, states, managed care organizations, and employers.

2010 included key strategic accomplishments, which we believe will fuel our growth in the years ahead:

- In June we acquired Allied Management Group (AMG), a leading provider of fraud, waste, and abuse prevention and detection solutions for healthcare payors. AMG provides audit and consulting services to both government and commercial healthcare payors, and offers a proprietary forensic claim editing system to analyze claim data for patterns of fraud, waste, and abuse. We are already seeing an adoption of these services by both state and managed care organizations.
- We also acquired Chapman Kelly in September, which provides dependent eligibility and benefit plan audits to large, self-insured employers, as well as claims audits to employers and managed care organizations. Our acquisition of Chapman Kelly allows us to provide many of our existing Program Integrity services to large employers, and also augments our claim audit offering for our Managed Care clients.
- Program integrity revenue nearly doubled in 2010. On the State Government side, we won key competitive procurements in the Recovery Audit Contractor (RAC) market, and continue to do so. In addition, a number of states have received permission from the Centers for Medicare & Medicaid Services to use our existing contracts to meet their RAC requirement.
- In the Managed Care market (MCO), we ended the year with 19.5 million lives, or 73.5% of the Medicaid managed care market. This market continues to benefit from the enrollment growth in Medicaid and the desire by states to shift more lives into Managed Care. Most states see the managed care model as more cost effective than fee for service and therefore we expect to continue to benefit from our MCO clients' organic growth.
- Lastly, our Federal market subsidiary, IntegriGuard, was awarded subcontracts to perform fraud, waste and abuse audits for Medicare Zone Program Integrity Contractors—ZPICS—in Zones 1 and 2. Along with Zone 7, our work now covers nearly 15 million Medicare beneficiaries and $94.0 billion in annual expenditures.

In summary, HMS continues to see opportunities across all our products and markets well in advance of the dramatic rise in Medicaid enrollment. We continue to make investments in infrastructure, product development, and human capital to ensure that we continue to execute successfully on our multi-year plan. We're proud of the work we've done and look forward to building on our strong performance in 2011 and beyond.

We are grateful to our customers, our shareholders, and our associates for their dedication, support, and ongoing commitment to make the healthcare system work better for everyone.

William C. Lucia
Chief Executive Officer
May 20, 2011

UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2010

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission File Number 000-50194

HMS HOLDINGS CORP.

(Exact name of registrant as specified in its charter)

New York	**11-3656261**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
401 Park Avenue South, New York, NY	**10016**
(Address of principal executive offices)	*(Zip Code)*

(212) 725-7965

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock $0.01 par value	NASDAQ Global Select Market

Securities registered pursuant to section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act) Yes ☐ No ☑

The aggregate market value of the registrant's common stock held by non-affiliates as of June 30, 2010, the last business day of the registrant's most recently completed second quarter was $1.4 billion based on the last reported sale price of the registrant's Common Stock on the NASDAQ Global Select Market on that date.

There were 27,875,869 shares of common stock outstanding as of February 18, 2011.

Documents Incorporated by Reference

None.

HMS HOLDINGS CORP. AND SUBSIDIARIES

ANNUAL REPORT ON FORM 10-K

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Special Note Regarding Forward-Looking Statements

This Annual Report on Form 10-K contains "forward-looking statements" within the meaning of the U.S. Private Securities Litigation Reform Act of 1995. From time to time, we also provide forward-looking statements in other materials we release to the public, as well as oral forward-looking statements. Such statements give our expectations or forecasts of future events; they do not relate strictly to historical or current facts.

We have tried, wherever possible, to identify such statements by using words such as "anticipate," "estimate," "expect," "project," "intend," "plan," "believe," "will," "target," "seek," "forecast" and similar expressions. In particular, these include statements relating to future actions, business plans, objects and prospects, future operating or financial performance or results of current and anticipated services, acquisitions and the performance of companies we have acquired, sales efforts, expenses, interest rates and the outcome of contingencies, such as financial results.

We cannot guarantee that any forward-looking statement will be realized. Forward-looking statements are based on our current expectations and assumptions regarding our business, the economy and other future conditions. Should known or unknown risks or uncertainties materialize, or should underlying assumptions prove inaccurate, actual results could differ materially from past results and those anticipated, estimated or projected. We caution you, therefore, against relying on any of these forward-looking statements. They are neither statements of historical fact nor guarantees or assurances of future performance.

Factors that could cause or contribute to such differences include, but are not limited to, those discussed in this Annual Report on Form 10-K and in particular, the risks discussed under the heading "Risk Factors" in Part I, Item 1A of this Annual Report on Form 10-K and those discussed in other documents we file with the Securities and Exchange Commission.

Any forward-looking statements made by us in this Annual Report on Form 10-K speak only as of the date on which they are made. Factors or events that could cause actual results to differ may emerge from time to time and it is not possible for us to predict all of them. We undertake no obligation to publicly update forward-looking statements, whether as a result of new information, future events or otherwise, except as may be required by law. You are advised, however, to consult any further disclosures we make on related subjects in our 10-Q and 8-K reports to the Securities and Exchange Commission.

PART I

Item 1. Business.

Unless the context otherwise indicates, references in this Annual Report to the terms "HMS," "we," "our" and "us" refer to HMS Holdings Corp. and its subsidiaries.

General Overview

We provide a variety of cost containment services, including coordination of benefits and program integrity services, for government and private healthcare payors and sponsors. These services are designed to help our clients recover amounts due from liable third parties, save dollars, reduce fraud, waste and abuse and ensure regulatory compliance.

Our clients are state Medicaid agencies, Medicaid and Medicare managed care plans, government and private self-funded employers, Pharmacy Benefit Managers, or PBMs, child support agencies, the Veterans Health Administration, or VHA, the Centers for Medicare & Medicaid Services, or CMS, commercial plans, other healthcare payors and large business outsourcing and technology firms. We help these entities contain healthcare costs by ensuring that claims are paid correctly, through our program integrity services and by ensuring that claims are paid by the responsible party, through our coordination of benefits services.

In September 2010, we acquired privately-held Chapman Kelly, Inc. or Chapman Kelly. Based in Jeffersonville, Indiana, Chapman Kelly provides dependent eligibility audits to large, self-insured employers, as well as plan and claims audits to employers and managed care organizations. With our acquisition of Chapman Kelly we have

developed a robust Employer Solutions product area that provides dependent eligibility audit services to employers of all sizes and also augments our claim audit offering for healthcare plans.

In June 2010, we acquired privately-held Allied Management Group — Special Investigation Unit, or AMG-SIU, a leading provider of fraud, waste and abuse prevention and detection solutions for healthcare payors. Based in Santa Ana, California, AMG-SIU provides audit and consulting services to both government and commercial healthcare payors and offers a proprietary forensic claim editing system to analyze claim data for patterns of fraud, waste and abuse. AMG-SIU employs an in-house special investigation unit to conduct preliminary research, investigations, medical record reviews and pharmacy reviews.

Our 2010 revenue increased to $302.9 million, $73.6 million, or 32%, over 2009 revenue, primarily as a result of the expansion of existing product offerings and acquisitions. In addition, we have leveraged our expertise to acquire new clients at the state, federal and employer levels and expand our current contracts to provide new services to current clients.

The Healthcare Environment

The largest government healthcare programs are Medicare, the healthcare program for aged and disabled citizens that is administered by CMS and Medicaid, the program that provides medical assistance to eligible low income persons, which is also regulated by CMS but administered by state Medicaid agencies. Medicare and Medicaid combined pay about one-third of the nation's healthcare expenditures and serve over 100 million beneficiaries. Many of these beneficiaries are enrolled in managed care plans, which have the responsibility for both patient care and claim adjudication.

By law, the Medicaid program is intended to be the payor of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. Under Title XIX of the Social Security Act, states are required to take all reasonable measures to ascertain the legal liability of "third parties" for healthcare services provided to Medicaid recipients. Since 1985, we have provided state Medicaid agencies with services to identify the other parties with liability for Medicaid claims and since 2005, we have provided these services to Medicaid managed care plans.

The Deficit Reduction Act, or the DRA, signed into law in February 2006, established a Medicaid Integrity Program to increase the government's capacity to prevent, detect and address fraud and abuse in the Medicaid program. The DRA is the largest dedicated investment the federal government has made in ensuring the integrity of the Medicaid program. Additionally, the DRA added new entities, such as self-insured plans, PBMs and other "legally responsible" parties to the list of entities subject to the provisions of the Social Security Act. To date, at least 47 states and the District of Columbia have enacted legislation in order to comply with requirements of the DRA. These measures at both the federal and state level have strengthened our ability to identify and recover erroneous payments made by our clients.

The Patient Protection and Affordable Care Act, as amended or the ACA, was signed into law on March 23, 2010. The legislation touches almost every sector of the healthcare system and we believe provides us with a range of opportunities across products and markets. We are focused on four critical areas related to this legislation:

- Medicaid Expansion
- Health Insurance Exchanges
- Program Integrity, and
- Employer-Sponsored Health Coverage

Medicaid Expansion: States will have to expand their Medicaid programs significantly at a time when most states are facing severe budget shortfalls. According to CMS's projections for national health expenditures for 2009-2019, which were updated in September 2010 and which we refer to as the CMS NHE Projections, the number of individuals enrolled in Medicaid and the Children's Health Insurance Program, or CHIP, is expected to increase from 60.4 million in 2010 to 82.2 million in 2019, with expenditures expected to more than double over the same

period from $427 billion to $896 billion. As a result, we anticipate a considerable increase in the need for our cost containment services.

Health Insurance Exchanges: The ACA calls for new pathways to coverage, including the creation of health insurance exchanges similar to the "Health Connector" program established in Massachusetts. CMS reports that 16 million people will receive health coverage through these newly created exchanges. The complex process of ensuring that all available benefits are coordinated at the time of enrollment is the target of our eligibility solutions. States will also be required to coordinate their exchanges with Medicaid agencies and will be charged with determining the appropriate level of federal subsidy for individuals. We believe that our experience with the Massachusetts Connector program and in administering health insurance premium payment programs for states will enable us to support states in developing premium assistance and coordination of benefits technology and processes across Medicaid and the exchange programs.

Program Integrity: The ACA contains a number of new provisions for combating fraud and abuse throughout the healthcare system, including in Medicaid and Medicare. These initiatives include (i) the expansion of CMS's Recovery Audit Contractor program to include Medicaid, (ii) the establishment of a national healthcare fraud and abuse data collection program and (iii) increased scrutiny of providers and suppliers who want to participate in Medicare, Medicaid and other federally-funded programs. The ACA allows for significant increases in funding for these and other fraud, waste and abuse efforts. We will be building on our current partnerships with CMS, states and health plans to provide innovative ideas for increasing our support of their new program integrity initiatives.

Employer-Sponsored Health Coverage: The ACA largely preserves and builds upon the existing employer-sponsored health coverage model. Though not all employers will be required to provide healthcare coverage, large employers (those with 50 or more employees) will pay a penalty if they fail to do so. Employers will also be prohibited from imposing waiting periods for enrollment of more than 90 days and in certain cases, employers will have to automatically enroll employees into their benefit plans, while providing them with the ability to opt out. These new requirements for employers, coupled with the Medicaid expansion and implementation of state exchanges, will result in more overlapping coverage situations and an opportunity for our employer clients and Medicaid to collaborate. We expect that HMS Employer Solutions will be able to offer claim audit services to employers of all sizes, which will be necessary as these employers extend coverage to their employees.

Principal Products and Services

The demand for our services arises, in part, from the small but significant percentage of government funds spent in error, where another payor was actually responsible for the service, or a mistake was made in applying complex claim processing rules. According to the 2010 Agency Financial Report, the U.S. Department of Health and Human services estimates that improper payments in the Medicaid and Medicare programs totaled $70.4 billion in 2010. Our services focus on containing costs by reducing errors that result in these improper payments.

Our services draw upon proprietary information management and data mining techniques and include coordination of benefits, cost avoidance and program integrity. In 2010, we recovered more than $1.7 billion for our clients and provided data to our clients that assisted them in preventing billions of dollars more in erroneous payments.

We provide the following services:

- *Coordination of benefits* services, which route claims already paid by a government program to the liable third party, which then reimburses the government payor. The Medicaid and Medicare programs, including Medicaid and Medicare managed care organizations and VHA must all coordinate benefits with other payors to ensure that claims are paid by the entitlement program, group health plan or other party that actually bears responsibility for a particular incident of medical service. By properly coordinating benefits, these programs are able to recover dollars spent in error and avoid unnecessary future costs.
- *Cost avoidance* services, which provide validated insurance coverage information that is used by government payors to reject claims that are the responsibility of a third party, typically a group health plan sponsored by a beneficiary's employer. Additionally, child support agencies use this information to identify children who have coverage from either the custodial or non-custodial parent, as well as to identify children

without coverage. With validated insurance information, healthcare payors can avoid unnecessary future costs.

- *Program integrity* services, which are designed to ensure that medical services are utilized, billed and paid appropriately. We identify payment errors and then recover the erroneous payments, if appropriate. Our program integrity services include: data mining; credit balance reviews; clinical reviews; fraud, waste and abuse detection; compliance audits; and recoupment services.

To perform our services, we aggregate medical claims, medical records, health insurance and other beneficiary data from a variety of sources. The data is mined to identify instances of health insurance coverage, or claims that were paid in error for administrative or clinical reasons. We provide our clients with ways to recover funds or avoid future errors, including validating primary insurance coverage, generating electronic claims to liable third parties, documenting liens that attach to personal injury litigation and estates, providing overpayment edits to claims adjudication systems and enrolling children under the insurance of non-custodial and custodial parents, as appropriate.

Clients

The majority of our clients consist of state Medicaid agencies and managed care organizations and large business outsourcing and technology firms. From 2005 through 2010, we increased our penetration into the Medicaid managed care market, as states increased their use of contracted health plans. As of December 31, 2010, we served 41 state Medicaid agencies and 125 Medicaid health plans under 57 contracts.

In 2008, we were awarded a Medicaid Integrity Program, or MIP, Task Order in the CMS Dallas jurisdiction and in 2009, we were awarded a second MIP Task Order in the San Francisco jurisdiction. Under these task orders, we examine payments to providers made under the Social Security Act, with the objective of identifying potential overpayments made as a result of fraud, waste, or abuse. We are now the CMS Audit Medicaid Integrity Contractor, or Audit MIC, for 22 state and territory Medicaid programs.

By the end of 2010, we also provided coordination of benefits and third party insurance identification services to medical centers across all 21 Veterans Integrated Service Networks of VHA and to child support agencies in 14 states.

In most cases, clients pay us contingency fees calculated as a percentage of the amounts recovered, or fixed fees for cost avoidance data. Most of our contracts have terms of three to four years.

Our largest client in 2010 was the New York State Office of the Medicaid Inspector General. This client accounted for 6.7%, 7.8% and 7.9% of our total revenue for the years ended December 31, 2010, 2009 and 2008, respectively. The New York State Office of the Medicaid Inspector General became our client in September 2006, as part of our acquisition of the Benefits Solutions Practice Area, or BSPA, of Public Consulting Group, Inc., or PCG. We provide services to the New York State Office of the Medicaid Inspector General pursuant to a contract awarded in October 2001, which was subsequently re-procured and extended through January 6, 2015. Our second largest client in 2010 was the New Jersey Department of Human Services. This client accounted for 5.3%, 6.2% and 6.6% of our total revenue in the years ended December 31, 2010, 2009 and 2008, respectively. We provide services to this client pursuant to a three year contract awarded in January 2008, which has been renewed through December 2012. The loss of either one of these contracts would have a material adverse effect on our financial position, results of operations and cash flows.

The list of our ten largest clients changes periodically. For the years ended December 31, 2010, 2009 and 2008, our ten largest clients represented 36.4%, 39.5% and 43.5% of our revenue, respectively. Our agreements with these clients expire between 2011 and 2015. In many instances, we provide our services pursuant to agreements that may be renewed subject to a competitive re-procurement process. Several of our contracts, including those with our ten largest clients, may be terminated for convenience. We cannot assure you that our contracts, including those with our ten largest clients, will not be terminated for convenience or that any of these contracts will be renewed, and, if renewed, that the fee rates will be equal to those currently in effect.

Market Trends/Opportunities

Containing healthcare expenditures presents challenges for the government due to the number and variety of programs at the state and federal level, the government appropriations process and the rise in the cost of care and number of beneficiaries. Healthcare reform legislation adds increased pressure to states to cover more individuals even as most states are projecting significant budget deficits, making cost containment a high priority.

Government healthcare programs continue to grow. CMS has projected that Medicaid, CHIP and Medicare expenditures will increase to $1.8 trillion by 2019.

According to CMS's NHE Projections, at the end of 2010, Medicare programs covered approximately 46.8 million people and spent approximately $535 billion. CMS projects that by the end of 2010, Medicaid/CHIP programs covered approximately 60.4 million people and spent approximately $427 billion. Altogether, it is projected that the government programs we serve covered more than 107 million people and have spent nearly $962 billion in 2010. We believe that enrollment in these programs will increase significantly under healthcare reform legislation.

In its financial report for 2010, the U.S. Department of Health and Human Services estimated that improper payments in Medicare and Medicaid will total approximately $70.4 billion for the 2010 fiscal year.

Coordinating benefits among these growing programs and ensuring that claims are paid appropriately, represents both an enormous challenge and opportunity for us.

Competition

We compete primarily with large business outsourcing and technology firms and with small regional firms specializing in one or more of our services, in addition to the states themselves, which may elect to perform coordination of benefits and cost avoidance functions in-house. Against these competitors, we typically succeed on the basis of our leadership position in the marketplace, staff expertise, extensive insurance eligibility database, proprietary systems and processes, existing relationships and effectiveness in cost recoveries and pricing.

Business Strategy

Over the course of 2011, we expect to grow our business through a number of strategic objectives or initiatives that may include:

- *Drive organic growth.* We will seek to tap demand for our services created by the steadily increasing expenditures of government-funded healthcare.
- *Strengthen regulatory framework.* On behalf of our clients, we will take advantage of congressional and state legislation reinforcing the ability of government agencies to implement more rigorous cost-containment programs.
- *Expand scope.* We will actively seek to expand our role with existing clients by extending our reach to new services and claim types and by providing earlier access to claim data.
- *Improve the quality and effectiveness of our services.* We will continue implementing new technology and processes to better engineer the services we provide to our clients, which we expect will enable us to increase cost recovery, cost-containment and client satisfaction.
- *Add new clients.* We will continue to market to additional healthcare payors and sponsors, including mid- to large employers, middle market Medicaid managed care plans, behavioral health programs and commercial plans.
- *Expand program integrity footprint.* We will continue to seek new program integrity business at the state and federal levels and in the employer and commercial markets.
- *Add new services.* Where opportunities exist, we will continue to add services closely related to cost containment through internal development and/or acquisition.

Employees

As of December 31, 2010, we had 1,736 employees, of which 1,656 were full time. Of our total employees, 100 support selling, general and administrative activities.

Executive Officers of HMS Holdings Corp.

Our executive officers are subject to annual appointment by the Board of Directors. Set forth below is information regarding each of our executive officers. Further information about Mr. Lucia is presented under the heading "Our Board of Directors" in Item 10 of Part III of this Annual Report on Form 10-K.

Name	Age	Position
William C. Lucia	53	President, Chief Executive Officer and Director
Walter D. Hosp	53	Senior Vice President, Chief Financial Officer
Sean Curtin	42	Executive Vice President of Operations
Christina Dragonetti	47	Executive Vice President of Corporate Development
Edith Marshall	59	General Counsel and Corporate Secretary
Cynthia Nustad	38	Senior Vice President, Chief Information Officer
Maria Perrin	47	Executive Vice President of Government Markets
John D. Schmid	53	Vice President of Human Resources
Ronald D. Singh	42	Executive Vice President of Commercial Markets

Walter D. Hosp has served as our Senior Vice President and Chief Financial Officer since July 2007. Mr. Hosp has over 20 years of experience in senior financial executive positions for large publicly-traded healthcare companies. From August 2002 to July 2007, Mr. Hosp was Vice President & Treasurer of Medco Health Solutions, Inc. (MHS). Prior to MHS, Mr. Hosp served as Chief Financial Officer of Ciba Specialty Chemicals Corporation and President of their Business Support Center. Mr. Hosp also served as Vice President & Treasurer for CIBA-GEIGY Corporation and Director of Treasury Operations for Avon Products, Inc. Mr. Hosp serves on the Board of Directors of the United Way of Westchester and Putnam.

Sean Curtin has served as our Executive Vice President of Operations since March 2009. From September 2006 to March 2009. Mr. Curtin served as our Senior Vice President of Government Services North. Mr. Curtin is responsible for managing our core products, shared service operations and information technology and systems department. Mr. Curtin joined HMS through our acquisition of BSPA in 2006. From 1997, until August 2006, Mr. Curtin served as a Manager at PCG's recovery unit, where he was responsible for PCG's subrogation product line. During his tenure at PCG, Mr. Curtin managed several large scale state third party contracts, including New York and Ohio and played an integral role in growing PCG's Child Support and Veteran's Administration product lines. Mr. Curtin also led the effort to develop Tracer, BSPA's integrated third party and child support recovery and case management system.

Christina Dragonetti has served as our Executive Vice President of Corporate Development since January 2011. From March 2009 to December 2010, Ms. Dragonetti served as our Executive Vice President of Managed Care Services and was responsible for our managed care and private health insurance arenas. Ms. Dragonetti has more than 20 years of experience within the HMS family of companies, having served in multiple roles in corporate communications and marketing, organizational development and product development. From 2005 to 2009, Ms. Dragonetti served as the Senior Vice President for the Reimbursement Services Group, our wholly owned subsidiary, where she led the delivery of cost reporting and audit support services. From 1997 to 1999 she served as Corporate Director of Strategy, focused on strategic planning and acquisition integration.

Edith Marshall has served as our General Counsel since May 2010. Prior to joining HMS, Ms. Marshall was Counsel at the law firm of Arnold & Porter, LLP, where, as a member of the firm's FDA and Healthcare Practice Group, she counseled and represented clients in a wide range of matters arising under Medicare and Medicaid, the Public Health Service Act, the Veterans Health Care Act, HIPAA, fraud and abuse laws, state and federal statutes and regulations pertaining to healthcare. In her over 30 years of practicing law, Ms. Marshall has held a variety of different positions in both the federal government and the private sector. Her extensive government experience

includes more than two decades of public service as an attorney at the U.S. Department of Health and Human Services (where she focused on Medicare and Medicaid issues), as a litigator at the U.S. Department of Justice and as an Assistant U.S. Attorney for the District of Columbia and supervisor of the Civil Division of the U.S. Attorney's Office.

Cynthia Nustad has served as our Senior Vice President and Chief Information Officer since February 2011. Ms. Nustad has over 15 years of management experience in the healthcare information technology industry. From January 2005 to January 2011, Ms. Nustad served as Vice President — Architecture & Technology for Regence (Blue Cross Blue Shield), where she was responsible for servicing a large corporation across multiple sites and states. From May 2002 to December 2004, Ms. Nustad served as the Vice President — Software Development and Product Management for OAO Healthcare Solutions, Inc. During her tenure at OAO, Ms. Nustad managed, from inception to commercialization, the strategic development of a flagship platform and database-independent managed care benefits and claims processing system designed for, among others, health care plans, self-insured employer groups and government agencies. Prior to OAO Ms. Nustad held leadership roles at e-MedSoft.com and WellPoint Health Networks.

Maria Perrin has served as our Executive Vice President of Government Services since March 2009. From April 2007 to March 2009, Ms. Perrin served as our Senior Vice President of Government Relations. Ms. Perrin has over 15 years of experience as a sales and operational executive for large and mid-tier companies. From October 2004 to April 2007, Ms. Perrin was Senior Vice President of Sales, Marketing and Business Development at Performant Financial Corporation, where she developed Performant's healthcare recovery audit division and led the business development and contract management functions for over 30 federal and state government clients. Ms. Perrin has also held senior strategic planning, finance and operational roles in Fortune 500 companies, including Bestfoods and Nissan Motor Corporation.

John D. Schmid has served as our Vice President of Human Resources since April 2007. Mr. Schmid has over 17 years of experience in the human resources field, having held senior human resource executive positions for public companies in the service and production industries. From December 2002 to April 2007, Mr. Schmid served as global Director of HR Operations for Perot Systems. At Perot, his responsibilities included IT outsourcing, international services and the management of new and existing service center operations to support Perot's healthcare provider back offices. Prior to Perot, Mr. Schmid held field and corporate human resource positions with Office Depot and Fleming Companies. Mr. Schmid served in the US Navy as a Surface Warfare Officer for eight years before moving into the corporate human resources arena.

Ronald D. Singh has served as our Executive Vice President of Commercial Markets since January 2011. From January 2008 to December 2010, Mr. Singh served as our Senior Vice President of Government Services South, responsible for managing large scope government agency contracts across 13 states with annual revenues exceeding $67 million. Mr. Singh has over 20 years of healthcare cost containment and management experience with commercial payors, government payors and large healthcare providers. In 1995 Mr. Singh joined PCG, where he was instrumental in growing the product offering and market share of BSPA. Mr. Singh joined HMS through our acquisition of BSPA in 2006.

Financial Information About Industry Segments

Since the beginning of the first quarter of 2007, we have been managed and operated as one business, with a single management team that reports to the chief executive officer. We do not operate separate lines of business with respect to any of our product lines. Accordingly, we do not prepare discrete financial information with respect to separate product lines or by location and do not have separately reportable segments as defined by the guidance provided by the Financial Accounting Standards Board (FASB).

Available Information

We maintain a website (www.hms.com) that contains various information about us and our services. Through our website, we make available, free of charge, access to all reports filed with the U.S. Securities and Exchange Commission, or the SEC, including our Annual Reports on Form 10-K, our Quarterly Reports on Form 10-Q, our Current Reports on Form 8-K and our Proxy Statements, as well as amendments to these reports or statements, as

filed with or furnished to the SEC pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended, or the Exchange Act, as soon as reasonably practical after we electronically file such material with, or furnish it to, the SEC. In addition, the SEC maintains a website (www.sec.gov) that contains reports, proxy and information statements and other information regarding issuers that file electronically with the SEC. You may also read and copy this information, for a copying fee, at the SEC's Public Reference Room at 100 F Street NE, Room 1580, Washington, D.C. 20549. Please call the SEC at 1-800-SEC-0330 to obtain information on the operation of the Public Reference Room. The content on any website referred to in this Form 10-K is not incorporated by reference into this Form 10-K unless expressly noted.

We also make the following documents available on our website under the "Investor Relations"/"Corporate Governance" tabs: the Audit Committee Charter, the Compensation Committee Charter, the Nominating Committee Charter, the Compliance Committee Charter, our Code of Conduct and our Code of Ethics. You may also obtain a copy of any of the foregoing documents, free of charge, if you submit a written request to our corporate office, Attention: Investor Relations, 401 Park Avenue South, New York, NY 10016.

Corporate Information

We were incorporated on October 2, 2002 in the state of New York. On March 3, 2003, we adopted a holding company structure and assumed the business of our predecessor, Health Management Systems, Inc. In connection with the adoption of this structure, Health Management Systems, which began doing business in 1974, became our wholly owned subsidiary.

Item 1A. Risk Factors.

We provide the following cautionary discussion of risks, uncertainties and possibly inaccurate assumptions relevant to our business that, individually or in the aggregate, may cause our actual results to differ materially from expected and historical results. We note these factors for investors as permitted by the "safe harbor" provisions of the Private Securities Litigation Reform Act of 1995. You should consider these factors, but understand that it is not possible to predict or identify all such factors. Consequently, you should not consider the following to be a complete discussion of all potential risks or uncertainties involved with investing in our stock. These risk factors should be read in connection with other information set forth in this Annual Report, including our Consolidated Financial Statements and the related Notes.

Risks Relating to Our Business

We face significant competition for our services and we expect competition to increase. Our business will be adversely impacted if we fail to properly manage our growth.

Competition for our services is evident in the markets we serve. We expect to encounter additional competition as we address new markets and new competitors enter our existing markets. In addition, our current and prospective clients evaluate our capabilities against the merits of their existing information management and data processing systems and expertise. We compete with other providers of healthcare information management and data processing services, including, Maximus, Inc., Affiliated Computer Services, Inc., Ingenix and Medicare Recovery Audit Contractor vendors, as well as healthcare consulting firms, including PCG and Accenture. To date, PCG has been prohibited from competing with us under the terms of a Non-Compete Agreement which we entered into in connection with the BSPA acquisition in 2006. Upon the expiration of that agreement in September 2011, PCG could re-enter as a competitor to HMS.

In order to remain competitive and expand our business, we must be able to quickly respond to new or emerging technologies, changes in client requirements and changes in the political, economic or regulatory environment in the healthcare industry. Some of our competitors have formed business alliances with other competitors that may affect our ability to work with potential clients. In addition, if some of our competitors merge, a stronger competitor may result. Many of our competitors and potential competitors have significantly greater financial, technical, product development, marketing and other resources and market recognition than we have and accordingly may be in a position to devote greater resources to the development, promotion and sale of their

services than we can. If we fail to design, develop, implement and improve our systems in response to our clients' needs, we may not be able to maintain or expand our client base, hire and retain new employees, pursue new business opportunities, complete future acquisitions or operate our business effectively. In addition, services, solutions and technologies offered by current or future competitors may make our services or solution offerings uncompetitive or obsolete. We cannot assure you that we will be able to compete successfully against existing or any new competitors. If, as a result of increased competition, we are forced to lower our pricing or if demand for our services decreases, our business, financial condition, results of operations and cash flow could be materially adversely affected.

Our business could be adversely affected if we lose a major client, if our clients are not satisfied with our services or if they elect to terminate our contracts before their scheduled expiration date.

We generate a significant portion of our revenue from a limited number of large clients. For the years ended December 31, 2010, 2009 and 2008, our three largest clients accounted for approximately 16%, 19% and 20%, respectively, of our revenue from continuing operations.

Our business model depends in large part on our ability to attract new work from our base of existing clients. It also depends on relationships we develop with our clients so that we can understand our clients' needs and deliver solutions and services that are tailored to meet those needs. If a client is not satisfied with the quality of work performed by us, or with the type of services or solutions delivered, then we could incur additional costs to address the situation, the profitability of that work might be impaired and the client's dissatisfaction with our services could damage our ability to obtain additional work from that client. In particular, since several of our contracts are terminable upon short notice for convenience by either party, clients that are not satisfied might seek to terminate existing contracts prior to their scheduled expiration date and could direct future business to our competitors. Negative publicity related to our client relationships, regardless of its accuracy, may further damage our business by affecting our ability to compete for new contracts with current and prospective clients. We cannot assure you that a material contract will not be terminated for convenience in the future.

In addition, some of our contracts contain liquidated damages provisions and financial penalties related to performance failures. Although we have liability insurance, the policy coverage and limits may not be adequate to provide protection against all potential liabilities. Under the terms of one of our contracts, we have posted an irrevocable standby letter of credit for $4.6 million. If a claim is made against this letter of credit or any similar instrument that we obtain in the future, we would be required to reimburse the issuer of the letter of credit for the amount of the claim.

If we were to lose a major client or incur significant costs or liabilities related to performance failures, our business, financial condition, results of operations and cash flow could be materially adversely affected.

Our operating results are subject to significant fluctuations due to factors including variability in the timing of when we recognize contingency fee revenue. As a result, you will not be able to rely on our operating results in any particular period as an indication of our future performance.

We have experienced significant variations in our revenue between reporting periods due to the timing of periodic revenue recovery projects and the timing and delays in third party payors' claim adjudication and ultimate payment to our clients where our fees are contingent upon such collections. In addition, our revenue and, consequently, our operating results may vary significantly from period to period as a result of factors including the terms and progress of contracts, fluctuations in sales activity given our sales cycle of approximately three to eighteen months, the commencement, completion or termination of contracts during any particular quarter, expenses related to certain contracts which may be incurred in periods prior to revenue being recognized, the schedules of government agencies for awarding contracts, the term of awarded contracts, potential acquisitions, the loss of clients and general economic conditions as they affect healthcare providers and payors. For example, a significant portion of our operating expenses are fixed. Any inability on our part to reduce spending or to compensate for any failure to receive anticipated revenues could magnify the adverse impact of such events on our operating results. We cannot predict the extent to which future revenue variations could occur due to these or other

factors. As a result, our results of operations are subject to significant fluctuation and our results of operations for any particular quarter or fiscal year may not be indicative of results of operations for future periods.

We are subject to extensive government regulation and our government contracts are subject to audit and investigation rights. Any violation of the laws and regulations applicable to us or a negative audit or investigation finding could have a material adverse effect on our business, financial condition, results of operations and cash flow.

Our business is regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers, rather than stockholders. The government agencies administering these laws and regulations have broad latitude to enforce them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer and how we interact with our clients, providers and the public. We are subject, on an ongoing basis, to various governmental reviews, audits and investigations to verify our compliance with our contracts and applicable laws and regulations.

In addition, because we receive payments from federal and state governmental agencies, we are subject to various laws, including the Federal False Claims Act, which permit the federal government to institute suits against us for violations and, in some cases, to seek treble damages, penalties and assessments. Many states, including states where we currently do business, likewise have enacted parallel legislation. In addition, private citizens, acting as whistleblowers, can sue on behalf of the government under a special provision of the False Claims Act.

If the government discovers improper or illegal activities in the course of audits or investigations, we may be subject to various civil and criminal penalties and administrative sanctions, which may include termination of contracts, forfeiture of profits, suspension of payments, fines and suspensions and debarment from doing business with the government. If we are found to be in violation of any applicable law or regulation, or if we receive an adverse review, audit or investigation, any resulting negative publicity, penalties or sanctions could have an adverse affect on our reputation in the industry, impair our ability to compete for new contracts and materially adversely affect our business, financial condition, results of operations and cash flow.

Changes in the United States healthcare environment and steps we take in anticipation of such changes, particularly as they relate to the recently adopted ACA, could have a material negative impact on our business financial condition, results of operations and cash flow.

The healthcare industry in the United States is subject to changing political, economic and regulatory influences that may affect the procurement practices and operations of healthcare organizations and agencies. The ACA was signed into law in March 2010 and in general seeks to reduce health care costs and decrease over time the number of uninsured legal U.S. residents. Especially because of the legislation's strong emphasis on program integrity and cost containment, we regard this legislation, on the whole, as creating potential, new opportunities for the expansion of our business and service offerings. However, it is difficult to predict the full impact of the legislation due to its complexity, as well as a wide range of other factors contributing to the uncertainty of the present healthcare landscape. These factors include a current lack of implementing regulations or administrative policy guidance, the unpredictability of responses by states, businesses and other entities to various choices available to them under the law and the possibility that implementation of some or all of the legislation could be blocked by Court challenges, repealed by Congressional efforts or otherwise modified at the state-level.

We have made and will continue to make investments in personnel, infrastructure and product development, as well as in the overall expansion of the services that we offer in order to support existing and new clients as they prepare for and implement the requirements of the ACA. However, the uncertain status of ACA implementation, combined with the unpredictability of the consequences of certain of its provisions, makes it difficult to determine which and when, adaptive changes should be undertaken. Our business, financial condition, results of operations and cash flow could be adversely affected if efforts to repeal, waive, modify or otherwise change the ACA, in whole or in part, succeed or, if the ACA is implemented as adopted and we are unable to adapt our products and services to meet its requirements.

In sum, recent or future legislative enactments may increase or decrease government involvement in healthcare, lower reimbursement rates and/or otherwise change the operating environment for our clients.

Healthcare organizations may react to changed circumstances, financial pressures and uncertainty surrounding ACA implementation by curtailing or deferring their retention of service providers such as us, thus reducing the demand for our services and, in turn, materially adversely affecting our business, financial condition, operational outcomes and cash flow.

Simplification of the healthcare payment process could reduce the need for and the price of our services.

The complexity of the healthcare payment process and our experience in offering services that improve the ability of our clients to recover incremental revenue through that process have contributed to the success of our service offerings. Complexities of the healthcare payment process include multiple payors and the coordination and utilization of clinical, operational, financial and/or administrative review instituted by third-party payors in an effort to control costs and manage care. If the payment processes associated with the healthcare industry are simplified significantly, the need for our services, or the price clients are willing to pay for our services, could be reduced, which could materially adversely affect our business, financial condition, results of operations and cash flow.

Budget deficits and/or fluctuations in the number of requests for proposals issued by governments and their agencies may adversely impact our business.

A significant percentage of our fiscal year 2010 revenues were derived from contracts with federal, state and local governments and their agencies. Our growth strategy includes aggressively pursuing new opportunities, leveraging our expertise to acquire new clients at the state, federal and employer levels and expanding our current contracts to provide new services to current clients. From time to time, government clients may face budget deficits. This is particularly true as a result of current economic conditions. Also, the number of requests for proposals, or RFPs, issued by government agencies is subject to fluctuation. If government budgets are reduced, then the services we provide could be considered non-essential, our contracts could be terminated and future contracting opportunities for government contracts could be limited. In addition, payments due to us from government agencies may be delayed due to billing cycles or as a result of failures to approve governmental budgets in a timely manner, which would increase our use of working capital. The failure to receive timely payments, as well as the loss of existing government contracts and future contracting opportunities, could materially adversely affect our business, financial condition, results of operations and cash flow.

We must comply with laws and regulations regarding patient privacy and information security, including taking steps to ensure that our workforce, our subcontractors and our business associates who obtain access to sensitive patient information maintain its confidentiality. Our failure, or a failure by our subcontractors or business associates, to comply with those laws and regulations, whether or not inadvertent, could subject us to legal actions and negatively impact our operations.

We process, transmit and store information relating to identifiable individuals, both in our role as a service provider and as an employer. The use of individually identifiable data by our business is regulated at the federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and disclosure of individually identifiable health data. Most are derived from the privacy and security provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996, or HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act, or HITECH. HIPAA also imposes standards and requirements on our business associates (as this term is defined in the HIPAA regulations) and our other subcontractors. Even though we take measures to comply with all applicable regulations and to ensure that our business associates and subcontractors are in compliance, we still have limited control over their actions and practices. Compliance with these proposals, requirements and new regulations may result in cost increases due to necessary systems changes, the development of new administrative processes and the effects of potential noncompliance by our business associates and subcontractors. Such proposals, requirements and new regulations also may impose further restrictions on our use of patient identifiable data that is housed in one or more of our administrative databases.

We have implemented security systems with the intent of maintaining the physical security of our facilities and protecting our clients' and our suppliers' confidential information and information related to identifiable individuals against unauthorized access through our information systems or by other electronic transmission or through

the misdirection, theft or loss of physical media. These include, for example, the encryption of information. Despite such efforts, we may become subject to a breach of our security systems which may result in unauthorized access to our facilities and/or the protected information.

If we, or our subcontractors that receive or utilize confidential information on our behalf, fail to comply with applicable laws or if unauthorized parties gain physical access to one of our facilities or electronic access to our information systems or such information is misdirected, lost or stolen during transmission or transport, any theft or misuse of such information could result in, among other things, unfavorable publicity, governmental inquiry and oversight, difficulty in marketing our services, allegations by our clients that we have not performed our contractual obligations, litigation by affected parties and possible financial obligations for damages related to the theft or misuse of such information, any of which could have a material adverse effect on our business, financial condition, results of operations and cash flow.

We obtain a significant portion of our business through competitive bidding in response to government RFPs. We may not be awarded contracts through this process on the same level in the future as in the past. If we fail to accurately estimate the factors upon which we base our contract pricing, we may generate less profit than expected or incur losses on those contracts.

In order to market our services to clients, we are often required to respond to government RFPs to compete for a contract. This requires that we accurately estimate our cost structure for servicing a proposed contract, the time required to establish operations and likely terms of the proposals submitted by competitors. We must also assemble and submit a large volume of information within an RFP's rigid timetable. Our ability to respond successfully to RFPs will greatly impact our business. We cannot assure you that we will continue to obtain contracts in response to government RFPs or that our proposals will result in profitable contracts. In addition, competitors may protest contracts awarded to us through the RFP process which may cause the award to be delayed or overturned or may require the client to reinitiate the RFP process.

Our pricing is dependent on our internal forecasts and predictions about our projects and the marketplace, which might be based on limited data and could turn out to be inaccurate. A majority of our contracts are contingency fee based. For contingency fee based offerings, we receive our fee based on recoveries received by our clients. To earn a profit on a contingency fee offering, we must accurately estimate costs involved and assess the probability of completing individual transactions within the contracted time period. Our contracts with the federal government generally are cost-plus or time and material based. Revenue on cost-plus contracts is recognized based on costs incurred plus an estimate of the negotiated fee earned. If we do not accurately estimate the costs and timing for completing projects, or if we encounter increased or unexpected costs, delays, failures or risks, including those outside our control, our contracts could prove unprofitable for us or yield lower profit margins than anticipated. Although we believe that we have recorded adequate provisions in our financial statements for losses on our fixed-price and cost-plus contracts where applicable, as required under United States generally accepted accounting principles, or U.S. GAAP, we cannot assure you that our contract loss provisions will be adequate to cover all actual future losses.

Our business depends on effective information systems and the integrity of the data in our information systems. A major failure of our information systems could harm our business.

Our ability to conduct our operations and accurately report our financial results depends on the integrity of the data in our information systems. These information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and handle our expansion and growth. In addition, as a result of our acquisition activities, we have acquired additional systems that have to be phased out or integrated with our current systems. If we encounter a business disruption, if we find the information we rely upon to run our businesses to be inaccurate or unreliable, or if we fail to maintain our information systems and data integrity effectively and our business continuity plans do not effectively compensate on a timely basis, we could suffer operational disruptions, loss of existing clients, difficulty in attracting new clients or in implementing our growth strategies, problems establishing appropriate pricing, disputes with clients, civil or criminal penalties, regulatory problems, increases in administrative expenses, loss of our ability to produce timely and accurate financial and other reports, or other adverse consequences, any of which could have a material adverse effect on our business, financial condition, results of operations and cash flow.

We depend on information suppliers. If we are unable to successfully manage our relationships with a number of these suppliers, the quality and availability of our services may be harmed.

We obtain some of the data used in our services from third party suppliers and government entities. If a number of suppliers are no longer able or are unwilling to provide us with certain data, we may need to find alternative sources. If we are unable to identify and contract with suitable alternative data suppliers and integrate these data sources into our service offerings, we could experience service disruptions, increased costs and reduced quality of our services. Additionally, if one or more of our data suppliers terminates our existing agreements, we cannot assure you that we will be able to obtain new agreements with other data suppliers on terms favorable to us, if at all. Loss of such access or the unavailability of data in the future due to increased governmental regulation or otherwise could have a material adverse effect on our business, financial condition, results of operations and cash flow.

We may rely on subcontractors and partners to provide clients with a single-source solution.

From time to time, we may engage subcontractors, teaming partners or other third parties to provide our clients with a single-source solution. While we believe that we perform appropriate due diligence on our subcontractors and teaming partners, we cannot guarantee that those parties will comply with the terms set forth in their agreements. We may have disputes with our subcontractors, teaming partners or other third parties arising from the quality and timeliness of their work, client concerns about them or other matters. Subcontractor performance deficiencies or misconduct could result in a client terminating our contract for default and/or could adversely affect our client relationships. We may be exposed to liability and we and our clients may be adversely affected if a subcontractor or teaming partner fails to meet its contractual obligations.

We use software vendors, utility providers and network providers in our business and could be materially adversely affected if they cannot deliver or perform as expected or if our relationships with them are terminated or otherwise change.

Our ability to service our clients and deliver and implement solutions requires that we work with certain third party providers, including software vendors, utility and network providers and depends on their meeting our expectations in a timely and quality manner. Our business could be materially and adversely affected and we might incur significant additional liabilities if the services provided by these third party providers do not meet our expectations or if they terminate or refuse to renew their relationships with us or were to offer their products to us in the future on less advantageous terms. In addition, while there are backup systems in many of our operating facilities, an extended outage of utility or network services may have a material adverse effect on our business, financial condition, results of operations and cash flow.

The federal government may limit or prohibit the outsourcing of certain programs or may refuse to grant consents and/or waivers necessary to permit private entities, such as us, to perform certain elements of government programs.

The federal government could limit or prohibit private contractors like us from operating or performing elements of certain government programs. State or local governments could be required to operate such programs with government employees as a condition of receiving federal funding. Moreover, under current law, in order to privatize certain functions of government programs, the federal government must grant a consent and/or waiver to the petitioning state or local agency. If the federal government does not grant a necessary consent or waiver, the state or local agency will be unable to outsource that function to a private entity, such as us. This situation could eliminate a contracting opportunity or reduce the value of an existing contract.

We may be precluded from bidding and performing certain work due to other work we currently perform.

Various laws, regulations and administrative policies prohibit companies from performing work for government agencies that might be viewed to create an actual or apparent conflict of interest. These factors may limit our ability to pursue and perform certain types of work. In particular, CMS has strict conflict of interest requirements which can limit our bidding for specific work for CMS. State governments also have conflict of interest

requirements that could limit our ability to bid for certain work. Conflict of interest requirements constantly change at the federal, state and municipal levels and we cannot assure you that we will be successful in securing new business for entities for which we are currently conducting or have conducted services. If we are prevented from expanding our business due to conflicts of interest, our business could be adversely affected.

If we do not successfully integrate the businesses that we acquire, our results of operations could be adversely affected.

Historically, we have made a significant number of acquisitions that have expanded the products and services we offer, provided a presence in a complementary business or expanded our geographic presence. Business combinations involve a number of factors that affect operations, including:

- diversion of management's attention;
- loss of key personnel;
- entry into unfamiliar markets;
- assumption of unanticipated legal or financial liabilities;
- becoming significantly leveraged as a result of incurring debt to finance an acquisition;
- unanticipated operating, accounting or management difficulties in connection with the acquired entities;
- impairment of acquired intangible assets, including goodwill; and
- dilution to our earnings per share.

We intend to continue our acquisition strategy. We cannot, however, assure you that we will be able to identify any potential acquisition candidates or consummate any additional acquisitions or that any future acquisitions will be successfully integrated or will be advantageous to us. Entities we acquire may not achieve the revenue and earnings we anticipated or their liabilities may exceed our expectations. Client dissatisfaction or performance problems with an acquired entity could materially and adversely affect our reputation as a whole. In addition, notwithstanding due diligence exercised during the acquisition process, we may subsequently be exposed to unanticipated financial liability and/or negative publicity related to prior acts by the acquired entity. We may be unable to profitably manage entities that we have acquired or that we may acquire or we may fail to integrate them successfully without incurring substantial expenses, delays or other problems, any of which could adversely affect our business, financial condition, results of operations and cash flow.

We may not be able to realize the entire book value of goodwill and other intangible assets from acquisitions.

As of December 31, 2010, we have approximately $107.4 million of goodwill and $19.8 million of intangible assets. We periodically assess these assets to determine if they are impaired. We monitor for impairment of goodwill on past and future acquisitions. We perform our impairment testing in the second quarter of each year. In the event that the book value of goodwill is impaired, any such impairment would be charged to earnings in the period of impairment. We cannot assure you that future impairment of goodwill will not have a material adverse effect on our business, financial condition, results of operations and cash flow.

We may be unable to attract and retain sufficient qualified personnel to properly operate our business.

The ability of our executive officers and our senior managers to generate business and execute projects successfully is important to our success. In addition, our delivery of services is labor-intensive. When we are awarded a contract, we must quickly hire project leaders and case management personnel. The additional staff also creates a concurrent demand for increased administrative personnel. Our success requires that we attract, develop, motivate and retain experienced and innovative executive officers; senior managers who have successfully managed or designed government services programs; and information technology professionals who have designed or implemented complex information technology projects.

Innovative, experienced and technologically proficient individuals are in great demand and are likely to remain a limited resource. We cannot assure you that we will be able to continue to attract and retain desirable executive officers and senior managers. Our inability to hire sufficient personnel on a timely basis or the loss of significant numbers of executive officers, senior managers or information technology professionals could adversely affect our business, financial condition, results of operations and cash flow.

Risks Related to Our Common Stock

The market price of our common stock may be volatile.

The market price of our common stock has fluctuated widely and may continue to do so. For example, during the 52-week period ended February 18, 2011, the closing price of our common stock on the NASDAQ Global Select market ranged from a high of $73.92 per share, to a low of $45.02 per share. We expect our stock price to be subject to fluctuations as a result of a variety of factors, including factors beyond our control. Some of these factors are:

- actual or anticipated variations in our results of operations;
- the gain or loss of significant contracts;
- delays in our development and introduction of new services;
- changes in government policies or regulations;
- developments in our relationships with current or future clients and suppliers;
- operating and stock price performance of other companies that investors deem comparable to our company;
- news reports relating to trends, concerns and other issues in the healthcare industry;
- perceptions in the marketplace regarding us and/or our competitors;
- acquisitions or business combinations, strategic partnerships, joint ventures or capital commitments by or involving us or our competitors;
- political developments affecting healthcare at the federal, state or local level;
- our failure to integrate acquisitions or realize anticipated benefits from acquisitions;
- the hiring or departure of key personnel;
- the introduction of new services by us or our competitors;
- changes in estimates of our performance or recommendations by securities analysts;
- future sales of shares of common stock in the public market;
- securities class action or other litigation; and
- market conditions in the industry and the economy as a whole.

In addition, the stock market often experiences significant price and volume fluctuations. These fluctuations are often unrelated to the operating performance of particular companies. These broad market fluctuations may adversely affect the market price of our common stock. When the market price of a company's stock drops significantly, shareholders often institute securities class action litigation against that company. Any litigation against us could cause us to incur substantial costs, divert the time and attention of our management and other resources, or otherwise harm our business.

Failure to fully comply with Section 404 of the Sarbanes-Oxley Act of 2002 could negatively affect our business, the price of our common stock and market confidence in our reported financial information.

We periodically evaluate and test our internal control over financial reporting to satisfy the requirements of Section 404 of the Sarbanes-Oxley Act. Our management has concluded that our internal control over financial

reporting was effective as of December 31, 2010. If in the future we are unable to report that our internal control over financial reporting is effective (or if our auditors do not agree with our assessment of the effectiveness of, or are unable to express an opinion on, our internal control over financial reporting), investors, customers and business partners could lose confidence in the accuracy of our financial reports, which could in turn have a material adverse effect on our business, investor confidence in our financial results may weaken and our stock price may suffer.

Certain provisions of our certificate of incorporation could discourage unsolicited takeover attempts, which could depress the market price of our common stock.

Our certificate of incorporation authorizes the issuance of up to 5,000,000 shares of "blank check" preferred stock with such designations, rights and preferences as may be determined by our Board of Directors. Accordingly, our Board of Directors is empowered, without shareholder approval, to issue preferred stock with dividend, liquidation, conversion, voting or other rights, that could adversely affect the voting power or other rights of holders of our common stock. In the event of issuance, preferred stock could be utilized, under certain circumstances, as a method of discouraging, delaying or preventing a change in control. Although we have no present intention to issue any shares of preferred stock, we cannot assure you that we will not do so in the future. In addition, our by-laws provide for a classified Board of Directors, which could also have the effect of discouraging a change of control.

Because we do not intend to pay dividends, you will benefit from an investment in our common stock only if it appreciates in value.

We have paid no cash dividends on any of our capital stock to date and we currently intend to retain our future earnings, if any, to fund the development and growth of our business. As a result, we do not expect to pay any cash dividends in the foreseeable future. The success of your investment in our common stock will likely depend entirely upon any future appreciation. There is no guarantee that our common stock will appreciate in value or even maintain the price at which you purchased your shares.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

Our New York City corporate headquarters consists of approximately 87,500 square feet of leased space, of which 35,000 square feet is subleased to other occupants. If not renewed, the lease for our corporate headquarters will expire in May 2013. In June 2010, we purchased the 223,000 square foot office building in Irving, Texas which houses the primary center for our operational activities. We currently occupy approximately 131,000 square feet of the building. As of December 31, 2010, we leased approximately 289,000 square feet of office space in 38 other locations throughout the United States, the leases for which expire between 2011 and 2016. See Note 12 of the Notes to Consolidated Financial Statements for additional information about our lease commitments. In general, we believe our facilities are suitable to meet our current and reasonably anticipated needs.

Item 3. Legal Proceedings.

Legal proceedings to which we are a party, in the opinion of our management, are not expected to have a material adverse effect on our financial position, results of operations, or liquidity.

Item 4. (Removed and Reserved)

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Market Information

Our common stock is included in the NASDAQ Global Select Market, under the symbol HMSY. The table below summarizes the high and low sales prices per share for our common stock for the periods indicated, as reported on the NASDAQ Global Select Market.

	High	Low
Year ended December 31, 2010		
Quarter ended December 31, 2010	$67.10	$55.37
Quarter ended September 30, 2010	59.84	50.58
Quarter ended June 30, 2010	57.06	49.30
Quarter ended March 31, 2010	54.07	43.13
Year ended December 31, 2009		
Quarter ended December 31, 2009	$50.67	$37.00
Quarter ended September 30, 2009	43.00	34.77
Quarter ended June 30, 2009	41.20	28.21
Quarter ended March 31, 2009	36.45	28.50

Holders

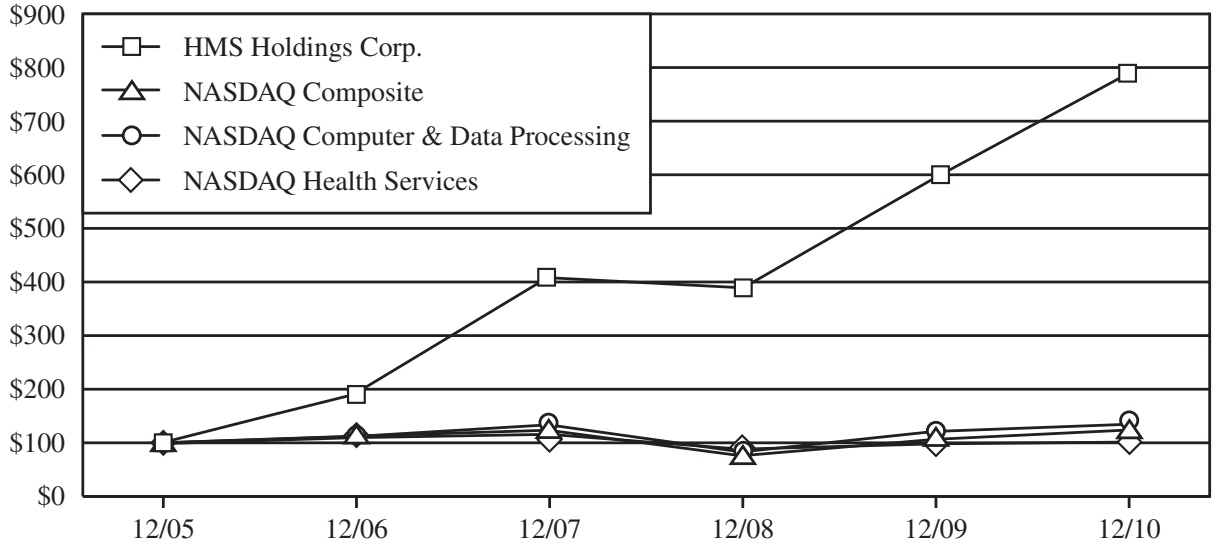
As of the close of business on February 18, 2011, there were 437 holders of record of our common stock.

Dividends

We have not paid any cash dividends on our common stock and do not anticipate paying cash dividends in the foreseeable future. Our current intention is to retain earnings to support the future growth of our business.

Comparative Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock with the cumulative total stockholders return of the NASDAQ Composite Index, the NASDAQ Computer and Data Processing Index and the NASDAQ Health Services Index assuming an investment of $100 on December 31, 2005 and the reinvestment of dividends through fiscal year ended December 31, 2010.



	12/31/05	12/31/06	12/31/07	12/31/08	12/31/09	12/31/10
HMS Holdings Corp.	100.00	198.04	434.12	412.03	636.47	846.67
NASDAQ Composite	100.00	111.74	124.67	73.77	107.12	125.93
NASDAQ Computer & Data Processing	100.00	112.40	134.94	77.33	122.47	135.78
NASDAQ Health Services	100.00	109.80	117.78	87.97	99.96	100.19

Notwithstanding anything to the contrary set forth in any of our previous or future filings under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, that might incorporate by reference this Annual Report on Form 10-K or future filings made by us under those statutes, the Stock Performance Graph is not deemed filed with the Securities and Exchange Commission, is not deemed soliciting material and shall not be deemed incorporated by reference into any of those prior filings or into any future filings we make under those statutes, except to the extent that we specifically incorporate such information by reference into a previous or future filing, or specifically request that such information be treated as soliciting material, in each case under those statutes.

Item 6. Selected Financial Data.

The following table sets forth selected consolidated financial data at and for each of the five fiscal years in the period ended December 31, 2010. It should be read in conjunction with the Consolidated Financial Statements and Supplementary Data thereto, included in Item 8 of this Annual Report and Management's Discussion and Analysis of Financial Condition and Results of Operations, included in Item 7 of this Annual Report.

	Year Ended December 31,				
	2010	2009	2008	2007	2006
	(In thousands, except per share data)				
Statement of Operations Data:					
Revenue	$302,867	$229,237	$184,495	$146,651	$87,940
Operating expenses	236,123	177,369	147,765	118,370	80,115
Operating income	66,744	51,868	36,730	28,281	7,825
Interest expense	(94)	(1,080)	(1,491)	(2,207)	(1,014)
Interest income	94	226	719	475	1,686
Other Expense, net	(69)	—	—	—	—
Income from continuing operations before income taxes	66,675	51,014	35,958	26,549	8,497
Income tax expense	26,583	20,966	14,583	11,593	3,588
Income from continuing operations	40,092	30,048	21,375	14,956	4,909
Discontinued operations:					
Income from discontinued operations	—	—	—	—	416
Net income	$ 40,092	$ 30,048	$ 21,375	$ 14,956	$ 5,325
Net Income Per Common Share:					
Basic net income per common share					
From continuing operations	$ 1.47	$ 1.15	$ 0.85	$ 0.63	$ 0.23
From discontinued operations	—	—	—	—	0.02
Net income per common share — Basic	$ 1.47	$ 1.15	$ 0.85	$ 0.63	$ 0.25
Diluted net income per common share					
From continuing operations	$ 1.41	$ 1.09	$ 0.80	$ 0.57	$ 0.21
From discontinued operations	—	—	—	—	0.01
Net income per common share — Diluted	$ 1.41	$ 1.09	$ 0.80	$ 0.57	$ 0.22
Weighted average shares:					
Basic	27,254	26,110	25,048	23,904	21,731
Diluted	28,458	27,621	26,816	26,249	23,859

	As of December 31,				
	2010	2009	2008	2007	2006
	(In thousands)				
Balance Sheet Data					
Cash and cash equivalents	$ 94,836	$ 64,863	$ 49,216	$ 21,275	$ 12,527
Working capital	147,546	113,967	70,753	37,110	25,264
Total assets	352,905	270,644	222,513	188,100	157,243
Long-term debt	—	—	11,025	17,325	23,625
Shareholder's equity	$307,638	$238,293	$178,362	$138,749	$106,907

Notes to Selected Consolidated Financial Data

- Discontinued Operations — In 2005, we sold our former subsidiary, Accordis Inc., or Accordis. This business was previously presented as a separate reportable segment and represented a separate class of clients and major business. Accordingly, the operating results are presented as discontinued operations for all periods presented.
- In August 2010, we acquired the assets and liabilities of Chapman Kelly for $13.0 million in cash. Chapman Kelly, which is based in Jeffersonville, Indiana, provides dependent eligibility audits to large, self-insured employers, as well as plan and claims audits to both employers and managed care organizations. The acquisition of Chapman Kelly did not have a material effect on our 2010 revenue, earnings, earnings per share or liquidity.
- In June 2010, we purchased all of the issued and outstanding common stock of AMG-SIU for a purchase price valued at $15.1 million, consisting of a $13.0 million initial cash payment (subsequently reduced by a working capital reduction of $0.2 million), and future contingent payments estimated and recognized as of the acquisition date at $2.3 million. These payments are contingent upon AMG-SIU's financial performance for each of the twelve month periods ending June 30, 2011 and June 30, 2012. The contingent payments are not subject to any cap. The undiscounted contingent payments are currently estimated to be $3.4 million and relate to the 12 month period ending June 30, 2012. AMG-SIU, which is based in Santa Ana, California, specializes in fraud, waste and abuse prevention and detection solutions for healthcare payors, which further strengthens our ability to service this segment of the market. The acquisition of AMG-SIU did not have a material effect on our 2010 revenue, earnings, earnings per share or liquidity.
- In December 2009, we acquired the assets and liabilities of Verify Solutions, LLC or Verify Solutions for $8.1 million, with additional future payments of up to $5.5 million contingent upon future financial performance ($2.7 million and $2.8 million for the years ended December 31, 2010 and 2011, respectively). The additional future payments will be made and recorded as compensation expense in the year in which the milestones are expected to be achieved. No compensation expense was recorded in 2010 as the performance milestones were not achieved. Verify Solutions specializes in dependent eligibility audit services for large, self-insured employers and is based in Alpharetta, Georgia. With this acquisition, we moved into the large and mid-market employer-based market.
- In September 2009, we acquired the assets and liabilities of IntegriGuard, LLC, or Integriguard, for $5.1 million. IntegriGuard, which operates as our wholly owned subsidiary, provides services for the prevention and detection of fraud, waste and abuse in the healthcare system and is based in Omaha, Nebraska. This acquisition expanded our portfolio of program integrity service offerings for government healthcare programs, particularly in the Medicare and Medicaid programs.
- In September 2008, we purchased the assets and liabilities of Prudent Rx for $4.5 million in cash. Prudent Rx is a pharmacy audit and cost containment company based in Culver City, California. This acquisition expanded our portfolio of program integrity service offerings for government healthcare programs and managed care organizations, particularly in the pharmacy arena. The acquisition of Prudent Rx did not have a material effect on our 2010, 2009 and 2008 revenue, earnings, earnings per share or liquidity.
- In September 2006, we acquired the assets and liabilities of the BSPA for $81.2 million in cash, 1,749,800 shares of our common stock, then valued at $24.4 million and a contingent cash payment of up to $15.0 million payable upon BSPA's achievement of certain revenue targets for the twelve months ended June 30, 2007. In September 2007, we paid PCG $15.0 million of additional consideration as a result of BSPA's achievement of the revenue targets. BSPA, which is based in Boston, Massachusetts, provides a variety of cost avoidance, insurance verification, recovery audit and related services to state Medicaid agencies, children and family services agencies and the U.S. Department of Veterans Affairs.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

We begin Management's Discussion and Analysis of Financial Condition and Results of Operations with a discussion of the critical accounting policies that we believe are important to understanding the assumptions and

judgments incorporated in our reported financial results. We then present a business overview followed by a discussion of our results of operations. Lastly, we provide an analysis of our liquidity and capital resources, including discussions of our cash flows, sources of capital and financial commitments.

The following discussions and analysis of financial condition and results of operations should be read in conjunction with the other sections of this Annual Report, including the Consolidated Financial Statements and Supplemental Data thereto appearing in Part II, Item 8 of this Annual Report, the Risk Factors appearing in Part I, Item 1A of this Annual Report and the disclaimer regarding forward-looking statements appearing at the beginning of Part I, Item 1 of this Annual Report. Historical results set forth in Part II, Item 6, Item 7 and Item 8 of this Annual Report should not be taken as necessarily indicative of our future operations.

Critical Accounting Policies

Revenue Recognition. A majority of our contracts are contingency fee based. We recognize revenue on contingency fee based contracts when third party payors remit payment to our clients and, consequently, the contingency is deemed to have been satisfied. For certain contracts, this may result in revenue being recognized in irregular increments. We recognize revenue on our general service agreements as work is performed and amounts are earned. We consider amounts to be earned once evidence of an arrangement has been obtained, services are delivered, fees are fixed or determinable and collectability is reasonably assured. Our contracts with the federal government generally are cost-plus or time and material based. Revenue on cost-plus contracts is recognized based on costs incurred plus an estimate of the negotiated fee earned. Revenue on time and materials contracts is recognized based on hours worked and expenses incurred.

Where contracts have multiple deliverables, we evaluate these deliverables at the inception of each contract and as each item is delivered. As part of this evaluation, we consider whether (i) a delivered item has value to a client on a stand-alone basis; (ii) there is objective and reliable evidence of the fair market value of the undelivered items; and (iii) the delivery of the undelivered items is considered probable and substantially within our control, if a general right of return exists. Where deliverables, or groups of deliverables, have all three of these characteristics, we treat each deliverable item as a separate unit of accounting and apply the relevant revenue recognition guidance to each deliverable. Arrangements, including implementation and transaction related revenue, are accounted for as a single unit of accounting. Since implementation services do not carry a standalone value, the revenue relating to these services is recognized over the term of the client contract to which it relates.

Expense Classifications: Our cost of services in our statement of income is presented in the seven categories set forth below. Each category of cost excludes costs relating to selling, general and administrative functions, which are presented separately as a component of total operating expenses. A description of the primary costs included in each cost of service category is provided below:

- *Compensation:* Salary, fringe benefits and bonus.
- *Data processing:* Hardware, software and data communication costs.
- *Occupancy:* Rent, utilities, depreciation, office equipment, repair and maintenance costs.
- *Direct project costs:* Variable costs incurred from third party providers that are directly associated with specific revenue generating projects and employee travel expense.
- *Other operating costs:* Professional fees, temporary staffing, travel and entertainment, insurance and local and property tax costs.
- *Amortization of intangibles:* Amortization cost of acquisition-related software and intangible assets.
- *Selling, general and administrative:* Costs related to general management, marketing and administration activities including stock-based compensation costs.

Accounting for Income Taxes. We file income tax returns with the federal government and various state jurisdictions. We are no longer subject to U.S. federal income tax examinations by tax authorities for years before 2007. Our 2008 federal tax return is currently being examined by the Internal Revenue Service. We operate in a number of state and local jurisdictions, most of which have never audited our records. Accordingly, we are subject to state and local income tax examinations based upon the various statutes of limitations in each jurisdiction.

There was a decrease in our valuation allowance of $2.6 million from December 31, 2009 to December 31, 2010, as a result of the expiration of the capital loss carry forward. The sale of our subsidiary Accordis, in 2005, resulted in a capital loss of $6.0 million, which was carried forward for five years and produced a deferred tax asset of $2.5 million, which expired December 31, 2010. Our remaining valuation allowance of $0.1 million at December 31, 2010 relates to certain state NOLs. There is sufficient doubt about our ability to utilize these NOLs that it is more likely than not that these state NOLs are not realizable.

At December 31, 2010 and 2009, we had approximately $1.4 million and $1.0 million of net unrecognized tax benefits, respectively, for which there is uncertainty about the allocation and apportionment impacting state taxable income. We do not expect any significant change in unrecognized tax benefits during the next twelve months. The accrued liabilities related to uncertain tax positions were $0.5 million and $0.4 million at December 31, 2010 and 2009, respectively. The additions to the accrued liabilities related to uncertain tax positions taken during 2010.

Valuation of long lived and intangible assets and goodwill. Goodwill, representing the excess of acquisition costs over the fair value of the assets and liabilities of acquired businesses, is not amortized but is reviewed for impairment at least annually at the reporting unit level and written down only in the periods in which it is determined that the recorded value is greater than its fair value. We determine fair value based on a projected discounted cash flow method using a discount rate reflective of our cost of funds. The fair values of our reporting units are substantially in excess of their carrying value. Accordingly, we have not recorded impairment losses for any of our acquisitions.

Long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying value may not be recoverable. Factors that could trigger an impairment review include the following:

- significant underperformance relative to historical or projected future operating results;
- significant changes in the manner of our use of the acquired assets or the strategy for our overall business;
- significant negative industry or economic trends;
- significant decline in our stock price for a sustained period; and
- a decrease in our market capitalization relative to our net book value.

We determine the recoverability of the carrying value of our long-lived assets based on a projection of the estimated undiscounted future net cash flows expected to result from the use of the asset. When we determine that the carrying value of long-lived assets may not be recoverable, we measure any impairment by comparing the carrying amount of the asset with the fair value of the asset. For identifiable intangibles, we determine fair value based on a projected discounted cash flow method using a discount rate reflective of our cost of funds.

Estimating valuation allowances and accrued liabilities, such as bad debts. The preparation of financial statements requires our management to make estimates and assumptions that affect the reported amount of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amount of revenue and expenses during the reported period. In particular, management must make estimates of the probability of collecting our accounts receivable. When evaluating the adequacy of the allowance for doubtful accounts, management reviews our accounts receivable based on an analysis of historical bad debts, client concentrations, client credit-worthiness, current economic trends and changes in our client payment terms. As of December 31, 2010 and 2009, the accounts receivable balance was $75.1 million and $64.7 million, net of allowance for doubtful accounts of $0.8 million and $0.6 million, respectively.

Stock-based Compensation. We grant stock options to purchase our common stock, restricted stock awards and restricted stock units to our employees and director. Stock-based compensation cost is measured at the grant date based on the fair value of the award and is recognized as expense on a straight-line basis over the requisite service period, which is generally the vesting period. Stock options granted under our 2006 or 1999 Plan generally vest over a one to four year period. The restricted stock awards and restricted stock units granted under our 2006 Plan vest over a three to five year period and the related stock-based compensation expense is ratably recognized over those same time periods.

We estimate the fair value of options granted using the Black-Scholes option pricing model. The application of this valuation model involves assumptions that are highly subjective, judgmental and sensitive in the determination of compensation cost. The Black-Scholes model incorporates the expected term of the option, the expected volatility of the price of our common stock, risk free interest rates and the expected dividend yield of our common stock. Expected volatilities are calculated based on the historical volatility of our stock. Management monitors stock option exercise and employee termination patterns to estimate forfeiture rates within the valuation model. Separate groups of employees that have similar historical exercise behavior are considered separately for valuation purposes. The expected holding period of options represents the period of time that options granted are expected to be outstanding. The risk-free interest rate for periods within the contractual life of the option is based on the interest rate of a 5-year U.S. Treasury Note in effect on the date of the grant. All share based payment awards are amortized on a straight-line basis over the requisite service period of the awards, which is generally the vesting period.

If factors change and we employ different assumptions for estimating stock-based compensation expense in future periods or if we decide to use a different valuation model, stock-based compensation in future periods may differ significantly from what we have recorded in the current period and could materially affect our operating income, net income and net income per share.

We estimate forfeitures at the time of grant and revise the forfeiture rate in subsequent periods if actual forfeitures differ from our estimates. If actual forfeitures vary from our estimates, we will recognize the difference in compensation expense in the period the actual forfeitures occur or at the time of vesting.

See Note 10 of the Notes to Consolidated Financial Statements for further information regarding our stock-based compensation plans.

Use of estimates. We prepare our Consolidated Financial Statements in accordance with U.S. GAAP. In doing so, we have to make estimates and assumptions that affect our reported amounts of assets, liabilities, revenue and expenses, as well as related disclosure of contingent assets and liabilities. In some cases, we could reasonably have used different accounting policies and estimates. In some cases, changes in the accounting estimates are reasonably likely to occur from period to period. Accordingly, actual results could differ materially from our estimates. To the extent that there are material differences between these estimates and actual results, our financial condition or results of operations will be affected. We base our estimates on past experience and other assumptions that we believe are reasonable under the circumstances and we evaluate these estimates on an ongoing basis. We refer to accounting estimates of this type as critical accounting policies and estimates, which we have discussed further above. We have reviewed our critical accounting policies and estimates with the Audit Committee of our Board of Directors.

The policies described above are not intended to be a comprehensive list of all of our accounting policies. In many cases, the accounting treatment of a particular transaction is specifically dictated by U.S. GAAP, with no need for management's judgment in their application. There are also areas in which the audited consolidated financial statements and notes thereto included in this Form 10-K contain accounting policies and other disclosures required by U.S. GAAP.

Business Overview

Beginning in the first quarter of 2007, we were managed and operated as one business, with a single management team that reports to the chief executive officer. We do not operate separate lines of business with respect to any of our product lines.

We provide a variety of cost containment services, including coordination of benefits and program integrity services, for government and private healthcare payors and sponsors. These services are designed to help our clients recover amounts due from liable third parties, save dollars, reduce fraud, waste and abuse and ensure regulatory compliance.

Our clients are state Medicaid agencies, Medicaid and Medicare managed care plans, government and private self-funded employers, PBMs, child support agencies, VHA, CMS, commercial plans, other healthcare payors and large business outsourcing and technology firms. We help these entities contain healthcare costs by ensuring that

claims are paid correctly, through our program integrity services and by ensuring that claims are paid by the responsible party, through our coordination of benefits services.

At December 31, 2010, our cash and cash equivalents and net working capital were $94.8 million and $147.5 million, respectively. In connection with our BSPA acquisition, we entered into a credit agreement with several banks and other financial institutions, with JPMorgan Chase Bank, N.A. as administrative agent, or the Credit Agreement. The Credit Agreement, which expires in September 2011, provided for a term loan of $40 million, or the Term Loan and revolving credit loans of up to $25 million, or the Revolving Loan. During the year ended December 31, 2009, we repaid in full the $17.3 million of debt outstanding under the Term Loan. Although to date we have not borrowed under the Revolving Loan, we continue to have an irrevocable standby Letter of Credit for $4.6 million against the Revolving Loan, as required by a contractual arrangement with a client. As a result of the Letter of Credit, the amount available under the Revolving Loan as of December 31, 2010 is $20.4 million. Although we expect that operating cash flows will continue to be a primary source of liquidity for our operating needs, we also have the remaining balance of the Revolving Loan available for future cash flow needs, if necessary.

Our revenue, most of which is derived from contingency fees, has increased at an average compounded rate of approximately 38.2% per year for the last five years. Our 2010 revenue increased to $302.9 million, $73.6 million over 2009 revenue. Our growth has been attributable to our expansion of existing product offerings and acquisitions, as well as the increase in Medicaid costs, which has historically averaged approximately 8% annually. In addition, state governments have increased their use of vendors for coordination of benefits and other cost containment functions and we have been able to increase our revenue through these initiatives. Leveraging our work on behalf of state Medicaid fee-for-service programs, we began to penetrate the Medicaid managed care market in 2005, into which more Medicaid lives are being shifted. In addition, to acting as a subcontractor for certain business outsourcing and technology firms, as of December 31, 2010, we served 41 state Medicaid agencies and 125 Medicaid health plans under 57 contracts.

To date, we have grown our business through the internal development of new services and through acquisitions of businesses whose core services strengthen our overall mission to help our clients control healthcare costs. In addition, we leverage our expertise to acquire new clients at the state, federal and employer levels and to expand our current contracts to provide new services to current clients.

With the exception of our acquisition of BSPA, to date we have used internally generated cash to fund our acquisitions.

Since 2006, we have acquired the following companies:

- *Benefits Solutions Practice Area.* In September 2006, we acquired the assets and liabilities of BSPA for $81.2 million in cash, 1,749,800 shares of our common stock, then valued at $24.4 million and a contingent cash payment of $15.0 million, which was paid to BSPA upon its achievement of certain revenue targets for the twelve months ended June 30, 2007. BSPA, which is based in Boston, Massachusetts, provides a variety of cost avoidance, insurance verification, recovery audit and related services to state Medicaid agencies, children and family services agencies and the U.S. Department of Veterans Affairs.
- *Prudent Rx.* In September 2008, we purchased the assets and liabilities of Prudent Rx for $4.5 million in cash. Prudent Rx is a pharmacy audit and cost containment company based in Culver City, California. With this acquisition, we further expanded our portfolio of program integrity service offerings for government healthcare programs and managed care organizations, particularly in the pharmacy arena. Prudent Rx's key products and services include audit programs, program design and benefit management, as well as general and pharmacy systems consulting. The acquisition of Prudent Rx did not have a material effect on 2010, 2009 and 2008 revenue, earnings, earnings per share or liquidity.
- *IntegriGuard.* In September 2009, we acquired the assets and liabilities of IntegriGuard for $5.1 million. IntegriGuard, which operates as our wholly owned subsidiary, provides services for the prevention and detection of fraud, waste and abuse in the healthcare system and is based in Omaha, Nebraska. This acquisition expanded our portfolio of program integrity service offerings for government healthcare programs, particularly in the Medicare and Medicaid programs.

- *Verify Solutions.* In December 2009, we acquired the assets and liabilities of Verify Solutions for $8.1 million, with additional future payments of up to $5.5 million contingent upon future financial performance ($2.7 million and $2.8 million for the years ended December 31, 2010 and 2011, respectively). The additional future payments will be made and recorded as compensation expense in the year in which the milestones are expected to be achieved. No compensation expense was recorded in 2010 as the performance milestones were not achieved. Verify Solutions, specializes in dependent eligibility audit services for large, self-insured employers and is based in Alpharetta, Georgia. With this acquisition, we moved into the large and mid-market employer-based market.
- *Allied Management Group — Special Investigation Unit.* In June 2010, we purchased all of the issued and outstanding common stock of AMG-SIU for a purchase price valued at $15.1 million, consisting of a $13.0 million initial cash payment (subsequently reduced by a working capital reduction of $0.2 million), and future contingent payments estimated and recognized as of the acquisition date at $2.3 million. These payments are contingent upon AMG-SIU's financial performance for each of the twelve month periods ending June 30, 2011 and June 30, 2012. The undiscounted contingent payments are currently estimated to be $3.4 million and relate to the 12 month period ending June 30, 2012. AMG-SIU, which is based in Santa Ana, California; specializes in fraud, waste and abuse prevention and detection solutions for healthcare payors, which further strengthens our ability to service this segment of the market. The acquisition of AMG-SIU did not have a material effect on our 2010 revenue, earnings, earnings per share or liquidity.
- *Chapman Kelly.* In August 2010, we acquired the assets and liabilities of Chapman Kelly for a $13.0 million cash payment. Chapman Kelly, which is based in Jeffersonville, Indiana, provides dependent eligibility audits to large, self-insured employers, as well as plan and claims audits to both employers and managed care organizations. The acquisition of Chapman Kelly did not have a material effect on our 2010 revenue, earnings, earnings per share or liquidity.

Years Ended December 31, 2010 and 2009

The following table sets forth, for the periods indicated, certain items in our Consolidated Statements of Income expressed as a percentage of revenue:

	Years Ended December 31,	
	2010	2009
Revenue	100.0%	100.0%
Cost of service		
Compensation	36.2%	33.7%
Data processing	6.0%	6.0%
Occupancy	4.5%	4.7%
Direct project costs	11.7%	12.4%
Other operating costs	5.6%	6.1%
Amortization of intangibles	2.1%	2.2%
Total cost of services	66.1%	65.1%
Selling, general and administrative expenses	11.9%	12.3%
Total operating expenses	78.0%	77.4%
Operating income	22.0%	22.6%
Interest expense	—	(0.5)%
Other expense, net	(0.1)%	—
Interest income	—	0.1%
Income before income taxes	21.9%	22.2%
Income taxes	(8.8)%	(9.1)%
Net income	13.1%	13.1%

Operating Results

Revenue for the year ended December 31, 2010 was $302.9 million, an increase of $73.6 million, or 32.1%, from revenue of $229.2 million for the year ended December 31, 2009. This increase reflects the organic growth in existing client accounts of $42.6 million, together with changes in the yield and scope of those projects and differences in the timing of when client projects were completed in the current year compared to the prior year. Revenue generated by our 2009 acquisitions, IntegriGuard and Verify Solutions, was $24.9 million, an increase of $21.2 million compared to the prior year. Revenue generated by our 2010 acquisitions, AMG-SIU and Chapman Kelly, was $2.3 million. Revenue generated by approximately 19 new clients for whom there was no revenue in the prior year was $14.9 million. These increases were partially offset by a decrease of $7.4 million as a result of expired contracts.

Compensation expense as a percentage of revenue was 36.2% for the year ended December 31, 2010, compared to 33.7% for the prior year. Compensation expense was $109.6 million for 2010, an increase of $32.4 million, or 42.0%, from the prior year compensation expense of $77.2 million. This increase reflects $24.2 million in additional salary expense, $6.4 million in additional expense related to employee benefits and $1.8 million in additional variable compensation. For the year ended December 31, 2010, we averaged 1,409 employees, a 43.8% increase over the year ended December 31, 2009, during which we averaged 980 employees. This increase reflects the addition of new staff as a result of our acquisitions of AMG-SIU and Chapman Kelly during the second and third quarters of 2010, respectively and the addition of staff in the areas of client support, technical support and operations during 2010.

Data processing expense as a percentage of revenue was 6.0% for the year ended December 31, 2010, compared to 6.0% for the prior year. Data processing expense was $18.1 million for 2010, an increase of

$4.4 million, or 31.9%, from the prior year data processing expense of $13.7 million. Revenue growth as well as acquisitions drove the need for increased capacity in our data processing environment. This increase reflects $2.7 million in additional software related costs, a $1.1 million increase for data communications and data costs due to the growth of our business, including the number of field offices and employees and a $0.6 million increase in hardware maintenance and related costs.

Occupancy expense as a percentage of revenue was 4.5% for the year ended December 31, 2010, compared to 4.7% for the prior year. Occupancy expense was $13.6 million for 2010, an increase of $2.8 million, or 25.4%, from the prior year occupancy expense of $10.9 million. Rent expense increased $1.3 million in connection with our acquisitions of IntegriGuard, Verify Solutions, AMG-SIU and Chapman Kelly. Other increases included a $0.8 million increase in depreciation of furniture and fixtures, leasehold improvements, office and telephone equipment, a $0.7 million increase in utilities and telephone expense and a $0.5 million increase in equipment expense, rental and maintenance, primarily for photocopy and mail machines. These increases were partially offset by a decrease of $0.6 million relating to the write off of accrued rent liabilities following our purchase of the office building in Irving, Texas. All other rental expenses increased by $0.1 million.

Direct project expense as a percentage of revenue was 11.7% for the year ended December 31, 2010, compared to 12.4% for the prior year. Direct project expense for 2010 was $35.4 million, an increase of $7.0 million, or 24.7%, from the prior year direct project expense of $28.4 million. This increase resulted primarily from a $2.6 million increase in subcontractor expenses primarily driven by new projects and revenue increases, a $1.4 million increase for temporary help, consultants and marketing partners, a $1.3 million increase for lockbox, postage and delivery expense. Direct project expense increased at a rate lower than revenue growth due to the composition of the revenue from our acquisitions which has a lower cost component.

Other operating expenses as a percentage of revenue were 5.6% for the year ended December 31, 2010, compared to 6.1% for the prior year. Other operating expenses for 2010 were $17.1 million, an increase of $3.1 million, or 22.0%, from the prior year expense of $14.0 million. This increase resulted from a $1.7 million increase in professional fees, including consulting, subcontractors and temporary help, a $0.7 million increase for supplies, printing, postage, delivery, a $0.4 million increase for travel expenses and $0.3 million in accretion expense related to the contingent payment for AMG-SIU.

Amortization of acquisition-related software and intangibles as a percentage of revenue was 2.1% for the year ended December 31, 2010, compared to 2.2% for the prior year. Amortization of acquisition-related software and intangibles expenses for 2010 were $6.2 million, an increase of $1.1 million, or 22.7%, compared to the prior year expense of $5.1 million. This expense consists primarily of amortization of client relationships, trade names and software. The increase in amortization of acquisition-related software and intangibles expense compared to last year is a result of our acquisitions of IntegriGuard, Verify Solutions, AMG-SIU and Chapman Kelly.

Selling, general and administrative expenses as a percentage of revenue were 11.9% for the year ended December 31, 2010, compared to 12.3% for the prior year. Selling, general and administrative expenses for 2010 were $36.1 million, an increase of $8.0 million, or 28.4%, compared to the prior year expense of $28.1 million. During the year ended December 31, 2010, we averaged 93 employees in the sales, general and administrative group, a 27.4% increase over our average of 73 employees in that group during the year ended December 31, 2009. Compensation increased by $4.7 million due to a $2.1 million increase due to headcount additions and annual salary increases, a $1.2 million increase due to fringe benefits, a $0.8 million increase in stock compensation expense and a $0.7 million increase for variable compensation. Other expenses increased by $3.1 million, of which $2.1 million related to an increase in professional fees, consisting of accounting fees, acquisition-related transaction fees, public company costs and consulting fees.

Operating income for the year ended December 31, 2010 was $67.0 million, or 22.1%, of revenue compared to $51.9 million, or 22.6%, of revenue for the prior year. This increase was primarily the result of increased revenue, which was partially offset by incremental operating costs incurred during the year ended December 31, 2010.

Interest expense was $0.1 million for the year ended December 31, 2010 compared to $1.1 million for the same period in 2009. For the year ended December 31, 2010, interest expense represents commitment fees for our Credit Agreement and issuance fees for our Letter of Credit. For the year ended December 31, 2009, interest expense was

attributable to borrowings under the Term Loan, amortization of deferred financing costs, commitment fees for our Credit Agreement and issuance fees for our Letter of Credit. Interest income was $94,000 for the year ended December 31, 2010, compared to interest income of $226,000 for the year ended December 31, 2009, principally due to lower interest rates, which were partially offset by higher cash balances. Net other expenses included $69,000 related to the acquisition of the office building in Irving, Texas. We did not incur any real estate expense in the prior period.

Income tax expense of $26.6 million was recorded for the year ended December 31, 2010, an increase of $5.6 million compared to the same period in 2009. Our effective tax rate decreased to 39.9% in 2010 from 41.1% for the year ended December 31, 2009, primarily due to a change in state apportionments. The principal difference between the statutory tax rate and our effective tax rate is state taxes.

During 2010, we utilized $32.4 million in tax deductions arising from 2010 stock option exercises, which resulted in an excess tax benefit of $12.6 million that was recorded to capital and an offsetting reduction to taxes payable.

Net income of $40.1 million for the year ended December 31, 2010 represents an increase of $10.1 million over net income for the same period in 2009 of $30.0 million.

Years Ended December 31, 2009 and 2008

The following table sets forth, for the periods indicated, certain items in our Consolidated Statements of Operations expressed as a percentage of revenue:

	Year Ended December 31,	
	2009	2008
Revenue	100.0%	100.0%
Cost of service		
Compensation	33.7%	32.8%
Data processing	6.0%	6.0%
Occupancy	4.7%	5.5%
Direct project costs	12.4%	15.3%
Other operating costs	6.1%	5.9%
Amortization of intangibles	2.2%	2.6%
Total cost of services	65.1%	68.1%
Selling general and administrative expenses	12.3%	12.0%
Total operating expenses	77.4%	80.1%
Operating income	22.6%	19.9%
Interest expense	(0.5)%	(0.8)%
Net interest income	0.1%	0.4%
Income before income taxes	22.2%	19.5%
Income taxes	(9.1)%	(7.9)%
Net Income	13.1%	11.6%

Operating Results

Revenue for the year ended December 31, 2009 was $229.2 million, an increase of $44.7 million, or 24.3%, from revenue of $184.5 million for the year ended December 31, 2008. This increase reflected the organic growth in existing client accounts of $42.7 million, together with changes in the yield and scope of client projects and differences in the timing of when client projects were completed compared to the prior year. Revenue generated by our 2008 and 2009 acquisitions, Prudent Rx and IntegriGuard, was $5.4 million, an increase of $5.0 million

compared to the prior year. Revenue generated by approximately 17 new clients for whom there was no revenue in the prior year was $5.0 million. These increases were partially offset by a decrease of $8.0 million as a result of expired contracts.

Compensation expense as a percentage of revenue was 33.7% for the year ended December 31, 2009, compared to 32.8% for the prior year. Compensation expense was $77.2 million for 2009, an increase of $16.6 million, or 27.5%, from the prior year compensation expense of $60.6 million. This increase reflects $12.5 million in additional salary expense, $2.4 million in additional expense related to employee benefits and $1.7 million in additional variable compensation. For the year ended December 31, 2009, we averaged 980 employees, a 24.8% increase over the year ended December 31, 2008, during which we averaged 785 employees. The increase reflects the addition of new staff as a result of our acquisition of Prudent Rx during the third quarter of 2008, our acquisition of IntegriGuard during the third quarter of 2009 and the addition of staff in the areas of client support, technical support and operations during 2009.

Data processing expense as a percentage of revenue was 6.0% in both fiscal 2009 and 2008. Data processing expense was $13.7 million for 2009, an increase of $2.7 million, or 24.7%, from the prior year data processing expense of $11.0 million. Revenue growth drove the need for increased capacity in our data processing environment. This increase reflects $1.7 million in software related costs, $0.8 million relating to depreciation and amortization of equipment and software and $0.2 million relating to network communications as required by business expansion.

Occupancy expense as a percentage of revenue was 4.7% for the year ended December 31, 2009, compared to 5.5% for the prior year. Occupancy expense was $10.9 million for 2009, an increase of $0.8 million, or 7.9%, from the prior year occupancy expense of $10.1 million. This increase reflected $0.5 million of additional equipment expense, rental and maintenance, $0.5 million of additional utilities and common area maintenance charges and $0.2 million of additional depreciation of leasehold improvements, furniture and fixtures and telephone systems. Rent and other occupancy expenses decreased by $0.4 million due to the migration of operational support to our Irving, Texas location and the savings associated with subleasing one of the floors in our New York City location.

Direct project expense as a percentage of revenue was 12.4% for the year ended December 31, 2009, compared to 15.3% for the prior year. Direct project expense for 2009 remained the same as the prior fiscal year expense of $28.4 million. Direct project expense increased at a lower rate than revenue growth due to our efforts to reduce subcontractor utilization by bringing work in-house, savings related to efficiencies and economies of scale and the content of revenue earned during the year.

Other operating expenses as a percentage of revenue were 6.1% for the year ended December 31, 2009, compared to 5.9% for the prior year. Other operating expenses for 2009 were $14.0 million, an increase of $3.2 million, or 29.5%, from the prior year expense of $10.8 million. This increase represents a $1.2 million increase in professional fees, including consulting, subcontractor and temporary help, an increase of $1.2 million in travel expenses and $0.8 million for supplies, printing, postage, delivery, management meetings and training expenditures within our operational departments as a result of the expansion of our business.

Amortization of acquisition-related software and intangibles as a percentage of revenue was 2.2% for the year ended December 31, 2009, compared to 2.6% for the prior year. Amortization of acquisition-related software and intangibles expenses for 2009 was $5.1 million, an increase of $0.4 million, or 7.5%, compared to the prior year expense of $4.7 million. This expense consists primarily of amortization of client relationships, trade names and software. The increase in amortization of acquisition-related software and intangibles expense compared to last year is a result of our acquisitions of Prudent Rx in 2008 and IntegriGuard in 2009.

Selling, general and administrative expenses as a percentage of revenue were 12.3% for the year ended December 31, 2009, compared to 12.0% for the prior year. Selling, general and administrative expenses for 2009 were $28.1 million, an increase of $6.0 million, or 26.9%, compared to the prior year expense of $22.1 million. During the year ended December 31, 2009, we averaged 73 employees in the sales, general and administrative group, a 17.7% increase over our average of 62 employees in that group during the year ended December 31, 2008. Compensation increased by $4.5 million due to a $2.9 million increase in stock compensation expense, a $0.7 million increase due to headcount additions and annual salary increases, a $0.7 million increase for variable

compensation and a $0.2 million increase due to fringe benefits. Occupancy expense increased by $0.6 million related to square footage utilization of the sales, general and administrative group. Other expenses increased by $1.0 million, of which $0.4 million represented transaction costs related to the IntegriGuard and Verify Solutions acquisitions, $0.3 million represented consulting and other professional fees and $0.3 million represented employee-related expenses. Data processing expenses decreased by $0.1 million related to the expiration of software leases.

Operating income for the year ended December 31, 2009 was $51.9 million, or 22.6%, of revenue compared to $36.7 million, or 19.9%, of revenue for the prior year. This increase was primarily the result of increased revenue, which was partially offset by incremental operating costs incurred during the year ended December 31, 2009.

Interest expense was $1.1 million for the year ended December 31, 2009 compared to $1.5 million for the same period in 2008. In both periods, interest expense was attributable to borrowing under the Term Loan and amortization of deferred financing costs. We repaid the Term Loan in full in 2009. As a result, the decrease in interest expense is due to both lower variable interest rates and a reduction in the principal balance of the Term Loan for the year ended December 31, 2009, compared to the same period in 2008, partially offset by the full amortization of deferred financing costs upon our repayment of the Term Loan. Interest income was $226,000 for the year ended December 31, 2009, compared to interest income of $719,000 for the year ended December 31, 2008, principally due to lower interest rates, which were partially offset by higher cash balances.

Income tax expense of $21.0 million was recorded for the year ended December 31, 2009, an increase of $6.4 million compared to the same period in 2008. Our effective tax rate increased to 41.1% in 2009, from 40.6% for the year ended December 31, 2008, primarily due to a change in state apportionments. The principal difference between the statutory tax rate and our effective tax rate is state taxes.

During 2009, we utilized $33.0 million in tax deductions arising from 2009 stock option exercises, which resulted in an excess tax benefit of $13.2 million that was recorded to capital and an offsetting reduction to taxes payable.

Net income of $30.0 million for the year ended December 31, 2009 represents an increase of $8.7 million over net income for the same period in 2008 of $21.4 million.

Off-Balance Sheet Arrangements

Other than our Letter of Credit, we do not have any off-balance sheet arrangements.

Liquidity and Capital Resources

Our principal source of funds has been from operations. We believe that our cash, cash equivalents, future cash flows from operations and our revolving credit facility will be adequate to fund our current operating requirements. At December 31, 2010, our cash and cash equivalents and net working capital were $94.8 million and $147.5 million, respectively. Although we expect that operating cash flows will continue to be a primary source of liquidity for our operating needs, we also have $20.4 million available under our Revolving Loan for future cash flow needs. There are currently no loans outstanding under the Revolving Loan; however, we have a $4.6 million Letter of Credit that reduces the availability under the Revolving Loan.

Net cash provided by operating activities was $61.9 million in 2010, compared to $32.8 million in 2009 and $30.9 million in 2008. Cash provided by operating activities primarily resulted from $40.1 million in net income, $15.9 million in depreciation and amortization, and $7.5 million in share based compensation, which was partially offset by a $9.7 million increase in accounts receivable.

Net cash used in investing activities during 2010 was $53.7 million, compared to $23.2 million in 2009; and $11.4 million in 2008. Cash used to purchase the office building in Irving, Texas in 2010 was $9.9 million. Capital expenditures, including investments in capital software, in 2010, 2009 and 2008 were $17.6 million, $10.6 million and $6.9 million, respectively. Cash used for acquisitions in 2010, 2009 and 2008 was $26.1 million, $12.5 million and $4.5 million, respectively.

Net cash provided by financing activities during 2010 was $21.7 million; compared to $6.0 million in 2009; and $8.5 million in 2008. In 2010, net cash provided by financing activities consisted of $9.1 million in proceeds from stock option exercises and an excess tax benefit of $12.6 million from exercised stock options. Proceeds from stock option exercises in 2010, 2009 and 2008 were $9.1 million, $10.1 million and $4.2 million, respectively. Excess tax benefits from stock option exercises in 2010, 2009 and 2008 were $12.6 million, $13.2 million and $10.5 million, respectively. Repayment of debt in 2009 and 2008 was $17.3 million and $6.3 million, respectively. We repaid all of our outstanding debt in 2009; therefore, no repayment of debt was made in 2010.

The net increase in cash and cash equivalents was $30.0 million in 2010 compared to $15.6 million in 2009 and $27.9 million in 2008.

The number of days sales outstanding at December 31, 2010 decreased to 78 days compared to 88 days at December 31, 2009.

Operating cash flows could be adversely affected by a decrease in demand for our services or if contracts with our largest clients are cancelled. The majority of our client relationships have been in place for several years, as a result, we do not expect any decrease in the demand for our services in the near term.

Contractual Obligations

The following tables represent the scheduled maturities of our contractual cash obligations and other commitments at December 31, 2010 (in thousands):

	Payments Due by Period				
Contractual Obligations[1]	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
Operating leases[2]	$35,463	$12,531	$18,952	$3,294	$686
Interest expense[3]	93	93	—	—	—
Total	$35,556	$12,624	$18,952	$3,294	$686

(1) Performance based milestone payments relating to our acquisitions of Verify Solutions, Chapman Kelly and AMG-SIU have not been included in the table due to the uncertainty of achieving the future financial performance targets. In the event that the future performance targets are met, the resulting aggregate milestone payment obligation would be approximately $2.8 million and $3.4 million in 2011 and 2012, respectively.

(2) The amounts presented represent the future minimum lease payments under non-cancelable operating leases. In addition to minimum rent, certain of our leases require the payment for insurance, maintenance and other costs. These costs have historically represented approximately 3 to 6 percent of the minimum rent amount. These additional amounts are not included in the table of contractual obligations as the timing and/or amounts of such payments are unknown.

(3) Interest expense represents the commitment fee due on the Credit Agreement and the interest due on the Letter of Credit. See Note 7 of the Notes to Consolidated Financial Statements for additional information regarding the Credit Agreement.

We have entered into lease and sublease arrangements for some of our facility obligations and expect to receive the following rental payments in connection with those arrangements (in thousands):

Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
$7,100	$2,110	$3,433	$1,534	$23

On May 28, 1997 the Board of Directors authorized us to repurchase such number of shares of our common stock that have an aggregate purchase price not to exceed $10.0 million. On February 24, 2006, our Board of Directors increased the aggregate purchase price to an amount not to exceed $20.0 million. During the years ended December 31, 2010, 2009 and 2008, we did not repurchase any shares of our common stock. Since the inception of the repurchase program, we have repurchased 1,662,846 shares of our common stock for an aggregate purchase price of $9.4 million.

We currently have $20.4 million available under our Revolving Loan for future cash flow needs. There are currently no loans outstanding under the Revolving Loan; however, we have a $4.6 million Letter of Credit that

reduces the availability under the Revolving Loan. At this time, management does not expect to borrow under these facilities in 2011.

Recent Accounting Pronouncements

In September 2006, the FASB issued guidance on fair value measurements and disclosures. This guidance establishes a common definition for fair value to be applied to U.S. GAAP guidance requiring the use of fair value, establishes a framework for measuring fair value and expands the disclosure about such fair value measurements.

Effective January 1, 2008, we adopted this guidance on fair value measurement and have applied its provisions to financial assets and liabilities that are recognized or disclosed at fair value on a recurring basis at least annually. Beginning January 1, 2009, we adopted this guidance as it related to nonfinancial assets and liabilities. We applied the provisions of this guidance in our accounting for our 2009 and 2010 acquisitions.

In September 2009, the FASB issued additional guidance on measuring the fair value of liabilities effective for the first reporting period beginning after its issuance.

In January 2010, the FASB issued guidance that requires reporting entities to make new disclosures about recurring or nonrecurring fair-value measurements, including significant transfers into and out of Level 1 and Level 2 fair value measurements and information on purchases, sales, issuances and settlements on a gross basis in the reconciliation of Level 3 fair value measurements. The guidance is effective for annual reporting periods beginning after December 15, 2009, except for Level 3 reconciliation disclosures, which are effective for annual periods beginning after December 15, 2010. We do not expect the adoption of this guidance to have a material impact on our consolidated financial statements.

In November 2008, the FASB ratified an issue providing guidance for accounting for defensive intangible assets subsequent to the acquisition of such assets in accordance with the new business combination and fair value standards, including the estimated useful life that should be assigned to such assets. The new guidance is effective for intangible assets acquired on or after December 15, 2008. We have applied the provisions of this standard to our 2009 and 2010 acquisitions as discussed in Note 2 of the Notes to Consolidated Financial Statements.

In October 2009, the FASB issued new accounting guidance related to the recognition of revenue for multiple-deliverable arrangements. This guidance provides accounting principles and application guidance on how the arrangement should be separated, and the consideration allocated. This guidance changes how to determine the fair value of undelivered products and services for separate revenue recognition. Allocation of consideration is now based on management's estimate of the selling price for an undelivered item where there is no other means to determine the fair value of that undelivered item. Also in October 2009, the FASB issued new accounting guidance altering the scope of revenue recognition for software deliverables to exclude items sold that include hardware with software that is essential to the hardware's functionality. This new guidance will be effective prospectively for revenue arrangements entered into or materially modified in fiscal years beginning on or after June 15, 2010. Early adoption is permitted. We have determined that this new guidance will not currently impact our existing accounting over our multiple element arrangements described in Note 1 to the Notes to Consolidated Financial Statements.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

At fiscal year-end 2010, we were not a party to any derivative financial instruments. We conduct all of our business in U.S. currency and hence do not have direct foreign currency risk. The interest on borrowings under the Credit Agreement is at a variable rate based on the prime rate or LIBOR and may include a spread over or under the applicable rate. Further, we currently invest substantially all of our excess cash in short-term investments, primarily money market accounts, where returns effectively reflect current interest rates. As a result, market interest rate changes may impact our interest income or expense. The impact will depend on variables such as the magnitude of rate changes and the level of borrowings or excess cash balances. We do not consider this risk to be material. We manage such risk by continuing to evaluate the best investment rates available for short-term, high quality investments.

Item 8. Financial Statements and Supplementary Data.

The information required by Item 8 is found on pages 73 to 102 of this Annual Report.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

We maintain disclosure controls and procedures (as defined in Rule 13a-15(e) under the Exchange Act) that are designed to ensure that information required to be disclosed by us in reports that we file under the Exchange Act is recorded, processed, summarized and reported as specified in the SEC's rules and forms and that such information required to be disclosed by us in reports that we file under the Exchange Act is accumulated and communicated to our management, including our Chief Executive Officer and our Chief Financial Officer to allow timely decisions regarding required disclosure.

As required by Rule 13a-15(b) under the Exchange Act, management, with the participation of our Chief Executive Officer and Chief Financial Officer, performed an evaluation of the effectiveness of our disclosure controls and procedures as of December 31, 2010. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by this Annual Report.

Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting and for the assessment of the effectiveness of internal control over financial reporting. As defined by Rule 13a-15(f) of the Exchange Act, internal control over financial reporting is a process designed by, or under the supervision of our Chief Executive Officer and our Chief Financial Officer and effected by our Board of Directors, management and other personnel, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the consolidated financial statements for external purposes in accordance with U.S. GAAP.

Our internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect our transactions and dispositions of our assets; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the consolidated financial statements in accordance with generally accepted accounting principles and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In connection with the preparation of our annual consolidated financial statements, management has undertaken an assessment of the effectiveness of our internal control over financial reporting as of December 31, 2010, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission, or the COSO Framework. Management's assessment included an evaluation of the design of our internal control over financial reporting and testing of the operational effectiveness of those controls.

Based on this assessment, management has concluded that as of December 31, 2010, our internal control over financial reporting was effective in providing reasonable assurance regarding the reliability of financial reporting and the preparation of the consolidated financial statements for external purposes in accordance with U.S. GAAP.

KPMG LLP, the independent registered public accounting firm that audited our consolidated financial statements included in this Annual Report, has issued an attestation report on our assessment of our internal control over financial reporting, a copy of which is appears on page 75.

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting identified in connection with the evaluation of our controls performed during the quarter ended December 31, 2010 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

On March 1, 2011, we entered in an Executive Employment Agreement with William C. Lucia, our President and Chief Executive Officer. The terms of this Agreement are described in detail in Item 11 Executive Compensation, under the captions "Executive Employment Agreements" and "Potential Payments upon Termination of Employment or Change-in-Control".

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Our Board of Directors

The following table sets forth information with respect to our directors.

Name	Age	Position	Committee Memberships
Robert H. Holster	64	Non-executive Chairman and Director	
James T. Kelly	64	Director	Audit, Compensation, Nominating
William C. Lucia	53	President, Chief Executive Officer and Director	
William F. Miller III	61	Director	Audit, Compensation, Nominating
William S. Mosakowski	57	Director	
Ellen A. Rudnick	60	Director	Audit*, Compliance, Nominating
Bart M. Schwartz	64	Director	Compliance*, Nominating
Michael A. Stocker, M.D.	69	Director	Compliance, Nominating*
Richard H. Stowe	67	Director	Audit, Compensation*, Nominating

* Committee Chair

The Board of Directors believes that the combination of the business and professional experience of our directors and the diversity of their areas of expertise has been a contributing factor to its effectiveness and provides a valuable resource to management. With the exception of our President and Chief Executive Officer, Mr. Lucia, and the latest addition to our Board, Mr. Schwartz, each of our directors has served on our Board for more than three years and, in particular, Ms. Rudnick and Messrs. Miller and Stowe have each served on our Board for more than ten years. During their tenures, our directors have gained considerable institutional knowledge about the Company and its operations. Given the growth of our business and the rapidly changing healthcare environment, this continuity of service and development of institutional knowledge enables our Board to be more efficient and more effective in developing strategy and long-term plans for the Company.

A description of the specific experience, qualifications, attributes and skills that led our Board of Directors to conclude that each member of the Board of Directors should serve as a director follows the biographical information of each director below.

Directors Whose Terms Expire in 2011

William F. Miller III has served as one of our directors since October 2000. Mr. Miller is a partner of Highlander Partners, a private equity group in Dallas, Texas focused on investments in healthcare products, services and technology. From October 2000 to April 2005, Mr. Miller served as our Chief Executive Officer and from December 2000 to April 2006, Mr. Miller served as our Chairman. From 1983 to 1999, Mr. Miller served as President and Chief Operating Officer of EmCare Holdings, Inc., a national healthcare services firm focused on the provision of emergency physician medical services. From 1980 to 1983, Mr. Miller served as Administrator/Chief Operating Officer of Vail Mountain Medical. Mr. Miller also serves as a director of Lincare Holdings, Inc. and several private companies.

Mr. Miller brings to the Board of Directors both a thorough understanding of our business and the healthcare industry and extensive experience in the financial markets. His significant operational experience, both at HMS and at EmCare Holdings, makes him well-positioned to provide the Company with insight on financial, operational and strategic issues and makes him a valuable member of our Audit and Compensation Committees.

Ellen A. Rudnick has served as one of our directors since 1997. Since 1999, Ms. Rudnick has served as Executive Director and Clinical Professor of the Polsky Center for Entrepreneurship, University of Chicago Booth

School of Business. From 1993 until 1999, Ms. Rudnick served as Chairman of Pacific Biometrics, Inc., a publicly held healthcare biodiagnostics company and its predecessor, Bioquant, which she co-founded. From 1990 to 1992, she served as President and Chief Executive Officer of Healthcare Knowledge Resources (HKR), a privately held healthcare information technology corporation and subsequently served as President of HCIA, Inc. (HCIA) following the acquisition of HKR by HCIA. From 1975 to 1990, Ms. Rudnick served in various positions at Baxter Health Care Corporation, including Corporate Vice President of Baxter Healthcare and President and Founder of Baxter Management Services Division. From 1992 to 2003, Ms. Rudnick served as Chairman of CEO Advisors, Inc., a privately held consulting firm. Ms. Rudnick also serves as a director of Patterson Companies, Inc. and First Midwest Bancorp, Inc.

Ms. Rudnick brings to the Board of Directors extensive business understanding and demonstrated management expertise, having served in key leadership positions at a number of healthcare companies. Ms. Rudnick has a comprehensive understanding of the operational, financial and strategic challenges facing companies and knows how to make businesses work effectively and efficiently. Her management experience has provided her with a thorough understanding of the financial and other issues facing large companies, making her particularly valuable as the Chairman of our Audit Committee and as a member of our Nominating and Compliance Committees.

Michael A. Stocker, M.D. has served as one of our directors since January 2007. Since September 2008, Dr. Stocker has served as Chairman of the Board of the New York City Health and Hospitals Corporation (HHC), the largest municipal hospital and health care system in the country. From January 2006 to April 2007, Dr. Stocker served as President and Chief Executive Officer of WellPoint, Inc.'s East Region. Dr. Stocker served as President and Chief Executive Officer of Empire Blue Cross Blue Shield from 1994 until its acquisition by Wellpoint, Inc. in December 2005. Dr. Stocker has also held executive level positions with both CIGNA and US Healthcare. Dr. Stocker serves as a director of Coventry Health Care, Inc. He also serves on the Boards of the Arthur Ashe Institute for Urban Health, New York Stem Cell Funding Committee, SeeChange Health and Triveris, Inc. (part of the Psilos Group).

Dr. Stocker brings a unique perspective to our Board of Directors given his background as a medical professional, his recognized expertise as a business leader, which is exemplified by his appointment as Chairman of HHC by New York's Mayor Bloomberg and his executive-level experience at some of the largest US health insurance companies. Dr. Stocker's background and experience make him well-positioned to serve as the Chairman of the Nominating Committee and as a member of the Compliance Committee.

Richard H. Stowe has served as one of our directors since 1989. Mr. Stowe is a general partner of Health Enterprise Partners LLP, a private equity firm. From 1999 to 2005, Mr. Stowe was a private investor, a senior advisor to the predecessor funds to Health Enterprise Partners and a senior advisor to Capital Counsel LLC, an asset management firm. From 1979 until 1998, Mr. Stowe was a general partner of Welsh, Carson, Anderson & Stowe. Prior to 1979, he was a Vice President in the venture capital and corporate finance groups of New Court Securities Corporation (now Rothschild, Inc.). Mr. Stowe is also a director of several private and not-for-profit companies and educational institutions. From 1998-2007, Mr. Stowe served as a director of MedQuist, Inc.

Mr. Stowe brings 40 years of financial, capital markets and investment experience to our Board of Directors. Mr. Stowe's background and experience make him well-positioned to serve as the Chairman of the Compensation Committee and as a member of the Audit and Nominating Committees.

Directors Whose Terms Expire in 2012

Robert M. Holster has served as one of our directors since May 2005 and as the Chairman of our Board of Directors since April 2006 (in a non-employee capacity since January 2011). From May 2005 to February 2009, Mr. Holster served as our Chief Executive Officer and from April 2001 to May 2005, he served as President and Chief Operating Officer. Previously, Mr. Holster served as our Executive Vice President from 1982 through 1993 and as one of our directors from 1989 through 1996. Mr. Holster previously served in a number of executive positions including Chief Executive Officer of HHL Financial Services, Inc., Chief Financial Officer of Macmillan, Inc. and Controller of Pfizer Laboratories, a division of Pfizer, Inc.

Mr. Holster has been a member of our management team and that of our predecessor, Health Management Systems, Inc. for an aggregate of over 20 years, including serving as our Chief Executive Officer for four years and as our President and Chief Operating Officer for four years. Given his extensive history with the Company, Mr. Holster brings an unmatched depth of industry and company-specific experience to his role as our Chairman.

James T. Kelly has served as one of our directors since December 2001. Mr. Kelly is a private investor. From 1986 to 1996, Mr. Kelly served as the Chief Executive Officer of Lincare Holdings, Inc., a publicly traded company that provides respiratory care, infusion therapy and medical equipment to patients in the home. From 1994 to 2000, Mr. Kelly served as Chairman of the Board of Directors of Lincare Holdings. Prior to joining Lincare, Mr. Kelly spent 19 years in various management positions within the Mining and Metals Division of Union Carbide Corporation. Mr. Kelly also serves as a director of Emergency Medical Services Corporation and from 1997 to 2009 Mr. Kelly served as a director of American Dental Partners, Inc.

Mr. Kelly brings over 20 years of public company experience to our Board of Directors, both through his board memberships and through his role as Chief Executive Officer of Lincare Holdings. Given his background and experiences, he provides the Company with valuable financial, operational and strategic expertise and his extensive experience with financial reporting rules and regulations in a public company environment make him well-positioned to serve as a member of the Audit Committee, as our Audit Committee Financial Expert and as a member of the Compensation Committee.

William C. Lucia has served as our President and Chief Executive Officer since March 2009 and as one of our directors since May 2008. From May 2005 to March 2009, Mr. Lucia served as our President and Chief Operating Officer. Since joining us in 1996, Mr. Lucia has held several positions with us, including: President of our subsidiary, Health Management Systems, Inc. from 2002 to 2009; President of our Payor Services Division from 2001 to 2002; Vice President and General Manager of our Payor Services Division from 2000 to 2001; Vice President of our Business Office Services from 1999 to 2000; Chief Operating Officer of our former subsidiary Quality Medical Adjudication, Incorporated (QMA) and Vice President of West Coast Operations from 1998 to 1999; Vice President and General Manager of QMA from 1997 to 1998; and Director of Information Systems for QMA from 1996 to 1997. Prior to joining us, Mr. Lucia served in various executive positions including Senior Vice President, Operations and Chief Information Officer for Celtic Life Insurance Company and Senior Vice President, Insurance Operations for North American Company for Life and Health Insurance. Mr. Lucia is a Fellow of the Life Management Institute (FLMI) Program through LOMA, an international association through which insurance and financial services companies around the world engage in research and educational activities to improve company operations.

