

Delays in Medicaid Claims Processing

Evaluation Report
March 2011

Office of Performance Evaluations
Idaho Legislature



Report 11-05

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2011–2012 Joint Legislative Oversight Committee

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Office of Performance Evaluations

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Director

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March 25, 2011

Members
Joint Legislative Oversight Committee
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Last month, you asked us to conduct a limited scope evaluation of the Medicaid payment processing system operated by Molina Healthcare, Inc. because of ongoing concerns that providers were receiving delayed or incorrect payments for services. I am pleased to submit to you our evaluation report detailing a number of issues we identified that contributed to delayed and incorrect payments.

Most of these issues could have been avoided if more pilot testing had occurred before the system went live and if better quality assurance measures were included in the Department of Health and Welfare's contract with Molina. Although both the department and Molina have made improvements to the system since it started processing claims in June 2010, many providers are still receiving delayed or incorrect payments for their claims.

We offer recommendations to address some of the disconnect that still exists among providers, the department, and Molina. These recommendations provide tools to prevent similar issues from happening again, and they serve as a reminder of the key role end users must play in the development of any new IT system.

We would not have been able to complete this report in seven weeks without the full cooperation of the department and Molina. We thank them for explaining to us the complexities of the system and providing data in a timely manner. Formal responses from the department, Molina, and the Governor are included in the report.

Sincerely,

A handwritten signature in blue ink that reads "Rakesh Mohan".

Rakesh Mohan

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Executive Summary

Delays in Medicaid Claims Processing

The transition to any new IT system requires sufficient planning and development and relies on clear communication among all involved parties, including end users. As Idaho transitioned its Medicaid claims processing to both a new system and a new vendor, a series of events led to what many have referred to as “the perfect storm.” Subsequently, legislators raised concerns about the events surrounding the transition and requested a limited scope evaluation of the new claims processing system. The study request is found in appendix A.

During the course of our evaluation, which was conducted within a seven-week period, we found that the challenges associated with the transition were not simply a series of unpredictable events. Instead, we found these challenges were the result of unclear contract requirements, a lack of system readiness, and the absence of adequate end user participation throughout the enrollment and testing phases.

The challenges associated with the new Medicaid claims processing system are not unique to healthcare. In 2006, we released a report that looked at the lessons learned from Idaho’s failed student information management system. In that report, we provided a checklist for agencies to use when developing large-scale IT projects. Appendix B highlights elements of this checklist (including end user involvement and realistic expectations of technology) and provides insight into some of the areas in which the Department of Health and Welfare, Molina Healthcare, Inc. (formerly Unisys), and providers failed to adequately prepare for the new system.

The total costs associated with implementing the new system are unclear. Although the system is now processing most claims in a timely manner, claims in the backlog largely reflect what failed early on. While the department and Molina are making progress in resolving outstanding issues, providers continue to express concerns that progress is not being made quickly enough. In addition, the department is still working to recoup more than \$60 million in outstanding interim payments. The department anticipates more than \$16 million will not be recouped before the end of the fiscal year of which more than \$2 million is at risk of not being recouped at all. Finally, Molina has submitted its first bill for monthly operations even though several deliverables related to system design and development remain outstanding.

Recommendations

Our recommendations to both Molina and the department, which are listed in chapter 8, are designed to build on current efforts and continue system improvements. These recommendations serve as a reminder of the importance of clear communication and specific contract requirements and will assist the department and other state agencies in improving the outcome of future large scale IT efforts.

Molina

Recommendation 1: Increase communication with providers to better resolve outstanding issues.

Recommendation 2: Assign provider portfolios to Molina staff to increase their expertise with certain provider and claim types.

Recommendation 3: Strengthen the methods and data used to measure system performance to create more meaningful performance indicators.

Recommendation 4: Test, monitor, and measure system fixes to reduce the risk of prematurely closing issues.

Department of Health and Welfare

Recommendation 5: Delay payment to Molina for system operations to ensure all design, development, and implementation milestones have been met and to allow the department to assess any resulting reductions in payment.

Recommendation 6: Require additional quality assurance measures to assist the department in determining whether the system is performing as intended and is aligning with the terms of the contract.

Recommendation 7: Include more specific requirements in future contracts to help ensure that similar systems in the future are implemented with a clear understanding of system readiness.

Recommendation 8: Formalize the terms of interim payments issued in the future to reduce challenges associated with recouping payments from providers.

The department should also monitor Molina's efforts to implement our recommendations to ensure those efforts align with department expectations and resolve outstanding provider concerns.

Acknowledgements

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

Amy Lorenzo, Maureen Brewer, Jared Tatro, Bryon Welch, and Hannah Crumrine of the Office of Performance Evaluations conducted this study. Margaret Campbell was copy editor and desktop publisher. Brekke Wilkinson designed exhibits.

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

Chapter 1

Introduction

In 2007, the Idaho Department of Health and Welfare entered into a contract with Unisys Corporation to develop the medical claims processing component, or base system, of its Medicaid Management Information System. After several delays in design and development, as well as the purchase of Unisys by Molina Healthcare, Inc., Idaho began processing Medicaid payments using the new system on June 4, 2010.

A series of design defects, provider enrollment issues, and a lack of coordination to resolve issues led to months of payment delays and inaccurate processing of claims. As problems continued to plague the new system, concerns were raised by providers and legislators about the amount of time taken to resolve defects and whether the system would ever function properly.

What Is the Medicaid Management Information System?

The Medicaid Management Information System (MMIS), which automates Medicaid payment processing, is made up of numerous components, including contracts with several vendors for the following four components:

1. Base, Systems Integration, and Fiscal Agent Services (base system)
2. Electronic Document Management System (EDMS)
3. Pharmacy Benefits Management (PBM)
4. Decision Support System/Data Warehouse (DSS/DW)

Idaho's Medicaid Management Information System (MMIS) is made up of multiple components and contractors, including Molina.

The success of Idaho's MMIS is contingent on all components working independently and collectively, and is contingent on the extent to which the MMIS and other entities are able to exchange information in an accurate and timely manner. Some of these other entities include subcontractors, the Office of the State Controller (issues checks to providers), the Department of Administration (oversees the contracts), and the Division of Welfare (determines

patient eligibility). Molina operates the base system and EDMS.¹ This report evaluates the terms and conditions of the base system contract, and the performance of that system. Unless otherwise stated in this report, “system” refers to the base system.

Why Did Legislators Request a Study?

Unless otherwise stated, *system* refers to Molina’s base system, the medical claims processing component of the Medicaid Management Information System (MMIS).

The Department of Health and Welfare manages Medicaid claims using an automated system designed to process thousands of claims each week. In fiscal year 2010, Idaho paid more than \$1.44 billion in patient claims.

In June 2010, the Department of Health and Welfare started using a new system to process claims. A detailed timeline of transition to this system is shown in exhibit 1.1. Problems with the system quickly surfaced and legislators and other state officials began receiving complaints from Medicaid providers.

According to our study request, many Medicaid providers have been in crisis—laying off employees, limiting services, and identifying exit plans to no longer provide Medicaid services.

In February 2011, the Joint Legislative Oversight Committee approved a limited scope study to evaluate the system and requested that we complete the study before the end of the session. For details about the study request, see appendix A.

Our study answers the following questions:

Contract. What are the general terms of the contract? What did Molina acquire when it purchased the Unisys contract? What has been the process for accepting contract deliverables? How can the department resolve issues of contract noncompliance? How much has the state paid for the new system?

Provider Enrollment and System Transition. What processes were in place to ensure the system was properly tested before it was implemented? What was the process to ensure providers were properly and timely enrolled in the system? What was the impact of Molina’s purchase of Unisys on the overall transition? Could the department have delayed implementation of the system to improve performance?

¹ The pharmacy system component is operated by Magellan and the data warehouse component is operated by Thomson Reuters.

EXHIBIT 1.1 TIMELINE FOR SYSTEM IMPLEMENTATION AND OPERATIONS

Year	Month	Events
2005		An RFP for a new Medicaid Management Information System (MMIS) was withdrawn over concerns about the bidding process. A subsequent RFP was separated into four contracts.
2006		Unisys was awarded the contract for the base system of MMIS.
2007		Unisys begins design, development, and implementation of the system.
2009		Implementation date for the system was postponed until February 2010. Molina enters negotiations with Unisys.
2010	Jan	Implementation date for the system was postponed again until "no later than" May 31, 2010.
	Apr	Molina and Unisys reach buy out agreement.
	May	Molina acquires the system from Unisys; it maintains nearly all of the same staff.
	Jun	Molina begins processing claims in the system. The state requires holdbacks; claims were processed but provider payments were suspended.
	Jul	Molina begins regular payment cycles. The department begins to issue interim payments.
	Aug	The department issues a second cycle of interim payments to providers. The governor meets with Molina and the department.
	Nov	The department and Molina begin to recoup interim payments.
2011	Feb	Molina submits its first bill to the department for operations from June to December 2010.
	Jun	Department deadline of June 30 for recouping interim payments from providers.
2014		Contract for the system is scheduled to expire unless a renewal is issued.

Source: Information from the Idaho Department of Health and Welfare and Molina Healthcare, Inc.

Claims Processing. How many claims does the system approve for payment? How many claims are denied payment? What is the status of pended claims? Why does the system pend claims?

Quality of Claims Processing. Is the system processing claims correctly? How are the department and Molina tracking system performance?

Customer Service. How are the department and Molina working with providers to resolve claim issues? How have staffing issues affected Molina's ability to communicate with providers?

Potential Liabilities. What are the state and federal requirements and penalties for timeliness of payments? What is the current status of interim payments? What is the cost of delayed claims processing? Why is federal certification important? Are there other liabilities to the state?

