

# Delays in Medicaid Claims Processing

Follow-up Report  
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Office of Performance Evaluations  
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# ***Follow-up Report***

# **Delays in Medicaid Claims Processing**

## **Executive Summary**

In June 2010, the Department of Health and Welfare implemented a new Medicaid Management Information System made up of numerous components including a claims processing system operated by Molina Healthcare, Inc. Our March 2011 evaluation study of delays in claims processing found that contract terms, conditions, and oversight fell short in ensuring the system was sufficiently designed and tested before being implemented. We made four recommendations to Molina and four recommendations to the department for continued improvement and for lessons learned in future projects.

## ***Implementation Status of Recommendations***

Since our evaluation, Molina has improved its responsiveness to providers and strengthened the function of its claims processing system. Of the four recommendations we made to Molina, two have been implemented and the intent of the other two recommendations has been addressed. Molina has increased communication with providers, improved customer service, and strengthened quality assurance procedures. It has also begun measuring system performance as opposed to only measuring the timeliness of claims processing. Additionally, the number of pended claims has substantially decreased.

The Department of Health and Welfare has implemented two of its recommendations by withholding and reducing payments to Molina for operations, and by requiring additional quality assurance measures. The other two recommendations are not applicable at this time because the department has indicated it does not have plans to issue more interim payments nor does it plan to contract for other IT services in the near future. We do, however, recommend that the department formally incorporate more specific requirements for future contracts into its policies and procedures manual. These requirements should include clearly defined roles and responsibilities, amount of end user testing, and contract monitoring of deliverables and milestones.

## ***Provider Survey Results***

For this follow-up review, we surveyed 5,068 providers to see how their satisfaction levels aligned with system improvements. We asked these providers for their perceptions on claims processing and customer service and received responses from 1,445 (28.5 percent). Overall, 43 percent of survey respondents indicated that they are satisfied or very satisfied with the system. However, 33 percent of respondents are unsatisfied or very unsatisfied. Given that the system is processing claims within expected timeframes and outcomes, we encourage Molina and the Department of Health and Welfare to continue to monitor providers' satisfaction levels and address their concerns to the extent possible.

## **Acknowledgments**

We appreciate the extensive cooperation and assistance we received from the Department of Health and Welfare, Molina Healthcare, Inc., and Legislative Audits.

Jared Tatro, Maureen Brewer, and Lance McCleve of the Office of Performance Evaluations conducted this follow-up review. Margaret Campbell was copy editor and desktop publisher.

Kathleen Sullivan, professor and former director of the Center for Education Research and Evaluation at the University of Mississippi, conducted the quality control review.

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# ***Follow-up Report***

# **Delays in Medicaid Claims Processing**

## **Original Report Overview**

On June 4, 2010, the Department of Health and Welfare implemented a new Medicaid Management Information System made up of numerous components including a claims processing system operated by Molina Healthcare, Inc. Soon after the implementation of the claims system, a series of design defects, provider enrollment issues, and a lack of coordination to resolve problems efficiently and effectively led to delays in claims processing and inaccurate payments to providers, if payments were made at all.

Our March 2011 evaluation report detailed the following key findings:

- The system was virtually untested by the providers before implementation
- Less than half of the providers were enrolled in the system when it was implemented
- Many more claims were pending than would have been expected had the system been functioning correctly
- Neither the department nor Molina could quantify the extent to which the system was processing claims incorrectly
- Call wait times for customer service were as high as 35–40 minutes
- Over \$117 million in interim payments were issued to providers without clear information about the purpose of the payments or guidance for repayment

## ***CMS Certification***

We noted in the evaluation report that the federal Center for Medicare and Medicaid Services (CMS) would need to certify the system. The system must be federally certified in order to maximize federal match rates for system operation. The department and Molina presented the system to CMS for certification during

the week of December 5, 2011, and expect a certification result by the end of the 2012 legislative session.

## **Methodology**

We received written updates from the department and Molina that detailed their efforts to implement our recommendations. We reviewed summary data to verify their implementation efforts and the extent of improvements to system performance. We also interviewed officials from the department and Molina to better understand the changes they had made since our evaluation.

Additionally, we contacted six associations about their current level of satisfaction with Molina's operation of the system: the Idaho Association of Developmental Disabilities Agencies, the Idaho Care Providers Network, the Idaho Health Care Association, the Idaho Hospital Association, the Idaho Medical Association, and the Idaho Primary Care Association.

In November, we surveyed a sample of providers to measure their level of satisfaction with the current operation of the system and their assessment of improvement since they began submitting claims to the system. The survey was not conducted to evaluate whether Molina and the department implemented our recommendations, but rather to inquire about the providers' experience with efforts made by Molina. We anticipated that the survey results could also give policymakers, the department, and Molina additional insight about provider responses to system changes. Our detailed results are in appendix A.

