



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

GEORGIA FAMILIES PROGRAM

**REPORT 5:
PHYSICIAN CLAIMS
GLOBAL ANALYSES**

ANALYSES OF CLAIMS SUBMITTED BY
PHYSICIANS AND OTHER SPECIALTY
PRACTITIONERS TO GEORGIA CARE
MANAGEMENT ORGANIZATIONS

FINAL DRAFT - MARCH 27, 2009


Myers and Stauffer_{LLC}

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GLOSSARY

These terms and references are used throughout this report:

- **Adjudicate** – A determination by the Care Management Organization of the outcome of a health care claim submitted by a health care provider. Claims may pay, deny, or in some cases have an alternative adjudication outcome.
- **Appeal** – A formal process whereby a health care provider requests that a payor review the outcome of a claim previously submitted to the payor for reimbursement. This term is typically reserved for claims that were originally denied for payment or paid at a lower amount by the payor, and the provider believes a payment should be made or paid at a higher amount.
- **Capitation Claim** - A per Medicaid and/or PeachCare for Kids™ member fixed payment amount made by DCH to a care management organization in return for the administration and provision of health care services rendered to the enrolled Medicaid and/or PeachCare for Kids™ member.
- **Care Management Organization (CMO)** – A private organization that has entered into a risk-based contractual arrangement with DCH to obtain and finance care for enrolled Medicaid or PeachCare for Kids™ members. CMOs receive a per capita or capitation claim payment from DCH for each enrolled member.
- **Centers for Medicare and Medicaid Services (CMS)** – The federal agency under the Department of Health and Human Services responsible for the oversight and administration of the federal Medicare program, state Medicaid programs, and State Children’s Health Insurance Programs.
- **Centers for Medicare and Medicaid Services 1500 (CMS-1500 or “1500”) Claim Form** – Document most often required by payors to be utilized by physicians and other non-institutional providers for submission of a claim request for reimbursement to the health care payor.
- **Claims Processing System** – A computer system or set of systems that determine the reimbursement amount for services billed by the health care provider.
- **Clean Claim** – A claim received by the CMO for adjudication in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment or alteration by the health care service provider in order to be processed and paid by the CMO. Per the DCH CMO model contract, the following exceptions apply: 1) A Claim for payment of expenses incurred during a period of time for which premiums are delinquent; 2) A Claim for which Fraud is suspected; and 3) A Claim for which a Third Party Resource should be responsible.

- **Current Procedural Terminology (CPT) Codes** – A listing of five character alphanumeric codes for use in reporting medical services and procedures performed by health care providers. CPT codes generally begin with a numeric character.
- **Denied Claim** – A claim submitted by a health care provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the health care provider and payor.
- **Explanation of Benefits (EOB)** – A statement from a payor to a patient and/or health care provider that includes information detailing the pricing and adjudication of a fee-for-service claim and/or claim detail.
- **Fee-For-Service (FFS)** – A health care delivery system in which a health care provider receives a specific reimbursement amount from the payor for each health care service provided to a patient.
- **Fee-For-Service (FFS) Claim** - A document, either paper or electronic, from a health care provider detailing health care services. Claims are submitted to a payor by a health care provider after a service has been provided to a patient covered by the payor. In some cases, the service must be authorized in advance. A FFS claim consists of one or more line items that detail all specific health care service(s) provided.
- **Filing Time Limit** – The maximum amount of time a provider can utilize to submit a claim to a health plan.
- **Georgia Families (GF)** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ where the Department contracts with Care Management Organizations to manage the care of eligible members.
- **Health Care Common Procedure Coding System Level II Codes (HCPCS Codes)** – A listing of five character alphanumeric codes for use in reporting medical services, supplies, devices, and drugs utilized by health care providers.
- **Health Check** – The Georgia Department of Community Health’s preventive health care program for eligible children. Medicaid-eligible children are eligible for the program until the age of twenty-one. PeachCare for Kids™-eligible children are eligible for the program until the age of nineteen.
- **Kick Payment** – A one-time payment made to a CMO for a newborn baby. This payment is in addition to the monthly capitation payment for the newborn and is intended to offset the cost of labor and delivery.

- **Medicaid Management Information System (MMIS)** – Claims processing system used by the Department’s fiscal agent claims processing vendor to process Georgia Medicaid and PeachCare for Kids™ FFS claims and capitation claims.
- **Paid Claim** – A claim submitted by a health care provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the health care provider and payor.
- **Payor** – An entity that reimburses a health care provider a portion or the entire health care expenses of a patient for whom the entity is financially responsible.
- **PeachCare for Kids™ Program (PeachCare)** – The Georgia DCH’s State Children’s Health Insurance Program (SCHIP) funded by Title XXI of the Social Security Act, as amended.
- **Prior Authorization (Authorization, PA, or Pre-Certification)** – An approval given by a health care payor to a health care provider before a health care service is performed, that allows the provider to perform a specific health care service for a patient who is the financial responsibility of the payor with the understanding that the payor will reimburse the provider for the service.
- **Provider Number (or Provider Billing Number)** – An alphanumeric code utilized by health care payors to identify providers for billing, payment, and reporting purposes.
- **Recoupment** – Repayment of an overpayment, either by a payment from the provider or an amount withheld from the payment on a claim.
- **Remittance Advice (RA)** – A document provided by a health care payor to a health care provider that lists health care claims billed by the provider to the payor and explains the payment (or denial) of those claims.
- **Specialty Practitioners** – A non-general practice physician who specializes in a specific medical discipline.

BACKGROUND

In July 2005, the Georgia Department of Community Health (DCH or Department) contracted with AMERIGROUP Community Care (AMGP), Peach State Health Plan (PSHP) and WellCare of Georgia (WellCare), (hereinafter referenced as “CMOs”) to provide health care services under the Georgia Families care management program. This risk-based managed care program is designed to bring together private health plans, health care providers, and patients to work proactively to improve the health status of Georgia’s Medicaid and PeachCare for Kids™ members. Approximately 600,000 members in the Atlanta and Central regions of the state began receiving health care services through Georgia Families on June 1, 2006. Georgia Families was expanded statewide to the remaining four regions, and approximately 400,000 additional members, on September 1, 2006.

DCH’s contract with the CMOs delineates the requirements of the CMOs , which are summarized below.

- The covered benefits and services that must be provided to the Medicaid and PeachCare for Kids™ members.
- The provider network and service requirements for the CMOs.
- Medicaid and PeachCare for Kids™ enrollment and disenrollment requirements.
- Allowed and disallowed marketing activities.
- General provider contracting provisions.
- Quality improvement guidance.
- Reporting requirements and other areas of responsibility.

In return for the CMOs satisfying the terms of the contract, the Department remits a monthly capitation payment for each enrolled Medicaid and PeachCare for Kids™ member, as well as kick payments for newborns.

The table below illustrates the participation of the three CMOs by coverage region.

Table 1: CMO Participation by Coverage Region

Region	AMGP	PSHP	WellCare
Atlanta	√	√	√
Central		√	√
East	√		√
North	√		√
Southeast	√		√
Southwest		√	√

PROJECT PURPOSE

The Department of Community Health engaged Myers and Stauffer LC to study and report on specific aspects of the GF program, including certain issues presented by providers, selected claims paid or denied by CMOs, and selected GF policies and procedures. The initial phase of the engagement focused on hospital provider subjects. Previously issued reports, available online at <http://dch.georgia.gov>, assessed payment and denial trends of hospital claims, as well as certain CMO policies and procedures. This report addresses the payment, prior authorization, and denial trends of physician claims, as well as details on the length of time required to complete contract loading and credentialing during the implementation period. Subsequent phases of the engagement will likely include similar analyses related to other provider categories.

This report, as well as the previously issued reports, focused on the first several months of the Georgia Families program, from December 1, 2006 through January 31, 2008. It should be acknowledged that the trends and issues identified during this period may vary significantly from the same analyses performed on post-implementation periods. We understand that considerable efforts have been made by providers, CMOs, and the Department to address start-up related issues as well as improve the accuracy of claim payments, and reduce denials made by CMOs. DCH anticipates conducting a subsequent analysis of physician claims data for the Georgia Families program to determine if there have been changes in the adjudication of physician claims in the post implementation period.

SCOPE OF REPORT

The scope of this report includes analyses of the Georgia Families program physician and specialty practitioner claims experience and supporting processes such as the length of time required to load contract terms into the CMOs' claims adjudication systems and to complete provider credentialing. The Department of Community Health developed the scope of these analyses considering the experiences and concerns raised by the provider industry. In addition, we provide an overview of the issues and concerns with the Georgia Families program, as expressed by physicians in meetings with association groups and individual providers.

Each of the CMOs was given an opportunity to provide comments related to the findings of this report. Those comments are incorporated as Exhibit 5 of this report.

METHODOLOGY

The Department of Community Health requested that we analyze and report our findings by Care Management Organization. For all providers, we analyzed claims with incurred dates of service from December 1, 2006 through January 31, 2008. The analyses included physician and specialty practitioner claims billed on the CMS-1500 claim form.

On February 20, 2008, Myers and Stauffer LC requested from each CMO a list of claims data and related documentation needed for this initiative. We requested from the CMOs specific payment terms for a selection of physician and specialty practitioner contracts and any subsequent contract amendments. The due date of the data and documentation was March 20, 2008. WellCare submitted all data by the due date. AMGP submitted all data by April 16, 2008. PSHP submitted all data by August 4, 2008.

Following receipt of the requested information, we worked closely with the CMOs to address questions regarding the requested data, as well as to obtain clarification and additional information required to complete the analyses. Complete claims and associated reference data was loaded into our secure SQL Server environment in August 2008.

In consultation with the Department of Community Health, we analyzed the data and documentation received from the CMOs, and we did not independently validate or verify the information. Each CMO attested and warranted that the information they provided was “accurate, complete, and truthful, and consistent with the ethics statements and policies of DCH”.

A summary of findings from the following analyses are included in this report:

- Analysis I:** Length of Time Required to Load Contract Terms – We analyzed the number of days required to load the contractual payment terms for each participating provider.
- Analysis II:** Length of Time Required to Complete Credentialing of Providers – We analyzed the number of days required to complete provider credentialing.
- Analysis III:** Accuracy of Provider Rates – We analyzed the accuracy of the provider rates in the electronic rate files provided by the CMOs.

Analysis IV: Claims Adjudication Analyses – We performed various analyses of the claims data to determine the average number of days required to adjudicate claims.

Analysis V: Denied Claims – We performed analyses of the claims data to identify claim denial rates and the reasons that claims denied.

Analysis V (A): Claim Denials Related to Member Eligibility – We analyzed the claims denied by the CMOs for issues related to member eligibility.

Analysis V (B): Claim Denials Related to Authorizations – We analyzed the claims denied by the CMOs for issues related to authorizations.

Analysis VI: Prior Authorization Time – We analyzed the number of days between an authorization request and the date the authorization was approved or denied.

Analysis VII: Georgia Families Program Provider Retention – We analyzed the claims data and provider network information to determine whether any trends or potential provider retention concerns might exist for the Georgia Families program.

For reference, the following claim counts for each CMO were received and utilized in our analyses. These claims include primary care and specialty care claims with incurred dates of service from December 1, 2006 through January 31, 2008 billed on the CMS-1500 claim form.

Table 2: Percentage of Paid and Denied Claims by CMO

	Claims	Percent
AMGP Paid Claims	2,531,028	82.34%
AMGP Denied Claims	542,783	17.66%
Subtotal	3,073,811	100.00%

	Claims	Percent
PSHP Paid Claims	882,636	74.65%
PSHP Denied Claims	299,734	25.35%
Subtotal	1,182,370	100.00%

	Claims	Percent
WellCare Paid Claims	2,672,737	84.39%
WellCare Denied Claims	494,414	15.61%
Subtotal	3,167,151	100.00%

Note: The data above represents paid and denied claim detail lines. Multiple paid or denied detail lines may occur on the same claim.

ASSUMPTIONS AND LIMITATIONS

The assumptions and limitations summarized below should be noted when reviewing this report.

- In consultation with the Department of Community Health, we analyzed the data and documentation received from the CMOs, but we did not independently validate or verify the information. Each CMO attested and warranted that the information they provided was “accurate, complete, and truthful, and consistent with the ethics statements and policies of DCH”.
- The information provided by the CMOs contains physician and specialty practitioner claims with dates of service December 1, 2006 through January 31, 2008. The data was provided to Myers and Stauffer by the CMOs between March and August 2008. All trends and information identified in the data is limited to the accuracy of information submitted at the time it was submitted. We are not able to determine whether changes have been made in policy, pricing, adjudication, or whether claims have been adjusted or reprocessed subsequent to when it was submitted.

ANALYTICAL SUMMARIES AND FINDINGS

In addition to the findings by analysis type described below, please also refer to the findings summary presented at the end of this section.

The analyses below are based on paid and denied claims submitted by the CMOs, with dates of service from December 1, 2006 through January 31, 2008, which is reflective of the inventory of claims as of the date the CMO extracted and submitted the information for our analysis.

ANALYSIS I: NUMBER OF DAYS REQUIRED TO LOAD CONTRACT TERMS

AMERIGROUP Community Care (AMGP)

- Approximately 29 percent of the physician and specialty practitioner contracts were loaded prior to their effective date. The 71 percent of contracts that were entered after their effective date had an average of 53 days between the effective date of the contract and the date the contract was loaded into the claims system.

Table 3: AMGP Contract Loading Statistics

Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered	Number of Providers	Percent
Contract Entered Prior to Effective Date	5,093	29.36%
Contract Entered Within 30 Days of Effective Date	6,054	34.90%
Contract Entered 31 to 60 Days After Effective Date	3,178	18.32%
Contract Entered 61 to 90 Days After Effective Date	1,189	6.85%
Contract Entered 91 to 120 Days After Effective Date	651	3.75%
Contract Entered 121 to 180 Days After Effective Date	542	3.12%
Contract Entered 181 to 365 Days After Effective Date	523	3.01%
Contract Entered More Than 365 Days After Effective Date	118	0.68%
Total Contracts Entered	17,348	100.00%

Peach State Health Plan (PSHP)

- Approximately 69 percent of the physician and specialty practitioner contracts were loaded prior to their effective date. The 31 percent of contracts that were entered after their effective date had an average of 125 days between the effective date of the contract and the date the contract was entered into the claims system.

Table 4: PSHP Contract Loading Statistics

Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered	Number of Providers	Percent
Contract Entered Prior to Effective Date	3,691	69.38%
Contract Entered Within 30 Days of Effective Date	27	0.51%
Contract Entered 31 to 60 Days After Effective Date	42	0.79%
Contract Entered 61 to 90 Days After Effective Date	187	3.52%
Contract Entered 91 to 120 Days After Effective Date	82	1.54%
Contract Entered 121 to 180 Days After Effective Date	33	0.62%
Contract Entered 181 to 365 Days After Effective Date	34	0.64%
Contract Entered More Than 365 Days After Effective Date	32	0.60%
Contract Entered Date Not Provided	1,192	22.41%
Total Contracts Entered	5,320	100.00%

WellCare of Georgia (WellCare)

- Approximately 76 percent of the physician and specialty practitioner contracts were loaded prior to their effective date. The 24 percent of contracts that were entered after their effective date had an average of 75 days between the effective date of the contract and the date the contract terms were entered into the claims system.

Table 5: WellCare Contract Loading Statistics

Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered	Number of Providers	Percent
Contract Entered Prior to Effective Date	3,343	75.63%
Contract Entered Within 30 Days of Effective Date	484	10.95%
Contract Entered 31 to 60 Days After Effective Date	153	3.46%
Contract Entered 61 to 90 Days After Effective Date	124	2.81%
Contract Entered 91 to 120 Days After Effective Date	97	2.19%
Contract Entered 121 to 180 Days After Effective Date	83	1.88%
Contract Entered 181 to 365 Days After Effective Date	120	2.71%
Contract Entered More Than 365 Days After Effective Date	16	0.36%
Total Contracts Entered	4,420	100.00%

DCH Contract with the CMOs:

We were unable to locate in either the original contract (effective June 1, 2006) or the current amended contract (effective July 1, 2008) between DCH and the CMOs a contractual requirement regarding the timeframe in which provider contracts must be loaded into the CMOs respective claims processing systems.

Please refer to Exhibit 1 for additional detail regarding Analysis I.

ANALYSIS II:

NUMBER OF DAYS REQUIRED TO COMPLETE CREDENTIALING

AMGP

- Approximately 80 percent of physicians and specialty practitioners were credentialed prior to the effective date of the contract. For the 20 percent of physicians and specialty practitioners credentialed after the effective date, the average number of days between the application and credentialing date was 47 days. The credentialing date was not provided for 334 contracts.

Table 6: AMGP Credentialing Statistics

Number of Days from Effective Date as Participating Provider to Credentialing Date	Number of Providers	Percent
Credentialed Prior to Effective Date	13,841	79.78%
Credentialed Within 30 Days of Effective Date	1,455	8.39%
Credentialed 31 to 60 Days After Effective Date	871	5.02%
Credentialed 61 to 90 Days After Effective Date	515	2.97%
Credentialed 91 to 120 Days After Effective Date	169	0.97%
Credentialed 121 to 180 Days After Effective Date	81	0.47%
Credentialed 181 to 365 Days After Effective Date	65	0.37%
Credentialed More Than 365 Days After Effective Date	17	0.10%
Credentialing Date Not Provided	334	1.93%
Total Contracts Entered	17,348	100.00%

PSHP

- Approximately 68 percent of physicians and specialty practitioners were credentialed prior to the effective date of the contract. For the 32 percent of physicians and specialty practitioners credentialed after the effective date, the average number of days between the application and credentialing date was 142 days. The credentialing date was not provided for 1,192 contracts.

Table 7: PSHP Credentialing Statistics

Number of Days from Effective Date as Participating Provider to Credentialing Date	Number of Providers	Percent
Credentialed Prior to Effective Date	3,632	68.19%
Credentialed Within 30 Days of Effective Date	21	0.39%
Credentialed 31 to 60 Days After Effective Date	30	0.56%
Credentialed 61 to 90 Days After Effective Date	46	0.86%
Credentialed 91 to 120 Days After Effective Date	261	4.90%
Credentialed 121 to 180 Days After Effective Date	46	0.86%
Credentialed 181 to 365 Days After Effective Date	65	1.22%
Credentialed More Than 365 Days After Effective Date	33	0.62%
Credentialing Date Not Provided	1,192	22.38%
Total Contracts Entered	5,326	100.00%

WellCare

- Approximately 81 percent of physicians and specialty practitioners were credentialed prior to the effective date of the contract. For the 19 percent of physicians and specialty practitioners credentialed after the effective date, the average number of days between the application and credentialing date was 70 days.

Table 8: WellCare Credentialing Statistics

Number of Days from Effective Date as Participating Provider to Credentialing Date	Number of Providers	Percent
Credentialed Prior to Effective Date	3,560	80.54%
Credentialed Within 30 Days of Effective Date	442	10.00%
Credentialed 31 to 60 Days After Effective Date	135	3.05%
Credentialed 61 to 90 Days After Effective Date	65	1.47%
Credentialed 91 to 120 Days After Effective Date	79	1.79%
Credentialed 121 to 180 Days After Effective Date	34	0.77%
Credentialed 181 to 365 Days After Effective Date	92	2.08%
Credentialed More Than 365 Days After Effective Date	13	0.29%
Total Contracts Entered	4,420	100.00%

DCH Contract with the CMOs:

The original model contract (effective June 1, 2006) between DCH and the CMOs did not include a contractual requirement listing a timeframe in which the credentialing process must be completed.

DCH has since amended the model contract (effective July 1, 2008) by adding to section 4.8.15.1 the following statement *"The Contractor shall Credential all completed application packets within 120 calendar days of receipt."*

NOTE: The data analyzed in these claims analyses includes claims incurred prior to the contract amendment.

Please refer to Exhibit 2 for additional detail regarding Analysis II.

ANALYSIS III: ACCURACY OF PROVIDER RATES

AMGP

- We selected a sample of 229 providers from the AMGP provider directory. Using the contracts AMGP provided, we compared the contracted reimbursement terms, including any rate schedule and/or percentage of Medicaid rates, to the rate schedule and/or percentage of Medicaid rate loaded in the AMGP system as of March 2008 for 229 providers. We identified no inconsistencies in the rates.

Table 9: AMGP Provider Rates Accuracy Statistics

Comparison of Rates in Claims Payment System to Rates Specified in Contract Between CMO and a Sample of Providers	Number	Percent
Number of contracts where all rates loaded correctly	229	100%
Number of contracts with at least one rates loaded where a rate was <i>HIGHER than</i> the rate specified in the contract	0	0%
Number of contracts with at least one rates loaded where a rate was <i>LOWER than</i> the rate specified in the contract	0	0%
Total Number of Contracts* Reviewed	229	100%

There were no claims incurred between December 1, 2006 and January 1, 2008 impacted by rate load issues.

PSHP

- We selected a sample of 212 providers from the PSHP provider directory. Using the contracts PSHP provided, we compared the contracted reimbursement terms, including any rate schedule and/or percentage of Medicaid rates, to the rate schedule and/or percentage of Medicaid rate loaded in the PSHP system as of March 2008. We found potential inconsistencies in thirteen (or six percent) of the provider rates. Eleven of the rates were entered into the PSHP system at a rate that exceeded the contract rate, while two of the rates were entered at a rate lower than the contracted rate. Only one provider with an incorrectly loaded rate had claim activity during the 14 month period. This provider had 11 claims processed during the date range analyzed for payment at a rate that exceeded the contract rate.

Table 10: PSHP Provider Rates Accuracy Statistics

Comparison of Rates in Claims Payment System to Rates Specified in Contract Between CMO and a Sample of Providers	Number	Percent
Number of contracts where all rates loaded correctly	199	93.9%
Number of contracts with at least one rates loaded where a rate was <i>HIGHER than</i> the rate specified in the contract	11	5.2%
Number of contracts with at least one rates loaded where a rate was <i>LOWER than</i> the rate specified in the contract	2	0.9%
Total Number of Contracts* Reviewed	212	100%

There were approximately 11 claims incurred between December 1, 2006 and January 1, 2008 impacted by rate load issues.

WellCare

- We selected a sample of 216 providers from the WellCare provider directory. WellCare was not able to provide contracts for 13 providers (6 percent). For those providers where WellCare provided a contract, we compared the contracted reimbursement terms, including any rate schedule and/or percentage of Medicaid rates, to the rate schedule and/or percentage of Medicaid rate loaded in the WellCare system as of March 2008 for 203 providers. We found potential inconsistencies in four (or two percent) provider rates. Two of the rates were entered into the WellCare system at a rate higher than the contracted rate. Two of the rates were entered at a rate that was lower than the contracted rate. It appears that 941 claims within the date range analyzed were impacted by the rate inconsistencies.

Table 11: WellCare Provider Rate Statistics

Comparison of Rates in Claims Payment System to Rates Specified in Contract Between CMO and a Sample of Providers	Number	Percent
Number of contracts where all rates loaded correctly	199	98%
Number of contracts with at least one rate loaded where a rate was <i>HIGHER than</i> the rate specified in the contract	2	1%
Number of contracts with at least one rate loaded where a rate was <i>LOWER than</i> the rate specified in the contract	2	1%
Total Number of Contracts* Reviewed	203	100%

There were approximately 941 claims incurred between December 1, 2006 and January 1, 2008 impacted by rate load issues.

*It should be noted that in certain instances, a single contract could include more than one provider selected for the analysis. However, there were instances where a single contract specifically indicated different rates for each of the providers included in the contract. Therefore, for purposes of this analysis, the use of the word “contract” indicates the specific contractual terms for each provider selected.

The DCH Contract with the CMOs:

Both the original and amended contracts between DCH and the CMOs contained the following language regarding payments to providers.

4.16.1.1

The Contractor shall administer an effective, accurate and efficient Claims processing function that adjudicates and settles Provider Claims for Covered Services that are filed within the time frames specified ... and in compliance with all applicable State and federal laws, rules and regulations.

In addition, in the most recent contract (effective July 1, 2008) between the CMOs and DCH, DCH has added:

4.9.7.5.4

For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment.

NOTE: The data analyzed in these claims analyses includes claims incurred prior to the contract amendment.

ANALYSIS IV: CLAIMS ADJUDICATION

AMGP

- Approximately 97 percent of the physician and specialty practitioner claims, excluding suspended claims, were adjudicated within 15 days. AMGP reported paying interest of more than \$61,000 on claims adjudicated in 15 or more days.

Table 12: AMGP Claims Adjudication Statistics

Physician Claim Adjudication Summary for Primary and Specialty Care Physician Claims Paid Between 12/1/2006 and 1/31/2008

	Claim Lines Paid	Claim Lines Denied	Total Claims Lines Adjudicated	Interest Paid
Number of Claims Manually Adjudicated	351,887	164,372	516,259	\$59,196.78
Number of Claims Auto Adjudicated	2,179,141	378,411	2,557,552	\$2,111.63
Total Claims Adjudicated	2,531,028	542,783	3,073,811	\$61,308.41

	Claim Lines Paid	Claim Lines Denied	Total Claims Lines Adjudicated	Interest Paid
Number of Claims Adjudicated on Day of Receipt	746,751	125,759	872,510	\$0.00
Number of Claims Adjudicated in 1-5 Days	1,593,646	312,238	1,905,884	\$0.00
Number of Claims Adjudicated in 6-10 Days	106,637	48,414	155,051	\$0.00
Number of Claims Adjudicated in 11-14 Days	28,923	24,224	53,147	\$0.00
Percent of Claims Adjudicated within 14 Days	97.82%	94.08%	97.16%	N/A

	Claim Lines Paid	Claim Lines Denied	Total Claims Lines Adjudicated	Interest Paid
Number of Claims Adjudicated in 15-30 Days	46,416	24,784	71,200	\$17,357.42
Number of Claims Adjudicated in 31-60 Days	6,327	4,260	10,587	\$12,090.54
Number of Claims Adjudicated in 61-90 Days	780	676	1,456	\$8,791.36
Number of Claims Adjudicated in 91-120 Days	345	330	675	\$3,749.44
Number of Claims Adjudicated in 121-180 Days	463	454	917	\$6,626.48
Number of Claims Adjudicated in 181 + Days	740	1,644	2,384	\$12,693.17
Percent of Claims Adjudicated 15 Days or Greater	2.18%	5.92%	2.84%	N/A

Table 13: AMGP Claim Denial Statistics

Top Ten Denial Reasons for Claims Denied Ten or More Days After Receipt

Denial Code	Denial Reason Description	Claim Count	Percent of Total
CDD	Definite Duplicate Claim	11,076	18.99%
N55	History Maximum Lifetime Occurrence	9,264	15.89%
CBP	Primary carrier info req	5,029	8.62%
TF0	Submitted after plan filing limit	4,312	7.39%
N01	Incidental to a current procedure	2,978	5.11%
ST	Termination	2,292	3.93%
N59	Incidental due to a procedure in history	2,257	3.87%
Y41	Deny preauth not obtained	1,722	2.95%
Y40	Deny preauth not obtained	1,664	2.85%
073	Deny All Claim Lines	1,509	2.59%
All Other	All Other	16,208	27.80%
TOTAL		58,311	100%

PSHP

- Ninety-one percent of the physician and specialty practitioner claims submitted to PSHP adjudicated within 15 days. PSHP reported paying more than \$48,000 in interest for the claims that adjudicated in 15 or more days.