Methodology

Given our time constraints and the abbreviated scope of our study, we limited our methodology to the following tasks:

- Reviewed contract terms and conditions, including milestones, deliverables, vendor requirements, and amendments
- Reviewed contract invoices and payments
- Reviewed summary data relevant to processing claims and supplemental documents provided by the department and Molina
- Interviewed officials from the department and Molina
- Interviewed several provider groups: the Idaho Health Care Association and some of its facility directors, the Idaho Hospital Association, the Idaho Medical Association, a representative of the Idaho Care Providers Network, which included a billing representative for certified family homes, and the Idaho Primary Care Association, which included a billing representative from one of its community health centers, Terry Reilly Health Services
- Consulted with legislators and officials from the Office of the Governor, the Office of the Attorney General, the Office of the State Controller, the Division of Financial Management, Legislative Audits, and the federal Centers for Medicare and Medicaid Services

Chapter 2

Contract

The contract between the Department of Health and Welfare and Molina Healthcare, Inc. lists the responsibilities of the vendor and the department and is made up of two main parts: (1) system design and development and (2) fiscal operations. The contract was initially signed in 2007 and contains a series of amendments related to items such as costs and timelines for deliverables. For deliverables to be considered complete, both the department and Molina need to mutually agree. When terms are not met, the department has a range of options for resolving noncompliant issues, including withholding payment and contract termination.

What Are the General Terms of the Contract?

The department is responsible for managing the day-to-day operations of the contract. Within the department, the Division of Medicaid monitors the operational performance of the contract, and the divisions of Medicaid and IT review and accept all deliverables throughout the development phase. The Division of Management Services monitors Molina's compliance with the overall contract terms and conditions.

Molina is responsible for the design, development, implementation, and successful operation of the system. This responsibility includes working with the other vendors that access or transmit data to the Medicaid Management Information System (MMIS), processing claims, providing training and assistance to providers, meeting all federal reporting requirements, and ultimately obtaining federal certification. The development of the system was broken into ten phases that begin with project initiation and end with federal certification.

What Has Been the Process for Accepting Contract Deliverables?

According to both Molina and the department, there was cooperation and coordination between the department and Molina (and its predecessor Unisys) throughout the design, development, and implementation of the system. The

The system began processing claims before two key deliverables were met: user acceptance testing and pilot operations.

contract amount for each phase was about \$3 million. Upon completion of each phase, Unisys submitted an invoice for payment and included any supporting evidence. According to the department, it verified the supporting evidence for accuracy and determined whether the phase and milestones within the phase were met. Evidence could include reports, system testing, or other data analyses.

The department did not require several contract-specified deliverables to be finalized before the system started processing claims, including user acceptance testing and pilot operations, which are discussed further in chapter 3.¹ The department said it weighed the risk of moving forward with implementation despite missing these outstanding deliverables. The department ultimately decided to move forward because it believed that core functions were in place to process claims.

How Can the Department Resolve Issues of Contract Noncompliance?

The department has several options for contract modification if Molina is not in compliance with the contract. These options include requiring Molina to fix the problem, reducing vendor payments according to the service provided, requiring Molina to subcontract at its own expense, withholding payments, purchasing the product in lieu of payment, and terminating the contract.

What Did Molina Acquire When It Purchased the Unisys Contract?

Molina retained most of Unisys' project staff.

Molina purchased the Medicaid Fiscal Agent Division of Unisys on May 1, 2010, which included the entire asset of people and software. This purchase took place approximately one month before the system was implemented. At the time of the purchase, the system was in the final stages of development and no major changes were made. Molina estimated that nearly 90 percent of Unisys' staff including the project manager remained after the transition, which meant that staff working for Molina had been part of the initial system design.

¹ According to the department, the outstanding deliverables are primarily reports, which are not a priority until Molina has resolved other operational issues. The reports are necessary for department approval of phase completion and payment.

How Much Has the Department Paid for the System?

The total value of the system contract is \$106 million, which includes monthly operation fees of \$1.3 million. As of March 8, 2011, the department has paid \$18.6 million from May 14, 2008, to June 14, 2010. As shown in exhibit 2.1, these payments were related to design, development, and implementation.² In early February 2011, Molina submitted seven invoices of \$1.3 million each for operational services rendered from June to December 2010. The department is reviewing these invoices in consultation with the Office of the Attorney General to determine what services have been rendered and what services should receive payment.

The department has not yet paid Molina for operational services.

EXHIBIT 2.1 CONTRACT AMOUNTS FOR THE DESIGN, DEVELOPMENT, IMPLEMENTATION, AND OPERATION OF THE SYSTEM

Total Contract Amount		\$106,072,004^a	
System Design, Development, and Implementation^b	Billed by Unisys or Molina (\$)	Completion Date	Paid by the Department (\$)
1. Project initiation	2,994,080	05/27/08	2,994,080
2. Requirements analysis	2,994,080	06/23/08	2,994,080
3. System design	2,979,080	02/19/09	2,979,080
4. Construction and unit testing	2,979,080	12/08/09	2,979,080
5. Data conversion	2,979,080	12/17/09	2,979,080
6. Integration and system testing	2,979,080	06/14/10	2,979,080
7. User acceptance testing	–	–	–
8. Pilot operations	–	–	–
9. Implementation	–	–	–
10. Certification	–	–	–
Monthly Operations ^c	9,070,831	11/25/14	–

Source: Information from the Idaho Department of Health and Welfare and the Statewide Accounting and Reporting System (STARS).

^a Contract amendments affect the total contract amount, timelines for deliverables, and contract duration. The department has paid \$682,081 for services outlined in various contract amendments.

^b Each phase is to be paid \$2,979,080 with the exceptions of project initiation and requirement analysis. These phases were each paid at \$2,994,080 and were conducted before a contract change that moved system responsibilities from the base contract to the Data Warehouse contract.

^c Molina has billed the department for monthly operations from June to December 2010; each invoice was for \$1,295,833. The contract is currently set to expire in November 2014.

² The majority of payments were made to Unisys before its purchase by Molina. Molina was paid just more than \$3 million in June 2010 for system development.

Chapter 3

Provider Enrollment and System Transition

This chapter and the next four chapters outline the process for moving to the new system, how the system is currently functioning in terms of the total volume of claims and the quality of claims processing, steps Molina is taking to improve system functions and customer service, and the potential liabilities that the state faces with a system that still needs improvement. To better describe some of the challenges associated with the transition to the new system, this chapter discusses the role, or lack thereof, providers played in preparing for the system.

Two major steps in the development process were affected by a lack of provider participation—end user pilot testing and proper enrollment in the new system. In addition to a lack of participation, some provider groups expressed concerns to us that once Molina purchased Unisys, it implemented a system that was not designed to process Medicaid payments. Provider groups also questioned whether Idaho could have reverted to the old claims processing system or further delayed implementation until the system was fully functional.

What Processes Were in Place to Ensure the System Was Properly Tested Before It Was Implemented?

According to Molina, quality assurance for the different phases of development was conducted according to the terms of the contract. Evidence was submitted to the department as milestones were met, and the department reviewed and signed off on the deliverables. The contract specified a length of time for pilot testing the system, which included internal checks and end-user testing with a sample of providers.

The contract did not specify a total number of providers, types of providers, a total number of claims, types of claims, or a dollar amount of claims that needed to be tested before implementing the new system. According to the department, approximately 50 providers representing a variety of provider types and specialties were selected to pilot test the system. When we spoke with one provider group, it indicated that it had agreed to pilot the system but never received any further instruction for how to proceed. Neither the department nor Molina were able to provide

Less than one percent of total providers were selected for a pilot test; neither the department nor Molina know how many claims providers submitted as part of the pilot.

detailed information on the number or types of providers who actually participated in the pilot test or submitted claims for testing in the system. One department staff member thought only three claims were submitted under this test environment.

The contract did not define adequate pilot testing.

Despite the extremely low rate of provider participation, the system was implemented based on the results of internal testing. According to Molina, a series of checks were performed with other entities who electronically interfaced with the system. Molina also conducted parallel testing, which meant some claims that had been adjudicated in the old claims processing system were reprocessed in the new system to compare the results of the claims and to test the accuracy of the system. The system then began processing new claims in June 2010.

What Was the Process to Ensure Providers Were Properly and Timely Enrolled in the System?

According to the terms of the contract, provider enrollment training was conducted in November and December 2009.¹ This training was conducted in each region with a variety of provider types. However, contract terms did not require the vendor to monitor the number of providers who were enrolling throughout the transition and did not link the completion of the deliverable to the number of providers who received training or the number of providers who enrolled by the deadline. The department paid for the training deliverable in December 2009.

The contract did not require a minimum number of providers to be properly enrolled before the system began processing claims.

Providers began enrolling in the new system as early as October 2009. According to the department and Molina, providers were initially responsible for properly enrolling themselves by June 3, 2010. Before the transition, neither the number of providers nor the types of providers were regularly monitored to ensure a sufficient number of providers were enrolled in the system. One provider said it waited until the last minute to enroll because the enrollment process was so complicated. According to Molina, approximately 12,400 providers were enrolled when the system began processing claims in June 2010.

¹ In addition to this training, the department publishes a monthly newsletter for providers, which includes information about enrollment, system updates, how to process claims, and changes to Medicaid programs.

As of February 2011, more than 23,000 providers were enrolled, which meant that nearly half of providers were not in the system when it was implemented.²

In addition to enrollment training, Molina offered several trainings related to billing. According to one provider group, training was general in nature and did not adequately address the unique challenges for more complex billing structures. Instead, providers were directed to the Molina website for additional information.

The department said the complexity of the new system was an issue when transitioning providers. Even when providers did enroll, they were not always configured correctly.³ As a result, claims for those providers did not process correctly. The department acknowledged that Unisys and Molina should have done more to assist providers with enrollment, particularly those providers who had not received training and were not familiar with the new system. Timely attention to providers' training and assistance needs could have reduced the significant number of claim processing problems that occurred for months after implementation.

What Was the Impact of Molina's Purchase of Unisys on Overall System Transition?

Molina's acquisition of the system had very little impact on the end product. In its August 2010 newsletter, the department stated that it had received written assurances from Molina that the system was ready to begin processing claims, along with its commitment to provide support for successful implementation and ongoing operations. Providers have raised questions about the overall compatibility of the new system with Idaho's Medicaid requirements, but the system that began processing claims was designed to meet Idaho's requirements and was a reflection of the collaboration of the department, Unisys, and Molina. This collaboration included mutual agreement among those entities that critical milestones had been met.

With department approval, Molina implemented the system built by Unisys.

² The department and Molina noted that they had difficulty determining whether the new system would have an overall increase or decrease in the total number of providers because the enrollment requirements between the old and new systems were very different.

³ Configuration issues were generally the result of providers either entering information incorrectly or system design flaws.

Could the Department Have Delayed Implementation of the New System to Improve Performance?