Approximately 10,000 unique providers submit Medicaid claims to the system. A survey of all providers was not feasible given the availability of our office resources. Instead, we distributed the survey to 5,068 providers who had an e-mail address on file with the department and who had submitted a claim since November 1, 2010. To verify that survey results would not be biased by our sample selection, we compared the specialties of providers who had an e-mail address on file with those who did not have an e-mail address on file.

We found no critical difference in the frequency of specialties among providers with or without e-mail addresses, meaning that no provider specialty is less likely than another to have an e-mail address. We also compared responses of the 1,445 providers (28.5 percent) who completed the survey and found no significant difference in responses among the various provider specialties. The results of these comparisons indicate that our sampling method of using e-mail addresses to select survey participants did not influence the survey results.

## Overall Survey Results

According to our survey results, 72 percent of providers were either unsatisfied or very unsatisfied with the system when they began submitting claims and only 16 percent indicated being satisfied or very satisfied with the system.<sup>1</sup> Now, 33 percent of providers are unsatisfied or very unsatisfied and 43 percent are satisfied or very satisfied. Further, 59 percent of providers we surveyed said the general use of the system is better or much better than when providers first began submitting claims and 12 percent said the system is worse or much worse.<sup>2</sup>

Substantially more providers are now satisfied or very satisfied with the system than when they first began submitting claims.

We experienced firsthand a sample of the e-mail messages and phone calls that policymakers have been receiving. As a result of the more than 5,000 e-mail messages we sent to conduct our survey, we received 26 unsolicited e-mail messages and phone calls from providers about their problems and frustrations with the claims processing system and with Medicaid overall. The department and Molina had already made us aware of some providers' problems and frustrations, but other provider issues were unique and we forwarded these to Molina for resolution. Some providers expressed frustration with factors beyond Molina's or the department's control, such as the rates at which they are reimbursed for services or a desire to revert back to the former system.

Many factors could be contributing to provider dissatisfaction. The following two factors and others like them demonstrate the challenges in addressing the broad scope of provider concerns:

1. Molina's system interfaces with other entities and those interfaces must function properly for Molina's system to function properly.
2. As the federal government and the Idaho Legislature make changes to Medicaid laws, Molina and the department must make sure the system evolves with the changes and that providers are sufficiently informed. Molina officials told us federal and state changes to Medicaid requirements is their single biggest challenge going forward.

Our survey showed that the satisfaction level of many providers has improved. It also showed that 33 percent of respondents are currently unsatisfied or very unsatisfied, and some providers believe the system is operating worse than before. Understanding this level of dissatisfaction, however, was beyond the

<sup>1</sup> At the time providers began submitting claims to the system, 12 percent were neither unsatisfied nor satisfied.

<sup>2</sup> Twenty-nine percent of providers indicated that their experience with general use of the system has not changed.

The department and Molina should further investigate reasons for provider dissatisfaction with the system and address those issues as appropriate.

scope of our follow-up review. We encourage the department and Molina to further review our survey findings, investigate ongoing dissatisfaction among providers, and address issues that are related to system functionality or Molina staff.

## Claims Processing Update

As was the case in March 2011, Molina continues to pay an average of 150,000 claims per week. Molina reported that each week the system pays about 84–86 percent of the claims submitted, it denies approximately 9 percent (about 11,000 claims), and it pends the remaining claims. As discussed in our evaluation report, denied claims are an appropriate system outcome if the system denies them in accordance with state policy. Molina officials told us that they expect the system to deny claims an average of ten percent or less each week.

By design, the new system pends more claims than the old system to better protect against Medicaid fraud and waste. Exhibit 1 depicts the number of pended claims by age from February to December 2011. Pended claims are those that require additional processing to finalize (resulting in a paid or denied claim) and make up the system's backlog.

The number of pended claims has decreased substantially and is now at a level (10,000 – 15,000 claims) expected by Molina and the federal Center for Medicare and Medicaid Services as representative of day-to-day business.

The exhibit shows that 94 percent of claims currently in the backlog are 30 or fewer days old.<sup>3</sup> Of the 6 percent of claims that are 31 days or older, 90 percent are pending the department's administrative review of the provider. The providers' claims will be held until that review has been completed. At that time, the department will authorize Molina to either pay or deny the claims.