With over 14 years experience working across multiple divisions at HMS and his prior experience in the insurance industry, Mr. Lucia brings to our Board of Directors in-depth knowledge of the Company and the healthcare and insurance industries. In his prior role as our President and Chief Operating Officer, Mr. Lucia gained critical insights into managing and growing our business in our complex and dynamic healthcare environment, making him well-positioned to lead our management team and provide essential insight and guidance to the Board of Directors from an inside perspective.

William S. Mosakowski has served as one of our directors since December 2006. Mr. Mosakowski is the President and Chief Executive Officer of Public Consulting Group, Inc. (PCG), which he founded in 1986. Prior to starting PCG, Mr. Mosakowski served as Assistant Revenue Director for the Massachusetts Department of Developmental Services (formerly the Department of Mental Health and Mental Retardation). He later served as Manager of Reimbursement for the Harvard Community Health Plan and was a senior consultant with Touche Ross & Company. Mr. Mosakowski is the Chairman of the Board of Trustees of Clark University and a founding benefactor of Clark University's Mosakowski Institute for Public Enterprise. Mr. Mosakowski serves on the Board of Directors of several private and not-for-profit companies.

Given Mr. Mosakowski's experiences founding and growing PCG, he brings to our Board of Directors a deep understanding of the healthcare industry, the services that we provide, the markets that we serve and the potential for our continued growth.

Bart M. Schwartz has served as one of our directors since July 2010. Mr. Schwartz currently serves as the Chairman and Chief Executive Officer of SolutionPoint International LLC which provides an integrated array of business intelligence, security and compliance, identity assurance and situational awarness solutions. In 2003, Mr. Schwartz founded his own law firm, which specializes in, among other areas, conducting independent investigations, monitoring and Independent Private Sector Inspector General engagements and developing, auditing and implementing compliance programs. From 1991 to 2003, Mr. Schwartz served as the Chief Executive Officer of Decision Strategies, an internationally recognized investigative and security firm, which was sold to SPX Corporation in 2001. Mr. Schwartz has over 30 years' experience managing domestic and international investigations, prosecutions and assessments for clients in both the public and private sectors.

Mr. Schwartz brings extensive legal and compliance experience to our Board of Directors, which is particularly valuable as we continue to expand our business. Mr. Schwartz's background makes him well-positioned to serve as the Chairman of the Compliance Committee and a member of the Nominating Committee.

Audit Committee and Audit Committee Financial Expert

We have a separately-designated standing Audit Committee which consists of Ms. Rudnick (Chair) and Messrs. Kelly, Miller and Stowe. Mr. Miller joined the Audit Committee effective January 2011. The Board of Directors has determined that each member of the Audit Committee is an independent director, as defined in the NASDAQ Marketplace Rules and the independence requirements contemplated by Rule 10A-3 under the Exchange Act and meets NASDAQ's financial knowledge and sophistication requirements. In addition, the Board has determined that Mr. Kelly qualifies as an "audit committee financial expert," as such term is defined in Item 407(d)(5)(ii) of Regulation S-K.

Material Changes to the Procedures for Recommending Nominees to the Board of Directors

On February 17, 2011, our Board of Directors amended our By-laws to include a provision requiring that shareholders provide us with advance notice in connection with director nominations to be presented at a shareholder meeting. Under the terms of our Amended Restated By-laws, a nomination for election to our Board at a meeting of shareholders may be made by any shareholder of the Corporation who (i) timely submits a notice, (ii) is a shareholder of record on the date of giving such notice and on the record date for the determination of shareholders entitled to vote at such meeting, and (iii) is entitled to vote at such meeting.

To be timely, a shareholders notice of intent, or Notice, to introduce a nomination must be received in writing by the Secretary at our principal executive offices located at 401 Park Avenue South, New York, NY 10016, as follows:

(i) For an annual meeting: not less than 90 days nor more than 120 days prior to the first anniversary of the preceding year's annual meeting.

(ii) For a special meeting: provided that the Board has determined that directors shall be elected at such meeting, not earlier than the 120th day prior to such special meeting and not later than the close of business on the later of (x) the 90th day prior to such special meeting and (y) the tenth day following the day on which notice of the date of such special meeting was mailed or the date was publicly disclosed, whichever first occurs.

Article II, Section 9 of our Amended and Restated By-laws sets forth the information about the nominee that must be contained in the Notice. This information includes, but is not limited to the following regarding the nominee:

- name, age, business address, and if known, residence address,
- principal occupation or employment,
- shares of our common stock that are, directly or indirectly, beneficially owned by such nominee,
- a description of all material monetary arrangements or other material relationships during the past three years, between or among: (x) the party (including affiliates, associates or others acting in concert with such

party) on whose behalf the nomination is being made, on the one hand, and (y) each proposed nominee (and his or her respective affiliates, associates, or others acting in concert with him/her), on the other hand

- the information that would be required to be disclosed pursuant to Item 404 of Regulation S-K if the party making the nomination and the party on whose behalf the nomination is made (including any affiliates, associates thereof or person acting in concert therewith) were the "registrant" for purposes of such Item and the proposed nominee were a director or executive officer of such registrant,
- the information concerning such person that must be disclosed as to nominees in proxy solicitations pursuant to Regulation 14A under the Exchange Act, and
- the written consent of the proposed nominee to serve as a Director if elected.

In addition, the Notice, as more specifically described in Article II, Section 9 of our Amended and Restated By-laws, must contain the following information as to the shareholder giving the notice and the beneficial owner, if any, on whose behalf the nomination is being made:

- name and address, as they appear on our books,
- shares of our common stock that are, directly or indirectly, beneficially owned,
- a description of any arrangement between such shareholder and/or such beneficial owner and each proposed nominee and any other person(s) (including their names) pursuant to which the nomination(s) are being made or who may participate in the solicitation of proxies in favor of electing such nominee(s),
- a description of any agreement, arrangement or understanding (including any derivative or short positions, profit interests, options, warrants, stock appreciation or similar rights, hedging transactions, and borrowed or loaned shares) that has been entered into by, or on behalf of, such shareholder or such beneficial owner, the effect or intent of which is to mitigate loss to, manage risk or benefit of share price changes for, or increase or decrease the voting power of, such shareholder or such beneficial owner with respect to shares of our common stock, and
- such other information that would be required to be disclosed in connection with solicitations of proxies for the election of such nominee in a contested election (even if an election contest is not involved) pursuant to Section 14 of the Exchange Act and the rules and regulations promulgated thereunder.

The Notice must also contain certain representations on behalf of the shareholder and/or such beneficial owner, as more fully described in Article II, Section 9 of the Amended and Restated By-laws.

Notwithstanding the foregoing, if the shareholder, or a qualified representative of the shareholder) does not appear at the meeting of shareholders to present a nomination, such nomination shall not be brought before the meeting.

The Chairman of the meeting has the power and duty to determine whether a nomination was made in accordance with our Amended and Restated By-laws, and the Chairman should determine that a nomination was not properly made, the Chairman shall declare so at the meeting and the nomination will not be brought before the meeting.

Section 16(A) Beneficial Ownership Reporting Compliance

Pursuant to Section 16(a) of the Exchange Act and the rules issued thereunder, our executive officers and directors are required to file with the SEC and NASDAQ reports of ownership and changes in ownership of common stock. Copies of such reports are required to be furnished to us.

Based solely on review of the copies of such reports furnished to us, or written representations that no other reports were required, we believe that during fiscal year 2010, all of our executive officers and directors complied with the requirements of Section 16(a), except that due to administrative error, (i) Mr. Lucia, our President and Chief Executive Officer and a director, filed one late Form 4 reporting the exercise of a stock option and the sale of the underlying shares of common stock pursuant to his 10b5-1 plan, (ii) Mr. Holster, our Chairman of the Board filed one late Form 4 reporting the exercise of a stock option and the sale of the underlying shares of common stock,

(iii) Mr. Schwartz, one of our directors, filed one late Form 3, (iv) Ms. Dragonetti, our Executive Vice President of Corporate Development filed an amended Form 3 to reflect her direct common stock holdings and (v) Mr. Miller, one of our directors, did not timely file a Form 4 to report the sale of shares of our common stock; however, this transaction was subsequently reported on a Form 5.

Code of Ethics

We have adopted a Code of Business Conduct For Designated Senior Financial Managers that applies to our principal executive officer, principal financial officer, principal accounting officer, controller, or persons performing similar functions and such other personnel of the Company or its wholly-owned subsidiaries as may be designated from time to time by the Chairman of the Company's Audit Committee. The Code of Business Conduct is posted on our website at www.hms.com under the "Investors Relations"/ "Corporate Governance" tabs and can also be obtained free of charge by sending a request to our Corporate Secretary at 401 Park Avenue South, New York, New York 10016. Any changes to or waivers under the Code of Business Conduct as it relates to our principal executive officer, principal financial officer, principal accounting officer, controller or persons performing similar functions must be approved by our Board of Directors and will be disclosed in a Current Report on Form 8-K within four business days of the change or waiver.

Item 11. Executive Compensation.

Compensation Discussion and Analysis

Introduction

This Compensation Discussion and Analysis, or CD&A, describes HMS's 2010 executive compensation program and should be read in conjunction with the compensation tables and related narrative descriptions that follow those tables. We use this program to attract, motivate and retain the individuals who lead our business. In particular, this CD&A explains how the Compensation Committee of the Board of Directors (the "Board") made its compensation decisions for our Named Executive Officers for 2010.

As of the end of the fiscal year ended December 31, 2010, our Named Executive Officers were:

- William C. Lucia, President and Chief Executive Officer;
- Walter D. Hosp, Chief Financial Officer;
- Sean Curtin, Executive Vice President, Operations;
- Christina Dragonetti, Executive Vice President, Commercial Markets; and
- Maria Perrin, Executive Vice President, Government Markets.

Executive Summary

The following is a brief overview of our executive compensation program and our financial performance in 2010.

- The objectives of our executive compensation program are to attract, develop, motivate and retain talented executives and to align their interests with those of our shareholders.
- Our executive compensation program is designed to provide a balance of total compensation opportunities that are competitive with similarly situated companies and reflective of our performance. Our executive compensation package consists of: cash in the form of base salary, annual short term (cash) incentive compensation and long-term incentive awards, primarily in the form of equity.
- For the full year 2010, we reported revenue of $302.9 million, a 32.1% increase over 2009 revenue of $229.2 million. Also for the full year, we reported net income increased to $40.1 million, a 33.4% increase over 2009 net income of $30.0 million.

- During 2010, we completed two strategic acquisitions: Allied Management Group — Special Investigations Unit and Chapman Kelly, Inc., further strengthening our products and services as we prepare our clients for addressing the requirements of the Patient Protection and Affordable Care Act, as amended.

The following highlights the Compensation Committee's key compensation decisions for 2010, as reported in the 2010 Summary Compensation Table. These decisions were made with the advice of the Compensation Committee's independent consultant, Frederic W. Cook & Co., Inc., or FWC, (see "Role of Compensation Consultant" below) and are discussed in greater detail elsewhere in this CD&A.

- In 2010, our executive group was expanded to include, among others, Mr. Curtin and Mses. Dragonetti and Perrin. Their inclusion in the executive team was based on their increased responsibilities under Mr. Lucia's stewardship of the Company and their contributions to its overall growth and performance. In connection with this expansion of the executive team, the Compensation Committee undertook, with the assistance of FWC, a full review of executive compensation. In recognition of the Company's performance, the integral role of the Named Executive Officers in achieving this performance and the Board's desire to maintain this core executive group, the Compensation Committee set, as a general guideline for setting 2010 compensation, a total direct compensation package for the Named Executive Officers at between the median and the 75th percentile for our 2010 Peer Group (as described below).

- In July 2010, in connection with the expansion of our executive team, base salaries for our Named Executive Officers were increased to approximate between the median and the 75th percentile for our 2010 Peer Group.

- Annual short term (cash) incentive compensation for the Named Executive Officers was determined in January 2011. The 2010 awards for the Named Executive Officers were paid at an average of 135.3% of target. The awards were based on predefined financial objectives, primarily consisting of achievement of net income, operating income and departmental operating income targets.

- Regular annual long-term incentive awards were granted in October 2010.

- In February 2011 the Board approved the grant, to our Named Executive Officers of restricted stock units with an aggregate value of $4.95 million. An aggregate of 66,962 restricted stock units were granted to our Named Executive Officers on February 18, 2011, based on the closing price of our common stock of $73.92 on the NASDAQ Global Select Market on that date. The restricted stock units vest in 25% increments, with the first 25% vesting on the second anniversary of the grant date and the remainder vesting ratably on the third, fourth and fifth anniversaries of the grant date.

Objectives and Philosophy of Our Executive Compensation Program

Our mission is to be a significant provider of quality services in the markets we serve. To support this and other strategic objectives as approved by the Board and to provide adequate returns to shareholders, we must compete for, attract, develop, motivate and retain top quality executive talent at the corporate office and operating business units during periods of both favorable and unfavorable business conditions.

Our executive compensation program is a critical management tool in achieving this goal. "Pay for performance" is the underlying philosophy for our executive compensation program. Consistent with this philosophy, the program has been carefully conceived and is independently administered by the Compensation Committee, which is comprised entirely of non-employee directors.

The program is designed and administered to:

- align the interests of our senior executives with the interests of our shareholders, thus rewarding individual and team achievements that contribute to the attainment of our business goals; and

- provide a balance of total compensation opportunities, including salary, bonus and longer-term cash and equity incentives that are competitive with similarly situated companies and reflective of our performance.

Role of Management

Our President and Chief Executive Officer develops recommendations regarding executive compensation program design and individual compensation levels for our other Named Executive Officers and certain other highly compensated individuals. He also provides the Compensation Committee with a performance assessment for each Named Executive Officer as input to base salary and incentive award recommendations and provides financial information relevant to determining the achievement of our performance objectives and related annual cash incentive bonuses. In addition, our President and Chief Executive Officer and our Chief Financial Officer are involved in setting the financial objectives that, subject to the approval of the Board and the Compensation Committee, are used as the performance measures for the annual and long-term incentive plans.

Role of Compensation Consultant

The Compensation Committee has retained FWC as its independent compensation consultant to provide executive compensation services to the Compensation Committee. FWC reports directly to the Compensation Committee and the Compensation Committee directly oversees the fees paid for FWC's services. The Compensation Committee utilizes FWC to review management's recommendations with the instruction that FWC is to advise the Compensation Committee independent of management and to provide such advice for the benefit of the Company and its shareholders. FWC does not provide any consulting services to the Company beyond its role as a consultant to the Compensation Committee.

FWC provided the following services to the Compensation Committee in connection with its review of the Company's 2010 executive compensation programs:

- assisted in the design and development of the 2010 executive compensation program;
- provided competitive benchmarking and market data analysis;
- provided analyses and industry trends relating to the compensation of our Chief Executive Officer and our other Named Executive Officers; and,
- provided updates with regard to emerging trends and best practices in executive compensation.

Peer Group Compensation Analysis

While our executive team is comprised of long-term employees of the Company, there has been a significant change in our Named Executive Officers in the last two years. Mr. Lucia became our President and Chief Executive Officer in 2009 and in 2010, Mr. Curtin and Mses. Dragonetti and Perrin became Named Executive Officers. As part of the development of the new executive team, the Compensation Committee used benchmarking as a tool to set appropriate pay levels; however, the Compensation Committee may not perform such benchmarking on an annual basis.

In determining 2010 executive compensation, the Compensation Committee compared our executive compensation against that paid by a peer group of public companies in the healthcare information services industry approved by the Compensation Committee, taking into account the recommendations of FWC. This peer group, which is periodically reviewed and updated by the Compensation Committee, consists of companies the Compensation Committee believes are generally comparable to us in size, financial profile and scope of operations and against which the Compensation Committee believes we compete for executive talent.

Companies included in this peer group for purposes of establishing 2010 compensation levels were: Allscripts-Misys Healthcare Solutions Inc., AthenaHealth, Inc., Computer Programs & Systems Inc., Eclipsys Corporation, Emdeon Inc., Healthways, Inc., MAXIMUS, Inc., MedAssets, Inc., Phase Forward, Incorporated and Quality Systems, Inc. (collectively, the "2010 Peer Group"). This peer group reflects (relative to the Company's prior peer group) the removal of CorVel Corporation and eResearch Technology, Inc. because they are no longer an appropriate size for inclusion in the peer group.

The chart below compares HMS's revenue, net income and market capitalization to the median revenue, net income and market capitalization for our 2010 Peer Group. Note that although HMS's revenue is below the median, its net income and market capitalization are above the median.

	HMS	2010 Peer Group Median
	(in millions)[1]	
Revenue	$ 244	$ 440
Reported Net Income[2]	$ 32	$ 19
Market Capitalization[3]	$1,473	$1,073

(1) Revenue and Net Income based on published earnings releases for the 12 month period ended March 31, 2010.

(2) Before extraordinary items and discontinued operations

(3) As of May 31, 2010

Components of our Executive Compensation Program

The primary elements of our executive compensation program are as follows:

Recognizing Skills/Experience/Responsibilities

Base salary: fixed compensation for performing day-to-day responsibilities.

Rewarding Short-Term Performance

Annual short term (cash) incentive compensation: cash compensation program based on the achievement of short-term financial goals and other strategic objectives measured over the current year.

Rewarding Long-Term Performance

Long-Term Incentive Awards: Annual awards, primarily in the form of equity, that are designed to build executive stock ownership, retain executives and align compensation with the achievement of HMS's long-term financial goals of creating shareholder value and achieving strategic objectives as measured over multi-year periods.

2010 Executive Compensation

The Compensation Committee does not have a formal or informal policy or target for allocating compensation between cash and non-cash compensation, or among the different forms of non-cash compensation. However, certain components of executive compensation are paid based on predefined targets established in connection with a Named Executive Officer's employment. For example, annual short term (cash) incentive compensation is based on a predetermined financial performance objective and paid based on a pre-established bonus target percentage. In allocating compensation between cash and non-cash forms, the Compensation Committee, after reviewing information provided by FWC, determines what it believes in its business judgment to be the appropriate level of each of the various compensation components with an overall goal of setting total direct compensation between the median and the 75th percentile for our 2010 Peer Group.

Base Salary.

Base salary is used to recognize the experience, skills, knowledge and responsibilities of our employees, including our Named Executive Officers. In determining the amount of compensation to be paid to our Named Executive Officers, the Compensation Committee adheres to long established compensation policies pursuant to which executive compensation is determined. Base salary determinants consist of the prevailing rate of compensation for positions of like responsibility and the level of the Named Executive Officer's compensation in relation to others with similar responsibilities and tenure. To ensure both competitiveness and appropriateness of base salaries, we retain independent compensation consultants on a periodic basis to update the job classification and pay scale structure pursuant to which individual Named Executive Officers are classified and the pay ranges with which their jobs are associated.

Base salaries are reviewed at least annually by our Compensation Committee and are adjusted from time to time to realign salaries with market levels after taking into account individual responsibilities, performance and experience. In 2010, in recognition of their increased responsibilities and contributions in light of HMS's significant growth, the Board designated Mr. Curtin, Mses. Dragonetti and Perrin, among others, as executive officers. In mid-2010, the Compensation Committee retained FWC to assist in the evaluation of the overall compensation packages of our Named Executive Officers. The compensation analysis was based on a review of the compensation of our Named Executive Officers to similarly situated executives in the 2010 Peer Group. Based on this analysis it was determined that the base salaries for the Named Executive Officers were generally below the median for the 2010 Peer Group. The Compensation Committee determined that, in light of (i) the Company's exemplary performance through July 2010, (ii) the integral role of the Named Executive Officers in achieving this performance and (iii) the Board's desire to maintain this core executive group, it would target base salaries for our Named Executive Officers between the median and the 75th percentile for the 2010 Peer Group for purposes of setting 2010 compensation.

William C. Lucia, President & Chief Executive Officer

In February 2010, following a review of Mr. Lucia's performance in his first year as President and Chief Executive Officer and taking into consideration the Company's past compensation practices for Chief Executive Officers and the salaries of Chief Executive Officers in the 2010 Peer Group, the Compensation Committee approved an increase in Mr. Lucia's annualized base salary from $400,000 to $525,000, effective March 1, 2010. In making this determination, the Compensation Committee also considered that the Company completed two acquisitions in 2009 and increased revenue and net income by more than 25% over the prior year.

In July 2010, as part of the overall review of compensation packages for our Named Executive Officers, the Compensation Committee increased Mr. Lucia's base salary from $525,000 to $650,000, effective August 1, 2010, placing him within the median and the 75th percentile for the 2010 Peer Group

Walter Hosp, Chief Financial Officer

In July 2010, the Compensation Committee approved an increase in Mr. Hosp's base salary from $325,000 to $425,000. This was Mr. Hosp's first salary increase since he joined the Company in 2007 and places him at approximately the 75th percentile for the 2010 Peer Group.

Sean Curtin, Executive Vice President, Operations

In July 2010, in connection with his designation as an executive officer, the Compensation Committee set Mr. Curtin's base salary at $400,000, placing him at the median for his position for the 2010 Peer Group.

Christina Dragonetti, Executive Vice President, Commercial Markets

In July 2010, in connection with her designation as an executive officer, the Compensation Committee set Ms. Dragonetti's base salary at $400,000, placing her at the 75th percentile for her position for the 2010 Peer Group.

Maria Perrin, Executive Vice President, Government Markets

In July 2010, in connection with her designation as an executive officer, the Compensation Committee set Ms. Perrin's base salary at $400,000, placing her at the median for her position for the 2010 Peer Group.

Annual Short Term (Cash) Incentive Compensation.

The Compensation Committee has the authority to award annual bonuses to our Named Executive Officers in accordance with specific performance criteria established each year and based on the extent to which those criteria were achieved. The Compensation Committee believes that the short term bonus plan promotes the Company's performance-based compensation philosophy by providing Named Executive Officers with direct financial incentives in the form of annual cash bonuses for achieving specific performance goals. Bonus criteria are established and bonuses are ultimately awarded, in a manner intended to reward both overall corporate performance and an individual's participation in attaining such performance. Our annual short term incentive bonus is paid in

cash, ordinarily in a single installment in the first quarter following the completion of the fiscal year and is tied to the achievement of predetermined annual corporate financial and, in some cases, individual performance objectives. The targeted amount of annual performance bonus for 2010 was 65% of base salary for Mr. Lucia and 50% of base salary for Messrs. Hosp and Curtin and Mses. Dragonetti and Perrin.

The primary factor that the Compensation Committee considers when determining short term (cash) incentive compensation for our Named Executive Officers is a predetermined financial performance objective. If the Company achieves its financial performance objective, the Named Executive Officers become entitled to short term cash incentive compensation. In addition, upon the Company's achievement of this objective, the Compensation Committee has the discretion to adjust short term cash incentive payments based upon its consideration of individual performance during the course of the year. There is no maximum on the bonus amount payable to our Named Executive Officers and the Compensation Committee may increase or decrease the annual bonus paid based on the attainment of goals relating to strategic objectives or to account equitably for items impacting the predetermined performance objectives that are non-recurring in nature.

The financial objective established for 2010 for Messrs. Lucia and Hosp was the achievement by the Company of a specific net income target. The Company uses net income because it is a primary reporting metric and is based on generally accepted accounting principles. Net income includes all income and expense items and all gains and losses, whether they are considered recurring or non-recurring. As illustrated in the chart below, the applicable percentage of the bonus target to be paid varies with the percentage of the Company's attainment of its net income target. The net income target for 2010 was $38.1 million.

Net Income Target (In millions)	Percent of Target Achieved	Bonus Multiple
$32.3	85%	—
$35.2	92.5%	0.5
$38.1	100%	1.0
$41.9	110%	1.5
$45.7	120%	2.0
$49.5	130%	2.5
$53.3	140%	3.0

As illustrated in the chart, upon the achievement of 100% of the Company's net income target, Messrs. Lucia and Hosp would be entitled to 100% of their respective bonus targets. The threshold for payment of any amount under the incentive plan for 2010 was attainment of more than 85% of the Company's net income target. The achievement of 92.5% of the Company's net income target would result in payment to Messrs. Lucia and Hosp of 50% of the bonus target.

Given the roles of Mr. Curtin and Mses. Dragonetti and Perrin as leaders of specific functional areas, the Committee, upon the advice of Mr. Lucia and FWC, determined that a more appropriate financial objective for these Named Executive Officers should include the achievement by the Company of a specified operating income target. Mr. Curtin's annual (cash) incentive bonus, as the Executive Vice President of Operations, is based entirely on the Company's achievement of a specified operating income target. In the case of Mses. Dragonetti and Perrin, their annual bonus will be determined as follows: (i) 25% will be based upon the Company's achievement of a specified operating income target and (ii) 75% will be based on their department's achievement of a specified departmental operating income target. The Company's operating income target for 2010 was $63.1 million. Ms. Dragonetti's

department operating income target was $47.2 million and Ms. Perrin's department operating income target was $67.4 million.

Company Operating Income Target (In millions)	Percent of Target Achieved	Bonus Multiple
$53.6	85%	—
$58.3	92.5%	0.5
$63.1	100%	1.0
$69.4	110%	1.5
$75.7	120%	2.0
$82.0	130%	2.5
$88.3	140%	3.0

As illustrated in the chart, upon the achievement of 100% of the Company's operating income target, Mr. Curtin and Mses. Dragonetti and Perrin would be entitled to 100% of their respective bonus targets. The threshold for payment of any amount under the incentive plan for 2010 was attainment of more than 85% of the Company's operating income target. The achievement of 92.5% of the Company's operating income target would result in payment to Mr. Curtin and Mses. Dragonetti and Perrin of 50% of the bonus target.

Specific individual goals are not set for each Named Executive Officer; rather, following completion of the fiscal year, the Compensation Committee assesses each Named Executive Officer's overall contributions to helping the Company achieve its financial objective by (i) improving revenue, net income, cash flow, operating margins, earnings per share and return on shareholders' equity, (ii) developing competitive advantages, (iii) dealing effectively with the growing complexity of our business, (iv) developing business strategies, managing costs and improving the quality of our services as well as customer satisfaction, (v) successfully executing divestitures, acquisitions and strategic partnerships, (vi) implementing operating efficiencies and (vii) general performance of individual job responsibilities. However, with the exception of awarding Mr. Curtin a one-time discretionary bonus for 2010, the Compensation Committee did not adjust bonuses for 2010 based on performance.

In February 2011, the Compensation Committee approved the cash bonus amounts to be paid to Messrs. Lucia and Hosp for services performed in 2010 based on the Company's net income for 2010 of $40.5 million, which was 6.5% over the targeted net income amount for 2010. The bonus amounts awarded to Messrs. Hosp and Lucia were 32.6% above their 2010 bonus target, or $497,632 and $243,219, respectively.

The Compensation Committee also approved the 2010 cash bonus amounts to be paid to Mr. Curtin based on the Company's operating income for 2010 of $67.5 million, which was 7.1% over the targeted operating income amount for 2010. The bonus amount awarded to Mr. Curtin was 35.5% above his 2010 bonus target, or $231,537. In addition, the Compensation Committee awarded Mr. Curtin a one-time discretionary bonus of $37,500 in recognition of his key role in leading the integration of the four companies that we acquired since September 2009.

Ms. Dragonetti's department's operating income for 2010 was 3.3% over the targeted operating income amount for 2010 for her department. Based on these results and the Company's achievement of its operating income target, the Compensation Committee awarded Ms. Dragonetti a bonus of $183,045, which was 17.1% above her 2010 bonus target.

Ms. Perrin's department's operating income for 2010 was 11.9% over the targeted operating income amount for 2010 for her department. Based on these results and the Company's achievement of its operating income target, the Compensation Committee awarded Ms. Perrin a bonus of $236,827, which was 38.6% above her 2010 bonus target.

Long Term Incentive Compensation.

The longer-term component of our executive compensation program has generally consisted of stock options and in 2009 was expanded to include restricted stock awards. We believe that equity grants provide our Named Executive Officers with a strong link to our long-term performance, create an ownership culture and help to align their interests with those of our shareholders.

Typically, during the fourth quarter of each year, the dates for the upcoming years' meetings of the Compensation Committee are scheduled. The award determination takes place at the regularly scheduled meeting of the Compensation Committee held following the second quarter of each year. Equity awards are typically granted to our executives annually on October 1. Equity awards are granted upon the recommendation of management and approval of the Compensation Committee based upon its subjective evaluation of the appropriate grant depending upon the level of responsibility of each Named Executive Officer. In accordance with our Third Amended and Restated 2006 Stock Plan (the "2006 Plan"), we set the exercise price of all stock options equal to the closing price of our common stock on the NASDAQ Global Select Market on the day of the grant. Stock options generally become exercisable in installments over the period specified by the Compensation Committee. Accordingly, a stock option grant will provide a return to the executive officer only if the executive officer remains employed during the vesting period and then only if the market price of our common stock appreciates from the option's exercise price. As a result, stock options strongly support our objective of ensuring that pay is aligned with changes in shareholder value. We have granted restricted stock to support the goal of retaining key Named Executive Officers. Restricted stock is issued to executives at par value ($0.01 per share) and generally vests in installments over the period specified by the Compensation Committee. Accordingly, a restricted stock grant will provide a return to the executive officer only if the executive officer remains employed during the vesting period. The value of the restricted stock to the executive increases as the market price of our common stock increases, but because no specific amount of market price appreciation is necessary for a return to be provided to the executive, the number of shares underlying a restricted stock grant is lower relative to the number of shares underlying a stock option grant.

For the 2010 fiscal year, the Compensation Committee considered the individual contributions of the Named Executive Officers discussed above under "Annual Short Term (Cash) Incentive Compensation" in making its determinations with respect to granting long term incentives, in addition to several more objective factors, including comparative share ownership of similarly-situated executives, the Company's financial performance, the amount of equity previously awarded, the vesting of such awards, the retention value of the award and FWC's recommendations. In determining amounts of long term incentive compensation to be awarded, no fixed or specific mathematical weighting was applied to the subjective or the objective assessment of the Named Executive Officers' individual achievements.

In September 2010, the Board approved the grant, on October 1, 2010, of non-qualified stock options to our executives. These stock options are exercisable over seven years and contain a performance vesting component. The performance vesting component ensures that stock option compensation is also tied to the achievement of multi-year performance objectives. The stock options vest as follows: 50% of the grant vests in one-third increments on December 31, 2011, 2012 and 2013 and the remaining 50% cliff vests on December 31, 2013 to the extent that pre-defined earnings per share (EPS) growth and service conditions are satisfied. In order for a Named Executive Officer to vest 100% of his stock option grant, (i) he must be an employee of the Company on December 31, 2013 and (ii) the Company's EPS for the fiscal year ending December 31, 2011 must be at least 15% higher than its EPS for the fiscal year ending December 31, 2010 and its EPS for the fiscal year ending December 31, 2012 must be at least 40% higher than its EPS for the fiscal year ended December 31, 2010. In October 2010, the Compensation Committee granted Messrs. Lucia stock options to purchase 20,000 shares of our common stock and Messrs. Hosp and Curtin and Mses. Dragonetti and Perrin stock options to purchase 16,000 shares of our common stock. The exercise price for these stock options was $59.32 per share and the vesting schedule was as described above.

In connection with its executive compensation review in July 2010, the Compensation Committee recommended that the Board approve a retention grant in February 2011 of restricted stock units to each of the Named Executive Officers. In February 2011, the Board approved the grant of restricted stock units with an aggregate value of $4.95 million. An aggregate of 66,962 restricted stock units were granted to our Named Executive Officers on February 18, 2011, based on the closing price of our common stock of $73.92 on the NASDAQ Global Select Market on that date. The restricted stock units vest in 25% increments, with the first 25% vesting on the second anniversary of the grant date and the remainder vesting ratably on the third, fourth and fifth anniversaries of the grant date.

Benefits and Other Compensation.

We maintain broad-based benefits that are provided to all employees, including health and dental insurance, life and disability insurance and a 401(k) plan. Our Named Executive Officers are eligible to participate in all of our

employee benefit plans, in each case on the same basis as other employees. The Company matches 100% of participant contributions to our 401(k) plan up to 3% and 50% of the next 2% of their eligible compensation contributed to the 401(k) plan, up to a maximum of $9,800 per annum.

Severance and Change-in-Control Benefits.

Pursuant to employment agreements we have entered into with our Named Executive Officers and under the terms of our 2006 Plan, our Named Executive Officers are entitled to certain benefits in the event of the termination of their employment under specified circumstances, including termination following a change in control of our Company. We have provided detailed information about these benefits, along with estimates of their value under various circumstances, under the caption "Potential Payments upon Termination of Employment or Change-in-Control" below.

We believe providing these benefits helps us compete for executive talent, promote stability and continuity of senior management and provide reasonable assurance so that they are not distracted from their duties during the uncertainty that may accompany a possible change in control.

Tax Considerations

Section 162(m) of the Internal Revenue Code prohibits us from deducting any compensation in excess of $1 million paid to our Chief Executive Officer and the three other most highly compensated Named Executive Officers employed at the end of the year (other than our Chief Financial Officer), except to the extent that such compensation is paid pursuant to a shareholder approved plan upon the attainment of specified performance objectives. The Compensation Committee believes that tax deductibility is an important factor, but not the sole factor, to be considered in setting executive compensation policy. Accordingly, the Compensation Committee periodically reviews the potential consequences of Section 162(m) and generally intends to take such reasonable steps as are required to avoid the loss of a tax deduction due to Section 162(m). However, the Compensation Committee may, in its judgment, authorize compensation payments that do not comply with the exemptions in Section 162(m) when it believes that such payments are appropriate to attract and retain executive talent.

Summary Compensation Table

The following table sets forth the cash and non-cash compensation awarded to or earned by our Named Executive Officers for the fiscal years ended December 31, 2010, 2009 and 2008.

Name and Principal Position	Year	Salary ($)	Bonus ($)	Stock Awards ($)	Option Awards[1] ($)	Non-Equity Incentive Plan Compensation ($)	All Other Compensation ($)[2]	Total Compensation ($)
William C. Lucia	2010	553,846	—	—	425,200[3]	497,632	9,800	1,486,478
President and Chief	2009	406,923	—	1,000,000[5]	289,600[6]	442,060	18,300[7]	2,156,883
Executive Officer[4]	2008	343,846	—	—	240,274	290,137	9,200	883,457
Walter D. Hosp	2010	367,308	—	—	340,160[3]	243,219	9,800	960,487
Chief Financial Officer	2009	337,500	—	800,000[5]	231,700[6]	221,030	9,800	1,600,030
	2008	325,000	—	—	142,668	161,200	7,015	635,883
Sean Curtin[8]	2010	340,384	37,500[9]	—	340,160[3]	231,537	—	949,581
Executive Vice President, Operations								
Christina Dragonetti[8]	2010	310,577	—	—	340,160[3]	183,045	9,800	843,582
Executive Vice President, Corporate Development								
Maria Perrin[8]	2010	340,384	—	—	340,160[3]	236,827	9,800	927,171
Executive Vice President, Government Markets								

(1) The amounts in this column represent the grant date fair value of each stock option grant computed in accordance with FASB guidance on stock-based compensation, assuming all service and performance conditions are met. The relevant assumptions made in the valuations may be found in Note 10 of the Notes to Consolidated Financial Statements.

(2) Except as described in footnote 7 below, the amounts in this column reflect 401(k) employer matching contributions.

(3) In October 2010, Messrs. Lucia, Hosp and Curtin and Mses. Dragonetti and Perrin were each granted non-qualified stock options to purchase shares of our common stock at a purchase price per share of $59.32. Mr. Lucia was granted 20,000 non-qualified stock options and the other Named Executive Officers were each granted 16,000 non-qualified stock options. The amounts in this column represent the grant date fair value of the service/performance-based option grants computed in accordance with FASB guidance on stock-based compensation, assuming all service and performance conditions are met. The relevant assumptions made in the valuations may be found in Note 10 of the Notes to Consolidated Financial Statements. The grant date fair value of service/performance-based stock options is determined based on the number of shares granted and the fair value of our common stock on the grant date, which is the closing sales price per share of our common stock reported on The NASDAQ Global Select Market on that date.

(4) Mr. Lucia became our Chief Executive Officer effective March 1, 2009. Prior to that date, Mr. Lucia served as our President and Chief Operating Officer.

(5) In February 2009, Messrs. Lucia and Hosp were granted 31,980 and 25,584 shares of restricted stock, respectively. Subject to Messrs. Lucia's and Hosp's continued employment with the Company, these restricted stock awards will vest in 25% increments in February 2011, 2012, 2013 and 2014. The amounts in this column represent the grant date fair value of the service-based restricted stock award computed in accordance with FASB guidance on stock-based compensation, assuming all service conditions are met. The relevant assumptions made in the valuations may be found in Note 11 of the Notes to Consolidated Financial Statements in our 2009 Annual Report on Form 10-K. The grant date fair value of service-based restricted stock is determined based on the number of shares granted and the fair value of our common stock on the grant date, which is the closing sales price per share of our common stock reported on The NASDAQ Global Select Market on that date, less the consideration paid by the recipient for the award. Under our 2006 Plan, restricted stock award recipients pay us the par value for the stock ($0.01 per share).

(6) In October 2009, Messrs. Lucia and Hosp were granted non-qualified stock options to purchase shares of our common stock at an exercise price per share of $37.82. Mr. Lucia was granted 20,000 non-qualified stock options and Mr. Hosp was granted 16,000 non-qualified stock options. The amounts in this column represent the grant date fair value of the service/performance-based option grants computed in accordance with FASB guidance on stock-based compensation, assuming all service and performance conditions are met. The relevant assumptions made in the valuations may be found in Note 11 of the Notes to Consolidated Financial Statements in our 2009 Annual Report. The grant date fair value of service/performance-based stock options is determined based on the number of shares granted and the fair value of our common stock on the grant date, which is the closing sales price per share of our common stock reported on The NASDAQ Global Select Market on that date.

(7) Represents $8,500 in relocation allowance and $9,800 in 401(k) employer matching contributions.

(8) Mr. Curtin and Mses. Dragonetti and Perrin were appointed as executive officers in July 2010.

(9) In January 2010, the Compensation Committee awarded Mr. Curtin a discretionary bonus based upon performance in 2010.

Narrative Discussion of Summary Compensation Table

Salary

The salaries of our Named Executive Officers for fiscal 2010 reflect mid-year changes that were approved by the Compensation Committee in 2010.

Bonus

This column represents one-time discretionary bonuses by our Compensation Committee or Board of Directors.

Stock Awards

We granted restricted stock awards to our Named Executive Officers in 2009.

See "Potential Payments upon Employment Termination or Change-in-Control" for additional information regarding matters that could affect the vesting of such awards.

Option Awards

In 2009 and 2010, we granted non-qualified stock options to our Named Executive Officers which vest as follows: (i) 50% of the grant vests annually in one-third increments, with the first one-third vesting on December 31 of the year after the grant date and the remaining two-thirds vesting on December 31 of the second and third year and (ii) 50% vests on December 31 of the third year to the extent that certain pre-defined earnings per share growth and service conditions are satisfied.

See "Grants of Plan Based Awards, for the year ended December 31, 2010" for information regarding the options granted in 2010 and "Potential Payments upon Employment Termination and Change-in-Control" for additional information regarding matters that could affect the vesting of such options.

Non-Equity Incentive Plan Compensation

The amounts set forth in this column reflect the amounts paid to our Named Executive Officers as part of their annual short term (cash) incentive compensation, as discussed in the Compensation Discussion and Analysis, which precedes the Summary Compensation Table. These amounts are based on a percentage of the individual's base salary for the fiscal year.

Grants of Plan-Based Awards For the Year Ended December 31, 2010

Name	Grant Date	Board Approval Date	Estimated Future Payouts Under Non-Equity Incentive Plan Awards[1]		Estimated Future Payouts Under Equity Incentive Plan Awards	All Other Option Awards: Number of Securities Underlying Options (#)	Exercise Price of Option Awards ($/sh)[2]	Grant Date Fair Value of Stock and Option Awards[3]
			Threshold ($)	Target ($)	Target (#)			
William C. Lucia			17,063	341,250				
	10/1/10	09/15/10			10,000[5]	10,000[4]	$59.32	425,200
Walter D. Hosp			8,125	162,500				
	10/1/10	09/15/10			8,000[5]	8,000[4]	$59.32	340,160
Sean Curtin			7,500	150,000				
	10/1/10	09/15/10			8,000[5]	8,000[4]	$59.32	340,160
Christina Dragonetti			6,250	125,000				
	10/1/10	09/15/10			8,000[5]	8,000[4]	$59.32	340,160
Maria Perrin			7,500	150,000				
	10/1/10	09/15/10			8,000[5]	8,000[4]	$59.32	340,160

(1) Amounts represent the threshold and target that could be earned by the Named Executive Officers. The threshold amount shown is 5% of the individual's bonus target amount, which would be payable if the Company achieved 86% of the applicable targeted financial measure for 2010. The target amount shown is 100% of the individual bonus target amount. Actual incentives paid for 2010 are shown in the Summary Compensation Table in the "Non-Equity Incentive Plan Compensation" column. Our short-term (cash) incentive plan is described in the Compensation Discussion and Analysis, under the heading "Annual Short Term (Cash) Incentive Compensation." Mr. Lucia's bonus target for 2010 was 65% of base salary and the bonus target for our other Named Executive Officers was 50% of base salary. Mr. Lucia's bonus target is higher than that of the other Named Executive Officers due to his overall responsibility for the operations and success of the Company. There is no maximum on the bonus amount payable to our Named Executive Officers.

(2) The exercise price equals the closing price of our Common Stock on the date of the grant.

(3) The amounts in this column represent the grant date fair value of each stock option grant computed in accordance with FASB guidance on stock-based compensation, assuming all performance conditions are met. The relevant assumptions made in the valuations may be found in Note 10 of the Notes to Consolidated Financial Statements.

(4) Amounts represent the portion of the non-qualified stock option grant made to the Named Executive Officers in 2010 that is conditioned on continued service. These non-qualified stock option grants are described in the Compensation Discussion and Analysis under the heading "Long Term Incentive Compensation." The vesting terms for these grants are described in the Narrative Discussion to the Summary Compensation Table.

(5) Amounts represent the portion of the non-qualified stock option grant made to the Named Executive Officers in 2010 that is conditioned on performance. These non-qualified stock option grants are described in the Compensation Discussion and Analysis under the heading "Long Term Incentive Plan." The vesting terms for these grants are described in the Narrative Discussion to the Summary Compensation Table.

Outstanding Equity Awards at December 31, 2010

	Option Awards					Stock Awards	
Name	Number of Securities Underlying Unexercised Options (#) Exercisable	Number of Securities Underlying Unexercised Options (#) Unexercisable	Equity Incentive Plan Awards: Number of Securities Underlying Unexercised Unearned Options (#)	Option Exercise Price ($)	Option Expiration Date	Number of Shares of Stock that Have Not Vested	Market Value of Shares of Stock That Have Not Vested ($)[1]
William C. Lucia						31,980[2]	2,071,344
	48,000	—	—	$ 6.95	4/14/2015		
	68,665	—	—	$ 9.44	5/4/2016		
	101,355	—	—	$10.98	6/26/2016		
	20,000	—	—	$25.45	9/30/2012		
	10,000	5,000[3]	15,000[3]	$23.99	9/30/2015		
	3,334	6,666[4]	10,000[4]	$37.82	10/1/2016		
	—	10,000[5]	10,000[5]	$59.32	9/30/2017		
Walter D. Hosp						25,584[2]	1,657,076
	45,000	15,000[6]	—	$19.12	7/2/2017		
	15,000	—	—	$25.45	9/30/2012		
	8,333	4,167[3]	12,500[3]	$23.99	9/30/2015		
	2,667	5,333[4]	8,000[4]	$37.82	10/1/2016		
	—	8,000[5]	8,000[5]	$59.32	9/30/2017		
Sean Curtin						19,187[2]	1,242,742
	11,668	—	—	$14.04	9/13/16		
	20,000	10,000[6]	—	$25.45	9/30/12		
	10,000	20,000[6]	—	$23.99	9/30/15		
	10,000	30,000[6]	—	$37.82	10/01/16		
	—	8,000[5]	8,000[5]	$59.32	9/30/17		
Christina Dragonetti . .						19,187[2]	1,242,742
	10,000			$ 2.92	11/04/13		
	10,474	—	—	$ 9.44	5/4/16		
	42,935	—	—	$10.98	6/26/16		
	12,000	—	—	$25.45	9/30/12		
	5,000	2,500[3]	7,500[3]	$23.99	9/30/15		
	2,334	4,666[4]	7,000[4]	$37.82	10/1/16		
	—	8,000[5]	8,000[5]	$59.32	9/30/17		
Maria Perrin						31,980[2]	2,071,345
	—	12,500[6]	—	$22.29	4/30/17		
	6,667	—	—	$25.45	9/30/12		
	5,000	5,000[3]	15,000[3]	$23.99	9/30/15		
	2,667	5,333[4]	8,000[4]	$37.82	10/1/16		
	—	8,000[5]	8,000[5]	$59.32	9/30/17		

(1) Market value is calculated by multiplying the closing sales price per share of our common stock on The NASDAQ Global Select Market ($64.77) on December 31, 2010 by the number of shares of stock that have not vested.

(2) Service-based restricted stock awards vest in 25% increments, with the first 25% vesting on February 19, 2011 and the remainder vesting ratably on February 19, 2012, 2013 and 2014.

(3) Stock options vest as follows: 50% vests in one-third increments on December 31, 2009, 2010 and 2011. The remaining 50% vests on December 31, 2011 to the extent that certain pre-defined performance and service conditions are satisfied.

(4) Stock options vest as follows: 50% vests in one-third increments on December 31, 2010, 2011 and 2012. The remaining 50% vests on December 31, 2012 to the extent that certain pre-defined performance and service conditions are satisfied.

(5) Stock options vest as follows: 50% vests in one-third increments on December 31, 2011, 2012 and 2013. The remaining 50% vests on December 31, 2013 to the extent that certain pre-defined performance and service conditions are satisfied.

(6) Stock options vest in 25% increments, with the first 25% vesting on the first anniversary of the grant date and the remainder vesting ratably on the second, third and fourth anniversaries of the grant date (Grant dates: (i) Mr. Curtin: October 1, 2007, October 1, 2008 and October 1, 2009, respectively; (ii) Mr. Hosp: July 2, 2007; and, (iii) Ms. Perrin: April 30, 2007).

2010 Option Exercises

The following table sets forth certain information concerning the exercise of stock options by our Named Executive Officers. Although certain of our Named Executive Officers have received service-based restricted stock awards, as of December 31, 2010 none of those awards had commenced vesting; hence, the table below does not include information relating to those restricted stock awards.

Name	Number of Shares Acquired on Exercise (#)	Value Realized on Exercise ($)[1]
William C. Lucia	104,000	$4,908,338
Sean Curtin	25,832	1,209,425
Maria Perrin	19,166	554,924

(1) The value realized on the exercise of stock options is based on the difference between the exercise price and the market price (used for tax purposes) of our common stock on the date of exercise.

Potential Payments Upon Termination of Employment or Change in Control

The following information and table set forth the additional amounts payable to each of our Named Executive Officers in the event of a termination of employment as a result of involuntary termination, resignation for Good Reason (as defined below), resignation for Good Reason upon a Change in Control (as defined below) and involuntary termination following a Change in Control.

On March 1, 2011, we entered into a new employment agreement with Mr. Lucia; therefore, the following table presents the amounts payable to Mr. Lucia under the terms of his new agreement, rather than his prior agreement, which expired on February 28, 2011.

Assumptions and General Principles

The following assumptions and general principles apply with respect to the following table and any termination of employment of a Named Executive Officer:

- The amounts shown in the table assume that each Named Executive Officer was terminated on December 31, 2010. Accordingly, the table reflects amounts earned as of December 31, 2010 and includes estimates of amounts that would be paid to the Named Executive Officer upon the occurrence of a termination or change in control. The actual amounts to be paid to a Named Executive Officer can only be determined at the time of the termination or change in control.
- Regardless of the manner in which the Named Executive Officer's employment is terminated, a Named Executive Officer is entitled to receive (i) any earned but unpaid salary and accrued but unused paid time off through the date of termination and (ii) in general, any earned but unpaid bonus for the calendar year preceding the calendar year in which his/her employment ends. Amounts due for unused paid time off for 2010 are not shown in the table.
- Under the terms of our 2006 Plan, upon a Named Executive Officer's termination of employment (for any reason other than gross misconduct), stock option exercises shall be limited to the stock options that were

immediately exercisable at the date of such termination. The amounts shown in the table do not include the value of such immediately exercisable stock options.

- Under the terms of our Restricted Stock Award Agreements, upon a Named Executive Officer's termination of employment for any reason other than as a result of his/her death, disability or involuntarily by the Company (i) for "cause" or (ii) for "cause" within 24 months following a Change in Control, the unvested shares underlying his/her restricted stock award shall be forfeited effective as of his/her termination date. As of December 31, 2010, none of the restricted stock awards granted to our Named Executive Officers had commenced vesting.

- Under the terms of our Restricted Stock Unit Agreements, upon a Named Executive Officer's termination of employment for any reason other than as a result of his/her death, disability or involuntarily by the Company without "cause" within 24 months following a Change in Control, any restricted stock units which are not then vested shall be forfeited effective as of his/her termination date. If the Named Executive Officer ceases to be employed by the Corporation by reason of his/her retirement, the restricted stock units shall continue to vest as if the Named Executive Officer had continued to be employed until the expiration of two years after his/her retirement.

- The amounts in the table assume that each of the Named Executive Officers would have been entitled to receive his/her target annual bonus payment for 2010 and not the amount that the Compensation Committee determined to pay based upon the level of attainment of the Company performance objectives. Therefore, the bonus payment amount set forth in the table is the target bonus for each Named Executive Officer, not the amount that was actually paid and shown as Non-Equity Incentive Plan Compensation in the Summary Compensation Table.

- Under our Restricted Stock Award, Restricted Stock Unit and Stock Option Agreements, "cause" means a termination with "cause" under the terms of the Named Executive Officer's employment agreement. If there is no such employment agreement in effect, a termination with "cause" as determined by the Board, shall mean a termination on account of deliberate gross misconduct or the violation, after any such termination, of the terms of a Restrictive Covenant and Confidentiality/Non-Disclosure Agreement with the Company.

- Under the terms of the 2006 Plan, a "Change of Control" shall mean the occurrence of any of the following events: (i) at least a majority of the Board shall cease to consist of directors of the Company who served in such capacity at the time the 2006 Plan was adopted or during each subsequent renewal term or were approved by a then majority of continuing directors for addition to Board; (ii) any "person" or "group" shall have acquired beneficial ownership (as defined in Regulation 13d-3) of shares having 30% or more of the voting power of all outstanding shares, unless such acquisition is preapproved by the Board; (iii) a merger or consolidation occurs in which the outstanding shares are converted into shares of another company, or other securities, or cash or other property and the pre-transaction shareholders cease to hold at least 55% of the post-change voting power, (iv) the sale of all, or substantially all, of the Company's assets occurs; or (v) the Company's stockholders approve a plan of complete liquidation of the Company, with the definition subject to further limitations if necessary to conform to Section 409A of the Internal Revenue Code of 1986.

Definitions Applicable to Mr. Lucia

- "Cause" means: (i) fraud with respect to the Company or any of its subsidiaries and affiliates; (ii) material misrepresentation to any regulatory agency, governmental authority, outside or internal auditors, internal or external Company counsel, or the Board concerning the operation or financial status of the Company or of any of its subsidiaries and affiliates; (iii) theft or embezzlement of assets of the Company or any of its subsidiaries or affiliates; (iv) conviction, or plea of guilty or nolo contendere to any felony (or to a felony charge reduced to a misdemeanor), or, with respect to the Mr. Lucia's employment, to any misdemeanor (other than a traffic violation); (v) material failure to follow the Company's conduct and ethics policies that have been provided or made available to Mr. Lucia; (vi) a material breach of his employment agreement; and/or (vii) continued failure to attempt in good faith to perform his duties as reasonably assigned by the Board. Certain of the foregoing definitions permit Mr. Lucia to attempt to cure the grounds for cause.

- "Good Reason" means, the occurrence, without Mr. Lucia's prior written consent, of any of the following events: (i) a material diminution in his authority, duties or responsibilities; (ii) a requirement that he report to an officer rather than to the Board; (iii) a material reduction in his base salary; (iv) the Company's requiring him to perform his principal services primarily in a geographic area more than 50 miles from both the Company's offices in Dallas, Texas and its principal headquarters in New York, New York (or such other place of primary employment for Mr. Lucia to which Mr. Lucia has moved after March 1, 2011); or (v) a material breach by the Company of any material provision of his employment agreement. Good Reason is also subject to certain timing restrictions and our ability to cure the proposed Good Reason.
- "Change in Control" means:
  - the acquisition by an individual, entity or group (a "Person") of beneficial ownership of any capital stock of the Company if, after such acquisition, such Person beneficially owns 50.01% or more of either (x) the then-outstanding shares of Company common stock or (y) the combined voting power of the then-outstanding Company securities entitled to vote in the election of directors ; provided, however, that an acquisition from the Company or pursuant to a Business Combination (as defined below) that complies with subclauses (x) and (y) of clause (ii) will not be a Change in Control;
  - the consummation of a merger, consolidation, reorganization, recapitalization or share exchange involving the Company or a sale or other disposition of all or substantially all (i.e., in excess of 85%), of its assets (a "Business Combination"), unless, immediately thereafter (x) all or substantially all of the beneficial owners immediately prior to such Business Combination beneficially own more than 50% of the then-outstanding shares of common stock and the combined voting power of the then-outstanding securities entitled to vote in the election of directors, respectively, of the resulting or acquiring corporation in substantially the same proportions as their initial ownership and (y) no Person beneficially owns 50.01%, or more, of the then-outstanding shares of common stock of the acquiring corporation, or of the combined voting power of the then-outstanding securities of such corporation entitled to vote in the election of directors (except if such ownership existed prior to the Business Combination); or
  - a change in the composition of the Board that results, during any one year period, in the current directors (including directors subsequently elected by at least a majority of the Board, but excluding directors

whose initial assumption of office occurred as a result of an actual or threated election contest or similar circumstance) no longer constituting a majority of the Board, or the Board of a successor corporation.

Named Executive Officer and Type of Payment	Involuntary Termination	Resignation for Good Reason	Resignation for Good Reason Upon a Change of Control	Involuntary Termination Upon a Change of Control
William C. Lucia, President & Chief Executive Officer[1][2]				
Cash severance	$1,300,000	$1,300,000	$1,300,000	$1,300,000
Bonus payment	$ 845,000	$ 845,000	$ 845,000	$ 845,000
Continued health insurance coverage	$ 12,478	$ 12,478	$ 12,478	$ 12,478
Restricted Stock[3]	—	—	$2,071,345	$2,071,345
Stock Options[4]	—	—	$3,670,257	$3,670,257
Total	$2,157,478	$2,157,478	$7,899,080	$7,899,080
Walter D. Hosp, Chief Financial Officer[5]				
Cash severance	$ 425,000	—	—	$ 425,000
Continued health insurance coverage	$ 20,016	—	—	$ 20,016
Restricted Stock[3]	—	—	—	$1,657,076
Stock Options[4]	—	—	—	$3,950,970
Total	$ 445,016	—	—	$6,053,062
Sean Curtin, Executive Vice President of Operations[6]				
Cash severance	$ 400,000	—	—	$ 400,000
Continued health insurance coverage	$ 20,100	—	—	$ 20,100
Restricted Stock[3]	—	—	—	$1,242,742
Stock Options[4]	—	—	—	$4,922,520
Total	$ 420,100	—	—	$6,585,362
Christina Dragonetti, Executive Vice President of Corporate Development[7]				
Cash severance	$ 200,000	—	—	$ 200,000
Continued health insurance coverage	$ 10,050	—	—	$ 10,500
Restricted Stock[3]	—	—	—	$1,242,742
Stock Options[4]	—	—	—	$2,439,627
		—	—	
Total	$ 210,050	—	—	$3,902,469
Maria Perrin, Executive Vice President of Government Markets[8]				
Cash severance	$ 200,000	—	—	$ 200,000
Continued health insurance coverage	$ 10,050	—	—	$ 10,050
Restricted Stock[3]	—	—	—	$2,071,345
Stock Options[4]	—	—	—	$4,004,923
		—	—	
Total	$ 210,050	—	—	$6,286,318

(1) If we terminate Mr. Lucia's employment without Cause or if his employment ceases because of his death or disability or if he terminates his employment with Good Reason, then provided Mr. Lucia executes a separation agreement and release and complies with certain restrictive

covenants (as described below) and confidentiality provisions contained in his employment agreement, he will be entitled to receive cash severance in an amount equal to (i) 24 times his monthly base salary paid ratably in equal installments over a 24 month period, (ii) twice a bonus component that will vary depending upon whether the bonus for the year of termination is intended to be "performance-based" compensation and the performance is satisfied, in which case it will be paid when bonuses are paid to the Company's executive officers, or whether the bonus is under a different program, in which case it will be his target bonus and will be paid on the same schedule as (i) above, and (iii) continued health coverage for 24 months or until he becomes eligible for health coverage from another employer, whichever is earlier. For the 24 months following Mr. Lucia's termination, he is prohibited from: (i) directly or indirectly engaging in competition with or owning any interest in, performing any services for, participating in, or being connected with any business that is competitive with the business of the Company and its subsidiaries, (ii) directly or indirectly inducing or attempting to induce any employee of the Company or its subsidiaries to leave the employ of the Company and (iii) directly or indirectly hiring, engaging or working with any supplier, contractor or other business relation of the Company or its subsidiaries if such action would be known by him to have a material adverse effect on the Company's business or materially interfere with the Company's relationship with that person/entity.

(2) If within 24 months following a Change in Control, Mr. Lucia's employment is terminated without Cause or he resigns for Good reason, provided he executes a separation agreement and release and complies with certain restrictive covenants and confidentiality provisions contained in his employment agreement (as described above), he will receive the amounts set forth in (1)(i) and (1)(ii) above in a single lump sum payment, rather than in installments as applies outside of a Change in Control.

(3) Under the terms of our Restricted Stock Agreements, in the event a Named Executive Officer ceases to be employed by the Company by reason of death, disability or involuntarily by the Company (other than (i) for "cause" and (ii) for "cause" within 24 months of a Change of Control), the restricted stock awards held by such Named Executive Officer shall vest in full. In addition, the Compensation Committee has the discretion to accelerate vesting of the restricted stock in the event of a Change of Control. Under the terms of our Restricted Stock Unit Agreements, in the event a Named Executive Officer ceases to be employed by the Company by reason of death, disability or involuntarily by the Company other than for "cause" within 24 months following a Change in Control, all of the restricted stock units held by such Named Executive Officer shall become fully vested. The amounts presented in the table represent the market value of outstanding restricted stock awards and restricted stock units, which is determined based on the number of shares/units granted and the fair value of our common stock on December 31, 2010, which is the closing sales price per share of our common stock reported on The NASDAQ Global Select Market on that date ($64.77), less the consideration paid by the recipient for the award ($0.01 per share).

(4) Under the 2006 Plan (assuming no contrary provisions in the award agreements/the 2006 Plan), if a Named Executive Officer ceases to be employed by the Company by reason of involuntary termination without "cause" by the Company during the 24-month period following a Change of Control, the Named Executive Officer's outstanding options, which are not then exercisable and vested, shall become fully vested and exercisable. The numbers included in the table represent the value of the unvested portion of the Named Executive Officer's stock options, assuming accelerated vesting (calculated based on the excess of the closing market price of our common stock on December 31, 2010, over the exercise prices of such options).

(5) In the event Mr. Hosp is involuntarily terminated or involuntarily terminated upon a Change of Control, provided he executes and does not revoke a severance agreement and release, he will be entitled to salary and benefits continuation for 12 months.

(6) In the event Mr. Curtin is involuntarily terminated and he executes and does not revoke a severance agreement and release, he will be entitled to his base salary for 12 months from the date of termination and the Company shall, for up to 12 months, continue to pay its share of the premium for COBRA coverage for Mr. Curtin.

(7) In the event Ms. Dragonetti is involuntarily terminated, she may be eligible to receive salary and benefits continuation for up to six months.

(8) In the event Ms. Perrin is involuntarily terminated and provided she executes and does not revoke a separation agreement and general release, she will be entitled to six months of salary and benefits continuation.

Executive Employment Agreements

See "*Potential Payments Upon Termination of Employment or Change in Control*" above for definitions of capitalized terms used below.

William C. Lucia — President and Chief Executive Officer

On March 1, 2011, we entered into a new employment agreement with Mr. Lucia. Unless earlier terminated, this agreement will terminate on February 28, 2013. In August 2010, Mr. Lucia's annualized base salary was increased from $525,000 to $650,000. Mr. Lucia is eligible to receive bonus compensation from us in respect of each fiscal year (or portion thereof) during the term of his employment, in each case as may be determined by our Compensation Committee in its sole discretion on the basis of performance or such other criteria as may be established from time to time by the Compensation Committee in its sole discretion. Mr. Lucia's target bonus is 65% of his base salary.

If we terminate Mr. Lucia's employment without Cause, in connection with a Change in Control or otherwise, or if his employment ceases because of his death or disability or if he terminates his employment with Good Reason, then provided Mr. Lucia executes and does not revoke a separation agreement and release and complies with certain

restrictive covenants (as described above) and confidentiality provisions contained in his employment agreement, he will be entitled to receive cash severance in an amount equal to (i) 24 times his monthly base salary paid ratably in equal installments over a 24 month period, (ii) twice a bonus component that will vary depending upon whether the bonus for the year of termination is intended to be "performance-based" compensation and the performance is satisfied or whether the bonus is under a different program, in which case it will be his target bonus and will be paid on the same schedule as (i) above, and (iii) continued health coverage for 24 months or until he becomes eligible for health coverage from another employer, whichever is earlier.

Walter D. Hosp — Chief Financial Officer

We have an employment letter agreement with Mr. Hosp that has an unspecified term. In August 2010, Mr. Hosp's annualized base salary was increased from $325,000 to $425,000. Mr. Hosp is also eligible to receive an annual performance bonus, which depends on our performance and his individual performance, in each case as determined by our Compensation Committee. In February 2010, the Compensation Committee increased Mr. Hosp's target bonus to 50% of his base salary.

In the event Mr. Hosp is involuntarily terminated or involuntarily terminated upon a Change of Control of the Company, provided he executes and does not revoke a severance agreement and release, he will be entitled to receive salary and benefits continuation for 12 months.

Sean Curtin — Executive Vice President of Operations

We have an employment letter agreement with Mr. Curtin that has an unspecified term. Mr. Curtin's current annualized base salary, as approved by the Compensation Committee, is $400,000. He is also eligible to receive an annual performance bonus, which will be determined based on actual performance with no minimum bonus and no cap on the maximum bonus, provided that he meets certain predefined targets or objectives and the Company exceeds its fiscal year performance targets. Mr. Curtin's target bonus is 50% of his base salary.

In the event Mr. Curtin is involuntarily terminated and he executes and does not revoke a severance agreement and release, he will be entitled to receive his base salary for 12 months from the date of termination and the Company shall, for up to 12 months, continue to pay its share of the premium for COBRA coverage for Mr. Curtin.

Christina Dragonetti — Executive Vice President of Corporate Development

We do not have an employment letter agreement with Ms. Dragonetti. Ms. Dragonetti's current annualized base salary, as approved by the Compensation Committee, is $400,000. She is also eligible to receive an annual performance bonus, which depends on our performance and her individual and department performance, in each case as determined by our Compensation Committee. Ms. Dragonetti's target bonus is 50% of her base salary.

In the event Ms. Dragonetti is involuntarily terminated, she may be eligible to receive salary and benefits continuation for up to six months.

Maria Perrin — Executive Vice President of Government Markets

We have an employment letter agreement with Ms. Perrin that has an unspecified term. Ms. Perrin's current annualized base salary, as approved by the Compensation Committee, is $400,000. She is also eligible to receive an annual performance bonus, which depends on our performance and her individual and department performance, in each case as determined by our Compensation Committee. Ms. Perrin's target bonus is 50% of her base salary.

In the event Ms. Perrin is involuntarily terminated and provided she executes and does not revoke a separation agreement and general release, she will be entitled to receive six months of salary and benefits continuation.

Director Compensation

General

A director who is one of our employees receives no additional cash compensation for his or her services as a director or as a member of a committee of our Board of Directors. A director who is not one of our employees (a

non-employee director) receives cash compensation for his or her services as described below. All cash compensation, unless deferred, is paid at the end of each quarter. All of our directors are reimbursed for reasonable expenses incurred in connection with attendance at meetings of the Board of Directors or its committees. In July 2010, our Board of Directors, with the guidance of F.W. Cook, compensation consultants, reviewed the compensation paid to directors for Board and committee service and adopted a new compensation program which became effective for the third quarter of 2010.

Non-Employee Board Member Retainer

Each non-employee director receives a quarterly retainer for service as a director, which is fixed from time to time by resolution of the Board. The quarterly retainer is currently $8,750 per quarter, or $35,000 annually. The quarterly retainer was not increased for 2010.

Committee Chair Retainer

Through the second quarter of 2010, the Audit Committee Chair, Ms. Rudnick, received a quarterly retainer of $1,250. In July 2010, the Board increased the Audit Committee Chair quarterly retainer to $2,500, or $10,000 annually, effective for the third quarter of 2010.

In addition, in July 2010, the Board approved a quarterly retainer of $2,500, or $10,000 annually, for each of our other Committee Chairs. This retainer became effective for the third quarter of 2010.

Stock Option Grants

Each of our non-employee directors is eligible to receive an annual award of stock options, the value of which is fixed from time to time by resolution of the Board. In July 2010, the Board approved the 2010 grant to each of our non-employee directors and to Mr. Holster of non-qualified stock options and restricted stock units (on an "equal number of units basis") with an aggregate value of $80,000, with the actual number of stock options and restricted stock units to be calculated based on the grant date fair value computed in accordance with FASB guidance on stock-based compensation, except that no assumption for forfeitures would be included. On October 1, 2010, each of our non-employee directors and Mr. Holster, was granted a stock option to purchase 933 shares of our common stock and 933 restricted stock units. Both of these grants vest quarterly over a one year period, with the first quarterly vest on December 31, 2010.

Non-Employee Chairman of the Board Quarterly Retainer

In July 2010, the Board approved the following compensation package for a non-employee Chairman of the Board: (i) annual cash retainer of $41,000 and (ii) equity compensation consisting of a grant of non-qualified stock options and restricted stock units (on an "equal number of units basis") with an aggregate value of $94,000, which would be granted on October 1 of each year and which would vest quarterly over a one year period commencing on the date of grant. The actual number of stock options and restricted stock units to be calculated based on the grant date fair value computed in accordance with FASB guidance on stock-based compensation, except that no assumption for forfeitures would be included.

Director Deferred Compensation Plan

Each of our non-employee directors is eligible to participate in our Director Deferred Compensation Plan, under which the non-employee director may elect to defer all or part of his or her Board of Director fees and annual restricted stock unit grants until the termination of his or her service as a member of the Board for any reason. The amount of any cash compensation deferred by a non-employee director is converted into a number of stock units, determined based upon the closing price of our common stock on the NASDAQ Global Select Market on the date such fees would otherwise have been payable and is credited to a deferred compensation account maintained in his or her name. Deferred restricted stock unit grants are converted on a share-for-share basis on the date such restricted stock units would otherwise have been payable and also credited to the non-employee director's account. The account will be credited with additional stock units, also based on such average market value, upon the payment date for any dividends declared on our common stock. Upon a director's termination of service on our Board, the

amounts accumulated in the deferred compensation account will be distributed in the form of common stock under the 2006 Plan equal to the number of whole stock units in the account and cash in lieu of any fractional shares.

The following table sets forth the deferred stock units held by our non-employee directors as of December 31, 2010.

Name	Deferred Stock Units
Robert M. Holster	933
James T. Kelly	933
William F. Miller III	467
William S. Mosakowski	—
Ellen A. Rudnick	467
Bart M. Schwartz	553
Michael A. Stocker, M.D.	—
Richard H. Stowe	1,106

2010 Director Compensation

The following table sets forth compensation earned and paid, as of December 31, 2010, to each of our non-employee directors and Mr. Holster, for service as a director during 2010.

Name[1]	Fees Earned or Paid in Cash	Stock Awards ($)[2]	Option Awards[3]	Total
Robert M. Holster	$474,508[4]	$19,836	$55,346	$549,690
James T. Kelly	$ 35,000	$19,836	$55,346	$110,182
William F. Miller III	$ 35,000	$19,836	$55,346	$110,182
William S. Mosakowski	$ 35,000	$19,836	$55,346	$110,182
Ellen A. Rudnick	$ 42,500	$19,836	$55,346	$117,682
Bart M. Schwartz	$ 22,500[5]	$19,836	$55,346	$ 97,682
Michael A. Stocker, M.D.	$ 40,000	$19,836	$55,346	$115,182
Richard H. Stowe	$ 40,000[5]	$19,836	$55,346	$115,182
Former Directors				
William W. Neal	$ 26,250	—	—	$ 26,250
Galen D. Powers	$ 17,500	—	—	$ 17,500

(1) The number of unexercised stock options outstanding as of December 31, 2010 held by the directors and former directors named in the above table was as follows: Mr. Kelly (21,033), Mr. Miller (21,033), Mr. Mosakowski (19,783), Mr. Neal (0), Mr. Powers (0), Ms. Rudnick (66,033), Mr. Schwartz (933), Dr. Stocker (19,783) and Mr. Stowe (66,033). Each of the directors named in the above table had 933 restricted stock units outstanding as of December 31, 2010. See footnote 2 for information regarding the deferral of these restricted stock units by some of our directors.

(2) On October 1, 2010, each non-employee director and Mr. Holster, was granted 933 restricted stock units. This grant vests quarterly, with the first quarter vesting on December 31, 2010. Pursuant to our 2010 Director Deferred Compensation Plan, Mr. Holster elected to defer 933 restricted stock units, Mr. Schwartz elected to defer 467 restricted stock units and Mr. Stowe elected to defer 933 restricted stock units. The restricted stock units vest quarterly, with the first quarter vesting on December 31, 2010. The amounts in this column represent the grant date fair value of the restricted stock units granted on October 1, 2010 computed in accordance with FASB guidance on stock-based compensation. The relevant assumptions made in the valuations may be found in Note 10 of the Notes to Consolidated Financial Statements. These amounts do not correspond to the actual value that may be realized by the directors with respect to these awards.

(3) On October 1, 2010, each non-employee director and Mr. Holster, was granted a non-qualified stock option to purchase 933 shares of common stock. The stock options vest quarterly, with the first quarter vesting on December 31, 2010. The amounts in this column represent the grant date fair value of that stock option grant computed in accordance with FASB guidance on stock-based compensation. The relevant assumptions made in the valuations may be found in Note 10 of the Notes to Consolidated Financial Statements. These amounts do not correspond to the actual value that may be realized by the directors with respect to these awards.

(4) In March 2009, in connection with Mr. Holster's resignation as our Chief Executive Officer, we amended and restated his employment agreement to reflect his continued employment with the Company as the Chairman of the Board of Directors. For his service under this agreement, Mr. Holster received an annualized base salary of $250,000 and was eligible to receive bonus compensation at a target of 65% of his base salary. Mr. Holster received a performance bonus of $219,700 for his 2010 service. Mr. Holster resigned as our employee effective December 31, 2010, but will continue as our non-employee Chairman of the Board of Directors.

(5) Includes the value of fully vested deferred stock units received in lieu of all or a specified portion of the non-employee director's regular quarterly cash retainer based on the fair market value of the underlying shares on December 31, 2010, the date the regular annual cash retainer would otherwise have been paid. Based on the prior election by each director, Mr. Stowe received 173 deferred stock units with a value of $11,250 and Mr. Schwartz received 56 deferred stock units with a value of $5,625.

COMPENSATION COMMITTEE INTERLOCKS AND INSIDER PARTICIPATION

During 2010, the members of our Compensation Committee were Richard H. Stowe, James T. Kelly and William W. Neal (through September 2010), none of whom has ever been an officer or employee of the Company and none of whom have had a related person transaction involving the Company. During 2010, none of our executive officers (i) served as a member of the board of directors or compensation committee (or equivalent entity) of any other entity that had one or more of its executive officers serving as a member of our Compensation Committee or (ii) served as a member of the compensation committee (or equivalent entity) of any other entity that had one or more of its executive officers serving as a member of our Board of Directors.

REPORT OF COMPENSATION COMMITTEE

The Compensation Committee of the Board of Directors (the "Board") of HMS Holdings Corp. (the "Company") has reviewed and discussed the Compensation Discussion and Analysis required by Item 402(b) of Regulation S-K with management. Based on this review and discussion, the Compensation Committee recommended to the Board that the Compensation Discussion and Analysis be included in the Company's Annual Report on Form 10-K for the year ended December 31, 2010.

By the Compensation Committee of the Board of Directors of HMS Holdings Corp.

Richard H. Stowe, *Chair*
James T. Kelly
William F. Miller III (as of January 2011)

The information contained in the Compensation Committee Report shall not be deemed to be "soliciting material" or to be "filed" with the Securities and Exchange Commission, nor shall such information be incorporated by reference into any future filing under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, except to the extent that we specifically incorporate it by reference in such filing.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

Equity Compensation Plan Information

The following table summarizes information about our equity compensation plans as of December 31, 2010. For additional information about our equity compensation plans see Note 10 of the Notes to Consolidated Financial Statements.

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a))
	(a)	(b)	(c)
Equity compensation plans approved by shareholders[1]	2,399,941	$25.56	1,437,208
Equity compensation plans not approved by shareholders[2]	107,916	$16.86	—
Total	2,507,857		

(1) This includes stock options to purchase common stock granted under our 1999 Long-Term Incentive Plan and the 2006 Plan and restricted stock awards and restricted stock units granted under the 2006 Plan.

(2) Options outstanding under plans not approved by the shareholders include: (i) 47,916 options granted in September 2006 to four former senior executives of BSPA in connection with their joining us and (ii) 60,000 options granted in July 2007 to Walter D. Hosp, our Chief Financial Officer, under the terms of his employment agreement.

Security Ownership of Certain Beneficial Owners and Management

The following table sets forth information known to us with respect to the beneficial ownership of our common stock as of February 18, 2011 by (i) each of our non-employee directors, (ii) Messrs. Lucia, Hosp and Curtin and Mses. Dragonetti and Perrin, whom we refer to as our Named Executive Officers, (iii) all of our directors and current executive officers as a group and (iv) each person (or group of affiliated persons) known by us to be the beneficial owner of more than 5% of our common stock.

Beneficial ownership and percentage ownership are determined in accordance with the rules of the SEC. This information does not necessarily indicate beneficial ownership for any other purpose. Under the SEC rules, beneficial ownership includes any shares as to which an entity or individual has sole or shared voting power or investment power and also any shares that the entity or individual has the right to acquire as of April 19, 2011 (60 days after February 18, 2011) through the exercise of stock options. Beneficial ownership includes all shares of restricted stock held by an entity or individual, whether or not vested, but excludes options or other rights vesting after April 19, 2011.

Percentage of beneficial ownership is based on 27,928,563 shares of common stock outstanding as of February 18, 2011. For each individual and group included in the table below, percentage ownership is calculated by dividing the number of shares beneficially owned by such entity or individual by the sum of the shares of common stock outstanding on February 18, 2011 and the number of shares of common stock that such entity or individual had the right to acquire as of April 19, 2011.

Unless otherwise indicated and subject to applicable community property laws, to our knowledge, each shareholder named in the following table possesses sole voting and investment power over the shares listed, except

for those jointly owned with that person's spouse. Unless otherwise noted below, the address of each person listed on the table is c/o HMS Holdings Corp., 401 Park Avenue South, New York, NY 10016.

Name of Beneficial Owner	Shares Beneficially Owned* Numbers of Shares	Percent (%)
Directors		
Robert M. Holster[1]	228,898	*
James T. Kelly[2]	21,034	*
William C. Lucia[3]	296,008	1.1
William F. Miller[4]	86,546	*
William S. Mosakowski[5]	19,784	*
Ellen A. Rudnick[6]	69,034	*
Bart M. Schwartz[7]	1,020	*
Michael A. Stocker M.D.[8]	19,784	*
Richard H. Stowe[9]	66,207	*
Named Executive Officers		
Sean Curtin[10]	70,855	*
Christina Dragonetti[11]	172,511	*
Walter D. Hosp[12]	107,584	*
Maria Perrin[13]	46,314	*
All current directors and executive officers as a group (17 persons)[14]	1,267,456	4.5
Five Percent Shareholders		
BlackRock, Inc.[15]	2,074,053	7.4
FMR, LLC[17]	2,132,450	7.6
William Blair & Co.[16]	1,597,220	5.7

* Represents less than 1%.

(1) Includes 16,773 shares of common stock owned by members of Mr. Holster's family, 26,900 shares of common stock issuable to Mr. Holster upon the exercise of options scheduled to vest by April 19, 2011 and 467 shares of common stock deferred under the Director Deferred Compensation Plan.

(2) Consists of 20,567 shares of common stock issuable to Mr. Kelly upon the exercise of options scheduled to vest by April 19 ,2011 and 467 shares of common stock deferred under the Director Deferred Compensation Plan.

(3) Includes 227,334 shares of common stock issuable to Mr. Lucia upon the exercise of options scheduled to vest by April 19, 2010 and 31,980 shares of restricted stock, which vest in equal installments on February 19, 2011, 2012, 2013 and 2014.

(4) Includes 4,000 shares of common stock owned by members of Mr. Miller's family, 20,567 shares of common stock issuable to Mr. Miller upon the exercise of options scheduled to vest by April 19, 2010 and 233 shares of common stock deferred under the Director Deferred Compensation Plan. Mr. Miller disclaims beneficial ownership of the shares of common stock held by his family.

(5) Includes of 19,317 shares of common stock issuable to Mr. Mosakowski upon the exercise of options scheduled to vest by April 19, 2011.

(6) Includes of 65,567 shares of common stock issuable to Ms. Rudnick upon the exercise of options scheduled to vest by April 19, 2011 and 233 shares of common stock deferred under the Director Deferred Compensation Plan.

(7) Consists of 467 shares of common stock issuable to Mr. Schwartz upon the exercise of options scheduled to vest by April 19, 2011 and 233 shares of common stock deferred under the Director Deferred Compensation Plan.

(8) Includes of 19,317 shares of common stock issuable to Dr. Stocker upon the exercise of options scheduled to vest by April 19, 2011.

(9) Consists of 65,567 shares of common stock issuable to Mr. Stowe upon the exercise of options scheduled to vest by April 19, 2011 and 467 shares of common stock deferred under the Director Deferred Compensation Plan.

(10) Consists of 51,668 shares of common stock issuable to Mr. Curtin upon the exercise of options scheduled to vest by April 19, 2011 and 19,187 shares of restricted stock, which vest in equal installments on February 19, 2011, 2012, 2013 and 2014.

(11) Includes of 82,743 shares of common stock issuable to Ms. Dragonetti upon the exercise of options scheduled to vest by April 19, 2011 and 19,187 shares of restricted stock, which vest in equal installments on February 19, 2011, 2012, 2013 and 2014.

(12) Includes 1,000 shares of common stock jointly owned by Mr. Hosp and his spouse, 71,000 shares of common stock issuable to Mr. Hosp upon the exercise of options scheduled to vest by April 19, 2011 and 25,584 shares of restricted stock, which vest in four equal installments on February 19, 2011, 2012, 2013 and 2014.

(13) Consists of 14,334 shares of common stock issuable to Ms. Perrin upon the exercise of options scheduled to vest by April 19, 2011 and 31,980 shares of restricted stock, which vest in equal installments on February 19, 2011, 2012, 2013 and 2014.

(14) Consists of: Mses. Dragonetti, Marshall, Nustad, Perrin and Rudnick and Dr. Stocker and Messrs. Curtin, Holster, Hosp, Kelly, Lucia, Miller, Mosakowski, Schmid, Schwartz, Singh and Stowe.

(15) In a Schedule 13G filed with the SEC on February 4, 2011, BlackRock, Inc. reported it has sole voting and dispositive power over 2,074,503 shares of our common stock. BlackRock's principal business address is 40 East 52nd Street, New York, NY 10022.

(16) In a Schedule 13G filed with the SEC on February 14, 2011, FMR, LLC reported that it beneficially owns 2,132,450 shares of our common stock, of which it has sole voting power over 41,750 shares and sole dispositive power over 2,132,450 shares. Fidelity Management & Research Company, or Fidelity, with its principal address at 82 Devonshire Street, Boston, Massachusetts 02109, is a wholly-owned subsidiary of FMR LLC and an investment adviser registered under Section 203 of the Investment Advisers Act of 1940. Fidelity is the beneficial owner of 2,093,150 shares of our common stock as a result of acting as investment adviser to various investment companies registered under Section 8 of the Investment Company Act of 1940. Edward C. Johnson 3d and FMR LLC, through its control of Fidelity and the funds each has sole power to dispose of the 2,093,150 shares owned by the funds. Members of the family of Edward C. Johnson 3d, Chairman of FMR LLC, are the predominant owners, directly or through trusts, of Series B voting common shares of FMR LLC, representing 49% of the voting power of FMR LLC. The Johnson family group and all other Series B shareholders have entered into a shareholders' voting agreement under which all Series B voting common shares will be voted in accordance with the majority vote of Series B voting common shares. Accordingly, through their ownership of voting common shares and the execution of the shareholders' voting agreement, members of the Johnson family may be deemed, under the Investment Company Act of 1940, to form a controlling group with respect to FMR LLC. Neither FMR LLC nor Edward C. Johnson 3d, Chairman of FMR LLC, has the sole power to vote or direct the voting of the shares owned directly by the Fidelity Funds, which power resides with the Funds' Boards of Trustees. Fidelity carries out the voting of the shares under written guidelines established by the Funds' Boards of Trustees. Pyramis Global Advisors, LLC, or PGALLC, with its principal address at 900 Salem Street, Smithfield, RI, 02917, is an indirect wholly-owned subsidiary of FMR LLC and an investment adviser registered under Section 203 of the Investment Advisers Act of 1940. PGALLC is the beneficial owner of 4,400 shares of our common stock as a result of its serving as investment adviser to institutional accounts, non-U.S. mutual funds, or investment companies registered under Section 8 of the Investment Company Act of 1940 owning such shares. Edward C. Johnson 3d and FMR LLC, through its control of PGALLC, each has sole dispositive power over 4,400 shares and sole power to vote or to direct the voting of 4,400 shares of our common stock owned by the institutional accounts or funds advised by PGALLC as reported above. FIL Limited, or FIL, with its principal address at Pembroke Hall, 42 Crow Lane, Hamilton, Bermuda and various foreign-based subsidiaries provide investment advisory and management services to a number of non-U.S. investment companies and certain institutional investors. FIL which is a qualified institution under section 240.13d-1(b)(1) (ii), is the beneficial owner of 34,900 shares of our common stock. Partnerships controlled predominantly by members of the family of Edward C. Johnson 3d, Chairman of FMR LLC and FIL, or trusts for their benefit, own shares of FIL voting stock with the right to cast approximately 39% of the total votes which may be cast by all holders of FIL voting stock. FMR LLC and FIL are separate and independent corporate entities and their Boards of Directors are generally composed of different individuals. FMR LLC and FIL are of the view that they are not acting as a "group" for purposes of Section 13(d) under the Exchange Act and that they are not otherwise required to attribute to each other the "beneficial ownership" of securities "beneficially owned" by the other corporation within the meaning of Rule 13d-3 promulgated under the Exchange Act. Therefore, they are of the view that the shares held by the other corporation need not be aggregated for purposes of Section 13(d). Notwithstanding the foregoing, FMR LLC filed the Schedule 13G on a voluntary basis as if all of the shares are beneficially owned by FMR LLC and FIL on a joint basis.

(17) In a Schedule 13G filed with the SEC on February 8, 2011, William Blair & Co. reported it has sole voting and dispositive power over 1,597,220 shares of our common stock. William Blair's principal business address is 222 W. Adams, Chicago, IL 60606.

Item 13. Certain Relationships and Related Transactions and Director Independence.

William S. Mosakowski, a member of our Board of Directors, is the President, Chief Executive Officer, controlling stockholder and a member of the Board of Directors of PCG. Since the acquisition of BSPA in 2006, we have entered into subcontractor agreements with PCG, pursuant to which we provide cost containment services. For the year ended December 31, 2010, we recognized $0.1 million as revenue under subcontractor agreements with PCG and had $2.4 million in outstanding accounts receivable related to these subcontractor agreements.

In addition, as part of the acquisition of BSPA in 2006, we entered into an office sublease agreement with PCG that expired in January 2010. For the years ended December 31, 2010, 2009, 2008, we recognized $5,500, $110,000 and $110,000, respectively, as expense under the sublease agreement with PCG. In connection with the BSPA acquisition, we entered into an Intercompany Services Agreement (ISA) with PCG to allow each party to perform services for the other, such as information technology support and contractual transition services. Services performed under the ISA are billed at pre-determined rates specified in the ISA. For the year ended December 31, 2010 services rendered by PCG under the ISA were valued at approximately $360,000 and our services rendered to PCG were valued at approximately $112,000.

Since the BSPA acquisition, amounts collected by or paid on our behalf by PCG are reimbursed to PCG at cost. At December 31, 2010 we owed $0.1 million to PCG.

One of our former directors, Galen D. Powers, was a senior partner in the law firm Powers Pyles Sutter & Verville PC, which we began using in 1984. For the year ended December 31, 2010 we incurred $0.2 million in legal fees for services rendered to us by Powers Pyles Sutters & Verville.

The Audit Committee has reviewed and approved these transactions.

Board Determination of Independence

Under Rule 5605(a)(2) of the NASDAQ Stock Market, Inc. Marketplace Rules (the "NASDAQ Marketplace Rules"), a director will only qualify as an "independent director" if, in the opinion of our Board of Directors, that person does not have a relationship which would interfere with the exercise of independent judgment in carrying out the responsibilities of a director.

Based on its review of the applicable independence standards and answers to annual questionnaires completed by the directors, our Board of Directors has determined that each of Ms. Rudnick, Dr. Stocker and Messrs. Kelly, Miller, Schwartz and Stowe is an "independent director" as defined under the NASDAQ Marketplace Rules. At the time they ceased to serve on our Board of Directors, Messrs. Powers & Neal were "independent directors" as defined under the NASDAQ Marketplace Rules.

The Board of Directors has the following standing committees: Audit Committee, Compensation Committee, Compliance Committee and Nominating Committee, each of which consists of independent director, as defined under the NASDAQ Marketplace Rules.

Item 14. Principal Accounting Fees and Services.

Fees of Independent Registered Public Accountants during Fiscal Years 2010 and 2009

In addition to retaining KPMG to audit our financial statements, from time to time, we engage KPMG to perform other services. The following table sets forth the aggregate fees billed by KPMG in connection with the services rendered during the past two fiscal years. All fees set forth below were approved by the Audit Committee of the Board of Directors.

Type of Fee	2010	2009
Audit Fees[1]	$580,000	$558,500
Audit-Related Fees	—	—
Tax Fees[2]	125,805	10,620
All Other Fees[3]	226,272	—
Total Fees for Services Provided	**$932,077**	**$569,120**

(1) Audit fees represent fees for professional services rendered for the audit of our consolidated financial statements, review of interim financial statements and services normally provided by the independent registered public accounting firm in connection with regulatory filings, including registration statements.

(2) Represents fees for tax services, including tax compliance, tax advice and tax planning provided during the ordinary course of operations and tax services related to our acquisition of the office building in Irving, Texas.

(3) Represents fees related to a review of a data conversion project.

Audit Committee Pre-Approval Policies and Procedures

In accordance with its Charter, the Audit Committee pre-approves all audit and permissible non-audit services provided by our independent registered public accounting firm.

PART IV

Item 15. Exhibits and Financial Statement Schedules.

1. *Financial Statements.*

The financial statements are listed in the Index to Consolidated Financial Statements on page 73.

2. *Financial Statement Schedules.*

Financial Statement Schedule II — Valuation and Qualifying Accounts is set forth on page 102. All other financial statement schedules have been omitted as they are either not required, not applicable, or the information is otherwise included.

3. *Exhibits.*

The Exhibits are set forth on the Exhibit Index on page 103 and incorporated herein by reference.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, Registrant has duly caused this annual report to be signed on its behalf by the undersigned, thereunto duly authorized.

HMS Holdings Corp.
(Registrant)

By: /s/ William C. Lucia
William C. Lucia
Chief Executive Officer
(Principal Executive Officer and Duly Authorized Officer)

Date: March 1, 2011

Pursuant to the requirements of the Securities Exchange Act of 1934, this annual report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signatures	Title	Date
/s/ Robert M. Holster Robert M. Holster	Chairman, Board of Directors	February 26, 2011
/s/ William C. Lucia William C. Lucia	Chief Executive Officer, Director (Principal Executive Officer)	March 1, 2011
/s/ Walter D. Hosp Walter D. Hosp	Chief Financial Officer (Principal Financial Officer)	March 1, 2011
/s/ Joseph M. Donabauer Joseph M. Donabauer	Vice President & Controller (Principal Accounting Officer)	February 28, 2011
/s/ James T. Kelly James T. Kelly	Director	March 1, 2011
/s/ William F. Miller III William F. Miller III	Director	February 23, 2011
/s/ William S. Mosakowski William S. Mosakowski	Director	March 1, 2011
/s/ Ellen A. Rudnick Ellen A. Rudnick	Director	February 28, 2011
/s/ Bart M. Schwartz Bart M. Schwartz	Director	February 23, 2011
/s/ Michael A. Stocker, M.D. Michael A. Stocker, M.D.	Director	February 23, 2011
/s/ Richard H. Stowe Richard H. Stowe	Director	February 24, 2011

HMS HOLDINGS CORP. AND SUBSIDIARIES

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Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
HMS Holdings Corp.:

We have audited the accompanying consolidated balance sheets of HMS Holdings Corp. and subsidiaries (the Company) as of December 31, 2010 and 2009, and the related consolidated statements of income, shareholders' equity and comprehensive income and cash flows for each of the years in the three-year period ended December 31, 2010. In connection with our audits of the consolidated financial statements, we also have audited financial statement schedule II. These consolidated financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements and financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of HMS Holdings Corp. and subsidiaries as of December 31, 2010 and 2009, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2010, in conformity with U.S. generally accepted accounting principles. Also in our opinion, the related financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2010, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated March 1, 2011 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP

KPMG LLP
New York, New York
March 1, 2011

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
HMS Holdings Corp.:

We have audited HMS Holdings Corp's internal control over financial reporting as of December 31, 2010, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). HMS Holdings Corp. management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, HMS Holdings Corp. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of HMS Holdings Corp. as of December 31, 2010 and 2009, and the related consolidated statements of income, shareholders' equity and comprehensive income and cash flows for each of the years in the three-year period ended December 31, 2010, and our report dated March 1, 2011, expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

KPMG LLP
New York, New York
March 1, 2011

HMS HOLDINGS CORP. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share and per share amounts)

	December 31, 2010	December 31, 2009
ASSETS		
Current assets:		
Cash and cash equivalents	$ 94,836	$ 64,863
Accounts receivable, net of allowance of $799 at December 31, 2010 and $614 at December 31, 2009, respectively	75,123	64,750
Prepaid expenses	5,521	5,722
Prepaid income taxes	3,533	4,234
Other current assets	371	68
Net deferred tax asset	664	804
Total current assets	180,048	140,441
Property and equipment, net	44,713	20,902
Goodwill, net	107,414	91,520
Intangible assets, net	19,826	16,798
Other assets	904	983
Total assets	$352,905	$270,644
LIABILITIES AND SHAREHOLDERS' EQUITY		
Current liabilities:		
Accounts payable, accrued expenses and other liabilities	$ 32,502	$ 26,474
Total current liabilities	32,502	26,474
Long-term liabilities:		
Contingent payment due to AMG-SIU	2,573	—
Accrued deferred rent	1,842	3,675
Other liabilities	2,582	1,876
Deferred tax liabilities	5,768	326
Total long-term liabilities	12,765	5,877
Total liabilities	45,267	32,351
Commitments and Contingencies — See Note 12		
Shareholders' equity:		
Preferred stock — $0.01 par value; 5,000,000 shares authorized; none issued		
Common Stock — $0.01 par value; 45,000,000 shares authorized; 29,447,182 shares issued and 27,784,336 shares outstanding at December 31, 2010; 28,533,406 shares issued and 26,870,560 shares outstanding at December 31, 2009	294	285
Capital in excess of par value	205,039	175,795
Retained earnings	111,702	71,610
Treasury stock, at cost: 1,662,846 shares at December 31, 2010 and December 31, 2009	(9,397)	(9,397)
Total shareholders' equity	307,638	238,293
Total liabilities and shareholders' equity	$352,905	$270,644

See accompanying notes to consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME
(In thousands, except per share amounts)

	Year Ended December 31, 2010	Year Ended December 31, 2009	Year Ended December 31, 2008
Revenue	$302,867	$229,237	$184,495
Cost of services:			
Compensation	109,601	77,208	60,571
Data processing	18,086	13,717	10,999
Occupancy	13,643	10,877	10,079
Direct project costs	35,383	28,384	28,429
Other operating costs	17,108	14,019	10,831
Amortization of acquisition related software and intangibles	6,217	5,066	4,714
Total cost of services	200,038	149,271	125,623
Selling, general and administrative expenses	36,085	28,098	22,142
Total operating expenses	236,123	177,369	147,765
Operating income	66,744	51,868	36,730
Interest expense	(94)	(1,080)	(1,491)
Other expense, net	(69)	—	—
Interest income	94	226	719
Income before income taxes	66,675	51,014	35,958
Income taxes	26,583	20,966	14,583
Net income	$ 40,092	$ 30,048	$ 21,375
Basic income per common share:			
Net income per share — basic	$ 1.47	$ 1.15	$ 0.85
Diluted income per share:			
Net income per share — diluted	$ 1.41	$ 1.09	$ 0.80
Weighted average shares:			
Basic	27,254	26,110	25,048
Diluted	28,458	27,621	26,816

See accompanying notes to consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF SHAREHOLDERS' EQUITY AND COMPREHENSIVE INCOME
(In thousands, except share amounts)

	Common stock		Capital In Excess of Par Value	Retained Earnings/ Accumulated Deficit	Accumulated Other Comprehensive Income/(Loss)	Treasury Stock		Total Shareholders' Equity
	# of Shares Issued	Par Value				# of Shares	Amount	
Balance at January 1, 2008	26,409,035	$264	$127,887	$ 20,187	$(192)	1,662,846	$(9,397)	$138,749
Comprehensive income:								
Net income	—	—	—	21,375	—	—	—	21,375
Current period net changes in hedging trans, net of tax $18	—	—	—	—	(28)	—	—	(28)
Total comprehensive income								21,347
Stock-based compensation cost	—	—	3,498	—	—	—	—	3,498
Exercise of stock options	765,840	8	4,218	—	—	—	—	4,226
Excess tax benefit from exercise of stock options	—	—	10,542	—	—	—	—	10,542
Balance at December 31, 2008	27,174,875	$272	$146,145	$ 41,562	$(220)	1,662,846	$(9,397)	$178,362
Comprehensive income:								
Net income	—	—	—	30,048	—	—	—	30,048
Current period net changes in hedging trans, net of tax $147	—	—	—	—	220	—	—	220
Total comprehensive income								30,268
Stock-based compensation cost	—	—	6,373	—	—	—	—	6,373
Exercise of stock options	1,358,531	13	10,054	—	—	—	—	10,067
Excess tax benefit from exercise of stock options	—	—	13,223	—	—	—	—	13,223
Balance at December 31, 2009	28,533,406	$285	$175,795	$ 71,610	$ —	1,662,846	$(9,397)	$238,293
Comprehensive income:								
Net income	—	—	—	40,092	—	—	—	40,092
Total comprehensive income								40,092
Stock-based compensation cost	—	—	7,544	—	—	—	—	7,544
Exercise of stock options	913,776	9	9,119	—	—	—	—	9,128
Excess tax benefit from exercise of stock options	—	—	12,581	—	—	—	—	12,581
Balance at December 31, 2010	29,447,182	$294	$205,039	$111,702	$ —	1,662,846	$(9,397)	$307,638

See accompanying notes to consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOW
(In thousands)

	Year Ended December 31, 2010	Year Ended December 31, 2009	Year Ended December 31, 2008
Operating activities:			
Net income	$ 40,092	$ 30,048	$ 21,375
Adjustments to reconcile net income to net cash provided by operating activities:			
Loss on disposal of fixed assets	23	70	90
Depreciation and amortization	15,908	13,567	11,967
Stock-based compensation expense	7,544	6,373	3,498
Deferred income taxes	2,316	3,111	32
Provision for doubtful accounts	197	—	—
Change in fair value of contingent consideration	273	—	—
Changes in assets and liabilities:			
Increase in accounts receivable	(9,657)	(16,593)	(4,531)
Decrease/(Increase) in prepaid expenses and other current assets	1,061	(6,101)	(504)
Decrease/(Increase) in other assets	90	(218)	(21)
Increase/(Decrease) in accounts payable, accrued expenses and other liabilities	4,078	2,585	(1,037)
Net cash provided by operating activities	61,925	32,842	30,869
Investing activities:			
Purchases of property and equipment	(15,603)	(8,979)	(5,988)
Purchase of building and land	(9,886)	—	—
Acquisition of Chapman Kelly	(13,001)	—	—
Acquisition of AMG-SIU	(13,000)	—	—
Acquisition of Verify Solutions	(148)	(7,500)	—
Acquisition of IntegriGuard, net of cash	—	(5,024)	—
Acquisition of Prudent Rx	—	—	(4,496)
Investment in capitalized software	(2,023)	(1,657)	(912)
Net cash used in investing activities	(53,661)	(23,160)	(11,396)
Financing activities:			
Repayment of debt	—	(17,325)	(6,300)
Proceeds from exercise of stock options	9,128	10,067	4,226
Excess tax benefit from exercised stock options	12,581	13,223	10,542
Net cash provided by financing activities	21,709	5,965	8,468
Net increase in cash and cash equivalents	29,973	15,647	27,941
Cash and cash equivalents at beginning of year	64,863	49,216	21,275
Cash and cash equivalents at end of year	$ 94,836	$ 64,863	$ 49,216
Supplemental disclosure of cash flow information:			
Cash paid for income taxes	$ 10,949	$ 8,517	$ 3,823
Cash paid for interest	$ 70	$ 734	$ 1,299
Supplemental disclosure of noncash investing activities:			
Tenant improvement allowance	$ 202	$ 1,011	$ 208
Accrued property and equipment purchases	$ 2,804	$ 1,365	$ 1,898
AMG-SIU acquisition-related contingent payments	$ 2,573	$ —	$ —

See accompanying notes to consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies

(a) Organization and Business

We were incorporated on October 2, 2002 in the state of New York. On March 3, 2003, we adopted a holding company structure and assumed the business of our predecessor, Health Management Systems, Inc. In connection with the adoption of this structure, Health Management Systems, which began doing business in 1974, became our wholly owned subsidiary. Unless the context otherwise indicates, references in these Notes to Consolidated Financial Statements to the terms "HMS," "we," "our," and "us" refer to HMS Holdings Corp. and its subsidiaries.

We provide a variety of cost containment, coordination of benefits and program integrity services for government and private healthcare payors and sponsors. These services are designed to help our clients recover amounts due from liable third parties, save dollars, reduce fraud, waste and abuse and ensure regulatory compliance. In September 2008, we purchased the assets and liabilities of Prudent Rx, expanding our portfolio of program integrity service offerings for government healthcare programs and managed care organizations, particularly in the pharmacy arena. In September 2009, we further expanded our portfolio of program integrity service offerings for government healthcare programs, particularly in the Medicare and Medicaid programs with our acquisition of IntegriGuard LLC, or IntegriGuard. In December 2009, with the acquisition of Verify Solutions,Inc., or Verify Solutions, we moved into the employer-based market with valuable new services that ensure that dependents covered by employees are eligible to receive healthcare benefits. In June 2010, we acquired Allied Management Group — Special Investigation Unit, or AMG-SIU, which provides fraud, waste and abuse prevention and detection solutions for healthcare payors. In August 2010, we acquired Chapman Kelly, Inc., or Chapman Kelly which provides claims audit and beneficiary eligibility audit services to employers and managed care organizations.

We are managed and operate as one business, with a single management team that reports to the Chief Executive Officer. We do not operate separate lines of business with respect to any of our product lines.

(b) Principles of Consolidation

The consolidated financial statements include our accounts and transactions and those of our wholly owned subsidiaries. All significant intercompany balances and transactions have been eliminated in consolidation.

(c) Use of Estimates

The preparation of the consolidated financial statements in conformity with United States generally accepted accounting principles, or U.S. GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenue and expenses during the reported period. Our actual results could differ from those estimates.

(d) Reclassifications

Certain reclassifications were made to prior year amounts to conform to the current presentation.

(e) Cash and Cash Equivalents

For purposes of financial reporting, all highly liquid investments purchased with an original maturity of three months or less are considered to be cash equivalents. Cash equivalents consist of deposits that are readily convertible into cash.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

(f) Depreciation and Amortization of Property and Equipment

Property and equipment are recorded at cost. Depreciation is provided over the estimated useful lives of the assets utilizing the straight-line method. We provide amortization of leasehold improvements on a straight-line basis over the shorter of a five year period or the term of the related lease. The estimated useful lives are as follows:

Equipment	2-3 years
Leasehold improvements	3-5 years
Furniture and fixtures	5 years
Building and building improvements	up to 39.5 years

(g) Software and Software Development Cost

Certain software development costs related to software that is developed for internal use while in the application development stage are capitalized. All other costs to develop software for internal use, either in the preliminary project stage or post implementation stage, are expensed as incurred. Amortization of software and software development costs is calculated on a straight-line basis over the expected economic life of the product, generally estimated to be between 3-5 years.

(h) Goodwill

Goodwill, representing the excess of acquisition costs over the fair value of assets and liabilities of acquired businesses, is not amortized but is reviewed for impairment at least annually. Fair value is based on a projection of the estimated discounted future net cash flows expected to be achieved from a reporting unit using a discount rate reflective of our cost of funds. The fair value of the reporting unit is compared with the asset's recorded value. If the recorded value is less than the fair value of the reporting unit, no impairment is indicated. If the fair value of the reporting unit is less than the recorded value, an impairment charge is recognized for the difference between the carrying value and the fair value. We perform our annual goodwill impairment testing in the second quarter of each year. No impairment losses have been recorded in any of the periods presented.

(i) Long-Lived Assets

Long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable, commonly referred to as a triggering event. Recoverability of assets to be held and used is measured by a comparison of the carrying value of its asset group to the estimated undiscounted future net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying value of the asset group exceeds the fair value of the assets, which amount is charged to earnings. Fair value is based on a projection of the estimated discounted future net cash flows expected to result from the asset group, using a discount rate reflective of our cost of funds. Assets to be disposed of are reported at the lower of the carrying amount or fair value, less the cost to sell.

(j) Purchase Accounting

The purchase method of accounting requires companies to assign values to assets and liabilities acquired based upon their fair value. In most instances there is not a readily defined or listed market price for individual assets and liabilities acquired in connection with a business, including intangible assets. The determination of fair value for individual assets and liabilities in many instances requires a high degree of estimation. The valuation of intangible assets, in particular, is very subjective. The use of different valuation techniques and assumptions could change the amounts and useful lives assigned to the assets and liabilities acquired, including goodwill and other intangible assets and related amortization expense.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

(k) Income Taxes

Income taxes are accounted for under the asset and liability method. Under the asset and liability method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. This method also requires the recognition of future tax benefits for net operating loss (NOL) carry-forwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as income in the period that includes the enactment date. A valuation allowance is provided against deferred tax assets to the extent their realization is not more likely than not.

Uncertain income tax positions are accounted for by prescribing a minimum recognition threshold that a tax position is required to meet before being recognized in the financial statements.

(l) Earnings Per Share

Basic income per share is calculated by dividing net income by the weighted average number of common shares outstanding during the period. Diluted income per share is calculated by dividing net income by the weighted average number of common shares and dilutive common share equivalents outstanding during the period. Our common share equivalents consist of stock options and restricted stock awards and units.

The following table reconciles the basic to diluted weighted average shares outstanding (shares in thousands):

	Year Ended December 31,		
	2010	2009	2008
Weighted average shares outstanding — basic	27,254	26,110	25,048
Potential shares exercisable under stock option plans	1,166	1,500	1,768
Potential issuable restricted stock awards and units	38	11	—
Weighted average shares outstanding — diluted	28,458	27,621	26,816

For the years ended December 31, 2010, 2009 and 2008, 65,141, 91,419 and 758,190 stock options, respectively, were not included in the diluted earnings per share calculation because the effect would have been anti-dilutive. For the year ended December 31, 2010 restricted stock units representing 8,834 shares of common stock were not included in the diluted earnings per share calculation because the effect would have been anti-dilutive.

(m) Revenue Recognition

A majority of our contracts are contingency fee based. We recognize revenue on contingency fee based contracts when third party payors remit payment to our clients and, consequently, the contingency is deemed to have been satisfied. For certain contracts, this may result in revenue being recognized in irregular increments. We recognize revenue on our general service agreements as work is performed and amounts are earned. We consider amounts to be earned once evidence of an arrangement has been obtained, services are delivered, fees are fixed or determinable and collectability is reasonably assured. Our contracts with the federal government generally are cost-plus or time and material based. Revenue on cost-plus contracts is recognized based on costs incurred plus an estimate of the negotiated fee earned. Revenue on time and materials contracts is recognized based on hours worked and expenses incurred.

Where contracts have multiple deliverables, we evaluate these deliverables at the inception of each contract and as each item is delivered. As part of this evaluation, we consider whether (i) a delivered item has value to a client on a stand-alone basis; (ii) there is objective and reliable evidence of the fair market value of the undelivered items; and (iii) whether the delivery of the undelivered items is considered probable and substantially within our control, if a general right of return exists. Where deliverables, or groups of deliverables, have all three of these characteristics,

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

we treat each deliverable item as a separate unit of accounting and apply the relevant revenue recognition guidance to each deliverable. Arrangements including implementation and transaction related revenue are accounted for as a single unit of accounting. Since implementation services do not carry a standalone value, the revenue relating to these services is recognized over the term of the client contract to which it relates.

(n) Stock-Based Compensation

The cost of stock-based compensation is recognized in our Consolidated Statements of Income based on the fair value of all awards granted using the Black-Scholes method of valuation. The fair value of each award is determined and the compensation cost is recognized over the service period required to obtain full vesting. Compensation cost to be recognized reflects an estimate of the number of awards expected to vest after taking into consideration an estimate of award forfeitures based on actual experience. The cash flows resulting from tax benefits recognized for those options (excess tax benefits) are classified as financing cash flows.

(o) Fair Value of Financial Instruments

The fair values of our financial instruments reflect the amounts that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date (exit price). In addition, FASB authoritative guidance requires us to disclose the fair value of financial instruments, both assets and liabilities recognized and not recognized in the statement of financial position, for which it is practicable to estimate fair value.

The carrying amounts for our cash equivalents, accounts receivable, accounts payable and accrued expense approximate fair value due to their short-term nature.

(p) Leases

We account for our lease agreements at their inception as either operating or capital leases, depending on certain defined criteria. We recognize lease costs on a straight-line basis without regard to deferred payment terms, such as rent holidays, that defer the commencement date of required payments. Additionally, incentives we receive, such as tenant improvement allowances, are capitalized and are treated as a reduction of our rental expense over the term of the lease agreement.

(q) Subsequent Events

We have evaluated events occurring after December 31, 2010, through the date and time these financial statements were issued. We have determined that there were no subsequent events or transactions that required recognition or disclosure in the consolidated financial statements, except as disclosed in Notes 10 and 11 of these Notes to the Consolidated Financial Statements.

(r) Recently Issued Accounting Pronouncement

In September 2006, the FASB issued guidance on fair value measurements and disclosures. This guidance establishes a common definition for fair value to be applied to U.S. GAAP guidance requiring the use of fair value, establishes a framework for measuring fair value, and expands the disclosure about such fair value measurements.

Effective January 1, 2008, we adopted this guidance on fair value measurement and have applied its provisions to financial assets and liabilities that are recognized or disclosed at fair value on a recurring basis at least annually. Beginning January 1, 2009, we adopted this guidance as it related to nonfinancial assets and liabilities. We applied the provisions of this guidance in our accounting for our 2009 and 2010 acquisitions.

In September 2009, the FASB issued additional guidance on measuring the fair value of liabilities effective for the first reporting period beginning after its issuance.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

In January 2010, the FASB issued guidance that requires reporting entities to make new disclosures about recurring or nonrecurring fair-value measurements, including significant transfers into and out of Level 1 and Level 2 fair value measurements and information on purchases, sales, issuances and settlements on a gross basis in the reconciliation of Level 3 fair value measurements. The guidance is effective for annual reporting periods beginning after December 15, 2009, except for Level 3 reconciliation disclosures, which are effective for annual periods beginning after December 15, 2010. We do not expect the adoption of this guidance to have a material impact on our consolidated financial statements.

In November 2008, the FASB ratified an issue providing guidance for accounting for defensive intangible assets subsequent to the acquisition of such assets in accordance with the new business combination and fair value standards, including the estimated useful life that should be assigned to such assets. The new guidance is effective for intangible assets acquired on or after December 15, 2008. We have applied the provisions of this standard to our 2009 and 2010 acquisitions as discussed in Note 2 of the Notes to Consolidated Financial Statements.

In October 2009, the FASB issued new accounting guidance related to the recognition of revenue for multiple-deliverable arrangements. This guidance provides accounting principles and application guidance on how the arrangement should be separated, and the consideration allocated. This guidance changes how to determine the fair value of undelivered products and services for separate revenue recognition. Allocation of consideration is now based on management's estimate of the selling price for an undelivered item where there is no other means to determine the fair value of that undelivered item. Also in October 2009, the FASB issued new accounting guidance altering the scope of revenue recognition for software deliverables to exclude items sold that include hardware with software that is essential to the hardware's functionality. This new guidance will be effective prospectively for revenue arrangements entered into or materially modified in fiscal years beginning on or after June 15, 2010. Early adoption is permitted. We have determined that this new guidance will not currently impact our existing accounting over our multiple element arrangements.

2. Acquisitions

The results of operations for our 2010, 2009 and 2008 acquisitions have been included in the Company's consolidated financial statements from the date of acquisition. The Company has concluded that these acquisitions were not material to its financial statements; therefore, pro forma financial information is not presented herein.

Chapman Kelly, Inc.

In August 2010, we acquired the assets and liabilities of Chapman Kelly, for $13.0 million in cash. Chapman Kelly, which is based in Jeffersonville, Indiana, provides dependent eligibility audits to large, self-insured employers, as well as plan and claims audits to both employers and managed care organizations. The acquisition of Chapman Kelly did not have a material effect on our 2010 revenue, earnings, earnings per share or liquidity.

As a result of the acquisition occurring late in August 2010, we have not yet completed a valuation of the assets and liabilities acquired from Chapman Kelly. Accordingly, we have not completed the purchase price allocation and therefore, the aggregate purchase price allocation of this acquisition presented below is subject to adjustments:

The preliminary allocation of the aggregate purchase price of the Chapman Kelly acquisition is estimated to be as follows (in thousands):

Goodwill	$10,208
Identifiable intangible assets	1,500
Capitalized software	276
Assets and liabilities acquired	1,017
Total purchase price	$13,001

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Identifiable intangible assets principally include covenants not to compete, customer relationships and Chapman Kelly's trade name.

Allied Management Group — Special Investigation Unit

In June 2010, we purchased all of the issued and outstanding common stock of AMG-SIU for a purchase price valued at $15.1 million, consisting of a $13.0 million initial cash payment (subsequently reduced by a working capital reduction of $0.2 million), and future contingent payments estimated and recognized as of the acquisition date at $2.3 million. These payments are contingent upon AMG-SIU's financial performance for each of the twelve month periods ending June 30, 2011 and June 30, 2012. The contingent payments are not subject to any cap. Any contingent payments owed for the periods ending June 30, 2011 and 2012 shall be payable by September 30, 2011 and 2012. The undiscounted contingent payments are currently estimated to be $3.4 million and relate to the 12 month period ending June 30, 2012. AMG-SIU, which is based in Santa Ana, California, specializes in fraud, waste and abuse prevention and detection solutions for healthcare payors, which further strengthens our ability to service this segment of the market. The acquisition of AMG-SIU did not have a material effect on our 2010 revenue, earnings per share or liquidity.