According to the department, delaying transition to the new system would not have reduced challenges. The department noted that its previous vendor had already begun winding down operations in preparation for the end of the contract

The old claims processing system was no longer viable.

and that many of the hardware warranties were set to expire. In terms of how well the system was working, issues only arose once providers submitted actual claims. According to the department, both the department and Molina did not become aware of the extent of problems until issues began emerging from end users.

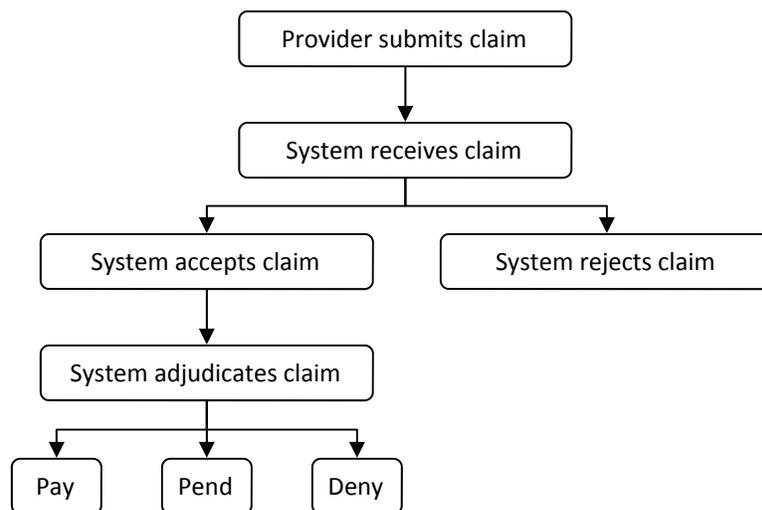
In addition to phasing out the prior vendor contract, Idaho had already received two extensions from the federal Centers for Medicare and Medicaid Services as part of its agreement to reimburse Idaho for a portion of the new system's development and implementation. The department indicated additional extensions were unlikely. Chapter 7 provides more information on the federal certification and reimbursement process.

Chapter 4

Claims Processing

Idaho's system receives about 150,000 claims each week and accepts an average of 87 percent of those claims.¹ Accepted claims enter an adjudication cycle, resulting in paid, denied, or pending claims. The remaining 13 percent of claims received by the system are rejected and do not adjudicate. For example, the system rejects a claim if the provider is not recognized. Exhibit 4.1 shows how a claim is processed through the system.

EXHIBIT 4.1 LIFE OF A CLAIM



Source: Information from Molina Healthcare, Inc.

¹ Information was analyzed from data summarized by Molina from June 27, 2010, to February 13, 2011. The number of weekly claims includes new claims and claims that are reprocessed because of an incorrect edit or change in the system. A system change could include system code defects, rate changes, and policy changes.

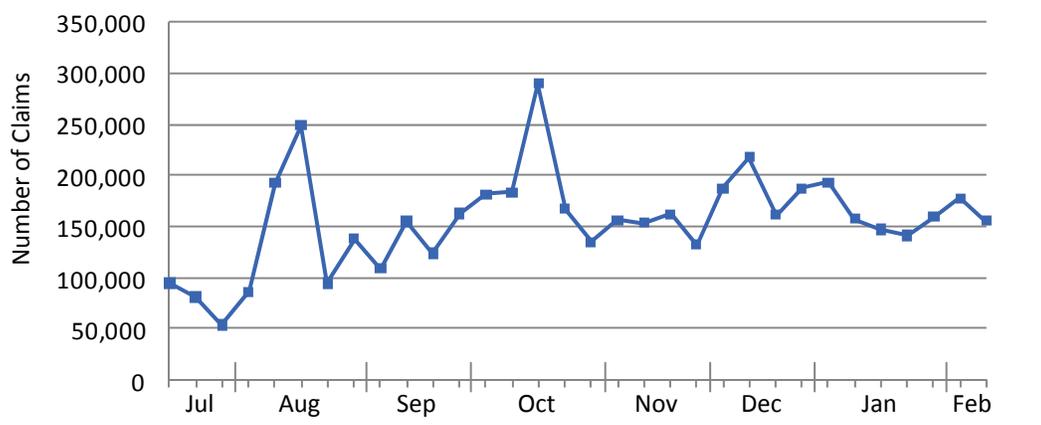
How Many Claims Does the System Approve for Payment?

The system approves payment for most claims.

Paid claims are those for which the system has approved payment. Most claims accepted by the system are paid. For new week claims from January 9, 2011, to February 13, 2011, the system paid an average of 80 percent of claims accepted each week. For all claims from June 2010 to February 2011, the number of paid claims averaged almost 150,000 each week.² The number of paid claims has varied over time. Exhibit 4.2 shows the trend in the number of claims paid each week from July 2010 to February 2011.

Paid claims sometimes require adjustments—changes made to correct an error in processing or billing of a paid claim. Molina staff or providers can adjust claims. If a provider discovers that a paid claim needs an adjustment, the provider can edit and resubmit the claim. From June 6, 2010, to February 6, 2011, the most common adjustments required for paid claims related to reprocessing claims that needed rate changes or changes in the coordination of benefits.

EXHIBIT 4.2 NUMBER OF CLAIMS PAID BY WEEK, JULY 11, 2010–FEBRUARY 13, 2011

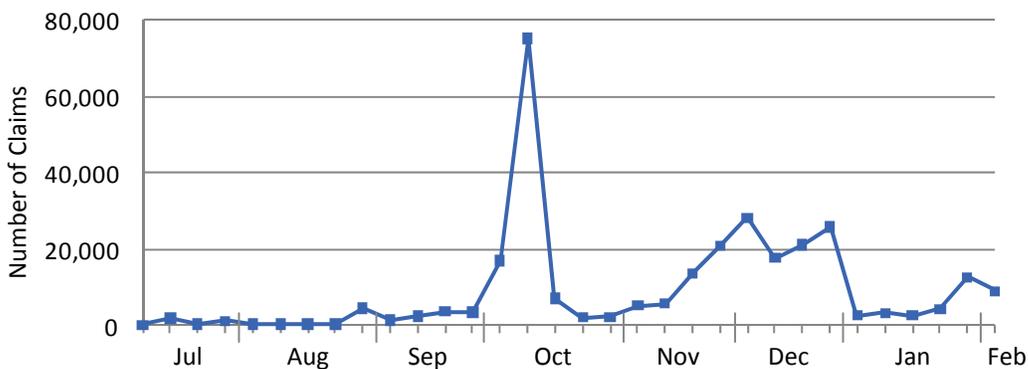


Source: Analysis of data from Molina Healthcare, Inc.

² These claims include new week claims as well as claims that have been pended in the system for longer than a week.

Exhibit 4.3 shows the weekly trend in the number of new paid claims that required adjustments.³ As shown in the exhibit, the number of new paid claims that required adjustments has varied since Molina began tracking this data in early July. There was a noticeable spike during the week ending October 10, 2010, when more than 75,000 claims required adjustments.⁴ At the time of our review of the data, about 9,000 claims required adjustments during the week of February 6, 2011.

EXHIBIT 4.3 NUMBER OF NEW CLAIMS PAID BY WEEK THAT REQUIRED ADJUSTMENTS, JULY 4, 2010–FEBRUARY 6, 2011



Source: Analysis of data from Molina Healthcare, Inc.

Note: Molina began tracking the number of new paid claims that required adjustments the first week of July. Also, when an original claim was adjusted multiple times, only the last adjustment has been included.

How Many Claims Are Denied Payment by the System?

Denied claims are those for which the system has denied payment. On average, the system denies about ten percent of claims each week or about 15,000 claims.⁵

Denying a claim is appropriate if the claim contains an error.

There are valid reasons why the system would deny some claims. The most common denial reason from June 6, 2010, to January 30, 2011, was duplicate claims submitted by providers. This denial reason represents approximately 45 percent of the most common denial reasons since June 2010. Other reasons claims are regularly denied include providers who do not have an active contract in the system and patients who are not enrolled in Medicaid at the start date of a claim. A provider may resubmit a denied claim after correcting the reason for the denial.

³ Adjustment does not necessarily mean the claim was paid differently, only that information within the claim required a change.

⁴ Molina reprocessed a number of hospital claims that needed rate updates and claims that needed correction because they had been paid as primary insurer instead of secondary insurer.

⁵ Percentage reflects data compiled since January 2011, the date Molina began tracking this information. Data are not available for any months in 2010.

According to Molina, enactment of House Bill 701, passed during the 2010 session and effective January 1, 2011, affected the number of claims denied. Among other reductions, the bill reduced mental health benefits, including psychosocial rehabilitation services.⁶ The billable hours for psychosocial rehabilitation services decreased from ten to five hours per week, and the system was set up on a rolling week schedule. However, providers were submitting claims by calendar week, resulting in many denied claims until Molina was able to change the system to reflect a calendar week.

The department has indicated that the timing of policy changes such as those enacted through House Bill 701 may cause problems for a new system. According to the department, states should freeze their Medicaid policy for at least one year when implementing a new system to allow for stabilization through the initial start-up process.

What Is the Status of Pended Claims?

Pended claims require at least some manual processing. The steps necessary to process a claim depend on the edit required. Pended claims make up the system's backlog. Pended claims are not considered finalized until they are processed, resulting in a pay or deny status.

Exhibit 4.4 shows the relationship between the number of claims the system accepts each week and the number of pended claims. Since November 2010, the number of pended claims has decreased overall. Additionally, the overall proportion of pended claims relative to the number of new claims accepted each week has decreased.