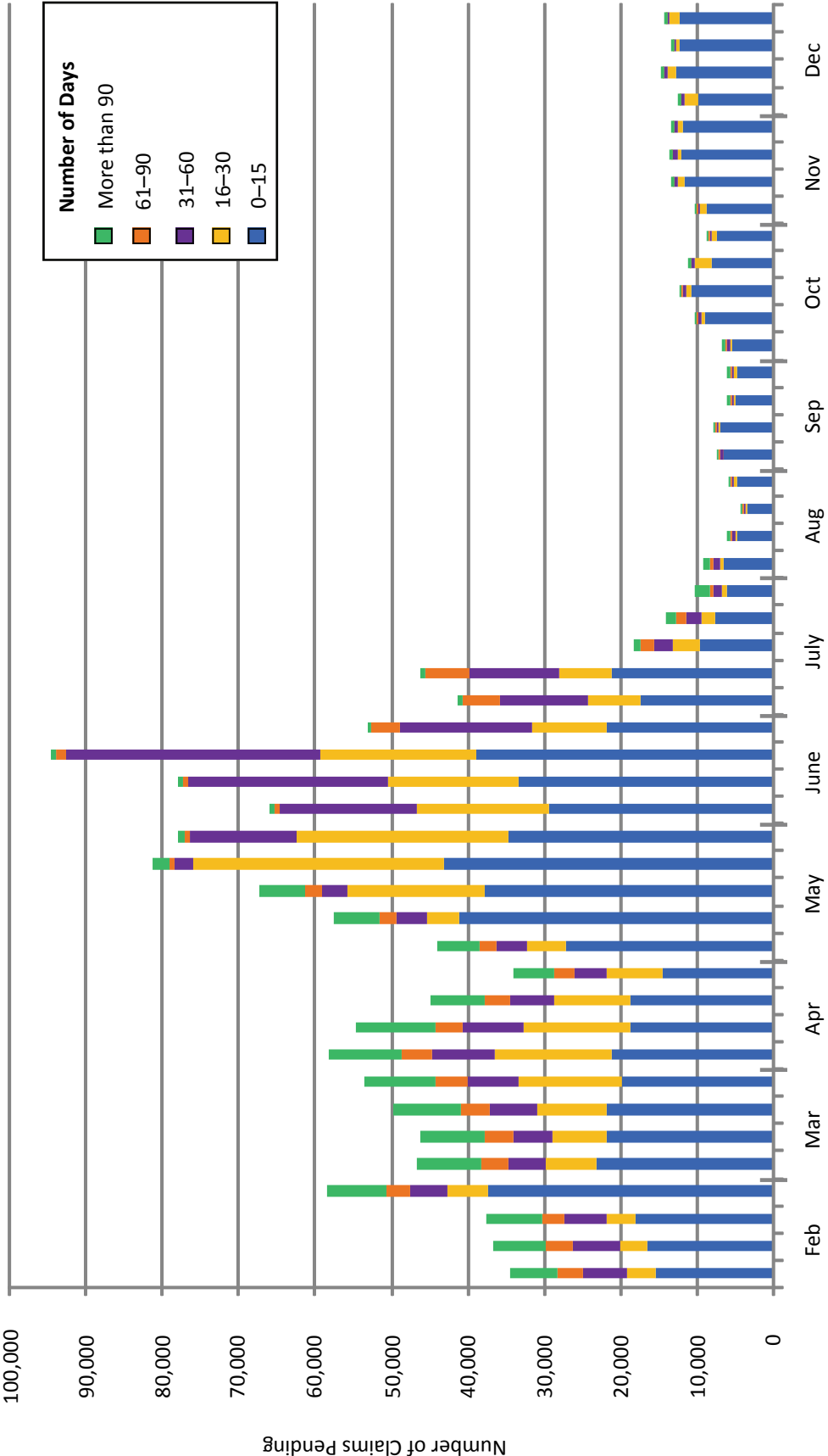
With the exception of spikes in the number of pended claims in May and June 2011, the average number of pended claims has decreased.<sup>4</sup> Molina attributes the decline to system refinements and increased automation of the pended claims processing.

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<sup>3</sup> From September 2010 to February 2011, an average of 52 percent of pended claims were 30 or fewer days old. The remaining 48 percent of pended claims were 30 or more days old.

<sup>4</sup> Molina officials told us that the system was not processing some claims correctly in May and June, so Molina intentionally pended the claims until a fix was implemented.

**EXHIBIT 1 NUMBER OF CLAIMS PENDING BY WEEK, FEBRUARY 6, 2011–DECEMBER 25, 2011**



Source: Analysis of data from Molina Healthcare, Inc.

Note: Additional details on pending claims are in appendix B.