Table 14: PSHP Claims Adjudication Statistics

Physician Claim Adjudication Summary for Primary and Specialty Care Physician Claims Paid Between 12/1/2006 and 1/31/2008

	Claim Lines Paid	Claim Lines Denied	Total Claims Lines Adjudicated	Interest Paid
Number of Claims Manually Adjudicated	192,182	108,051	300,233	\$42,358.48
Number of Claims Auto Adjudicated	636,268	163,168	799,436	\$5,752.19
Total Claims Adjudicated	828,450	271,219	1,099,669	\$48,110.67

	Claim Lines Paid	Claim Lines Denied	Total Claims Lines Adjudicated	Interest Paid
Number of Claims Adjudicated on Day of Receipt	1,826	195	2,021	\$0.00
Number of Claims Adjudicated in 1-5 Days	511,603	145,995	657,598	\$0.00
Number of Claims Adjudicated in 6-10 Days	210,263	80,768	291,031	\$0.00
Number of Claims Adjudicated in 11-14 Days	35,257	15,709	50,966	\$0.00
Percent of Claims Adjudicated within 14 Days	91.61%	89.47%	91.08%	N/A

	Claim Lines Paid	Claim Lines Denied	Total Claims Lines Adjudicated	Interest Paid
Number of Claims Adjudicated in 15-30 Days	25,710	12,536	38,246	\$3,039.00
Number of Claims Adjudicated in 31-60 Days	13,444	6,845	20,289	\$6,676.19
Number of Claims Adjudicated in 61-90 Days	6,286	3,347	9,633	\$9,730.69
Number of Claims Adjudicated in 91-120 Days	7,293	2,054	9,347	\$8,903.06
Number of Claims Adjudicated in 121-180 Days	11,965	2,424	14,389	\$13,252.71
Number of Claims Adjudicated in 181 + Days	4,803	1,346	6,149	\$6,509.02
Percent of Claims Adjudicated 15 Days or Greater	8.39%	10.53%	8.92%	N/A

Table 15: PSHP Claim Denial Statistics

Top Ten Denial Reasons for Claims Denied Ten or More Days After Receipt

Denial Code	Denial Reason Description	Claim Count	Percent of Total
EX18	Deny: Duplicate Claim/Service	51,048	28.30%
EXN3	Your NPI is not on file/valid or you have not billed with your NPI	23,904	13.25%
EX28	Deny: Coverage Not in Effect when service provided	19,785	10.97%
EX29	Deny: The time limit for filing has expired	15,197	8.42%
EX57	Deny: Code was denied by code auditing software	9,760	5.41%
EXRC	Deny: Required referral code for Health Check visit invalid or missing	9,682	5.37%
EXVC	Deny – Please resubmit according to vaccines for children guidelines	6,977	3.87%
EX9M	Deny: This CPT code is invalid when billed with this diagnosis	5,759	3.19%
EXEC	Diagnosis cannot be used as primary diagnosis, please resubmit	5,661	3.14%
EXA1	Deny: Authorization not on file	4,298	2.38%
All Other	All Other	28,330	15.70%
TOTAL		180,401	100%

WellCare

- WellCare adjudicated approximately 99.7 percent of the physician and specialty practitioner claims within 15 days. WellCare reported paying \$156 in interest payments on the claims adjudicated in 15 or more days.

Table 16: WellCare Claims Adjudication Statistics

Physician Claim Adjudication Summary for Primary and Specialty Care Physician Claims Paid Between 12/1/2006 and 1/31/2008

	Claim Lines Paid	Claim Lines Denied	Total Claims Lines Adjudicated	Interest Paid
Number of Claims Manually Adjudicated	261,903	105,210	367,113	\$16.96
Number of Claims Auto Adjudicated	2,780,638	384,265	3,164,903	\$138.75
Total Claims Adjudicated	3,042,541	489,475	3,532,016	\$155.71

	Claim Lines Paid	Claim Lines Denied	Total Claims Lines Adjudicated	Interest Paid
Number of Claims Adjudicated on Day of Receipt	747,824	92,315	840,139	\$0.00
Number of Claims Adjudicated in 1-5 Days	2,263,737	384,630	2,648,367	\$0.00
Number of Claims Adjudicated in 6-10 Days	20,403	11,633	32,036	\$0.00
Number of Claims Adjudicated in 11-14 Days	772	265	1,037	\$0.00
Percent of Claims Adjudicated within 14 Days	99.68%	99.87%	99.70%	N/A

	Claim Lines Paid	Claim Lines Denied	Total Claims Lines Adjudicated	Interest Paid
Number of Claims Adjudicated in 15-30 Days	1,556	207	1,763	\$123.15
Number of Claims Adjudicated in 31-60 Days	2,319	119	2,438	\$13.28
Number of Claims Adjudicated in 61-90 Days	2,327	60	2,387	\$2.62
Number of Claims Adjudicated in 91-120 Days	1,437	113	1,550	\$3.11
Number of Claims Adjudicated in 121-180 Days	1,082	16	1,098	\$9.75
Number of Claims Adjudicated in 181 + Days	1,084	117	1,201	\$3.80
Percent of Claims Adjudicated 15 Days or Greater	0.32%	0.13%	0.30%	N/A

Table 17: WellCare Claim Denial Statistics

Top Ten Denial Reasons for Claims Denied Ten or More Days After Receipt

Denial Code	Denial Reason Description	Claim Count	Percent of Total
DN001	Payment adjusted for absence of precertification/ authorization.	246	24.19%
DN053	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	174	17.11%
TFLDN	The time limit for filing has expired	149	14.65%
EXDUC	Duplicate claim/service.	141	13.86%
LIMIT	Benefit maximum for this time period or occurrence has been reached.	80	7.87%
DN018	Payment adjusted because this care may be covered by another payer	50	4.92%

Denial Code	Denial Reason Description	Claim Count	Percent of Total
	per coordination of benefits.		
DN062	Payment is included in the allowance for another service/procedure.	49	4.82%
DN075	Duplicate claim/service.	20	1.97%
DN016	This service/equipment/drug is not covered under the patients current benefit plan	20	1.97%
DN218	Missing/incomplete/invalid diagnosis or condition	16	1.57%
All Other	All Other	72	7.08%
TOTAL		1,017	100%

The DCH Contract with the CMOs:

The amended contract (effective July 1, 2008) between DCH and the CMOs contains the following language regarding the adjudication of claims.

4.16.1.1

The Contractor shall utilize the same time frames and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims as the time frames and deadlines that the Department of Community Health uses on claims its pays directly. The Contractor shall administer an effective, accurate and efficient Claims processing function that adjudicates and settles Provider Claims for Covered Services that are filed within the time frames specified by the Department of Community Health (see Part I. Policy and Procedures for Medicaid/PeachCare for Kids Manual) and in compliance with all applicable State and federal laws, rules and regulations.

The original contract (effective June 1, 2006) contained only the second sentence of that contract requirement.

Section 4.16.1.8 of both the original and amended contract states:

Not later than the fifteenth (15th) business day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Contractor shall suspend the Claim and request in writing (notification via e-mail, the CMO plan Web Site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all outstanding information such that the Claim can be deemed clean. Upon receipt of all the requested information from the Provider, the CMO plan shall complete processing of the Claim within fifteen (15) Business Days.

In addition, as described in Analysis III, the amended contract between the CMOs and DCH now includes the following:

4.9.7.5.4

For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment.

NOTE: The data analyzed in these claims analyses includes claims incurred prior to the contract amendment.

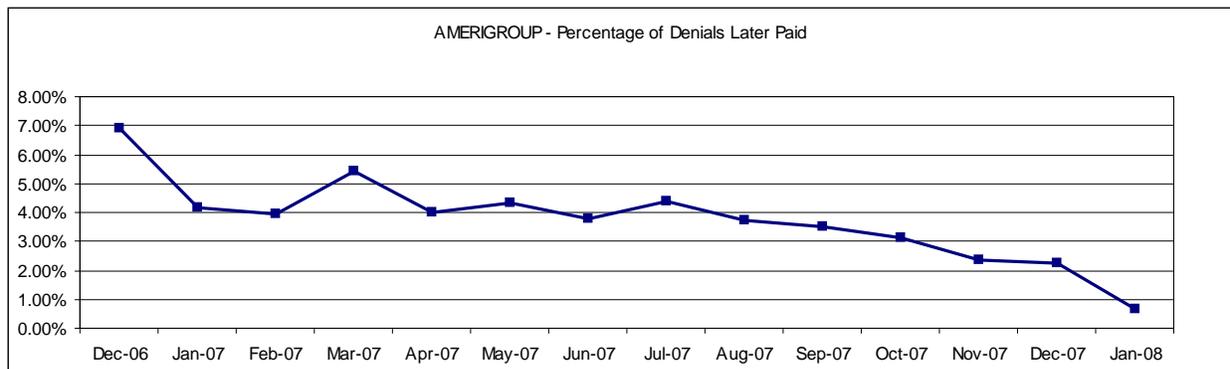
ANALYSIS V:

DENIED CLAIMS

AMGP

- Approximately 18 percent of all claims submitted to AMGP were denied. Approximately four percent of those denials (or four percent of 18 percent) were later paid by AMGP within an average of 41 days. AMGP reported paying approximately \$7,600 in interest related to these claims. The monthly percentage of denied claims ranged from about 13 percent in December 2006 to a peak of nearly 21 percent in November 2007 before decreasing to approximately 17 percent in January 2008. The chart below illustrates the percentage of claim denials that were later paid, by month. The claims data suggests an improving trend in the need to reprocess previously denied claims.

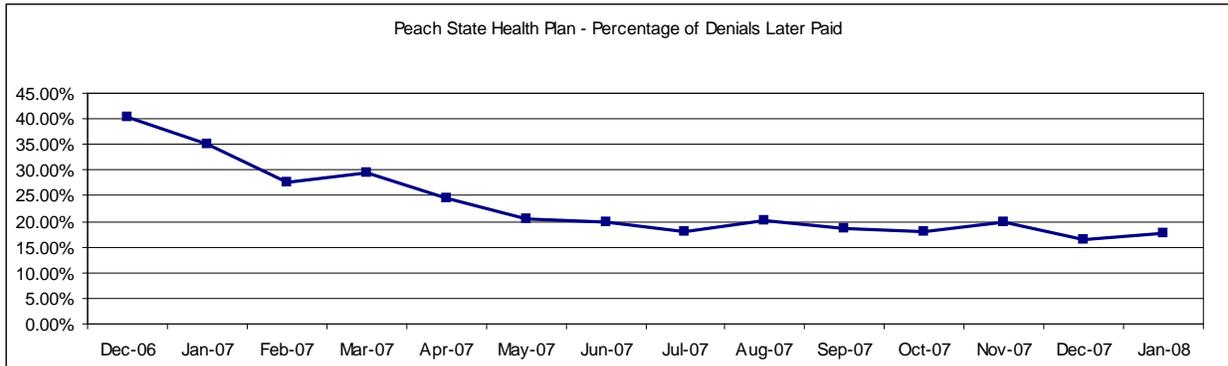
Table 18: AMGP Claim Denials Later Paid Trend



PSHP

- Approximately 25 percent of all claims submitted to PSHP were denied. Approximately 21 percent of those denials (or 21 percent of 25 percent) were later paid by PSHP within an average of 83 days. PSHP reported paying approximately \$49,600 in interest related to these claims. PSHP claims denials appeared to reveal an upward trend in the percentage of claims denied between December 2006 and September 2007. In December 2006, slightly less than 14 percent of claims were denied compared to more than 31 percent in September 2007. The denial rate leveled off at approximately 25 percent for the remaining months of the analysis. The chart below illustrates the percentage of claim denials that were later paid, by month. Although the claims data suggests an improving trend in the need to reprocess previously denied claims, there continue to be a significant number of denied claims that require reprocessing.

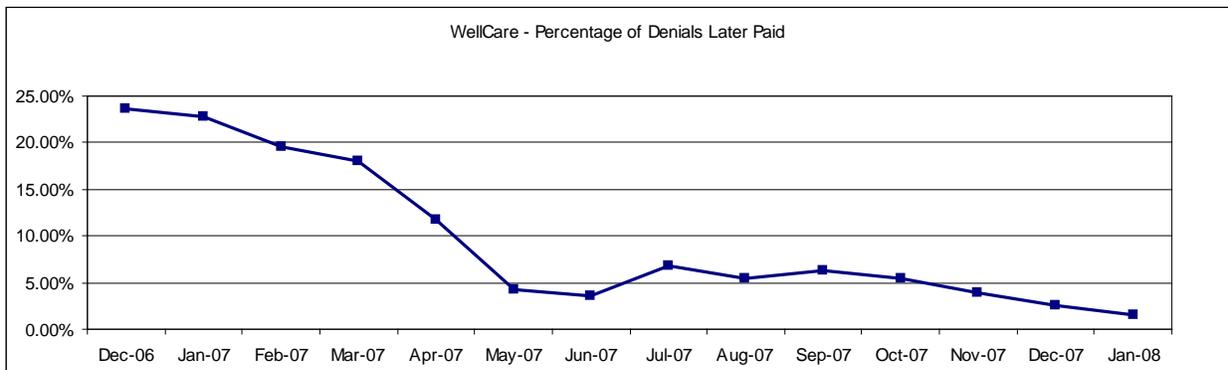
Table 19: PSHP Claim Denials Later Paid Trend



WellCare

- Approximately 16 percent of claims submitted to WellCare were denied. Approximately nine percent of those denials (or nine percent of 16 percent) were later paid by WellCare within an average of 57 days. WellCare reported paying \$4 in interest related to these claims. Claim denials by month ranged from a low of 10 percent to a high of 17 percent, with January 2008 at 16 percent. The chart below illustrates the percentage of claim denials that were later paid, by month. The percentage of denied claims that were later paid by WellCare steadily decreased from approximately 24 percent in December 2006 to approximately two percent in January 2008

Table 20: WellCare Claim Denials Later Paid Trend



The DCH Contract with the CMOs:

The most recent contract (effective July 1, 2008) between the CMOs and DCH addresses claims that are inappropriately denied or underpaid:

4.9.7.5.4

For all claims that are initially denied or underpaid by a care management organization but

eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment.

NOTE: The data analyzed in these claims analyses includes claims incurred prior to the contract amendment.

Please refer to Exhibit 3 for additional detail regarding Analysis V.

ANALYSIS V (A): CLAIM DENIALS RELATED TO MEMBER ELIGIBILITY

AMGP

- We identified 32,576 physician and specialty practitioner claims of 542,783 total denied claims (or six percent of total denials) that were denied due to member eligibility issues. Of the claims denied for eligibility issues, 712 claims or two percent were for members that, according to DCH’s fiscal agent, were locked-in to AMGP during the time the denied service occurred. Ninety-nine percent of the denied claims denied due to member termination. The remaining one percent of denied claims denied for reasons related to the Subscriber ID and/or future enrollment. Approximately one percent of these eligibility-related denied claims were later reprocessed and paid.

Table 21: AMGP Claim Lines Denied for Eligibility Related Issues

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Active Lock-in Span on Service Date	Reprocessed Claims related to Lock-in Spans
376	Incorrect subscriber ID	47	3	47	3
377	Incorrect subscriber ID	56	12	55	12
378	Incorrect subscriber ID	255	28	248	26
S13	All Enroll events are Future	129	8	47	7
ST	Termination	32,089	215	315	135
TOTAL		32,576	266	712	183

Note: Active lock-in span based upon member lock-in table provided by the Georgia Department of Community Health's fiscal agent.

PSHP

- Approximately 31,000 PSHP physician and specialty practitioner claims of 299,734 total denied claims (or 10 percent of total denials) denied due to member eligibility issues. Of the claims denied for eligibility issues, 4,834 claims or 16 percent were for members that, according to DCH’s fiscal agent, were locked-in to PSHP on the date(s) the denied service occurred. Approximately eight percent of these eligibility-related denied claims were later reprocessed and paid.

Table 22: PSHP Claim Lines Denied for Eligibility Related Issues

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Active Lock-in Span on Service Date	Reprocessed Claims related to Lock-in Spans
EX26	Deny: Expenses Incurred Prior To Coverage	6	0	2	0
EX28	Deny: Coverage Not In Effect When Service Provided	26,313	392	353	66
EXMA	Medicaid# Missing Or Not On File, Please Correct And Resubmit	2,151	1,170	2,081	1,158
EXMQ	Deny: Member Name/Number/Date Of Birth Do Not Match, Please Resubmit	2,527	869	2,398	854
TOTAL		30,997	2,431	4,834	2,078

Note: Active lock-in span based upon member lock-in table provided by the Georgia Department of Community Health's fiscal agent.

WellCare

- We identified approximately 659 WellCare physician and specialty practitioner claims of 494,414 total denied claims (or 0.1 percent) denied due to member eligibility issues. Because WellCare's denial rate for this reason is substantially different than the other two CMOs, we contacted WellCare to confirm our findings. We received the following response:

*"1. Paradigm level-member's eligibility record against date of service on claim, which would show up in the M/S files they reviewed.
2. At the Front End level- if the member is not identifiable, they will also be rejected at the DCR level. At any rate; these are returned by a letter and would not be reflected in the data obtained from Paradigm.*

We have two sets of business rules within the Front-End:

The first set of rules checks to see if the member is a WellCare member. If the business rules cannot find a member then the claim will error into DCR and the Front-End team will manually try to find a WellCare member within Paradigm. If a member cannot be found then the claim is rejected back to the provider with a letter that advises the provider that a WellCare member could not be found in the system.

The second set of business rules checks member eligibility. It checks to make sure that the member is eligible for the DOS that the provider has billed. If the system cannot make the eligibility with the subscriber ID that is listed then the claim will error into DCR and the front-end team will manually try to find a WellCare member within Paradigm. If a member

(Subscriber ID) cannot be found with eligibility for the DOS billed then the claim is rejected back to the provider with a letter that the member is not eligible for that DOS.”

Because WellCare rejects the claim during the electronic claim import process, the claims are not reflected in the claims data. We are unable to confirm the impact of this issue based on the claims data. Additional analysis of electronic claim rejection data from WellCare, including the analysis of the quantity and reasons for claims rejected during the import process, could be completed at the request of the Department

Table 23: WellCare Claim Lines Denied for Eligibility Related Issues

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Active Lock-in Span on Service Date	Reprocessed Claims related to Lock-in Spans
DN073	Member not Eligible on the date of service	154	14	36	8
DN205	Incorrect member ID #	293	33	291	33
INELG	Member not Eligible on the date of service	212	19	52	9
TOTAL		659	66	379	50

Note: Active lock-in span based upon member lock-in table provided by the Georgia Department of Community Health's fiscal agent.

The DCH Contract with the CMOs:

The most recent contract (effective July 1, 2008) between the CMOs and DCH contains the following provision regarding eligibility and eligibility denials.

4.16.1.9:

If a provider submits a claim to a responsible health organization for services rendered within 72 hours after the provider verifies the eligibility of the patient with that responsible health organization, the responsible health organization shall reimburse the provider in an amount equal to the amount to which the provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the provider's claim, if the responsible health organization made payment for a patient for whom it was not responsible, then the responsible health organization may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the provider.

In addition, please refer to Analysis V (Denied Claims) regarding contract language (effective July 1, 2008) that addresses claims that are inappropriately denied (4.9.7.5.4).

NOTE: The data analyzed in these claims analyses includes claims incurred prior to the contract amendment.

ANALYSIS V (B):

CLAIM DENIALS RELATED TO AUTHORIZATION FOR SERVICES

AMGP

- We identified 30,785 claim detail lines of a total of 542,783 (or six percent of total denials) denied by AMGP for authorization related issues. We found that 21 percent of the denied claim detail lines (or 6,374 of 30,785 denied claim lines) were later reprocessed for payment. We analyzed the authorization data submitted by AMGP in an attempt to match an authorization to the denied claim. AMGP did not provide procedure codes or date spans with their authorization data but we were able to match 8,143 claims to an authorization based on provider and member match. Our analysis suggests that approximately 8,143 of the 30,785 denials related to eligibility (or 26 percent) may have been inappropriately denied. Many of the claims identified have now been reprocessed for payment. The authorization data did not contain a date last updated for the authorization so we are unable to determine if the authorization existed at the time of denial or was modified after the original denial and prior to the re-adjudication of the claim.

Table 24: AMGP Claim Lines Denied for Authorization Related Issues

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Authorization on Service Date
379	Level of care not authorized	1,282	316	518
UM0	Services Disallowed by UM	161	22	58
UM1	Units exceed UM authorization	277	58	187
UM5	Units exceed UM authorization	4	0	1
UM6	Units exceed UM authorization	92	18	64
Y29	Dates of service are outside dates authorized	341	68	143
Y39	Dates of service are outside dates authorized	208	63	96
Y40	Deny preauth not obtained	14,458	2,778	3,438
Y41	Deny preauth not obtained	13,962	3,051	3,638
TOTAL		30,785	6,374	8,143

Note: AMERIGROUP did not provide authorization date spans or authorized procedures. Authorization matched on member ID and provider ID

PSHP

- We identified 13,737 claim detail lines of a total of 299,734 (or five percent) denied by PSHP for authorization related issues. We found that 41 percent of the denied claim detail lines (or 5,591 of 13,737 denied claim lines) were later reprocessed for payment. We were unable to compare the denied claims with

the authorization data since PSHP did not provide provider IDs, authorized procedures or authorization date(s) in their authorization data.

Table 25: PSHP Claim Lines Denied for Authorization Related Issues

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Authorization on Service Date
EXA1	DENY: AUTHORIZATION NOT ON FILE	10,296	3,900	3,900
EXDZ	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	511	188	188
EXHL	DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH	1,082	702	702
EXHP	DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING	584	226	226
EXHS	DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING	992	499	499
EXHT	DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING	272	76	76
TOTAL		13,737	5,591	5,591

Note: Authorization on service date reflects only those claims reprocessed with an authorization number. We were unable to independently determine if an authorization existed because Peach State did not provide provider, procedure or authorization dates as requested.

WellCare

- We identified 46,056 claim detail lines of a total of 494,414 (or nine percent) denied by WellCare for authorization related issues. We found that 15 percent of the denied claim detail lines (or 6,798 of 46,056 denied claim lines) were later reprocessed for payment. We analyzed the authorization data submitted by WellCare in an attempt to match the authorization to the claim. We found an exact match between the denied claim and the authorization data on provider, member, date of service and procedure code for 1,756 claim detail lines. It appears that the majority of those claims with matching authorizations have been reprocessed. The authorization data did not contain a date last updated for the authorization so we are unable to determine if the authorization existed at the time of denial or was modified after the original denial and prior to the re-adjudication of the claim. Our analysis suggests that approximately 1,756 of the 46,056 denials related to eligibility (or four percent) may have been inappropriately denied.

Table 26: WellCare Claim Lines Denied for Authorization Related Issues

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Authorization on Service Date
AUCLO	Authorization Closed	248	42	23
AUEXP	Authorization Expired - Date Of Svc After Authoriz	22	22	7
CNMFA	Criteria Not Met For Authorization	18	0	0
DAUTH	Prior Authorization Request Was Denied	1,082	99	61
DN001	Prior Authorization Is Required But Was Not Obtain	39,059	5,532	920
DN004	Authorization Denied	300	36	24
DN038	Svcs Billed Not Consistent With The Authorization	3,511	694	551
DN039	Services Not Included In Authorization	347	58	49
DN045	This Svc Requires Medical Records For Review	496	103	29
DN161	Exceeds Authorized Cost	1	0	0
FI01	Medical Record Required Send To Po Box 26021 Tampa Fl 33623	99	53	1
FI12	No Authorization/Not Billed As Authorized	38	15	0
FI29	Service Exceeded The Benefit Limit.	1	1	0
LIMAR	Limit Reached-Authorization Required	366	17	9
OUTAU	Date Of Svc Of Procedure Is Outside Of What Was Au	89	39	17
VSTEX	The Days/Visits/Units Billed On Claim Exceed The #	379	87	65
TOTAL		46,056	6,798	1,756

Note: Authorization match based on member, provider, place of service, date of service and exact procedure code

The DCH Contract with the CMOs:

We were unable to locate specific contractual requirements in either the original or amended contracts specifically addressing the incorrect denial of claims for prior authorization. Please refer to Analysis V (Denied Claims) regarding contract language (effective July 1, 2008) that addresses claims that are inappropriately denied (4.9.7.5.4).

NOTE: The data analyzed in these claims analyses includes claims incurred prior to the contract amendment.

ANALYSIS VI: PRIOR AUTHORIZATION TIME

We analyzed the number of calendar days between the date an authorization was requested and the date the authorization was approved or denied.

AMGP

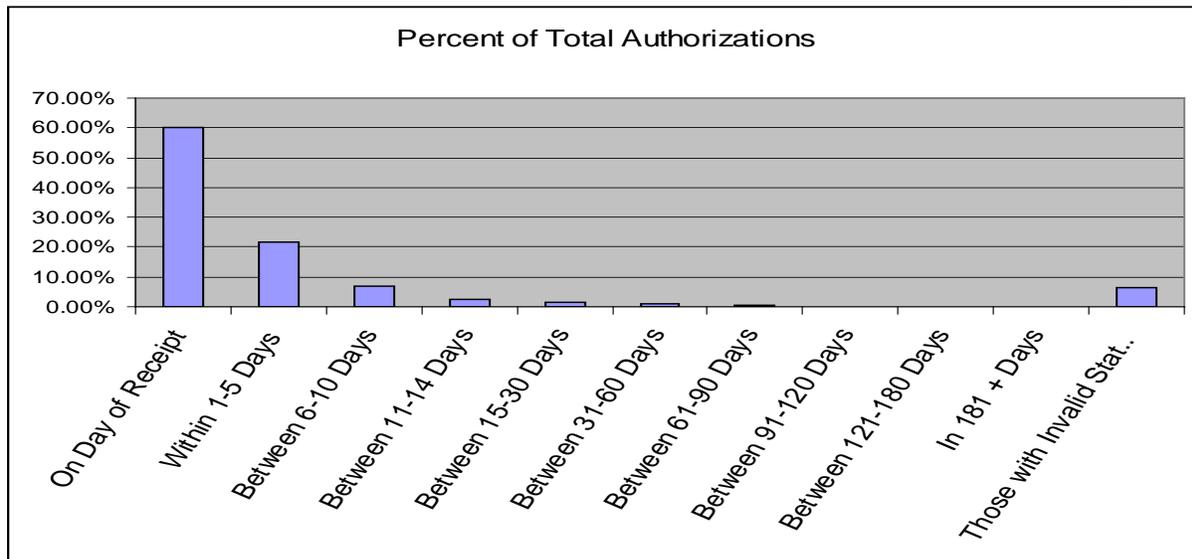
- AMGP approved or denied 433,170 prior authorization requests over the period analyzed. Approximately 60 percent of these requests were approved on the date of the request and 82 percent were approved within five days. The remaining 18 percent of requests were approved within an average of 16 days.