The fair value of the contingent consideration recognized on the acquisition date of June 30, 2010 was estimated by applying the income approach. That measure is based on significant inputs not observable in the market that are defined by FASB guidance on fair value as Level 3 inputs.

The acquisition of AMG-SIU was accounted for under the acquisition method of accounting.

The following table summarizes the final amounts recognized for assets acquired and liabilities assumed as of the acquisition date, as well as adjustments made to the amounts initially recorded in June of 2010 (measurement period adjustments).

	Amounts Recognized as of Acquisition Date (Provisional)	Measurement Period Adjustments	Amounts Recognized as of Acquisition Date (Final)
		(in thousands)	
Goodwill	$19,934	$(10,948)	$ 8,986
Identifiable Intangible assets	5,000	(1,100)	3,900
Assets and liabilities acquired	750	(235)	515
Capitalized software	3,000	2,300	5,300
Deferred tax liability	(2,707)	(855)	(3,562)
Total purchase price	$25,977	$(10,838)	$15,139
Contingent payments	12,977	(10,677)	2,300

Identifiable intangible assets principally include covenants not to compete, customer relationships and AMG-SIU's trade name.

Verify Solutions, LLC

In December 2009, we acquired the assets of Verify Solutions, an Alpharetta, Georgia-based company specializing in dependent eligibility audit services for large, self insured employers. With this acquisition, we moved into the large and mid-market employer-based market.

The purchase price for Verify Solutions was $8.1 million, with additional future payments contingent upon Verify Solutions' achievement of financial performance milestones. The additional future payments of up to $5.5 million ($2.7 million and $2.8 million for the years ended December 31, 2010 and 2011, respectively) will be made and recorded to compensation expense in the year in which the milestones are achieved. No compensation expense was recorded in 2010 as the performance milestones were not achieved.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The allocation of the purchase price for Verify Solutions was based upon the fair value estimate of its assets and liabilities. The acquisition of Verify Solutions was based on management's consideration of past and expected future performance as well as the potential strategic fit with our long-term goals. The expected long-term growth, market position and expected synergies to be generated by Verify Solutions were the primary factors that gave rise to an acquisition price that resulted in the recognition of identifiable intangible assets.

In December 2010, following our acquisition of Chapman Kelly, which together with Verify Solutions forms HMS Employer Solutions, we amended the terms of the contingent payment for 2011. Under the terms of this amendment, the former owners of Verify Solutions could earn a contingent payment of between $1.3 million and $2.8 million based on the revenue generated by HMS Employer Solutions for the year ending December 31, 2011. If earned, the contingent payment will be accrued and expensed to Compensation in 2011.

The following table summarizes the final amounts recognized for assets acquired and liabilities assumed as of the acquisition date, as well as adjustments made in 2010 to the amounts initially recorded in 2009 (measurement period adjustments). The measurement period adjustments did not have a significant impact on our consolidated statements of income, balance sheets or cash flows in any period and, therefore, we have not retrospectively adjusted our financial statements.

	Amounts Recognized as of Acquisition Date (Provisional)	Measurement Period Adjustments	Amounts Recognized as of Acquisition Date (Final)
		(in thousands)	
Goodwill	$7,401	$(3,300)	$4,101
Identifiable intangible assets	—	3,000	3,000
Assets and liabilities acquired	747	(301)	446
Capitalized software	—	601	601
Total purchase price	$8,148	$ —	$8,148

Identifiable intangible assets principally include covenants not to compete and Verify Solutions' trade name. The total purchase price reflects an additional $148,000 working capital payment made in 2010 and a $500,000 payable to the seller in 2011.

IntegriGuard LLC

In September 2009, we acquired the assets and liabilities of IntegriGuard, for $5.1 million in cash. IntegriGuard, which operates as our wholly owned subsidiary, provides services for the prevention and detection of fraud, waste and abuse in the healthcare system and is based in Omaha, Nebraska. This acquisition was accounted for under the purchase method of accounting. This acquisition further expanded our portfolio of program integrity service offerings for government healthcare programs, particularly in the Medicare and Medicaid programs.

The allocation of the purchase price for IntegriGuard was based upon the fair value estimate of its assets and liabilities. The acquisition of IntegriGuard was based on management's consideration of past and expected future performance as well as the potential strategic fit with our long-term goals. The expected long-term growth, market position and expected synergies to be generated by IntegriGuard were the primary factors that gave rise to an acquisition price that resulted in the recognition of unidentified intangible assets.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The allocation of the aggregate purchase price of the IntegriGuard acquisition is as follows (in thousands):

Goodwill	$1,777
Assets and liabilities acquired, inclusive of cash of $110	1,712
Intangible assets	1,405
Capitalized software	240
Total purchase price	$5,134

Identifiable intangible assets principally include client relationships and IntegriGuard's trade name.

Prudent Rx

In September 2008, we purchased the assets and liabilities of Prudent Rx, a pharmacy audit and cost containment company based in Culver City, California. This acquisition further expanded our portfolio of program integrity service offerings for government healthcare programs and managed care organizations, particularly in the pharmacy arena. Prudent Rx's key products and services include audit programs, program design and benefit management, as well as general and pharmacy systems consulting.

We purchased the assets and liabilities of Prudent Rx for $4.5 million in cash, with additional future payments of up to $2.3 million contingent upon Prudent Rx's achievement of financial performance milestones. Prudent Rx did not achieve the 2009 and 2010 performance milestones, as a result no contingent payments were made to Prudent Rx.

The allocation of the purchase price of Prudent Rx was based upon estimates of the fair value of its assets and liabilities. The acquisition of Prudent Rx was based on management's consideration of past and expected future performance as well as the potential strategic fit with our long-term goals. The expected long-term growth, market position and expected synergies to be generated by Prudent Rx were the primary factors that gave rise to an acquisition price that resulted in the recognition of goodwill.

The allocation of the aggregate purchase price of the Prudent Rx acquisition is as follows (in thousands):

Goodwill	$2,100
Identifiable intangible assets	1,432
Assets and liabilities acquired	964
Total purchase price	$4,496

Identifiable intangible assets principally include client relationships and Prudent Rx's trade name.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

3. Property and Equipment

Property and equipment at December 31, 2010 and 2009 consisted of the following (in thousands):

	December 31, 2010	December 31, 2009
Equipment	$ 40,445	$ 29,005
Leasehold improvements	5,988	7,514
Building	8,639	—
Building improvements	1,556	—
Land	1,113	—
Furniture and fixtures	10,174	7,858
Capitalized software	16,814	8,916
	84,729	53,293
Less accumulated depreciation and amortization	(40,016)	(32,391)
Property and equipment, net	$ 44,713	$ 20,902

Depreciation and amortization expense related to property and equipment charged to operations for the years ended December 31, 2010, 2009 and 2008 was $10.5 million, $8.2 million and $7.1 million, respectively. In connection with our operating leases for our facilities, we recorded tenant improvement allowances totaling $0.2 million, $1.0 million and $0.2 million for the years ended December 31, 2010, 2009 and 2008, respectively.

4. Intangible Assets

Intangible assets at December 31, 2010 and 2009 are as follows (in thousands):

	December 31, 2010	December 31, 2009	Useful Life
Customer relations	$ 32,247	$ 29,547	6-10 years
Trade name	3,932	732	5-10 years
Restrictive covenant	2,626	126	3-5 years
	38,805	30,405	
Less accumulated amortization	(18,979)	(13,607)	
Intangible assets, net	$ 19,826	$ 16,798	

Annual estimated amortization expense of intangibles is expected to approximate the following (in thousands):

Year Ending December 31,	
2011	5,752
2012	5,713
2013	4,181
2014	1,283
2015 and thereafter	2,897
Total	$19,826

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The changes in the carrying amount of goodwill for the years ended December 31, 2010 and 2009 are as follows (in thousands):

Balance at December 31, 2008	$ 82,342
IntegriGuard acquisition	1,777
Verify Solutions acquisition	7,401
Balance at December 31, 2009	$ 91,520
AMG-SIU acquisition	8,986
Chapman Kelly acquisition	10,208
Verify Solutions adjustment	(3,300)
Balance at December 31, 2010	$107,414

For the years ended December 31, 2010, December 31, 2009 and December 31, 2008, amortization expense related to intangible assets amounted to $5.5 million, $5.4 and $4.9 million respectively.

5. Accounts Payable, Accrued Expenses and Other Liabilities

Accounts payable, accrued expenses and other liabilities at December 31, 2010 and 2009 consisted of the following (in thousands):

	December 31, 2010	December 31, 2009
Accounts payable, trade	$10,408	$ 8,981
Accrued compensation	15,279	11,457
Accrued direct project costs	721	1,470
Accrued other expenses	6,094	4,566
	$32,502	$26,474

6. Income Taxes

The income tax expense for the years ended December 31, 2010, 2009 and 2008 is as follows (in thousands):

	December 31, 2010	December 31, 2009	December 31, 2008
Current tax expense:			
Federal	$19,956	$13,211	$11,242
State	4,311	4,644	3,309
	24,267	17,855	14,551
Deferred tax expense:			
Federal	2,191	2,959	(255)
State	125	152	287
	2,316	3,111	32
Total income tax expense	$26,583	$20,966	$14,583

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

A reconciliation of the income tax expense calculated using the applicable federal statutory rates to the actual income tax expense for the years ended December 31, 2010, 2009 and 2008 is as follows (in thousands):

	December 31,					
	2010	%	2009	%	2008	%
Computed at federal statutory rate	$23,336	35.0	$17,855	35.0	$12,585	35.0
State and local tax expense, net of federal benefit	2,894	4.3	3,117	6.1	2,337	6.5
Other, net	353	0.6	(6)	—	(339)	(0.9)
Total income tax expense	$26,583	39.9	$20,966	41.1	$14,583	40.6

Deferred income taxes are recognized for the future tax consequences of temporary differences between the financial statement and tax bases of assets and liabilities. The tax effect of temporary differences that give rise to a significant portion of the deferred tax assets and deferred tax liabilities at December 31, 2010 and 2009 were as follows (in thousands):

	December 31, 2010	December 31, 2009
Deferred tax assets:		
Allowance for doubtful accounts and deferred revenue	$ 624	$ 620
Restructuring cost	191	233
Goodwill and other intangibles	4,922	3,765
Software	4	44
Net operating loss carry forwards	136	183
Capital loss carry forward	—	2,466
Deferred stock compensation	4,789	3,325
Deferred rent	662	855
Other	902	284
Total deferred tax assets before valuation allowance	12,230	11,775
Less valuation allowance	(81)	(2,666)
Total deferred tax assets after valuation allowance	12,149	9,109
Deferred tax liabilities:		
Goodwill and other intangibles	12,382	6,682
Capitalized software cost	1,791	1,266
Property and equipment	3,080	683
Total deferred tax liabilities	17,253	8,631
Total net deferred tax (liabilities)/assets	$ (5,104)	$ 478
Net current deferred tax assets	$ 664	$ 804
Net non-current deferred tax liabilities	(5,768)	(326)
Total net deferred (liabilities)/tax assets	$ (5,104)	$ 478

At December 31, 2010, we had net operating loss (NOL) carry-forwards of $0.1 million which are available to offset future state and local taxable income. During 2010, we utilized $32.4 million in tax deductions arising from 2010 stock option exercises, which resulted in an excess tax benefit of $12.6 million that was recorded to capital and an offsetting reduction to taxes payable.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

There was a decrease in our valuation allowance of $2.6 million from December 31, 2009 to December 31, 2010, as a result of the expiration of the capital loss carry forward. The sale of our subsidiary Accordis, in 2005, resulted in a capital loss of $6.0 million, which was carried forward for five years and produced a deferred tax asset of $2.5 million, which expired December 31, 2010. Our remaining valuation allowance of $0.1 million at December 31, 2010 relates to certain state NOLs.

At December 31, 2010 and 2009, we had approximately $1.4 million and $1.0 million of net unrecognized tax benefits, respectively, for which there is uncertainty about the allocation and apportionment impacting state taxable income. We do not expect any significant change in unrecognized tax benefits during the next twelve months. We have recognized interest accrued related to unrecognized tax benefits in interest expense and penalties in tax expense. The accrued liabilities related to uncertain tax positions were $0.5 million and $0.4 million at December 31, 2010 and 2009, respectively. The additions to the accrued liabilities related to uncertain tax positions taken during 2010.

7. Debt

We have a credit agreement with several banks and other financial institutions, with JPMorgan Chase Bank, N.A. (JPMCB) as administrative agent, or the Credit Agreement. The Credit Agreement, which expires in September 2011, provided for a term loan of $40 million, or the Term Loan and revolving credit loans of up to $25 million, which we refer to as the Revolving Loan. During the year ended December 31, 2009, we repaid in full the $17.3 million of debt outstanding under the Term Loan. However, we continue to have an irrevocable standby Letter of Credit for $4.6 million against the Revolving Loan, as required by a contractual arrangement with a client.

We secured the Term and Revolving Loans with the grant of a security interest, covering our assets and subsidiaries, in favor of the lenders. Interest on borrowings under the Credit Agreement is calculated, at our option, at either (i) LIBOR, including statutory reserves, plus a variable margin based on our leverage ratio, or (ii) the higher of (a) the prime lending rate of JPMCB and (b) the Federal Funds Effective Rate plus 0.50%, in each case, plus a variable margin based on our leverage ratio. In connection with the Revolving Loan, we agreed to pay a commitment fee on the unused portion of the Revolving Loan, payable quarterly in arrears, at a variable rate based on our leverage ratio.

Commitments under the Credit Agreement will be reduced and borrowings are required to be repaid with the net proceeds of, among other things, sales or issuances of equity (excluding equity issued under employee benefit plans and equity issued to sellers as consideration in acquisitions), sales of assets and any incurrence of indebtedness by us, subject, in each case, to limited exceptions. Our obligations under the Credit Agreement may be accelerated upon the occurrence of an event of default under the Credit Agreement, which encompasses customary events of default including, without limitation, payment defaults, defaults in the performance of affirmative and negative covenants, the inaccuracy of representations or warranties, bankruptcy and insolvency related defaults, defaults relating to such matters as ERISA, uninsured judgments and the failure to pay certain indebtedness and a change of control default.

In addition, the Credit Agreement contains affirmative, negative and financial covenants customary for financings of this type. The negative covenants include restrictions on indebtedness, liens, fundamental changes, dispositions of property, investments, dividends and other restricted payments. The financial covenants include a consolidated fixed charge coverage ratio, as defined, of not less than 1.75 to 1.0 and a consolidated leverage ratio, as defined, not to exceed 3.0 to 1.0, through December 31, 2010. We are currently in full compliance with these covenants.

On March 30, 2010, we entered into an amendment to the Credit Agreement, which we refer to as the First Amendment, to increase the total amount we could spend on acquisitions in any one year from $10.0 million to $30.0 million. In connection with entering into the First Amendment, the lenders agreed to waive any default that

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

may have occurred and be continuing as a result of the Verify Solutions acquisition, which closed on December 31, 2009, as a result of which we exceeded the aggregate acquisition amount in 2009. This default did not have a material impact on our 2009 financial statements since we had no outstanding debt and only a Letter of Credit outstanding.

Fees and expenses incurred in 2006 of $0.9 million related to the Credit Agreement have been recorded as deferred financing costs (included in other assets, non-current) and are amortized to interest expense over the five-year life of the Credit Agreement using the effective interest method. Since the Term Loan was repaid in 2009, the remaining deferred financing costs of $224,000 as of October 2009 have been charged against income.

8. Equity

(a) Treasury Stock

On May 28, 1997, the Board of Directors authorized the repurchase of such number of shares of our common stock that have an aggregate purchase price not to exceed $10 million. On February 24, 2006, the Board of Directors increased the authorized aggregate purchase price to an amount not to exceed $20 million. We are authorized to repurchase these shares from time-to-time on the open market or in negotiated transactions at prices deemed appropriate by our management. Repurchased shares are deposited in the treasury and used for general corporate purposes. During the years ended December 31, 2010, 2009 and 2008, we did not repurchase any shares of common stock. Since the inception of the repurchase program in June 1997, we have repurchased 1,662,846 shares of common stock at an average price of $5.65 per share and for an aggregate purchase price of $9.4 million.

(b) Preferred Stock

Our certificate of incorporation, as amended, authorizes the issuance of up to 5,000,000 shares of "blank check" preferred stock with such designations, rights and preferences as may be determined by our Board of Directors. As of December 31, 2010, no preferred stock had been issued.

9. Employee Benefit Plan

We sponsor a benefit plan to provide retirement benefits for our employees, which is known as the HMS Holdings Corp. 401(k) Plan, or the 401(k) Plan. Participants may make voluntary contributions to the 401(k) Plan of up to 60% of their annual base pre-tax compensation not to exceed the federally determined maximum allowable contribution. The 401(k) Plan permits us to make discretionary contributions. These contributions are not in the form of our common stock.

Participants are permitted to invest their contributions in our common stock. For the years ended December 31, 2010, 2009 and 2008, we contributed $2.5 million, $1.6 million and $1.3 million, respectively, to the 401(k) Plan.

10. Stock-Based Compensation Plans

We grant stock options to purchase our common stock, restricted stock awards and restricted stock units to our employees and directors under our Third Amended and Restated 2006 Stock Plan, or the 2006 Plan. Our 2006 Plan was adopted in June 2006 and superseded our 1999 Long-Term Incentive Stock Plan, or the 1999 Plan. There are options outstanding that were granted under the 1999 Plan. In addition, there are options outstanding that were granted outside these plans. Stock-based compensation cost is measured at the grant date based on the fair value of the award and is recognized as expense on a straight-line basis over the requisite service period, which is generally the vesting period. Stock options granted under our 2006 or 1999 Plan generally vest over a one to four year period. The restricted stock awards and restricted stock units granted under our 2006 Plan vest over a three to five year period and the related stock-based compensation expense is ratably recognized over those same time periods.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Total stock-based compensation expense charged as a selling, general and administrative expense in our consolidated statements of income related to our stock compensation plans was $7.5 million, $6.4 million and $3.5 million for the years ended December 31, 2010, 2009 and 2008, respectively. The total income tax benefit recognized in our consolidated statements of income for the years ended December 31, 2010, 2009 and 2008 related to our stock compensation plans was $3.0 million, $2.6 million and $1.4 million, respectively.

(a) Third Amended and Restated 2006 Stock Plan

As of December 31, 2010, we had one stock-based compensation plan, the 2006 Plan. The 2006 Plan permits the granting of incentive stock options, non-qualified stock options, stock appreciation rights (SARs), restricted stock awards and restricted stock units, performance shares and performance units, share awards and phantom stock awards.

Our 2006 Plan was approved by our shareholders in June 2006. The purpose of the 2006 Plan is to furnish a material incentive to our employees and non-employee directors by making available to them the benefits of a larger common stock ownership through stock options and awards. We believe that these increased incentives stimulate the efforts of employees and non-employee directors towards our continued success, as well as assist in the recruitment of new employees and non-employee directors.

A total of 4,000,000 shares have been authorized for issuance under the 2006 Plan. Any shares issued in connection with awards other than stock options and SARs are counted against the 4,000,000 share limit as one and eighty-five hundredths (1.85) of a share for every one share issued in connection with such award or by which the award is valued by reference.

All of our employees as well as our non-employee directors are eligible to participate in the 2006 Plan. However, only our employees are eligible to receive incentive stock options. The exercise price of stock options granted under the 2006 Plan may not be less than fair market value of a share of stock on the grant date, as measured by the closing price of our common stock on The NASDAQ Global Select Market and the term of a stock option may not exceed seven years.

During the fourth quarter of 2010, the Compensation Committee of the Board of Directors approved stock option grants to purchase an aggregate of 224,408 shares of common stock to our directors, executive officers and employees under the 2006 Plan at an exercise price of $59.32 per share, the closing price of our common stock on the date of the grant. Stock options granted to our directors vest quarterly over a one year period. Stock options granted to employees vest as follows: half of the stock options vest in one-third increments on December 31, 2011, 2012 and 2013 and the other half vests on December 31, 2013, provided certain pre-defined performance and service conditions are satisfied.

During the year ended December 31, 2010, stock options to purchase an aggregate of 224,841 shares of common stock and 38,805 restricted stock units were granted under the 2006 Plan. There were no restricted stock awards granted, leaving 1,437,208 shares of common stock available for grant under the 2006 Plan. As of December 31, 2010, options to purchase 1,714,596 shares of common stock, 127,918 restricted stock awards and 56,930 restricted stock units were outstanding under the 2006 Plan.

(b) 1999 Long-Term Incentive Plan

Our 1999 Long-Term Incentive Stock Plan, or the 1999 Plan, was approved by our shareholders in March 1999. The 1999 Plan was terminated upon approval of the 2006 Plan by our shareholders in June 2006 and, accordingly, no additional awards options may be granted thereunder. As of December 31, 2010 and 2009, there were 500,497 and 878,273 stock options outstanding, respectively.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

(c) Options Issued Outside the Plans

As of December 31, 2010 and 2009, there were stock options to purchase an aggregate of 107,916 and 391,250 shares of our common stock, respectively outstanding that were not granted under the 2006 Plan or the 1999 Plan. These stock options outstanding as of December 31, 2010 are as follows: (i) 47,916 options granted in September 2006 to four former senior executives of Benefits Solutions Practice Area or BSPA in connection with their joining us and (ii) 60,000 options granted in July 2007 to Walter D. Hosp, our Chief Financial Officer, under the terms of his employment agreement.

(d) Summary of Options

Presented below is a summary of our stock option activity for the years ended December 31, 2008, 2009 and 2010, respectively (in thousands, except for weighted average exercise price and weighted average remaining contractual terms):

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Terms	Aggregate Intrinsic Value
Outstanding at January 1, 2010	3,036	17.39		
Granted	225	59.27		
Exercised	(914)	9.99		
Forfeitures	(24)	31.60		
Expired	—	—		
Outstanding at December 31, 2010	2,323	24.20	4.45	$94,244
Vested or expected to vest at December 31, 2010	2,194	23.52	4.40	$90,503
Exercisable at December 31, 2010	1,423	$16.35	3.80	$68,902

The fair value of each option grant was estimated using the Black-Scholes option pricing model. Expected volatilities are calculated based on the historical volatility of our common stock. Management monitors share option exercise and employee termination patterns to estimate forfeiture rates within the valuation model. Separate groups of employees that have similar historical exercise behavior are considered separately for valuation purposes. The expected holding period of options represents the period of time that options granted are expected to be outstanding. The expected terms of options granted are based upon the Company's historical experience for similar types of stock option awards. The risk-free interest rate is based on U.S. Treasury notes.

During the years ended December 31, 2010, 2009 and 2008, we issued 0.9 million shares, 1.4 million shares and 0.8 million shares, respectively, of our common stock upon the exercise of outstanding stock options and received proceeds of $9.1 million, $10.1 million and $4.2 million, respectively. For the years ended December 31, 2010, 2009 and 2008, we realized a $12.6 million, $13.2 million and $10.5 million tax benefit from the exercise of stock options, respectively. The total intrinsic value of options exercised during the years ended December 31, 2010, 2009 and 2008 was $41.9 million, $37.2 million and $14.9 million, respectively.

For the years ended December 31, 2010, 2009 and 2008, approximately $6.3 million, $5.6 million and $3.5 million, respectively, of stock-based compensation cost relating to stock options has been charged against income. As of December 31, 2010, there was approximately $10.1 million of total unrecognized compensation cost, adjusted for estimated forfeitures, related to stock options outstanding, which is expected to be recognized over a weighted-average period of 1.6 years.

The aggregate intrinsic value in the previous table reflects the total pretax intrinsic value (the difference between our closing stock price on the last trading day of the period and the exercise price of the options, multiplied

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

by the number of in-the-money stock options) that would have been received by the option holders had all option holders exercised their options on December 31, 2010. The intrinsic value of our stock options changes based on the closing price of our common stock.

The weighted-average grant-date fair value per share of the stock options granted during the years ended December 31, 2010, 2009 and 2008 was $21.25, $14.62 and $8.47, respectively. We estimated the fair value of options granted using a Black-Scholes option pricing model with the following assumptions:

	Year Ended December 31,		
	2010	2009	2008
Expected dividend yield	0%	0%	0%
Risk-free interest rate	1.51%	2.32%	2.96%
Expected volatility	43.8%	45.8%	40.08%
Expected life	4.0 years	4.0 years	4.0 years

(e) Restricted Stock Units

In October 2010 and October 2009, certain employees received restricted stock units under the 2006 Plan. In October 2010 our Board of Directors also received restricted stock units under the 2006 Plan. The fair value of restricted stock units is estimated based on the closing sale price of our common stock on the NASDAQ Global Select Market on the date of issuance. The total number of restricted stock units expected to vest is adjusted by estimated forfeiture rates. As of December 31, 2010 and 2009, there was approximately $2.6 million and $0.9 million, respectively, of unamortized compensation cost related to restricted stock units which is expected to be recognized over the remaining weighted-average vesting period of 2.0 years. For the years ended December 31, 2010 and 2009, stock-based compensation expense related to restricted stock units was $0.4 million and $0.1 million, respectively.

A summary of the status of our restricted stock units, as of December 31, 2010 and of and changes in restricted stock units outstanding under the 2006 Plan for the years ended December 31, 2010 and 2009 is as follows (in thousands, except for weighted average grant date fair value per unit):

	Number of Units	Weighted Average Grant Date Fair Value per Unit	Aggregate Intrinsic Value
Non-vested balance at December 31, 2008	—	—	
Granted	25	$37.82	
Non-Vested balance at December 31, 2009	25	$37.82	
Granted	39	59.32	
Cancelled	(2)	53.71	
Converted into common stock	(5)	41.44	
Non-vested balance at December 31, 2010	57	$51.46	$3,687

In February 2011 our Board of Directors approved the grant of restricted stock units with an aggregate value of $4.95 million to certain of our executive officers. An aggregate of 66,962 restricted stock units were granted to these executive officers on February 18, 2011, based on the closing price of our common stock of $73.92 on the NASDAQ Global Select Market on that date. The restricted stock awards vest in 25% increments, with the first 25% vesting on the second anniversary of the grant date and the remainder vesting ratably on the third, fourth and fifth anniversaries of the grant date

(f) Restricted Stock Awards

Our executive officers have received grants of restricted stock awards under the 2006 Plan. The vesting of restricted stock awards is subject to the executive officers' continued employment with us. Recipients of restricted

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

stock awards are not required to provide us with any consideration other than rendering service. Holders of restricted stock are permitted to vote and to receive dividends.

The stock-based compensation expense for restricted stock awards is determined based on the closing market price of our common stock on the grant date of the awards applied to the total number of awards that are anticipated to fully vest. At December 31, 2010, there was unrecognized stock-based compensation of $2.8 million stock-based compensation related to restricted stock awards, which is expected to be recognized over the weighted-average period of 1.6 years. For the years ended December 31, 2010 and 2009, stock-based compensation expense related to restricted stock awards was $0.8 million and $0.7 million, respectively.

A summary of the status of our restricted stock awards as of December 31, 2010 and of changes in restricted stock awards outstanding under the 2006 Plan for the year ended December 31, 2010 is as follows (in thousands, except for weighted average grant date fair value):

	Shares	Weighted Average Grant Date Fair Value per Share	Aggregate Intrinsic Value
Non-vested balance at December 31, 2008	—	—	
Granted	128	$31.27	
Non-vested balance at December 31, 2009 and December 31, 2010	128	$31.27	$8,285

11. Transactions with Officers, Related Parties and Others

(a) Public Consulting Group, Inc.

One of our directors is the President, Chief Executive Officer, controlling stockholder and a member of the Board of Directors of PCG. Since the acquisition of BSPA in 2006, we have entered into subcontractor agreements with PCG, pursuant to which we provide cost containment services. For the years ended December 31, 2010, 2009, 2008, amounts we recognized as revenue under subcontractor agreements with PCG were $0.2 million, $2.8 million and $2.3 million, respectively. For the years ended December 31, 2010, 2009 and 2008 accounts receivable outstanding related to these subcontractor agreements with PCG were $2.5 million, $2.9 million and $1.1 million, respectively.

In addition, as part of the acquisition of BSPA in 2006, we entered into an office sublease agreement with PCG, which expired in January 2010. For the years ended December 31, 2010, 2009, 2008, we recognized $5,500, $110,000 and $110,000, respectively, as expense under the sublease agreement with PCG. In connection with the BSPA acquisition, we entered into an Intercompany Services Agreement (ISA) with PCG to allow each party to perform services for the other, such as information technology support and contractual transition services. Services performed under the ISA are billed at pre-determined rates specified in the ISA. For the years ended December 31, 2010, 2009 and 2008 services rendered by PCG under the ISA were valued at approximately $360,000, $122,000 and $33,000, respectively. For the years ended December 31, 2010, 2009 and 2008 our services rendered to PCG were valued at approximately $112,000, $184,000 and $58,000, respectively.

Since the BSPA acquisition, amounts collected by or paid on our behalf by PCG are reimbursed to PCG at cost. For the years ended December 31, 2010, 2009 and 2008 the amount owed to PCG was $119,000, $170,000 and $72,000, respectively and classified as a current liability.

(b) Powers, Pyles, Sutter & Verville, P.C.

One of our former directors, Galen D. Powers, was a senior partner in the law firm Powers Pyles Sutter & Verville PC. For the year ended December 31, 2010 we incurred $0.2 million in legal fees for services rendered to us by Powers Pyles Sutters & Verville.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

(c) Employment Agreements

On March 1, 2011, we entered into a new employment agreement with Mr. Lucia, our President and Chief Executive Officer. If we terminate Mr. Lucia's employment without Cause, in connection with a Change in Control or otherwise, or if his employment ceases because of his death or disability or if he terminates his employment with Good Reason, then provided Mr. Lucia executes a Separation Agreement and Release and complies with restrictive covenants and confidentiality provisions contained in his employment agreement, he will be entitled to (i) 24 times his monthly base salary, (ii) a bonus component equal to twice his target bonus and (iii) continued health coverage for 24 months or until he becomes eligible for health coverage from another employer, whichever is earlier.

In addition, under the terms of our letter agreements of employment for our other executive officers, we could be required to provide salary and benefit continuation for between six to 12 months if they are involuntarily terminated.

12. Commitments and Contingencies

Lease commitments

We lease office space, data processing equipment and software licenses under operating leases that expire at various dates through 2016. The lease agreements provide for rent escalations. Lease expense, exclusive of sublease income, for the years ended December 31, 2010, 2009 and 2008, was $13.8 million, $10.7 million and $9.2 million, respectively. Lease and sublease income was $1.2 million, $484,000 and $40,000, for the years ended December 31, 2010, 2009 and 2008, respectively.

Minimum annual lease payments to be made and sublease payments to be received for each of the next five years ending December 31 and thereafter are as follows (in thousands):

Year	Payments	Sublease Receipts
2011	$12,531	$2,110
2012	11,441	2,182
2013	7,511	1,251
2014	2,234	909
2015	1,060	625
Thereafter	686	23
Total	$35,463	$7,100

13. Geographical Information

(a) Geographic Information

We operate within the continental United States.

(b) Major Clients

Our largest client in 2010 was the New York State Office of the Medicaid Inspector General. This client accounted for 6.7%, 7.8%, and 7.9% of our total revenue in the years ended December 31, 2010, 2009 and 2008, respectively. The New York State Office of the Medicaid Inspector General became our client September 2006, as part of our acquisition of BSPA. We provide services to this customer pursuant to a contract awarded in October 2001, which was subsequently re-procured and extended through January 6, 2015. Our second largest client in 2010 was the New Jersey Department of Human Services. This client accounted for 5.3%, 6.2% and 6.6% of our total revenue in the years ended December 31, 2010, 2009 and 2008, respectively. We provide services to this client pursuant to a three year contract awarded in January 2008, which has been renewed through December 2012.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

(c) Concentration of Revenue

The list of our ten largest clients changes periodically. For the years ended December 31, 2010, 2009 and 2008, the concentration of revenue from our ten largest clients represented 36.4%, 39.5% and 43.5% of our revenue, respectively. Our three largest clients accounted for approximately 16%, 19% and 20% of our revenue for each of the years ended December 31, 2010, 2009 and 2008, respectively. Our agreements with our ten current largest clients expire between 2011 and 2015. In many instances, we provide our services pursuant to agreements that may be renewed subject to a competitive re-procurement process. Several of our contracts, including those with our ten largest clients, may be terminated for convenience. We cannot assure you that our contracts, including those with our ten largest clients, will not be terminated for convenience or that any of these contracts will be renewed and, if renewed, that the fee rates will be equal to those currently in effect.

14. Quarterly Financial Data (unaudited)

The table below summarizes our unaudited quarterly operating results for the last two fiscal years (in thousands, except per share amounts).

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Year ended December 31, 2010[1]				
Revenue	$64,952	$70,726	$80,022	$87,167
Operating income	12,716	15,185	18,278	20,565
Net income	7,579	9,112	11,046	12,355
Basic net income per share	0.28	0.34	0.40	0.45
Diluted net income per share	0.27	0.32	0.39	0.43
Year ended December 31, 2009				
Revenue	$49,941	$53,814	$59,164	$66,318
Operating income	9,860	11,440	14,361	16,207
Net income	5,705	6,638	8,379	9,326
Basic net income per share	0.22	0.26	0.32	0.35
Diluted net income per share	0.21	0.24	0.30	0.33

(1) The summation of the above quarterly results may not agree to the full year 2010 reported results as amounts have been rounded for presentation purposes.

HMS HOLDINGS CORP. AND SUBSIDIARIES

Schedule II — Valuation and Qualifying Accounts
For the years ended December 31, 2010, 2009, 2008

Allowance for doubtful accounts (in thousands):

Balance, December 31, 2007	$662
Provision	—
Recoveries	2
Charge-offs	—
Balance, December 31, 2008	$664
Provision	—
Recoveries	—
Charge-offs	(50)
Balance, December 31, 2009	$614
Provision	197
Recoveries	(12)
Charge-offs	—
Balance, December 2010	**$799**

HMS Holdings Corp. and Subsidiaries

Exhibit Index

Where an exhibit is filed by incorporation by reference to a previously filed registration statement or report, such registration statement or report is identified after the description of the exhibit.

Exhibit Number	Description
2.1	Agreement and Plan of Merger, dated as of December 16, 2002, among Health Management Systems, Inc., HMS Holdings Corp. and HMS Acquisition Corp. Incorporated by reference to Exhibit A to HMS Holdings Corp.'s Prospectus and Proxy Statement, File No. 333-100521, filed with the SEC on January 24, 2003.
3.1	Restated Certificate of Incorporation of HMS Holdings Corp. Incorporated by reference to Exhibit 3.1 to Amendment No. 1 to HMS Holdings Corp.'s Registration Statement on Form S-4, File No. 333-100521, filed with the SEC on December 20, 2002.
3.2	Certificate of Amendment of the Certificate of Incorporation of HMS Holdings Corp. Incorporated by reference to Exhibit 3.1(a) to HMS Holdings Corp.'s Registration Statement on Form S-8, File No. 333-108436, filed with the SEC on September 2, 2003.
3.3	Amended and Restated By-laws of HMS Holdings Corp. Incorporated by reference to Exhibit 3.2 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on February 24, 2011.
4.1	Specimen Common Stock Certificate. Incorporated by reference to Exhibit 4.1 to HMS Holdings Corp.'s Annual Report on Form 10-K, File No. 000-50194, filed with the SEC on February 26, 2010.
4.2	See Exhibits 3.1, 3.2 and 3.3 for provisions defining the rights of holders of common stock of HMS Holdings Corp.
10.1†	HMS Holdings Corp. 1999 Long-Term Incentive Stock Plan, as amended. Incorporated by reference to Exhibit 4 to HMS Holdings Corp.'s Registration Statement on Form S-8, File No. 333-108436, filed with the SEC on September 2, 2003.
10.2†	Form of Incentive Stock Option Agreement under the 1999 Long-Term Incentive Stock Plan. Incorporated by reference to Exhibit 10.1 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on December 14, 2004.
10.3†	Form of Employee Non-Qualified Stock Option Agreement under the 1999 Long Term Incentive Stock Plan. Incorporated by reference to Exhibit 10.2 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on December 14, 2004.
10.4†	Form of Director Non-Qualified Stock Option Agreement under the 1999 Long Term Incentive Stock Plan. Incorporated by reference to Exhibit 10.3 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on December 14, 2004.
10.5†	HMS Holdings Corp. Third Amended and Restated 2006 Stock Plan (the "2006 Plan"). Incorporated by reference to Annex 1 of HMS Holdings Corp.'s Definitive Proxy Statement on form DEF 14A, File No. 000-50194, filed with the SEC on April 30, 2009.
10.6†	Form of Incentive Stock Option Agreement under the 2006 Plan. Incorporated by reference to Exhibit 4.6(i) to HMS Holdings Corp.'s Registration Statement on Form S-8, File No. 333-139025, filed with the SEC on November 30, 2006.
10.7†	Form of Non-Qualified Stock Option Agreement under the 2006 Plan. Incorporated by reference to Exhibit 4.6(ii) to HMS Holdings Corp.'s Registration Statement on Form S-8, File No. 333-139025, filed with the SEC on November 30, 2006.
10.8†	Form of 2009 Employee Restricted Stock Agreement Under the 2006 Plan. Incorporated by reference to Exhibit 10.1 to HMS Holding Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on April 29, 2009.
10.9†	Form of 2009 Non-Qualified Stock Option Agreement under the 2006 Plan. Incorporated by reference Exhibit 10.1 to HMS Holding Corp.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2009, File No. 000-50194, filed with the SEC on November 6, 2009.

Exhibit Number	Description
10.10†	Form of 2009 Restricted Stock Unit Agreement under the 2006 Plan. Incorporated by reference Exhibit 10.2 to HMS Holding Corp.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2009, File No. 000-50194, filed with the SEC on November 6, 2009.
10.11†	Form of 2010 Director Non-Qualified Stock Option Agreement under the 2006 Plan. Incorporated by reference to Exhibit 10.2 to HMS Holdings Corp.'s Quarterly Report on Form 10-Q, File No. 000-50194, filed with the SEC on November 8, 2010.
10.12†	Form of 2010 Director Restricted Stock Unit Agreement under the 2006 Plan. Incorporated by reference to Exhibit 10.3 to HMS Holdings Corp.'s Quarterly Report on Form 10-Q, File No. 000-50194, filed with the SEC on November 8, 2010.
10.13†	Form 2010 Employee Non-Qualified Stock Option Agreement under the 2006 Plan. Incorporated by reference to Exhibit 10.4 to HMS Holdings Corp.'s Quarterly Report on Form 10-Q, File No. 000-50194, filed with the SEC on November 8, 2010.
10.14†	Form of 2010 Employee Restricted Stock Unit Agreement under the 2006 Plan. Incorporated by reference to Exhibit 10.5 to HMS Holdings Corp.'s Quarterly Report on Form 10-Q, File No. 000-50194, filed with the SEC on November 8, 2010.
10.15†	Amended and Restated Employment Agreement between HMS Holdings Corp. and Robert M. Holster dated as of March 1, 2009. Incorporated by reference to Exhibit 10.1 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on March 6, 2009.
10.16†	Amended and Restated Employment Agreement between William C. Lucia and HMS Holdings Corp. dated as of March 1, 2009. Incorporated by reference to Exhibit 10.2 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on March 6, 2009.
10.17†*	Letter Agreement by and between William C. Lucia and HMS Holdings Corp. dated as of December 29, 2010.
10.18†*	Executive Employment Agreement between William C. Lucia and HMS Holdings Corp. dated as of March 1, 2011.
10.19†	Employment Agreement between Walter D. Hosp and HMS Holdings Corp. dated as of May 30, 2007. Incorporated by reference to Exhibit 10.1 to HMS Holdings Corp.'s Quarterly Report on Form 10-Q, File No. 000-50194, filed with the SEC on August 6, 2010.
10.20†*	Letter Agreement by and between Walter D. Hosp and HMS Holdings Corp. dated as of December 29, 2010.
10.21†*	Employment Agreement between Sean Curtin and HMS Holdings Corp. dated as of August 31, 2006.
10.22†*	Letter Agreement by and between Sean Curtin and HMS Holdings Corp. dated as of December 29, 2010.
10.23†*	Employment Agreement between Maria Perrin and HMS Holdings Corp. dated as of March 22, 2007.
10.24†*	Letter Agreement by and between Maria Perrin and HMS Holdings Corp. dated as of December 29, 2010.
10.25	Lease, dated September 24, 1981, between 401 Park Avenue South Associates and Health Management Systems, Inc. Incorporated by reference to Exhibit 10.13 to Health Management Systems, Inc.'s Registration Statement on Form S-1, File No. 33-46446, dated June 9, 1992 and to Exhibit 10.5 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended January 31, 1994.
10.26*	Amendment of Lease, dated October 9, 1981, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for 4th floor).
10.27*	Amendment of Lease, dated September 24, 1982, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for 4th floor).
10.28*	Second Amendment of Lease, dated January 6, 1986, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for 4th floor).
10.29*	Third Amendment of Lease, dated February 28, 1990, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for 4th floor).
10.30*	Fourth Amendment of Lease, dated March 15, 1996 between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for 4th floor).

Exhibit Number	Description
10.31	Fifth Amendment of Lease, dated May 30, 2000, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for 4th floor & penthouse). Incorporated by reference to Exhibit 10.7 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended July 31, 2000, File No. 000-20946, filed with the SEC on September 14, 2000.
10.32	Sixth Amendment of Lease, dated May 1, 2003, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for 4th floor & penthouse). Incorporated by reference to Exhibit 10.8 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended July 31, 2000, File No. 000-20946, filed with the SEC on September 14, 2000.
10.33	Seventh Amendment of Lease, dated March 1, 2001, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for 4th floor & penthouse). Incorporated by reference to Exhibit 10.1(iv) to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended April 30, 2001, File No. 000-20946, filed with the SEC on June 14, 2001.
10.34*	Eighth Amendment of Lease, dated March 29, 2007, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for 4th floor and Penthouse).
10.35	Lease, dated September 24, 1982, between 401 Park Avenue South Associates and Health Management Systems, Inc. Incorporated by reference to Exhibit 10.13 to Health Management Systems, Inc.'s Registration Statement on Form S-1, File No. 33-46446, dated June 9, 1992 and to Exhibit 10.5 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended January 31, 1994.
10.36*	Amendment of Lease, dated January 6, 1986, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for certain premises on the 10th floor).
10.37*	Second Amendment of Lease, dated February 28, 1990, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for certain premises on the 10th floor).
10.38*	Third Amendment of Lease, dated August 7, 1991, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for certain premises on the 10th, 11th and 12th floors).
10.39*	Fourth Amendment of Lease, dated January 11, 1994, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for certain premises on the 9th 10th, 11th and 12th floors).
10.40	Fifth Amendment of Lease, dated May 30, 2000, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for floors 8-10 and part of the floors 11 &12). Incorporated by reference to Exhibit 10.1 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended July 31, 2000, File No. 000-20946, filed with the SEC on September 14, 2000.
10.41	Sixth Amendment of Lease, dated May 1, 2000, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for floors 8-10 and part of the floors 11 &12). Incorporated by reference to Exhibit 10.2 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended July 31, 2000, File No. 000-20946, filed with the SEC on September 14, 2000.
10.42	Seventh Amendment of Lease, dated April 1, 2001, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for floors 8-10 and part of the floors 11 &12). Incorporated by reference to Exhibit 10.1(v) to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended April 30, 2001, File No. 000-20946, filed with the SEC on June 14, 2001.
10.43	Lease, dated January 6, 1986, between 401 Park Avenue South Associates and Health Management Systems, Inc. Incorporated by reference to Exhibit 10.13 to Health Management Systems, Inc.'s Registration Statement on Form S-1, File No. 33-46446, dated June 9, 1992 and to Exhibit 10.5 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended January 31, 1994.
10.44*	First Amendment of Lease, dated November 25, 1987, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for a portion of the 11th floor).
10.45*	Second Amendment of Lease, dated February 28, 1990, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for a portion of the 11th floor).

Exhibit Number	Description
10.46	Third Amendment of Lease, dated May 30, 2000, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for a portion of the 11th floor). Incorporated by reference to Exhibit 10.3 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended July 31, 2000, File No. 000-20946, filed with the SEC on September 14, 2000.
10.47	Fourth Amendment of Lease, dated May 1, 2000, 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for a portion of the 11th floor). Incorporated by reference to Exhibit 10.4 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended July 31, 2000, File No. 000-20946, filed with the SEC on September 14, 2000.
10.48	Fifth Amendment of Lease, dated May 1, 2003, between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (for a portion of the 11th floor). Incorporated by reference to Exhibit 10.1(vi) to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended April 30, 2001, File No. 000-20946, filed with the SEC on June 14, 2001.
10.49	Sublease Agreement, dated as of January 2003, between Health Management Systems, Inc. and Vitech Systems Group, Inc. Incorporated by reference to Exhibit 10.17 to HMS Holdings Corp.'s Annual Report on Form 10-K for the year ended December 31, 2002, File No. 000-50194, filed with the SEC on March 31, 2003.
10.50	Data Services Agreement, dated June 4, 2007, between HMS Business Services, Inc. and Zavata, Inc. Incorporated by reference to Exhibit 10.12 to HMS Holdings Corp.'s Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-50194, filed with the SEC on March 11, 2009.
10.51	Amendment, dated October 16, 2008, to Data Services Agreement between HMS Business Services, Inc. and Apollo Health Street, Inc. Incorporated by reference to Exhibit 10.13(ii) to HMS Holdings Corp.'s Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-50194, filed with the SEC on March 11, 2009.
10.52	Data Services Agreement, dated July 31, 2007, between HMS Business Services, Inc. and Accordis Holding Corp. Incorporated by reference to Exhibit 10.13(i) to HMS Holdings Corp.'s Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-50194, filed with the SEC on March 11, 2009.
10.53	Form of Subcontracting Agreement, made the 31st day of August 2005, by and between Accordis Inc. and Reimbursement Services Group Inc. Incorporated by reference to Exhibit 99.8 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on September 7, 2005.
10.54	Form of Software License Agreement, dated as of August 31, 2005 between Accordis, Inc. and Health Management Systems, Inc. Incorporated by reference to Exhibit 99.9 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on September 7, 2005.
10.55	Stock Purchase Agreement, dated August 31, 2005, between HMS Holdings Corp. and Accordis Holding Corp. Incorporated by reference to Exhibit 99.2 to HMS Holdings Corp.'s Current Report on Form 8-K/A, File No. 000-50194, filed with the SEC on September 8, 2005.
10.56	Asset Purchase Agreement, dated as of June 22, 2006, by and among HMS Holdings Corp., Health Management Systems, Inc. and Public Consulting Group, Inc. Incorporated by reference to Exhibit 99.1 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on June 26, 2006.
10.57	Amendment No. 1 to Asset Purchase Agreement, dated as of September 13, 2006, by and among HMS Holdings Corp., Health Management Systems, Inc. and Public Consulting Group, Inc. Incorporated by reference to Exhibit 99.1 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on September 14, 2006.
10.58	Master Teaming Agreement, dated as of September 13, 2006, by and between Health Management Systems, Inc. and Public Consulting Group, Inc. Incorporated by reference to Exhibit 99.2 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on September 14, 2006.

Exhibit Number	Description
10.59	Credit Agreement, dated as of September 13, 2006, among HMS Holdings Corp., the Guarantors named therein, the Lenders named therein, JPMorgan Chase Bank, N.A., as administrative agent, J.P. Morgan Securities, Inc., as sole lead arranger and sole bookrunner, Bank of America, N.A., as syndication agent and Citizens Bank of Massachusetts, as documentation agent (the "Credit Agreement"). Incorporated by reference to Exhibit 99.3 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on September 14, 2006.
10.60	First Amendment to the Credit Agreement. Incorporated by reference to 10.1 to HMS Holdings Corp.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2010, File No. 000-50194, filed with the SEC on May 7, 2010.
10.61	Stock Purchase Agreement Between HMS Holdings Corp. and Dennis Demetre, Lori Lewis, John Alfred Lewis and Christopher Brandon Lewis and Allied Management Group — Special Investigation Unit (AMG-SIU). Incorporated by reference to Exhibit 10.1 to HMS Holdings Corp.'s Current Report on Form 8-K, File No. 000-50194, filed with the SEC on July 7, 2010.
10.62†*	HMS Holdings Corp. Director Deferred Compensation Plan.
21.1*	HMS Holdings Corp. List of Subsidiaries
23.1*	Consent of Independent Registered Public Accounting Firm
31.1*	Rule 13a-14(a)/15d-14(a) Certification of the Principal Executive Officer of HMS Holdings Corp., as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2*	Rule 13a-14(a)/15d-14(a) Certification of the Principal Financial Officer of HMS Holdings Corp., as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1‡	Section 1350 Certification of the Principal Executive Officer of HMS Holdings Corp., as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2‡	Section 1350 Certification of the Principal Financial Officer of HMS Holdings Corp., as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

† Indicates a management contract or compensatory plan, contract or arrangement

* Filed herewith

‡ Furnished herewith

Board of Directors:

Robert M. Holster
Chairman of the Board
HMS Holdings Corp.

James T. Kelly
Private Investor and former Chairman and CEO
Lincare Holdings, Inc.

William C. Lucia
Chief Executive Officer
HMS Holdings Corp.

William F. Miller III
Partner, Highlander Partners and former Chairman and CEO, HMS Holdings Corp.

William S. Mosakowski
President, CEO and Director
Public Consulting Group, Inc.

Ellen A. Rudnick
Executive Director
Polsky Center for Entrepreneurship
University of Chicago Booth School of Business

Bart M. Schwartz
Chairman and Chief Executive Officer
SolutionPoint International LLC

Michael A. Stocker, M.D.
Private Investor and former CEO
Empire Blue Cross Blue Shield

Richard H. Stowe
General Partner
Health Enterprise Partners LLP

Executive Officers:

William C. Lucia
Chief Executive Officer
HMS Holdings Corp.

Walter D. Hosp
Senior Vice President and Chief Financial Officer

Sean Curtin
Executive Vice President of Operations

Christina M. Dragonetti
Executive Vice President of Corporate Development

Edith S. Marshall
General Counsel and Corporate Secretary

Cynthia Nustad
Senior Vice President, Chief Information Officer

Maria G. Perrin
Executive Vice President of Government Markets

John D. Schmid
Corporate Vice President of Human Resources

Ronald D. Singh
Executive Vice President of Commercial Markets

Corporate Headquarters:
401 Park Avenue South
New York, NY 10016
Tel. 212.857.5000
Fax. 212.857.5004

Other Offices:
Albany, NY
Alhambra, CA
Alpharetta, GA
Anchorage, AK
Atlanta, GA
Austin, TX
Boise, ID
Charleston, WV
Charlestown, MA
Charlotte, NC
Columbia, SC
Culver City, CA
Des Moines, IA
East Lansing, MI
East Windsor, NJ
Frankfort, KY
Hamilton, NJ
Harrisburg, PA
Indianapolis, IN
Irving, TX
Jeffersonville, IN
Jackson, MS
Lakewood, CO
Mercerville, NJ
Miramar, FL
Nashville, TN
Omaha, NE
Phoenix, AZ
Raleigh, NC
Reno, NV
Sacramento, CA
Santa Ana, CA
Santa Fe, NM
Tallahassee, FL
Topeka, KS
Washington, DC
Westerville, OH
Windsor, CT

Form 10-K Report/Quarterly Reporting
The Company's Annual Report on Form 10-K, as filed with the Securities and Exchange Commission, is included as part of this Annual Report. Copies of the Company's quarterly earnings results and additional copies of the Form 10-K are available on the Internet at http://investor.hms.com/sec.cfm or upon request from our Office of Investor Relations, telephone 212.857.5986.

Stock Registrar and Transfer Agent
Common stock of HMS Holdings Corp. is traded on the NASDAQ Stock Exchange under the symbol HMSY. Questions with regard to registered shares of HMSY should be sent in writing to: Mellon Investor Services LLC, 480 Washington Boulevard, Jersey City, NJ 07310.

HMS HOLDINGS CORP

FORM 10-Q
(Quarterly Report)

Filed 05/09/11 for the Period Ending 03/31/11

Address	401 PARK AVENUE SOUTH NEW YORK, NY 10016
Telephone	2126854545
CIK	0001196501
Symbol	HMSY
SIC Code	7374 - Computer Processing and Data Preparation and Processing Services
Industry	Computer Services
Sector	Technology
Fiscal Year	12/31

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-Q

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2011

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission File Number 000-50194

HMS HOLDINGS CORP.

(Exact name of registrant as specified in its charter)

New York (State or Other Jurisdiction of Incorporation or Organization)	**11-3656261** (I.R.S. Employer Identification No.)
401 Park Avenue South, New York, NY (Address of principal executive offices)	**10016** (Zip Code)

(Registrant's Telephone Number, Including Area Code)
(212) 725-7965

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for shorter period that the registrant was required to submit and post such files). ☒ Yes ☐ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of May 5, 2011 there were approximately 28,157,348 shares of the registrant's common stock (par value $0.01 per share) outstanding.

HMS HOLDINGS CORP. AND SUBSIDIARIES
QUARTERLY REPORT ON FORM 10-Q
FOR THE QUARTER ENDED MARCH 31, 2011
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Special Note Regarding Forward-Looking Statements

This Quarterly Report on Form 10-Q contains "forward-looking statements" within the meaning of the U.S. Private Securities Litigation Reform Act of 1995. From time to time, we also provide forward-looking statements in other materials we release to the public, as well as oral forward-looking statements. Such statements give our expectations or forecasts of future events; they do not relate strictly to historical or current facts.

We have tried, wherever possible, to identify such statements by using words such as "anticipate," "estimate," "expect," "project," "intend," "plan," "believe," "will," "target," "seek," "forecast" and similar expressions. In particular, these include statements relating to future actions, business plans, objects and prospects, future operating or financial performance or results of current and anticipated services, acquisitions and the performance of companies we have acquired, sales efforts, expenses, interest rates, and the outcome of contingencies, such as financial results.

We cannot guarantee that any forward-looking statement will be realized. Forward-looking statements are based on our current expectations and assumptions regarding our business, the economy and other future conditions. Should known or unknown risks or uncertainties materialize, or should underlying assumptions prove inaccurate, actual results could differ materially from past results and those anticipated, estimated or projected. We caution you, therefore, against relying on any of these forward-looking statements. They are neither statements of historical fact nor guarantees or assurances of future performance. Factors that could cause or contribute to such differences include, but are not limited to, those discussed in our Annual Report on Form 10-K, and in particular, the risks discussed under the heading "Risk Factors" in Part I, Item 1A of our Annual Report on Form 10-K, Part II of this 10-Q and those discussed in other documents we file with the Securities and Exchange Commission.

Any forward-looking statements made by us in this Report on Form 10-Q speak only as of the date on which they are made. Factors or events that could cause actual results to differ may emerge from time to time and it is not possible for us to predict all of them. We undertake no obligation to publicly update forward-looking statements, whether as a result of new information, future events or otherwise, except as may be required by law. You are advised, however, to consult any further disclosures we make on related subjects in our 10-K and 8-K reports to the Securities and Exchange Commission.

HMS HOLDINGS CORP. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

(in thousands, except share and per share amounts)

(unaudited)

	March 31, 2011	December 31, 2010
Assets		
Current assets:		
Cash and cash equivalents	$ 116,233	$ 94,836
Accounts receivable, net of allowance of $799 at March 31, 2011 and at December 31, 2010	67,222	75,123
Prepaid expenses	5,978	5,521
Prepaid income taxes	1,518	3,533
Other current assets	230	371
Net deferred tax asset	687	664
Total current assets	191,868	180,048
Property and equipment, net	44,350	44,713
Goodwill, net	106,675	107,414
Intangible assets, net	19,057	19,826
Other assets	1,500	904
Total assets	$ 363,450	$ 352,905
Liabilities and Shareholders' Equity		
Current liabilities:		
Accounts payable, accrued expenses and other liabilities	$ 22,869	$ 32,502
Total current liabilities	22,869	32,502
Long-term liabilities:		
Contingent payment due to AMG-SIU	2,703	2,573
Accrued deferred rent	1,733	1,842
Other liabilities	1,874	2,582
Deferred tax liabilities	6,134	5,768
Total long-term liabilities	12,444	12,765
Total liabilities	35,313	45,267
Shareholders' equity:		
Preferred stock—$0.01 par value; 5,000,000 shares authorized; none issued	—	—
Common Stock—$0.01 par value; 45,000,000 shares authorized; 29,807,421 shares issued and 28,144,575 shares outstanding at March 31, 2011; 29,447,182 shares issued and 27,784,336 shares outstanding at December 31, 2010	298	294
Capital in excess of par value	215,718	205,039
Retained earnings	121,518	111,702
Treasury stock, at cost; 1,662,846 shares at March 31, 2011 and December 31, 2010	(9,397)	(9,397)
Total shareholders' equity	328,137	307,638
Total liabilities and shareholders' equity	$ 363,450	$ 352,905

See accompanying notes to unaudited consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

(in thousands, except per share amounts)

(unaudited)

	Three months ended March 31,	
	2011	2010
Revenue	$ 82,457	$ 64,952
Cost of services:		
Compensation	31,311	23,789
Data processing	4,982	3,819
Occupancy	3,808	3,341
Direct project costs	9,589	7,574
Other operating costs	4,214	3,228
Amortization of acquisition related software and intangibles	1,740	1,503
Total cost of services	55,644	43,254
Selling, general and administrative expenses	10,704	8,982
Total operating expenses	66,348	52,236
Operating income	16,109	12,716
Interest expense	(23)	(23)
Other income, net	257	—
Interest income	35	17
Income before income taxes	16,378	12,710
Income taxes	6,562	5,131
Net income	$ 9,816	$ 7,579
Basic income per common share:		
Net income per share—basic	$ 0.35	$ 0.28
Basic income per common share:		
Net income per share—diluted	$ 0.34	$ 0.27
Weighted average shares:		
Basic	27,937	26,919
Diluted	28,958	28,177

See accompanying notes to unaudited consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF SHAREHOLDERS' EQUITY AND COMPREHENSIVE INCOME

For the Three Months Ended March 31, 2011

(in thousands, except share amounts)

(unaudited)

	Common stock				Treasury Stock		
	# of Shares Issued	Par Value	Capital in Excess of Par Value	Retained Earnings	# of Shares	Amount	Total Shareholders' Equity
Balance at December 31, 2010	29,447,182	$ 294	$ 205,039	111,702	1,662,846	$ (9,397)	$ 307,638
Comprehensive income:							
Net income	—	—	—	9,816	—	—	9,816
Total comprehensiv income							9,816
Stock-based compensatior cost	—	—	2,036	—	—	—	2,036
Exercise of Stock Options	339,169	4	6,276	—	—	—	6,280
Vesting of restricted stock awards, net of shares withheld for employee tax	21,070	—	(897)	—	—	—	(897)
Excess tax benefit from exercise of stock options	—	—	3,264	—	—	—	3,264
Balance at March 31, 2011	29,807,421	$ 298	$ 215,718	$ 121,518	1,662,846	$ (9,397)	$ 328,137

See accompanying notes to unaudited consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF CASH FLOWS

(in thousands)

(unaudited)

	Three months ended March 31,	
	2011	2010
Operating activities:		
Net income	$ 9,816	$ 7,579
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	4,837	3,680
Stock-based compensation expense	2,036	1,761
Deferred income taxes	342	(529)
Change in fair value of contingent consideration	130	—
Loss on disposal of fixed assets	2	—
Changes in assets and liabilities:		
Decrease in accounts receivable	7,901	2,391
Decrease in prepaid expenses and other current assets	1,538	4,423
(Increase)/decrease in other assets	(596)	78
Decrease in accounts payable, accrued expenses and other liabilities	(8,156)	(7,749)
Net cash provided by operating activities	17,850	11,634
Investing activities:		
Purchases of property and equipment	(4,793)	(3,122)
Acquisition of AMG-SIU	161	—
Investment in capitalized software	(468)	(541)
Net cash used in investing activities	(5,100)	(3,663)
Financing activities:		
Proceeds from exercise of stock options	6,280	1,180
Payments of tax withholdings on behalf of employees for net-share settlement for stock-based compensation	(897)	—
Excess tax benefit from exercised stock options	3,264	1,384
Net cash provided by financing activities	8,647	2,564
Net increase in cash and cash equivalents	21,397	10,535
Cash and cash equivalents at beginning of period	94,836	64,863
Cash and cash equivalents at end of period	$ 116,233	$ 75,398
Supplemental disclosure of cash flow information:		
Cash paid for income taxes	$ 1,048	$ 572
Cash paid for interest	$ 23	$ —
Supplemental disclosure of noncash investing activities:		
Accrued property and equipment purchases	$ 480	$ 183

See accompanying notes to unaudited consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

1. Basis of Presentation

The accompanying unaudited consolidated financial statements have been prepared in accordance with U.S. Generally Accepted Accounting Principles, or U.S. GAAP, for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all of the information and notes required by U.S. GAAP for complete financial statements. In the opinion of management, the unaudited interim financial statements furnished herein include all adjustments necessary (consisting only of normal recurring adjustments) for a fair presentation of our subsidiaries' financial position at March 31, 2011, the results of our operations for the three months ended March 31, 2011 and 2010 and cash flows for the three months ended March 31, 2011 and 2010. Interim financial statements are prepared on a basis consistent with our annual financial statements. The financial statements included herein should be read in conjunction with the financial statements and notes included in our Annual Report on Form 10-K for the year ended December 31, 2010, which we refer to as our Annual Report.

We provide a variety of cost containment, coordination of benefits and program integrity services for government and private healthcare payors and sponsors. These services are designed to help our clients recover amounts due from liable third parties, save dollars, reduce fraud, waste and abuse and ensure regulatory compliance. In September 2008, we purchased the assets and liabilities of Prudent Rx, expanding our portfolio of program integrity service offerings for government healthcare programs and managed care organizations, particularly in the pharmacy arena. In September 2009, we further expanded our portfolio of program integrity service offerings for government healthcare programs, particularly in the Medicare and Medicaid programs with our acquisition of IntegriGuard LLC, or IntegriGuard. In December 2009, with the acquisition of Verify Solutions, Inc., or Verify Solutions, we moved into the employer-based market with valuable new services that ensure that dependents covered by employees are eligible to receive healthcare benefits. In June 2010, we acquired Allied Management Group—Special Investigation Unit, or AMG-SIU, which provides fraud, waste and abuse prevention and detection solutions for healthcare payors. In August 2010, we acquired Chapman Kelly, Inc., or Chapman Kelly, which provides claims audit and beneficiary eligibility audit services to employers and managed care organizations.

These consolidated financial statements include our accounts and transactions and those of our wholly owned subsidiaries. All significant intercompany balances and transactions have been eliminated in consolidation.

We are managed and operated as one business, with a single management team that reports to the Chief Executive Officer. We do not operate separate lines of business with respect to any of our product lines.

The preparation of financial statements in conformity with U.S. GAAP requires management to make certain estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting periods. Our actual results could differ from those estimates.

We consider all highly liquid instruments with an original maturity of three months or less to be cash equivalents. Cash equivalents consist of deposits that are readily convertible into cash.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

1. Basis of Presentation (Continued)

Our financial instruments are categorized into a three-level fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value into three broad levels. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). If the inputs used to measure fair value fall within different levels of the hierarchy, the category level is based on the lowest priority level input that is significant to the fair value measurement of the instrument. Financial assets recorded at fair value on our consolidated balance sheets are categorized as follows:

- Level 1: Observable inputs such as quoted prices in active markets;
- Level 2: Inputs, other than the quoted prices in active markets, that are observable either directly or indirectly; and
- Level 3: Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

Our policy is to limit our credit exposure by placing our investments with financial institutions evaluated as being creditworthy, or in short-term money market funds which are exposed to minimal interest rate and credit risk. We maintain our cash primarily in investment accounts within large financial institutions. Currently, the Federal Deposit Insurance Corporation insures these balances up to $250,000 per bank account. We have not experienced any losses on our bank deposits and we believe these deposits do not expose us to any significant credit risk.

We grant credit, generally without collateral, to our clients, which are primarily in the healthcare market. Consequently, we are subject to potential credit risk related to changes in economic conditions within that market. However, we believe that our billing and collection policies are adequate to minimize the potential credit risk.

We evaluate the recoverability of goodwill and long-lived assets either annually or whenever events or changes in circumstances indicate that an asset's carrying amount may not be recoverable. Such circumstances could include, but are not limited to (i) a significant decrease in the market value of an asset, (ii) a significant adverse change in the extent or manner in which an asset is used, or (iii) an accumulation of costs significantly in excess of the amount originally expected for the acquisition of an asset. We measure the carrying amount of the asset against the estimated undiscounted future cash flows associated with it. If the sum of the expected future net cash flows is less than the carrying value of the asset being evaluated, an impairment charge would be recognized. The impairment charge would be calculated as the amount by which the carrying value of the asset exceeds its fair value. The determination of fair value is based on quoted market prices, if available. If quoted market prices are not available, the estimate of fair value is based on various valuation techniques, including the discounted value of estimated future cash flows. We did not recognize any impairment charges related to our long-lived assets, property and equipment, goodwill or intangible assets, during the three months ended March 31, 2011 and 2010, as management believes that carrying amounts were not impaired.

The carrying amounts for our cash equivalents, accounts receivable, accounts payable and accrued expenses approximate fair value due to their short-term nature.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

1. Basis of Presentation (Continued)

Certain reclassifications were made to prior year amounts to conform to the current presentation. These reclassifications had no impact on previously reported net income or financial position.

2. Acquisitions

The results of operations for our 2010 acquisitions have been included in our consolidated financial statements from the date of acquisition. We have concluded that these acquisitions were not material to our financial statements; therefore, pro forma financial information is not presented herein.

Chapman Kelly, Inc.

In August 2010, we acquired the assets and liabilities of Chapman Kelly for $13.0 million in cash. Chapman Kelly, which is based in Jeffersonville, Indiana, provides dependent eligibility audits to large, self-insured employers, as well as plan and claims audits to both employers and managed care organizations. The acquisition of Chapman Kelly was accounted for under the acquisition method of accounting.

The following table summarizes the final amounts recognized for assets acquired and liabilities assumed (in thousands):

Goodwill	$ 9,468
Identifiable intangible assets	2,239
Assets and liabilities acquired	1,018
Capitalized software	276
Total purchase price	$ 13,001

Identifiable intangible assets principally include covenants not to compete, customer relationships and Chapman Kelly's trade name.

In connection with Q1, we finalized the purchase price allocation which resulted in an increase to customer relationships of $739 thousand and an offsetting decrease to goodwill as compared to the amounts recorded at December 31, 2010.

Allied Management Group—Special Investigation Unit

In June 2010, we purchased all of the issued and outstanding common stock of AMG-SIU for a purchase price valued at $15.1 million, consisting of a $13.0 million initial cash payment (subsequently reduced by a working capital reduction of $0.2 million) and future contingent payments estimated and recognized as of the acquisition date at $2.3 million. These payments are contingent upon AMG-SIU's financial performance for each of the twelve month periods ending June 30, 2011 and June 30, 2012. The contingent payments are not subject to any cap. Any contingent payments owed for the periods ending June 30, 2011 and 2012, shall be payable by September 30, 2011 and 2012, respectively. The undiscounted contingent payments are currently estimated to be $3.4 million and relate to the 12 month period ending June 30, 2012. AMG-SIU, which is based in Santa Ana, California, specializes in fraud, waste and abuse prevention and detection solutions for healthcare payors, which further

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

2. Acquisitions (Continued)

strengthens our ability to service this segment of the market. The acquisition of AMG-SIU was accounted for under the acquisition method of accounting.

The fair value of the contingent consideration recognized on the acquisition date of June 30, 2010 was estimated by applying the income approach. The measure is based on significant inputs not observable in the market that are defined by the Financial Accounting Standards Board, or FASB, guidance on fair value as Level 3 inputs. As of March 31, 2011 and December 31, 2010, the fair value of the contingent payments was $2.7 million and $2.6 million, respectively.

Verify Solutions, LLC

In December 2009, we acquired the assets of Verify Solutions, an Alpharetta, Georgia-based company specializing in dependent eligibility audit services for large, self insured employers. With this acquisition, we moved into the large and mid-market employer-based market.

The purchase price for Verify Solutions was $8.1 million, with additional future payments contingent upon Verify Solutions' achievement of financial performance milestones. The additional future payments of up to $5.5 million ($2.7 million and $2.8 million for the years ended December 31, 2010 and 2011, respectively) are not included in the financial statements because the 2010 performance milestone was not achieved and we do not expect the 2011 performance milestones to be achieved.

The allocation of the purchase price for Verify Solutions was based upon the fair value estimate of its assets and liabilities. The acquisition of Verify Solutions was based on management's consideration of past and expected future performance as well as the potential strategic fit with our long-term goals. The expected long-term growth, market position and expected synergies to be generated by Verify Solutions were the primary factors that gave rise to an acquisition price that resulted in the recognition of identifiable intangible assets.

In December 2010, following our acquisition of Chapman Kelly, which together with Verify Solutions forms HMS Employer Solutions, we amended the terms of the contingent payment for 2011. Under the terms of this amendment, the former owners of Verify Solutions could earn a contingent payment of between $1.3 million and $2.8 million based on the revenue generated by HMS Employer Solutions for the year ending December 31, 2011. If earned, the contingent payment will be accrued and recorded to compensation expense in 2011. During 2011, it has been determined that the conditions to earn this contingent payment will not be achieved, accordingly no amounts have been accrued.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

3. Intangible Assets

Intangible assets consisted of the following at March 31, 2011 and December 31, 2010 (in thousands):

	March 31, 2011	December 31, 2010	Useful Life
Customer relations	$ 32,987	$ 32,247	5 - 10 years
Trade name	3,932	3,932	3 - 7 years
Restrictive covenant	2,626	2,626	3 - 5 years
	39,545	38,805	
Less accumulated amortization	(20,488)	(18,979)	
Intangible assets, net	$ 19,057	$ 19,826	

Estimated amortization expense for intangible assets is expected to approximate the following (in thousands):

Year Ending December 31,	
Remainder of 2011	$ 4,381
2012	5,816
2013	4,263
2014	1,320
2015	994
Thereafter	2,283

The changes in the carrying amount of goodwill for the three months ended March 31, 2011 are as follows (in thousands):

Balance at December 31, 2010	$ 107,414
Chapman Kelly acquisition measurement period adjustments	(739)
Balance at March 31, 2011	$ 106,675

For the three months ended March 31, 2011 and 2010, amortization expense related to intangible assets and acquisition software amounted to $1.5 million and $1.3 million, respectively.

4. Income Taxes

Our effective tax rate decreased to 40.1% for the three months ended March 31, 2011 from 40.4% for the three months ended March 31, 2010, primarily due to a change in state apportionments. The principal difference between the statutory rate and our effective rate is state taxes.

We file income tax returns with the U.S. federal government and various state jurisdictions. We are no longer subject to U.S. federal income tax examinations for years before 2007. We operate in a number of state and local jurisdictions, most of which have never audited our records. Accordingly, we

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

4. Income Taxes (Continued)

are subject to state and local income tax examinations based upon the various statutes of limitations in each jurisdiction.

During the three months ended March 31, 2011 and 2010, we recorded a tax benefit of $3.3 million and $1.4 million, respectively, related to the utilization of the income tax benefit from stock transactions by reducing income tax payable and crediting capital.

At March 31, 2011 and 2010, we had approximately $1.3 million and $1.1 million of net unrecognized tax benefits, respectively, for which there is uncertainty about the allocation and apportionment impacting state taxable income. We do not expect any significant change in unrecognized tax benefits during the next twelve months. We have recognized interest accrued related to unrecognized tax benefits in interest expense and penalties in tax expense. The accrued liabilities related to uncertain tax positions were $0.5 million for each of the three month periods ending March 31, 2011 and 2010.

We believe that it is reasonably possible that decreases in unrecognized tax benefits of up to $70,000 may be recorded within the next year.

5. Debt

We have a credit agreement with several banks and other financial institutions, with JPMorgan Chase Bank, N.A. (JPMCB) as administrative agent, which we refer to as the Credit Agreement. The Credit Agreement, which expires in September of 2011, provided for a term loan of $40 million, which we refer to as the Term Loan, and revolving credit loans of up to $25 million, which we refer to as the Revolving Loan. The term loan was fully repaid in 2009. Although to date we have not borrowed under the Revolving Loan, we continue to have an irrevocable standby Letter of Credit for $4.6 million against the Revolving Loan, which we refer to as the Letter of Credit, as required by a contractual agreement with a client. As a result of the Letter of Credit, the amount available under the Revolving Loan as of March 31, 2011 is $20.4 million.

We secured the Term and Revolving Loans with the grant of a security interest, covering our assets and subsidiaries, in favor of the lenders. Interest on borrowings under the Credit Agreement is calculated, at our option, at either (i) LIBOR, including statutory reserves, plus a variable margin based on our leverage ratio, or (ii) the higher of (a) the prime lending rate of JPMCB, and (b) the Federal Funds Effective Rate plus 0.50%, in each case plus a variable margin based on our leverage ratio. In connection with the Revolving Loan, we agreed to pay a commitment fee on the unused portion of the Revolving Loan, payable quarterly in arrears, at a variable rate based on our leverage ratio.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

5. Debt (Continued)

Commitments under the Credit Agreement will be reduced and borrowings are required to be repaid with the net proceeds of, among other things, sales or issuances of equity (excluding equity issued under employee benefit plans and equity issued to sellers as consideration in acquisitions), sales of assets and any incurrence of indebtedness by us, subject, in each case, to limited exceptions. Our obligations under the Credit Agreement may be accelerated upon the occurrence of an event of default under the Credit Agreement, which encompasses customary events of default including, without limitation, payment defaults, defaults in the performance of affirmative and negative covenants, the inaccuracy of representations or warranties, bankruptcy and insolvency related defaults, defaults relating to such matters as ERISA, uninsured judgments and the failure to pay certain indebtedness and a change of control default.

In addition, the Credit Agreement contains affirmative, negative and financial covenants customary for financings of this type. The negative covenants include restrictions on indebtedness, liens, fundamental changes, dispositions of property, investments, dividends and other restricted payments. The financial covenants include a consolidated fixed charge coverage ratio, as defined, of not less than 1.75 to 1.0 and a consolidated leverage ratio, as defined, not to exceed 3.0 to 1.0 through March 31, 2011. As of the date hereof, we are in full compliance with these covenants.

In March 2010, we entered into an amendment to the Credit Agreement, which we refer to as the First Amendment, to increase the total amount we could spend on acquisitions in any one year from $10.0 million to $30.0 million.

6. Earnings Per Share

Basic income per share is calculated by dividing net income by the weighted average number of common shares outstanding during the period. Diluted income per share is calculated by dividing net income by the weighted average number of common shares and dilutive common share equivalents outstanding during the period. Our common share equivalents consist of stock options and restricted stock awards and units.

The following table reconciles the basic to diluted weighted average shares outstanding using the treasury stock method (shares in thousands):

	Three months ended March 31,	
	2011	2010
Weighted average shares outstanding—basic	27,937	26,919
Potential shares exercisable under stock option plans	966	1,228
Potential issuable restricted stock awards and units	55	30
Weighted average shares outstanding—diluted	28,958	28,177

For the three months ended March 31, 2011 and 2010, 187,611 and 321,100 stock options, respectively, were not included in the diluted earnings per share calculation because the effect would have been anti-dilutive. For the three months ended March 31, 2011, restricted stock units representing

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

6. Earnings Per Share (Continued)

7,996 shares of common stock were not included in the diluted earnings per share calculation because the effect would have been anti-dilutive.

We issue restricted stock units under the terms of our Third Amended and Restated 2006 Stock Plan, or the 2006 Stock Plan. For the majority of restricted stock units granted, the number of shares issued on the date the restricted stock units vest is net of the statutory withholding requirements that we pay on behalf of our employees. During 2011, we withheld 12,000 shares to satisfy $0.9 million of employees' tax obligations. Although shares withheld are not issued, they are treated as common stock repurchases for accounting and disclosure purposes, as they reduce the number of shares that would have been issued upon vesting.

7. Stock-Based Compensation

Total stock-based compensation expense charged as a selling, general and administrative expense in our consolidated statements of income related to our stock compensation plans was $2.0 million and $1.8 million for the three months ended March 31, 2011 and March 31, 2010, respectively. The total income tax benefit recognized in our consolidated statements of income for the three months ended March 31, 2011 and 2010 was $0.8 million and $0.7 million, respectively.

Presented below is a summary of our stock option activity for the three months ended March 31, 2011 (shares in thousands):

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Terms	Aggregate Intrinsic Value
Outstanding at December 31, 2010	2,323	$ 24.20		
Granted	5	67.17		
Exercised	(336)	18.71		
Forfeitures	(4)	34.41		
Expired	—	—		
Outstanding at March 31, 2011	1,988	25.21	4.48	$ 112,621
Expected to vest at March 31, 2011	868	36.85	5.25	$ 39,055
Exercisable at March 31, 2011	1,093	$ 15.71	3.84	$ 72,322

The fair value of each option grant was estimated using the Black-Scholes option pricing model. Expected volatilities are calculated based on the historical volatility of our common stock. Management monitors share option exercise and employee termination patterns to estimate forfeiture rates within the valuation model. Separate groups of employees that have similar historical exercise behavior are considered separately for valuation purposes. The expected holding period of options represents the period of time that options granted are expected to be outstanding. The expected terms of options granted are based upon our historical experience for similar types of stock option awards. The risk-free interest rate is based on U.S. Treasury notes.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

7. Stock-Based Compensation (Continued)

We estimated the fair value of each stock option grant on the date of the grant using a Black-Scholes option-pricing model and the weighted-average assumptions set forth in the following table:

	Three months ended March 31,	
	2011	2010
Expected dividend yield	0%	0%
Risk-free interest rate	3.04%	2.32%
Expected volatility	43.7%	45.8%
Expected life	4.0 years	4.0 years

During the three months ended March 31, 2011 and 2010, we issued 0.3 million shares, and 0.1 million shares, respectively, of our common stock upon the exercise of outstanding stock options and received proceeds of $6.3 million, and $1.2 million, respectively. For the three months ended March 31, 2011 and 2010, we realized a $3.3 million and $1.4 million tax benefit from the exercise of stock options, respectively.

For the three months ended March 31, 2011, and 2010, approximately $1.3 million, and $1.8 million, respectively, of stock-based compensation cost relating to stock options has been charged against income. As of March 31, 2011, there was approximately $8.2 million of total unrecognized compensation cost, adjusted for estimated forfeitures, related to stock options outstanding, which is expected to be recognized over a weighted-average period of 1.3 years.

The aggregate intrinsic value in the previous table reflects the total pretax intrinsic value (the difference between our closing stock price on the last trading day of the period and the exercise price of the options, multiplied by the number of in-the-money stock options) that would have been received by the option holders had all option holders exercised their options on March 31, 2011. The intrinsic value of our stock options changes based on the closing price of our common stock. The total intrinsic value of options exercised (the difference in the market price of our common stock on the exercise date and the price paid by the optionee to exercise the option) for the three months ended March 31, 2011 and 2010 was approximately $18.0 million and $4.4 million, respectively.

Restricted Stock Units

In February 2011, October 2010 and October 2009, certain employees received restricted stock units under the Third Amended and Restated 2006 Stock Plan, or the 2006 Stock Plan. In October 2010, our Board or Directors also received restricted stock units under the 2006 Stock Plan. The fair value of restricted stock units is estimated based on the closing sale price of our common stock on the NASDAQ Global Select Market on the date of issuance. The total number of restricted stock units expected to vest is adjusted by estimated forfeiture rates.

During the three months ended March 31, 2011, we granted 68,828 restricted stock units, with an aggregate fair market value of $5.1 million. At March 31, 2011 approximately 118,572 restricted stock units remained unvested and there was approximately $6.7 million of unamortized compensation cost related to restricted stock units, which is expected to be recognized over the remaining

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

7. Stock-Based Compensation (Continued)

weighted-average vesting period of 2.71 years. For the three months ended March 31, 2011 and 2010, stock-based compensation expense related to restricted stock units was $0.4 million and $0.1 million, respectively.

A summary of the status of our restricted stock units as of March 31, 2011 and of changes in restricted stock units outstanding under the 2006 Stock Plan for the three months ended March 31, 2011 is as follows (in thousands, except for weighted average grant date fair value per unit):

	Number of Units	Weighted Average Grant Date Fair Value per Unit	Aggregate Intrinsic Value
Outstanding balance at December 31, 2010	57	$ 51.46	
Granted	69	74.13	
Cancelled	(2)	57.85	
Outstanding balance at March 31, 2011	124	$ 64.10	$ 10,118

Restricted Stock Awards

Our executive officers have received grants of restricted stock awards under the 2006 Stock Plan. The vesting of restricted stock awards is subject to the executive officers' continued employment with us. Recipients of restricted stock awards are not required to provide us with any consideration other than rendering service. Holders of restricted stock are permitted to vote and to receive dividends.

The stock-based compensation expense for restricted stock awards is determined based on the closing market price of our common stock on the grant date of the awards applied to the total number of awards that are anticipated to fully vest. Upon the vesting of the restricted stock units, shares withheld to pay taxes are retired. We did not issue restricted stock awards during the three months ended March 31, 2011. At March 31, 2011 approximately 95,940 shares underlying restricted stock awards remained unvested and there was approximately $2.2 million of unrecognized compensation cost related to restricted stock awards, which is expected to be recognized over the weighted-average period of 1.9 years. For the three months ended March 31, 2011and 2010, stock-based compensation expense related to restricted stock awards was $0.3 million and $0.2 million, respectively.

HMS HOLDINGS CORP. AND SUBSIDIARIES

NOTES TO UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

For the Three Months Ended March 31, 2011 and 2010

(unaudited)

7. Stock-Based Compensation (Continued)

A summary of the status of our restricted stock awards at March 31, 2011 and of changes in restricted stock awards outstanding under the 2006 Stock Plan for the three months ended March 31, 2011 is as follows (in thousands, except for weighted average grant date fair value):

	Shares	Weighted Average Grant Date Fair Value per Share	Aggregate Intrinsic Value
Outstanding balance at December 31, 2010	128	$ 31.27	
Granted	—	—	
Vesting of Restricted Shares	(21)	31.27	
Shares withheld for payment of taxes upon vesting of restricted stock units	(11)	31.27	
Outstanding balance at March 31, 2011	96	$ 31.27	$ 7,853

The total fair value of restricted stock vested during the three months ended March 31, 2011 was $1.0 million.

8. Subsequent Events

On April 28, 2011, our Board of Directors adopted resolutions conditionally approving a three-for-one forward stock split to be effected in the form of a stock dividend of two shares of common stock for each share of common stock outstanding on or about July 22, 2011, the proposed record date for the stock split. The stock split is conditioned upon shareholder approval, at our 2011 Annual Meeting, of an amendment to our Certificate of Incorporation, as amended, to increase the number of shares of common stock that we are authorized to issue. If our shareholders do not approve the amendment, the stock split cannot be effected.

In conjunction with the preparation of these financial statements, an evaluation of subsequent events was performed through the date these financial statements were issued and there are no events that have occurred that would require adjustments or disclosure to our condensed consolidated financial statements.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

We begin Management's Discussion and Analysis of Financial Condition and Results of Operations with a discussion of the critical accounting policies that we believe are important to understanding the assumptions and judgments incorporated in our reported financial results. We then present a business overview followed by a discussion of our results of operations. Lastly, we provide an analysis of our liquidity and capital resources, including discussions of our cash flows, sources of capital and financial commitments.

The following discussions and analysis of financial condition and results of operations should be read in conjunction with the other sections of the Annual Report, including the Consolidated Financial Statements and Supplemental Data thereto appearing in Part II, Item 8 of the Annual Report, the Risk Factors appearing in Part I, Item 1A of the Annual Report and the disclaimer regarding forward-looking statements appearing at the beginning of Part I, Item 1 of the Annual Report. Historical results set forth in Part II, Item 6, Item 7 and Item 8 of the Annual Report should not be taken as necessarily indicative of our future operations.

Critical Accounting Policies

Since the date of our Annual Report on Form 10-K for the year ended December 31, 2010, there have been no material changes to our critical accounting policies.

General Overview

We provide a variety of cost containment services, including coordination of benefits and program integrity services, for government and private healthcare payors and sponsors. These services are designed to help our clients recover amounts due from liable third parties, save dollars, reduce fraud, waste and abuse and ensure regulatory compliance.

Our clients are state Medicaid agencies, Medicaid and Medicare managed care plans, government and private self-funded employers, Pharmacy Benefit Managers, or PBMs, child support agencies, the Veterans Health Administration, or VHA, the Centers for Medicare & Medicaid Services, or CMS, commercial plans, other healthcare payors and large business outsourcing and technology firms. We help these entities contain healthcare costs by ensuring that claims are paid correctly, through our program integrity services and by ensuring that claims are paid by the responsible party, through our coordination of benefits services.

In September 2010, we acquired privately-held Chapman Kelly, Inc., or Chapman Kelly. Based in Jeffersonville, Indiana, Chapman Kelly provides dependent eligibility audits to large, self-insured employers, as well as plan and claims audits to employers and managed care organizations. With our acquisition of Chapman Kelly we have developed a robust Employer Solutions product area that provides dependent eligibility audit services to employers of all sizes and also augments our claim audit offering for healthcare plans.

In June 2010, we acquired privately-held Allied Management Group—Special Investigation Unit, or AMG-SIU, a leading provider of fraud, waste and abuse prevention and detection solutions for healthcare payors. Based in Santa Ana, California, AMG-SIU provides audit and consulting services to both government and commercial healthcare payors and offers a proprietary forensic claim editing system to analyze claim data for patterns of fraud, waste and abuse. AMG-SIU employs an in-house special investigation unit to conduct preliminary research, investigations, medical record reviews and pharmacy reviews.

At March 31, 2011, we had cash and cash equivalents of $116.2 million, and net working capital of $169.0 million. We have a credit agreement with several banks and other financial institutions with JPMorgan Chase Bank, N.A. (JPMCB), as administrative agent, which we refer to as the Credit

Agreement. The Credit Agreement, which expires in September 2011, provided for a term loan of $40 million, which we refer to as the Term Loan, and revolving credit loans of up to $25 million, which we refer to as the Revolving Loan. The term loan was repaid in 2009. Although to date we have not borrowed under the Revolving Loan, we continue to have an irrevocable standby Letter of Credit for $4.6 million against the Revolving Loan, which we refer to as the Letter of Credit, as required by a contractual arrangement with a client. As a result of the Letter of Credit of $4.6 million, the amount available under the Revolving Loan as of March 31, 2011 is $20.4 million. Although we expect that operating cash flows will continue to be a primary source of liquidity for our operating needs, we also have the remaining balance of the Revolving Loan available for future cash flow needs, if necessary.

Our revenue, most of which is derived from contingency fees, has increased at an average compounded rate of approximately 38.2% per year for the last five years. Our growth has been attributable to our expansion of existing product offerings and acquisitions, as well as an overall increase in Medicaid costs, which has historically averaged approximately 8% annually. In addition, state governments have increased their use of vendors for the coordination of benefits and other cost containment functions, and we have been able to increase our revenue through these initiatives. Leveraging our work on behalf of state Medicaid fee-for-service programs, we have penetrated the Medicaid managed care market, into which more Medicaid lives are being shifted. In addition, to acting as a subcontractor for certain business outsourcing and technology firms, as of March 31, 2011, we served the District of Columbia and 42 state Medicaid programs, and 127 Medicaid health plans under an aggregate of 57 contracts.

To date, we have grown our business through the internal development of new services and through acquisitions of businesses whose core services strengthen our overall mission to help our clients control healthcare costs. In addition, we leverage our expertise to acquire new clients at the state, federal and employer levels and to expand our current contracts to provide new services to current clients. We are continuously evaluating opportunities that will enable us to expand the breadth of the services we provide and will consider acquisition opportunities that enable us to continue to grow our business to address the increasing needs of the healthcare industry in the post-healthcare reform era.

In March 2010, the Patient Protection and Affordable Care Act, or the Affordable Care Act, was signed into law. According to Centers for Medicare & Medicaid Services, or CMS, under the Affordable Care Act, approximately an additional 18 million lives will be added to Medicaid by 2019. In addition, the Affordable Care Act includes a number of provisions for combating fraud and abuse throughout the healthcare system, allows for significant increases in funding for program integrity initiatives and provides for the creation of insurance exchanges. The Affordable Care Act largely preserves and builds upon the employer-sponsored health coverage model. However, under the Affordable Care Act, employers are faced with new compliance guidelines, coverage requirements and mandates that will challenge their systems and processes and will likely raise their healthcare costs. We plan to build on our existing partnerships with states, the federal government, and health plans to provide services that address the program integrity, fraud and abuse initiatives created by the Affordable Care Act and to assist these clients in meeting the requirements of the Affordable Care Act. In addition, we believe that we are well-positioned to work with employers to address the new requirements of the Affordable Care Act and plan to work with our clients to develop collaborations that support the overarching goal of controlling healthcare costs.

In addition to the information provided below, you should refer to the items disclosed as our Critical Accounting Policies in Part II, Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations" of our Annual Report.

SUMMARY OF OPERATING RESULTS

Three Months Ended March 31, 2011 Compared to Three Months Ended March 31, 2010

The following table sets forth, for the periods indicated, certain items in our consolidated statements of income expressed as a percentage of revenue:

	Three months ended March 31,	
	2011	2010
Revenue	100.0%	100.0%
Cost of service		
Compensation	38.0%	36.6%
Data processing	6.0%	5.9%
Occupancy	4.6%	5.1%
Direct project costs	11.7%	11.7%
Other operating costs	5.1%	5.0%
Amortization of intangibles	2.1%	2.3%
Total cost of services	67.5%	66.6%
Selling, general, and administrative expenses	13.0%	13.8%
Total operating expenses	80.5%	80.4%
Operating income	19.5%	19.6%
Interest expense	0.0%	0.0%
Other income, net	0.4%	0.0%
Interest income	0.4%	0.0%
Income before income taxes	19.9%	19.6%
Income taxes	(8.0)%	(7.9)%
Net income	11.9%	11.7%

Revenue for the three months ended March 31, 2011 was $82.5 million, an increase of $17.5 million, or 27.0%, compared to revenue of $65.0 million in the same quarter for the prior year. Organic growth in existing client accounts, together with changes in the yield and scope of those projects, and differences in the timing of when client projects were completed in the current year compared to the prior year, provided $14.2 million of the increase in revenue. Revenue generated by our 2010 acquisitions, AMG-SIU and Chapman Kelly, was $2.0 million. Revenue generated by six new clients for whom there was no revenue in the same quarter of the prior year was $1.3 million.

Compensation expense as a percentage of revenue was 38.0% for the three months ended March 31, 2011, compared to 36.6% for the three months ended March 31, 2010. Compensation expense for the current quarter was $31.3 million, a $7.5 million, or 31.6%, increase over compensation expense of $23.8 million for the same quarter in the prior year. During the quarter ended March 31, 2011, we averaged 1,618 employees, a 28.8% increase over our average of 1,256 employees during the quarter ended March 31, 2010. This increase reflects the addition of new staff as a result of our acquisitions of AMG-SIU and Chapman Kelly during the second and third quarters of 2010, respectively, and the addition of staff in the areas of client support, technical support and operations.

Data processing expense as a percentage of revenue was 6.0% for the three months ended March 31, 2011, compared to 5.9% for the three months ended March 31, 2010. Data processing expense was $5.0 million for the current quarter, an increase of $1.2 million, or 30.5%, over data processing expense of $3.8 million for the same quarter in the prior year . Revenue growth as well as

acquisitions drove the need for increased capacity in our data processing environment. This increase reflects $0.6 million in additional software related costs, $0.4 million in additional hardware costs, and $0.2 million in additional data communications and data costs due to the growth of our business, including the number of field offices and employees.

Occupancy expense as a percentage of revenue was 4.6% for the three months ended March 31, 2011, compared to 5.1% for the three months ended March 31, 2010. Occupancy expense for the current quarter was $3.8 million, a $0.5 million, or 14.0%, increase compared to occupancy of expense of $3.3 million for the same quarter in the prior year. This increase reflects $0.4 million in additional rent and related expense, and $0.1 million in additional depreciation of leasehold improvements, furniture and equipment.

Direct project expense as a percentage of revenue was 11.7% for the three months ended March 31, 2011 and 2010. Direct project expense for the current quarter was $9.6 million, a $2.0 million, or 26.6%, increase, compared to direct project expense of $7.6 million for the same quarter in the prior year. This increase resulted from additional of expenses of $1.0 million increase for temporary help, consultants and marketing partners, $0.7 million for subcontractor expenses primarily driven by new projects and revenue increases, $0.2 million for project-specific software costs, and $0.1 million for lockbox, postage and delivery expense. Direct project expense increased at a rate similar to that of revenue growth in the current quarter as compared to the prior year comparable quarter.

Other operating costs as a percentage of revenue were 5.1% for the three months ended March 31, 2011 compared to 5.0% for the three months ended March 31, 2010. Other operating costs for the current quarter were $4.2 million, an increase of $1.0 million, or 30.5%, compared operating costs of $3.2 million for the same quarter in the prior year.. This increase resulted from additional expenses of $0.5 million in professional services, consisting of temporary help and consulting services, $0.2 million of travel expenses related to business expansion, $0.1 million of employee relocation expenses, $0.1 million for supplies, delivery and other office-related expenses, and $0.1 million in accretion expense related to the future contingent payment that may be payable to the former owners of AMG-SIU.

Amortization of acquisition-related software and intangibles as a percentage of revenue was 2.1% for the three months ended March 31, 2011, compared to 2.3% for the three months ended March 31, 2010. Amortization of acquisition-related software and intangibles for the current quarter was $1.7 million, a $0.2 million, or 15.8%, increase compared to amortization of $1.5 million for the same quarter in the prior year. The $0.2 million increase resulted from our acquisitions of AMG-SIU and Chapman Kelly. There was no amortization expense in the prior year period related to these acquisitions.

Selling, general, and administrative expense as a percentage of revenue was 13.0% for the three months ended March 31, 2011 compared to 13.8% for the three months ended March 31, 2010. Selling, general, and administrative expense for the current quarter was $10.7 million, a $1.7 million, or 19.2%, increase compared $9.0 million for the same quarter in the prior year. During the quarter ended March 31, 2011, we averaged 115 corporate employees, a 4.5% increase over our average of 110 corporate employees during the quarter ended March 31, 2010. Compensation expense increased by $0.3 million as a result of the increase in headcount and related fringe benefits expense. Other operating expenses increased by $1.0 million, of which $0.8 million related to professional fees, including consultants, legal fees and costs associated with annual audit expenses and SEC filings, and $0.2 million related to employee recruitment. Data processing expense increased by $0.4 million relating to expenses for hosting services and disaster recovery preparedness. Occupancy expenses were roughly equivalent in both periods.

Operating income for the three months ended March 31, 2011 was $16.1 million, an increase of $3.4 million, or 26.7%, compared to $12.7 million for the three months ended March 31, 2010. This increase was primarily the result of increased revenue, which was partially offset by incremental operating costs incurred during the quarter ended March 31, 2011.

Interest expense was $23,000 for the three months ended March 31, 2011 and 2010. Interest expense represents commitment fees for our Credit Agreement and issuance fees for our Letter of Credit. Interest and other income was $35,000 for the three months ended March 31, 2011, compared to interest income of $17,000 for the three months ended March 31, 2010. Net other income relating to rental income from our office building in Irving, Texas was $257,000 for the quarter ended March 31, 2011. We purchased the office building in Irving, Texas in in June 2010, as a result, we did not realize any rental income during the first quarter of 2010.

We recorded income tax expense of $6.6 million for the quarter ended March 31, 2011, compared to income tax expense of $5.1 million for the three months ended March 31, 2010, an increase of $1.5 million. Our effective tax rate decreased to 40.1% for the quarter ended March 31, 2011 from 40.4% for the quarter ended March 31, 2010, primarily due to a change in state apportionments. The principal difference between the statutory rate and our effective rate is state taxes.

Net income of $9.8 million in the current quarter represents an increase of $2.2 million, or 29.5%, compared to net income of $7.6 million in the same quarter for the prior year.

Contractual Obligations

There have been no material changes in our contractual obligations as presented in our Annual report on Form 10-K for the year ended December 31, 2010.

Off-Balance Sheet Arrangements

Other than our Letter of Credit, we do not have any off-balance sheet arrangements. See Footnote 5 of the Notes to Unaudited Consolidated Financial Statements in this Quarterly Report on Form 10-Q.

Liquidity and Capital Resources

Our principal source of funds has been from operations. We believe that our cash, cash equivalents, future cash flows from operations and our Revolving Loan will be adequate to fund our current operating requirements. At March 31, 2011, our cash and cash equivalents and net working capital were $116.2 million and $169.0 million, respectively. Although we expect that operating cash flows will continue to be a primary source of liquidity for our operating needs, we also have $20.4 million available under our Revolving Loan for future cash flow needs. There are currently no loans outstanding under the Revolving Loan; however, we have a $4.6 million Letter of Credit that reduces the availability under the Revolving Loan.

Net cash provided by operating activities for the three months ended March 31, 2011 was $17.9 million, compared to $11.6 million for the same period in 2010. The increase in cash provided by operating activities primarily resulted from net income of $9.8 million, decreases in accounts receivable and prepaid expenses, and non-cash expenses of stock-based compensation, depreciation and amortization. These sources of cash were partially offset by decreases in accounts payable, accrued expenses and other liabilities, deferred income tax assets and other assets.

Net cash used in investing activities for the three months ended March 31, 2011 was $5.1, million compared to $3.7 million for the same period in 2010. Investment in property and equipment for the three months ended March 31, 2011 and 2010 was $4.8 million and $3.1 million, respectively. Investment in capitalized software for each of the three months ended March 31, 2011 and 2010 was

$0.5 million. A working capital adjustment in the amount of $0.2 million was received in the three months ended March 31, 2011 in connection with the AMG-SIU acquisition in June 2010.

Net cash provided by financing activities for the three months ended March 31, 2011 was $8.6 million, compared to $2.6 million for the same period in 2010. Proceeds from stock option exercises for the three months ended March 31, 3011 and 2010 were $6.3 million and $1.2 million, respectively. The excess tax benefits from stock option exercises for the three months ended March 31, 2011 and 2010 were $3.3 million and $1.4 million, respectively. Payments of tax withholdings on behalf of employees for net-share settlements for stock-based compensation were $0.9 million in the three months ended March 31, 2011.

The net increase in cash and cash equivalents for the three months ended March 31, 2011 was $21.4 million compared to $10.5 million for the same period in 2010.

The number of days sales outstanding for the three months ended March 31, 2011 decreased to 73 days from 86 days at March 31, 2010.

Operating cash flows could be adversely affected by a decrease in demand for our services or if contracts with our largest clients are cancelled. The majority of our client relationships have been in place for several years, as a result, we do not expect any decrease in the demand for our services in the near term.

Recently Issued Accounting Pronouncements

In December 2010, the FASB issued authoritative accounting guidance on the disclosure of supplementary pro forma information for business combinations to clarify the reporting of pro forma financial information related to business combinations of public entities and expand certain supplemental pro forma disclosures. This guidance is effective prospectively for business combinations that occur on or after the beginning of the fiscal year beginning on or after December 15, 2010, with early adoption permitted. We do not expect that this guidance will have a material effect on our consolidated financial statements.

Excluding the recently issued authoritative accounting guidance noted above, there have been no developments to recently issued accounting standards, including the expected dates of adoption and estimated effects on our consolidated financial statements, from those disclosed in the our Annual Report on Form 10-K for the year ended December 31, 2010.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

At March 31, 2011, we were not a party to any derivative financial instruments. We conduct all of our business in U.S. currency and hence do not have direct foreign currency risk. The interest on borrowings under the Credit Agreement is at a variable rate based on the prime rate or LIBOR and may include a spread over or under the applicable rate. Further, we currently invest substantially all of our excess cash in short-term investments, primarily money market accounts, where returns effectively reflect current interest rates. As a result, market interest rate changes may impact our interest income or expense. The impact will depend on variables such as the magnitude of rate changes and the level of borrowings or excess cash balances. We do not consider this risk to be material. We manage such risk by continuing to evaluate the best investment rates available for short-term, high quality investments.

Item 4. Controls and Procedures

We maintain disclosure controls and procedures (as defined in Rule 13a-15(e) under the Exchange Act) that are designed to ensure that information required to be disclosed by us in reports that we file under the Exchange Act is recorded, processed, summarized and reported as specified in the SEC's rules and forms, and that such information required to be disclosed by us in reports that we file under the Exchange Act is accumulated and communicated to our management, including our Chief Executive Officer and our Chief Financial Officer, to allow timely decisions regarding required disclosure.

As required by Rule 13a-15(b) under the Exchange Act, management, with the participation of our Chief Executive Officer and Chief Financial Officer, performed an evaluation of the effectiveness of our disclosure controls and procedures as of March 31, 2011. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by this quarterly report.

There have been no changes in our internal control over financial reporting identified in connection with the evaluation of our controls performed during the quarter ended March 31, 2011 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II—OTHER INFORMATION

Item 1A. Risk Factors

Risks that could have a negative impact on our business, results of operations and financial condition include without limitation (i) the development by competitors of new or superior services or products or the entry into the market of new competitors; (ii) all the risks inherent in the development, introduction, and implementation of new products and services; (iii) the loss of a major customer, customer dissatisfaction or early termination of customer contracts triggering significant costs or liabilities; (iv) variations in our results of operations; (v) negative results of government reviews, audits or investigations to verify our compliance with contracts and applicable laws and regulations; (vi) changing conditions in the healthcare environment, particularly as they relate to current healthcare reform initiatives; (vii) government regulatory, political and budgetary pressures that could affect the procurement practices and operations of healthcare organizations, reducing the demand for our services; and (viii) our failure to comply with laws and regulations governing health data or to protect such data from theft and misuse. A more detailed description of each of these and other risk factors can be found under the caption "Risk Factors" in our most recent Annual Report on Form 10-K, filed with the SEC on March 1, 2011. There have been no material changes to the risk factors described in our most recent Annual Report on Form 10-K.

Item 6. Exhibits

The Exhibits filed as part of this Quarterly Report on Form 10-Q are listed on the Exhibit Index immediately following the Signatures.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

Date: May 9, 2011

HMS HOLDINGS CORP.

By: /s/ WILLIAM C. LUCIA

William C. Lucia
President and Chief Executive Officer
and Duly Authorized Officer
(Principal Executive Officer)

By: /s/ WALTER D. HOSP

Walter D. Hosp
Chief Financial Officer
and Duly Authorized Officer
(Principal Financial Officer)

Exhibit Index

Exhibit No.	Description
‡31.1	Rule 13a-14(a)/15d-14(a) Certification of the Principal Executive Officer of HMS Holdings Corp., as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
‡31.2	Rule 13a-14(a)/15d-14(a) Certification of the Principal Financial Officer of HMS Holdings Corp., as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
‡32.1	Section 1350 Certification of the Principal Executive Officer of HMS Holdings Corp., as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
‡32.2	Section 1350 Certification of the Principal Financial Officer of HMS Holdings Corp., as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

‡ Furnished herewith

Exhibit 31.1

Certification

I, William C. Lucia, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of HMS Holdings Corp.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15 (f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 9, 2011

/s/ WILLIAM C. LUCIA

William C. Lucia
Chief Executive Officer
(Principal Executive Officer)

QuickLinks

Exhibit 31.1

Exhibit 31.2

Certification

I, Walter D. Hosp, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of HMS Holdings Corp.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15 (f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 9, 2011

/s/ WALTER D. HOSP

Walter D. Hosp
Chief Financial Officer
(Principal Financial Officer)

QuickLinks

Exhibit 31.2

Exhibit 32.1

Certification Pursuant To 18 U.S.C. Section 1350 as Adopted Pursuant To Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Quarterly Report of HMS Holdings Corp. (the " *Company* ") on Form 10-Q for the period ended March 31, 2011 as filed with the Securities and Exchange Commission (the " *Report* "), I, William C. Lucia, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. §1350, as adopted pursuant to §906 of the Sarbanes-Oxley Act of 2002, that:

(1) the Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ WILLIAM C. LUCIA

William C. Lucia
Chief Executive Officer
(Principal Executive Officer)

May 9, 2011

A signed original of this written statement required by Section 906 has been provided to HMS Holdings Corp. and will be retained by HMS Holdings Corp. and furnished to the Securities and Exchange Commission or its staff upon request. This written statement accompanies the Form 10-Q to which it relates, is not deemed filed with the Securities and Exchange Commission, and will not be incorporated by reference into any filing of HMS Holdings Corp. under the Securities Act of 1933 or the Securities Exchange Act of 1934, irrespective of any general incorporation language contained in such filing.

QuickLinks

Exhibit 32.1

Certification Pursuant To 18 U.S.C. Section 1350 as Adopted Pursuant To Section 906 of the Sarbanes-Oxley Act of 2002

Exhibit 32.2

Certification Pursuant To 18 U.S.C. Section 1350 as Adopted Pursuant To Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Quarterly Report of HMS Holdings Corp. (the " *Company* ") on Form 10-Q for the period ended March 31, 2011 as filed with the Securities and Exchange Commission (the " *Report* "), I, Walter D. Hosp, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. §1350, as adopted pursuant to §906 of the Sarbanes-Oxley Act of 2002, that:

(1) the Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ WALTER D. HOSP

Walter D. Hosp
Chief Financial Officer
(Principal Financial Officer)

May 9, 2011

A signed original of this written statement required by Section 906 has been provided to HMS Holdings Corp. and will be retained by HMS Holdings Corp. and furnished to the Securities and Exchange Commission or its staff upon request. This written statement accompanies the Form 10-Q to which it relates, is not deemed filed with the Securities and Exchange Commission, and will not be incorporated by reference into any filing of HMS Holdings Corp. under the Securities Act of 1933 or the Securities Exchange Act of 1934, irrespective of any general incorporation language contained in such filing.

QuickLinks

Exhibit 32.2

Certification Pursuant To 18 U.S.C. Section 1350 as Adopted Pursuant To Section 906 of the Sarbanes-Oxley Act of 2002

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hms

HMS Holdings Corp. Performance Guarantee

HMS Holdings Corp. will unconditionally guarantee performance by Health Management Systems, Inc. ("HMS") of each and every obligation, warranty, covenant, term and condition of the Contract for Coordination of Benefit and Overpayment Services entered into between HMS and AMERIGROUP Corporation and effective June 1, 2006.

Walter Hosp
Chief Financial Officer
HMS Holdings Corp.
June 15, 2011

5615 High Point Drive | Suite 100 Irving, TX 75038 tel 214.453.3000 www.hms.com

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SUBCONTRACTOR RESUMES FOR HEALTH MANAGEMENT SYSTEMS (HMS)

PHYLLIS M. HARTSTEIN

Vice President Managed Care

Experience

Vice President, Managed Care for HMS, (2005 to present)

- Identifies and develops revenue maximization programs and services for managed care clients
- Provides executive oversight to service delivery, including administrative and financial management for 52 million Medicaid Managed Care plans with 9 million covered lives
- Develops new business/client relationships
- Develops new programs and services
- Builds strategic alliances

Senior Manager, Public Consulting Group, Inc. (1999 – 2005)

- Managed all Medicaid/Medicare MCO accounts and established a Research & Development division
- Established the R&D division to identify and develop service lines and expand current services
- Identified services that are applicable to the Medicaid/Medicare MCO market segment, including COB, cost containment, overpayment identification and recovery and others
- Determined the process for profitable implementation and operation of services
- Marketed and contracted with target MCOs
- Delivered contracted services
- Managed client support staff and certain operations including the oversight of work and quality control for centralized staff
- Advocated with Federal and State agencies and health insurers on behalf of clients, as required
- Directed IT development and operations team to provide services to all southern and western clients
- Developed, marketed and managed overpayment identification, recovery and revenue maximization services for multiple clients
- Directed all aspects of TPL, cost containment and recipient disenrollment services for multiple clients
- Developed long-range program goals based on extensive knowledge of the Medicaid industry, particularly in the area of managed care

Senior Manager, Deloitte Consulting, LLC - Health Care Fraud and Abuse Services (1994 – 1999)

- Identified opportunity and developed new service line, including the overall delivery approach
- Identified and negotiated agreements with technology, marketing and supplemental service delivery partners
- Developed and implemented marketing strategy, directed development of service delivery plan and prioritized technology upgrades

- Led consulting and technical teams that provide broad range of claims review services to large commercial payers and self-insured Fortune 500 Companies; major services included medical claims reviews (e.g. unbundling, mutually exclusive, duplicates, CLIA, etc); hospital claims issues (e.g. transfer cases, outliers improperly calculated, payments exceeding contract terms) and coordination of benefits (TPL identification and recovery)
- Oversight of IT division responsible for serving the TPL practice area
- Consulting services
- Developed a process reengineering engagement for the third party claims process for a large Blue Cross plan
- Conducted an assessment of problems in workers compensation payments for the U.S. Postal Service

Director, Health Management Systems, Inc. - Third Party Liability Operations (1987-1993)

- Directed the development and service delivery to 14 Federal and State Third Party Liability Recovery contracts; services included identification and recovery from Medicare, Commercial Insurers, Blue Cross/Blue Shield plans, accident claims, estate recovery and inter-title funds transfers, using automated data matching, claims preparation and editing and electronic and paper claims submissions.

Director, Copeland and Associates, Inc. - Maryland Disability Entitlement Advocacy Program (1986-1987)

Deputy Commissioner of Social Services, Westchester County (1980-1986)

Academic Background and Professional Certifications

- Temple University, **M.P.A., Public Administration**
- Goucher College, **B.A., Political Science**

MATTHEW J. COFFIN

Regional Vice President – Account/Client Management

Experience

Regional Vice President, Account Client Management for HMS, (2006 to present)

- Responsible for maintaining and growing client relationships in the Managed Care Organization (MCO) Division.
- Implemented best practice tools utilized for current contract management and new implementations, as well as developed management and business trend reporting.
- Established client relationship manager for several of the organizations key east region contracts.
- Responsible for $30M in annual contract revenue.
- Manage a team of 6 professional contract managers.

Senior Consultant, Public Consulting Group (2003 – 2006)

- Responsible for developing and implementing Medicaid Cost Containment / Third Party Liability and Revenue Maximization initiatives.
- Responsibilities included state government client relationship management, implementation Manager for Revenue Maximization contracts, as well as managing new contract proposal writing and sales.
- Medicaid HMO Third Party Recoveries – Implemented a complete PC based process for third party payor identification, claim selection, and file transformations. Managed all related project deliverables.
- Medicare Drug Recoveries – Created and implemented a Medicare covered drug recovery process. Work included federal regulation and payment manual analysis, process design, and EDI implementation. Managed data mining and analysis efforts, as well as billing and accounts receivable processes.
- Upper Payment Limits – Implemented several upper payment limits initiatives for physician practice plans and hospitals, as well as assisting with nursing home analysis. Increased federal matching funds by over $40 million annually. Successfully assisted state agencies with drafting State Plan Amendments as well as CMS negotiations.
- Schools Rate Setting – Effectively managed data extraction, analysis, and cost settlement process to calculate actual supplemental payments worth $10 million annually in federal matching funds to state DOE districts.

Vice President , Bank of America Investment Services, Inc. - Product Analysis & Research (1999 - 2003)

- Directed strategic and tactical analysis organization in support of the overall line of business.
- Spearheaded efforts to provide business analysis, strategic planning, and project management within the Retail Brokerage Group and Bank of America Consumer Banking Division.
- Direct supervisory responsibilities included advanced business analysts, advanced system technical analysts, and programmers.
- Responsible for coaching and developing associates and managers within the business unit.

- Developed new product business cases and market / customer research. Supported the lines of business with ad hoc and ongoing business intelligence, development of research project plans, and effective client relationship management for partnership sales models.
- Implemented performance and sales measurement reporting strategies to effectively manage sales force productivity and new product opportunities designed to meet the firm's 25% annual growth target.
- Provided the business with demographic and competitor intelligence for retail center site selection decisions, market optimization, as well as merger and acquisition analysis in support of the corporate growth model.