Sixty-two percent of survey respondents indicated that the length of time for claims processing is better or much better than when they first began submitting claims to the system and 13 percent of respondents indicated the length of time to process claims is worse or much worse.<sup>5</sup>

## **Recommendations to Molina**

We made four recommendations to Molina: (1) increase communication with providers, (2) assign provider portfolios, (3) begin tracking more meaningful data on system performance, and (4) better test, measure, and monitor system fixes. We found that Molina has successfully addressed the intent of two of our recommendations and has implemented the other two.

Presentations made to the Health Care Task Force on November 17, 2011, were similarly positive. Officials testified on behalf of the Idaho Medical Association, the Idaho Hospital Association, the Idaho Health Care Association, and the Idaho Association of Developmental Disabilities Agencies and spoke to the improvements seen in Molina's operation of the system. However, the Idaho Health Care Association told us that its providers continue to experience significant issues, particularly for deducting the correct share of cost.<sup>6</sup> Molina officials told us that the issue will be resolved in January 2012 by having providers locate the correct share of cost information from Molina's portal. Molina plans to share information about the solution in several ways: on the portal, through the regional provider representatives, in the Health Care Association's newsletter, and in Molina's newsletter.

### ***Recommendation 1: Increase Communication with Providers***

Providers expressed frustration during our evaluation study because the system was not properly processing their claims and resolution was either slow or seemingly nonexistent. As a result, in our evaluation report, we recommended that Molina formalize its use of provider reconciliation reports, which help resolve discrepancies between claims submitted to the system and the generated status of the claims (paid, denied, or pending and for what reason). We recommended Molina use these reports as a tool to enhance communication with providers.

To address this recommendation, Molina has increased its on-site provider visits by more than 30 percent since January 2011. Molina tracks the number of visits (by region and provider specialty) and topics covered during those visits in its

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<sup>5</sup> Twenty-five percent of respondents indicated their experience has not changed for the length of time to process claims.

<sup>6</sup> Some Medicaid patients are required to pay a specified amount for services (their share of cost) that Medicaid deducts before paying for the remainder of the services.

executive steering committee reports submitted to the department every week.<sup>7</sup> For example, regional consultants who are specifically assigned to provider relations conducted 242 site visits in November 2011—nearly 73 percent more visits than the contract requires within a one-month timeframe.<sup>8</sup>

Molina stated that it uses provider reconciliation reports to prepare for and assist during its on-site visits. In addition, Molina said that the priority research team uses the reconciliation reports as part of its efforts to communicate with providers. Fifty-five percent of survey respondents indicated that the ability to reconcile claims is better or much better and 15 percent said their ability to reconcile claims is worse or much worse than when they started submitting claims.<sup>9</sup>

Molina has increased its use of regional consultants who are responsible for conducting on-site provider relations visits.

**Status:** The intent of this recommendation has been **addressed**. We encourage Molina to continue its efforts to not only increase communication with providers, but also more effectively monitor and improve the quality of its communication with providers.

## ***Recommendation 2: Assign Provider Portfolios***

During our evaluation study, providers expressed frustration with the accessibility and expertise of Molina staff. At the time, Molina told us that unless a provider was designated as a priority (assigned to the priority research team, formerly the triage or escalation team), customer service calls were answered in the order they were received. We recommended that Molina assign specific provider portfolios to call center staff to increase staff's familiarity and expertise with different providers and claim types.

From July 2010 to February 2011, Molina's call center was receiving almost 4,000 calls per week and, in August 2010, wait times peaked at an average of more than 35 minutes. Now, the call center receives about 3,000 calls per week and wait times are averaging less than two minutes. Molina measures average wait time each week and has a wait time goal of two minutes or less. Since the middle of May 2011, call center staff have met this goal with the exception of one week in October. Sixty percent of survey respondents indicated that access to Molina staff is better or much better than it was when they first began submitting claims, and 11 percent said access is worse or much worse.<sup>10</sup>

<sup>7</sup> Executive steering reports detail information on system changes, claims processing, financial data, provider services, and other relevant information.

<sup>8</sup> The state is made up of seven regions. Each region has one provider relations consultant except the Boise region, which has two.

<sup>9</sup> Thirty percent of providers indicated that their experience with the ability to reconcile claims has not changed.

<sup>10</sup> Twenty-nine percent indicated that their experience with access to Molina staff has not changed.

The lower call volume and shorter wait times may, at least in part, be attributed to fewer providers calling in. Instead, some providers are working with Molina through e-mail messages because call center staff are unable to solve the problems related to their specific claims. Molina officials stated that they use e-mail as part of their regular communication with providers. Molina has given nursing homes their own inbox to help consolidate workflow—particularly for questions related to claims that need to be reprocessed.

Molina’s call center staff participate in a training and certification process.