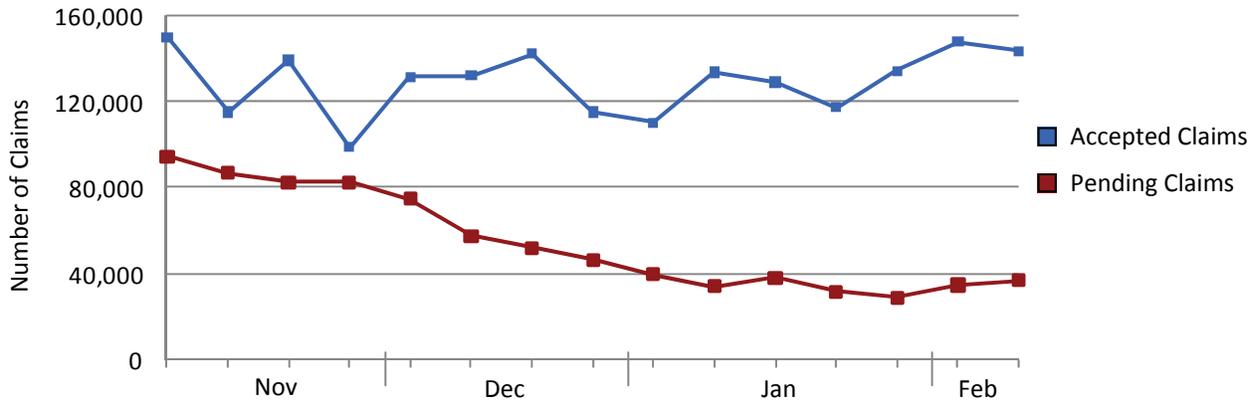
The number of claims in the backlog is decreasing.

As of February 27, 2011, approximately 58,400 claims were in the backlog. The number of claims in the backlog each week and the amount of time those claims spend in the backlog has changed over time. Exhibit 4.5 shows the total number of claims in the backlog each week and a breakdown of how long those claims have been pending.

Exhibit 4.5 shows a general decrease in the number of claims that have been in the backlog. The percentage of claims that have been in the backlog for 30 or fewer days has averaged 52 percent a week from September 2010 to February 2011. The percentage of claims that have been in the backlog for 90 or fewer days has averaged 87 percent during this time.

⁶ The bill reduced mental health benefits, vision benefits, developmental disabilities services, school-based services, home- and community-based services, aged and disabled benefits, and personal care benefits. It also restructured the Healthy Connections primary care case management fee and halted reimbursement for certain drug ingredients.

EXHIBIT 4.4 COMPARISON OF THE NUMBER OF CLAIMS ACCEPTED AND THE NUMBER OF CLAIMS PENDING BY WEEK, NOVEMBER 7, 2010–FEBRUARY 13, 2011



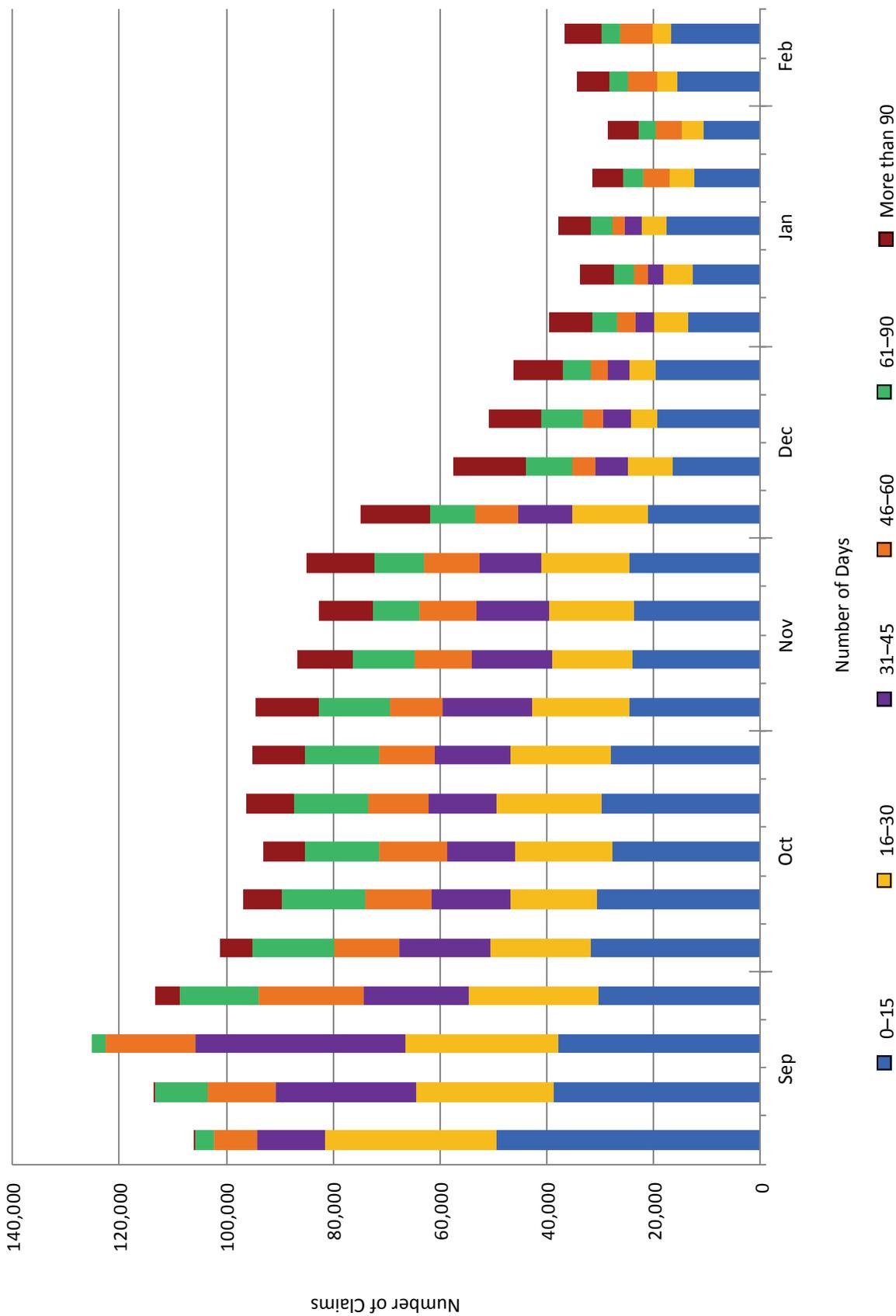
Source: Analysis of data from Molina Healthcare, Inc.

Note: Molina began tracking the number of accepted and pending claims the first week of November.

Molina also tracks the amount of money associated with claims in the backlog; however, not all pended claims result in paid claims. The system eventually denies some pended claims. The amount of money associated with claims in the backlog has averaged about \$41 million each week since Molina began tracking this data in December 2010. For the same time period, the dollar value of the claims in the backlog over 90 days has averaged about \$7 million.

The department’s contract with Molina dictates that 92 percent of all claims must be adjudicated for payment or denial within 30 days of receipt. On average, 93.6 percent of claims have finalized in 30 days since the system began processing claims in June 2010. Molina did not meet the contractual requirements for processing 92 percent of claims within 30 days in September and November 2010.

EXHIBIT 4.5 NUMBER OF CLAIMS PENDING BY WEEK, SEPTEMBER 6, 2010–FEBRUARY 13, 2011



Week Ending	0-15 Days	16-30 Days	31-45 Days ^a	46-60 Days ^a	61-90 Days	More than 90 Days	Total
Sept 6	49,340	32,113	12,704	8,195	3,397	98	105,847
Sept 12	38,781	25,563	26,538	12,491	10,031	321	113,725
Sept 19	37,871	28,685	39,362	16,548	2,595	0	125,061
Sept 26	30,118	24,468	19,626	19,700	14,721	4,746	113,379
Oct 3	31,709	18,928	16,887	12,277	15,154	6,101	101,056
Oct 10	30,463	16,298	14,745	12,390	15,810	7,032	96,738
Oct 17	27,727	18,049	12,714	12,919	13,821	7,869	93,099
Oct 24	29,594	19,635	12,890	11,206	13,992	8,908	96,225
Oct 31	27,993	18,731	14,278	10,331	13,846	10,036	95,215
Nov 7	24,390	18,393	16,787	9,612	13,476	11,744	94,402
Nov 14	23,763	15,038	15,167	10,674	11,552	10,506	86,700
Nov 21	23,657	15,842	13,613	10,750	8,738	9,926	82,526
Nov 28	24,561	16,300	11,676	10,397	9,226	12,692	84,852
Dec 5	21,053	14,145	10,174	8,043	8,402	12,966	74,783
Dec 12	16,455	8,175	6,139	4,468	8,696	13,447	57,380
Dec 19	19,324	4,749	5,255	3,837	7,672	9,980	50,817
Dec 26	19,435	5,153	3,811	3,406	5,101	9,341	46,247
Jan 2	13,506	6,416	3,375	3,419	4,809	7,995	39,520
Jan 9	12,517	5,530	2,807	2,721	3,712	6,532	33,819
Jan 16	17,434	4,822	2,960	2,335	4,004	6,194	37,749
Jan 23	12,380	4,516	—	5,086	3,504	5,991	31,477
Jan 30	10,654	4,098	—	4,724	3,318	5,786	28,580
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

Source: Analysis of data from Molina Healthcare, Inc.

Note: Molina began tracking the number of claims in the backlog the first week of September.

^a Molina changed the way it tracks claims older than 30 days. Beginning on January 23, the group labeled 46-60 days actually represents 31-60 days.

Why Does the System Pend Claims?

The system is designed to pend more claims than the old system.

Molina and the department told us that by design, the system pends more claims than the old system. Therefore, in many instances, pending a claim is the intended outcome in order for information to be verified about the legitimacy of the claim. Molina tracks the most common edits that pended claims require before processing. Some of the most common reasons a claim will pend include issues ranging from missing information to the need for further documentation or authorization of services. Molina does not report the most common edits made to claims by the total number of days a claim has been in the backlog.⁷

For new claims entering the system the week ended February 27, about 48 percent of claims automatically pended the first time through the system. However, by week end, only 19 percent of those claims were still pending.

Molina told us that it prioritizes pended claims by addressing the oldest claims first. Molina also organizes pended claims by how many claims are affected by a given edit. The oldest claims within the edit are worked first. Additionally, Molina told us that it prioritizes pended claims by provider type. Some provider types are given priority. For example, Molina gives priority to providers who are completely dependent on Medicaid payments to sustain their services.

⁷ Molina has the ability to report this data going forward, but it cannot create historical reports for the weeks since the system started processing claims.

Chapter 5

Quality of Claims Processing

The system's error rate for claims processing has not been measured. Calculating an error rate may be premature at this time because the system is still undergoing changes. Despite not knowing exactly how many claims have processed incorrectly, provider groups we spoke with voiced ongoing concern about the problems they have faced since the system began processing claims. The department and Molina use several methods to monitor problems with claims processing.