Academic Background and Professional Certifications

- University of North Carolina at Charlotte, NC, **Master of Public Administration (MPA)**
- University at Buffalo, NY, **Bachelor of Arts in Economics (BAE)**

DEAN S. HAGGERTY, III

Director, Account Management

Experience

Account Director, MNS (2009 – Present)

- Administers revenue growth strategies and ensures realization of budget forecasts to exceed annual projections for $50+ million recovery goal. Recruitment, development, and supervision of account management staff to assure client satisfaction, identify client cost containment opportunities, and achieve financial results. Set direction and drive efficiency of resources by implementing internal protocols, cross-functional follow-up, issue tracking, and team-building strategies. Orchestrates selection of resources and management of subcontractors for contracted deliverables. Negotiates contract expansion with clients and Sales to explore upsell opportunities and guarantee fulfillment of client service needs. Augments all aspects of upsell projects, including client relations, technical specifications, and executive reporting needs. Conducts strategic liaisons between MCOs and State Medicaid Agencies to eliminate overlap or gaps in recovery services, interpret risk to clients, and communicate impact to all levels of the organization.
- Pioneered an executive level focus group between account management and marketing, which launched client marketing platform, emphasizing company value via monthly updates on product offerings and corporate news.
- Instrumental in Voice of Customer improvement initiative to implement client-friendly best practices that increased customer participation, generated accountability for results, and resolved question content.
- Accelerated client satisfaction within HMS standard operation to achieve 100% client referral rate.
- Consults with clients and internal support areas to secure additional revenue by leveraging operational efficiencies and delivering program integrity and audit recovery services.
- Oversee timely and quality generation of deliverables for commercial recovery, provider disallowance, and cost avoidance product lines.
- Consulted on deliverable quality and value with Key MCO client, in order to re-establish lost product line for an additional $500,000 in revenue.

Medco Health Solutions, Inc, Franklin Lakes, New Jersey (1994 – 2009)

Regional Director, Account Management (2005-2009)

- Elevated regional growth and performance through new business development, client retention, up selling, and overhead reduction as the leader of a professional team. Maximized growth and pull-thru opportunities to achieve business and program up sell goals using extensive product knowledge and installation experience, particularly for Health plan, Medicare-D, and Consumer Driven plan designs. Recruited and hired top-performers as account management professionals, further advancing their contract negotiation, installation, and customer service skills through intense training and support. Spearheaded internal process improvements, including the quick, efficient resolution of client concerns. Crafted actionable business plans congruent with corporate and client objectives, trimming expenses while detailing viable drug trend management strategies. Set regional and individual employee goals as the administrator of the

Selling, General, and Administrative expenses (SG&A) budget. Enhanced client discussions and meetings by assessing client needs to recommend measurable cost reductions.

- Captured a 96% client retention rate, deftly managing a $390M regional book of business. Achieved 100% of the region's business development goal.
- Surpassed up sell targets by 10%+, heightened efficiency, and reduced customer complaints after outlining performance metrics for Broker and TPA partners.
- Recouped additional payments and minimized the non-compliance risk for the $1.5M Medicare-D reimbursement of a key Union client as the head of the assigned resolution team.
- Skyrocketed audit compliance from an average 6% to >95% in one year as a top contributor to the senior executive-level team tasked with the initiative. Strengthened company's overall position by limiting its exposure to potential financial and legal claims.

Account Manager/Senior Account Manager, 1998 - 2005

- Contributed to the flawless installation of a 12M member strategic account, skillfully managing benefit design and the system integration of intricate prescription drug benefit data as a recognized top-performer on a team handpicked by senior level executives. Leveraged deep technical knowledge of Medco operating and service delivery platforms encompassing mail service, client profile, plan file, customer service, and claims processing to effectively complete the high-profile project. Supervised cross-functional teams in the execution of such design elements as account structure, billing, reporting, and over 130 specialized co-payment exception rules. Tracked customer service problems, continually assessing plan performance. Managed new benefit installations and plan modifications. Authorized to handle billing and financial protocols, instituting a zero tolerance policy for file errors. Mitigated risk for late payments on multi-million dollar invoice payments.

Additional Medco experience includes Account Coordinator and Senior Account Coordinator from 1995 through 1998.

Academic Background and Professional Certifications

- Master of Business Administration in Business Management, William Paterson University, Wayne New Jersey
- Bachelor of Science in Business Management, Seton Hall University, South Orange New Jersey
- Certifications / Accreditations

  Academy of Managed Care Pharmacy
  Pharmacy Benefit Management Professionals
  Medicaid Certification, The Medicaid Institute

JOSEPH DIFIORE

Account Analyst Managed Care

Experience

Account Analyst, HMS - Managed Care Division (2008 – Present)

- Primary point of contact for analytical issues on accounts totaling $12+M in annual revenue
- Support the analytical and operation functions required to maximize client revenue
- Develop new services for current clients; identify and implement processes improvements resulting in cost savings or revenue enhancement opportunities for existing products
- Work with clients to understand and document their business needs; report on progress and results
- Coordination of internal services to ensure accurate and timely delivery of contracted services
- Quality review of deliverables and invoices
- Financial and process analysis; ad hoc report development for both internal and external clients
- Quantitative and qualitative analysis of contracts and services

Intern, The Bank of New York: The Pershing Division – Account Transfer Division (2004)

- Located, examined and analyzed client account transfer errors
- Worked closely with other financial entities to reconcile discrepancies
- Ensured customer satisfaction at all times

Academic Background and Professional Certifications

- Lehigh University, B.S., Business Economics

Certifications/Societies

- MLC Certified Medicaid Professional, 2010
- American Mensa Society, 2008 - Present

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Health Management Systems, Inc. Publicly Funded Managed Care Contracts

Due to confidentiality agreements with clients, Health Management Systems, Inc. is not able to disclose specific information relating to managed care contracts.

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HMS References

Please see Attachment B.11.p in our **ORIGINAL** proposal for sealed envelopes containing completed reference questionnaires for HMS.

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PROVIDENCE SERVICE CORP (PRSC)

10-K

Annual report pursuant to section 13 and 15(d)
Filed on 03/11/2011
Filed Period 12/31/2010

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Item 8. ***Financial Statements and Supplementary Data.***

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Management's Report on Internal Control Over Financial Reporting

Our management has the responsibility for establishing and maintaining adequate internal control over financial reporting for the registrant, as such term is defined in the Securities Exchange Act of 1934 Rule 13a-15(f). Under the supervision and with the participation of our principal executive officer and principal financial officer, we conducted an assessment, as of December 31, 2010, of the effectiveness of our internal control over financial reporting based on the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission in Internal Control–Integrated Framework.

We designed our internal control over financial reporting to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. Our internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

All internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Based on our assessment, we concluded our internal control over financial reporting is effective as of December 31, 2010.

KPMG LLP, an independent registered public accounting firm, which audited our consolidated financial statements included in this report on Form 10-K has issued an attestation report on the effectiveness of our internal control over financial reporting. KPMG LLP's attestation report is also included in this report on Form 10-K.

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Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
The Providence Service Corporation:

We have audited The Providence Service Corporation's internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control—Integrated Framework*, issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Providence Service Corporation's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying management's annual report on internal control over financial reporting. Our responsibility is to express an opinion on the effectiveness of The Providence Service Corporation's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with U.S. generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, The Providence Service Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of The Providence Service Corporation and subsidiaries as of December 31, 2010 and 2009, and the related consolidated statements of operations, stockholders' equity and comprehensive income (loss), and cash flows for each of the years in the three-year period ended December 31, 2010, and our report dated March 11, 2011 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP
Phoenix, Arizona
March 11, 2011

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Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
The Providence Service Corporation:

We have audited the accompanying consolidated balance sheets of The Providence Service Corporation and subsidiaries (the Company) as of December 31, 2010 and 2009, and the related consolidated statements of operations, stockholders' equity and comprehensive income (loss), and cash flows for each of the years in the three-year period ended December 31, 2010. In connection with our audits of the consolidated financial statements, we have also audited the financial statement schedules contained in Item 15(a)(2). These consolidated financial statements and financial statement schedules are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements and financial statement schedules based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of The Providence Service Corporation and subsidiaries as of December 31, 2010 and 2009, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2010, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedules, when considered in relation to the consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control—Integrated Framework*, issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated March 11, 2011 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP
Phoenix, Arizona
March 11, 2011

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The Providence Service Corporation

Consolidated Balance Sheets

	December 31, 2009	December 31, 2010
Assets		
Current assets:		
Cash and cash equivalents	$ 51,157,429	$ 61,260,661
Accounts receivable—billed, net of allowance of $2.9 million in 2009 and $5.3 million in 2010	80,458,245	75,845,917
Accounts receivable—unbilled	329,577	265,691
Management fee receivable(1)	7,160,001	5,839,735
Other receivables	4,118,213	3,929,866
Restricted cash	8,153,610	7,314,535
Prepaid expenses and other(2)	12,439,613	15,478,221
Deferred tax assets	3,558,034	1,633,644
Total current assets	167,374,722	171,568,270
Property and equipment, net	11,166,272	16,401,107
Goodwill	113,672,945	113,783,389
Intangible assets, net	73,963,261	66,441,817
Restricted cash, less current portion	5,941,924	9,079,563
Other assets	10,987,542	9,659,349
Total assets	$ 383,106,666	$386,933,495
Liabilities and stockholders' equity		
Current liabilities:		
Current portion of long-term obligations	$ 17,480,918	$ 18,113,512
Accounts payable	4,010,560	2,887,837
Accrued expenses	33,389,729	33,551,129
Accrued transportation costs	40,907,527	41,868,694
Deferred revenue	8,347,258	5,373,742
Interest rate swap	372,408	—
Reinsurance liability reserve	12,644,670	11,898,200
Total current liabilities	117,153,070	113,693,114
Long-term obligations, less current portion	186,732,342	164,190,260
Other long-term liabilities	5,143,322	8,721,610
Deferred tax liabilities	11,740,340	11,579,849
Total liabilities	320,769,074	298,184,833
Commitments, contingencies and subsequent events (Notes 19, 22 and 24)		
Stockholders' equity		
Common stock: Authorized 40,000,000 shares; $0.001 par value; 13,521,959 and 13,580,385 issued and outstanding (including treasury shares)	13,522	13,580
Additional paid-in capital	170,551,301	172,540,912
Retained deficit	(102,128,229)	(78,501,586)
Accumulated other comprehensive loss, net of tax	(1,675,572)	(880,814)
Treasury shares, at cost, 619,768 shares	(11,383,967)	(11,383,967)
Total Providence stockholders' equity	55,377,055	81,788,125
Non-controlling interest	6,960,537	6,960,537
Total stockholders' equity	62,337,592	88,748,662
Total liabilities and stockholders' equity	$ 383,106,666	$386,933,495

(1) Includes related party management fee receivable of approximately $281,000 and $237,000 at December 31, 2009 and 2010, respectively.
(2) Includes related party prepaid travel expenses of approximately $108,000 at December 31, 2009 and 2010.

See accompanying notes to the consolidated financial statements

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The Providence Service Corporation

Consolidated Statements of Operations

	Year ended December 31,		
	2008	2009	2010
Revenues:			
Home and community based services	$ 258,003,077	$ 289,006,655	$ 292,735,117
Foster care services	32,343,247	37,283,711	35,547,733
Management fees(1)	20,217,211	14,447,586	13,637,781
Non-emergency transportation services	381,106,735	460,275,314	537,776,026
	691,670,270	801,013,266	879,696,657
Operating expenses:			
Client service expense(2)	253,652,123	275,126,619	289,152,011
Cost of non-emergency transportation services	356,271,344	415,299,812	474,128,586
General and administrative expense(2)	48,411,826	44,009,666	46,460,682
Asset impairment charges	169,930,171	—	—
Depreciation and amortization	12,721,494	12,852,107	12,652,027
Total operating expenses	840,986,958	747,288,204	822,393,306
Operating income (loss)	(149,316,688)	53,725,062	57,303,351
Other (income) expense:			
Interest expense	19,578,404	20,798,250	16,267,881
Interest income	(978,877)	(365,853)	(256,033)
Income (loss) before income taxes	(167,916,215)	33,292,665	41,291,503
Provision (benefit) for income taxes	(12,311,542)	12,167,058	17,664,860
Net income (loss)	$ (155,604,673)	$ 21,125,607	$ 23,626,643
Earnings (loss) per common share:			
Basic	$ (12.42)	$ 1.61	$ 1.79
Diluted	$ (12.42)	$ 1.60	$ 1.78
Weighted-average number of common shares outstanding:			
Basic	12,531,869	13,130,092	13,194,226
Diluted	12,531,869	13,211,393	14,964,516

(1) Includes related party management fees of approximately $509,000, $292,000 and $270,000 for the years ended December 31, 2008, 2009 and 2010, respectively.

(2) Includes related party expenses of approximately $321,000, $388,000 and $520,000 for the years ended December 31, 2008, 2009 and 2010, respectively.

See accompanying notes to the consolidated financial statements

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The Providence Service Corporation

Consolidated Statements of Stockholders' Equity and Comprehensive Income (Loss)

	Common Stock					Accumulated Other	Treasury Stock			
	Shares	Amount	Additional Paid-In Capital	Common Stock Subscription Receivable	Retained Earnings (Deficit)	Comprehensive Income (Loss)	Shares	Amount	Non-Controlling Interest	Total
Balance at December 31, 2007	12,756,392	$ 12,756	$ 159,176,594	$ (714,654)	$ 32,350,837	$ 1,093,367	612,026	$(11,259,207)	$ 7,648,946	$ 188,308,639
Stock-based compensation	—	—	8,760,435	—	—	—	—	—	—	8,760,435
Restricted stock issued/withheld	567,645	567	(567)	—	—	—	7,742	(124,760)		(124,760)
Exercise of employee stock options including income tax shortfall of $1.3 million	33,504	34	(843,672)	—	—	—	—	—	—	(843,638)
Unregistered stock issued to former members of WD Management, L.L.C.	78,740	79	2,223,381	—	—	—	—	—	—	2,223,460
PSC of Canada Exchange Corp. shares exchanged	14,379	14	382,439	—	—	—	—	—	(382,453)	—
Stock option cancellation and exchange—Logisticare	11,696	12	(12)	—	—	—	—	—	—	—
Common stock subscription receivable	—	—	—	714,654	—	—	—	—	—	714,654
Change in fair value of derivative, net of income tax benefit of $653,241	—	—	—	—	—	(991,091)	—	—	—	(991,091)
Foreign currency translation adjustments	—	—	—	—	—	(4,551,823)	—	—	—	(4,551,823)
Net loss	—	—	—	—	(155,604,673)	—	—	—	—	(155,604,673)
Total comprehensive loss										(161,147,587)
Balance at December 31, 2008	13,462,356	13,462	169,698,598	—	(123,253,836)	(4,449,547)	619,768	(11,383,967)	7,266,493	37,891,203
Stock-based compensation	—	—	302,071	—	—	—	—	—	—	302,071
Exercise of employee stock options, including net tax benefit of $95,068	48,100	48	244,688		—	—	—	—	—	244,736
PSC of Canada Exchange Corp. shares exchanged	11,503	12	305,944	—	—	—	—	—	(305,956)	—
Change in fair value of derivative and impact of de-designation, net of income tax of $543,929	—	—	—	—	—	820,121	—	—	—	820,121
Foreign currency translation adjustments	—	—	—	—	—	1,953,854	—	—	—	1,953,854
Net income	—	—	—	—	21,125,607	—	—	—	—	21,125,607
Total comprehensive income										23,899,582
Balance at December 31, 2009	13,521,959	13,522	170,551,301	—	(102,128,229)	(1,675,572)	619,768	(11,383,967)	6,960,537	62,337,592
Stock-based compensation	—	—	1,694,371	—	—	—	—	—	—	1,694,371
Exercise of employee stock options, including net tax shortfall of $175,589	57,760	57	295,241	—	—	—	—	—	—	295,298
Restricted stock issued	666	1	(1)	—	—	—	—	—	—	—
Change in fair value of derivative, net of income tax of $94,449	—	—	—	—	—	170,970	—	—	—	170,970
Foreign currency translation adjustments	—	—	—	—	—	623,788	—	—	—	623,788
Net income	—	—	—	—	23,626,643	—	—	—	—	23,626,643
Total comprehensive income										24,421,401
Balance at December 31, 2010	13,580,385	$ 13,580	$ 172,540,912	$ —	$ (78,501,586)	$ (880,814)	619,768	$(11,383,967)	$ 6,960,537	$ 88,748,662

See accompanying notes to the consolidated financial statements

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The Providence Service Corporation

Consolidated Statements of Cash Flows

	Year ended December 31,		
	2008	2009	2010
Operating activities			
Net income (loss)	$ (155,604,673)	$ 21,125,607	$ 23,626,643
Adjustments to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation	4,505,214	4,689,709	4,952,722
Amortization	8,216,280	8,162,398	7,699,305
Amortization of deferred financing costs	2,698,184	2,979,515	2,445,848
Provision for doubtful accounts	4,084,333	4,479,094	4,899,377
Deferred income taxes	(14,553,560)	2,299,614	1,369,316
Stock based compensation	8,760,435	302,071	1,694,371
Excess tax benefit upon exercise of stock options	(184,908)	(140,312)	(66,372)
Asset impairment charges	169,930,171	—	—
Other	27,878	109,212	87,566
Changes in operating assets and liabilities, net of effects of acquisitions:			
Billed and unbilled accounts receivable	(9,276,794)	(10,542,465)	28,979
Management fee receivable	(2,364,483)	542,357	1,320,267
Other receivables	(417,295)	(1,109,999)	97,397
Restricted cash	(214,098)	112,043	5,333
Prepaid expenses and other	(5,828,653)	3,005,629	(3,387,496)
Reinsurance liability reserve	2,621,087	4,114,560	1,511,582
Accounts payable and accrued expenses	(6,680,776)	7,046,947	(906,472)
Accrued transportation costs	7,474,815	8,856,202	961,167
Deferred revenue	(702,259)	4,885,641	(3,011,441)
Other long-term liabilities	(104,912)	183,519	697,127
Net cash provided by operating activities	12,385,986	61,101,342	44,025,219
Investing activities			
Purchase of property and equipment, net	(4,664,007)	(3,699,385)	(10,265,944)
Acquisition of businesses, net of cash acquired	(3,597,766)	(1,037,650)	—
Acquisition of management agreement	(418,462)	(100,000)	—
Acquisition earnout payments	(6,670,655)	—	—
Restricted cash for contract performance	2,506,353	(1,196,637)	(2,303,897)
Purchase of short-term investments, net	(185,515)	(194,304)	(120,733)
Collection of notes receivable	3,291,943	599,841	—
Net cash used in investing activities	(9,738,109)	(5,628,135)	(12,690,574)
Financing activities			
Repurchase of common stock, for treasury	(124,760)	—	—
Proceeds from common stock issued pursuant to stock option exercise	469,320	149,667	470,887
Excess tax benefit upon exercise of stock options	184,908	140,312	66,372
Repayment of long-term debt	(8,650,000)	(33,545,345)	(21,909,488)
Debt financing costs	(88,775)	(802,329)	(61,053)
Capital lease payments	(1,012)	(69,413)	(13,364)
Net cash used in financing activities	(8,210,319)	(34,127,108)	(21,446,646)
Effect of exchange rate changes on cash	(451,956)	447,083	215,233
Net change in cash	(6,014,398)	21,793,182	10,103,232
Cash at beginning of period	35,378,645	29,364,247	51,157,429
Cash at end of period	$ 29,364,247	$ 51,157,429	$ 61,260,661

See accompanying notes to the consolidated financial statements

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The Providence Service Corporation

Supplemental Cash Flow Information

	Year ended December 31,		
	2008	2009	2010
Supplemental cash flow information			
Cash paid for interest	$ 16,773,008	$ 17,789,734	$ 14,581,039
Cash paid for income taxes	$ 4,177,798	$ 7,066,871	$ 19,820,184
Note payable obtained to finance prepaid insurance	$ 989,925	$ —	$ —
Stock issued to former members of WD Management, L.L.C.	$ 2,223,460	$ —	$ —
PSC of Canada Exchange Corp. shares exchanged	$ 382,453	$ 305,956	$ —
Change in fair value of derivative and impact of de-designation	$ (991,091)	$ 820,121	$ 170,970
Business acquisitions:			
Purchase price	$ 8,900,000	$ 29,478	$ —
Costs of acquisition	599,291	213,193	—
Less:			
Cash (received) paid for working capital adjustment	(479,716)	269,979	—
Amount due to former shareholder	(525,000)	525,000	—
Credit for indebtedness of management fees	(4,827,425)	—	—
Cash acquired	(69,384)	—	—
Acquisition of business, net of cash acquired	$ 3,597,766	$ 1,037,650	$ —

See accompanying notes to the consolidated financial statements

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The Providence Service Corporation

Notes to Consolidated Financial Statements

December 31, 2010

1. Nature of Operations

Description of Business

The Providence Service Corporation (the "Company") is a government outsourcing privatization company. The Company operates in the following two segments: Social Services and Non-Emergency Transportation Services ("NET Services"). As of December 31, 2010, the Company operated in 43 states, and the District of Columbia, United States, and British Columbia, Canada.

The Social Services operating segment responds to governmental privatization initiatives in adult and juvenile justice, corrections, social services, welfare systems, education and workforce development by providing home-based and community-based counseling services and foster care services to at-risk families and children. These services are purchased primarily by state, county and city levels of government, and are delivered under block purchase, cost based and fee-for-service arrangements. The Company also contracts with not-for-profit organizations to provide management services for a fee.

The NET Services operating segment provides non-emergency transportation management services, primarily to Medicaid beneficiaries. The entities that pay for non-emergency medical transportation services primarily include state Medicaid programs, health maintenance organizations and commercial insurers. Most of the Company's non-emergency medical transportation services are delivered under capitated contracts where the Company assumes the responsibility of meeting the transportation needs of a specific geographic population.

Seasonality

The Company's quarterly operating results and operating cash flows normally fluctuate as a result of seasonal variations in its business. In the Company's Social Services operating segment, lower client demand for its home and community based services during the holiday and summer seasons generally results in lower revenue during those periods; however, the Company's expenses related to the Social Services operating segment do not vary significantly with these changes. As a result, the Company's Social Services operating segment experiences lower operating margins during the holiday and summer seasons. The Company's NET Services operating segment also experiences fluctuations in demand for its non-emergency transportation services during the summer, winter and holiday seasons. Due to higher demand in the summer months and lower demand in the winter and holiday seasons, coupled with a fixed revenue stream based on a per member per month base structure, the Company's NET Services operating segment experiences lower operating margins in the summer season and higher operating margins in the winter and holiday seasons.

The Company expects quarterly fluctuations in operating results and operating cash flows to continue as a result of the seasonal demand for its home and community based services and non-emergency transportation services. As the Company enters new markets, it could be subject to additional seasonal variations along with any competitive response by other social services and transportation providers.

2. Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all of its subsidiaries, including its foreign wholly-owned subsidiary WCG International Ltd. ("WCG"). All intercompany accounts and transactions have been eliminated in consolidation.

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3. Basis of Accounting

The Company follows accounting standards set by the Financial Accounting Standards Board ("FASB"). The FASB establishes accounting principles generally accepted in the United States ("GAAP") that the Company follows. Rules and interpretive releases of the Securities and Exchange Commission ("SEC") under authority of federal securities laws are also sources of authoritative GAAP for SEC registrants, which the Company is required to follow. References to GAAP issued by the FASB in these footnotes are to the FASB *Accounting Standards Codification* ("ASC"), which serves as a single source of authoritative non-SEC accounting and reporting standards to be applied by nongovernmental entities. The FASB finalized the ASC effective for periods ending on or after September 15, 2009. Prior FASB standards like FASB Statement of Accounting Standards and FASB Staff Positions are no longer being issued by the FASB.

4. Significant Accounting Policies

Foreign Currency Translation

The financial position and results of operations of WCG are measured using WCG's local currency (Canadian Dollar) as the functional currency. Revenues and expenses of WCG have been translated into U.S. dollars at average exchange rates prevailing during the period. Assets and liabilities have been translated at the rates of exchange on the balance sheet date. The resulting translation gain and loss adjustments are recorded directly as a separate component of stockholders' equity. At present and for the foreseeable future, the Company intends to reinvest any undistributed earnings of its foreign subsidiary in foreign operations. As a result, the Company is not providing for U.S. or additional foreign withholding taxes on its foreign subsidiary's undistributed earnings. Generally, such earnings become subject to U.S. tax upon the remittance of dividends and under certain other circumstances. It is not practicable to estimate the amount of unrecognized deferred tax liability for temporary differences that are essentially permanent in duration on such undistributed earnings.

Cash and Cash Equivalents

Cash and cash equivalents include all cash balances and highly liquid investments with an initial maturity of three months or less. Investments in cash equivalents are carried at cost, which approximates fair value. The Company places its temporary cash investments with high credit quality financial institutions. At times such investments may be in excess of the Federal Deposit Insurance Corporation (FDIC) and the Canada Deposit Insurance Corporation (CDIC) insurance limits.

At December 31, 2009 and 2010, approximately $4.4 million and $3.8 million, respectively, of cash was held by WCG and is not freely transferable without unfavorable tax consequences between the Company and WCG.

Restricted Cash

The Company had approximately $14.1 million and $16.4 million of restricted cash at December 31, 2009 and 2010 as follows:

	December 31,	
	2009	2010
Collateral for letters of credit—Contractual obligations	$ 418,000	$ 243,000
Contractual obligations	786,801	781,468
Subtotal restricted cash for contractual obligations	1,204,801	1,024,468
Collateral for letters of credit—Reinsured claims losses	4,041,000	4,808,921
Escrow—Reinsured claims losses	8,849,733	10,560,709
Subtotal restricted cash for reinsured claims losses	12,890,733	15,369,630
Total restricted cash	14,095,534	16,394,098
Less current portion	8,153,610	7,314,535
	$ 5,941,924	$ 9,079,563

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Of the restricted cash amount at December 31, 2009 and 2010:

- $418,000 and $243,000 served as collateral for irrevocable standby letters of credit that provide financial assurance that the Company will fulfill certain contractual obligations;
- approximately $787,000 and $781,000 was held to fund the Company's obligations under arrangements with various governmental agencies through the correctional services business acquired by the Company in 2006 ("Correctional Services");
- approximately $4.0 million and $4.8 million served as collateral for irrevocable standby letters of credit to secure any reinsured claims losses under the Company's general and professional liability and workers' compensation reinsurance programs and was classified as noncurrent assets in the accompanying consolidated balance sheets;
- approximately $1.6 million and $4.0 million was restricted and held in trust for reinsurance claims losses under the Company's general and professional liability reinsurance program; and
- approximately $7.2 million and $6.5 million was restricted in relation to our auto liability program.

At December 31, 2010, approximately $5.1 million, $4.0 million, $6.3 million and $250,000 of the restricted cash was held in custody by the Bank of Tucson, Wells Fargo, Fifth Third Bank and Bank of America, respectively. The cash is restricted as to withdrawal or use and is currently invested in certificates of deposit or short-term marketable securities. The remaining balance of approximately $781,000 is also restricted as to withdrawal or use, and is currently held in various non-interest bearing bank accounts related to Correctional Services.

Short-Term Investments

As part of its cash management program, the Company from time to time maintains short-term investments. These investments have a term to earliest maturity of less than one year and are comprised of certificates of deposit. These investments are carried at cost, which approximates market and are classified as "Prepaid expenses and other" in the accompanying consolidated balance sheets.

Derivative Instruments and Hedging Activities

The Company held a derivative financial instrument for the purpose of hedging interest rate risk. The type of risk hedged related to the variability of future earnings and cash flows caused by movements in interest rates applied to the Company's floating rate long-term debt. The Company documented its risk management strategy and hedge effectiveness at the inception of the hedge and continued to assess its effectiveness during the term of the hedge. The Company designated the interest rate swap as a cash flow hedge under ASC Topic 815-*Derivatives and Hedging* ("ASC 815").

Derivatives that have been designated and qualify as cash flow hedging instruments are reported at fair value. The Company measures hedge effectiveness by formally assessing, at least quarterly, the correlation of the expected future cash flows of the hedged item and the derivative hedging instrument. The gain or loss on the effective portion of the hedge (i.e. change in fair value) is reported as a component of accumulated other comprehensive loss. The remaining gain or loss of the ineffective portion of the hedge, if any, is recognized in earnings. The fair value of the cash flow hedging instrument was a liability of approximately $372,000 as of December 31, 2009, which was classified as "Interest rate swap" in the accompanying consolidated balance sheets. As of December 31, 2010, the Company did not have any hedging instruments.

Fair Value of Financial Instruments

The carrying amounts of cash and cash equivalents, restricted cash, accounts receivable, management fee receivable and accounts payable approximate their fair value because of the relatively short-term maturity of these

instruments. The fair value of the Company's long-term obligations is estimated based on interest rates for the same or similar debt offered to the Company having same or similar remaining maturities and collateral requirements. The carrying amount of the long-term obligations approximates its fair value.

Accounts Receivable and Allowance for Doubtful Accounts

Clients are referred to the Company through governmental social services programs and it only provides services at the direction of a payer under a contractual arrangement. These circumstances have historically minimized any uncollectible amounts for services rendered. However, the Company recognizes that not all amounts recorded as accounts receivable will ultimately be collected.

The Company records all accounts receivable amounts at their contracted amount, less an allowance for doubtful accounts. The Company maintains an allowance for doubtful accounts at an amount it estimates to be sufficient to cover the risk that an account will not be collected. The Company regularly evaluates its accounts receivable, especially receivables that are past due, and reassesses its allowance for doubtful accounts based on specific client collection issues. The Company pays particular attention to amounts outstanding for 365 days and longer. Any account receivable older than 365 days is generally deemed uncollectible and written off or fully reserved unless the Company has specific information from the payer that payment for those amounts is forthcoming or has other evidence which the Company believes supports that amounts older than 365 days will be collected. In circumstances where the Company is aware of a specific payer's inability to meet its financial obligation, the Company records a specific addition to its allowance for doubtful accounts to reduce the net recognized receivable to the amount the Company reasonably expects to collect.

Under certain of the Company's contracts, billings do not coincide with revenue recognized on the contract due to payer administrative issues. These unbilled accounts receivable represent revenue recorded for which no amount has been invoiced and for which the Company expects an invoice will not be provided to the payer within the normal billing cycle. Unbilled amounts are considered current when billed, which generally occurs within one year from the date of service.

The Company's write-off experience for each of the years ended December 31, 2008, 2009 and 2010 was approximately 1% of the Company's revenue.

Property and Equipment

Property and equipment are stated at historical cost, or at fair value if acquired by acquisition. Depreciation is provided using the straight-line method over the estimated useful life of the assets. Maintenance and repairs are charged to expense when they are incurred. Upon the disposition of any asset, its accumulated depreciation is deducted from the original cost, and any gain or loss is reflected in operating expense.

Impairment of Long-Lived Assets

Goodwill

The Company analyzes the carrying value of goodwill at the end of each fiscal year and between annual valuations if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying value. Such circumstances could include, but are not limited to: (1) a significant adverse change in legal factors or in business climate, (2) unanticipated competition, or (3) an adverse action or assessment by a regulator. In connection with its analysis of the carrying value of goodwill, the Company reconciles the aggregate fair value of its reporting units to the Company's market capitalization including a control premium that is reasonable within the context of industry data on premiums paid. When determining whether goodwill is impaired, the Company compares the fair value of the reporting unit to which the goodwill is assigned to the reporting unit's carrying amount, including goodwill. If the carrying amount of a reporting unit exceeds its fair value, then the amount of the impairment loss must be measured. The impairment loss would be calculated by

comparing the implied fair value of reporting unit goodwill to its carrying amount. In calculating the implied fair value of the reporting unit goodwill, the fair value of the reporting unit is allocated to all of the other assets and liabilities of that unit based on their fair values. The excess of the fair value of a reporting unit over the amount assigned to its other assets and liabilities is the implied fair value of goodwill. An impairment loss would be recognized when the carrying amount of goodwill exceeds its implied fair value. The Company's annual evaluation of goodwill completed as of December 31, 2010 resulted in no impairment loss.

Intangible assets subject to amortization

The Company separately values all acquired identifiable intangible assets apart from goodwill. The Company allocated a portion of the purchase consideration to customer relationships, developed technology, management contracts, restrictive covenants and software licenses acquired in the years 2006–2008 based on the expected direct or indirect contribution to future cash flows on a discounted cash flow basis over the useful life of the assets.

The Company assesses whether any relevant factors limit the period over which acquired assets are expected to contribute directly or indirectly to future cash flows for amortization purposes. With respect to acquired management contracts, the useful life is limited by the stated terms of the agreements. The Company determines an appropriate useful life for acquired customer relationships based on the expected period of time it will provide services to the payer.

While the Company uses discounted cash flows to value the acquisition of intangible assets, the Company has elected to use the straight-line method of amortization to determine amortization expense. If applicable, the Company assesses the recoverability of the unamortized balance of its long-lived assets based on undiscounted expected future cash flows. Should this analysis indicate that the carrying value is not fully recoverable, the excess of the carrying value over the fair value of any intangible asset is recognized as an impairment loss.

Accrued Transportation Costs

Transportation costs are estimated and accrued in the month the services are rendered by outsourced providers utilizing gross reservations for transportation services less cancellations and average costs per transportation service by customer contract. Average costs per contract are derived by utilizing historical cost trends. Actual costs relating to a specific accounting period are monitored and compared to estimated accruals. Adjustments to those accruals are made based on reconciliations with actual costs incurred. Accrued transportation costs amounted to approximately $40.9 million and $41.9 million at December 31, 2009 and 2010, respectively.

Deferred Financing Costs

The Company capitalizes direct expenses incurred in connection with its long-term debt obligations and amortizes them over the term of the respective debt agreements. The Company incurred approximately $10.6 million in deferred financing costs in connection with the credit facility with its senior creditor entered into in December 2007 and the amendment to the credit facility in March 2009, as described in note 13 below. In addition, the Company incurred approximately $2.3 million in deferred financing costs in connection with its senior subordinated notes issued in November 2007. Deferred financing costs are amortized to interest expense on a straight-line basis or the effective interest method over the term of the credit facility. Deferred financing costs, net of amortization, totaling approximately $7.5 million and $5.1 million at December 31, 2009 and 2010, are included in "Other assets" in the accompanying consolidated balance sheets.

Revenue Recognition

The Company recognizes revenue at the time services are rendered at predetermined amounts stated in its contracts and when the collection of these amounts is considered to be reasonably assured.

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At times the Company may receive funding for certain services in advance of services actually being rendered. These amounts are reflected in the accompanying consolidated balance sheets as deferred revenue until the actual services are rendered.

As services are rendered, documentation is prepared describing each service, time spent, and billing code under each contract to determine and support the value of each service provided. This documentation is used as a basis for billing under the Company's contracts. The billing process and documentation submitted under its contracts vary among payers. The timing, amount and collection of the Company's revenues under these contracts are dependent upon its ability to comply with the various billing requirements specified by each payer. Failure to comply with these requirements could delay the collection of amounts due to the Company under a contract or result in adjustments to amounts billed.

The performance of the Company's contracts is subject to the condition that sufficient funds are appropriated, authorized and allocated by each state, city or other local government. If sufficient appropriations, authorizations and allocations are not provided by the respective state, city or other local government, we are at risk of immediate termination or renegotiation of the financial terms of the Company's contracts.

Social Services segment

Fee-for-service contracts. Revenues related to services provided under fee-for-service contracts are recognized as revenue at the time services are rendered and collection is determined to be probable. Such services are provided at established billing rates.

Cost based service contracts. Revenues from the Company's cost based service contracts are recorded based on a combination of direct costs, indirect overhead allocations, and stated contractual margins on those incurred costs. These revenues are compared to annual contract budget limits and, depending on reporting requirements, allowances may be recorded for certain contingencies such as projected costs not incurred or excess cost per service over the allowable contract rate. This policy results in recognizing revenue from these contracts based on allowable costs incurred. The annual contract amount is based on projected costs to provide services under the contracts with adjustments for changes in the total contract amount. The Company annually submits projected costs for the coming year, which assist the contracting payers in establishing the annual contract amount to be paid for services provided under the contracts. After the contracting payers' year end, the Company submits cost reports which are used by the contracting payers to determine the amount, if any, by which funds paid to the Company for services provided under the contracts were greater than the allowable costs to provide these services. Completion of this review process may range from one month to several years from the date the Company submits the cost report. In cases where funds paid to the Company exceed the allowable costs to provide services under contract, the Company may be required to pay back the excess funds.

The Company's cost reports are routinely audited by payers on an annual basis. The Company periodically reviews its provisional billing rates and allocation of costs and provides for estimated adjustments from the contracting payers. The Company believes that adequate provisions have been made in its consolidated financial statements for any adjustments that might result from the outcome of any cost report audits. Differences between the amounts provided and the settlement amounts, which historically have not been material, are recorded in the Company's consolidated statement of operations in the year of settlement.

Annual block purchase contract. The Company's annual block purchase contract with The Community Partnership of Southern Arizona ("CPSA") requires it to provide or arrange for behavioral health services to eligible populations of beneficiaries as defined in the contract. The Company must provide a complete range of behavioral health clinical, case management, therapeutic and administrative services. The Company is obliged to provide services only to those clients with a demonstrated medical necessity. The annual funding allocation amount is subject to increase when the Company's encounters exceed the contract amount; however, such increases in the annual funding allocation amount are subject to government appropriation and may not be approved. There is no

contractual limit to the number of eligible beneficiaries that may be assigned to the Company, or a specified limit to the level of services that may be provided to these beneficiaries if the services are deemed to be medically necessary. Therefore, the Company is at-risk if the costs of providing necessary services exceed the associated reimbursement.

The Company is required to regularly submit service encounters to CPSA electronically. On an on-going basis and at the end of CPSA's June 30 fiscal year, CPSA is obligated to monitor the level of service encounters. If the encounter data is not sufficient to support the year-to-date payments made to the Company, unless waived, CPSA has the right to prospectively reduce or suspend payments to the Company.

For revenue recognition purposes, the Company's service encounter value (which represents the value of actual services rendered) must equal or exceed 90% of the revenue recognized under its annual block purchase contract for the contract year. The remaining 10% of revenue recognized in each reporting period represents payment for network overhead administrative costs incurred in order to fulfill the Company's obligations under the contract. Administrative costs include, but are not limited to, intake services, clinical liaison oversight for each behavioral health recipient, cultural liaisons, financial assessments and screening, data processing and information systems, staff training, quality and utilization management functions, coordination of care and subcontract administration.

The Company recognizes revenue from its annual block purchase contract corresponding to the service encounter value. If the Company's service encounter value is less than 90% of the amounts received from CPSA for the contract year, unless waived, the Company recognizes revenue equal to the service encounter value and records a liability for any excess amounts received. CPSA has not reduced, withheld, or suspended any material payments that have not been subsequently reimbursed. The Company believes its encounter data is sufficient to have earned all amounts recorded as revenue under this contract.

If the Company's service encounter value equals 90% of the amounts received from CPSA for the contract year, the Company recognizes revenue at the contract amount, which is one-twelfth of the established annual contract amount each month.

If the Company's service encounter value exceeds 90% of the contract amount, the Company recognizes revenue in excess of the annual funding allocation amount if collection is reasonably assured. The Company evaluates factors such as cash receipt and written confirmation regarding payment probability related to the determination of whether any such additional revenue over the contractual amount is considered to be reasonably assured. The terms of the contract may be reviewed prospectively and amended as necessary to ensure adequate funding of the Company's contractual obligations, however, we cannot guaranty that amendments will be completed.

Management agreements. The Company maintains management agreements with a number of not-for-profit social services organizations whereby it provides certain management services for these organizations. In exchange for the Company's services, the Company receives a management fee that is either based on a percentage of the revenues of these organizations or a predetermined fee.

The Company recognizes management fees revenue from its management agreements as such amounts are earned, as defined by the respective management agreements, and collection of such amount is considered reasonably assured.

The costs associated with generating the Company's management fee revenue are accounted for in client service expense and in general and administrative expense in the accompanying consolidated statements of operations.

NET Services segment

Capitation contracts. Approximately 89% of the Company's non-emergency transportation services revenue is generated under capitated contracts where the Company assumes the responsibility of meeting the transportation needs of a specific geographic population. Revenues under capitation contracts with the Company's payers result from per-member monthly fees based on the number of participants in its payer's program.

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Fee-for-service contracts. Revenues earned under fee-for-service contracts are recognized when the service is provided. Revenues under these types of contracts are based upon contractually established billing rates less allowance for contractual adjustments. Estimates of contractual adjustments are based upon payment terms specified in the related agreements.

Non-Controlling Interest

In connection with the Company's acquisition of WCG in August 2007, PSC of Canada Exchange Corp. ("PSC"), a subsidiary established by the Company to facilitate the purchase of all of the equity interest in WCG, issued 287,576 exchangeable shares as part of the purchase price consideration. The exchangeable shares were valued at approximately $7.8 million in accordance with the provisions of the purchase agreement ($7.6 million for accounting purposes). The shares are exchangeable at each shareholder's option, for no additional consideration, into shares of the Company's common stock on a one-for-one basis ("Exchangeable Shares"). Of the 287,576 Exchangeable Shares, 25,882 were exchanged as of December 31, 2010.

The Exchangeable Shares are non-participating such that they are not entitled to any allocation of income or loss of PSC. The Exchangeable Shares represent ownership in PSC and are accounted for as "Non-controlling interest" included in stockholders' equity in the accompanying consolidated balance sheets in the amount of approximately $7.0 million at December 31, 2009 and 2010.

The Exchangeable Shares and the 25,882 shares of the Company's common stock issued upon the exchange of the same number of Exchangeable Shares noted above are subject to a Settlement and Indemnification Agreement dated November 17, 2009 ("Indemnification Agreement") by and between the Company and the sellers of WCG. The Indemnification Agreement secures the Company's claims for indemnification and associated rights and remedies provided by the Share Purchase Agreement (under which the Company acquired all of the equity interest in WCG on August 1, 2007) arising from actions taken by British Columbia to strictly enforce a contractually imposed revenue cap on a per client basis and contractually mandated pass-throughs subsequent to August 1, 2007. The actions taken by British Columbia resulted in an approximate CAD $3.0 million dispute and termination of one of its six provincial contracts with WCG, which the Company is disputing. Under the Indemnification Agreement, the sellers have agreed to transfer their rights to the Exchangeable Shares and 25,882 shares of the Company's common stock issued upon the exchange of the same number of Exchangeable Shares to the Company to indemnify the Company against any losses suffered by the Company as the result of an unfavorable ruling upon the conclusion of arbitration.

Effective April 14, 2010, an arbitrator issued an award with respect to the dispute between WCG and British Columbia regarding British Columbia's actions to strictly enforce a contractually imposed revenue cap on a per client basis and contractually mandated pass-throughs subsequent to August 1, 2007. Under the arbitration award, essentially all amounts disputed shall be paid to WCG (except for approximately CAD $13,000 which will be subject to the terms of the Indemnification Agreement) plus interest. The award affirmed the termination of one of the six provincial contracts that had been terminated effective October 31, 2008. During the second quarter of 2010, British Columbia filed a petition for leave to appeal the arbitration award. There is no financial statement impact related to these events included in our financial results for the year ended December 31, 2010. The petition for leave to appeal is still pending at December 31, 2010.

Stock-Based Compensation

The Company follows the fair value recognition provisions of ASC Topic 718-*Compensation-Stock Compensation* ("ASC 718"), which requires companies to measure and recognize compensation expense for all share based payments at fair value.

Other Comprehensive Loss

Other comprehensive loss is defined as the change in equity of a business during a period from transactions and other events and circumstances from non-owner sources, including foreign currency translation adjustments. Other

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comprehensive loss was derived from foreign currency translation adjustments and the change in fair value of the Company's interest rate swap (as more fully described in note 14 below). The components of the ending balances of accumulated other comprehensive loss are as follows:

	December 31,	
	2009	2010
Cumulative foreign currency translation adjustments	$ (1,504,602)	$ (880,814)
Unrealized losses on cash flow derivative hedges, net	(170,970)	—
	$ (1,675,572)	$ (880,814)

Income Taxes

Deferred income taxes are determined by the liability method in accordance with ASC Topic 740-*Income Taxes* ("ASC 740"). Under this method, deferred tax assets and liabilities are determined based on differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes and are measured using the enacted tax rates and laws that will be in effect when the differences are expected to reverse. The Company records a valuation allowance which includes amounts for state net operating loss carryforwards, as more fully described in note 21 below, for which the Company has concluded that it is more likely than not that these net operating loss carryforwards will not be realized in the ordinary course of operations. The Company recognizes interest and penalties related to income taxes as a component of income tax expense.

Loss Reserves for Certain Reinsurance and Self-funded Insurance Programs

The Company reinsures a substantial portion of its general and professional liability and workers' compensation costs under reinsurance programs though the Company's wholly-owned subsidiary Social Services Providers Captive Insurance Company ("SPCIC"). SPCIC is a licensed captive insurance company domiciled in the State of Arizona. SPCIC maintains reserves for obligations related to the Company's reinsurance programs for its general and professional liability and workers' compensation coverage.

SPCIC reinsures third-party insurers for general and professional liability exposures for the first dollar of each and every loss up to $1.0 million per loss and $5.0 million in the aggregate. Additionally, SPCIC reinsures a third-party insurer for worker's compensation insurance for the first dollar of each and every loss up to $250,000 per occurrence with a $6.0 million annual policy aggregate limit. As of December 31, 2009 and 2010, the Company had reserves of approximately $4.6 million and $6.8 million, respectively, for the general and professional liability and workers' compensation programs. The reserves are classified as "Reinsurance liability reserve" and "Other long-term liabilities" in the accompanying consolidated balance sheets.

In addition, the Company owns Provado Insurance Services, Inc. ("Provado"), which is a licensed captive insurance company domiciled in the State of South Carolina. Provado has historically provided reinsurance for policies written by a third party insurer for general liability, automobile liability, and automobile physical damage coverage to various members of the network of subcontracted transportation providers and independent third parties within the Company's NET Services operating segment. Effective February 15, 2011, Provado does not intend to renew its reinsurance agreement and will not assume liabilities for policies incepting after that date. It will continue to administer existing policies for the foreseeable future and resolve remaining and future claims related to these policies.

Under a reinsurance agreement with a third party insurer, Provado reinsures the third party insurer for the first $250,000 of each loss for each line of coverage, subject to an annual aggregate equal to 107.7% of gross written premium, and certain claims in excess of $250,000 to an additional aggregate limit of $1.1 million. Provado maintains reserves for obligations related to the reinsurance programs for general liability, automobile liability, and automobile physical damage coverage. As of December 31, 2009 and 2010, Provado had reserves of approximately $7.2 million and $6.5 million, respectively. The reserves are classified as "Reinsurance liability reserve" in the accompanying consolidated balance sheets.

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These reserves are reflected in the Company's consolidated balance sheets as reinsurance liability reserves. The Company utilizes analyses prepared by third party administrators and independent actuaries based on historical claims information with respect to the general and professional liability coverage, workers' compensation coverage, automobile liability, automobile physical damage, and health insurance coverage to determine the amount of required reserves.

The Company also maintains a self-funded health insurance program with a stop-loss umbrella policy with a third party insurer to limit the maximum potential liability for individual claims to $200,000 per person and for a maximum potential claim liability based on member enrollment. With respect to this program, the Company considers historical and projected medical utilization data when estimating its health insurance program liability and related expense. As of December 31, 2009 and 2010, the Company had approximately $1.6 million and $1.3 million, respectively, in reserve for its self-funded health insurance programs. The reserves are classified as "Reinsurance liability reserve" in the accompanying consolidated balance sheets.

The Company continually analyzes its reserves for incurred but not reported claims, and for reported but not paid claims related to its reinsurance and self-funded insurance programs. The Company believes its reserves are adequate. However, significant judgment is involved in assessing these reserves such as assessing historical paid claims, average lags between the claims' incurred date, reported dates and paid dates, and the frequency and severity of claims. The Company is at risk for differences between actual settlement amounts and recorded reserves and any resulting adjustments are included in expense once a probable amount is known. There were no significant adjustments recorded in the periods covered by this report. Any significant increase in the number of claims or costs associated with claims made under these programs above the Company's reserves could have a material adverse effect on its financial results.

5. Concentration of Credit Risk

Contracts with governmental agencies and other entities that contract with governmental agencies accounted for approximately 85%, 82% and 81% of the Company's revenue for the years ended December 31, 2008, 2009 and 2010, respectively. The related contracts are subject to possible statutory and regulatory changes, rate adjustments, administrative rulings, rate freezes and funding reductions. Reductions in amounts paid under these contracts for the Company's services or changes in methods or regulations governing payments for the Company's services could materially adversely affect its revenue and profitability.

For the years ended December 31, 2008, 2009 and 2010, the Company conducted a portion of its operations in Canada through WCG. At December 31, 2009 and 2010, approximately $13.9 million, or 22.2%, and $13.8 million, or 15.6%, of the Company's net assets, respectively, were located in Canada. Additionally, approximately $28.0 million, or 4.0%, $22.5 million, or 2.8%, and $22.2 million, or 2.5%, of the Company's consolidated revenue for the years ended December 31, 2008, 2009 and 2010, respectively, was generated from the Company's Canadian operations. The Company is subject to the risks inherent in conducting business across national boundaries, any one of which could adversely impact its business. In addition to currency fluctuations, these risks include, among other things: (i) economic downturns; (ii) changes in or interpretations of local law, governmental policy or regulation; (iii) restrictions on the transfer of funds into or out of the country; (iv) varying tax systems; (v) delays from doing business with governmental agencies; (vi) nationalization of foreign assets; and (vii) government protectionism. The Company intends to continue to evaluate opportunities to establish additional operations in Canada. One or more of the foregoing factors could impair the Company's current or future operations and, as a result, harm its overall business.

6. Use of Estimates

The Company has made a number of estimates relating to the reporting of assets and liabilities, revenues and expenses and the disclosure of contingent assets and liabilities to prepare these consolidated financial statements in conformity with GAAP. The Company based its estimates on historical experience and on various other assumptions the Company believes to be reasonable under the circumstances.

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However, actual results may differ from these estimates under different assumptions or conditions. Some of the more significant estimates impact revenue recognition, accounts receivable and allowance for doubtful accounts, accounting for business combinations, goodwill and other intangible assets, accrued transportation costs, accounting for management agreement relationships, loss reserves for reinsurance and self-funded insurance programs, stock-based compensation, foreign currency translation, derivative instruments and hedging activities and income taxes.

7. New and Pending Accounting Pronouncements

New Accounting Pronouncements

In January 2010, the FASB issued ASU 2010-06-*Fair Value Measurements and Disclosures (Topic 820): Improving Disclosures about Fair Value Measurements* ("ASU 2010-06"). ASU 2010-06 amends certain disclosure requirements of Subtopic 820-10 and provides additional disclosures for transfers in and out of Levels I and II and for activity in Level III. This ASU also clarifies certain other existing disclosure requirements including level of desegregation and disclosures around inputs and valuation techniques. The final amendments to the ASC will be effective for annual or interim reporting periods beginning after December 15, 2009, except for the requirement to provide the Level 3 activity for purchases, sales, issuances, and settlements on a gross basis. That requirement will be effective for fiscal years beginning after December 15, 2010, and for interim periods within those fiscal years. Early adoption is permitted. ASU 2010-06 does not require disclosures for earlier periods presented for comparative purposes at initial adoption. The Company adopted ASU 2010-06 as of January 1, 2010 with respect to the provisions required to be adopted as of January 1, 2010. The adoption of these provisions of ASU 2010-06 did not have a material impact on the Company's consolidated financial statements. The Company does not believe that the provisions of ASU 2010-06 that are effective for fiscal years beginning after December 15, 2010 will have a material impact on the Company's consolidated financial statements.

In February 2010, the FASB issued ASU No. 2010-08-*Technical Corrections to Various Topics* ("ASU 2010-08"). ASU 2010-08 is the result of the FASB's review of its standards to determine if any provisions are outdated, contain inconsistencies, or need clarifications to reflect the FASB's original intent. The FASB believes the amendments do not fundamentally change U.S. GAAP. However, certain clarifications on embedded derivatives and hedging (Subtopic 815-15) may cause a change in the application of that Subtopic and special transition provisions are provided for those amendments. The ASU contains various effective dates. The clarifications of the guidance on embedded derivatives and hedging (Subtopic 815-15) are effective for fiscal years beginning after December 15, 2009. The amendments to the guidance on accounting for income taxes in a reorganization (Subtopic 852-740) applies to reorganizations for which the date of the reorganization is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. All other amendments are effective as of the first reporting period (including interim periods) beginning after February 2, 2010. On January 1, 2010, the Company adopted ASU 2010-08. The adoption of ASU 2010-08 did not have a material impact on the Company's consolidated financial statements.

Pending Accounting Pronouncements

In December 2010, the FASB issued ASU No. 2010-28-*Intangibles—Goodwill and Other (Topic 350): When to Perform Step 2 of the Goodwill Impairment Test for Reporting Units with Zero or Negative Carrying Amounts* ("ASU 2010-28"). The amendments in this ASU modify Step 1 of the goodwill impairment test for reporting units with zero or negative carrying amounts. For those reporting units, an entity is required to perform Step 2 of the goodwill impairment test if it is more likely than not that a goodwill impairment exists. In determining whether it is more likely than not that a goodwill impairment exists, an entity should consider whether there are any adverse qualitative factors indicating that an impairment may exist. The qualitative factors are consistent with the existing guidance and examples, which require that goodwill of a reporting unit be tested for impairment between annual tests if an event occurs or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount. For public entities, the amendments in this ASU are effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. Early adoption is not permitted.

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The Company believes that ASU 2010-28 will not have a material impact on its consolidated financial statements.

In December 2010, the FASB issued ASU 2010-29-*Business Combinations (Topic 805): Disclosure of Supplementary Pro Forma Information for Business Combinations* ("ASU 2010-29"). The amendments in this ASU affect any public entity as defined by Topic 805, Business Combinations, that enters into business combinations that are material on an individual or aggregate basis. The amendments in this ASU specify that if a public entity presents comparative financial statements, the entity should disclose revenue and earnings of the combined entity as though the business combination(s) that occurred during the current year had occurred as of the beginning of the comparable prior annual reporting period only. The amendments also expand the supplemental pro forma disclosures to include a description of the nature and amount of material, nonrecurring pro forma adjustments directly attributable to the business combination included in the reported pro forma revenue and earnings. The amendments are effective prospectively for business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2010. Early adoption is permitted. The Company believes that ASU 2010-29 will not have a material impact on its consolidated financial statements.

Other accounting standards and exposure drafts, such as exposure drafts related to revenue recognition, leases, derivatives, comprehensive income and fair value measurements, that have been issued or proposed by the FASB or other standards setting bodies that do not require adoption until a future date are being evaluated by the Company to determine whether adoption will have a material impact on the Company's consolidated financial statements.

8. Fair Value Measurements

ASC Topic 820-*Fair Value Measurement and Disclosures* ("ASC 820") defines fair value as the exchange price that would be received for an asset or paid to transfer a liability in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. ASC 820 establishes a valuation hierarchy for disclosure of the inputs to valuation used to measure fair value. This hierarchy prioritizes the inputs into three broad levels as follows. Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities. Level 2 inputs are quoted prices for similar assets and liabilities in active markets or inputs that are observable for the asset or liability, either directly or indirectly through market corroboration, for substantially the full term of the financial instrument. Level 3 inputs are unobservable inputs based on the Company's assumptions used to measure assets and liabilities at fair value. A financial asset or liability's classification within the hierarchy is determined based on the lowest level input that is significant to the fair value measurement.

The following table provides the assets and liabilities carried at fair value measured on a recurring basis at December 31, 2009 and 2010:

		Fair Value Measurement Using		
	Total Carrying Value	Quoted prices in active markets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Interest rate swap at December 31, 2009	$ (372,408)	$ —	$ (372,408)	$ —
Interest rate swap at December 31, 2010	$ —	$ —	$ —	$ —

The Company's interest rate swap is carried at fair value measured on a recurring basis. The Company has elected to use the income approach to value the derivatives, using observable Level 2 market expectations at the measurement date and standard valuation techniques to convert future amounts to a single present amount assuming that participants are motivated, but not compelled to transact. Level 2 inputs for the swap valuations are limited to quoted prices for similar assets or liabilities in active markets (specifically futures contracts) and inputs other than quoted prices that are observable for the asset or liability (e.g., LIBOR cash and swap rates and credit risk at

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commonly quoted intervals as published by Bloomberg on the last day of the period for financial institutions with the same credit rating as the counterparty). Mid-market pricing is used as a practical expedient for fair value measurements. Key inputs, including the cash rates for short term, futures rates and swap rates beyond the derivative maturity are used to interpolate the spot rates at the three month rate resets specified by each swap. A credit default swap rate based on the current credit rating of the counterparty is applied to all cash flows when the swap is in an asset position. The Company uses the floating rate factor related to its variable rate debt (6.5%) to discount all cash flows when the derivative is in a liability position to reflect the potential credit risk to lenders.

9. Other Receivables

At December 31, 2009 and 2010, insurance premiums of approximately $3.3 million and $3.1 million, respectively, were receivable from third parties related to the reinsurance activities of the Company's two captive subsidiaries. The insurance premiums receivable is classified as "Other receivables" in the accompanying consolidated balance sheets. In addition, the Company's expected losses related to workers' compensation and general and professional liability in excess of the Company's liability under its associated reinsurance programs at December 31, 2009 were approximately $2.3 million, of which approximately $805,000 was classified as "Other receivables" and approximately $1.5 million was classified as "Other assets" in the accompanying consolidated balance sheets. The Company's expected losses related to workers' compensation and general and professional liability in excess of the Company's liability under its associated reinsurance programs at December 31, 2010 were approximately $2.9 million, of which approximately $698,000 was classified as "Other receivables" and approximately $2.2 million was classified as "Other assets" in the accompanying consolidated balance sheets. The Company recorded a corresponding liability, which offset these expected losses. This liability was classified as "Reinsurance liability reserve" in current liabilities and "Other long-term liabilities" in the accompanying consolidated balance sheets.

10. Prepaid Expenses and Other

Prepaid expenses and other comprised the following:

	December 31,	
	2009	2010
Prepaid payroll	$ 2,578,670	$ 2,411,556
Prepaid insurance	2,242,499	3,365,500
Prepaid taxes	1,576,956	2,889,515
Prepaid rent	743,402	828,807
Provider advances	83,265	279,068
Prepaid maintenance agreements and copier leases	634,474	707,672
Prepaid bus tokens and passes	1,076,377	992,432
Prepaid commissions and brokerage fees	608,566	523,680
Interest receivable—certificates of deposit	889,156	1,009,888
Other	2,006,248	2,470,103
Total prepaid expenses and other	$ 12,439,613	$ 15,478,221

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11. Goodwill and Intangibles

Changes in goodwill were as follows:

	Social Services	NET Services	Consolidated Total
Balances at December 31, 2008			
Goodwill	$ 78,285,906	$ 191,185,511	$ 269,471,417
Accumulated impairment losses	(60,700,851)	(96,000,000)	(156,700,851)
	17,585,055	95,185,511	112,770,566
AW working capital true-up and other adjustments	554,078	—	554,078
WCG foreign currency translation adjustment	317,672	—	317,672
CCC additional acquisition costs	1,151	—	1,151
Safecar Services, LLC acquisition	—	29,478	29,478
Balances at December 31, 2009			
Goodwill	79,158,807	191,214,989	270,373,796
Accumulated impairment losses	(60,700,851)	(96,000,000)	(156,700,851)
	18,457,956	95,214,989	113,672,945
WCG foreign currency translation adjustment	110,444	—	110,444
Balances at December 31, 2010			
Goodwill	79,269,251	191,214,989	270,484,240
Accumulated impairment losses	(60,700,851)	(96,000,000)	(156,700,851)
	$ 18,568,400	$ 95,214,989	$ 113,783,389

When the Company acquires a business the Company's pricing is typically based upon a multiple of the target entity's historical earnings before interest, taxes, depreciation and amortization ("EBITDA") and over the years the Company has been a successful competitor using this basis for determining the value of and price paid for its acquisitions. The Company believes this pricing method is also used by its competitors to value their business combinations and is typical in the mergers and acquisition market. During the six months ended December 31, 2008, the Company believed the market for mergers and acquisitions deteriorated such that by the end of 2008, the EBITDA multiples being used to price acquisitions had dropped to approximately half of what they had been for the Company historically. In addition, during the six months ended December 31, 2008, the Company had a significant and sustained decline in market capitalization due to the decrease in the market price of its common stock. The Company believes this decrease in stock price resulted primarily from its lower than anticipated financial results during such period. These financial results were caused by significant changes in the climate of the Company's business, the uncertainty in the state governmental payer environment, the impact of related budgetary decisions, and by the sharp down turn in the United States economy generally. The $169.9 million non-cash asset impairment charge recorded by the Company for the year ended December 31, 2008, all of which was recorded during the six months ended December 31, 2008, reflects the magnitude of both the decline in its market capitalization and the deterioration of the mergers and acquisitions market (including peer group guideline company multiples of EBITDA) during that six-month period, all as explained further below.

In connection with the Company's annual asset impairment analysis, the Company reduced the total aggregate fair value of its reporting units to reconcile it to the Company's substantially decreased market capitalization plus a reasonable control premium as of December 31, 2008. In subsequently determining whether or not the Company had goodwill impairment to report for 2008, the Company considered both a market-based valuation approach and an income-based valuation approach when estimating the fair values of its reporting units with goodwill balances as of such date. Under the market approach, the fair value of the reporting unit is determined using one or more methods based on current values in the market for similar businesses. Under the income approach, the fair value of the reporting unit is based on the cash flow streams expected to be generated by the reporting unit over an

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appropriate period and then discounting the cash flow to present value using an appropriate discount rate. The income approach is dependent on a number of significant management assumptions, including estimates of future revenue and expenses, growth rates and discount rates.

In arriving at the fair value of the reporting units in the Company's Social Services operating segment, greater weight was attributed to the market approach due to the continuing market deterioration reflected in current market comparables. For these reporting units, the Company weighted the market-based valuation results at 75% and the income-based valuation results at 25%. In arriving at the fair value for its NET Services operating segment, the Company used the indications of value received by it from potential acquirers of this segment as they represented prices that market participants were willing to offer for this reporting unit under the then current market conditions at that time.

As a result of the Company's annual impairment test, it recorded a total goodwill impairment charge for the year ended December 31, 2008 of $156.7 million, which is included in "Asset impairment charges" in the accompanying consolidated statements of operations. Of this non-cash impairment charge, approximately $60.7 million was related to the Company's Social Service operating segment and approximately $96.0 million was related to its NET Services operating segment.

The total amount of goodwill that was deductible for income tax purposes for acquisitions as of December 31, 2009 and 2010 was approximately $35.6 million and $35.8 million, respectively.

Intangible assets are comprised of acquired customer relationships, developed technology, management contracts, restrictive covenants and software licenses. The Company valued customer relationships and the management contracts acquired in these acquisitions based upon expected future cash flows resulting from the underlying contracts with state and local agencies to provide social services in the case of customer relationships, and management and administrative services provided to the managed entity with respect to the acquired management contract.

Intangible assets consisted of the following:

		December 31,			
		2009		2010	
	Estimated Useful Life	Gross Carrying Amount	Accumulated Amortization	Gross Carrying Amount	Accumulated Amortization
Management contracts	10 Yrs	$ 12,849,562	$ (6,169,122)	$ 12,849,562	$ (7,535,023)
Customer relationships	15 Yrs	75,487,152	(13,505,600)	75,698,777	(18,551,748)
Customer relationships	10 Yrs	1,417,000	(460,525)	1,417,000	(602,225)
Developed technology	6 Yrs	6,000,000	(2,067,204)	6,000,000	(3,067,204)
Software licenses	5 Yrs	801,708	(443,742)	824,549	(619,693)
Restrictive covenants	5 Yrs	144,209	(90,177)	144,678	(116,856)
Total	13.6 Yrs*	$ 96,699,631	$ (22,736,370)	$ 96,934,566	$ (30,492,749)

* Weighted-average amortization period

No significant residual value is estimated for these intangible assets. Amortization expense was approximately $8.2 million, $8.2 million and $7.7 million for the years ended December 31, 2008, 2009 and 2010, respectively. The total amortization expense is estimated to be approximately $7.7 million for 2011, $7.5 million for 2012, $7.3 million for 2013, $6.2 million for 2014 and $5.6 million for 2015, based on completed acquisitions as of December 31, 2010.

In connection with its annual asset impairment analysis conducted as of December 31, 2008, the Company determined that the same factors that required it to conduct goodwill impairment tests with respect to the

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Company's reporting units as of December 31, 2008 also required the Company to conduct impairment tests with respect to the other intangible assets in these reporting units. In conducting such tests, the Company compared the undiscounted cash flow associated with each such intangible asset over its remaining life to the carrying value of such asset. If there was an indication of impairment, a discounted cash flow analysis was performed to determine the fair value of the intangible asset as of December 31, 2008, which was then compared to its carrying value.

As a result of its annual impairment tests, the Company recorded a total asset impairment charge related to other intangible assets for the year ended December 31, 2008 of $13.2 million, which is included in "Asset impairment charges" in the accompanying consolidated statements of operations. This non-cash impairment charge includes the $11.0 million recorded with respect to the Company's NET Services operating segment as of September 30, 2008 and the $2.2 million recorded with respect to its Social Services operating segment as of December 31, 2008.

12. Detail of Other Balance Sheet Accounts

Property and equipment consisted of the following:

	Estimated Useful Life	December 31, 2009	December 31, 2010
Land	—	$ 20,000	$ 754,702
Building	39 years	230,000	993,405
Furniture and equipment	3-7 years	25,571,835	33,384,132
		25,821,835	35,132,239
Less accumulated depreciation		14,655,563	18,731,132
		11,166,272	16,401,107

Depreciation expense was approximately $4.5 million, $4.7 million and $5.0 million for the years ended December 31, 2008, 2009 and 2010, respectively.

Accrued expenses consisted of the following:

	December 31, 2009	December 31, 2010
Accrued compensation	$ 18,168,094	$ 19,257,580
Income taxes payable	2,155,109	—
Accrued interest payable	1,528,605	823,402
Other	11,537,921	13,470,147
	$ 33,389,729	$ 33,551,129

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13. Long-Term Obligations

The Company's long-term obligations were as follows:

	December 31, 2009	December 31, 2010
5% unsecured, subordinated note to former stockholder of acquired company, interest payable semi-annually beginning December 2005 and all unpaid principal and any accrued and unpaid interest was paid in June 2010	$ 618,680	$ —
4% unsecured, subordinated note to former owner of acquired company, interest payable semi-annually beginning April 2008 with principal of $300,000 due April 2008, but withheld due to a dispute, and all remaining unpaid principal and any accrued and unpaid interest due April 2010, which was paid in April 2010	1,800,000	—
6.5% convertible senior subordinated notes, interest payable semi-annually beginning May 2008 with principal due May 2014	70,000,000	70,000,000
$30,000,000 revolving loan, LIBOR plus 6.5% (effective rate of 6.77% at December 31, 2010) through December 2012	—	—
$173,000,000 term loan, LIBOR plus 6.5% with principal and interest payable quarterly (as described below) through December 2013	131,794,580	112,303,772
	204,213,260	182,303,772
Less current portion	17,480,918	18,113,512
	$186,732,342	$164,190,260

The carrying amount of the long-term obligations approximated its fair value at December 31, 2009 and 2010. The fair value of the Company's long-term obligations was estimated based on interest rates for the same or similar debt offered to the Company having same or similar remaining maturities and collateral requirements.

Annual maturities of long-term obligations as of December 31, 2010 are as follows:

Year	Amount
2011	$ 18,113,512
2012	21,736,214
2013	72,454,046
2014	70,000,000
Total	$ 182,303,772

Convertible senior subordinated notes.

On November 13, 2007, the Company issued $70.0 million in aggregate principal amount of 6.5% Convertible Senior Subordinated Notes due 2014 (the "Notes"), under the amended note purchase agreement dated November 9, 2007 to the purchasers named therein. The proceeds of $70.0 million were initially placed into escrow and were released on December 7, 2007 to partially fund the cash portion of the purchase price of LogistiCare. The Notes are general unsecured obligations subordinated in right of payment to any existing or future senior debt including the Company's credit facility with CIT Capital Securities LLC ("CIT") described below.

In connection with the Company's issuance of the Notes, the Company entered into an Indenture between the Company, as issuer, and The Bank of New York Trust Company, N.A., as trustee (the "Indenture").

The Company will pay interest on the Notes in cash semiannually in arrears on May 15 and November 15 of each year beginning on May 15, 2008. The Notes will mature on May 15, 2014.

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The Notes are convertible, under certain circumstances, into common stock at a conversion rate, subject to adjustment as provided for in the Indenture, of 23.982 shares per $1,000 principal amount of Notes. This conversion rate is equivalent to an initial conversion price of approximately $41.698 per share. On and after the occurrence of a fundamental change (as defined below), the Notes will be convertible at any time prior to the close of business on the business day before the stated maturity date of the Notes. In the event of a fundamental change as described in the Indenture, each holder of the notes shall have the right to require the Company to repurchase the Notes for cash. A fundamental change includes among other things: (i) the acquisition in a transaction or series of transactions of 50% or more of the total voting power of all shares of the Company's capital stock; (ii) a merger or consolidation of the Company with or into another entity, merger of another entity into the Company, or the sale, transfer or lease of all or substantially all of the Company's assets to another entity (other than to one or more of the Company's wholly-owned subsidiaries), other than any such transaction (A) pursuant to which holders of 50% or more of the total voting power of the Company's capital stock entitled to vote in the election of directors immediately prior to such transaction have or are entitled to receive, directly or indirectly, at least 50% or more of the total voting power of the capital stock entitled to vote in the election of directors of the continuing or surviving corporation immediately after such transaction or (B) which is effected solely to change the jurisdiction of incorporation of the Company and results in a reclassification, conversion or exchange of outstanding shares of the Company's common stock into solely shares of common stock; (iii) if, during any consecutive two-year period, individuals who at the beginning of that two-year period constituted the Company's board of directors, together with any new directors whose election to the Company's board of directors or whose nomination for election by the Company's stockholders, was approved by a vote of a majority of the directors then still in office who were either directors at the beginning of such period or whose election or nomination for election was previously approved, cease for any reason to constitute a majority of the Company's board of directors then in office; (iv) if a resolution approving a plan of liquidation or dissolution of the Company is approved by its board of directors or the Company's stockholders; and (v) upon the occurrence of a termination of trading as defined in the Indenture.

The Indenture contains customary terms and provisions that provide that upon certain events of default, including, without limitation, the failure to pay amounts due under the Notes when due, the failure to perform or observe any term, covenant or agreement under the Indenture, or certain defaults under other agreements or instruments, occurring and continuing, either the trustee or the holders of not less than 25% in aggregate principal amount of the Notes then outstanding may declare the principal of the Notes and any accrued and unpaid interest through the date of such declaration immediately due and payable. Upon any such declaration, such principal, premium, if any, and interest shall become due and payable immediately. In the case of certain events of bankruptcy or insolvency relating to the Company or any significant subsidiary of the Company, the principal amount of the Notes together with any accrued interest through the occurrence of such event shall automatically become and be immediately due and payable without any declaration or other act of the Trustee or the holders of the Notes.

Credit facility.

The following disclosure is as of December 31, 2010. On March 11, 2011, the Company refinanced the senior credit facility described below. See note 24 below for additional information regarding the Company's long-term debt refinancing

On December 7, 2007, the Company entered into a Credit and Guaranty Agreement (the "Credit Agreement") with CIT Healthcare LLC, as administrative agent, Bank of America, N.A. and SunTrust Bank, as co-documentation agents, ING Capital LLC and Royal Bank of Canada, as co-syndication agents, other lenders party thereto, and CIT, as sole lead arranger and bookrunner. The Credit Agreement replaced the Company's previous credit facility with CIT Healthcare LLC.

The Credit Agreement, as amended, provided the Company with a senior secured first lien credit facility in aggregate principal amount of $203.0 million comprised of a $173.0 million, six year term loan and a $30.0 million, five year revolving credit facility ("Credit Facility"). On December 7, 2007, the Company borrowed the entire amount available under the term loan facility and used the proceeds of the term loan to (i) fund a portion of the purchase price paid by the Company to acquire LogistiCare; (ii) refinance all of the then existing indebtedness under its second amended loan agreement with CIT Healthcare LLC in the amount of approximately $17.3 million; and (iii) pay fees and expenses related to the acquisition of LogistiCare and the financing thereof. The revolving credit

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facility must be used to (i) provide funds for general corporate purposes of the Company; (ii) fund permitted acquisitions; (iii) fund ongoing working capital requirements; (iv) collateralize letters of credit; and (v) make capital expenditures.

The Credit Agreement contained customary representations and warranties, affirmative and negative covenants, yield protection, indemnities, expense reimbursement, material adverse change clauses, and events of default and other terms and conditions. In addition, the Company is required to maintain certain financial covenants under the amendment to the Credit Agreement described below. As of December 31, 2010, the Company was in compliance with all of the financial covenants under the amendment to the Credit Agreement. Further, the Company was prohibited from paying cash dividends if there was a default under the facility or if the payment of any cash dividends would result in default.

On March 11, 2009, the Company agreed with its creditors to amend certain terms in the Credit Agreement ("Amendment No. 1 to the Credit Agreement" and, together with the Credit Agreement, the "Amended Credit Agreement") to, among other things:

- decrease the revolving credit facility from $40 million to $30 million;
- increase the interest rate spread on the annual interest rate from LIBOR plus 3.5% to LIBOR plus 6.5% and, with respect to Base Rate Loans (as such terms are defined in the Credit Agreement), increase the interest rate spread on the annual interest rate from Base Rate plus 2.5% to Base Rate plus 5.5% effective March 11, 2009; provided the interest rate will be adjusted upwards and the Company will incur a fee if certain consolidated senior leverage ratios exceed the corresponding ratio ceilings set forth in Amendment No. 1 to the Credit Agreement determined as of September 30, 2009 and December 31, 2009;
- amend certain financial covenants to change the requirements to a level where the Company met the requirements for the fourth quarter of 2008 and would likely meet the requirements for the fiscal year 2009;
- establish a new financial covenant through December 31, 2009 based upon the Company's operations maintaining a minimum earnings before interest, taxes, depreciation and amortization level (as such term is defined in Amendment No. 1 to the Credit Agreement) commencing with the three months ending March 31, 2009; and,
- require the Company to deliver to the lenders monthly consolidated financial statements and a 13-week rolling cash flow forecast each week from the effective date of Amendment No. 1 to the Credit Agreement to December 31, 2009.

In exchange for the amendments described above, the Company paid an amendment fee to certain lenders equal to $565,000 (0.40% of the aggregate amount of the Revolving Commitment and Term Loan outstanding related to those lenders (as such terms are defined in the Amended Credit Agreement)), which was capitalized as deferred financing fees and is included in "Other assets" in the accompanying consolidated balance sheet at December 31, 2009. In addition, in connection with this transaction, the Company incurred fees and expenses of approximately $2.0 million, including arrangement, legal, accounting and other related costs. These fees and expenses are reflected in "General and administrative expense" in the amount of approximately $1.7 million and "Interest expense" in the amount of approximately $348,000 in the accompanying consolidated statement of operations for the year ended December 31, 2009. The Company determined that the amendment did not represent a substantial modification of terms of the agreement.

Under the Amended Credit Agreement the outstanding principal amount of the loans accrued interest at the per annum rate of LIBOR plus 6.5% or the Base Rate plus 5.5% at the Company's election. The Company was permitted, from time-to-time, request to convert the loan (whether borrowed under the term loan facility or the revolving credit facility) from a Base Rate Loan (subject to the per annum rate of the Base Rate plus 5.5%) to a LIBOR Loan (subject to the per annum rate of LIBOR plus 6.5%). The conversion to a LIBOR Loan had to have been selected for a period of one, two, three or six months with interest payable on the last day of the period selected except where a period of six months is selected by the Company interest is payable quarterly. If not renewed by the Company subject to CIT approval, the loan would automatically convert back to a Base Rate Loan at the end of the

conversion period. The interest rate applied to the Company's term loan at December 31, 2010 was 6.77%. In addition, the Company is subject to a 0.75% fee per annum on the unused portion of the available funds as well as other administrative fees. No amounts were borrowed under the revolving credit facility as of December 31, 2010, but the entire amount available under this facility may be allocated to collateralize certain letters of credit. As of December 31, 2009, there were five letters of credit in the amount of approximately $7.3 million and three letters of credit as of December 31, 2010 in the amount of approximately $3.7 million collateralized under the revolving credit facility. At December 31, 2009 and 2010, the Company's available credit under the revolving credit facility was $22.7 million and $26.3 million, respectively.

The Company's obligations under the Credit Facility were guaranteed by all of its present and future domestic subsidiaries (the "Guarantors") other than the Company's insurance subsidiaries and managed entities. The Company's and each Guarantors' obligations under the Credit Facility were secured by a first priority lien, subject to certain permitted encumbrances, on the Company's assets and the assets of each Guarantor, including a pledge of 100% of the issued and outstanding stock of the Company's domestic subsidiaries and 65% of the issued and outstanding stock of its first tier foreign subsidiaries. If an event of default occurred, including, but not limited to, failure to pay any installment of principal or interest when due, failure to pay any other charges, fees, expenses or other monetary obligations owing to CIT when due or particular covenant defaults, as more fully described in the Credit Agreement, the required lenders could have caused CIT to declare all unpaid principal and any accrued and unpaid interest and all fees and expenses immediately due. Under the Credit Agreement, the initiation of any bankruptcy or related proceedings would automatically cause all unpaid principal and any accrued and unpaid interest and all fees and expenses to become due and payable. In addition, it is an event of default under the Credit Agreement if the Company defaulted on any indebtedness having a principal amount in excess of $5.0 million.

Each extension of credit under the Credit Facility was conditioned upon: (i) the accuracy in all material respects of all representations and warranties in the definitive loan documentation; and (ii) there being no default or event of default at the time of such extension of credit. Under the repayment terms of the Credit Agreement, the Company is obligated to repay the term loan in quarterly installments on the last day of each calendar quarter, which commenced on March 31, 2008, so that the following percentages of the term loan borrowed on the closing date are paid as follows: 5% in 2008, 7.5% in 2009, 10% in 2010, 12.5% in 2011, 15% in 2012 and the remaining balance in 2013. With respect to the revolving credit facility, the Company was required to repay the outstanding principal balance and any accrued but unpaid interest by December 2012. The Company was permitted at any time and from time-to-time prepay the Credit Facility without premium or penalty, provided that it may not re-borrow any portion of the term loan repaid.

The Credit Facility also required the Company to prepay the loan in an aggregate amount equal to 100% of the net cash proceeds of any disposition, or, to the extent the applicable net cash proceeds exceed $500,000. Notwithstanding the foregoing, if at the time of the receipt or application of such net cash proceeds no default or event of default has occurred and was continuing and the Company delivered to the Administrative Agent a certificate, executed by the Company's chief financial officer, that it intended within three hundred sixty-five days after receipt thereof to use all or part of such net cash proceeds either to purchase assets used in the ordinary course of business of the Company and its subsidiaries or to make capital expenditures, the Company could use all or part of such net cash proceeds in the manner set forth in such certificate; provided, however, that, (A) any such net cash proceeds not so used within the period set forth in such certificate would have, on the first business day immediately following such period, be applied as a prepayment and (B) any assets so acquired would have been subject to the security interests under the collateral documents in the same priority (subject to permitted liens) as the assets subject to such disposition or involuntary disposition.

The Company agreed with CIT to subordinate its management fee receivable pursuant to management agreements established with the Company's managed entities, which have stand-alone credit facilities with CIT Healthcare LLC, to the claims of CIT in the event one of these managed entities defaults under its credit facility. During 2009, these entities obtained stand-alone credit facilities from other lenders and, as of December 31, 2009, none of these entities had stand-alone credit facilities with CIT Healthcare LLC. As a result, as of December 31, 2009 and 2010, the Company's management fee receivable related to these managed entities was not subject to the subordination agreement.

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Liquidity Matters

The Company's board of directors authorized an additional prepayment of $5.0 million of the Company's term loan debt under the Amended Credit Agreement in January 2010. The prepayment was made on January 11, 2010. The $5.0 million voluntary prepayment, in addition to regularly scheduled principal payments in the aggregate amount of $14.5 million during 2010, brought the balance of the Company's term loan to approximately $112.3 million at December 31, 2010.

The Credit Facility requires the Company to prepay an aggregate principal amount of the loan in an amount equal to 75% of its Excess Cash Flow, as defined, for each fiscal year. Excess Cash Flow is calculated based on the Company's consolidated net income plus decreases or minus increases in net working capital plus non-cash depreciation and amortization and other non-cash charges, minus capital expenditures, certain transaction fees and expenses related to the Company's acquisition of LogistiCare and the negotiation of the Credit Facility and the Notes, principal amortization with respect to capital leases, all regularly scheduled principal payments and voluntary principal prepayments under the Credit Facility and earn out payments related to completed acquisitions permitted by the lender as more fully described in the Amended Credit Agreement. For 2009, the Company prepaid an aggregate principal amount of approximately $4.1 million representing 75% of its Excess Cash Flow. Due to the refinancing of the Company's debt subsequent to December 31, 2010, the Excess Cash Flow calculation for 2010 was not performed. Additional information regarding the Company's long-term debt refinancing is included in note 24 below.

14. Interest Rate Swap

In February 2008, the Company entered into an interest rate swap to convert a portion of its floating rate long-term debt expense to fixed rate debt expense. The purpose of this instrument was to hedge the variability of the Company's future earnings and cash flows caused by movements in interest rates applied to its floating rate long-term debt. The Company held this derivative only for the purpose of hedging such risks, not for speculation. Under the swap agreement, the Company paid 3.026% and received three-month LIBOR on a notional amount of $86.5 million through February 2010. The Company designated the interest rate swap as a cash flow hedge under ASC 815. Prior to amending the Company's Credit Agreement, the Company anticipated that it would not be in compliance with certain financial covenants as of December 31, 2008. As a result, during the first quarter of 2009, the Company's long-term debt was converted from a LIBOR Loan to a Base Rate Loan in accordance with the terms of the Credit Agreement beginning February 27, 2009 through April 1, 2009. The swap was de-designated and all changes in the fair value of the swap from the last effective date (January 31, 2009) were recognized in earnings. Additionally, the balance in other comprehensive loss at January 31, 2009 was recognized to income ratably through the maturity date of the swap in February 2010. On March 31, 2009, the swap was re-designated as a cash flow hedge under ASC 815 and beginning April 2, 2009 the Company's long-term debt was converted from a Base Rate Loan to a LIBOR Loan.

Upon the expiration of the interest rate swap discussed above, the Company entered into a new interest rate swap to convert its floating rate long-term debt to fixed rate debt effective March 11, 2010. The purpose of this instrument is to hedge the variability of the Company's future earnings and cash flows caused by movements in interest rates applied to its floating rate long-term debt. The Company holds this derivative only for the purpose of hedging such risks, not for speculation. The Company entered into the interest rate swap with a notional amount of $63.4 million that matured on December 13, 2010. Under the swap agreement, the Company received interest equivalent to one-month LIBOR and payed a fixed rate of interest of .58% with settlement occurring monthly. The Company had designated the interest rate swap as a cash flow hedge under ASC 815. Additionally, the swap's effectiveness was evaluated monthly and effective gains and losses were accumulated in other comprehensive loss until the hedged interest expense was accrued.

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The fair value amounts in the consolidated balance sheet at December 31, 2009 and 2010, related to the Company's interest rate swap were as follows:

	Liability Derivatives		
	Balance Sheet Location	Fair Value of Swap Liability	
		December 31, 2009	December 31, 2010
Derivatives designated as hedging instruments under ASC 815			
Interest rate contracts	Interest rate swap	$ 372,408	$ —
Total derivatives designated as hedging instruments under ASC 815		$ 372,408	$ —
Total derivatives		$ 372,408	$ —

The derivative gains and losses in the consolidated statements of operations for the years ended December 31, 2009 and 2010, related to the Company's interest rate swap were as follows:

Derivatives in ASC 815 cash flow hedging relationship	Pretax loss recognized in Other Comprehensive Income on effective portion of derivative	Pretax loss on effective portion of derivative reclassified from Accumulated Other Comprehensive Loss into Income		Ineffective portion of gain (loss) on derivative recognized in Income	
	Amount	Location	Amount	Location	Amount
Interest rate contract for the year ended:					
December 31, 2009	$ (246,256)	Interest expense	$ (1,610,306)	Interest expense	$ (177,848)
December 31, 2010	$ (148,679)	Interest expense	$ (428,962)	Interest expense	$ 1,337

Derivatives not designated as hedging instruments under ASC 815	Location of amounts recognized in income on derivative	Amount of loss recognized in income on derivative
Interest rate contract for the year ended:		
December 31, 2009	Interest expense	$ (132,029)
December 31, 2010	Interest expense	$ —

Additional information regarding the Company's interest rate swap is included in notes 4 and 8 above.

15. Business Segments

The Company's operations are organized and reviewed by management along its services lines. The Company operates in two reportable segments: Social Services and NET Services. The Company operates these reportable segments as separate divisions and differentiates the segments based on the nature of the services they offer. The following describes each of the Company's segments and its corporate services area.

Social Services. Social Services includes government sponsored social services consisting of home and community based counseling, foster care and not-for-profit management services. Through Social Services the Company provides services to a common customer group, principally individuals and families. All of the operating

entities within Social Services follow similar operating procedures and methods in managing their operations and each operating entity works within a similar regulatory environment, primarily under Medicaid regulations. The Company manages the activities of Social Services by actual to budget comparisons within each operating entity rather than by comparison between entities. The Company's budget related to Social Services is prepared on an entity-by-entity basis which represents the aggregation of individual location operating budgets within each Social Services entity and is comprised of:

- Payer specific revenue streams based upon contracted amounts;
- Payroll and related employee expenses by position corresponding to the contracted revenue streams; and
- Other operating expenses such as facilities costs, employee training, mileage and communications in support of operations.

The actual operating contribution margins of the operating entities that comprise Social Services ranged from approximately 1.3% to 12.3% for the year ended December 31, 2010. The Company believes that the long term operating contribution margins of the operating entities that comprise Social Services will approximate between 8% and 12% as the respective entities' markets mature, the Company cross sells its services within markets, and standardizes its operating model among entities including acquisitions.

In evaluating the financial performance and economic characteristics of Social Services, the Company's chief operating decision maker regularly reviews the following types of financial and non-financial information for each operating entity within Social Services:

- Consolidated financial statements;
- Separate condensed financial statements for each individual operating entity versus their budget;
- Monthly non-financial statistical information;
- Productivity reports; and
- Payroll reports.

While the Company's chief operating decision maker evaluates performance in comparison to budget based on the operating results of the individual operating entities within Social Services, the operating entities are aggregated into one reporting segment for financial reporting purposes because the Company believes that the operating entities exhibit similar long term financial performance. In conjunction with the financial performance trends, the Company believes the similar qualitative characteristics of the operating entities it aggregates within Social Services and budgetary constraints of the Company's payers in each market provide a foundation to conclude that the entities that the Company aggregates within Social Services have similar economic characteristics. Thus, the Company believes the economic characteristics of its operating entities within Social Services meet the criteria for aggregation into a single reporting segment under ASC Topic 280, "*Segment Reporting*".

NET Services. NET Services includes managing the delivery of non-emergency transportation services. The Company operates NET Services as a separate division of the Company with operational management and service offerings distinct from the Company's Social Services operating segment. Financial and operating performance reporting is conducted at a contract level and reviewed weekly at both the operating entity level as well as the corporate level by the Company's chief operating decision maker. Gross margin performance of individual contracts is consolidated under the associated operating entity and direct general and administrative expenses are allocated to the operating entity.

Corporate. Corporate includes corporate accounting and finance, information technology, business development, compliance, marketing, internal audit, employee training, legal and various other overhead costs, all of which are directly allocated to the operating segments.

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Segment asset disclosures include property and equipment and other intangible assets. The accounting policies of the Company's segments are the same as those of the consolidated Company. The Company evaluates performance based on operating income. Operating income is revenue less operating expenses (including client service expense, cost of non-emergency transportation services, general and administrative expense and depreciation and amortization) but is not affected by other income/expense or by income taxes. Other income/expense consists principally of interest expense and interest income. In calculating operating income for each segment, general and administrative expenses incurred at the corporate level are allocated to each segment based upon their relative direct expense levels excluding costs for purchased services. All intercompany transactions have been eliminated.

The following table sets forth certain financial information attributable to the Company's business segments for the years ended December 31, 2008, 2009 and 2010. In addition, none of the segments have significant non-cash items other than depreciation, amortization and asset impairment charges in reported income.

	For the year ended December 31, 2008			
	Social Services(c)(d)	NET Services(e)	Corporate(a)(b)	Consolidated Total
Revenues	$ 310,529,499	$ 381,106,735	$ 34,036	$ 691,670,270
Depreciation and amortization	$ 5,534,242	$ 7,187,252	$ —	$ 12,721,494
Operating income (loss)	$ (50,975,738)	$ (98,374,986)	$ 34,036	$ (149,316,688)
Net interest expense (income)	$ (506,992)	$ 19,106,519	$ —	$ 18,599,527
Total assets	$ 153,891,688	$ 204,847,944	$ 6,923,601	$ 365,663,233
Capital expenditures	$ 1,470,170	$ 2,487,557	$ 706,280	$ 4,664,007

	For the year ended December 31, 2009			
	Social Services(c)	NET Services	Corporate(a)(b)	Consolidated Total
Revenues	$ 340,737,952	$ 460,275,314	$ —	$ 801,013,266
Depreciation and amortization	$ 6,443,423	$ 6,408,684	$ —	$ 12,852,107
Operating income	$ 24,219,690	$ 29,505,372	$ —	$ 53,725,062
Net interest expense (income)	$ (178,110)	$ 20,610,507	$ —	$ 20,432,397
Total assets	$ 148,459,757	$ 219,928,437	$ 14,718,472	$ 383,106,666
Capital expenditures	$ 1,606,453	$ 1,621,783	$ 471,149	$ 3,699,385

	For the year ended December 31, 2010			
	Social Services(c)	NET Services	Corporate(a)(b)	Consolidated Total
Revenues	$ 341,920,631	$ 537,776,026	$ —	$ 879,696,657
Depreciation and amortization	$ 6,193,718	$ 6,458,309	$ —	$ 12,652,027
Operating income	$ 10,121,320	$ 47,182,031	$ —	$ 57,303,351
Net interest expense (income)	$ (190,540)	$ 16,202,388	$ —	$ 16,011,848
Total assets	$ 148,305,013	$ 204,085,367	$ 34,543,115	$ 386,933,495
Capital expenditures	$ 1,734,495	$ 2,968,148	$ 5,563,301	$ 10,265,944

(a) Corporate costs have been allocated to the Social Services and NET Services operating segments.

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(b) Corporate assets as of December 31, 2009 and 2010 include cash totaling approximately $12.2 million and $27.0 million, property and equipment totaling approximately $1.3 million and $6.2 million, prepaid expenses of approximately $768,000 and $921,000, and other assets of approximately $403,000 and $450,000, respectively.
(c) Excludes intersegment revenues of approximately $182,000 for the years ended December 31, 2008 and 2009, and $671,000 for the year ended Decmeber 31, 2010, that have been eliminated in consolidation.
(d) Includes a non cash impairment charge to goodwill and certain intangible assets of approximately $60.7 million and $2.2 million, respectively.
(e) Includes a non cash impairment charge to goodwill and certain intangible assets of approximately $96.0 million and $11.0 million, respectively.

The following table details the Company's revenues, net income (loss) and long-lived assets by geographic location.

	For the year ended December 31, 2008		
	United States(a)(b)	Canada(a)(b)	Consolidated Total
Revenue	$ 663,712,020	$ 27,958,250	$ 691,670,270
Net loss	$ (149,039,617)	$ (6,565,056)	$ (155,604,673)
Long-lived assets	$ 199,787,519	$ 6,522,002	$ 206,309,521
	For the year ended December 31, 2009		
	United States(b)	Canada(b)	Consolidated Total
Revenue	$ 778,504,781	$ 22,508,485	$ 801,013,266
Net income	$ 20,572,881	$ 552,726	$ 21,125,607
Long-lived assets	$ 191,782,887	$ 7,019,591	$ 198,802,478
	For the year ended December 31, 2010		
	United States(b)	Canada(b)	Consolidated Total
Revenue	$ 857,507,678	$ 22,188,979	$ 879,696,657
Net income	$ 23,321,638	$ 305,005	$ 23,626,643
Long-lived assets	$ 189,961,245	$ 6,665,068	$ 196,626,313

(a) Includes a non-cash impairment charge of $163.6 million related to our domestic operations and $6.3 million related to our Canadian operations, respectively.
(b) The Social Services and NET Services operating segments, on an aggregate basis, derived approximately 14.2%, 14.2% and 12.8% of the Company's consolidated revenue from one payer for the years ended December 31, 2008, 2009 and 2010, respectively.

16. Stockholders' Equity

The Company's second amended and restated certificate of incorporation provides that the Company's authorized capital stock consists of 40,000,000 shares of common stock, $0.001 par value per share, and 10,000,000 shares of preferred stock, $0.001 par value per share.

During the year ended December 31, 2010, the Company granted a total of 437,711 ten-year options under the 2006 Long-Term Incentive Plan ("2006 Plan") to purchase the Company's common stock at exercise prices equal to

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the market value of the Company's common stock on the date of grant. The options were granted to non-employee directors of its board of directors, executive officers and certain key employees. The option exercise price for all options granted ranged from $15.73 to $17.35 and the options vest in three equal installments on the first, second and third anniversaries of the date of grant. The weighted-average fair value of the options granted during the year ended December 31, 2010 totaled $12.23 per share.

The Company granted a total of 74,101 shares of restricted stock to non-employee directors of its board of directors and executive officers during the year ended December 31, 2010. The awards vests in three equal installments on the first, second and third anniversaries of the date of grant. The weighted-average fair value of these awards totaled $16.88 per share.

During the year ended December 31, 2010, the Company issued 56,331 shares of its common stock in connection with the exercise of employee stock options under the 2006 Plan. In addition, during the year ended December 31, 2010, the Company issued 1,429 shares of its common stock in connection with the exercise of employee stock options under the Company's 1997 Stock Option and Incentive Plan ("1997 Plan"). The Company also issued 666 shares of its common stock to a non-employee director upon the vesting of certain restricted stock awards granted in 2009 under the Company's 2006 Plan.

At December 31, 2009 and 2010, there were 13,521,959 and 13,580,385 shares of the Company's common stock outstanding, respectively, (including 619,768 treasury shares at December 31, 2009 and 2010) and no shares of preferred stock outstanding.

The following table reflects the total number of shares of the Company's common stock reserved for future issuance as of December 31, 2010:

Shares of common stock reserved for:	
Exercise of stock options and restricted stock awards	1,767,068
Exchangeable shares issued in connection with the acquisition of WCG that are exchangeable into shares of the Company's common stock	261,694
Convertible senior subordinated notes	2,224,320
Total shares of common stock reserved for future issuance	4,253,082

Subject to the rights specifically granted to holders of any then outstanding shares of the Company's preferred stock, the Company's common stockholders are entitled to vote together as a class on all matters submitted to a vote of the Company's stockholders and are entitled to any dividends that may be declared by the Company's board of directors. The Company's common stockholders do not have cumulative voting rights. Upon the Company's dissolution, liquidation or winding up, holders of the Company's common stock are entitled to share ratably in the Company's net assets after payment or provision for all liabilities and any preferential liquidation rights of the Company's preferred stock then outstanding. The Company's common stockholders do not have preemptive rights to purchase shares of the Company's stock. The issued and outstanding shares of the Company's common stock are not subject to any redemption provisions and are not convertible into any other shares of the Company's capital stock. The rights, preferences and privileges of holders of the Company's common stock will be subject to those of the holders of any shares of the Company's preferred stock the Company may issue in the future.

On December 9, 2008, the Board declared a dividend of one preferred share purchase right (a "Right") for each outstanding share of the Company's common stock, par value $0.001 per share. The dividend was payable on December 22, 2008 (the "Record Date") to the stockholders of record on that date. Each Right entitles the registered holder to purchase from the Company one one-hundredth of a share of Series A Junior Participating Preferred Stock, par value $0.001 per share (the "Preferred Shares"), of the Company at a price of $15.00 per one one-hundredth of a Preferred Share, subject to adjustment. The description and terms of the Rights are set forth in the Preferred Stock Rights Agreement, dated December 9, 2008 (the "Rights Agreement"), between the Company and Computershare Trust Company, N.A., as Rights Agent, which provides for a stockholder rights plan.

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Initially, the Rights are attached to all outstanding shares of the Company's common stock and no separate Rights certificates will be issued until the distribution date (as defined in the Rights Agreement). The Rights are not exercisable until the distribution date. The Rights will expire on December 9, 2011, unless this date is amended or unless the Rights are earlier redeemed or exchanged by the Company. In addition, the Rights Agreement also provides that the Rights among other things: (i) will not become exercisable in connection with a qualified fully financed offer for any or all of the outstanding shares of the Company' s common stock (as described in the Rights Agreement); (ii) permit each holder of a Right to receive, upon exercise, shares of the Company's common stock with a value equal to twice that of the exercise price of the Right if 20% or more of the Company's outstanding common stock is acquired by a person or group; and (iii) in the event that the Company is acquired in a merger or other business combination transaction or 50% or more of its consolidated assets or earning power are sold after a person or group has acquired 20% or more of the Company's outstanding common stock, will allow each holder of a Right to receive, upon the exercise thereof at the then-current exercise price of the Right, that number of shares of common stock of the acquiring company, which at the time of such transaction will have a market value of two times the exercise price of the Right.

The number of outstanding Rights and the number of one one-hundredths of a Preferred Share to be issued upon exercise of each Right are subject to adjustment under certain circumstances. Because of the nature of the Preferred Shares' dividend, liquidation and voting rights, the value of the one one-hundredth interest in a Preferred Share purchasable upon exercise of each Right should approximate the value of one share of the Company's common stock. Until a Right is exercised, the holder thereof, as such, will have no rights as a stockholder of the Company, including, without limitation, the right to vote or to receive dividends. The Rights will not prevent a takeover of the Company. However, the Rights may cause substantial dilution to a person or group that acquires 20% or more of the Company's outstanding common stock. The Rights however, should not interfere with any merger or other business combination approved by the Board.

Effective as of October 9, 2009, the Board unanimously approved and adopted an amendment to the Rights Agreement ("Rights Amendment No. 1"). The principal purpose of Rights Amendment No. 1 is to revise the definition of a "qualified offer" and the related process by which stockholders can request, following the Company's receipt of a "qualified offer," that a special meeting be called to redeem the Rights issued pursuant to the Rights Agreement, to be consistent with additional published guidance that was issued by a leading proxy advisory firm subsequent to the adoption by the Board of the Rights Agreement. In addition, Rights Amendment No. 1 requires that any amendment to the Rights Agreement that extends its term shall be submitted for ratification by the Company's stockholders within one year of the adoption by the Board of such an amendment.

17. Stock-Based Compensation Arrangements

The Company provides stock-based compensation under the Company's 1997 Plan, 2003 Stock Option Plan ("2003 Plan") and 2006 Plan to employees, non-employee directors, consultants and advisors. These plans have contributed significantly to the success of the Company by providing for the grant of stock-based and other incentive awards to enhance the Company's ability to attract and retain employees, directors, consultants, advisors and others who are in a position to make contributions to the success of the Company and any entity in which the Company owns, directly or indirectly, 50% or more of the outstanding capital stock as determined by aggregate voting rights or other voting interests and encourage such persons to take into account the long-term interests of the Company and its stockholders through ownership of the Company's common stock or securities with value tied to the Company's common stock. The Company, upon stockholder approval of the 2006 Plan in 2006, replaced the 1997 Plan and 2003 Plan with the 2006 Plan. While all awards outstanding under the 1997 Plan and 2003 Plan remain in effect in accordance with their terms, no additional grants or awards will be made under either plan.

To achieve the purposes of the Company's stock-based compensation program described above, the 2006 Plan allows the flexibility to grant or award stock options, stock appreciation rights, restricted stock, unrestricted stock, stock units including restricted stock units and performance awards to eligible persons.

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Stock option awards granted under the 1997 Plan, 2003 Plan and 2006 Plan were generally ten year options granted at fair market value on the date of grant with time based vesting over a period determined at the time the options were granted, ranging from one to four years (which is equal to the requisite service period) prior to the acceleration of vesting noted below. The Company does not intend to pay dividends on unexercised options. New shares of the Company's common stock are issued when the options are exercised.

The following table summarizes the activity under the 1997 Plan, 2003 Plan and 2006 Plan as of December 31, 2010:

	Number of shares of the Company's common stock authorized for issuance	Number of shares of the Company's common stock remaining available for future grants	Number of shares of the Company's common stock subject to	
			Options	Stock Grants
1997 Plan	428,572	—	8,176	—
2003 Plan	1,400,000	—	701,366	—
2006 Plan	2,900,000(1)	644,183	982,091	75,435
Total	4,728,572	644,183	1,691,633	75,435

(1) On May 20, 2010, the Company's stockholders approved an amendment to the 2006 Plan to increase the number of shares of the Company's common stock authorized for issuance under the 2006 Plan by 1,100,000 shares from 1,800,000 shares to 2,900,000 shares.

The Company chose to follow the short-cut method prescribed by ASC 718 to calculate its pool of excess tax benefits available to absorb tax deficiencies recognized subsequent to the adoption of ASC 718 ("APIC pool"). There was no effect on the Company's financial results for 2008, 2009 or 2010 related to the application of the short-cut method to determine its APIC pool balance.

The Company calculates the fair value of stock options using the Black-Scholes-Merton option-pricing formula. Stock-based compensation expense for stock options granted prior to December 31, 2005 is not reflected in the Company's consolidated statements of operations for the years ended December 31, 2008, 2009 and 2010 as all of the outstanding stock options granted prior to December 31, 2005 were vested at December 31, 2005.

Stock-based compensation expense charged against income for stock options and stock grants awarded subsequent to December 31, 2005 (the date of acceleration of all of the then outstanding unvested stock options) for the year ended December 31, 2008 was based on the grant-date fair value adjusted for estimated forfeitures based on awards expected to vest in accordance with the provisions of ASC 718, and amounted to approximately $6.3 million (net of tax of $2.5 million). On December 30, 2008, the Compensation Committee of the Board approved, effective as of that date, the acceleration of the vesting dates of all outstanding unvested stock options and restricted stock awarded subsequent to December 31, 2005 to eligible employees, directors and consultants, including stock options and restricted stock granted to executive officers and non-employee directors, under the 2006 Plan; provided the equity holder was actively an employee, director or consultant of the Company on December 30, 2008. All other terms of the stock options and restricted stock remained the same. Stock-based compensation expense charged against income for stock options and stock grants awarded subsequent to December 30, 2008 for the years ended December 31, 2009 and 2010 was based on the grant-date fair value adjusted for estimated forfeitures based on awards expected to vest in accordance with the provisions of ASC 718 and totaled approximately $291,000 (net of tax of approximately $11,000) and $1.5 million (net of tax of approximately $156,000), respectively. ASC 718 requires forfeitures to be estimated at the time of grant and revised as necessary in subsequent periods if the actual forfeitures differ from those estimates.

For the years ended December 31, 2008, 2009 and 2010, the amount of excess tax benefits resulting from the exercise of stock options was approximately $185,000, $140,000 and $66,000, respectively. For the years ended

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December 31, 2008, 2009 and 2010, the Company had tax shortfalls resulting from the exercise of stock options of approximately $1.5 million, $45,000 and $176,000, respectively. The excess tax benefits resulting from the exercise of stock options are reflected as cash flows from financing activities for the years ended December 31, 2008, 2009 and 2010 in the accompanying consolidated statements of cash flows.

Prior to the acceleration of vesting in December 2008, stock-based compensation expense was amortized over the vesting period of three to four years with approximately 32% recorded as client services expense, and 68% as general and administrative expense in the Company's consolidated statements of operations for the year ended December 31, 2008. For stock-based compensation awards granted subsequent to December 30, 2008, the associated expense is amortized over the vesting period of three years with approximately 55% and 16% recorded as client services expense, 36% and 38% as cost of non-emergency transportation services and 9% and 46% as general and administrative expense in the Company's consolidated statements of operations for the years ended December 31, 2009 and 2010, respectively.

The following table summarizes the stock option activity for the year ended December 31, 2010:

	Year ended December 31, 2010			
	Number of Shares Under Option	Weighted-average Exercise Price	Weighted-average Remaining Contractual Term	Aggregate Intrinsic Value
Balance at beginning of period	1,428,876	$ 20.84		
Granted	437,711	16.50		
Exercised	(57,760)	8.16		
Forfeited or expired	(117,194)	23.20		
Outstanding at end of period	1,691,633	$ 19.99	6.6	$ 1,941,414
Vested or expected to vest at end of period	1,662,288	$ 20.07	6.5	$ 1,898,752
Exercisable at end of period	1,164,259	$ 22.02	5.4	$ 1,384,256

The weighted-average grant-date fair value for options granted, total intrinsic value and cash received by the Company related to options exercised during the years ended December 31, 2008, 2009 and 2010 were as follows:

	Year ended December 31,		
	2008	2009	2010
Weighted-average grant date fair value	$ 6.85	$ 8.52	$ 12.23
Options exercised:			
Total intrinsic value	$ 488,921	$ 460,471	$ 454,088
Cash received	$ 469,320	$ 149,667	$ 470,888

The following table summarizes the activity of the shares and weighted-average grant date fair value of the Company's non-vested common stock during the year ended December 31, 2010:

	Shares	Weighted-average grant date fair value
Non-vested at December 31, 2009	2,000	$ 13.07
Granted	74,101	$ 16.88
Vested	(666)	$ 13.07
Forfeited	—	$ —
Non-vested at December 31, 2010	75,435	$ 16.82

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Stock grants were not made prior to the approval of the 2006 Plan on May 25, 2006. The fair value of a non-vested stock grant is determined based on the closing market price of the Company's common stock on the date of grant.

As of December 31, 2010, there was approximately $5.7 million of unrecognized compensation cost related to non-vested stock-based compensation arrangements granted under the 2006 Plan. The cost is expected to be recognized over a weighted-average period of 2.3 years. The total fair value of shares vested was $10.0 million, $0 and $428,000 for the years ended December 31, 2008, 2009 and 2010, respectively.

The fair value of each stock option awarded during the years ended December 31, 2008, 2009 and 2010 was estimated on the date of grant using the Black-Scholes-Merton option-pricing formula and amortized over the option's vesting periods with the following assumptions:

	Year ended December 31,		
	2008	2009	2010
Expected dividend yield	0.0%	0.0%	0.0%
Expected stock price volatility	34.7%-89.3%	91.6%-95.7%	90.9%-91.2%
Risk-free interest rate	1.6%-3.5%	1.7%-2.7%	2.4%
Expected life of options (in years)	5-6	6	6

The risk-free interest rate was based on the U.S. Treasury security rate in effect as of the date of grant. The expected lives of options and the expected stock price volatility were based on the Company's historical data. Implied volatility was not considered due to the low volume of traded options on the Company's common stock.

18. Earnings (Loss) Per Share

The following table details the computation of basic and diluted earnings (loss) per share:

	Year ended December 31,		
	2008	2009	2010
Numerator:			
Net income (loss), basic	$(155,604,673)	$21,125,607	$23,626,643
Effect of Interest related to Convertible Debt	—	—	2,942,004
Net income (loss) available to common stockholders, diluted	$(155,604,673)	$21,125,607	$26,568,647
Denominator:			
Denominator for basic earnings (loss) per share—weighted-average shares	12,531,869	13,130,092	13,194,226
Effect of dilutive securities:			
Common stock options and restricted stock awards	—	81,301	91,550
Convertible Debt	—	—	1,678,740
Denominator for diluted earnings (loss) per share—adjusted weighted-average shares assumed conversion	12,531,869	13,211,393	14,964,516
Basic earnings (loss) per share	$ (12.42)	$ 1.61	$ 1.79
Diluted earnings (loss) per share	$ (12.42)	$ 1.60	$ 1.78

All potentially dilutive securities were anti-dilutive for purposes of computing diluted earnings per share for the year ended December 31, 2008 as the Company recorded a net loss available to common stockholders for this period. For the years ended December 31, 2009 and 2010, employee stock options to purchase 11 and 1,620 shares, respectively, of common stock were not included in the computation of diluted earnings per share as the exercise price of these options was greater than the average fair value of the common stock for the period and, therefore, the

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effect of these options would have been anti-dilutive. The effect of issuing 1,678,740 shares of common stock on an assumed conversion basis related to the Notes was not included in the computation of diluted earnings per share for the years ended December 31, 2008 and 2009 as it would have been antidilutive.

19. Leases

Capital leases

The Company has various capital leases related to office equipment. The cost of equipment under capital leases is included in the accompanying consolidated balance sheet at December 31, 2009 and 2010 as property and equipment and was approximately $75,000. Accumulated amortization of the leased vehicles and equipment at December 31, 2009 and 2010 was approximately $13,000 and $29,000, respectively. Amortization of assets under capital leases is included in depreciation and amortization expense in the consolidated statement of operations for the years ended December 31, 2008, 2009 and 2010. Capital lease obligations of approximately $65,000 and $51,000 as of December 31, 2009 and 2010, respectively, are included in "Accrued expenses" and "Other long-term liabilities" in the accompanying consolidated balance sheets.

Operating leases

The Company leases many of its operating and office facilities for various terms under non-cancelable operating lease agreements. The leases expire in various years and provide for renewal options. In the normal course of business, it is expected that these leases will be renewed or replaced by leases on other properties.

The operating leases provide for increases in future minimum annual rental payments based on defined increases in the Consumer Price Index, subject to certain minimum increases. Several of these lease agreements contain provisions for periods in which rent payments are reduced. The total amount of rental payments due over the lease term is being charged to rent expense on a straight-line basis over the term of the lease. The difference between rent expense recorded and the amount paid as of December 31, 2009 and 2010 was approximately $334,000 and $521,000, respectively, and was included in "Accrued expenses" in the accompanying consolidated balance sheets. Also, the lease agreements generally require the Company to pay executory costs such as real estate taxes, insurance, and repairs.

Future minimum payments under capital leases and non-cancelable operating leases with initial terms of one year or more consisted of the following at December 31, 2010:

	Capital Leases	Operating Leases
2011	$ 22,789	$ 14,058,806
2012	20,481	9,685,721
2013	15,376	7,207,838
2014	7,068	4,630,257
2015	—	2,854,570
Thereafter	—	4,299,454
Total future minimum lease payments	65,714	$ 42,736,646
Less: amount representing interest	14,343	
Present value of net minimum lease payments (including current portion of $15,476)	$ 51,371	

Rent expense related to operating leases was approximately $15.1 million, $16.8 million and $18.7 million, for the years ended December 31, 2008, 2009 and 2010, respectively.

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20. Retirement Plan

Social Services

The Company maintains qualified defined contribution plans under Section 401(k) of the Internal Revenue Code of 1986, as amended ("IRC"), for all employees of its Social Services operating segment as well as corporate personnel. The Company, at its discretion, may make a matching contribution to the plans. The Company's contributions to the plans were approximately $375,000, $399,000 and $391,000, for the years ended December 31, 2008, 2009 and 2010, respectively.

On August 31, 2007, the Board adopted The Providence Service Corporation Deferred Compensation Plan (the "Deferred Compensation Plan") for the Company's eligible employees and independent contractors or a participating employer (as defined in the Deferred Compensation Plan). Under the Deferred Compensation Plan participants may defer all or a portion of their base salary, service bonus, performance-based compensation earned in a period of 12 months or more, commissions and, in the case of independent contractors, compensation reportable on Form 1099. As of December 31, 2010, there were seven participants in the Deferred Compensation Plan.

NET Services

The Company maintains a qualified defined contribution plan under Section 401(k) of the IRC for all employees of its NET Services operating segment. Under this plan, the Company contributes an amount equal to 25% of the first 5% of participant elective contributions. At the end of each plan year, the Company may also make a contribution on a discretionary basis on behalf of participants who have made elective contributions for the plan year. In no event will participant shares of the Company's matching contribution exceed 1.25% of participants' compensation for the plan year. For the years ended December 31, 2008, 2009 and 2010, the Company made contributions to this plan totaling approximately $107,000, $213,000 and $124,000, respectively.