Molina has not assigned provider portfolios to call center staff because of some inherent challenges. For example, as the system evolves, the relevant issues change as does the call volume associated with those issues. Instead of assigning specific provider portfolios, Molina implemented a training and certification process in July 2011. Call center staff must participate in the training and pass special topic area tests before taking calls in those areas.<sup>11</sup>

Half of the survey respondents said that the expertise of Molina staff in resolving claims has become better or much better since the time providers first began submitting claims, and 14 percent said the expertise of Molina staff is worse or much worse.<sup>12</sup> Although the survey indicates improvement in expertise, Molina’s relationship with providers could benefit from continued efforts to improve its level of customer service.

**Status:** Because Molina addressed the specific intent of our recommendation to improve call center staff’s familiarity and expertise with different providers and claim types, this recommendation has been **addressed**.

### ***Recommendation 3: Strengthen the Measurement of System Performance***

At the time of our evaluation study, the primary form of quality assurance was corrective action reports, which captured only limited information and did not track any information about whether claims processed correctly. Molina could provide documentation on the timeliness of claims processing, but many provider issues had to do with incorrectly paid, denied, or pended claims. Although the number of claims pending had started to decrease, neither Molina nor the department knew how accurately the system was processing claims.

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<sup>11</sup> Training covers special topic areas such as eligibility, prior authorization, and the claims process.

<sup>12</sup> Thirty-six percent indicated that their experience with the expertise of Molina staff has not changed.

As a result, we recommended that Molina begin shifting its focus from the timeliness of claims processing to the accuracy of claims processing. We recommended that Molina provide data on the accuracy of claims processing in weekly reports to the department. This reporting tool would give Molina and the department an assessment of whether system fixes were improving the system's ability to correctly process claims.

Molina implemented auditing as part of its improved quality assurance process.

Molina has made several changes to its quality assurance process that includes auditing the system and staff performance. Molina now conducts three primary audits each week:

1. An **end-to-end audit** uses a random sample of finalized claims and follows the claims from submission to finalization.
2. A **focused audit** is performed on specific areas or initiatives and Molina uses this audit to ensure that system changes are working as intended.
3. A **claims staff audit** ensures the accuracy of claims processed manually by staff and measures adherence to standards.

Each audit uses the following measures to assess system functionality:

- **Financial dollar accuracy** is the percentage of the total amount that was paid correctly for claims.
- **Financial incident accuracy** is the total number of times an incorrect amount was paid for a claim.
- **Statistical incident accuracy** is the total number of times a process was not followed correctly that affected other processes or actions.
- **Overall incident accuracy** is the combination of financial and statistical incident errors.

Molina has set a goal for 98 percent accuracy on these measures and has reached that goal for most weeks. For example, Molina reached its overall incident accuracy goal for its end-to-end audits 17 out of 21 times for the weeks from August 6, 2011, to December 25, 2011. Molina provides the department with this type of quality control information in weekly executive steering committee reports. In addition to information about general claims processing, the weekly reports now include the results of each of the three audits.

Another indicator of Molina's improvement in quality control is the feedback provided by the federal Center for Medicare and Medicaid Services (CMS). Department officials presented information on the certification process to the

Health Care Task Force on December 14, 2011, and indicated that CMS gave positive feedback to the department about the quality assurance processes now in place.

**Status:** This recommendation has been **implemented**.

#### ***Recommendation 4: Test, Monitor, and Measure System Fixes***

We recommended Molina better test, monitor, and measure system fixes to avoid prematurely closing out issues or considering them resolved. When we conducted our evaluation study, we heard from providers that system fixes implemented to resolve one issue were either ineffective or caused new issues. To address this problem, Molina reports that its priority research team, responsible for resolving high priority issues, no longer closes issues until Molina, the department, and the affected providers agree the issue has been resolved. Provider associations indicated that system fixes are working better.

The system now operates under new processes that test, monitor, and measure changes to the system to ensure system fixes are working as intended.

Molina and the department report that they have significantly changed how they resolve system defects. The process now identifies each system component that is impacted by a change, confirms that the solution works using test cases, and tests scenarios from the receipt of a claim until the system pays the claim. The test results are then shared with the department before the change is implemented.

To complement the process used to resolve defects, the department has implemented a new process to validate system changes. The process uses a spreadsheet to track and measure the requirements put in place as part of the defect resolution process. Each change must now be assigned to a specific Molina staff person and accompanied by a validation plan. Molina management teams review and monitor the plans to ensure all activities associated with a change are performed and documented.

**Status:** This recommendation has been **implemented**.

### **Recommendations to Department of Health and Welfare**

We made four recommendations to the department to improve vendor payment accountability and to increase contract management practices. We also recommended that the department monitor changes and fixes made by Molina to ensure the solution meets the state's expectations and resolves outstanding provider concerns.