Is the System Processing Claims Correctly?

The standards for processing claims, required by the American Recovery and Reinvestment Act and Molina's contract with the department, only measure how many claims must be finalized within certain timeframes.¹ The requirements do not measure whether the claims processed correctly (i.e., the provider receives the correct payment amount).

Molina's contract with the department does not require that Molina either (1) measure an error rate, or (2) remain at or below a minimum error rate threshold.² The contract only specifies that Molina comply with the Payment Error Rate Measurement conducted by the Centers for Medicare and Medicaid Services every three years. Federal officials last measured Idaho's payment error rate in federal fiscal year 2009. A new measurement is scheduled to begin in October 2011 for federal fiscal year 2012.³

The contract requires measurement of the timeliness of claims processing but does not require measurement of whether claims are processed correctly.

¹ Finalized claims have a paid or denied status.

² A payment error rate measures the number of improper payments. According to the federal government, "improper payments occur when funds go to the wrong recipient, the recipient receives the incorrect amount of funds (overpayment or underpayment), documentation is not available to support a payment, or the recipient uses funds in an improper manner." "Payment Accuracy," US Government, <http://paymentaccuracy.gov/> (accessed February 27, 2011).

³ The process for a Payment Error Rate Measurement has three components: (1) a documentation contractor collects policies from the state and medical providers; (2) a review contractor performs medical and data processing reviews and conducts difference resolution with states; and (3) a statistical contractor conducts quality control and selects random samples to review. After the payment error rate is calculated, states must submit corrective action plans to the Centers for Medicare and Medicaid Services that detail the corrective steps taken.

We believe that calculating an error rate is premature at this time because the following issues indicate the system is still in flux:

- The department, Molina, and providers continue to identify and address system defects.
- The department has not signed off on all phases of the system design, development, and implementation process, including user acceptance testing, pilot testing, and implementation.
- The final phase of the design, development, and implementation process is certification by the federal government. The certification process entails documenting that various system components are functional and that the system is working as intended. The department reports that it is currently compiling the documentation needed to certify the system.

The system electronically interfaces with other entities to collect the necessary information to process claims correctly. As examples, the system both receives data from and sends data to STARS in the Controller's office and IBES in the Division of Welfare.⁴ Therefore, these entities rely on the quality of information transmitted to and from each interface to process claims correctly.

Further, not all providers were correctly configured within the system when they enrolled. If a provider was incorrectly configured, the system could not function as intended. The department told us that the largest issues fall back to whether providers were correctly set up for their specific needs, allowing the system software to function properly.

Finally, the contract required that the system use commercial off-the-shelf software products.⁵ The department confirmed that it wanted off-the-shelf products to the extent possible but acknowledged that these products require modifications to meet state-specific needs and that Molina has had to customize the system to a greater degree than was expected. Molina told us that it has created special codes (i.e., fixes) to improve system functions. According to the department, it currently monitors the quality of outcomes for only those claims associated with a system fix. Once the defects are addressed, the department's goal is to randomly sample claims and test them for quality assurance.

⁴ STARS (Statewide Accounting and Reporting System) issues provider payments and IBES (Idaho Benefit and Eligibility System) provides eligibility information.

⁵ Many government programs mandate the use of commercial off-the-shelf products because the products offer cost savings in procurement, development, and maintenance. Use of commercial off-the-shelf products often requires configuration of the software for specific purposes.

How Are the Department and Molina Tracking System Performance?

The department and Molina primarily track system performance using four documents:

Contract Monitoring Reports. Molina reports weekly about whether it has met the terms of the contract, and the department spot checks the contract monitoring reports for accuracy.

System Defect Log. According to Molina, it has maintained a defect log since the day the system began processing claims. Molina reports that it logs any issue or problem as a defect, and then the department and Molina review the defects weekly to categorize each one and assign a severity level.⁶ The department said that the root cause of a defect is analyzed and the fix is tested.

As shown in exhibit 5.1, on March 3, 2011, the log had 241 active defects.⁷ Twenty-eight of these defects were considered severe, 201 were major, and 12 were minor. Seventy-nine of these issues were classified as “red hot,” which means that they were a top priority.⁸ Additionally, 43 of the defects were 90 days or older.⁹

EXHIBIT 5.1 SUMMARY OF SYSTEM DEFECTS AS OF MARCH 3, 2011

	Severe	Major	Minor	Total
Red hot defects	19	58	2	79
All other defects	9	143	10	162
TOTAL	28	201	12	241

Source: Analysis of data from Molina Healthcare, Inc.

Escalation List. Molina tracks certain issues through a triage team that works to resolve escalated issues.¹⁰ As of February 17, 2011, Molina’s escalation list had a total of 1,661 open and closed issues: 1,499 issues were closed, 155 were active, and Molina was monitoring 7 more.

⁶ The department told us that the issues providers bring up are also logged as defects.

⁷ Molina reports that as of March 6, 2011, it had closed 1,350 defects.

⁸ In addition to “red hot,” Molina classifies defects as urgent, high, and medium priorities.

⁹ We calculated the age of defects by the number of calendar days.

¹⁰ Chapter 6 has additional information about the escalation list.

Corrective Action Reports. Molina submits weekly corrective action reports to the department. The reports capture information in two broad areas: processing of claims and performance updates. Molina provides data in the reports such as the number of claims paid, denied, or pended in the past week and an update on the status of 18 issues jointly identified by Molina and the department.

The department and Molina’s performance tracking reports, particularly the weekly corrective action reports, do not have sufficient data to measure whether claims are processed correctly.

The department told us that the corrective action reports are currently its primary form of quality assurance. However, we found that the reports may only capture a subset of issues. For example, the reports provide information about the number of claims that have adjudicated and the number which have not, but the reports do not provide information about whether any of the adjudicated claims resulted in incorrect payments. As a result, we found limited data in the reports addressing issues that providers identified as most significant.

In our interviews with Molina and provider groups, we received feedback which suggests that ongoing system performance is not meeting all providers’ needs. As an example, a fix implemented to address one problem in some cases did not fix the problem or caused a new problem. We also heard from provider groups that “fixed” issues may be prematurely closed out and considered nonissues.

Incorrect Payments

Most provider groups we spoke with expressed concern about the significant problems they continue to experience with the incorrect processing of claims.

Provider groups we spoke with indicated that underpayments, overpayments, and reconciliation problems were significant, ongoing issues. For example, as of February 11, 2011, the Idaho Primary Care Association estimated that eight of the state’s 13 community health centers were owed more than \$1.1 million because of various errors in processed claims. We did not verify or quantify the extent of problems providers are experiencing. However, we outline the following four examples of providers’ perceptions of system problems and their experiences with specific issues:

Coordination of Benefits

Coordination of benefits is used to establish the order in which health insurance plans pay claims when more than one plan exists. By design, Medicaid is the payer of last resort and other insurances are billed first. The Idaho Medical Association told us that the system is paying incorrect amounts on secondary claims.

The Idaho Primary Care Association also outlined issues with coordination of benefits. According to the association, community health centers are either denied payment or paid an incorrect amount when Medicaid is listed as the secondary payer, especially when the primary payer is a carrier other than Medicare.

The Idaho Medical Association reported, and Molina confirmed, that Molina has an action plan to fix the coordination of benefits issue, which will be done in two phases. Implementation of the first phase is scheduled for the middle of March, and implementation of the second phase is scheduled for April.

Healthy Connections

Healthy Connections is designed to provide Medicaid patients with a primary care physician to manage their healthcare. Healthy Connections patients are assigned to a specific primary care physician or clinic. No referral is necessary when a patient sees his or her assigned primary care physician. We heard from provider groups that the system has not linked Healthy Connections patients to a primary care physician. As a result, providers are unaware of whether the patient needs a referral. The department and Molina have identified problems with Healthy Connections as a top 18 issue.

The department estimates the number of patients without a linked primary care physician in the system at 60,000, and said the issue affects 86 providers. According to Molina, it is working with the department to identify a solution for how to assign patients to a primary care physician.

Share of Cost

Some Medicaid patients do not get free health services but instead are required to incur a certain amount of medical expenses each month before Medicaid pays for their services. This amount is called share of cost. In nursing homes, patients' insurance and income are used to calculate their share of cost for services. Problems with share of cost are identified as a top 18 issue by the department and Molina.

The Division of Welfare manages the Idaho Benefits Eligibility System (IBES), which calculates share of cost. In the past several weeks, it was discovered that the eligibility system is not calculating share of cost correctly. As a result, the Idaho Health Care Association said that providers have received under and overpaid claims. One provider estimated that his facility has been overpaid by \$680,000 for some claims and underpaid by about the same amount for other claims.

The Idaho Health Care Association said that providers have not resubmitted claims with inaccurate share-of-cost calculations because the system has not been fixed. If they resubmitted the claims right now, providers would see the same inaccurate results. For its part, Molina said that it has worked with

providers individually to resubmit these claims. However, Molina acknowledges that the issue still exists for some providers. The department said that the fix should be completed by the end of March and estimated that more than 200 claims will need to be reprocessed.

Reconciling Payments

Another top 18 issue identified by the department and Molina is that providers cannot reconcile payments to claims. Molina told us that one of the initial problems of the system was that providers' remittance advices did not match the claims submitted. Molina processes claims and then sends them to the State Controller's office for payment. The Controller's office was splitting one claim into more than one payment, making it difficult for providers and Molina to reconcile multiple payments to the right claim. In response, Molina modified the format of the remittance advices to provide more detailed information so that providers could balance their books.

Despite having resolved at least one part of the issue, provider groups we spoke with remain concerned about whether they will be able to reconcile incorrectly paid claims and the time and resources required to continually do so. Molina's March 2, 2011, corrective action report indicated the issue was coded "red," meaning that Molina was behind schedule to implement a fix or that the issue was recurring. However, in the March 16, 2011, corrective action report, the issue was coded "green," indicating that the issue has been resolved.

Chapter 6

Customer Service

In addition to problems with incorrectly processed claims, providers faced challenges in resolving issues and communicating with Molina staff. Molina acknowledged that it was understaffed and unable to deal with the volume of provider issues. It indicated that steps have been taken to increase staff and work more closely with providers. While some provider groups have reported improvement in the processing and accuracy of processed claims, other groups have expressed frustration that issues continue to remain unresolved.