The Company also maintains a 409 (A) Deferred Compensation Rabbi Trust Plan for highly compensated employees of its NET Services operating segment. This plan was put in place to compensate for the inability of highly compensated employees to take full advantage of the Company's 401(k) plan. As of December 31, 2010, there were 15 highly compensated employees who participated in this plan.

21. Income Taxes

The federal and state income tax provision (benefit) is summarized as follows:

	Year ended December 31,		
	2008	2009	2010
Federal:			
Current	$ 287,101	$ 8,325,467	$ 13,487,468
Deferred	(10,274,362)	2,320,618	1,201,825
	(9,987,261)	10,646,085	14,689,293
State			
Current	$ 2,199,934	$ 1,913,762	$ 2,569,947
Deferred	(4,092,234)	(274,230)	277,554
	(1,892,300)	1,639,532	2,847,501
Foreign			
Current	$ (245,018)	$ (371,785)	$ 238,129
Deferred	(186,963)	253,226	(110,063)
	(431,981)	(118,559)	128,066
Total provision (benefit) for income taxes	$ (12,311,542)	$ 12,167,058	$ 17,664,860

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A reconciliation of the provision (benefit) for income taxes with amounts determined by applying the statutory U.S. federal income tax rate to income before income taxes is as follows:

	Year Ended December 31,		
	2008	2009	2010
Federal statutory rates	35%	35%	35%
Federal income tax at statutory rates	$ (58,790,996)	$ 11,652,434	$ 14,452,026
Goodwill impairment	46,634,045	—	—
Change in valuation allowance	54,165	95,501	347,775
State income taxes, net of federal benefit	(1,229,995)	635,692	1,850,876
Difference between federal statutory and foreign tax rate	29,340	(33,533)	(35,607)
Stock option expense	837,047	96,380	394,606
Meals and entertainment	95,619	92,587	76,413
Other	59,233	(372,003)	578,771
Provision (benefit) for income taxes	$ (12,311,542)	$ 12,167,058	$ 17,664,860
Effective income tax rate	7%	37%	43%

The Company's effective income tax rate for 2008 was significantly lower than 2009 and 2010. For 2008, approximately $133.2 million of the total goodwill impairment charge of approximately $156.7 million was not deductible for income tax purposes as the goodwill was related to the Company's acquisition of the equity interest in several businesses. As a result, the Company's effective income tax rate for 2008 decreased.

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Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of the Company's deferred tax assets and liabilities are as follows:

	December 31,	
	2009	2010
Deferred tax assets:		
Net operating loss carryforwards	$ 1,579,000	$ 1,337,000
Accounts receivable allowance	1,520,000	387,000
Property and equipment depreciation	292,000	418,000
Accrued items and prepaids	2,537,000	2,216,000
Nonqualified stock options	993,000	882,000
Interest rate swap	145,000	—
Deferred Rent	132,000	549,000
Deferred Financing Costs	—	469,000
Other	94,000	287,000
	7,292,000	6,545,000
Deferred tax liabilities:		
Prepaids	876,000	1,386,000
Property and equipment depreciation	1,602,000	2,910,000
Goodwill and intangibles amortization	12,138,000	11,021,000
Other	340,000	308,000
	14,956,000	15,625,000
Net deferred tax liabilities	(7,664,000)	(9,080,000)
Less valuation allowance	(518,000)	(866,000)
Net deferred tax liabilities	$ (8,182,000)	$ (9,946,000)
Current deferred tax assets, net of $340,000 and $463,000 valuation allowance for 2009 and 2010, respectively	$ 3,558,000	$ 1,634,000
Noncurrent deferred tax liabilities, net of $178,000 and $403,000 valuation allowance for 2009 and 2010, respectively	(11,740,000)	(11,580,000)
	$ (8,182,000)	$ (9,946,000)

At December 31, 2010, the Company had approximately $192,000 of federal net operating loss carryforwards which expire in years 2017 through 2025 and $28.7 million of state net operating loss carryforwards which expire as follows:

2012	$ 1,055,266
2013	501,952
2014	239,141
2015	272,449
Thereafter	26,650,707
	$ 28,719,515

As a result of statutory "ownership changes" (as defined for purposes of Section 382 of the IRC), the Company's ability to utilize its federal net operating losses is restricted. Realization is dependent on generating sufficient taxable income prior to expiration of the loss carryforwards. Although realization is not assured, management believes it is more likely than not that all of the deferred tax assets will be realized, to the extent they are not covered by a valuation allowance. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

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The net change in the total valuation allowance for the year ended December 31, 2010 was $348,000. The valuation allowance includes $17.4 million of state net operating loss carryforwards for which the Company has concluded that it is more likely than not that these net operating loss carryforwards will not be realized in the ordinary course of operations. The Company will continue to assess the valuation allowance and to the extent it is determined that the valuation allowance should be adjusted an appropriate adjustment will be recorded.

The Company recognized certain excess tax benefits related to stock option plans for the years ended December 31, 2008, 2009 and 2010 in the amount of $185,000, $140,000 and $66,000, respectively. Such benefits were recorded as a reduction of income taxes payable and an increase in additional paid-in-capital and are included in "Exercise of employee stock options" in the accompanying statements of stockholders' equity and comprehensive income (loss).

The Company recognized a tax shortfall related to stock option plans for the years ended December 31, 2008, 2009 and 2010 in the amount of $1.5 million, $45,000 and $242,000, respectively. This was recorded as a reduction of deferred tax assets and a decrease to additional paid-in-capital and is included in "Exercise of employee stock options" in the accompanying statements of stockholders' equity and comprehensive income (loss).

The Company expects approximately $153,000 of the unrecognized tax benefits to be recognized during the next twelve months. The Company recognizes interest and penalties as a component of income tax expense. During the years ended December 31, 2008, 2009 and 2010, the Company recognized approximately $0, $7,000 and ($2,000), respectively, in interest and penalties. The Company had approximately $7,000 and $5,000 for the payment of penalties and interest accrued as of December 31, 2009 and 2010. A reconciliation of the liability for unrecognized income tax benefit is as follows:

	December 31,		
	2008	2009	2010
Unrecognized tax benefits, beginning of year	$ —	$ 169,000	$ 119,000
Increase (decrease) related to prior year positions	169,000	(44,000)	54,000
Increase related to current year tax positions	—	—	—
Settlements	—	(6,000)	—
Unrecognized tax benefits, end of year	$ 169,000	$ 119,000	$ 173,000

The total amount of unrecognized tax benefits that, if recognized, would favorably affect the effective tax rate in future periods was approximately $11,000 as of December 31, 2010.

The Company is subject to taxation in the United States, Canada and various state jurisdictions. The statute of limitations is generally three years for the United States, four years for Canada, and between eighteen months and four years for states. The Company is subject to the following material taxing jurisdictions: United States, Canada, California, Philadelphia and Virginia. The tax years that remain open for examination by the United States, Philadelphia and Virginia jurisdictions are years ended December 31, 2007, 2008, 2009 and 2010; the California filings that remain open to examination are years ended December 31, 2006, 2007, 2008, 2009 and 2010.

Residual United States income taxes have not been provided on undistributed earnings of the Company's foreign subsidiary. These earnings are considered to be indefinitely reinvested and, accordingly, no provision for United States federal and state income taxes has been provided thereon. Upon distribution of those earnings in the form of dividends or otherwise, the Company would be subject to both United States income taxes and withholding taxes payable to Canada less an adjustment for foreign tax credits. As of December 31, 2010 there were no undistributed earnings in the foreign subsidiary as it had cumulative losses.

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22. Commitments and Contingencies

The Company is involved in various claims and legal actions arising in the ordinary course of business. In the opinion of management, the ultimate disposition of these matters will not have a material adverse effect on the Company's consolidated financial position, results of operations, or liquidity.

The Company has two deferred compensation plans for management and highly compensated employees. These deferred compensation plans are unfunded; therefore, benefits are paid from the general assets of the Company. The total of participant deferrals, which is reflected in "Other long-term liabilities" in the accompanying consolidated balance sheets, was approximately $457,000 and $655,000 at December 31, 2009 and 2010, respectively.

The Company may be obligated to pay an amount up to $650,000 to the sellers under an earn out provision pursuant to a formula specified in an asset purchase agreement dated July 1, 2009 by which the Company acquired certain assets of an entity located in California. The earn out payment as such term is defined in the asset purchase agreement, if earned, will be paid in cash. The earn out period ends on December 31, 2013. If the contingency is resolved in accordance with the related provisions of the asset purchase agreement and the additional consideration becomes distributable, the Company will record the fair value of the consideration issued as an additional cost to acquire the associated assets, which will be charged to earnings.

23. Transactions with Related Parties

Mr. Geringer, one of the Company's directors, resigned from his position as a member of the Board on April 10, 2008. Prior to his resignation the following transaction was deemed to be a related party transaction. Mr. Geringer is a holder of capital stock and the non-executive chairman of the board of Qualifacts Systems, Inc. ("Qualifacts"). Qualifacts is a specialized healthcare information technology provider that entered into a software license, maintenance and servicing agreement with the Company. This agreement became effective on March 1, 2002 and was to continue for five years. Effective January 10, 2006, a new software license, maintenance and servicing agreement between the Company and Qualifacts was signed and continues for five years. This agreement replaces the agreement which began on March 1, 2002 and may be terminated by either party without cause upon 90 days written notice and for cause immediately upon written notice. The new agreement grants the Company access to additional software functionality and licenses for additional sites. Qualifacts provided the Company services and the Company incurred expenses in the amount of approximately $245,000 for the year ended December 31, 2008 under the agreement.

Upon the Company's acquisition of Maple Services, LLC in August 2005, Mr. McCusker, the Company's chief executive officer, Mr. Deitch, the Company's chief financial officer, and Mr. Norris, the Company's chief operating officer, became members of the board of directors of the not-for-profit organization (Maple Star Colorado, Inc.) formerly managed by Maple Services, LLC. Maple Star Colorado, Inc. is a non-profit member organization governed by its board of directors and the state laws of Colorado in which it is incorporated. Maple Star Colorado, Inc. is not a federally tax exempt organization and neither the Internal Revenue Service rules governing IRC Section 501(c)(3) exempt organizations, nor any other IRC sections applicable to tax exempt organizations, apply to this organization. The Company provided management services to Maple Star Colorado, Inc. under a management agreement for consideration in the amount of approximately $509,000, $292,000 and $270,000 for the years ended December 31, 2008, 2009 and 2010, respectively. Amounts due to the Company from Maple Star Colorado, Inc. for management services provided to it by the Company at December 31, 2009 and 2010 were approximately $281,000 and $237,000, respectively.

The Company is using a twin propeller KingAir airplane operated by Las Montanas Aviation, LLC for approved business travel purposes on an as needed basis subject to a joint operating agreement and regulated by Federal Aviation Administration Code of Federal Regulations 91:501. Las Montanas Aviation, LLC is owned by Mr. McCusker. The Company currently pays a flat fee of $9,000 per month plus incidental costs such as fuel and

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landing fees. For the years ended December 31, 2008, 2009 and 2010, the Company expensed amounts related to Las Montanas Aviation, LLC of approximately $76,000, $119,000 and $109,000, respectively, for use of the airplane for business travel purposes. The plane is available for use related to the Company's business only when commercial flights are not practical.

The Company operates a call center in Phoenix, Arizona. The building in which the call center is located is currently leased by the Company from VWP McDowell, LLC ("McDowell") under a five year lease that expires in 2014. Under the lease agreement, as amended, the Company may terminate the lease after the first 36 months of the lease term with a six month prior written notice. Certain members of Mr. Schwarz's (the chief executive officer of LogistiCare) immediate family have partial ownership interest in McDowell. In the aggregate these family members own approximately 13% interest in McDowell directly and indirectly through a trust. For 2009 and 2010, the Company expensed approximately $269,000 and $411,000, respectively, in lease payments to McDowell. Effective November 2009, the lease agreement was amended to provide additional office space resulting in increased rent expense for 2010 as compared to 2009. Future minimum lease payments due under the amended lease total approximately $1.6 million at December 31, 2010.

24. Subsequent Events

On March 11, 2011, the Company completed the refinancing of its Credit Facility. December 31, 2010 pro forma borrowings consist of the following:

	Actual December 31, 2010	Pro forma December 31, 2010 (Unaudited)
6.5% convertible senior subordinated notes, interest payable semi-annually beginning May 2008 with principal due May 2014	$ 70,000,000	$ 70,000,000
$30,000,000 revolving loan, LIBOR plus 6.5% through December 2012	—	—
$173,000,000 term loan, LIBOR plus 6.5% with principal and interest payable quarterly through December 2013	112,303,772	—
$40,000,000 revolving loan, LIBOR plus 2.25% to 3.00% or Base Rate plus 1.25% to 2.00% through March 2016	—	—
$100,000,000 term loan, LIBOR plus 2.25% to 3.00% or Base Rate plus 1.25% to 2.00% with principal and interest payable quarterly through March 2016	—	100,000,000
	182,303,772	170,000,000
Less current portion	18,113,512	7,500,000
	$ 164,190,260	$ 162,500,000

Actual and pro forma annual maturities of long-term obligations as of December 31, 2010 are as follows:

Year	Actual Amount	Pro forma Amount (Unaudited)
2011	$ 18,113,512	$ 7,500,000
2012	21,736,214	10,000,000
2013	72,454,046	13,750,000
2014	70,000,000	85,000,000
2015	—	18,750,000
Thereafter	—	35,000,000
Total	$ 182,303,772	$ 170,000,000

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The new credit agreement provides certain covenants including financial covenants. Additionally, the Company expects to incur fees of approximately $2.9 million to refinance its long-term debt. The Company is accounting for fees related to the refinancing of its Credit Facility, as well as unamortized deferred financing fees related to the Credit Facility, under ASC 470-50 – *Debt Modifications and Extinguishments*. As both credit facilities were loan syndications, and a number of lenders participated in both credit facilities, the Company is evaluating the accounting for financing fees on a lender by lender basis. Of the total amount of deferred financing fees related to the Credit Facility as of March 11, 2011, the Company expects approximately $1.2 million will continue to be deferred and amortized and approximately $2.4 million is anticipated to be expensed in the quarter ending March 31, 2011. Of the $2.9 million of fees expected to be incurred to refinance the long-term debt, approximately $2.5 million will be deferred and amortized and approximately $400,000 is anticipated to be expensed in the quarter ending March 31, 2011.

Item 9. ***Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.***

None.

Item 9A. ***Controls and Procedures.***

(a) Evaluation of disclosure controls and procedures

The Company, under the supervision and with the participation of its management, including its principal executive officer and principal financial officer, evaluated the effectiveness of the design and operation of its disclosure controls and procedures, as defined in Rule 13a-15(e) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") as of the end of the period covered by this report (December 31, 2010) ("Disclosure Controls"). Based upon the Disclosure Controls evaluation, the principal executive officer and principal financial officer have concluded that the Disclosure Controls are effective in reaching a reasonable level of assurance that (i) information required to be disclosed by the Company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms and (ii) information required to be disclosed by the Company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the Company's management, including its principal executive and principal financial officers, or persons performing similar functions, as appropriate to allow timely decisions regarding required disclosure.

(b) Changes in internal controls

The principal executive officer and principal financial officer also conducted an evaluation of the Company's internal control over financial reporting ("Internal Control") to determine whether any changes in Internal Control occurred during the quarter ended December 31, 2010 that have materially affected or which are reasonably likely to materially affect Internal Control. Based on that evaluation, there has been no such change during the quarter ended December 31, 2010.

(c) Limitations on the Effectiveness of Controls

Control systems, no matter how well conceived and operated, are designed to provide a reasonable, but not an absolute, level of assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, within the Company have been detected. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected. The Company conducts periodic evaluations of its internal controls to enhance, where necessary, its procedures and controls.

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the quarterly period ended March 31, 2011

OR

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission File Number 001-34221

The Providence Service Corporation
(Exact name of registrant as specified in its charter)

Delaware (State or other jurisdiction of incorporation or organization)	86-0845127 (I.R.S. Employer Identification No.)
64 East Broadway Blvd., Tucson, Arizona (Address of principal executive offices)	85701 (Zip Code)

(520) 747-6600
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☐ Yes ☐ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☐	Accelerated filer	☒
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

As of May 3, 2011, there were outstanding 12,962,044 shares (excluding treasury shares of 619,768) of the registrant's Common Stock, $0.001 par value per share.

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PART I—FINANCIAL INFORMATION

Item 1. Financial Statements.

The Providence Service Corporation
Condensed Consolidated Balance Sheets

	December 31, 2010	March 31, 2011 (Unaudited)
Assets		
Current assets:		
Cash and cash equivalents	$ 61,260,661	$ 57,617,091
Accounts receivable, net of allowance of $5.3 million in 2010 and 2011	76,111,608	82,549,485
Management fee receivable	5,839,735	5,957,587
Other receivables	3,929,866	3,487,769
Restricted cash	7,314,535	7,354,147
Prepaid expenses and other	15,478,221	13,949,597
Deferred tax assets	1,633,644	2,144,319
Total current assets	171,568,270	173,059,995
Property and equipment, net	16,401,107	16,906,504
Goodwill	113,783,389	113,849,797
Intangible assets, net	66,441,817	64,615,233
Restricted cash, less current portion	9,079,563	9,080,174
Other assets	9,659,349	9,382,241
Total assets	$386,933,495	$386,893,944
Liabilities and stockholders' equity		
Current liabilities:		
Current portion of long-term obligations	$ 18,113,512	$ 16,626,000
Accounts payable	2,887,837	3,164,512
Accrued expenses	33,551,129	35,468,263
Accrued transportation costs	41,868,694	48,222,447
Deferred revenue	5,373,742	4,752,975
Reinsurance liability reserve	11,898,200	9,745,438
Total current liabilities	113,693,114	117,979,635
Long-term obligations, less current portion	164,190,260	153,374,000
Other long-term liabilities	8,721,610	10,046,763
Deferred tax liabilities	11,579,849	11,295,543
Total liabilities	298,184,833	292,695,941
Commitments and contingencies (Note 15)		
Stockholders' equity		
Common stock: Authorized 40,000,000 shares; $0.001 par value; 13,580,385 and 13,580,813 issued and outstanding (including treasury shares)	13,580	13,581
Additional paid-in capital	172,540,912	173,160,160
Retained deficit	(78,501,586)	(74,032,325)
Accumulated other comprehensive loss, net of tax	(880,814)	(519,983)
Treasury shares, at cost, 619,768 shares	(11,383,967)	(11,383,967)
Total Providence stockholders' equity	81,788,125	87,237,466
Non-controlling interest	6,960,537	6,960,537
Total stockholders' equity	88,748,662	94,198,003
Total liabilities and stockholders' equity	$386,933,495	$386,893,944

See accompanying notes to unaudited condensed consolidated financial statements

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The Providence Service Corporation
Unaudited Condensed Consolidated Statements of Income

	Three months ended March 31,	
	2010	2011
Revenues:		
Home and community based services	$ 76,465,480	$ 77,244,287
Foster care services	8,735,268	8,251,253
Management fees	3,294,945	3,344,940
Non-emergency transportation services	132,463,701	138,965,856
	220,959,394	227,806,336
Operating expenses:		
Client service expense	73,644,411	72,813,914
Cost of non-emergency transportation services	113,487,655	126,108,419
General and administrative expense	10,787,851	11,923,781
Depreciation and amortization	3,126,698	3,249,078
Total operating expenses	201,046,615	214,095,192
Operating income	19,912,779	13,711,144
Other (income) expense:		
Interest expense	4,374,393	3,731,831
Loss on extinguishment of debt	—	2,463,482
Interest income	(71,351)	(59,363)
Income before income taxes	15,609,737	7,575,194
Provision for income taxes	6,502,641	3,105,933
Net income	$ 9,107,096	$ 4,469,261
Earnings per common share:		
Basic	$ 0.69	$ 0.34
Diluted	$ 0.66	$ 0.34
Weighted-average number of common shares outstanding:		
Basic	13,166,784	13,222,566
Diluted	14,936,288	13,320,443

See accompanying notes to unaudited condensed consolidated financial statements

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The Providence Service Corporation
Unaudited Condensed Consolidated Statements of Cash Flows

	Three months ended March 31,	
	2010	2011
Operating activities		
Net income	$ 9,107,096	$ 4,469,261
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	1,202,280	1,321,219
Amortization	1,924,418	1,927,859
Amortization of deferred financing costs	628,787	479,363
Loss on extinguishment of debt	—	2,463,482
Provision for doubtful accounts	1,929,599	835,797
Deferred income taxes	(502,709)	(1,019,333)
Stock based compensation	118,853	690,231
Excess tax benefit upon exercise of stock options	(18,382)	(1,959)
Other	(145,937)	380,194
Changes in operating assets and liabilities:		
Accounts receivable	(9,753,990)	(7,108,867)
Management fee receivable	29,691	(117,851)
Other receivables	388,388	442,119
Restricted cash	(305,008)	(401,901)
Prepaid expenses and other	385,397	1,214,910
Reinsurance liability reserve	(892,119)	(782,901)
Accounts payable and accrued expenses	5,470,317	2,130,673
Accrued transportation costs	6,253,853	6,353,753
Deferred revenue	(394,387)	(623,142)
Other long-term liabilities	(28,099)	9,170
Net cash provided by operating activities	15,398,048	12,662,077
Investing activities		
Purchase of property and equipment, net	(2,523,555)	(1,818,405)
Restricted cash for contract performance	(47,362)	361,680
Purchase of short-term investments, net	(30,906)	(28,755)
Net cash used in investing activities	(2,601,823)	(1,485,480)
Financing activities		
Proceeds from common stock issued pursuant to stock option exercise	69,409	2,004
Excess tax benefit upon exercise of stock options	18,382	1,959
Proceeds from long-term debt	—	100,000,000
Repayment of long-term debt	(8,622,702)	(112,303,771)
Debt financing costs	—	(2,606,371)
Capital lease payments	(3,124)	(3,668)
Net cash used in financing activities	(8,538,035)	(14,909,847)
Effect of exchange rate changes on cash	95,152	89,680
Net change in cash	4,353,342	(3,643,570)
Cash at beginning of period	51,157,429	61,260,661
Cash at end of period	$ 55,510,771	$ 57,617,091
Supplemental cash flow information:		
Cash paid for interest	$ 2,900,451	$ 1,822,892
Cash paid for income taxes	$ 4,469,748	$ 4,158,817

See accompanying notes to unaudited condensed consolidated financial statements

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The Providence Service Corporation
Notes to Unaudited Condensed Consolidated Financial Statements
March 31, 2011

1. Basis of Presentation

The accompanying unaudited condensed consolidated financial statements (the "consolidated financial statements") include the accounts of The Providence Service Corporation and its wholly-owned subsidiaries, including its foreign wholly-owned subsidiary WCG International Ltd. ("WCG"). Unless the context otherwise requires, references to the "Company", "our", "we" and "us" mean The Providence Service Corporation and its wholly-owned subsidiaries.

The Company follows accounting standards set by the Financial Accounting Standards Board ("FASB"). The FASB establishes accounting principles generally accepted in the United States ("GAAP"). Rules and interpretive releases of the Securities and Exchange Commission ("SEC") under authority of federal securities laws are also sources of authoritative GAAP for SEC registrants, which the Company is required to follow. References to GAAP issued by the FASB in these footnotes are to the FASB *Accounting Standards Codification* ("ASC"), which serves as a single source of authoritative non-SEC accounting and reporting standards to be applied by nongovernmental entities.

The Company's consolidated financial statements have been prepared in accordance with GAAP for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all of the information and footnotes required by GAAP for complete financial statements. In the opinion of management, all adjustments (consisting of normal recurring accruals) considered necessary for fair presentation have been included. Operating results for the three months ended March 31, 2011 are not necessarily indicative of the results that may be expected for the fiscal year ending December 31, 2011. Management has evaluated events and transactions that occurred after the balance sheet date and through the date these consolidated financial statements were issued and considered the effect of such events in the preparation of these consolidated financial statements.

The consolidated balance sheet at December 31, 2010 has been derived from the audited financial statements at that date but does not include all of the information and footnotes required by GAAP for complete financial statements. The consolidated financial statements contained herein should be read in conjunction with the audited financial statements and notes included in the Company's Annual Report on Form 10-K for the year ended December 31, 2010.

Certain amounts have been reclassified in prior periods in order to conform with the current period presentation with no affect on net income or stockholders' equity.

2. Description of Business

The Company is a government outsourcing privatization company. The Company operates in the following two segments: Social Services and Non-Emergency Transportation Services ("NET Services"). As of March 31, 2011, the Company operated in 42 states, and the District of Columbia, United States, and British Columbia, Canada.

The Social Services operating segment responds to governmental privatization initiatives in adult and juvenile justice, corrections, social services, welfare systems, education and workforce development by providing home-based and community-based counseling services and foster care services to at-risk families and children. These services are purchased primarily by state, county and city levels of government, and are delivered under block purchase, cost based and fee-for-service arrangements. The Company also contracts with not-for-profit organizations to provide management services for a fee.

The NET Services operating segment provides non-emergency transportation management services to Medicaid and MediCare beneficiaries. The entities that pay for non-emergency medical transportation services primarily include state Medicaid programs, health maintenance organizations and commercial insurers. Most of the Company's non-emergency transportation services are delivered under capitated contracts where the Company assumes the responsibility of meeting the transportation needs of a specific geographic population.

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3. Concentration of Credit Risk

Contracts with governmental agencies and other entities that contract with governmental agencies accounted for approximately 81% of the Company's revenue for the three months ended March 31, 2010 and 2011. The related contracts are subject to possible statutory and regulatory changes, rate adjustments, administrative rulings, rate freezes and funding reductions. Reductions in amounts paid under these contracts for the Company's services or changes in methods or regulations governing payments for the Company's services could materially adversely affect its revenue and profitability.

For the three months ended March 31, 2010 and 2011, the Company conducted a portion of its operations in Canada through WCG. At December 31, 2010 and March 31, 2011, approximately $13.8 million, or 15.6%, and $14.1 million, or 15.0%, of the Company's net assets, respectively, were located in Canada. In addition, approximately $5.5 million, or 2.5%, and $5.5 million, or 2.4%, of the Company's consolidated revenue for the three months ended March 31, 2010 and 2011, respectively, was generated from the Company's Canadian operations. The Company is subject to the risks inherent in conducting business across national boundaries, any one of which could adversely impact its business. In addition to currency fluctuations, these risks include, among other things: (i) economic downturns; (ii) changes in or interpretations of local law, governmental policy or regulation; (iii) restrictions on the transfer of funds into or out of the country; (iv) varying tax systems; (v) delays from doing business with governmental agencies; (vi) nationalization of foreign assets; and (vii) government protectionism. The Company intends to continue to evaluate opportunities to establish additional operations in Canada. One or more of the foregoing factors could impair the Company's current or future Canadian operations and, as a result, harm its overall business.

4. Significant Accounting Policies

Foreign Currency Translation

The financial position and results of operations of WCG are measured using WCG's local currency (Canadian Dollar) as the functional currency. Revenues and expenses of WCG have been translated into U.S. dollars at average exchange rates prevailing during the period. Assets and liabilities have been translated at the rates of exchange on the balance sheet date. The resulting translation gain and loss adjustments are recorded directly as a separate component of stockholders' equity. At present and for the foreseeable future, the Company intends to reinvest any undistributed earnings of its foreign subsidiary in foreign operations. As a result, the Company is not providing for U.S. or additional foreign withholding taxes on its foreign subsidiary's undistributed earnings. Generally, such earnings become subject to U.S. tax upon the remittance of dividends and under certain other circumstances. It is not practicable to estimate the amount of unrecognized deferred tax liability for temporary differences that are essentially permanent in duration on such undistributed earnings.

Cash and Cash Equivalents

Cash and cash equivalents include all cash balances and highly liquid investments with an initial maturity of three months or less. Investments in cash equivalents are carried at cost, which approximates fair value. The Company places its temporary cash investments with high credit quality financial institutions. At times such investments may be in excess of the Federal Deposit Insurance Corporation (FDIC) and the Canada Deposit Insurance Corporation (CDIC) insurance limits.

At December 31, 2010 and March 31, 2011, approximately $3.8 million and $3.4 million, respectively, of cash was held by WCG and is not freely transferable without unfavorable tax consequences between the Company and WCG.

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Restricted Cash

The Company had approximately $16.4 million of restricted cash at December 31, 2010 and March 31, 2011, as follows:

	December 31, 2010	March 31, 2011
Collateral for letters of credit - Contractual obligations	$ 243,000	$ 243,000
Contractual obligations	781,468	1,183,370
Subtotal restricted cash for contractual obligations	1,024,468	1,426,370
Collateral for letters of credit - Reinsured claims losses	4,808,921	4,808,921
Escrow - Reinsured claims losses	10,560,709	10,199,030
Subtotal restricted cash for reinsured claims losses	15,369,630	15,007,951
Total restricted cash	16,394,098	16,434,321
Less current portion	7,314,535	7,354,147
	$ 9,079,563	$ 9,080,174

Of the restricted cash amount at December 31, 2010 and March 31, 2011:

- $243,000 served as collateral for irrevocable standby letters of credit that provide financial assurance that the Company will fulfill certain contractual obligations at December 31, 2010 and March 31, 2011;
- approximately $781,000 and $1.2 million was held to fund the Company's obligations under arrangements with various governmental agencies through the correctional services business ("Correctional Services") at December 31, 2010 and March 31, 2011, respectively;
- approximately $4.8 million served as collateral for irrevocable standby letters of credit to secure any reinsured claims losses under the Company's general and professional liability and workers' compensation reinsurance programs and was classified as noncurrent assets in the accompanying balance sheets at December 31, 2010 and March 31, 2011;
- approximately $4.0 million was restricted and held in trust for reinsurance claims losses under the Company's general and professional liability reinsurance program at December 31, 2010 and March 31, 2011; and
- approximately $6.5 million and $6.2 million was restricted in relation to our auto liability program at December 31, 2010 and March 31, 2011, respectively.

At March 31, 2011, approximately $5.1 million, $4.0 million, $5.9 million and $250,000 of the restricted cash was held in custody by the Bank of Tucson, Wells Fargo, Fifth Third Bank and Bank of America, respectively. The cash is restricted as to withdrawal or use and is currently invested in certificates of deposit or short-term marketable securities. The remaining balance of approximately $1.2 million is also restricted as to withdrawal or use, and is currently held in various non-interest bearing bank accounts related to Correctional Services.

Deferred Financing Costs

The Company capitalizes direct expenses incurred in connection with its borrowings or establishment of credit facilities and amortizes such expenses over the life of the respective borrowing or credit facility. The Company incurred approximately $2.2 million in deferred financing costs in connection with the credit facility it entered into in March 2011 ("Senior Credit Facility"). The Company also retains certain deferred

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financing costs of approximately $1.1 million related to its prior amended credit facility ("Old Credit Facility"), as certain lenders who participated in the Old Credit Facility also participate in the Company's Senior Credit Facility. In addition, the Company incurred approximately $2.3 million in deferred financing costs in connection with its senior subordinated notes issued in November 2007. Deferred financing costs are amortized to interest expense on a straight-line basis or based upon the effective interest method over the life of the credit facilities. Deferred financing costs, net of amortization, totaling approximately $5.1 million and $4.4 million at December 31, 2010 and March 31, 2011, respectively, are included in "Other assets" in the accompanying consolidated balance sheets.

Non-Controlling Interest

In connection with the Company's acquisition of WCG in August 2007, PSC of Canada Exchange Corp. ("PSC"), a subsidiary established by the Company to facilitate the purchase of all of the equity interest in WCG, issued 287,576 exchangeable shares as part of the purchase price consideration. The exchangeable shares were valued at approximately $7.8 million in accordance with the provisions of the purchase agreement ($7.6 million for accounting purposes). The shares are exchangeable at each shareholder's option, for no additional consideration, into shares of the Company's common stock on a one-for-one basis ("Exchangeable Shares"). Of the 287,576 Exchangeable Shares, 25,882 were exchanged as of December 31, 2010 and March 31, 2011.

The Exchangeable Shares are non-participating such that they are not entitled to any allocation of income or loss of PSC. The Exchangeable Shares represent ownership in PSC and are accounted for as "Non-controlling interest" included in stockholders' equity in the accompanying condensed consolidated balance sheets in the amount of approximately $7.0 million at December 31, 2010 and March 31, 2011.

The Exchangeable Shares and the 25,882 shares of the Company's common stock issued upon the exchange of the same number of Exchangeable Shares noted above are subject to a Settlement and Indemnification Agreement dated November 17, 2009 ("Indemnification Agreement") by and between the Company and the sellers of WCG. The Indemnification Agreement secures the Company's claims for indemnification and associated rights and remedies provided by the Share Purchase Agreement (under which the Company acquired all of the equity interest in WCG on August 1, 2007) arising from actions taken by British Columbia to strictly enforce a contractually imposed revenue cap on a per client basis and contractually mandated pass-throughs subsequent to August 1, 2007. The actions taken by British Columbia resulted in an approximate CAD $3.0 million dispute and termination of one of its six provincial contracts with WCG, which the Company is disputing. Under the Indemnification Agreement, the sellers have agreed to transfer their rights to the Exchangeable Shares and 25,882 shares of the Company's common stock issued upon the exchange of the same number of Exchangeable Shares to the Company to indemnify the Company against any losses suffered by the Company as the result of an unfavorable ruling upon the conclusion of arbitration.

Effective April 14, 2010, an arbitrator issued an award with respect to the dispute between WCG and British Columbia regarding British Columbia's actions to strictly enforce a contractually imposed revenue cap on a per client basis and contractually mandated pass-throughs subsequent to August 1, 2007. Under the arbitration award, essentially all amounts disputed shall be paid to WCG (except for approximately $13,000 CAD which will be subject to the terms of the Indemnification Agreement) plus interest. The award affirmed the termination of one of the six provincial contracts that had been terminated effective October 31, 2008. During the second quarter of 2010, British Columbia filed a petition for leave to appeal the arbitration award. There is no financial statement impact related to these events included in our financial results for the three months ended March 31, 2011. The petition for leave to appeal was still pending at March 31, 2011.

Stock-Based Compensation Arrangements

Stock-based compensation expense charged against income for stock options and stock grants for the three months ended March 31, 2010 and 2011 was based on the grant-date fair value adjusted for estimated forfeitures based on awards expected to vest in accordance with the provisions of ASC Topic 718-*Compensation-Stock Compensation* and totaled approximately $115,000 (net of tax of $4,000) and $619,000 (net of tax of $71,000), respectively.

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For the three months ended March 31, 2010 and 2011, the amount of excess tax benefits resulting from the exercise of stock options was approximately $18,000 and $2,000. These amounts are reflected as cash flows from financing activities for the three months ended March 31, 2010 and 2011 in the accompanying condensed consolidated statements of cash flows.

As of March 31, 2011, there was approximately $7.1 million of unrecognized compensation cost related to non-vested stock-based compensation arrangements granted under the Company's 2006 Long-Term Incentive Plan ("2006 Plan"). The cost is expected to be recognized over a weighted-average period of 2.3 years.

5. Summary of Critical Accounting Estimates

The Company has made a number of estimates relating to the reporting of assets and liabilities, revenues and expenses and the disclosure of contingent assets and liabilities to prepare these consolidated financial statements in conformity with GAAP. The Company based its estimates on historical experience and on various other assumptions the Company believes to be reasonable under the circumstances. However, actual results may differ from these estimates under different assumptions or conditions. Some of the more significant estimates impact revenue recognition, accounts receivable and allowance for doubtful accounts, accounting for business combinations, goodwill and other intangible assets, accrued transportation costs, accounting for management agreement relationships, loss reserves for reinsurance and self-funded insurance programs, stock-based compensation, foreign currency translation and income taxes.

6. New and Pending Accounting Pronouncements

New Accounting Pronouncements

In January 2010, the FASB issued Accounting Standards Update ("ASU") 2010-06-*Fair Value Measurements and Disclosures (Topic 820): Improving Disclosures about Fair Value Measurements* ("ASU 2010-06"). ASU 2010-06 amends certain disclosure requirements of Subtopic 820-10 and provides additional disclosures for transfers in and out of Levels I and II and for activity in Level III. This ASU also clarifies certain other existing disclosure requirements including level of desegregation and disclosures around inputs and valuation techniques. The final amendments to the ASC will be effective for annual or interim reporting periods beginning after December 15, 2009, except for the requirement to provide the Level 3 activity for purchases, sales, issuances, and settlements on a gross basis. That requirement will be effective for fiscal years beginning after December 15, 2010, and for interim periods within those fiscal years. Early adoption is permitted. ASU 2010-06 does not require disclosures for earlier periods presented for comparative purposes at initial adoption. The Company adopted ASU 2010-06 as of January 1, 2010 with respect to the provisions required to be adopted as of January 1, 2010, and adopted the remaining provisions as of January 1, 2011. The adoption of ASU 2010-06 did not have a material impact on the Company's consolidated financial statements.

In December 2010, the FASB issued ASU No. 2010-28-*Intangibles - Goodwill and Other (Topic 350): When to Perform Step 2 of the Goodwill Impairment Test for Reporting Units with Zero or Negative Carrying Amounts* ("ASU 2010-28"). The amendments in this ASU modify Step 1 of the goodwill impairment test for reporting units with zero or negative carrying amounts. For those reporting units, an entity is required to perform Step 2 of the goodwill impairment test if it is more likely than not that a goodwill impairment exists. In determining whether it is more likely than not that a goodwill impairment exists, an entity should consider whether there are any adverse qualitative factors indicating that an impairment may exist. The qualitative factors are consistent with the existing guidance and examples, which require that goodwill of a reporting unit be tested for impairment between annual tests if an event occurs or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount. For public entities, the amendments in this ASU are effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Company adopted ASU 2010-28 as of January 1, 2011. The adoption of ASU 2010-28 did not have a material impact on the Company's consolidated financial statements.

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In December 2010, the FASB issued ASU 2010-29-*Business Combinations (Topic 805): Disclosure of Supplementary Pro Forma Information for Business Combinations* ("ASU 2010-29"). The amendments in this ASU affect any public entity as defined by Topic 805, *Business Combinations*, that enters into business combinations that are material on an individual or aggregate basis. The amendments in this ASU specify that if a public entity presents comparative financial statements, the entity should disclose revenue and earnings of the combined entity as though the business combination(s) that occurred during the current year had occurred as of the beginning of the comparable prior annual reporting period only. The amendments also expand the supplemental pro forma disclosures to include a description of the nature and amount of material, nonrecurring pro forma adjustments directly attributable to the business combination included in the reported pro forma revenue and earnings. The amendments are effective prospectively for business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2010. The Company adopted ASU 2010-29 as of January 1, 2011. The adoption of ASU 2010-29 will only impact disclosures in the Company's consolidated financial statements, and did not have an impact on the financial statements in the current period.

Other accounting standards and exposure drafts, such as exposure drafts related to revenue recognition, leases, derivatives, comprehensive income and fair value measurements, that have been issued or proposed by the FASB or other standards setting bodies that do not require adoption until a future date are being evaluated by the Company to determine whether adoption will have a material impact on the Company's consolidated financial statements.

7. Other Receivables

At December 31, 2010 and March 31, 2011, insurance premiums of approximately $3.1 million and $2.4 million, respectively, were receivable from third parties related to the reinsurance activities of the Company's two captive subsidiaries. The insurance premiums receivable is classified as "Other receivables" in the accompanying condensed consolidated balance sheets. In addition, the Company's expected losses related to workers' compensation and general and professional liability in excess of the Company's liability under its associated reinsurance programs at December 31, 2010 were approximately $2.9 million, of which approximately $698,000 was classified as "Other receivables" and approximately $2.2 million was classified as "Other assets" in the accompanying condensed consolidated balance sheet. The Company's expected losses related to workers' compensation and general and professional liability in excess of the Company's liability under its associated reinsurance programs at March 31, 2011 were approximately $3.1 million, of which approximately $495,000 was classified as "Other receivables" and approximately $2.6 million was classified as "Other assets" in the accompanying condensed consolidated balance sheet. The Company recorded a corresponding liability, which offset these expected losses. This liability was classified as "Reinsurance liability reserve" in current liabilities and "Other long-term liabilities" in the accompanying condensed consolidated balance sheets.

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8. Prepaid Expenses and Other

Prepaid expenses and other were comprised of the following:

	December 31, 2010	March 31, 2011
Prepaid payroll	$ 2,411,556	$ 2,717,543
Prepaid insurance	3,365,500	1,360,379
Prepaid taxes	2,889,515	2,813,742
Prepaid rent	828,807	729,554
Provider advances	279,068	201,793
Prepaid maintenance agreements and copier leases	707,672	726,652
Prepaid bus tokens and passes	992,432	1,017,017
Prepaid commissions and brokerage fees	523,680	354,212
Interest receivable - certificates of deposit	1,009,888	1,038,644
Other	2,470,103	2,990,061
Total prepaid expenses and other	$ 15,478,221	$ 13,949,597

9. Long-Term Obligations

	December 31, 2010	March 31, 2011
6.5% convertible senior subordinated notes, interest payable semi-annually beginning May 2008 with principal due May 2014	70,000,000	70,000,000
$30,000,000 revolving loan, LIBOR plus 6.5% (effective rate of 6.77% at December 31, 2010) that was terminated in March 2011	—	—
$173,000,000 term loan, LIBOR plus 6.5% with principal and interest payable quarterly that was terminated in March 2011	112,303,772	—
$40,000,000 revolving loan, LIBOR plus 2.75% (effective rate of 3.00% at March 31, 2011) through March 2016	—	—
$100,000,000 term loan, LIBOR plus 2.75% with principal and interest payable at least once every three months through March 2016	—	100,000,000
	182,303,772	170,000,000
Less current portion	18,113,512	16,626,000
	$164,190,260	$153,374,000

On March 11, 2011, the Company replaced the Old Credit Facility with the Senior Credit Facility and paid all amounts due under the Old Credit Facility with cash in the amount of $12.3 million and proceeds from the Senior Credit Facility as discussed in further detail below.

On March 11, 2011, the Company entered into a Credit Agreement, representing the Senior Credit Facility, with Bank of America, N.A., as administrative agent, swing line lender and letter of credit issuer, SunTrust Bank, as syndication agent, Bank of Arizona, Alliance Bank of Arizona and Royal Bank of Canada, as co-documentation agents, Merrill Lynch, Pierce, Fenner & Smith Incorporated and SunTrust Robinson Humphrey, Inc., as joint lead arrangers and joint book managers and other lenders party thereto ("New Credit Agreement").

The New Credit Agreement provides the Company with the Senior Credit Facility in aggregate principal amount of $140.0 million, comprised of a $100.0 million term loan facility and a $40.0 million revolving credit facility. There is an option to increase the amount of the term loan facility and/or the revolving credit facility by an aggregate amount of up to $85.0 million as described below. The Senior

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Credit Facility includes sublimits for swingline loans and letters of credit in amounts of up to $10.0 million and $25.0 million, respectively. On March 11, 2011, the Company borrowed the entire amount available under the term loan facility and used the proceeds thereof to repay amounts outstanding under the Old Credit Facility. Prospectively, the proceeds of the Senior Credit Facility may be used to (i) fund ongoing working capital requirements; (ii) make capital expenditures; (iii) repay the 6.5% convertible senior subordinate notes ("Notes"); and (iv) other general corporate purposes.

Under the Senior Credit Facility the Company has an option to request an increase in the amount of the revolving credit facility and/or the term loan facility from time to time (on substantially the same terms as apply to the existing facilities) by an aggregate amount of up to $85.0 million with either additional commitments from lenders under the New Credit Agreement at such time or new commitments from financial institutions acceptable to the administrative agent in its reasonable discretion, so long as no default or event of default exists at the time of any such increase. The Company may not be able to access additional funds under this increase option as no lender is obligated to participate in any such increase under the Senior Credit Facility.

The Senior Credit Facility matures on March 11, 2016; provided, however that, if there are more than $25.0 million of the Company's Notes outstanding on September 30, 2013, the Senior Credit Facility will terminate and all amounts outstanding thereunder will be due and payable in full on November 15, 2013, unless the Company has provided the administrative agent with cash collateral on or before September 30, 2013 in an amount sufficient to repay the aggregate outstanding principal amount of the Notes. In the event that there are more than $25.0 million of the Company's Notes outstanding on September 30, 2013, the maturity date will be automatically reinstated to March 11, 2016 if: (i) we reduce the principal amount of the Notes to an aggregate amount of no more than $25.0 million on a date prior to November 15, 2013, (ii) we have availability under the revolving credit facility plus unrestricted cash in an amount at least equal to the aggregate outstanding principal amount of the Notes on such date and (iii) there is no default or event of default under the Senior Credit Facility on such date. The Company may prepay the Senior Credit Facility in whole or in part, at any time without premium or penalty, subject to reimbursement of the lenders' breakage and redeployment costs in connection with prepayments of LIBOR loans. The unutilized portion of the commitments under the Senior Credit Facility may be irrevocably reduced or terminated by the Company at any time without penalty.

Interest on the outstanding principal amount of the loans accrues, at the Company's election, at a per annum rate equal to the London Interbank Offering Rate, or LIBOR, plus an applicable margin or the base rate plus an applicable margin. The applicable margin ranges from 2.25% to 3.00% in the case of LIBOR loans and 1.25% to 2.00% in the case of the base rate loans, in each case, based on the Company's consolidated leverage ratio as defined in the New Credit Agreement. Interest on the loans is payable quarterly in arrears. In addition, the Company is obligated to pay a quarterly commitment fee based on a percentage of the unused portion of each lender's commitment under the revolving credit facility and quarterly letter of credit fees based on a percentage of the maximum amount available to be drawn under each outstanding letter of credit. The commitment fee and letter of credit fee ranges from 0.35% to 0.50% and 2.25% to 3.00%, respectively, in each case, based on the Company's consolidated leverage ratio.

The term loan facility is subject to quarterly amortization payments, commencing on June 30, 2011, so that the following percentages of the term loan outstanding on the closing date plus the principal amount of any term loans funded pursuant to the increase option are repaid as follows: 10% in each of the first two years, 15% in each of the third and fourth years and the remaining balance in the fifth year. The Senior Credit Facility also requires the Company (subject to certain exceptions as set forth in the New Credit Agreement) to prepay the outstanding loans in an aggregate amount equal to 100% of the net cash proceeds received from certain asset dispositions, debt issuances, insurance and casualty awards and other extraordinary receipts.

The New Credit Agreement contains customary representations and warranties, affirmative and negative covenants and events of default. The negative covenants include restrictions on the Company's ability to, among other things, incur additional indebtedness, create liens, make investments, give guarantees, pay dividends, sell assets and merge and consolidate. The Company is subject to financial covenants, including consolidated net leverage and consolidated net senior leverage covenants as well as a consolidated fixed charge covenant.

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The Company's obligations under the Senior Credit Facility are guaranteed by all of its present and future domestic subsidiaries, excluding certain domestic subsidiaries, which include its insurance captives and not-for-profit subsidiaries. The Company's obligations under, and each guarantor's obligations under its guaranty of the Senior Credit Facility are secured by a first priority lien on substantially all of its respective assets, including a pledge of 100% of the issued and outstanding stock of its domestic subsidiaries and 65% of the issued and outstanding stock of its first tier foreign subsidiaries. If an event of default occurs, the required lenders may cause the administrative agent to declare all unpaid principal and any accrued and unpaid interest and all fees and expenses under the Senior Credit Facility to be immediately due and payable. All amounts outstanding under the Senior Credit Facility will automatically become due and payable upon the commencement of any bankruptcy, insolvency or similar proceedings. The New Credit Agreement also contains a cross default to any of the Company's indebtedness having a principal amount in excess of $7.5 million.

Additionally, the Company incurred financing fees of approximately $2.6 million to refinance the Old Credit Facility and is accounting for such fees, as well as unamortized deferred financing fees related to the Old Credit Facility, under ASC 470-50 – *Debt Modifications and Extinguishments*. As both credit facilities were loan syndications, and a number of lenders participated in both credit facilities, the Company evaluated the accounting for financing fees on a lender by lender basis. Of the total amount of unamortized deferred financing fees related to the Old Credit Facility as of March 11, 2011, approximately $1.1 million will continue to be deferred and amortized to interest expense and approximately $2.5 million was expensed in the quarter ended March 31, 2011 and is included in "Loss on extinguishment of debt" in the accompanying condensed consolidated statement of income. Of the $2.6 million of fees incurred related to the Senior Credit Facility, approximately $2.2 million will be deferred and amortized to interest expense and approximately $389,000 was expensed as interest expense in the quarter ended March 31, 2011.

In April 2011, the Company repurchased approximately $6.6 million of the Notes which is included in "Current portion of long-term obligations" in the accompanying condensed consolidated balance sheet at March 31, 2011.

The carrying amount of the long-term obligations approximated its fair value at December 31, 2010 and March 31, 2011. The fair value of the Company's long-term obligations was estimated based on interest rates for the same or similar debt offered to the Company having same or similar remaining maturities and collateral requirements.

10. Business Segments

The Company's operations are organized and reviewed by management along its services lines. The Company operates in two reportable segments as separate divisions and differentiates the segments based on the nature of the services they offer. The following describes each of the Company's segments and its corporate services area.

Social Services. Social Services includes government sponsored social services consisting of home and community based services, foster care and not-for-profit management services. Through Social Services the Company provides services to a common customer group, principally individuals and families. All of the operating entities within Social Services follow similar operating procedures and methods in managing their operations and each operating entity works within a similar regulatory environment, primarily under Medicaid regulations. The Company manages the activities of Social Services by actual to budget comparisons within each operating entity rather than by comparison between entities. The Company's budget related to Social Services is prepared on an entity-by-entity basis which represents the aggregation of individual location operating budgets within each Social Services entity and is comprised of:

- Payer specific revenue streams based upon contracted amounts;
- Payroll and related employee expenses by position corresponding to the contracted revenue streams; and

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- Other operating expenses such as facilities costs, employee training, mileage and communications in support of operations.

The actual operating contribution margins of the operating entities that comprise Social Services ranged from approximately 1.3% to 12.3% for the year ended December 31, 2010. The Company believes that the long term operating contribution margins of the operating entities that comprise Social Services will approximate between 8% and 12% as the respective entities' markets mature, the Company cross sells its services within markets, and standardizes its operating model among entities including acquisitions.

In evaluating the financial performance and economic characteristics of Social Services, the Company's chief operating decision maker regularly reviews the following types of financial and non-financial information for each operating entity within Social Services:

- Consolidated financial statements;
- Separate condensed financial statements for each individual operating entity versus their budget;
- Monthly non-financial statistical information;
- Productivity reports; and
- Payroll reports.

While the Company's chief operating decision maker evaluates performance in comparison to budget based on the operating results of the individual operating entities within Social Services, the operating entities are aggregated into one reporting segment for financial reporting purposes because the Company believes that the operating entities exhibit similar long term financial performance. In conjunction with the financial performance trends, the Company believes the similar qualitative characteristics of the operating entities it aggregates within Social Services and budgetary constraints of the Company's payers in each market provide a foundation to conclude that the entities that the Company aggregates within Social Services have similar economic characteristics. Thus, the Company believes the economic characteristics of its operating entities within Social Services meet the criteria for aggregation into a single reporting segment under ASC Topic 280, "*Segment Reporting*".

NET Services. NET Services is comprised primarily of managing the delivery of non-emergency transportation services. The Company operates NET Services as a separate division of the Company with operational management and service offerings distinct from the Company's Social Services operating segment. Financial and operating performance reporting is conducted at a contract level and reviewed weekly at both the operating entity level as well as the corporate level by the Company's chief operating decision maker. Gross margin performance of individual contracts is consolidated under the associated operating entity and direct general and administrative expenses are allocated to the operating entity.

Corporate. Corporate includes corporate accounting and finance, information technology, business development, compliance, marketing, internal audit, employee training, legal and various other overhead costs, all of which are directly allocated to the operating segments.

Segment asset disclosures include property and equipment and other intangible assets. The accounting policies of the Company's segments are the same as those of the consolidated Company. The Company evaluates performance based on operating income. Operating income is revenue less operating expenses (including client service expense, cost of non-emergency transportation services, general and administrative expense and depreciation and amortization) but is not affected by other income/expense or by income taxes. Other income/expense consists principally of interest expense, loss on extinguishment of debt and interest income. In calculating operating income for each segment, general and administrative expenses incurred at the corporate level are allocated to each segment based upon their relative direct expense levels excluding costs for purchased services. All intercompany transactions have been eliminated.

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The following table sets forth certain financial information attributable to the Company's business segments for the three months ended March 31, 2010 and 2011. In addition, none of the segments have significant non-cash items other than depreciation, amortization and loss on extinguishment of debt in reported income.

	For the three months ended March 31, 2010			
	Social Services	NET Services	Corporate (a)(b)	Consolidated Total
Revenues	$ 88,495,693	$ 132,463,701	$ —	$ 220,959,394
Depreciation and amortization	$ 1,516,520	$ 1,610,178	$ —	$ 3,126,698
Operating income	$ 4,591,335	$ 15,321,444	$ —	$ 19,912,779
Net interest expense (income)	$ (52,726)	$ 4,355,768	$ —	$ 4,303,042
Total assets	$ 150,197,184	$ 213,705,746	$ 29,739,530	$ 393,642,460
Capital expenditures	$ 679,577	$ 937,230	$ 906,748	$ 2,523,555

	For the three months ended March 31, 2011			
	Social Services	NET Services	Corporate (a)(b)	Consolidated Total
Revenues	$ 88,840,480	$ 138,965,856	$ —	$ 227,806,336
Depreciation and amortization	$ 1,641,277	$ 1,607,801	$ —	$ 3,249,078
Operating income	$ 4,928,345	$ 8,782,799	$ —	$ 13,711,144
Net interest expense (income)	$ 198,044	$ 3,474,424	$ —	$ 3,672,468
Loss on extinguishment of debt	$ 1,857,029	$ 606,453	$ —	$ 2,463,482
Total assets	$ 148,151,871	$ 204,775,097	$ 33,966,976	$ 386,893,944
Capital expenditures	$ 389,995	$ 401,970	$ 1,026,440	$ 1,818,405

(a) Corporate costs have been allocated to the Social Services and NET Services operating segments.

(b) Corporate assets as of March 31, 2010 and 2011 include cash totaling approximately $25.9 million and $25.3 million, prepaid expenses totaling approximately $956,000 and $847,000, property and equipment totaling approximately $2.1 million and $7.0 million, and other assets of approximately $760,000 and $835,000, respectively.

11. Stockholders' Equity and Other Comprehensive Income

The Company's second amended and restated certificate of incorporation provides that the Company's authorized capital stock consists of 40,000,000 shares of common stock, $0.001 par value per share, and 10,000,000 shares of preferred stock, $0.001 par value per share.

During the three months ended March 31, 2011, the Company granted options to purchase an aggregate of 100,500 shares of the Company's common stock under its 2006 Plan at exercise prices equal to the market value of the Company's common stock on the date of grant. The options were granted to executive officers and certain key employees. The options vest in equal installments at various times over the next three years and have a term of ten years. The weighted-average fair value of the options granted during the three months ended March 31, 2011 totaled $10.75 per share.

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The Company granted a total of 73,500 shares of restricted stock to its executive officers on March 14, 2011. These awards vest in three equal annual installments on the first, second and third anniversaries of the date of grant. The weighted-average fair value of the restricted stock awards granted on March 14, 2011 totaled $14.72 per share.

At December 31, 2010 and March 31, 2011, there were 13,580,385 and 13,580,813 shares of the Company's common stock outstanding, respectively, (including 619,768 treasury shares at December 31, 2010 and March 31, 2011) and no shares of preferred stock outstanding.

Other comprehensive income included foreign currency translation adjustments which amounted to a gain of approximately $361,000 for the three months ended March 31, 2011.

The components of comprehensive income, net of taxes, for the three months ended March 31, 2010 and 2011 were as follows:

	Three months ended March 31,	
	2010	2011
Net income	$ 9,107,096	$ 4,469,261
Other comprehensive income:		
Change related to derivative, net of income tax (A)	128,881	—
Foreign currency translation adjustments	387,754	360,831
Total other comprehensive income	516,635	360,831
Total comprehensive income	$ 9,623,731	$ 4,830,092

(A) For the three months ended March 31, 2010, the change in fair value of the interest rate swap was net of tax of approximately $58,000.

The following table reflects changes in common stock, additional paid-in capital and accumulated other comprehensive loss for the three months ended March 31, 2011:

	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Loss
	Shares	Amount		
Balance at December 31, 2010	13,580,385	$ 13,580	$ 172,540,912	$ (880,814)
Stock-based compensation	—	—	690,231	—
Exercise of employee stock options, including net tax shortfall of $72,988	428	1	(70,983)	—
Foreign currency translation adjustments	—	—	—	360,831
Balance at March 31, 2011	13,580,813	$ 13,581	$ 173,160,160	$ (519,983)

12. Performance Restricted Stock Units

On March 14, 2011, the Company granted 122,144 performance restricted stock units ("PRSUs") to its executive officers that may be settled in cash. The number of PRSUs eligible to be settled in cash will be based on the achievement of return on equity (determined by the quotient resulting from dividing the Company's consolidated net income by its stockholders' equity) ("ROE"), and will not be determinable until March 1, 2012 or soon thereafter, but in no event later than March 15, 2012 ("Settlement Date") when the Compensation Committee of the Company's Board of Directors will certify the ROE level achieved for 2011. The payout percentages for the ROE target levels are as follows:

- 50% of the PRSUs will be awarded if the Company achieves an ROE equal to or greater than 14%; and,

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- 100% of the PRSUs will be awarded if the Company achieves an ROE equal to or greater than 18%.

If the Company's actual ROE falls between the 14% and 18% levels, the payout amount will be determined by linear interpolation on the Settlement Date.

If the payout level is achieved, then the amount of the award will be determined by multiplying the number of PRSUs corresponding to the ROE level achieved by the fair market value (at closing market price) of the Company's common stock on the Settlement Date. Payment of the award will be equally divided into three tranches corresponding to the required vesting period where the first tranche will be paid on the Settlement Date and the remaining tranches will be paid to vested participants on or between March 1 and March 15, 2013 and 2014, respectively. Vesting criteria for PRSU awards require employment with our company throughout 2011 as well as achievement of the performance goal, and employment up through each applicable service vesting date which will be December 31, 2011, 2012 and 2013 for each of the three respective tranches.

The Company applies a graded vesting expense methodology when accounting for the PRSUs and the fair value of the liability is remeasured at the end of each reporting period through the expected cash settlement. Compensation expense associated with the PRSUs is based upon the closing market price of the Company's common stock on the measurement date and the number of units expected to be earned after assessing the probability that certain performance criteria will be met and the associated targeted payout level that is forecasted will be achieved, net of estimated forfeitures. Cumulative adjustments are recorded each quarter to reflect changes in the stock price and estimated outcome of the performance-related conditions until the date results are determined and settled. Compensation expense of approximately $280,000 was recorded by the Company for the three months ended March 31, 2011 related to the PRSUs.

13. Earnings Per Share

The following table details the computation of basic and diluted earnings per share:

	Three months ended March 31,	
	2010	2011
Numerator:		
Net income, basic	$ 9,107,096	$ 4,469,261
Effect of interest related to the convertible debt	735,501	—
Net income available to common stockholders, diluted	$ 9,842,597	$ 4,469,261
Denominator:		
Denominator for basic earnings per share — weighted-average shares	13,166,784	13,222,566
Effect of dilutive securities:		
Common stock options and restricted stock awards	90,764	97,877
Notes	1,678,740	—
Denominator for diluted earnings per share — adjusted weighted-average shares assumed conversion	14,936,288	13,320,443
Basic earnings per share	$ 0.69	$ 0.34
Diluted earnings per share	$ 0.66	$ 0.34

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The effect of issuing 1,678,740 shares of common stock on an assumed conversion basis related to the Notes was included in the computation of diluted earnings per share for the three months ended March 31, 2010 as they have a dilutive effect. In addition, the effect of issuing 1,678,740 shares of common stock on an assumed conversion basis related to the Notes was not included in the computation of diluted earnings per share for the three months ended March 31, 2011 as it would have been antidilutive. For the three months ended March 31, 2010 and 2011, employee stock options to purchase 830 and 1,133 shares of common stock, respectively, were not included in the computation of diluted earnings per shares as the exercise price of these options was greater than the average fair value of the common stock for the period and, therefore, the effect of these options would have been antidilutive.

14. Income Taxes

The Company's effective tax rate from continuing operations for the three months ended March 31, 2010 and 2011 was 41.7% and 41.0%, respectively. For the three months ended March 31, 2010 and 2011, the Company's effective tax rate was higher than the United States federal statutory rate of 35.0% due primarily to state income taxes.

15. Commitments and Contingencies

The Company is involved in various claims and legal actions arising in the ordinary course of business. In the opinion of management, the ultimate disposition of these matters will not have a material adverse effect on the Company's consolidated financial position, results of operations, or liquidity.

The Company has two deferred compensation plans for management and highly compensated employees. These deferred compensation plans are unfunded; therefore, benefits are paid from the general assets of the Company. The total of participant deferrals, which is reflected in "Other long-term liabilities" in the accompanying condensed consolidated balance sheets, was approximately $655,000 and $723,000 at December 31, 2010 and March 31, 2011, respectively.

The Company may be obligated to pay an amount up to $650,000 to the sellers under an earn out provision pursuant to a formula specified in an asset purchase agreement dated July 1, 2009 by which the Company acquired certain assets of an entity located in California. The earn out payment as such term is defined in the asset purchase agreement, if earned, will be paid in cash. The earn out period ends on December 31, 2013. If the contingency is resolved in accordance with the related provisions of the asset purchase agreement and the additional consideration becomes distributable, the Company will record the fair value of the consideration issued as an additional cost to acquire the associated assets, which will be charged to earnings.

16. Transactions with Related Parties

Upon the Company's acquisition of Maple Services, LLC in August 2005, Mr. McCusker, the Company's chief executive officer, Mr. Deitch, the Company's chief financial officer, and Mr. Norris, the Company's chief operating officer, became members of the board of directors of the not-for-profit organization (Maple Star Colorado, Inc.) formerly managed by Maple Services, LLC. Maple Star Colorado, Inc. is a non-profit member organization governed by its board of directors and the state laws of Colorado in which it is incorporated. Maple Star Colorado, Inc. is not a federally tax exempt organization and neither the Internal Revenue Service rules governing IRC Section 501(c)(3) exempt organizations, nor any other IRC sections applicable to tax exempt organizations, apply to this organization. The Company provided management services to Maple Star Colorado, Inc. under a management agreement for consideration in the amount of approximately $71,000 and $61,000 for the three months ended March 31, 2010 and 2011, respectively. Amounts due to the Company from Maple Star Colorado, Inc. for management services provided to it by the Company at December 31, 2010 and March 31, 2011 were approximately $237,000 and $253,000, respectively.

The Company operates a call center in Phoenix, Arizona. The building in which the call center is located is currently leased by the Company from VWP McDowell, LLC ("McDowell") under a five year lease that expires in 2014. Under the lease agreement, as amended, the Company may terminate the lease

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after the first 36 months of the lease term with a six month prior written notice. Certain members of Mr. Schwarz's (the chief executive officer of a wholly-owned subsidiary) immediate family have partial ownership interest in McDowell. In the aggregate these family members own approximately 13% interest in McDowell directly and indirectly through a trust. For the three months ended March 31, 2010 and 2011, the Company expensed approximately $106,000 and $99,000, respectively, in lease payments to McDowell. Future minimum lease payments due under the amended lease total approximately $1.5 million at March 31, 2011.

Providence Service Corporation

May 24, 2011

To whom it may concern,

The Providence Service Corporation, as the sole parent organization of Logisticare Solutions, LLC, confirms that it will unconditionally guarantee performance by Logisticare Solutions, LLC of each and every obligation, warranty, covenant, term and condition of the Louisiana Medicaid Coordinated Care Program RFP #305PUR-DHHRFP-CCN-P-MVA.

THE PROVIDENCE SERVICE CORPORATION,

By: _____
Name: Michael N. Deitch
Title: Chief Financial Officer

64 East Broadway Boulevard • Tucson, Arizona 85701 • 520/747-6600 • Fax 520/747-6605 • www.provcorp.com

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Gregg Bryars

VICE PRESIDENT OPERATIONS

QUALIFICATIONS

An accomplished senior executive with a consistent history of achievement in sales and operations management. Recognized for strong leadership, strategic planning, relationship development and analytical skills.

EXPERIENCE

January 2008 to Present
Vice President of Operations, LogistiCare

- Responsible for all operational aspects of LogistiCare's contracts in Missouri, Arkansas, Oklahoma, Colorado, Mississippi, Michigan, Kansas, and Ohio
- Develops programs to enhance the quality, effectiveness, and efficiency of all day-to-day operational functions: operational implementation of new business contracts including staffing, training, technical (telephone, compute, and software systems), network development, policies, and procedures; financial and operational analysis with regards to vendor costs, utilization
- Fosters positive relationships with local and state government officials, medical facility staff, and patient advocacy groups to ensure confidence in the LogistiCare brokerage system

2006-2007
Consultant, Houston, TX

- Conducted sales management training, performance evaluations, proposal development and introduced metric-based tools for a division of a national waste management firm
- Conducted an in-depth analysis of business functions, designed new marketing, communication, and management plans for a pet care facility
- Active consultant on staffing & scheduling, operations, P&L management, expense control, marketing and performance evaluations

2004-2006
Vice President, Sales, GCA Services Group, Inc., Houston, TX

- Key change agent in transitioning the sales team from a transactional focus to a consultative, relationship driven sales model
- Effectively mentored existing staff in implementation of the new model. Recruited, trained and deployed top performers into the region in order to increase sales effectiveness
- Designed and executed the sales strategy that increased revenue 10% in the division within one year, with pipeline revenues exceeding $40M. Played a significant role in growing the revenue from $190M to over $400M through organic growth and carefully selected acquisitions
- Managed sales and marketing integration for acquired companies exceeding $50M in revenues

1998-2003
Senior Vice President, Sales Marketing, National Linen Service, Atlanta, GA

- Accountable for revenue, sales forces, national & major accounts, contract management, marketing and budgeting.
- Executive committee member responsible for company's P&L.
- Restructured National Account group and grew revenues from $37M to $58M
- Grew Healthcare segment annual revenues from $38M to $81M
- Grew Lodging segment annual revenues from $6M to $10M

1990-1998
Division Vice President, Wells Fargo Armored & ATM Service Corporation, Atlanta, GA

Division Vice President 01/97 – 05/98
- Accountable for the $75M Northeast Division including revenue, sales, pricing, operations, compliance, union negotiations and P&L. Division consisted of 24 branches and employed more than 1,000 associates
- Increased revenue per route hour by 24.8% and reduced route hours per day by 23.9%
- Reduced cargo claims to prior year by 55% and cargo losses to prior year by 49%
- Negotiated union contracts in Virginia, New Jersey and the metro New York City operations
- Completed NYC branch turnaround from an annual operating loss exceeding $1M to double digit operating margins

District Manager 05/93 – 01/97
- Achieved the highest District profit in the company in 1995 & 1996
- District produced $35M in revenue and consisted of 31 profit centers, 13 of which had union representation and employed approximately 620 associates
- Achieved organic revenue improvement over prior year of 4% (1996) and 9.4% (1995)
- Achieved operating income improvement over prior year of 5% (1996) and 10.7% (1995)
- Awarded District Manager of the Year award; 1995 & 1996

Area Manager, Tennessee, 09/92 – 05/93
- Managed all operations within Tennessee (approx $10M in revenues)
- Achieved 105% of budgeted revenue expectations

Regional Sales Manager, 10/90 – 09/92
- Managed sales force of approximately 25 reps for 7 state operations
- Achieved 120% of budgeted sales production

EDUCATION

B.S., Business Administration, Nicholls State University

Albert Cortina, CPA

CHIEF ADMINISTRATIVE OFFICER

QUALIFICATIONS

Senior executive and technology manager with more than 17 years of financial and operational management experience. Extensive experience developing financial and operational systems for physician groups and medical clinics. Skilled in increasing operating efficiencies.

EXPERIENCE

1997 to Present
LogistiCare

Chief Administrative Officer (April 2007 to Present)

Responsible for negotiating client and provider contracts. Ensures compliance with contracts. Participates in staffing and managing of new business implementation teams. Oversees the development of transportation network. Assists CEO and COO in development of overall corporate growth and organizational development strategies.

COO and Executive Vice President for Operations (2000 to 2007)

Responsible for successful operation of all existing operations. Ensured that financial, customer service, and provider network development goals were achieved in all existing operational areas. Directly managed regional operations directors and corporate technology support units. Participated in staffing and managing of new business implementation teams. Assisted CEO in development of overall corporate growth and organizational development strategies.

Executive Vice President-Finance/Strategic Planning (1997 to 2000)

Responsibilities ranged from setting up financial and operational systems (such as staffing and reporting structures) to relocating and consolidating all financial services for the corporate headquarters in Georgia. Represented the organization through the State budgeting and legislative sessions and sub-appropriations committees responsible for the statewide Medicaid transportation developmental programs. Prepared presentations for quarterly board meetings. Developed transportation agreements and negotiated rates with governmental and commercial providers. Created financial trends for operations centers in Connecticut, Florida and Georgia. Monitored monthly transportation provider costs and assisted in developing a strategic plan that allows for additional utilization within the same cost structure. Responsible for annual budget and quarterly projections. Negotiated financing for capital improvements and developments.

1996 to 1997
Chief Financial Officer, Premier Practice Management

Responsibilities ranged from setting up financial and operational systems of a startup company for over 85 physician and consolidation of similar functions. Developed and presented Physician Compensation Committee standards for establishing physician base and bonus compensations. Developed a Practice Acquisition Model and Financial Due Diligence checklist. Negotiated all

Albert Cortina, CPA

CHIEF ADMINISTRATIVE OFFICER

aspects of acquiring new practices. Participated with the CEO, Medical Director and Chairman in the development of business initiatives.

1994 to 1996
Director of Finance, Caremark Inc.

Responsibilities included financial and operational management of Atlanta Medical Clinic, a 48 multi-specialty practice group with six satellites representing 23 specialties and ancillary services. Served on one of four voting seats for the Executive Committee (The Governing Body). Supervised Planning and Analysis for annual budgets. Project Coordinator for a 12/95 medical software conversion for the main clinic and its six satellites. Presented to Physician Shareholders and Corporate Officers monthly financial results, recommendations and operational changes.

1992 to 1994
Controller, Atlanta Medical Associates

Converted Information Systems hardware from Systems 38 to AS400 for a partnership of 45 physicians providing multi-specialty medical care. Developed and implemented financial, accounting and internal control systems. Reviewed PPOS, HMOs, POS plans for reimbursement profitability, contract language and operational billing implementation.

1985 to 1991
Senior Auditor, Georgia Department of Audits

Managed multiple healthcare audits for proper Medicare and Medicaid cost reporting and compliance adherence to HCFA guidelines. Developed internal control questionnaire for healthcare facilities. Performed audits of local educational agencies and city authorities.

EDUCATION

Certified Public Accountant, Georgia Certificate # 12009,1995
BS of Accounting - 1990 Florida State University, Tallahassee, Florida

Samantha Garcia

GENERAL MANAGER

QUALIFICATIONS

A seasoned professional with over 15 years of managerial experience in call center, customer care, and account management capacities. Experienced manager of bi-lingual workforce.

EXPERIENCE

November 2007 – Present
General Manager, LogistiCare Phoenix, AZ

- Direct responsibility for call center servicing of contracts covering 700,000 lives.
- Supervise 170 transportation companies in the running of 57,000 trips per month
- Supervise a staff of 63 that includes a Transportation Department, Healthcare Manager, Field Monitor and Call Center support staff
- Direct responsibility for budgeting, P&L review and development and maintaining of on going relationship with state officials

October 2003 – September 2007
Consultant, New Business Consulting

- Consulted with companies to develop business plans, IT requirements, recruiting strategies, new hire training, sales goals, and success metrics.
- Establish financial goals and objectives to ensure profitability.

November 2002 – October 2003
Director of Operations, TSE Enterprises, Phoenix, AZ

- Responsibilities included managing Call Center, Human Resources, Project Management; Web based client support, data base management and IT organizations.
- Oversaw operations in multiple sites in multiple states.
- Developed recruiting strategy to accommodate seasonal and short term projects.

August 1997 – November 2002
Director of Operations, DCI Companies, Phoenix, AZ

- Responsible for day to day management of a blended Call Center, with revenue in excess of $20 million.
- Development of business strategy, including development of success metrics, sales objectives and growth goals.

Samantha Garcia

GENERAL MANAGER

- Integrated systems (CTI, IVR, FTP, Email, Web and dialing systems) to streamline processes and increase productivity.
- Full budgetary and P&L responsibilities

April 1997 – August 1997
On-Site Manager, SOS Staffing (On-site at DCI Companies), Phoenix, AZ

- Responsibilities included recruiting, hiring, and Human Resources responsibilities for assigned accounts.
- Developed and conducted training curriculum.
- Ensured that the Call Center was staffed at appropriate levels.
- Resolved all employee issues, including termination of non-performing employees.

October 1995 – April 1997
Senior Staffing Coordinator, Nesco Staffing, Tempe, AZ

- Responsible for all phases of recruiting and hiring of employees for 65 locations, with total employee count in excess of 200.
- Ensured compliance to all EEO, ADA, State and Federal regulations and/or laws.
- Developed company specific recruiting strategies, including print ad, networking, partnering with city and state agencies and any other means necessary to ensure staffing objectives were met.
- Conducted random audit of employee files to ensure that all employees complied with FLSA and city and state regulations.

Previous Managerial Experience

April 1990 – April 1995
Multi-Store Manager, Circle K Corporation, Phoenix, AZ

EXPERIENCE

B.S. **Business Management,** University of Phoenix

Tashena Jana Gasaway

1316 Adcox Square · Stone Mountain, GA 30088
(678) 360-7471· tashenag@hotmail.com

Professional Strengths

- Analytical Skills
- Attention to Detail
- Multi-tasking/Prioritization
- Written Communication Skills
- Verbal Communication Skills
- Presentation Skills
- Problem Resolution
- Project Management
- Relationship Building
- Organizational Skills
- Time Management Skills

Computer Skills

MS PowerPoint, MS Word, MS Excel, MS Access, MS Outlook, MS Project, Adobe Acrobat, Internet

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EDUCATION:

December 2004 **Master of Public Health (3.65/4.0 GPA)**
Health Policy and Management
Emory University, Atlanta, GA

August 2003 **Bachelor of Science (Magna Cum Laude)**
Health Care Administration and Planning
Tennessee State University, Nashville, TN

WORK EXPERIENCE:

8/07– Present LogistiCare Solutions, LLC, College Park, GA
Client Services Account Manager

- Manage new account implementations involving coordination with cross-functional internal and external departments, which include development of project plans outlining required tasks and timelines, weekly status calls 60-90 days prior to go-live, and development of project documentation to be distributed to appropriate stakeholders and management
- Maintain client relationships and serve as primary point of contact post-implementation
- Define, implement, and oversee performance measures and operational goals for managed care accounts in coordination with Operations management
- Identify, address, and resolve operational and/or account related issues
- Negotiate contracts with managed care clients including development of client-specific transportation protocols (Statement of Work and Summary of Covered Benefits)
- Coordinate responses to pre-delegation and annual audits (desk and on-site) conducted by managed care clients

1/05 – 8/07 Sullivan Consulting Group, Atlanta, GA
Health Care Consultant

- Composed high quality Certificate of Need (CON) applications for construction, expansion, purchase of medical equipment and implementation of new services in compliance with state rules and regulations while working within a multidisciplinary team
- Reviewed operating, ground, and medical equipment leases
- Extracted, analyzed, and summarized data
- Interacted regularly with health care providers (hospitals/hospital systems, single and group physician practices, ambulatory surgery centers, and DTRCs) to determine facility needs
- Assisted in the strategic planning process for hospitals/health care systems
- Prepared presentations to be used in appeal and administrative hearings
- Trained and supervised new consultants and research assistants

5/04 – 12/04 Emory University, Atlanta, GA
Research Assistant, Neighborhood Parks and Active Living

- Conducted qualitative and quantitative analysis of park usage data
- Lead author in preparation of journal article on the impact of governance and ownership on the use of neighborhood parks

8/03 – 1/04 Hughes Spalding Children's Hospital, Atlanta, GA
Intern, Planning and Development

- Conducted patient flow analysis to reduce inefficiencies in the Emergency Department
- Managed program databases

5/01 – 5/03 Tennessee Department of Health, Nashville, TN
Senior Executive Intern, TN Breast and Cervical Cancer Early Detection Program

- Communicated with health care providers concerning patient accounts and performed patient follow-up
- Processed health claims
- Created and managed program databases (Access)

References available upon request

Kenneth K. Piehl

CORPORATE OPERATIONS DIRECTOR

QUALIFICATIONS

Experienced executive with 30 years of senior management responsibility. Extensive experience and skills in right-sizing companies, strategy development, security and risk management, and organizational development.

EXPERIENCE

March 2007 to Present
Corporate Operations Director, LogistiCare

Oversees all operational aspects of LogistiCare's contracts in Connecticut, Missouri, Nevada, and California. Develops programs to enhance the quality, effectiveness, and efficiency of all day-to-day operational functions. Responsible for operational implementation of new business contracts including staffing, training, technical (telephone, compute, and software systems), network development, policies, and procedures. Provides financial and operational analysis with regards to vendor costs, utilization, and efficiency. Fosters positive relationships with local and state government officials, medical facility staff, and patient advocacy groups to ensure confidence in the LogistiCare brokerage system.

1996-2006
Senior Vice President of Administration, National Service Industries

Responsible for driving turnaround efforts with two multi-state operating divisions, National Linen Service and Atlantic Envelope, with over 11,000 employees, both involved in a turnaround, downsizing, and preparation for sale. Functional responsibilities included managing a labor budget of $88 million, driving labor productivity through shop floor accountability, reducing delivery labor, legal compliance, litigation management, employee and labor relations, safety, security and risk management.

Major accomplishments while in this role include:

- Drove consolidation effort, reducing overhead in excess of $12 million annually.
- Improved delivery labor by 5% by reducing overtime through use of GPS tracking device and negotiated improved labor contract terms.
- Developed field operations audit to serve as template for right running branch.
- Upgraded 80% of field operating and sales teams through aggressive recruiting
- and linking performance management process to business strategy.
- Improved responsiveness to the front line of the business system through management restructure, reducing expense by over $3 million.
- Negotiated multiple cost effective vendor and labor agreements.
- Managed downsizing and sale of two operating divisions without incurring any service disruption or litigation from customers or employees.
- Drove culture change to instill employee ownership at the service level.
- Eliminated all employee litigation.
- Consolidated and eliminated staff to provide service center concept.

1994-1996
Executive Search Consultant, Jim Parham & Associates, Inc.

Successfully opened the Atlanta office of a retained search firm specializing in the recruitment of mid-level and executive management for the transportation and security industries.

1977-1994
Senior Vice President of Administration, Borg-Warner Security Corporation

Responsible for reducing labor and overhead at over 165 locations with over 8,000 employees. Functional responsibilities included labor control, branch operational audits, properties, fleet, contracts, legal compliance, risk management, communications, and labor relations.

Major accomplishments while in this role are as follows:

- Initiated and implemented an operational reengineering effort resulting in annual savings in excess of $1,000,000 in labor and vendor costs.
- Directed the installation of a contract billing program at all field locations.
- Recruited and trained JMOs to upgrade field operations team.
- Eliminated all unions from a ground courier company.
- Directed activities in four major acquisitions, consolidated staff and achieved smooth transitions without loss of productivity.
- Achieved $600,000 reduction in group insurance costs, $3,000,000 reduction in the All Risk Insurance and $1,056,000 reduction in liability insurance.

1973-1977
Industrial Relations Manager, The Warner & Swasey Company

Responsible for all HR activities.

1971-1973
Assistant Personnel Manager, The Sherwin Williams Company

Responsible for recruiting, benefits, safety, security, and grievance handling at a paint manufacturer.

EDUCATION AND AFFILIATIONS

B.B.A – 1971, Cleveland State University
Member of Society for Human Resource Management
Member of American Society of Industrial Security
Member of Employment Management Association

Sandra K. Reifel

VICE PRESIDENT, MANAGED CARE BUSINESS

QUALIFICATIONS

- Excellent Negotiation Skills gained through years of contract negotiation
- Experience working with all levels of management to set, implement and achieve stated goals
- Excellent presentation skills
- Comprehensive project management skills
- Ability to lead/manage through results-oriented management expertise and ability to motivate others to excel
- Strong analytical and strategic thinking skills for problem solving
- Ability to communicate business and technical data to a wide variety of audiences
- Excellent Vendor Management skills
- Experience in Strategic Marketing and Marketing Research
- Experience in Value Chain Management and Six Sigma methodology (incremental process improvement)

EXPERIENCE

LOGISTICARE (www.logisticare.com)
VP, Managed Care Business
Responsible for all aspects of LogistiCare's Managed Care Business from new business development, contract negotiation, rate establishment, development of scope of services, program implementation, oversight of all ongoing account management, including contract compliance and compliance review. Oversees the Client Services department.

BANTA CORPORATION (RR Donnelley) (www.rrdonnelley.com)
Senior Account Executive
Work with executives and senior managers of Fortune 500 corporations to identify outsource opportunities of non-core competencies, specifically focused on PreMedia, Literature Management and Fulfillment, and Print programs including POD, sheetfed, and web printing.

- Negotiate, implement, and monitor contracts with new and existing accounts
- Develop integrated print and fulfillment solutions across multiple business units
- Develop pricing strategies for industry specific markets
- Develop custom proposals and negotiate final contracts.
- Manage print and fulfillment programs for specific customers including Home Depot Pro Business, Siemens Energy & Automation, International Paper, Progress Lighting, and United Communications Group (printed, and fulfilled approximately 25,000 tax code titles weekly during Nov, Dec, and Jan)
- Managed internal teams and external vendors for print and fulfillment accounts

Exceeded assigned performance quota by average of 10 - 25% annually. Awarded President's Circle recognition for outstanding performance.

STIBO DATAGRAPHICS
Sales Manager
Managed a staff of eight sales professionals with complete accountability for hiring, training, sales performance, and review processes. Established and managed sales department budget to

ensure corporate goals were met. Analyzed market trends to determine new product offerings.
Account Executive
Managed account portfolio that consisted of existing and new customer acquisitions. Exceeded annual assigned quota by average of 15 - 25%. Received "Salesperson of the Year"
Director of Training
Managed all aspects of training department and hiring of all technical personnel.
Managed staff of 22 typographer/graphic artists that served as production department for creation of all technical catalog data for customer base. Average weekly output of catalog page creation/edits approximately 2,500.
Developed a series of CBT interactive learning modules used throughout corporation.
Developed custom courseware for project management of technical projects.
Member of start-up management team of the Swindon, England location in 1988.

EDUCATION

KENNESAW STATE UNIVERSITY, Kennesaw, GA
Bachelor of Science, Psychology, magna cum laude
KENNESAW STATE UNIVERSITY, Kennesaw, GA
MBA
National Honor Society for Psychology - Psi Chi

Herman Schwarz

CHIEF OPERATIONS OFFICER

QUALIFICATIONS

Over 20 years of experience and proven skills in profit and loss accountability, strategy development, operations management, mergers and acquisitions, sales and marketing, organizational development, and the application of public company requirements including Board of Director, investor relations, and Sarbanes-Oxley compliance.

EXPERIENCE

January 2007 to Present
Chief Operations Officer, LogistiCare

Responsible for success of all existing operations. Ensures that financial, customer service, and provider network development goals are achieved in all existing operational areas. Directly manages corporate operations directors and corporate technology support units. Participates in staffing and managing of new business implementation teams. Assists CEO in development of overall corporate growth and organizational development strategies.

2005-2006
Founder and Partner, C3 Marketplace, LLC

Created a buying service and sourcing venture that delivers direct pricing from Asia to small and medium sized retailers and manufacturers. Partnered with associate to provide leadership through the start-up phase. Primary responsibilities included raising capital, business development, designing infrastructure, and managing financial, legal, and accounting matters.

2000-2004
Aegis Communications, Inc

President, Chief Executive Officer, and Director (2001-2004)
Leader of the country's seventh largest publicly traded provider of outsourced call center services. Implemented new corporate governance changes as required by Sarbanes-Oxley legislation. Led negotiations with lenders and investors to extend credit line expiration and allow for the orderly sale of the company.

President, Elrick & Lavidge (2000-2001)
Directed the financial turnaround of this marketing research division of Aegis with offices and production facilities in seven locations. Improved margins through a staff resizing and the introduction of financial accountability measures down to the individual. Executed a wholesale upgrade in management personnel and new incentive programs to exact a cultural shift from a comfortable, intellectual atmosphere to a results oriented, business environment creating positive financial results within nine months.

1992-2000
National Service Industries

President, Selig Industries (1999-2000)
Leader of this $35 million specialty chemical division. Implemented a new sales model for national accounts and introduced a regional management structure leading to record sales months and real sales growth of double the historical rate. Only Division President in FY 2000 to earn maximum incentive payout based on achievement of targeted profit plan.

Senior Vice President, National Linen Service (1998-1999)
Directed all sales and marketing activities for $310 million textile rental division, managed the operating plants in South Florida region (six industrial laundries and a sterilization facility accounting for $50 million in revenue), and had overall responsibility for the company's healthcare segment. Initiated management team upgrades and physical plant improvements leading to improved customer retention and 9% increase in profits versus prior year.

Vice President of Healthcare, National Linen Service (1996-1998)
Had overall management responsibility for this $100 million segment of the company. Restructured the sales and service functions to create a more customer centric offering. Launched major account sales effort that utilized a team selling approach to simultaneously pitch corporate and local levels of major hospital corporations. Effort was instrumental in re-acquiring over 50% of a previously lost $20 million customer. Signed additional $10 million in annual revenues.

Vice President Strategic Planning, National Linen Service (1994-1996)
Initiated and developed a planning process for the $550 million company (prior to divestiture of uniform rental operations). Designed and managed an activity based costing study to create action plans focused on the more profitable products and customers.

1989-1992
Senior Consultant, Mars & Company

Led project teams focused on developing strategic alternatives for clients based on product line and distribution channel economics, prevailing market trends and the competitive landscape. Interacted with and presented recommendations to CEO and senior management team of multi-billion dollar clients in the beverage, restaurant, cable, and wholesale distribution industries.

1984-1987

Senior Accountant, Arthur Anderson & Co.
Managed on-site audit engagements for clients in the banking, construction, entertainment, consulting, and non-profit sectors. Promoted on fast track schedule.

EDUCATION

M.B.A., Finance – 1989, Wharton School of Business, University of Pennsylvania
B.S., Commerce – 1984, University of Virginia (Beta Alpha Psi, Raven Society)
Passed CPA exam – 1984 (non-current license)

Logisticare List of Government Clients

The Following contracts are for the management of government funded transportation services (Medicaid or Medicare) through contracts with HMOs or other managed care organizations.

ST	Client	Summary	Start Date	End Date	Contract Type	Auth Net Trips YR 2011
CA	Care 1st Health Plan	**Medicaid NET:** Broker shall provide NET services for Care 1st enrollees within the state of California in Los Angeles, San Diego, Orange, San Bernadino, Riverside, and Santa Clara counties.	1-Dec-10	11/30/2011; 4 additional 1 year renewal options	Fee-for-Service	
CA	HealthNet	**Medicaid & Medicare NET:** Broker shall provide NET services for SNP eligibles for Northern & Southern California	South 01/01/07; North 01/01/08	EVERGREEN	Capitated Payment Schedule	
CA	SCAN Health plan	**Medicare NET:** Social HMO NET: Broker shall provide NET services for SCAN Members of California.	1-Aug-05	EVERGREEN	Capitated Payment Schedule	
CT	Wellcare of Connecticut, Inc.	**Medicare NET MCO:** Broker shall provide NET services to Medicaid eligible individuals identified by ODJFS.	1-Nov-06	EVERGREEN	Capitated Payment Schedule	1,310
CT	Aetna Better Health	**Medicaid NET:** Broker shall provide NET services to eligible members in the state of Connecticut	1-May-08	EVERGREEN	Capitated Payment Schedule	13,833
DC	DC Chartered Health Plan	**Medicaid NET MCO:** Broker shall provide NET services to eligible members in DC Counties: Coverage of the DC Metropolitan Area includes the following counties…Alexandria (VA), Arlington (VA), Falls Church (VA), Prince George's (MD), Charles County (MD), Montgomery (MD), Anne Arundel (MD)	1-Jun-08	EVERGREEN	Capitated Payment Schedule	1,310
DC	Unison Health Plan	**Medicaid NET MCO:** Broker shall provide NET services to eligible members in DC	1-May-08	EVERGREEN	Capitated Payment Schedule	11,079
FL	Amerigroup Community Care of Florida, Inc.	**Medicaid & Medicare NET:** Broker shall provide NET services for Medicaid members enrolled with AMERIGROUP-Florida.	1-Sep-06	EVERGREEN	Capitated Payment Schedule	12,649
FL	Citrus Health Care	**Medicare NET MCO:** Broker shall provide NET services for members enrolled in the Citrus Health Plan	1-Jan-08	EVERGREEN	Capitated Payment Schedule	6,011
FL	HUMANA Medical Plan	**Medicaid NET:** Broker shall provide NET services for members enrolled in the Humana Medical Plan	1-Feb-06	EVERGREEN	Capitated Payment Schedule	2,189

Logisticare List of Government Clients

The Following contracts are for the management of government funded transportation services (Medicaid or Medicare) through contracts with HMOs or other managed care organizations.

ST	Client	Summary	Start Date	End Date	Contract Type	Auth Net Trips YR 2011
FL	JMH Health Plan	**Medicaid NET MCO:** Broker shall provide NET services for eligible members enrolled with the health plan	1-Jan-10	EVERGREEN	Capitated Payment Schedule	109,558
FL	Preferred Medical Plan	**Medicaid NET MCO:** Broker shall provide NET services for Medicaid members enrolled in the Preferred Medical Plan Network.	6-Aug-03	EVERGREEN	Capitated Payment Schedule	2,053,195
FL	United Health Care, Inc.	**Medicaid NET MCO:** Provision of NEMT to United members	1-Sep-06	EVERGREEN	Capitated Payment Schedule	535,430
FL	Wellcare - Healthease program	**Medicaid NET MCO:** Broker shall provide NET services for Medicaid members enrolled with Wellcare - Healthease of Florida, Inc.	22-Oct-04	EVERGREEN	Capitated Payment Schedule	1,273
FL	Wellcare of Florida, Inc.	**Medicare NET:** Broker shall provide NET services for Medicaid members enrolled with Wellcare of Florida, Inc.	18-Apr-07	EVERGREEN	Capitated Payment Schedule	1,611
FL	Public Health Trust (Part of the SFCCN Network)	**Medicaid NET MCO:**	1-Jul-08	EVERGREEN	Capitated Payment Schedule	2,053,195
KS	Unicare Health Plan of Kansas, Inc. (Wellpoint)	**Medicaid NET MCO:** Broker shall provide NET services for Medicaid members enrolled with UNICARE of Kansas.	1-Jan-07	12/31/2008; 3 additional 1 year renewal options 12/31/2011	Capitated Payment Schedule	2,935
MI	Care Source Michigan f/k/a Community Choice Michigan	**Medicare & Medicaid NET:** Broker shall provide NET services for Medicaid members enrolled in the Michigan Community Choice Network.	1-Feb-07	3/31/2011	Capitated Payment Schedule	721
NAT	HUMANA Medical Plan	**Medicare NET:** Broker shall provide NET services for members enrolled in the Humana Medical Plan	1-Jan-07	EVERGREEN	Capitated Payment Schedule	526,713
NAT	Munich Re d/b/a Windsor Health Plan	**Medicare NET MCO:** Broker shall provide NET services to eligible Windsor Health Plan Members of MS, AR, SC, TN & AL	1-Jul-09	EVERGREEN	Capitated Payment Schedule	-
NAT	United Health Care	**Medicare & Medicaid NET MCO:** Provision of NEMT to United members; Each population added by addendum	1-Jan-08	EVERGREEN	Capitated Payment Schedule	4,689,622

Logisticare List of Government Clients

The Following contracts are for the management of government funded transportation services (Medicaid or Medicare) through contracts with HMOs or other managed care organizations.

ST	Client	Summary	Start Date	End Date	Contract Type	Auth Net Trips YR 2011
NJ	WellCare Health Plans of New Jersey	**Medicare NET:** Broker shall provide NET services for Medicare members enrolled with Wellcare of NJ, Inc.	1-Jan-09	EVERGREEN	Capitated Payment Schedule	No. is combined with NY and NJ
NM	HCSC Insurance Services d/b/a Blue Cross Blue Shield of New Mexico	**Medicaid NET MCO:** Broker is to arrange NET services covered under the MedicaidAdvantage Plans which BCBSNM has agreed contractually to provide or arrange for Enrollees	1-Jan-08	EVERGREEN	Capitated Payment Schedule	407,691
NV	JSA P5 Nevada, LLC d/b/a Healthcare Partners of Nevada, Inc.: Letter of Intent	**Medicare NET:** Broker is to arrange NET services covered under the Medicare Advantage Plans which HCPN has agreed contractually to provide or arrange for Enrollees	1-Mar-09	EVERGREEN	Capitated Payment Schedule	59,030
NY	Affinity Health Plan	**Medicare NET:** Broker shall provide NET services for Medicare members enrolled with Affinity Health Plan of NY	1-Jan-10	EVERGREEN	Capitated Payment Schedule	49,404
NY	Affinity Health Plan	**Medicaid NET:** Broker shall provide NET services for Medicaid members enrolled with Affinity Health Plan of NY	9-Nov-09	EVERGREEN	Capitated Payment Schedule	59,030
NY	Cuatro, LLC d/b/a Access Medicare	**Medicare NET:** Broker shall provide NET services for Medicare members enrolled with Access Medicare.	1-Jan-11	EVERGREEN	Capitated Payment Schedule	
NY	Quality Health Plan of New York	**Medicare & Medicaid NET MCO**	1-Oct-09	EVERGREEN	Capitated Payment Schedule	
NY	United Health Care of New York, Inc. Americhoice	**Medicaid NET MCO:** Provision of NEMT to United members; Broker shall provide NET services to eligible UHC Americhoice Members of New York.	1-Nov-09	EVERGREEN	Capitated Payment Schedule	172,819
NY	WellCare Health Plans of New York	**Medicare NET:** Broker shall provide NET services for Medicare members enrolled with Wellcare of NY, Inc.	1-Jan-09	EVERGREEN	Capitated Payment Schedule	40,604
OH	Amerigroup Ohio, Inc.	**Medicaid NET:** Broker shall provide NET brokerage services to transport Medicaid participants to and from medical appoints. Additional Scope - Broker may be enlisted to provide transportation brokerage services to other state agencies in the future.	1-Sep-05	EVERGREEN	Capitated Payment Schedule	165,036

Logisticare List of Government Clients

The Following contracts are for the management of government funded transportation services (Medicaid or Medicare) through contracts with HMOs or other managed care organizations.

ST	Client	Summary	Start Date	End Date	Contract Type	Auth Net Trips YR 2011
TX	Wellcare of Texas, Inc.	**Medicare NET:** Broker shall provide NET services for members enrolled with Wellcare of TX, Inc. (Bexar, Dallas, Tarrant and Harris counties)	1-Jan-11	EVERGREEN	Capitated Payment Schedule	
VA	Amerigroup Virginia, Inc.	**Medicaid NET MCO:** Broker shall provide NET services for Medicaid members enrolled with AMERIGROUP-Virginia.	1-Sep-05	EVERGREEN	Capitated Payment Schedule	4
VA	Anthem Blue Cross Blue Shield	**Medicaid NET MCO:** Broker shall provide NET services to eligible Anthem BCBS Members of Virginia.	1-Mar-05	EVERGREEN	Capitated Payment Schedule	756
VA	Southern Health Services, Inc.	**Medicaid NET MCO:** Broker shall provide NET services to eligible Southern Health Services, Inc. members of Virginia.	1-Nov-08	EVERGREEN	Capitated Payment Schedule	-
VA	Optima Health Plan	**Medicaid NET MCO:** Broker shall provide NET services for Medicaid members enrolled with Optima Family Health.	1-Feb-07	02/28/2010; EVERGREEN after initial three-year period	Capitated Payment Schedule	-
36	TOTAL INDIRECT GOVERNMENT CONTRACTS					

Logisticare References

Please see Attachment B.11.u in our **ORIGINAL** proposal for sealed envelopes containing completed reference questionnaires for Logisticare.

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June 15, 2011

Darren C. Morgan
Amerigroup Corporation

Dear Mr. Morgan:

We understand that the Louisiana Department of Health and Hospitals ("DHH") is soliciting competitive proposals for managed care services through Medicaid Coordinated Care Network Request for Proposals (RFP # 305PUR-DHHRFP-CCN-P-MVA) (the "RFP") and Amerigroup Corporation intends to respond to the RFP.

Please accept this correspondence as the required statement that Verity, a proposed subcontractor for Amerigroup's Medicaid managed care business in the State of Louisiana, will unconditionally guarantee performance by Verity of each and every obligation, warranty, covenant, term and condition of the contract between Verity and Amerigroup Corporation.

Sincerely,

Julie Morgan
Director of Client Services
Verity HealthNet

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VERITY HEALTHNET KEY PERSONNEL RESUMES

JOSEPH A. BONSIGNORE

President of Verity HealthNet

Experience

President, Verity HealthNet, (2002 to present)

- Develops and implements the comprehensive corporate Quality Management Program to meet the needs of served populations
- Responsible for initial start up of company.y
- Responsible for strategic direction and goals of organization.
- Responsible for implementation of all processes necessary to achieve overall goals of organization.
- Oversaw growth of company to current membership of 50,000.
- Oversaw financial growth of company, with 32 consecutive quarters of financial growth and profitability.

JULIE MORGAN

Director of Client Services

Experience

Director of Client Services, Verity HealthNet, (2002 to present)

- Oversees interaction between client and Verity data systems and maintains responsibility of managing the relationship with Verity clients.
- Implemented and Oversees procedures to implement and maintain necessary provider data elements.
- Maintains individual provider data demographics as necessary to ensure accurate contracted provider information.
- Ensures other departments are collecting data as necessary for client systems to ensure accurate provider claim payments.

MARY JENKINS

Director of Provider Relations

Experience

Director of Provider Relations, Verity HealthNet, (2002 to present)

- Responsible for implementation and management of provider contracting strategy
- Responsible for receipt and maintenance of all necessary provider contracts and documentation
- Coordinates with other departments to provide necessary data to ensure accurate and timely provider demographic information.

Verity References

Please see Attachment B.11.x in our **ORIGINAL** proposal for sealed envelopes containing completed reference questionnaires for Verity.

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B.12 Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.

Corporate Compliance Program

Amerigroup's corporate-wide Compliance Program gives testimony to our commitment to compliance and adherence to the highest ethical standards. Our program's success is dependent on each one of our more than 4,000 employees across the 11 states where we operate. We strongly believe that through a unified effort in promoting program integrity and supporting the appropriate use of health care services, we preserve and promote Amerigroup's reputation and leadership role in the health care industry. that will apply to Amerigroup Louisiana.

The Amerigroup compliance program includes:

- Audit and oversight of health plan operations including field reviews and extensive "secret shops" of marketing and enrollment activities
- An Independent Compliance Expert to advise the Nominating and Corporate Governance Committee of the Amerigroup Corporation Board of Directors in its assessment of the compliance program's effectiveness
- A Beneficiary Rights Ombudsman who is responsible for accepting and responding to comments, concerns and complaints by Medicaid and Medicare members and potential enrollees
- A Code of Business Conduct and Ethics that all employees must acknowledge and agree to comply with as a condition of employment
- Compliance Committees and an Anonymous Compliance Hotline
- Extensive Compliance Training for all employees including two hours of initial compliance training and one hour of annual general compliance training, which includes education on the Agreement's requirements; Fraud, Waste and Abuse; HIPAA and the Amerigroup compliance program. In 2010, more than 5,000 employees across all Amerigroup Health Plans and certain contractors and consultants who meet an established threshold of service hours completed overall compliance training. Further, more than 400 employees received specific compliance training related to marketing and enrollment activities for Medicare and Medicaid.
- A Plan Compliance Officer designated for each Amerigroup Health Plan and accountable to for maintaining oversight of day-to-day compliance activities for the health plans in which they serve; responsible for working with executive leads of health plans to identify and assist in mitigation of potential risks and monitor key performance standard measurements.

Together, these components constitute a proactive, robust monitoring and enforcement program that ensures a comprehensive focus on compliance with all state and federal requirements. We believe compliance makes good business sense.

At the end of this response (Attachment B.12.a), we have included an organization chart that identifies all staff involved in the Amerigroup Corporate Compliance Program.

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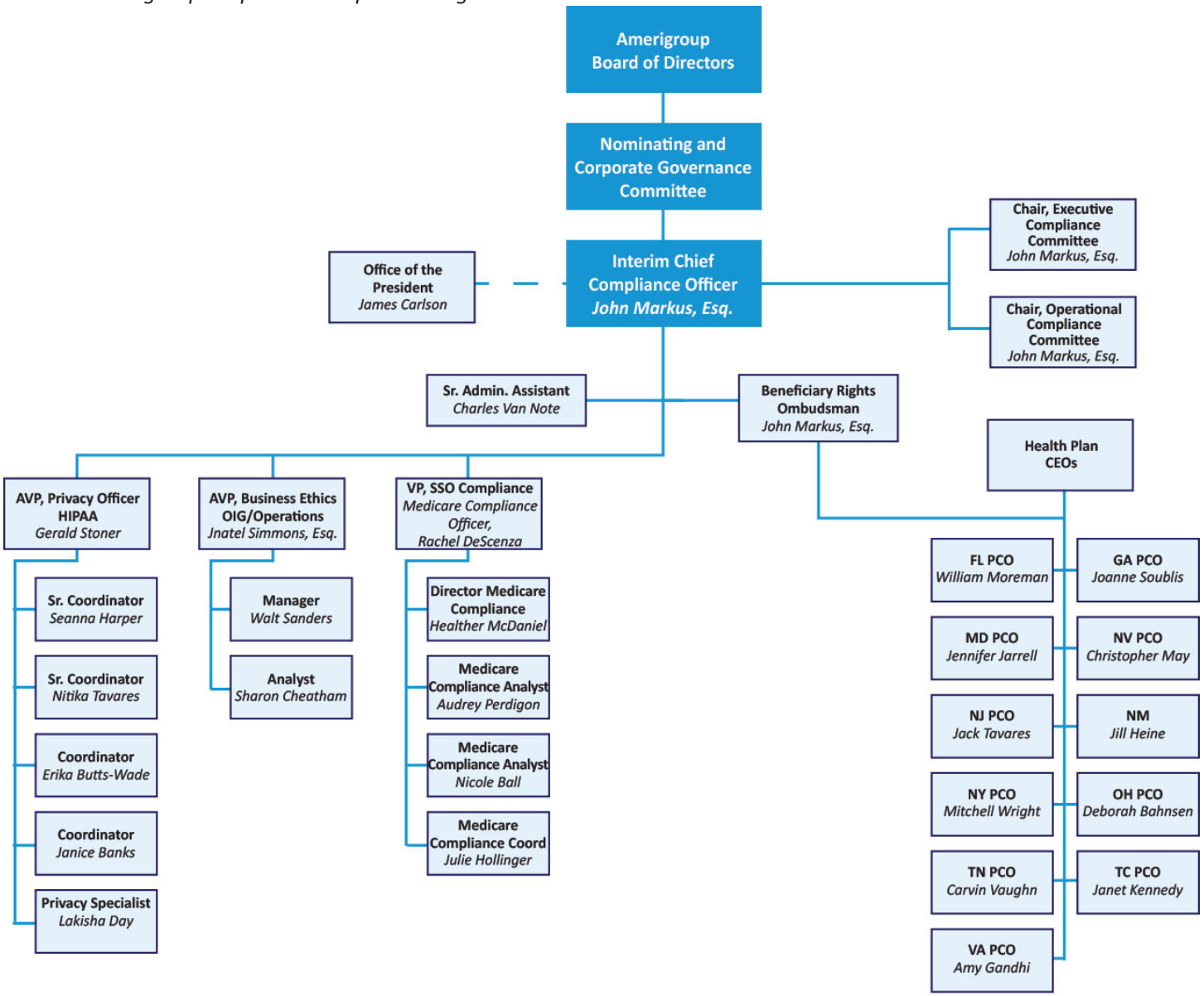
Attachment B.12.a
Chart B: Amerigroup Corporate Compliance Organization Chart



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B.13 Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, Do not include press releases that are primarily promotional in nature.

Press Releases

As a newly formed entity, there are no press releases related to Amerigroup Louisiana from the previous twelve (12) months. However, we have provided copies of the press releases related to Amerigroup Corporation and its other health plan subsidiaries as Attachment B.13.a at the end of this response. These press releases, all issued within in the past 12 months, mention or discuss financial results for the last several quarters, our recent expansion activities in Texas and a new Chief Marketing Officer at Amerigroup Corporation.

A summary of these press releases is included in Table B-24.

Table B-24. Press Releases Issued within Past 12 Months

Date Released	Press Release
May 4, 2010	Texas Selects Amerigroup for Expanded STAR+PLUS Program
July 30, 2010	Amerigroup Announced Net Income for the Second Quarter of 2010
October 19, 2010	Amerigroup Announced Net Income for the Third Quarter of 2010
February 10, 2011	Amerigroup Expands Health Plan Operations in Texas, Deploys iPads® to Support Member Needs
February 18, 2011	Amerigroup Announced Net Income for the Fourth Quarter of 2010
February 23, 2011	Amerigroup Named to 2011 “Best Places to Work in Virginia” List
February 25, 2011	Amerigroup Names Patrick Blair Chief Marketing Officer
April 25, 2011	Amerigroup to Open West Regional Service Center in Houston
April 29, 2011	Amerigroup Announced Net Income for the First Quarter of 2011

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AMERIGROUP CORPORATION

PRESS RELEASE

CONTACTS:
Investors: Julie Loftus Trudell
Senior Vice President, Investor Relations
Amerigroup Corporation
(757) 321-3597
Jtrudel@amerigroupcorp.com

Media: Tara J. Wall
Senior Vice President, Communications
Amerigroup Corporation
(757) 518-3671
Twall01@amerigroupcorp.com

Texas Selects Amerigroup for Expanded STAR+PLUS Program

VIRGINIA BEACH, Va. (May 14, 2010) – Amerigroup Corporation (NYSE: AGP) today announced that its Texas health plan has won its bid to expand health care coverage to seniors and people with disabilities in Tarrant County (Fort Worth). The award was announced by the Texas Health and Human Services Commission (HHSC). It came as the result of a competitive two-region bidding process that increases the role of Amerigroup's Texas subsidiary in the STAR+PLUS program.

"We are excited about the expansion of our services to the aged, blind and disabled population in the Tarrant Service Area," said Aileen McCormick, Southwest Regional CEO for Amerigroup. "This award recognizes that our experience serving this population throughout other parts of the State has made a significant difference in their lives, while simultaneously saving money for the State and taxpayers. HHSC is a national leader in managing this most challenging and expensive part of Medicaid, and we look forward to expanding our partnership with them."

In this bid, HHSC expanded the STAR+PLUS program to two regions, the Dallas and Tarrant service areas. Tarrant is a fully integrated program that includes behavioral health services. Amerigroup Texas will be one of two health plans serving approximately 30,000 members in that region. The announcement is subject to final contract negotiations between HHSC and Amerigroup Texas. These contract negotiations are expected to be finalized in summer 2010, with an operational start date in early 2011.

As of March 31, 2010, Amerigroup Texas served approximately 510,000 members, among them, over 55,000 who are aged, blind or disabled (ABD). Nationally, Amerigroup is a leader in coordinating care for individuals who participate in ABD programs, with approximately 200,000 members among this population.

About Amerigroup Corporation

Amerigroup, a Fortune 500 Company, coordinates services for individuals in publicly funded health care programs. Serving approximately 1.9 million members in 11 states nationwide, Amerigroup accepts all eligible people regardless of age, sex, race or disability. The Company's product offerings do not utilize any individual underwriting nor deny coverage due to pre-existing medical conditions. Amerigroup is dedicated to offering real solutions that improve health care access and quality for its members, while proactively working to reduce the overall cost of care to taxpayers. For more information and real story examples of these solutions, please visit www.amerigroupcorp.com.

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AMERIGROUP CORPORATION

PRESS RELEASE

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Amerigroup Reports Second Quarter 2010 Results

Net Income of $67.2 Million or $1.31 per Diluted Share

VIRGINIA BEACH, Va. (July 30, 2010) – Amerigroup Corporation (NYSE: AGP) today announced that net income for the second quarter of 2010 was $67.2 million, or $1.31 per diluted share, versus net income of $49.6 million, or $0.94 per diluted share, for the second quarter of 2009. Second quarter of 2009 results were positively impacted by a tax adjustment of $0.43 per diluted share related to litigation settled in 2008. Excluding the tax adjustment, second quarter of 2009 net income would have been $27.2 million, or $0.51 per diluted share. A reconciliation of this non-GAAP financial measure to GAAP is included on page 9 of this release.

Highlights include:

- Membership increased 41,000 members, or 2.2%, to approximately 1.9 million at the end of the second quarter compared to the first quarter of 2010, and a 10.5% increase over the second quarter of 2009.
- Second quarter total revenues were $1.4 billion, a 4.8% increase over the first quarter of 2010, and an 11.3% increase over the second quarter of 2009.
- Health benefits expense was 82.3% of premium revenues for the second quarter of 2010.
- Selling, general and administrative expenses were 7.5% of total revenues for the second quarter of 2010.
- Cash provided by operations was $116.4 million for the three months ended June 30, 2010.
- Unregulated cash and investments were $239.5 million as of June 30, 2010.
- Medical claims payable, as of June 30, 2010, totaled $525.6 million compared to $549.2 million, as of March 31, 2010.
- Days in claims payable was 41, compared to 43 days in the previous quarter.
- The Company repurchased approximately 1.05 million shares of its common stock during the second quarter for approximately $36.7 million.
- In May of 2010, the Texas Health and Human Services Commission announced that Amerigroup's Texas health plan was selected through a competitive procurement to expand health care coverage to seniors and people with disabilities in the six county service area surrounding Fort Worth. Pending final contract negotiations, the Company anticipates beginning operations in early 2011.

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"We are pleased with our performance in the second quarter and first-half of the year. More than any other time in our history, our state partners need the value we offer – expanded access to care, better coordination of services and clinical outcomes, as well as cost containment for their Medicaid-dependant populations," said James G. Carlson, Amerigroup's chairman and chief executive officer. "In particular, we are excited about our expansion of coverage to seniors and people with disabilities in Fort Worth, Texas, which is expected to begin in early 2011. The STAR+PLUS program is a national model for how to enable people to live independently, improve the quality of their lives and save taxpayer dollars."

Premium Revenues

Premium revenues for the second quarter of 2010 increased 11.2% to $1.4 billion compared to $1.3 billion in the second quarter of 2009. Sequentially, premium revenues increased $62.1 million, or 4.5%, compared with the first quarter of 2010.

The sequential increase in premium revenues primarily reflects the impact of the previously announced New Jersey acquisition and launch of the Tennessee long-term care program, both of which occurred on March 1, 2010. In addition, revenues benefited from continued membership increases across many of the Company's markets due to the macroeconomic environment driving expanded Medicaid participation.

Investment Income and Other Revenues

Second quarter investment income and other revenues were $8.6 million versus $6.5 million in the second quarter of 2009, and compared to $4.9 million in the first quarter of 2010. Investment income and other revenue increased on a sequential basis due to the sale of a trademark for $4.0 million.

Health Benefits

Health benefits expenses, as a percent of premium revenues, were 82.3% for the second quarter of 2010 versus 85.9% in the second quarter of 2009, and compared to 83.5% in the first quarter of 2010. The sequential decrease in the health benefits ratio was primarily due to continued moderate medical trends and normal seasonal declines in medical costs from the first to the second quarter.

Continuing what began most significantly in the fourth quarter of 2009, medical cost trends remained at moderate levels during the quarter. Costs remained in line with or better than expectations in most markets, with all major categories of service exhibiting lower trends in recent periods.