### **Recommendation 5: Delay Payments to Molina for System Operations**

The system had not been operating as intended when we conducted our evaluation study. As a result, we recommended the department withhold payments for operations until the remaining contract deliverables for design, development, and implementation were met.

In August 2011, the department signed off on three of the remaining contract deliverables: user acceptance testing, pilot operations, and implementation.<sup>13</sup> The department paid Molina nearly \$3 million for each of the three deliverables (totaling \$8.9 million) because Molina met the terms of the contract. As noted in our evaluation report, the contract did not provide adequate or specific terms for meeting the deliverables, and because the system was already implemented, it was too late to negotiate new terms. Consequently, Molina did not have to meet adequate or specific terms for the payment of each deliverable.

Molina has been paid for operations from June 2010 to March 2011.

The department could, however, make changes to the contract terms for how Molina would be paid for system operations. In August 2011, Molina submitted an invoice to the department for payment of operations totaling \$13.7 million. Because of specific issues with system performance, the department used criteria outlined in recommendation 6 and reduced the payment by \$2.7 million from the contract-specified amount. Therefore, Molina was paid nearly \$11 million in September for ten months of operations.

**Status:** This recommendation has been **implemented**.

### **Recommendation 6: Require Additional Quality Assurance Measures**

Not only did the department's contract with Molina lack terms for meeting deliverables, but it also lacked performance measures for operations. As a result, we recommended the department develop a contract amendment that measured claims processing accuracy and not simply the timeliness of claims processing.

The department and Molina have worked collaboratively to create a contract amendment which outlines a schedule to reduce payment for operations in the event that system issues are not resolved. The department will determine these payment reductions

Molina and the department have agreed to a contract amendment to hold Molina financially accountable for system issues.

<sup>13</sup> System certification is the only outstanding contract deliverable.

by the level of importance, impact, and frequency of the issue. The Attorney General's office has reviewed the amendment and, as of January 5, 2012, Molina was in the process of reviewing it. The department and Molina used this agreed upon criteria, as noted in recommendation 5, to calculate the \$2.7 million reduction for payment of operations.

**Status:** This recommendation has been **implemented**, assuming the contract amendment is formally signed.

### ***Recommendation 7: Include More Specific Requirements in Future Contracts***

We recommended the department include the following requirements in future contracts to avoid issues similar to those experienced with the implementation of the Medicaid claims processing system:

- Establish a minimum number of end users that the vendor must enroll in the system before implementation
- Establish a minimum number of end users to test the system during the design, development, and implementation phases
- Allow a period of time for cross testing between the old system and the new system, when applicable

Department officials indicated that they are not planning to implement any new comparable systems in the next few years. Department officials also said that they learned many lessons and continue to implement quality improvement strategies.

**Status:** The Department of Health and Welfare does not plan to issue similar contracts in the next few years. To ensure this recommendation is not overlooked in the future, we encourage the department to formally incorporate the recommendation in its policies and procedures manual.

### ***Recommendation 8: Formalize Terms of Interim Payments***

In July and August 2010, the department issued \$117 million in interim payments to supplement provider cash flow because the system was not processing claims correctly. The department issued this money to providers without communicating sufficient information on the purpose of the payments or guidance on how the money was to be repaid to the department. We recommended the department establish criteria for issuing interim payments in the future. The criteria would include information on the purpose of the payment and the terms for repayment. Department officials said that they are not planning to issue more interim payments to providers at this time.

Although the department has no plans to issue more interim payments, it is still working to recoup the payments issued in July and August 2010. As of March 2011, the department needed to recoup \$60 million and had a goal to collect this balance by the end of fiscal year 2011.<sup>14</sup>

As of January 9, 2012, the department needed to recoup \$3.5 million. Of this amount, department officials said they plan to recoup 75 percent according to agreed upon levels of repayment. However, the other 25 percent will be more challenging to collect because the department is turning over the amount to a collection agency. Officials estimate that they will be able to recoup most of the amount through the collection agency, but not all because some providers have filed for bankruptcy or are deceased.

Department officials note that the state has not incurred any legal costs for recouping the interim payments. Officials also said that providers, not the state, will be responsible for any fees associated with the collection agency.

Legislative Audits has completed its audit work for the Comprehensive Annual Financial Report (CAFR), which includes a review of the department and the interim payments. The report is scheduled to be released in late February.

**Status:** The Department of Health and Welfare does not plan to issue interim payments to providers in the next few years. Therefore, no action is needed at this time.

The Department of Health and Welfare is still trying to recoup \$3.5 million from providers in outstanding interim payments.

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<sup>14</sup> The department collected \$45 million by the end of fiscal year 2011.