Table 27: AMGP Authorization Lag Time

Authorization Lag Time for Primary Care and Specialty Care Authorizations Approved or Denied between 12/1/2006 and 1/31/2008

Number of Authorizations Approved or Denied	Approved	Denied	Total Authorizations	Percent of Total Authorizations
On Day of Receipt	257,640	2,852	260,492	60.14%
Within 1-5 Days	85,634	7,711	93,345	21.55%
Between 6-10 Days	23,103	5,889	28,992	6.69%
Between 11-14 Days	7,548	2,188	9,736	2.25%
Between 15-30 Days	5,746	804	6,550	1.51%
Between 31-60 Days	3,219	404	3,623	0.84%
Between 61-90 Days	1,094	112	1,206	0.28%
Between 91-120 Days	211	67	278	0.06%
Between 121-180 Days	96	30	126	0.03%
In 181 + Days	216	11	227	0.05%
Those with Invalid Status Date	28,361	234	28,595	6.60%
Total Authorizations Approved or Denied	412,868	20,302	433,170	100%

Table 28: AMGP Authorization Lag Time – Percent of Total Authorizations



PSHP

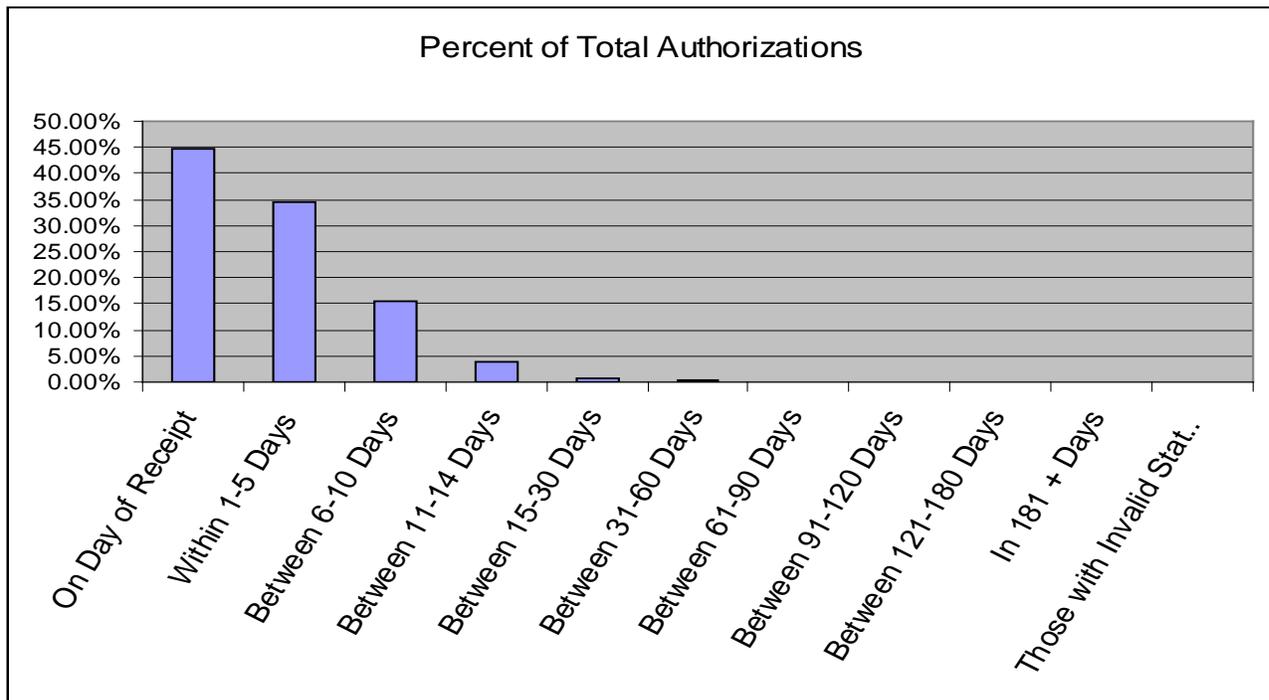
- PSHP approved or denied 47,603 prior authorization requests over the period analyzed. Approximately 45 percent of these requests were approved on the date of the request and 79 percent were approved within five days. The remaining 21 percent of requests were approved within an average of 9 days.

Table 29: PSHP Authorization Lag Time

Authorization Lag Time for Primary Care and Specialty Care Authorizations Approved or Denied between 12/1/2006 and 1/31/2008

Number of Authorizations Approved or Denied	Approved	Denied	Total Authorizations	Percent of Total Authorizations
On Day of Receipt	21,035	294	21,329	44.81%
Within 1-5 Days	15,285	1,113	16,398	34.45%
Between 6-10 Days	7,012	445	7,457	15.66%
Between 11-14 Days	1,623	220	1,843	3.87%
Between 15-30 Days	297	30	327	0.69%
Between 31-60 Days	138	23	161	0.34%
Between 61-90 Days	53	8	61	0.13%
Between 91-120 Days	14	3	17	0.04%
Between 121-180 Days	8	2	10	0.02%
In 181 + Days	0	0	0	0.00%
Those with Invalid Status Date	0	0	0	0.00%
Total Authorizations Approved or Denied	45,465	2,138	47,603	100%

Table 30: PSHP Authorization Lag Time – Percent of Total Authorizations



WellCare

- WellCare approved or denied 636,339 prior authorization requests over the period analyzed. Approximately 47 percent of these requests were approved on the date of the request and 94 percent were approved within five days. The remaining 6 percent of requests were approved within an average of 11 days.

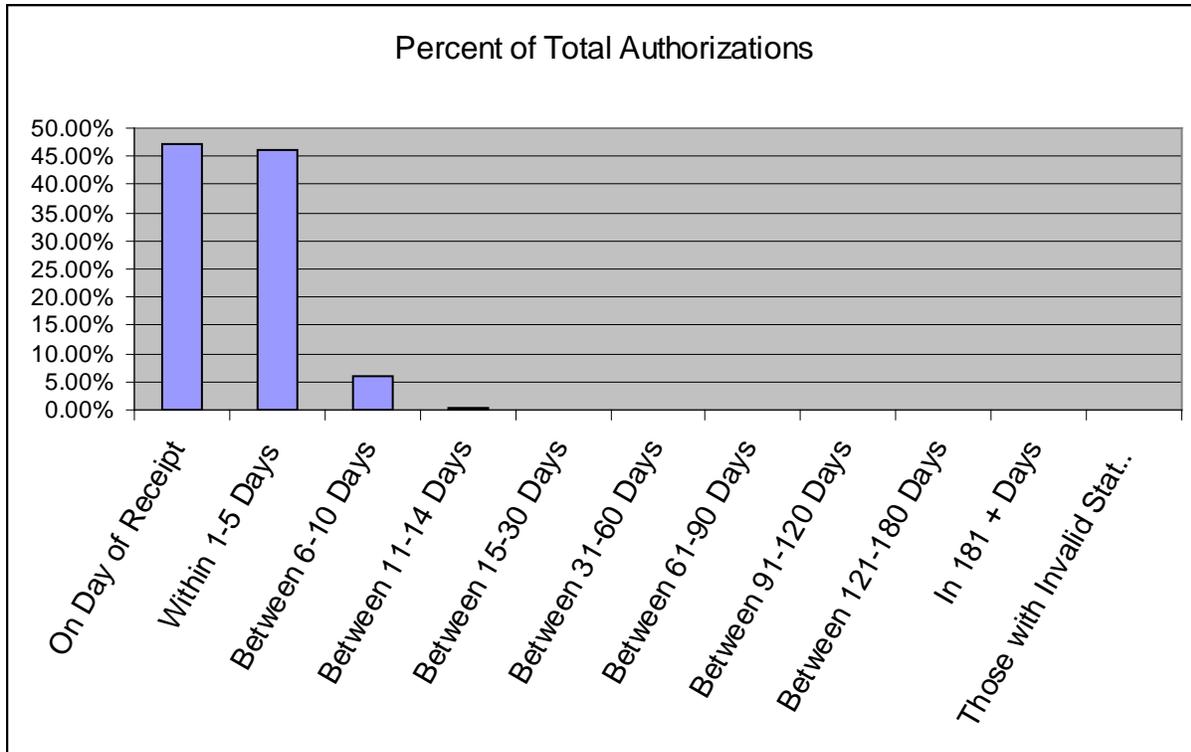
Table 31: WellCare Authorization Lag Time

Authorization Lag Time for Primary Care and Specialty Care Authorizations Approved or Denied between 12/1/2006 and 1/31/2008

Number of Authorizations Approved or Denied	Approved	Denied	Total Authorizations	Percent of Total Authorizations
On Day of Receipt	299,073	1,101	300,174	47.17%
Within 1-5 Days	281,270	13,365	294,635	46.30%
Between 6-10 Days	29,583	8,953	38,536	6.06%
Between 11-14 Days	1,133	402	1,535	0.24%
Between 15-30 Days	371	4	375	0.06%
Between 31-60 Days	330	1	331	0.05%
Between 61-90 Days	230	1	231	0.04%
Between 91-120 Days	90	8	98	0.02%
Between 121-180 Days	64	0	64	0.01%
In 181 + Days	170	7	177	0.03%

Number of Authorizations Approved or Denied	Approved	Denied	Total Authorizations	Percent of Total Authorizations
Those with Invalid Status Date	182	1	183	0.03%
Total Authorizations Approved or Denied	612,496	23,843	636,339	100%

Table 32: WellCare Authorization Lag Time – Percent of Total Authorizations



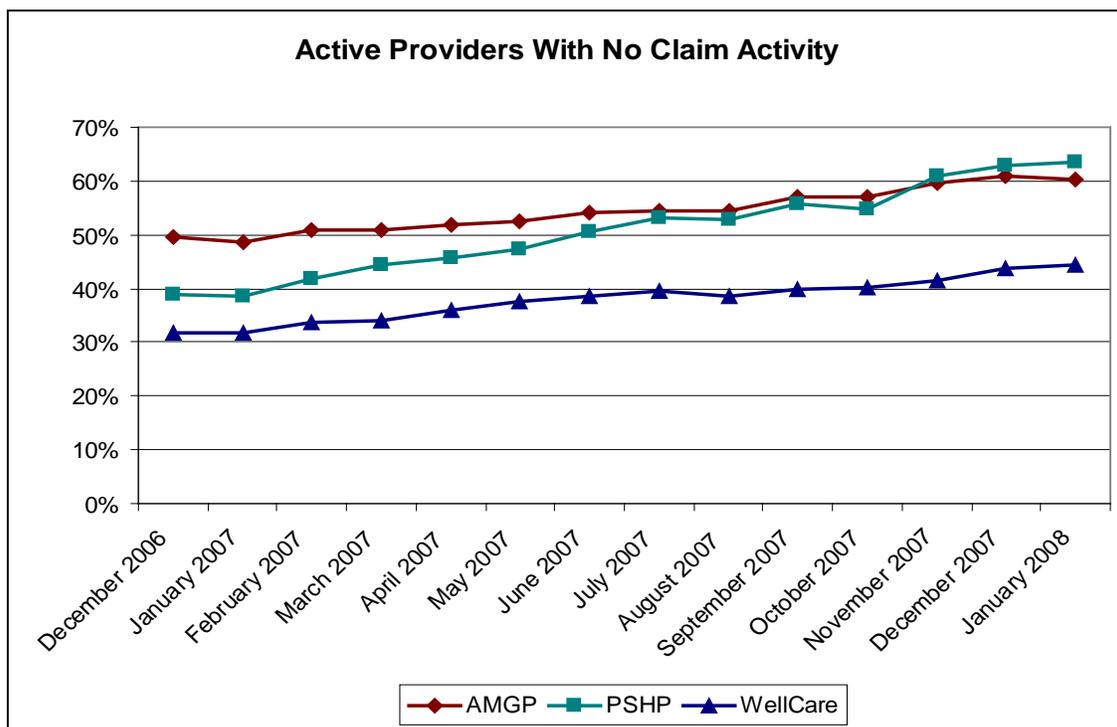
The DCH Contract with the CMOs

Prior Authorization timeframes for standard, expedited and retrospective services appear to be clearly described in section 4.11.2.5 of both the original and amended contracts. However, the data we analyzed did not include the type (standard, expedited and retrospective) of authorization request the provider was seeking nor whether an extension of timeframes was granted.

ANALYSIS VII: GEORGIA FAMILIES PROGRAM PROVIDER RETENTION

We analyzed the claims data and provider network information to determine whether any trends or potential provider retention concerns might exist for the Georgia Families program. We noted, across all CMO groups, a significant number of active providers with no claim activity. The lack of claim activity may be a result of providers ceasing network participation or having a capitation reimbursement agreement, but we are unable to confirm the exact reason(s) for limited claim activity for these providers. As indicated by the following chart, the percentage of providers with no claim activity increased for all CMOs during the fourteen-month period.

Table 33: Active Providers with No Claim Activity – All CMOs



WellCare and PSHP reported no provider terminations during the 14 month period. Ten providers terminated participation with PSHP shortly after the end of the review period. AMGP reported 448 provider terminations during the 14 month period. Given the number of providers without claim activity and the experiences shared by providers, it appears unlikely that there have been no provider terminations with PSHP and WellCare. Perhaps they have made a distinction between voluntary and involuntary provider terminations. We requested all terminations, either voluntary or involuntary.

The DCH Contract with the CMOs:

Both the original and amended contracts state in section 4.8 "*Provider Network*" that each CMO must have written selection and retention policies and procedures, however no specific retention requirements were found. The contracts also provide specific parameters regarding the providers that are required to be included in the network and, pursuant to section 2.8.1.5, in accordance with 42 CFR 438.204, DCH will monitor "The Contractor's policies and procedures for selection and retention of Providers".

Please refer to Exhibit 5 for additional detail regarding Analysis VII.

TABLE 34: FINDINGS SUMMARY

	AMGP	PSHP	WellCare
Number of Days Required to Load Contract Terms	29% prior to effective date; 71% after the effective date with average of 53 days required	69% prior to effective date; 31% after the effective date with average of 125 days required	76% prior to effective date; 24% after the effective date with average of 75 days required
Number of Days Required to Complete Credentialing	80% prior to effective date; 20% after the effective date with average of 47 days required	68% prior to effective date; 32% after the effective date with average of 142 days required	81% prior to effective date; 19% after the effective date with average of 70 days required
Accuracy of Provider Rates	We analyzed 229 provider contracts and identified no inconsistencies between the rates described in the contract and the rates in the electronic file provided by AMGP.	We analyzed 212 provider contracts and identified 13 (6%) potential inconsistencies between the rates described in the contract and the rates in the electronic file provided by PSHP. Eleven (11) claims impacted.	We analyzed 203 provider contracts and identified 4 (2%) potential inconsistencies between the rates described in the contract and the rates in the electronic file provided by WellCare. Nine hundred forty-one (941) claims impacted.
Claims Adjudication	97% paid or denied within 15 days; AMGP reported interest payments of approximately \$61,000 for claims paid or denied greater than or equal to 15 days.	91% paid or denied within 15 days; PSHP reported interest payments of approximately \$48,000 for claims paid or denied greater than or equal to 15 days.	99.7% paid or denied within 15 days; WellCare reported interest payments of approximately \$128 for claims paid or denied greater than or equal to 15 days.
Denied Claims	18% denied; 4% of those later paid within 41 days; range is 13% denied to 21% denied; January 2008 was 17%.	25% denied; 21% of those later paid within 83 days; range is 14% denied to 31% denied; January 2008 was 25%.	16% denied; 9% of those later paid within 57 days; range is 10% denied to 17% denied; January 2008 was 16%.
Denied Claims Related to Member Eligibility	6% of total claim denials related to member eligibility issues; 2% of member related denials were found to be eligible according to the lockin file of the fiscal agent contractor.	10% of total claim denials related to member eligibility issues; 16% of member related denials were found to be eligible according to the lockin file of the fiscal agent contractor.	0.1% of total claim denials related to member eligibility issues.

	<u>AMGP</u>	<u>PSHP</u>	<u>WellCare</u>
Denied Claims Related to Prior Authorization	30,785 claims denied for prior authorization out of 542,783 total denials (6%). It appears that 6,374 of the 30,785 denials for prior authorization (26%) were incorrectly denied.	13,737 claims denied for prior authorization out of 299,734 total denials (5%). We were unable to compare the denied claims with the authorization data since PSHP did not provide provider IDs, authorized procedures or authorization date(s) in their authorization data.	46,056 claims denied for prior authorization out of 494,414 total denials (9%). It appears that 1,756 of the 46,056 denials for prior authorization (4%) were incorrectly denied.
Prior Authorization Time	82% approved or denied within 5 days; 18% approved or denied within 16 days on average.	79% approved or denied within 5 days; 21% approved or denied within 9 days on average.	94% approved or denied within 5 days; 6% approved or denied within 11 days on average.
Provider Retention	High number of active providers that do not submit claims; range from approximately 50% in Dec. 2006 to approximately 60% in Jan. 2008. The number of terminations reported is 448 from Dec. 2006 to Jan. 2008.	High number of active providers that do not submit claims; range from approximately 39% in Dec. 2006 to approximately 63% in Jan. 2008. The number of terminations reported is 0 from Dec. 2006 to Jan. 2008.	High number of active providers that do not submit claims; range from approximately 32% in Dec. 2006 to approximately 45% in Jan. 2008. The number of terminations reported is 0 from Dec. 2006 to Jan. 2008.

PHYSICIAN ISSUES AND CONCERNS

Myers and Stauffer LC conducted a series of meetings with physicians and professional associations to identify issues and concerns physicians had regarding the implementation and operation of the Georgia Families program. Invitations for initial meetings were issued via e-mail and follow up telephone calls to the following professional associations:

- Medical Association of Georgia
- Georgia State Medical Association
- Georgia Chapter, American Academy of Family Physicians
- Georgia Psychiatric Physicians Association
- Georgia Chapter, American Academy of Pediatrics
- Georgia Pediatric Practice Managers Association
- Georgia Pediatric Nurses Association
- Georgia Obstetrical and Gynecological Society
- Georgia Medical Group Management Association
- Georgia Society of Ophthalmology
- Georgia Osteopathic Medical Association

On Wednesday, February 27, 2008 and Thursday, February 28, 2008, meetings were held with each professional association that responded to the invitation. The associations and their representatives included:

Medical Association of Georgia (MAG)

- David A. Cook, Executive Director
- Camilla R. Grayson, MSW, Director of Health Policy, Director of Third Party Payer

Georgia Psychiatric Physicians Association (GPPA)

- Patrice Harris, MD, Immediate Past President, GPPA
- Angela P. Shannon, MD, Vice President, GPPA
- Jenelle Martin, MD
- Michelle Crider, JLH Consulting

Georgia Chapter, American Academy of Pediatrics (GAAAP)

- Pam Patterson, Practice Administrator, Longstreet Clinic Pediatrics
- Mary A. Van Meter, PA Manager, Van Meter Pediatric Endocrinology

- Lauri Gebhart, Administrator, Childrens Center for Digestive Health Care
- Mike Chaney, Immunization Coordinator, GAAAP
- Sara “Sally” Goza, MD, Immediate Past President, GAAAP
- Avril P. Beckford, MD, Vice President, GAAAP
- Melinda Willingham, MD, Vice Chair Legislative Committee, GAAAP
- William Sexson, MD, GAAAP
- Leticia Mayfield, Program Specialist, Georgia Department of Community Health

Georgia Obstetrical and Gynecological Society

- Carole Bridges, Practice Administrator, Associates in Obstetrics & Gynecology, PC
- Juanita Marcus, Physician Practice Liaison, Atlanta Womens Health Group
- Joel Higgins, MD, Georgia Obstetrical and Gynecological Society
- Pat Cota, Executive Director, Georgia Obstetrical and Gynecological Society
- Willis Lanier, MD, Georgia Obstetrical and Gynecological Society

On Wednesday, March 12, 2008, meetings were held in Tifton and Gainesville, GA. These meetings were attended by:

- Tibisay Villalobos-Fry, M.D., Affinity Pediatrics
- Carlene Sellers, Manager, Affinity Pediatrics
- Becky Wilkerson, Pediatrics Manager, Affinity Pediatrics
- Kathy Griffin, Valdosta Children’s Healthcare
- Kathy Thomas, Accounts Receivable, Dr. Loeffler

Physicians and professional organizations were also encouraged to submit their concerns in writing if they were unable to attend. The table below presents a summary of the physician issues and concerns reported to Myers and Stauffer, by category.

Table 35: Provider-reported Issues

Issue	Reported in General	Reported for AMGP	Reported for PSHP	Reported for WellCare
CMO administration, includes inability by local management to timely and effectively resolve provider issues.	√	√	√	√
Contract provisions, the inclusion (exclusion) or changes of certain provisions or acting in a manner not specified by the contract.	√			√
CMO not paying according to contractual agreements	√	√		√
CMO coding requirements contrary to accepted standards	√	√	√	√
Global charges - interpretation of what is included	√			

Issue	Reported in General	Reported for AMGP	Reported for PSHP	Reported for WellCare
There are problems when members switch between CMOs and/or FFS	√	√		√
TPL - denying payment or recovering payments already made when possible TPL exists.	√	√	√	√
CMO not paying for covered, authorized services	√	√		√
Slow or delayed payments to providers	√	√	√	√
Miscellaneous processing issues resulting in delayed or denied payment	√	√	√	√
Utilization Management/Medical Necessity Denials and Issues	√	√		√
Precertification/Preauthorization	√	√	√	√
Communications	√			√
Eligibility related issues, including conflicting information and denial of claims	√	√	√	√
Appeals, issues with processes and timeframes	√	√	√	√
Miscellaneous processing and confidentiality issues	√		√	
Contract loading and credentialing, accuracy and length of time to accomplish issues	√	√	√	√
Timely filing issues	√	√	√	
Case Management Issues	√			
Access, provider retention and acceptance of Medicaid beneficiaries	√	√		√
System configuration/web portal issues	√		√	√
Recoupments, inadequate explanations, inappropriate recoupments	√	√	√	√
Provider reimbursement issues, not satisfied with reimbursement	√			
Provider set-up Issues, incorrect set ups including mis-assignment of members.	√	√	√	√
Pharmacy issues	√	√	√	√
Provider administrative issues/burden	√	√		
DCH is not paying the co-pays on Medicare dual eligibles.	√			

Please note that this table represents a compilation of issues and concerns submitted to Myers and Stauffer and may not represent the universe of issues and concerns from all providers. Providers decided whether to submit issues and concerns. The issues and concerns as listed and described in this table have not been verified, validated, checked, or confirmed.

RECOMMENDATIONS

We make the following observations and recommendations resulting from our analyses of physician and specialty provider claims data.

Recommendations Applicable to the CMOs

- 1) Contracts between CMOs and providers should clearly identify all of the parameters used to determine when the contract terms are effective, specifically whether the effective date is based on service date of the claim or whether it is based on the adjudication or paid date of the claim. In the situation where service date is the appropriate parameter, the contract should specify whether the date is the first or last date of service. In addition, all factors used when determining the payment of a claim should be clearly outlined.
- 2) In the event a CMO applies deviations from a written policy, affected providers and DCH should be notified in writing of the deviation and provided the rationale for such deviation prior to or within at least 5 business days following the policy deviation. The CMOs' procedures for addressing instances of deviations from written policy should be described in the CMOs' contract with all providers.
- 3) The CMO should take steps to ensure that Explanation of Benefit (EoB) codes included on the claims are accurate and sufficiently informative for the provider to clearly identify the reason a claim denies or pays differently than anticipated. A CMO should post on their web portal additional information regarding EoBs, such that providers may access this information to learn more about why claims deny and how they can address these denial issues. Based on the large volume of claims that denied for reasons related to billing, CMOs should also take steps to improve the understanding of billing requirements and minimize the frequency of billing policy changes.
- 4) The CMOs should take adequate care to ensure that the information contained in the provider directories is current and accurate. We observed a number of instances where the provider directory contained incorrect information. We recommend that the CMOs complete periodic reviews of their directories to ensure their accuracy.
- 5) We recommend that CMOs modify their policies to automatically reprocess claims paid or denied inappropriately as a result of system corrections, claims denied for members that were truly eligible and fee-related updates without requiring the provider to resubmit the claim or contact the CMO to initiate the reprocessing.

- 6) Based on the sample of provider contracts that were reviewed, one CMO loaded rates for 13 providers incorrectly. Another CMO loaded rates for four providers incorrectly. CMOs should correct these rates and adjust the associated claims. We recommend that CMOs complete an analysis to identify and correct, for other providers, all contract terms that have been loaded incorrectly, as well as correct all incorrectly adjudicated claims.
- 7) CMOs should evaluate the issues for those providers with the largest number of denied claims and develop training, education, or additional resources targeted to those providers' issues.
- 8) During the analysis of denied claims, we observed that for two CMOs, approximately 50 percent of all denied claims, and for one CMO approximately 25 percent of all denied claims, were related to the provider not understanding coding requirements, benefit limits, covered services and related issues. We recommend that CMOs continue efforts to improve the transparency of information for providers, including updating, publishing, and maintaining lists of covered services, services that require prior authorization, services included in global fee periods, specific benefit limitations, age/sex restrictions, and other applicable billing and coverage information that may be helpful to providers to reduce claim denial rates.
- 9) For AMGP and WellCare, there are a large number of denied claims that did not contain an EoB. CMOs should include an EoB on each claim denied to ensure that providers are able to determine the reasons for denials.
- 10) Upon loading of contracts or contract amendments, we recommend that CMOs generate a report of the effective and end dates of the contract, facility characteristics (e.g., physical address, payment address, etc), provider-based entities as applicable, effected practice and service groups (e.g., anesthesia groups, emergency physician groups) billing under the provider identification number, and all provider rates. This report should be submitted to the provider. The provider should carefully review and upon concurrence, sign the document and return a copy to the CMO. The CMOs and providers should maintain a copy of the document.

Recommendations Applicable to Physician Providers

- 11) In some cases, the contracts between the CMOs and physicians, as well as the provider manuals and written policies of the CMOs, include terms and information that might be subject to interpretation. Physicians have ultimate responsibility for the contracts they execute and should exercise increased due diligence before signing contracts with the CMOs. Physician providers should review contracts with the CMOs and ensure that all provisions are clear and

unambiguous within the contract itself, and any verbal assurances by a representative of a health plan are detailed in writing within the contract.