Favorable reserve development (net of associated accruals for experience rebate in Texas, applicable medical loss ratio floors, and other gain sharing arrangements with state customers) positively impacted the health benefits ratio in the second quarter by approximately 200 basis points compared to 250 basis points of favorable reserve development reported in the first quarter of 2010.

Selling, General and Administrative Expenses

Selling, general and administrative expenses were 7.5% of total revenues for the second quarter of 2010, unchanged from the second quarter of 2009, and compared to 8.6% for the first quarter of 2010. Selling, general and administrative expenses remained stable and at expected levels in the second quarter. The selling, general and administrative expense ratio was elevated in the first quarter of 2010 due to variable compensation accruals.

Premium Taxes
Second quarter premium taxes were $33.2 million versus $34.6 million for the second quarter of 2009, and compared to $31.5 million in the first quarter of 2010. The composite premium tax rate was essentially unchanged from the first to the second quarter of 2010.

Balance Sheet Highlights
Cash and investments at June 30, 2010 totaled $1.5 billion of which $239.5 million was unregulated, compared to $257.4 million of unregulated cash and investments at the end of the first quarter of 2010. Unregulated cash declined during the quarter primarily due to $36.7 million in share repurchase activity under the Company's ongoing stock repurchase program.

The debt to total capital ratio decreased to 18.4%, as of June 30, 2010, from 18.8%, as of March 31, 2010.

Medical claims payable as of June 30, 2010 totaled $525.6 million compared to $549.2 million as of March 31, 2010. Days in claims payable represented 41 days of health benefits expense, compared to 43 days in the previous quarter. The primary factor that drove the decline in days in claims payable was an increase in claims processing speed.

Included on page 9 is a table presenting the components of the change in medical claims payable for the six months ended June 30, 2010 and the year ended December 31, 2009.

Cash Flow Highlights
Cash flow from operations totaled $109.6 million for the six months ended June 30, 2010 and $116.4 million for the three months ended June 30, 2010. The key drivers of cash flow in the quarter were solid earnings and a net favorable change in working capital accounts.

Second Quarter Earnings Call
Amerigroup senior management will discuss the Company's second quarter results on a conference call Friday, July 30, 2010 at 8:00 a.m. Eastern Daylight Time (EDT). The conference can be accessed by dialing 866-260-3161 (domestic) or 706-679-7245 (international) approximately ten minutes prior to the start time of the call. A recording of the call may be accessed by dialing 800-642-1687 (domestic) or 706-645-9291 (international) and providing passcode 84750550. The replay will be available shortly after the conclusion of the call until Friday, August 6, at 11:59 p.m. EDT. The conference call will also be available through the investors' page of the Company's web site, www.amerigroupcorp.com, or through www.earnings.com. A 30-day replay of this webcast will be available on these web sites beginning approximately two hours following the conclusion of the live broadcast earnings conference call.

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Forward-Looking Statements

This release is intended to be disclosure through methods reasonably designed to provide broad, non-exclusionary distribution to the public in compliance with the Securities and Exchange Commission's Fair Disclosure Regulation. This release contains certain "forward-looking" statements, including statements related to moderating medical cost trends and the timing and expansion of our services in Texas. These statements are made pursuant to the Safe Harbor provisions of the Private Securities Litigation Reform Act of 1995. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated in the forward-looking statements. These risks and uncertainties include, but are not limited to: our inability to manage medical costs; our inability to operate new products and markets at expected levels, including, but not limited to, profitability, membership and targeted service standards; local, state and national economic conditions, including their effect on the rate-setting process and timing of payments; the effect of government regulations and changes in regulations governing the health care industry including the impact of recently enacted health care reform legislation; changes in Medicaid and Medicare payment levels and methodologies; increased use of services, increased cost of individual services, epidemics, pandemics, the introduction of new or costly treatments and technology, new mandated benefits, insured population characteristics and seasonal changes in the level of health care use; our ability to maintain and increase membership levels; our ability to enter into new markets or remain in existing markets; changes in market interest rates or any disruptions in the credit markets; our ability to maintain compliance with all minimum capital requirements; liabilities and other claims asserted against us; demographic changes; the competitive environment in which we operate; the availability and terms of capital to fund acquisitions, capital improvements and maintain capitalization levels required by state agencies; our ability to attract and retain qualified personnel; the unfavorable resolution of new or pending litigation; and catastrophes, including acts of terrorism or severe weather.

Investors should also refer to our annual report on Form 10-K for the year ended December 31, 2009 filed with the Securities and Exchange Commission ("SEC") and subsequent quarterly reports on Form 10-Q and current reports on Form 8-K filed with or furnished to the SEC, for a discussion of certain known risk factors that could cause our actual results to differ materially from our current estimates. Given these risks and uncertainties, we can give no assurances that any forward-looking statements will, in fact, transpire and, therefore, caution investors not to place undue reliance on them. We specifically disclaim any obligation to update or revise any forward-looking statements, whether as a result of new information, future developments or otherwise.

AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED INCOME STATEMENTS
(dollars in thousands, except per share data)
(unaudited)

	Three months ended June 30,		Six months ended June 30,	
	2010	2009	2010	2009
Revenues:				
Premium	$1,428,879	$1,284,890	$2,795,646	$2,502,337
Investment income and other	8,634	6,517	13,516	18,864
Total revenues	1,437,513	1,291,407	2,809,162	2,521,201
Expenses:				
Health benefits	1,176,445	1,103,213	2,318,017	2,122,516
Selling, general and administrative	108,189	96,285	225,612	206,660
Premium taxes	33,172	34,623	64,644	62,741
Depreciation and amortization	8,905	9,680	17,615	18,006
Interest	4,019	4,232	8,009	8,470
Total expenses	1,330,730	1,248,033	2,633,897	2,418,393
Income before income taxes	106,783	43,374	175,265	102,808
Income tax expense (benefit)	39,570	(6,225)	65,870	16,300
Net income	$67,213	$49,599	$109,395	$86,508
Diluted net income per share	$1.31	$0.94	$2.14	$1.63
Weighted average number of common shares and dilutive potential common shares outstanding	51,318,044	53,029,943	51,235,939	53,224,753

The following table sets forth selected operating ratios. All ratios, with the exception of the health benefits ratio, are shown as a percentage of total revenues.

	Three months ended June 30,		Six months ended June 30,	
	2010	2009	2010	2009
Premium revenue	99.4 %	99.5 %	99.5 %	99.3 %
Investment income and other	0.6	0.5	0.5	0.7
Total revenues	100.0 %	100.0 %	100.0 %	100.0 %
Health benefits [1]	82.3 %	85.9 %	82.9 %	84.8 %
Selling, general and administrative expenses	7.5 %	7.5 %	8.0 %	8.2 %
Income before income taxes	7.4 %	3.4 %	6.2 %	4.1 %
Net income	4.7 %	3.8 %	3.9 %	3.4 %

[1] The health benefits ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium received and the health benefits provided.

The following table sets forth the approximate number of members the Company served in each state as of June 30, 2010 and 2009. Because the Company receives two premiums for members that are both in the Medicare Advantage and Medicaid products, these members have been counted twice in the states where we offer both plans.

	June 30,	
	2010	**2009**
Texas[1]	539,000	476,000
Florida	259,000	264,000
Georgia	259,000	220,000
Maryland	202,000	183,000
Tennessee	199,000	195,000
New Jersey	145,000	112,000
New York	111,000	111,000
Nevada	72,000	53,000
Ohio	58,000	60,000
Virginia	39,000	29,000
New Mexico	21,000	20,000
Total	1,904,000	1,723,000

[1] Membership includes approximately 14,000 members under an ASO contract in 2010 and 13,000 in 2009.

The following table sets forth the approximate number of members in each of the Company's products as of June 30, 2010 and 2009. Because the Company receives two premiums for members that are in both the Medicare Advantage and Medicaid products, these members have been counted in each product.

	June 30,	
Product	**2010**	**2009**
TANF (Medicaid)	1,337,000	1,189,000
CHIP	274,000	262,000
ABD (Medicaid)[1]	204,000	205,000
FamilyCare (Medicaid)	71,000	54,000
Medicare Advantage	18,000	13,000
Total	1,904,000	1,723,000

[1]Membership includes approximately 14,000 members under an ASO contract in 2010 and 13,000 in 2009.

AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
(dollars in thousands, except per share data)
(unaudited)

	June 30, 2010	December 31, 2009
Assets		
Current assets:		
Cash and cash equivalents	$409,833	$505,915
Short-term investments	221,007	137,523
Premium receivables	115,007	104,867
Deferred income taxes	26,779	26,361
Prepaid expenses, provider and other receivables and other	55,058	47,316
Total current assets	827,684	821,982
Property, equipment and software, net	97,809	101,002
Goodwill	260,496	249,276
Long-term investments, including investments on deposit for licensure	889,324	813,976
Other long-term assets	13,550	13,398
	$2,088,863	$1,999,634
Liabilities and Stockholders' Equity		
Current liabilities:		
Claims payable	$525,603	$529,036
Unearned revenue	47,824	98,298
Accounts payable	4,844	4,685
Accrued expenses and other	183,565	127,278
Total current liabilities	761,836	759,297
Long-term debt	240,427	235,104
Other long-term liabilities	18,017	20,789
Total liabilities	1,020,280	1,015,190
Stockholders' equity:		
Common stock, $.01 par value	552	546
Additional paid-in capital, net of treasury stock	365,706	391,912
Accumulated other comprehensive income	2,298	1,354
Retained earnings	700,027	590,632
Total stockholders' equity	1,068,583	984,444
	$2,088,863	$1,999,634

AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(unaudited)

	Six months ended June 30,	
	2010	**2009**
	(dollars in thousands)	
Cash flows from operating activities:		
Net income	$109,395	$86,508
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	17,615	18,006
Loss on disposal of property, equipment and software	24	412
Deferred tax (benefit) expense	(1,972)	4,630
Compensation expense related to share-based payments	9,571	8,022
Convertible debt non-cash interest expense	5,323	4,987
Gain on sale of intangible assets	(4,000)	-
Gain on sale of contract rights	-	(5,810)
Other	4,189	(201)
Changes in assets and liabilities (decreasing) increasing cash flows from operations:		
Premium receivables	(10,140)	(15,683)
Prepaid expenses, provider and other receivables and other current assets	(6,138)	(35,928)
Other assets	(55)	(439)
Claims payable	(3,433)	26,883
Unearned revenue	(50,474)	(18,161)
Accounts payable, accrued expenses and other current liabilities	41,371	(36,605)
Other long-term liabilities	(1,714)	(2,583)
Net cash provided by operating activities	109,562	34,038
Cash flows from investing activities:		
Purchase of investments, net	(150,908)	(72,369)
Purchase of investments on deposit for licensure, net	(12,516)	(3,913)
Purchase of property, equipment and software	(13,508)	(15,865)
Proceeds from sale of intangible assets	4,000	-
Proceeds from sale of contract rights	-	5,810
Purchase of contract rights and other related assets	(13,420)	-
Net cash used in investing activities	(186,352)	(86,337)
Cash flows from financing activities:		
Repayments of borrowings under credit facility	-	(26,318)
Proceeds and tax benefits from exercise of stock options and change in bank overdrafts and other, net	24,384	(1,609)
Treasury stock repurchases	(43,676)	(28,555)
Net cash used in financing activities	(19,292)	(56,482)
Net decrease in cash and cash equivalents	(96,082)	(108,781)
Cash and cash equivalents at beginning of period	505,915	763,272
Cash and cash equivalents at end of period	$409,833	$654,491

AMERIGROUP CORPORATION AND SUBSIDIARIES
Components of the Change in Medical Claims Payable
(dollars in thousands)

	Six months ended June 30, 2010	Twelve months ended December 31, 2009
Medical claims payable, beginning of period	$529,036	$536,107
Health benefits expenses incurred during period:		
Related to current year	2,408,166	4,492,590
Related to prior years	(90,149)	(85,317)
Total incurred	2,318,017	4,407,273
Health benefits payments during period:		
Related to current year	1,960,389	4,007,789
Related to prior years	361,061	406,555
Total payments	2,321,450	4,414,344
Medical claims payable, end of period	$525,603	$529,036

Health benefits expense incurred during both periods were reduced for amounts related to prior years. The amounts related to prior years include the impact of amounts previously included in the liability to establish it at a level sufficient under moderately adverse conditions that were not needed and the reduction in health benefits expense due to revisions to prior estimates.

Reconciliation of Non-GAAP Financial Measures

Second Quarter 2009 Operating Results Excluding the Favorable Tax Adjustment
AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENT OF OPERATIONS
(dollars in thousands, except per share data)
(unaudited)

	GAAP Three months ended June 30, 2009	Less: Impact of Tax Adjustment	Adjusted Three months ended June 30, 2009
Revenues:			
Premium	$1,284,890	$ -	$1,284,890
Investment income and other	6,517	-	6,517
Total revenues	1,291,407	-	1,291,407
Expenses:			
Health benefits	1,103,213	-	1,103,213
Selling, general and administrative	96,285	-	96,285
Premium taxes	34,623	-	34,623
Depreciation and amortization	9,680	-	9,680
Interest	4,232	-	4,232
Total expenses	1,248,033	-	1,248,033
Income before income taxes	43,374	-	43,374
Income tax (benefit) expense	(6,225)	(22,449)	16,224
Net income	$49,599	$22,449	$27,150
Diluted net income per share	$0.94	$0.43	$0.51
Weighted average number of common shares and dilutive potential common shares outstanding	53,029,943		53,029,943

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AMERIGROUP CORPORATION

PRESS RELEASE

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Amerigroup Reports Third Quarter 2010 Results

Net Income of $84.3 Million or $1.68 per Diluted Share

VIRGINIA BEACH, Va. (October 29, 2010) – Amerigroup Corporation (NYSE: AGP) today announced that net income for the third quarter of 2010 was $84.3 million, or $1.68 per diluted share, versus net income of $22.5 million, or $0.43 per diluted share, for the third quarter of 2009 and compared to $67.2 million, or $1.31 per diluted share, for the second quarter of 2010.

Highlights include:

- Membership increased 29,000 members to approximately 1.9 million at the end of the third quarter, a 1.5% increase compared to the second quarter of 2010 and an 8.7% increase over the third quarter of 2009.
- Third quarter total revenues were $1.5 billion, a 4.0% increase over the second quarter of 2010, and a 14.6% increase over the third quarter of 2009.
- Health benefits expense was 80.5% of premium revenue for the third quarter of 2010.
- Selling, general and administrative expenses were 7.1% of total revenues for the third quarter of 2010.
- Cash flow provided by operations was $92.9 million for the three months ended September 30, 2010.
- Unregulated cash and investments were $251.4 million as of September 30, 2010.
- Medical claims payable, as of September 30, 2010, totaled $521.8 million compared to $525.6 million, as of June 30, 2010.
- Days in claims payable was 40, compared to 41 days in the previous quarter.
- The Company repurchased approximately 1.9 million shares of its common stock during the third quarter for approximately $70.5 million.

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"We are pleased with our performance in the quarter. Our membership grew and we generated strong cash flow, allowing us to build our unregulated cash position, even as we were actively repurchasing shares," said James G. Carlson, Amerigroup's chairman and chief executive officer. "Most importantly, we improved the services provided to our members and state partners, continuing our progress to improve access to care and enhance clinical quality outcomes. Our value proposition is being delivered day by day, member by member, at this critical time and our states are saving money and getting better results from their safety net programs."

Premium Revenue

Premium revenue for the third quarter of 2010 increased 14.7% to $1.5 billion compared to $1.3 billion in the third quarter of 2009. Sequentially, premium revenues increased $61.0 million, or 4.3%, compared with the second quarter of 2010. The sequential increase primarily reflects continued membership increases across many of the Company's markets.

Third quarter premium revenue also benefited from annual rate increases in several markets including New Jersey, Texas, Virginia and New York, the latter of which was retroactive to April 1, 2010 and recognized in the third quarter.

The Company received initial confirmation of its rate increase in Georgia but did not receive a fully executed rate amendment by the end of the quarter. The Company expects to recognize approximately $0.10 earnings per diluted share in the fourth quarter of 2010 for the retroactive portion of the rate increase associated with the third quarter.

Investment Income and Other Revenues

Third quarter investment income and other revenues were $5.0 million versus $5.3 million in the third quarter of 2009, and compared to $8.6 million in the second quarter of 2010. Investment income and other revenues for the second quarter of 2010 included the sale of a trademark for $4.0 million. Excluding the trademark sale, the slight increase in investment income on a sequential basis is due to a higher average investment yield as well as higher investment balances.

Health Benefits

Health benefits expense, as a percent of premium revenue, was 80.5% for the third quarter of 2010 versus 87.5% in the third quarter of 2009, and compared to 82.3% in the second quarter of 2010.

The sequential decrease in the health benefits ratio was primarily due to the impact of rate increases received in the quarter. Medical cost trends also remained at moderate levels during the third quarter of 2010, consistent with Company experience in the second quarter. Third quarter costs remained in line with, or better than, expectations in most markets, with all major categories of service exhibiting lower trends in recent periods.

Favorable reserve development (net of associated accruals for experience rebate in Texas, applicable medical loss ratio floors, and other gain sharing arrangements with state customers) positively impacted the health benefits ratio in the third quarter by approximately 180 basis points compared to 200 basis points reported in the second quarter of 2010.

Selling, General and Administrative Expenses

Selling, general and administrative expenses were 7.1% of total revenues for the third quarter of 2010, versus 6.3% in the third quarter of 2009, and compared to 7.5% for the second quarter of

2010. Sequentially, selling, general and administrative expenses remained stable, while the selling, general and administrative expense ratio declined due to total revenue growth in the quarter.

Premium Taxes
Third quarter premium taxes were $40.3 million versus $38.3 million for the third quarter of 2009, and compared to $33.2 million in the second quarter of 2010. The sequential increase in premium taxes was primarily due to the reinstatement of premium tax in Georgia effective July 1, 2010.

Balance Sheet Highlights
Cash and investments at September 30, 2010 totaled $1.6 billion of which $251.4 million was unregulated, compared to $239.5 million of unregulated cash and investments at the end of the second quarter of 2010. During the quarter, the Company repurchased 1.9 million shares of common stock for $70.5 million, pursuant to its ongoing share repurchase program. This unregulated cash outlay was offset by dividends and the timing of disbursements during the quarter.

The debt to total capital ratio decreased to 18.2% as of September 30, 2010 from 18.4% as of June 30, 2010.

Medical claims payable as of September 30, 2010 totaled $521.8 million compared to $525.6 million as of June 30, 2010. Days in claims payable represented 40 days of health benefits expense, compared to 41 days in the previous quarter.

Included on page 9 is a table presenting the components of the change in medical claims payable for the nine months ended September 30, 2010 and the year ended December 31, 2009.

Cash Flow Highlights
Cash flow from operations totaled $202.5 million for the nine months ended September 30, 2010 and $92.9 million for the three months ended September 30, 2010. The key driver of cash flow in the quarter was solid earnings with routine variation in working capital accounts.

Third Quarter Earnings Call
Amerigroup senior management will discuss the Company's third quarter results on a conference call Friday, October 29, 2010 at 8:00 a.m. Eastern Daylight Time (EDT). The conference can be accessed by dialing 866-260-3161 (domestic) or 706-679-7245 (international) approximately ten minutes prior to the start time of the call. A recording of the call may be accessed by dialing 800-642-1687 (domestic) or 706-645-9291 (international) and providing passcode 98624159. The replay will be available shortly after the conclusion of the call until Friday, November 5, at 11:59 p.m. EDT. The conference call will also be available through the investors' page of the Company's web site, www.amerigroupcorp.com, or through www.earnings.com. A 30-day replay of this webcast will be available on these web sites beginning approximately two hours following the conclusion of the live broadcast earnings conference call.

About Amerigroup Corporation
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members, while proactively working to reduce the overall cost of care to taxpayers. For more information and real story examples of these solutions, please visit www.amerigroupcorp.com.

Forward-Looking Statements

This release is intended to be disclosure through methods reasonably designed to provide broad, non-exclusionary distribution to the public in compliance with the Securities and Exchange Commission's Fair Disclosure Regulation. This release contains certain "forward-looking" statements, including statements related to moderating medical cost trends and expected rate increases in the state of Georgia. These statements are made pursuant to the Safe Harbor provisions of the Private Securities Litigation Reform Act of 1995. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated in the forward-looking statements. These risks and uncertainties include, but are not limited to: our inability to manage medical costs; our inability to operate new products and markets at expected levels, including, but not limited to, profitability, membership and targeted service standards; local, state and national economic conditions, including their effect on the rate-setting process and timing of payments; the effect of government regulations and changes in regulations governing the health care industry, including the impact of recently enacted health care reform legislation; changes in Medicaid and Medicare payment levels and methodologies; increased use of services, increased cost of individual services, epidemics, pandemics, the introduction of new or costly treatments and technology, new mandated benefits, insured population characteristics and seasonal changes in the level of health care use; our ability to maintain and increase membership levels; our ability to enter into new markets or remain in existing markets; changes in market interest rates or any disruptions in the credit markets; our ability to maintain compliance with all minimum capital requirements; liabilities and other claims asserted against us; demographic changes; the competitive environment in which we operate; the availability and terms of capital to fund acquisitions, capital improvements and maintain capitalization levels required by state agencies; our ability to attract and retain qualified personnel; the unfavorable resolution of new or pending litigation; and catastrophes, including acts of terrorism or severe weather.

Investors should also refer to our annual report on Form 10-K for the year ended December 31, 2009 filed with the Securities and Exchange Commission ("SEC") and subsequent quarterly reports on Form 10-Q and current reports on Form 8-K filed with or furnished to the SEC, for a discussion of certain known risk factors that could cause our actual results to differ materially from our current estimates. Given these risks and uncertainties, we can give no assurances that any forward-looking statements will, in fact, transpire and, therefore, caution investors not to place undue reliance on them. We specifically disclaim any obligation to update or revise any forward-looking statements, whether as a result of new information, future developments or otherwise.

AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED INCOME STATEMENTS
(dollars in thousands, except per share data)
(unaudited)

	Three months ended September 30,		Nine months ended September 30,	
	2010	2009	2010	2009
Revenues:				
Premium	$1,489,884	$1,298,969	$4,285,530	$3,801,306
Investment income and other	5,020	5,315	18,536	24,179
Total revenues	1,494,904	1,304,284	4,304,066	3,825,485
Expenses:				
Health benefits	1,199,706	1,136,391	3,517,723	3,258,907
Selling, general and administrative	106,815	82,238	332,427	288,898
Premium taxes	40,317	38,336	104,961	101,077
Depreciation and amortization	8,737	8,441	26,352	26,447
Interest	3,991	3,929	12,000	12,399
Total expenses	1,359,566	1,269,335	3,993,463	3,687,728
Income before income taxes	135,338	34,949	310,603	137,757
Income tax expense	50,990	12,400	116,860	28,700
Net income	$84,348	$22,549	$193,743	$109,057
Diluted net income per share	$1.68	$0.43	$3.81	$2.07
Weighted average number of common shares and dilutive potential common shares outstanding	50,197,740	51,920,745	50,895,807	52,754,511

The following table sets forth selected operating ratios. All ratios, with the exception of the health benefits ratio, are shown as a percentage of total revenues.

	Three months ended September 30,		Nine months ended September 30,	
	2010	2009	2010	2009
Premium revenue	99.7 %	99.6 %	99.6 %	99.4 %
Investment income and other	0.3	0.4	0.4	0.6
Total revenues	100.0 %	100.0 %	100.0 %	100.0 %
Health benefits [1]	80.5 %	87.5 %	82.1 %	85.7 %
Selling, general and administrative expenses	7.1 %	6.3 %	7.7 %	7.6 %
Income before income taxes	9.1 %	2.7 %	7.2 %	3.6 %
Net income	5.6 %	1.7 %	4.5 %	2.9 %

[1] The health benefits ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium received and the health benefits provided.

The following table sets forth the approximate number of members the Company served in each state as of September 30, 2010 and 2009. Because the Company receives two premiums for members that are both in the Medicare Advantage and Medicaid products, these members have been counted twice in the states where we offer both plans.

	September 30,	
	2010	**2009**
Texas[1]	557,000	498,000
Georgia	268,000	236,000
Florida	263,000	270,000
Tennessee	204,000	192,000
Maryland	201,000	188,000
New Jersey	138,000	117,000
New York	109,000	112,000
Nevada	76,000	56,000
Ohio	58,000	59,000
Virginia	38,000	30,000
New Mexico	21,000	20,000
Total	1,933,000	1,778,000

[1] Membership includes approximately 14,000 members under an ASO contract in 2010 and 13,000 in 2009.

The following table sets forth the approximate number of members in each of the Company's products as of September 30, 2010 and 2009. Because the Company receives two premiums for members that are in both the Medicare Advantage and Medicaid products, these members have been counted in each product.

	September 30,	
Product	**2010**	**2009**
TANF (Medicaid)	1,373,000	1,240,000
CHIP	274,000	264,000
ABD (Medicaid)[1]	197,000	202,000
FamilyCare (Medicaid)	70,000	58,000
Medicare Advantage	19,000	14,000
Total	1,933,000	1,778,000

[1]Membership includes approximately 14,000 members under an ASO contract in 2010 and 13,000 in 2009.

AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
(dollars in thousands, except per share data)
(unaudited)

	September 30, 2010	December 31, 2009
Assets		
Current assets:		
Cash and cash equivalents	$490,575	$505,915
Short-term investments	250,474	137,523
Premium receivables	144,044	104,867
Deferred income taxes	27,624	26,361
Prepaid expenses, provider and other receivables and other	55,884	47,316
Total current assets	968,601	821,982
Property, equipment and software, net	95,458	101,002
Goodwill	260,496	249,276
Long-term investments, including investments on deposit for licensure	823,125	813,976
Other long-term assets	13,401	13,398
	$2,161,081	$1,999,634
Liabilities and Stockholders' Equity		
Current liabilities:		
Claims payable	$521,820	$529,036
Unearned revenue	38,299	98,298
Accounts payable	3,119	4,685
Accrued expenses and other	238,160	127,278
Total current liabilities	801,398	759,297
Long-term debt	243,088	235,104
Other long-term liabilities	21,837	20,789
Total liabilities	1,066,323	1,015,190
Stockholders' equity:		
Common stock, $.01 par value	550	546
Additional paid-in capital, net of treasury stock	305,702	391,912
Accumulated other comprehensive income	4,131	1,354
Retained earnings	784,375	590,632
Total stockholders' equity	1,094,758	984,444
	$2,161,081	$1,999,634

AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(unaudited)

	Nine months ended September 30,	
	2010	2009
	(dollars in thousands)	
Cash flows from operating activities:		
Net income	$193,743	$109,057
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	26,352	26,447
Loss on disposal of property, equipment and software	17	289
Deferred tax (benefit) expense	(1,222)	2,481
Compensation expense related to share-based payments	14,594	12,034
Convertible debt non-cash interest expense	7,984	7,480
Gain on sale of intangible assets	(4,000)	-
Gain on sale of contract rights	-	(5,810)
Other	6,772	(326)
Changes in assets and liabilities (decreasing) increasing cash flows from operations:		
Premium receivables	(39,177)	(863)
Prepaid expenses, provider and other receivables and other current assets	(8,144)	(26,534)
Other assets	(396)	(1,146)
Claims payable	(7,216)	14,005
Unearned revenue	(59,999)	(16,481)
Accounts payable, accrued expenses and other current liabilities	73,732	(10,245)
Other long-term liabilities	(533)	(3,793)
Net cash provided by operating activities	202,507	106,595
Cash flows from investing activities:		
Purchase of investments, net	(115,804)	(221,987)
Purchase of investments on deposit for licensure, net	(7,586)	(9,901)
Purchase of property, equipment and software	(19,397)	(21,680)
Proceeds from sale of intangible assets	4,000	-
Proceeds from sale of contract rights	-	5,810
Purchase of contract rights and other related assets	(13,420)	-
Net cash used in investing activities	(152,207)	(247,758)
Cash flows from financing activities:		
Repayments of borrowings under credit facility	-	(44,318)
Proceeds and tax benefits from exercise of stock options and change in bank overdrafts and other, net	48,495	1,227
Treasury stock repurchases	(114,135)	(62,828)
Net cash used in financing activities	(65,640)	(105,919)
Net decrease in cash and cash equivalents	(15,340)	(247,082)
Cash and cash equivalents at beginning of period	505,915	763,272
Cash and cash equivalents at end of period	$490,575	$516,190

AMERIGROUP CORPORATION AND SUBSIDIARIES
Components of the Change in Medical Claims Payable
(dollars in thousands)

	Nine months ended September 30, 2010	Twelve months ended December 31, 2009
Medical claims payable, beginning of period	$529,036	$536,107
Health benefits expenses incurred during period:		
Related to current year	3,615,124	4,492,590
Related to prior years	(97,401)	(85,317)
Total incurred	3,517,723	4,407,273
Health benefits payments during period:		
Related to current year	3,151,419	4,007,789
Related to prior years	373,520	406,555
Total payments	3,524,939	4,414,344
Medical claims payable, end of period	$521,820	$529,036

Health benefits expenses incurred during both periods were reduced for amounts related to prior years. The amounts related to prior years include the impact of amounts previously included in the liability to establish it at a level sufficient under moderately adverse conditions that were not needed and the reduction in health benefits expenses due to revisions to prior estimates.

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Amerigroup Expands Health Plan Operations in Texas Deploys iPads® to Support Member Needs

VIRGINIA BEACH, Va. (Thursday, February 10, 2011) – Amerigroup Corporation's (NYSE: AGP) Texas subsidiary expanded its footprint into Tarrant County (Fort Worth) offering health care coverage to approximately 30,000 new members in the STAR+PLUS Program beginning February 1, 2011. This growth is a result of a competitive procurement solicited by the Texas Health and Human Services Commission, which selected Amerigroup's Texas health plan as one of two plans to help expand health care coverage to seniors and people with disabilities in the six county service area surrounding Fort Worth.

With the expansion, Amerigroup services reach more than 80,000 within the aged, blind and disabled community throughout the State. To continue providing the best quality of service, Amerigroup has added over 60 new employees to the Company, bringing their total workforce in the State to almost 450 full time associates.

An exciting aspect of the operations expansion is the launch of new technology that advances the efficiency and capability of Amerigroup's service coordinators. The Company designed and developed a mobile software application for the Apple® iPad® to actively assess and record health care needs in real time with members in their homes or other places of care. By having access to the tools on site, administrative time is saved allowing better service and more time with the member.

"Amerigroup is a pioneer in introducing such a creative and user-friendly tool," said Aileen McCormick, Southwest Regional CEO for Amerigroup. "This takes our ability to work with members needing home and community based services to a whole new level, and now there is an 'app for that.' We are excited to launch this in conjunction with our Fort Worth implementation and look forward to implementing the iPad® solution for our other Texas STAR+PLUS markets in Austin, Houston and San Antonio the latter part of this year."

"We know that Texas wants to continue to make its Medicaid program as effective and efficient as possible. By ensuring quality coordinated care for more Texans and engaging innovative new platforms in the process, Amerigroup continues to help Texas manage the health care needs of its citizens, while keeping it more affordable for taxpayers," said James G. Carlson, Amerigroup chairman and chief executive officer.

About Amerigroup Corporation

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PRESS RELEASE

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Amerigroup Reports Q4 Net Income of $79.6 Million or $1.59 per Diluted Share
Full-Year Net Income of $273.4 Million or $5.40 per Diluted Share

VIRGINIA BEACH, Va. (February 18, 2011) – Amerigroup Corporation (NYSE: AGP) today announced that net income for the fourth quarter of 2010 was $79.6 million, or $1.59 per diluted share, versus net income of $40.2 million, or $0.79 per diluted share, for the fourth quarter of 2009.

For the year ended December 31, 2010, the Company's net income was $273.4 million, or $5.40 per diluted share, versus net income of $149.3 million, or $2.85 per diluted share, for the full-year 2009.

Highlights include:

- Annual membership increased 143,000 members to approximately 1.9 million at the end of the fourth quarter, an 8.0% increase year-over-year and essentially unchanged from the third quarter of 2010.
- Fourth quarter total revenues were $1.5 billion, a 10.2% increase over the fourth quarter of 2009, and a 0.5% increase over the third quarter of 2010.
- Health benefits expense was 80.4% of premium revenue for the fourth quarter of 2010.
- Selling, general and administrative expenses were 8.0% of total revenues for the fourth quarter of 2010.
- Cash flow provided by operations was $401.9 million for the full-year ended December 31, 2010 and $199.4 million for the three months ended December 31, 2010.
- Unregulated cash and investments were $248.6 million as of December 31, 2010 compared to $251.4 million as of September 30, 2010.
- Medical claims payable, as of December 31, 2010 totaled $510.7 million compared to $521.8 million as of September 30, 2010.
- Days in claims payable was 39, compared to 40 days in the previous quarter.
- The Company repurchased approximately 562,000 shares of its common stock during the fourth quarter for $24.4 million. For the full year, the Company repurchased 3.75 million shares of its common stock for $138.5 million at an average price of $36.96.

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- On February 1, 2011, the Company began serving STAR+PLUS members in Fort Worth, Texas, offering health care coverage on a full-risk basis to approximately 27,000 members. This expansion is a result of a competitive procurement whereby the Texas Health and Human Services Commission selected Amerigroup's Texas health plan as one of two plans to expand managed health care coverage to seniors and people with disabilities in the six-county service area surrounding Fort Worth.

"We are pleased with the quarter and gratified by the performance of our business. We continue to help our members obtain the quality health care they need, while helping to save taxpayer dollars," said James G. Carlson, Amerigroup's chairman and chief executive officer. "We achieved moderate medical cost trends during the year, in part due to effective management by our clinical teams and also due to a more benign environment for medical cost inflation. We feel good about 2010 and are excited by the opportunities ahead."

Premium Revenue

Premium revenue for the fourth quarter of 2010 increased 10.3% to $1.5 billion compared to $1.4 billion in the fourth quarter of 2009. Sequentially, premium revenue increased $8.0 million, or 0.5%. The sequential increase primarily reflects the impact of rate increases in Georgia, Texas and Florida, partially offset by retroactive membership reductions and lower supplemental premium revenue associated with births.

In December, the Company received final confirmation of its rate increase in Georgia, which was retroactive to July 1, 2010. The Company recognized approximately $0.09 earnings per diluted share in the fourth quarter of 2010 for the retroactive portion of the rate action associated with the third quarter, which included a premium rate increase and implementation of hospital pass-through payments.

For the year ended December 31, 2010, premium revenue increased 12.1% to $5.8 billion from $5.2 billion for the year ended December 31, 2009.

Investment Income and Other Revenues

Fourth quarter investment income and other revenues were $4.3 million versus $4.9 million in the fourth quarter of 2009, and compared to $5.0 million in the third quarter of 2010. The sequential decline was the result of lower rates of return on short-term fixed income securities.

For the full-year 2010, investment income and other revenues were $22.8 million versus $29.1 million in 2009.

Health Benefits

Health benefits expense, as a percent of premium revenue, was 80.4% for the fourth quarter of 2010 versus 84.6% in the fourth quarter of 2009, and compared to 80.5% in the third quarter of 2010. For the full-year 2010, the health benefits ratio was 81.6% compared to 85.4% for the full-year 2009.

The health benefits ratio declined slightly from the third quarter of 2010 to the fourth quarter. The benefit of favorable reserve development and premium rate increases received in the quarter offset normal seasonal increases in medical costs. Medical cost trends remained at moderate levels during the fourth quarter of 2010, consistent with the Company's experience in the third quarter.

Favorable reserve development (net of associated accruals for experience rebate in Texas, applicable medical loss ratio floors, and other gain sharing arrangements with state customers) positively impacted the health benefits ratio in the fourth quarter by approximately 210 basis points compared to 180 basis points reported in the third quarter of 2010. In addition, the effect of the retroactive rate increase in Georgia positively impacted the health benefits ratio by 30 basis points.

Selling, General and Administrative Expenses
Selling, general and administrative expenses were 8.0% of total revenues for the fourth quarter of 2010 versus 7.7% in the fourth quarter of 2009, and compared to 7.1% for the third quarter of 2010.

Selling, general and administrative expenses increased sequentially due to variable compensation, costs associated with the expansion in Fort Worth, Medicare marketing, as well as spending for claim payment recoveries.

For the full-year 2010, the selling, general and administrative expense ratio was 7.8% compared with 7.6% for the full-year 2009.

Premium Taxes
Fourth quarter premium taxes were $38.9 million versus $33.2 million for the fourth quarter of 2009, and compared to $40.3 million in the third quarter of 2010.

For the full-year 2010, premium taxes were $143.9 million versus $134.3 million for the full-year 2009.

Balance Sheet Highlights
Cash and investments at December 31, 2010 totaled $1.7 billion of which $248.6 million was unregulated compared to $251.4 million of unregulated cash and investments at September 30, 2010. During the quarter, the Company repurchased approximately 562,000 shares of common stock for $24.4 million, pursuant to its ongoing share repurchase program. For the full year, the Company repurchased 3.75 million shares of its common stock for $138.5 million at an average price of $36.96.

The debt to total capital ratio decreased to 17.4% as of December 31, 2010 from 18.2% as of September 30, 2010.

Medical claims payable as of December 31, 2010 totaled $510.7 million compared to $521.8 million as of September 30, 2010. Days in claims payable represented 39 days of health benefits expense compared to 40 days in the previous quarter.

Included on page 10 is a table presenting the components of the change in medical claims payable for the years ended December 31, 2010 and December 31, 2009.

Cash Flow Highlights

Cash flow from operations totaled $401.9 million for the twelve months ended December 31, 2010 and $199.4 million for the three months ended December 31, 2010. The key driver of cash flow in the quarter was solid earnings and accelerated collection of premium revenue in the quarter.

Fourth Quarter Earnings Call

Amerigroup senior management will discuss the Company's fourth quarter results on a conference call Friday, February 18, 2011 at 8:00 a.m. Eastern Time (ET). The conference can be accessed by dialing 866-260-3161 (domestic) or 706-679-7245 (international) approximately ten minutes prior to the start time of the call. A recording of the call may be accessed by dialing 800-642-1687 (domestic) or 706-645-9291 (international) and providing passcode 35392107. The replay will be available shortly after the conclusion of the call until Friday, February 25, at 11:59 p.m. ET. The conference call will also be available through the investors' page of the Company's web site, www.amerigroupcorp.com, or through www.earnings.com. A 30-day replay of this webcast will be available on these web sites beginning approximately two hours following the conclusion of the live broadcast earnings conference call.

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This release is intended to be disclosure through methods reasonably designed to provide broad, non-exclusionary distribution to the public in compliance with the Securities and Exchange Commission's Fair Disclosure Regulation. This release contains certain ''forward-looking'' statements, including statements regarding moderating medical cost trends and our growth opportunities. These statements are made pursuant to the Safe Harbor provisions of the Private Securities Litigation Reform Act of 1995. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated in the forward-looking statements.

These risks and uncertainties include, but are not limited to: our inability to manage medical costs; our inability to operate new products and markets at expected levels, including, but not limited to, profitability, membership and targeted service standards; local, state and national economic conditions, including their effect on the rate-setting process and timing of payments; the effect of government regulations and changes in regulations governing the health care industry, including the impact of recently enacted health care reform legislation; changes in Medicaid and Medicare payment levels and methodologies; increased use of services, increased cost of individual services, epidemics, pandemics, the introduction of new or costly treatments and technology, new mandated benefits, insured population characteristics and seasonal changes in the level of health care use; our ability to maintain and increase membership levels; our ability to enter into new markets or remain in existing markets; changes in market interest rates or any disruptions in the credit markets; our ability to maintain compliance with all minimum capital requirements; liabilities and other claims asserted against us; demographic changes; the competitive environment in which we operate; the availability and terms of capital to fund acquisitions, capital improvements and maintain capitalization levels required by state agencies; our ability to attract and retain qualified personnel; the unfavorable resolution of new or pending litigation; and catastrophes, including acts of terrorism or severe weather.

Investors should also refer to our annual report on Form 10-K for the year ended December 31, 2009 filed with the Securities and Exchange Commission ("SEC") and subsequent quarterly reports on Form 10-Q and current reports on Form 8-K filed with or furnished to the SEC, for a discussion of certain known risk factors that could cause our actual results to differ materially from our current estimates. Given these risks and uncertainties, we can give no assurances that any forward-looking statements will, in fact, transpire and, therefore, caution investors not to place undue reliance on them. We specifically disclaim any obligation to update or revise any forward-looking statements, whether as a result of new information, future developments or otherwise.

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AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED INCOME STATEMENTS
(dollars in thousands, except per share data)
(unaudited)

	Three months ended December 31,		Twelve months ended December 31,	
	2010	2009	2010	2009
Revenues:				
Premium	$1,497,928	$1,357,683	$5,783,458	$5,158,989
Investment income and other	4,307	4,902	22,843	29,081
Total revenues	1,502,235	1,362,585	5,806,301	5,188,070
Expenses:				
Health benefits	1,204,383	1,148,366	4,722,106	4,407,273
Selling, general and administrative	119,642	105,191	452,069	394,089
Premium taxes	38,935	33,200	143,896	134,277
Depreciation and amortization	8,696	8,299	35,048	34,746
Interest	4,011	3,867	16,011	16,266
Total expenses	1,375,667	1,298,923	5,369,130	4,986,651
Income before income taxes	126,568	63,662	437,171	201,419
Income tax expense	46,940	23,440	163,800	52,140
Net income	$79,628	$40,222	$273,371	$149,279
Diluted net income per share	$1.59	$0.79	$5.40	$2.85
Weighted average number of common shares and dilutive potential common shares outstanding	49,924,608	51,069,265	50,608,008	52,309,268

The following table sets forth selected operating ratios. All ratios, with the exception of the health benefits ratio, are shown as a percentage of total revenues.

	Three months ended December 31,		Twelve months ended December 31,	
	2010	2009	2010	2009
Premium revenue	99.7 %	99.6 %	99.6 %	99.4 %
Investment income and other	0.3	0.4	0.4	0.6
Total revenues	100.0 %	100.0 %	100.0 %	100.0 %
Health benefits [1]	80.4 %	84.6 %	81.6 %	85.4 %
Selling, general and administrative expenses	8.0 %	7.7 %	7.8 %	7.6 %
Income before income taxes	8.4 %	4.7 %	7.5 %	3.9 %
Net income	5.3 %	3.0 %	4.7 %	2.9 %

[1] The health benefits ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium received and the health benefits provided.

The following table sets forth the approximate number of members the Company served in each state as of December 31, 2010 and 2009. Because the Company receives two premiums for members that are both in the Medicare Advantage and Medicaid products, these members have been counted twice in the states where we offer both plans.

	December 31,	
	2010	**2009**
Texas[1]	559,000	505,000
Georgia	266,000	249,000
Florida	263,000	236,000
Tennessee	203,000	195,000
Maryland	202,000	194,000
New Jersey	134,000	118,000
New York	109,000	114,000
Nevada	79,000	62,000
Ohio	55,000	60,000
Virginia	40,000	35,000
New Mexico	21,000	20,000
Total	1,931,000	1,788,000

[1] Membership includes approximately 14,000 members under an ASO contract in 2010 and 13,000 in 2009.

The following table sets forth the approximate number of members in each of the Company's products as of December 31, 2010 and 2009. Because the Company receives two premiums for members that are in both the Medicare Advantage and Medicaid products, these members have been counted in each product.

	December 31,	
Product	**2010**	**2009**
TANF (Medicaid)	1,373,000	1,255,000
CHIP	271,000	259,000
Aged, Blind and Disabled (Medicaid)[1]	197,000	196,000
FamilyCare (Medicaid)	71,000	63,000
Medicare Advantage	19,000	15,000
Total	1,931,000	1,788,000

[1]Membership includes approximately 14,000 members under an ASO contract in 2010 and 13,000 in 2009.

AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
(dollars in thousands, except per share data)
(unaudited)

	December 31, 2010	December 31, 2009
Assets		
Current assets:		
Cash and cash equivalents	$763,946	$505,915
Short-term investments	230,007	137,523
Premium receivables	83,203	104,867
Deferred income taxes	28,063	26,361
Prepaid expenses, provider and other receivables and other	53,482	47,316
Total current assets	1,158,701	821,982
Property, equipment and software, net	96,967	101,002
Goodwill	260,496	249,276
Long-term investments, including investments on deposit for licensure	754,004	813,976
Other long-term assets	13,220	13,398
	$2,283,388	$1,999,634
Liabilities and Stockholders' Equity		
Current liabilities:		
Claims payable	$510,675	$529,036
Unearned revenue	103,067	98,298
Accounts payable	7,023	4,685
Accrued expenses and other	230,076	127,278
Total current liabilities	850,841	759,297
Long-term debt	245,750	235,104
Other long-term liabilities	21,160	20,789
Total liabilities	1,117,751	1,015,190
Stockholders' equity:		
Common stock, $.01 par value	554	546
Additional paid-in capital, net of treasury stock	300,453	391,912
Accumulated other comprehensive income	627	1,354
Retained earnings	864,003	590,632
Total stockholders' equity	1,165,637	984,444
	$2,283,388	$1,999,634

AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)
(unaudited)

	Twelve months ended December 31,	
	2010	**2009**
Cash flows from operating activities:		
Net income	$273,371	$149,279
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	35,048	34,746
Loss on disposal of property, equipment and software	354	585
Deferred tax (benefit) expense	(2,262)	818
Compensation expense related to share-based payments	19,635	15,936
Convertible debt non-cash interest expense	10,646	9,974
Gain on sale of intangible assets	(4,000)	-
Gain on sale of contract rights	-	(5,810)
Other	9,219	(167)
Changes in assets and liabilities increasing (decreasing) cash flows from operations:		
Premium receivables	21,664	(18,272)
Prepaid expenses, provider and other receivables and other current assets	(10,818)	(2,310)
Other assets	(691)	(1,146)
Claims payable	(18,361)	(7,071)
Unearned revenue	4,769	15,710
Accounts payable, accrued expenses and other current liabilities	61,967	(43,758)
Other long-term liabilities	1,408	(1,480)
Net cash provided by operating activities	401,949	147,034
Cash flows from investing activities:		
Purchase of investments, net	(29,377)	(265,307)
Purchase of investments on deposit for licensure, net	(12,392)	(7,410)
Purchase of property, equipment and software	(29,463)	(29,738)
Proceeds from sale of intangible assets	4,000	-
Proceeds from sale of contract rights	-	5,810
Purchase of contract rights and other related assets	(13,420)	-
Net cash used in investing activities	(80,652)	(296,645)
Cash flows from financing activities:		
Repayments of borrowings under credit facility	-	(44,318)
Change in bank overdrafts	40,890	(2,492)
Proceeds and tax benefits from exercise of stock options and other, net	34,384	8,815
Repurchase of common stock shares	(138,540)	(69,751)
Net cash used in financing activities	(63,266)	(107,746)
Net increase (decrease) in cash and cash equivalents	258,031	(257,357)
Cash and cash equivalents at beginning of year	505,915	763,272
Cash and cash equivalents at end of year	$763,946	$505,915

AMERIGROUP CORPORATION AND SUBSIDIARIES
Components of the Change in Medical Claims Payable
(dollars in thousands)

	Twelve months ended December 31, 2010	Twelve months ended December 31, 2009
Medical claims payable, beginning of period	$529,036	$536,107
Health benefits expenses incurred during period:		
Related to current year	4,828,321	4,492,590
Related to prior years	(106,215)	(85,317)
Total incurred	4,722,106	4,407,273
Health benefits payments during period:		
Related to current year	4,359,216	4,007,789
Related to prior years	381,251	406,555
Total payments	4,740,467	4,414,344
Medical claims payable, end of period	$510,675	$529,036

Health benefits expenses incurred during both periods were reduced for amounts related to prior years. The amounts related to prior years include the impact of amounts previously included in the liability to establish it at a level sufficient under moderately adverse conditions that were not needed and the reduction in health benefits expenses due to revisions to prior estimates.

-END-

PRESS RELEASE

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Amerigroup Named to 2011 "Best Places to Work in Virginia" List

VIRGINIA BEACH, Va. (Wednesday, February 23, 2011) – Amerigroup Corporation (NYSE: AGP) has been named one of Virginia's Best Places to Work for 2011 through a survey conducted by the Best Companies Group.

Amerigroup associates in Virginia were selected randomly last fall by the Best Companies Group to complete an outside survey – an initiative used to identify and recognize Virginia's best employers. As a result of the associate's responses, Amerigroup received the honor in the large employer category. The full results are in the February issue of *Virginia Business* magazine. Lists also were compiled for small and midsize employers.

"At Amerigroup, we are able to attract and retain the best and brightest associates because of our mission of making the health care system work for those who need a little help, as well as our competitive compensation and benefit offerings," said Linda Whitley-Taylor, Amerigroup executive vice president of Human Resources.

The Best Companies Group ranked companies in ten categories, including employee stock options, 401(k) retirement plan, health plan offerings, telecommuting opportunities and tuition reimbursement.

About Amerigroup Corporation
Amerigroup, a Fortune 500 Company, coordinates services for individuals in publicly funded health care programs. Serving more than 1.9 million members in 11 states nationwide, Amerigroup accepts all eligible people regardless of age, sex, race or disability. The Company's product offerings do not utilize any individual underwriting nor deny coverage due to preexisting medical conditions. Amerigroup is dedicated to offering real solutions that improve health care access and quality for its members, while proactively working to reduce the overall cost of care to taxpayers. Click here for more information about Amerigroup Corporation.

PRESS RELEASE

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Amerigroup Names Blair Chief Marketing Officer

VIRGINIA BEACH, Va. (Friday, February 25, 2011) – Amerigroup Corporation (NYSE: AGP) announced today that Patrick Blair has been named chief marketing officer, charged with business and product development, marketing operations and communications, multimedia and e-business.

Prior to being tapped as chief marketing officer, Blair led the Amerigroup Specialty Products Group as chief executive officer responsible for management and growth of the Company's Medicare, long-term care and other products serving seniors and people with disabilities. Prior to joining Amerigroup, Blair was a senior manager in the Business Transformation and Strategy practice for Deloitte Consulting and a senior consultant with Cap Gemini Ernst & Young's health care consulting practice.

"Patrick Blair's extensive experience in the areas of business unit strategy, growth strategy, product development and process improvement make him perfectly suited to manage Amerigroup's growth as we head into a great time of change within the health industry," said John E. Littel, Amerigroup executive vice president of external relations.

Blair holds a bachelor's of economics and a master's of health administration from Indiana University and a master's of business administration from Henley Business School, University of Reading, Oxfordshire, England. He serves on the Board of The Up Center, a Norfolk, Va.-based non-profit organization dedicated to assisting the needs of the underserved in the community.

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Amerigroup to Open West Regional Service Center in Houston

VIRGINIA BEACH, Va. (Monday, April 25, 2011) – Amerigroup Corporation (NYSE: AGP) announced that it will open a new West Regional Service Center in Houston, Texas, in the fourth quarter of 2011 to service customers in Texas, New Mexico and Nevada. The Company will begin to occupy the facility in the summer of 2011 and it will be staffed by more than 300 associates, with capacity to grow in the future. With the opening of the service center, Amerigroup will employ more than 750 full-time associates throughout the State.

The new service center will provide call and claims support to the Amerigroup West Region, serving more than 650,000 members in those markets. "We believe this local focus and presence will enable us to optimize the customer experience we deliver to our members, providers and state partners in the West Region," said Aileen McCormick, Amerigroup west region chief executive officer.

"Texas continues to shine as the best state in the nation to live, work and raise a family thanks to our low taxes, reasonable and predictable regulatory environment, fair legal system and skilled workforce," Governor Rick Perry said. "I want to congratulate Amerigroup on this expansion and the 300 jobs it will create in Houston, and wish them continued success in their future in the Lone Star State."

In February, Amerigroup expanded its footprint in Texas with the addition of STAR+PLUS members in Tarrant County. "We are committed to providing the best support for our members as we expand our west region operations by investing the resources in Texas to ensure all receive quality coordinated care," said James G. Carlson, Amerigroup chairman and chief executive officer.

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proactively working to reduce the overall cost of care to taxpayers. Click here for more information about Amerigroup Corporation.

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Amerigroup Reports First Quarter 2011 Results

Revenues of $1.5 Billion Increased 12.3% Year-Over-Year
Net Income of $70.5 Million or $1.37 per Diluted Share

VIRGINIA BEACH, Va. (April 29, 2011) – Amerigroup Corporation (NYSE: AGP) today announced that net income for the first quarter of 2011 was $70.5 million, or $1.37 per diluted share, versus net income of $42.2 million, or $0.82 per diluted share, for the first quarter of 2010. Total revenues for the first quarter of 2011 increased 12.3% to $1.54 billion compared with $1.37 billion in the first quarter of 2010. Sequentially, total revenues increased 2.5% from the fourth quarter of 2010.

Highlights include:

- Membership increased 36,000 members, or 1.9%, to approximately 2.0 million at the end of the first quarter compared to the fourth quarter of 2010.
- Health benefits expense was 81.8% of premium revenue for the first quarter of 2011.
- Selling, general and administrative expenses were 7.6% of total revenues for the first quarter of 2011.
- Cash flow provided by operations was $83.5 million for the three months ended March 31, 2011.
- Unregulated cash and investments were $269 million as of March 31, 2011 compared to $249 million as of December 31, 2010.
- Medical claims payable as of March 31, 2011 totaled $540 million compared to $511 million as of December 31, 2010.
- Days in claims payable was 39, consistent with the fourth quarter of 2010.
- The Company repurchased approximately 440,000 shares of its common stock during the first quarter, for $24.8 million, pursuant to its ongoing share repurchase program.
- On February 1, 2011, the Company began serving approximately 29,000 aged, blind and disabled (ABD) members in Fort Worth, Texas, on a full-risk basis. Previously, the Company served approximately 14,000 ABD members in Dallas/Fort Worth on an administrative services only basis.
- On March 30, 2011, Standard and Poor's raised its counterparty credit and senior debt ratings on Amerigroup to BB+ from BB.

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- On April 25, 2011, the Company announced that it will open a new West Regional Service Center in Houston, Texas, in the fourth quarter of 2011 to service customers in Texas, New Mexico and Nevada. The Company will begin to occupy the facility in the summer of 2011, and it will be staffed by more than 300 associates, with capacity to grow in the future. The new service center will provide call and claims support to the Amerigroup West Region, serving more than 650,000 members in those markets.

"Medical cost trends continued to be moderate in the first quarter, and, while this can be partially attributed to favorable market conditions, it is also due to adept execution of our strategies and interventions to drive better delivery system access, performance and accountability," said James G. Carlson, Chairman and CEO of Amerigroup. "This execution is critical as we prepare for the opportunities ahead of us and proves that real solutions for the healthcare challenges facing our nation do exist and are possible on a much bigger scale."

Premium Revenue

Premium revenue for the first quarter of 2011 increased 12.4% to $1.54 billion versus $1.37 billion in the first quarter of 2010. Sequentially, premium revenue increased $37.9 million, or 2.5%.

The sequential increase primarily reflects the expansion in Fort Worth, Texas, where the Company began serving approximately 29,000 aged, blind and disabled members on February 1st under a full-risk contract. In addition, revenues benefited from continued membership increases across many of the Company's markets, rate increases in several states, as well as lower accruals in the quarter for gain sharing arrangements with State customers. As previously reported, premium revenue for the fourth quarter of 2010 benefited from the retroactive portion of the Georgia rate increase in the amount of $15.0 million which yielded approximately $0.09 earnings per diluted share net of associated hospital and premium taxes.

Investment Income and Other Revenues

First quarter investment income and other revenues were $4.1 million versus $4.9 million in the first quarter of 2010, and compared to $4.3 million in the fourth quarter of 2010.

Health Benefits

Health benefits expense, as a percent of premium revenue, was 81.8% for the first quarter of 2011 versus 83.5% in the first quarter of 2010, and compared to 80.4% in the fourth quarter of 2010.

Favorable reserve development (net of associated accruals for experience rebate in Texas, applicable medical loss ratio floors, and other gain sharing arrangements with State customers) positively impacted the health benefits ratio in the first quarter by 140 basis points compared to 210 basis points in the fourth quarter of 2010.

Expected seasonality was the primary driver of the sequential increase in the health benefits ratio in the first quarter of 2011. Medical costs remained at moderate levels during the first

quarter of 2011, consistent with the Company's recent experience, favorably impacting the health benefits ratio.

Selling, General and Administrative Expenses
Selling, general and administrative expenses were 7.6% of total revenues for the first quarter of 2011 versus 8.6% in the first quarter of 2010, and compared to 8.0% for the fourth quarter of 2010. The selling, general and administrative ratio decreased sequentially due to increased membership and the Company's continued leveraging of administrative costs.

Premium Taxes
First quarter premium taxes were $40.4 million versus $31.5 million for the first quarter of 2010, and compared to $38.9 million in the fourth quarter of 2010.

Balance Sheet Highlights
Cash and investments at March 31, 2011 totaled $1.84 billion of which $269 million was unregulated compared to $249 million of unregulated cash and investments at December 31, 2010. During the quarter, the Company repurchased approximately 440,000 shares of its common stock for $24.8 million, pursuant to its ongoing share repurchase program.

The debt-to-total-capital ratio decreased to 16.8% as of March 31, 2011 from 17.4% as of December 31, 2010.

Medical claims payable as of March 31, 2011 totaled $540 million compared to $511 million as of December 31, 2010. Days in claims payable represented 39 days of health benefits expense which is consistent with the fourth quarter of 2010.

Included on page 10 is a table presenting the components of the change in medical claims payable for each of the three-month periods ended March 31, 2011 and 2010.

Cash Flow Highlights
Cash flow from operations totaled $83.5 million for the three months ended March 31, 2011, compared to cash used in operations of $6.8 million in the first quarter of 2010. Cash flow in the quarter was stronger than previously expected due to stronger earnings and earlier premium payments by certain states.

Outlook
While the Company does not provide earnings per diluted share guidance, updated parameters associated with the Company's full-year 2011 outlook can be found on page 10 of this release.

First Quarter Earnings Call
Amerigroup senior management will discuss the Company's first quarter results on a conference call Friday, April 29, 2011 at 8:00 a.m. Eastern Time (ET). The conference can be accessed by dialing 866-260-3161 (domestic) or 706-679-7245 (international) approximately ten minutes prior to the start time of the call. A recording of the call may be accessed by dialing

800-642-1687 (domestic) or 706-645-9291 (international) and providing passcode 53948437. The replay will be available shortly after the conclusion of the call until Friday, May 6, at 11:59 p.m. ET. The conference call will also be available through the investors' page of the Company's web site, www.amerigroupcorp.com, or through www.earnings.com. A 30-day replay of this webcast will be available on these web sites beginning approximately two hours following the conclusion of the live broadcast earnings conference call.

About Amerigroup Corporation

Amerigroup, a Fortune 500 Company, coordinates services for individuals in publicly funded healthcare programs. Serving approximately 2.0 million members in 11 states nationwide, Amerigroup accepts all eligible people regardless of age, sex, race or disability. The Company's product offerings do not utilize any individual underwriting nor deny coverage due to pre-existing medical conditions. Amerigroup is dedicated to offering real solutions that improve health care access and quality for its members, while proactively working to reduce the overall cost of care to taxpayers. Click here for more information about Amerigroup Corporation.

Forward-Looking Statements

This release is intended to be disclosure through methods reasonably designed to provide broad, non-exclusionary distribution to the public in compliance with the Securities and Exchange Commission's Fair Disclosure Regulation. This release contains certain ''forward-looking'' statements, including those with respect to our 2011 outlook, that are made pursuant to the Safe Harbor provisions of the Private Securities Litigation Reform Act of 1995. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated in the forward-looking statements. These risks and uncertainties include, but are not limited to: our inability to manage medical costs; our inability to operate new products and markets at expected levels, including, but not limited to, profitability, membership and targeted service standards; local, state and national economic conditions, including their effect on the rate-setting process and timing of payments; the effect of government regulations and changes in regulations governing the healthcare industry, including the impact of recently enacted healthcare reform legislation; changes in Medicaid and Medicare payment levels and methodologies; increased use of services, increased cost of individual services, epidemics, pandemics, the introduction of new or costly treatments and technology, new mandated benefits, insured population characteristics and seasonal changes in the level of healthcare use; our ability to maintain and increase membership levels; our ability to enter into new markets or remain in existing markets; changes in market interest rates or any disruptions in the credit markets; our ability to maintain compliance with all minimum capital requirements; liabilities and other claims asserted against us; demographic changes; the competitive environment in which we operate; the availability and terms of capital to fund acquisitions, capital improvements and maintain capitalization levels required by state agencies; our ability to attract and retain qualified personnel; the unfavorable resolution of new or pending litigation; and catastrophes, including acts of terrorism or severe weather.

Investors should also refer to our annual report on Form 10-K for the year ended December 31, 2010 filed with the Securities and Exchange Commission ("SEC") and subsequent current reports on Form 8-K filed with or furnished to the SEC, for a discussion of certain known risk factors that could cause our actual results to differ materially from our current estimates. Given these risks and uncertainties, we can give no assurances that any forward-looking statements will, in fact, transpire and, therefore, caution investors not to place undue reliance on them. We specifically disclaim any obligation to update or revise any forward-looking statements, whether as a result of new information, future developments or otherwise.

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AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED INCOME STATEMENTS
(dollars in thousands, except per share data)
(unaudited)

	Three months ended March 31,	
	2011	**2010**
Revenues:		
Premium	$1,535,795	$1,366,767
Investment income and other	4,120	4,882
Total revenues	1,539,915	1,371,649
Expenses:		
Health benefits	1,256,962	1,141,572
Selling, general and administrative	116,459	117,423
Premium taxes	40,448	31,472
Depreciation and amortization	9,090	8,710
Interest	4,179	3,990
Total expenses	1,427,138	1,303,167
Income before income taxes	112,777	68,482
Income tax expense	42,300	26,300
Net income	$70,477	$42,182
Diluted net income per share	$1.37	$0.82
Weighted average number of common shares and dilutive potential common shares outstanding	51,534,794	51,226,435

The following table sets forth selected operating ratios. All ratios, with the exception of the health benefits ratio, are shown as a percentage of total revenues.

	Three months ended March 31,	
	2011	**2010**
Premium revenue	99.7 %	99.6 %
Investment income and other	0.3	0.4
Total revenues	100.0 %	100.0 %
Health benefits [1]	81.8 %	83.5 %
Selling, general and administrative expenses	7.6 %	8.6 %
Income before income taxes	7.3 %	5.0 %
Net income	4.6 %	3.1 %

[1] The health benefits ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium received and the health benefits provided.

The following table sets forth the approximate number of members the Company served in each state as of March 31, 2011 and 2010. Because the Company receives two premiums for members that are both in the Medicare Advantage and Medicaid products, these members have been counted twice in the states where we offer both plans.

	March 31,	
	2011	**2010**
Texas	582,000	510,000 [1]
Georgia	270,000	250,000
Florida	263,000	250,000
Maryland	207,000	197,000
Tennessee	205,000	202,000
New Jersey	133,000	158,000
New York	109,000	113,000
Nevada	82,000	69,000
Ohio	55,000	56,000
Virginia	39,000	37,000
New Mexico	22,000	21,000
Total	1,967,000	1,863,000

[1] Membership includes approximately 13,000 members under an ASO contract in 2010.

The following table sets forth the approximate number of members in each of the Company's products as of March 31, 2011 and 2010. Because the Company receives two premiums for members that are in both the Medicare Advantage and Medicaid products, these members have been counted in each product.

	March 31,	
Product	**2011**	**2010**
TANF (Medicaid)	1,394,000	1,309,000
CHIP	268,000	269,000
Aged, Blind and Disabled and Long-Term Care (Medicaid)	215,000	197,000 [1]
FamilyCare (Medicaid)	72,000	72,000
Medicare Advantage	18,000	16,000
Total	1,967,000	1,863,000

[1]Membership includes approximately 13,000 members under an ASO contract in 2010.

AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
(dollars in thousands, except per share data)
(unaudited)

	March 31, 2011	December 31, 2010
Assets		
Current assets:		
Cash and cash equivalents	$601,950	$763,946
Short-term investments	307,072	230,007
Premium receivables	110,315	83,203
Deferred income taxes	27,952	28,063
Prepaid expenses, provider and other receivables and other	61,534	53,482
Total current assets	1,108,823	1,158,701
Long-term investments, including investments on deposit for licensure	926,418	754,004
Property, equipment and software, net	99,074	96,967
Goodwill	260,496	260,496
Other long-term assets	14,050	13,220
	$2,408,861	$2,283,388
Liabilities and Stockholders' Equity		
Current liabilities:		
Claims payable	$539,767	$510,675
Unearned revenue	100,231	103,067
Contractual refunds payable	51,645	44,563
Acounts payable, accrued expenses and other	216,585	192,536
Total current liabilities	908,228	850,841
Long-term debt	248,591	245,750
Other long-term liabilities	19,442	21,160
Total liabilities	1,176,261	1,117,751
Stockholders' equity:		
Common stock, $.01 par value	560	554
Additional paid-in capital, net of treasury stock	297,533	300,453
Accumulated other comprehensive income	27	627
Retained earnings	934,480	864,003
Total stockholders' equity	1,232,600	1,165,637
	$2,408,861	$2,283,388

AMERIGROUP CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)
(unaudited)

	Three months ended March 31,	
	2011	**2010**
Cash flows from operating activities:		
Net income	$70,477	$42,182
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Depreciation and amortization	9,090	8,710
Loss on disposal of property, equipment and software	159	8
Deferred tax expense (benefit)	227	(821)
Compensation expense related to share-based payments	4,856	4,427
Convertible debt non-cash interest expense	2,841	2,661
Other	3,451	1,903
Changes in assets and liabilities (decreasing) increasing cash flows from operations:		
Premium receivables	(27,112)	(44,041)
Prepaid expenses, provider and other receivables and other current assets	(9,873)	(15,567)
Other assets	(1,296)	(783)
Claims payable	29,092	20,184
Accounts payable, accrued expenses, contractual refund payable and other current liabilities	5,917	28,949
Unearned revenue	(2,836)	(51,172)
Other long-term liabilities	(1,471)	(3,489)
Net cash provided by (used in) operating activities	83,522	(6,849)
Cash flows from investing activities:		
Purchase of investments, net	(249,401)	(31,481)
Purchase of property, equipment and software	(10,890)	(6,435)
Purchase of investments on deposit for licensure, net	(4,492)	(3,166)
Purchase of contract rights and other related assets	-	(13,420)
Net cash used in investing activities	(264,783)	(54,502)
Cash flows from financing activities:		
Change in bank overdrafts	23,514	-
Proceeds and tax benefits from exercise of stock options and other, net	20,543	3,602
Repurchase of common stock shares	(24,792)	(6,982)
Net cash provided by (used in) financing activities	19,265	(3,380)
Net decrease in cash and cash equivalents	(161,996)	(64,731)
Cash and cash equivalents at beginning of period	763,946	505,915
Cash and cash equivalents at end of period	$601,950	$441,184

AMERIGROUP CORPORATION AND SUBSIDIARIES

Components of the Change in Medical Claims Payable
(dollars in thousands)

	Three months ended March 31, 2011	Three months ended March 31, 2010
Medical claims payable, beginning of period	$510,675	$529,036
Health benefits expenses incurred during period:		
Related to current year	1,307,566	1,208,760
Related to prior years	(50,604)	(67,188)
Total incurred	1,256,962	1,141,572
Health benefits payments during period:		
Related to current year	900,625	798,460
Related to prior years	327,245	322,929
Total payments	1,227,870	1,121,389
Medical claims payable, end of period	$539,767	$549,219

Health benefits expenses incurred during both periods were reduced for amounts related to prior years. The amounts related to prior years include the impact of amounts previously included in the liability to establish it at a level sufficient under moderately adverse conditions that were not needed and the reduction in health benefits expenses due to revisions to prior estimates.

2011 Outlook

	Current Parameters As of April 29, 2011	Previous Parameters As of February 18, 2011
Total revenues percentage growth	upper single digits	upper single digits
Health benefits ratio	82.8% - 83.8%	83.6% - 84.6%
Selling, general & administrative ratio	7.6% plus or minus 20 bps	7.6% plus or minus 20 bps
Net income margin	Upper-end to above the range of 2.5% – 3.5%	Mid to upper-end of the range of 2.5% – 3.5%
Diluted shares outstanding	53 – 54 million	51 – 52 million

-END-

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B.14 Describe your plan for meeting the Performance Bond, other bonds, and insurance requirements set forth in this RFP requirement including the type of bond to be posted and source of funding.

Bond and Insurance Requirements

Amerigroup Louisiana assures DHH that it will comply with *all* insurance and bond requirements specified in Sections 2.5 and 2.6 of the RFP. Such insurance and bonds will be established upon notice of Contract award and maintained throughout the life of the Contract and for as long as we have related liabilities of $50,000 or more outstanding or for 15 months following termination of the Contract.

We will obtain the required performance bond from an agent appearing on the U.S. Department of Treasury's list of approved sureties, will assure that the bond is made payable to the State of Louisiana and that it identifies both the Contract and dates of performance. Funding for the performance bond will come from Amerigroup Corporation's cash and investment portfolio.

We will also obtain the required fidelity bond and maintain it throughout the life of the Contract. Funding for the fidelity bond will also come from Amerigroup Corporation's cash and investment portfolio.

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B.15 Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:31: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.

Summary-Level Financial Information

Amerigroup Louisiana provides the requested information based on Unaudited Financial Statements in Table B-25 below. As of March 31, 2011, our total net worth was $3,014,360 – all start-up funds provided by our parent organization, Amerigroup Corporation.

Table B-25. Financial Summary Information for Amerigroup Louisiana

	As of 6/30/2010	As of 9/30/2010	As of12/31/2010	As of 3/31/2011
Current Assets	--	$3,010,023	$3,012,885	$3,014,383
Current Liabilities	--	--	--	--
1) Working Capital	--	$3,010,023	$3,012,885	$3,014,383
2) Current Ratio Current Assets Current Liabilities	N/A	N/A	N/A	N/A
3) Quick Ratio Current Assets – Inventories = Current Liabilities	N/A	N/A	N/A	N/A
4) Net Worth Total Stockholder's Equity	--	$3,010,123	$3,012,862	$3,014,360
5) Debt-to-Worth Total Liabilities Total Net Worth	N/A	N/A	N/A	N/A

We have also provided the requested information for Amerigroup Corporation.

Table B-26. Financial Summary Information for Amerigroup Corporation

	As of 6/30/2010	As of 9/30/2010	As of12/31/2010	As of 3/31/2011
Current Assets	$827,684	$968,601	$1,158,701	$1,108,823
Current Liabilities	$761,836	$801,398	$850,841	$908,228
1) Working Capital	$65,848	$167,203	$307,860	$200,595
2) Current Ratio Current Assets / Current Liabilities	108.6%	120.9%	136.2%	122.1%
3) Quick Ratio Current Assets – Inventories = Current Liabilities	108.6%	120.9%	136.2%	122.1%
4) Net Worth Total Stockholder's Equity	$1,068,583	$1,094,758	$1,165,637	$1,232,600
5) Debt-to-Worth Total Liabilities / Total Net Worth	48.8%	49.3%	49.0%	48.8%

B.16 Identify all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization's parent organization, affiliates, and subsidiaries.

Publicly-Funded Managed Care Contracts for Medicaid and CHIP

Amerigroup Corporation, an organization that focuses *solely* on meeting the health care needs of financially vulnerable Americans, currently serves Medicaid and Children's Health Insurance Program (CHIP) members through affiliated health plans in 11 states across the nation. The tables that follow provide the requested information.

Table B-27. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – New Jersey

NEW JERSEY	
New Jersey Medicaid and CHIP	
1. Trade name	AMERIGROUP New Jersey, Inc. (Amerigroup New Jersey)
2. Contract name and phone number	Contract Name: New Jersey Department of Human Services Division of Medical Assistance and Health Services Phone Number: Dr. Clifford Green, 609.588.7379
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive Medicaid and CHIP managed care services inclusive of acute, pharmacy, vision, dental, non-emergent transportation and limited behavioral health services
4. Dates of the contract	02/01/1996 – 06/30/2011
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: 131,500 Population Types: TANF, CHIP, SSI, uninsured adults
6. Annual contract payments	$378,000,000
7. Whether payment was capitated or other	Capitated

NEW JERSEY	
8. Role of subcontractors, if any	Amerigroup New Jersey utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup New Jersey uses subcontractors for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory, durable medical equipment and transportation. Amerigroup New Jersey also utilizes subcontractors for administrative services including, but not limited to, *Nurse HelpLine* administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup New Jersey including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-28. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – Texas

TEXAS	
Texas Medicaid and CHIP Managed Care Contract	
1. Trade name	AMERIGROUP Texas, Inc. (Amerigroup Texas)
2. Contract name and phone number	Contract Name: Health and Human Services Commission, (HHSC) Managed Care Contract 529-06-0280-00002-S Phone Number: Cindy Jorgensen, Director, Managed Care Operations, Phone: 512.491.1302
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive Medicaid and CHIP managed care services. inclusive of acute, long term care support, behavioral health, vision, dental and limited non-emergent transportation services
4. Dates of the contract	11/15/2005* – 08/31/2113 *Original contract term began 09/01/1996
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: 551,300 Population Types: TANF, SSI, Duals, CHIP, CHIP Perinatal
6. Annual contract payments	$1,358,000,000
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup Texas utilizes various subcontractors to deliver

TEXAS	
	certain specialized covered services. Under this contract, Amerigroup Texas uses subcontractors for the provision of services including, but not limited to, dental, vision, laboratory, durable medical equipment and transportation. Amerigroup Texas also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup Texas including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.
Texas Medicaid Managed Care Contract (Fort Worth STAR+PLUS)	
1. *Trade name*	AMERIGROUP Texas, Inc. (Amerigroup Texas)
2. *Contract name and phone number*	Contract Name: HHSC Managed Care Contract 529-10-0020-000 Phone Number: Cindy Jorgensen, Director, Managed Care Operations, 512.491.1302
3. *Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP*	Comprehensive Medicaid managed care services for SSI Members in the Tarrant Service Area. Covered services include acute, long-term, behavioral health, vision, dental and limited non-emergent transportation services
4. *Dates of the contract*	06/30/2010 – 08/31/2013
5. *Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)*	Number of Members: 28,500 Population Types: SSI, Duals
6. *Annual contract payments*	$135,600,000
7. *Whether payment was capitated or other*	Capitated
8. *Role of subcontractors, if any*	Amerigroup Texas utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Texas uses subcontractors for the provision of services including, but not limited to vision, laboratory, durable medical equipment and transportation. Amerigroup Texas also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and utilization review of radiology

TEXAS	
	services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup Texas including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-29. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – Maryland

MARYLAND	
Maryland Medicaid, CHIP, and Primary Adult Care	
1. Trade name	AMERIGROUP Maryland, Inc. (Amerigroup Maryland)
2. Contract name and phone number	Contract Name: Department of Health and Mental Hygiene Managed Care Organization HealthChoice Provider Agreement Phone Number: Ms. Dianne Herr, Director, HealthChoice and Acute Care Administration, 410.767.4248
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive Medicaid and CHIP managed care services inclusive of acute, substance abuse, pharmacy, vision, dental and limited non-emergent transportation services
4. Dates of the contract	06/01/1999 – present with automatic renewal each year
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: 198,800 Population Types: TANF, CHIP, SSI*, SOBRA, Uninsured Adults *Does not include individuals age 65 and older
6. Annual contract payments	$659,900,000
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup Maryland utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Maryland uses subcontractors for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory, durable medical equipment and transportation. Amerigroup Maryland also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup

MARYLAND	
	Maryland including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-30. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – Florida

FLORIDA	
Florida Medicaid and Supplemental Security Income (SSI)	
1. Trade name	AMERIGROUP Florida, Inc. (Amerigroup Florida)
2. Contract name and phone number	Contract Name: Florida Agency for Health Care Administration (AHCA) Contract No. FA913 Phone Number: Melanie Brown-Woofter, Chief, Bureau of Health Systems Development, 850.922.7339
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive Medicaid managed care services (non-reform) inclusive of acute, behavioral health, pharmacy and vision services
4. Dates of the contract	09/01/2009* – 08/31/2012 *Original contract term began 01/01/2003
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: 174,300 Population Types: TANF, SSI and (under certain conditions) Duals, SOBRA and Foster Care children
6. Annual contract payments	$387,800,000
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup Florida utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Florida uses subcontractors for the provision of services including, but not limited to, pharmacy, vision, laboratory and durable medical equipment. Amerigroup Florida also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup Florida including, but not limited to, finance, claim administration, call center activities, Information Technology

FLORIDA	
	(IT) systems, legal, regulatory, treasury and compliance.
Florida Healthy Kids	
1. Trade name	AMERIGROUP Florida, Inc. (Amerigroup Florida)
2. Contract name and phone number	Contract Name: Florida Healthy Kids Corporation Phone Number: Jennifer Kiser Lloyd, Director of External Affairs, 850.701.6108
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive CHIP managed care services inclusive of acute, behavioral health, pharmacy and vision services
4. Dates of the contract	10/01/2010* – 09/30/2011 *Original contract term began 01/01/2003
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: 83,700 Population Types: CHIP
6. Annual contract payments	$98,500,000
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup Florida utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Florida uses subcontractors for the provision of services including, but not limited to, pharmacy, vision, laboratory and durable medical equipment. Amerigroup Florida also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup Florida including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.
Florida Long Term Care Nursing Home Diversion Waiver Program)	
1. Trade name	AMERIGROUP Florida, Inc. (Amerigroup Florida)
2. Contract name and phone number	Contract Name: Florida Department of Elder Affairs Long-Term Community Diversion Pilot Project

FLORIDA	
	Phone Number: Davis Oropallo, Chief-Bureau of Long Term Care and Support, 850.414.2000
3. *Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP*	Nursing home diversion program funded by Medicaid, with the objective of meeting the long-term care needs of the frail elderly through the delivery of coordinated medical and long term care services. Services provided include acute, long-term care, behavioral health, dental, vision and pharmacy.
4. *Dates of the contract*	09/01/2010* – 08/31/2011 * Original contract term began 01/01/2003
5. *Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)*	Number of Members: 2,900 Population Types: Medicaid-eligible individuals age 65 or older that **a)** have Medicare Parts A and B and **b)** are at risk for nursing home placement
6. *Annual contract payments*	$53,700,000
7. *Whether payment was capitated or other*	Capitated
8. *Role of subcontractors, if any*	Amerigroup Florida utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Florida uses subcontractors for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory and durable medical equipment. Amerigroup Florida also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and, utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup Florida including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-31. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – Georgia

GEORGIA	
Georgia Medicaid and CHIP	
1. *Trade name*	AMGP Georgia Managed Care Company, Inc. (Amerigroup Georgia)
2. *Contract name and phone number*	Contract Name: The Georgia Department of Community Health Phone Number: Jerry Dubberly, Chief Medicaid Division, 404.651.8681

GEORGIA	
3. *Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP*	Comprehensive Medicaid and CHIP managed care services inclusive of acute, behavioral health, pharmacy, vision, non-emergent transportation and dental services
4. *Dates of the contract*	07/01/2005 – 06/30/2011
5. *Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)*	Number of Members: 265,000 Population Types: TANF, CHIP
6. *Annual contract payments*	$691,300,000
7. *Whether payment was capitated or other*	Capitated
8. *Role of subcontractors, if any*	Amerigroup Georgia utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Georgia uses subcontractors for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory, durable medical equipment and transportation. Amerigroup Georgia also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup Georgia including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-32. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – Ohio

OHIO	
Ohio Medicaid	
1. *Trade name*	AMERIGROUP Ohio, Inc. (Amerigroup Ohio)
2. *Contract name and phone number*	Contract Name: Ohio Department of Job and Family Services Ohio Medical Assistance Provider Agreement for Managed Care Plan Phone Number: Dale E. Lehmann, Esq. Chief – Managed Care Section, OHP*, 614-752-4778 **If contacted for reference purposes, we are informed it is the policy of the OHP to only confirm facts and not make*

OHIO	
	statements about specific aspects of performance.
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive Medicaid and CHIP managed care services inclusive of acute, vision, dental, non-emergent transportation and limited behavioral health services
4. Dates of the contract	07/01/2010* – 06/30/2011 *Original contract term began 09/01/2005
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: Medicaid: 55,500 Population Type: TANF, CHIP
6. Annual contract payments	$151,600,000
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup Ohio utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Ohio uses subcontractors for the provision of services including, but not limited to dental, vision, laboratory, durable medical equipment and transportation. Amerigroup Ohio also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup Ohio including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-33. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – New York

NEW YORK	
New York Medicaid and Family Health Plus	
1. Trade name	AMERIGROUP New York, LLC (Amerigroup New York)
2. Contract name and phone number	Contract Name: New York Medicaid Managed Care and Family Health Plus *(Amerigroup New York holds contracts with both New York City and New York State)* Phone Number: Patrick Roohan, Director, Division of Quality and Evaluation, 518.486.9012
3. Brief description of the scope	Comprehensive Medicaid managed care services inclusive of

NEW YORK	
of work and services provided. Highlight any services provided similar to those outlined in this RFP	acute, behavioral health, vision, dental and non-emergent transportation services
4. Dates of the contract	New York State: 10/01/2005* – 02/28/2013 New York City: 10/01/2005* – 09/30/2011 *Original contract term began 01/01/2005
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: 98,300 Population Types: TANF, SSI, uninsured adults,
6. Annual contract payments	$251,100,000
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup New York utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup New York uses subcontractors for the provision of services including, but not limited to dental, vision, laboratory, durable medical equipment and transportation. Amerigroup New York also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup New York including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.
New York CHIP	
1. Trade name	AMERIGROUP New York, LLC (Amerigroup New York)
2. Contract name and phone number	Contract Name: New York State Department of Health Child Health Plus Program Phone Number: Patrick Roohan, Director, Division of Quality and Evaluation, 518.486.9012
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive CHIP managed care services inclusive of acute, behavioral health, pharmacy, vision and dental services

NEW YORK	
4. Dates of the contract	01/01/2008* – 12/31/2012 * Previous contract term began 01/01/2005
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: 8,800 Population Types: CHIP
6. Annual contract payments	$13,900,000
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup New York utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup New York uses subcontractors for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory and durable medical equipment. Amerigroup New York also utilizes subcontractors for administrative services including, but not limited to, *Nurse HelpLine* administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup New York including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.
New York Managed Long Term Care	
1. Trade name	AMERIGROUP New York, LLC (Amerigroup New York)
2. Contract name and phone number	Contract Name: New York State Department of Health Managed Long-Term Care Phone Number: Patrick Roohan, Director, Division of Quality and Evaluation, 518.486.9012
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Coverage and coordination of services for people who are chronically ill or have disabilities and who need health and long-term care services, such as home care or adult day care. Covered services include: care management, nursing home care, home care (including therapy and nursing services), adult day health care, personal care, durable medical equipment/prosthetics, personal emergency response system, non-emergency transportation, podiatry, dental care, optometry, audiology, social, and environmental supports.
4. Dates of the contract	01/01/2007* – 12/31/2011

NEW YORK	
	* Original contract term began 12/01/2005
5. *Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)*	Number of Members: 900 Population Types: Individuals age 18 and over (including duals) eligible for Medicaid and nursing home-level of care but capable of residing at home without jeopardy to health
6. *Annual contract payments*	$29,500,000
7. *Whether payment was capitated or other*	Capitated
8. *Role of subcontractors, if any*	Amerigroup New York utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup New York uses subcontractors for the provision of services including, but not limited to dental, vision, durable medical equipment and transportation. Amerigroup New York also utilizes subcontractors for administrative services including, but not limited to Nurse HelpLine administration. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup New York including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.
New York Medicaid Advantage Plus	
1. *Trade name*	AMERIGROUP New York, LLC (Amerigroup New York)
2. *Contract name and phone number*	Contract Name: New York State Medicaid Advantage Plus Phone Number: Patrick Roohan, Director, Division of Quality and Evaluation, 518.486.9012
3. *Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP*	Provision of care management services and coverage of services to the extent not covered by Medicare. This includes, but is not limited to, personal care, adult day health care, home health care, durable medical equipment, hearing, vision, dental, nutritional counseling, medical social services, non-emergency transportation, private duty nursing and social/environmental supports.
4. *Dates of the contract*	01/01/2010 – 12/31/2011
5. *Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)*	Number of Members: 12 Population Types: Duals also enrolled with Amerigroup as Medicare Advantage Members who are eligible for nursing home-level of care but capable of residing at home without jeopardy to health

NEW YORK	
6. Annual contract payments	$582,305
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	New York utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup New York uses subcontractors for the provision of services including, but not limited to dental, vision, durable medical equipment and transportation. Amerigroup New York also utilizes subcontractors for administrative services including, but not limited to, *Nurse HelpLine* administration. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup New York including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.
New York Medicaid Advantage	
1. Trade name	AMERIGROUP New York, LLC (Amerigroup New York)
2. Contract name and phone number	Contract Name: New York City Medicaid Advantage Contract Phone Number: Patrick Roohan, Director, Division of Quality and Evaluation, 518.486.9012
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Coverage of services to the extent not covered by Medicare. This includes, but is not limited to, private duty nursing, non-emergency transportation, dental, vision, hearing, home health and durable medical equipment.
4. Dates of the contract	01/01/2010 – 12/31/2010* *Agreement remains in effect until execution of extension, renewal or replacement agreement
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: 0 Population Types: Duals also enrolled with Amerigroup as Medicare Advantage Members
6. Annual contract payments	None
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup New York, utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup New York uses subcontractors for the provision of

NEW YORK	
	services including, but not limited to dental, vision, durable medical equipment and transportation. Amerigroup New York also utilizes subcontractors for administrative services including, but not limited to, *Nurse HelpLine* administration. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup New York including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-34. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – Virginia

VIRGINIA	
Virginia Medicaid	
1. Trade name	AMERIGROUP Virginia, Inc. (Amerigroup Virginia)
2. Contract name and phone number	Contract Name: Commonwealth of Virginia Department of Medical Assistance Services Medallion II Managed Care Contract Phone Number: Mary Mitchell, Manager, Managed Care Program, 804.786.3594
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive Medicaid managed care services inclusive of acute, behavioral health, pharmacy, vision, and non-emergency transportation services
4. Dates of the contract	07/01/2010* – 06/30/2011 *Original contract term began 09/01/2005
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: 35,600 Population Types: TANF, SSI
6. Annual contract payments	$96,700,000
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup Virginia utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Virginia uses subcontractors for the provision of services including, but not limited to, pharmacy, vision,

VIRGINIA	
	laboratory, durable medical equipment and transportation. Amerigroup Virginia also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup Virginia including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.
Virginia CHIP	
1. *Trade name*	AMERIGROUP Virginia, Inc. (Amerigroup Virginia)
2. *Contract name and phone number*	Contract Name: Commonwealth of Virginia Department of Medical Assistance Services Contract to Provide Managed Care Services for the Family Access to Medical Insurance Security (FAMIS) Program Phone Number: Mary Mitchell, Manager, Managed Care Program, 804.786.3594
3. *Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP*	Comprehensive CHIP managed care services inclusive of acute, behavioral health, pharmacy, vision, and non-emergency transportation services
4. *Dates of the contract*	07/01/2010* – 06/30/2011 *Original contract term began 09/01/2005
5. *Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)*	Number of Members: 3,900 Population Types: CHIP
6. *Annual contract payments*	$5,200,000
7. *Whether payment was capitated or other*	Capitated
8. *Role of subcontractors, if any*	Amerigroup Virginia utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Virginia uses subcontractors for the provision of services including, but not limited to, pharmacy, vision, laboratory, durable medical equipment and transportation. Amerigroup Virginia also utilizes subcontractors for administrative services including, but not limited to, Nurse HelpLine administration and utilization review of radiology

VIRGINIA	
	services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup Virginia including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-35. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – Tennessee

TENNESSEE	
Tennessee Medicaid and Long Term Care	
1. *Trade name*	AMERIGROUP Tennessee, Inc. (Amerigroup Tennessee)
2. *Contract name and phone number*	Contract Name: The State of Tennessee (TennCare) Contractor Risk Agreement Phone Number: Darin J. Gordon, Executive Director, 615.507.6443
3. *Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP*	Comprehensive Medicaid managed care services inclusive of acute, long term care support, behavioral health, vision and non-emergent transportation services
4. *Dates of the contract*	08/15/2006 – 06/30/2011
5. *Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)*	Number of Members: 202,100 Population Types: TANF, ABD
6. *Annual contract payments*	$855,100,000
7. *Whether payment was capitated or other*	Capitated
8. *Role of subcontractors, if any*	Amerigroup Tennessee utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Tennessee uses subcontractors for the provision of services including, but not limited to vision, laboratory, durable medical equipment and transportation. Amerigroup Tennessee also utilizes subcontractors for administrative services including, but not limited to, *Nurse HelpLine* administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup

TENNESSEE	
	Tennessee including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-36. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – New Mexico

NEW MEXICO	
New Mexico LTC	
1. Trade name	Amerigroup Community Care of New Mexico, Inc. (Amerigroup New Mexico)
2. Contract name and phone number	Contract Name: Medicaid Long-Term Services Agreement with the State of New Mexico Human Services Department and Aging & Long-Term Services Department Phone Number: Cathy Sisneros, Long-Term Services and Support Bureau, MAD-HSD Administrative Operations Manager II – CoLTS, 505.827.3178
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive Medicaid managed care services and long-term care services inclusive of acute, long-term care, pharmacy, vision, dental, non-emergent transportation and limited behavioral health services
4. Dates of the contract	07/01/2008 – 06/30/2012
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: 19,700 Population Types: ABD, Duals
6. Annual contract payments	$419,500,000
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup New Mexico utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup New Mexico uses subcontractors for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory, durable medical equipment and transportation. Amerigroup New Mexico also utilizes subcontractors for administrative services including, but not limited to, *Nurse HelpLine* administration. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup

NEW MEXICO	
	New Mexico including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-37. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – Nevada

NEVADA	
Nevada Medicaid and CHIP	
1. *Trade name*	AMERIGROUP Nevada, Inc. (Amerigroup Nevada)
2. *Contract name and phone number*	Contract Name: Nevada Department of Health and Human Services Health Care Financing and Policy Division Phone Number: John Whaley, Chief of Business Lines – Division of Health Care Financing and Policy, 775.684.3691
3. *Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP*	Comprehensive Medicaid and CHIP managed care services inclusive of acute, behavioral health, pharmacy, vision and dental services
4. *Dates of the contract*	09/08/2008 – 06/30/2012
5. *Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)*	Number of Members: Medicaid: 79,200 Population Types: TANF, CHIP
6. *Annual contract payments*	$161,500,000
7. *Whether payment was capitated or other*	Capitated
8. *Role of subcontractors, if any*	Amerigroup Nevada utilizes various subcontractors to deliver certain specialized covered services. Under this contract, Amerigroup Nevada uses subcontractors for the provision of services including, but not limited to, pharmacy, vision, laboratory, durable medical equipment and transportation. Amerigroup Nevada also utilizes subcontractors for administrative services including, but not limited to, *Nurse HelpLine* administration and utilization review of radiology services. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of Amerigroup Nevada including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

In addition to the current contracts listed above, Amerigroup has also held and voluntarily terminated contracts in two states and the District of Columbia.

Table B-38. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – Illinois

ILLINOIS	
Illinois Medicaid and CHIP	
1. Trade name	AMERIGROUP Illinois, Inc. (Amerigroup Illinois)
2. Contract name and phone number	State of Illinois Department of Public Aid Contract for Furnishing Health Services by a Managed Care Organization
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive Medicaid and CHIP managed care services
4. Dates of the contract	08/01/2004* – 07/31/2006 *Original contract term began 04/01/1996
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: Medicaid: 37,200 Population Types: TANF, CHIP
6. Annual contract payments	$32,602,509
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup Illinois utilized various subcontractors to deliver certain specialized/ancillary covered services. Amerigroup Illinois also utilized subcontractors for some administrative services. Additionally, Amerigroup Corporation performed certain administrative and support services on behalf of Amerigroup Illinois including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-39. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – District of Columbia

DISTRICT OF COLUMBIA	
District of Columbia Medicaid and CHIP	
1. Trade name	AMERIGROUP DC Inc. (Amerigroup DC)
2. Contract name and phone number	POHC-2002-D-003
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive Medicaid and CHIP managed care services
4. Dates of the contract	08/01/2002* - 06/30/2008 *Original contract term began 08/01/1999
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: Medicaid 34,042 Population Types: TANF, CHIP
6. Annual contract payments	$79,060,577
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup DC utilized various subcontractors to deliver certain specialized/ancillary covered services. Amerigroup DC also utilized subcontractors for some administrative services. Additionally, Amerigroup Corporation performed certain administrative and support services on behalf of Amerigroup DC including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Table B-40. Publicly-Funded Managed Care Contracts for Medicaid and CHIP – South Carolina

SOUTH CAROLINA	
South Carolina Medicaid	
1. Trade name	AMERIGROUP South Carolina, Inc. (Amerigroup South Carolina)
2. Contract name and phone number	Contract name: South Carolina Department of Health and Human Services Purchase and Provision of Medical Services under the South Carolina Medicaid MCO Program
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive Medicaid managed care services
4. Dates of the contract	04/01/2008 – 03/31/2010 *Contract effective was 11/08/2007; however Operations began 04/1/2008
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: Medicaid 13,243 Population Types: TANF
6. Annual contract payments	$13,122,710
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup South Carolina utilized various subcontractors to deliver certain specialized/ancillary covered services. Amerigroup South Carolina also utilized subcontractors for some administrative services. Additionally, Amerigroup Corporation performed certain administrative and support services on behalf of Amerigroup South Carolina including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.
South Carolina SCHIP	
1. Trade name	AMERIGROUP South Carolina, Inc. (Amerigroup South Carolina)
2. Contract name and phone number	South Carolina Department of Health and Human Services Purchase and Provision of Medical Services under the Healthy Connections Kids Program
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Comprehensive CHIP managed care services

SOUTH CAROLINA	
4. Dates of the contract	05/01/2008 – 03/31/2010
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Number of Members: Medicaid 1,427 Population Types: CHIP
6. Annual contract payments	$523,019
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Amerigroup South Carolina utilized various subcontractors to deliver certain specialized/ancillary covered services. Amerigroup South Carolina also utilized subcontractors for some administrative services. Additionally, Amerigroup Corporation performed certain administrative and support services on behalf of Amerigroup South Carolina including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

Publicly-Funded Managed Care Contracts for Non-Medicaid and CHIP Populations

Amerigroup offers Medicare Advantage and Special Needs Plan (SNP) benefits to approximately 20,000 members through our subsidiary health plans in seven states: Florida, Maryland, New Jersey, New Mexico, New York, Tennessee and Texas. The table that follows provides the requested information.

Table B-41. Publicly-Funded Managed Care Contracts for Non-Medicaid and CHIP

RFP Requirement	Texas
1. Trade name	AMERIGROUP Texas, Inc. (Amerigroup Texas)
2. Contract name and phone number	Kermnine Domond, Regional Plan Manager, 212.616.2322
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Medicare Advantage. This plan provides the following covered services: hospital insurance, medical insurance, vision, hearing, dental, wellness program and prescription drug coverage
4. Dates of the contract	01/01/2006 – 12/31/2011
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Medicare and Dual Eligibles: 7,272 (as of 12/2010 ending)
6. Annual contract payments	$92,500,000 (2010)
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Each of Amerigroup's subsidiary health plans utilizes various subcontractors to deliver certain specialized covered services. Depending on the covered services and managed care program design, subcontractors may be used for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory, durable medical equipment and transportation. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of each of its health plan subsidiaries including, but not limited to, finance, claim administration, call center activities, management information systems, legal, regulatory, treasury and compliance.
RFP Requirement	**New Jersey**
1. Trade name	AMERIGROUP New Jersey, Inc. (Amerigroup New Jersey)
2. Contract name and phone number	Kermnine Domond, Regional Plan Manager, 212.616.2322
3. Brief description of the scope	Medicare Advantage. This plan provides the following covered

of work and services provided. Highlight any services provided similar to those outlined in this RFP	services: hospital insurance, medical insurance, vision, hearing and dental services, wellness program and prescription drug coverage
4. Dates of the contract	01/01/2008 – 12/31/2011
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Medicare and Dual Eligibles: 2,455 (as of 12/2010 ending)
6. Annual contract payments	$25,100,000 (2010)
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Each of Amerigroup's subsidiary health plans utilizes various subcontractors to deliver certain specialized covered services. Depending on the covered services and managed care program design, subcontractors may be used for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory, durable medical equipment and transportation. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of each of its health plan subsidiaries including, but not limited to, finance, claim administration, call center activities, management information systems, legal, regulatory, treasury and compliance.
RFP Requirement	**Florida**
1. Trade name	AMERIGROUP Florida, Inc. (Amerigroup Florida)
2. Contract name and phone number	Kermnine Domond, Regional Plan Manager, 212.616.2322
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Medicare Advantage. This plan provides the following covered services: hospital Insurance, medical insurance, vision, hearing and dental services, wellness program, and prescription drug coverage
4. Dates of the contract	01/01/2008 – 12/31/2011
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Medicare and Dual Eligibles: 2,210 (as of 12/2010 ending)
6. Annual contract payments	$24,600,000 (2010)
7. Whether payment was	Capitated

capitated or other	
8. Role of subcontractors, if any	Each of Amerigroup's subsidiary health plans utilizes various subcontractors to deliver certain specialized covered services. Depending on the covered services and managed care program design, subcontractors may be used for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory, durable medical equipment and transportation. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of each of its health plan subsidiaries including, but not limited to, finance, claim administration, call center activities, management information systems, legal, regulatory, treasury and compliance.
RFP Requirement	**New Mexico**
1. Trade name	AMERIGROUP Community Care of New Mexico, Inc. (Amerigroup New Mexico)
2. Contract name and phone number	Kermnine Domond, Regional Plan Manager, 212.616.2322
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Medicare Advantage. This plan provides the following covered services: hospital insurance, medical insurance Vision, hearing, dental, wellness program and prescription drug coverage
4. Dates of the contract	01/01/2008 – 12/31/2011
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Medicare and Dual Eligibles: 1,604 (as of 12/2010 ending)
6. Annual contract payments	$16,500,000 (2010)
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Each of Amerigroup's subsidiary health plans utilizes various subcontractors to deliver certain specialized covered services. Depending on the covered services and managed care program design, subcontractors may be used for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory, durable medical equipment and transportation. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of each of its health plan subsidiaries including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory,

	treasury and compliance.
RFP Requirement	**Tennessee**
1. Trade name	AMERIGROUP Tennessee, Inc. (Amerigroup Tennessee)
2. Contract name and phone number	Kermnine Domond, Regional Plan Manager, 212.616.2322
3. Brief description of the scope of work and services provided. Highlight any services provided similar to those outlined in this RFP	Medicare Advantage. This plan provides the following covered services: hospital insurance, medical insurance, vision, hearing, dental, wellness program and prescription drug coverage
4. Dates of the contract	01/01/2008 – 12/31/2011
5. Number of Members and the population types (e.g. TANF, SOBRA, SSI (Aged, Blind and Disabled), CHIP, Duals)	Medicare and Dual Eligibles: 1,389 (as of 12/2010 ending)
6. Annual contract payments	$16,800,000 (2010)
7. Whether payment was capitated or other	Capitated
8. Role of subcontractors, if any	Each of Amerigroup's subsidiary health plans utilizes various subcontractors to deliver certain specialized covered services. Depending on the covered services and managed care program design, subcontractors may be used for the provision of services including, but not limited to, pharmacy, dental, vision, laboratory, durable medical equipment and transportation. Additionally, Amerigroup Corporation performs certain administrative and support services on behalf of each of its health plan subsidiaries including, but not limited to, finance, claim administration, call center activities, IT, legal, regulatory, treasury and compliance.

B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/non-renewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries.

Contract Termination or Non-Renewal

AMERIGROUP Louisiana, Inc. is a new health plan created to serve Medicaid enrollees under the CCN program. We have never had a contract to provide managed care services terminated or not renewed at the initiation of one of our state or federal agency clients.

Amerigroup and its health plan subsidiaries take our commitment to our state partners, our network providers, and most importantly, to our members very seriously. As evidence of this commitment, **neither Amerigroup, nor any of its health plan subsidiaries, has ever terminated a state or federal agency contract prior to its defined contract term, and likewise, no Amerigroup subsidiary has ever been subject to a state-initiated termination of a contract**. As part of the commitment we maintain to the communities we serve, we strive to build sustainable partnerships with our government agency customers to provide meaningful solutions to the health care challenges faced by those served by public health programs including financially disadvantaged families and individuals with disabilities. Our three most tenured affiliates in New Jersey, Texas and Maryland have been in continuous operations, serving a wide range of health care programs for well over a decade. Of our remaining eight markets, five have been in operation for five or more years. We are proud of the commitment and partnership we bring to the states and people we serve.

In response to DHH Question #11 published on May 23, 2011, Amerigroup provides the following information about Affiliates which voluntarily chose to end health plan operations in the past five years. In our 15-year operating history, we have only three instances when we voluntarily chose to end our contract in accordance with the agreement's terms:

- Amerigroup Maryland opted not to enter into a new contract with the District of Columbia Medical Assistance Agency in 2008 after nine years in operation in the District. The contract was awarded as the result of a reprocurement. To ensure a smooth transition and continuity of care for our membership, we readily agreed to the District's request to extend benefit coverage for an additional thirty days beyond the end of our contract term. Ultimately, Amerigroup Maryland's contract with the District of Columbia ended on June 30, 2008.
- Amerigroup Illinois opted to let its contract with the Illinois Department of Healthcare and Family Services expire in accordance with its contract terms in 2008 after nine years of operations in the state.
- Amerigroup South Carolina ended its contract with the South Carolina Department of Health and Human Services (DHHS) in accordance with the contract's provisions as part of an approved asset purchase agreement. Amerigroup South Carolina successfully transitioned its approximately 9,000 members to another health plan as of March 1, 2009.

Amerigroup makes significant investments in the communities we serve and maintains long-term commitments to our members as demonstrated by our tenure and growth in the markets we serve.

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B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.

Contract Termination or Non-Renewal Based on Performance

AMERIGROUP Louisiana, Inc. attests that we have never had a contract to provide managed care services terminated or not renewed based on organizational performance.

Amerigroup Corporation affirms that none of our affiliated health plans have had a contract to provide managed care services terminated or not renewed based on organizational performance.

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B.19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:

- ***AM Best Company (financial strengths ratings);***
- ***TheStreet.com, Inc. (safety ratings); and***
- ***Standard & Poor's (long-term insurer financial strength.***

Financial Ratings

As a new entity, formed solely for the purpose of providing health care services to the citizens of Louisiana through publicly funded health care programs, Amerigroup Louisiana has not been rated.

AM Best Company has not provided a rating for Amerigroup Corporation or our affiliated health plans. TheStreet.com and Standard & Poor's have rated Amerigroup Corporation but neither organization has provided a rating for our affiliated health plans.

Please note that Amerigroup requests ratings from Moody's for our largest health plans as part of Moody's requirement to rate our public debt. Thus, our health plans in Texas, Florida, Maryland and New Jersey have been rated by Moody's and those ratings are listed below in Table B-42.

With respect to AM Best, their business model is such that they decide to rate companies according to their ability to sell the ratings and they use only publicly filed statutory reports to build their rating. Several years ago, they stopped rating many Medicaid health plans, including Amerigroup's Medicaid health plans.

Table B-42 below provides the ratings achieved by our parent organization, Amerigroup Corporation and our affiliated health plans, as applicable.

Table B-42. Financial Ratings

Organization Rated	Rating Organization	Rating
Amerigroup Corporation	TheStreet.com	B
Amerigroup Corporation	Standard & Poors	BB+
AMERIGROUP Texas, Inc.	Moody's	Rating Outlook STABLE Insurance Financial Strength Baa3
AMERIGROUP Florida, Inc.	Moody's	Rating Outlook STABLE Insurance Financial Strength Baa3
AMERIGROUP Maryland, Inc.	Moody's	Rating Outlook STABLE Insurance Financial Strength Baa3
AMERIGROUP New Jersey, Inc.	Moody's	Rating Outlook STABLE Insurance Financial Strength Baa3

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B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries.

Breach of Contract

AMERIGROUP Louisiana, Inc. is a new organization formed solely with the purpose of serving Medicaid enrollees enrolled in the CCN program. Amerigroup Louisiana does not yet hold a contract to provide physical health services.

As described in response to Question B.3, our affiliates in 11 other states have active contracts with State Medicaid Agencies to provide the full range of Medicaid benefits including physical health services. Amerigroup understands the term breach of contract to represent a ***willful or material breach that has not been cured such that the State agency would have grounds to terminate the contract for cause.*** In this context, Amerigroup affirmatively states that none of our affiliated health plans have been found by a contracting party to be in breach of contract.

Note that we provide instances or findings of deficiencies, regulatory actions and other matters of discussion that occur during the ordinary course of business between the contracting parties in response to Question B.25.

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B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.

NCQA Accreditation

Amerigroup Louisiana has not yet requested or received accreditation from NCQA but is committed to ensuring that quality services are delivered to our members and to pursuing NCQA accreditation at the earliest possible date we can apply for such recognition.

Amerigroup Corporation places its highest priority of focus on meeting the needs of our members and furnishing excellent service across the continuum of care. We are pleased to state that **we have received full NCQA accreditation for our affiliated health plans in Georgia, Virginia and Tennessee. Our health plans in Ohio and New Mexico are NCQA accredited as New Health Plans.**

Disease Management Program Accreditation

Amerigroup Corporation disease management programs are fully accredited by NCQA. We were initially accredited in 2006 and then re-accredited in 2009. The Patient- and Practitioner-Oriented accreditation is designed, as noted by NCQA, **"to highlight only those programs that truly improve chronic care."** Many of our accredited Disease Management programs help our members self-manage their chronic conditions and complex needs. Our current accredited programs include those focused on the following diseases and conditions: Asthma, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Diabetes, HIV/AIDS, Major Depressive Disorder, and Schizophrenia. We are also actively pursuing accreditation for three other disease management programs: Bipolar Disorder, Hypertension and Obesity.

"NCQA's Disease Management accreditation program is thorough and rigorous. It's designed to highlight only those programs that truly improve chronic care," said NCQA President Margaret E. O'Kane. "Amerigroup is to be commended for being one of the first organizations in the nation to come forward to be reviewed."

Delivering high-quality services to Amerigroup members is our first priority, and the pursuit of accreditation represents a significant investment of our resources.

Table B-43. Amerigroup NCQA Accreditations and Accreditation Term Effective Dates

NCQA Accreditation	Held By	Expiration Date	Date of Next Review
Health Plan Accreditation	Amerigroup Georgia Managed Care Company, Inc.	December 6, 2013	September 11, 2013
Health Plan Accreditation	Amerigroup Tennessee, Inc.	October 13, 2012	July 18, 2012

NCQA Accreditation	Held By	Expiration Date	Date of Next Review
Health Plan Accreditation	Amerigroup Virginia, Inc.	February 22, 2014	December 4, 2013
Disease Management Accreditation and Certification	Amerigroup Corporation	September 25, 2012	TBD

Privacy Accreditations from URAC

The following Amerigroup health plans hold HIPAA Privacy Accreditation from URAC: Amerigroup Florida, Amerigroup Georgia, Amerigroup Ohio, Amerigroup Maryland, Amerigroup New Jersey, Amerigroup New York, Amerigroup Nevada, Amerigroup New Mexico, Amerigroup Tennessee, Amerigroup Texas and Amerigroup Corporation's offices in Virginia Beach, VA. Additionally, Amerigroup Virginia is scheduled for accreditation in 2012.

B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization's parent organization, affiliates, and subsidiaries.

Accreditation Status

Amerigroup Louisiana has not yet requested or received accreditation from NCQA or URAC and thus has not had its status adjusted down, suspended or revoked.

Amerigroup Corporation is pleased to state that the accreditation status of our affiliated health plans noted above, in states other than Louisiana, has never been adjusted down, suspended or revoked.

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B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries.

NCQA Health Plan Report Cards

Amerigroup Louisiana is not yet NCQA accredited; however, several of our affiliated health plans in other states have received such accreditation and their most recent NCQA health plan report cards are included as Attachment B.23.a to this proposal.

Our fully accredited health plans in Georgia, Tennessee and Virginia have each received "Commendable" ratings. On the most recent report card, our Georgia health plan received four stars for "Access and Service" and "Qualified Providers." Our Tennessee health plan received four stars in the same two categories and received four stars in the "Getting Better" category as well. Our Virginia health plan received four stars in the "Getting Better" category and three stars in the other referenced categories.

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AMERIGROUP Community Care Of New Mexico, Inc.

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General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	6565 Americas Parkway NE, Suite 110, Albuquerque, NM, 87110
Number of members enrolled:	19,732
Website:	www.realsolutions.com
Other Names:	CoLTS

This health plan serves members in the following state(s):
New Mexico

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Date of Next Review:	01/08/2014

Performance Results

Accreditation Status:	Scheduled

Accreditation Star Ratings

Access and Service:	
Qualified Providers:	
Staying Healthy:	
Getting Better:	
Living with Illness:	

Other

For cost of benefits information, please contact this plan directly or speak with the benefits manager at your place of work.

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AMERIGROUP Community Care Ohio

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General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	10123 Alliance Road, Suite 140, Cincinnati, OH, 45242
Number of members enrolled:	56,934
Website:	amerigroupcorp.com
Other Names:	Amerigroup Community Care of Ohio, Inc.

This health plan serves members in the following state(s):
Ohio

For specific areas covered, please contact the plan directly.

Accreditation Details

This Plan has achieved New Health Plan Accreditation

Accreditation Type:	Health Plan Accreditation
Date of Next Review:	08/30/2011

Performance Results

Accreditation Status: Scheduled

Accreditation Star Ratings

Access and Service:

Qualified Providers:

Staying Healthy:

Getting Better:

Living with Illness:

Other

For cost of benefits information, please contact this plan directly or speak with the benefits manager at your place of work.

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AMERIGROUP Georgia Managed Care Company, Inc.

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General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	303 Perimeter Center North, Suite 400, Atlanta, GA, 30346
Number of members enrolled:	263,756
Website:	www.amerigroupcorp.com
Other Names:	Amerigroup Georgia Managed Care Co, Inc.

This health plan serves members in the following state(s):
Georgia

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	12/06/2013
Date of Next Review:	09/11/2013
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status: Commendable

Accreditation Star Ratings

Access and Service:	★★★★
Qualified Providers:	★★★★
Staying Healthy:	★★☆☆
Getting Better:	★★★☆
Living with Illness:	★★☆☆

Other

For cost of benefits information, please contact this plan directly or speak with the benefits manager at your place of work.

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AMERIGROUP Tennessee, Inc

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General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	22 Century Blvd, Suite 310, Nashville, TN, 37214
Number of members enrolled:	175,112
Website:	www.amerigroupcorp.com
Other Names:	AMERIGROUP Community Care

This health plan serves members in the following state(s):
Tennessee

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	10/13/2012
Date of Next Review:	07/18/2012
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status: Commendable

Accreditation Star Ratings

Access and Service:	★★★★
Qualified Providers:	★★★★
Staying Healthy:	★☆☆☆
Getting Better:	★★★★
Living with Illness:	★★☆☆

Other

For cost of benefits information, please contact this plan directly or speak with the benefits manager at your place of work.

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AMERIGROUP Virginia, Inc.

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General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	2815 Hartland Road, Suite 140, Merrifield, VA, 22043
Number of members enrolled:	39,582
Other Names:	AMERIGROUP Virginia

This health plan serves members in the following state(s):
Virginia

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	02/22/2014
Date of Next Review:	12/04/2013
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status: Commendable

Accreditation Star Ratings

Access and Service:	★★★☆
Qualified Providers:	★★★☆
Staying Healthy:	☆☆☆☆
Getting Better:	★★★★
Living with Illness:	★★★☆

Other

For cost of benefits information, please contact this plan directly or speak with the benefits manager at your place of work.

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B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.

External Quality Review Report

Amerigroup Louisiana provides a copy of the 2011 External Quality Review Organization of Amerigroup Georgia. Amerigroup Texas had the largest number of enrollees serving 551,300 members as of January 1, 2011; however, the Texas Health and Human Services Commission (HHSC) *does not publish* a final report to the MCOs as part of the EQRO. As such, we provide the most recent report for our 2nd largest health plan, Amerigroup Georgia, which is serving 270,000 members as of January 1, 2011. We will provide a report to DHH in the future should one become available.