# Appendix A

## Provider Survey Results

We surveyed providers about their satisfaction with Molina and the Medicaid claims processing system. The results of the survey are presented in this appendix.

When did you begin submitting claims to the Molina Medicaid claims processing system? (N=1,361)

	2010		2011	
	Responses	% of Responses	Responses	% of Responses
January			28	2.1
February			6	0.4
March			9	0.7
April			16	1.2
May			5	0.4
June	838	61.6	11	0.8
July	221	16.2	4	0.3
August	63	4.6	7	0.5
September	34	2.5	5	0.4
October	29	2.1	4	0.3
November	57	4.2	1	0.1
December	22	1.6	1	0.1

Note: Percentages may not sum to 100 because of rounding.

From the time you began submitting claims until now, please indicate whether the changes made by Molina have improved your experiences for the following items:<sup>a</sup>

	Much Worse		Worse		No Change		Better		Much Better	
	Responses	% of Responses	Responses	% of Responses	Responses	% of Responses	Responses	% of Responses	Responses	% of Responses
Access to Molina staff in resolving claims (N=1,375)	69	5.0	83	6.0	396	28.8	545	39.6	282	20.5
Expertise of Molina staff in resolving claims (N=1,370)	78	5.7	113	8.2	498	36.4	477	34.8	204	14.9
Ability to reconcile claims to payments (N=1,385)	94	6.8	114	8.2	410	29.6	512	37.0	255	18.4
Length of time for claims processing (N=1,420)	81	5.7	107	7.5	354	24.9	535	37.7	343	24.2
General use of the claims processing system (N=1,418)	75	5.3	95	6.7	417	29.4	546	38.5	285	20.1

Note: Percentages may not sum to 100 because of rounding.

<sup>a</sup> Responses indicate whether providers feel that their experience with each item is better, worse, or has not changed, regardless of their initial or current level of satisfaction.

What was your initial level of satisfaction when you began submitting claims to the system? (N=1,445)

	Responses	% of Responses
Very unsatisfied	739	51.1
Unsatisfied	297	20.6
Neither unsatisfied nor satisfied	179	12.4
Satisfied	204	14.1
Very satisfied	26	1.8

Note: Percentages may not sum to 100 because of rounding.

What is your current level of satisfaction with the system? (N=1,445)

	Responses	% of Responses
Very unsatisfied	190	13.1
Unsatisfied	287	19.9
Neither unsatisfied nor satisfied	350	24.2
Satisfied	529	36.6
Very satisfied	89	6.2

Note: Percentages may not sum to 100 because of rounding.

Analysis of survey results using the providers' initial level of satisfaction with the system compared with their current level of satisfaction with the system. (N=1,445)

	Current Level of Satisfaction									
	Very Unsatisfied		Unsatisfied		Neither Unsatisfied nor Satisfied		Satisfied		Very Satisfied	
	Responses	% of Responses	Responses	% of Responses	Responses	% of Responses	Responses	% of Responses	Responses	% of Responses
739 providers who were initially very unsatisfied	152	20.6	201	27.2	187	25.3	186	25.2	13	1.8
297 providers who were initially unsatisfied	15	5.1	57	19.2	73	24.6	132	44.4	20	6.7
179 providers who were neither unsatisfied nor satisfied	8	4.5	18	10.1	73	40.8	69	38.5	11	6.1
204 providers who were initially satisfied	13	6.4	9	4.4	15	7.4	141	69.1	26	12.7
26 providers who were initially very satisfied	2	7.7	2	7.7	2	7.7	1	3.8	19	73.1

Note: Percentages may not sum to 100 because of rounding.

# Appendix B Pended Medicaid Claims by Week

**NUMBER OF CLAIMS PENDING BY WEEK, FEBRUARY 6, 2011–DECEMBER 25, 2011**

Week Ending	0–15 Days	16–30 Days	31–60 Days	61–90 Days	More than 90 Days	Total
Feb 6	15,357	3,832	5,653	3,397	6,179	34,418
Feb 13	16,602	3,518	6,068	3,574	6,878	36,640
Feb 20	18,072	3,669	5,538	2,887	7,343	37,509
Feb 24	37,333	5,332	4,941	3,023	7,765	58,394
Mar 6	23,261	6,651	4,874	3,538	8,284	46,608
Mar 13	21,945	6,960	5,119	3,723	8,497	46,244
Mar 20	21,868	9,091	6,082	3,884	8,780	49,705
Mar 27	19,756	13,607	6,714	4,199	9,311	53,587
Apr 3	21,162	15,235	8,140	3,989	9,529	58,055
Apr 10	18,797	13,929	7,928	3,627	10,335	54,616
Apr 17	18,670	9,943	5,792	3,478	7,042	44,925
Apr 24	14,508	7,280	4,179	2,656	5,451	34,074
May 1	27,133	5,021	4,123	2,268	5,543	44,088
May 8	41,090	4,205	4,083	2,228	5,792	57,398
May 15	37,797	17,899	3,322	2,161	6,008	67,187
May 22	42,985	32,849	2,566	668	2,011	81,079
May 29	34,756	27,498	13,959	680	1,043	77,936
Jun 5	29,279	17,355	17,841	672	675	65,822
Jun 12	33,404	17,091	25,926	873	502	77,796
Jun 19	38,991	20,179	33,364	1,343	516	94,393
Jun 26	21,727	9,785	17,310	3,872	368	53,062