- 12) Providers and provider associations should work closely with the CMOs on follow-up training workshops, including procedures to track prior authorization requests and responses, clarifying CMO prior authorization policies and policy changes, and outlining the differences between CMO prior authorization requirements and traditional Medicaid prior authorization requirements.
- 13) Providers should confirm via the GHP web portal that patients are Medicaid eligible and are enrolled in a CMO prior to providing services and again when submitting a claim, in accordance with HB 1234, section 33-21A-9(a). We understand that a data/time stamp functionality is now available when to assist providers in documenting member eligibility.

Recommendations Applicable to the Department of Community Health

- 14) Many of the contracts with physicians and specialists required an extended period of time to be entered into the CMOs' claims processing systems. Among the three CMOs, it appears that for 166 providers, or 0.6 percent of providers, it took greater than 365 days to enter contract terms. While the percentage of providers that required greater than 365 days is minimal, each CMO had certain providers where it appears that it required greater than 500 days, and greater than 600 days for two of the CMOs. Based on these cases, we recommend that the Department consider adopting contract loading timeline requirements, similar to those they implemented for credentialing, for the DCH/CMO contract.
- 15) We observed a number of instances where claims were denied and reprocessed by the CMOs. Information received from both providers and CMOs suggested that reprocessing may only be applied when requested by providers. DCH may wish to consider additional contract terminology in contract provision 4.9.7.5.4 that would require CMOs to periodically test the claims data to ensure that mispayments are identified and reprocessed.
- 16) A significant number of active providers appeared to have no claim activity during the period December 31, 2007 through January 31, 2008. When evaluating network adequacy, DCH may wish to consider conducting additional procedures to identify providers who are being reported as participating providers by the CMOs but who do not appear to have any claim activity for an extended period of time.

EXHIBITS

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 1 – Analysis I: Provider Contracting Timeliness

AMERIGROUP			
Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Hoffman Jr, James C.	2/6/2008	6/1/2006	615
Williams, Sara L.	1/28/2008	6/1/2006	606
Tomlinson, Michelle A.	1/22/2008	6/1/2006	600
Griggs, Susan	1/15/2008	6/1/2006	593
Chaney, Joyce M.	1/8/2008	6/1/2006	586
Darling, James D.	1/3/2008	6/1/2006	581
Kim, Robert E.	1/3/2008	6/1/2006	581
Duncan, Karen S.	1/3/2008	6/1/2006	581
Tang, Xuexin	1/3/2008	6/1/2006	581
Pollard, Derek B.	1/2/2008	6/1/2006	580
Curtin, Jay L.	1/2/2008	6/1/2006	580
Cameron, Tricia M.	1/2/2008	6/1/2006	580
Christie, Ryan M.	1/2/2008	6/1/2006	580
Lawrence, Richard L.	1/2/2008	6/1/2006	580
Smith, Venneisa	12/28/2007	6/1/2006	575
Bland, William H.	12/20/2007	6/1/2006	567
Flowers, Lynn K.	3/11/2008	8/26/2006	563
Burban, Thomas	3/11/2008	8/28/2006	561
Shouse, Karen	1/15/2008	7/6/2006	558
Dalwai, Fatima	12/6/2007	6/1/2006	553
Gandhi, Peahen H.	12/6/2007	6/1/2006	553
Pugh, Jacqueline	12/6/2007	6/1/2006	553
Sayers, Julie M.	12/6/2007	6/1/2006	553
Schwartz, Meyer P.	12/6/2007	6/1/2006	553
Lindstrom, Eric J.	1/3/2008	7/1/2006	551

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Fernhoff, Paul M.	11/16/2007	6/1/2006	533
Augustin, Gerald M.	1/15/2008	8/3/2006	530
Jung, Janet C.	11/13/2007	6/1/2006	530
Cinnamon, Jay	1/22/2008	8/14/2006	526
Fernhoff, Paul M.	11/1/2007	6/1/2006	518
Killingsworth, Daniel	10/25/2007	6/1/2006	511
Rogido, Marta R.	10/19/2007	6/2/2006	504
Schoffner, Kindell R.	10/19/2007	6/2/2006	504
Cheshire, Stephen L.	10/17/2007	6/1/2006	503
Al Rabbat, Mohammed H.	10/11/2007	6/2/2006	496
Butterfield, Patrice H.	10/11/2007	6/2/2006	496
Caudill, Tina M.	10/12/2007	6/3/2006	496
Douglas, Jason F.	10/12/2007	6/3/2006	496
Fenlon, Whatley B.	10/12/2007	6/3/2006	496
Herbert - Jones, Deborah	10/12/2007	6/3/2006	496
Lilburn WIC, Clinic	10/12/2007	6/3/2006	496
Mullins, Heather	10/10/2007	6/1/2006	496
Oehler, Daniel A.	10/10/2007	6/1/2006	496
Piri, Manuel	10/10/2007	6/1/2006	496
Adiele, Chime J.	10/11/2007	6/3/2006	495
Brummett, Darin M.	10/9/2007	6/1/2006	495
Burchfield, Brittany E.	10/11/2007	6/3/2006	495
Lin, Ho Nien	10/9/2007	6/1/2006	495
Marchand, Arturo E.	10/9/2007	6/1/2006	495
Morin, Alexandre	10/9/2007	6/1/2006	495
Patel, Alpesh D.	10/9/2007	6/1/2006	495

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Payan, John M.	10/9/2007	6/1/2006	495
Sistrunk, Thomas L.	10/9/2007	6/1/2006	495
Sterling, Howard W.	10/9/2007	6/1/2006	495
Arnold, John F.	10/8/2007	6/1/2006	494
Kneff Jr, James	1/3/2008	8/28/2006	493
Lipp, Lynette N.	1/3/2008	8/28/2006	493
Reeves, Julie O.	11/30/2007	7/25/2006	493
White, Iris L.	1/3/2008	8/28/2006	493
Lause, Cree M.	10/5/2007	6/1/2006	491
Smith, Sarah R.	10/17/2007	6/14/2006	490
Vera, Eric	1/29/2008	9/30/2006	486
Madhu, Purushothaman	9/28/2007	6/1/2006	484
Schoffner, Kindell R.	12/28/2007	9/1/2006	483
Ussery, Donna (Renee)	12/28/2007	9/1/2006	483
Khirbat, Rohit	1/3/2008	9/8/2006	482
Simmons, Lorenza A.	3/4/2008	11/8/2006	482
Adan, Dante C.	9/20/2007	6/1/2006	476
Mandock, Ofelia S.	9/20/2007	6/1/2006	476
Duquette, Joyce M.	10/17/2007	6/30/2006	474
Lindstrom, Eric J.	10/17/2007	7/1/2006	473
Jacobs, Sol	10/10/2007	7/1/2006	466
Foreman, Kristofer R.	12/4/2007	9/1/2006	459
Lokey, John L.	1/2/2008	10/6/2006	453
Moncada, Jr, Armando	8/30/2007	6/3/2006	453
Moncada, Jr, Armando	8/30/2007	6/3/2006	453
Todd, James M.	1/2/2008	10/6/2006	453

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Jacoby, Darin	8/27/2007	6/1/2006	452
Akiki, Hanna T.	8/23/2007	6/1/2006	448
Naggar, Heather F.	10/23/2007	8/1/2006	448
Amerson, Meliha	8/21/2007	6/1/2006	446
Cameron, Joana M.	9/7/2007	6/20/2006	444
Kehl, Melissa E.	10/17/2007	7/31/2006	443
Patel, Himanshu M.	10/17/2007	7/31/2006	443
Secrest, Desha L.	10/17/2007	7/31/2006	443
Cook, Michael W.	8/16/2007	6/1/2006	441
Cook, Michael W.	8/16/2007	6/1/2006	441
DeMuth, Karen A.	8/16/2007	6/1/2006	441
Robinowitz, Michael S.	8/14/2007	6/1/2006	439
Burton, Jr, Charles H.	8/14/2007	6/1/2006	439
Goodman, Michelle L.	8/10/2007	6/1/2006	435
Mendoza, Maria Theresa	8/10/2007	6/1/2006	435
Villa, John F.	8/9/2007	6/1/2006	434
Jeon, Connie Y.	8/8/2007	6/1/2006	433
Hans, Robyn J.	8/8/2007	6/1/2006	433
Harrison, Raymond E.	8/3/2007	6/1/2006	428
Mount, Jason M.	8/3/2007	6/1/2006	428
Brito, Esther D.	8/1/2007	6/1/2006	426
Eanes, John T.	7/31/2007	6/3/2006	423
Johnson, Charlene	9/11/2007	7/20/2006	418
Herran, Francisco J.	1/18/2008	11/27/2006	417
Flacker, Jonathan M.	7/20/2007	6/1/2006	414
Watson, Elizabeth	7/13/2007	6/1/2006	407

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Sherman, Margaret A.	3/17/2008	2/12/2007	399
Pedrick, Heather H.	10/17/2007	9/17/2006	395
Curtin, Jay L.	6/25/2007	6/3/2006	387
Pittman, Houston H.	6/25/2007	6/3/2006	387
Dragun, Anthony	7/13/2007	6/26/2006	382
Mezzatesta, Rita S.	10/17/2007	9/30/2006	382
Morin, Alexandre	7/13/2007	6/26/2006	382
Samady, Habib	6/20/2007	6/3/2006	382
Payne, Mailee	6/15/2007	6/1/2006	379
Pajaro, Julio E.	3/11/2008	2/28/2007	377
Shevitz, Stewart A.	6/15/2007	6/3/2006	377
Crawford, Edward C.	12/10/2007	11/29/2006	376
Graham, Donald V.	6/14/2007	6/3/2006	376
Purohit, Bhumiben S.	1/14/2008	1/8/2007	371
Malloy, Jacqueline A.	12/6/2007	12/1/2006	370
Alcorn, Bonnie A.	8/10/2007	8/11/2006	364
Verrilli, Sandy E.	5/30/2007	6/1/2006	363
Rosen, Wayne M.	12/6/2007	12/11/2006	360
Delong Jr, James M.	12/6/2007	12/12/2006	359
Bosch, Ortelio	11/14/2007	11/21/2006	358
Mackey, Kelly M.	12/6/2007	12/13/2006	358
Nguyen, Khoa D.	8/10/2007	8/18/2006	357
Piros, George P.	8/10/2007	8/18/2006	357
Zimmerman, Keith W.	1/28/2008	2/12/2007	350
Shih, Jennifer A.	5/17/2007	6/3/2006	348
Blain, Michel W.	7/26/2007	8/14/2006	346

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Gunchick, Kathleen M.	8/10/2007	8/30/2006	345
Crawford, Edward C.	1/8/2008	1/29/2007	344
Cantey, William	2/25/2008	3/21/2007	341
Pugliese, Marcy M.	10/17/2007	11/10/2006	341
Cummings, Kristina M.	2/4/2008	3/1/2007	340
Horton, Beverli L.	5/7/2007	6/1/2006	340
Phillips, Michael A.	1/2/2008	1/30/2007	337
Chang, Hans	1/3/2008	2/1/2007	336
Horn, Jon D.	10/17/2007	11/15/2006	336
Haynes-Renz, Dale H.	7/9/2007	8/8/2006	335
Dodds, Nedra R.	8/11/2007	9/12/2006	333
Newton, Judy R.	11/12/2007	12/18/2006	329
Goldsmith, Toby	4/24/2007	6/3/2006	325
Harvey, III, James E.	4/24/2007	6/3/2006	325
Kelly, Jason	4/24/2007	6/3/2006	325
Lee, Daniel J.	4/24/2007	6/3/2006	325
Letts, Maureen	4/24/2007	6/3/2006	325
Upchurch, Timothy	4/24/2007	6/3/2006	325
Walker, Paul L.	8/22/2007	10/1/2006	325
White, Brent	4/24/2007	6/3/2006	325
Callaway, Juaquita D.	1/17/2008	2/27/2007	324
Jacobson, Michael S.	1/31/2008	3/16/2007	321
Nwosu, Oguchi O.	4/24/2007	6/7/2006	321
Bilek, William	9/6/2007	10/23/2006	318
Patel, Bhaskerrao M.	4/24/2007	6/13/2006	315
Abernathy, Robert A.	4/9/2007	6/1/2006	312

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Kahan, Karen	4/10/2007	6/3/2006	311
McIntosh, Modupe D.	4/10/2007	6/3/2006	311
Agbulos, Stanley A.	12/6/2007	1/30/2007	310
Myers, Jr, Robert K.	6/22/2007	8/16/2006	310
Sinclair, Scott P.	12/6/2007	1/30/2007	310
Atkinson, Denis	4/5/2007	6/1/2006	308
Jones, Anna C.	10/17/2007	12/13/2006	308
Jani, Ashesh B.	4/4/2007	6/1/2006	307
Yarmer, Kristie L.	6/5/2007	8/2/2006	307
Atkinson, Denis	4/5/2007	6/3/2006	306
Childers, Dona F.	12/4/2007	2/1/2007	306
Farber, Eugene W.	4/5/2007	6/3/2006	306
Fasy, Elizabeth A.	4/5/2007	6/3/2006	306
Lugo, Esteban	4/5/2007	6/3/2006	306
Lugo, Esteban	4/5/2007	6/3/2006	306
Martinez, Enrique J.	4/5/2007	6/3/2006	306
Munoz-Mantilla, Doris	4/5/2007	6/3/2006	306
Pae, David H.	4/5/2007	6/3/2006	306
Sharon, Elad	4/5/2007	6/3/2006	306
Shaz, David J.	4/5/2007	6/3/2006	306
Shaz, David J.	4/5/2007	6/3/2006	306
Solis Lopez, David	4/5/2007	6/3/2006	306
Wint, Dylan	4/5/2007	6/3/2006	306
Bruce, Beau	4/4/2007	6/3/2006	305
Bruce, Beau	4/4/2007	6/3/2006	305
Cribbs, Blaine E.	4/4/2007	6/3/2006	305

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Cribbs, Blaine E.	4/4/2007	6/3/2006	305
Dworetz, April R.	4/4/2007	6/3/2006	305
Gordon, Anthony	4/4/2007	6/3/2006	305
Hein, Eric W.	4/4/2007	6/3/2006	305
Hein, Eric W.	4/4/2007	6/3/2006	305
Hui, Ferdinand	4/4/2007	6/3/2006	305
Hui, Ferdinand	4/4/2007	6/3/2006	305
Iqbal, Ayesha A.	4/4/2007	6/3/2006	305
Jani, Ashesh B.	4/4/2007	6/3/2006	305
Khalid, Asma	4/4/2007	6/3/2006	305
Krakov, David A.	4/4/2007	6/3/2006	305
Kuhar, David T.	4/4/2007	6/3/2006	305
Kuhar, David T.	4/4/2007	6/3/2006	305
Shaz, Beth	4/4/2007	6/3/2006	305
Shaz, Beth	4/4/2007	6/3/2006	305
Sollinger, Ann	4/4/2007	6/3/2006	305
Sollinger, Ann	4/4/2007	6/3/2006	305
Young, Andrew	4/4/2007	6/3/2006	305
Harris, Angela D.	4/3/2007	6/3/2006	304
Hoffman, Sue L.	8/23/2007	10/23/2006	304
Mekoya, Abiy D.	8/20/2007	10/20/2006	304
Fulton County, Health & Well	3/30/2007	6/1/2006	302
Barnett, III, Golden	3/30/2007	6/3/2006	300
Bernstein, Lisa B.	3/28/2007	6/1/2006	300
Bouloux, Gary F.	3/30/2007	6/3/2006	300
Bouloux, Gary F.	3/30/2007	6/3/2006	300

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Kalra, Guruman S.	3/30/2007	6/3/2006	300
Oskoui, Frederick R.	3/30/2007	6/3/2006	300
Oskoui, Frederick R.	3/30/2007	6/3/2006	300
Posner, Geoffrey	3/30/2007	6/3/2006	300
Tindol, Jr, George A.	3/30/2007	6/3/2006	300
Tindol, Jr, George A.	3/30/2007	6/3/2006	300
Anderson, Albert	3/29/2007	6/3/2006	299
Baloch, Imran A.	3/29/2007	6/3/2006	299
Bloom, Heather	3/29/2007	6/3/2006	299
Bloom, Heather	3/29/2007	6/3/2006	299
Brann Jr, Alfred	3/29/2007	6/3/2006	299
Carter, Alexis B.	3/29/2007	6/3/2006	299
Castro-Revoredo, Iris A.	3/29/2007	6/3/2006	299
Dolak, James A.	3/29/2007	6/3/2006	299
El-Kebbi, Imad M.	3/29/2007	6/3/2006	299
Gilbert, James	3/29/2007	6/3/2006	299
Herman, Adam	3/29/2007	6/3/2006	299
Jackson, III, James F.	3/29/2007	6/3/2006	299
Massaquoi, Iyesatta	3/29/2007	6/3/2006	299
Massaquoi, Iyesatta	3/29/2007	6/3/2006	299
Nemi, Ajit	3/29/2007	6/3/2006	299
Nemi, Ajit	3/29/2007	6/3/2006	299
Patel, Alpen A.	3/29/2007	6/3/2006	299
Patel, Alpen A.	3/29/2007	6/3/2006	299
Sabino, Jr, Henaro C.	3/29/2007	6/3/2006	299
Schwartz, Ira K.	3/29/2007	6/3/2006	299

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Shane, Andrea L.	3/29/2007	6/3/2006	299
Amaral, Sandra G.	3/28/2007	6/3/2006	298
Arellano, Martha	3/28/2007	6/3/2006	298
Arellano, Martha	3/28/2007	6/3/2006	298
Bawa, Maneesh	3/28/2007	6/3/2006	298
Bearden, Christopher M.	3/28/2007	6/3/2006	298
Herndon, Emily J.	3/26/2007	6/1/2006	298
Hewitt, William H.	3/28/2007	6/3/2006	298
Hewitt, William H.	3/28/2007	6/3/2006	298
Highsmith, Jason	3/28/2007	6/3/2006	298
Highsmith, Jason	3/28/2007	6/3/2006	298
Hirsh, Daniel A.	3/28/2007	6/3/2006	298
Hochberg, Natasha S.	3/28/2007	6/3/2006	298
Jacob, Maryann K.	3/28/2007	6/3/2006	298
Kelly, Jason	3/28/2007	6/3/2006	298
Kim, Youjeong	3/28/2007	6/3/2006	298
Kobaidze, Ketevan	3/28/2007	6/3/2006	298
Lee, Daniel J.	3/28/2007	6/3/2006	298
Letts, Maureen	3/28/2007	6/3/2006	298
Liebzeit, Jason E.	3/28/2007	6/3/2006	298
Liebzeit, Jason E.	3/28/2007	6/3/2006	298
Lo, Wayne R.	3/28/2007	6/3/2006	298
Lo, Wayne R.	3/28/2007	6/3/2006	298
Melson, Mark	3/28/2007	6/3/2006	298
Melson, Mark	3/28/2007	6/3/2006	298
Mosley, Christopher K.	3/28/2007	6/3/2006	298

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Mosley, Christopher K.	3/28/2007	6/3/2006	298
Mulligan, Mark	3/28/2007	6/3/2006	298
Mulligan, Mark	3/28/2007	6/3/2006	298
Nathan, Sandra	3/28/2007	6/3/2006	298
Nathan, Sandra	3/28/2007	6/3/2006	298
Niyyar, Vandana	3/28/2007	6/3/2006	298
O'Donnell, Kathleen T.	3/28/2007	6/3/2006	298
O'Donnell, Kathleen T.	3/28/2007	6/3/2006	298
O'Donnell, Kathleen T.	3/28/2007	6/3/2006	298
Ohuabunwa, Ugochi	3/28/2007	6/3/2006	298
Osborn, Melissa K.	3/28/2007	6/3/2006	298
Parker, Monica L.	3/28/2007	6/3/2006	298
Petrillo, Tony M.	3/28/2007	6/3/2006	298
Pollack, Brian P.	3/28/2007	6/3/2006	298
Pollack, Brian P.	3/28/2007	6/3/2006	298
Ponnambalam, Sasikala	3/28/2007	6/3/2006	298
Rossi, Peter J.	3/26/2007	6/1/2006	298
Vos, Miriam B.	3/28/2007	6/3/2006	298
Vos, Miriam B.	3/28/2007	6/3/2006	298
Wheatley, Matthew A.	3/28/2007	6/3/2006	298
White, Brent	3/28/2007	6/3/2006	298
White, Terry	3/28/2007	6/3/2006	298
White, Terry	3/28/2007	6/3/2006	298
Zagorski, Stanley	3/28/2007	6/3/2006	298
Acker, Sara	3/27/2007	6/3/2006	297
Acker, Sara	3/27/2007	6/3/2006	297

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Amaral, Sandra G.	3/27/2007	6/3/2006	297
Amaral, Sandra G.	3/27/2007	6/3/2006	297
Bawa, Maneesh	3/27/2007	6/3/2006	297
Bawa, Maneesh	3/27/2007	6/3/2006	297
Blossom, Marie M.	3/27/2007	6/3/2006	297
Blossom, Marie M.	3/27/2007	6/3/2006	297
Chatterjee, Sanjukta R.	3/27/2007	6/3/2006	297
Christie, Ryan M.	3/27/2007	6/3/2006	297
Christie, Ryan M.	3/27/2007	6/3/2006	297
Copland, Susannah	3/27/2007	6/3/2006	297
Craighead, Wade	3/27/2007	6/3/2006	297
Crawford, Kelly B.	3/27/2007	6/3/2006	297
Dekle, Catherine	3/27/2007	6/3/2006	297
Doherty, Terrence J.	3/27/2007	6/3/2006	297
Doherty, Terrence J.	3/27/2007	6/3/2006	297
Durham, Megan M.	3/27/2007	6/3/2006	297
Eskildsen, Manuel	3/27/2007	6/3/2006	297
Farmer, Timothy L.	3/27/2007	6/3/2006	297
Gerardi, Maryrose	3/27/2007	6/3/2006	297
Gogia, Rajesh	3/27/2007	6/3/2006	297
Gogia, Rajesh	3/27/2007	6/3/2006	297
Goldberg, Susan	3/27/2007	6/3/2006	297
Goldsmith, Toby	3/27/2007	6/3/2006	297
Hamrick, Shannon E.	3/27/2007	6/3/2006	297
Hamrick, Shannon E.	3/27/2007	6/3/2006	297
Handley, Sarah	3/27/2007	6/3/2006	297

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Handley, Sarah	3/27/2007	6/3/2006	297
Hess, Jeremy J.	3/27/2007	6/3/2006	297
Hess, Jeremy J.	3/27/2007	6/3/2006	297
Robinson, Kimberly	3/27/2007	6/3/2006	297
Shah, Neil	3/27/2007	6/3/2006	297
Shih, Jennifer A.	3/27/2007	6/3/2006	297
Shirey, Neal D.	3/27/2007	6/3/2006	297
Shirey, Neal D.	3/27/2007	6/3/2006	297
Smith Jr, Willie	3/27/2007	6/3/2006	297
Sood, Shalini	3/27/2007	6/3/2006	297
Sood, Shalini	3/27/2007	6/3/2006	297
Starsiak, Michael	3/27/2007	6/3/2006	297
Stoltz, Christine	3/27/2007	6/3/2006	297
Sutter, Mark E.	3/27/2007	6/3/2006	297
Takle, Leiv M.	3/27/2007	6/3/2006	297
Takle, Leiv M.	3/27/2007	6/3/2006	297
Terk, Michael	3/27/2007	6/3/2006	297
Thadani, Sharmila S.	3/27/2007	6/3/2006	297
Thomas, Lisa-Gail	3/27/2007	6/3/2006	297
Thompson, Karen	3/27/2007	6/3/2006	297
Upchurch, Timothy	3/27/2007	6/3/2006	297
VanderEnde, Daniel S.	3/27/2007	6/3/2006	297
Wheatley, Matthew A.	3/27/2007	6/3/2006	297
Atkinson, Bruce E.	3/17/2008	5/26/2007	296
Leski, Mark J.	8/29/2007	11/6/2006	296
Doss, Basem N.	10/17/2007	12/30/2006	291

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Eiring, Cynthia	8/29/2007	11/11/2006	291
Faudree, Cyndi B.	7/13/2007	9/26/2006	290
Coan, Marc	5/17/2007	8/1/2006	289
Youmans, Cassandra D.	10/17/2007	1/3/2007	287
Parmer, Keith M.	11/2/2007	1/25/2007	281
Brelsford, George	5/8/2007	8/1/2006	280
Hayes-Boucher, Angela	4/5/2007	7/1/2006	278
McCall, Calvin O.	3/7/2007	6/3/2006	277
Raynor, B D.	3/7/2007	6/3/2006	277
Costarides, Anastasios P.	3/6/2007	6/3/2006	276
Holder, Chad A.	3/6/2007	6/3/2006	276
Holton, Benjamin R.	3/6/2007	6/3/2006	276
Kallen, Caleb B.	3/6/2007	6/3/2006	276
Ruffin, Saliem F.	11/5/2007	2/2/2007	276
Seelig, Beth J.	3/6/2007	6/3/2006	276
Tepper, Micah R.	11/16/2007	2/14/2007	275
Piazza, Anthony J.	3/7/2007	6/6/2006	274
Richard, Gary M.	8/29/2007	11/28/2006	274
Hammerberg, Eric M.	3/6/2007	6/8/2006	271
King, Randall S.	5/30/2007	9/1/2006	271
Miller, Maribel D.	10/30/2007	2/1/2007	271
Bishara, Moe H.	9/28/2007	1/1/2007	270
Bruno, Salvador	7/31/2007	11/6/2006	267
Perkins, Kathirae S.	4/24/2007	8/1/2006	266
Black, Damon A.	3/22/2007	7/1/2006	264
Hirsh, Emily L.	2/19/2007	6/1/2006	263

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Flunker, Annabel R.	8/21/2007	12/1/2006	263
Blackston, Ronald	2/19/2007	6/3/2006	261
Greenidge, Colleen M.	2/19/2007	6/3/2006	261
Hamilton, James G.	2/16/2007	6/1/2006	260
Medrzycki, Robert A.	2/16/2007	6/1/2006	260
Butler, Michael H.	7/24/2007	11/7/2006	259
Littlefield, Jerry M.	10/17/2007	1/31/2007	259
Worthington, Laura L.	10/17/2007	1/31/2007	259
Falcon Jr, Hugo	2/16/2007	6/3/2006	258
Huff, Erica A.	4/24/2007	8/9/2006	258
Johnson, Alan R.	2/16/2007	6/3/2006	258
Johnson, Alan R.	2/16/2007	6/3/2006	258
Knopf, Richard R.	5/3/2007	8/18/2006	258
Sands, Natasha A.	10/17/2007	2/1/2007	258
Falcon Jr, Hugo	2/15/2007	6/3/2006	257
Falcon Jr, Hugo	2/15/2007	6/3/2006	257
Aliotta, Brandy T.	11/9/2007	3/1/2007	253
Bailey, Kathryn S.	11/9/2007	3/1/2007	253
Bowen, Mark T.	11/9/2007	3/1/2007	253
Bradley, Catherine J.	11/9/2007	3/1/2007	253
Brown, Rena I.	11/9/2007	3/1/2007	253
Catalan, Susan E.	11/9/2007	3/1/2007	253
Chumley, Angela D.	11/9/2007	3/1/2007	253
Davis, Jaqueline M.	11/9/2007	3/1/2007	253
Gardner, Robyn M.	11/9/2007	3/1/2007	253
Hannah, Jody L.	11/9/2007	3/1/2007	253