How Are the Department and Molina Working with Providers to Resolve Claim Issues?

The terms of the contract require Molina to have adequate staffing, a call center, and a help desk. In addition, the department and Molina work with providers through several means, including weekly calls and the creation of an escalation team to work directly with providers with larger issues.

Molina has taken steps to resolve provider issues but results are mixed.

Weekly Calls. Once the system began processing claims and defects were identified, the department and Molina began conducting weekly calls with individual provider groups to discuss outstanding issues and strategies for resolution. Most calls are now made bi-weekly or conducted as needed. One provider group continues to have weekly calls.

When we spoke to provider groups, their perspective on the usefulness of these calls varied. According to one group, the calls have been productive and have helped facilitate resolution of major issues. According to other groups, communication with Molina initially appeared to be productive but results have not materialized. Despite commitments from staff, Molina does not seem to have a clear work plan for resolving issues. Further, when system fixes for one problem are made, one provider noted that a new set of problems arise elsewhere in the system.

Escalation Lists. Throughout the months of June and July 2010, the department expressed concerns to Molina that it could not keep up with the volume of calls from providers about payment delays. At the request of the department, Molina established a triage team in August 2010. The team was made up of Molina staff with expertise in areas such as claims, provider enrollment, provider configuration setup, and eligibility. The goal of this team was to resolve escalated issues and follow up with providers who had previously contacted the department for assistance.

In addition to these two initiatives, at least two providers indicated they have also met with Molina staff individually to resolve issues. In both instances, the providers indicated that they assigned themselves to certain Molina staff and worked directly with that staff to correct enrollment and claims issues. When we asked Molina whether providers are generally assigned to specific representatives, it told us that unless a provider is assigned to the triage team, calls are routed to the first available customer service representative in the call center. As a result, providers may not be consistently working with Molina representatives who have specialized information about certain provider types or certain types of claims.

How Have Staffing Issues Affected Molina’s Ability to Communicate with Providers?

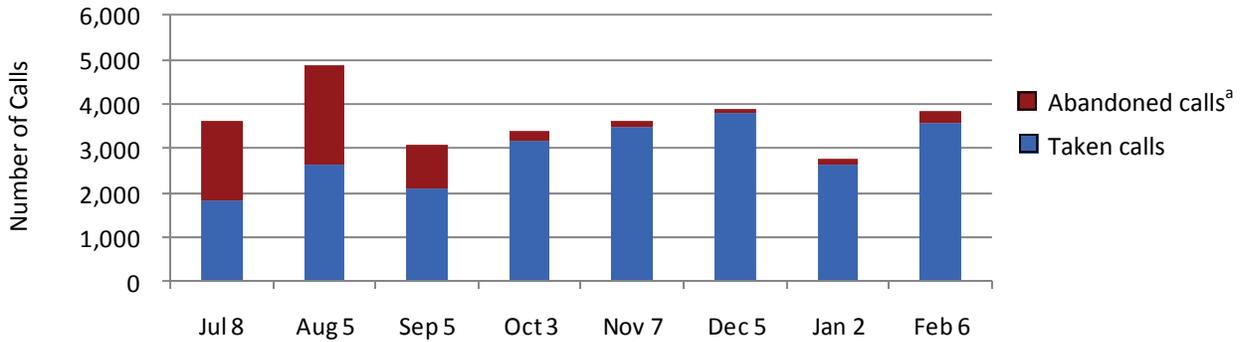
As discussed, Molina was not sufficiently staffed to resolve the number and types of issues that providers faced when the system began processing claims. Between July 2010 and February 2011, Molina increased its provider support staff by 85 percent, growing from 34 to 63 positions; the largest increase in staff

Molina has increased staff in key areas.

was in customer service representatives. According to Molina, it has also added staff to support defect resolution, policy changes, enhancements, and other issues. These added positions include configuration analysts, who review the system setup for the contracts, benefits, and terms in order to support pricing claims.

Exhibit 6.1 shows the total weekly calls made to Molina have remained relatively constant over the past eight months and the number of abandoned calls has greatly decreased. As shown, the percentage of abandoned calls has decreased from nearly 50 percent in July to 7 percent in February. Exhibit 6.2 highlights that wait times dropped significantly in October and have remained relatively low. Although this data does not directly measure the outcome of these calls, it does suggest that more providers are able to directly communicate with Molina staff when issues arise.

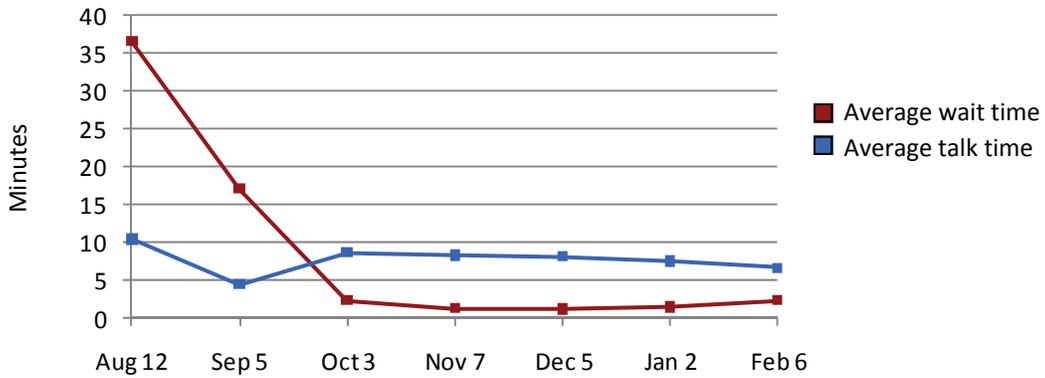
EXHIBIT 6.1 MOLINA CALL CENTER TRENDS AS OF FEBRUARY 2011



Source: Information from Molina Healthcare, Inc. using data captured the first week of each month.

^a Calls in which a caller hangs up after asking to be transferred to an agent or while in the automated voice response.

EXHIBIT 6.2 WAIT AND TALK TIME TRENDS AS OF FEBRUARY 2011



Source: Information from Molina Healthcare, Inc. using data captured the first week of each month.

Note: Wait and talk times were not tracked until August 12.

Chapter 7

Potential Liabilities

The state faces potential liabilities if outstanding system issues are not resolved. When the system was implemented, many providers were not enrolled in the system and claims were not processed correctly. To alleviate some of these concerns, the department advanced \$117 million in interim payments to providers, but it has only recouped a portion of those payments. Because the system currently meets its contract requirements for processing claims, the department is working toward federal system certification; a lack of certification reduces the federal match rate for operation costs.

What Are the State and Federal Requirements and Penalties for Timeliness of Payments?

The federal American Recovery and Reinvestment Act states that 90 percent of all clean Medicaid claims must be paid within 30 days of receipt and 99 percent of claims must be paid within 90 days.¹ Idaho received a waiver from the federal Centers for Medicare and Medicaid Services that exempted the department from federal prompt pay requirements through December 2010.

The department's contract with Molina is more stringent than the federal requirements. According to the contract, Molina must ensure that 92 percent of claims are adjudicated for payment or denial within 30 days of receipt. Molina must also produce a report on processing times for provider adjustment requests. With the exception of September and November 2010, Idaho has met the contract requirements for processing claims. Since the system began processing Medicaid claims in June 2010, the state has averaged an overall adjudication rate of 93.6 percent in 30 days and 99.3 percent in 90 days.

The system has been compliant with contract requirements for seven out of nine months.

¹ A clean claim has no defects or special circumstances, including incomplete documentation, that would delay timely payment.

What Is the Current Status of Interim Payments?

To assist providers who were having difficulty getting claims processed correctly through the new system, the department issued interim payments of \$117 million to supplement provider cash flow. Interim payments were primarily issued during July and August and payment amounts were based on the providers' average claim volume from January to March of 2010. Payments were made in two cycles depending on provider type. The first cycle accounted for about 80 percent of the interim payments and targeted mostly smaller providers who relied more on Medicaid dollars. The second cycle of payments was issued to all providers.

Interim payments were sent to providers without formal guidance or instructions.

Most providers received their interim payment in July or August; however, they did not receive any instruction or guidance before receiving their check. Rather, the department and Molina used various means to reach out to the providers in the following months to make repayment arrangements. According to the department, payments would automatically be deducted at 25 percent of each weekly claim until the balance was paid or unless providers requested different payment arrangements:

- Returning the check if the money is not needed
- Making full repayment with one check
- Reducing each claim paid by more than 25 percent until repayment is complete
- Making payments divided equally over 4 months
- Working directly with Molina to request a postponement of payment

Because the system was not consistently processing claims correctly, providers were not required to repay the interim payment immediately. Now that the system is performing better, the department has requested and is actively trying to recoup 100 percent of the interim payments from providers by June 30, 2011, which is the end of the fiscal year.

The department is working to recoup more than \$60 million in interim payments.

According to the department, it is allowing those providers who are still having challenges receiving correctly paid claims to make payments after June 30. However, when we spoke to representatives for certified family homes, they indicated some providers had not been given additional flexibility and that payments are being recouped at a higher rate than initially agreed.

As shown in exhibit 7.1, the department has recouped \$49 million of the initial payment distribution. According to the department, some providers are refusing to return the interim payments until all outstanding claims are reconciled, and some have stated that they spent the payments on other expenses. The department is working to ensure payment will be returned by all providers, but it estimates that about \$16 million from about 200 providers will not be recouped by June 30. Of that total, more than \$2 million is owed by providers who have not submitted claims in 2011 and have not been part of recoupment efforts. The department is considering other options for resolving these outstanding balances.

The department is at risk of losing more than \$2 million in unrecouped interim payments.

EXHIBIT 7.1 INTERIM PAYMENT RECOUPMENT AMOUNTS

Interim Payment Status as of March 13, 2011

Interim payments issued	\$117,884,841
Provider payments recouped	\$49,255,624
Returned or cancelled checks ^a	\$6,937,664
Total outstanding balance	\$61,691,553

Source: Information from the Idaho Department of Health and Welfare.

^a Returned by providers who did not wish to accept an interim payment.

What Is the Cost of Delayed Claims Processing?