*Appendix B—continued*

Week Ending	0–15 Days	16–30 Days	31–60 Days	61–90 Days	More than 90 Days	Total
Jul 3	17,470	6,874	11,543	4,800	554	41,241
Jul 10	21,150	6,796	11,842	5,761	613	46,162
Jul 17	9,565	3,568	2,586	1,598	1,032	18,349
Jul 24	7,575	1,784	1,997	1,303	1,333	13,992
Jul 31	6,203	591	1,136	500	1,890	10,320
Aug 7	6,621	426	900	484	767	9,198
Aug 14	4,839	170	350	246	404	6,009
Aug 21	3,465	139	261	281	152	4,298
Aug 28	4,718	490	282	222	103	5,815
Sep 4	6,495	133	276	230	137	7,271
Sep 11	7,001	213	267	250	191	7,922
Sep 18	4,983	316	223	255	247	6,024
Sep 25	4,852	405	249	265	282	6,053
Oct 2	5,391	360	393	267	319	6,730
Oct 9	9,047	368	423	216	342	10,396
Oct 16	10,861	652	374	106	319	12,312
Oct 23	8,105	2,220	398	104	344	11,171
Oct 30	7,421	640	286	142	392	8,881
Nov 6	8,794	782	319	138	397	10,430
Nov 13	11,753	754	494	47	402	13,450
Nov 20	12,074	566	500	63	406	13,609
Nov 27	11,922	678	276	43	414	13,333
Dec 4	9,802	1,882	317	61	422	12,484
Dec 11	12,800	1,118	343	62	427	14,750
Dec 18	12,327	413	180	110	429	13,459
Dec 25	12,346	1,360	101	66	429	14,302

Source: Analysis of data from Molina Healthcare, Inc.

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## Office of Performance Evaluations Reports, 2008–Present

Publication numbers ending with “F” are follow-up reports of previous evaluations. Publication numbers ending with three letters are federal mandate reviews—the letters indicate the legislative committee that requested the report.

<b>Pub. #</b>	<b>Report Title</b>	<b>Date Released</b>
08-01	Governance of Information Technology and Public Safety Communications	March 2008
08-02F	State Substance Abuse Treatment Efforts	March 2008
08-03F	Virtual School Operations	March 2008
09-01	Public Education Funding in Idaho	January 2009
09-02F	Higher Education Residency Requirements	January 2009
09-03	Idaho Transportation Department Performance Audit	January 2009
09-04	Feasibility of School District Services Consolidation	February 2009
09-05F	School District Administration and Oversight	February 2009
09-06F	Use of Average Daily Attendance in Public Education Funding	February 2009
09-07F	Child Welfare Caseload Management	February 2009
09-08F	Public Education Technology Initiatives	February 2009
09-09F	Management in the Department of Health and Welfare	March 2009
09-10F	Governance of Information Technology and Public Safety Communications	April 2009
10-01	Operational Efficiencies in Idaho’s Prison System	January 2010
10-02	Increasing Efficiencies in Idaho's Parole Process	February 2010
10-03F	Use of Average Daily Attendance in Public Education	March 2010
10-04	Governance of EMS Agencies in Idaho	November 2010
10-05F	Governance of Information Technology and Public Safety Communications	November 2010
11-01	Distribution and Sale of Liquor in Idaho	January 2011
11-02	Coordination and Delivery of Senior Services in Idaho	February 2011
11-03F	Increasing Efficiencies in Idaho’s Parole Process	February 2011
11-04F	Idaho Transportation Department Performance Audit	March 2011
11-05	Delays in Medicaid Claims Processing	March 2011
11-06	Higher Education Funding Equity	November 2011
11-07	End-Stage Renal Disease Program	November 2011
11-08F	Distribution and Sale of Liquor in Idaho	November 2011
12-01	Reducing Barriers to Postsecondary Education	January 2012
12-02F	Delays in Medicaid Claims Processing	January 2012

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