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Ignacio, Katherine Y.	11/9/2007	3/1/2007	253
Johnson, Catherine B.	11/9/2007	3/1/2007	253
Johnston, James M.	11/9/2007	3/1/2007	253
Jones, Paula D.	11/9/2007	3/1/2007	253
Khatami, Khatereh	11/9/2007	3/1/2007	253
Lanier, Wendy E.	11/9/2007	3/1/2007	253
Lester, Windy S.	11/9/2007	3/1/2007	253
Lyons, Ella C.	11/9/2007	3/1/2007	253
Mellick, Larry B.	2/9/2007	6/1/2006	253
Miale, Thomas D.	11/9/2007	3/1/2007	253
Musto, Michele M.	11/9/2007	3/1/2007	253
Peigh, Beth A.	11/9/2007	3/1/2007	253
Reeves, Kimberly M.	11/9/2007	3/1/2007	253
Sumner, Warren R.	11/9/2007	3/1/2007	253
Wallace, James H.	11/9/2007	3/1/2007	253
Woods, Judith A.	11/9/2007	3/1/2007	253
Yarbrough, Claudia E.	11/9/2007	3/1/2007	253
Delaurier, Gregory A.	8/9/2007	12/1/2006	251
Jackson, Rhonda M.	2/9/2007	6/3/2006	251
Johnson, Paul S.	2/7/2007	6/1/2006	251
Taylor-Mahone, Stephanie	2/9/2007	6/3/2006	251
Zweig, Julie L.	2/9/2007	6/3/2006	251
Dourron, Rodney M.	4/24/2007	8/18/2006	249
Ferrelle, Christine B.	2/13/2008	6/12/2007	246
Harrison, Douglas G.	9/4/2007	1/1/2007	246
Cheng, John I.	3/28/2007	7/26/2006	245

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Craycraft, Amy M.	4/3/2007	8/1/2006	245
Steele, Wendy L.	4/24/2007	8/22/2006	245
Moore, Russell R.	1/31/2007	6/1/2006	244
Grossman, Peter D.	10/2/2007	2/1/2007	243
Parkos, Charles A.	1/30/2007	6/1/2006	243
Primo, Susan A.	1/30/2007	6/1/2006	243
Ramsay, James G.	1/30/2007	6/1/2006	243
Whitfield, Raymond L.	4/24/2007	8/24/2006	243
Cleveland, Iris B.	1/30/2007	6/3/2006	241
Hehn, Rudolf J.	5/17/2007	9/18/2006	241
Darvish, Victoria M.	8/3/2007	12/6/2006	240
Morag, Rumm M.	1/27/2007	6/1/2006	240
Hendrix III, Vernon J.	1/26/2007	6/1/2006	239
Boudreaux, Daniel J.	1/25/2008	5/31/2007	239
Moulton, Amber	8/1/2007	12/5/2006	239
Fortes, Tia	4/24/2007	8/29/2006	238
Nixon, Samuel C.	4/24/2007	8/30/2006	237
Paradisis, Peggy M.	3/28/2007	8/3/2006	237
Ready, Jawana N.	1/18/2007	6/1/2006	231
Goswami, Ketan G.	2/21/2007	7/5/2006	231
Greenwald, Michael H.	1/26/2007	6/9/2006	231
Harrison, Jennifer B.	10/12/2007	2/24/2007	230
Fresh, Edith M.	4/30/2007	9/13/2006	229
Idowu, Olatunde O.	2/6/2007	6/22/2006	229
Diebolt, Whitney H.	4/24/2007	9/8/2006	228
Misra, Sudipta	8/16/2007	1/1/2007	227

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Holloway, Tiffany	8/3/2007	12/21/2006	225
Kavuri, Surendranath	8/28/2007	1/18/2007	222
Burnside, Donna M.	9/24/2007	2/15/2007	221
Franklin, Mary E.	9/24/2007	2/15/2007	221
Reeves, Julie O.	9/24/2007	2/15/2007	221
Chastain, John B.	1/7/2008	6/1/2007	220
DeGeorge, Nikki J.	3/30/2007	8/22/2006	220
Jaglan, Sandeep	1/7/2008	6/1/2007	220
Rishel-Brier, Janie C.	1/7/2008	6/1/2007	220
Andruik, Alexander J.	7/9/2007	12/2/2006	219
Baens-Bailon, Rita G.	7/9/2007	12/2/2006	219
Combes-Osacar, Ana	5/8/2007	10/1/2006	219
Cowart III, Loy D.	5/3/2007	9/26/2006	219
Barnes, Dawn K.	12/4/2007	5/1/2007	217
Davenport, Lottie S.	12/4/2007	5/1/2007	217
Deweese, Vicki R.	12/4/2007	5/1/2007	217
Kimball, Michelle S.	12/4/2007	5/1/2007	217
Flanigan, Jr, Clarence	2/16/2007	7/20/2006	211
Hunter, Hermeyone T.	7/25/2007	12/26/2006	211
Godfrey, Angela S.	10/18/2007	3/22/2007	210
McRae, Lorraine	4/24/2007	9/26/2006	210
Becton, James L.	12/27/2006	6/1/2006	209
Lawhead, Jr, Raymond A.	2/19/2008	7/25/2007	209
Bain, Janice K.	4/24/2007	9/29/2006	207
Awe, Olugbenga A.	8/9/2007	1/17/2007	204
Brichant, Kathie L.	2/21/2008	8/1/2007	204

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Cornille, Christopher J.	1/2/2008	6/12/2007	204
Hamilton, James G.	5/25/2007	11/2/2006	204
Heffinger, Emily G.	8/9/2007	1/17/2007	204
Ratchford, Christopher	5/25/2007	11/2/2006	204
Hill, Julius N.	3/12/2007	8/21/2006	203
Lavine, Peter G.	10/10/2007	3/21/2007	203
Manfredi, John R.	10/10/2007	3/21/2007	203
Nagle, Nancy F.	3/12/2007	8/21/2006	203
Leggett, Richard	12/20/2006	6/1/2006	202
Lindstrom, Eric J.	6/25/2007	12/5/2006	202
McCurdy, Lacy F.	12/20/2006	6/1/2006	202
Mehta, Anand	12/20/2006	6/1/2006	202
Messias, Erick	12/20/2006	6/1/2006	202
Parish, Anjali P.	12/20/2006	6/1/2006	202
Pedersen-White, Jennifer R.	12/20/2006	6/1/2006	202
Petty, Grant D.	12/20/2006	6/1/2006	202
Isales, Carlos M.	12/19/2006	6/1/2006	201
Jump, Rebecca L.	12/19/2006	6/1/2006	201
Kinsey, Timothy Jr R.	12/19/2006	6/1/2006	201
Kruse, Edward J.	12/19/2006	6/1/2006	201
Polglase, Robert F.	4/24/2007	10/5/2006	201
Chisholm, William C.	4/24/2007	10/6/2006	200
Crew, Heather A.	2/27/2007	8/11/2006	200
Edwards, Michael A.	12/18/2006	6/1/2006	200
Fuhrman, Jr, Thomas M.	12/18/2006	6/1/2006	200
Gagen, Rachel	12/18/2006	6/1/2006	200

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Hanevold, Coral D.	12/18/2006	6/1/2006	200
Huey, Jarrod D.	12/18/2006	6/1/2006	200
Mullinax, Ashley L.	12/18/2006	6/1/2006	200
Peterson, John	3/12/2007	8/24/2006	200
Rogozinski, Zbigniew	12/18/2006	6/1/2006	200
Sager, Christine M.	12/20/2006	6/3/2006	200
Sandvi, Muhammad A.	12/20/2006	6/3/2006	200
Stephenson, Allan M.	12/20/2006	6/3/2006	200
Vick, Clyde W.	12/20/2006	6/3/2006	200
Wiggers, Nancy H.	12/18/2006	6/1/2006	200
Winger Jr, Leland H.	12/18/2006	6/1/2006	200
Araque, Julio M.	2/18/2008	8/3/2007	199
Fenlon, Whatley B.	12/18/2006	6/2/2006	199
Bedford, Mary S.	7/18/2007	1/1/2007	198
Johnson, Whitney D.	6/26/2007	12/11/2006	197
Dellaperuta, Maggie	12/14/2006	6/1/2006	196
Barrett, Robert L.	3/12/2007	8/28/2006	196
Benford, Paul A.	3/12/2007	8/28/2006	196
Bennett, Veronica J.	3/12/2007	8/28/2006	196
De Armas-Benitez, Lourdes	3/16/2007	9/1/2006	196
Dickerson, Robert	3/12/2007	8/28/2006	196
Lofton, Yushonda D.	3/12/2007	8/28/2006	196
Polglase, Robert F.	3/17/2007	9/2/2006	196
Veal, Tonya D.	3/12/2007	8/28/2006	196
Curtin, Jay L.	12/13/2006	6/1/2006	195
Brownlee, Richard E.	12/13/2007	6/1/2007	195

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Kirkland, Quianna M.	3/12/2007	8/29/2006	195
Lanier, Mary C.	3/12/2007	8/29/2006	195
Logan, James R.	12/13/2007	6/1/2007	195
Patterson, David L.	3/12/2007	8/29/2006	195
Poole, Michael D.	12/13/2007	6/1/2007	195
Ronen, Helise S.	3/12/2007	8/29/2006	195
Aull, Allyson	3/12/2007	8/30/2006	194
Brown, Kirk	3/12/2007	8/30/2006	194
Campbell, Kenneth	3/12/2007	8/30/2006	194
Duncan, Errol	3/12/2007	8/30/2006	194
Eberhardt, Michael	3/12/2007	8/30/2006	194
Harris, Laurence	3/12/2007	8/30/2006	194
Schillinger, David S.	3/12/2007	8/30/2006	194
Sharma, Sanjay	3/12/2007	8/30/2006	194
Cheeks , Jr, Curtis	3/12/2007	8/31/2006	193
Hunter, Michele H.	3/12/2007	8/31/2006	193
Mirmow, Dwight P.	3/12/2007	8/31/2006	193
Wade, Robert K.	3/12/2007	8/31/2006	193
Zafar, Syed N.	12/11/2007	6/1/2007	193
Carter, Jr, William E.	2/9/2007	8/1/2006	192
Christiansen, Amy C.	12/14/2006	6/5/2006	192
Mulberry, Michael J.	3/9/2007	8/29/2006	192
Patel, Shila	3/12/2007	9/1/2006	192
Towson, Jacqueline P.	3/12/2007	9/1/2006	192
Haberlin, John W.	5/30/2007	11/20/2006	191
Limbaugh, Brent H.	1/9/2008	7/2/2007	191

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Yang, Jin	3/9/2007	8/30/2006	191
Huff, Thomas A.	12/8/2006	6/1/2006	190
Sharma, Suash	12/8/2006	6/1/2006	190
Sheram, Mary L.	12/8/2006	6/1/2006	190
Stachura, Max E.	12/8/2006	6/1/2006	190
Stevens, Mark R.	12/8/2006	6/1/2006	190
Switzer, Jeffery A.	12/8/2006	6/1/2006	190
Valcourt, Karl M.	12/8/2006	6/1/2006	190
Valcourt, Yvrose	12/8/2006	6/1/2006	190
Becker, Ann Y.	12/7/2006	6/1/2006	189
Becton, James Jr L.	12/7/2006	6/1/2006	189
Bhaskar, Mini	12/7/2006	6/1/2006	189
Biddinger, Paul W.	12/7/2006	6/1/2006	189
Burkhead, Lori M.	12/7/2006	6/1/2006	189
Chang, Albert S.	12/7/2006	6/1/2006	189
Chin, Edward Jr	12/7/2006	6/1/2006	189
Edwards, Edwards A.	12/7/2006	6/1/2006	189
Farrow, Stephanie B.	12/7/2006	6/1/2006	189
Fowlkes, William C.	12/7/2006	6/1/2006	189
Tsai, Jonathan H.	12/7/2006	6/1/2006	189
Blanton, Jann L.	12/6/2006	6/1/2006	188
Lewis, Joyce R.	12/6/2006	6/1/2006	188
Anderson, Susan K.	12/6/2006	6/1/2006	188
Berman, Adam E.	12/6/2006	6/1/2006	188
Bollin, Nicholas R.	3/7/2008	9/1/2007	188
Florentino, Frances M.	12/6/2006	6/1/2006	188

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Humphrey, Steven S.	12/6/2006	6/1/2006	188
Johnson, Sandra M.	12/6/2006	6/1/2006	188
Kunavarapu, Chandrasekhar R.	12/6/2006	6/1/2006	188
McKinnon, Brian J.	12/6/2006	6/1/2006	188
Okoye, Oguguo C.	4/24/2007	10/18/2006	188
Physicians Health Group, Wadley	12/6/2006	6/1/2006	188
Forseen, Caralee J.	12/5/2006	6/1/2006	187
Gater, Jameelah J.	12/5/2006	6/1/2006	187
Hendrix III, Vernon J.	12/7/2006	6/3/2006	187
Manaker, Lawrence W.	12/5/2006	6/1/2006	187
Maqsood, Farhan	12/5/2006	6/1/2006	187
Miller, Douglas D.	12/5/2006	6/1/2006	187
Naseem, Kashif	12/5/2006	6/1/2006	187
Negri, Fancisco J.	12/7/2006	6/3/2006	187
Oswald, Brenda D.	12/5/2006	6/1/2006	187
Pleasant, Shyronda Y.	2/19/2007	8/16/2006	187
Rivera, Carlos A.	4/5/2007	9/30/2006	187
Saleeby, Yusuf	12/7/2006	6/3/2006	187
Sattin, Richard W.	12/5/2006	6/1/2006	187
Shukla, Sanjay K.	12/5/2007	6/1/2007	187
Smith, James K.	12/5/2006	6/1/2006	187
Supinski, Gerald S.	12/5/2006	6/1/2006	187
Tanna, Saloni H.	12/5/2006	6/1/2006	187
Turner, Sandra	12/5/2006	6/1/2006	187
Young, Sara E.	12/5/2006	6/1/2006	187
Richardson, Deborah K.	12/4/2006	6/1/2006	186

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Johnson, Alan R.	12/4/2006	6/1/2006	186
Jeffries, Barry F.	12/4/2006	6/1/2006	186
Gilbert, Stewart D.	12/4/2006	6/1/2006	186
Mulick, Arthur L.	12/4/2006	6/1/2006	186
O'Brien, Sean T.	12/4/2006	6/1/2006	186
Ajjan, Mahdi	12/4/2006	6/1/2006	186
Bailey, Melissa L.	12/4/2006	6/1/2006	186
Barnes, Verdain H.	12/4/2006	6/1/2006	186
Brice, John W.	12/4/2006	6/1/2006	186
Brown, Traesa A.	12/4/2006	6/1/2006	186
Callahan, Leigh Ann	12/4/2006	6/1/2006	186
Dadig, Bonnie	12/4/2006	6/1/2006	186
Diamond, Matthew J.	12/4/2006	6/1/2006	186
Ewald, Frank W.	12/4/2006	6/1/2006	186
Gupta, Mini	12/4/2006	6/1/2006	186
Hawasli, Mohammad H.	12/4/2006	6/1/2006	186
Piquette, Ashley S.	1/18/2007	7/17/2006	185
Dekalb County Board of, Health	12/4/2006	6/3/2006	184
Lee, Michael M.	12/4/2006	6/3/2006	184
Logendra, Narendra P.	12/4/2006	6/3/2006	184
Long, Carla L.	12/4/2006	6/3/2006	184
Rojas-Molina, Daniela M.	12/4/2006	6/3/2006	184
Sarma, Seshu P.	12/4/2006	6/3/2006	184
Sherrod, Darryl	11/30/2006	6/1/2006	182
Berman, Brian L.	11/30/2006	6/1/2006	182
Bristol, William P.	11/30/2006	6/1/2006	182

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Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Dadig, Bonnie	11/30/2006	6/1/2006	182
Lee, Laurance I.	2/16/2007	8/18/2006	182
Levy-Eliceiri, Carlos A.	11/30/2006	6/1/2006	182
Lyon, Matthew L.	11/30/2006	6/1/2006	182
Philbrick, Thomas H.	2/16/2007	8/18/2006	182
Piazza, Gina M.	11/30/2006	6/1/2006	182
Piros, George P.	2/16/2007	8/18/2006	182
Prainito, Aimee G.	11/30/2006	6/1/2006	182
Rivera, Carlos A.	2/16/2007	8/18/2006	182
Wilson, Dawn S.	4/24/2007	10/24/2006	182
Wingate, Cheryl B.	4/24/2007	10/24/2006	182
Yarima, Wakili	11/30/2006	6/1/2006	182
Zerden, Solomon G.	2/16/2007	8/18/2006	182
Atkins, Christopher	3/12/2007	9/12/2006	181
Carney, David E.	11/29/2006	6/1/2006	181
Conrad, Paul C.	3/12/2007	9/12/2006	181
Taylor, Earle M.	11/29/2006	6/1/2006	181
Wilson, Katherine A.	10/17/2007	4/19/2007	181

Dates represent the actual dates provided by the CMO. See report for comments regarding accuracy of dates reported.

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Peach State Health Plan			
Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
GARY S KIPP	11/7/2007	6/1/2006	524
J ALAN WILSON	11/7/2007	6/1/2006	524
KAY LADERER	11/7/2007	6/1/2006	524
ARIC ALDRIDGE	11/7/2007	6/1/2006	524
KHALID BASHIR	10/24/2007	6/1/2006	510
SEAN HOLLONBECK	10/1/2007	6/1/2006	487
RORY R DALTON	9/1/2007	6/1/2006	457
ELIZABETH J MANALLOOR	9/1/2007	6/1/2006	457
ELIZABETH J MANALLOOR	9/1/2007	6/1/2006	457
JOHN C STEELE JR	9/1/2007	6/1/2006	457
LLOYD O COOK	9/1/2007	6/1/2006	457
MICHELLE REID NICHOLSON	9/1/2007	6/1/2006	457
PREETHA RAMALINGAM	9/1/2007	6/1/2006	457
STEPHEN PEIPER	9/1/2007	6/1/2006	457
THOMAS J ALLRED	9/1/2007	6/1/2006	457
THOMAS J ALLRED	9/1/2007	6/1/2006	457
CHARLES R BAISDEN	9/1/2007	6/1/2006	457
DORTH FALLS	9/1/2007	6/1/2006	457
FARIVAR YAGHMAI	9/1/2007	6/1/2006	457
JEFFREY R LEE	9/1/2007	6/1/2006	457
JOHN H CROSBY	9/1/2007	6/1/2006	457
LAWRENCE J FREANT	9/1/2007	6/1/2006	457
MICHELLE REID NICHOLSON	9/1/2007	6/1/2006	457
PAUL W BIDDINGER	9/1/2007	6/1/2006	457
PREETHA RAMALINGAM	9/1/2007	6/1/2006	457
PAUL M MALSKY	8/31/2007	6/1/2006	456

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Peach State Health Plan			
Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
PAUL M MALSKY	8/31/2007	6/1/2006	456
CHARLES NEWELL	8/31/2007	6/1/2006	456
ALICIA ESTILLORE	11/7/2007	9/1/2006	432
DEBORAH FLOWERS	11/7/2007	9/1/2006	432
OVIDIU POPA	11/7/2007	9/1/2006	432
PAUL J BENNETT	11/7/2007	9/1/2006	432
BRIAN A MOOGERFELD	11/6/2007	9/1/2006	431
GRADY HEALTH SYSTEM	1/3/2008	2/14/2007	323
JACQUELINE C CASTAGNO	4/2/2007	6/1/2006	305
JAMES A THOMAS	10/1/2007	12/1/2006	304
MARSHALL C DUNAWAY	10/1/2007	12/1/2006	304
WILLIAM L COOPER	10/1/2007	12/1/2006	304
JENNIFER EVANGELIST	3/20/2007	6/1/2006	292
KATHRYN CHEEK	3/20/2007	6/1/2006	292
SUSAN MCWHIRTER	3/20/2007	6/1/2006	292
THOMAS ELLISON	3/20/2007	6/1/2006	292
DOUGLAS HARRISON	3/17/2007	6/1/2006	289
DOZIER R HOOD	2/15/2007	6/1/2006	259
DANKO CERENKO	2/15/2007	6/1/2006	259
JOSE STOLOVITZKY	2/15/2007	6/1/2006	259
MICHAEL C NEUENSCHWANDER	2/15/2007	6/1/2006	259
DOZIER R HOOD	2/15/2007	6/1/2006	259
FELIX PELAEZ	2/7/2007	6/1/2006	251
CORAL D HANEVOLD	9/1/2007	1/1/2007	243
MICHAEL L GEE	10/1/2007	2/1/2007	242
PATRICK B FENLON	10/1/2007	2/1/2007	242

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Peach State Health Plan			
Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
DANIEL DUBOVSKY	1/26/2007	6/1/2006	239
RICHARD FREEMAN	1/25/2007	6/1/2006	238
MARK OLIVER	3/20/2007	8/1/2006	231
JAMES CRAFT	9/1/2007	1/17/2007	227
MICHAEL BLAIVAS	9/1/2007	1/17/2007	227
CHELSE MOORE	8/13/2007	1/1/2007	224
EMORY ALEXANDER	8/9/2007	1/1/2007	220
MALATHI GINJUPALLI	8/9/2007	1/1/2007	220
ANGEL BLANCO	1/4/2007	6/1/2006	217
DINESH B PATEL	10/1/2007	3/1/2007	214
SHERRY ROGERS MOORE	12/27/2006	6/1/2006	209
ZHENGXIANG WANG	12/25/2006	6/1/2006	207
KARYN WHITE	10/24/2007	4/1/2007	206
JOHN PENUEL	12/21/2006	6/1/2006	203
WINFIELD E BUTLIN	12/5/2006	6/1/2006	187

Note: Dates represent the actual dates provided by the CMO. See report for comments regarding accuracy of dates reported.

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WellCare			
Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
BURGERSUSANR	3/6/2008	6/1/2006	644
STEWARTLARRYD	12/27/2007	6/1/2006	574
BLEVENSKIMBERLY	12/20/2007	6/1/2006	567
BOLINGCHARLESW	12/18/2007	6/1/2006	565
GABRIELSBRYA	12/17/2007	6/1/2006	564
ROCHEWILLIAMP	12/17/2007	6/1/2006	564
VAFAIJALLEH	3/22/2008	2/1/2007	415
OSBORNEWILLIAME	10/9/2007	9/1/2006	403
ROBINSONTODDA	10/9/2007	9/1/2006	403
ROBINSONTODDA	10/9/2007	9/1/2006	403
HEIDESCHTROYA	10/2/2007	9/1/2006	396
HEIDESCHTROYA	10/2/2007	9/1/2006	396
HEIDESCHTROYA	10/2/2007	9/1/2006	396
MILLERJACK	6/29/2007	6/1/2006	393
ESTEESANDIW	7/27/2007	7/1/2006	391
BARBERSARAHC	9/11/2007	9/1/2006	375
CLINENYLAF	8/22/2007	9/1/2006	355
DENNISONDAVIDR	5/11/2007	6/1/2006	344
IBRAHEEMMUSIBAU	11/29/2007	1/1/2007	332
RINGERDAVEA	7/26/2007	9/1/2006	328
GEHLOTROSY	7/23/2007	9/1/2006	325
GREERSTEVENA	8/8/2007	10/1/2006	311
CORDLEROGENAD	7/1/2007	9/1/2006	303
CORNFORTHMATTHE	7/1/2007	9/1/2006	303
CORNFORTHMATTHE	7/1/2007	9/1/2006	303
CORNFORTHMATTHE	7/1/2007	9/1/2006	303

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WellCare			
Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
CORNFORTHMATTHE	7/1/2007	9/1/2006	303
CORNFORTHMATTHE	7/1/2007	9/1/2006	303
CORNFORTHMATTHE	7/1/2007	9/1/2006	303
CORNFORTHMATTHE	7/1/2007	9/1/2006	303
CORNFORTHMATTHE	7/1/2007	9/1/2006	303
DEANDARRELL	7/1/2007	9/1/2006	303
DEANDARRELL	7/1/2007	9/1/2006	303
DEANDARRELL	7/1/2007	9/1/2006	303
DEANDARRELL	7/1/2007	9/1/2006	303
DEANDARRELL	7/1/2007	9/1/2006	303
DEANDARRELL	7/1/2007	9/1/2006	303
DOUGLASJAMEST	7/1/2007	9/1/2006	303
MOMINMUSHARAF	7/1/2007	9/1/2006	303
MOMINMUSHARAF	7/1/2007	9/1/2006	303
MOMINMUSHARAF	7/1/2007	9/1/2006	303
CORNFORTHMATTHE	6/30/2007	9/1/2006	302
CORNFORTHMATTHE	6/30/2007	9/1/2006	302
CORNFORTHMATTHE	6/30/2007	9/1/2006	302
CORNFORTHMATTHE	6/30/2007	9/1/2006	302
CORNFORTHMATTHE	6/30/2007	9/1/2006	302
CORNFORTHMATTHE	6/30/2007	9/1/2006	302
CORNFORTHMATTHE	6/30/2007	9/1/2006	302
CORNFORTHMATTHE	6/30/2007	9/1/2006	302
CORNFORTHMATTHE	6/30/2007	9/1/2006	302
MOMINMUSHARAF	6/29/2007	9/1/2006	301
MOMINMUSHARAF	6/28/2007	9/1/2006	300

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 1 - Provider Contracting Timeliness

WellCare			
Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
MOMINMUSHARAF	6/28/2007	9/1/2006	300
CORNFORTHMATTHE	6/27/2007	9/1/2006	299
CORNFORTHMATTHE	6/27/2007	9/1/2006	299
MOMINMUSHARAF	6/27/2007	9/1/2006	299
AL-MULKIMOHAMMA	9/18/2007	12/1/2006	291
BARNWELLODELL	7/13/2007	10/1/2006	285
BOWERSRALPHE	6/12/2007	9/1/2006	284
BOWERSRALPHE	6/12/2007	9/1/2006	284
COMFORTHMATHEWT	6/12/2007	9/1/2006	284
BOWERSRALPHE	6/11/2007	9/1/2006	283
BOWERSRALPHE	6/11/2007	9/1/2006	283
BOWERSRALPHE	6/11/2007	9/1/2006	283
ASBURYGREG	6/10/2007	9/1/2006	282
BARNWELLODELL	7/10/2007	10/1/2006	282
BROWNTRAESAA	5/31/2007	9/1/2006	272
AYENIOLUROPOA	8/27/2007	12/1/2006	269
ELLENBERGJOHN	5/15/2007	9/1/2006	256
PAYNE-PAMPHILER	2/1/2007	6/1/2006	245
KURTZKIMBERLYM	8/7/2007	1/1/2007	218
GIBBONSKATHLEEN	3/30/2007	9/1/2006	210
DUNNIDAM	1/25/2007	7/1/2006	208
AYENIOLUROPOA	8/27/2007	2/1/2007	207
CURRYVIRGINIA	3/25/2008	9/1/2007	206
BUSSOLETTIAPRIL	3/21/2007	9/1/2006	201
ATHERTONANNR	1/16/2008	7/1/2007	199
BLEDISOETOMD	12/15/2006	6/1/2006	197