As noted in the attached EQRO report (Attachment B.24.a), Amerigroup Georgia demonstrated strong performance in complying with the requirements related to the federal Medicaid managed care measurement and improvement standards and the Georgia's Department of Community Health (DCH) contract requirements for the care management organizations (CMOs). The plan received the highest overall percentage of compliance score of 92% when compared to all plans.

The standards addressed in the report relate to the CMOs:

- Adoption and use of practice guidelines to help shape quality provider practices
- Quality assessment and performance improvement (QAPI) programs and activities
- Health information systems' capabilities

The report notes that Amerigroup Georgia's performance in the review met the 47 applicable requirements across the three standards in 100% of the cases. The plan had ample written documentation describing its processes, practices, action plans, and performance results/outcomes related to each requirement. During the interviews, staff members' responses to HSAG's questions, including their descriptions and examples of the CMO's processes and practices for ensuring compliance with the requirements, were consistent with and expanded upon the information in the documentation. In combination, the documentation and information staff presented during the interview was sufficient to demonstrate that Amerigroup Georgia was in compliance with each of the requirements during both the desk audit and at the time of review.

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State of Georgia

Department of Community Health (DCH)

2009–2010
EXTERNAL QUALITY REVIEW ANNUAL REPORT

for

Georgia Families
Care Management Organizations (CMOs)

July 2010

HSAG HEALTH SERVICES ADVISORY GROUP

1600 East Northern Avenue, Suite 100 • Phoenix, AZ 85020

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HSAG HEALTH SERVICES ADVISORY GROUP

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HSAG HEALTH SERVICES ADVISORY GROUP

1. Executive Summary

This is the second year for which the Georgia Department of Community Health (DCH) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to conduct a quality review of three mandatory Medicaid activities and to prepare an annual report of results, as federally required. The three activities included a review and evaluation of compliance with federal Medicaid managed care regulations and the associated State contract requirements; validation of performance improvement projects (PIPs); and validation of performance measures.

As part of the review, HSAG identified strengths and weaknesses of the Georgia Families care management organizations (CMOs) and offered recommendations for improvement. Because the Centers for Medicare & Medicaid Services (CMS) has chosen the domains of quality, access, and timeliness as keys to evaluating performance, HSAG also evaluated and drew conclusions about the performance of the CMOs in each of these domains.

Overview of the 2009–2010 External Quality Review Activities

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, states that each contract with a Medicaid managed care organization must provide for an annual external quality review (EQR), conducted by a qualified independent entity, of the quality outcomes and timeliness of, and access to, the care and services for which the organization is responsible.[1-1]

The Code of Federal Regulations (CFR) also describes EQR activities that must occur regarding state Medicaid managed care programs. These are described specifically at 42 CFR 438.358(b). As noted above, they require a review and evaluation of compliance with federal Medicaid managed care regulations and the associated State contract requirements, and the validation of PIPs and performance measures.

DCH is responsible for the administration and oversight of the Medicaid managed care program in the State of Georgia. DCH contracts with three privately owned managed care organizations to deliver services to its members who are enrolled in its Medicaid managed care program and its Children's Health Insurance Program (CHIP). The State refers to its Medicaid managed care program as Georgia Families and to its CHIP program as PeachCare for Kids™. DCH refers to its three Medicaid managed care contractors as care management organizations (CMOs). The three CMOs under contract with DCH during 2009–2010 were AMERIGROUP Community Care (AMERIGROUP), Peach State Health Plan (Peach State), and WellCare of Georgia, Inc. (WellCare).

Following is a brief description of the scope of work for each EQR activity:

- *Review of compliance with State-specified operational standards*. HSAG's review determined the CMOs' compliance with requirements for six DCH-selected performance categories, or

[1-1] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*

standards, which are sets of related requirements. The six included requirements associated with federal Medicaid managed care structure and operations standards found at 42 CFR 438.214–230, as well as the additional requirements cross-referenced within them.

- *Validation of performance measures.* HSAG validated the DCH-selected set of six performance measures to evaluate the accuracy of the performance measures reported by the CMOs. The validation also determined the extent to which Medicaid-specific performance measures calculated by the CMOs followed the DCH-established specifications.
- *Validation of PIPs*. HSAG reviewed six DCH-selected PIPs per CMO to ensure that the CMOs designed, conducted, and reported on the projects in a methodologically sound manner, allowing real improvements in care and services and creating confidence in the reported improvements.

Conclusions

For each of the EQR activities, HSAG conducted a thorough review and analysis of the data. Because the activities varied in types of data, the methodology for identifying strengths and weaknesses was designed to accommodate the data available for each activity.

Compliance With State-Specified Operational Standards

HSAG's compliance audit for the DCH-contracted CMOs consisted of a desk review of each CMO's documents and an on-site review of additional documents, as well as interviews with key CMO staff members. HSAG evaluated the degree to which each CMO complied with federal Medicaid managed care regulations and the associated DCH contract requirements in six performance categories, or standards:

I. Selecting, credentialing, and recredentialing providers.
II. Subcontractual relationships and delegation of CMO administrative responsibilities.
III. Ensuring member rights and protections.
IV. Information provided to members.
V. Member grievances, appeals, and access to State administrative law hearings.
VI. Disenrollment requirements and limitations.

HSAG assigned a score of *Met* (value of 1 point), *Partially Met* (value of .5 points), or *Not Met* (value of 0 points) to reflect a CMO's performance in complying with each of the requirements. If a requirement was not applicable to a CMO for the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. Individual CMO scores were then calculated for each standard and across all standards (total points divided by the number of applicable standards). Table 1-1 presents the statewide and CMO-specific performance for all six standards. The statewide overall compliance score was 91 percent. No CMO had a percentage-of-compliance score of less than 90 percent. While none of the CMOs had areas of weakness as defined by scores at or below 60 percent, opportunities for improvement were identified for one or more of the CMOs for all standards except Standard III.

Table 1-1—Individual CMO and Statewide Compliance Scores					
Standard #	**Standard Name**	**AMERIGROUP Community Care**	**Peach State Health Plan**	**WellCare of Georgia, Inc.**	**Statewide**
I	Provider Selection, Credentialing and Recredentialing	90%	100%	100%	97%
II	Subcontractual Relationships and Delegation	92%	83%	100%	92%
III	Member Rights and Protections	100%	100%	100%	100%
IV	Member Information	90%	93%	85%	89%
V	Grievance System	90%	89%	84%	88%
VI	Disenrollment Requirements and Limitations	100%	81%	100%	94%
	Overall Percentage-of-Compliance Scores	**92%**	**91%**	**90%**	**91%**

AMERIGROUP received the highest overall percentage-of-compliance score (92 percent), followed by Peach State (91 percent), and WellCare (90 percent). These findings suggest that all three CMOs demonstrated fairly strong performance across the six standards, most notably for Standard III, for which all CMOs received fully compliant scores.

HSAG provided specific recommendations to each CMO for any scores that were less than *Met*. The CMOs were required to develop corrective action plans (CAPs) and implement interventions to address the deficiencies and bring the areas into full compliance.

Performance Improvement Projects (PIPs)

PIPs are designed to assess health care processes, implement process improvements, and improve outcomes of care. In 2009–2010, DCH selected and HSAG validated six PIPs for each of the three CMOs, for a total of 18 PIPs. The six PIP topics were:

- *Access/Service Capacity*
- *Childhood Immunization*
- *Improving Childhood Lead Screening Rates*
- *Member Satisfaction*
- *Provider Satisfaction*
- *Well-Child Visits During the First 15 Months of Life With Six or More Visits*

This was a second-year validation. Once the PIPs have progressed to the point that remeasurement data become available for comparison to baseline results, HSAG will also evaluate the PIP results for statistically significant improvement.

Table 1-2 shows that the total percentage of all evaluation elements receiving a score of *Met* was 99 percent, demonstrating a high level of success for the CMOs' efforts on their second-year submissions. All 18 PIPs received a *Met* validation status, which was a major improvement from the

previous year, when three of the nine PIPs evaluated received a *Met* validation status and the remaining six received a validation status of either *Partially Met* or *Not Met*.

Table 1-2—PIP Validation Status by CMO and Statewide				
	AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia, Inc.	Statewide
Overall CMO Performance				
Total Percentage Score for Evaluation Elements *Met*	**98%**	**99%**	**98%**	**99%**
Number of PIPs by Validation Status	**6**	**6**	**6**	**18**
Not Met	0	0	0	0
Partially Met	0	0	0	0
Met	6	6	6	18

During 2009–2010, the Georgia Families CMOs not only exhibited improvements in conducting and documenting PIPs from their first-year submission, but also applied lessons learned from existing PIPs to the new PIPs.

While the CMOs demonstrated numerous strengths, HSAG also identified areas for improvement. It is HSAG's recommendation that the CMOs review HSAG's comments and recommendations in the PIP reports and make the suggested changes for the next submission for all applicable evaluation elements not achieving a *Met* score or receiving a *Point of Clarification*. It is also HSAG's recommendation that DCH hold the CMOs accountable for making these changes to enhance PIP performance.

Performance Measures

HSAG designed the validation of performance measures activity to ensure the accuracy of the performance indicator results the CMOs reported to DCH. To determine that the results were valid and accurate, HSAG evaluated the CMOs' data collection and calculation processes. HSAG validated six performance measures for each CMO to assess its compliance with performance measure technical requirements, specifications, and construction. The six were:

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Use of Appropriate Medications for People With Asthma*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Childhood Immunization Status—Combination 2*
- *Lead Screening in Children*
- *Adults' Access to Preventive/Ambulatory Health Services*

The performance indicators were reported and validated for CMO data from calendar year 2008 (January 1, 2008, through December 31, 2008). HSAG scored all the measures *Fully Compliant* for each CMO. Additionally, the CMOs achieved acceptable performance on data integration, data control, and performance indicator documentation, and their medical record abstraction processes were a strength. The CMOs used adequate processes for claims, enrollment, and provider data

processing, and all CMOs used a software vendor certified by the National Committee for Quality Assurance (NCQA) to generate the Healthcare Effectiveness Data and Information Set (HEDIS®) rates.

With respect to performance levels, HSAG analyzed the performance measure data by comparing each CMO's reported rate for each performance measure to the national HEDIS 2008 Medicaid percentiles. Table 1-3 presents the performance measure rates for the Georgia Families CMOs. Any CMO rate that exceeded the high performance level (HPL) on a given measure[1-2] was considered an area of strength for the CMO, and any CMO rate that was below the low performance level (LPL) was considered an area of weakness. CMO rates that fell between the HPL and the LPL presented opportunities for improvement.

Table 1-3—Performance Measure Results, Statewide and by CMO

	Indicator	AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia, Inc.	Statewide
1.	*Comprehensive Diabetes Care—HbA1c Testing*	74.50%	64.23%[a]	72.26%	70.46%[b]
2.	*Use of Appropriate Medications for People With Asthma*	91.84%	91.12%[a]	90.58%	91.09%
3.	*Well-Child Visits in the First 15 Months of Life—Six or More Visits*	62.25%	51.58%[a]	57.42%[c]	*Not Calculated*[c]
4.	*Childhood Immunization Status—Combination 2*	29.84%[d]	62.77%[a]	75.91%	*Not Calculated*[e]
5.	*Lead Screening in Children*	68.21%	57.18%[a]	65.94%	*Not Calculated*[f]
6.	*Adults' Access to Preventive/Ambulatory Health Services*				
	20 to 44 Years of Age	81.20%	78.88%	78.64%	79.19%
	45 to 64 Years of Age	86.29%	80.98%	84.58%	83.91%

[a] This rate represents only the Georgia Medicaid population; the PeachCare for Kids population was not included.
[b] Because the number of PeachCare for Kids members who qualified for the age requirement of this measure (i.e., 18 years of age or older) would be small, Peach State's exclusion of this population from this measure should not substantially affect the statewide rate.
[c] The statewide rate was not calculated because WellCare calculated the measure based on a different time frame for medical record procurement. The CMO did not start to collect medical records for the measure until summer 2009. Peach State did not include PeachCare for Kids in its calculation of the measure.
[d] AMERIGROUP reported the measure using the administrative method (e.g., no medical record review was conducted).
[e] The statewide rate was not calculated because AMERIGROUP reported the administrative-only rate while WellCare reported the hybrid rate. Peach State did not include PeachCare for Kids in its calculation of this measure.
[f] The statewide rate was not calculated because Peach State did not include PeachCare for Kids in its calculation of this measure.

HSAG observed strong performance across all CMOs for the *Use of Appropriate Medications for People With Asthma* measure, with the statewide rate just below the national 2008 HEDIS 90th

[1-2] The national Medicaid HEDIS percentiles were published by NCQA. The high performance level was identified as meeting or exceeding the most recent national Medicaid HEDIS 90th percentile for most measures. The low performance level was identified as the most recent national Medicaid 25th HEDIS percentile.

percentile (the HPL). Pharmacological management of asthmatics appears to be a strength for the Georgia Families program.

HSAG also noted some opportunities for improvement. The statewide rate for *Comprehensive Diabetes Care—HbA1c Testing* ranked between the national HEDIS 2008 Medicaid 10th and 25th percentiles. For this measure, all CMOs were below the national HEDIS 2008 Medicaid 50th percentile (79.6 percent), with two CMOs performing below the 25th percentile (74.2 percent). The CMOs should focus efforts on ensuring that all diabetics receive the HbA1c test. Additionally, rates for both age group categories for the *Adults' Access to Preventive/Ambulatory Health Services* ranked between the 25th and 50th percentiles and represented areas in which the CMOs should focus improvement efforts. Exploring barriers to accessing care, including assessing network adequacy, appointment wait times, transportation and other member-related issues should be considered. Finally, one CMO experienced challenges with reporting the measures on the required populations, which impacted the ability to evaluate statewide performance across all measures. For future performance measure reporting, DCH has clarified with the CMOs that all measures must include the appropriate populations. While opportunities exist to improve performance on several key performance measures, focused, targeted improvement efforts coupled with sound causal-barrier analysis by the CMOs should result in improved performance in subsequent years.

Quality, Timeliness, and Access to Care

For each of the three mandatory activities, HSAG prepared and submitted individual, CMO-specific reports of HSAG results to DCH and the CMOs. HSAG's findings, conclusions, and recommendations to improve the CMOs' performance on quality, timeliness, and access to care and services are described in greater detail in Section 6 of this report.

HSAG HEALTH SERVICES ADVISORY GROUP

2. Background

This section of the report includes a brief history of the DCH Georgia Families Medicaid managed care program and a description of DCH's quality assessment and performance improvement (QAPI) strategy. The description of the QAPI strategy summarizes DCH's:

- Quality strategy goals and objectives.
- Operational performance standards used to evaluate CMO performance in complying with BBA regulations and State contract requirements.
- Requirements and targets used to evaluate CMO performance on DCH-selected measures and to evaluate the validity of and improvements achieved through the CMOs' DCH-specified performance improvement projects.

History of the Georgia Medicaid Managed Care Program

The State of Georgia implemented its Georgia Families Medicaid managed care program in 2006. Through its three private CMO contractors that DCH selected in a competitive bid process, DCH provides services to individuals enrolled in the State's managed care Medicaid and PeachCare for Kids™ programs. According to DCH, it implemented the Georgia Families program to:

- Offer care coordination to members.
- Enhance access to health care services.
- Achieve budget predictability as well as cost containment.
- Create systemwide performance improvements.
- Continuously and incrementally improve the quality of health care and services provided to members.
- Improve efficiency at all levels.

Based on these drivers, DCH established the following program goals:

- Improve the health care status of the member population
- Establish contractual accountability for access to, and the quality of, health care
- Lower costs through more effective utilization management
- Establish budget predictability and administrative simplicity

DCH's three-part mission is to ensure:

- Access to affordable, quality health care in the community.
- Responsible health planning and use of health care resources.
- Healthy behaviors and improved health outcomes.

Each CMO was contracted to deliver services within three or more of the six designated geographic regions. To ensure a smooth and successful transition from fee for service to the Georgia Families managed care program, DCH implemented the program in two phases, beginning with two of the six regions (Atlanta and Central) on June 1, 2006, followed by the remaining four regions (North, East, Southeast, and Southwest) on September 1, 2006. DCH awarded contracts to at least two CMOs within each of the six geographic regions.

The Georgia Families program includes more than half of the State's Medicaid population and a majority of the State's PeachCare for Kids™ population. Enrollment is mandatory for the following Medicaid eligibility categories: the Low Income Medicaid (LIM) program, transitional Medicaid, pregnant women and children in the Right from the Start Medicaid (RSM) program, newborns of Medicaid-covered women, refugees, and women with breast and cervical cancer. The majority of Georgia Families members are children. Members have the right to choose from the CMOs providing services within their respective geographic regions. For members not making a choice, DCH uses several criteria to assign them to a health plan, such as maintaining family continuity by enrolling all family members in the same CMO and maintaining member-to-provider relationships. In addition to providing all medically necessary, Medicaid-covered services to members, the CMOs also provide a range of enhanced services to members, including dental and vision services, enhanced access to specialty services, and disease management and education/wellness/preventive services and programs.

Georgia Department of Community Health Quality Strategy

Section 1932(c)(1) of the Social Security Act (the Act) sets forth specifications for the quality assessment and performance improvement strategies that states must implement to ensure the delivery of quality health care by all managed care organizations. The CMS Medicaid managed care regulations at 42 CFR 438.200 and 438.202 implemented Section 1932(c)(1) of the Act, defining certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies operating managed care programs to develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their members. The written strategy must describe the standards that the state and its contracted managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) must meet. A Medicaid state agency must:

- Conduct periodic reviews to examine the scope and content of its quality strategy and evaluate its effectiveness.
- Ensure compliance with standards established by the state that are at least as stringent as the federal Medicaid managed care regulations.
- Update the strategy periodically as needed.
- Submit to CMS a copy of the state's initial strategy, a copy of its revised strategy whenever significant changes have occurred in the program, and regular reports describing the implementation and effectiveness of the strategy.

Federal Medicaid managed care regulations specify at 42 CFR 438.204 the elements that, at a minimum, the state Medicaid agencies must address in their quality strategies. The elements include:

- MCO or PIHP contract provisions that incorporate the standards specified in 42 CFR 438 related to access, structure and operations, and measurement and improvement.
- Procedures that:
  - Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO or PIHP contracts, and to individuals with special health care needs.
  - Identify the race, ethnicity, and primary language spoken by each Medicaid enrollee and provide this information to the MCOs and PIHPs for each Medicaid enrollee at the time of enrollment.
  - Regularly monitor and evaluate MCO and PIHP compliance with the standards.
  - Arrange for external, independent reviews each year of quality outcomes and the timeliness of, and access to, services covered under each MCO and PIHP contract.
  - For MCOs, appropriately use intermediate sanctions that, at a minimum, meet the applicable requirements.
- Any national performance measures and levels that may be identified and developed by CMS in consultation with states and other relevant stakeholders.
- An information system that supports initial and ongoing operation and review of a state's quality strategy.
- Standards at least as stringent as those described in 42 CFR 438.206–242.

DCH obtained public input on its initial June 2007 Quality Strategic Plan for ensuring that it provided timely, accessible, and quality services to members of Georgia Families. The initial strategy described the mechanisms DCH would use to continually assess the quality of care delivered through the CMOs and how, based on its assessment, DCH would improve the quality of care the CMOs provided to members. In July 2008 and March 2009, DCH submitted to CMS its Quality Strategic Plan Update progress reports.

Quality Strategy Objectives

DCH's March 2009 Quality Strategic Plan Update progress report was well organized, detailed, and specific in describing the mechanisms DCH planned to continue or initiate to ensure that Georgia Families members received accessible, timely, and quality care/services. The progress report also included mechanisms to ensure that the CMOs complied with federal Medicaid managed care regulations and the associated DCH contract requirements. The progress report described the State's four primary goals and the associated process and/or outcome objectives. For each objective, the progress report described DCH's specific strategic actions, and for each of these actions, the initial or revised target completion dates and whether the State was on schedule, at risk of being behind schedule, or critically delayed. DCH also included a narrative description of the status of each of its strategic actions.

The four DCH goals described in both its initial strategy and its March 2009 Quality Strategic Plan Update progress report were to:

1. Promote commitment across the organization to quality of care and services.
2. Improve and enhance the quality of patient care through ongoing, objective, and systematic measurement, analysis, and improvement of performance.
3. Promote a system of health delivery that provides coordinated and improved access to comprehensive health care and enhanced provider and client satisfaction.
4. Promote acceptable standards of health care within managed care programs by monitoring internal and external processes for improvement opportunities.

As noted previously, for each of the four goals described in the plan and progress report, DCH also described its process and/or outcome objectives.

Goal 1—The 2009 progress report update stated that DCH's objectives in promoting commitment across the organization to quality of care and services were to:

- Establish an EQRO to provide an independent evaluation of the Georgia Families program.
- Ensure CMO compliance with adoption and dissemination of three clinical practice guidelines.

Goal 2—The 2009 progress report described DCH's objectives for improving and enhancing the quality of patient care through ongoing, objective, and systematic performance measurement, analysis, and improvement. The objectives were to:

- Ensure the provision of quality care and ongoing improvement in the health baseline and health outcomes through performance-based measurement and performance-driven objectives.
- For children's preventive health:
  - Over the next five years, meet or exceed the Healthcare Effectiveness Data and Information Set (HEDIS) 2006 90th percentile for managed care-eligible children with well-child visits during their first 15 months of life.
  - Over the next five years, in collaboration with Georgia's immunization program, demonstrate an improvement of 5 percentage points in the number of managed care-eligible children younger than 36 months of age who are compliant with the 4:3:1:3:3:1 immunization series. The series is composed of the following vaccinations—four diphtheria, tetanus, and pertussis (DTaP); three polio; one measles, mumps, and rubella (MMR); three Haemophilus influenzae type b (Hib); three hepatitis B (Hep B); and one varicella zoster virus (chicken pox, or VZV).
  - Over the next five years, in collaboration with Georgia's Childhood Lead Poisoning Prevention Program (GCLPP), demonstrate an improvement of 10 percentage points in the number of children eligible for managed care who are 1 and 2 years of age and receive a blood screening for lead.
- Within the next five years demonstrate an improvement of:
  - Ten percentage points in ambulatory or preventive care visits, bringing Georgia to the HEDIS 2006 90th percentile level for adults 21 to 44 years of age in Medicaid managed care plans.

- Twenty percentage points for members eligible for managed care who are 18 to 75 years of age with diabetes and have had at least one HbA1c test, bringing Georgia to the HEDIS 2006 75th percentile level for Medicaid managed care plans.
- Five percentage points for members eligible for managed care who have asthma and received appropriate medications, bringing Georgia to the HEDIS 2006 90th percentile level for Medicaid managed care plans.

- Within the next five years, demonstrate a 10-percent decrease in the rate of low-birth-weight babies in managed care, improving Georgia's infant mortality rates.
- Coordinate with Georgia's transparency Web site to facilitate increased and informed decision-making, leading to improved health choices.

Goal 3—The objectives DCH described in its 2009 progress report for promoting a system of health care delivery that provides coordinated and improved access to comprehensive health care and enhanced provider and client satisfaction were to:

- Ensure an ongoing CMO quality management program.
- Develop a plan for preferential auto-assignment of new members to CMOs that demonstrate improved quality of care.
- Ensure CMO compliance with contractual standards related to:
  - Access to care.
  - Coordination of care.
  - Covered services.

Goal 4—DCH described objectives in its 2009 progress report that were consistent with the six "aims for improvement" described in the Institute of Medicine's report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. These six "aims for improvement" were: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. DCH's objective was to promote acceptable standards of health care within managed care programs by monitoring internal and external processes for improvement opportunities. DCH sought to ensure CMO compliance with contractual standards in the following areas:

- Grievance system (i.e., member appeals and member grievances)
- Subcontractor relations
- Structure and operations
- Utilization management

DCH also documented in its March 2009 Quality Strategic Plan Update progress report that DCH was on schedule for implementing almost all of the strategic actions described for meeting each objective. The plan update described a very small number of strategic actions at risk of being behind schedule. None of the actions was identified as critically delayed.

After assessing the progress achieved under its original Georgia Families Quality Strategic Plan and the March 2009 update, DCH identified its accomplishments and opportunities for improvement. DCH also reevaluated its initiatives and established goals identified in the plan update submitted to CMS in February 2010.

Operational Standards Requirements

Through its contract with the three CMOs, DCH requires compliance with contractual standards that are as stringent, and in many instances, more stringent and detailed, than the CMS requirements for Medicaid managed care plans described in 42 CFR 438.206–242. These requirements, and the standards cross-referenced within them, address performance related to access, structure and operations, and measurement and improvement standards. DCH continually evaluates the sufficiency of its contract terms and conditions in both incorporating all applicable CMS Medicaid managed care regulations and in continually driving improvement in CMO performance across a broad range of quality, access, and timeliness-of-care indicators, as well as administrative efficiencies. Based on these assessments, DCH has, with CMS approval, updated its CMO contract several times and is revising it further.

For the first year of its EQRO contract, DCH requested that HSAG conduct a review of the CMOs' performance in complying with one of the three sets of federal Medicaid managed care standards (i.e., the access standards described at 42 CFR 438.206–210) and the associated DCH contract requirements. For the second year of the contract, and as described in detail in this report, DCH asked HSAG to conduct the review of the CMOs' compliance with the CMS structure and operations standards described at 42 CFR 438.214–230 and the associated DCH contract requirements. For the third year of the contract, the EQRO will evaluate the CMOs' performance for the remaining set of federal Medicaid managed care standards (i.e., the measurement and improvement standards described at 42 CFR 438.236–242) and the associated DCH contract requirements.

Performance Improvement Project Requirements

DCH required the CMOs to conduct PIPs that crossed both clinical and nonclinical areas. The CMOs had to conduct PIPs that addressed the following clinical areas:

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens
- Childhood immunizations
- Blood lead level screens
- Detection of chronic kidney disease
- Emergency room treatment

DCH required the CMOs to perform one additional clinical PIP chosen from the following areas:

- Coordination/continuity-of-care management
- High-volume or high-risk conditions

DCH required the CMOs to conduct PIPs that addressed the following nonclinical areas:

- Member satisfaction
- Provider satisfaction

DCH required one additional nonclinical PIP that the CMOs could select from any of the following areas:

- Cultural competence
- Appeals/grievances/provider complaints
- Access/service capacity
- Appointment availability

The CMOs were required to submit to DCH all data necessary to enable the State to measure and evaluate the CMOs' performance in conducting their PIPs, including the CMOs' mechanisms and interventions for tracking and improving performance over time, the effectiveness of the interventions, and CMO activities for increasing and sustaining improvement. In addition, the CMOs had to document for DCH's review their data collection methodologies, including the steps they took to ensure that their data were valid and reliable. DCH reported to HSAG that the CMOs complied with the requirements to report to DCH the status and results of their PIPs and provided examples of the reports to HSAG.

For the first year of its EQRO contract with HSAG, DCH requested that HSAG validate and report its findings for the following three PIPs for each CMO:

- Lead screens
- EPSDT well-child visits
- Provider satisfaction

As described in detail in this report, for the second contract year, DCH selected the following six PIPs for HSAG to validate for each of the CMOs:

- Access/service capacity
- Childhood immunizations
- Improving childhood lead screening rates
- Provider satisfaction
- Well-child visits during the first 15 months of life, with six or more visits
- Member satisfaction

DCH also contracted with HSAG to facilitate and participate with DCH and the CMOs in meeting collaboratively to identify barriers and improvement strategies for increasing performance across the CMOs for the well-child visit PIP.

Performance Measure Requirements

During the period covered by this report, DCH:

- Increased the overall number of CMO performance metrics that it monitors to a total of 32 to provide a better perspective of the health of Georgia's Medicaid managed care population and incorporated the new metrics into the CMO contract amendment.

- Moved from HEDIS-like to HEDIS performance measures and Agency for Healthcare Research and Quality (AHRQ) prevention metrics. Results will be reported and analyzed in the 2010–2011 EQR Annual Report.
- Established performance metric targets that align with HEDIS and AHRQ percentiles and benchmarks, allowing Georgia's Medicaid managed care performance to be compared with that of other states.
- Continually reviewed and updated its metrics of performance reports the CMOs are required to submit to DCH.

For the first year of its EQRO contract, DCH requested that HSAG:

- Validate the same three performance measures for each CMO.
- Report its findings for two of the measures (i.e., diabetes—the percentage of members with diabetes who had least one HbA1c test, and asthma—the percentage of members with asthma receiving appropriate medications).
- Provide information to DCH about the readiness of the CMOs to report complete and accurate data for a third measure, childhood immunizations.

For the second year of the contract, and as described in detail in this report, DCH contracted with HSAG to validate and report its findings for the following six measures for each of the CMOs:

- Comprehensive Diabetes Care—HbA1c Testing (Hybrid—i.e., a method that uses both administrative data and medical record data/documentation when calculating the rates)
- Use of Appropriate Medications for People With Asthma
- Well-Child Visits in the First 15 Months of Life—Six of More Visits (Hybrid)
- Childhood Immunization Status—Combination 2 (Hybrid)
- Lead Screening in Children (Hybrid)
- Adults' Access to Preventive/Ambulatory Health Services

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3. Description of EQRO Activities

Mandatory Activities

The CFR describes the mandatory activities at 42 CFR, Part 438, Managed Care, Subpart E, External Quality Review, 438.358(b). The three mandatory activities are: (1) validating PIPs, (2) validating performance measures, and (3) conducting reviews to determine compliance with standards established by the State to comply with the requirements of 42 CFR 438.204(g). According to 42 CFR 438.358(a), "the State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities."

In the second year of its EQRO contract with HSAG (i.e., contract year 2009–2010) and as described in Section 1—Executive Summary, DCH contracted with HSAG to perform the functions associated with the three CMS mandatory activities. These activities were performed for the State's three CMOs that make up the Georgia Families program. The CMOs are managed care organizations as defined by CMS.

In accordance with its contract with DCH, HSAG:

- Conducted a review of the CMOs' performance in complying with federal Medicaid managed care regulations related to structure and operations standards (as described at 42 CFR 438.214–230) and the associated DCH contract requirements for the second year of a three-year cycle of compliance reviews.
- Validated six performance measures for each of the three CMOs.
- Validated six PIPs for each of the CMOs.

For each of the three mandatory activities it conducted, HSAG prepared individual CMO reports of its findings and recommendations and submitted the reports to DCH and the appropriate CMOs.

HSAG planned for and conducted the three mandatory activities in a manner consistent with the guidelines set forth by CMS in the following protocols for conducting Medicaid external quality review (EQR) activities:

- *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002.
- *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002.
- *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al., February 11, 2003.

Optional Activities

For the second year of its EQRO contract, DCH requested that HSAG conduct one CMS-specified optional activity—encounter data validation (EDV)—for each of its three CMOs. One component of the study included evaluating EPSDT components in the medical record, as well as the evaluation of encounter data compared to medical record documentation. This study component addressed the following questions:

1. To what extent are services omitted from administrative and medical record sources?
2. To what extent are administrative encounters for services coded accurately?
3. To what extent are required components of an EPSDT visit documented in the medical record?

The EDV study included the abstraction of medical records by HSAG's trained record reviewers. HSAG used a customized medical record data collection tool approved by DCH to validate encounter data. HSAG has implemented policies and procedures, operational practices, and internal auditing systems to maintain a work place compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for all EQRO activities.

HSAG planned for and conducted the EDV activities in a manner consistent with the guidelines set forth by CMS in its protocol, *Validating Encounter Data: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Department of Health and Human Services, Centers for Medicare & Medicaid Services: Final Protocol, Version 1.0, May 1, 2002.

Due to the timelines negotiated by DCH and HSAG for conducting the EDV activities, HSAG's findings, conclusions, and recommendations from conducting the activities were not available to include in this report.

Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

DCH also contracted with HSAG to aggregate and analyze the data it obtained from conducting the activities and to prepare this CMS-required 2009–2010 EQR annual report of findings and recommendations related to the quality and timeliness of, and access to, care and services the three CMOs provided to their Georgia Families members.

DCH plans to use the information HSAG obtained from conducting each of the three mandatory activities and documented in this EQR annual report to, in part:

- Strengthen its processes for further educating and working with the CMOs to both understand and fully comply with the Medicaid managed care regulations and the associated DCH contract requirements.
- Identify needs and opportunities for CMO-wide collaborative performance improvement initiatives across the three activities: compliance with standards, calculating and reporting performance measures, and conducting valid and reliable PIPs that result in sustained improvement.

- Identify areas for strengthening DCH monitoring and oversight of the CMOs' performance.
- Identify areas for systematically increasing the benchmarks for CMO performance (e.g., compliance with appointment timeliness standards and geographic access standards).
- Guide future revisions of its contracts with the CMOs to strengthen and add detail to select requirements and performance areas.
- Inform DCH about current CMO performance and select minimum performance standards, benchmarks, and goals regarding quality measures as DCH moves forward with plans to implement a system to add quality-based auto-assignment of members to its current algorithms.
- Guide specifications for future requests for proposals (RFPs) for CMOs.

Categorizing EQR Activity Results

The Centers for Medicare & Medicaid Services (CMS) has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs and PIHPs. HSAG used the following methodology to evaluate and draw conclusions about the performance of the CMOs in each of these domains.

To draw conclusions and make recommendations about the quality and timeliness of, and access to, care provided by the CMOs**,** HSAG assigned the components reviewed for each EQR activity (compliance reviews, validation of PIPs, and validation of performance measures) to one or more of the three domains: quality, timeliness, and access. Of note is that for validation of PIPs and validation of performance measures, the EQR activities were primarily evaluating the quality/validity of the PIP process and the validity of the performance measure calculation and reporting processes rather than the actual performance results for the select performance measures or PIP study indicators. Nonetheless, performance outcomes for these two activities still reflected the CMOs' efforts and commitment to improve performance in the quality, timeliness, and access domains.

HSAG used the following definitions for the purpose of categorizing the EQR activity results:

Quality

CMS defines quality in the final rule at 42 CFR 438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[3-1]

Timeliness

The National Committee for Quality Assurance (NCQA) defined timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3-2] NCQA further discussed the intent of this

[3-1] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*. *Code of Federal Regulations*. Title 42, Vol 3, October 1, 2005.
[3-2] National Committee for Quality Assurance. 2006 Standards and Guidelines for MCOs and MBHOs.

standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require a timely response by the MCO or PIHP—e.g., processing expedited appeals and providing timely follow-up care.

Access

In the preamble to the BBA Rules and Regulations[3-3] CMS discusses access to and the availability of services to Medicaid enrollees as the degree to which MCOs and PIHPs implement the standards set forth by the state to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that reflects the needs and characteristics of the enrollees served by the MCO or PIHP.

Table 3-1 below displays the assignment of the EQR activity components reviewed to the categories of quality, access, and timeliness.

Table 3-1—Categorizing Related to Quality, Access, and Timeliness

	Review of Compliance With Standards			
	Standard	**Quality**	**Access**	**Timeliness**
I.	Provider Selection, Credentialing, and Recredentialing	√		
II.	Subcontractual Relationships and Delegation	√		
III.	Member Rights and Protections	√		
IV.	Member Information		√	
V.	Grievance System	√		√
VI.	Disenrollment Requirements and Limitations		√	
	PIPs			
	PIP	**Quality**	**Access**	**Timeliness**
I.	Access/Service Capacity	√	√	
II.	Improving Childhood Lead Screening Rates	√		
III.	Childhood Immunization	√		
IV.	Well-Child Visits During the First 15 Months of Life With Six or More Visits	√		
V.	Provider Satisfaction	√	√	
VI.	Member Satisfaction	√	√	√
	Performance Measures			
	Performance Measure	**Quality**	**Access**	**Timeliness**
I.	Comprehensive Diabetic Care—HbA1c (Hybrid)	√		
II.	Use of Appropriate Medications for People With Asthma	√		
III.	Well-Child Visits in the First 15 Months of Life—Six or More Visits (Hybrid)	√		
IV.	Childhood Immunization Status—Combination 2 (Hybrid)	√		
V.	Lead Screening in Children (Hybrid)	√		
VI.	Adults' Access to Preventive/Ambulatory Health Services	√	√	

[3-3] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

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Georgia Department of Community Health Quality Initiatives

In its commitment to continually improve access to, and the quality and timelines of, the care and services provided to members through its three Medicaid CMOs, DCH implemented and/or actively participated with other stakeholders in numerous improvement initiatives. From July 2008 through September 2009, these initiatives included the following:

- Sponsored a Dental Colloquium in spring 2009.
- Actively participated in the Obesity Action Network to decrease childhood obesity in Georgia.
- Assumed an active role in working on the new Medicaid Management Information System (MMIS) in the areas of EPSDT, periodicity schedules, and performance measures.
- Moved from HEDIS-like to HEDIS performance measures and AHRQ prevention metrics in spring 2009.
- Increased the overall number of metrics monitored to 32 to provide a better perspective of the health of Georgia's Medicaid managed care population. Incorporated the new metrics into the CMO contract amendment.
- Established performance metric targets that align with HEDIS and AHRQ percentiles and benchmarks, allowing a comparison of Georgia's Medicaid managed care performance to that of other states.
- Added language to the CMOs' contract relative to their failure to achieve the quality performance metric targets to encourage achievement of those targets. Updated the Quality Strategic Plan to reflect the above changes in the performance metrics.
- After discussions with CMS, discussed the mandatory components of EPSDT visits with the CMO quality and medical directors, who were to ensure their network providers were compliant in performing all required EPSDT visit components during each periodic visit. Added clarifying language in the EPSDT section of the CMO contract amendment.
- Established and participated with the CMOs and HSAG on a well-child visit collaborative PIP to improve members' access to and utilization of primary care providers (PCPs).
- Supported the establishment of common study questions for each PIP conducted by the CMOs.
- Included member data for PeachCare for Kids in the CMOs' results for PIPs and performance measures.
- Modified the CMO contract amendment to allow nominal-value incentives for providers and members to encourage compliance with EPSDT requirements.
- Gained clarity regarding the vaccine source for members of PeachCare for Kids enrolled in the CMOs and communicated this to the CMOs through the contract amendment.
- Allowed the CMOs to include Georgia's immunization registry information/data in their future performance data to obtain a more complete picture of the immunization status of Georgia Medicaid members.

- Stressed to the CMOs the importance of proper screening and documentation for lead exposure and required the reporting of all lead screening results to the Georgia Division of Public Health.
- Streamlined and revised the required quality reports to allow the CMOs to focus their attention on initiatives that would result in improved health outcomes.
- Enhanced monitoring of the CMOs' case and disease management programs and activities by adding CMO quarterly reporting requirements to the contracts.
- Initiated a project to reduce low birth weight (LBW) rates to address Georgia's high LBW rate.
- Formed a Strategic Quality Council, which is focusing on preventing and decreasing cardiovascular deaths.
- Contracted and worked collaboratively with HSAG in developing an enhanced member auto-assignment algorithm to include CMO performance on select quality performance indicators.
- Contracted and worked collaboratively with HSAG to design and conduct encounter data validation with a special focus on providers performing, documenting, and submitting encounters for DCH-required EPSDT well-child visits.

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5. CMO Best and Emerging Practices

Through its work under the EQRO contract with DCH and in conducting the three mandatory activities for each of the DCH-contracted Georgia Families CMOs, HSAG identified several noteworthy CMO practices.

DCH's June 2007 Quality Strategic Plan and its March 2009 plan update described the strategic actions DCH had initiated or planned to implement. These actions were designed to ensure a system of continuous improvements throughout the Georgia Families program in providing timely, accessible, and quality services that result in improved member health outcomes. In its contracts with the CMOs, DCH incorporated standards at least as stringent as—and frequently more stringent than—federal regulations. As a result, the CMOs had clear and detailed information about DCH's expectations for their performance under the contract.

HSAG had an opportunity—through its on-site observations, reviews of multiple documents, and information CMO staff members provided during formal on-site interviews or other discussions—to identify several noteworthy practices used by one or more of the CMOs. HSAG identified these practices through its work with the CMOs when conducting the three mandatory activities (reviewing CMO compliance with federal Medicaid managed care regulations and State contract requirements, validating select CMO performance measures, and validating CMO PIPs).

The noteworthy practices included the following:

- The CMOs had Web sites that would convert the site, including all associated documents, from English into Spanish (the only non-English prevalent language spoken by members) by clicking the "en espanol" button.
- Two of the CMOs (AMERIGROUP and Peach State) had member handbooks that had both the English and Spanish versions in the same booklet (front half/back half).

For AMERIGROUP:

- AMERIGROUP's provider directory for members contained all the required elements and had an additional feature that was considered a best practice. The directory contained a section that alphabetically listed languages (e.g., Spanish, French, Russian) and identified the PCPs who spoke that language.
- AMERIGROUP had step-by-step grievance system procedures that went hand in hand with its written policies related to member grievances, appeals, and requests for State administrative law hearings and trained staff members on each step.
- AMERIGROUP had a high percentage of claims received electronically (approximately 90 percent), and a high percentage of these (approximately 82 percent) were automatically adjudicated. This high level of electronically received and auto-adjudicated claims enables a high degree of efficiency related to the timeliness of claims processing, as well as a high degree of reliability based on the accuracy of claims.
- AMERIGROUP used certified software to produce the hybrid performance measure samples and to calculate the HEDIS measures. In addition, the CMO used a medical record abstraction vendor

to collect the medical record information and had well-documented, excellent processes in place to perform oversight of the medical record and data vendors.

- AMERIGROUP had good processes in place to ensure complete pharmacy data, meeting weekly with the pharmacy to address utilization/edits and issues with claims that were incorrectly paid or denied. This practice may have contributed to the high ranking of the asthma measure (at the 90th percentile).
- The CMO reported that it had also reduced the preauthorization requirement list and provided extensive member educational outreach efforts through its case management, disease management, and quality management/health promotion using both telephone contacts and mailings to members/families.

For Peach State:

- Peach State processed the majority of claims using optical character recognition (OCR) technology, and the claims were automatically loaded into the transaction system (Amysis). The CMO tightly controlled paper claims as they were received in the mailroom and during processing. The structure of the mailroom and claims-processing department procedures were best practices for Peach State. The processes in place in the mailroom were impressive.
- Peach State used certified software to generate the hybrid samples and calculate the HEDIS measures. The CMO also used a medical record abstraction vendor. Peach State staff had exceptional processes in place to conduct oversight of the medical record review vendor. These processes included performing ongoing reliability testing, reviewing all exclusions and replacement selections, and monitoring the timeliness of important milestones. Peach State also tightly controlled data exchange between the CMO, the NCQA-certified software vendor, and the medical record abstraction vendor.
- Peach State reported that it had also:
  - Received the Silver Honors 2009 URAC Best Practices Award in Health Care Consumer Empowerment and Protection for its Connections Plus Program for providing free, pre-programmed cell phones to high-risk members who do not have steady access to a telephone.
  - Implemented the Physician Summit Award program, which honors primary care physicians who demonstrate exemplary performance on HEDIS scores.
  - Implemented a new provider pay-for-performance program for HEDIS and other quality initiatives.
  - Conducted quarterly medical management meetings with key providers to discuss quality/cost profiles and recommendations for improving health care outcomes.

For WellCare:

- In addition to its other outreach and provider education efforts, WellCare provided step-by-step instructional materials to providers on how they should resubmit encounter data if files are rejected, especially when they have to work with a clearinghouse to achieve resubmission. This demonstrated the CMO's commitment to complete encounter data reporting.
- For the credentialing process, WellCare used a tracking form for entering and editing information into its electronic systems. This demonstrated the CMO's efforts to ensure that provider data are entered completely and accurately throughout the provider data load process.

- WellCare conducted an independent over-read of records abstracted by its vendor. The CMO took the extra step of monitoring its vendor by conducting a separate assessment of vendor abstraction accuracy, even though the vendor conducted its own internal, independent over-read activities. This additional step exemplified the CMO's thorough oversight of its medical record review vendor.
- To improve performance on childhood immunizations, lead screenings, and well-child visits during the first 15 months of life, the CMO reported that it implemented telephonic outreach protocols to educate and assist noncompliant members who had not received preventive services. The outreach included proactive appointment scheduling and transportation referrals. The CMO also conducted member reminder calls to reinforce the need to keep scheduled appointments.
- To improve performance on the asthma measure, WellCare reported that it performed targeted in-home assessments on identified members with asthma who were not compliant with recommended pharmaceutical treatment. WellCare provided to the members/families, as appropriate, peak flow meters, nebulizers, pest control agents, and sheet casings. The goal was to improve members' living conditions, provide education, and increase member knowledge of asthma and environmental factors that affect the condition.
- To improve member satisfaction survey results, WellCare strengthened its Cultural Competency Program by adding customized questions to the 2009 Medicaid Child Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey that focused on the use of interpretation services for members in their communications with health care providers.
- The CMO developed a HEDIS provider tool kit used by provider relations representatives to assist physicians in their outreach to noncompliant members.

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6. External Quality Review Activities: Findings, Strengths, and Recommendations With Conclusions Related to Health Care Quality, Timeliness, and Access

Introduction

This section of the report provides a summary of HSAG's findings and its conclusions about each CMO's performance in providing quality, timely, and accessible services to Georgia Families members. Section 8 of this report, Plan Comparison, provides data comparing CMO performance for each of the three activities.

Review of Compliance With Operational Standards

For the compliance review, the second year of a three-year cycle of HSAG external quality reviews for the DCH-contracted CMOs, HSAG performed a desk review of each CMO's documents and an on-site review that included reviewing additional documents and conducting interviews with key CMO staff members. HSAG evaluated the degree to which each CMO complied with federal Medicaid managed care regulations and the associated DCH contract requirements in six performance categories (i.e., standards). The six standards included requirements associated with federal Medicaid managed care structure and operations standards found at 42 CFR 438.214–438.230. The standards HSAG evaluated included requirements for:

- Selecting, credentialing, and recredentialing providers.
- Subcontractual relationships and delegation of CMO administrative responsibilities.
- Member rights and protections.
- Member information.
- Member grievances, appeals, and access to State administrative law hearings.
- Disenrollment requirements and limitations.

Based on its findings for each CMO, HSAG assigned a score of *Met*, *Partially Met*, or *Not Met* to the CMO's performance in complying with each of the requirements. HSAG also calculated a percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the six standards. If a requirement was not applicable to a CMO for the period covered by the review, HSAG used an *NA* designation.

HSAG planned for and conducted the compliance review process and activities in a manner that was consistent with the guidelines set forth in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al.

Appendix A, Reviewing Compliance With Operational Standards, contains a complete description of HSAG's methodology.

AMERIGROUP Community Care

Findings

Table 6-1 presents a summary of the results from HSAG's review, reporting the number of elements for each of the standards that received a score of *Met*, *Partially Met*, *Not Met*, or *NA*. HSAG's External Quality Review of Compliance With Standards for AMERIGROUP Community Care report contained the complete details of HSAG's review findings.

Table 6-1—Standards and Compliance Scores for *AMERIGROUP Community Care*

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Provider Selection, Credentialing, and Recredentialing	10	10	8	2	0	0	90%
II	Subcontractual Relationships and Delegation	6	6	5	1	0	0	92%
III	Member Rights and Protections	6	6	6	0	0	0	100%
IV	Member Information	20	20	16	4	0	0	90%
V	Grievance System	35	35	28	7	0	0	90%
VI	Disenrollment Requirements and Limitations	8	8	8	0	0	0	100%
	Totals	85	85	71	14	0	0	92%

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*.

Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Overall, AMERIGROUP's performance was good, with a total percentage-of-compliance score of 92 percent across all standards and 71 out of 85 requirements receiving a score of *Met*. Performance for two standards (Standard III—Member Rights and Protections, and Standard VI—Disenrollment Requirements and Limitations) received a score of 100 percent. Performance for the other four standards received scores of 90 percent or more.

AMERIGROUP's performance strengths for each standard are summarized below.

Standard I—Provider Selection, Credentialing, and Recredentialing

In addition to providing clearly written documents to its providers, delegates, and staff that contained accurate information related to the CMO's requirements and expectations for selecting, credentialing, and recredentialing its providers. AMERIGROUP's approach to ensuring strong performance for this standard included regular performance monitoring, timely and automated comparisons of all contracted providers against the Office of Inspector General (OIG) database to ensure that the CMO did not contract with providers on the federal list of excluded individuals and entities, and the incorporation of NCQA guidelines into its grids/checklists to facilitate and ensure its compliance with the requirements for this standard.

Standard II—Subcontractual Relationships and Delegation

The CMO had policies, processes, and practices in place to ensure that all contracted entities complied with applicable federal and State regulations and requirements related to delegated functions. The CMO conducted predelegation audits to ensure that a prospective subcontractor had the ability to perform the delegated activities. Its oversight process, which included the activities of multiple committees, and its ongoing monitoring of reports also enabled the CMO to work diligently and collaboratively with its providers and delegates to identify and address any deficiencies the CMO identified in their performance.

Standard III—Member Rights and Protections

AMERIGROUP used the activities of multiple departments (i.e., the Associate Services Department, Communications Department, Provider Services—Corporate Department, and National Contact Center) to ensure that members, providers, and staff were informed about member rights and the staff's and providers' responsibilities related to them. The CMO included the list of member rights and the providers' responsibilities in the provider manual, newsletters, and contracts and conducted monitoring activities to ensure the CMO's compliance with the requirements for this standard.

Standard IV—Member Information

AMERIGROUP's efforts to ensure that members could understand the plan benefits and requirements included: (1) providing, or having available, the member handbook in Spanish and English, in large print, in an audio version, and in Braille; (2) maintaining a CMO Web site where the information could be easily converted to Spanish; and (3) providing highly trained member services staff to assist members with questions. In its provider directory available to members, the CMO's addition of a section that alphabetically listed different languages spoken by primary care providers was considered a best practice.

Standard V—Grievance System

The CMO had a sophisticated system for processing, documenting, and tracking grievances and administrative reviews and developed step-by-step instructions to ensure its staff members had a clear understanding of the two processes. The CMO sent the required written notices of proposed action within the required time frames, and the notices contained the required information. In

addition, the member handbook contained easy-to-understand information for members about their right to file grievances and appeals and the processes for filing them. Other strengths included AMERIGROUP's timely performance in sending out acknowledgment letters following receipt of member grievances, resolving grievances, and having staff with appropriate levels of expertise for resolving the grievances.

Standard VI—Disenrollment Requirements and Limitations

AMERIGROUP included the disenrollment requirements in the member handbook. An additional strength was the CMO's provision of additional assistance to members wishing to disenroll after CMO efforts to resolve issues and to retain the member (e.g., providing the disenrollment form to members and referring them to DCH to conduct the disenrollment determinations).

Opportunities for Improvement and Recommendations

Based on HSAG's review of AMERIGROUP's performance, the CMO was required to complete a corrective action plan and implement corrective actions for four standards: Standard I—Provider Selection, Credentialing, and Recredentialing; Standard II—Subcontractual Relationships and Delegation; Standard IV—Member Information; and Standard V–Grievance System.

Standard I—Provider Selection, Credentialing, and Recredentialing

While HSAG scored 8 of the 10 applicable elements for this standard as *Met*, two elements received a *Partially Met* score, resulting in a total percentage-of-compliance score of 90 percent. To improve its compliance, AMERIGROUP was required to ensure that all providers' credentialing records included documentation of OIG verification and documentation of primary source verification.

Standard II—Subcontractual Relationships and Delegation

For this standard, five of the six applicable requirements received a *Met* score and one received a *Partially Met* score, resulting in a total compliance score of 92 percent. To improve compliance with this standard, AMERIGROUP was required to define in each of its written delegation agreements the specific functions, activities, and reporting responsibilities for each delegated activity and to revise its delegation agreement with National Imaging Associates to reflect the actual (current) activities the CMO delegated to the contractor.

Standard IV—Member Information

Of the 20 applicable requirements, HSAG scored 16 as *Met* and 4 as *Partially Met*, resulting in a total compliance score of 90 percent. Although AMERIGROUP was revising the member handbook at the time of the review, the version available to members at the time of HSAG's review was evaluated for this audit. Based on the results, AMERIGROUP was required to submit to DCH and implement DCH-approved corrective actions for the four requirements HSAG scored as *Partially Met*. To improve compliance, the CMO was required to provide additional information to members about their rights related to: (1) not being liable for the CMO's debts or payment for covered services, (2) the name of the appropriate State agency for filing complaints concerning provider

noncompliance with advance directive requirements, (3) obtaining assistance when filing an appeal, and (4) the rules that govern representation at an administrative law hearing.

Standard V—Grievance System

Of the 35 applicable requirements, AMERIGROUP received a *Met* score for 28 requirements and a *Partially Met* score for 7 requirements, resulting in a compliance score of 90 percent for the standard. To improve compliance, the CMO was required to: (1) update all applicable documents to include complete definitions of an "action" and the accurate associated timelines and (2) develop a process for ensuring that a notice of action is sent to the member when failing to meet grievance and appeal/administrative review timelines. In addition, AMERIGROUP was required to ensure that the revised member handbook includes accurate information about filing grievances and the CMO's review process, including the definition of an action, the phone number for the teletype/telecommunications device for the deaf (TTY/TDD), the right to present evidence and review files during an administrative law hearing, and the time frames for requesting continuation of benefits and how to begin the process. The CMO was also required to update its provider manual to include information about each element in the member grievance system. To be consistent with the grievance filing process, AMERIGROUP was required to revise its template documents so that members who filed an oral grievance were not required to follow up with a written grievance submission. Lastly, the CMO was required to go beyond mailing an "unable to contact" letter to members after multiple attempts to follow up on the initial grievance. The CMO was required to investigate all matters to the extent possible and send a resolution letter that included any information the CMO was able to obtain and the resolution.

Summary

AMERIGROUP demonstrated strong performance in all three domains (i.e., providing quality, accessible, and timely care and services to its members). All four standards related to the quality domain received a compliance score of at least 90 percent, and one achieved full compliance (Standard III—Member Rights and Protections). At the requirement level, 47 of 57 requirements in the standards related to quality received a score of *Met*. Similarly, both of the standards (Standard IV—Member Information and Standard VI—Disenrollment Requirements and Limitations) related to the access domain received a compliance score of at least 90 percent, with 24 of the 28 applicable requirements receiving a score of *Met*. In addition, performance for Standard VI—Disenrollment Requirements and Limitations, was scored as fully compliant. Lastly, the CMO's performance for the only standard related to the timeliness domain (Standard V—Grievance System) was scored as 90 percent compliant.

Peach State Health Plan

Findings

Table 6-2 presents a summary of the results from HSAG's review, reporting the number of elements for each of the standards that received a score of *Met*, *Partially Met*, *Not Met*, or *NA*. HSAG's

External Quality Review of Compliance With Standards for Peach State Health Plan report contained complete details of HSAG's review findings.

Table 6-2—Standards and Compliance Scores for *Peach State Health Plan*

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Provider Selection, Credentialing, and Recredentialing	**10**	**10**	**10**	**0**	**0**	**0**	**100%**
II	Subcontractual Relationships and Delegation	**6**	**6**	**4**	**2**	**0**	**0**	**83%**
III	Member Rights and Protections	**6**	**6**	**6**	**0**	**0**	**0**	**100%**
IV	Member Information	**20**	**20**	**17**	**3**	**0**	**0**	**93%**
V	Grievance System	**35**	**35**	**27**	**8**	**0**	**0**	**89%**
VI	Disenrollment Requirements and Limitations	**8**	**8**	**5**	**3**	**0**	**0**	**81%**
	Totals	**85**	**85**	**69**	**16**	**0**	**0**	**91%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*.

Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Overall, Peach State's performance was good, with a total percentage-of-compliance score of 91 percent across all standards. Two standards (Standard I—Provider Selection, Credentialing, and Recredentialing, and Standard III—Member Rights and Protections) received overall percentage-of-compliance scores of 100 percent. Performance for Standard IV (Member Information) received an overall compliance score of 93 percent.

Peach State's strengths for each standard are summarized below.

Standard I—Provider Selection, Credentialing, and Recredentialing

Peach State's comprehensive policies and procedures were not only consistent with the standards established by NCQA, but they also incorporated standards from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Utilization Review Accreditation Commission (URAC). The CMO's policies and procedures supported a nondiscriminatory approach to provider selection and adequately addressed all applicable federal Medicaid managed care and DCH requirements. Peach State's staff was knowledgeable of the credentialing and recredentialing policies and demonstrated strong understanding of the related procedures. In addition, results from

the on-site credentialing and recredentialing file reviews showed that all files HSAG reviewed contained the required documents and were processed within the required time frame.

Standard II—Subcontractual Relationships and Delegation

Peach State had policies related to delegation and followed a documented process to evaluate prospective subcontractors' ability to perform the proposed delegated administrative functions. In addition, the CMO provided adequate documentation of each delegation contract, and each contract contained the required revocation clause. Peach State also conducted ongoing monitoring and formal reviews of each delegate related to the delegated functions. Its policies required the delegate to submit to the CMO and to implement corrective actions for any deficiencies/areas for improvement the CMO identified as part of its monitoring processes. Documentation HSAG reviewed demonstrated the CMO's strong monitoring and oversight processes related to its delegates. The documentation included examples of the CMO's monitoring activities, notices it issued to delegates of required corrective actions, and follow-up reviews to determine whether the plans had been implemented and effective in correcting the deficiencies. Peach State staff was knowledgeable about the CMO's written policies and procedures related to the requirements and processes associated with this standard.

Standard III—Member Rights and Protections

Peach State's comprehensive staff training and member and provider materials ensured that its staff and providers were informed about and protected member rights. New hire orientation included training on member rights. Staff was also required to complete annual compliance and ethics training and was subject to routine HIPAA desk audits related to protected health information. For providers, the CMO included a list of member rights in the provider manual, newsletters, and on the Web site and specific requirements in the provider contracts/agreements. Providers were also required to offer interpreter services to members free of charge.

Standard IV—Member Information

Peach State ensured that members were informed of their rights, covered services and benefits, and other information through multiple avenues, including: (1) initial mailings of the member handbook, provider directory, and welcome letter, all written at a fifth-grade reading level and available in various formats such as compact disc, Braille and large print; (2) a welcome call; (3) a Web site that easily converted from English to a Spanish version; and (4) comprehensively trained member services representatives. The member handbook included information on all available Georgia Families benefits and services, with information related to limitations, copays, and noncovered services. The CMO's Member Connections™ representatives offered assistance not only in obtaining health plan services but also in accessing social services.

Standard V—Grievance System

The CMO had an organized system for processing, documenting, and tracking grievances and administrative reviews, with detailed processes for its operations. Staff members had a clear understanding of the processes as well as the differences between grievances and administrative

reviews. Notices of proposed action contained required information and were issued within the required time frames. Administrative review decisions were made by physicians not previously involved with the case. In addition, Peach State informed members in the member handbook of their rights related to, and the processes for filing, grievances and appeals. Documentation HSAG reviewed related to specific grievances from members appeared sufficient, and each case was handled within the required time frame by individuals with the appropriate expertise.

Standard VI—Disenrollment Requirements and Limitations

Peach State's disenrollment requirements were congruent with the DCH contract requirements and were included in the member handbook. The CMO also offered assistance to members wishing to disenroll—including working with members in an effort to resolve any problems and to retain the member, providing disenrollment forms to members wishing to disenroll, and referring them to DCH for disenrollment determinations.

Opportunities for Improvement and Recommendations

Based on HSAG's review of Peach State's performance, CMO corrective action was required for four standards: Standard II—Subcontractual Relationships and Delegation; Standard IV—Member Information; Standard V—Grievance System; and Standard VI—Disenrollment Requirements and Limitations. For three of the standards (Standards II, V, and VI) scores fell below 90 percent, suggesting considerable opportunities for improvement.

Standard II—Subcontractual Relationships and Delegation

For this standard, two of the six applicable requirements received a *Partially Met* score, resulting in a total compliance score of 83 percent. To improve its compliance, Peach State was required to: (1) review each delegation agreement and ensure that the functions/activities listed as delegated reflected those actually and currently performed by the delegate and (2) revise each agreement as needed.

Standard IV—Member Information

For this standard, 3 of the 20 applicable requirements received a *Partially Met* score, resulting in a total compliance score of 93 percent. To improve compliance with the requirements, Peach State was required to use easy-to-understand terms and language when informing members about their right "to get services in agreement with QAPI Access Standards" and to define terms such as "administrative law hearing" and "administrative review." The CMO was also required to clarify its written information about providers' appeal rights.

Standard V—Grievance System

Of the 35 applicable requirements in the Grievance System standard, the CMO's performance received a *Partially Met* score for 8 requirements, resulting in a total compliance score of 89 percent. To improve compliance with this standard, the CMO was required to revise the member handbook to include the time frame for filing requests for administrative reviews, requirements related to continuation of benefits, a clear definition of appeals and administrative reviews,

procedures for obtaining assistance for requesting administrative law hearings, and the fact that the time frame for authorization decisions may be extended. In addition, Peach State needed to review and revise all applicable documents and other materials related to multiple aspects of the administrative review processes and its notices of action and resolution letters. The CMO was required to train its staff on the changes to processes, notices, and resolution letters. Lastly, Peach State was required to include all required information about the member grievance system in all appropriate provider materials.

Standard VI—Disenrollment Requirements and Limitations

Three of the eight applicable requirements received a *Partially Met* score for this standard, resulting in an overall compliance score of 81 percent. To improve compliance with requirements for this standard, the CMO was required to revise the member handbook to include all the allowable reasons to request disenrollment. Additionally, the CMO was required to include in its disenrollment policy the fact that one of the plan's reasons for requesting member disenrollment was the member's noncompliance with the treating physician's plan of care.

Summary

Peach State demonstrated mixed performance related to the domain of providing care and services to improve the likelihood of quality outcomes, with two standards (Standard I—Provider Selection, Credentialing, and Recredentialing, and Standard III—Member Rights and Protections) receiving a score of 100 percent and the scores for the other two falling below 90 percent (Standard II—Subcontractual Relationships and Delegation, and Standard V—Grievance System). Of the 57 requirements in the standards related to quality, 10 received a score of *Partially Met*, indicating opportunities for improvement, especially for requirements in Standard V. With only one of the two access-related standards (Standard IV—Member Information) achieving a compliance score of at least 90 percent, Peach State's performance related to providing accessible care and services suggested room for improvement. More specifically, of the 28 applicable requirements, 6 received a *Partially Met* score, requiring the CMO to implement corrective actions. Last, with 8 of the 35 applicable requirements for the Grievance System standard receiving a score of *Partially Met*, Peach State's compliance performance for the Grievance System requirements, some of which related to the timeliness domain, also suggested considerable room for improvement.

WellCare of Georgia, Inc.

Findings

Table 6-3 presents a summary of the results from HSAG's review, reporting the number of elements for each of the standards that received a score of *Met*, *Partially Met*, *Not Met*, or *NA*. HSAG's External Quality Review of Compliance With Standards for WellCare of Georgia, Inc., report contained complete details of HSAG's review findings.

Table 6-3––Standards and Compliance Scores for *WellCare of Georgia, Inc.*

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Provider Selection, Credentialing, and Recredentialing	**10**	**10**	**10**	**0**	**0**	**0**	**100%**
II	Subcontractual Relationships and Delegation	**6**	**6**	**6**	**0**	**0**	**0**	**100%**
III	Member Rights and Protections	**6**	**6**	**6**	**0**	**0**	**0**	**100%**
IV	Member Information	**20**	**20**	**14**	**6**	**0**	**0**	**85%**
V	Grievance System	**35**	**35**	**24**	**11**	**0**	**0**	**84%**
VI	Disenrollment Requirements and Limitations	**8**	**8**	**8**	**0**	**0**	**0**	**100%**
	Totals	**85**	**85**	**68**	**17**	**0**	**0**	**90%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*.

Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Overall, WellCare's performance was good, with a total percentage-of-compliance score of 90 percent across all standards. Four standards (Standard I—Provider Selection, Credentialing, and Recredentialing; Standard II—Subcontractual Relationships and Delegation; Standard III—Member Rights and Protections; and Standard VI—Disenrollment Requirements and Limitations) received a compliance score of 100 percent.

WellCare's strengths related to each standard are summarized below:

Standard I—Provider Selection, Credentialing, and Recredentialing

WellCare's comprehensive policies and procedures demonstrated consistency with the standards established by NCQA, JCAHO, and URAC and adequately addressed all applicable federal Medicaid managed care and DCH contract requirements. Staff was well trained and educated in the credentialing and recredentialing policies and demonstrated a strong understanding of the related procedures. In addition, all credentialing and recredentialing files HSAG reviewed on-site contained the required documents and were processed within the required time frames.

Standard II—Subcontractual Relationships and Delegation

The CMO had policies that defined the delegation activities and WellCare's procedures for addressing each of the applicable requirements, including conducting predelegation assessments of the prospective subcontractor's ability to perform the delegated functions. Written delegation agreements with each contractor contained all applicable provisions, including a revocation clause. WellCare conducted ongoing monitoring and formal reviews for all delegated functions and, as applicable, required delegates to submit and implement corrective actions for deficiencies WellCare had identified during its monitoring/review processes. Documentation available for HSAG's review demonstrated that WellCare ensured that the delegates satisfactorily completed the required corrective actions.

Standard III—Member Rights and Protections

WellCare ensured that members were informed of their rights by including and describing member rights and protections in the member handbook. The provider manual informed providers about these member rights/protections and their obligations related to them. The CMO also incorporated the rights and provider obligations into the provider written agreements and monitored for evidence of compliance through medical record reviews and provider site inspections. Providers were also required to post member rights in offices/facilities. WellCare provided comprehensive training related to member rights to its customer service representatives, which included staff obligations related to member rights.

Standard IV—Member Information

WellCare ensured that members had easy and appropriate access to member information through multiple avenues, including: (1) initial mailings of the member handbook, provider directory, and welcome letter, all written at a fifth-grade reading level and available in Spanish, as well as in various alternative formats such as compact disc, Braille and large print; (2) a welcome call; (3) a Web site that was easily converted to a Spanish version; and (4) comprehensively trained member services representatives available to assist members with needed information. Multiple documents HSAG reviewed also demonstrated that the CMO provided oral interpretation services to members free of charge.

Standard V—Grievance System

WellCare had a sophisticated system for processing, documenting, and tracking grievances and administrative reviews and processes for accepting both oral and written member requests. Notices

of proposed action contained the required information and were sent within the required time frames. Administrative reviews conducted by independent physicians were processed and resolved in a timely manner. Documentation of grievances and administrative reviews included all required information. The CMO also had a system for sending resolution letters in the member's primary language. In addition, WellCare informed the members in the member handbook, written in easy-to-understand language, of their rights and processes related to filing grievances and appeals. The CMO informed providers about the member grievance system in the provider manual. HSAG's review of a sample of WellCare's member grievance records confirmed that all grievances were resolved within the required time frames and decisions were made by individuals with an appropriate level of expertise.

Standard VI—Disenrollment Requirements and Limitations

All WellCare enrollment and disenrollment policies were aligned and consistent with the applicable DCH contract requirements. In addition, the CMO provided its associates with training materials that described how they were to handle processes for member voluntary and involuntary disenrollment. WellCare had a policy related to disenrollment and trained its staff on disenrollment procedures. Using its standardized template, the CMO mailed letters to members who requested voluntary disenrollment within 24 hours of receiving the request. Members were instructed to call Georgia Families' toll-free number to disenroll. Member data in the eligibility maintenance system were updated based on the disenrollment request. The CMO submitted monthly disenrollment reports to DCH.

Opportunities for Improvement and Recommendations

HSAG's review of WellCare's performance identified room for improvement and required corrective actions for two standards: Standard IV—Member Information and Standard V—Grievance System. Scores for these standards were below 90 percent, indicating considerable opportunities for improvement.

Standard IV—Member Information

For this standard, of the 20 applicable requirements, 6 received a score of *Partially Met*, resulting in a total compliance score of 85 percent. To improve compliance with requirements for this standard, WellCare was required to include in the list of member rights it communicated to members and providers, the right to be furnished services in accordance with federal requirements and the right to be responsible for cost-sharing only as specified in the DCH contract. The CMO was also required to clarify the member's right regarding requesting, receiving, or amending his or her medical records and the right not to be held liable for the CMO's debts. WellCare was also required to provide information to members about: (1) the State agency to which they should direct complaints concerning provider noncompliance with advance directive requirements and (2) rules governing representation at an administrative law hearing. Lastly, the CMO was required to remove a statement in the member handbook that required members to tell the plan before seeking emergent/urgent care and poststabilization services.

Standard V—Grievance System

Of the 35 applicable requirements for this standard, WellCare received a score of *Partially Met* for 11 requirements, resulting in an overall compliance score of 84 percent. To improve compliance with the requirements, the CMO was required to clarify in its policies and procedures the definition of a proposed action and the time frames associated with all grievance-related processes. WellCare was also required to revise its policies and corresponding training documents to ensure that they addressed and were consistent with all applicable requirements. In addition, the CMO was required to develop a method to ensure that it used easy-to-understand language in the customized sections of the notices of proposed action letters. Finally, WellCare was required to revise its member handbook and applicable provider materials to include all required information about the requirements and procedures related to the member grievance system.

Summary

WellCare demonstrated mixed performance related to the standards that addressed providing care and services in ways that increase the likelihood of quality outcomes, with compliance scores of 100 percent for three standards (Standard I—Provider Selection, Credentialing, and Recredentialing; Standard II—Subcontractual Relationships and Delegation; and Standard III—Member Rights and Protections) and a compliance score of 84 percent for the remaining standard (Standard V—Grievance System). Of the 57 requirements related to the quality domain, 11 requirements, all within Standard V, received a score of *Partially Met*, indicating opportunities for improving performance related to these requirements. Performance for one of the two standards that related to providing access to care and services (Standard VI—Disenrollment Requirements and Limitations) achieved a compliance score of 100 percent. The second standard (Standard IV—Member Information) received a score of 85 percent, suggesting mixed performance related to the access domain. More specifically, of the 28 applicable requirements, 6 received a score of *Partially Met*, requiring the CMO to implement corrective action to improve its performance. Lastly, a number of the elements of the Grievance System standard related to the timeliness domain. WellCare's scores of *Partially Met* for 11 of the 35 requirements in this standard reinforced the need for corrective actions in this area.

Validation of Performance Improvement Projects

DCH required each CMO to conduct PIPs in accordance with 42 CFR 438.240. The purpose of PIPs is to achieve—through ongoing assessments, measurements, and interventions—improvement sustained over time in clinical and nonclinical areas. As one of three mandatory EQR activities under the BBA, Public Law 105-33, the State is required to annually validate the PIPs conducted by its contracted Medicaid managed care organizations. To meet this requirement for the CMOs, DCH contracted with HSAG to validate the CMOs' PIPs. During this second contract year, DCH selected the following six PIPs for HSAG to validate for each CMO:

- *Access/Service Capacity*
- *Childhood Immunization*
- *Improving Childhood Lead Screening Rates*
- *Member Satisfaction*
- *Provider Satisfaction*
- *Well-Child Visits During the First 15 Months of Life With Six or More Visits*

Appendix B—Validating Performance Improvement Projects (PIPs) contains a complete description of HSAG's methodology for this activity.

The following findings sections provide PIP results in tables that present each CMO's performance for each PIP and an overall performance score across the six PIPs. In addition to detailed performance results by activity, the tables also report PIP performance based on three overarching categories (i.e., Study Design, Study Implementation, and Quality Outcomes Achieved). These categories, in general, follow the PIP design, implementation, and evaluation of quality improvement processes. The values within the parentheses show the percentage of applicable evaluation elements with a *Met* score. The findings sections also include narrative discussions of each CMO's strengths and opportunities for improvement.

AMERIGROUP Community Care

Findings

Five of AMERIGROUP's submitted PIPs were validated through Activity VI, while the remaining PIP was validated through Activity IX. Table 6-4 displays AMERIGROUP's performance for each PIP and an overall performance score across the six PIPs.

Table 6-4—AMERIGROUP Community Care's 2009–2010 PIP Performance

Activities	*Access/ Service Capacity*	*Childhood Immunization*	*Lead Screening Rates*	*Member Satisfaction*	*Provider Satisfaction*	*Well-Child Visits*	Overall Performance Across 6 PIPs
Study Design	**16/16 (100%)**	**17/17 (100%)**	**17/17 (100%)**	**17/17 (100%)**	**15/15 (100%)**	**17/17 (100%)**	**99/99 (100%)**
I. Choose the Study Topic	5/5 (100%)	6/6 (100%)	6/6 (100%)	5/5 (100%)	4/4 (100%)	6/6 (100%)	32/32 (100%)
II. Define the Study Question(s)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	12/12 (100%)
III. Select the Study Indicator(s)	6/6 (100%)	6/6 (100%)	6/6 (100%)	7/7 (100%)	6/6 (100%)	6/6 (100%)	37/37 (100%)
IV. Use a Representative and Generalizable Study Population	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	18/18 (100%)
Study Implementation	**5/5 (100%)**	**5/5 (100%)**	**5/5 (100%)**	**15/15 (100%)**	**18/18 (100%)**	**5/5 (100%)**	**53/53 (100%)**
V. Use Sound Sampling Techniques	0/0	0/0	0/0	6/6 (100%)	6/6 (100%)	0/0	12/12 (100%)
VI. Use Valid and Reliable Data Collection Procedures	5/5 (100%)	5/5 (100%)	5/5 (100%)	9/9 (100%)	9/9 (100%)	5/5 (100%)	38/38 (100%)
VII. Include Improvement Strategies	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	3/3 (100%)	*Not Assessed*	3/3 (100%)
Quality Outcomes Achieved	***Not Assessed***	***Not Assessed***	***Not Assessed***	***Not Assessed***	**10/13 (77%)**	***Not Assessed***	**10/13 (77%)**
VIII. Data Analysis and Interpretation of Study Results	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	7/9 (78%)	*Not Assessed*	7/9 (78%)
IX. Assess for Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	3/4 (75%)	*Not Assessed*	3/4 (75%)
X. Assess for Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*
Overall PIP Performance							
Percentage Score of Evaluation Elements *Met*	100%	100%	100%	100%	93%	100%	98%
Percentage Score of Critical Elements *Met*	100%	100%	100%	100%	100%	100%	100%
Validation Status	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*

Strengths

Overall, AMERIGROUP staff demonstrated a strong understanding of the requirements, especially related to the study design and implementation of a PIP. Ninety-eight percent of all evaluation elements across the six PIPs had a *Met* score, and 100 percent of all critical evaluation elements had a *Met* score. All of the applicable evaluation elements in these categories scored a *Met*, with individual overall PIP scores ranging from 93 to 100 percent. Five of AMERIGROUP's six submitted PIPs scored 100 percent.

At the activity level, all six PIPs had 100 percent of the evaluation elements scoring a *Met* for Activities I through VI. The only PIP that was validated past Activity VI received *Met* scores for all of the evaluation elements in Activity VII. All of the critical elements were scored a *Met*.

AMERIGROUP's strengths were very consistent across all six PIPs, which included thorough background documentation for the selection of the study topic, development of the study question and respective study indicators, identifying the study population, explaining the sampling methodology, defining the data collection procedures, developing the improvement strategies based on causes/barriers identified through data analysis and quality improvement processes, and the CMO's ability to design and implement interventions that lead to system-level changes.

Opportunities for Improvement and Recommendations

Any evaluation elements that did not receive a *Met* status constituted an opportunity for improvement. Although all of the PIPs received an overall *Met* status, the one PIP that went through Activity IX did not receive *Met* scores for all evaluation elements within Activities VIII and IX. The *Provider Satisfaction* PIP scored a *Met* for only 78 percent of the elements in Activity VIII and 75 percent of the elements in Activity IX, representing opportunities for improvement.

Based on the validation results for these PIPs, AMERIGROUP had three evaluation elements that did not receive a *Met* score and a total of seven unique *Points of Clarification* for its PIPs. HSAG recommended that:

- AMERIGROUP focus on the elements that received either a *Point of Clarification* or a score of *Partially Met* or *Not Met*, including those in Activities VIII and IX, and make appropriate changes associated with those evaluation elements. More specifically, HSAG recommended that AMERIGROUP ensure that the study results are presented in a way that provides accurate, clear, and easily understood information. The CMO should also be sure to provide accurate statistical testing results.
- AMERIGROUP carefully review each PIP across all activities before submission to ensure consistency throughout the PIP, and to ensure that results and processes are included correctly in the PIP Summary Form when working with vendors.

Summary

Overall, AMERIGROUP demonstrated a strong understanding of the PIP requirements, especially those related to the study design and implementation of a PIP. Individual overall PIP scores ranged

from 93 to 100 percent, with five of the six submitted PIPs scoring 100 percent. AMERIGROUP's strengths in conducting Activities I through VI were extremely consistent across all six PIPs. AMERIGROUP also had some opportunities for improvement, including those related to the evaluation elements within Activities VIII and IX that did not receive *Met* scores and HSAG's *Points of Clarification* documented within the submitted PIPs.

While the primary purpose of HSAG's PIP validation methodology was to assess the validity and quality of processes for conducting PIPs, HSAG also identified that AMERIGROUP's submitted PIPs contained study indicators related to the quality, access, and timeliness domains. More specifically, all six PIPs provided an opportunity for AMERIGROUP to improve the quality of care for its members. The *Access/Service Capacity*, *Provider Satisfaction*, and *Member Satisfaction* PIP study indicators were also designed to improve members' access to care.

Peach State Health Plan

Findings

Five of Peach State's submitted PIPs were validated through Activity VI, while the remaining PIP was validated through Activity IX. Table 6-5 displays Peach State's performance across the six submitted PIPs and reports the overall PIP performance for this year's submission.

Table 6-5—Peach State Health Plan's 2009–2010 PIP Performance

Activities	*Access/ Service Capacity*	*Childhood Immunization*	*Lead Screening Rates*	*Member Satisfaction*	*Provider Satisfaction*	*Well-Child Visits*	Overall Performance Across 6 PIPs
Study Design	**16/16 (100%)**	**17/17 (100%)**	**17/17 (100%)**	**17/17 (100%)**	**15/15 (100%)**	**17/17 (100%)**	**99/99 (100%)**
I. Choose the Study Topic(s)	5/5 (100%)	6/6 (100%)	6/6 (100%)	5/5 (100%)	4/4 (100%)	6/6 (100%)	32/32 (100%)
II. Define the Study Question(s)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	12/12 (100%)
III. Select the Study Indicator(s)	6/6 (100%)	6/6 (100%)	6/6 (100%)	7/7 (100%)	6/6 (100%)	6/6 (100%)	37/37 (100%)
IV. Use a Representative and Generalizable Study Population	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	18/18 (100%)
Study Implementation	**5/5 (100%)**	**5/5 (100%)**	**5/5 (100%)**	**15/15 (100%)**	**12/12 (100%)**	**5/5 (100%)**	**47/47 (100%)**
V. Use Sound Sampling Techniques	0/0	0/0	0/0	6/6 (100%)	0/0	0/0	6/6 (100%)
VI. Use Valid and Reliable Data Collection Procedures	5/5 (100%)	5/5 (100%)	5/5 (100%)	9/9 (100%)	9/9 (100%)	5/5 (100%)	38/38 (100%)
VII. Include Improvement Strategies	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	3/3 (100%)	*Not Assessed*	3/3 (100%)
Quality Outcomes Achieved	***Not Assessed***	***Not Assessed***	***Not Assessed***	***Not Assessed***	**12/13 (92%)**	***Not Assessed***	**12/13 (92%)**
VIII. Data Analysis and Interpretation of Study Results	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	9/9 (100%)	*Not Assessed*	9/9 (100%)
IX. Assess for Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	3/4 (75%)	*Not Assessed*	3/4 (75%)
X. Assess for Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*
Overall PIP Performance							
Percentage Score of Evaluation Elements *Met*	100%	100%	100%	100%	98%	100%	99%
Percentage Score of Critical Elements *Met*	100%	100%	100%	100%	100%	100%	100%
Validation Status	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*

Strengths

Peach State staff had a solid understanding of the activities and the documentation requirements needed for the study design and implementation of a PIP, as all six PIPs scored 100 percent of the evaluation elements *Met* for Activities I through VI. For overall PIP performance, one PIP scored 98 percent while the remaining five PIPs scored 100 percent.

At the activity level and for each of the six PIPs, all evaluation elements achieved a *Met* score for Activities I through VI. The one PIP that progressed to Activity IX also scored 100 percent for all applicable evaluation elements in Activities VII and VIII. All critical elements in each of the six PIPs were scored a *Met*.

Peach State's strengths were consistent across all six PIPs, including having adequate documentation of how the study topic was selected; appropriate and well-defined study questions and indicators; a sufficiently identified study population; an explanation of the sampling methodology; defined data collection procedures; and barrier-driven, system-level improvement strategies through data analysis and quality improvement processes.

Opportunities for Improvement and Recommendations

HSAG identified opportunities for improvement for the one Peach State PIP that was validated through Activity IX, as one evaluation element did not receive a *Met* score in that activity. The element indicated the CMO's lack of statistical evidence to demonstrate real improvement in all the study indicators. In addition, HSAG documented five unique *Points of Clarification* for Peach State's PIPs. Based on these PIP validation results, HSAG recommended that:

- Peach State focus on and make appropriate changes to the evaluation elements that received either a *Point of Clarification* or a score of *Partially Met*, including those in Activity IX.
- Peach State carefully review each PIP across all activities before submission to ensure the consistency of statements made in more than one activity of the PIP and to ensure that results and processes are included correctly in the PIP Summary Form when working with vendors.

Summary

Overall, Peach State had a solid understanding of the PIP requirements, especially those related to the study design and implementation of a PIP. Individual overall PIP scores ranged from 98 to 100 percent, with five of the six submitted PIPs scoring 100 percent. Peach State's strengths in conducting Activities I through VI were extremely consistent across all six PIPs. HSAG also identified opportunities for Peach State to further improve its performance. HSAG recommended that Peach State target its improvement efforts on those evaluation elements within Activity IX that did not receive *Met* scores and the *Points of Clarification* HSAG described for the PIPs Peach State submitted.

While the primary purpose of HSAG's PIP validation methodology was to assess the validity and quality of Peach State's processes for conducting PIPs, HSAG also recognized that the PIPs Peach State submitted contained study indicators related to the quality and timeliness of, and access to,

care and services provided to members. More specifically, all six PIPs provided an opportunity for Peach State to improve the quality of outcomes for its members. The *Access/Service Capacity*, *Provider Satisfaction*, and *Member Satisfaction* PIP study indicators were also designed to improve members' access to care. Finally, some study indicators for the *Member Satisfaction* PIP were identified as ones that addressed timeliness of care.

WellCare of Georgia, Inc.

Findings

Five of WellCare's six submitted PIPs were validated through Activity VI, while the remaining PIP was validated through Activity IX. Table 6-6 displays WellCare's individual PIP and overall performance results across all activities.

Table 6-6—WellCare of Georgia, Inc.'s 2009–2010 PIP Performance

Activities	*Access/ Service Capacity*	*Childhood Immunization*	*Lead Screening Rates*	*Member Satisfaction*	*Provider Satisfaction*	*Well-Child Visits*	Overall Performance Across 6 PIPs
Study Design	**16/16 (100%)**	**17/17 (100%)**	**17/17 (100%)**	**17/17 (100%)**	**15/15 (100%)**	**17/17 (100%)**	**99/99 (100%)**
I. Choose the Study Topic(s)	5/5 (100%)	6/6 (100%)	6/6 (100%)	5/5 (100%)	4/4 (100%)	6/6 (100%)	32/32 (100%)
II. Define the Study Question(s)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	12/12 (100%)
III. Select the Study Indicator(s)	6/6 (100%)	6/6 (100%)	6/6 (100%)	7/7 (100%)	6/6 (100%)	6/6 (100%)	37/37 (100%)
IV. Use a Representative and Generalizable Study Population	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	18/18 (100%)
Study Implementation	**5/5 (100%)**	**5/5 (100%)**	**5/5 (100%)**	**15/15 (100%)**	**18/18 (100%)**	**5/5 (100%)**	**53/53 (100%)**
V. Use Sound Sampling Techniques	0/0	0/0	0/0	6/6 (100%)	6/6 (100%)	0/0	12/12 (100%)
VI. Use Valid and Reliable Data Collection Procedures	5/5 (100%)	5/5 (100%)	5/5 (100%)	9/9 (100%)	9/9 (100%)	5/5 (100%)	38/38 (100%)
VII. Include Improvement Strategies	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	3/3 (100%)	*Not Assessed*	3/3 (100%)
Quality Outcomes Achieved	***Not Assessed***	***Not Assessed***	***Not Assessed***	***Not Assessed***	**10/13 (77%)**	***Not Assessed***	**10/13 (77%)**
VIII. Data Analysis and Interpretation of Study Results	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	9/9 (100%)	*Not Assessed*	9/9 (100%)
IX. Assess for Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	1/4 (25%)	*Not Assessed*	1/4 (25%)
X. Assess for Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*
Overall PIP Performance							
Percentage Score of Evaluation Elements *Met*	100%	100%	100%	100%	93%	100%	98%
Percentage Score of Critical Elements *Met*	100%	100%	100%	100%	100%	100%	100%
Validation Status	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*

Strengths

Based on this year's PIP performance, WellCare's staff demonstrated a strong understanding of all the review activities, as 98 percent of all the evaluation elements received a score of *Met* and 100 percent of all the critical elements were scored as *Met* across all six PIPs. The CMO had an excellent command of the requirements related to the study design of a PIP, with 100 percent of the applicable evaluation elements in this category scored as *Met* for all six PIPs. Performance for all six PIPs was also excellent related to the Study Implementation category, with 100 percent of the applicable elements scored as *Met*. Among the individual overall PIP scores, one PIP scored 93 percent while the five remaining PIPs scored 100 percent.

At the activity level and for each of the six PIPs, all evaluation elements achieved a *Met* score for Activities I through VI. The only PIP that progressed to Activity IX received *Met* scores for 100 percent of its applicable evaluation elements in Activities VII and VIII. All critical elements in each of the six PIPs were scored as *Met*.

WellCare's strength was consistent and impressive across all six PIPs. These strengths included having solid documentation of all required evaluation elements at the study design stage (i.e., selecting an appropriate study topic, designing a focused study question, and defining an appropriate study indicator and study population); systematic and well-documented data collection processes; and appropriate improvement strategies identified through well-documented quality improvement processes.

Opportunities for Improvement and Recommendations

Any elements not receiving a *Met* status constituted an opportunity for improvement. WellCare had only three evaluation elements that did not receive a *Met* score, and HSAG documented only three unique *Points of Clarification* for each PIP. Based on the validation results for these PIPs, HSAG recommended that:

- WellCare focus on and make appropriate changes to the evaluation elements that received a *Point of Clarification* or a score of *Partially Met*, including those in Activity IX.
- WellCare carefully review each PIP across all activities before submission to ensure the consistency of statements made in more than one activity of the PIP and to ensure that results and processes are included correctly in the PIP Summary Form when working with vendors.

Summary

Overall, WellCare staff had a solid understanding of the requirements for conducting PIPs, especially related to the study design and implementation of a PIP. Individual overall PIP scores ranged from 93 to 100 percent, with five of the six submitted PIPs scoring 100 percent. WellCare's strengths in conducting Activities I through VI were very consistent across all six PIPs.

HSAG also identified some opportunities for WellCare to improve its performance, including those related to evaluation elements in Activity IX that did not receive *Met* scores and those related to HSAG's documentation of *Points of Clarification* within the PIPs WellCare submitted.

While the primary purpose of HSAG's PIP validation methodology was to assess the validity and quality of processes for conducting valid PIPs, HSAG also identified that WellCare's submitted PIPs contained study indicators related to the quality and access domains. More specifically, all six PIPs provided an opportunity for WellCare to improve the quality of outcomes for its members. The *Access/Service Capacity*, *Provider Satisfaction*, and *Member Satisfaction* PIP study indicators were also designed to improve members' access to care.

Validation of Performance Measures

For the validation of performance measures, DCH required that the measures be calculated using NCQA's HEDIS® 2009 specifications. During the second contract year, HSAG validated the following set of six performance indicators selected by DCH:

- *Comprehensive Diabetes Care—HbA1c Testing* (Hybrid)
- *Use of Appropriate Medications for People With Asthma*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits* (Hybrid)
- *Childhood Immunization Status—Combination 2* (Hybrid)
- *Lead Screening in Children* (Hybrid)
- *Adults' Access to Preventive/Ambulatory Health Services*

While the CMOs followed HEDIS specifications in reporting their performance measures, the validation of performance measures audit time frame was considered "HEDIS-like" as it was outside the standard HEDIS time frame. The audit was outside the scope of the standard HEDIS time frame because it was conducted retrospectively (after rates were submitted). Although the audit was considered "HEDIS-like," it met the requirements and was conducted consistent with the CMS validation of performance measures protocol. Appendix C—Validating Performance Measures (PMs), contains a complete description of HSAG's methodology for this activity.

AMERIGROUP Community Care

Findings

Table 6-7 presents the results of HSAG's validation of AMERIGROUP's performance measures and the CMO's reported rates. The November 2009 Validation of Performance Measures Report for AMERIGROUP Community Care included additional details of the validation results. The *Childhood Immunization Status—Combination 2* rate was substantially lower than the national 2008 HEDIS Medicaid 10th percentile. It is important to note, however, that the rate for this measure was obtained using administrative data only, while national benchmarks include mostly hybrid results.

Table 6-7—Performance Measure Results *for* AMERIGROUP Community Care

	Indicator	Reported Rate	Audit Designation
1.	*Comprehensive Diabetes Care—HbA1c Testing*	74.50%	*Fully Compliant*
2.	*Use of Appropriate Medications for People With Asthma*	91.84%	*Fully Compliant*
3.	*Well-Child Visits in the First 15 Months of Life—Six or More Visits*	62.25%	*Fully Compliant*
4.	*Childhood Immunization Status—Combination 2*	29.84%	*Fully Compliant*
5.	*Lead Screening in Children*	68.21%	*Fully Compliant*
6.	*Adults' Access to Preventive/Ambulatory Health Services* 20 to 44 Years of Age 45 to 64 Years of Age	 81.20% 86.29%	*Fully Compliant*

Strengths

HSAG determined that AMERIGROUP's processes related to data integration, data control, and performance indicator documentation were all acceptable. For medical record procurement and abstraction services, AMERIGROUP contracted with Outcomes, Inc., which demonstrated excellent processes for medical record abstraction. In addition, AMERIGROUP had sufficient processes in place for processing claims, enrollment, and provider data. Another noteworthy strength was AMERIGROUP's use of an NCQA-certified software vendor to generate the HEDIS rates, newly implemented for this year's calculation of HEDIS rates. An additional strength was the CMO's rate for the *Use of Appropriate Medications for People With Asthma* measure, which almost reached the national 2008 HEDIS Medicaid 90th percentile of 91.9 percent. Finally, AMERIGROUP improved performance on its *HbA1c Testing* rate by using supplemental lab data obtained directly from its lab vendor. The use of these data was approved by the audit team to be compliant with NCQA requirements. Although the performance measure results from the prior year are not directly comparable due to different measurement periods (FY 2007 versus CY 2008), the *HbA1c Testing* rate increased by 15 percentage points to 74.50 percent, demonstrating a strength for AMERIGROUP.

Opportunities for Improvement and Recommendations

Although AMERIGROUP did not have any data collection and reporting issues related to the measures, the CMO's performance on these measures suggested opportunities for improvement. Only one measure, *Use of Appropriate Medications for People With Asthma*, was close to the national 2008 HEDIS Medicaid 90th percentile, and four of the seven measures ranked between the national Medicaid 50th and 75th percentiles. AMERIGROUP should evaluate which measures require targeted interventions to meet DCH's performance targets.

Summary

In general, AMERIGROUP demonstrated valid, sound processes for the calculation of performance measure rates, as indicated by its procedures for data integration and data control and its documentation of the performance indicators. HSAG's only recommendation was to align the supplemental data sources with NCQA requirements.

HSAG also reviewed AMERIGROUP's actual performance results for the indicators related to quality outcomes and the accessibility and timeliness of services provided to members. All of the performance measures were related to the quality domain. The *Adults' Access to Preventive/Ambulatory Health Services* measure was also related to access. None of the measures was related to the timeliness domain. AMERIGROUP's performance on measures designed to increase quality outcomes for members varied, with results for four of the seven measures ranking between the national 2008 HEDIS Medicaid 50th and 75th percentiles, and another measure nearly reaching the national 2008 HEDIS Medicaid 90th percentile. For the *Use of Appropriate Medications for People With Asthma* measure, AMERIGROUP's performance was very close to the national 2008 HEDIS Medicaid 90th percentile (91.9 percent), suggesting strong CMO commitment to providing high-quality asthma care to its members. HSAG recommended that AMERIGROUP consider using the hybrid method for the *Childhood Immunization Status—Combination 2* measure to produce a rate comparable to the national HEDIS Medicaid percentiles. AMERIGROUP's performance related to the access domain was reflected in the measure *Adults' Access to Preventive/Ambulatory Health Services*. With rates between the national 2008 HEDIS Medicaid 50th and 75th percentiles, the CMO's results were slightly above the national average for both the 20-to-44-year-old and 45-to-64-year-old age groups.

Peach State Health Plan

Findings

Table 6-8 presents the results of HSAG's validation of Peach State's performance measures and the reported rates. The November 2009 Validation of Performance Measures Report for Peach State Health Plan includes additional details of the validation results. Of note is that the PeachCare for Kids population was not included for all performance measures.

Table 6-8—Performance Measure Results *for* Peach State Health Plan

	Indicator	Reported Rate	Audit Designation
1.	*Comprehensive Diabetes Care—HbA1c Testing*	64.23%	*Fully Compliant*
2.	*Use of Appropriate Medications for People With Asthma*	91.12%	*Fully Compliant*
3.	*Well-Child Visits in the First 15 Months of Life—Six or More Visits*	51.58%	*Fully Compliant*
4.	*Childhood Immunization Status—Combination 2*	62.77%	*Fully Compliant*
5.	*Lead Screening in Children*	57.18%	*Fully Compliant*
6.	*Adults' Access to Preventive/Ambulatory Health Services* 20 to 44 Years of Age 45 to 64 Years of Age	 78.88% 80.98%	*Fully Compliant*

Note: Peach State reported all measures only for the Georgia Medicaid population; the PeachCare for Kids population was not included.

Strengths

HSAG determined that Peach State's processes related to data integration, data control, and performance indicator documentation were all acceptable. For medical record procurement and abstraction services, Peach State contracted with Outcomes, Inc., which demonstrated excellent processes for medical record abstraction. In addition, Peach State had sufficient processes in place for processing claims, enrollment, and provider data. Another noteworthy strength was Peach State's use of an NCQA-certified software vendor to generate the HEDIS rates, newly implemented for this year's calculation of HEDIS rates.

Opportunities for Improvement and Recommendations

Although Peach State did not have any data collection and reporting issues related to the measures, the CMO's performance on these measures suggested opportunities for improvement. For *Childhood Immunization Status—Combination 2*, Peach State performed between the national 2008 HEDIS Medicaid 10th and 25th percentiles. For *Comprehensive Diabetes Care—HbA1c Testing*, Peach State performed below the national 2008 HEDIS Medicaid 10th percentile. HSAG recommended that Peach State include all appropriate populations in the calculations of the performance measures. The CMO should also evaluate which measures require targeted interventions to meet DCH's performance targets.

Summary

In general, Peach State demonstrated valid, reliable processes for the calculation of performance measures, as indicated by its procedures for data integration and data control and its documentation of performance indicators. HSAG's only recommendation was to align the supplemental data sources with NCQA requirements.

HSAG also assessed Peach State's actual performance results for the indicators related to quality outcomes and access to and timeliness of care and services provided to members. With only one exception, all of the performance measures were related only to the domain of quality. The *Adults' Access to Preventive/Ambulatory Health Services* measure was also related to access. No measures were related to the timeliness domain. Peach State's performances on the measures addressing quality outcomes varied, with four of the seven measures ranking between the national 2008 HEDIS Medicaid 25th and 50th percentiles and only one measure performing between the national 2008 HEDIS Medicaid 75th and 90th percentiles. The two remaining measures performed below the national 2008 HEDIS Medicaid 25th percentile. For the *Use of Appropriate Medications for People With Asthma* measure, Peach State's performance was very close to the national 2008 HEDIS Medicaid 90th percentile (91.9 percent), suggesting strong CMO commitment to providing high-quality asthma care to its members. Peach State's performance related to access to care and services was reflected in the *Adults' Access to Preventive/Ambulatory Health Services* measure. With rates between the national 2008 HEDIS Medicaid 25th and 50th percentiles, the CMO was performing below the national average for both the 20-to-44-year-old and 45-to-64-year-old age groups. This finding suggests opportunities for improvement in members accessing this service.

WellCare of Georgia, Inc.

Findings

Table 6-9 presents the results of the validation of performance measures and the reported rates. The November 2009 Validation of Performance Measures Report for WellCare of Georgia, Inc., includes additional details of the validation results. Through the validation process, HSAG noted that WellCare of Georgia, Inc., did not follow the HEDIS time frame for medical record review for all hybrid measures.

Table 6-9—Performance Measure Results *for* WellCare of Georgia, Inc.

	Indicator	Reported Rate	Audit Designation
1.	*Comprehensive Diabetes Care—HbA1c Testing*	72.26%	*Fully Compliant*
2.	*Use of Appropriate Medications for People With Asthma*	90.58%	*Fully Compliant*
3.	*Well-Child Visits in the First 15 Months of Life—Six or More Visits*	57.42%	*Fully Compliant*
4.	*Childhood Immunization Status—Combination 2*	75.91%	*Fully Compliant*
5.	*Lead Screening in Children*	65.94%	*Fully Compliant*
6.	*Adults' Access to Preventive/Ambulatory Health Services*		*Fully Compliant*
	20 to 44 Years of Age	78.64%	
	45 to 64 Years of Age	84.58%	

Strengths

HSAG determined that WellCare's processes related to data integration, data control, and performance indicator documentation were all acceptable. For medical record procurement and abstraction services, WellCare contracted with Outcomes, Inc., which demonstrated excellent processes for medical record abstraction. In addition, WellCare had sufficient processes in place for processing claims, enrollment, and provider data. For its supplemental data, WellCare confirmed that all data sources undergo the same staging process for de-duplication and other checks. Another noteworthy strength was that WellCare reported all but one measure (i.e., *Well-Child Visits in the First 15 Months of Life*) out of CRMS, an NCQA-certified software product. Source code for this one measure, although developed outside of the software certification, was approved on-site by HSAG.

Opportunities for Improvement and Recommendations

HSAG recommended that WellCare continue enhancing its mechanism for tracking and monitoring rejected claims/encounters from the data clearinghouses. HSAG also suggested that WellCare implement a formal reconciliation process for its provider data between CACTUS, the initial database into which data is entered, and Paradigm, the database where data is eventually loaded.

Summary

In general, WellCare employed acceptable processes for the calculation of performance measures, as indicated by its procedures for data integration and data control and its documentation of performance indicators. However, HSAG provided several recommendations, including those for improving its data clearinghouse mechanisms for tracking and monitoring, employing a formal reconciliation process for provider data, and aligning supplemental data with NCQA requirements.

HSAG also reviewed WellCare's performance on the indicators related to quality member outcomes and providing accessible and timely services to members. All but one of the performance measures were related only to the quality domain. The *Adults' Access to Preventive/Ambulatory Health Services* measure also related to the access domain. No measures were related to the timeliness domain. WellCare's performance varied across the quality measures, with three of the seven quality-related measures ranking between the national HEDIS 2008 Medicaid 50th and 75th percentiles, three ranking between the national HEDIS 2008 Medicaid 25th and 50th percentiles, and one measure ranking between the 10th and 25th percentiles. For three of the measures—*Use of Appropriate Medications for People With Asthma*, *Childhood Immunizations—Combination 2*, and *Lead Screening for Children*—WellCare performed between the national HEDIS 2008 Medicaid 50th and 75th percentiles. However, WellCare did not perform as well for the remaining measures, as three of them—i.e., *Well-Child Visits in the First 15 Months of Life—Six or More Visits* and the two *Adults' Access to Preventive/Ambulatory Health Services* measures—were between the national HEDIS 2008 Medicaid 25th and 50th percentiles. The *Comprehensive Diabetes Care—HbA1c Testing* measure was between the national HEDIS 2008 Medicaid 10th and 25th percentiles. Considerable opportunities exist for improving the rates for these four measures. WellCare's performance in the access domain was reflected in the measure, *Adults' Access to Preventive/Ambulatory Health Services.* With its rates between the national 2008 HEDIS Medicaid 25th and 50th percentiles, the plan was performing below the national average for the 20-to-44-year-old and 45-to-64-year-old age groups. This finding also suggests opportunities for improving performance for this measure of access to care and services.

Suggestions and Other Considerations

While HSAG's primary role during these EQR activities was to evaluate and report on the validity of the CMOs' PIP and performance measure processes and data, HSAG also recognizes the importance of the CMOs demonstrating continuous improvement in the results of the PIPs and the rates achieved for the performance measures. For performance measures and PIPs that address HEDIS measures, HSAG, through its experience in working with numerous states, has identified various best practices related to improving HEDIS rates. To this end, the following initiatives and interventions have been found to be successful for other health plans in other states and are included as a resource for the CMOs when addressing similar barriers and desired outcomes identified within their own populations and the DCH Medicaid managed care environment. Supplemented by current literature, the following information serves only to augment DCH's and the CMOs' efforts in these areas. Whenever available and appropriate, evidence-based interventions are described that target specific areas and/or HEDIS rates, which HSAG identified as opportunities for CMO performance improvement.

Many of the same interventions implemented to improve well visits and access to care for other age groups are used to improve the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS measure results. One potential strategy includes a patient-centered care model to improve a patient's health outcomes and satisfaction. The Economic and Social Research Institute Report outlines barriers and lessons learned in implementing this approach.[6-1] While the Medicaid population is insured, navigating through the health care system can be challenging for members.

Components related to access include:

- Providing a "medical home."
- Keeping waiting times to a minimum.
- Providing convenient service hours.
- Promoting access and patient flow.
- Educating patients on how to access and navigate the health care system.

One method to operationalize this model includes developing a collaborative project such as a statewide PIP. HSAG has documented successful interventions for increasing member satisfaction with provider interactions and also for improving customer service and communication in the adult member population.

Interventions include:

- Keeping medical records for all family members in one folder.
- Providing Web-based clinical guidelines.
- Supplying refrigerator magnets with plan contact information to members.
- Encouraging patient-provider joint decision making through a "Patient Action Plan."

[6-1] Silow-Carroll S, Alteras T, Stepnick L. Patient-Centered Care for the Underserved Populations: Definition and Best Practices. Economic and Social Research Institute. 2006.

- Providing a postvisit summary to members that includes the following: provider seen, location seen, diagnosis, medications being taken and/or prescribed, and referrals made.

The patient-centered care model and any related interventions can also apply to other HEDIS screening-related measures and chronic disease management.

The CMOs were required to report measure results using HEDIS specifications. However, based on this year's performance validation audit, the CMOs used different populations and data collection methodologies for generating their HEDIS measures. As such, the reported rates for four of the six measures were not comparable across CMOs, and statewide performance could not be summarized. DCH has clarified the reporting requirements and appropriate populations for future performance measure reporting In addition, individual CMO performances on the *Comprehensive Diabetes Care—HbA1c Testing* measure showed that the rates for all three CMOs were below the national HEDIS 2008 50th percentile (79.6 percent), with two CMOs' rates falling below the 25th percentile (74.2 percent).

HSAG has documented several successful interventions that have been implemented to improve *Comprehensive Diabetes Care* HEDIS rates. Successful in this context is defined as achieving sustained improvement over several years. PIPs focusing on diabetes care have been effective in improving HEDIS rates corresponding to the *Comprehensive Diabetes Care* measures of *Eye Exam, HbA1c Testing* and *LDL-C Screening.* HSAG has compiled information from PIPs demonstrating sustained improvement for these HEDIS rates.[6-2] After identifying specific barriers from causal/barrier analyses, health plans have implemented one or more of the following interventions:

For both members and providers:

- Instituted a Diabetic Health Management Program
- Changed the benefit to eliminate referral requirements for diabetic members' annual eye exams
- Created a dedicated diabetes health management committee to develop and implement interventions and program improvements, and to review guidelines

For members:

- Identified diabetic members in a new member welcome call assessment
- Distributed health report cards to members with their testing and result history
- Provided incentives to members compliant with all screening requirements
- Distributed quarterly newsletters with diabetes articles and updates
- Contacted noncompliant members using reminder letters/calls

For providers:

- Informed providers of member incentives

[6-2] Health Services Advisory Group. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

- Sent report cards to providers documenting their care of diabetic members and included the identification of diabetic members, a summary of all diabetes services received, and a chart tool
- Recognized top-performing practitioners in diabetes care
- Mailed diabetes clinical care guidelines to practitioners, including an assessment tool
- Posted diabetes clinical care guidelines for practitioners on the Web site
- Distributed monthly newsletters to practitioners with articles related to diabetic guidelines and care

Interventions related to education, either for the member or practitioner, were more successful if they were repeated numerous times and the educational materials were distributed using varied modalities.

Complete Data

Improving data completeness is a common goal among states. Three targeted components are: claims and encounter data, supplemental data sources, and vendor data from sources such as labs, radiology facilities, and pharmacies. Efforts to improve the submission of encounter data have the potential to improve all HEDIS rates as well as reduce the burden of medical record review. Regardless of the plan type, plans that establish a method to collect individual dates of service, either through global billing documentation requirements or the use of monitoring programs, have successfully decreased their reliance on medical record review and improved performance results. In addition, performing a data refresh of the encounter/claims data prior to the final reporting of HEDIS rates is valuable in producing more accurate and complete results and accounting for any lags in reporting.

Identifying supplemental data sources also appears to be successful in increasing data completeness. The use of state registries and even internal registries is valuable in identifying data that could be missing from administrative data. Other internal databases created from the collection of supplemental member data derived from standardized forms or electronic tools are additional methods to enhance data completeness. Another important source of supplemental data is noncontract entities that may be providing services. Plans could negotiate arrangements with these entities to obtain the data.

Plans that work closely with vendors such as labs, radiology facilities, and pharmacies seem to be able to enhance the completeness of their data. Once a secure contract is in place, oversight and ongoing monitoring are necessary. Reconciling vendor claims with test results often leads to improved rates. Many plans have found that creating a case management registry allows for the tracking of current lab results and prescriptions.

Identify Barriers

In approaching barrier analysis, plans should identify and evaluate barriers to improvement in terms of the greatest impact. A comprehensive barrier analysis can assist in targeting interventions that would bring about the most effective results. Several Web sites provide reliable information on effective interventions. The AHRQ Health Care Innovations Exchange Web site documents

successful interventions addressing a wide range of barriers.[6-3] More importantly, it also provides examples of interventions that were not successful. A review of preventive service interventions with corresponding task force ratings can also be found on the Community Guide Web site.[6-4]

Interventions focused on providers can educate, inform, and/or reward providers. Data mining can highlight areas for improvement such as identifying missed opportunities, patterns of inadequate data submissions, and the omission of data sharing with registries. Supplying providers with feedback on their data serves to both educate and inform. In addition, implementing tracking tools and standardized forms has led to improved rates across numerous HEDIS measures. In conjunction with financial incentives based on achieving specific goals or benchmarks, pay for performance can also be used to promote quality improvement by awarding bonuses for significant improvement of HEDIS rates.[6-5]

Ideally, member interventions should specifically target identified barriers. Effective communication is necessary to address any cultural barriers and to educate and inform plan members of any required services. While several interventions are often implemented simultaneously, stepped interventions have been shown to be effective in improving rates for preventive services. Members are initially notified by mail of a required service. Those members who have not responded to the mailing are then called. Members who still have not responded to the two previous interventions are then provided case management and receive a home visit.[6-6]

Share Best Practices

Ideally, health plans should be afforded the opportunity and routinely encouraged to share successes. Clearly documenting the details of an intervention and the results facilitate the transition from study to practice. Even if a plan does not plan to publish its study, adapting aspects of the Standards for Quality Improvement Reporting Excellence, or SQUIRE, permits a plan to share its successes in such a way that the results can be replicated by other plans.[6-7] The Center for Health Transformation has provided a location for each state to report its best practices for the Medicaid program. While outcomes are not provided, many states have included detailed descriptions of their successful initiatives/reforms.[6-8]

PIPs, most notably those conducted statewide, have the potential to improve statewide HEDIS rates. Through a statewide collaborative project, managed care organizations go through a formalized process for evaluating interventions, and through collective wisdom, are more likely to identify and develop evidence-based practices.

[6-3] AHRQ Innovations Exchange. Innovation and Tools to Improve Quality and Reduce Disparities. Available at http://www.innovations.ahrq.gov/index.aspx.

[6-4] The Community Guide. What works to promote health. Available at: http://www.thecommunityguide.org. Accessed August 7, 2009.

[6-5] Rosenthal MB, Fernandopulle R, et al. Paying For Quality: Providers' Incentives For Quality Improvement. *Health Affairs*. 2004. 23(2):127-141.

[6-6] Hambridge SJ, Phibbs SL, et al. A Stepped Intervention Increases Well-Child Care and Immunization Rates in a Disadvantaged Population. *Pediatrics*. 2009, 124(2):455.

[6-7] Davidoff F, Batalden P, et al. Publication Guidelines for Improvement Studies in Health Care: Evolution of the SQUIRE Project. *Ann Intern Med*. 2008, 149:670-676.

[6-8] Center for Health Transformation. Better Health, Lower Cost. Available at: http://www.healthtransformation.net. Accessed August 7, 2009.

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7. Assessment of CMO Follow-up on Prior Recommendations

This section presents the improvement actions the CMOs took in response to recommendations HSAG made the prior year (2008–2009) as a result of its EQRO activities (i.e., review of compliance with federal Medicaid managed care regulations and the associated State standards, validation of PIPs, and validation of performance measures). The information provided as "follow-up" in this section was reported in documentation the CMOs submitted to HSAG.

AMERIGROUP Community Care

Compliance With Standards

AMERIGROUP's performance in complying with the federal Medicaid managed care regulations and the associated DCH contract requirements that HSAG reviewed for the first year of a three-year cycle of compliance reviews resulted in several recommendations to improve the CMO's performance. For the requirements for which HSAG found AMERIGROUP's performance as not fully compliant, AMERIGROUP was required to prepare and submit to DCH corrective action plans (CAPs) addressing each HSAG recommendation. Once the CAPs were approved, AMERIGROUP reported that it implemented the following performance improvement activities in response to each recommendation. The recommendations and the information AMERIGROUP submitted describing its follow-up actions are listed below. HSAG recommended that AMERIGROUP:

- Continue recruitment efforts to achieve a utilization management (UM) committee (or other committee that performs UM tasks) composed of network providers from each service area. Follow-up: AMERIGROUP successfully recruited an additional provider from each of the two areas that had not been represented on the CMO's UM committee at the time of HSAG's review.
- Revise its applicable policies/procedures, program descriptions, and other documents to: (1) clarify the decision and notification time frames for standard authorization decisions and extensions and for expedited authorizations and extensions and (2) ensure that the information in the documents is consistent across all applicable policies/procedures and other relevant documents**.** Follow-up: AMERIGROUP stated it had reviewed and, as needed, revised all relevant policies and procedures, program descriptions, and the member and provider manuals to ensure that they were consistent and accurate in addressing the time frames.
- Revise its policies/procedures and program descriptions to ensure that they accurately describe the requirements related to notices of action for decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Information across all applicable documents must be consistent and compliant with Medicaid managed care regulations and the associated DCH contract requirements. Follow-up: AMERIGROUP revised its policies/procedures and program descriptions to ensure that they accurately and consistently described the requirements related to notices of action for decisions to deny a service

authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

- Revise its applicable policies/procedures to ensure that they address the readability, language, and format of notices of action. Follow-up: AMERIGROUP reviewed and revised the applicable policies/procedures to address the readability, language, and format of notices of action.
- Revise its policies/procedures to ensure that they accurately describe the requirements related to the content of notices of action. All applicable documents must be consistent in content related to the requirement and comply with Medicaid managed care regulations and associated DCH contract requirements. Follow-up: AMERIGROUP reviewed and, as applicable, revised its policies and procedures and other documents to ensure that they accurately and consistently described the requirements related to the content of notices of actions.
- Revise its policies/procedures to accurately describe the requirements related to notices of action for denials of requests for services; authorizations in an amount, duration, or scope that is less than requested; and decisions that suspend, reduce, or terminate services that have been previously authorized. Information in all these documents must be consistent and comply with the applicable Medicaid managed care regulations and associated DCH contract requirements. Most importantly, the information must reflect AMERIGROUP's actual processes and practices. Follow-up: AMERIGROUP reviewed and, as applicable, revised its policies/procedures and other documents to ensure that they accurately and consistently described the requirements related to the content of notices of actions.
- While the payment dispute process is crucial to health plans and resolves the majority of payment denial challenges, once the final decision is made that a payment is denied with no further resolution possible, AMERIGROUP should consider this an action as defined in the Medicaid managed care regulations (see 42 CFR 438.400[b][3]). Therefore, AMERIGROUP should provide notice of action at the time it makes a final decision to deny payment of a provider claim. Follow-up: AMERIGROUP, with DCH's and HSAG's consultation and review, revised the notice—i.e., the Explanation of Benefits (EOB)—it provides to members when it denies payment to a provider for services provided to a member. The CMO prepared the revised notice in both English and Spanish following DCH's approval of the revision, and implementation was scheduled approximately 90 days following the approval.
- Revise policies/procedures or program descriptions to ensure that they address notification of members and providers of the authorization decision time frame (and resulting notice of action). All documents must comply with the applicable Medicaid managed care regulations and associated DCH contract requirements and must reflect AMERIGROUP's operations. Follow-up: AMERIGROUP reviewed and. as applicable, revised its policies, procedures, and other relevant documents to ensure that they accurately and consistently described the requirements related to notifying members and providers of authorization decision time frames (and resulting notices of action). AMERIGROUP also addressed the requirement to carry out decisions as expeditiously as a member's health condition requires and not later than the date the extension expires.
- Ensure that it has policies/procedures that address the requirement for providing notice of action if AMERIGROUP does not reach a decision for a standard and/or expedited authorization within the required time frame. All applicable policies/procedures and other written documents, and the CMOs' practices, must comply with the applicable Medicaid managed care regulations and associated DCH contract requirements and must reflect AMERIGROUP's operations and

practices. Follow-up: AMERIGROUP reviewed and, as applicable, revised its policies/procedures and other relevant documents to ensure that they accurately and consistently addressed the requirement for providing notice of action if AMERIGROUP does not reach a decision for a standard and/or expedited authorization within the required time frame.