The American Recovery and Reinvestment Act (ARRA) was designed, in part, to temporarily increase match rates for Medicaid programs. Federal match rates will be permanently reduced on July 1, 2011, once ARRA ends. Exhibit 7.2 shows the quarterly declines in rates.

The timely processing of claims is particularly important while ARRA is still in effect because the corresponding federal match rate aligns with the date each claim is paid, not the date each claim is submitted. As a result, claims that are not immediately adjudicated or are later adjusted may be subject to a lower

EXHIBIT 7.2 FEDERAL MATCH RATE CHANGES FOR MEDICAID CLAIMS

Match Rate Change by Date	Corresponding Federal Match Rate (%)
Before 12/31/2010	79.18
1/1/2011	76.18
4/1/2011	74.18
7/1/2011	68.85

Source: *American Recovery and Reinvestment Act of 2009*, Public Law III-5, Statutes at Large 123 (2009), 115.

federal match rate. For example, if a claim for \$10,000 was submitted and paid in December 2010, Idaho would have been reimbursed \$7,918. If that same claim is not paid until July 2011, Idaho will only be reimbursed \$6,885.

Because the system is generally processing claims correctly, most claims will not be affected by the reduction.² However, both the department and Molina acknowledge that claims in the backlog or claims requiring future adjustments may be paid at a lower rate. Until those claims are finalized, the department cannot calculate the potential lost federal matching funds associated with delayed claims processing.

Why Is Federal Certification Important?

Certification will increase Idaho's federal match amount for operations by \$323,958 each month.

The final phase of establishing a new Medicaid Management Information System (MMIS) is certification. The certification process is conducted by the federal Centers for Medicare and Medicaid Services. Certification designates all of the components making up the MMIS as working correctly. Federal certification affects the federal match amounts for system operations but does not affect the match rates for provider claims.

There are two major incentives for becoming federally certified:

Incentive to State. A federally certified MMIS increases federal match rates for Medicaid funds for system operations. Once Idaho becomes certified, match rates will increase from 50 percent to 75 percent for monthly operation costs. We calculate the difference between a certified system and noncertified system of about \$4 million a year, or \$323,958 each month.

Incentive to Molina. Molina will receive the final payment from the department for its system development contract. Under the terms of the contract, Molina will be paid \$2,979,080 upon Idaho's certification.

The department has hired a consultant to assess MMIS's readiness for the certification process and to complete the certification checklist. The department estimates the certification process will begin within a few months, indicating that states cannot apply for certification until all of the components of MMIS have been operating for at least six months. The department said that most states begin the certification process after about one year of operation.

² Some claims, even if processed timely, may be affected by the rate reductions if the claim is finalized after a lower match rate goes into effect. According to Molina, rate changes such as these are a normal part of business and are not necessarily related to a system problem. These types of changes also occurred in the old system.

Are There Other Liabilities to the State?

We identified two other areas of concern for the state: (1) report on internal controls, and (2) prompt payments to providers.

Report on Internal Controls. As part of the audit of the Statewide Comprehensive Annual Financial Report (CAFR), Legislative Audits reviews internal controls and procedures used to develop financial statements. For fiscal year 2010, Legislative Audits identified control weaknesses related to payments to Medicaid providers who were not properly identified to an allowable cost.³ If outstanding payments, including interim payments issued as part of the Molina transition, are not resolved by June 30, 2011, they could contribute to similar weaknesses and negatively affect the audit opinion for the fiscal year 2011 CAFR.⁴

Prompt Payments to Providers. Idaho is required to pay all of its bills within 60 days of receipt.⁵ According to the Attorney General's office, if a provider files a lawsuit against the state for nonpayment and the provider prevails, the state must pay an automatic penalty of interest and attorney fees to the provider. These penalties would come from the state's General Fund and would not be eligible for a federal match, ultimately reducing state funds that could be leveraged for eligible services. Although the current backlog of claims in the system may have exposed the state to risks for penalties and fees, this risk was mitigated by the issuance of interim payments to providers.

³ State of Idaho Internal Control Report, Fiscal Year 2010. Note: Molina was only processing claims for one month during this time frame.

⁴ Legislative Audits will issue its Statewide Single Audit Report for fiscal year 2010 by the end of March. This report contains a review of all federal monies used by state programs, including Medicaid. The report may offer additional insight in the reconciliation of Medicaid payments to specific provider claims.

⁵ IDAHO CODE § 67-2302.

Chapter 8

Recommendations

Our recommendations are designed with both short- and long-term goals in mind, and we have certain findings for which our recommendations can only apply to future efforts. For example, the opportunity to pilot test the system with end users no longer exists, nor does the opportunity to ensure providers were properly enrolled in the system *before* it began processing claims. In addition, Molina has been inconsistent in the level and type of data it tracks and reports; as a result, certain historical trend data on overall system performance will never be possible.

However, going forward, Molina can begin to track meaningful trends on system performance and the department can increase its level of accountability and oversight for the remaining contract deliverables. In addition, the lessons learned by the department, Molina, and providers can help ensure that similar systems in the future are implemented with more end user involvement, including sufficient pilot testing.

Recommendations to Molina

Because Molina has entered into a contract with the state and is paid with state funds, we have addressed four recommendations to Molina that build on existing efforts and improve overall claims processing.

Recommendation 1: Increase Communication with Providers

Molina should more formally use provider reconciliation reports as a tool to enhance communication with providers and to identify discrepancies between what providers submit and what the system generates. Molina should give providers the option to receive regular reports until providers, the department, and Molina agree that the system is correctly processing their claims. These reports should identify the status of ongoing issues specific to the provider and describe the status of implementing a solution.

Implementation of this recommendation will (1) enhance focus of provider outreach, including the regular meetings with provider groups, (2) help quantify the scope of issues providers are facing, (3) offer a provider-specific way to

track progress and mark improvement, (4) encourage consensus before deciding whether an issue is actually fully resolved, and (5) potentially reduce the amount of time and money providers are spending to try to identify and track issues.

Recommendation 2: Assign Provider Portfolios

In addition to the efforts taking place with Molina's triage team for escalated issues, Molina should assign customer service staff working in the call center to specific provider portfolios.

Implementation of this recommendation will increase Molina staff's familiarity with certain providers and allow staff to develop expertise about issues specific to each provider and claim type. Additionally, this recommendation provides an opportunity for Molina to improve customer service relations by better targeting efforts already underway.

Recommendation 3: Strengthen Measurement of System Performance

As the number of claims in the backlog continues to decrease, Molina should review the criteria for data currently included in the corrective action reports. Molina should consider adding elements such as the results of system fixes, the total number and type of claims a fix affects, and the total number of claims reprocessed after a given fix is implemented. Molina could also consider including additional information on the number of outstanding issues, the complexity of those issues, and a timeline for implementation of solutions to those issues.

Implementation of this recommendation will allow Molina to shift its focus from the data currently reported to more meaningful measures of system performance. As a result, Molina will be better able to identify where improvements have been made versus where issues still persist. For example, we know that Molina generally processes claims in a timely manner. However, the extent to which the system ultimately results in a *correctly* paid or denied claim has not been measured. Once the department and Molina begin tracking these recommended data elements, they can use this information to evaluate whether system fixes have improved system performance.

Recommendation 4: Test, Monitor, and Measure System Fixes

Molina should improve the methods it uses to test, monitor, and measure the success rates of fixes and the impact of those fixes on other system functions *before* considering whether the issues are resolved or closed. As a part of this effort, Molina should develop benchmarks for success to determine whether a system fix actually resolved the issue.

Implementation of this recommendation will reduce the risk of closing issues prematurely. Further, it increases the ability of Molina officials to communicate to providers the exact status of a system fix.

Recommendations to the Department of Health and Welfare

We have addressed four recommendations to the department to improve vendor payment accountability and to increase contract management practices. In addition to the recommendations outlined below, we recommend the department monitor Molina's efforts to implement our recommendations to ensure those efforts align with department expectations and to resolve outstanding provider concerns.

Recommendation 5: Delay Payment to Molina for System Operations

As part of its consultation with the Office of the Attorney General and the Division of Purchasing, the department should consider delaying payment for monthly system operations until Molina has met the contract deliverables associated with design, development, and implementation of the system.¹

Implementation of this recommendation will ensure all design, development, and implementation phases are satisfactorily completed before the state begins making payment for system operations. When payment for system operations does begin, the department should consult with the Office of the Attorney General to determine whether Molina will incur any penalties for nonperformance that may result in an overall reduction in payment and modification to the contract.

Recommendation 6: Require Additional Quality Assurance Measures

The department should consider amending the contract to include more meaningful performance measures. This amendment should include requirements that measure the timeliness of processing claims and the percentage of *correct* payments issued to providers.

Implementation of this recommendation will help the department determine whether the system is performing as intended and help identify the extent to which Molina has meaningfully met the terms of its operations contract.

¹ The deliverables for user acceptance testing, pilot operations, and implementation are still outstanding.

Recommendation 7: Include More Specific Requirements in Future Contracts

Similar contracts in the future should include more specific milestones and deliverables. For example, future contracts should include minimum requirements for the number of end users needed to test the system and a minimum number of end users who should be properly enrolled and configured before the system begins processing claims.

Implementation of this recommendation will help ensure that the department does not implement similar systems in the future without a clear understanding of whether the system was fully tested. In addition, more specific contract provisions will help ensure system readiness.

Recommendation 8: Formalize Terms of Interim Payments

If the department issues interim payments in the future, it should specify how and when providers must return those advances to the state and require providers to agree to those terms before accepting the interim payment.

Implementation of this recommendation will reduce the challenges of recouping payments from providers.

Appendix A

Study Request

Representative Janice McGeachin
DISTRICT 32A
Bonneville



COMMITTEES

Health & Welfare
State Affairs
Millennium Fund

HOME ADDRESS
6121 N. 5th. W.
Idaho Falls, Idaho 83401
Work (208) 523-1718
jmcgeachin@house.idaho.gov

House of Representatives State of Idaho

February 7, 2011

Subject: Limited-Scope Performance Evaluation of Medicaid Payment Processing System

Health-care providers in Idaho have been experiencing many problems with Molina Healthcare's Medicaid billing system and many of their claims have not been paid correctly or paid at all. Many providers still have unpaid claims for denial code N95 from June and July when the system was at its worse. Recent changes enacted by the Department of Health and Welfare in January have led to an increased incidence of these problems, including a 30-40% denial rate for some providers. As a result, many health-care providers are in a crisis mode, laying off employees, limiting services to recipients and directing them to the hospital emergency rooms, and beginning an exit plan out of Medicaid funded services.