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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 Exhibit 1 - Provider Contracting Timeliness

WellCare			
Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
MILLERJOHN-MARK	12/15/2006	6/1/2006	197
PARKERALMAL	12/15/2006	6/1/2006	197
JESTERMARK	12/13/2006	6/1/2006	195
STROUBKENNETHJ	12/13/2006	6/1/2006	195
STROUBKENNETHJ	12/13/2006	6/1/2006	195
STROUBKENNETHJ	12/13/2006	6/1/2006	195
STROUBKENNETHJ	12/13/2006	6/1/2006	195
TALBOTGINAC	12/13/2006	6/1/2006	195
DOUGLASJAMEST	12/12/2006	6/1/2006	194
JAGERJOELK	12/12/2006	6/1/2006	194
STROUBKENNETH	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	6/1/2006	194
DAILEY-SMITHMAR	12/11/2006	6/1/2006	193
DAILEY-SMITHMAR	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	6/1/2006	193
OLDFIELDCHRISTO	8/13/2007	2/1/2007	193

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 1 - Provider Contracting Timeliness

WellCare			
Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
STROUBKENNETHJ	12/11/2006	6/1/2006	193
STROUBKENNETHJ	12/11/2006	6/1/2006	193
###ASBURYGREGW	12/9/2006	6/1/2006	191
BISCHOFSTEVEND	12/9/2006	6/1/2006	191
###ASBURYGREGW	12/8/2006	6/1/2006	190
###ASBURYGREGW	12/8/2006	6/1/2006	190
###ASBURYGREGW	12/8/2006	6/1/2006	190
###ASBURYGREGW	12/8/2006	6/1/2006	190
ASBURYGREGW	12/8/2006	6/1/2006	190
ASBURYGREGW	12/8/2006	6/1/2006	190
DAILEY-SMITHMAR	12/8/2006	6/1/2006	190
DAILEY-SMITHMAR	12/8/2006	6/1/2006	190
DOWLINGRICHARDJ	12/7/2006	6/1/2006	189
MILLERJOHN-MARK	12/7/2006	6/1/2006	189
WIGLEYJERRYM	12/7/2006	6/1/2006	189
PURDIEALLANC	12/6/2006	6/1/2006	188
TUCKERWL	12/6/2006	6/1/2006	188
DAILEY-SMITHMAR	12/5/2006	6/1/2006	187
DAILEY-SMITHMAR	12/5/2006	6/1/2006	187
MADDENREBECCAB	12/5/2006	6/1/2006	187
MADDENROBERTJ	12/5/2006	6/1/2006	187
DAILEY-SMITHMAR	12/4/2006	6/1/2006	186
DAILEY-SMITHMAR	12/4/2006	6/1/2006	186
DAILEY-SMITHMAR	12/4/2006	6/1/2006	186
DAILEY-SMITHMAR	12/4/2006	6/1/2006	186
KURTZKIMBERLY	12/4/2006	6/1/2006	186

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 1 - Provider Contracting Timeliness

WellCare			
Providers Loaded into Claim System More than 180 Days After Effective Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
KURTZKIMBERLY	12/4/2006	6/1/2006	186
MILLERJOHN-MARK	12/3/2006	6/1/2006	185
MILLERJOHN-MARK	12/3/2006	6/1/2006	185
MILLERJOHN-MARK	12/3/2006	6/1/2006	185
TOOLERONDAS	10/3/2007	4/1/2007	185
HOLCOMBEROBERTH	12/1/2006	6/1/2006	183

Note: Dates represent the actual dates provided by the CMO. See report for comments regarding accuracy of dates reported. Provider name may appear more than once if the provider has more than one provider ID.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 2 – Analysis II: Provider Credentialing Timeliness

AMERIGROUP						
Providers Credentialed More than 180 Days After Effective Date	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
Williams, Sara L.	12/4/2007	1/17/2008	1/28/2008	6/1/2006	44	595
Bland, William H.	11/9/2007	12/13/2007	12/20/2007	6/1/2006	34	560
Shouse, Karen	10/11/2007	1/8/2008	1/15/2008	7/6/2006	89	551
Dalwai, Fatima	10/2/2007	11/27/2007	12/6/2007	6/1/2006	56	544
Gandhi, Peahen H.	10/2/2007	11/27/2007	12/6/2007	6/1/2006	56	544
Sayers, Julie M.	10/3/2007	11/27/2007	12/6/2007	6/1/2006	55	544
Pugh, Jacqueline	10/11/2007	11/27/2007	12/6/2007	6/1/2006	47	544
Killingsworth, Daniel	NULL	10/24/2007	10/25/2007	6/1/2006	N/A	510
White, Iris L.	11/5/2007	1/2/2008	1/3/2008	8/28/2006	58	492
Kneff Jr, James	12/11/2007	1/2/2008	1/3/2008	8/28/2006	22	492
Lipp, Lynette N.	12/11/2007	1/2/2008	1/3/2008	8/28/2006	22	492
Khirbat, Rohit	10/31/2007	12/27/2007	1/3/2008	9/8/2006	57	475
Lawrence, Richard L.	NULL	9/1/2007	1/2/2008	6/1/2006	N/A	457
Bell, Bruce	NULL	9/1/2007	4/20/2006	6/1/2006	N/A	457
Cook, Michael W.	NULL	8/8/2007	8/16/2007	6/1/2006	N/A	433
Cook, Michael W.	NULL	8/8/2007	8/16/2007	6/1/2006	N/A	433
DeMuth, Karen A.	NULL	8/8/2007	8/16/2007	6/1/2006	N/A	433
Purohit, Bhumiben S.	11/20/2007	1/8/2008	1/14/2008	1/8/2007	49	365
Doss, Basem N.	NULL	12/30/2007	10/17/2007	12/30/2006	N/A	365
Pedrick, Heather H.	7/18/2006	9/17/2007	10/17/2007	9/17/2006	426	365
Malloy, Jacqueline A.	10/2/2007	11/27/2007	12/6/2007	12/1/2006	56	361
Fletcher, James E.	NULL	5/23/2007	8/7/2006	6/1/2006	N/A	356
Beisel, James	NULL	9/1/2007	10/9/2006	9/26/2006	N/A	340
Bosch, Ortelio	10/9/2006	10/25/2007	11/14/2007	11/21/2006	381	338
Newton, Judy R.	12/5/2006	10/31/2007	11/12/2007	12/18/2006	330	317

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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 Exhibit 2 – Analysis II: Provider Credentialing Timeliness

AMERIGROUP						
Providers Credentialed More than 180 Days After Effective Date	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
Agbulos, Stanley A.	10/3/2007	11/27/2007	12/6/2007	1/30/2007	55	301
Sinclair, Scott P.	10/3/2007	11/27/2007	12/6/2007	1/30/2007	55	301
Payne, Mailee	1/23/2006	3/21/2007	6/15/2007	6/1/2006	422	293
Robinson, Kimberly	NULL	3/19/2007	3/27/2007	6/3/2006	N/A	289
Shah, Neil	NULL	3/19/2007	3/27/2007	6/3/2006	N/A	289
Shih, Jennifer A.	NULL	3/19/2007	3/27/2007	6/3/2006	N/A	289
Shih, Jennifer A.	NULL	3/19/2007	5/17/2007	6/3/2006	N/A	289
VanderEnde, Daniel S.	NULL	3/19/2007	3/27/2007	6/3/2006	N/A	289
Wheatley, Matthew A.	NULL	3/19/2007	3/27/2007	6/3/2006	N/A	289
Wheatley, Matthew A.	NULL	3/19/2007	3/28/2007	6/3/2006	N/A	289
Doherty, Terrence J.	NULL	3/17/2007	3/27/2007	6/3/2006	N/A	287
Doherty, Terrence J.	NULL	3/17/2007	3/27/2007	6/3/2006	N/A	287
Eskildsen, Manuel	NULL	3/17/2007	3/27/2007	6/3/2006	N/A	287
Gerardi, Maryrose	NULL	3/17/2007	3/27/2007	6/3/2006	N/A	287
Tepper, Micah R.	2/12/2007	11/27/2007	11/16/2007	2/14/2007	288	286
Blossom, Marie M.	NULL	3/16/2007	3/27/2007	6/3/2006	N/A	286
Blossom, Marie M.	NULL	3/16/2007	3/27/2007	6/3/2006	N/A	286
Copland, Susannah	NULL	3/16/2007	3/27/2007	6/3/2006	N/A	286
Craighead, Wade	NULL	3/16/2007	3/27/2007	6/3/2006	N/A	286
Crawford, Kelly B.	NULL	3/16/2007	3/27/2007	6/3/2006	N/A	286
Dekle, Catherine	NULL	3/16/2007	3/27/2007	6/3/2006	N/A	286
Garg, Murari L.	9/14/2006	6/28/2007	10/10/2006	9/19/2006	287	282
Freeman, Dixon L.	NULL	2/28/2007	6/13/2006	6/1/2006	N/A	272
Pickens, Christopher J.	NULL	2/28/2007	6/14/2006	6/1/2006	N/A	272
Durham, Megan M.	NULL	3/1/2007	3/27/2007	6/3/2006	N/A	271

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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 Exhibit 2 – Analysis II: Provider Credentialing Timeliness

AMERIGROUP						
Providers Credentialed More than 180 Days After Effective Date	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
Reeves, Julie O.	2/6/2007	4/10/2007	11/30/2007	7/25/2006	63	259
Ozturk, Ceyhun	6/1/2006	2/14/2007	8/22/2006	6/1/2006	258	258
King, Randall S.	5/7/2007	5/10/2007	5/30/2007	9/1/2006	3	251
Levenson, Dmitry	8/16/2006	4/23/2007	10/10/2006	8/18/2006	250	248
Rossi, Peter J.	NULL	2/1/2007	3/26/2007	6/1/2006	N/A	245
El-Kebbi, Imad M.	NULL	2/1/2007	3/29/2007	6/3/2006	N/A	243
Graham, Donald V.	12/13/2006	1/24/2007	6/14/2007	6/3/2006	42	235
Wrobel, Peter M.	8/10/2006	3/21/2007	9/1/2006	8/1/2006	223	232
Idowu, Olatunde O.	NULL	2/6/2007	2/6/2007	6/22/2006	N/A	229
Ojadi, Vallier	1/30/2007	9/10/2007	6/7/2007	1/30/2007	223	223
Boss-Cole, Etta W.	NULL	1/5/2007	8/22/2006	6/1/2006	N/A	218
Dourron, Rodney M.	8/17/2006	3/21/2007	4/24/2007	8/18/2006	216	215
Chumley, Angela D.	NULL	9/25/2007	11/9/2007	3/1/2007	N/A	208
Miale, Thomas D.	NULL	9/25/2007	11/9/2007	3/1/2007	N/A	208
Wallace, James H.	NULL	9/25/2007	11/9/2007	3/1/2007	N/A	208
Butler, Michael H.	11/1/2006	5/26/2007	7/24/2007	11/7/2006	206	200
Immaneni, Rao	NULL	12/11/2006	8/11/2006	6/1/2006	N/A	193
Reynolds, Amy E.	8/17/2006	12/9/2006	8/4/2006	6/1/2006	114	191
Reynolds, Amy E.	8/17/2006	12/9/2006	8/28/2006	6/1/2006	114	191
Moogerfeld, Brian A.	9/12/2006	12/8/2006	11/21/2006	6/1/2006	87	190
Bussenius, Hope V.	8/9/2006	2/28/2007	10/10/2006	8/23/2006	203	189
Sharma, Sanjay	NULL	3/6/2007	3/12/2007	8/30/2006	N/A	188
Levy-Eliceiri, Carlos A.	10/23/2006	12/6/2006	11/30/2006	6/1/2006	44	188
Bristol, William P.	NULL	11/30/2006	11/30/2006	6/1/2006	N/A	182
Mager, Sandra L.	6/20/2006	11/30/2006	7/28/2006	6/1/2006	163	182

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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 Exhibit 2 – Analysis II: Provider Credentialing Timeliness

AMERIGROUP						
Providers Credentialed More than 180 Days After Effective Date	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
Johnson, David B.	6/30/2006	11/30/2006	7/28/2006	6/1/2006	153	182
Stanfill, Teresa B.	7/18/2006	11/30/2006	7/28/2006	6/1/2006	135	182
Williams, Marilyn B.	7/18/2006	11/30/2006	7/28/2006	6/1/2006	135	182
Boland, Pamela G.	8/17/2006	11/30/2006	11/2/2006	6/1/2006	105	182
Agarwal, Nishi	6/30/2006	11/30/2006	7/28/2006	6/1/2006	153	182
Rosa, Antonio A.	3/27/2006	11/30/2006	4/11/2006	6/1/2006	248	182
Rosa, Antonio A.	3/27/2006	11/30/2006	4/12/2006	6/1/2006	248	182

Notes:

- *AMERIGROUP did not provide application dates and/or credentialing dates for all providers.*
- *Dates represent the actual dates provided by the CMO. See report for comments regarding reliability of data.*
- *Duplicate names may indicate the provider has multiple locations.*
- *If the CMO reported an application date that appeared to be after the credentialing date then the number of days between the two dates is reflected as zero.*

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 Exhibit 2 – Analysis II: Provider Credentialing Timeliness

Peach State Health Plan					
Providers Credentialed More than 180 Days After Effective Date	Application Date	Credentialing Date	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
GARY S KIPP	11/7/2007	1/16/2008	6/1/2006	70	594
J ALAN WILSON	11/7/2007	1/16/2008	6/1/2006	70	594
KAY LADERER	11/7/2007	1/16/2008	6/1/2006	70	594
ARIC ALDRIDGE	11/7/2007	1/16/2008	6/1/2006	70	594
KHALID BASHIR	10/24/2007	11/21/2007	6/1/2006	28	538
ALICIA ESTILLORE	11/7/2007	1/16/2008	9/1/2006	70	502
BRIAN A MOOGERFELD	11/6/2007	1/16/2008	9/1/2006	71	502
DEBORAH FLOWERS	11/7/2007	1/16/2008	9/1/2006	70	502
OVIDIU POPA	11/7/2007	1/16/2008	9/1/2006	70	502
PAUL J BENNETT	11/7/2007	1/16/2008	9/1/2006	70	502
SEAN HOLLONBECK	10/1/2007	10/1/2007	6/1/2006	0	487
PAUL M MALSKEY	8/31/2007	9/28/2007	6/1/2006	28	484
PAUL M MALSKEY	8/31/2007	9/28/2007	6/1/2006	28	484
CHARLES NEWELL	8/31/2007	9/28/2007	6/1/2006	28	484
RORY R DALTON	9/1/2007	9/1/2007	6/1/2006	0	457
ELIZABETH J MANALLOOR	9/1/2007	9/1/2007	6/1/2006	0	457
ELIZABETH J MANALLOOR	9/1/2007	9/1/2007	6/1/2006	0	457
JOHN C STEELE JR	9/1/2007	9/1/2007	6/1/2006	0	457
LLOYD O COOK	9/1/2007	9/1/2007	6/1/2006	0	457
MICHELLE REID NICHOLSON	9/1/2007	9/1/2007	6/1/2006	0	457
PREETHA RAMALINGAM	9/1/2007	9/1/2007	6/1/2006	0	457
STEPHEN PEIPER	9/1/2007	9/1/2007	6/1/2006	0	457
THOMAS J ALLRED	9/1/2007	9/1/2007	6/1/2006	0	457
THOMAS J ALLRED	9/1/2007	9/1/2007	6/1/2006	0	457

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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Peach State Health Plan					
Providers Credentialed More than 180 Days After Effective Date	Application Date	Credentialing Date	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
CHARLES R BAISDEN	9/1/2007	9/1/2007	6/1/2006	0	457
DORTH FALLS	9/1/2007	9/1/2007	6/1/2006	0	457
FARIVAR YAGHMAI	9/1/2007	9/1/2007	6/1/2006	0	457
JEFFREY R LEE	9/1/2007	9/1/2007	6/1/2006	0	457
JOHN H CROSBY	9/1/2007	9/1/2007	6/1/2006	0	457
LAWRENCE J FREANT	9/1/2007	9/1/2007	6/1/2006	0	457
MICHELLE REID NICHOLSON	9/1/2007	9/1/2007	6/1/2006	0	457
PAUL W BIDDINGER	9/1/2007	9/1/2007	6/1/2006	0	457
PREETHA RAMALINGAM	9/1/2007	9/1/2007	6/1/2006	0	457
ANN WARD	4/27/2006	6/1/2007	6/1/2006	400	365
KEITH HANNAY	4/27/2006	6/1/2007	6/1/2006	400	365
KEITH HANNAY	4/27/2006	6/1/2007	6/1/2006	400	365
KEITH PARMER	4/27/2006	6/1/2007	6/1/2006	400	365
RICHARD SPANJER	4/27/2006	6/1/2007	6/1/2006	400	365
WILSON TUCKER	4/27/2006	6/1/2007	6/1/2006	400	365
ALICE SCHULTZ	4/28/2006	6/1/2007	6/1/2006	399	365
ALTHEA MCPHAIL	4/28/2006	6/1/2007	6/1/2006	399	365
PAUL FEKETE	4/28/2006	6/1/2007	6/1/2006	399	365
PUNAM BHANOT	4/28/2006	6/1/2007	6/1/2006	399	365
RICHARD DELGADO	4/28/2006	6/1/2007	6/1/2006	399	365
ROBERT SIEGEL	4/28/2006	6/1/2007	6/1/2006	399	365
JENNIFER EVANGELIST	3/20/2007	5/30/2007	6/1/2006	71	363
KATHRYN CHEEK	3/20/2007	5/30/2007	6/1/2006	71	363
SUSAN MCWHIRTER	3/20/2007	5/30/2007	6/1/2006	71	363
THOMAS ELLISON	3/20/2007	5/30/2007	6/1/2006	71	363

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Peach State Health Plan					
Providers Credentialed More than 180 Days After Effective Date	Application Date	Credentialing Date	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
JACQUELINE C CASTAGNO	4/2/2007	5/30/2007	6/1/2006	58	363
BRET HINTZE	3/1/2006	5/1/2007	6/1/2006	426	334
BRET HINTZE	3/1/2006	5/1/2007	6/1/2006	426	334
BRET HINTZE	3/1/2006	5/1/2007	6/1/2006	426	334
BRET HINTZE	3/1/2006	5/1/2007	6/1/2006	426	334
GRADY HEALTH SYSTEM	1/3/2008	1/3/2008	2/14/2007	0	323
ANGEL BLANCO	1/4/2007	4/18/2007	6/1/2006	104	321
SHRADDHA TONGIA	7/13/2006	4/18/2007	6/1/2006	279	321
JAMES A THOMAS	10/1/2007	10/1/2007	12/1/2006	0	304
MARSHALL C DUNAWAY	10/1/2007	10/1/2007	12/1/2006	0	304
WILLIAM L COOPER	10/1/2007	10/1/2007	12/1/2006	0	304
MARK OLIVER	3/20/2007	5/30/2007	8/1/2006	71	302
DOUGLAS HARRISON	3/17/2007	3/28/2007	6/1/2006	11	300
RICHARD FREEMAN	1/25/2007	3/26/2007	6/1/2006	60	298
DOZIER R HOOD	2/15/2007	3/1/2007	6/1/2006	14	273
DANKO CERENKO	2/15/2007	3/1/2007	6/1/2006	14	273
JOSE STOLOVITZKY	2/15/2007	3/1/2007	6/1/2006	14	273
MICHAEL C NEUENSCHWANDER	2/15/2007	3/1/2007	6/1/2006	14	273
DOZIER R HOOD	2/15/2007	3/1/2007	6/1/2006	14	273
MARIAM GEORGE	10/2/2006	2/21/2007	6/1/2006	142	265
FELIX PELAEZ	2/7/2007	2/21/2007	6/1/2006	14	265
THOMAS BROSKY II	10/26/2006	2/21/2007	6/1/2006	118	265
SHERRY ROGERS MOORE	12/27/2006	2/5/2007	6/1/2006	40	249
DANIEL DUBOVSKY	1/26/2007	2/5/2007	6/1/2006	10	249
JOHN PENUEL	12/21/2006	2/5/2007	6/1/2006	46	249

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Georgia Families
 Exhibit 2 – Analysis II: Provider Credentialing Timeliness

Peach State Health Plan					
Providers Credentialed More than 180 Days After Effective Date	Application Date	Credentialing Date	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
ZHENGXIANG WANG	12/25/2006	2/5/2007	6/1/2006	42	249
CORAL D HANEVOLD	9/1/2007	9/1/2007	1/1/2007	0	243
MICHAEL L GEE	10/1/2007	10/1/2007	2/1/2007	0	242
PATRICK B FENLON	10/1/2007	10/1/2007	2/1/2007	0	242
KARYN WHITE	10/24/2007	11/21/2007	4/1/2007	28	234
CHELSE MOORE	8/13/2007	8/21/2007	1/1/2007	8	232
EMORY ALEXANDER	8/9/2007	8/21/2007	1/1/2007	12	232
MALATHI GINJUPALLI	8/9/2007	8/21/2007	1/1/2007	12	232
EARNEST RILEY	11/10/2006	1/17/2007	6/1/2006	68	230
CESAR VINUEZA	8/6/2006	1/17/2007	6/1/2006	164	230
JAMES CRAFT	9/1/2007	9/1/2007	1/17/2007	0	227
MICHAEL BLAIVAS	9/1/2007	9/1/2007	1/17/2007	0	227
CHARLES MIDDLETON III	12/5/2007	1/16/2008	6/8/2007	42	222
DINESH B PATEL	10/1/2007	10/1/2007	3/1/2007	0	214
HELENA BENTLEY	11/28/2006	12/19/2006	6/1/2006	21	201
WINFIELD E BUTLIN	12/5/2006	12/19/2006	6/1/2006	14	201
ENGLEWOOD HEALTH SYSTEMS INC	11/17/2006	12/19/2006	6/1/2006	32	201
JOEL ROSENFELD	10/18/2006	12/19/2006	6/1/2006	62	201
CHATTAHOOCHEE HEALTH CARE	2/6/2007	3/1/2007	9/1/2006	23	181
ELLARD GEORGE JR	2/6/2007	3/1/2007	9/1/2006	23	181
PLAINS MEDICAL CENTER	2/6/2007	3/1/2007	9/1/2006	23	181
QUITMAN HEALTH CARE	2/6/2007	3/1/2007	9/1/2006	23	181
REBECCA BROSCART	2/6/2007	3/1/2007	9/1/2006	23	181
STEWART WEBSTER RHC	2/6/2007	3/1/2007	9/1/2006	23	181

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 2 – Analysis II: Provider Credentialing Timeliness

Notes:

- *Peach State Health Plan did not provide application dates and/or credentialing dates for all providers.*
- *Dates represent the actual dates provided by the CMO. See report for comments regarding reliability of data.*
- *Duplicate names may indicate the provider has multiple locations.*
- *If the CMO reported an application date that appeared to be after the credentialing date then the number of days between the two dates is reflected as zero.*

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 2 – Analysis II: Provider Credentialing Timeliness

WellCare				
Providers Credentialed More than 180 Days After Effective Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Effective Date as Participating Provider to Credentialing Date
BLEVENSKIMBERLY	12/20/2007	12/20/2007	6/1/2006	567
BOLINGCHARLESW	12/18/2007	12/18/2007	6/1/2006	565
GABRIELTABRYA	12/17/2007	12/17/2007	6/1/2006	564
STEWARTLARRYD	12/17/2007	12/27/2007	6/1/2006	564
VERAMERNAM	3/27/2008	10/17/2006	10/1/2006	543
ROCHEWILLIAMP	10/22/2007	12/17/2007	6/1/2006	508
CORNWELLJAMESR	10/9/2007	8/23/2006	6/1/2006	495
HARRIGANMARCJ	10/9/2007	11/6/2006	6/1/2006	495
MCELHANEYSHAMEK	10/9/2007	11/6/2006	7/1/2006	465
VAFIJALLEH	3/22/2008	3/22/2008	2/1/2007	415
MILLERMARIBELD	3/17/2008	4/13/2007	2/1/2007	410
ROBINSONTODDA	10/9/2007	10/9/2007	9/1/2006	403
ESTESSANDIW	7/27/2007	7/27/2007	7/1/2006	391
CLINENYLAF	8/22/2007	8/22/2007	9/1/2006	355
DENNISONDAVIDR	5/11/2007	5/11/2007	6/1/2006	344
RINGERDAVEA	7/26/2007	7/26/2007	9/1/2006	328
GEHLOTROSY	7/23/2007	7/23/2007	9/1/2006	325
GANTTJAMESS	7/18/2007	7/26/2006	9/1/2006	320
GREERSTEVENA	8/8/2007	8/8/2007	10/1/2006	311
CORDLEROGENAD	6/29/2007	7/1/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	6/30/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	6/30/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	6/30/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	6/30/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	6/30/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	6/30/2007	9/1/2006	301

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 2 – Analysis II: Provider Credentialing Timeliness

WellCare				
Providers Credentialed More than 180 Days After Effective Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Effective Date as Participating Provider to Credentialing Date
CORNFORTHMATTHE	6/29/2007	6/30/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	6/30/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	6/30/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	7/1/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	7/1/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	7/1/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	7/1/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	7/1/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	7/1/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	7/1/2007	9/1/2006	301
CORNFORTHMATTHE	6/29/2007	7/1/2007	9/1/2006	301
DEANDARRELL	6/29/2007	7/1/2007	9/1/2006	301
DEANDARRELL	6/29/2007	7/1/2007	9/1/2006	301
DEANDARRELL	6/29/2007	7/1/2007	9/1/2006	301
DEANDARRELL	6/29/2007	7/1/2007	9/1/2006	301
DEANDARRELL	6/29/2007	7/1/2007	9/1/2006	301
DOUGLASJAMEST	6/29/2007	7/1/2007	9/1/2006	301
MOMINMUSHARAF	6/29/2007	7/1/2007	9/1/2006	301
SUAREZJOANNAH	6/28/2007	9/22/2006	9/1/2006	300
CORNFORTHMATTHE	6/27/2007	6/27/2007	9/1/2006	299
CORNFORTHMATTHE	6/27/2007	6/27/2007	9/1/2006	299
MOMINMUSHARAF	6/27/2007	7/1/2007	9/1/2006	299
MOMINMUSHARAF	6/27/2007	7/1/2007	9/1/2006	299
MOMINMUSHARAF	6/27/2007	6/29/2007	9/1/2006	299
MOMINMUSHARAF	6/27/2007	6/28/2007	9/1/2006	299
MOMINMUSHARAF	6/27/2007	6/28/2007	9/1/2006	299
AL-MULKIMOHAMMA	9/18/2007	9/18/2007	12/1/2006	291
BARNWELLODELL	7/13/2007	7/13/2007	10/1/2006	285