- Use the prudent layperson standard to determine if visits to the emergency room were actual emergencies. AMERIGROUP must also inform members that the prudent layperson standard is used to determine if the member might be charged a copay for emergency services. Follow-up: AMERIGROUP made the decision to remove the copay from all emergency visits and revised all applicable documents accordingly, including the provider and member manuals and the Emergency Care—GA policy and procedure.
- Revise provider and member materials and applicable policies and procedures to specifically address the fact that AMERIGROUP will not charge members any more for out-of-network poststabilization services than it would charge had the services been obtained through an in-network provider. Follow-up: AMERIGROUP revised its provider and member manuals and applicable policies/procedures to address the CMO's policy and practice of not charging members any more for out-of-network poststabilization services than it would have charged for services obtained through an in-network provider. AMERIGROUP submitted the revised member and provider manuals to DCH for review and approval.

Performance Improvement Projects

As a result of its findings from validating AMERIGROUP's PIPs, HSAG made the following recommendations:

- For the *Well-Child Visits During the First 15 Months of Life With Six of More Visits* PIP, HSAG recommended the following:
  - The documentation in Activity I should include a discussion regarding the eligible study population and the inclusion or exclusion criteria for members with special health care needs.
  - The study question should set the framework for the study. The study question should also reflect the focus of the study, which was to improve rates for six or more well-child visits in the first 15 months of life.
  - The study indicator should be completely defined, objective, and measurable. The PIP documentation should accurately reflect DCH specifications pertaining to the study indicator.
  - The guidelines used for the study indicator should be documented in the "description/rationale" of the study indicator.
  - The study indicator and the study question should align, allowing for the study indicator to answer the study question and be structured to measure changes in member health and functional status.
  - The study population definition should capture all members to whom the study question applies.
  - The documentation in Activity V should clearly specify that sampling techniques were not used and that the entire eligible population was used for the study.

- A defined and systematic process for the collection of baseline and remeasurement data should be outlined in the PIP documentation and include complete date ranges for each measurement period.
- The PIP should discuss the administrative data process that shows all activities involved in the production of the study indicator, and it should include the estimated degree of administrative completeness with the process of how the plan calculated the reported percentage.

Follow-up: AMERIGROUP reported that it took the following actions in response to HSAG's recommendations for this PIP:

- AMERIGROUP replaced the PIP HSAG reviewed with the collaborative PIP involving DCH, HSAG, and the three CMOs. Activity I of the new baseline PIP included a discussion of the eligible study population and included criteria for members with special health care needs.
- The study question for the collaborative PIP was agreed to and approved by DCH, HSAG, and the three CMOs and reflected the focus of the study.
- The study indicator was completely defined, with the numerator and denominator following HEDIS specifications. The study indicator and study question were aligned to allow the indicator to answer the study question. The study indicator was structured to measure changes in member health and functional status.
- The study population definition captured all members to whom the question applied. The study question for the collaborative PIP was restated to maintain the focus of the study.
- Documentation was added stating that sampling was not used and that the entire eligible population was used for this study.
- The resubmitted PIP documented a defined and systemic process for collecting baseline and remeasurement data with date ranges.
- The resubmitted PIP described an administrative process that shows the activities involved in the production of the study indicator.
- The resubmitted PIP provided documentation of the estimated degree of administrative data completeness and the process used to calculate the percentage of completeness.

- For the *Improving Childhood Lead Rates* PIP, HSAG recommended the following:

  - The documentation in Activity I should include a discussion regarding the eligible study population.
  - Activity I should include the inclusion or exclusion criteria for members with special health care needs.
  - The study question should set the framework for the study. The study question should be restated to reflect the focus of the study, which was to increase the percentage of members who received at least one blood lead screening on or before 25 months of age.

- The study indicator should be completely defined, objective, and measurable. The PIP documentation should accurately reflect the DCH specifications pertaining to the study indicator.
- The guidelines used for the study indicator should be documented in the "description/rationale" of the study indicator.
- The study indicator and study question should align, allowing for the study indicator to answer the study question and be structured to measure changes in member health and functional status.
- The study population definition should capture all members to whom the study question applies.
- The documentation in Activity V should clearly specify that sampling techniques were not used and that the study used the entire eligible population.
- The PIP documentation should outline a defined and systematic process for the collection of baseline and remeasurement data and include complete date ranges for each measurement period.
- The PIP should discuss the administrative data process that shows all activities involved in the production of the study indicator, and it should include the estimated degree of administrative completeness with the process of how the plan calculated the reported percentage.

Follow-up: In response to HSAG's recommendations for this PIP, AMERIGROUP reported the following information and actions:

- The PIP HSAG reviewed was replaced with a new baseline PIP using administrative HEDIS specifications. Activity I of the new baseline PIP included a discussion of the eligible study population and the inclusion criteria for members with special health care needs.
- The study question for the new baseline PIP was restated and reflects the focus of the study.
- The study indicator was completely defined, with the numerator and denominator following HEDIS specifications. The study indicator and study question were aligned to allow the indicator to answer the study question. The study indicator was structured to measure changes in member health and functional status.
- The study population definition captured all members to whom the study question applied. The study question for the new baseline PIP was restated to maintain the focus of the study.
- Documentation was added stating that sampling was not used and that the entire eligible population was used for this study.
- The PIP documented a defined and systemic process for collecting baseline and remeasurement data with date ranges.
- The PIP described an administrative process that shows the activities involved in the production of the study indicator.
- The PIP documented an estimated degree of administrative data completeness and the process used to calculate the percentage of completeness.

- For AMERIGROUP's *Provider Satisfaction* PIP, HSAG recommended the following:

  - The PIP should include the data in Activity I as background information as to why the CMO wanted to focus on Questions 7, 8, 9, and 17.
  - Activity I should include a discussion of the eligible study population and how the providers were broken out for the study.
  - The PIP should document complete date ranges for the measurement period dates.
  - In addition to providing information regarding the basis for each study indicator in Activity VIII, the PIP should also document the information in Activity III. Information regarding the "key driver analysis" by the vendor should also be included in the rationale for each study indicator.
  - The PIP should include a complete definition of the study population that includes an anchor date for when the provider list is pulled.
  - If a particular study indicator requires that a provider be contracted with the CMO for a length of time, then the required contract time should be documented in the study population.
  - The PIP documentation should include the provider population size. The sampling techniques should ensure a representative sample of the eligible population and be in accordance with generally accepted principles of research design and statistical analysis.
  - The PIP documentation should outline a defined and systematic process for the collection of baseline and remeasurement data and include complete date ranges for each measurement period.
  - The PIP should include the qualifications, experience, and training of the data collection staff (phone survey).
  - An overview of the purpose of the study should be included on the provider survey. If a cover letter was provided to the providers, this should be included with the PIP submission.
  - The PIP should include a complete description of the data collection process. The PIP should provide a flow chart or algorithm that shows the production of the study indicators.

  In response to HSAG's recommendations, AMERIGROUP reported that it took the following corrective actions:

  - AMERIGROUP added plan-specific data to Activity I as background information as to why the CMO focused on Questions 7, 8, 9, and 17. Discussion of the eligible study population and the inclusion criteria for members with special health care needs were added to Activity I.
  - AMERIGROUP added complete date ranges for the measurement periods. Documentation of information regarding the basis for each study activity was added to the PIP. The key driver analysis was also added.
  - The resubmitted PIP documented the complete definition of the study population, including the anchor date for when the provider list was pulled. There was no requirement for length of service as an in-network provider to be part of the survey sample, and this was documented in the PIP.

- The resubmitted PIP included the provider population size and sampling techniques and added the number of PCPs and specialty care providers (SCPs) selected from each of the segments that make up the providers selected as part of the sample frame. A vendor conducted sampling techniques using acceptable principles of research and statistical design.

Performance Measures

As a result of its findings from validating AMERIGROUP's performance measures, HSAG made just two recommendations:

- AMERIGROUP should create a data freeze for the data used to generate the measures to ensure that the same original data can be used if the queries need to be run again. Follow-up: As the methodology and specific performance measures were changed for the second year of the contract, AMERIGROUP began using HEDIS specifications.
- AMERIGROUP should continue to ensure that all data are being received from capitated providers. Follow-up: AMERIGROUP reported that this was an ongoing challenge when using medical record chart review to identify potential issues related to claims submission for services rendered. The CMO enhanced its provider education to address this issue through contact with provider relations staff members and other communication mechanisms.

While not related to the validity of its performance measure calculation and reporting processes, the actual rate of 59.3 percent attained for the HbA1c measure represented an additional opportunity for improvement. Follow-up: AMERIGROUP reported that its initiatives to improve the rates included enhancing member outreach by the CMO's vision vendor and enhancing AMERIGROUP's vision benefit to include members older than 21 years of age.

Peach State Health Plan

Compliance With Standards

HSAG's findings from its review of Peach State's performance in complying with federal Medicaid managed care regulations and the associated DCH contract requirements that HSAG reviewed for the first year of a three-year cycle resulted in several recommendations to improve the CMO's performance. For the requirements for which HSAG found Peach State's performance as not fully compliant, the CMO was required to prepare and submit to DCH corrective action plans addressing each HSAG recommendation. Once the CAPs were approved, Peach State submitted documentation demonstrating that the CMO implemented the performance improvement activities described below in response to each recommendation. HSAG recommended the following:

- The CMO must ensure that it provides sufficient detail in its cultural competency plan (e.g., specific actions/activities planned, goals/objectives for each, evaluation methodologies, timelines for milestones and completing the activities, and individuals/organizational units accountable for each) that describes specific, planned actions/activities and provides the basis upon which the CMO can evaluate its performance in meeting the goals and objectives. Follow-

up: Peach State reported that during the year, it implemented numerous activities to ensure that it had a comprehensive cultural competency program. These activities included the following:

- The CMO continued to increase its presence in the community through participation in collaborative meetings and health fairs with faith- and community-based organizations. Peach State described numerous, specific examples of these activities.
- Peach State recognized various cultures by participating in heritage appreciation month, including articles in its employee newsletter, and participating in community events. Peach State provided specific examples.
- In 2009 Peach State launched the following internship and emerging talents programs (e.g., the General Internship Program), which included three general interns with various educational backgrounds who participated in an 8–10 week internship; the Professional Internship Program, which included three fourth-year pharmacy students who participated in a five-week internship; and Emerging Talent—The 2009 Inaugural Class, which included six inductees from different internal departments. The program included a diverse group of emerging top performers, providing opportunities to further develop their talent and leadership skills related to cultural competency.
- Peach State's Human Resources Department began participating in the Consortium for Graduate Study in Management. The consortium is the country's preeminent organization for promoting diversity and inclusion in American business. Peach State employees are receiving ongoing cultural competency and diversity training.
- Peach State employees completed the annual diversity training offered through Centene University: Centene 101 Diversity and Anti Harassment Course 46. Peach State described several additional training programs the CMO provides.
- Peach State employees received annual compliance and ethics training, which included informing them about the importance of being compliant with the cultural competency strategic plan.

- Peach State must revise applicable documents related to standard authorization decision time frames and extensions to reflect actual Peach State practice, provide contracted providers with accurate information, and reflect consistency across documents. HSAG strongly encourages Peach State to consider using extension time or, at a minimum, more of the CMS-allotted 14 calendar days for decisions and notifications when additional information is required. Follow-up: Peach State reported that in addition to updating its policies and procedures and related documents that address timeliness of UM decisions and notifications, the CMO initiated several additional actions to address HSAG's recommendations. These actions included: (1) staff retraining—effective January 2009, the UM staff is retrained each quarter on UM policies and procedures, including clinical guidelines and decision time frames; and (2) weekly file audits—effective October 2008, all managers review and audit random files for each staff member and provide weekly feedback to the staff on areas of excellence and areas needing improvement.
- Peach State must ensure that its delegate complies with CMS' and DCH's required time frames for authorization of services. Follow-up: Peach State reported that in May 2009, the CMO advised each vendor that the applicable policies and procedures and practices had to be updated to align with the time frames required by CMS and the DCH contract; vendors were required to provide copies of their newly updated policies and procedures to Peach State as part of their delegated oversight activities; and the CMO's UM audit tool was updated to reflect these time frames to ensure that the correct standards are applied during reviews of delegated functions.

- Peach State must revise applicable documents related to expedited authorization decision time frames and extensions to reflect Peach State's practice, provide contracted providers with accurate information, and reflect consistency across documents. Follow-up: Peach State updated applicable policies and procedures, the relevant section in the provider manual, and the UM and call center staff training material to include references to these time frames.
- Peach State must revise its Adverse Determinations (Denial) Notices policy to address notices of action sent to members and providers for any decision to authorize a service in an amount, duration, or scope that is less than requested. Follow-up: Peach State: (1) added to the applicable policy to show that all adverse determination notifications for services that are authorized in an amount, duration, or scope that is less than requested are sent to both the member and provider and (2) added the requirement to the denial and appeal coordinators' training and conducted ongoing oversight of the process.
- Peach State must revise the applicable policy to address the format of notice of proposed adverse action letters. Follow-up: Peach State updated its applicable policy to note that the Spanish version of the adverse determination letter is available to members and to provide direction for hearing and visually impaired members for accessing assistance. The information the CMO provided stated that the changes were made to the notice of proposed action letter template, which directs members who have trouble understanding the letter to the member services call center for assistance. The letter template was reviewed and approved by DCH and judged to be at a fifth-grade reading level.
- Peach State must revise its policies and processes to be consistent with each other to ensure that for all proposed actions to terminate, suspend, or reduce previously authorized, covered services, Peach State mails the notice of proposed action 10 calendar days before the date of the proposed action or no later than the date of the proposed action in the event of one of the permitted exceptions. Follow-up: Peach State: (1) revised the applicable policies to add language addressing proposed actions to terminate, suspend, or reduce previously authorized, covered services; and (2) trained denial and appeal coordinators on the process.
- Since the DCH contract requires that CMOs have written policies and procedures that address each requirement in the UM section of the contract, once Peach State determines how it will handle (or if it will allow) time frame extensions, it must develop or revise applicable policies and other documents to reflect Peach State's practice and inform providers and/or members of the process. Follow-up: Peach State reported that it revised the applicable policies and letter templates or, in some instances, developed new ones to address extensions of time frames. The CMO trained UM staff and call center representatives on extensions of time frame requirements, including the process for requesting an extension, appropriate extensions, and the process for approving a request for an extension. Peach State developed a letter template in early 2009 to direct the process for possible requests for an extended time frame.
- Since the DCH contract requires that CMOs have written policies and procedures that address each requirement in the UM section of the DCH contract, Peach State must develop policies that address standard and expedited authorization decisions not reached within the required time frames and the process for sending the resulting notice of action. Follow-up: Peach State updated the applicable policy to address authorization decisions not reached within the required time frame. The CMO also developed a letter template for this purpose and trained UM staff and call center representatives on handling such events.

Performance Improvement Projects

Based on its prior-year EQR findings from validating three Peach State Health Plan (PSHP) PIPs, HSAG recommended that the CMO implement a number of enhancements to improve the future validity of its PIPs.

- For the *Improving Blood Lead Screening Rates in PSHP Children Age 24 Months* PIP, HSAG's recommendations were that:
  - The study question should set the framework for the study and be answerable through the study indicator. Follow-up: The CMO revised the question to read: "Do standard blood lead testing promotional activities by Peach State Health Plan targeted to parents and providers increase the number of blood tests performed on Peach State's members age 24 months during the measurement period?"
  - The study indicator should align with the study question. Follow-up: Peach State revised the study indicator to read: "The percent of members, age 2 in the reporting period, who received a blood test screening and who were continuously enrolled 12 months during the measurement period."
  - The study population should be completely and accurately defined and should capture all eligible members to whom the study question applies. Follow-up: The CMO further defined the study population to include the data type, eligibility, time frame, source code, and procedure code as provided by Thompson-Reuters on October 22, 2008.
  - Future submissions of the PIP should include the date range for data collection for Remeasurement 2. Follow-up: Peach State included the timeline for collecting baseline and remeasurement data.
- For the *Well-Child Visits During Their First 15 Months of Life With Six or More Visits* PIP, HSAG recommended the following:
  - Activity I should include a discussion of the eligible population. Follow-up: Peach State enhanced the discussion of the eligible population to include the following: (1) children, age 0 to 2 years of age, represent 16 percent of PSHP's population as of December 31, 2008; (2) the eligible population includes all children who turned 15 months of age in 2008, were continuously enrolled from 31 days after birth to 15 months of age, and had no more than a one-month gap in coverage, as enrollment is verified monthly for Medicaid beneficiaries; (3) children represent a high-volume, high-risk group of PSHP members; (4) no special needs children were excluded; and (5) the study was selected as the Georgia CMO collaborative PIP project.
  - The study question should set the framework for the study and be answerable through the study indicator. Follow-up: The CMO rewrote the study question to state: "Does directing targeted interventions to providers and parents of children aged 15 months and under, increase the rate/percentage of PSHP children who have the recommended six plus well child visits before their 15 month birthday?"
  - The study indicator should align with the study question. Follow-up: Peach State rewrote the selected study indicator to read: "The percent of members who turned 15 months in the reporting period and who received the recommended six or more well-child visits with a PCP during their first 15 months of life."

- The study population should capture all eligible members to whom the study question applied. Follow-up: The CMO defined the study population as follows: "The eligible population is identified based on the following criteria: all Medicaid and PeachCare for Kids children who turn 15 months of age during 2008; the anchor date applied towards this measure was the day the child turns 15 months old; continuous enrollment from 31 days after birth to 15 months of age; had no more than a one-month gap in coverage, as enrollment is verified monthly for Medicaid beneficiaries; and no special needs children were excluded."
- Activity VI should include complete timelines for both the baseline and remeasurement periods. Follow-up: On resubmission of the PIP, Peach State included the timeline for collecting baseline and remeasurement data.
- Future submissions of the PIP should specify the process the CMO used to identify barriers (e.g., brainstorming, fishbone diagramming, etc.). Follow-up: Peach State stated in the documentation submitted to HSAG that in the 2009–2010 submission, the PIP activity was again one of collecting baseline measurement data due to the PIP becoming a collaborative PIP for all of the CMOs. Therefore, identifying causes/barriers through data analysis and quality improvement processes was not applicable as the study had not progressed to the point of developing and implementing improvement strategies.

For Peach State's *Provider Satisfaction* PIP, HSAG recommended that:

- The survey results that determined the key drivers for the study indicators should be included in Activity I; Activity I should include a discussion of how the study topic, provider satisfaction, addresses a broad spectrum of care and services; and future submissions of the PIP should include a discussion in Activity I of the eligible study population and how the providers were broken out in the study. Follow-up: Peach State revised the study topic to include information about the survey respondents for 2007 and 2008, such as the specialty, number of doctors in practice, years in practice, and managed care volume of practice. In addition, Peach State reported that the key drivers of satisfaction for both 2007 and 2008 and the correlation coefficients were included in the PIP resubmission.
- Future submissions of the PIP should restate the study questions as discussed in detail in the PIP Validation Tool, the PIP should include complete date ranges when referencing measurement periods and data collection timelines, and the PIP should include a more descriptive basis for the study indicators as discussed in detail in the PIP Validation Tool. Follow-up: The CMO rewrote the study question as follows: "Will health plan actions (interventions) designed to increase PCP provider satisfaction improve scores of targeted questions on the provider satisfaction survey?" Peach State also rewrote the study indicators and added complete date ranges when resubmitting the PIP.
- The PIP should include a complete definition for the study population that includes an anchor date for when the provider list is pulled. The PIP should also explain that if a study indicator requires that a provider be contracted with the CMO for a certain length of time, the required time should be documented in the study population. Follow-up: In describing its follow-up actions, Peach State stated that the dates indicating when the provider lists were pulled were added to the resubmissions. The resubmissions also stated that there was no requirement for length of time providers were contracted with the CMO.

- The PIP should include a complete description of the data collection process and a flow chart or algorithm that shows the production of the study indicators. The PIP documentation should provide information on the training provided to staff responsible for conducting the phone surveys, as well as the qualifications and experience of this staff. Activity VI should include complete date ranges for all remeasurement data collection timelines. Instructions for conducting the phone survey should be provided if they are different than the instructions on the mailed survey. The PIP should provide a detailed explanation of how the responses from the Internet and phone surveys will be combined with the mail option. An overview or purpose of the study should be included in the written instructions for the survey. (A cover letter that accompanies the provider survey would also be acceptable.) Follow-up: The CMO stated that all the information listed above was obtained and added as attachments or embedded in the PIP resubmission.
- Activity VII should provide an explanation of the two tables provided. Follow-up: After further review, Peach State determined that the second table was redundant and removed it for the resubmission of the PIP.

Performance Measures

Based on its prior-year EQR findings from validating Peach State's performance measures, HSAG recommended the following:

- Peach State should save final numerator and denominator files used to calculate reported rates and put in place a formal validation process to verify that final output files are in compliance with specifications (i.e., a spot check of members in the numerator and denominator). Follow-up: Peach State's documentation describing its follow-up stated the CMO now: (1) saves numerator and denominator information within the CRMS HEDIS warehouse, where the calculation is performed and member-level information is stored; (2) reviews numerators and denominators at the time of initial warehouse availability and prior to reporting to confirm appropriate selection for the measure as well as to check for compliance/noncompliance with the specifications, (3) selects 10 to 15 members from the populations, and (4) reviews the claims history in Amisys to confirm compliance or noncompliance.
- HSAG recommends that Peach State save the final numerator and denominator files used to calculate reported rates and archive quarterly files that are run for performance measure reporting for future reference and validation activities. Follow-up: In documenting its follow-up actions, Peach State stated that: (1) the CMO had contracted with McKesson for the HEDIS CRMS software package, (2) HEDIS warehouses are built and maintained in this platform annually for HEDIS as well as quarterly for project management purposes, (3) quarterly warehouses are available for 9 to 12 months, and (4) reportable annual HEDIS rates are maintained for 3 to 4 years.

In addition, the actual rates attained for both measures (i.e., 73 percent for HbA1c testing, which was below the national HEDIS Medicaid 10th percentile, and 80.11 percent for appropriate medications for asthma) represented opportunities for improvement. Follow-up: In documenting its follow-up actions, Peach State stated that the rates resulted from following the HEDIS-like specifications the State used for the time frame of October 1, 2006, through September 30, 2007. Subsequent to this, Peach State transitioned to the HEDIS specifications as directed by DCH, and

the 2009 HEDIS year was a baseline against the formal HEDIS specifications. In 2009, following the results of its second HEDIS season, Peach State established a data team to review and improve data capture and completeness. The data team investigated its data extract and loading processes to ensure data completeness and to identify any potential areas for improvement, and conducted an intensive mapping session held in September 2009 that revealed several actionable items. Peach State reported that the results of this team's investigation should be reflected in the HEDIS 2010 reported rates.

WellCare of Georgia, Inc.

Compliance With Standards

HSAG had only two recommendations for WellCare related to its performance for the first year of HSAG's external quality review of the CMO's performance in complying with the standards HSAG reviewed. Both recommendations addressed the written information the CMO communicated to members and providers related to emergency services. WellCare was required to revise the information to clearly communicate that authorization was not required for emergency services and to avoid language in communicating with members that could potentially discourage them from seeking needed emergency services. Follow-up: WellCare submitted a CAP to DCH addressing each recommendation/required action. Following approval of the CAP, the CMO stated in documentation submitted to HSAG that WellCare: (1) revised its member and provider written information to ensure it clearly communicated that authorization was not required for emergency services and (2) revised its member informational materials to ensure they did not unintentionally discourage members from seeking emergency care, including affirmatively stating that there was no copay for emergency services.

Performance Improvement Projects

As a result of its validation of WellCare's PIPs, HSAG had a limited number of recommendations associated with the CMOs' performance for each of the three PIPs HSAG validated.

- For the *Improving Lead Screening Rates for Members Birth to 24 Months of Age* PIP, HSAG recommended the following: (1) future submissions of the PIP should provide complete date ranges for data collection timelines, (2) documentation for Activity VI should discuss the process used to calculate the estimate of 100 percent administrative data completeness, and (3) the PIP should include the type of process used to identify the barriers (e.g., brainstorming or fishbone diagramming). Follow-up: In response to the recommendations, WellCare's HEDIS 2008–2009 improving lead screening PIP included the data collection timelines in Activity VIb and a completeness statement that outlined how the estimated degree of automated data completeness was determined. WellCare also reported that because the methodology changed from HEDIS-like to HEDIS, the 2008–2009 CMO submission required documentation only through Activity VI. Therefore, documentation of the methods for identifying barriers was not applicable for the 2008–2009 submission.

- For the *Well-Child Visits During the First 15 Months of Life With Six or More Visits* PIP, HSAG recommended the following: (1) future submissions of the PIP should provide complete date ranges for data collection timelines, (2) Activity VI should discuss the process used to calculate the estimate of 100 percent administrative data completeness, and (3) the PIP should include the type of process used to identify barriers (e.g., brainstorming or fishbone diagramming). Follow-up: In response to the recommendations, WellCare stated that its HEDIS 2008–2009 well-child visits in the first 15 months of life PIP included the data collection timelines in Activity VIb. The CMO will continue to include this information in future PIP submissions. Activity VI included a completeness statement that outlined how the estimated degree of administrative data completeness was determined. The CMO was required to submit only Activities I–VI for the 2008–2009 submission. Documentation of the methods for identifying barriers was not applicable for the 2008–2009 submission.
- For the *Provider Satisfaction* PIP, HSAG recommended the following: (1) the PIP should include a complete definition for the study population that includes an anchor date for when the provider list is pulled; (2) if a study indicator requires that a provider be contracted with the CMO for a certain length of time, the required time should be documented in the study population; (3) the PIP documentation should discuss the training and experience of the Meyers Group staff conducting the phone surveys; (4) when a phone survey is used for nonresponders, future submissions of the PIP should provide the instructions given to staff if they were different than the instructions included on the mailed survey; and (5) an overview or purpose of the PIP should be included on the survey instructions, or a cover letter to providers explaining the purpose of the survey should be included as part of the PIP. Follow-up: In response to the recommendations, WellCare stated in the documentation describing its follow-up actions that the CMO:
  - Added the following to the revised version of the PIP submitted to HSAG September 4, 2009, in the first paragraph of Section D, Activity IV: "The provider population data was pulled in February 2009 and included the entire physician practitioner network who were contracted with the CMO for all 12 months of the measurement year with an anchor date of December 31, 2008."
  - Added text to Section F, Activity VIa, stating, "The Research Analyst involved with this PIP has 4 years of SPSS programming experience analyzing health care data. For the CATI (i.e., Computer Assisted Telephone Interviewing) staff, TMG (i.e., The Myers Group) performs regular, simultaneous visual and audio, unobtrusive electronic monitoring of interviewers and maintains a ratio of monitors to interviewers of at least 1:9."
  - Added Attachment I, "Interviewer Training May 2008 TMG.doc" and Attachment H, "CATI Training Methods and Quality Assurance.doc."
  - Added Attachment E, "WCGA Provider Sat CATI Script.pdf."

Performance Measures

As with the compliance review, HSAG had only two recommendations for WellCare to further strengthen its performance related to the validity of its data reported for the DCH-required measures.

HSAG encouraged WellCare to consider implementing encounter data-to-medical record audits to ensure that data obtained by high-volume providers are complete and accurate. In addition, HSAG recommended that WellCare continue its close monitoring of its subcapitated providers to ensure that the data are complete. Follow-up: WellCare reported that it initiated an encounter data-to-medical records audit process that included using an Excel tool to randomly determine the specific member records for review. WellCare used a medical record vendor to review the records at the applicable provider office and to complete a specialized claims validation survey tool. In response to HSAG's second recommendation, WellCare stated in documentation related to its follow-up that the CMO's processes include monthly evaluations of the data submitted by capitated providers, including trending month-over-month and year-over-year changes to identify any potential data issues.

While not related to the validity of the data, HSAG also noted that the actual rates obtained for both the measures HSAG validated (appropriate asthma medications and HbA1c testing) represented further opportunities for improvement. Follow-up: For the asthma measure, WellCare's follow-up documentation stated that the CMO took the following actions designed to improve the CMO's performance results:

- Contracted with a community agency specifically focused on the disease state to provide in-home asthma assessments and conduct education on the asthmatic condition to members in the Atlanta region. Staff from the agency also trained WellCare outreach workers so the service could be provided in all regions statewide.
- Secured peak flow meters, nebulizers, pest control agents, and sheet casings to distribute during the in-home visits.
- Conducted in-home visits with members who needed improved medication management and performed both an environmental and educational assessment, reinforced the PCP's asthma treatment plan, conveyed the importance of taking/using medications appropriately, provided education on the proper use of peak flow meters and nebulizers, assisted with PCP appointments, and facilitated community agency referrals as needed.
- Arranged for information from home visit assessments to be uploaded to the WellCare disease management system, enabling reinforcement of the educational message upon repeat contact with the member.
- Informed involved PCPs:
  - By letter, of those members on their panel who would receive a communication regarding the availability of this outreach initiative.
  - Through in-office consultation of members in need of improved medication management and assisted the provider practice with member appointment scheduling as needed.

To address the rate of HbA1c testing, WellCare stated that the CMO:

- Developed a community educational offering on diabetes, which consisted of educational material promoted by the ADA. Appropriate testing, including the importance of HbA1c testing at regular intervals, was emphasized. The offering included providing a glucometer and pharmaceutical consultation regarding medication use.

- Invited members to the community educational offering who, based on the lack of HbA1c testing, were in need of focused education on diabetes. For members presenting with the comorbidity of high blood pressure, communication also referenced instruction on securing and using a blood pressure cuff.
- Conducted sessions with members in need of diabetic education, who could be reached.
- Educated the members on the self-management aspects of diabetes, such as the importance of diet, regular monitoring of blood sugar, and taking medication consistently (as appropriate).
- Instructed members on appropriate equipment use (glucometer and blood pressure cuff), reviewed current medications, scheduled PCP appointments, and facilitated community agency referrals as needed.
- Arranged for information provided during educational sessions to be uploaded into the WellCare disease management system, enabling reinforcement of the educational message upon repeat contact with the member.

HSAG HEALTH SERVICES ADVISORY GROUP

8. Plan Comparison

Introduction

This section provides a high-level overview of the statewide CMO performance and a comparison of the CMOs' individual performance for each of the three mandatory EQR activities HSAG conducted.

Plan Comparisons

Review of Compliance With Operational Standards

Findings

Figure 8-1 compares the percentages of applicable requirements scored as *Met*, *Partially Met*, and *Not Met* across the three CMOs for all six standards HSAG reviewed. These percentages were derived by strictly dividing the total number of *Met* and *Partially Met* elements by the total number of applicable elements. Figure 8-1 shows that the Georgia Families CMOs demonstrated excellent performance for Standard III—Member Rights and Protections, with performance for all of the applicable requirements receiving a score of *Met*. None of the CMOs received a score of *Not Met* for all the requirements within a standard. Nonetheless, CMO performance varied widely for Standard I—Provider Selection, Credentialing, and Recredentialing; Standard II—Subcontractual Relationships and Delegation; and Standard VI—Disenrollment Requirements and Limitations, with at least one CMO having all requirements scored as *Met* and one CMO with at least 20 percent of the requirements scored as *Partially Met*. Across all the CMOs, at least 15 percent of the applicable requirements were scored as *Partially Met* for Standards IV and V.

Figure 8-1—CMO Compliance with Requirements by Standard

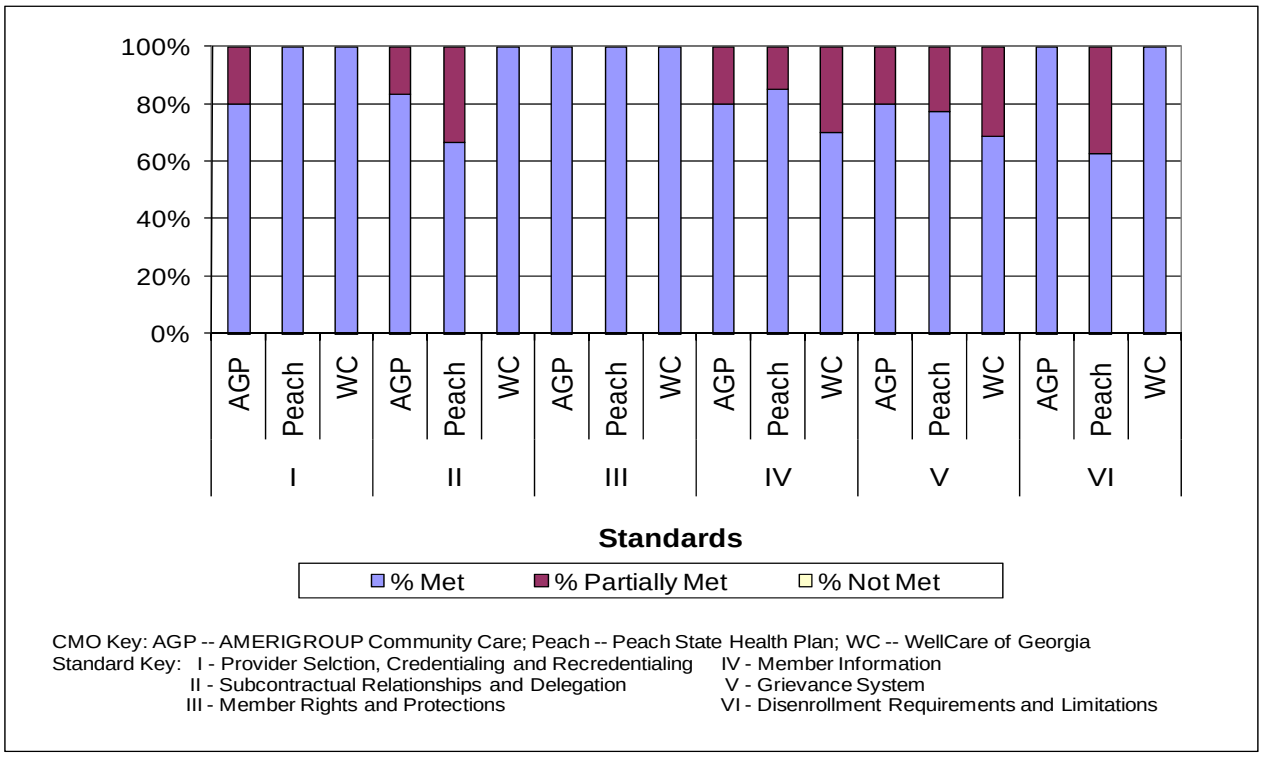

Table 8-1 presents the statewide and CMO-specific performance for all six standards. For this table, the overall compliance percentages were calculated by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.5) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Table 8-1—Individual CMO and Statewide Compliance Scores

Standard #	Standard Name	AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia, Inc.	Statewide
I	*Provider Selection, Credentialing, and Recredentialing*	90%	100%	100%	97%
II	*Subcontractual Relationships and Delegation*	92%	83%	100%	92%
III	*Member Rights and Protections*	100%	100%	100%	100%
IV	*Member Information*	90%	93%	85%	89%
V	*Grievance System*	90%	89%	84%	88%
VI	*Disenrollment Requirements and Limitations*	100%	81%	100%	94%
	Overall Percentage-of-Compliance Scores	**92%**	**91%**	**90%**	**91%**

Strengths

Overall statewide performance in complying with the requirements across the standards was good, with performance for 208 of the 255 total applicable requirements receiving a *Met* score and a statewide overall percentage-of-compliance score of 91 percent. All three CMOs received a score of 100 percent compliance for Standard III—Member Rights and Protections). Two CMOs received full compliance scores for Standard I—Provider Selection, Credentialing, and Recredentialing, and Standard VI—Disenrollment Requirements and Limitations. Strengths HSAG identified for each CMO are described in Section 6, External Quality Review Activities: Findings, Strengths, and Recommendations With Conclusions Related to Health Care Quality, Timeliness, and Access (the Findings Section). Strengths HSAG identified for more than one CMO for each standard are summarized below.

Statewide performance for Standard I—Provider Selection, Credentialing, and Recredentialing, was strong, with a statewide compliance score of 97 percent. Two CMOs demonstrated excellent performance by achieving a score of 100 percent, and one CMO exhibited good performance with a score of 90 percent. In general, the CMOs maintained and followed clear and accurate policies and procedures that were consistent with the standards established by NCQA and addressed all applicable federal Medicaid managed care regulations and DCH contract requirements. HSAG's review of provider credentialing and recredentialing files demonstrated that they contained almost all of the required documents and were processed within the required time frames.

For Standard II—Subcontractual Relationships and Delegation, all the CMOs had policies and procedures in place prior to subcontracting to ensure that all potential delegates had the ability to perform the delegated functions. Most delegation contracts contained adequate documentation. The CMOs also conducted ongoing monitoring of the delegates' performance related to the delegated functions and, as needed, required the delegates to submit to the CMO a corrective action plan for any identified deficiencies. The CMOs worked diligently with the delegated entities to ensure that the corrective actions were implemented and the deficiencies resolved.

For Standard III—Member Rights and Protection, all CMOs achieved full compliance and demonstrated excellent performance related to ensuring that members, providers, and staff were informed about member rights. CMO actions included listing member rights in the member handbooks and on the CMOs' Web sites, which addressed both members' rights and the providers' responsibilities related to them. The CMOs also used multiple informational and media resources to provide the information to providers (e.g., contracts/agreements, provider manuals, and provider newsletters). The CMOs conducted comprehensive staff training during new hire orientation, conducted staff annual training, required providers to post member rights in their offices/facilities, and conducted provider medical record reviews and office/site inspections.

While the statewide compliance score for Standard IV—Member Information, was only 89 percent, several CMO strengths related to this standard should be noted. All CMOs provided the member handbook in multiple versions, including English and Spanish, and had the ability to make them available if needed in large print, on audio tape, in Braille, and/or on compact disc. Member handbooks were written at a fifth-grade reading level. In addition, CMOs maintained a Web site with a convenient feature for clicking on a link to move between English and Spanish versions. Other CMO strengths included listing all available Georgia Families benefits and covered services

in the member handbook and making assistance in obtaining covered services and accessing other social services available to members.

The statewide performance for Standard V—Grievance System, was the lowest of the six standards. However, the CMOs in general did maintain an organized system for processing, documenting, and tracking grievances and administrative reviews. For all the CMOs, notices of proposed action contained all required information and were sent within the required time frames. The member handbook descriptions of member rights related to, and processes for, filing grievances and appeals were written in easy-to-understand language. For two of the CMOs, documentation and information staff members provided during the interviews demonstrated that administrative reviews were conducted by physicians who had not been involved with the case, and grievances were handled within the required time frame by staff with the appropriate level of expertise.

For Standard VI—Disenrollment Requirements and Limitations, statewide performance was good, with a compliance score of 94 percent. All the CMOs included the disenrollment requirements in the member handbook and offered assistance to members wishing to disenroll, including helping them when they were considering disenrollment, giving them the disenrollment forms, and referring them to DCH for disenrollment determinations.

Opportunities for Improvement and Recommendations

Statewide compliance scores for all but one of the six standards (Standard III—Member Rights and Protections) presented opportunities for improvement for the CMOs. All CMOs were required to implement corrective actions related to their performance for Standard IV—Member Information, and Standard V—Grievance System. Statewide compliance scores were below 90 percent (89 percent and 88 percent, respectively). Highlighted below is a summary of the opportunities for improvement and required corrective actions related to performance for requirements in Standards II, IV, and V that HSAG identified for more than one CMO.

Two CMOs received a compliance score of less than 95 percent for Standard II—Subcontractual Relationships and Delegation. The CMOs were required to ensure that each written delegation agreement described all of the administrative functions the CMO delegated and the delegate performed on behalf of the CMO.

All CMOs received a compliance score of 93 percent or less for Standard IV—Member Information, and a score of 90 percent or less for Standard V—Grievance System. For Standard IV, the CMOs were required to include or clarify in the member handbook a number of member rights related to the member not being held liable for a CMO's debts or for payment for covered services, the process for filing complaints with the applicable State agency when a provider did not comply with advance directive requirements, requirements for filing an appeal, and rules that govern representation at an administrative law hearing. For Standard V, all CMOs were required to update all applicable documents, including the member handbook and policies/procedures, to include complete and consistent definitions of terms and a description of the processes and timelines related to grievances and administrative reviews. Additionally, all CMOs were required to include information about the member grievance system in all appropriate provider materials.

Summary

Overall, the CMOs' performance related to the quality domain was mixed, with all CMOs demonstrating fairly consistent and strong performance on two of the four standards but diverse and moderate performance on the other two standards. All CMOs demonstrated excellent performance for Standard III—Member Rights and Protection (100 percent). Strong statewide performance of 97 percent for Standard I—Provider Selection, Credentialing, and Recredentialing, was also noted, with two CMOs achieving full compliance scores and one achieving 90 percent. However, statewide performance on the other two standards addressing the quality domain (i.e., Standard II—Subcontractual Relationships and Delegation, and Standard V—Grievance System, reflected considerable variation in CMO compliance scores, with scores for two CMOs falling below 93 percent for Standard II and scores for all three CMOs falling below 91 percent for Standard V. Statewide performance on standards related to the access domain (Standards IV and VI) was moderately good, with overall compliance scores of 89 percent and 94 percent, respectively. For Standard IV—Member Information, none of the CMOs achieved a compliance score of greater than 93 percent. CMO variation in compliance scores was the greatest for Standard VI—Disenrollment Requirements and Limitations, which had a difference in compliance scores of 19 percentage points (i.e., from 81 percent for one CMO to 100 percent for the other two CMOs). These results demonstrate inconsistent CMO performance and suggest the need for CMO-specific and targeted improvement actions for these standards. Lastly, only one standard (Standard V—Grievance System) was related to the timeliness domain. With all three CMOs scoring no greater than 90 percent, statewide performance highlights the need for DCH and the CMOs to collaborate in:

- Exploring root causes to identify the CMOs' barriers to performing at a higher level.
- Ensuring that the DCH contract with the CMOs clearly and consistently reflects the terminology and requirements of the applicable CMS federal Medicaid managed care regulations related to member grievances, appeals, and requests for State administrative law hearings.
- Ensuring that the CMOs design and implement rapid-cycle performance improvement initiatives to ensure that their documentation and actions are consistent and compliant with the DCH and CMS requirements.

Validation of Performance Improvement Projects

Table 8-2 presents the overall CMO performance results for each of the six PIPs HSAG validated for each CMO and the overall PIP results at the statewide level. With an overall score of 99 percent for the 18 PIPs, the Georgia Families CMOs demonstrated a high level of success on their second-year submissions. All CMOs received a *Met* status for all of their PIPs, with very little variation among the CMOs in the percentage scores for evaluation elements receiving a score of *Met* (i.e., scores ranged from 98 percent to 99 percent). This finding demonstrated strong performance across all CMOs for all 18 PIPs. The *Well-Child Visits* and *Improving Lead Screening Rates* PIPs—for which the methodology changed from the first- to the second-year submissions—were again designated as first-year PIPs. These two PIPs and the other new first-year PIPs were evaluated through Activity VI per DCH instructions. Only the *Provider Satisfaction* PIPs had progressed through Activity IX.

Table 8-2—Comparison of PIP Validation Status by CMO and Statewide				
	AMERIGROUP	Peach State	WellCare	Statewide
Overall CMO Performance				
Total Percentage Score for Evaluation Elements *Met*	**98%**	**99%**	**98%**	**99%**
Number of PIPs by Validation Status	**6**	**6**	**6**	**18**
Not Met	0	0	0	0
Partially Met	0	0	0	0
Met	6	6	6	18

Table 8-3 compares the overall CMO performance on PIPs submitted previously with the second-year submission for those same PIPs. The table shows that for the three PIPs submitted for the first time during the 2008–2009 submission there was wide variation in CMO performance, ranging from 62 percent to 94 percent. During the current submission year, the quality of these PIPs improved and the variation among the CMOs decreased. The CMOs' overall performance on these PIPs ranged from 98 percent to 99 percent. Although the methodology for the *Improving Lead Screening Rates* and *Well-Child Visits* PIPs changed from HEDIS-like to HEDIS, the comparison of the PIP process between submission years for these PIPs was still valid.

Table 8-3—Comparison of CMO Performance on Select PIPs, by Submission Year[1]						
	AMERIGROUP		Peach State		WellCare	
Submission Year	2008-2009	2009-2010	2008-2009	2009-2010	2008-2009	2009-2010
Overall Performance Score	**62%**	**97%**	**77%**	**99%**	**94%**	**97%**
Provider Satisfaction	79%	93%	73%	98%	91%	93%
Well-Child Visits	50%	100%	79%	100%	96%	100%
Improving Lead Screening Rates	50%	100%	79%	100%	96%	100%

[1] Comparison is limited to PIPs submitted in the first contract year (2008–2009).

Table 8-4 presents the overall statewide and CMO-specific percentages of applicable evaluation elements achieving a *Met* score for all the PIPs, broken down by activity and the three overarching categories (i.e., Study Design, Study Implementation, and Quality Outcomes Achieved).

Table 8-4—Comparison of Performance on PIP Activities I–X (N=18 PIPs)* by CMO and Statewide				
Activities	**AMERIGROUP**	**Peach State**	**WellCare**	**Statewide**
Study Design	**100%**	**100%**	**100%**	**100%**
I. Choose the Study Topic(s)	100%	100%	100%	100%
II. Define the Study Question(s)	100%	100%	100%	100%
III. Select the Study Indicator(s)	100%	100%	100%	100%
IV. Use a Representative and Generalizable Study Population	100%	100%	100%	100%
Study Implementation	**100%**	**100%**	**100%**	**100%**
V. Use Sound Sampling Techniques (N=5)	100%	100%	100%	100%
VI. Use Valid and Reliable Data Collection Procedures	100%	100%	100%	100%
VII. Include Improvement Strategies (N=3)	100%	100%	100%	100%
Quality Outcomes Achieved (N=3)	**77%**	**92%**	**77%**	**82%**
VIII. Data Analysis and Interpretation of Study Results	78%	100%	100%	93%
IX. Assess for Real Improvement	75%	75%	25%	58%
X. Assess for Sustained Improvement **	--	--	--	--
* All 18 PIPs were assessed for each activity unless otherwise noted. ** No PIPs were assessed for this activity.				

Strengths

Based on the CMOs' performance in conducting these PIPs, HSAG was confident that the reported results were valid. All 18 PIPs submitted this year achieved a *Met* validation status, indicating that they were likely to improve the health and functional status of members, member satisfaction, and provider satisfaction. Results from Table 8-2 and Table 8-3 show that the Georgia Families CMOs not only exhibited improvements in conducting and documenting PIPs since their first-year submissions, but also applied lessons learned from existing PIPs to new PIPs submitted in the second year. This is particularly evident since all the CMOs' PIPs received a *Met* score across all applicable evaluation elements for Activity I through Activity VI.

Opportunities for Improvement and Recommendations

Despite the strengths identified and most notable in the study design and study implementation activities, HSAG did note some opportunities for improvement. For all the applicable evaluation elements not achieving a *Met* score or receiving a *Point of Clarification*, HSAG recommends that the CMOs review the specific comments and recommendations HSAG described in its individual CMO PIP reports and make the suggested changes prior to the next submission. HSAG also recommends that DCH hold the CMOs accountable for making these changes to improve their PIP performance.

Not all the PIPs progressed to the stage at which baseline and remeasurement results could be compared and evaluated. Of those that progressed to the activities related to quality outcomes achieved (i.e., Activities VIII–X), there was some variation in CMO performance. The CMOs should focus on improving their documentation of PIPs, especially for Activity IX—Assess for Real Improvement, as the overall scores for this activity ranged from 25 percent to 75 percent. The

CMOs should carefully review each PIP across all activities before submission to ensure the consistency of statements throughout the PIP and that results and processes are included correctly in the PIP Summary Form when working with vendors.

Summary

This year's CMO PIP performance demonstrated strengths, with impressive improvement from the prior year's submission. Overall performance for PIPs submitted the first year improved substantively for the current submission. New PIPs submitted this year also received satisfactory validation results.

Nonetheless, the CMOs' processes for conducting and documenting valid PIPs have room for improvement, especially as more PIPs will progress to the results comparison stage. For each PIP validated, HSAG identified and documented in its reports the areas in which the CMOs could improve their PIP processes and recommended ways to strengthen the current PIP structure and achieve improvement across all study indicators. HSAG also recommended that DCH continue to hold the CMOs accountable for making these changes to improve their PIP performance.

While the primary purpose of HSAG's PIP validation methodology was to evaluate the validity and quality of processes for conducting PIPs, HSAG recognizes that the CMOs' PIPs contained study indicators related to access to, and the quality and timeliness of, member care and services. More specifically, all 18 PIPs provided an opportunity for the CMOs to improve the quality of care and outcomes for their members. In addition to improving quality of care, the *Access/Service Capacity*, *Provider Satisfaction*, and *Member Satisfaction* PIP study indicators were also designed to improve members' access to care. The *Member Satisfaction* PIP was the only one to contain study indicators intended to address timeliness of care.

Validation of Performance Measures

Table 8-5 presents the rates for the four hybrid and two administrative-only performance measures for the Georgia Families CMOs. Four of the six performance measures reported for the first time in the current measurement year were: *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Childhood Immunization Status—Combination 2*, *Lead Screening in Children*, and *Adults' Access to Preventive/Ambulatory Health Services*.

For five of the measures (i.e., *Comprehensive Diabetes Care—HbA1c Testing*, *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Childhood Immunization Status—Combination 2*, *Use of Appropriate Medications for People with Asthma*, and *Lead Screening in Children*), the CMOs reported that they had calculated the rates using different populations, as described in the footnotes to Table 8-5 below. For most measures, the reported rates for these measures were not comparable across CMOs, and statewide rates were not calculated.

Statewide rates were calculated for the two administrative-only measures and the *Comprehensive Diabetes Care—HbA1c Testing* hybrid measure. For the *Comprehensive Diabetes Care—HbA1c Testing* measure, because the number of PeachCare for Kids members who qualified for the age requirement for this measure (i.e., 18 years of age or older) would be small, Peach State's exclusion of this population from the measure should not substantially affect the statewide rate. Statewide

rates were not calculated, however, for the other three hybrid measures since the CMOs used different populations.

Table 8-5—Performance Measure Results Statewide and by CMO

	Indicator	AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia, Inc.	Statewide
1.	*Comprehensive Diabetes Care—HbA1c Testing*	74.50%	64.23% [a]	72.26%	70.46% [b]
2.	*Use of Appropriate Medications for People With Asthma*	91.84%	91.12% [a]	90.58%	91.09%
3.	*Well-Child Visits in the First 15 Months of Life—Six or More Visits*	62.25%	51.58% [a]	57.42% [c]	*Not Calculated* [c]
4.	*Childhood Immunization Status—Combination 2*	29.84% [d]	62.77% [a]	75.91%	*Not Calculated* [e]
5.	*Lead Screening in Children*	68.21%	57.18% [a]	65.94%	*Not Calculated* [f]
6.	*Adults' Access to Preventive/Ambulatory Health Services*				
	20 to 44 Years of Age	81.20%	78.88%	78.64%	79.19%
	45 to 64 Years of Age	86.29%	80.98%	84.58%	83.91%

[a] The rate represents only the Georgia Medicaid population; the PeachCare for Kids population was not included.

[b] Because the number of PeachCare for Kids members who qualified for the age requirement of this measure (i.e., 18 years of age or older) would be small, Peach State's exclusion of this population from this measure should not substantially affect the statewide rate.

[c] The statewide rate was not calculated because WellCare calculated the measure based on a different time frame for medical record procurement. The CMO did not start to collect medical records for the measure until summer 2009. Peach State did not include PeachCare for Kids data in its calculation of this measure.

[d] AMERIGROUP reported the measure using the administrative method (i.e., no medical record review was conducted).

[e] The statewide rate was not calculated because AMERIGROUP reported the administrative-only rate while WellCare reported the hybrid rate. Peach State did not include PeachCare for Kids in its calculation of this measure.

[f] The statewide rate was not calculated because Peach State did not include PeachCare for Kids in its calculation of this measure.

Strengths

Overall, all CMOs achieved acceptable performance for data integration and data control, and the CMOs' performance indicator documentation was also acceptable. This year's performance measure validation process and results suggested that by contracting with the same medical record procurement organization, all three CMOs demonstrated excellent processes for medical record abstraction. In addition, all three CMOs had sufficient processes in place for processing claims, enrollment, and provider data and started using NCQA-certified software vendors to generate the HEDIS rates.

With the rates for all three CMOs above 90 percent, statewide performance on the *Use of Appropriate Medications for People With Asthma* measure was strong. The statewide rate (91.1 percent) almost reached the national HEDIS 2008 Medicaid 90th percentile (91.9 percent).

Opportunities for Improvement and Recommendations

While all of the CMOs demonstrated valid and appropriate processes related to performance measures, HSAG identified opportunities for improvement in lower-performing measures. Recommendations specific to each CMO are presented in Section 6 of this report (i.e., the Findings section).

The statewide rate for *Comprehensive Diabetes Care—HbA1c Testing* presented an opportunity for improvement, with a rate ranking between the national HEDIS 2008 Medicaid 10th and 25th percentiles. Because the number of PeachCare for Kids members who qualified for the age requirement of this measure (i.e., 18 years of age or older) would be small, Peach State's exclusion of this population from the measure should not substantially affect the statewide rate. With its ranking between the national HEDIS 2008 Medicaid 25th and 50th percentiles, statewide performance on the *Adult's Access to Preventive/Ambulatory Health Services* measure (79.19 percent for the 20-to-44-year-old age group and 83.91 percent for the 45-to-64-year-old age group) presented opportunities for improvement. Two of the CMOs consistently reported lower rates on the two *Adults' Access* measures. For the 45-to-64-year-old age group, the difference between the low-performing CMO (80.98 percent) and high-performing CMO (86.29 percent) was 5.31 percentage points. The CMOs should initiate aggressive performance improvement efforts related to these measures to ensure that in future submissions, their rates meet the applicable DCH performance targets.

Summary

All of the CMOs generally demonstrated strong processes, including data control and integration and performance indicator documentation, related to performance measures. For one CMO, HSAG identified a few recommendations for improving its performance measure processes.

HSAG also reviewed the CMOs' performance on the indicators related to quality, access, and timeliness. All of the performance measures were related only to quality, except for the *Adults' Access to Preventive/Ambulatory Health Services* measure, which was also related to access. No measures were related to the timeliness domain. Since the CMOs used different data collection methodologies (i.e., administrative vs. hybrid) to generate their measures, statewide performance could only be summarized and discussed for the *Comprehensive Diabetes Care—HbA1c Testing*, the *Use of Appropriate Medications for People With Asthma*, and the *Adults' Access to Preventive/Ambulatory Health Services* measures. Statewide performance varied for these three quality measures. The results for the *Comprehensive Diabetes Care—HbA1c Testing* measure ranked between the 10th and 25th national HEDIS 2008 percentiles. The results for the *Use of Appropriate Medications for People With Asthma* measure almost reached the national 2008 HEDIS 90th percentile (91.9 percent), and results for the *Adults' Access* measure fell below the 50th percentile for both age groups. In addition to the *Comprehensive Diabetes Care—HbA1c Testing* measure, since the *Adults' Access* measure also represented statewide performance related to access to care and services, the Georgia Families CMOs should focus on improving their rates for both of these measures. For future performance measure reporting, DCH has clarified the populations to be included, which will allow for comparison across the CMOs.

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Appendix A. Reviewing Compliance With Operational Standards

The following description of the manner in which HSAG conducted—in accordance with 42 CFR 438.358—the external quality review of compliance with standards for the DCH Georgia Families CMOs addresses HSAG's:

- Objective for conducting the reviews.
- Activities in conducting the reviews.
- Technical methods of collecting the data, including a description of the data obtained.
- Data aggregation and analysis processes.
- Processes for preparing the draft and final reports of findings.

HSAG followed standardized processes in conducting the review of each CMO's performance.

Conducting the Activity

To accomplish its objective, and based on the results of its collaborative planning with DCH, HSAG developed and used a data collection tool to assess and document the CMOs' compliance with certain federal Medicaid managed care regulations, State rules, and the associated DCH contractual requirements. The review tool included requirements that addressed the following six performance areas:

- Standard I—Provider Selection, Credentialing, and Recredentialing
- Standard II—Subcontractual Relationships and Delegation
- Standard III—Member Rights and Protections
- Standard IV—Member Information
- Standard V—Grievance System
- Standard VI—Disenrollment Requirements and Limitations

HSAG also evaluated how the CMOs implemented a number of the requirements by using work sheets to review the CMOs' records/files associated with the requirements. HSAG used the work sheets to review a sample of the CMOs' provider credentialing and recredentialing files and a sample of member grievances, including associated documentation of the CMOs' decisions/actions and correspondence. HSAG reviewers also reviewed a sample of each CMO's fully executed contracts/agreements for delegation of its administrative functions.

The 2009–2010 review was the second year of a three-year cycle of compliance reviews that the EQRO will conduct for the CMOs under its contract with DCH.

HSAG's Objective for Conducting the Review

The primary objective of HSAG's review was to provide meaningful information to DCH and the CMOs. DCH and the CMOs will use the information and findings that resulted from HSAG's review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

HSAG assembled a team to:

- Collaborate with DCH to determine the scope of the review as well as the scoring methodology, data collection methods, schedules for the desk review and on-site review activities, and agenda for the on-site review.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the report of its findings.

HSAG's Methodology for Conducting the Review

Before beginning the compliance review, HSAG developed a data collection tool to guide and document the review. The requirements in the tool were selected based on applicable federal and State regulations and laws, and on the requirements set forth in the contract between DCH and the CMOs as they related to the scope of the review.

HSAG also followed the guidelines set forth in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al, for the following activities.

Pre-on-site review activities included:

- Developing the compliance review tool and associated reviewer work sheets.
- Preparing and forwarding to the CMOs a customized desk review form and instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the on-site review agendas for each day of the two-day on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to the CMOs to facilitate their preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DCH, and of documents the CMOs submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMOs' operations, identify areas needing clarification, and begin compiling information before the on-site review.

On-site review activities: HSAG reviewers conducted on-site reviews, which included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.
- A review of the documents HSAG requested that the CMOs have available on-site.
- Interviews conducted with the CMOs' key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

HSAG documented its findings in the data collection (compliance review) tool, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the CMOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Table A-1 presents a more detailed, chronological description of the above activities that HSAG performed throughout its review.

Table A-1—Compliance Review Activities HSAG Performed

For this step,	HSAG…
Step 1:	**Established the review schedule.**
	Before the review, HSAG coordinated with DCH and the CMOs to set the schedule and assigned HSAG reviewers to the review team.
Step 2:	**Prepared the data collection tool for reviewing the six standards and submitted it to DCH for review and comment.**
	To ensure that all applicable information was collected, HSAG developed a compliance review tool consistent with CMS protocols. HSAG used the requirements in the contract between DCH and the CMOs to develop the standards (groups of requirements related to broad content areas) to be reviewed. HSAG also used the federal Medicaid managed care regulations described at 42 CFR 438, with revisions issued June 14, 2002, and effective August 13, 2002. Additional criteria used in developing the monitoring tool included applicable State and federal requirements. Prior to finalizing the tool, HSAG submitted the draft to DCH for its review and comments.
Step 3:	**Prepared and submitted the Desk Review Form to the CMOs.**
	HSAG prepared and forwarded a Desk Review Form to the CMOs and requested that they submit specific information and documents to HSAG within a specified number of days of the request. The Desk Review Form included instructions for organizing and preparing the documents related to the review of the six standards, submitting documentation for HSAG's desk review, and having additional documents available for HSAG's on-site review.
Step 4:	**Forwarded a Documentation Request and Evaluation Form to the CMOs.**
	HSAG forwarded to the CMOs, as an attachment to the Desk Review Form, a Documentation Request and Evaluation Form containing the same standards and DCH contractual requirements as the tool HSAG used to assess the CMOs' compliance with each of the requirements within the standards. The Desk Review Form included instructions for completing the "Evidence/Documentation as

Table A-1—Compliance Review Activities HSAG Performed	
For this step,	**HSAG…**
	Submitted by the CMO" portion of this form. This step: (1) provided the opportunity for the CMOs to identify for each requirement the specific documents or other information that provided evidence of their compliance with the requirement and (2) streamlined the ability of HSAG's reviewers to identify all applicable documentation for their review.
Step 5:	**Developed a compliance monitoring on-site review agenda and submitted it to the CMOs.**
	HSAG developed an agenda to assist the CMOs' staff members in planning for their participation in HSAG's on-site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective on-site review and minimizing disruption to an organization's day-to-day operations. An agenda sets the tone and expectations for the on-site review so that all participants understand the process and time frames.
Step 6:	**Provided orientation for the CMOs**
	If requested by a CMO, HSAG staff members conducted an orientation for the CMO to preview HSAG's 2009–2010 desk and on-site review processes and to respond to any questions from the CMO staff members.
Step 7:	**Responded to the CMOs' questions related to the review and provided any other needed information before the on-site reviews.**
	Prior to conducting the on-site reviews, HSAG maintained contact with the CMOs as needed to answer questions and provide information to key management staff members. This telephone and/or e-mail contact gave the CMOs' representatives the opportunity to request clarification about the request for documentation for HSAG's desk review and the on-site review processes. HSAG communicated regularly with DCH about its discussions with the CMOs and its responses to the CMOs' questions.
Step 8:	**Received the CMOs' documents for HSAG's desk review and evaluated the information before conducting the on-site reviews.**
	HSAG reviewers used the documentation received from the CMOs to gain insight into the organizations' structure, provider network, services, operations, resources, and delegated functions, if applicable, and to begin compiling the information and preliminary findings before the on-site portion of the review. During the desk review process, reviewers: ◆ Documented findings from the review of the materials submitted by the CMOs as evidence of their compliance with the requirements. ◆ Identified areas and issues requiring further clarification or follow-up during the on-site interviews. ◆ Identified information not found in the desk review documentation to be requested during the on-site reviews.
Step 9:	**Received from the CMOs lists of providers credentialed and recredentialed and a list of member grievances.**
	The Desk Review Form provided the CMOs with the purpose, timelines, and

Table A-1—Compliance Review Activities HSAG Performed	
For this step,	**HSAG…**
	instructions for submitting lists of providers credentialed and recredentialed during the time period specified and a list of member grievances received during the time period specified. From the lists, HSAG selected a sample of 10 and an oversample of 5 unduplicated records. Fourteen days prior to each CMO's on-site review, HSAG posted the applicable list of records that the CMO was to have available for HSAG's review when on-site. HSAG also reviewed a sample of the CMOs' fully executed written delegation agreements selected from lists the CMOs submitted.
Step 10:	**Conducted the on-site portion of the review.**
	During the on-site review, staff members from the CMOs were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. HSAG's activities completed during the on-site review included the following: ◆ Conducted an opening conference that included introductions, HSAG's overview of the on-site review process and schedule, the CMOs' overview of their structure and processes, and a discussion about any changes needed to the two-day agenda and general logistical issues. ◆ Conducted interviews with the CMOs' staff. HSAG used the interviews to obtain a complete picture of the CMOs' compliance with federal Medicaid managed care standards and associated DCH contract requirements, explore any issues not fully addressed in the documents that HSAG had reviewed, and increase HSAG reviewers' overall understanding of the CMOs' performance. ◆ Reviewed additional documentation while on-site and used the review tool to identify relevant information sources and to document its review findings. Documents reviewed on-site included written policies and procedures, minutes of key committee or other group meetings, data and reports across a broad range of areas, provider credentialing and recredentialing files, member grievances, and delegation agreements. Reviewers used standardized work sheets to document their findings regarding requirements for the CMOs' processes, actions, and correspondence associated with provider credentialing and recredentialing and with processing and responding to member grievances. Reviewers used the completed work sheets as a source of information to arrive at their findings and to assign scores for the associated requirements in the compliance review tool. ◆ Summarized findings at the completion of the on-site portion of the review. As a final step, HSAG conducted a closing conference the last day of the on-site reviews to provide the CMOs' staff members with a high-level summary of HSAG's preliminary findings. For each of the six standards, the findings included HSAG's assessment of an organization's strengths and, when applicable, the areas requiring corrective action.
Step 11:	**Calculated the individual scores and determined the overall compliance score for the CMOs' performance.**
	HSAG evaluated the CMOs' performance in complying with the requirements in each of the six standards contained in the review tool. HSAG analyzed the information to determine the CMOs' performance for each of the requirements in the six standards. HSAG used *Met*, *Partially Met*, and *Not Met* scores to

Table A-1—Compliance Review Activities HSAG Performed	
For this step,	**HSAG…**
	document the degree to which the organizations complied with each of the requirements. A designation of *NA* (*Not Applicable*) was used if an individual requirement did not apply to the CMOs during the period covered by the review.
Step 12:	**Prepared a report of findings and required corrective actions.**
	After completing the documentation of findings and scoring for each of the six standards, HSAG prepared a draft report for each of the CMOs that described HSAG's compliance review findings, the scores it assigned for each requirement within the six standards, and HSAG's assessment of the CMO's strengths and any areas requiring corrective action. HSAG forwarded the reports to DCH and the CMOs for their review and comment. Following DCH's approval of the draft report, HSAG issued the final reports to DCH and the CMOs.

Technical Methods of Collecting the Data, Including a Description of the Data Obtained

To assess the CMOs' compliance with federal regulations, State rules, and DCH contract requirements, HSAG obtained information from a wide range of written documents produced by the CMOs, including the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- The provider manual and other CMO communication to providers/subcontractors
- The member handbook and other written informational materials
- Narrative and/or data reports across a broad range of performance and content areas

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the CMOs' key staff members.

Table A-2 lists the major data sources HSAG used in determining the CMOs' performance in complying with requirements and the time period to which the data applied.

Table A-2—Description of the CMOs' Data Sources	
Data Obtained	**Time Period to Which the Data Applied**
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	October 31, 2008, through the last day of the on-site review
Information obtained through interviews	October 31, 2008, through the last day of the on-site review
List of providers credentialed and recredentialed	March 1, 2009–August 31, 2009
List of member grievances	January 1, 2009–June 30, 2009

Aggregating and Analyzing the Data and Information Collected

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the CMOs' performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a CMO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al, dated February 11, 2003. The protocol describes the scoring as follows:

Met indicates full compliance defined as both of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance defined as either of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.

Not Met indicates noncompliance defined as either of the following:

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (0 points), and *Not Applicable* (0 points) and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the six standards by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the result by the total number of applicable requirements).

To draw conclusions about the quality and timeliness of, and access to, care and services the CMOs provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the CMOs' performance in complying with each of the requirements.
- Scores assigned to the CMOs' performance for each requirement.
- The total percentage-of-compliance score calculated for each of the six standards.

- The overall percentage-of-compliance score calculated across the six standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Partially Met* or *Not Met*.

Processes for Preparing the Draft and Final Reports of Findings

Based on the results of the data aggregation and analysis, HSAG prepared a draft report of its external quality review of compliance findings for each of the CMOs. The reports described the CMOs' strengths and, when applicable, actions required to bring their performance into compliance with the requirements. Each report also included as an attachment the compliance review tool HSAG used to evaluate the CMO's performance and to document its findings and the performance scores it assigned for each requirement. HSAG forwarded the draft reports to DCH and to the CMOs for their review and comment prior to preparing and issuing the final reports.

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Appendix B. Validating Performance Improvement Projects (PIPs)

Conducting the Activity

DCH required each CMO to conduct PIPs in accordance with 42 CFR 438.240. The purpose of PIPs is to achieve—through ongoing assessments, measurements, and interventions—improvement sustained over time in clinical and nonclinical areas. As one of three mandatory EQR activities under the BBA, Public Law 105-33, the State is required to annually validate the PIPs conducted by its contracted Medicaid managed care organizations. To meet this requirement for the CMOs, DCH contracted with HSAG to validate the CMOs' PIPs. The PIP validation focused on services provided to the CMOs' Medicaid and PeachCare for Kids™ (CHIP) members DCH selected the six performance improvement projects HSAG validated for each CMO. Each CMO submitted the following PIPs:

- *Access/Service Capacity*
- *Childhood Immunization*
- *Improving Childhood Lead Screening Rates*
- *Member Satisfaction*
- *Provider Satisfaction*
- *Well-Child Visits during the First 15 Months of Life With Six or More Visits*

This was the second year the CMOs submitted PIPs to DCH and to HSAG for validation. Due to the DCH-directed realignment of measurement parameters from HEDIS-like criteria to the *HEDIS 2009 Technical Specifications*, a new baseline was established for each PIP (except for the *Provider Satisfaction* PIP). With this change, HSAG validated Activities I through VI for the second contract year of the PIP validation cycle for the PIPs that changed to HEDIS measures. For the *Provider Satisfaction* PIP, HSAG validated Activities I–IX.

HSAG's Objective for Validating the PIPs

The primary objective of PIP validation was to determine each CMO's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

HSAG's Methodology for Validating the PIPs

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The

methodology used to validate PIPs was based on CMS guidelines as outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002. Using this protocol, HSAG, in collaboration with DCH, developed a PIP Summary Form to ensure uniform validation of PIPs. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

With DCH input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. Using this tool, HSAG reviewed each PIP to the appropriate point of progression following the CMS PIP validation protocol steps:

- Step I. Review the Selected Study Topic(s)
- Step II. Review the Study Question(s)
- Step III. Review the Selected Study Indicator(s)
- Step IV. Review the Identified Study Population
- Step V. Review Sampling Methods
- Step VI. Review the MCO's/PIHP's Data Collection Procedures
- Step VII. Assess the MCO's/PIHP's Improvement Strategies
- Step VIII. Review Data Analysis and the Interpretation of Study Results
- Step IX. Assess for Real Improvement
- Step X. Assess for Sustained Improvement

HSAG obtained the data needed to conduct the PIP validation from the CMO's PIP Summary Form. This form provided detailed information about each CMO's PIPs related to the activities completed and evaluated for the 2009–2010 validation cycle.

Each required protocol step consisted of evaluation elements necessary to complete a valid PIP. The HSAG PIP Review Team scored evaluation elements within each step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All of the critical elements had to be *Met* for the PIP to produce valid and reliable results. Given the importance of critical elements to this scoring methodology, any critical element that received a *Not Met* score resulted in an overall validation rating for the PIP of *Not Met*. A CMO would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*.

HSAG documented a *Point of Clarification* in its reports when documentation for an evaluation element included the basic components to meet requirements for the evaluation element, but enhanced documentation would demonstrate a stronger understanding of the CMS protocol.

In addition to the validation status (e.g., *Met*) each PIP was given an overall percentage score for all evaluation elements (including critical elements). HSAG calculated the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the study's findings on the validity and reliability of the results with one of the following three determinations of validation status:

- *Met*: High confidence/confidence in the reported PIP results.
- *Partially Met*: Low confidence in the reported PIP results.
- *Not Met*: Reported PIP results that were not credible.

After completing the validation review, HSAG prepared a 2009–2010 PIP validation report of its findings and recommendations for each CMO's PIPs. These reports, which complied with 42 CFR 438.364, were forwarded to DCH for comment and approval. The final 2009–2010 PIP validation reports were then sent to the applicable CMOs. In addition, HSAG prepared and submitted to DCH an annual summary PIP report with aggregate statewide results and recommendations.

HSAG anticipates that as the PIPs progress, the CMOs will submit a revised PIP Summary Form that includes additional information to address any *Points of Clarification* and any critical and noncritical areas scored as *Partially Met* or *Not Met*.

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Appendix C. Validating Performance Measures (PMs)

Conducting the Activity

As set forth at 42 CFR 438.358, validation of performance measures is one of three mandatory EQR activities that the BBA requires state Medicaid agencies to perform. HSAG, the EQRO for DCH, conducted the validation activities. For the current review period, DCH contracted with three CMOs to provide all services to the Medicaid managed care-eligible population. DCH identified a set of performance measures (indicators) that the CMOs calculated and reported for validation. HSAG conducted the validation activities as outlined in the CMS publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities,* Final Protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol).

HSAG's Objectives for Validating the Performance Measures

The primary objectives of HSAG's performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected by the CMOs.
- Determine the extent to which the specific performance measures calculated by the CMOs (or on behalf of the CMOs) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

HSAG validated a set of performance indicators that DCH developed and selected for HSAG's validation. DCH also specified the reporting cycle and review period for each indicator. The performance indicators were reported and validated for calendar year (CY) 2008 (January 1, 2008, through December 31, 2008) CMO data.

HSAG's Methodology for Validating the Performance Measures

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS Performance Measure Validation Protocol as well as in the NCQA *HEDIS Compliance Audit™: Standards, Policies, and Procedures*, Volume 5. HSAG obtained a list of the indicators that DCH selected for validation. DCH also provided the indicator reporting templates for review by the HSAG validation team.

HSAG prepared a document request letter that was submitted to each CMO outlining the steps in the performance measure validation process. The document request letter included a request for each CMO's HEDIS Roadmap, source code for each performance measure, the final audit reports from previous HEDIS audits, and any additional supporting documentation necessary to complete the audit. HSAG sent an additional letter to the CMOs describing the medical record over-read process for the hybrid measures. This letter requested that each CMO submit numerator-positive

case listings for the two selected over-read measures. HSAG responded to the CMO's Roadmap and medical record-related questions during the pre-on-site phase.

HSAG prepared an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG forwarded the agendas to the respective CMOs approximately three weeks prior to the on-site visit. When requested, HSAG conducted pre-on-site conference calls with the CMOs to discuss any outstanding Roadmap questions and on-site visit activities.

Technical Methods of Data Collection and Analysis

The CMS Performance Measure Validation Protocol identified key types of data that should be reviewed as part of the validation process. The list below indicates the type of data collected and how HSAG conducted an analysis of this data:

- A *HEDIS Record of Administration, Data Management, and Processes (Roadmap)* was requested and received from each CMO. Upon receipt, HSAG conducted a high-level review of the Roadmaps to ensure that all sections were completed and all attachments were present. The Roadmaps were then forwarded to the validation team for review. The validation team reviewed all Roadmap documents, noting issues or items that needed further follow-up. The review team used information included in the Roadmap to begin completing the review tools, as applicable.
- *Source code (programming language) for performance indicators* was requested. CMOs that calculated the indicators using automated computer code submitted the requested information. During the site visit, the review team completed line-by-line code review and observation of program logic flow to ensure compliance with State indicator definitions. Areas of deviation were identified and shared with the lead auditor to evaluate the impact of the deviation on the indicator and assess the degree of bias (if any). If a CMO contracted with an NCQA-certified software vendor to calculate its performance indicators, submitting source code was not necessary.
- *NCQA HEDIS 2009 Final Audit Reports* were reviewed by the validation team.
- *Supporting documentation* included any documentation that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. The validation team reviewed all supporting documentation, with issues or clarifications flagged for further follow-up.

Description of Data Obtained

As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data as part of the validation of performance measures:

- **HEDIS Record of Administration, Data Management, and Processes (Roadmap)**—HSAG received this tool from each CMO. The completed Roadmap provided HSAG with background information on the CMOs' policies, processes, and data in preparation for the on-site validation activities.

- **Source code (programming language) for performance measures**—HSAG obtained this source code from each CMO (if applicable). HSAG used the code to determine compliance with the performance measure definitions.
- **Previous performance measure reports**—HSAG obtained these reports from each CMO and reviewed the reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—This documentation provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Current performance measure results—**HSAG obtained the calculated results from DCH and each of the CMOs.
- **On-site interviews and demonstrations—**HSAG also obtained information through interaction, discussion, and formal interviews with key CMO staff members, as well as through system demonstrations.

Table C-1 displays the data sources used in the validation of performance measures and the time period to which the data applied.

Table C-1—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
Roadmap (From CMOs)	CY 2008
Source Code (Programming Language) for Performance Measures (From CMOs)	CY 2008
Previous Performance Measure Reports (From CMOs)	CY 2008
Supporting Documentation (From CMOs)	CY 2008
Current Performance Measure Results (From CMOs and DCH)	CY 2008
On-site Interviews and Demonstrations (From CMOs)	CY 2008

On-Site Activities

HSAG conducted on-site visits to each CMO. Information was collected using several methods, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- **Opening meetings**—introductions of HSAG's validation team members and key CMO staff involved in the performance indicator activities. The discussions addressed the purpose of the review, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—included an information systems assessment focusing on the processing of claims and encounter data, member/patient data, and provider data. Additionally, the review evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification and algorithmic

compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

- **Review of Roadmap and supporting documentation**—included a review of the processes used for collecting, storing, validating, and reporting performance indicator data. This session was designed to be interactive with key CMO staff members so the review team could obtain a complete picture of all the steps taken to generate the performance indicators. The goal of the session was to obtain a complete picture of the degree of compliance with written documentation. Interviews were used to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed in daily practice.
- **Medical record review**—included a review of the CMOs' medical record processes. This included a review of the methods for medical record procurement, development and training on medical record abstraction tools, data entry and validation, and oversight of the medical record process.
- **Overview of data integration and control procedures**—included discussion and observation of source code logic and a review of how all data sources were combined and how the analytic file was produced for the reporting of selected performance indicators. Primary source verification was performed to further validate the output files. Backup documentation on data integration was reviewed. Data control and security procedures were also addressed during this session.
- **Closing conference**—summarized preliminary findings based on the review of the Roadmap and the on-site visit, and revisited the documentation requirements for any postvisit activities.

B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.

Respondent and Parent Organization

The Respondent Organization, Amerigroup Louisiana, Inc. is an entity in formation and will be a wholly owned subsidiary of Amerigroup Corporation. **Neither the Respondent nor its Parent Organization has regulatory actions, sanctions or fines to report for the last five years.**

Respondent's Affiliates

Amerigroup Louisiana has existing affiliates in 11 other states delivering services to Medicaid and CHIP enrollees. Participation in health care programs funded through taxpayer dollars inherently brings with it a higher level of scrutiny, accountability and oversight for performance than is typically seen under commercial contracts. As such, and as part of the ordinary course of business, these Affiliates have received notices, sanctions and other regulatory actions related to the numerous requirements of any public program contract. As new programs are launched, the corrective action and sanction process serves to support a meaningful dialogue between the contractor and the State customer and helps to refine both the State Agency's expectations and to target the discussion to those elements that best serve the administration and the members. As programs mature, we find that the dialogue and partnership created in the resolution of differences of opinion and interpretation of requirements helps to strengthen the program and the efficiency of administration and oversight.

Table B-44 provides a description of each of these Affiliates and a summary of their experience related to regulatory or corrective actions and sanctions. All of these Affiliates are subsidiaries of Amerigroup Corporation. We also listed those Affiliates with experience in the last five years which are no longer operational today.

Table B-44. Amerigroup Louisiana Affiliates in 11 Other States

Amerigroup Virginia	Amerigroup Virginia has consistently met performance standards over the last five years. The plan has been subject to two corrective action plans for certain operational standards including network adequacy, credentialing and clinical measures. They have been subject to minimal financial penalties.
Amerigroup Florida	Amerigroup Florida has consistently met performance standards over the last five years. The plan has been subject to two corrective action plans for certain operational standards related to reporting pharmacy encounters and raising clinical quality measures. They have been subject to financial penalties for regulatory reporting, claims processing and clinical quality measures.
Amerigroup New Mexico	Amerigroup New Mexico has consistently met performance standards since its inception in 2008. The plan has been subject to three corrective action plans for certain operational standards, including claims processing and network adequacy. None of these resulted in

	financial penalties or sanctions.
Amerigroup New York	Amerigroup New York has consistently met the 52 performance standards included in the contract over the last five years, with some exceptions. The plan has periodically been subject to corrective action plans related to operational requirements, reporting and other matters. Since 2006, Amerigroup New York has incurred seven financial penalties related to violation of prompt pay rules and deficient audit data.
Amerigroup Georgia	Amerigroup Georgia has consistently met the 29 performance standards included in the contract over the last five years, with some exceptions. They have been subject to corrective action plans related to certain operational requirements, reporting and clinical quality measures. One corrective action also included a financial penalty for the submission of deficient reports. Amerigroup Georgia has incurred minimal financial penalties related to provider data.
Amerigroup Tennessee	Amerigroup Tennessee has met the majority of the 86 performance standards included in the contract over the last five years. Amerigroup Tennessee has periodically been subject to corrective action plans related to certain operational issues, reporting and other matters. Amerigroup Tennessee has periodically been assessed financial penalties. Due to a commitment to improved performance and through various operational improvements, the majority of financial penalties assessed were related to the claim processing performance of a subcontracted transportation vendor, provider data accuracy and errors in member appeal notices required by a federal consent decree.
Amerigroup Maryland	During the 10 years of the current contract, Amerigroup Maryland has consistently met the 27 performance standards, with minimal exceptions. Amerigroup Maryland has periodically been subject to corrective action plans related to certain operational matters. Since the start of the contract term in January 2000, Amerigroup Maryland has averaged less than one penalty per year. Financial penalties assessed against Amerigroup Maryland primarily have been related to value-based purchasing standards. Amerigroup Maryland also had a contract with the DC Medical Assistance Agency to serve Medicaid members in Washington, DC which was in place until 2008. Amerigroup Maryland consistently met the 25 performance standards in the contract. The plan was subject to certain operational notices of deficiencies related to encounter submission, reporting requirements and network adequacy. However, no financial penalties were levied for these deficiencies. One additional deficiency was noted which included financial penalties related to the provision of 72-hour supply of medication. While the plan was awarded a new contract during the reprocurement, Amerigroup decided not to continue its DC operation.
Amerigroup New Jersey	Amerigroup New Jersey has consistently met the 42 performance standards over the last five years, with minimal exceptions. During the 10 years of the current contract term, Amerigroup New Jersey has periodically been subject to corrective action plans related to certain operational requirements, reporting and other matters. Since the start of the current contract in October 2000, Amerigroup New Jersey has averaged two financial penalties per year. Past penalties primarily have been related to failure to meet specified Early Periodic Screening, Diagnosis, and Treatment standards; encounter data processing; and medical cost-ratio standards.

Amerigroup Nevada	Amerigroup Nevada has consistently met operational standards since its inception in 2009. The plan has been subject to five corrective action plans related to issues associated with the former dental vendor's outreach practices. Due to these issues, Amerigroup terminated the contract and has replaced the vendor with the material subcontractor included with this proposal. Minimal financial penalties have been levied for late payment of administrative fee.
Amerigroup Ohio	Amerigroup Ohio is currently meeting the majority of the 43 performance standards included in the contract. Over the last five years, Amerigroup Ohio has periodically been subject to corrective action plans related to certain operational issues, reporting and other matters. Additionally, Amerigroup Ohio has periodically been assessed financial penalties. Due to a commitment to improved performance and through various operational improvements, the plan has reduced their deficiencies substantially. The majority of financial penalties assessed were related to the complaint/appeal processing and network adequacy.
Amerigroup South Carolina	During its period of operation from 2007 through 2009, Amerigroup South Carolina consistently met the 23 performance standards included in the contract and received no corrective actions or sanctions.
Amerigroup Illinois	Amerigroup Illinois has no sanctions, regulatory actions or deficiencies to report for the last five years.
Amerigroup Texas	Amerigroup Texas is currently meeting the majority of then 93 performance standards included in the contract and has established a track record of resolving deficiencies promptly. In fact, the Texas health plan has reduced liquidated damages by over 80 percent since 2007 by working closely with the State Agency, the Texas Health and Human Services Commission. The health plan has continued to refine and improve interpretation and adherence to HHSC's expectations, establishing a more effective partnership serving Medicaid members. Over the course of the current contract period beginning in November 2005, Amerigroup Texas has been subject to corrective action plans related to certain operational requirements related to complaint/appeals processing, claims process, regulatory reporting and other matters. During the past five years of the current contract period, Amerigroup Texas has periodically incurred financial penalties for claims processing, complaint and appeals reports and other matters that amount to less than one tenth of one percent of premium.

Amerigroup Louisiana will draw on the experience of these Affiliates for best practices in serving Medicaid members and their State customer. For example, Amerigroup recommends that DHH consider a model of transparency of operations and accountability as established by the Texas Health and Human Services Commission (HHSC). HHSC publishes on the web the liquidated damages of all of its contractors on a periodic basis offering all stakeholders an opportunity to understand how contractors are performing and to engage in an informed dialogue with the State about refinements and/or program revisions.

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B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.

Criminal or Civil Investigation

AMERIGROUP Louisiana, Inc. is not currently and has never been the subject of a criminal or civil investigation by a state or federal agency.

One health plan affiliated with Amerigroup Louisiana has been the subject of such an investigation within the past five years. In February 2008, Amerigroup Maryland, Inc. received a civil investigative demand ("CID") from the Attorney General for the District of Columbia. The CID stated that the Attorney General was investigating whether Amerigroup Maryland had violated the provisions of D.C. Official Code Section 2-308.14. Amerigroup Maryland provided documents in response to the CID. On March 28, 2008, the District of Columbia filed a Complaint in the Superior Court of the District of Columbia alleging a violation of the aforementioned code section. **On July 22, 2008, the District of Columbia filed a Consent Motion to dismiss the Complaint and the Court dismissed the Complaint on July 24, 2008.**

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B.27 Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:

- ***Your/Subcontractor's name;***
- ***Geographic Service Area(s) for which the reference is being submitted;***
- ***Reference organization's name; and***
- ***Reference contact's name, title, telephone number, and email address.***

b. Send the form to each reference contact along with a new, sealable standard #10 envelope;
c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;
d. Instruct the reference contact to:

- ***Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);***
- ***Sign and date it;***
- ***Seal it in the provided envelope;***
- ***Sign the back of the envelope across the seal; and***
- ***Return it directly to you.***

e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.

THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.

Each completed questionnaire should include:

- ***Proposing Organization/Subcontractor's name;***
- ***GSA (s) for which the reference is being submitted;***
- ***Reference Organization's name;***
- ***Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;***
- ***Date reference form was completed; and***
- ***Responses to numbered items in RFP Attachment # (as applicable).***

DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.

References

As Attachment B.27.a, we have provided the required reference documents in sealed envelopes. The following client references for Amerigroup Corporation and its subsidiaries have completed and submitted the appropriate form RFP Appendix PP:

- Jerry Dubberly, Chief Medicaid Division, Georgia Department of Community Health
- Darin J. Gordon, Executive Director, Tennessee Department of Finance & Administration, Bureau of TennCare
- Mary Mitchell, Manager, Managed Care Program, Virginia Department of Medical Assistance Services
- Patrick Roohan, Director of Quality and Evaluation, New York Department of Health

Amerigroup References

Please see Attachment B.27.a in our **ORIGINAL** proposal for sealed envelopes containing completed reference questionnaires for Amerigroup.

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B.28 Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence (e.g. Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.

Web Sites and Social Media

Amerigroup Louisiana utilizes several web sites and social media sites for the benefit of our members and providers.

Web Sites

Amerigroup Corporation provides a "corporate" web site at www.amerigroupcorp.com, which serves as the primary site for those seeking general information about our company, products and the markets we serve.

The principal web site for members in all Amerigroup health plans is www.myamerigroup.com. From the landing page at this site, our members are either directed to market-specific information or they can register and log in for self-service.

We also offer a suite of tools for providers in our network at www.amerigroupcorp.com/Providers.

Member Site

Our web site at www.myamerigroup.com includes detailed descriptions of our programs and services, a listing of free services and links to area resources – in ***both*** English and in Spanish. Our information is culturally appropriate and geared toward the health needs of our members.

Members may also log in to a secure area of the site where they can access their benefit information. In this section, members may change their demographic information, change their PCP and request a new ID card.

Additionally, we display our current community events for members to see, as we recognize the need for one-on-one interactions and want to encourage members to participate in these free services and events.

Members and visitors also have access to our online provider directory. The provider directory is tied to our core operations system and updated nightly. Any changes made to a provider record are available online through this tool. This ensures the accuracy and timeliness of information being displayed. The provider directory is the most utilized feature of any health care web site. As such, we have worked diligently to simplify the experience and provide sortable search results to ensure our members can find the physician, specialist or facility they need.

The web site also provides detailed information on our health and wellness programs and services and access to Health A to Z by *Healthwise.* Health A to Z is an extensive resource of information related to

health conditions, diseases and wellness. *MedlinePlus,* the most comprehensive library of health information in the country, can also be accessed through the Amerigroup site.

Provider Site

Our web site at www.myamerigroupcorp.com/Providers allows registered providers to access necessary policy and billing information, submit claims, review eligibility and more.

Social Media

Amerigroup Corporation maintains a presence on popular social media sites such as Facebook (http://www.facebook.com/AmerigroupCorporation); Twitter (http://twitter.com/Amerigroup) and YouTube (http://www.youtube.com/AmerigroupCorp). Facebook and Twitter are used to provide information to and solicit feedback from our "followers;" we use YouTube to highlight videos of our "Real Solutions" stories.

B.29 Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals.

Certificate of Authority

Amerigroup Louisiana is licensed to act as a Health Maintenance Organization (HMO) in the State of Louisiana. Amerigroup Louisiana's HMO license is effective as of May 12, 2011.

Amerigroup Corporation, our parent organization, is licensed to act as a Medical Necessity Review Organization in the State of Louisiana. Amerigroup Corporation's MNRO license was effective as of February 10, 2011.

Evidence of these licenses is provided as Attachment B.29.a to this proposal.

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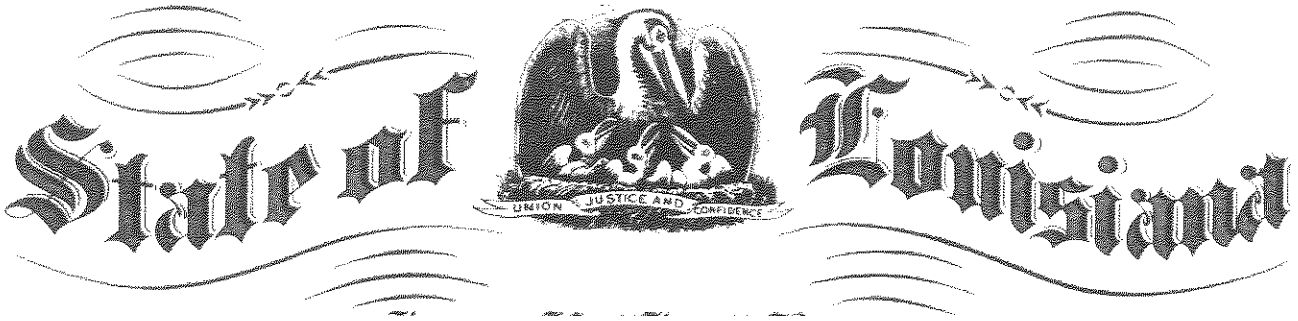

JAMES J. DONELON

COMMISSIONER OF INSURANCE

I, THE UNDERSIGNED **COMMISSIONER OF INSURANCE** OF THE STATE OF LOUISIANA,

DO HEREBY CERTIFY THAT

Amerigroup Louisiana, Inc.
(Trade Name – Amerigroup Community Care)

has complied with all requirements and is hereby licensed to act as a
HEALTH MAINTENANCE ORGANIZATION
in the State of Louisiana
This license shall remain in effect until canceled, suspended, revoked or the renewal thereof refused.

Given Under my signature, authenticated with the impress of my

Seal of office, at the City of Baton Rouge, this 12th day of

May A.D. 2011

James J. Donelon
Commissioner of Insurance

LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

May 16, 2011

Mr. Errol King
450 Laurel St.,
Chase Tower North, 20th Floor
Baton Rouge, LA 70801

RE: Amerigroup Louisiana, Inc.

Dear Mr. King:

This letter is to officially notify you that the application for Certificate of Authority as a health maintenance organization in the State of Louisiana for the above referenced company has been approved effective May 12, 2011.

Please note that the issuance of the Certificate of Authority is not intended as and should not be construed as an approval of any contract forms submitted in association with the application package. You will receive a separate notice regarding the forms as soon as they are in compliance with all applicable Louisiana laws.

The company is approved with a service area as indicated in the submitted application.

I am pleased that you have requested license in Louisiana and am confident that your company will recognize and be responsive to the laws of this State regulating the business of insurance.

I wish you success in the conduct of business in Louisiana and invite you to contact this Department should you have any questions or concerns.

Sincerely,

James J. Donelon
Commissioner of Insurance
State of Louisiana

JD/cs

P. O. BOX 94214 • BATON ROUGE, LOUISIANA 70804-9214
PHONE (225) 342-5900 • FAX (225) 342-3078
http://www.ldi.state.la.us

LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

February 10, 2011

Mark C. Wilson
Amerigroup RealSoultions
C/o Amerisure Corporation
4425 Corporation Lane
Virginia Beach, Virginia 23462

RE: Application to Act as a Medical Necessity Review Organization for Amerigroup Corporation

Dear Mr. Wilson:

The application for licensure as a Medical Necessity Review Organization in the State of Louisiana for the above referenced company has been approved effective February 10, 2011.

Please find enclosed your license authorizing you to act as a Medical Necessity Review Organization in this state. This license shall remain valid for as long as you continue to operate in this state and remain in full compliance with the applicable provisions of the Louisiana Insurance Code.

I wish you success in the conduct of business in Louisiana and invite you to contact this Department if you have any questions or concerns.

Sincerely,

James J. Donelon
Commissioner of Insurance
State of Louisiana

JJD/ts

Attachment

P. O. BOX 94214 • BATON ROUGE, LOUISIANA 70804-9214
PHONE (225) 342-5900 • FAX (225) 342-3078
http://www.ldi.state.la.us

State of Louisiana

James J. Donelon

COMMISSIONER OF INSURANCE

I, THE UNDERSIGNED COMMISSIONER OF INSURANCE OF THE STATE OF LOUISIANA, DO HEREBY CERTIFY THAT

Amerigroup Corporation

has applied for a license and made all filings required of a Medical Necessity Review Organization and is hereby authorized to act as a

MEDICAL NECESSITY REVIEW ORGANIZATION

in this state in accordance with the laws thereof. This license shall continue unless surrendered, revoked, or suspended.

Given Under my signature, authenticated with the impress of my Seal of office, at the City of Baton Rouge, this 10th day of February A.D. 2011

James J. Donelon
Commissioner of Insurance

B.30 Provide the following as documentation of financial responsibility and stability:

- ***a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing;***
- ***two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months;***
- ***a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate; and***
- ***a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars ($500,000.00).***

Financial Responsibility and Stability

We have provided the following documents as Attachments B.30.a through B.30.f:

- A letter from US Bank demonstrating our positive standing
- Letters from vendors that provide positive credit references
- A copy of a valid certificate of insurance for liability insurance in an amount greater than the specified requirement
- A letter of commitment from Wells Fargo Bank for a general line of credit meeting the specified requirement

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usbank

All of **us** serving you™

US Bank Institutional Trust Custody
1021 East Cary St., Suite 1850
Richmond, VA 23219

June 7, 2011

Mr. Nelson L. Murphy, Assistant Treasurer
Amerigroup Corporation
4425 Corporation Lane
Virginia Beach, VA 23462

Re: Amerigroup Louisiana, Inc.

Dear Nelson,

As requested by the Louisiana Department of Insurance, Amerigroup Corporation's Institutional Trust & Custody relationship with US Bank is in positive standing.

Sincerely,

Deitra C. Mitchell
Vice President & Relationship Manager

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PLANIT technology group

June 9, 2011

State of Louisiana

Dear Sir/Madam,

It is with pleasure that PLANIT Technology Group, LLC provide you with this letter of reference on behalf of Amerigroup Corporation.

They have been an outstanding customer of PLANIT Technology for many years. Our partnership with Amerigroup began in 1998 and includes both sales and service related to the Information Technology industry. From a financial standpoint, they have a current credit limit of $1,000,000.00. Terms are net 30 and they are very prompt in their payments.

Please feel free to contact me if you have any further questions or concerns about this customer.

Sincerely,

Elizabeth Deans
Accounts Receivable

100 Landmark Square
Virginia Beach, VA 23452

T: (757) 313-6500 F: (757) 313-6501
Toll Free: 800-761-6898
www.planittech.com

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Electronic Systems

POWERFUL TECHNOLOGY. SMART SOLUTIONS.SM

Main: 757.497.8000
Fax: 757.497.2095
www.esi.net

369 Edwin Drive ▪ Virginia Beach, VA 23462

369 Edwin Drive
Virginia Beach, VA 23462

June 26th 2011

To whom it may concern:
State of Louisiana

Subject: Amerigoup

Amerigroup has been doing business with Electronic Systems, Inc. for over 10 years. Their terms are Net 30 days and they have always paid within these terms. They have had a high credit in excess of $100,000.00 and they are have been extended a $500,000.00 line of credit with Electronic System, Inc. Amerigroup has been a valued customer for a number of years. Their staff is effiencient, courteous, and responsive. We look forward to a long business relationship with them. Should you have any further questions or concerns, please do not hesitate to contact me directly at 757-217-1376.

Sincerely,

Lisa Cahoon
Accounts Receivable Manager
Electronic Systems Inc.

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ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/01/2010

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh Inc.
150 West Main Street
Suite 1650
Norfolk, VA 23510

101015-E&O-E&O-10-11

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:
PRODUCER CUSTOMER ID #:

INSURED
AMERIGROUP Louisiana, Inc.
4425 Corporation Lane
Virginia Beach, VA 23462

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Homeland Insurance Company Of New York	34452
INSURER B : N/A	N/A
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** CLE-002709741-04 **REVISION NUMBER:** 2

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	CLAIMS-MADE / OCCUR						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$
	POLICY / PRO-JECT / LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident)	$
	HIRED AUTOS							$
	NON-OWNED AUTOS							$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DEDUCTIBLE							$
	RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)** N	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Managed Care			MCP 4461-10	10/01/2010	10/01/2011	Limit Each Claim	20,000,000
A	Errors and Omissions Liability			Retention $1,500,000	10/01/2010	10/01/2011	Limit- Aggregate	20,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

Louisiana Department of Insurance
Company Licensing Division
P.O. Box 94214
Baton Rouge, LA 70804-9214

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE of Marsh USA Inc.

Melvy Cokes

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ADDITIONAL INFORMATION

CLE-002709741-04

DATE (MM/DD/YY) 10/01/2010

PRODUCER

Marsh Inc.
150 West Main Street
Suite 1650
Norfolk, VA 23510

101015-E&O-E&O-10-11

INSURERS AFFORDING COVERAGE | **NAIC #**

INSURED

AMERIGROUP Louisiana, Inc.
4425 Corporation Lane
Virginia Beach, VA 23462

INSURER F:	
INSURER G:	
INSURER H:	
INSURER I:	

TEXT

Excess Managed Care E&O
Carrier - Lexington Insurance Co.
Policy #3571-4369
$10,000,000 limit each claim excess of $20,000,000 underlying
Effective 10/01/2010 - 10/01/2011

Excess Managed Care E&O
Carrier - Illinois Union Insurance Co.
Policy #XMS G21816577-004
Limit: $10,000,000 Excess of $30,000,000 Underlying
Effective 10/01/2010 - 10/01/2011

Excess Managed Care E & O
Carrier: Ironshore Specialty Insurance Company
Policy #000725901
Limit: $10,000,000 Excess of $40,000,000 Underlying
Effective: 10/01/2010 - 10/01/2011

CERTIFICATE HOLDER

Louisiana Department of Insurance
Company Licensing Division
P.O. Box 94214
Baton Rouge, LA 70804-9214

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Melvy Cokes

Melvy Cokes

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 03/30/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh USA, Inc.
Three James Center
1051 East Cary Street, Suite 900
Richmond, VA 23219

101015--BASIC-11-12

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:
PRODUCER CUSTOMER ID #:

INSURED
AMERIGROUP Louisiana, Inc.
4425 Corporation Lane
Virginia Beach, VA 23462

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Charter Oak Fire Insurance Company	25615
INSURER B : N/A	N/A
INSURER C : Sentry Insurance A Mutual Co	24988
INSURER D :	
INSURER E :	
INSURER F :	

COVERAGES CERTIFICATE NUMBER: CLE-002972681-06 REVISION NUMBER: 2

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY	X		P630-6108A795-COF-11	04/01/2011	04/01/2012	EACH OCCURRENCE	$ 1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident)	$
	HIRED AUTOS							$
	NON-OWNED AUTOS							$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DEDUCTIBLE							$
	RETENTION $							$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			90-15621-01 AOS	04/01/2011	04/01/2012	X WC STATU-TORY LIMITS OTH-ER	
C	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		90-15621-02 HI, MA, OH, WA	04/01/2011	04/01/2012	E.L. EACH ACCIDENT	$ 500,000
							E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
The certificate holder is an additional insured as respects General Liability Insurance as required by contract.

CERTIFICATE HOLDER

Louisiana Department of Insurance
Company Licensing Division
P.O. Box 94214
Baton Rouge, LA 70804-9214

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Melvy Cokes

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ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 08/06/2010

PRODUCER
Marsh Inc.
150 West Main Street
Suite 1650
Norfolk, VA 23510

101015-Crime-25M-10/11

THIS CERTIFICATION IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED
AMERIGROUP Louisiana, Inc.
4425 Corporation Lane
Virginia Beach, VA 23462

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: Zurich American Insurance Co	16535
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES 3

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS	
		GENERAL LIABILITY				EACH OCCURRENCE	$
		COMMERCIAL GENERAL LIABILITY				DAMAGE TO RENTED PREMISES(Ea occurrence)	$
		CLAIMS MADE / OCCUR				MED EXP (Any one person)	$
						PERSONAL & ADV INJURY	$
						GENERAL AGGREGATE	$
		GENERAL AGGREGATE LIMIT APPLIES PER POLICY / PRO-JECT / LOC				PRODUCTS - COMP/OP AGG	$
		AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident)	$
		ANY AUTO					
		ALL OWNED AUTOS				BODILY INJURY (Per person)	$
		SCHEDULED AUTOS					
		HIRED AUTOS				BODILY INJURY (Per accident)	$
		NON-OWNED AUTOS					
						PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
		ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS / UMBRELLA LIABILITY				EACH OCCURRENCE	$
		OCCUR / CLAIMS MADE				AGGREGATE	$
							$
		DEDUCTIBLE					$
		RETENTION $					$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATU-TORY LIMITS / OTH-ER	
		ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N [N]				E.L. EACH ACCIDENT	$
		(Mandatory in NH) If yes, describe under SPECIAL PROVISIONS below				E.L. DISEASE - EA EMPLOYEE	$
						E.L. DISEASE - POLICY LIMIT	$
A		OTHER FIDELITY BOND	FID 525480506	08/08/2010	11/15/2011	BLANKET EMPLOYEE DISHONESTY	25,000,000

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS
One Year Discovery Period. Deductible - $250,000

CERTIFICATE HOLDER CLE-002606481-01

Louisiana Department of Insurance
Company Licensing Division
P.O. Box 94214
Baton Rouge, LA 70804-9214

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Barbara B. Cannady

Barbara B. Cannady

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IMPORTANT

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If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

This Certificate of Insurance does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

WELLS FARGO

Norfolk Regional Commercial Banking Office
MAC R3586-116
440 Monticello Avenue
Suite 1100
Norfolk, VA 23510

wellsfargo.com

June 14, 2011

Mr. Scott W. Anglin
Senior Vice President & Treasurer
Amerigroup Corporation
4425 Corporation Lane
Virginia Beach, VA 23462

Dear Scott:

Wells Fargo Bank, N.A. ("Bank") is pleased to offer you a commitment to lend based on the following Terms:

Borrower:	Amerigroup Louisiana, Inc.
Amount:	$500,000
Type:	Line of Credit
Maturity:	One year from closing

This letter does not contain all of the terms and provisions, which will be contained in various documents to be executed if the transaction closes. All other terms and conditions to be mutually agreed upon between Bank and Borrower. As a condition to closing the Line of Credit, all documents shall be in form and substance satisfactory to the Bank.

Sincerely,

Jeff Joyce

Jeffrey T. Joyce
Vice President

cc: George G. Ball, III

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B.31 Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required:

- ***The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be:***
  - ***Prepared with all monetary amounts detailed in U.S. currency;***
  - ***Prepared under U.S. generally accepted accounting principles; and***
  - ***Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements.***
- ***The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to- Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.***
- ***Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable***

Proposer shall include the Proposer's parent organization.

Financial Strength and Resources

Amerigroup Louisiana has established the required minimum net worth per requirements of the Department of Insurance. Additionally, Amerigroup Louisiana's parent organization, Amerigroup Corporation, is a strong, fiscally sound and financially well-managed organization. As a public company, Amerigroup Corporation has access to capital markets and greater transparency of financial operations. Most importantly, our financial strength gives us the ability to be a strong partner to DHH and the State of Louisiana in serving its neediest citizens.

Independently Audited Financial Statements

Although licensed, Amerigroup Louisiana is not an active health plan and has not been independently audited, so we cannot provide audited financial statements. Because the health plan is not currently active, it has zero membership.

Please see our response to Section B.6, which includes as an attachment consolidated financial statements for our parent organization, Amerigroup Corporation and its subsidiaries. These statements were prepared and audited using Generally Accepted Accounting Principles.

Internally Prepared Unaudited Quarterly Financial Statements

Amerigroup Louisiana, as the proposer, provides the four most recent internally prepared unaudited quarterly financial statements as Attachment B.31.a to this proposal. The negative operating cash flow on the quarter ending September 30, 2010 is due to timing of the intercompany account, when the parent organization issued common stock to the proposer.

Amerigroup Corporation made a $3 million contribution to the proposer in September 2010. There have been no additional contributions since Amerigroup Corporation's 10-Q filing for the quarter ending March 31, 2011.

B. 31
Amerigroup Louisiana, Inc.
Unaudited Income Statement
Internally Prepared - May 11, 2011

	Q2 2010	Q3 2010	Q4 2010	Total 2010	Q1 2011
Membership	-	-	-	-	-
Net Premium Revenues	$ -	$ -	$ -	$ -	$ -
Investment Income (net of expenses)	-	33	4,019	4,052	3,134
Expenses:					
Medical Expenses	-	-	-	-	-
SG&A	-	-	-	-	-
Total Medical Expenses and SG&A	-	-	-	-	-
Depreciation and Amortization	-	-	-	-	-
Income Before Income taxes	-	33	4,019	4,052	3,134
Income Tax Expense	-	1	1,506	1,507	1,175
Net Income	$ -	$ 32	$ 2,513	$ 2,545	$ 1,959

B. 31
Amerigroup Louisiana, Inc.
Unaudited Balance Sheet
Internally Prepared May 11, 2011

	As of 6/30/2010	As of 9/30/2010	As of 12/31/2010	As of 3/31/2011
Current assets:				
Cash and cash equivalents	$ -	$ 11,921	$ 11,921	$ 14,451
Short-term investments	-	2,998,080	3,000,560	2,999,768
Premium receivables	-	-	-	-
Deferred income taxes	-	-	-	-
Prepaids, AR and other (net allow)	-	22	403	163
Total current assets	-	3,010,023	3,012,885	3,014,383
Long-term investments	-	-	-	-
Property and equipment, net	-	-	-	-
Investments on deposit for licensure	-	-	-	-
Deferred income taxes	-	-	-	-
Other long-term assets	-	-	-	-
Goodwill and other intangible assets, net	-	-	-	-
Total Assets	$ -	$ 3,010,023	$ 3,012,885	$ 3,014,383
Liabilities and stockholders' equity				
Current liabilities:				
Claims payable	-	-	-	-
Unearned Revenue	-	-	-	-
Accounts payable	-	-	-	-
Accrued expenses and other	-	-	-	-
Current Portion of LT Debt	-	-	-	-
Total current liabilities	-	-	-	-
Long-term debt	-	-	-	-
Other long-term liabilities	-	(100)	(100)	(100)
Deferred income taxes	-	-	123	123
Total liabilities	-	(100)	23	23
Stockholders' equity				
Common stock	-	100	100	100
Additional paid-in capital	-	3,010,000	3,010,000	3,010,000
Total APIC	-	3,010,100	3,010,100	3,010,100
Total Other Comprehensive	-	(9)	217	(244)
Retained earnings - Prior Year	-	-	-	2,545
Retained earnings - Current Year	-	32	2,545	1,959
Total Retained Earnings	-	23	2,762	4,260
Total stockholders' equity	-	3,010,123	3,012,862	3,014,360
Total liabilities and stockholders' equity	$ -	$ 3,010,023	$ 3,012,885	$ 3,014,383

B. 31
Amerigroup Louisiana, Inc.
Unaudited Statement of Cash Flows
Internally Prepared May 11, 2011

	Three Months ended 6/30/2010	Three Months ended 9/30/2010	Three Months ended 12/31/2010	Twelve Months Ended 12/31/2010	Three Months Ended 3/31/2011
Cash flows from operating activities:					
Net Income	$ -	$ 32	$ 2,513	$ 2,545	$ 1,959
Adjustments to reconcile net income(loss) to net cash provided by operating activities:					
Depreciation and Amortization	-	-	-	-	-
Gain(Loss) on disposal or abandonment of property, equipment and software	-	-	-	-	-
Deferred tax (benefit) expense	-	-	-	-	-
Compensation expense related to share-based payments	-	-	-	-	-
Impairment of goowill	-	-	-	-	-
Other	-	-	-	-	-
Changes in assets and liabilities increasing (decreasing) cash flows from operating activities:				-	
Premium receivables	-	-	-	-	-
Prepaid expense, provider and other receivables	-	(22)	(381)	(403)	240
Other Assets	-	-	-	-	-
Claims Payable	-	-	-	-	-
Accounts payable, accrued expenses, and other current liabilities	-	-	-	-	-
Unearned revenue	-	-	-	-	-
Other long-term liabilities	-	(100)	-	(100)	-
Net cash provided by operating activities	-	(90)	2,132	2,041	2,199
Cash flows from investing activities:					
Proceeds (purchase) from investments		10,091	349	10,440	(461)
Capital Contribution from parent		3,000,000	-	3,000,000	-
Proceeds from sale of intangible assets		-	-	-	-
Purchase of intangible assets		-	-	-	-
Net cash (used in) provided by investing activities	-	3,010,091	349	3,010,440	(461)
Net cash (used in) provided by financing activities	-	-	-	-	-
Net increase(decrease) in cash and cash equivalents	$ -	$ 3,010,001	$ 2,481	$ 3,012,481	$ 1,738
Cash and cash equivalents at beginning of year	-	$ -	$ 3,010,001	$ -	$ 3,012,481
Cash and cash equivalents at end of period	$ -	$ 3,010,001	$ 3,012,481	$ 3,012,481	$ 3,014,220

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