In light of these problems facing the Idaho Medicaid system, we are requesting that JLOC approves a limited-scope performance evaluation of the payment processing system for Medicaid providers in Idaho. Considering that significant problems continue to persist 7 months after Molina launched the new Medicaid Management and Information System (MMIS) in July 2010, we request that JLOC direct OPE to start the evaluation at the earliest date possible.

Specifically, we would like OPE to address the following questions:

1. What are the terms and conditions of the contract between Health and Welfare and Molina?
2. What are Molina's contractual obligations to provide adequate staffing, and meeting timely payments? What, if any, penalties exist if Molina does not meet those contractual obligations? Has Molina been paid for its services since July 2010, and if so, how much?
3. What policies and procedures are in place to process payments, address backlog, and resolve provider complaints?
4. What are Health and Welfare and Molina doing to manage the payment crisis? How are they communicating with providers who continue to experience problems with the payment processing system?
5. Is Molina adequately staffed to handle the payment crisis healthcare providers in Idaho are still experiencing?

6. What is the status of backlog of claims that have not yet been reviewed and reviewed but not paid?
7. What is the error rate in payment processing?
8. What causes a claim to be categorized as a pending claim, and what is the reason for the delay in resolving those pending claims?
9. What is the potential liability, such as penalties imposed by the federal government, if Idaho does not make timely payments to Medicaid providers?

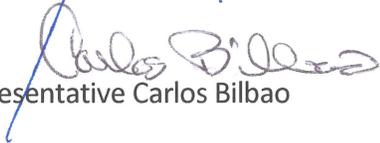
Thank you for your assistance in this important matter.

Sincerely,

Representative Janice McGeachin



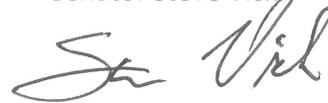
Representative Carlos Bilbao



Senator Bart M. Davis



Senator Steve Vick



Appendix B

Checklist for IT Projects

BEST PRACTICES CHECKLIST FOR INFORMATION TECHNOLOGY PROJECTS

Clearly Defined Roles and Responsibilities

- Are stakeholders clearly identified?
- Are the roles and responsibilities of all parties clearly defined?
- Does executive management have sufficient expertise and authority for contract oversight and budget control?

User Involvement

- Have the needs of end users been identified and incorporated into the project objectives?
- Have *existing* resources (infrastructure, time, staff, funding) been identified and incorporated into the project development plan?
- Does the project have a clear method for two-way communication between end users with technical expertise and project management and executive leadership?

Realistic Expectations of Technology

- Have vendors provided a clear statement of requirements that addresses end user needs and project objectives?
- Are the components of the project based on established or proven technologies?
- Is the project divided into manageable stages of development and implementation?
- Is the project guided by a continually-updated project plan?

Proper Planning

- Does the project have a clear method for regularly distributing updated planning documents to stakeholders?

Source: Office of Performance Evaluations, *Idaho Student Information Management System (ISIMS)—Lessons for Future Technology Projects*, August 2006, 59.

Responses to the Evaluation



C. L. "BUTCH" OTTER
GOVERNOR

March 22, 2011

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St.
Boise, ID 83702

Dear Rakesh,

Thank you for the opportunity to respond to the Medicaid Management Information System report for the Department of Health and Welfare.

Systems change is difficult in the best of times, but changing systems during an economic downturn with a change in company ownership creates heightened frustration and difficulty. The financial uncertainty for providers and clients is regrettable.

While the information provided in the report already is recognized, it is highly useful to have the research and recommendations organized for continued consideration. The analysis will provide valuable assistance for future planning efforts and setting accountability standards and processes.

Thank you for your research and recommendations to improve the Department of Health and Welfare's management of the contract with Molina and the State's Medicaid Management Information System.

As Always – Idaho, "Esto Perpetua"

A handwritten signature in black ink, appearing to read "C.L. Butch Otter".

C.L. "Butch" Otter
Governor of Idaho

CLO/tp



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - GOVERNOR
RICHARD M. ARMSTRONG - DIRECTOR

OFFICE OF THE DIRECTOR
450 W. State Street, 10th Floor
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March 24, 2011

Rakesh Mohan, Director
Office of Performance Evaluations
Idaho Legislature
954 W. Jefferson Street
PO Box 83720
Boise ID 83720-0055

RE: Final Draft Report On Medicaid Claims Processing System

Dear Mr. Mohan:

The Office of Performance Evaluations (OPE) has conducted a balanced and objective review of the issues occurring with Idaho Medicaid's claims processing system and contractor, Molina Medicaid Solutions. The Department appreciates the thoroughness of the report considering the short timeframe for the review.

We have reviewed the final draft report on the audit of delays in Medicaid claims processing. OPE makes four recommendations for the Department. Our responses to these recommendations are below:

Recommendation 5: Delay Payment to Molina for System Operations

The Department has delayed payments to Molina for operational activities, and is currently reviewing, in conjunction with the Office of the Attorney General, when and how these operational invoices will be paid. The Department will include the Division of Purchasing in the review process.

Recommendation 6: Require Additional Quality Measures

The Department will work with Molina to develop additional performance measures.

Recommendation 7: Future Contracts Should Include More Specific Requirements

The Department agrees with this recommendation.

Recommendation 8: Formalize Terms of Interim Payments

The Department agrees with this recommendation.

Rakesh Mohan
March 24, 2011
Page 2

If you have any questions, please contact Patti Campbell with the Medicaid System Support Team at 287-1158. Thank you for your recommendations.

Sincerely,

A handwritten signature in blue ink, appearing to read "Richard M. Armstrong", with a long horizontal flourish extending to the right.

RICHARD M. ARMSTRONG
Director

RMA/ksl

c: Leslie M. Clement, Division of Medicaid
Patti Campbell, Division of Medicaid



9415 W. Golden Trout Street
Boise, ID 83704

March 24, 2011

Mr. Rakesh Mohan
Director, Office of Performance Evaluations
Idaho Legislature
954 W Jefferson Street, 2nd Floor
Boise, ID 83720-0055

Dear Mr. Mohan:

Thank you for the opportunity to respond to your report on "Delays in Medicaid Claims Processing." We appreciate the professional manner in which your team approached and conducted the evaluation as well as the opportunity you gave Molina to provide background and insight for the review. It is our experience that understanding the Medicaid program and operational processing in such a short period of time is a challenging undertaking. However, in reviewing this report it is apparent your staff was able to focus on key aspects of our operations and have gained a firm understanding of the project. Molina generally agrees with the information provided, conclusions derived, and recommendations specified, but we would like to clarify a couple of key points in the report.

First, in chapter 3 the report states that "some provider groups expressed concerns to us that once Molina purchased Unisys, it implemented a system that was not designed to process Medicaid payments." We would like to clarify that the system implemented by Molina was the same system designed, developed and built by Unisys to meet the Idaho Medicaid requirements. The system was not changed by Molina after the purchase. The core products are commercial off the shelf (COTS) products, as discussed in this report, which were required by the contract. In some specific areas the COTS products were customized to meet the requirements of the state of Idaho, but these were changes done by Unisys as outlined in the system design. The system implemented was designed to process Medicaid claims.

Chapter 3 also states that "as of February 2011 over 23,000 providers were enrolled which meant that nearly half of providers were not in the system when it implemented." It should be noted that although there were no contractual requirements for the number of providers that needed to be enrolled prior to going live, providers had been given over six months to begin their enrollment in the system. Unisys/Molina reported regularly to, and reviewed with, the Department the number of applications received and processed leading up to going live. We also reviewed the number of providers by region for several large provider types as part of the decision to go live. This was done to try and ensure that members would have coverage for key services at go live, even if not all providers had enrolled. Nonetheless, we agree in hindsight that more could have been done to make sure that providers had enrolled, had been configured correctly, and were properly trained on the functions of the new system.

Second, Molina appreciates and recognizes the importance of the report's recommendations from the perspective of short and long term goals that may provide benefits to the project and providers. We see value in these recommendations but also recognize potential challenges in their implementation.

- For example, the first recommendation outlines the need to increase communication with providers. We wholeheartedly agree. However, the suggested approach to implementing this recommendation may not be practical because it suggests that Molina give providers the option of receiving regular reconciliation reports containing information specific to the issues faced by that provider. Creating such a report would be costly and time consuming, and would probably not provide a provider with sufficient and useful information. Furthermore, Molina currently provides weekly reconciliation reports through the remittance advice that show the provider claims processed along with a separate pended claims report. To take this further by providing potentially 23,000 provider specific reports with individualized issues and progress is simply not workable. Molina supports the adoption of reasonable alternatives such as portal messaging about key issues by provider type, or remittance advice banner messages on specific provider type concerns and looks forward to working

with the Department to discover better ways to enhance provider communication channels and improve the information provided.

- We agree with the intent of the second recommendation to develop customer support staff that are familiar enough with specific provider and claim types to answer provider questions efficiently and accurately. Working with the Department and providers, I'm sure that we'll find a reasonable and effective way to deal with and resolve this issue.
- We agree with recommendations three and four and will work with the Department to define processes and measures to more effectively and accurately measure and report on system performance and provide acceptable problem resolution.

Again, we appreciate having been given the opportunity to review and comment on the final report. Molina has invested significantly in addressing and resolving concerns expressed by providers and the Department. We believe that in the past few months we have made much progress in improving many aspects of our operational systems and processes. We are committed to delivering a Medicaid claims processing system in Idaho that is efficient and meets the states requirements. Rest assured that in conjunction with the Department and the provider community we will work to quickly incorporate the recommendations contained in this report.

Sincerely,



Terry Bayer
Chief Operating Officer
Molina Healthcare, Inc.

cc: Del Bell, Account Executive, Molina Medicaid Solutions, Idaho
Norman Nichols, President, Molina Medicaid Solutions
Gary Zeiss, Associate General Counsel, Molina Healthcare, Inc.
Ann Koontz, Senior Vice President, Provider Payment, Molina Healthcare, Inc.

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.

<u>Pub. #</u>	<u>Report Title</u>	<u>Date Released</u>
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

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