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 2 – Analysis II: Provider Credentialing Timeliness

WellCare				
Providers Credentialed More than 180 Days After Effective Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Effective Date as Participating Provider to Credentialing Date
BOWERSRALPHE	6/12/2007	6/12/2007	9/1/2006	284
BOWERSRALPHE	6/12/2007	6/12/2007	9/1/2006	284
COMFORTHMATHEWT	6/12/2007	6/12/2007	9/1/2006	284
BOWERSRALPHE	6/11/2007	6/11/2007	9/1/2006	283
BOWERSRALPHE	6/11/2007	6/11/2007	9/1/2006	283
BOWERSRALPHE	6/11/2007	6/11/2007	9/1/2006	283
BARNWELLODELL	7/10/2007	7/10/2007	10/1/2006	282
TAYLORJERTHITIA	4/1/2008	6/6/2007	7/1/2007	275
SUBBIANANANDI	2/27/2007	11/9/2006	6/1/2006	271
AYENIOLUROPOA	8/27/2007	8/27/2007	12/1/2006	269
EVERETTJAMES	5/2/2007	10/30/2006	9/1/2006	243
KURTZKIMBERLYM	8/7/2007	8/7/2007	1/1/2007	218
DUNNIDAM	1/25/2007	1/25/2007	7/1/2006	208
AYENIOLUROPOA	8/27/2007	8/27/2007	2/1/2007	207
MUNOZ-MANTILLAD	12/22/2006	10/19/2006	6/1/2006	204
PARKERALMAL	12/15/2006	12/15/2006	6/1/2006	197
JESTERMARK	12/13/2006	12/13/2006	6/1/2006	195
STROUBKENNETHJ	12/13/2006	12/13/2006	6/1/2006	195
STROUBKENNETHJ	12/13/2006	12/13/2006	6/1/2006	195
STROUBKENNETHJ	12/13/2006	12/13/2006	6/1/2006	195
STROUBKENNETHJ	12/13/2006	12/13/2006	6/1/2006	195
DOUGLASJAMEST	12/12/2006	12/12/2006	6/1/2006	194
JAGERJOELK	12/12/2006	12/12/2006	6/1/2006	194
STROUBKENNETH	12/12/2006	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	12/12/2006	6/1/2006	194

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Exhibit 2 – Analysis II: Provider Credentialing Timeliness

WellCare				
Providers Credentialed More than 180 Days After Effective Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Effective Date as Participating Provider to Credentialing Date
STROUBKENNETHJ	12/12/2006	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	12/12/2006	6/1/2006	194
STROUBKENNETHJ	12/12/2006	12/12/2006	6/1/2006	194
OLDFIELDCHRISTO	8/13/2007	8/13/2007	2/1/2007	193
DAILEY-SMITHMAR	12/11/2006	12/11/2006	6/1/2006	193
DAILEY-SMITHMAR	12/11/2006	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	12/11/2006	6/1/2006	193
JAGERJOELK	12/11/2006	12/11/2006	6/1/2006	193
STROUBKENNETHJ	12/11/2006	12/11/2006	6/1/2006	193
STROUBKENNETHJ	12/11/2006	12/11/2006	6/1/2006	193
STROUBKENNETHJ	12/11/2006	12/12/2006	6/1/2006	193
IBRAHEEMMUSIBAU	7/11/2007	11/29/2007	1/1/2007	191
###ASBURYGREGW	12/9/2006	12/9/2006	6/1/2006	191
BISCHOFSTEVEND	12/9/2006	12/9/2006	6/1/2006	191
###ASBURYGREGW	12/8/2006	12/8/2006	6/1/2006	190
###ASBURYGREGW	12/8/2006	12/8/2006	6/1/2006	190
###ASBURYGREGW	12/8/2006	12/8/2006	6/1/2006	190
###ASBURYGREGW	12/8/2006	12/8/2006	6/1/2006	190
ASBURYGREGW	12/8/2006	12/8/2006	6/1/2006	190
ASBURYGREGW	12/8/2006	12/8/2006	6/1/2006	190
DAILEY-SMITHMAR	12/8/2006	12/8/2006	6/1/2006	190
DIKKALAVENKATES	1/30/2007	12/14/2006	8/1/2006	182

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 2 – Analysis II: Provider Credentialing Timeliness

Notes:

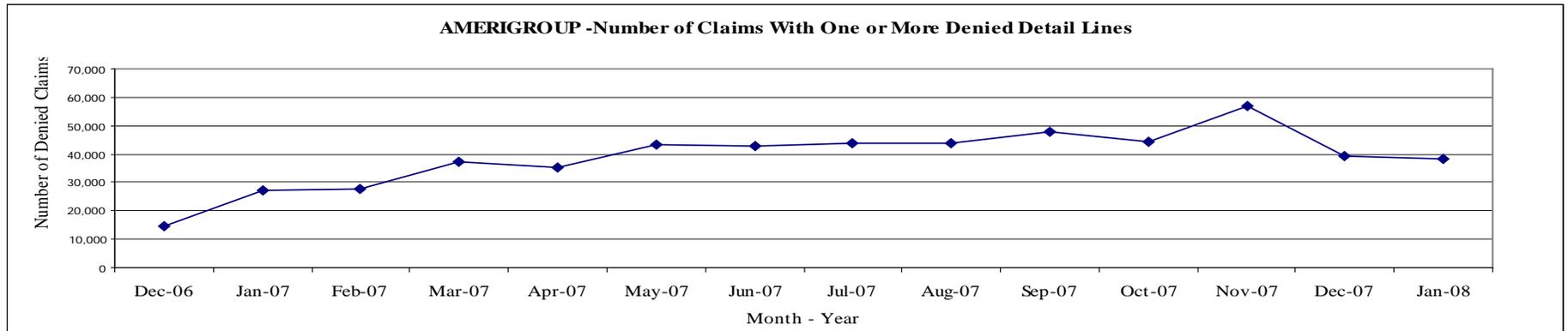
- *WellCare did not provide application dates for providers.*
- *Dates represent the actual dates provided by the CMO. See report for comments regarding reliability of data.*
- *Duplicate names may indicate the provider has multiple locations.*
- *If the CMO reported an application date that appeared to be after the credentialing date then the number of days between the two dates is reflected as zero.*

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 3 – Analysis V: Claim Denials (AMERIGROUP)

Claim Detail Line Denials for Claims Adjudicated Between 12/1/2006 and 1/31/2008, by Month

	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	TOTAL
Paid	100,305	157,203	168,863	199,906	159,387	199,995	185,908	168,733	189,032	207,086	196,652	218,681	189,779	189,498	2,531,028
Denied	14,433	26,949	27,947	37,501	35,310	43,260	42,672	43,711	43,966	47,848	44,480	57,153	39,263	38,290	542,783
Total	114,738	184,152	196,810	237,407	194,697	243,255	228,580	212,444	232,998	254,934	241,132	275,834	229,042	227,788	3,073,811
Percent Denied	12.58%	14.63%	14.20%	15.80%	18.14%	17.78%	18.67%	20.58%	18.87%	18.77%	18.45%	20.72%	17.14%	16.81%	17.66%

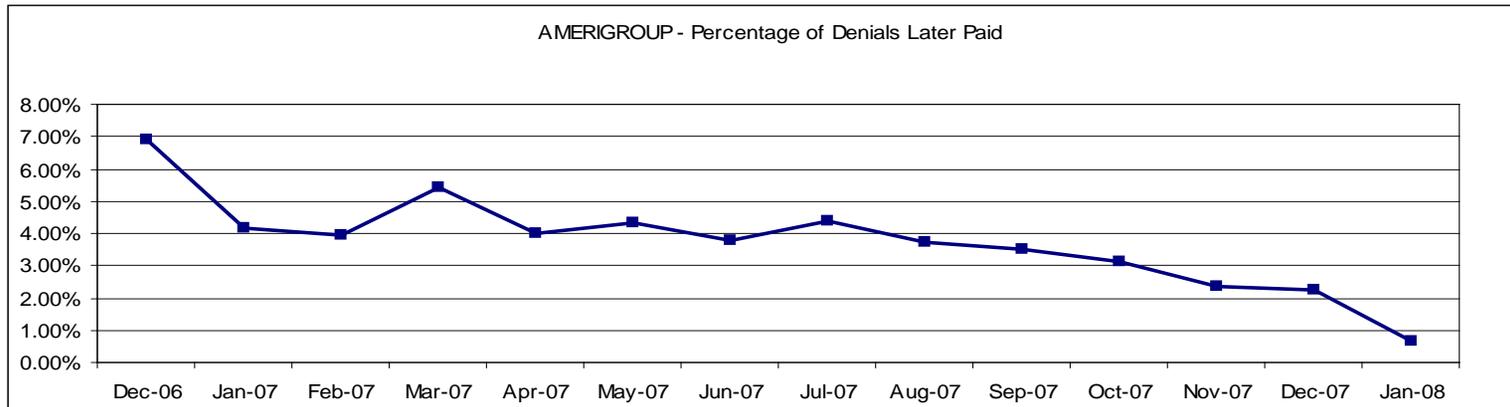
Note: An individual claim may appear in both the paid and denied totals if one or more claim detail lines was denied.



GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 3 – Analysis V: Claim Denials (AMERIGROUP)

Claim Line Denials Overturned or Later Processed for Payment

Month	Number of Denials	Number of Denials Later Paid	Percentage of Denials Later Paid	Average Length of Time Between Denial and Payment	Number of Interest Payments	Amount of Interest Paid
December-06	14,433	996	6.90%	49	32	\$240.29
January-07	26,949	1,122	4.16%	43	49	\$379.06
February-07	27,947	1,099	3.93%	48	40	\$227.66
March-07	37,501	2,028	5.41%	53	159	\$736.09
April-07	35,310	1,421	4.02%	50	135	\$489.34
May-07	43,260	1,873	4.33%	48	202	\$2,382.98
June-07	42,672	1,611	3.78%	53	86	\$362.17
July-07	43,711	1,928	4.41%	45	100	\$477.09
August-07	43,966	1,630	3.71%	42	134	\$667.87
September-07	47,848	1,668	3.49%	41	151	\$443.71
October-07	44,480	1,379	3.10%	39	120	\$538.90
November-07	57,153	1,330	2.33%	30	87	\$467.34
December-07	39,263	870	2.22%	22	28	\$186.78
January-08	38,290	247	0.65%	12	3	\$17.29
Total	542,783	19,202	3.54%	41 Days	1,326	\$7,616.57



GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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 Exhibit 3 – Analysis V: Claim Denials (AMERIGROUP)

Claim Denials by Reason Code

Reason Code / Group	Reason Description	Claim Line Count	Percent of All Denials
Included in Global Payment		140,693	25.53%
N01	Incidental to a current procedure	98,201	17.82%
N59	Incidental due to a procedure in history	13,807	2.51%
N02	Mutually Exclusive to another procedure	12,128	2.20%
N05	Medical visit occurred on same day	9,869	1.79%
N58	Mutually Exclusive procedure in history	4,942	0.90%
N65	Post-Op within 90 day of surgery in hist	881	0.16%
N51	History Procedure Rebundle	477	0.09%
N04	Post Op Procedure included in Surgery	274	0.05%
IND	Included in per diem/case rate	111	0.02%
Y50	Service line included in per diem paymen	3	0.00%
Duplicate Submission		110,983	20.14%
CDD/Y38	Definite Duplicate Claim	107,351	19.48%
346	Duplicate Service	3,350	0.61%
N52/N53	Duplicate Uni or Bilateral Procedure	282	0.05%
Non-Covered Benefit or Service		73,322	13.31%
PS0/Y57	Not a Covered Service	44,794	8.13%
N54/N55	Maximum Allowed Lifetime Occurrence	21,430	3.89%
B29	Not Covered for GA Medicaid members	3,434	0.62%
073	Deny All Claim Lines	1,985	0.36%
B33	Not covered for GA PeachCare member	940	0.17%
N06	Assistant Surgeon Disallow	605	0.11%
104	Claim level disallow	63	0.01%
383	Deny per Medical Director	45	0.01%
YB2/YB3	Not a covered benefit	23	0.00%
B30	Not Covered for GA Medicaid members >21	3	0.00%
Eligibility Issue		56,131	10.19%
ST	Termination	49,406	8.97%
S23	Date req. Prior to Subscriber Eff Dt.	5,969	1.08%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 3 – Analysis V: Claim Denials (AMERIGROUP)

Reason Code / Group	Reason Description	Claim Line Count	Percent of All Denials
376/377/378	Incorrect subscriber ID	561	0.10%
S13	All Enroll events are Future	195	0.04%
Incorrect/Invalid Information		55,362	10.05%
G40/G49/G50/G51	Inappropriate Modifier for Service	23,569	4.28%
G42/G52/G53/G54/G55/G56	Location not appropriate for procedure	13,922	2.53%
G25/G81/G82	Invalid ICD9 Diagnosis Code	3,337	0.61%
N66	History Medical Visit Conflict	2,150	0.39%
G24	Non-Compliant CPT/HCPCS code	2,067	0.38%
Y86/Y87/Y88	Billing Error	2,022	0.37%
Y12/Y97/YA8	Consent form required	1,447	0.26%
G04/G46/G47/G48	Inappropriate billing for this contract	996	0.18%
N15	Age exceeds normal range for procedure	951	0.17%
Y06/Y70/Y71	Description of service required	843	0.15%
Y53/Y54/Y55	Inappropriate procedure-modifier comb	735	0.13%
N13	Unlisted/Nonspecific Procedure Code	701	0.13%
Y92/Y93/Y94	Submit medical records for review	583	0.11%
N81	Modifier 22 requires additional document	376	0.07%
Y66/Y67	Deny - resubmit with a valid code	230	0.04%
N28/N64	PreOp Conflict within 1 day of surgery	220	0.04%
G91	Resubmit with Servicing Address	173	0.03%
N14/N85	Invalid Gender for Procedure	150	0.03%
N79	Units do not match submitted date range.	146	0.03%
384/385/386	Please resubmit claim with TPI number	115	0.02%
G60	Incorrect billing form/provider	97	0.02%
N77	Invalid Modifier	94	0.02%
G80	Resubmit with modifier	68	0.01%
N11	Outdated Procedure Disallow	59	0.01%
G39	Non-Compliant Modifier	44	0.01%
Y05/Y68/Y69	Time units in total minutes needed	40	0.01%
S1C	Plan not effective on date requested	24	0.00%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 3 – Analysis V: Claim Denials (AMERIGROUP)

Reason Code / Group	Reason Description	Claim Line Count	Percent of All Denials
G79	Resubmit with servicing provider	23	0.00%
V21	Submit claim to Georgia State Lab	21	0.00%
G68	Certificate of Med Necessity Req.	19	0.00%
G23	Invalid ICD9 Procedure Code	19	0.00%
S2	Date requested < Subscriber's Birth Date	18	0.00%
Y48	Claim billed under mother's ID	16	0.00%
V20	Submit claim to Avesis Third Party Admin	16	0.00%
G09	Incorrect Tax ID#	16	0.00%
Y61/Y62	Resubmit with individual dates of servic	11	0.00%
G92	Resubmit with Billing Address	7	0.00%
G89/G90	Resubmit with valid/correct Service Date	6	0.00%
382	ER Records	6	0.00%
G95	Technical Denial/Medical Record not sent	4	0.00%
YA2	Rebill NonGlobal Maternity Code	3	0.00%
Y43	Tx-School based svc-not ordered by physi	3	0.00%
G87/G88	Resubmit with valid charged amount	2	0.00%
Y58/Y59	Rebill with appropriate surgical CPT	2	0.00%
N82	Modifiers do not match units billed.	2	0.00%
UM2	Units reduced by UM authorization	2	0.00%
Y85	Resubmit with itemized bill	2	0.00%
Y47	Invoice required	2	0.00%
G36	Procedure code invalid after 12/31/2004	1	0.00%
380	Invalid anesthesia code	1	0.00%
Y89	Submit mother's claim - nb chrgs incl	1	0.00%
Time Filing Limit		55,349	10.04%
TF0/X15/X16	Submitted after plan filing limit	55,347	10.04%
TF1	Submitted After Provider's Filing Limit	2	0.00%
Authorization Issue		30,785	5.59%
Y40/Y41	Deny preauth not obtained	28,420	5.16%
379	Level of care not authorized	1,282	0.23%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 3 – Analysis V: Claim Denials (AMERIGROUP)

Reason Code / Group	Reason Description	Claim Line Count	Percent of All Denials
Y29/Y39	Dates of service are outside dates autho	549	0.10%
UM1/UM5/UM6	Units exceed UM authorization	373	0.07%
UM0	Services Disallowed by UM	161	0.03%
Coordination of Benefits Issue		21,838	3.96%
CBO/CBP	Primary carrier information required	21,838	3.96%
No EOB Code Provided		6,589	1.20%
" "	Not Assigned	6,589	1.20%

Notes:

- *All figures reflect a distinct count of claims paid or denied between December 1, 2006 and January 31, 2008.*
- *A claim may have more than one denial reason code.*
- *M&S created 'Reason Groups' to categorize similar types of denials.*
- *Denial reasons only exist on claims that are adjudicated. Claims rejected prior to adjudication were not included in the data submitted by the CMO*

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

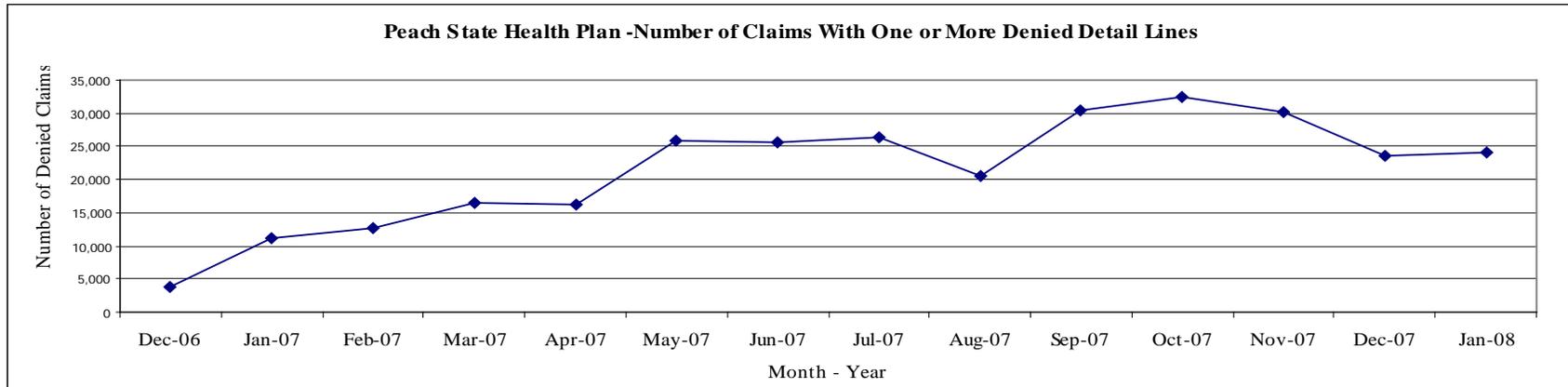
Georgia Families

Exhibit 3 – Analysis V: Claim Denials (Peach State Health Plan)

Claim Detail Line Denials for Claims Adjudicated Between 12/1/2006 and 1/31/2008, by Month

	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	TOTAL
Paid	24,355	50,708	49,724	77,761	53,125	73,012	64,585	75,487	62,598	66,709	76,976	72,574	68,560	66,462	882,636
Denied	3,851	11,270	12,627	16,463	16,130	25,961	25,558	26,276	20,641	30,439	32,519	30,292	23,500	24,207	299,734
Total	28,206	61,978	62,351	94,224	69,255	98,973	90,143	101,763	83,239	97,148	109,495	102,866	92,060	90,669	1,182,370
Percent Denied	13.65%	18.18%	20.25%	17.47%	23.29%	26.23%	28.35%	25.82%	24.80%	31.33%	29.70%	29.45%	25.53%	26.70%	25.35%

Note: An individual claim may appear in both the paid and denied totals if one or more claim detail lines was denied.



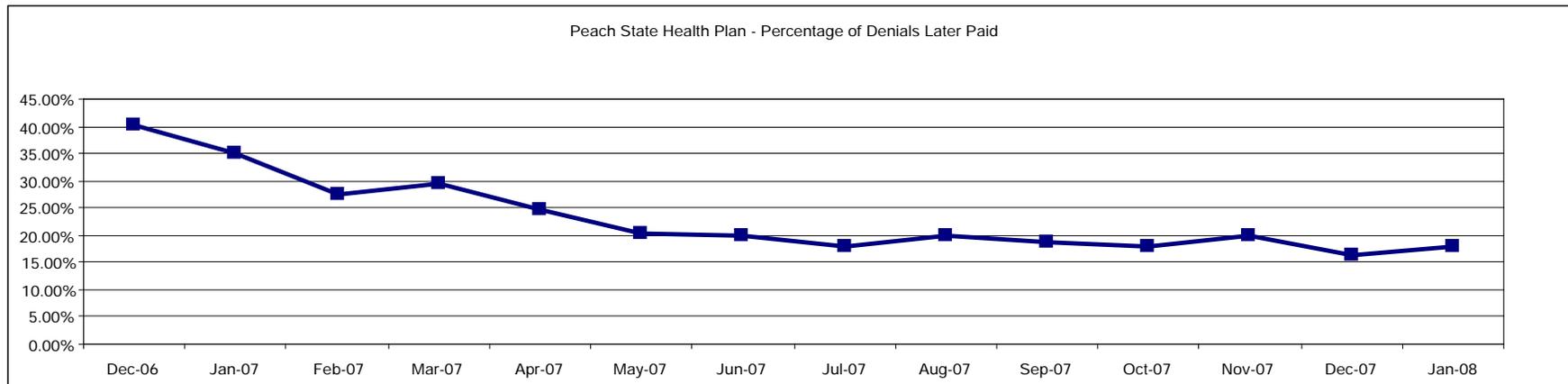
GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 3 – Analysis V: Claim Denials (Peach State Health Plan)

Claim Line Denials Overturned or Later Processed for Payment

Month	Number of Denials	Number of Denials Later Paid	Percentage of Denials Later Paid	Average Length of Time Between Denial and Payment	Number of Interest Payments	Amount of Interest Paid
December-06	3,851	1,550	40.25%	91	181	\$565.70
January-07	11,270	3,965	35.18%	115	646	\$3,781.14
February-07	12,627	3,486	27.61%	119	548	\$6,294.19
March-07	16,463	4,867	29.56%	113	777	\$5,065.75
April-07	16,130	3,960	24.55%	96	666	\$2,710.84
May-07	25,961	5,322	20.50%	75	923	\$3,806.84
June-07	25,558	5,101	19.96%	82	1,040	\$4,045.02
July-07	26,276	4,732	18.01%	87	947	\$4,216.08
August-07	20,641	4,148	20.10%	79	856	\$3,284.57
September-07	30,439	5,694	18.71%	69	802	\$4,404.64
October-07	32,519	5,882	18.09%	64	938	\$4,439.38
November-07	30,292	5,980	19.74%	70	792	\$3,904.64
December-07	23,500	3,877	16.50%	58	642	\$1,647.37
January-08	24,207	4,308	17.80%	40	510	\$1,479.46
Total	299,734	62,872	20.98%	83 Days	10,268	\$49,645.62



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 3 – Analysis V: Claim Denials (Peach State Health Plan)

Claim Denials by Reason Code

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
Incorrect/Invalid Information		120,953	32.92%
EXN3	Your Npi Is Not On File/Valid Or You Have Not Billed With Your Npi	48,014	13.07%
EXRC	Deny: Required Referral Code For Health Check Visit Invalid Or Missing	19,234	5.23%
EXEC	Diagnosis Cannot Be Used As Primary Diagnosis, Please Resubmit	13,461	3.66%
EXVC	Deny - Please Resubmit According To Vaccines For Children Guidelines	11,786	3.21%
EXMF	Deny: Inappropriate Medicaid# Submitted For Svc Provider,Please Resubmit	8,514	2.32%
EX9M	Deny: This Cpt Code Is Invalid When Billed With This Diagnosis	6,328	1.72%
EX4D	Deny: Non-Specific Diagnosis- Requires 5Th Digit Please Resubmit	2,750	0.75%
EX09	Deny: The Diagnosis Is Inconsistent With The Patient'S Age	1,009	0.27%
EX3D	Deny: Non-Specific Diagnosis- Requires 4Th Digit Please Resubmit	950	0.26%
EXU1	Claim Cannot Be Processed Without Medical Records	745	0.20%
EX86	Deny: This Is Not A Valid Modifier For This Code	695	0.19%
EXZ3	Deny: Cpt And Modifier Not Reimbursed Separately	657	0.18%
EXMG	Deny: Signature Missing From Box 31, Please Resubmit	686	0.19%
EXIV	Deny: Invalid/Deleted/Missing Cpt Code	643	0.18%
EXTJ	Deny: Required Modifier For Epsdt Services Missing Or Invalid	573	0.16%
EXBG	Deny: Type Of Bill Missing Or Incorrect On Claim, Please Re-Submit	551	0.15%
EX99	Deny:Misc/Unlisted Codes Can Not Be Processed W/O Description/Report	460	0.13%
EX1K	Deny: Cpt Or Dx Code Is Not Valid For Age Of Patient	396	0.11%
EX10	Deny: The Diagnosis Is Inconsistent With The Patient'S Sex	376	0.10%
EXNX	Deny: Invalid Or No Tax Id Number Submitted On Claim, Please Resubmit	301	0.08%
EXDX	Diagnosis Billed Is Invalid, Please Resubmit With Correct Code.	285	0.08%
EXIM	Deny: Resubmit With Modifier Specified By State For Proper Payment	261	0.07%
EXKZ	Deny: Invalid Place Of Service, Please Consult The Georgia Prov Manual	271	0.07%
EXHQ	Deny: Edi Claim Must Be Submitted In Hard Copy W/Consent Form Attached	253	0.07%
EXLO	Deny: Cpt & Location Are Not Compatible, Please Resubmit.	235	0.06%
EXDJ	Deny:Inappropriate Code Billed,Correct & Resubmit	199	0.05%
EX16	Deny: Revenue Code Not Reimbursable - Cpt/Hcpcs Code Required	179	0.05%
EXRM	Deny: Modifier Required For Payment Of Service - Resubmit W/Modifier	171	0.05%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 3 – Analysis V: Claim Denials (Peach State Health Plan)

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
EX9N	Claim Cannot Be Processed Without Operative Report	159	0.04%
EXDD	Deny:Required Form/Statement For Service Not Received	153	0.04%
EXNV	Deny: Required Form/Statement For Service Not Valid/Missing Informationn	107	0.03%
EX07	Deny: The Procedure Code Is Inconsistent With The Patient'S Sex	78	0.02%
EX17	Deny: Requested Information Was Not Provided	64	0.02%
EXND	Deny: This Is A Deleted Code At The Time Of Service	63	0.02%
EX0A	Deny: Not Reimbursable - Bill Under Ambulance Medicaid Id	62	0.02%
EXGM	Deny: Resubmit W/ Medicaid# Of Individual Servicing Provider In Box 24K	54	0.01%
EXBK	Deny: Add On Code Billed Without Primary Procedure	38	0.01%
EXN5	Deny: Name Of Drug, Ndc Number And Quantity Is Required To Process Claim	35	0.01%
EXVD	Deny: Only One Visit Code Is Allowed On A Given Date	33	0.01%
EXLY	Deny: Please Resubmit With Invoice For Payment	29	0.01%
EXFZ	Deny: Documentation Does Not Reflect All Components Of Billed E/M	19	0.01%
EXIL	Verify The Correct Location Code For Service Billed And Resubmit	18	0.00%
EXAW	Deny: Resubmit With Anesthesia Service To Receive Reimbursement For Proc	12	0.00%
EX62	Deny: Required Epsdt Referral Code Invalid Or Missing	10	0.00%
EXAQ	Deny: Billed Service Does Not Match Units/Dates - Correct And Resubmit	4	0.00%
EXUT	Deny: Cpt/Modifier Not Appropriate When Billed With Multiple Units	6	0.00%
EXYN	Medicaid # Must Be Billed In 24K/Hcfa, Or 51/Ub	5	0.00%
EXI6	Deny: Diagnosis Or Cpt/Hcpcs/Icd-9 Proc Code Invalid For Date Of Service	4	0.00%
EX1L	Deny: Visit & Preven Codes Are Not Payable On Same Dos W/O Documentation	4	0.00%
EXPF	Deny: Professional Fee Must Be Billed On Hcfa Form	3	0.00%
EXED	Deny - Please Resubmit Epsdt Services Under Provider'S Epsdt Id Number	2	0.00%
EX9I	Information Requested Was Not Received Within The Time Frame Specified	2	0.00%
EX9K	Claim Cannot Be Processed Without Pathology Report	1	0.00%
EXTF	Deny: Cpt/Hcpcs Codes Not Acceptable For Service Dates Prior To New Year	1	0.00%
EXI9	Deny: Diagnosis Is An Invalid Or Deleted Icd9 Code	1	0.00%
EXDW	Deny: Inappropriate Diagnosis Billed, Correct And Resubmit	1	0.00%
EXU4	Deny:Upon Review Of Records-No Indication Of Phys Services	1	0.00%
EXV3	Med Records Received For Wrong Date Of Service	1	0.00%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 3 – Analysis V: Claim Denials (Peach State Health Plan)

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
Duplicate Submission		109,947	29.92%
EX18	Deny: Duplicate Claim/Service	106,156	28.89%
EXDS	Deny: Duplicate Submission-Original Claim Still In Pend Status	3,791	1.03%
Eligibility Issue		44,752	12.18%
EX28	Deny: Coverage Not In Effect When Service Provided	38,000	10.34%
EXMQ	Deny: Member Name/Number/Date Of Birth Do Not Match,Please Resubmit	3,376	0.92%
EXMA	Medicaid# Missing Or Not On File, Please Correct And Resubmit	3,368	0.92%
EXK4	Deny: Member Is Not The Responsibility Of Peach State Health Plan	8	0.00%
Time Filing Limit		37,743	10.27%
EX29	Deny: The Time Limit For Filing Has Expired	36,744	10.00%
EXQR	Deny: Adjustment Was Not Received Within Timely Filing Limit	907	0.25%
EXRQ	Deny: Original Submission Was Not Received Within Timely Filing Limit	92	6.76%
Non Covered Service or Benefit		24,851	6.76%
EX57	Deny: Code Was Denied By Code Auditing Software	12,163	3.31%
EX46	Deny: This Service Is Not Covered	5,228	1.42%
EXMY	Deny: Member'S Pcp Is Capitated - Service Not Reimbursable To Other Pcps	2,174	0.59%
EX58	Deny: Code Replaced Based On Code Auditing Software Recommendation	1,932	0.53%
EXZW	After Review, Prev Decision Upheld, See Prov Handbook For Appeal Process	1,162	0.32%
EX35	Deny: Benefit Maximum Has Been Reached	705	0.19%
EXG1	Deny: Procedure Under This Program Is Not Covered For The Member'S Age	565	0.15%
EXZC	Deny: Procedure Is Inappropriate For Provider Specialty	431	0.12%
EXGA	Deny: Procedure Not Covered For The Member'S Age	282	0.08%
EXEB	Deny: Denied By Medical Services	126	0.03%
EX47	Deny: This Diagnosis Is Not Covered	49	0.01%
EX24	Deny: Charges Covered Under Capitation	19	0.01%
EXBD	Deny: Benefit Is Not Covered By Hmo	9	0.00%
EX48	Deny: This Procedure Is Not Covered	2	0.00%
EX50	Deny:Not A Mco Covered Benefit	2	0.00%
EXRE	Deny: Rental Benefit Exhausted - After 10 Rentals Considered Purchased	1	0.00%
EX81	Original Code Was Replaced By Hpr Codereview Software	1	0.00%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 3 – Analysis V: Claim Denials (Peach State Health Plan)

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
Authorization Issue		13,737	3.74%
EXA1	Deny: Authorization Not On File	10,296	2.80%
EXHL	Deny: Claim And Auth Locations Do Not Match	1,082	0.29%
EXHS	Deny: Claim And Auth Provider Specialty Not Matching	992	0.27%
EXHP	Deny: Claim And Auth Service Provider Not Matching	584	0.16%
EXDZ	Deny: Service Has Exceeded The Authorized Limit	511	0.14%
EXHT	Deny: Claim And Auth Treatment Type Not Matching	272	0.07%
Coordination of Benefits Issue		6,879	1.87%
EXL6	Deny: Bill Primary Insurer 1St. Resubmit With Eob.	6,644	1.81%
EXI1	Other Insurance Eob Submitted Does Not Match Billed, Please Resubmit	90	0.02%
EX6L	Eob Incomplete-Please Resubmit With Reason Of Other Insurance Denial	71	0.02%
EXLR	Deny:When Prime Ins.Recieves Info-Resubmit To Secondary Ins.	45	0.01%
EXNA	Other Ins. Denied - Oop Provider/Not Authorized - Services Not Payable	27	0.01%
EXY6	Deny:Insufficient Info For Processing, Resubmit W/Prime'S Original Eob	2	0.00%
Fee, Service Limit, or Charge Issue		6,587	1.79%
EXN6	Deny: Service Not On Stat Lab Schedule-Ineligible For Reimbursement	6,586	1.79%
EX0R	Deny: Service Not On Hmo Radiology Schedule-Ineligible For Reimbursement	1	0.00%
Claim Submission Error		1,257	0.34%
EXFQ	Deny: Resubmit Claim Under Fqhc/Rhc Clinic Medicaid Number	406	0.11%
EXRX	Deny: Please Submit To The Pharmacy Vendor For Processing.	355	0.10%
EXVS	Deny: Please Submit To The Vision Vendor For Processing.	252	0.07%
EXMH	Deny: Please Submit To Mental Health Plan For Processing	227	0.06%
EXVX	Deny: Resubmit To Carecentrix For Consideration	17	0.00%
Included in Global Payment		715	0.19%
EXOX	Deny: Code Is Considered An Integral Component Of The E/M Code Billed	468	0.13%
EXHW	Deny: Payment Included In The Higher Intensity Code Billed	128	0.03%
EXSU	Deny: Visit Is Included In Surgery	82	0.02%
EX97	Payment Is Included In Allowance For Basic Service	32	0.01%
EX8T	Deny: Service Included In Delivery Payment	3	0.00%
EXIE	Cpt Not Reimbursed Separately. Included As Part Of Inclusive Procedure	2	0.00%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 3 – Analysis V: Claim Denials (Peach State Health Plan)

Notes:

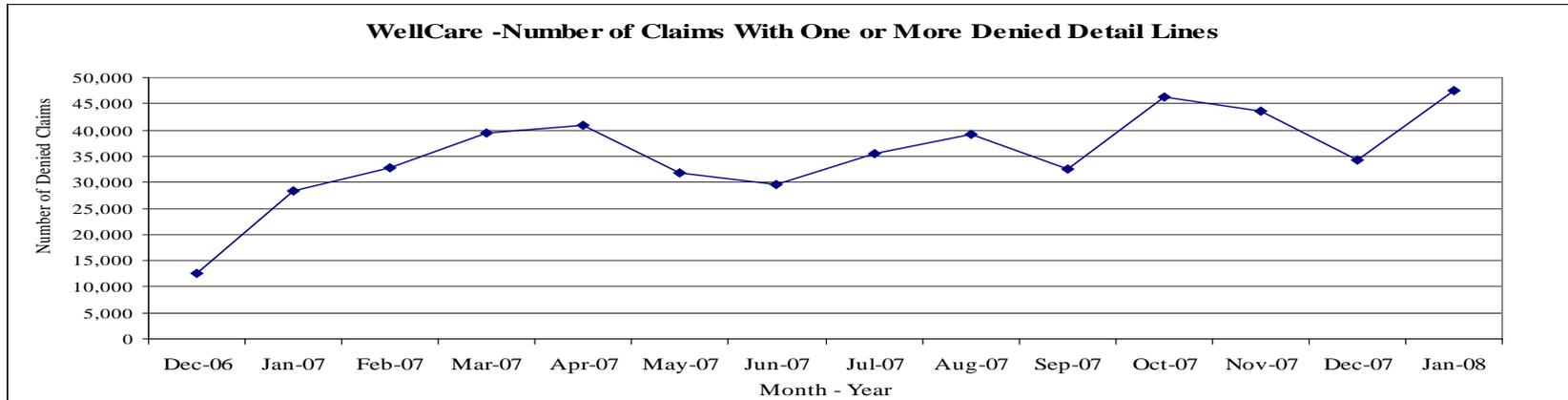
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GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 3 – Analysis V: Claim Denials (WellCare)

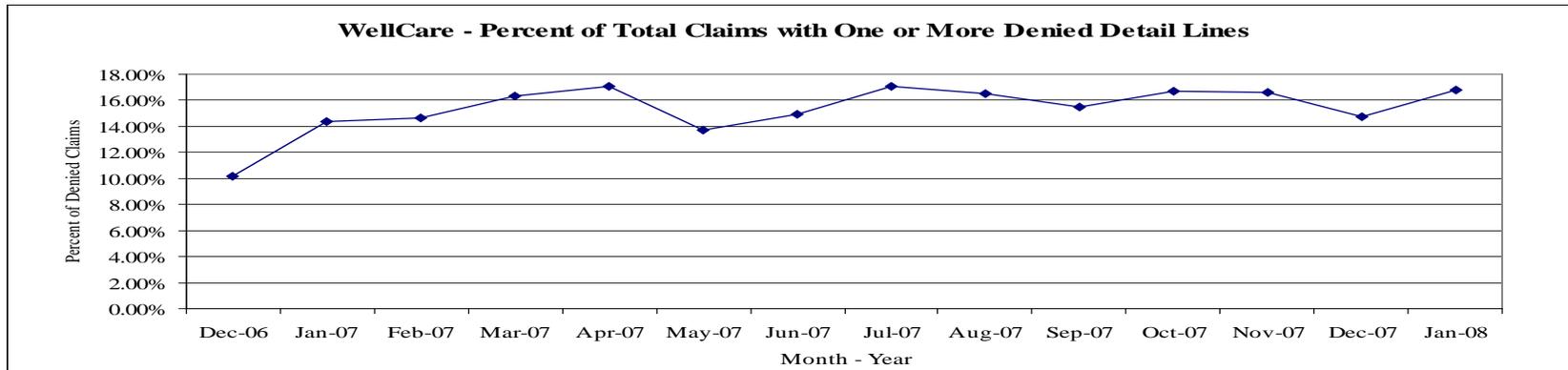
Claim Detail Line Denials for Claims Adjudicated Between 12/1/2006 and 1/31/2008, by Month

	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	TOTAL
Paid	110,594	169,036	190,937	202,895	198,153	200,155	168,326	172,261	197,729	177,576	231,744	219,010	198,037	236,284	2,672,737
Denied	12,568	28,409	32,650	39,511	40,872	31,805	29,614	35,444	39,135	32,618	46,422	43,522	34,317	47,527	494,414
Total	123,162	197,445	223,587	242,406	239,025	231,960	197,940	207,705	236,864	210,194	278,166	262,532	232,354	283,811	3,167,151
Percent Denied	10.20%	14.39%	14.60%	16.30%	17.10%	13.71%	14.96%	17.06%	16.52%	15.52%	16.69%	16.58%	14.77%	16.75%	15.61%

Note: An individual claim may appear in both the paid and denied totals if one or more claim detail lines was denied.



GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 3 – Analysis V: Claim Denials (WellCare)



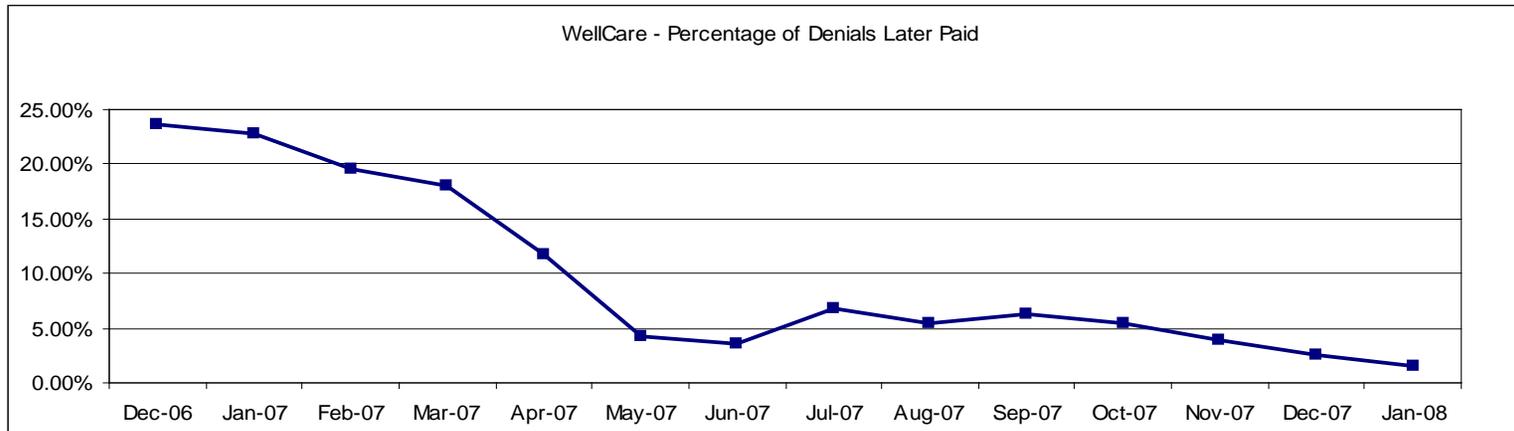
Claim Line Denials Overturned or Later Processed for Payment

Month	Number of Denials	Number of Denials Later Paid	Percentage of Denials Later Paid	Average Length of Time Between Denial and Payment	Number of Interest Payments	Amount of Interest Paid
December-06	12,568	2,980	23.71%	111	0	\$0.00
January-07	28,409	6,476	22.80%	94	0	\$0.00
February-07	32,650	6,412	19.64%	96	0	\$0.00
March-07	39,511	7,116	18.01%	73	0	\$0.00
April-07	40,872	4,764	11.66%	58	0	\$0.00
May-07	31,805	1,371	4.31%	66	0	\$0.00
June-07	29,614	1,070	3.61%	58	0	\$0.00
July-07	35,444	2,439	6.88%	45	0	\$0.00
August-07	39,135	2,112	5.40%	52	1	\$1.54
September-07	32,618	2,036	6.24%	52	0	\$0.00
October-07	46,422	2,498	5.38%	37	1	\$2.00
November-07	43,522	1,700	3.91%	27	0	\$0.00
December-07	34,317	887	2.58%	20	0	\$0.00
January-08	47,527	746	1.57%	6	0	\$0.00
Total	494,414	42,607	8.62%	57 Days	2	\$3.54

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 3 – Analysis V: Claim Denials (WellCare)



Claim Denials by Reason Code

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
Duplicate Submission		185,230	36.10%
EXDUC/DN075	Exact Duplicate Of Another Claim Or Service	179,682	35.02%
DUPCD	Duplicate Procedure Code Previously Processed	4,845	0.94%
DN078	Pmnt For This Claim/Service Was Provided In A Previous Pmnt	649	0.13%
FI11	Dup Claim/Services(S)	34	0.01%
DN041	Procedure Was Billed Twice For Same Date Of Service	12	0.00%
DUPCM	Duplicate Claim	8	0.00%
No EOB Code Provided		130,505	25.43%
None	Remark Code Not Provided	130,505	25.43%
Non Covered Service or Benefit		68,819	13.41%
DN016	This Is Not A Covered Procedure	41,597	8.11%
LIMIT	Service Not Covered. Benefit Maximum Has Been Reached	26,365	5.14%
DN053	Svcs Capitated	283	0.06%
PRONC	Procedure Code Is Not Covered	144	0.03%
SETLE	Dates Of Service Included In Settlement	133	0.03%
NOTCV	Svc Is Not A Covered Benefit Or Exceeded The Benefit Limit	117	0.02%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 3 – Analysis V: Claim Denials (WellCare)

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
FI04	Excess Services(S)	83	0.02%
DN019	Denied After Medical Review	25	0.00%
DN026	Non-Covered Benefit	17	0.00%
DN040	Assistant Surgeon Not Warrented	16	0.00%
FI23	Service Not A Covered Benefit Or Exceeded Benefit Limit	15	0.00%
FI13	Denied After Medical Record Review	8	0.00%
DN055	Days/Visits/Units Billed Exceed Benefit Max For Time Period	7	0.00%
FI24	Provider Ineligible Or Prohibited To Provide Service	3	0.00%
DN064	Reimbursement For Prof Component Only	3	0.00%
DN015	Benefits Exhausted	2	0.00%
DN195	Anesthesia Not Payable When Rendered By Non-Anesthesiologist	1	0.00%
Authorization Issue		46,056	8.98%
DN001	Prior Authorization Is Required But Was Not Obtained	39,059	7.61%
DN038	Svcs Billed Not Consistent With The Authorization On File	3,511	0.68%
DAUTH	Prior Authorization Request Was Denied	1,082	0.21%
LIMAR	Limit Reached-Authorization Required	366	0.07%
DN045	This Svc Requires Medical Records For Review	496	0.10%
VSTEX	The Days/Visits/Units Billed On Claim Exceed The # Authd	379	0.07%
DN039	Services Not Included In Authorization	347	0.07%
DN004	Authorization Denied	300	0.06%
AUCLO	Authorization Closed	248	0.05%
FI01	Medical Record Required Send To Po Box 26021 Tampa Fl 33623	99	0.02%
OUTAU	Date Of Svc Of Procedure Is Outside Of What Was Authorized	89	0.02%
FI12	No Authorization/Not Billed As Authorized	38	0.01%
AUEXP	Authorization Expired - Date Of Svc After Authorized Dates	22	0.00%
CNMFA	Criteria Not Met For Authorization	18	0.00%
FI29	Service Exceeded The Benefit Limit.	1	0.00%
DN161	Exceeds Authorized Cost	1	0.00%
Included in Global Payment		26,758	5.21%
DN062	Pmnt Was Included In The Allowance For Another Svc/Procedure	24,721	4.82%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 3 – Analysis V: Claim Denials (WellCare)

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
DN048	Procedure Is Mutually Exclusive	1,070	0.21%
DN007	Pmnt Inclusive With The Surgical Procedure	787	0.15%
DN009	Inclusive With Epsdt Services	163	0.03%
DNM05	Pmnt Included In Apc Pricing Allowable For Another Svc/Proc	13	0.00%
DN068	Included In Triage Fee Allowance	2	0.00%
DN070	Pre-Op Services Inclusive With Surgery	1	0.00%
DN011	Svc Is Included In Total Ob Care	1	0.00%
Incorrect/Invalid Information		21,394	4.17%
DN218	Resubmit Dx With Appropriate 4Th And/Or 4Th And 5Th Digit	10,829	2.11%
DN083	The Proc/Revenue Code Is Inconsistent With The Patients Age	7,572	1.48%
DN198	Add-On Code Billed Without Base Code	705	0.14%
DN086	Gender Conflict, Inappropriate For Patient` S Gender	544	0.11%
DN197	Diagnosis Code Does Not Warrant Procedure	414	0.08%
DN205	Incorrect Member Id #	327	0.06%
FI03	Procedure Code And Modifier Conflict	236	0.05%
DN165	Please Submit With Correct Tax Id#	226	0.04%
DN187	Pos Missing/Invalid For Cpt Billed	163	0.03%
DN178	Provider Billed Zero	146	0.03%
DN185	Resubmit With Ndc Number	114	0.02%
FI16	Submit With Correct Vendor Info Po Box 26021 Tampa FI 33623	54	0.01%
FI19	Please Resubmit With Correct Pos	20	0.00%
DN112	Please Resubmit Claim Under Individual Provider Number	8	0.00%
DN108	Unlisted Procedure Code	8	0.00%
DN054	Invalid Procedure Code. Rebill With Valid Code	8	0.00%
FI05	Coding Not Supported By Medical Documentation	7	0.00%
DN201	Bilateral Procedure Billed Inappropriately	4	0.00%
FI06	Coding Partially Supports Medical Documentation	4	0.00%
FI28	Ndc Number Required In Area Above 24-A On Cms-1500	2	0.00%
DN183	The Diagnosis Is Inconsistent With The Procedure.	2	0.00%
FI25	Required Information Missing	1	0.00%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 3 – Analysis V: Claim Denials (WellCare)

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
Time Filing Limit		17,045	3.32%
TFLDN	The Time Limit For Filing This Claim Has Expired	17,000	3.31%
TIMEF/TIMLY/TIMEL	Exceeds Filing Time Limit	35	3.49%
DN027	The Time Limit For Filing This Claim Has Expired	10	0.00%
Coordination of Benefits Issue		10,558	2.06%
DN018	Must submit an EOB from the Primary Insurance Carrier	10,352	2.02%
DN148	Submit Eob From Auto Carrier	178	0.03%
DN017	Must submit an EOB from Medicare	26	0.01%
FI22	Submit EOB from Primary Insurance	2	0.00%
Fee, Service Limit, or Charge Issue		5,974	1.16%
DN025	No Contractual Fee Allowance	5,780	1.13%
DN023	No Medicaid Allowable	163	0.03%
FI08	Ocr Or Data Entry Problem	27	0.01%
VEFEE	Vendor Contingency Fee	4	0.00%
Eligibility Issue		714	0.14%
INELG/DN073	Member not Eligible on the date of service	714	0.14%
Claim Submission Error		88	0.02%
DN101	Submit to United Resource Networks for repricing.	81	0.02%
BMCD	Bill Medicaid Directly	6	0.00%
MAGEL	Submit to Magellan Behavioral Health	1	0.00%

Notes:

- All figures reflect a distinct count of claims paid or denied between December 1, 2006 and January 31, 2008.
- A claim may have more than one denial reason code.
- M&S created 'Reason Groups' to categorize similar types of denials.
- Denial reasons only exist on claims that are adjudicated. Claims rejected prior to adjudication were not included in the data submitted by the CMO.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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Exhibit 4 – Analysis VII: Provider Retention

AMERIGROUP – Provider Retention and Claim Activity

	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08
Active Provider Count	13,741	14,120	14,581	14,855	15,071	15,210	15,303	15,469	15,827	16,364	16,773	16,979	17,082	16,932
Provider Terminations	8	13	17	21	15	68	43	45	29	38	27	36	58	30
Percent of Providers Terminating Participation	0.06%	0.09%	0.12%	0.14%	0.10%	0.45%	0.28%	0.29%	0.18%	0.23%	0.16%	0.21%	0.34%	0.18%
Count of Providers with Claim Encounters	6,943	7,271	7,149	7,296	7,246	7,202	7,023	7,037	7,212	7,041	7,229	6,880	6,687	6,741
Count of Claim Line Count	138,161	151,992	146,694	154,852	141,690	144,739	125,178	133,016	156,282	137,571	164,556	149,424	122,583	134,792
Percent of Active Providers with No Claim Activity	49.47%	48.51%	50.97%	50.89%	51.92%	52.65%	54.11%	54.51%	54.43%	56.97%	56.90%	59.48%	60.85%	60.19%

Average Percentage of Providers with No Claim Activity: 54.42%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Georgia Families
 Exhibit 4 – Analysis VII: Provider Retention

Peach State Health Plan – Provider Retention and Claim Activity

	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08
Active Provider Count	2,646	2,721	2,801	2,987	3,083	3,267	3,443	3,722	3,861	4,007	4,221	4,873	5,091	5,204
Provider Terminations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percent of Providers Terminating Participation	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Count of Providers with Claim Encounters	1,616	1,675	1,631	1,660	1,670	1,726	1,700	1,738	1,827	1,769	1,906	1,898	1,886	1,903
Count of Claim Line Count	48,453	52,435	50,386	51,133	46,702	48,674	40,960	46,175	54,544	46,408	58,568	56,052	46,630	54,707
Percent of Active Providers with No Claim Activity	38.93%	38.44%	41.77%	44.43%	45.83%	47.17%	50.62%	53.30%	52.68%	55.85%	54.84%	61.05%	62.95%	63.43%

Average Percentage of Providers with No Claim Activity: 50.81%

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Families

Exhibit 4 – Analysis VII: Provider Retention

WellCare – Provider Retention and Claim Activity

	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08
Active Provider Count	3,738	3,772	3,817	3,858	3,894	3,922	3,958	4,017	4,047	4,089	4,149	4,233	4,294	4,327
Provider Terminations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percent of Providers Terminating Participation	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Count of Providers with Claim Encounters	2,550	2,576	2,536	2,545	2,492	2,443	2,432	2,425	2,491	2,462	2,477	2,478	2,420	2,402
Count of Claim Line Count	156,810	168,809	162,084	156,845	139,642	139,919	115,269	126,289	155,702	137,711	173,392	168,085	141,040	161,690
Percent of Active Providers with No Claim Activity	31.78%	31.71%	33.56%	34.03%	36.00%	37.71%	38.55%	39.63%	38.45%	39.79%	40.30%	41.46%	43.64%	44.49%

Average Percentage of Providers with No Claim Activity: 37.94%